

CCO 2.0 General Feedback Survey #1

Survey period: March 15 - April 15

Open-Ended Comments

Comments submitted have not been edited except to remove any personally identifiable information.

QUESTION: DO YOU HAVE ANYTHING ELSE TO ADD ABOUT HOW CCOS CAN IMPROVE IN THE FUTURE?

Comment

1 I would like to see more incentive payments go to Community Advisory councils to carry out projects in communities, as they represent the best change for collaboration and cross organization work, which I feel is vital to truly lowering cost and improving community health.

I am also a bit disturbed by the trend of CCOs often developing services of their own, rather than utilizing funding to support services already in communities. This dilutes the effectiveness of services and is not the most efficient use of resources.

I would like to see CCOs mandated to do a collaborative assessment and health improvement plan with other entities in the communities, as too many are still doing their own in silos.

I would like to see that CCOs are mandated to have a required number of consumer seats on the board.

While CCOS have done good work, I still see them as being too health care system focused, with partnerships and value based payments focused only on those contracted health care providers, which I think is limiting.

2 Expand hospital and residential coverage for patient with complex co-morbid physical and behavioral health needs.

3 While cost containment is an issue, it is also important that CCO's provide the entire continuum of care. Where this is not happening, CCO's could be required to purchase capacity from other areas or give back funds to the State to create such services.

4 In my experience as a mental health provider for OHP members, the more flexible CCO's can be in addressing social determinants of health (e.g., subsidizing or paying for a month's rent if needed, or shower grab-bars, or transportation to the grocery store twice a month, etc.), the better the projected outcome for patients/clients/members' long-term stability.

5 Increase funding from state,fed and private sources.

6

1. Too many CCO's in one geographic area leads to duplication in administrative costs, confusion in care coordination, and fewer covered lives to create operating efficiencies.
2. Require CCO's to place behavioral healthcare services and funding as priority to reduce overall cost drivers of health and social determinants of health.
3. For-profit CCO's still hold profit as bottom line over care and services. End the for-profit experiment.
4. Incentivize CCO's to facilitate the advent of CCBHC's
5. Move ID/DD and Senior services under CCO's
6. Move residential service payments under CCO's
7. Require specific amounts of reinvestment of profits towards innovation and facilitate move to value based payments

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8. Rural health and network adequacy are not receiving enough attention. Require more access and health equity in contracts.
 9. Still too many conflicts of interest in board structures and contracts. Add contracting/legal expertise to OHA and build in safeguards for due process for patients and service providers when conflicts arise.
 10. Continue to require investments in early intervention and prevention to achieve overall health improvement and lower costs.
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7 Get rid of Trilium

8 It would be wonderful if Centene could figure out how to pay providers in a timely manner. For every mistaken denial on EOB's, clients have been notified and scared that they could no longer have services and have large bills to pay.

9 By removing barriers for improving health care access to individuals that cannot provide the cost of office visits and co-pays to the low income population and those that are not eligible for health coverage.

10 A robust CCO audit process, conducted by OHA, every 3 months is required!

11 Move toward a single payer system, move away from different CCOs in each state, and move away from privatization of services. More requirements for coordination and specialization of services increase cost. Reduce the amount of documentation.

12 Oral health integration has been inhibited by DCOs. It's hard to develop new systems of care when DCOs had legislative protection to maintain status quo.

The enrollment and re-enrollment process is not designed for nor measured to serve clients. Instead, the metrics appear to be agency-based and geared towards creating hurdles to retaining continuous enrollment for those who meet requirements. This is a barrier for CCOs to deliver great care.

13 Two areas that would enhance long term improvement of population and individual outcomes in health include:
1) More evidence based (guided) early prevention and intervention efforts. Early efforts are impactful in the long term across all metrics. Those that would impact mental and physical health outcomes by focusing on prenatal, maternity, and early childhood pay back dividends in reduced care costs for adolescents and adults.

2) Adopting a broader net of incorporating not so mainstream initiatives in preventive health care and patient empowered education. This is a primary method by which learning can be made and shared where long term benefits can be realized while attracting a larger swath of the population. Specific examples of ideas along these lines include well-researched implementation of prenatal nutrition and exercise, specific medication avoidance, etc. that may impact early mental health and cognitive outcomes in children. Another dimension may include diabetes self care by improved whole-foods nutrition and overall reduced intake, and increased exercise. CCO's could play a key role in empowering patient and member self-education and ownership of health outcomes.

14 It has been difficult to get timely services for the youth we work with who come from a different region to ours. We are not a "provider" but as a contractor for residential services, it is our responsibility to make sure the youth in our care get timely medical and mental health services. Since we are not a "provider" and don't have a "provider number" it is hard to communicate another region's CCO to get preauthorization for services in order to find a provider in our region to provide the care.

15 State should get out of the way. State should be a helpful partner, asking CCOs what changes to make in the system, rather than creating more administrative hoops and associated costs for CCOs to incur to jump through. State to focus on systematic changes that benefit all CCO models. GET OUT OF THE WAY state. State worry about collecting and providing quality data to CCOs.

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- 16** The driving costs are the Hospitals & the Docs- but containing those costs have not worked. In fact monies are taken from other pools to keep the Hospitals & Docs growing. The dirty little secret: The Hospitals & Docs not interested in integration. They create bigger Silos for themselves. This has caused unchecked expansion and growth. We are in Denial & the money ran dry. We are seeing the failed 1980's Managed Care system rebooted as "Alternative Payments Systems" ..where the incentive is not to see clients. We also did not address or pay for Tobacco Smoking Cessation (a huge cost driver) as we do Substance Abuse. We also don't address Obesity and do not pay for successful weight loss programs (a huge cost driver). We shift costs and we redefine success- smoke & mirrors. Please hire Kitzhaber as a consultant and bench Dale Jarvis.
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- 17** The CCO model does not work well for anyone who splits their time between county's. For example college kids who are at home with parents 4-5 months a year and at college the other 7 or 8. Or for kids who may split time between living with different parents in different parts of the state. My daughter had to wait for mental health services, birth control services and primary care services for an inordinate amount of time when she went to college in Southern Oregon 6 hours away from where we are in Northern Oregon. Despite the fact that she filled out her own health care application when she moved, it got caught up in red tape because of where we as her parents live, and having more than one address in the system. She was suicidal and a freshman at college and a long way from home and trying to change plans to access services was way harder and took way longer than it should have been. I spend a lot of time on the phone getting different answers from different people to the same questions. It was horrible. I hope the system can be fixed to streamline services across the state and not make it so dependent on which county one lives.
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- 18** Rural areas, where there is no specialty care within a County or geographic area and no public transportation, suffer huge barriers to care (especially when primary care is limited to PA's and they are unwilling to refer due to an unmet matrix)
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- 19** The Columbia Pacific CCO and specifically Columbia County is a health care shortage area. Many of our residents are accustomed to traveling to neighboring counties to receive high quality care in Astoria, Portland, Hillsboro and even in Longview, WA. Allowing CCO members to access services in these neighboring communities will provide more options for members to access critical services. Transportation, though, remains a big issue as does the housing shortage and the poor condition of many housing units here. Housing rehab is one area of interest here locally (making changes to someone's dwelling to promote health and safety). Opening our school based health centers up to adults has also been positive addition to improving access to care but many people do not know that they can access these services. So promoting existing local services is very important as well.
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- 20** No
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- 21** GOBHI has proved itself in our region to be utilizing much needed direct care dollars for unnecessary indirect "services" that do not benefit our patients and only further stress direct providers of healthcare. They, along with our local public mental health provider (CHD) have continued NOT to measure meaningful outcome data. Rapid turnover of staff at CHD as well as blocking access to AVAILABLE external resources for necessary psychiatric care has been an ongoing problem. Valuable resources are unfortunately wasted, illness is perpetuated, and the potential for quality care is driven down. CHD's over-reliance on trauma informed care also drives down outcomes as it delays more comprehensive intervention. It is not unusual for patients to wait WEEKS if not months to see a psychiatric nurse practitioner or teledoc. Access is difficult at best and psychiatrists as well as psychologists are not integrated into either primary care or behavioral health homes. Old siloed systems strangle access to appropriate care.
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- 22** No, I think you are headed in the right direction. I appreciate the risk sharing groups that allow for immediate feedback from partners on planning for priorities of services and spending.
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23 Housing is STILL a huge reason why many clients find themselves back in the systems!! Especially after they are successful.

24 Consider focusing on Addiction in a broader way, that might include addressing behavioral addictions (gambling and gaming).

25 Incentive measures should be directly linked to other public systems measures to incentivize cost effectiveness and ensure increased service accessibility which is bot culturally responsive and requires investment in addressing disproportionate social determinants which impact a community's overall safety and health.

Gaps of service sure to 'policy/interpretation of behavioral or mental health should be closed. This should be informed by service recipients and system partners.

Service provision should be adaptive, rather than fiscally driven.

26 Care coordination across systems has improved dramatically with CCOs. Thanks Oregon!

27 As long as for profit insurance companies have decision making authority for levels and types of care there will be irreconcilable problems with access unless there is an independent oversight process which manages level of care decisions and appeals in real time

Performance measures that are not evaluated from the perspective of other systems leave a gap in how accurately the system is being assessed

Some of these questions seem to put children's health outside the scope of the behavioral health questions and I would caution that children's behavioral health seems to be the thing CCOs need help with the most--they seem the least familiar with it, and totally unfamiliar with the residential spectrums

28 Oral health integration is critical in the next round of CCO improvement. Please reach out to Oral health proponents to find new ways of approaching integration.

29 Begin to incorporate more peer delivered care/services in Residential settings, or even establish a peer run respite programs.

30 No

31 The incentive metrics seem like pretty low-hanging fruit in some cases. We need to push CCOs harder for better outcomes and lower cost.

32 more services to be included

33 Coordination between providers, hospitals and the CCO plan, for example the Central Oregon model with Pacific Source, St. Charles Hospital System and the providers under the Central Oregon IPA have shown success by working together to improve the lives of this population. Other areas of the state could learn from them. There also needs to be payment equity for other providers types (NP's, PA's, BH etc) and improved options to assist this population with some payment for technology related health care.

34 Focusing only on the CCO population creates more disparity because all the costs, risks, and benefits are unfairly put on those insured in the private sector. Oregon's needs to have a universal health care system. There is not incentive to not be a CCO recipient because the private health care system is too expensive including the premiums

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- 35** The biggest issue that I have seen in dealing with CCO's is that when a mental health facility or program denies a youth supports/services, there is no alternative option to serve that youth. If incentives for programs were in place, this may be able to be achieved. Some programs only take one CCO payment, and if they are denied, service is not able to be obtained.
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- 36** Freedom to use out-of-network providers in rural areas. Or freedom to join a CCO that is not in the county you live (for example, someone living in Boardman might prefer driving into Portland to see a more seasoned physician than is available in their CCO).
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- 37** Being able to move from county to county without the major problems it seems to cause at this time. In addition, being able to get clients health care in a much more timely manner.
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- 38** CCO's are not serving Oregon's highest need children very well, if at all. Their focus is solely at the front end and gaining access to high end services has been a significant challenge. This is especially true with Health Share, Oregon's largest CCO. Children are sleeping in hotel rooms awaiting the appropriate level of care. Children do not have ready access to physical, dental or mental health care when out-of-home placement is found out of the CCO's service area.

One thought is to have ONE CCO be responsible to serve all children experiencing foster care throughout the State (like Colorado) to assure that children's needs are met regardless of their placement location.

The 'value based' payment should reflect the high needs of this population and be significant enough in nature that these children are not limited to 'up front' services.

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- 39** One of your CCOs has left the system. I recommend you do not replace it and keep all the patients on open cards. Then look at outcomes. There has never been a comparison between just letting the patients get treated and using these CCOs to limit care while they cream profits off for big bonuses every year. It is at the point that at least one of them (Trillium) looked like a great profitable investment to an out of state hedge fund. Why not see if just treating the patients is more cost effective by using this heaven sent trial group as a test case? Then decide if giving a bunch of investors state money to not treat patients makes any sense.
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- 40** Have someone who knows how to design survey design surveys.
All questions should not require answers. Why do you have all the answers already?
This is the longest most prescriptive survey ever. Do you care about input?
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- 41** I no longer provide direct care, but one of the hopes emotional health providers had when CCOs began was to reduce the documentation load, perhaps making it more similar to other areas of health care. I believe this would give more time for the care of our members.
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- 42** Provide better access to services and support to children with mental health needs, discontinue the practice of labeling an issue as 'behavioral' rather than mental health in order to not provide services, view the child as part of the family system and increase parental capacity to address their children's mental health. Work with OHA to study the availability of PRTS and Sub acute and increase providers/beds. Advocate with hospitals to better serve children in crisis. Better utilization of wrap/ICC for acute children, increased supports for families.
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- 43** More innovative program like FamilyCare had - the care coordination, support for integrated mental health with pay for performance measures, common sense on the formulary and covered services - not just above and below the line (ie treating allergies reduces secondary infection and improve QOL)
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- 44** Incentives for CCO's to support the use of Case Managers and Community Health Workers for care integration and preventative care/social determinants integration.
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- 45** More transparency!!
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- 46** A lot time for quality of care VS quantity because success rates fail with this.
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47 When CCO's are offered incentives to pay particular attention to one outcome it often creates an overload in another area. For example, when CCO's were incentivized on developmental screens for children it increased the number of children screened and referred for services but no increase was given to those providing the services. The incentives should be reinvested into the community-based organization providing the service to help meet the new increased demand.

Any incentives given should have a percentage that must be reinvested in an area that was impacted by that focus. When they focus so diligently on those area's, it feels like a hit and run in the community. The should then reevaluate the impact and reinvest monies into continuous improvement.

48 The way you have written the questions implies that the behavioral health side is not working to integrate with the primary health side, when in fact it is primary health that is difficult to engage. Primary health does not want behavioral issues in their offices, they do not want to take on behavioral health meds, even if the person has been stable for years and they do not want to be the focal point for identifying social determinants that are impacting their members.

49 More than one CCO should be available to patients. They are limited by counties and CCO's seem to have a monopoly therein.

There are more patients that need care and outreach to recruit new providers is narrow and not in the best interest of patients.

CareOregon should be audited for process, recruitment and minimally policy. Their actions are NOT in the best interest of patient care.

Their process are sloppy and embarrassing to our State, healthcare and the OHA

50 Go to community based health care instead of state or federal programs.

51 stop the time required for all the prior authorizations for medications and referrals; staff spends tooooooo much time on this process which interferes wtih direct patient care

52 Understanding this is a difficult population with many issues, we somehow must get them to their healthcare appointments. Most clinics experience at least a 50% No Show rate with this population - unacceptable under any circumstance. Many clinics have closed their doors to this population for this reason. While there are many reasons patients don't show up, the CCO's need to do a much better job making patients who really have no 'skin in the game' (no cost to them) understand their responsibilities when it comes to keeping their appointments and how the CCO can help them if they have issues like transportation, childcare, etc.

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- 53** <https://www.statnews.com/2018/01/30/pay-for-performance-doctors-hospitals/>
<http://annals.org/aim/article-abstract/2664654/value-based-payment-modifier-program-outcomes-implications-disparities>
<https://jamanetwork.com/journals/jama/article-abstract/2673607?redirect=true>

VALUE BASED PAYMENTS:

- *Do not improve the health of patients
- *Harm sicker and poorer patients
- *Encourage doctors and hospitals to avoid or “fire” sicker patients who drag down quality scores due to factors outside physicians’ control
- *Cause some doctors to stop using lifesaving treatments if they don’t result in bonuses
- *Create interruptions in needed medical care
- *Reduce job satisfaction and undermine altruism and professionalism among doctors
- *Cause doctors to game quality measures. For example, a Medicare program that punished hospitals for hospital-acquired infections actually induced some hospitals to characterize infections acquired after admission as “present upon admission” or to simply not report the infection rather than reduce actual infection rates.

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- 54** Stop the thinking that throwing money at a problem is going to fix it. Same with technology - you don't always need big data to tell you. You don't need to spend millions on things tangentially related to health either. I think the CCO's are a huge waste of time, energy and public good will towards the state. They try to reinvent the wheel and just empire build for their staff.

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- 55** Yes, they need to be in compliance with utilizing Traditional Health Workers within their systems. In the first five years, many have not hired or utilized this cost saving and health improvement source that could make a real difference in all aspects of health care.

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- 56** It is noteworthy that none of the options suggested for controlling the costs of health care spending in Oregon included state and public employee expenditures and costs. The original plan of the CCO's was to include OEBC and PEBC members and "require" state/public employees to be enrolled in a CCO.

I believe this is critical to the fiscal success of any health care policy/program.

In addition, a recent study in JAMA on comparison of health care costs between the US and ten (10) other "wealthy" countries concluded that there are really only two substantial differences between the US and these other health systems that drive our expenses to a level not seen elsewhere: Cost and Regulatory Burden. It's not utilization, it's not resources, it's not salaries, etc. It is HIGH COST and EXCESS REGULATION. And so, anything that the architects of CCO 2.0 can do to address these two drivers will likely be fiscally successful. Most everything else will not.

I would especially plea for a reduction in the reporting/administrative burden placed on the CCO's. This generates significant increases in health plan overhead and reduces the amount of money available for patient care and innovation. Thank you.

57 Actually listen and try to take in what we are saying about the individual LCAC's and what works best for our communities. When we have things that work locally the CCO's don't seem to listen to what they are being told and want to go back to way that things have been done. For instance looking at the Veggie RX programs that are being implemented through the local funds. We know that social determinants of health, specifically food insecurity, needs addressed out here in Frontier Rural Oregon and if we are not able to continue to look at the "whole Health" of the person, then we should just stop having LCAC meetings and working on CHIP plans if we are not going to be able to implement anything new that is not necessarily tied directly to an incentive measure.

We are thinking outside the box and that needs to continue.

58 They hoard a great deal of money and yet are stingy about in doling it out to organizations.

59 the theory is for CCO to be integrated with all services yet OHA allows CCO to still be like the old FCHP in that they have CCO-A, CCO B- CCO C etc all with different aspects of care some only having physical health. There still is a single MHO all of this is contrary to the aspect of having a CCO, They should not be called a CCO unless they truly are a CCO as the law was intended to be.

60 To lower costs and improve BH access: Require CCOs to increase BH rates so that community-based BH providers can (a) pay staff at the same level as a primary care or hospital setting and (b) expand capacity to ensure quick access to services. This increase could be based on the predicted savings in medical costs. It could also come from a bigger push towards integration. The promise of integrated care isn't playing out as we'd hoped. For example, funding is still kept in separate categories and there are billing issues.

Require CCO funding for supports that help clients achieve recovery in both mental health and addictions (examples include telephonic therapy, post-discharge maintenance, dual diagnosis/co-occurring services for all levels, employment and housing support, family counseling by time instead of session, multifamily counseling and education, basic needs vouchers, service plan development, time for documenting and supervision of outcome work, no show and travel codes, residential care requiring medical services, etc.) Require OHA and CCOs to reduce administrative burden for providers while at the same time helping providers to increase the pool of well-trained behavioral health candidates with higher levels of education. One step could be requiring CCOs to standardize payment models and allowable codes across the state.

61 you need more primary care physicians who accept the CCO patients.

62 No

63 YES!!!! CCO's should be willing to contract with all legal and licensed providers so that members can choose where they wish to receive services versus being told there is only one provider in the entire county who can provide behavioral health services. The others can provide services but will not be paid for providing those services. People have the RIGHT to choose who provides there care, especially in rural areas where that one provider has been "providing" services for years but the person has not improved. I hear individuals say all the time "I have received services there all my life and I just want to find something that will work."

64 Too much time and human resource being spent to chase a few relatively unimportant hard line quality measures. A BP of 140 over 90 is no more dangerous than one that is 139 over 89 yet we are spinning our wheels against these measures and not putting effort into more effective care. there is value in financial incentive's however I think we are running around too much over a borderline BP, or a hard date.

We need to improve access to care by creating pathways that recognize the work flow differences between minor acute care, Preventative care, Care of Chronic disease, and End of Life care. Currently we suffer from too few resources for non emergent acute care and a practical lack of solutions and resources for end of life care choices that are not just repeated trips into the health care system.

We need to find ways to provide for preventative screening that does not have to involve a provider visit. Many people do not get routine annual or even biennial routine care. Many people do not see the value. Providers often believe they must do it all themselves...

Delegate delegate delegate. More well trained community health workers.

65 I still do not understand the value added of having both the Health Share CCO and all the RAEs. It seems unclear which of those entities is the decision-maker and who is guiding the process. Seems there is an additional and perhaps unnecessary layer of administration.

66 Parents who are behavioral clients have children with the same. How do we prevent those children from falling through the crack. They both need help and are not seeking it. #Frustratedgrandparent

67 Yes, when referring to care management make sure to call out that the patient is the most important "care team member" and that we collaborate "with" the patient. When we always do "to" and "for" the patient we can stifle empowerment/learning. Healthcare providers are the experts on health information and the patients are the experts on their own patient experience/bodies. Let's respect that.

68 There is a big disconnect, and a real conflict of interest, for CCO operations in Douglas County and anywhere else in Oregon that has the same for-profit model with care delivery clinics a part of the CCO's business line. It is unfathomable that a CCO entity such as Umpqua Health Alliance can have the authority to place patients for a PCP panel when they also have care delivery clinics...how can a CCO be a competitor for the fellow members of a coalition they get tax payer money for? Who's to say they aren't cherry-picking commercial payor patients? Also, there is little to no oversight on how the money is spent from the incentive pool, and much transparency is needed. It goes beyond the "public meeting" laws into a full disclosure of their financial books.

As a taxpayer I'm very concerned. As a leader for a "competitor" who goes heads up against them in my market I'm angry. The access to the 1st Dollar they have gives them a HUGE advantage...they simply should not be allowed to deliver healthcare. They could invest in a joint provider recruiting program for the entire "alliance" with taxpayer funds rather than build a new office/clinic for their own operation. How is a large capital construction project cheaper and more effective to improve access than plussing up existing healthcare providers in the area?

It has been an enigma that nothing has been done since inception, particularly after the CCO in Lane County sold itself and the private shareholders made a huge windfall off of the collateral set by taxpayer subsidizing Trillium operations.

69 Provide access to health care at elementary schools as kids can be transported there and are regularly available there.

Allow people to buy into the cci at a sliding scale rate, we give everything to people who have nothing and it prevents anyone from getting stability.

70 I think there needs to be better coordination between CCO's and schools. Schools would be a good place to connect to both children and families.

71 Thanks for asking about the rest and good job on doing listening rounds and continuing the tradition of engaging stakeholders . Must go beyond CCO fixes to address key issues must include all stakeholders and payers in solutions that work for all Oregonians.

72 More flexibility, more case management/care coordination. Person/centered practices. Use of motivational interviewing/motivation science to inspire and influence patient behavior change.

73 CCO's need to look at the utilization of THW's across the board. There should be metrics that do not hinder the work of the THW, but rather allows them to do what they do best without worrying about metrics. There needs to also be proper supervision within CCO's of the THW's.

CCO's need to look at transportation barriers for those living in rural areas who are not accessing healthcare.

74 Yes. Based on this survey it seems you have all the answers. Have you considered asking what people want to see? Not just give them a formulated list of what you at OHA want.

75 I believe that CCOs have generally resulted in a net improvement in coordination of services and improvement in quality of care. The incentives related to the CCO clinical metrics have definitely had the desired impact of focusing provider and community efforts toward achieving demonstrable clinical improvement. Provider practices/agencies have changed workflows, processes, and systems to achieve these results.

76 CCO 2.0 should focus on breaking down the silos between physical and mental health. CCOs should not be allowed to delegate (carve out) the mental health benefits to separate organizations (i.e. the counties) and should be required to reimburse all integrated behavioral services provided in primary care settings. Also, CCOs are using tax payer dollars and should not be profiting from those dollars. CCOs should be non-profit and should conform to all public meeting laws and increased transparency about how those dollars are being spent. CCOs are regional monopolies and they need more oversight.

77 When pulling information in regards to a client on the Medicaid eligibility screen under the Managed Care section it shows Health Share of Oregon CCOA plan the only way I can find out what Managed Care plan they have under Health Share of Oregon is to call and I am then told which plan (Providence, Care Oregon, Kaiser, and Tuality). In turn I then have to call one of these other managed care plans. If you could include the Managed care plan specifically vs just Health Share of Oregon, would be great. It is also very unfortunate for our patients who have Medicaid with a Managed Care plan is for the smaller hospices are not able to get into network with larger Managed care plans such as Providence, Kaiser, Tuality, etc. Therefore our clients can not choose which hospice they want for their loved one. My example comes from a recent attempt at a request to become in Network with Tuality. Tuality decided not to move forward with contracting with us because they have 1 hospice already in their network. How do our clients benefit with hospice services of their choice when Managed care company's won't accept other hospices to be in Network?

78 For health equity and cost saving, it is really important the CCO's contract with doulas. Please connect with the OHA's Office of Equity and Inclusion's Traditional Health Worker Commission for more details on how to integrate doulas into systems of care.

79 Adequate time & processes for all providers to truly coordinate & collaborate on care.

80 In regards to mental health, there is a cap check that doesn't really increase through the years and yet has a better probability of decreasing. Then the agencies are required to add more positions but do not provide additional funding for those positions. This makes it harder and harder for agencies to afford to pay staff competitive wages which causes larger rates of turn over within the agencies. The turn over is detrimental to clients as they are unable to form a lasting and beneficial relationship with a clinician. Agencies are always short staffed because of the turn over as well as not having the money to hire enough clinicians and staff to fill the needs of our communities.

I believe that the cap check should be set at one specific rate that actually allows the agencies to hire at competitive wages and includes enough to help fund new positions that are mandated. The rate should also increase by a set percentage every year to allow the agency the ability to effectively serve their communities.

81 Increased transparency would be beneficial.

82 Please ensure that when you are looking at populations needing access to CCO supports, SODH and behavioral health that you also consider the unique needs of particular populations - especially those experiencing intellectual or developmental disabilities.

83 I initially thought this new system would be a good thing. Instead it has been a night mare... Causing way may barriers to care than it fixed.. It has become a system just like the rest of american government.. What's in it for me. Letting insurance companies have say so in health care is crazy.. I have yet to meet the insurance company that is not out to make a buck at the risk of there beneficiaries.. Cutting treatment days etc.. for adolescent.. not providing adequate funding for reimbursements.. Really The CCO model has proven to be more of a sham than anything else.. As life long resident and 35 year career working with disadvantaged populations I am mostly appalled by the changes this process has made on our health care..

84 There needs to be specific, clear and consistent auditing of the entire business line of a CCO.

The audits should include all aspects of the CCO. For example: payments to providers, recoveries when clients have other health insurance, DME authorizations and denials, client access to services for physical, dental and mental health, wait times for appointments and client satisfaction.

Historically there has been very little substantive oversight by DMAP/OHA of CCO's that deal directly with the administrative component of a CCO.

85 Investment into social determinants of health should be included in as allowable spends out of member rates.

There should be one CCO per region so that CCOs can focus on health improvement without being concerned with membership.

86 The residential MH benefit needs to move from HSD to the CCOs to create more consistent local control over utilization management as well as to support creative and innovative approaches to treatment funded with CCO monies.

87 Many CCO's, like Care Oregon, pay primary care physicians the CMS Medicare conversion factor. The 2018 conversion factor is less today than it was in the year 2000. Unsurprising, after 18 years the cost to keep a practice viable and to keep the doors open is substantially higher than the CMS Medicare conversion factor. For this reason, many independent groups who do not have alternative funding sources are serving a limited number, or are closed, to CCO patients. This leaves those physicians with alternative funding sources such as FQHC's who receive Federal funding and health system medical groups who receive hospital system funding to serve CCO members. Question: Will there be sufficient physicians, primary care and specialty, to serve the CCO members? How long can CCO's continue to keep the payment rate flat and not a livable wage?

88 be more familiar with their population demographics, create more outreach to community partners who are working on similar equity work.

89 Oh yes.

1. When you conduct a survey (like this) have some ability to recognize that maybe something you did not think of matted. The vast majority of my answers are less than accurate, but it appears this survey is not about knowing what needs to be fixed, just being able to say "we did a survey".

2. CHOICE mattes. As both a service provider and a parent who has children in the "care" of the CCO system I can speak from both sides stating that the system regularly denies choice to the people being served. Clients are often given little or no choice in their care.

3. Admin heavy. I've seen a massive growth in hoops to be jumped and little going into actually caring for the clients. Over the past 4 years (working as a front line admin in behavioral health) I've seen my paperwork load double. What does this mean in reality? Many hours every week that I can't be treating clients. Our nation has efficiency standards for cars (MPG) yet when it comes to the paper work load vs the real work of serving people we seem determined to be as inefficient as possible.

4. Let's do some real prevention and support healthy families. The studies are far too many to cite here. I will state that the most effective preventative care is stable families. It will reduce ACE (Adverse Childhood Experience's), it will reduce crime, it will reduce substance use, behavioral problems, unhealthy behaviors like binge eating, and poverty. It's as close to a panacea as we are going to see in the real world.

5. Let's get back to focusing in indivial needs not artificial time tables and delusional assumptions about clients safety. I've sadly been in the front row to the human carnage the recent reforms in mental health have caused and I will state for the record that people are dead today who would be alive if we did not take away their choices and put artificial "progress" over safety and client need.

I'm sure that's more than you wanted to know, but that is the truth unlike most of what your very tightly controlled survey is going to generate.

90 The most frustrating thing about my local CCO is that I often feel that it removes the direction of care from the hands of the provider and instead turns it into a game of "what will they approve?" As a physician, I make diagnostic and treatment decisions based on my education and experience. I truly attempt to practice value-based care and not order unnecessary procedures or studies. It is frustrating to extensively and faithfully document why a patient needs a particular study or medication, only to have it denied, without my documentation seemingly ever taken into account. Often the onus of getting it reviewed and approved falls on the patient, who often do not understand the process or get too discouraged to follow through.

Also, I understand the principle around care based on outcomes rather than volume, but this has the potential to significantly hurt the practices of those who serve some of the most challenging populations. Some of our patients, for many reasons, are simply non-compliant with care. It is unfair that we faithfully educate them, prescribe appropriate medications and attempt to control their chronic disease, but their disease is not well-controlled simply because the patient cannot or will not comply with the prescribed treatment plan.

91 Include patients and behavioral health providers on how to dhspe programs and management.

92 No

93 Appropriate services for all levels of health care don't have to be expensive, but my concern is capping or limiting services due to costs and clients not receiving the services they need in an ongoing format.

94 We have an amazing CCO here. I would not be able to practice in the current economy without the amazing support of AllCare to help with managing our Medicaid patients.

95 Investments in social determinants of health are key to keeping cost down but these SDOH investments will not have the intended effect unless they are evidence-based and community-specific. All SDOH investments should be grounded in evidence, and local communities should be able to exercise their judgement when using flexible spending dollars.

96 To truly integrate care healthcare dollars need to be in "one bucket" not split between medical and behavioral health.

Behavioral healthcare should be seen as a specialty just like surgery or oncology.

Basic needs are taken care of in primary care settings and complex needs are referred to the specialist.

This frees up specialist time for those more complex (and expensive) patients to be seen in a more timely manner.

This would truly be integrated care for the whole person, would help reduce the stigma, and improve access for those with the highest needs.

There should not be two separate payment systems. They are all just diseases, and we will get better outcomes if we can find a way to the whole person.

Also, implement a patient reported outcome metric as part of the VBP calculation (See PROMIS Global Health).

Pay people for making a difference, not just treating the member.

97 1. The public should be allowed and encouraged to attend CCO board meetings and the and community advisory committee meetings. Members of the CCO board should be well known to the public and approachable by the public. The board members are fiduciary agents for the public in the use of Medicaid money. What happened with Trillium could have been avoided had the public been fully aware of how the flow of Medicaid money was being handled.

2. Rethink the value-based payment schemes. They add defeating levels of record keeping and assume that monetary rewards for "good behavior" will improve outcomes. The following white paper by Stephen Kemble MD, former president of the Hawaiian Medical Association gives compelling insights on physician attitudes and behavior in respect to value-based payments.

https://www.dropbox.com/sh/zz2evmapeggceop/AADGCQpxjkCIeli8UsIM_upua?dl=0

Donald Berwick MD is quoted in this article

How Value-Based Medicare Payments Exacerbate Health Care Disparities

<https://jamanetwork.com/journals/jama/fullarticle/2673607>

JAMA. Published online February 21, 2018. doi:10.1001/jama.2018.0240

98 Improve access to behavioral health.

99 protect the global budget concept that was the foundation of developing the CCO concept. allow communities to decide how to allocate and spend resources.

100 CCO sounds good on paper but human behavior is reactive and people only deal with their own problems when it is at crisis mode to them.

101 Limit regulations that hinder better care of patients. Regulations that keep care providers so busy with extraneous "improvements" they have less time and staff for the demands of true quality patient care.

102 Partnership between the CCO's and the medical providers should be a requirement. Speaking from experience, and watching the transition from a community based organization to a corporate buy out, so much has changed. Financial transparency is no longer, leadership is less involved, medical providers are left in the dark, all the while the large corporation is posting profits from tax payer dollars.

To improve CCO creditability, community support, transparency, involved leadership from CEO/CFO, should all be requirements to operate a CCO.

Moreover, some medical responsibility and liability much be placed on the patient. CCO's being penalized for non-compliant patients is unjust. Educating patients to understand why they qualify for OHP, where the money comes from to pay for their medical services, and imposing community service requirements to receive OHP may decrease the patient entitlement issues Oregon has brought upon itself.

103 Reduce WRAP payment so total payment does not exceed market payment rates which is strangling the taxpayers and wasting hard earned dollars. Quality should be proven and paid extra based on estimated Quality benefit. CCO beneficiaries should have to provide something to receive insurance, for example, some sort of community project participation. Insurance should not be a handout with no accountability, i.e., lack of patient compliance with provider care plans should be grounds for losing insurance benefit to encourage patient responsibility for own healthcare. The role of Non-profit organizations should be increased significantly and major part of the CCO plan. Non-profits need to earn a return on investment but at a greater cost or risk to taxpayers.

104 The credentialing of providers needs to be more streamlined. DMAP will credential our providers in a very timely manner, but our CCO takes 2-3 times as long. We have providers on staff (3 currently) who have been with us since Dec. 2017 and they still aren't credentialed. How can we provide access to our patients when the CCO won't expedite or timely credential the providers? We are remote, access is limited in the surrounding 50 mile radius, and our providers can't get credentialed. This also costs us lots of extra money. We had a change in Supervising Physician for our mid-levels and we had to pay the prior Supervising Physician an overlap of four months worth of salary to stay on, at the same time as the new one, so that the credentialing of the new physician was complete!! And, you want to lower health care costs??

105 My biggest concern is how behavioral health services are contracted for in the Portland Metro area with HealthShare. While CCOs and the State value and promote behavioral health integration into primary care, the current contract between HealthShare and the counties very effectively silos the care for behavioral health. Changing OHA rules to allow freer participation of non-county aligned behavioral health providers (such as those already embedded in primary care offices) should be the highest priority for CCOs going forward.

Thank you for soliciting our opinions!

106 Why does Metro have so many RAES for each component of health (physical, behavioral/mental, oral health). These should be integrated into whole patient care and each system carry a fair market share of OHP or pay other systems a tax for their share they forego

Fewer regional CCOs (five in state) would seem prudent and more cost effective

Children's (and Women's) care should not be 'shortchanged' since they are overall a) cheap and b) have the longer and stronger ROI.

Children with special health care needs should also get enhanced services even prior to 'ultimate' diagnosis based on disability/delay. Decent evidence that if addressed earlier, their ultimately is lower cost.

We should revisit non evidence based practices (most of ND) being provided by CCOs in absence of MD/DO oversight.

107 Pay mental health care providers more as they are in short supply

108 Require they focus on getting patients into medical homes. Clinics are often paid for assigned members, but many members are never seen. They need to increase the patients that are seen to the clinics they are assigned to.

109 It seems wise for CCOs to direct some of their focus on over-all "community health". If a larger portion of their profits were designated to addressing these kind of things (housing, transportation, mental health/special needs housing & services, out reach, etc.), I think it would be helpful. So far I am very impressed with what CCOs have accomplished and appreciate their work!

110 Provide funding/reimbursements for addressing social determinants of health with regards to food and healthy eating (such as food vouchers/Veggie Rx programs, etc.)

111 None.

112 I think it is important for OHP members to have a choice of CCOs as a matter of equity (e.g. if someone has private insurance, they often can choose between plans, but when only once CCO is available to manage OHP in a certain region, OHP members are not able to exercise the choice they deserve.

113 Provide safe harbor for CCO's to invest in the SDoH, especially food and housing. CMS currently disallows investment of that type, which is precisely what's needed most.

Design structures that will allow smaller and rural hospitals to move to a true APM that incentivizes quality and creativity, not merely diminished cost-based reimbursement. These institutions will need some form of insulation from risk, but they hold the most promise for creative experimentation with new models.

Be cautious about using capitation for behavioral health, where there is so little transparency in measuring how the dollars are expended. FFS is not a bad model; in fact, it's very useful when you want to incentivize more of something. BH is a good example of that. I recommend a serious look at moving all BH to FFS. You'd get tons of pushback from CMHP's accustomed to low accountability, but it would ultimately drive better care.

114 Make additional funding available for psychiatric rehabilitation and recovery orientated programs and housing programs.

115 It seems like they are doing a good job. Locally, I believe All Care is a CCO. I'm wondering what the names of other local CCOs are. I'm assuming Asante is not a CCO, perhaps an insurance company?

116 Focus on prevention, prevention, prevention...and cost efficiencies, integration of health care with coordination and collaboration between mental health, primary care, and public health--and, yes, those who focus on the environment and the economic environments.

Create healthier communities: 1) Limit exposure to tobacco 2) Improve addiction treatment resources 3) Raise tobacco taxes and use for prevention...

Support education, education, education and entrepreneurship and policies to create healthier individual and community health.

Craft careful plans with lots of input and then work the plans. Quality improvement for Oregon is what we're ALL about. Public and personal health and development is what we're all about as Oregonians.

The CCO model can help set the way for the broader delivery of all health care in Oregon.

Thanks.

117 I believe the CCO's are barriers sometimes to our patients getting the healthcare they need.

118 The CCOs do a great job administering local systems. Costs are being contained (about 2% rate of growth) in areas that CCOs can control but in cost areas that are not in control of the CCO like drug cost, A/B hospitals, continued changes in the benefit package, and administrative chaos at the state level it is 7-8% rate of growth. Costs in the parts of the system the CCO cannot manage need to be addressed.

The OHP open card population continues to grow and lack its own incentives and metrics. That population has to be reduced and moved to the CCOs.

Incentive based payment has had the biggest impact on CCO success, additional regulation and oversight is not the answer.

119 Let us buy the "air conditioners" like originally promised!

120 They need to really work on the housing or lack of housing problems we have here and also try to find ways to do outreach to the homeless so that we can serve them where they are and cut back on ED use.

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- 121** Requiring the elimination of mental/behavioral health carveouts is likely to assist with reducing barriers to care and improving outcomes. In the CCO my region, we continue to operate with a mental health carveout and unfortunately, this carveout serves as the most significant barrier to mental/behavioral health care in the area. As well, operation of a separate carveout is a significant and unnecessary financial burden which should be eliminated. Centralized administration for all types of care would assist with integration throughout the system as well as cut costs.
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- 122** Fewer CCOs (like, 6 max); ensure that each CCO has a critical mass of members so as to have a true population approach; require certain percentage of spending on social determinants
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- 123** No
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- 124** The law did not require CCOs to pay for services when their transient clients moved between CCO regions. This places an undue burden on service providers that are trying to provide the care needed - where the client is. The CCO home gets to keep the funds provided for the client, and the actual service provider gets nothing. This needs to change!
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- 125** Incorporate public health into the system as part of the payment.
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- 126** I think the newly passed legislation begins to address some of the concerns I have. I think that how the CCO is formed (business model) should ensure that some extra dollars flow back into the communities instead of individual company members pockets.
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- 127** IN none of the questions did you provide the opportunity for true and honest answers only your distorted view of the answers you want.. when will you do what you promised of treating the total person? Instead of your very limited view of what everyone should be allowed?
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- 128** There's currently a huge gap between the case workers and the client's access to health care services (through their CCO), or any case management at all - at least here in Lane county. My clients are required to work through their case worker, who they are unable to gain access to (even over months at a time), or who are uninformed or under-resourced to provide even basic guidance or support. Likewise, as an employer of an agency that provides services for SDS clients, SDS is implementing new processes for client access and reimbursement for services provided that they clearly don't understand, causing considerable confusion for our clients and lots of our time to educate them on how the process isn't working.
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- 129** Coverage disparities between CCOs should be eliminated
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130 I have been very pleased by how my CCO has performed with regard to specialty care and preventive care. I have been less impressed with the performance of primary care providers, w/regards wellness care (which is almost the only use). In the area of this CCO, the primary (close to a monopoly) care provider (clinics, hospital, urgent care) provider has been unable to retain medical personnel so there is zero continuity of care, in terms of seeing the same provider for well person care or the occasional other care I've received. I don't know how much the CCO pays the clinic/non-profit corporation, but it's probably not getting its money's worth since visits last for 15 minutes or so, w/about 1/2 of the provider's time spent staring a computer screen. Preventive care that is supposed to be provided (checking for moles, etc., on skin for prevention/early detection of skin cancers) doesn't happen--ever, unless it's explicitly requested by me. Electronic records are great but the GIGO rule (garbage in, garbage out) still applies. I've had to submit records more then once (the first copy disappeared, was never scanned into my file), and on the occasions when I've had access the one page of the file (via computer screen) I've observed information I had provided orally that day (an example is receipt of a flu shot) incorrectly reported. This same provider has effectively lost all records older then 3-4 years old when it made a transition from one form of electronic records to another. Thus, longitudinal information has disappeared.

The particular primary health care provider (almost the only provider of health in the county) receives several types of subsidies, etc., because it's serving that's classified as a rural area. It'd be helpful if the CCO could "work with" (i.e., use its bargaining power) to persuade the provider to provide better quality primary care.

Again the specialty care I've received via outside practitioners has been fine and I am grateful that I have had OHP coverage when I needed it. The CCO helped make that happen and it happened with a minimum amount of stress re: coverage, payment, etc. I do not want the CCO's role in that relative lack of stress to be underestimated, as it was a great boon for me. In that sense, I believe the CCO has done everything that can be expected of it, and done it very well.

It also doesn't matter how well the CCO performs in the financial/budget sense if the county mental health care system for adults is understaffed/staffed by less qualified providers then in years past by choice of the county commissioners, et al.

131 Access to specialty services are severely impacted. Most CCOs are no longer accepted by specialty providers. Often times, new rules are implemented only to be rolled back and the amount of paperwork providers must do to provide care causes them to avoid seeing Medicaid patients.

132 Klamath County has a severe shortage of primary care services. The local CCO has been used to give the local domination of the local health services.sky Lakes has run all but 3 or 4 providers from private practice. Everyone works for the hospital. The local CCO has forced 6 Nurse Practitioner clinics to close. All physicians have been forced to become hospital employees the rest choose to leave. Our hospital and county have #35 out of 36 counties in the state. The local hospital has the highest cost in the state. People pay 4200 dollars for back MRIs here and 1800 dollars in Medford at OPI. The local CCO is paid a capitation for patients they do not have the capacity to serve. Access to Primary Care Services is 3 to 6 months out. The CCO clinics advise providers to only address one problem in each visit. Paying people for not seeing patients and not providing comprehensive primary care services. Open CCO meetings all to public. The CCO boards and hospital are getting their pockets stuffed with cash. The CCO was developed by Governor Kitzhopper to take care of his friends. You have created a greedy monopoly here that does not well serve the patients.Why does the state turn its back on the corruption in Klamath County?

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- 133** 1. The drugs that are available to OHP clients is very limited. The drug list should be expanded especially pain - relieving agents (non-narcotic) i.e.Lidocaine patches, a wider range of NSAIDS
2. Since opiates are being reduced OHP clients should be able to access physical therapy, acupuncture, massage, and exercise programs WITHIN THE PRIMARY CARE SETTING. The staff that is needed for these services should also be included in states payments to CCO.
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- 134** Value based payment models will improve the operations of the behavioral health services offered. because much of the services that need to be provided are not ones that can be billed, increasing traditional health workers and peer supports will improve the clinical care that is being provided.
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- 135** CCO's should increase the percentage of overall spend that is spent on primary care. Payments to primary care should be a blended model including:
1. PMPM payments for E&M and preventive services to primary care homes to support the PCPCH model and practice transformation.
 2. PMPM payments to primary care homes to support non-face-to-face services such as patient portal access, telephone access, care coordination, and population health management.
 3. Fee for service payments for non-E&M services provided at primary care homes (surgical services, Xray, lab, special testing).
 4. Quality payments based on standard measures across the state and across payers.
- CCO's should support integrated behavioral health in primary care homes by paying either an additional PMPM to practices with integrated behavioral health or by covering fee-for-service payments to primary care practices for service provided by behavioral health clinicians.
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- 136** Public health integration should be incorporated into CCO work. I see governmental resources going towards for-profit CCO activities. Unconscionable to me as a tax payer. Public health assists with accomplishment of CCO incentive measures, yet public health departments scramble for small CCO grants that have historically gone unfunded. I see the CCO using our under-funded public health system for profit. CCOs need to give back to public health. Public health are the experts in population health and integration of public health should undoubtedly be incorporated into CCO 2.0.
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- 137** Serving in the behavioral health field for many years and running residential acute care facility as well as out patient programs, I have found that many CCO members cannot receive mental health services due to there being a deficiency in providers and long wait times at community mental health agencies. I have personally tried to become a panel provider for CCOs only to be told that their provider panel was closed to private providers. This is confusing and frustrating as I have frequent calls from people who belong to local CCOs, but cannot find any openings in community mental health and no open providers. I believe the CCOs have failed in this area greatly! There are many people out there in need of mental health services that cannot receive care, because the CCOs are "closed" to individual, private providers and agencies. It doesn't matter how wonderful a new system, CCO 2.0, may be if people cannot access the care they need to decrease risk and further decompensation.
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138 Trying to get services in a timely manner has been a nightmare for me. I'll get an appointment months out and then show up to find my OHP plan isn't current. The paperwork is impossible for me to keep up with. I have higher degrees, am a full time, self-employed worker who became impoverished from out of pocket expenses due to a cancer diagnosis. I've been in a confusing, disorienting world ever since. My experience of health care has been a kind of cruel and unusual punishment. I have no "expert/advocate" to help me with this and no access to anyone else's income. I don't even know how to further comment.

139 With the overwhelming amount of research on ACEs and research connecting parenting and children's early relationships with parents and caregivers as one of the strongest protective factors, CCOs have an opportunity to help normalize parenting education and to make these supports part of every family's health care plan. Oregon is a unique state in many ways. With the CCO system, the Early Learning Hubs, and the Oregon Parenting education collaborative (OPEC) hubs, there is potential for Oregon to be a national model in these efforts to improve short and long term outcomes for children, adults, and families.

140 CCOs should engage with providers and stakeholders about services offered and administering access to services. CCOs have too much power to place arbitrary restrictions on speciality services (such as too-frequent prior authorizations) without engaging in the community to find out what will actually work for patients and providers.

141 CCOs should cover home birth and birth center birth with Licenced Direct-Entry Midwives (LDMs) and Certified Nurse Midwives. The evidence is clear that these options provide HUGE cost savings and safe satisfying care for low-risk pregnant people.

CCOs should be required to get feedback from patients about how the CCO can improve.

142 Don't make people go to the Dr multiple times just to get everything taken care of. If I have 5 things that can be handled quickly, I still have to split them up because the Dr's can only charge for so many things for one visit. Don't require unnecessary steps towards getting the testing people need and the Dr's know they need. When you have a lower spinal injury, you shouldn't have to go to physical therapy when there is a history of physical therapy not working in the past, then an x ray, then a specialist just to get an mri. Then sometimes you find out that you have a problem that the specialist doesn't do and now have to go to another one. Waste of money. Spend more on preventative care that you know will lead to worse health. I can't get surgery on my feet just because I can still walk. I shouldn't have to get that disabled to get help. Keeping me from getting to that point and helping me get back in the work force and off OHP will save you money. Talk to the Dr's and listen to their complaints.

143 Basic needs come first. I have experienced so many of my patients die or need long-term expensive care because their housing subsidies from Family care etc. disappeared. More access to inpatient substance use treatment for those SPMI. Increased access to supported housing for those who struggle with chronic mental and physical health problems. Reduced motel funding and increased supported housing. Increase MCDC physical and mental health services including coordination with outside providers. More communication with social workers and case managers re: patient need for services; social workers are also trying to help save money. When looking at Kepro and other gatekeepers, don't just look at money saved by denying auths; also look at money wasted, worse outcomes, deaths, incarcerations that might have been preventable with 1915i supports in place to people to reduce need to access emergency services. Demand Kepro etc. pay for hospital admissions related to denial of 1915i or untimely processing and patient's not being able to meet basic needs or receive 1915i services who may have been qualified. If an early discharge leads to an overall more expensive outcome, holding hospitals accountable for early homeless discharges that lead to death, loss of limbs, etc. Better communication with providers to reduce costs connected with extremely time consuming coordination. Increase fees for mental health services to address chronic burnout issues related to low pay to avoid

duplicated interventions due to high turnover. Increase communication between hospitals, doctors, and social workers, etc.

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- 144** Create more opportunities for existing consumer-run organizations for mental health, behavioral health and addiction.

Create more jobs for Peer Support Specialists and other Traditional Healthcare Workers

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- 145** I strongly believe that our chance to improve preventative health is to have the opportunity to see our CCO patients. Establishing care with providers will ensure that the patient has the opportunity to reduce the cost to the organization and address potential health risks outside of an emergent visit.

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- 146** Oregon Health Authority blatantly did not mention inclusion peer-based workforce. There might be stricter standards down the line. Maybe have a webinar to how the traditional healthcare model can include addition peer-based. An example might certify peer recover mentors in addictions treatment. I know a lot of CADC 1 licensed practitioners are not big fans of the peer workers. I came from California and took me awhile to know the understanding of the Oregon Model.

CCO's should be all non profits . They should place the needs of the clients in front the needs of the shareholder. I have a finance degree too.

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- 147** I believe that NO CCO should be a for-profit business.

Tax payers might as well be putting money right in the pockets of the stock holders. And to tie this to the mental/physical well being of the disadvantaged is horrific.

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- 148** Find funding source for addiction treatment facilities in Coos and Curry counties as well as half-way houses. I do not think the CCOs are addressing the Meth and Heroin epidemic that are devastating the members and their families in Coos and Curry county.

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- 149** Making tougher criteria and longer timelines to receive services causes more health deficits and higher costs in the long run for an already challenged population. Illnesses, be they physical or mental, suffered by young or old, rich or poor, should be treated with the same urgency. CCO have created a language that is increasing more difficult o understand. Services are accessed under such a complicated process that advocates for patients have no access to assist. Procedures have so many loop holes in favor of discouraging timely service that level of despair and hopelessness affect this population. I would advocate for more transparent criteria for services, more timely responses, personal consultations for extended services, treating the whole family and whole person, more community collaboration and access and reasonable timelines. I would also advocate for
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the CCO's to collaborate with communities in supporting and creating resources without negotiating contracts down to where the providers cannot maintain their programs.

150 After digging in and finding out that there are incentives for specifically services that result in drugging of children. There's zero incentive to keep children and patients healthy. As an advocate for parents, I have had so many reports from them that CCOs are bullying them to get their child vaccinated, get antibiotics, get psychiatric drugs because they are all tied to incentives. This is such a false goal. Also have found that DHS is being pushed by CCOs to do mental health screenings on BABIES!!! Why? Because OHA added a benchmark that incentivized doctors to get foster care children mental health assessments and then put them on drugs. Now the drugging of foster care children is out of control. But specifically reports on CCOs bullying parents that if they don't do the CDC vaccine schedule on their child they are going to kick them out of their CCO or call DHS. Why? Because they lose out on the bonus. No incentive to create Healthy children. This is a huge crime to our children. Oregon has one of the highest rates of children with autism and auto immune diseases and it's because we incentivize CCOs to drug and over vaccinate our children. Must change.

151 Quicker transfer when someone moves. I had to wait 2 weeks for emergency dental surgery and ended up in the emergency room instead of the dentist for a tooth abscess.

152 Require CCOs to pay for services needed by members placed out-of-CCO-region for medical or behavioral health care, and require providers of those services to accept payment by member's home CCO at their contracted rate with their local CCO.

153 All CCO's should be non-profit. I live in an area where the CCO is for-profit, and has lots of sweetheart deals with the largest clinic, which also happens to be for-profit.

This has resulted in OHP patients getting priority over other patients, and most people I know who have private insurance now receive sub-par care and struggle with access to care (in an area where there is already a provider shortage!).

While I do see all the good that CCO's do, I can't help but be frustrated because unfortunately (at least in my geographical area) the model has resulted in decreased access and care for the rest of us.

154 Nope

155 Anyway to have access to a "social worker" through CCO who could co-ordinate care, or a central hub of data access. Also cutting down on physical paper trail and going digital.

156 1. Prohibit for-profit enterprises from owning/operating CCO's. This is ethically, operationally, and organizationally disastrous for the recipients of OHP and the taxpayers of Oregon.

2. Prohibit capitation as a quick and dirty way for CCO's to impose capitation. (This is happening in BH in Lane County. Watch penetration and outcomes fall. HMO model all over again.)

3. Anything that can be done to further care integration between BH and PCP/ED would be huge - it's just not happening.

157 More focus on dual eligible population - addressing barriers to health including non-medical transportation, housing, and access to care

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- 158** I feel that CCO's should not dictate on if the procedures or visit should be covered. Patients should be able to get what test and procedures done with out the CCO's saying yes or no. CCO's should not play doctors!!!
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- 159** The CCO's were created to better manage funds, reduce barriers and improve access to care - I think the results are that we have created more barriers as we have 16 CCO's - Perhaps one CCO divided by region. The efforts at integration, addressing health disparities, building up PCP homes etc. are all good efforts and I think have helped improve care. Another issue is that the funding streams are so divided that if your CCO is not contracted with a certain provider, and that provider is the only one that provides that service, the person does not get the care they need in a timely manner and end up in the emergency care system.
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- 160** Rural frontier counties have done many of the coordinated aspects of health prior to formal CCO's. It has proven to be an even greater asset to these counties to coordinate and share practices across a larger region. Keep that focus as 2.0 moves forward.
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- 161** IHN-CCO has been an amazing leader in SDoH, THW and and peer ran projects. GREAT JOB to IHN-CCO
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- 162** Funding for the treatment piece of intensive supportive housing is critical to keeping people out of higher levels of care. It reduces hospital utilization, it helps people avoid homelessness, and keeps people well and successful in the community.
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- 163** Regulatory oversight, and every-year EQR processes (when, in fact, CMS requires an EQR process once every three years) contribute tremendously to the costs associated with providing health care services. The EQR process gets all tied up on details like screening providers on a MONTHLY basis for exclusion from participation in federal health care programs, and using member-facing materials that are at the sixth-grade reading level (for concepts like "covered benefits" that are NOT sixth-grade concepts). Tremendous and costly staff time is diverted to these processes.

Eliminate the Transformation Center. It cannot effectively do its work until it can articulate a theory of change. There are multiple change theories, but to date, the Transformation Center has not been able to ground its work in any one of several effective models. Require the Transformation Center to produce a Logic Model with clearly stated outcome measures for its work, and hold the Transformation Center accountable for delivering these outcomes.

The new Quality and Transformation Strategy plan is overly-prescriptive and overly burdensome. Allow CCOs greater flexibilities in producing their quality and transformation strategies. Eliminate the templates that were obviously prepared by a brand-new MPH graduate who has never worked in the functional field. Do not think that the TQS should be reworked every year. These should be three-to-five year documents with semi-annual reporting throughout the three-year term.

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- 164** Social service providers are addressing SDOHs through the course of their work. They are willing partners, and want to collaborate with health care. It's important to take the time to understand common goals, challenges, and gaps in service with all stakeholders, in order to build effective programming together. Making grants available is great, but building sustainable partnerships is much better. Grant funded projects start then stop, over and over again based on funding--we lose talent and capacity. Through smart program design aligning health care with CBOs we can create affordable systems addressing SDOHs that will increase prevention and community health and generate cost savings in the long term. It may require some leaps of faith before the data is collected, but examples from around the county are proving that these collaborations work!
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- 165** Some very high cost medicines may need to be eliminated, such as those for cancers which provide little benefit for very high cost.
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The funding for the CCOs must be adequate or there will not be adequate access for patients.

166 Have more oversight over 3rd party vendors and the services provided.

Improve communication between services, vendors and patients.

Set an example of holistic care for medical, oral and mental health.

167 The two greatest obstacles to the triple aim are the social determinants of health and the for-profit health care delivery system.

168 Regarding Social Determinants of Health: The importance of secure housing AND a reliable source of income, whether through employment or disability benefits, cannot be overstated. Providers need to have honest conversations with their patients about living situations and the importance of either returning to work, volunteering, or pursuing a disability application. We all need to recognize that lack of housing or income leads to poor health outcomes. CCOs need to find a way to be partners in helping their customers either return to work or find another source of income. This is a root problem. In this survey, "income" was not even included in the list of potential Social Determinants of Health. Until there is an accounting of root causes, the likelihood of significant improvements to our health systems (at least insofar as far as they attempt to meet the needs of under-served communities/populations) will be all the more challenging.

169 Continue moving forward with the integration of Behavioral and Physical Health.

170 CCO's are forced to be social service agencies and health insurance companies at the same time, and some are failing on both fronts in terms of improving the health of the population while containing costs. Engagement with provider networks and other community partners needs to evolve to spread the burden and the funding more intelligently. For all of the federal money the state of Oregon has secured for the OHP and the CCOs, our public health outcomes are among the worst in the nation on many measures. Maybe it's time to re-examine how our state prioritizes spending and decides which partners are worthy of investment.

171 Require CCO's to invest a minimum percentage of incentive dollars in children's health and the social determinants of health.

172 I'm a patient, in my 70s with All Care Advantage and was surprised recently to learn that my Medicare annual visit would be administered by a nurse rather than my primary care physician. I was given no explanation for this change. It disturbed me in that I appreciate the one-on-one relationship and annual visit with my physician and her first-hand knowledge that comes with that meaningful visit and examination. When calling for this appointment, I asked to see my PCP instead. Whether or not that involves an increased fee, the person to whom I spoke did not share info. I was also able to arrange to see my physician at an earlier date than had I consented to visit with a nurse. It seems that more transparency is needed here. So far, my health costs have been minimal with two generic prescriptions, and I do all I can to practice wellness, get regular exercise, proper nutrition, and a good social network. I feel that AllCare failed to inform me of this change of practice and the reasoning involved.

173 Focus on the person needing care...not the cost.

174 CCOs are vital community partners but can sometimes impede local entities whom are working on health and wellness (non-profits, community based organizations, and/or local county/tribal health departments.) These groups have to then compete for local grant funding from the CCO when in many ways they are the reason that the funding was received in the first place. If CCOs are going to be grant making agencies, they should invest in staff who have experience with grants (applications, monitoring, and evaluation.) It's discouraging when funding is allocated to projects that are not evidence-based or even promising practice while many organizations barely scrape by financially.

175 Question number 6 on "value based payments" didn't allow an option to choose primary care; prevention is the key to decreasing health care costs long term.

Also question number 16 which asked about spending within targets to ensure health care costs are controlled, did not include an option to pick value based payment methods that are directly tied to long term health outcomes.

Driving down cost is best achieved by funding programs up front to ensure resources are adequately deployed; and any other bonus payment incentives should be directly tied to health outcomes. Currently the state does some of this with the CCO metrics, however those metrics could be improved in many ways.

The state would benefit from encouraging CCOs to eliminate waste and inefficiencies within their systems. One of the CCOs has too many layers which directly impacts a member's ability to get health care when they need it. The state should not allow hospital systems and former MHOs to hide under a non profit identity while still operating as a for profit organization running funds through multiple layers of the different subsidiaries in order to leave the impression that they are fiscally conservative. There should be transparency of all the layers if they decide to operate that way.

176 The barriers in providing co-occurring services (Mental Health and Substance Abuse) must be addressed. The funding silos and billing issues create significant inefficiency in care and multiply the barriers in providing good care.

177 I believe the 'Compliance' piece in the current CCO Contract needs to come back to the state staff to monitor. In the Managed Care Days the Compliance sections were monitored closely by staff with DMAP. The Pre-Paid Health Plan Coordinators were responsible for holding the CCOs accountable when they chose to not cover a service or follow the CMS CFRs, OARs or contract language. The PHPC's would then raise the compliance issue to the Quality Improvement Coordinators. They in turn would work with the CCO's QI coordinators to resolve the issue. This compliance piece was placed directly on the CCOs with no monitoring from the state, other than capacity. I think the Compliance piece should be monitored by the current Account Representatives who have 3-4 CCOs to be responsible for. The ARs are familiar with the CCO Contracts, CMS, CFRs, OARs rules as they are already doing the missing compliance piece but in a 'soft' way instead of with authority. May times the manager of the Provider Systems unit lets the compliance piece go away from the CCOs inappropriately.

178 There is a lot of focus on more control of CCOs in this survey. The private sector has a better handle on how to follow the triple aim that was the initial impetus behind CCOs. The state needs to stay out of the regulations business get in to regulation oversight and allow the CCOs to follow their contract with OHA to deliver the care they agree to in the contracts and to report information back to the state. It is not the state's business to try and run the business of a private entity.

179 Be more focused on social determinants of health; specifically regarding housing. Use the Housing First model.

180 As an agency that works with each of the CCO in the state for adult mental health,

1) there is a great disparity in how each CCO works/interprets/resources available/customer service attitudes for persons served, therefore, for the next generation, CCO's should operate with the same structure and resource availability across the state, and this should be transparent, efficient, and well known to all providers.

2) There are great inefficiencies in CCOs that require immediate resolution in order to improve the health efficacy of persons served:

a) CCO's have the tendency duplicate and/or micromanage and/or create barriers with providers due to their own/system inefficiencies. CCO 2.0 absolutely needs clearly defined roles across the state to prevent duplication, waste, omission from provider services. The fact that a provider has to have so many touches with a CCO in itself creates waste: it subtracts time from delivering direct services to an individual and creates inefficient bureaucracy. The time and money involved in this current rendition could be going directly to person's needs instead of layers of inefficient bureaucracy. Or less CCO workers would be needed if there was less waste. The needs to be a clear division of labor here. KEPRO also creates waste in the similar manner.

b) No service will be effective if CCOs cannot retain flexibility to address basic needs and individual uniqueness: housing access and affordability, nutrition, medication costs, timely access to alternate therapies, and integrated care and specialty care therapies for co-occurring disorders.

181 I have worked with a couple of CCOs in the last few years. I firmly believe that the CCOs that are non-profits are run more efficiently, effectively and provide better access to care than the for-profit CCOs. The for-profit CCOs are very invested in the politics, the profits and cutting costs. They do not seem to care much about patient care, access or providing necessary services to prevent worsening medical needs. The non-profit CCOs, specifically IHN, have worked hard to address social determinants of health along side with supporting innovative new programs that address specific needs in our rural community. I'm tied in with the children's behavioral health network in Oregon and the horror stories I hear about the for-profit CCOs are almost criminal. I believe that working with people who are in poverty and receive state funded health insurance should be done for the right reasons. Doing this difficult work should not be done with the goal of making a buck off the state or the poorest of our community.

I also firmly believe that any sort of outcomes based payment method for behavior health is extremely foolish, risky and unethical. The only provider that I have heard supporting this value based payment idea in the behavioral health world has been a provider that is the same company as a for-profit CCO (which by itself is an obvious monopoly that no one wants to talk about). Trillium was experimenting with outcomes based repayment for higher levels of children's health care and I heard so many stories of kids waiting for 6 months to a year to get the treatment they need in a residential setting then getting kicked out back to the community in a matter of weeks with little to no change. I even heard one story of the residential staff frantically trying to change a kiddos meds on the day they had to leave to go back to the community after three weeks in residential following a 8 month wait to get in to the program. This is so highly unethical and dangerous I'm surprised they did not get sued. Please please do not wreck the positive changes that have been made in the last five years by putting the money ahead of the clients. You want to see change then consider incentivizing the clients for outcomes, not the providers. Incentivizing the clients enables them to meet their basic needs while encouraging them to focus on their behavioral health needs without tying the providers hands.

182 Fix the problem of patients being auto-assigned and or changed from one CCO to another when care has already been established at a specific CCO.

183 Do more community engagement strategies that use a strong collective impact model where other agencies/business/communities are investing in a vision for wellness. These projects need sustainable funding. The key to increasing overall health is community healing and building models of resilience for communities that have high levels of trauma.

184 Mental health care needs more attention and funding.

185 These questions lumped all CCOs together. My company works with six CCOs and there are many differences. Any given CCO is strong in some areas and weak in others, and some clearly better than others.

I don't mind a CCO making a buck, but there needs to be incentives for longer-term investments.

Thank you for asking.

186 CCO's that increase services were punished this year because they spent too much. The amount of services expansion should be factored in as a positive and rewarded.

187 Get the counties in the metro area out of behavioral health and get the benefit integrated to physical health.

188 I do appreciate the accountability of CCO's; however I would like to see more accountability from the healthcare delivery system as well...like hospitals who continue to readmit patients and encourage more robust discharge plans so that patients whom are homeless do not consistently get put back on the streets with infections, wounds and chronic illnesses without ensuring patients have proper follow up appts. The sharing of EHR and proper Care Recommendations so that everyone across healthcare delivery systems are in alignment and understand patients goals of care. I feel like the CCO's have little authority especially when they don't manage behavioral benefits and long term care services and some of the lowest performing clinical providers.

189 Pay for performance programs DO NOT WORK> PCPs cannot regulate the behavior of patients and control for the social determinants of health. This only increases the administrative costs of the PCP clinics and with little overall reduction in cost for the CCO

Primary care services are very inexpensive to provide and the current expenses comes from the overwhelming administrative burden of documentation, coding, billing, and prior authorization. Cut the administrative costs for clinics and you will decrease the costs by at least 50%.

Negotiate directly with national laboratories, radiology centers and wholesale pharmacies. Decrease the administrative burden and these costs will decrease 70-90%

Invest in behavioral health and addiction programs. These patients are the high utilizers of health care and the more access to A&D treatment, counseling, housing, employment the better. Improved care with less utilization of high cost services (ie ER)

190 There were very few mentions of focusing on:

1. Trauma informed care - one of the biggest missed opportunities in our health care system is related to unaddressed trauma, and misunderstandings about how many Oregonians came to experience such significant healthcare issues to begin with. Our health, behavioral health, and other practitioners such as social workers, case managers and others need new approaches that are grounded in trauma informed practice principles. Otherwise, we will keep putting a 'bandaid' on the real wounds Oregonians experience, and continue to treat symptoms rather than the person. Let's get rid of our language in the DSM-5 around things like Borderline Personality Disorder, and start respecting what is really going on in their lives.
2. Person Center Primary Care Homes - a really good concept - and yet where are we in ensuring that patients really have one place they can go to get their needs met. We have some wonderful examples of how this model works in the state - and we need more.
3. There was very little mention of Traditional Health Workers in the survey. This is deeply concerning. The ways in which we pay for services, and hold CCO's accountable financially are significantly important. However, we also need to look at this virtually untapped resource. Those who are working as the this workforce have been able to accomplish what the rest of the healthcare system has not. Yet we seem to be very proud of the fact we have Community Health Workers, Personal Health Navigators, Peer Support Specialists/Peer Wellness Specialists, Doula's and DV Advocates. We don't acknowledge these providers by paying them adequately, and where are we investing in the capacity for the CCO's to ensure their availability in every community - to every CCO member who wishes to receive the services and supports where they are. We want the CCO's and OHA to be more accountable to this extremely important workforce.

191 I wish everyone could have CCO care working American's and seniors it is better insurance then Medicare and private insurance

192 CCOs should be non profit organizations!

193 I had hoped that when Health Share started there would be more integration between Multnomah, Clackamas and Washington County mental health departments to look at the resource base in the region and more efficiently use the residential and other housing/treatment supports that currently exist. This did not occur. We remain completely separated, and islands unto ourselves. Having worked at Washington County Mental Health for 13 years, I see absolutely no benefit to the SPMI population by virtue of enrollment in a CCO.

We, if anything, have fewer options given the rules around rate setting for residential care and use of 1915i funds. However there is considerably more pressure to find resources for a large cadre of patients who lack insight, are in grave distress, and at times on life-threatening paths which are not immediately imminent, sufficient to warrant civil commitment.

We have an increasing contingent of SPMI folks who are homeless.

The mental health delivery system in the state is very stressed and entirely focused on meeting the demands of the Justice Department Agreement, despite the considerable negative impacts on patient care. We have a larger number of undertreated patients who cycle in and out of acute care, never staying long enough to regain functional stability then not being able to make adequate decisions about their community needs to avoid the next decompensation.

It may help if the CCO's did take charge of residential payment and UR. It is abundantly clear that providers

need to be able to pay staff more, to avoid turn-over such that a client has 3 different case manager within a calendar year. There is no other profession in the country where the employee is expected to have a Master's degree and become professionally licensed, and is offered a salary of \$38 to \$40 thousand dollars per year. This impacts the quality of orientation, as well as the on-going clinical and administrative supervision provided. We have a condition where the most complex and difficult clients in the system, frequently with co-occurring brain injury, personality disorders, Substance use disorders, or multiple medical co-morbidities, are being treated by the least experienced and lightly supervised providers. We would not deem this adequate for care of medical conditions. Why is it the norm for mental health?

194 They need to reward programs that are doing evidenced based practices.

195 As a state we need to improve Behavioral Health Services, specifically the quality of programming and access.

196 Do not allow CCO's to be "for profit," thereby requiring all CCO's to be more transparent to their communities and to the state, with open meeting laws and composition of Board of Directors and Advisory Boards that prohibit conflicts of interest (such as shareholders being board members and providers being shareholders).

Reign in the practice of non-provider CCO employees dictating decisions that should be made between patients and providers.

Require more input from providers before instituting sweeping rules that affect treatment decisions, allowing for more discretion in individual treatment plans.

And when such rule changes are made, the providers should not be the LAST to know!

Allow providers to contract with multiple CCO's, provide more choice across CCO regions, and require more uniformity in the way OHP is administered in each CCO region.

197 In the area of Behavioral Health I would recommend more patient choice for CCO members. Workforce development/telemedicine for specialty behavioral health.

The other area for CCO 2.0 is focus and investment on prevention and community health promotion. Incentivizing CCO integration of prevention/promotion into behavior health and primary care payments.

198 set reimbursement rates to providers that meet actual costs of providing care. Look at A&D residential rates and outpatient treatment rates.

199 I have found it very challenging in finding doctors who are non-white. Is there a program which offer incentives for medical personnel with racial or ethnic backgrounds? I have mentioned this in the past, and it seems to fall on "deaf ears".

This is the 21st century.... let's act like it!

200 As a provider, I have not had an increase in the reimbursement rates for Behavioral Health Services from the EOCCO since 2014. I was accidentally sent a Reimbursement rate sheet by mistake that showed higher levels of reimbursement, but was told that was a mistake and I was still to use the original. What I believe is the CCO's keep getting larger with Staff with good salaries, and as an independent provider, with overhead costs to be in business (woman small business owner) hard to keep up costs to the point where I have had to purchase my private health insurance on the Market Place. The CCO's cater to the CMHP providers and not to others. I am the only other provider outside of the acting CMHP. CCO's are just another for profit insurance company. The expectations for documentations and other criteria

keeps increasing over time with little revenue for the laborious expectations. I cannot afford to hire employees. I speak from experience with 33 years of service in the State of Oregon in Behavioral Health.

201 The biggest gap is mental health care for children and appropriate and evidenced based care for individuals struggling with addiction. Integrated and coordinated care is a must, and allowing families to chose clinics that provide this service should be allowed. I never understood why mental health is limited to a panel, limiting families' choices, and ultimately success. I also would like to see better options for dental care than just pulling problem teeth- again there is a lot of evidence that toothless grins decrease jobs, housing opportunities, and mental health. Finally, having more providers willing and able to work with other community agencies, such as schools, would greatly increase success and long term, reduce costs. Many providers interpret being efficient with giving quick and inadequate care- that really needs to be addressed.

202 I found the survey to be quite limiting and steering in the available responses. It leads me to believe that we still don't know the best way to deliver care services.

It is unclear how some of the determinants even made the list. What data supports these as the leading contributing issues to costs and utilization of healthcare services or population health?

For example, how do we know that diaper insecurity is a lead determinant? For example: for which segment? Is it babies or toddlers? I am aware of a study that shows the top three reasons that lead to E.R. usage in newborn babies 24 months. The main contributing determinant issues are a lack of resources to clean blankets and supplies (bacteria and viruses), ability to baby proof and safety equipment (accidents and injuries), drawers cupboards and stairs, and at least one other reason that I don't recall. So where is the data, the study, or the task force that concludes these determinants?

I also find it difficult to comment on if more alternative payments can be used or how, or where certain payments can be reduced let alone how to show accountability for how good any one CCO performs compared to another or even another state. CCO metrics seem to be unique to Oregon so it's very difficult to benchmark performance or know comparatively how the CCO system performs. CCOs should adopt nationally standardized measures i.e. HEDIS. But back to payment, it's difficult to know where Oregon's reimbursements compare to other states or even in terms of access. So how do we know that payments to certain providers or services can be reduced? When looking at hospital margins, given all of the change in healthcare, however, most hospitals can be served a payment cut.

The rate setting process seems to need some improvement too. It is unclear how any business model can survive under the current rates. Is it that there are too many CCOs (economies of scale), not enough competition, lack of understanding of the inflation of healthcare services relative to overall economic real inflation?

There are many more improvements but these are fairly overarching improvements that should be considered in CCO2.0.

203 The State of Oregon should consider the benefit of contracting with a CCO that is local and re-invests profits in area, and not with a national company who boasts how they are climbing the Fortune 500 list of most profitable organizations at their staff meetings and who also pay their employees huge quarterly bonuses!

204 No thanks!

205 CCO's must provide oversight to their contracted providers. We have been informed that they do not provide oversight. They should give the Behavioral Health speciality providers the infrastructure they need to provide adequate services that address the needs in rural areas of the State.

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- 206** Provide more education to Primary Care doctors about behavioral health and addiction treatment. Many PCP's, PA's provide misinformation to clients. Provide more education to PCP's about prescribing medications for client with behavioral health and addiction disorders. Visit community mental health providers to experience first hand what services are offered and how they are offered. Big disconnect between PCP's knowledge level about behavioral health (includes SUD treatment) services and what is really available to offer. Provide more funding for reduction in caseloads of behavioral health clients with intensive needs. More supportive housing opportunities.
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- 207** They should model after IHN CCO. IHN has collaborated quite successfully with the county and private agencies in their regions. They value the county and private agencies' input as far as how services are delivered and where they need improvement. They collaborate with these agencies on committee's to further meet and exceed the metrics. IHN CCO, Linn County, Benton County and Lincoln County have proven that if the CCO and agencies within the CCO region work collaboratively it will be successful in providing quality services to the populations served.
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- 208** Would like to be able to contract with ALL CCOs at one time....extensive contracting requirements and exclusions prohibits our care for all Oregonians.
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- 209** The cost of prescription drugs is largely outside the influence of CCO's. The State should consider carving out the entire prescription drug benefit from the CCO's and aggressively negotiate price with the manufacturers and cut the PBM's out of the equation. The State should not acquiesce to organizations funded by Pharma. The State should de-politicize pharmacy review committees and HERC and get back to prioritizing the impact of the prescription drug benefit.
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- 210** Not the best business model.
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- 211** Find ways to continue encouraging integration/coordination of care across community providers including medical, dental, behavioral and alternative health care providers. Put dollars on the line and require providers to demonstrate at least coordination, preferably integration.
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- 212** We cannot address health care without addressing some of the bigger social challenges in our communities - lack of housing, limited transportation, substance use, and low-paid employment/unemployment. CCOs should engage in greater psychosocial care coordination and communities need additional supports to be able to provide resources for these critical needs.
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- 213** While savy in navigating systems, it took numerous phone calls and a total of 8 hours on hold to make a simple change (adult son experiencing disability no longer had private insurance coverage). I can't imagine what that would be like for a parent unable to take time off work, spoke a language other than English, or that was not able to access online resources. There must be a way to make simple transactions...simple.
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- 214** the state should provide more standards of work rather than make individual CCO's create their own "wheel". Sharing of best practices within CCO's, not necessarily at the clinic level, would be helpful for those having issues with developing systems.
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215 Many of these questions presume the CCO system works and that capitation benefits healthcare consumers. These assumptions create an overall bias in the available answers and thus in the data you will receive from this survey. The reality expressed by both providers and clients is that the system is not working: wait times are long, physical health gets cut off or can only be single issue appointments, mental health is provided by overtaxed agencies whose capitation encourages fewer and limited appointments that leaves people in crisis or in a negative maintenance state instead of improving, and the lack of culturally humble practices limits options for multiple groups leading to scarcity and higher negative outcomes (not seeking service, discontinuing service, only using services when no other options are available. This feedback has been consistent in healthcare forums, amongst providers, and in client forums (both open public meetings and closed social media spaces.) If you really are invested in providing better care the question should not be how to we confirm what we already think will work and instead be how do we slow down, listen, and address consistent complaint. I fear this survey will not help you in addressing deeper issues though I hope it helps in addressing some of them.

216 Reporting fraudulent use of transportation benefit. Hold members accountable. Especially in the case of "no showing" transportation. Adherence to the OAR's related to transportation. Less using their own interpretations of OAR's for member satisfaction surveys.

217 The behavioral health issue is large. Need to find a way to integrate/share records with primary care, and to improve retention of therapists that are trained in trauma informed therapy methods. Difficult to measure outcomes of social determinants of health in the short term. These are long term improvements that may show results in 10-20 years as we support children and families, see less trauma/poverty/housing and food insecurity and have better adult health outcomes, more productive adults and better parenting in next generation.

218 CCO model has been effective in addressing the quadruple aim of health care reform. There is a lot of work that needs to be done to address all the social determinants that effect an individual's health status. We need to begin thinking outside the box and supporting initiatives to address the social determinants. We need to go upstream and get to the root cause of the communities issues. If we do not, nothing will change and we will continue to keep doing the same thing and getting the same results. It is time for CCO 2.0 to support the CCOs to work with the community to address these issues.

219 CCOs are spending taxpayer funds in my mind they should all be required to be non-profits.

220 Improve accountability particularly when there are subcapitated organizations as primary delivery systems of care. Currently, financial reporting and tracking of spending only applies to "umbrella" top organization with no transparency below. Require CCOs to actually move towards coordination. It is in the name but is not happening. Ongoing assessments of network adequacy for health, dental and mental health. CCOs must develop plans for when provider networks are inadequate to meet the needs of the population.

221 Oral health must be increased.

Social anxiety and being unable to eat with others because of lack of any molar teeth and broken front partials lead to isolation and depression, and avoiding nuts, seeds, vegetables in favor of bland and softer processed foods aggravates obesity, depression and chronic illnesses.

Language and speech also depend upon teeth, and missing teeth, periodontal diseases make people unemployable and marginalized, perpetuating poverty and cycles of anxiety and mental illness.

222 Need investments in workforce for behavioral health

223 I sense hostility from the CCO level in the WVCH region towards projects taking on social determinants of health. The hoops which WVCH has required organizations and members to jump through to receive Flex Funds, NEMT, or to take on any innovative approach are dramatically more extreme than in neighboring regions. I am concerned with a toxicity of culture at the top of this organization, and their primary contractor for most services WVP, where they openly talk about the members we serve in ways which seem demeaning. In addition the pervasive stated fear of fraud and abuse of the system by members as a justification for consistently making access to services more difficult feels as though it cuts against the entire purpose of the CCO system.

While the CCO has become very connected within the social service world, I do not see this as them becoming an integrated partner to social service agencies to work to alleviate problems and injustices for their members, but rather the CCOs role in this almost feels like they are pushing the social service world toward their own agenda which is very clinical and specific - and seems to steer social service agencies to look exclusively at things which are very directly linked to the incentive metrics set by OHA and are hostile to holistic or indirect approaches which evidence and common sense show would also have effects on community health.

I don't know how OHA can force CCO's to treat its members in a more respectful way, however I think this needs to be a priority. The promise of CCO's was to have medicaid providers be part of communities in a way that makes them an effective partner to being part of social service solutions in that region. My experience with our CCO has been the opposite - that they represent the interest of clinical provider agencies and doctors, acting as a shield from complaints or reform. Even on issue that members are not passionate about but people hoping for coordination within the healthcare system are, like better Electronic Health Record integration, is a disaster at the CCO level because they are there to represent provider agency issues and they do not want to change.

The hostility towards OHP members would not be acceptable in other social service industries, and is far worse in our CCO - its sub contractors - and provider agencies, than it is in the counties or traditional social service world. Whatever OHA can do to align the incentives of the CCO with treating members like people is essential to making this system work. Having a CCO and WVP staff continually engage in demeaning members and their concerns - being in a constant liability minded mode that does not allow the CCO to admit fault or fix issues because of the denial that those issues exist is more than ineffective, it is detrimental to this region.

224 Oregon has followed a different model for Medicaid managed care than many other states. The appears to reflect the values of Oregonians.

Unfortunately, the CCOs are too small and have too much input /control from/by providers to be able to negotiate competitive rates from providers.

Consolidation of CCOs to make the CCOs larger & give the CCOs more "market power" (to negotiate lower prices from providers) may deliver additional value to taxpayers in Oregon. Also, Medicaid beneficiaries in Oregon (outside of Portland) do not have a choice of what Medicaid plan they wish to enroll in.

Not clear that the "prioritized list" is really saving much money, it appears to cover all the services that are high cost (hospital admission, cancer care, multiple chronic illness care), and deny coverage only for marginal low cost services. Additionally I have a concern that denying coverage for unfunded ("below the line") conditions may lead these conditions to worsen and progress to a more serious funded condition that then later costs more to treat (example: untreated allergic rhinitis later progresses to serious sinusitis leading to a need for costly sinus surgery). Additionally, some "below the line" conditions can be disabling to beneficiaries (example: member unable to work due to wrist pain from DeQuervains tenosynovitis). I have a concern by denying coverage for below the line conditions the prioritized list may be worsening Medicaid beneficiaries health in Oregon.

I believe that the administrative costs to the OHA (as well as the legal risk) of maintaining the prioritized list are significant, so the state may wish to diminish the role of the prioritized list in future.

The Guideline Notes with criteria developed by the OHA also take a significant amount of work and health plans have other tools (such as MCG Health or Interqual) to make determinations of medical appropriateness (if OHA abandons some of the guideline notes CCOs can just use MCG or Interqual).

Of note, the average premium that the state of Oregon pays for a Medicaid beneficiary (around \$400) appears to be higher than in other states (around \$250).

Four or 5 larger Medicaid managed care plans in Oregon should be enough to provide member choice. The state can bid out the contract to 4-5 Medicaid plans (which may include current CCOs), having them compete on price, access, quality (HEDIS please not homegrown metrics), and beneficiary satisfaction.

Please consider following the successful Medicaid managed care model that has delivered value in many other states.

225 Focus on the patient, especially people with disabilities whose basic health care needs are very different from other people's basic health care needs. Maybe they need monthly dental cleanings, but don't need PAP tests. Define "basic" patient by patient.

226 Their providers should be paid competitively so there is less turnover. As it is now, the salaries do not provide enough compensation to retain great doctors and nurses. Working at a CCO is a VERY tough job, and you can't expect to have great outcomes when providers aren't paid enough. Providers turnover quickly and continuity is lost.

The reliance on nurse practitioners makes me uncomfortable. A nurse practitioner receives very different

training than a physician, and therefore, their responsibilities and oversight should be very different. Everyone has an important role to play; they should not be the same role.

227 The most important tool we have to control spending and improve outcomes of health care is to follow evidence-based treatment strategies and not pay for high-cost, low-benefit interventions. No amount of reporting, limiting CCOs profits, or increased financial transparency will reduce spending when the push from OHA is to pay for more treatments regardless of effectiveness.

If we want to invest in social determinants of health, we need to ensure that rates are set appropriately and that outcomes are measured appropriately. Most of the social determinants (like the local economy and local population education levels) are not modifiable by CCOs in the short run.

228 CCO's should be contracted with more specialty and other providers throughout the state and shouldn't require their folks to only be seen locally.

229 The CCO model of care has delivered and met the goals set forth in 2012. However, along the way, the global budget concept was cast aside, claw backs (2015), uncertain funding, added on requirements occurred; still the CCOs pushed forward. Programs that had been terribly mismanaged by DMAP for decades- NEMT, Oral Health - were taken on by the CCOs and improvements were made.

Building on the successes, revising programs to address the areas not making the targets should be key elements in CCO 2.0. Overhauling the entire model of care will carry grave consequences that will set Oregon back.

Behavioral Health improvement for adults and children? Absolutely, but there must also be co-occurring changes at the OHA administrative level. Viable vendors are scarce and these improvements will have to be supported at a State level not just the responsibilities placed on the CCOs.

CCO 2.0 should address the health care disparities, utilize the knowledge gained in understanding the connection between the SDoH and health outcomes (continue to do so). However, the current payment structure does not address this area. In our region, we are collaborating with other CCOs and using best practices to take advantage of 'economies of scale'. It concerns me for our communities that there would be drastic changes to a model of care that has proven successful for everyone involved.

230 HealthShare took over for Family Care. Too many Family Care clients fell through the cracks and are not covered even this late into the year. HealthShare DID NOT live up to the letter guidelines that was sent out to all Family Care clients. Thus, their benefits ended in varying months between December and now. They have no other health coverage, too. Some of them are on life saving, literally, prescriptions and devices that they no longer have access to.

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- 231** Two things rise to the surface for me that I believe have really limited CCO's ability to reach their full potential. The first is the segregation of primary care, mental health and dental health care providers. While CCOs are trying to work on this, there are many barriers that are difficult for them to overcome. In particular, there are often legal/ethical barriers that prevent mental health and primary care from integrating and coordinating efficiently. CMHPs feel legally prevented from sharing information with the primary care partners, and often from getting information from other sectors like education that are vital for us to really achieve our integration goals. I think it's important that the state help break down some of these barriers that are systemic. Second, it is really challenging for CCOs to adequately control cost when often they do not have the leverage to impact two of the largest cost categories: inpatient hospital and pharmacy. In rural CCOs, we've found that 50-100% of hospitals are AB. This seriously handicaps the ability of CCOs to negotiate favorable rates. These CCOs often have no choice but to pay rates much higher than those paid in the Portland metro area. Drug costs are also a challenge and perhaps there is an opportunity at the state level to negotiate better rates collectively.
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- 232** Allowing CCO's to contract with those they feel will best serve our community. CCO's are required to contract with certain entities and they often don't perform to the standards expected by the state. CCO's should be allowed to explore outside those contracts if they can show the required contracts are a hindrance to the performance and service expectations.
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- 233** Pay providers fairly for reasonable work hours. Provide mental health benefits, especially counseling easily. Anxiety, boredom, frustration and mental illness drive too many medical needs. Operate more like a coordinated medical system/socialized medicine with definite limits on services communicated to the patients, but not by the providers, but by the system. Create communities with lifestyles that address the foundations of good health, decent food, vegetables, walking trails/exercise opportunities where it is safe, employment or labor trades for services. Limit disability payments without some form of return for society. Provide pain management programs, non-drug based.
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- 234** CCO's should collectively purchase drugs used on their lists of approved drugs with other local medical/dental/behavioral health entities. If possible, these purchases should be made on a statewide basis, rather than just a local one.
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- 235** Identify neighborhoods with underperforming metrics and underserved populations and engage with neighborhood level cross-sector teams to address those gaps in an innovative and coordinated approach.
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- 236** Standardization across CCOs in relation to reporting, data and metrics. Standardization in corrective action plans, increased and standardized compliance measures to hold CCOs accountable to the requirements (rules regs., contract), partnership and evaluation of other models that employ evidence based practices and cost containment, ex. Virginia Mason hospital
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- 237**
- Increase transparency (policies, procedures, contracts, reimbursement rates, meetings, etc.)
 - Investigate impact of Value Based Payment on client care in mental health (Is it working? Is the mental health of clients improving if they cannot see providers often or for very long?)
 - Find better ways to balance costs that don't result in restricting access to care
 - More closely monitor whether clients are getting their care needs met (Can they get in to see their PCP quickly? Can they find a mental health counselor when they want one? How long are the wait lists at community mental health agencies?)
 - Ensure there are more than one provider for services so clients have choice
 - Obtain data on client satisfaction with services they obtain (not just clinical outcomes measured by a provider/clinician)
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238 CCOs need to work on improving the integration of oral health care. If oral health integration cannot be one of the top priorities, it must be included in the other work to contain costs, use value-based payments effectively, and address equity. And, although the focus of behavioral health integration is integration with physical health, there is also room to increase integration of oral health and behavioral health.

239 Include investments in SDOH work in rate setting!

240 Make it easier to get special care like occupational therapy for kids who need it and not have to wait so long for insurance to approve it.

241 COO'S should pay behavioral health equivalent to physical health as mandated by mental health parity laws. Behavioral health providers should not be treated as second class providers. Behavioral health providers should be trusted to take care of their patients in the same way medical providers are.

Patients should be allowed to choose their mental health providers.

It should be recognized that physical health and mental health treatment is fundamentally different and while VB payments may make sense in the physical care world, fee for service continues to make the most sense for mental health.

242 Have payment systems that balance need to attract quality providers with approaches that pay for health outcomes, not by procedures.

Get internal house in order by better coordinating care across disciplines (physical, mental, dental health), then focus on non-direct health care investments that make a direct impact on health (pay \$1500 for a wood stove change out if a kid has asthma, or for an air conditioner for an elderly person at risk from excessive heat), then consider larger societal/structural issues that are extremely important but require broad societal partnership to move the needle (racism, affordable housing).

243 I think that it will be important to do a deep dive into the communities to find out what programs (both private and public) that might be addressing social determinants, and increasing their skills and capacity (i.e. coordinating with existing parish nurse programs, Meals on Wheels programs or community health worker programs that can help support education, home needs/safety assessments), if there are existing school parent programs or meetings providing resource connections with existing education programs (CHA's resiliency program, Providence and Randall's trauma focused care program, OPS's ACES training program).

244 The biggest thing is more choice for the recipients.

245 CCOs should focus on only allowing treatments that are evidenced based. If the science shows more women are harmed by having a mammogram than helped then stop giving mammograms. Never happen, but if healthcare is going to improve at some point you have to start using science based evidence. With Medical error as the 3rd leading cause of death in the U.S. I don't think the concept is about to catch on.

246 I would like to see CCOs do a better job with sharing accurate and timely data with organizations who they hold responsible for care and quality incentives.

I would like to see CCOs provide more consistency with formularies.

I would like to see CCOs improve their formularies to provide 90 day supplies of more chronic medications.

247 CCOs to invest and to work closely with CBOs who are working in a culturally and linguistically communities by increasing the workforce for Traditional Health Workers (THWs). Social determinants of health can be addressed by supporting the work of community health workers.

248 OHP members should not be auto-assigned to CCO at initial approval/renewal. In my work at one of the largest oncology providers in the state, this is a constant problem; patients in midst of cancer treatment and without their knowledge, assigned to a CCO that is not contracted with their established oncology specialist and often not even their established PCP. This constantly creates confusion and difficulty obtaining authorization for typically urgent care, often leading to delayed care. There needs to be a more intentional process for assigning CCO to ensure members are assigned according to their established providers. Perhaps members should be required to indicate their established providers on application, or OHA outreach to applicants to ask at the point of approval.

249 Increase funding, hiring and commitment to peer support across physical and behavioral health care. Do not limit it to the adult system of mental health and addictions but to move to a more proactive approach by providing youth and family peers to work along side families and youth before they are in crisis.

250 These issues are NOT my issues.

My issue: folks seeking behavioral health care should be able to choose their own providers (as it was done by Family Care) and NOT have to have someone else (ie a care coordinator) refer them to services.

CCOs should allow behavioral health and specialty providers to contract with them, EVEN IF they are sole practitioners.

There should be a choice amongst CCOs in each county. A monopoly is never a good thing.

251 I would like to see CCO's increase their emphasis on proactive care, especially in the area of behavioral health services. The level of care model would benefit from a re-vamp, as it makes sense for highly acute patients to receive more services, but clients who are doing well but continue to benefit from regular (weekly) sessions should not be penalized for their health and wellness. This model actually adds to the motivation to continue to be in crisis, as dysregulation gives these folks more access to the care that they need. Also, I would love to see CCO's increase willingness to contract with solo practitioners, as they have skill-sets that often cannot be found on a regular basis in the larger agency settings. I recognize the value in having coordinated care within an agency, but this can be replicated in private practice by encouraging the development of relationships between providers (therapists, prescribers, PCP's, etc). As solo providers are added to the system, I hope that CCO's increase understanding that the case-rate model does not work when you're not seeing hundreds of clients per week. A fee-for-service model is much more appropriate in smaller practices. Finally, I agree with the use of evidence-based practices, but would like to caution against the overuse of formalized measures of progress. This can take away from the therapeutic process and hinder overall treatment gains, as clients often report to me that they feel more like a number or a subject as opposed to a person who is working on hard issues that may not easily translate into a Likert scale of severity (and may result in over self-reporting in order to continue to receive the services they benefit from). Thanks for listening and for this opportunity.

252 Continue providing and/or sponsoring trainings

253 Find better ways to measure whether people are actually receiving the services when they need them. Health Share has one way of measuring whether people get into mental health services or not - but it is not accurate and there are many people who can't get in to see a provider but don't get tracked.

254 I think it should not be possible for a for-profit corporation to have or be any part of a CCO contract with the State of Oregon.

255 Better coordination of care between providers.

256 Continue to collaborate with community partners working together to produce one community health assessment (CHA) and one community health improvement plan (CHIP). Have the innovator agents work with more than just the CCO. Be more transparent making CHAs and CHIPs, along with metrics more readily available.

257 There is a need for CCOs to support the work/contribution of LHAs towards meeting objectives and incentive targets.

258 NO

259 We are making all of the changes to providers or care rather than the seekers of care. We are spending so much extra to solve a problem from the wrong end. In my experience in rural healthcare in Oregon over the last two decades I have seen that it is not the access to care that is the barrier (although it can play a small part) it is the mindset of the OHP members. When a patient calls and asks for an appt at our office and we offer them one within 24 hours they will take the appt then go to the ER later that same day and not show up to their scheduled appt.

The ED is over utilized because so many OHP members want "immediate" access to care not because they cannot access it. We need to start addressing the utilization problem from the patient or member side. Hold members accountable when they don't show up to a scheduled appt and hold them accountable for choosing to go to the ER when they have options to go elsewhere.

Also we need more specialty care that is open to Oregon Health Plan members as well as more Primary Care that is open to OHP patients. The lack of mental health and addiction treatment programs also creates community wide problems like child welfare and criminal activity.

We need to have inpatient treatment facilities that are available to our own communities and not first come first serve to the rest of the state. Douglas County NEEDS inpatient mental health and addiction treatment. This would greatly reduce the cost of healthcare in our area.

260 There are so many barriers that get in the way of families being able to access behavioral services as well as other services including: transportation, employment, housing, and child care. Meeting these needs would greatly improve a family's ability to attend services regularly.

261 Public Health offers services to improve the CCO's incentive measure rates but unlike clinics, they do not receive any financial incentives. I would hope that in the future this would change because unlike the financial incentives in the clinic, the money received by Public Health would go back in to the community.

262 It is unconscionable that CCOs receive public dollars and are not required to have a clearly defined and transparent process for distributing their community benefit dollars. As a public employee my salary is a matter of public record, as are all emails I ever sent. Hold CCOs accountable for communicating how to access community benefit dollars to the public and share the resultant impacts.

263 CCO's should not be allowed to be sold for profit. We the citizens of Oregon invested in these organizations, they are a public asset and should be treated like a public agency. I do not agree with the concept that I pay to make a program work for Oregon and it can be sold out from under us.

264 Make CCOs subject to same rules and regulations as commercial insurers. Many CCOs seem to think rules don't apply to them. Don't allow behavioral health carve outs. Period.

265 There needs to be more comprehensive addictions treatment and peer support programs

266 The CCO's should keep in mind that a large factor in the success of their efforts to cut costs is the partnerships with service providers in their communities. Alienating and de-funding programs that work directly toward their incentive metrics and/ or social determinate of health is a short sighted plan that results in cutting off one's nose to spite their face. These partnerships have been extremely fruitful in the past, and decisions made in the last six months have put a large amount of undue strain on these relationships that will have far reaching consequences for the consumer if these practices are the foundation upon which the CCO 2.0 model is built.

267 I found that our CCO was very limited in choices for primary care doctors. In fact, my children were never able to find primary doctors that were MDs. We could only find nurse practitioners, and in our experience, they weren't that helpful as our medical issues are very complex. For us, being able to choose a primary doctor outside of the CCO would be a huge benefit. I also think if we had a competent primary care doctor, we wouldn't need specialist care or hospital visits as often, which would help keep costs down.

Our choices for specialists I found to be adequate.

268 1. County of origin: remove barriers for family that receive their benefits in one county and choose or need to seek care in another county. As a regional medical center for certain medical specialties we often care for families in the hospital who live in other counties or families choose to receive primary care in our hospital based pediatric clinic due to lack of choices in their home community. There is a tremendous amount of time and energy required to get authorization for these type of out of county services.

2. Improve options/remove barriers for families seeking to reach OHP or their CCO about things like address changes. The local CCO should be able to handle all of their member's insurance needs rather than redirecting families to call OHP where it's likely they will wait for long periods of time. Many of my clients are using pay by minute phones, this is a huge barrier and very confusing to families who don't understand the structure of the OHP.

3. Change the way children are assigned to CCO's. In my practice we are routinely advising families of a change in their CCO. Most families don't understand the process and are surprised to know they now have an insurance our clinic doesn't take. Often families insurance will terminate and they will be assigned to a different CCO when they reapply for benefits. There appears to be no notice taken of whether family has been long time patient of this clinic or not. This is very disruptive. Additionally, when authorizing outpatient specialty medications that are often time sensitive when a child's insurance changes the entire prior authorization needs to be redone with both specialty pharmacy and CCO. This routinely leads to placing children at risk for infection while paperwork is reprocessed and a time delay.

4. improve options for mental health prescribers across all counties.

269 We must increase the number of mental health therapist in this area, Jackson and Josephine County of Oregon. There are way too many people slipping through the cracks that are in need of mental health and addiction care.

270 Provide more services for children with high mental health/behavioral needs. Do not use strict portal to determine who gets services based on a profit goal. Invest in wraparound services for these youth.

271 No

272 CCOs need to contract with the state public health lab. Many local health departments use the OSPHL and since the CCO in Eugene does not contract with the state lab, the local health department and OSPHL can't bill the CCO for lab services. So the local health department ends up using general funds for lab services that should be billed to the CCO.

- 273**
1. eliminate carved out mental health budgets and systems...eg. no more use of independent entities who are given an annual MH/ SUD budget to "manage" with secondary loss of parity and impaired coordination.
 2. eliminate for-profit entities while maintaining reasonable reserves
 3. increase financial incentives for prenatal and early childhood programs for all CCOS...the benefit may be seen years later but annual budgets and moving populations disincentive prevention and promotion programs.
 4. Make CCOs participate in the responsibility for maintenance of behavioral health continuum of care with OHA, DHS, OYA DOE...bricks and mortar as well as provider expertise to deliver evidence based or informed practices in a trauma informed way.
 5. Create uniform statewide contracting practices between CCOs and behavioral health and SUD providers:
 - a. rates are aligned with living wages for provider employees to encourage retention
 - b. rates are high enough that providers can maintain infrastructure
 - c. contracts have the same language
 - d. UR practices are based on consistent UR criteria and implementation is consistent across CCOs
 6. create strategies to have the potential for blended funding for members who's psychosocial determinants of health are impacting health care through community partnerships.
 7. incentivize and eliminate barriers to high quality MH providers succeeding in the PCMH.
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274 Not all CCO's are the same. That in itself is a problem. In Lane County our CCO is a for-profit, private corporation. That is so against what should be allowed for overseeing Medicaid dollars and Medicaid client care. The whole push for CCO's was to "improve client care." In the past 5-6 years I have only watched them decrease client care and focus primarily on their profits. Lowering reimbursement rates for mental health practitioners has effectively lowered the quality of care they are receiving. There is no way to be a fully effective provider, if your caseload is too high to allow time to research and/or thoroughly staff, plan, and conceptualize a client's issues. If providers are continually forced to see clients back to back, the clients are not getting a provider who has time to thoroughly consider and address the client's support needs. The CCO in Lane County cannot provide any logical reasoning for reducing the reimbursement rates to providers when they are mainly focused on providing their shareholders an ongoing profit payout.

There should be regulations against for-profit, private corporations, managing Medicaid dollars. If you want quality care for clients, then you need to pay the providers to provide that quality care. The CCO's are putting providers in a position of not being able to provide quality care. Therapists are burning out and not staying at agencies for any length of time. PCP's no longer stay at medical clinics for the duration of their career. There is high turnover happening among providers that never happened before and clients/patients are paying the price. The CCO's are certainly not paying any price for the lower quality of care being provided.

275 We have experienced a significant difference in payment methods and rates from the various CCOs in Oregon. Some have purposely kept their rates lower, which impacts the provider's ability to pay competitive wages and provide adequate care to clients.

276 Prevent clerical debacles like I experienced in late 2017, where I very clearly requested Health Share of Oregon to maintain my healthcare of 20 years with Kaiser for my rare genetic condition. Yet was incorrectly assigned to Family Share (I think it was), the one that was folding. (Ironically right before it folded.) I was without health care for 3 months for a tricky medical condition (I manage joint subluxations and mild anaphylaxis on my own daily). It was a nightmare getting this sorted out and that was independent of the massive challenge posed by Family Share closing forcing other CCOs to onboard all their clients. These were needless and costly (to me) clerical errors. (Slow down, pause and check, train better, whatever you need to do, but get it right the first time.) This was a massive and needless debacle IMHO.

I'd also REALLY like the ability to see a naturopath and get acupuncture and massage - these are all MUCH better for me than regular "pilling and billing" standards of care, truly. I'm positive you could save millions by allowing people to access naturopathic care, and/or functional medicine which actually helps treat root causes, vs traditional allopathic western care only which keeps people sick by only treating symptoms. (Think about it.) I feel I'm having to suffer needlessly because of this. I would also need less pain medication with massage and acupuncture and naturopathic care. TY.

277 Health equity isn't only gender, race, religion, ethnicity and language. It is also related to behavioral health, transportation and housing. Frequently members who have trouble navigating society because of their behavior also have problems with maintaining employment, housing and health care. They get fired, evicted and even fired from their providers. To me this means we are not meeting their needs. Both the health care/behavioral health and substance use providers need to be educated on how best to work with these members who often get most of their services from ED or Urgent care. They also need education but we all need to learn how to work with these members so they can receive preventive care rather than emergent care.

278 As a Case Manager who has worked w/ Mental Health clients, everyday I see how the negative impact of lack of housing and income cause clients' health outcomes to be limited by these barriers. RideSource is a shining example of a great way CCO's can reach out and assist those in need. It would be nice to see this level of support w/ housing and other things that limit clients' overall physical and mental health. I believe OR should lead the nation in showing the positive impacts upon its population of truly having a Housing First model, where there is lots of talk but much less action. It's difficult--if not impossible--to help someone become healthier when they leave the clinic to go back to the Mission or their tent in the middle of winter.

Oral Care is also something that desperately needs to be improved. In the decade+ I've worked w/ clients on Medicaid, I've seen abysmal practices where insurance only seems to cover pulling teeth. When I've seen clients get denied housing and jobs due to poor oral health (e.g., missing and/or rotted teeth) for years, it's very frustrating for them and for their helpers such as myself.

Also, most of my clients complain about having to wait "months" to see their PCP, who is often so overbooked that even when they finally do get to be seen, they aren't really given the time, care, and attention that these people deserve.

As a community worker, it would also be nice to see better compensation rates for those of us literally delivering health to Medicaid consumers. It's a convenience for the patients, and it would be nice if those of us who do this very difficult community work were compensated more appropriately as such.

279 Give providers/agencies credit for when clients do not show to their appointments.

280 MORE RESOURCES FOR ADDICTION AND RECOVERY!!! ALLOW CHOICE FOR INPATIENT TREATMENT SERVICES AND FAITH BASED PROVIDERS!!! HELP SOLVE THE GROWING OPIOID EPIDEMIC NOW!

281 The CCO model is good, but it is overlaid on a bloated and dysfunctional provider system. It is very difficult to change the practices of the providers to increase efficiency and responsiveness to the system's needs, like better access, longer clinic hours, more responsive services. It is such a huge and entrenched system, and patients are taking less responsibility for their health. Disparities are great as well. It is hard to make change in a system like this, yet the CCOs are doing that at many levels. It will take a lot more time though!

282 The CCO's have helped a lot of people improve and maintain their health. I am happy that the State of Oregon has invested the time, energy and money in the CCOs.

283 I may be bias, but PacificSource in Central Oregon and the Columbia Gorge has been a great model that OHA should reflect on for what should be expected from CCOs. They have done a great job of focusing on integration with the community and partnering with local health councils to distribute incentive dollars back into the community to fund healthcare improvement programs from a wide variety of community providers. They have built solid relationships with providers in all domains (i.e. Physical Health, Behavioral Health, Dental Health) and taken a collaborative approach to address disparities within the communities and identify opportunities to improve the overall health of the OHP population.

In the future I would like to see more work being shifted towards prevention and targeting the entire population, not just OHP members, as I think this could ultimately have a greater impact on the Triple Aim.

284 With the move toward more value-based payment structure adding capacity funding as an additional way to improve care, improve patient experience and save money.

285 It is my understanding that YCCO providers in behavioral health are the only ones required to limit sessions to 8, 10, or 12. Adding paperwork to re-evaluate client's mental health symptoms in such short periods is not very trauma informed. If we look at the population we serve, it is not very trauma informed to ask client's to lessen symptoms within that time frame. It would be better if we can focus on treatment and supporting clients to manage skills with the understanding that the population we serve will be in treatment for 1-2 years (LOC A & B's).

286 I am a provider working for a community clinic. I find that endless surveys, metrics add an unnecessary time burden to already time-pressured medical assistants and providers.

For example, filling out an EHR form re social determinants of health does nothing to improve the state of the client. Instead, we need more ACTION and RESOURCES and less filling out of forms whose data simply ends up in the EHR.

There is excessive bureaucracy and insufficient action to address the variety of issues that clients face.

287 Create a Citizen Review Board model of oversight.

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- 288** There is still an inordinately high level of red tape to navigate, and unfortunately long delays for approving referrals, treatments, etc. The system is a good one, but it needs to be streamlined.
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- 289** Have specific requirements in place and disseminated to the CCOs well before requiring reporting on these metrics.
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- 290** Trauma informed practices need to be required in all settings. Especially with children.
Increase use of CHWs
Use Community Health Workers to better engage patients in their care through portals to view their own notes (OpenNotes)
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- 291** no thank you!!! i would not like to add anything nor do i have anything to say , thank u.
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- 292** I am very proud of our local CCO- Yamhill County CCO!!!!!!! I think all CCOs should be non profit and I am proud that our CCO also looks are education and other social services in a very integrated and authentic way.
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- 293** Implement a performance management framework similar to the one Washington State has with Affordable Housing and Community Action Partnership receiving more than \$500,000 in funding.

It is based on a framework similar to the original CCO governance model and eight domains. Senator Mark Milocia was key in setting it up.
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- 294** Be strategic and get lots of input. Ensure there are enough well paid providers including licensed naturopathic doctors and other modalities who are well qualified to provide services. It is one thing to have health coverage, but access to healthcare is significantly lacking particularly regarding dental, mental health, and addiction services.
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- 295** A bigger problem is the way the State of Oregon handles financial affairs
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- 296** If there was \$\$\$ or resources from a CCO to help with housing will be much cheaper than paying for ED visits.
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- 297** The EOCCO / GOBHI is an outstanding organization!

Anyone w/ an OHP # should be treatable across the entire CCO treatment spectrum, regardless of location w/in Oregon.
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- 298** Assist with oral health integration-
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- 299** I think that CCO's as well as OHA need and must place a higher value on universal/primary prevention and behavioral health promotion. Right now the system seems more motivated on developing a new cost containment system - new way to control costs and way to provide payment to providers but not prioritizing and investing in strategies to really be more proactive instead of reactive. Behavioral health promotion and prevention must have a more valued seat at the table for lasting positive change to become a reality. CCO's need more accountability.
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300 More funds need to be allocated to preventative services. CCO's should not be giving out hundreds of thousands of dollars for pilots that more or may not work while paying the actual (and proven) preventative services at a lower rate.

APM's and quality measures should not use the Michigan model. You don't know what benchmark you need across the state to contain cost/achieve outcomes that you're looking for? i.e. all CCO's should be held to the same benchmark. Putting the burden on primary care to reach the 90th percentile in metrics puts an undue burden on clinics and has less 'bang for the buck' for the CCO's when we should know the outcomes we're looking for. The feeling is that you're spending a quarter to save a nickel in many cases. Five pilots can't say they saved a CCO a dollar when something only cost 3 dollars to begin with. Provide those funds to the people who are actually doing the outreach to patients on a daily basis to provide better care. If primary care has a 20% increase in staff, we could do daily outreach to patients on the metric gap reports.

Metric gap reports need to be provided to those doing outreach in a more efficient manner. You can't hold clinics accountable to metrics and not provide them the list of patients that are not meeting the metric.

Specialty care practices should share in the quality improvement initiatives. An orthopedic provider can't check someone's blood pressure?

Focus needs to continue towards preventative services and funds need to be allocated that way by CCOs. We put more burden on primary care, have them work harder and harder on ever rising metrics yet put very little emphasize on specialty and hospital care where the majority of cost is incurred. Better fund the primary care without stricter metrics and shift that mentality to where the majority of cost actually is. Better fund preventative services without the strict thresholds and put those thresholds on higher cost services instead. Better financially support the people working to improve population health on the front line everyday. Step foot in the clinic and see what they need. The number of CCO representatives in our clinic in the last two years?: One, from One person just to hand a notebook of the new metrics.

301 To improve the outcomes for behavioral health, the CCO's need to significantly increase the rates paid to community treatment programs. A recent cost study showed that HealthShare is paying far below market to thier community non profit partners. DMAP FFS rates need to be raised to reflect the true cost of delivering quality mh and addiction treatment. Another issue for those using alternative payment methodologies is that we still need to reconcile to billed encounters in order to meet the "risk corridor". Many codes don't capture the true nature of our work to better engage and support our clients.

302 Transparency. Public open forums.

303 CCOs operated by corporate interests do not have community needs and reinvestment at the heart of their operational motives. They are charged with returning profits to investors. It's OHAs job to create policies that put Oregonians' health first.

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- 304** CCOs must have more oversight. They provide less than quality care due to low reimbursement rates for providers. Many providers are dropping out of the pool resulting in less qualified providers providing services and fewer providers available. The state could do better using the FFS model with more controls using the successful features of coordinated care models without turning state (taxpayers) money over to companies with little to no oversight of how the money is being used. Lack of accountability is detrimental to healthcare for our needy and with adequate financial oversight the state could cover more needy individuals without raising taxes. Only through accountability will the state be able to provide the best care to the maximum number of people.
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- 305** Require all CCOs to do centralized data reporting to the state, and that the state be transparent in its use of these data
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- 306** Pairing with more agencies to address SDH.
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- 307** The expectations for care, coordination and collaboration is great with little funds to supply the governmental expectations.
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- 308** CCOs are performing unequally across the state - Health share for example is doing a tremendous job with integration of Wraparound, SOC and traditional healthcare workers who address many areas that are in this survey and lacking elsewhere. Move over to another CCO in Lane County and they don't invest the same or even have an understanding of the importance and role THW play in the community and are sorely under-funding services and supports - especially with the transition aged youth population. A major problem are the inequalities between the CCO's with options for care, community involvement, understanding of SOC/THW/social determinants of health/transition aged youth etc. Overall behavioral health care with the CCO's has played out the fears we had with integration of physical/oral/behavioral health in many areas with the medical models taking over because that is what they know the best. We don't want to give up on integrated care, but changes need to be made to ensure that behavioral health care is quality regardless of where you live. Additionally, community based services and supports must continue to be invested in while also addressing the inpatient challenges for children/youth and addiction treatment. The wait times are literally killing people across the state - the suicide rates are way higher this time of year and we are losing youth.
-
- 309** Implement measures that require CCO's to work collaboratively with local health and human service agencies (i.e. mental health, local public health, DHS etc.) Some CCO's are very collaborative while others don't see the added value and benefits for it's members. Help CCO leadership understand that it's not always the \$\$\$ brought in by every dollar invested, but rather the improved health outcomes of it's members and dollar saved through prevention of disease states.
-
- 310** Health Equity is vital
-

311 I am disappointed in the lack of service for Behavioral Health. Access is a big issue and will continue to be until Oregon puts money into the provider base. We cannot expect clinicians to work with our most vulnerable people on a salary that barely pays the cost of living.

Also I look at states like California and Washington which have a single medicaid plan across the state and feel that system would help relieve the burden on providers to have multiple contracts with different CCO's different systems and requirements for billing and reimbursement.

We have a long way to go before we can start tooting a horn about the way Oregon has managed the Medicaid population.

312 Some CCOs require more from their Primary Care offices than other CCOs and don't adopt the Alternative Payment Model forcing their patients to have to travel to the Primary Care office to get the services they need. In turn driving up the cost of health care and putting a burden on the patient. I would like to see more coordination across the CCOs for organizations that work with multiple CCOs that have less hoops to jump through for the Primary Care Offices.

313 CCO's need to require patients get screening such as colorectal cancer screenings to maintain eligibility with Medicaid.

314 Better follow-through when clients are entering services, more flexibility for young adults in regard to income limits, better collaboration between organizations.

315 Consolidate to a single payer system in the state of Oregon. Managing to 16 or more separate CCO policies is insane. If that's not realistic, then insure all CCO's have standard systems for referral management and authorization processes.

316 CCO's need to have consistent electronic pathways/tools for providers to access for prior authorizations and eligibility

317 They need to take care of their patients. I have long piles of procedures that have been rejected and refused for services. We have lines of complaints and people's health in jeopardy because they don't want to pay for medically necessary services. Hernia repairs are just an example. We almost had someone die in the ER due to the CCO not approving a hernia repair procedure. The CCO ended up paying extra on a surgery if it had not been neglected for such a long period of time.

I had a lady dying of breast cancer. We simply needed her to be able to see the physician she had been seeing (prior to being on OHP) and she was denied care because they wanted her to see the physician of THE CCO'S choice. I am not even sure if she is going to the doctor anymore. She told me she gave up getting care.

The closed borders of the CCO's keep Oregonians from receiving proper care. We are in a very rural setting here in Curry County so 80% of our patients HAVE TO TRAVEL to see out of area physicians. Obtaining these referrals/authorizations have been crippling, time consuming, and such a stress to our patients. Open these restrictions and allow us to put these certain people back on open card!

318 CCOs should be community-based nonprofits, not large corporations.

319 The time has come for this to end. The CCO's are not working. As it is a national pilot... end the pilot and implement a roll-out of the Affordable Care Act that is more aligned with what other states are doing. Oregon need not be unique. At minimum... remove Children's Behavioral Health from the CCO structure as it is not working and the CCO's have shown no desire to fix it.

320 No. Thank you.

-
- 321** Everyone should have more than one cco to choose from regardless of location. No private for profit corporations should be allowed to be ccos. No one should be forced into a cco if they prefer open card. Especially natives. Every pcp should be required to accept open card.
-
- 322** CCOs need to be more involved with the wide community. It seems that only selected groups or organizations are involved with them. More transparency in their organizations. And to start thinking outside the box to really help their community.
-
- 323** More local options for families of children who experience Mental Health challenges. Like more Respite. Or local overnight stays in a home like settings to stabilize and then return home.
-
- 324** - If possible, OHA should only contract with non-profit organizations for the next CCO contracting period.
- Related to behavioral health specifically, OHA should maintain more oversight over each CCOs Utilization Management processes.
- More money for children's services.
-
- 325** Your survey is a very leading survey , leads you the answers you want. Oregon would be in much better position if the Oregon Health Authority would have never implemented, when has a program developed by the government been successful? It is a way to create new tax to pay for the people they hire. I guess everyone needs a job. The fewer people we have working for the government, the less taxes the government would need.
-
- 326** First there were HMOs then PPOs then CCOs. Stop with the verbage and just provide decent care to all who need it. My supervisor spends hours at CCO meetings, but I do not see any change in the type or quantity or quality of care provided. OHP has way too many limitations on payments for children with special needs. It really does not speak well for us as a country. Insurance companies and pharmaceutical companies run medical care. This is a ghastly truth. It needs to be fixed.
-
- 327** Behavioral health agencies are not well funded and State documentation standards are barriers to recruitment of highly qualified staff members.
-
- 328** Make it more difficult to enroll in the OHP. A waiting period may be beneficial. Now that we cover Hep C and transgender, family members and friends move to OR specifically for treatment. This is not a sustainable practice.
-
- 329** No. They have provided a great deal of support for our communities.
-

330 I would like to see the CCO in my county take a more active role in engaging social service providers. The CCO has an opportunity to bring people together to work toward some common goals, but in my county, many social service providers are left out of that conversation.

I would like to see more investment in wraparound. The value of getting everyone who serves a family sitting down at the same table to collaborate can't be underestimated.

I'd like to see person-centered planning as a stronger value / approach of our primary care physicians. I would also like trauma informed practices to be brought to every level of our healthcare system.

I would like to see further investment in prevention services (in a broad sense). Knowing the impact of ACEs, I would hope to see increased support of programs such as Relief Nursery and Healthy Families.

My strongest recommendation is to increase investment in traditional healthcare workers. For example, family and youth peer support workers can address many of the social determinants of health. They are trained to approach the individual / family from a holistic perspective, and their services cost less than most medical / mental health services.

Thank you for seeking feedback. I really appreciate the effort being made to gather many people's viewpoints as you move into the next stage of planning.

331 Provide easy to read material, and place it in locations where people might see it... places where people would not necessarily be looking for such information... maybe grocery stores, shopping malls, Wal-Mart, drug stores. It was years before my family knew such services were available... and we have seen some we would not use due to inadequate personnel and/or facilities... coupled with lack of appropriate training.

332 It would be helpful to allow children to be covered by private insurance and have a cco as secondary. My child lost his ohp due to having private insurance. He needed dental work which cost me \$1200+ out of pocket. I didn't know what to do. I had to put it on a credit card and borrow from family to cover it. The working poor should not have to endure this.

333 More availability of evidence-based substance use disorder treatment is needed

334 Organizations that administer public funds for the benefit of our community should not be permitted to make a profit on those funds. Limiting CCO's profits, requiring investments in improving the social determinants of health and requiring use of alternative payment models are the three most likely strategies to improve health and reduce costs.

335 CCOs should explore more integration of clinical pharmacy services into the primary care setting.

336 should include preventative care, such as naturopathic care and acupuncture.

337 My experience in terms of my son's behavioral health is that Trillium gets good metrics for reducing costs by denying services such as hospital stays and residential treatment. They do this by either refusing the stays or by not allowing him to stay as long as necessary. They seem to focus more on getting their own bonuses - yes, we do know that they get them - for "reducing costs" than improving mental health outcomes.

338 The CCOs should be more consistent with each other. Providers should also be more willing to take OHP in general. Kaiser Permanente should either get all the way on board or get all the way out. Accepting health share and not wvch should stop.

339 I feel strongly about oversight and requirements for CCOs profits and salary structure within the organizations; most seem to pay themselves well and then refuse to pass appropriate payments on to providers. Health Share created an additional level of bureaucracy, rather than streamlining, and even years into the conversion they are still struggling to make decisions.

An additional recommendation is around the differences between CCOs and how they interact with providers; I know that discussions have begun to get them to behave in more similar ways- I think that is a huge step in the right direction. Each group has created their own set of expectations, processes, payment structures, APMs, etc. Instead of making processes more easily navigated and coordinated, this has the opposite effect.

340 When an individual as to be sent out of their catchment area for services (ie. residential SUD or residential MH services), they are typically in need of physical health and oral health needs as well. It is almost impossible to get them easy access to local health care outside of the cco. It was much easier to access these service elements when it was an open card.

The credentialing process needs to be the same between all CCO's with a central credentialing bank. Also, authorizations for services needs to be the same between CCO's as well, one application and process for all.

341 I would like to see CCO's work with existing programs in place such as NEON- Community Health worker training program and work with organizations like NEON in rural communities to balance the care to community members.

342 OHA should take back residential treatment for adults and children. OHA should increase its oversight about quality of services and adequacy of care coordination. All services and care should be available in all CCO areas and not different in some. CCO's should either cost less than what it took for OHA to administer OHP or administration should revert back to OHA.

CCOs should collectively pay for statewide ombudsman services for children (in and out of state custody) and adults.

343 Require funds be spent on patients not profits. Require support of public health services.

344 Do not allow CCO's to pocket money and then sell themselves to an out of state buyer, and the share holders of the CCO make out with millions of tax payer money. Many OHP consumers in Lane County have had to wait years to get the services they need as a result. Stop this criminal behavior by CCO's.

345 There is way too much variability in the quality of CCO's around the state. I don't think that any of them should be for profit---profit should all be reinvested into the community. Increase use (and payment to) peer delivered services. Support local training to bring on more certified health care interpreters. CCO's need to work closely with community behavioral health services and schools--and plan WITH LMHA's how to treat the uninsured. I'd like to see more upstream spending in early childhood education and early childhood mental health as well as in family-centered approaches. Particularly in mental health, take a look at any billing that requires the patient to only be the child--working with (especially younger) children should almost always use a family approach and there need to be billing mechanisms to support innovative approaches to working with parents or other longterm care givers.

I think that Ride Share is working well and have liked the role that CCO's are taking in promoting the Systems of Care approach in the children's system.

346 It would be very helpful and more cost effective for patients and providers alike if the CCO could better align assignments with a patient's primary coverage or their request for a specific provider. So often patients aren't seen at the correct location because they do not understand that they were assigned to an organization that they didn't request. This creates an issue with not only payment but coordination of care.

347 Integrate BH funding. Reassert relationship and joint authority with LMHA/LPHA/CCO. Insure PH /prevention supported in local communities. Eliminate clinical COI on CCO onwards. Give equal consideration for BH integration as a primary health home.

Thanks for asking!

348 Work on getting the word about what you actually are. I work in the healthcare industry and I barely know what you guys do-- I can't imagine how invisible you are to the average Oregonian.

349 I feel that our CCO should help us more. When we have questions on codes or billing they say they can't tell us how to bill. Who else can then if our CCO can't. Our phone calls are not returned in a timely manner or not returned at all.

350 Enable greater flexibility in accessing providers, especially in cases of minority care (e.g. trans/LGB healthcare needs) and rural access

351 I think there should be a cap on the amount of money a CCO can receive and redistribute to their shareholders. This is federal money that is supposed to be used to take care of the people, not line the pockets of the company just because they "save money" or meet their metrics. The amount of money that was distributed to one of the CCOs and redistributed to the shareholders in our community was criminal, in my humble opinion.

I feel that the funds could have been used to better our community rather than taken as a bonus by the CCO. The CCOs should be more transparent and report to the communities where the money is going and how it has helped, with supported data. They should also help out in the community and schools with updated, relevant, evidence based programs to help break the cycle of homelessness, violence, drug addiction and poverty.

If you want to take a pulse on how our children are doing, I would invite you to volunteer in a Title I grade school classroom. It is truly heartbreaking to see the lack of support these children are receiving outside of the classroom in their communities. These children at an early age, are already dealing with problems such as; drug affected parents, poverty, hunger, mental health issues of both their parents and themselves, homelessness, and the list goes on. No child should be saddled with such issues and not have the support to cope effectively and in a healthy manner. Our educators should be given financial support, staffing and tools to help support the child's ability to learn, even though that child may live in chaos.

The CCOs need to also sponsor workshops for the medical, public health providers, and school employees in the communities to hit these problems head on. There is not enough training to recognize some of these problems at an early age to prevent future increased disparities. The CCOs need to spend money so that EACH school, in EVERY district, has at least one behavioral health specialist and several community health workers to help families receive wrap around services.

By addressing these issues at early age, the CCOs are going to save money in the future. You also have the potential to change the life course of these children and possibly save their lives, while breaking the chain of disparity.

352 I do think it is important for the state to transfer the residential MH benefit to CCOs. Also important to work toward putting CCOs at risk for state psychiatric hospital.

I would also recommend Oregon seek a waiver for SUD services within the 1115 Waiver authority to allow Oregon to use Medicaid for residential SUD treatment, thereby freeing up dollars to put toward other components of the SUD system such as peer recovery mentors, expanded use of Medication Assisted Treatment for opioid use disorders, intensive case management and outreach to individuals who have not yet been identified but have serious addictions.

Screening, early intervention, assessment, and treatment in the area of early childhood development and learning needs to be more pronounced in CCO contract language to drive attention and focus upstream.

353 As an agency, we need to be careful about not giving too much power and authority to the CCOs. There are many people they don't serve, that OHA serves in other ways. I get concerned that if our focus is only on people being served through CCOs, others in need of services aren't getting what they need from OHA.

I don't believe that they should be the lead in SDOH work; rather they should be mandated to be the followers. The correlation and economics around Countries who invest in SDOH is clear; they require less of an investment in their healthcare system. If we're going to have healthcare invest in SDOH, it should be at the State level, not at the individual CCO level. My solution is more radical - put some of the CCO funding into a pooled statewide fund and then OHA should fund social service organizations to work with OHA and our joint clients to improve housing, transportation, poverty, hunger, and inequity.

354 People seem to be more invested in their care if they pay at least a very small amount for their services.

355 Thank you.

356 CCOs should not be owned by massive, national corporations who profit from public healthcare dollars that should be going to patients. CCO profits should be heavily regulated and taxed, and nonprofit CCOs should have preference and protections. Nonprofit CCOs provide a higher value for Oregon patients.

CCOs have an incredible amount of power in shaping local community healthcare infrastructure, and a balance should be maintained between making sure that CCOs are funding high-quality care through specific service requirements and allowing local clinics to practice in ways that they have designed to meet the needs of their community. Currently, new healthcare services and expansions are designed around bending over backwards to meet the needs of the CCOs, frequently causing an increased barrier to services due to the decrease in service flexibility.

The state should collaborate with CCOs to address social determinants of health, particularly the state-wide housing crisis. Housing should be the highest priority - justice and human rights aside, a lack of housing is well-documented as causing cascading health risks and drastically reduced outcomes. Investing in affordable public housing will save everyone money, and save lives.

357 1) Create structures to measure and evaluate issues with discrimination, access to healthcare
2) Be a leader as it relates to driving issues of health problems - namely, homelessness, lack of affordable housing, benefits income which are poverty rates (TANF, social security), food insecurity, racism
3) Be a leader nationally on pharmaceutical costs. Bring the costs down and make sure that essential treatments are available regardless of income. Example, HEP C
4) Set reasonable guidelines on the structures of CCO's, including salary/benefits. Make sure they are not operating in a manner which is causing financial harm to the provider system. We should make sure those providing the services have the appropriate pay and benefits so that we are not impacted by high staff turnover and quality of care is not compromised.
5) Promote excellence. Training's on best practices are available across the system of providers in an equitable and cost effective manner.

358 CCOs should have an easier process to access Behavioral Health Services. Possible create a system/organization where a building is created for housing, mental health, oral and primary care is housed for medicaid recipients seeking help. A 360 approach to healthcare. Not just health but food, transportation, mental health, oral services, and primary / specialty care. This can greatly impact a better outcome of the patient succeeding in their treatment plan.

359 Make it easier for members to understand options for primary care that best suits their needs rather than randomly assigning people to a provider. If I'm a gay man, or speak Spanish, or am African American I should know that there is a clinic designed especially for my needs. Not that I HAVE to go there, but I should be made aware of all the choices. Good for patients as well as a critical step towards health equity.

360 CCOs need to focus on Behavioral Health as the integration of mental health and substance use. These agencies are currently often separated with separate revenue streams, separate codes, separate CCO oversight and less monies devoted to SUD. Agencies are de incentivized to bill SUD codes, and driven to bill MH codes.

361 CCOs should reflect the demographic of the area they serve and not just be made up of the Health Services community (primary / behavioral / oral). Hospitals, Health Departments, etc work in silos. When you only talk to others just like you, you end up with a lopsided view.

You need organizations other than health at the table -- with a vote and a voice. You also need clients. You need law enforcement, schools, faith, business. They are the big fish in your 'clients' world and they should be represented.

Health is not just about going to the doctor when needed. Health is about having someplace to live (stable housing), food security, job security, etc.

One of the biggest gaps is . . . what happens when someone is homeless and ends up in the hospital. Where do they go for aftercare? Especially in small rural areas the CCOs serve. What happens to these people?

362 I would love to see more coordination with public health in the region. A lot of the work being done ties into public health programs and services. I think public health has valuable insight into how to help the CCO be a more effective provider.

363 I see many boards comprised of local providers. This can be a source of input as to current infrastructure, but more often creates what should be viewed as a conflict of interest. On one hand, these individuals are in a position to provide information on the need and usage of services. On the other, they benefit as a result of decisions made as by the boards they are on. I would like to see a balance between doctors, nurse practitioners, mental health professionals, consumers, educators, administrators, early childhood specialists, economists, social services, and the general public on CCO boards.

364 I think there is need for a check-in system with members. I come across a lot of clients who don't know anything about their coverage, their options, or how to communicate with their CCO. Many members don't do basic things like update their address or income because it's too much of a barrier to call and get put on hold for an hour. Perhaps more, smaller CCOs that can provide more individualized attention to members would be beneficial.

365 Look at differences between urban and rural CCO's, as their community needs will be different. Encourage CCO's in rural areas to provide more support to providers to address lack of providers/specialists. Give incentives to providers to work with specialists to help address local patient needs more. Knowledge sharing platforms like Project ECHO out of University of New Mexico: <https://echo.unm.edu/>

366 Oregon should adopt a Single-Payer system. Thank you!

367 --To decrease costs and ensure good BH care, require that CCOs pay parity between PH and BH side for same/similar service. Increased rates mean community-based BH providers can (a) pay staff at the same level as a primary care or hospital setting and (b) expand capacity to ensure quick access to services. This increase could be based on the predicted savings that would come on the physical health side. It could also come from a bigger push towards integration. The promise of integrated care isn't playing out as we'd hoped. For example, funding is still kept in separate categories.

-Paying for supports that help clients achieve recovery (examples include telephonic therapy, post-discharge maintenance, dual diagnosis/co-occurring services for all levels, employment and housing support, family counseling w/o patient, multifamily counseling and education, basic needs vouchers, service plan development, time for documenting and supervision of outcome work, no show and travel codes, residential care requiring medical services, etc.). This will require a thorough review of DMAP since many CCOs follow DMAP codes.

-Requiring OHA and CCOs to reduce administrative burden while helping us to increase the pool of well-trained behavioral health candidates with higher levels of education. One step could be requiring CCOs to standardize payment models and allowable codes across the state.

368 Any focus on social determinants of health will create better outcomes for lower costs.

369 My CCO feels like a just another arm of the hospital network that is in charge of it. They do not communicate with Social Determinant of Health Organizations very well (non-profits, social services, schools, etc.). They have a heavy focus on clinic services, specifically their own. There also needs to be a better coordination, communication, and relationship between the Public Health department and the CCO, specifically around the CHAs and CHIPs.

370 I would like to see patients be able to immediately transition to another CCO, that covers the area a treatment facility is located in, when patients are sent to a treatment facility in a different area from where they live, and then be able to transition back to their original CCO when they return to their home. Lack of ability to do this causes over-utilization of ER services because local providers will not accept patients with CCO coverage from out of area due to lack of reimbursement for services provided, by the out of area CCO.

371 There should be a standard formulary across CCOs with the same prior authorization and approval criteria to ensure equitable access to care. For certain medications, the requirement for a specialty pharmacy prohibits access in rural counties where no specialty pharmacy is available. It is important that the standard formulary and restrictions take this into account so as not to create barriers to healthcare and prevention services.

CCOs should have broader incentives for treating/preventing public health conditions, such as Hepatitis C, HIV, syphilis, and other infectious diseases. By screening and treating people we will decrease the disease burden in our state, thereby decreasing the long term costs of these illnesses. Screening and early treatment of HIV saves over \$350,000 in medical costs per patient and prevents new infections. For every HIV infection averted, we save over \$550,000 in HIV related medical expenses alone. We need CCOs to add incentives for preventing high costs illnesses in our state as well as the general primary care and HEDIS measures.

372 I would like to see EOCCO include a healthy living aspect to their care plan which would provide funding for individuals to access fitness facilities to provide patients with the ability to be involved in healthy life choices and thereby improve their physical, mental, emotional, and social health needs. I believe that through this type of program patients overall health would improve and thus reduce health care costs per person.

373 CCOs could improve by

- keeping providers happy-paying sustainably
- hiring more peer support providers for families, youth, and consumers
- require CCOs to work and/or fund with existing programs such as Title V and the Oregon Family to Family Health Information Center
- implementing a Shared Plan of Care for complex needs for children, youth, as well as adults

374 Case management should be prioritized and some home visiting services that were done by Family care should be considered by other CCOs

375 Currently, CCOs have incentives to implement short-term projects that meet incentive metrics. If they meet these metrics, they get money. However, these metrics can change. Once a metric changes, they move onto the new priorities and abandon work they did on old ones.

There seems to be very few directives on how CCOs spend the money they get for improving metrics. This can create disparities on how money is spent. For example, where I live, we have a regional CCO, and very little time or money goes to our coastal, rural area as compared to the more populated areas that already have superior resources.

When partnering with public health, CCOs have an expectation that small, underfunded health departments bear the majority of the burden and work, while they receive the lion's share of the credit and money. Why can't CCOs put funding into public health, fund positions, fund health promotion projects. It is incredibly frustrating to see the inequity in funding.

376 Given the inadequacy of traditional approaches to management of acute and chronic pain and the high cost/disability burden of musculoskeletal conditions, CCOs need to provide greater access to and inclusion of non-pharmacological approaches to pain management by qualified providers (e.g. chiropractic physicians, physical therapists, etc.), not just for "back pain" but for other common and impactful musculoskeletal conditions.

377 CCOs have done a great job in standardizing care and coordinating care among competing providers. OHP and Medicaid members are typically the hardest members to treat and improve health outcomes. VBP models can be challenging for CCOs to implement because it may incentivize poor quality of care if providers receive higher payments for sicker members, and reduce payment for doing a good job providing quality care and improving the health of members.

378 I do not. However, I think there is an opportunity to improve this survey! On several of the questions related to cost containment, social determinants, and health disparity, I found the choices were very limited. Adding open-ended "what else" fields may capture respondents' additional ideas.

379 In these decisions please include input from detox and residential facilities that work with ALL the CCO's. These individuals know how each CCO operates and must keep 16 different processes in context. A more unified set of processes would be extremely helpful.

Small town medical clinics seem to have little to no interest in learning or adjusting to CCO processes outside of their own CCO. When a client travels around the state or is sent to another CCO region for detox or residential treatment, clinics are refusing to treat clients without them signing promise to pay agreements that state, "client understands we will not be billing your CCO". This is frustrating.

As well, the switch/flip in dental coverage for this same clientele and lack of dental practices who will accept the coverage once it is switched are large treatment barriers.

380 Greater transparency as to their funding streams as well as how they allocate out the dollars, particularly as it relates to behavioral health, is essential - especially the Columbia Pacific CCO. In addition, greater focus in the communities on collaborative efforts, with all entities providing services in the community at the table, with an equal voice, is needed if we're really going to focus on improving the health of a community. Having at the table only those entities that they funnel dollars through leaves a huge gap in facilitating access to services for community citizens.

Heavy handed approaches, with mandates, do not do well when only certain populations of providers within a community are involved in those decisions, or dollars are funneled only to those public entities that the CCO has chosen to disperse dollars to - especially as it relates to behavioral health services.

While in general, the CCO staff appear to work hard to "standardize" processes throughout their network, standardization only works if you understand the workflows of all of the entities you are trying to standardize a particular process within and all of the patient populations they must work with. Due diligence is needed to accomplish this.

When it comes to access for behavioral health services in a county, such as Tillamook County, the roadblocks created for patients by the CCO by virtue of restricting payment for those services to ONLY those provided through the funneled dollars from GOBHI are insurmountable. In an era of integrated healthcare via Patient Centered Medical Homes, this approach is totally counter-intuitive and actually does the OPPOSITE of what the OHA has stipulated they desire to see for the OHP population and, for that matter, for all of the residents in a community.

381 More integration with Public Health. Public Health is able to impact health outcomes and increase health status and we are not included in any CCO funding. Some direct funding from CCO's should go to help support Public Health Services at County Health Departments to help give parity to smaller Public Health Departments who have less access to funding, yet do a lot of health equity work and direct services as well.

382 Providence Mental Health Services in Milwaukee has a great model for integrated care; very updated.

However, the financial aid determination is a significant barrier (tax returns, etc) that can not provide an accurate picture of current crises.

Its designed to prevent cheating, but the result is that any delayed treatment is essentially a failure to treat and needless suffering.

seniors on fixed social security are at risk;

The ideal solution as universal healthcare. It's such a politically charged issued that obviously in the last 10 years it's a polarized outcome. The state needs to be bold in taking steps to protect those at risk when they're asking for services. Financial ability to pay should never be the first limiting factor

If margins are so low that this matters, then the CCO may not be effective

383 Improve reimbursement rates for services provided. When you pay less for a vaccine than what the cost is for the provider to purchase the vaccine it makes it harder for providers to want to take OHP pt's. That is one example. I work at a clinic where we are small and put pt's before profit. We will never turn OHP pt's down, but get very discouraged when this happens.

Find more specialists in the Lane County area. Pt's can't afford to go out of area for specialty care.

384 Make it illegal for companies like family care to essentially give two weeks notice to patients and providers. Hire qualified staff to work in mental health (healthshare), don't allow government staff to drink on the job. Hire people who know what they are doing. Care for Oregonians. Offer rides to appointments, and more accountability to those on OHP who are abusing the system. Pay providers what they are worth.

385 Increase transparency at all level of CCO leadership and management, increase integration of care to address whole system health, including social determinants, use market share to drive down costs of care- including specialty physician and leadership salaries- as well as pharmaceuticals and supplies. Medical systems are all top heavy while the patients and taxpayers bear the brunt of financing that top. Health care is not suitable for a pure capitalist business model; the goal should not be to maximize profit over equity and accessibility of care. Period.

386 CCOs should be focused on delivering quality care and care coordination. Incentivizing CCOs to do the job they are contracted to do does not seem a sustainable strategy. Enforcing a contract that is already in existence seems a more efficient and fair way forward.

387 Take down the barriers for transgender people and add hair removal for the face i don't go anywhere my way of life is low because my dysphoria with my facial hair is so extreme and I have no way to take care of it this is a big deal for so meny of us please add this we need it.

388 The idea of outcome-based reimbursement is a little frustrating for us working in the healthcare field (and paying for our own health insurance).

Patients can comment negatively on services when their meal is bad for example "the hospital is terrible" etc

Patients need to be held accountable more, not necessarily the health care providers.

Someone seen in the ER time after time may not follow the recommendations of the providers and come back over and over to utilize the ER as their primary care -and the tax payers money (or cost the small hospitals money). I know someone who is diabetic and still eats a horrible diet... who's fault is that if his A1C is elevated still??? Not the healthcare providers!

Many healthcare problems stem from lifestyle. More lifestyle coaching, funtional

Medicine would be more helpful. Thank you

389 It's unacceptable to wait over a month for a primary care provider visit. The CCO most expand and include more providers

390 n/a

391 I feel like the whole OHP application and eligibility is a mess. I feel like we will often see families where one child is on OHP and another is not even though the application was submitted as a family. I also don't feel the that application process is very trauma sensitive, the system expects people with negative experiences related to opening mail to rely almost solely on mail information to get the information they need. Additionally I have had clients who were sent and completed the wrong renewal information and were then cut off from their OHP because they didn't complete the full application, which they weren't sent! I realize these things are bigger issues with OHP but they flow down to the CCOs. If the CCOs were truly interested in maintaining coverage and preventative access for clients there should be more assistance from the CCOs to do so rather than having clients who thought they had completed all the paperwork they needed to in order to maintain coverage show up to well visits only to find out coverage has ended and they have to postpone the visit until the coverage is re-instated.

392 Being fully transparent about changes in the community, keeping an open line of communication with the public regarding how/why the rules for billing/payments are in place, and being open about how funding is spent in regards to what health outcomes are projected to be improved or affected from that funding.

393 I believe CCOs should be limited to nonprofits. Every community should have a health advisory board made up of community members and service providers that works with OHP services.

The need for training & utilization of Traditional Health Care Workers (THCW) is huge in primary care, oral health care, and behavioral health. We need these positions to do the outreach & follow-up necessary for success of any programs we are currently offering.

Education of all sectors of support services regarding the Social Determinants of Health is crucial for all sectors to understand the importance of collective impact on supporting the health of our communities. CCOs should be rewarding collaborative efforts among service providers across sectors (healthcare, education, social services)

The Community Health Improvement Plan should not stop after its 3 year cycle, it should be ongoing with relevant updates from all stakeholders.

The oral health component of CCOs is not working. They are being paid for services they are unable/unwilling to provide:

-Current screening, fluoride, and sealant programs in schools do not necessarily result in children receiving the treatment they need. Communication between screening programs & treatment providers is poor

-Children in need of dental treatment are waiting 4-6 months for treatment

-There are no pediatric dental providers in rural areas

394 I realize this is a large issue and requires the involvement of many entities. This alone makes its success a challenge. I believe there are competent providers who are not able to services those in need because of the heavy paperwork load of OHP. I know there are disadvantages adults who have disabilities for which Oregon has not appropriate treatment (e.g. Fetal Alcohol Syndrome, DV couple treatment, adolescent recovery). I also believe that we have some professional on higher level decision-making boards who allow their desire for control to get in the way of making appropriate and necessary changes to our system.

395 The behavioral health side of CCOs needs to be looked at more closely with streamlined processes, transparently and oversight put in place. Although EOCCO has many successes, their structure for Behavioral Health lies on the line of corrupt.

Their Local Mental Health Agency Directors form the Board of Directors for GOBHI and then some GOBHI Board Members are also on the EOCCO Board (currently director at a local mental health agency serves as the board chair). By allowing the directors to form rules and policy on the GOBHI side and have a strong say in what happens on the EOCCO side, it provides opportunity to make a lot of money for their local agencies.

Many often deny services that are available locally, and requested by patients to ensure the money continues to flow into their agency. The current system is not patient centric it is BH Agency centric. If CCOs truly want to see BH integration, allow primary care practices to do this on their own and get paid for their services. The local mental health agencies are blocking this access and model of care because they do not want to lose funding.

Please make this an area of focus for 2.0. It is extremely broken!!

396 There need to be member responsibilities that are enforceable. There are currently no incentives to assist members with becoming less dependent on services. The list of member responsibilities is not enforced.

Members will call an ambulance and be taken to the emergency room for non-emergent conditions: i.e. skin rash/itch, unspecified sores, minor pain, and chronic conditions that do not change over time.

Members with mental health and addiction issues use the emergency room very frequently. Often times, other than being intoxicated, they do not have any other complaints. Many of these members are homeless and have nowhere else to go on cold, rainy nights. They will sometimes do this four or five times a month, and on some occasions they go twice in one day.

There are also no consequences for members who have anger issues and become violent. A member who brandished a gun at the county mental health department and has threatened CCO personnel should have been immediately terminated. There were no consequences for his behavior. Case managers were afraid to go to his home so he was not getting the assistance he needed.

There are transsexual members who are changing from male to female or vice versa. Any person who can afford to pay for their own health insurance does not receive this benefit. What is the annual cost to the state for these services? I suppose there are some circumstances where the transition is medically necessary, but no one else in the state is granted this benefit.

There are also the people who go through drug/alcohol rehabilitation over and over again. At what point does the State say it's not going to pay any more for this individual?

397 The quality of behavioral and mental health services available to people on OHP, despite the creation of CCOs, continues to be a significant issue. There are serious questions about the quality of these services based on licensure and qualifications (or lack of providers at higher level qualifications). While improvements have been made, physical and behavioral health services continue to operate in silos for the most part. It appears that in the effort to "prove" holistic screening and coordination, some patients are simply experiencing duplicate screening, etc so that all providers can check the appropriate boxes rather than truly integrating care. Perhaps this is due to the discrepancy between the providers who can accept OHP.

Additionally, the CCO regions do not align with other service regions. For example, there may be a single DHS district that has multiple CCOs serving families. Many of these families are highly mobile and/or communities have limited resources. When families have to access services in a neighboring community that is not in their CCO, it creates barriers to payment, coordination, and timely services.

398 Health Share needs to markedly improve in new enrollment to a RAE. There is significant issue with patients well-established in primary care getting assigned to a RAE not contracted with the primary care. This leads to major issues such as delays in care when clinic becomes aware of RAE assignment and has to request change to accommodate patient, and this creates unnecessary and avoidable frustration and anxiety for the patient. This issue is a major challenge and annoyance.

The OHP application needs to move the CCO choice (Appendix A) to section prior to signature. I have many patients who sign the application and think they are finished, so never look at subsequent pages.

Furthermore, the CCO choice page should have a section which asks if person is currently receiving care from a primary care provider, and to list that provider (and address/phone #?) if person wants to continue care. Then, this info should be provided to CCO so there can be proactive about making sure person is enrolled in a compatible RAE. This would be a simple fix leading to fantastic coordination of care. To ignore this is disgraceful.

- a clinic case manager

399 A major success of the CCOs lies in the localization of risk, decision making and community focus of the design. This has allowed a higher level of engagement from the provider community and changed how each community determines how they will spend their funds. While not perfect it is a different model and should be maintained while finding ways to increase economies of scale, reduce costs/waste/duplication and ensuring financial solvency of the system. While this survey focused on some aspects of policy there are modifications to the procurement process that can have a larger impact than these changes.

400 CCOs need to take direct responsibility for contractual obligations made by the state. At this point the CCOs are passing these requirements to service providers as part of those contracts which creates work for the service providers that is mostly not reimbursable. These duties create administrative burdens for service providers which results in decreased services availability for client/patient care.

401 Thank you for your efforts to improve EVERYONE'S health in Oregon.

402 In Wasco, Sherman, Hood River Counties (and maybe Crook and Deschutes) The residential drug and alcohol treatment programs that they are required to use, Best Care in Klamath Falls and Redmond only allow a parent to attend. All of the other counties in the state have at least one residential treatment program that allow a parent to attend treatment with a child while they are in treatment. This model has many benefits. When this started in 2012 this made it more difficult to reunify Child Welfare clients with their children since they can no longer attend residential treatment with their children being in treatment with them. Mid Columbia Center for Living has really struggled to be able to provide adequate services for children. They may have a child with suicidal ideation seen once a week by a crisis worker for at least a month until they can be put on the schedule to be seen on a regular basis by the same therapist. Center for Living will frequently deny children certain services due to what appears to be them saving money and not meeting the needs of the children. The CCOs have made it worse for our children to receive services and worse for families to be together when parents are in treatment.

403 CCOs should be required to maintain an adequate network of service providers and should not be permitted to keep a closed network (for example, community mental health provider monopolies). OHP members should have as much choice between providers as individuals with private insurance.

404 CCOs on paper are good, but in reality have fallen short. OHA has shuffled Oregonians over to CCOs and not held CCOs accountable for their care. If people do not like the way they are being treated they have no options for other care because they are tied down to their CCO.

Now there is talk of putting people with private insurance into CCOs. How will coordination of benefits work if that happens? If I have Kaiser insurance and state enrolls me in a Providence CCO my Kaiser will not pay if I go to my CCO and my CCO won't pay if I go to Kaiser. If coordination of benefits is not done OHA will force Oregonians to choose between using their private health insurance or their CCO coverage which is not fiscally responsible and also does not meet the self professed Core Values of DHS.

If OHA wants to make changes to a broken system they should do the work to find out how it is broken then make sure all of the "players" are at the table to address and fix the problems. Changes need to be measured and tracked. Too often things get changed based on an idea, but there is no baseline measurement and no follow through measurements to see if the changes are effective. Also, too many changes occur at once so even if things were being measured effectively you would have no idea which changes were good and which were not effective.

405 Non-profit and not-for-profit providers should get preferential consideration.

406 This survey was difficult to address because of the disparity between CCOs. Answering as "all CCOs" instead of the benefits of the different CCOs is difficult. The loss of Family Care was HUGE for this community this year particularly for behavioral health and specialty care, as well as the way FamilyCare met the support needs of clients (ie housing, transportation, employment). FamilyCare was an amazing organization that cared about members and supported providers. Their model needs to be studied and replicated in as many ways as possible. Finding a provider to offer a similar model is imperative.

Having Healthshare the only remaining provider (ie a monopoly) in Multnomah County is causing terrible danger to many clients from a behavioral health and specialty care perspective. Healthshare is inefficient and ineffective at providing mental health services to patients because it is forcing patients to use community mental health agencies in the name of saving money...even when it doesnt serve many patient needs effectively or at all, and the agencies have not kept up with community demand at all... This is not to say that HealthShare doesnt do some things well.. I do get feedback from clients and providers that they do a good job with medical services. However we simply MUST allow for another service model in this community in order to allow patients choice and control in their own care.

I am a provider who hears many times a week from community members that want to be clients... that community mental health has traumatized them, that their experiences at community agencies were "terrible" and that they wish to never return. Wait lists are dangerously long (months in many cases), provider turnover is too high to develop effective relationships, clients are misdiagnosed, and the process of getting care is too confusing and convoluted for many people on Medicaid so they simply drop out and dont get the care they need. I repeatedly have issues with people requesting to get care from me, and HealthShare turning services down "because community mental health can provide the same care for less money", but instead clients simply

drop completely out of care because they are horrified at the prospect of going into community mental health due to prior experiences. They are literally waiting for a new CCO to come on board to get help, or begging to pay out of pocket (which I cannot ethically do) .

. Clients are told they can not choose their own providers (ie private practice) and must use community mental health. It is a terrible disservice to clients to not allow them to choose private practice providers over community mental health because they feel it is best for them, and having HealthShare instead FORCE them into Community mental health. I believe this even violates mental health parity laws.

Meanwhile the invasiveness of HS's process makes it a nightmare for providers to take on administratively - the cost of putting together an authorization that is turned down a vast majority of the time makes it an ineffective use of time for private practice. They are essentially bullies.

Models more similar to FamilyCare, or even some of the other agencies like Clackamas County Mental Health, Jackson Care Connect, and other organizations which allow space for providers, allows clients to choose their care, and is not invasive, which allows providers to effectively provide care.

Also, Family Care was AMAZING at paying attention to issues such as housing, jobs, transportation and the like, and was helpful at supporting clients financially and with man power to help them get on their feet...which ultimately is the goal of mental health isnt it? To help clients be well enough to be productive members of society.

Please pursue THESE issues. THESE should be priority..not getting rid of FFS care, not integrating physical and mental health into one building - which only perpetuates the problem with the model that healthshare already is failing at...

407 |

408 In Columbia County, patients have exceedingly limited choices in providers and due to the byzantine contract structure, some providers may well be put out of business -- leaving patients with no choice, and only CCMH as the provider.

409 In all honesty, the CCO's should be not for profit organizations. There are not enough incentives to keep costs down and more incentives to drive up profit.

410 Raise the medical loss ratio to increase the money spent on health care and lower the amount spent on administration.

Prohibit CCOs from using Medicaid dollars to make campaign contribution.

Require CCO reserves to be the property of the state: available to the CCO if they are needed but revert to the state if the CCO goes out of business.

411 It would be nice if the CCOs were at least following OAR at the minimum. There is too much variability between what is covered based on where a pt. lives and which CCO they are under.

412 Decrease barriers to providers doing their job, requiring EMR and review of management to ensure reduction of obstacles in doing the paperwork required for patient benefits and access to care.

413 transparency, transparency, transparency.

when contracts were held by the counties for behavioral health, there were RFP processes and public viewing rights to how money is spent. While this can add time to the process it allows for buy in and feedback.

414 Psychiatrists need to be allowed to order critical diagnostic tests (head imaging, for example) and make direct referrals to physicians in other specialties. Having to go through primary care delays and sometimes prevents getting these things done because there is a small but significant subset of people with serious mental illness who refuse to see a PCP or cannot communicate effectively with the PCP regarding the need for such tests and referrals. Furthermore, PCPs don't usually understand the need for such tests or referrals either.

Psychiatrists need to have more access to PsyDs and PhD psychologists. The current models that I am a part of prevents me from getting these consultations far too often, resulting in more treatment failures due to diagnostic uncertainty or lack of clarity regarding specific neuropsychological deficits.

The definitions of level of care (A, B, C, D) need to be changed to be more focused on level of functioning, not diagnosis, Borderline Personality Disorder can be just as disabling as severe schizophrenia and yet individuals with severe BPD cannot get the same level of enhanced services as a person with serious schizophrenia can get.

We need more highly skilled psychotherapists. Many of the therapists working in CCO-funded environments are still in training at the Bachelor's or Master's level. When they finally do get a little experience, they move on to different jobs. Our CCO patients are some of the most complex and challenging patients in the state— They need more highly skilled therapists such as experienced QMHPs and doctoral level therapists (psychologists). Also CCOs need to require therapists to use specific psychotherapeutic modalities (not just rent-a friend with a little motivational interviewing thrown in) and audits should be done to ensure fidelity.

415 Improve accountability across all CCOs regardless of whether they are providing services in urban, rural or frontier parts of our state.

416 The biggest problem we deal with in Clatsop County is that there is no mental health care available. I personally have known several people who have had mental health crises and they were given appointments 6 weeks away to speak with a provider, went in, were given a med, and then had then never heard from the providers again. Quite frankly, the money those providers received for services was totally wasted.

417 Address "healthcare deserts" areas where there are no specialty, mental health providers or easy access to those.

418 Transportation in The Gorge continues to be a huge barrier to health care.

The need for caregiver access for seniors and disabled persons is also a need.

Most of all, access to behavioral health and chemical dependency services are severely limited and especially for children and teens. The need for substance abuse treatment for children is profound.

419 Given HR hiring practices and their qualification standards, other criteria, guidelines, rules, and legislation complexities used to guide the direction, priorities, and set the policies of the work of CCOs. I do not see CCOs improving the future in achieving its goals or the goals of the state. The leadership at the helm of these organizational operations reflects insurmountable incompetence.

It is the blind leading the blind and no one seems to understand the components and importance of how these segments should integrate and function. Change begins with effective and efficient leadership qualities and not just academic achievements.

420 If you are going to cut the use of emergency rooms you have to have viable alternatives especially in rural areas where care after five o'clock is hard to get. There is a distance problem and transportation problems after 5 as well as providers offices being closed. In rural areas the number of providers and the distance between them is a problem and I think the legislature and Salem in general thinks everyone lives in a big city and what they see and experience where they come from they think this is not a problem. It is in particular a problem for the working poor who need evening hours. However the providers may not have the staff or money for staffing longer hours so you leave the patient no where to go except the emergency room. You also need to educate people in the proper use of health care and emphasize that continuity of care found in seeing the primary care doctor makes for better care. Many of the OHP patients have only had ER for treatment before they got on OHP and they don't actually know why it is better to establish a relationship with a primary care provider. There is a shortage of providers nationwide and it takes money to get them which rural areas in particular don't have. Unless you have sufficient providers in accessible areas and days and hours of service you are going to have more use of ER. I live in Lincoln County and we have all of these problems. I am not sure IHN-CCO has addressed this problem sufficiently. The CCOs all need to improve reporting from their billing systems to see who goes to ER, who their assigned primary care provider is, where they are located and access after 5. Also there is a question of how you get behavioral health providers after 5 and whether there are local respite care facilities, etc.

421 I was disappointed to see education left out of the social determinants of health options, other than early childhood education. That is a big oversight. Focusing only on early childhood education has been a trend since about 2011 and nearly all of resources for children have been directed that way at the expense of the K-12 population. Early childhood should have all the resources that it has, because it is critical, AND K-12 needs more resources and support now, especially mental health, trauma informed care, and social-emotional supports.

In some instances, ACEs don't begin to occur until children reach older ages (for example, many homeless and abused youth are LGBTQ, which is not an issue at earlier ages, parents divorce later, intimate partner violence begins, etc.) Adolescence is when mental illness typically begins to appear in earnest (hence the severely underfunded EASA program), risky behaviors occur, and relationships are important. It is also the second biggest time of brain development in a person's lifetime, after early childhood. Finally, this is the time to establish health literacy, helping people learn how to navigate the healthcare system effectively so they will have better health in the long run.

In future surveys and conversations, please don't overlook this very important population. Just because they are low cost now does not mean they will be for long if we don't continue prevention activities.

422 Wider and deeper adoption of advanced analytics

423 The process of applying and qualifying for Medicaid is highly confusing. A simple introduction package should be mailed to individuals. Often anyone excepting Oregon health plan gives poor care services or won't except Oregon health plan at all.

424 It would be good to have service providers be able to collaborate with mental health care from a wider selection of providers. Currently one health care provider seems to have monopolized the field by arranging for most other service providers in the area to only accept collaborated services from that one provider.

425 continue communicating with providers

426 Return to basic principles of OHP: we can't pay for everything for everyone.

427 Definitely increase dental and oral health providers within the CCO network. Current dentist wait time for OHP members suffering dental issues is about 3.5 months, which leads to unhealthy outcomes, increased prescriptions of opioids and antibiotics during months-long wait times for appointments, etc., etc.

The current extremely poor oral health conditions of a great majority of OHP patients greatly devastates their employability and impacts mental health, increasing social anxiety, depression, integration and many other social determinants.

428 Review requirements for Board membership and control. There are two boards in our area. One Board is the CCO Board, but the 2nd Board is a combination of CCO and Hospital Board (This board makes the financial decisions). Some members sit on both boards. Two of the largest entities in the area are basically in charge and the smaller offices have little input. There is also very little primary care (only a single family medicine member) on the 2nd board. This shows a lack of emphasis in primary care. This situation is very difficult to explain, but the recommendation is to ensure that Primary Care membership on the Board is at least 50% and that at least two independent (not employed by CCO Primary Care) primary care physicians are also on the board (in addition to the 50% requirement). This will prevent Specialty Medicine Physicians from making most of the financial decisions about primary care reimbursement, etc.

429 By having employees that are totally competent in their jobs. Requirements to be a top leader must include both administrative degrees and clinical degrees and experience working with clients. Governing board members must include those being served by the CCO.

ADVISORY committees are a waste of time and money since we have NO SAY in what changes unless we are a voting board member.

Next, Medicaid money belongs to the people and not for profit making in private companies that DON'T reinvest in our communities. Very skilled number crunchers could bring better balance to the proper billing process

430 increase opportunity for non OHP patients to access CCO's

431 Continue to allow CCOs to support community based programs with discretionary money dedicated for these issues in improving the culture of health in local communities served by the CCO.

432 Coordinate with chronic and long term care especially in home.

433 DEAR SIR. IN INDIA PATIENTS GENERALLY GO TO MULTI SPECIALITY SUPER HIGH TECH HOSPITALS. . THIS IS VERY GOOD. BUT WE NEED TO BUILD HOSPITALS ON A LARGER SCALE WITH SPECIALITIE IN VARIOUS AREAS. (EYE, NOSE .THROAT. B.P. SUGAR. CHOLESTORAL CANCER. HEART DISEASES. AND KIDNEY DISEASES. ETC). THIS IS URGENTLY REQUIRED FOR ASIA, AFRICA AND LATIN AMERICA. THANK YOU. V.RAJAN. AND ASSOCIATES. COMPANY SECRETARIES. SITE NO 10. VOC NAGAR. 2ND STREET. KOVAIPUDUR. COIMBATORE-641042. TAMILNADU. INDIA. 17-03-2018.

434 I think one of the most frustrating pieces of working with CCOs is with behavioral health benefits. Yamhill Community Care (YCCO) requires mental health providers to ask for preapproval of counseling services every 8, 10, or 12 visits based on a client's level of care. This causes a lot of paperwork for therapists, which takes away from a therapist's capacity to see clients and provide services to more OHP/YCCO subscribers. As far as I have seen, YCCO is the only CCO in the state that has this cap/requirements, and I feel like it is a HUGE inefficiency and poor use of taxpayer funds. Preparing documentation and justification for an extension of care takes about an hour per client. When each therapist is expected to have a 60-85% productivity rate, it's difficult to meet this standard when nonbillable paperwork preparation is eating into caseload times.

435 To participate in APM and quality payment programs, CCOs and their provider members need to have and correctly use certified electronic health record technology. Ideally the State could provision access to a hosted EHR system and/or qualified registry for its provider members (and CCO analytics teams). Currently CCOs sponsor access to PreManage increasing the ability to analyze emergency department over-utilization and its factors. Continuing to provide CCO providers with access to systems and tools like this will become critical if providers are realistically expected to successfully participate in Medicaid, Medicare, and private payor incentive programs. This is an ingredient that is missing from the CCO model. Successful ACOs and APMs include this as a component. It is not simply enough to say that we want providers to participate in APMs. We have to build that framework and guide them logistically. To many providers these are nothing more than buzzword acronyms they will ignore until their payor requires they pay attention. They cannot afford to do anything else. The State's quality metric program should become aligned with and implemented in tandem with existing QPP/MACRA programs rather than re-inventing the proverbial wheel. The State has the opportunity to parlay this movement towards standardizing technology and reporting to improve the quality of care and health of OHP members.

By using one common EHR system, the State would create the opportunity to align and improve the workflows of all providers using it. With this combined purchasing power, CCOs could work together developing and providing timely and relevant training and support resources to their providers. CCOs could also provide the hands-on technical and workflow support that providers are desperately lacking.

A byproduct of standardizing the clinical workflows of participating CCO providers is the data that would be captured. By capturing data from all of providers using the provisioned system in a common and structured format, a data warehouse housing the data could be built. The warehouse could theoretically house and interface data from outside sources, too – immunization registry, PreManage, labs, hospitals, etc.

If properly implemented and managed, the CCOs (and the State) could generate quality metric data for OHP members in a common format. The financial savings of no longer working with thousands of silos of data being inconsistently generated from disparate EHR systems would likely be significant. By analyzing patient-level and population-level data, gaps in quality, access, utilization, etc. would be easier to identify. Rather than expecting already over-burdened providers to buy a system, implement it, develop and train staff on consistent clinical workflows, deal with updates/upgrades, contract IT support, understand quality metrics, generate database

reports (often requiring customization and knowledge of a querying language), the CCOs could fill this gap. The CCOs could be expected to develop or manage a robust quality metrics program. By identifying important healthcare markers, CCOs would become positioned to work together to improve the health of OHP members. They would be able to generate valid, relevant, and timely data to support quality improvement and drive the care management and care coordination of the vulnerable population they serve.

436 Attention is needed in the reduction of recitivism rates and patient non-compliance. Patients need more accountability for maintaining progress toward sobriety, improved wellness and treatments plans set up in hospital. I work in an acute care environment where difficult to place people linger at very high expense and some have come to learn the game of going "home" or back to the environment that created the issues only to stop treatment and come back for another stay. This past week when I admitted an OHP member I asked where they lived and their response was "here." To clarify I asked do you mean you live at the hospital? The response was "yes...they make me leave periodically but I always come back home."

We are facing staffing cuts meaning we are to do more with far too few hands. We cannot nor can our healthcare system continue to treat people who use the system to provide home at the hospital. It's the most expensive form of healthcare available and the malingering of some mean others do not have access to adequate care when needed in the hospital.

437 If what the state wants is equity and quality care in the system/CCOs? Please employ those that are actually facing health inequalities and disparities. The issue here is poverty and lack of quality education. It is so much more than just health, fix the institutional determinants of health/institutional racism first. Most people do not want to depend on the state. Support people in need with tools and please stop using them as Ginny-pigs.

438 My husband and I are on OHP and I don't see any benefit of a CCO at all. I would think in a functioning CCO, someone would have recommended my husband get a liver scan because he had Hep C and is a current diabetic with high A1Cs. Nobody has said a word. I don't get their purpose. We have to have more behavioral clinicians. I tried for 6 months to get a psychiatrist in order to get an official diagnosis, finally gave up and had my general GP make the prescription. I've been on anti-depressants for 10 years and never seen a psychiatrist. That's not right. There are just not enough available. We need more. We also need prescription drug price negotiation and maybe even an incentive for OHP clients to pay for the \$4 prescriptions ourselves if it would cost less than billing through the OHP plan. It might be a good idea to spin off dental & vision and offer an insurance so people can actually get some of the services needed. If I could have gotten the partials I needed several years ago, I'd probably be back at work and off OHP altogether. But you won't give them to me. It's stupid. I also can't use the discount program my dentist offers. You need to talk with people who use these programs and stop listening to all this "language" that means nothing and improves nothing.

439 On the transparency of incentive payments, as we work harder and harder each year to fulfill QM with ever increasing better results, yet our incentive payments have significantly decreased year after year.

440 It's difficult for patients and their health care providers to learn all of the varying rules and policies among different CCOs in one population area. Sometimes the difficulties are so great that patients change their plans to the one that seems to have a better benefit.

It would be wonderful if there was more standardization across CCOs on access to specialists, medications etc. I want to say that I work with several CCO leaders on the impact of the opioid epidemic in my area and they are wonderful, active, smart and generous people. I am extremely grateful I get to change our area, our state and even our country with them. For me, they are "the CCOs".

441 From the survey, it seems that the wrong questions are being asked so it will be hard to get to the right answers. CCO's should focus on building a system of prevention and support for people and families so they do not need to access higher levels of care and medications. Universal supports coordination, for the person to access the services and supports they need, not just to navigate a complicated healthcare system. Supports coordination for the person not the system for everyone supported by a CCO to access systems of support for housing, jobs, food, transportation, and other basic needs. CCO's should invest in things that we know help improve health like stable housing, job support/income support, access to food and basic social services. Supports should be provided at the right time and place and not force people into crisis and emergent situations. The CCO's should be run directly through the state with all the funds going to the care and support of the patients, not to the profits and overhead of private for-profit and non-profit entities that look just like for-profit entities with bloated management structures and ridiculously compensated CEO's. CCO's should be part of the transition to universal single payer health care with schools, local government, universities, and other entities able to buy into them at cost. Value-based payments will only exacerbate the inequity of the health system by giving higher compensation to wealthier and healthier communities who are healthier not through any work of the CCO, but because of the privileges of the communities they exist within. CCO's across the state spend twice as much on psychotropic medication than they do on housing. Supported housing should be a much bigger focus. CCO's should be tasked with partnering to end homelessness. Most of the tuberculosis and other serious communicable diseases are found in shelters and houseless populations. It is nearly impossible for someone to maintain their health and not threaten population health when their most basic needs are not met. This survey is the same conventional thinking that perpetuates the system we have today which benefits healthcare providers but does not serve patients or the communities who pay for these services and supports. Behavioral health is a disaster in this state. They provide appropriate services to a very small percentage of the population with ACT and Wrap, but even those are calcified by fidelity scales and evidence-based practice rigidities. We know what works and those principles of support need to be offered at an appropriate level to everyone who needs support. It can take years to get a diagnosis and we require a diagnosis to access the minimal supports and the dysfunctional system. If we could support people, especially kids, with whatever they need before the system traumatizes them enough to be diagnosed, we would have better outcomes for people for less money. Behavioral health has been in crisis for decades and we can put money on the fire, but it will never go out until we change the structure of the flawed system. You can pour water in a leaky bucket and you will never have enough water. We need to build the social and health support people need as they need them and not force them into a crisis system that does not meet their needs. They need to care for the whole person, not just the diagnosis. Until there is access to universal supports coordination, supported housing, supported employment, and wraparound type supports for everyone as they need them and before they have entered institutional care, jail, or hospital; behavioral health will burn forever and take down health care, law enforcement, and our other systems with it. The solutions or actions suggested in this survey, for the most part, are the same thinking that have created the problems we have and will not help us to improve. We need the right supports at the right time that are not medical or clinical services and we need to pay for supports that help people not that prop up providers in a bloated and broken physical health and behavioral health system.

442 Particularly with dental care, the dentist is noticeably limiting options in treatment with a limited focus of only coverage obtainable from OHP. For the well-being of aging(elderly) patients in late 50s or 60s, it should be best to look into options in restoring and keeping the teeth than suggesting extraction and partial denture right out of the bet.

Being able to eat normally is just a basic human need for health. Why are root canal, crowns(except for children), gum/bone grafting and dental implants not the options? It would be equitable if all patients should be taken care of their basic ability to eat normally regardless of their age.

443 Please include HIV testing in the quality metrics and focus on improving LGBTQ+ populations access to care

444 Follow open meetings laws. Only not for profit CCO's. Mandatory diverse composition of CCO boards, representative of consumers, social services, community and all health care professions. Require a minimum % of Incentive payments to go to Social determinant work

445 I take pain medications for spine/neck/head damage. I've seen the pendulum swing from proper pain management to elimination of such programs and "sude" programs in place. I watched the Oregon Health authority grow it's departments/personal for the pain management/deferment of options to the people whom are not able to afford other "options"! Yet any employee of this Oregon health authority are themselves exempt from such a political position and/or program. I did not have any choice in my life, yet I'm effected by people wishing to be relevant and continue their generous carriers the this health authority! I'm just disgusted by the lack of a "pro" pain patient advocate! Seems to me this is all about justifying long term employment rather than the consumer of last resort!

446 There needs to be more transparency on the auditing of insurance carriers who are taking advantage of the Medicaid population. It is my impression that the insurance companies are not in the best interest of the patients and place profits over care for the population they collect payment from the federal government.

447 Please stop allowing individual ccos to have different standards and rules for covered benefits. Please standardize the titles and functions of Exceptional Needs Care Coordinators. Please standardize language across handbooks, Please make up consumer information about ENCCs/ICMs. Please don't hide phone numbers of ENCCs (be more transparent with how to reach and utilize them)

Require CCOs to have meaningful family involvement that goes far beyond CACs.

448 Ensure that when payment is made through Value Based Payment methodologies the CCO has a way to measure the effectiveness of the program. Encourage experimentation, but ensure there is a control group for comparison and that there are methods to measure whether the program is a success in containing costs and improving patient outcomes.

For \$ spent on social determinates of health the State should require that CCOs have a reporting methodology to measure the impact of the program. Understand that spending on social determinates will not have an immediate effect on reducing CCO medical expenditures, because it could take decades to have an impact (like in the case of children's oral health interventions) and the member may not be on OHP at the time that those rewards are reaped, but the State and the CCO needs to look at the long-game and measure total health costs throughout the population (using APAC data) to determine the effectiveness of a program. They also need to look at the reduction of members on OHP - because addressing social determinates also move people out of poverty, and into jobs with insurance. That means that social determinate funding needs to be separate from

rates that are meant to cover cost of care because spending there may never be recouped by the CCO in reduced healthcare spending. I hope that makes sense. :)

449 CCO's have been effective in creating a "collective impact" approach to meeting clinical quality metrics. These metrics should also include health equity and social determinants measures, if we want providers to also focus on these issues. Clear standards defined for health equity reported on a regular basis, just like cancer screening or diabetes will move systems to take these issues seriously.

CCO's have less control on the cost of drugs, which have been going up exponentially- a state or national strategy to contain drug costs is needed- in the CCO's we participate in, drugs have become the single biggest area of cost- even over inpatient hospital!

CCO's should be expected to partner with other sectors of the community: education, housing, social services: some sort of "Social Determinants Strategy" should be included with needs assessment of community. Some OHA grant funds, similar to the initial transformation grants could help develop collaborations across sectors.

450 I would grade our CCO an F for failure to work with the community. there needs to be less arrogance, greater collaboration, much, much better communication and the ability to honor and invest in the evidence based initiatives that already exist

451 More focus and funding should be aimed at implementing trauma-informed practices and addressing social determinants of health.

452 The CCOs with the same business model as Cascade Health Alliance, which is for-profit owned by local doctors who are also venders of the CCO.

Creates a conflict, as the owners/venders of the company have competing interests; they are getting paid for services delivered as a vender... and getting paid for services not delivered as owners of the CCO.

The antithesis of ACA and goals or Oregon Health reformation.

We need to be more careful who we entrust these valuable resources. Cascade Health Alliance, or any other CCO like them, need to go away.

453 -Oral Health Care access

-More accessible medical transport with destination/pick-up options

-More mental health providers

-More navigators

-Foster care support

454 measure the right things.

455 I would suggest that OHA work with CCOs to develop a standard system for allocating grant funding.

The CCO I work with recently released an RFP and the community went through a grant funding process that lacked consistency and transparency. I would like our CCO to make clear to community partners and consumers where its funds come from (QIMs, etc.), how the CCO intends to allocate it, and what the process is for funding allocation.

Thank you!

456 I would like to see CCOs influence community and state environments and systems that support health- the default environments for health. So, not just upstream SDOH- but a true commitment to help members and the larger community live tobacco-free, move more, eat better and consume less alcohol. Support local jurisdictions and the state in evidence-based policy strategies that do this, as outlined in the SHIP and CHIPs.

I also think that there are efficiencies in joining together on community approaches, such as mass communication campaigns that educate the public and promote key health behaviors. For example, warning of the dangers of sugary beverages, or alcohol; Promoting the Tobacco Quit Line, or quitting tobacco in general.

457 Focus on coordination of care from ED patients

458 Some of the questions were frustrating because all the answers are important. One spills over on the other to where they really can't be separated. So much of this has a domino effect that is a part of a chain reaction.

459 Create one point of contact for OHP members - I'm still confused when I should contact HealthShare or CareOregon. I've no idea who is responsible for what.

Also, I've been on the same medication regimen for over a decade but cannot get more than a 30 day supply. I've been told that dispensing in bulk could save money. While I understand that this won't be the case for everyone, it seems that pharmacists should be able to make a decision on patient stability and be able to lower drug costs using such methods.

Last, I can't tell you how frustrating it is for whoever blocks a prescription that costs less than \$5 when my total monthly prescription bill is easily over \$1000. Of course paperwork can be passed about - which usually means I have to take the script to the pharmacy, have it denied, return to the doctor to complete the prior authorization, wait for it to be approved, etc. Really? This is how we SAVE money? by having professionals push paper for a generic pill?

PS - Wow, you include gender identity but IGNORE sexual orientation all throughout this survey. Thanks for telling me just how little I matter! Talk about the need for cultural competency.

460 The state should allow CCO's to be more creative and limit rules on what kind of services children with MH diagnosis need and require.

Blend funding streams to allow more care for social determinants of health.

461 Invest in transitional housing for patients who have housing insecurity especially before, during and after inpatient medical procedures.

462 No

463 Ensure that pediatric patients are able to receive behavioral health care in the PCPCH setting -- that may mean eliminating the county mental health carve-out.

464 The community governance model used in Central Oregon for the PacificSource Community Solutions CCO is the model that should be expanded across the state. This has gotten all the major players in the health care system at the table and mutually solving common problems. We have over 200 professionals volunteering their time in one committee or another, working on QIMs and Regional Health Improvement Plans. The problems are shared and solved by the health care community in an equitable manner. This is definitely not the case in many parts of the state.

465 Care for dual eligible populations (also known as traditional Medicaid populations of low-income seniors and persons with disabilities) have been largely ignored because we added 400,000 members to CCOs from the ACA. There should be more accountability to impact health outcomes for these members with high needs, and to ensure we are moving the needle on care for these vulnerable populations. First, there should be metrics added to place an incentive for improving care of these populations, and there should be some \$\$ tied to it. Current measures do not help look closely at the duals. OHA should ensure CCO dashboards track outcomes and monitor places to improve. CCOs have often said because they don't see all the financial rewards of care coordination, they shouldn't have to focus on duals for whom Medicare is primary (1st) payer. OHA should place more emphasis on trying to help align duals Medicare and Medicaid to support better integration of care. Perhaps a pilot to look at allowing integration of long-term care services into managed care should be considered to see how it supports duals outcomes.

466 I would love to see more encouragement for hospitals, government agencies, health care providers, and social service providers to work together to build and act upon the Community Health Improvement Plan. There is often quite a bit of willingness for many partners to work together, but often there is at least one key partner where there are barriers to working together (politics, etc), and some outside encouragement(/regulation?) would be useful to get everyone moving together in the same direction further along the collaboration continuum. I know the Transformation Center is offering TA on creating a collaborative CHA/CHIP, but sometimes TA isn't enough to get all the partners to the table.

467 I am incredibly disappointed to find there is no focus on older adults. This is our largest growing population and can have the highest need. Behavioral health access is incredibly difficult for this population. Oregon can no longer afford to ignore our largest growing population. We do not have the resources available to provide care and this issue will only grow by leaps and bounds.

468 Continue to fund (and fund ADDITIONAL) Prevention strategies through Public Health agencies to further improve health outcomes in the future and reduce costs.

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- 469** Willamette valley community health for Medicaid works with Atrio for Medicare. The case manager that coordinates care between them told me she does not have anything to do with mental health care. This is illegal considering the new parity laws in Oregon. I have no case manager because I see a private psychologist. I have no in home health care even though I qualify for 1915i because the state has no teeth in requiring Shangri-la and Pelton Projects to follow through with their contracts to provide in home care for independent living clients. Clients across the state who qualify for in home help through 1915i cannot receive services because there are no agencies willing to provide workers. This must become mandated just as mental health services are mandated through mental health agencies, in which, theoretically at least, the counselors cannot turn away someone just because they don't want to work with a particular client. 1915i services, if fully used, would help eliminate homelessness for mentally ill clients.
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- 470** There are so many different hoops to jump through with each CCO on trying to obtain specialty authorizations on medications and referrals for procedures, making one simple to use online systems would be great.
- Often our CCO's are dictating the specialty care that our patients receive.
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- 471** Every CCO is very different in their administration and interpenetration of Oregon Medicaid which is causing a higher cost of administration costs. I think if you either consolidate some CCO's or require certain benefits to be administered a like it will help to bring down the administrative cost.
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- 472** The future of CCOs depends largely on OHA; there's so much CCOs don't have control over!
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- 473** Staff should be sent to The People's Institute workshop called "Undoing Racism" to understand the systemic roots of racism, how to analyze power, and make lasting change.
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- 474** Yes, do so, without spending funds on those who are not U.S. Citizens, or have valid Visas.
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- 475** I would have liked this survey to have asked about the patient experience of care and maintain that framework throughout. It is ironic that it didn't, since CCOs are supposed to be delivering patient-centered care.
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- 476** Enforce state laws that require complete transparency on health care cost and utilization. Consumers have a right to see the price of services. Publicly developed data is not a trade secret.
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- 477** There is only real value in the CCO model if they are all actively managing the full suite of services (Acute, Behavioral, Dental, SoDH) and not simply sub-capitating portions of the system with no true integration and understanding of Total Cost of Care.
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- 478** Continue to encourage CCOs to combine or at least increase integration between disparate parts of plans-not such a big divide between physical behavioral and dental. Completely different entities managing these parts of the benefits doesn't make sense if we say we are looking at members as whole people. Having CCOE and CCOG doesn't help this situation, as you have members who only part of their care is managed by the CCO, reinforcing these unnatural divides. Having the SUD benefit be part of the medical side of the plan when it is usually managed by behavioral health providers/parts of the plan also makes no sense.
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- 479** There needs to be transparency and parity regarding how rates are set i.e. why one CCO in the same region would get more per month than another (HealthShare v Family Care).
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480 Even though I am probably more familiar with CCOs than most of the general public, I really do not have a very good grasp on any changes short of another layer of bureaucracy. That may be because the CCOs or OHA has not done a real good job getting the word out about how well they are doing or how their being in existence has improved people's lives or the system.

Also, I find that coordination and collaboration of care between different providers, especially for those who have co-morbid or complicated health needs, one of the things I was hoping to see more of, is still lacking. Without that there are always going to be some frequent flyers or people who should be getting better and using less services who never do. Or they are getting their health needs met in one area but no others. This is especially true of folks with mental health needs.

481 Ensuring contracting encourages CCO's activities to bend the cost curve through investing savings or generated income from reduced hospital and pharmaceutical costs into community based services, early intervention and ongoing in home/community supports for chronic conditions/disease that reduce hospitalization or other higher cost interventions.

482 I am disappointed with the CCO experience. My experience has not been great. What I see is that patients are only allowed to talk about one issue at a time and then reschedule to talk about other conditions. How does this help the individual when all systems are interrelated? I have seen the paperwork that states to list the area of most concern followed by listing other areas of concern. It states on the paperwork that if there is time other areas may be discuss or another appointment may be needed. What I have seen is that additional appointments must be made. There is too much pressure to get patients in and out. This means additional time off work for the patient.

Also, when CCOs are looking at specific outcomes the focus of care really shifts. For example, dental sealants are an outcome for dental so DCOs have focused on increasing the # of sealants provided in the schools but what about the preventative and restorative care that is needed? Where is the incentive to clean a child's teeth and address nutrition with the parents? The DCO is rewarded for # screening and sealant appointments but not as much for addressing the preventative and restorative care needs.

If a CCO or DCO is contracted to care for a certain # of individuals, it should focus on the total care of the individual and not just the specific outcomes that are being tracked.

483 Improved access to non-pharmacologic treatments such as chiropractic, acupuncture and massage therapy.

484 There has not been nearly enough attention on cost containment. In addition to options mentioned in the survey, I would like to see clear reductions in administrative costs (administrative simplifications, increasing MLR), and efforts to reduce waste, redundancy and misuse of resources. There are national efforts to propel ccos toward quality improvements and APMs and addressing social determinants. What the state should hold ccos accountable to most of all is reducing costs.

Health care uses too many state dollars. If we could significantly reduce state health care spending through the cco model (not just limit the rate of growth, but actually reduce per capita spending), that money could be

redistributed to housing, education and other social supports. Unless CCOs demonstrate that health care can take up less of the budget, the model will never fulfill its potential.

485 Definitely keep the CCO model and re-contract in 2019.

Keep local CCO's - do not move to a single CCO. Local CCO involvement helps ensure successful integration with local/regional partner networks, especially where SDoH is concerned.

Fix the funding issue that disincentives CCOs from investing in SDoH - instead, incentivize CCO SDoH investment.

Work on Medicaid solutions that would facilitate the medical encountering of social services to help formalize and support CCO social determinants of health (SDoH) partnership with key, credible, social service providers.

486 We have several CCO's in our area (Southern Oregon). They function quite differently. The for profit entities deny payment on a wide range of care for unclear, capricious reasons. They are unwilling to engage the service providers outside of a tightly controlled group with vested financial interests. They have deployed resources towards plant that are in no way related to patient care. I could continue and I suspect OHA is aware of the challenges with this for profit entity. I would ask, why are public resources allowed to be allocated to enrich a few individuals?

The not for profit entities are much more collaborative in their approach. They have engaged providers in managing unnecessary variation, utilization and cost in a meaningful and respectful manner. It is astounding that these entities are both called "CCO's" as their interactions with care providers are quite different.

I suspect the differences in the care deployment relate to the incentives that exist for the entity in our area that is for profit

487 Lack of providers accepting OHP and CCO

488 CCO should be non-profit

489 Personalized and consistent care matters. Well paid and trained providers are what makes the difference. Take care of the caregivers. Clients who are resourced with adequate visits, transportation, etc, get well faster.

490 There is a wide variation of how well CCOs perform. Our organization contracts with all of the CCOs. Some are very well organized and truly embracing the Triple Aim model in an ethical manner. Others need some consultation and are well intentioned but need some support to evolve more efficiently by learning less from experience and more from models within the State that are working well. A couple of CCOs seem to be all about the money and are spending Medicaid dollars on investors and not plowing the money back into the system to improve the system by developing more services including prevention or expanding current services to better meet the needs.

I think the State (OHA) needs to insure that the CCOs are contracting at rates that truly cover the cost of care for the providers who deliver that care. Some do this well, several CCOs do not do this well.

491 I think all Oregonians ought to be enrolled in CCO's in accordance with Governor Kitzhaber's original vision. A Medicare for all system would be ideal.

Since Medicaid expansion, in many cases, CCO OHP enrollees are far better off than their fellow citizens who are un or under-insured. I think it's important to admit that, in some cases, CCO enrollees are better off than many of their non-CCO enrollees who are enrolled in sub-standard private plans.

CCO's can affect change in the overall health care system (and amongst themselves) by calling attention to CCO achievements and strengths. A broad qualitative understanding of the impact CCOs have on real people's lives may be important to generating a better understanding as to why trends influenced by CCOs continue to work well for Oregonians. Thus we need to interpret, draw conclusions, or at least generate hypothesis based on the data points that are gathered.

For example in primary care, because of Medicaid expansion, tens of thousands of Oregonians now have access to basic healthcare. This in itself is a giant achievement. We know that better access to basic healthcare along with exposure to prevention and population health strategies make a difference. The CCO's continue to pro-actively claim moral victories in ways that may or may not show up in the data points. What are some creative ways to paint this picture beyond CCO offices and the halls of Salem so that the general population can understand?

For example, as an employee of a CCO who works in behavioral health, I'd forward the argument that many advancements may still be in the offing, however I believe Medicaid CCO's are truly leading the charge on health integration, attention to disparities and SDOHs, coordination efforts, impact of trauma, etc. If Medicaid were to be rolled back in Washington DC or Salem, I think many of these trends would in turn be rolled back as well.

There is a great deal at stake tied to the future fate of the CCO's in Oregon. Things are going well. We must continue to improve and focus on high level and community message discipline.

492 Support funding, development, technical assistance and support of local peer run organizations providing drop in centers, individual one-on-one peer support (whether by phone or in person), which helps people needing services build natural support networks and increase wellness activities, thereby promoting healthy coping strategies, lifestyle choices, preventative care, etc. Hire paid and volunteer part-time and full-time peers and peer supervisors with lived experience. Address trauma-free, trauma-informed care for all patients across all healthcare delivery settings and modalities. Promote shared ownership of outcomes with person-driven, family-driven individualized responsive care. Build on the success of work already initiated addressing social determinants of health such as housing stabilization, hospital diversion, brokerage services (e.g. air conditioner instead of repeat hospital visits due to overheating/dehydration/heat stroke risk, etc.)

493 Funding for behavioral health services is woefully inadequate and results in high turnover of clinicians and disrupted treatment relationships. There needs to be a substantial increase in funding of behavioral services to improve access and increase the quality of services. Increased funding would allow for more creative approaches such as increasing BH staff located in primary care, schools and corrections without jeopardizing the existing system of care.

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- 494** There is a significant amount of medicaid waste through all of the administrative burdens and the lack of oversight on how CCOs are using their funds.
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- 495** Increase the range of providers with which the CCOs contract with. Encourage the incorporation of ALL HEALTHCARE PROVIDER types, and include non-contracted providers or out of network providers in payment plans and allow for them to be paid at out of network rates so members of the CCO have the option to retain their rights and choose their healthcare provider and type of provider.
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- 496** Putting more emphasis on Upstream Prevention in order to decrease the need for treatment will be money well spent.
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- 497** Require that CCOs focus on preventative care rather than treatment. Spending money on just treating illnesses will cost more money over the long term if the root cause of the illness is not addressed.
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- 498** There is too much emphasis on race and ethnicity from OHA. Where we are, there are very few minorities at all and OHA doesn't recognize that. Being rural poor is the issue. Being a woman in a rural, poor, area is a problem.

499 Focus on people born in America who are entitled to health care and quit providing care to illegal immigrants. Focus on Native Americans who require care, focus on Veterans who are in need of medical care and housing, focus on all the homeless that are standing on street corners asking for hand outs.

Quit providing incentive payments to organizations that are not doing their jobs.

Quit providing health care to anyone that has a positive pregnancy test the incentive should be to quit providing care to all women that continue to have child after child basically because it has become free in the state of Oregon.

Women know that the minute they become pregnant they automatically get free health care. this is wrong. Families should be penalized for having to many children not rewarded.

If women have to pay for having a baby maybe they will stop having children in an already over populated country.

Provide housing for the mentally ill with 24/7 on site assistance this is not rocket science the state of Oregon already wastes tons of money use some of this money for good.

500 Empower/ require the CCO's to apply special cost reduction care-plans for those people on their plan who are users or High utilizers. For example, the homeless man or Woman who always comes to the ER for infections or hypothermia would have interventions implemented that could include paying for housing for 6 months while Social workers works with them toward a long term housing plan.

I dont believe everyone show have free or low cost housing because it could foster a dependency that could be unhealthy, but the some do need this. Housing with health care goals in mind could benefit and significantly reduce health care costs if patients are actually working towards a goal and receiving support and accountability.

501 CCOs need to work within existing community frameworks to address social determinants and health disparities. For example, CCOs should partner with and invest in local public health efforts to improve social determinants in the community. This improves health for all, which will ultimately save money for CCOs and improve CCO metrics.

502 The CCO and the Oregon Health Authority support of CCOs has greatly improved the medical service in Oregon. Please keep of the good work and improve even more the health system in Oregon. The one area needing additional change more then any other is Drug use and cost.

503 Trillium appears to be the worst CCO of the bunch. they do not follow even their own guidelines. They do not follow the 48/96 hour rule for labor and delivery or newborns and they are very difficult to work with.

It would be an improvement to find another company to work with. Trillium is the worst.

Intercommunity is hard to make contact with as it appears they have one person working claims and one person working appeals.

504 Eliminate CCOs and use OHP with same benefits and services regardless of what county they resides.

505 A deep dive into metrics and rate setting to ensure there are not perverse incentives. Ensure that the compensation supports investing upstream in behavioral health and social determinants. Give CCOs the resources necessary to invest upstream, understanding that the cost reductions in other areas of the system may not be realized immediately.

It is critical the State steps up as a leader in Behavioral Health (MH and SUD) and PROACTIVELY works to better the BH system. For far too long, we have under-resourced the BH system in Oregon, and have relegated the priority of BH to the back of the line. This is not to say there hasn't been any effort by the State on BH -- it has simply not produced a comprehensive approach to BH that is adequately resourced/funded.

While CCOs absolutely need to invest more time, energy, and funds towards BH, I fear, without significant contract requirements between the OHA and CCOs, CCOs will continue to focus/fund on physical care as opposed to working upstream (i.e. BH) on the causes of negative health outcomes, as opposed to the effects stemming from their members' health conditions. So step 1, increase the requirements, through the OHA/CCO contract, of CCOs to serve the BH needs of the OHP member.

In addition, it would be wonderful to see the OHA propose bold and innovative policy/funding ideas for the 2019 Legislative Session. Without a significant investment into BH by the Legislature, Oregon's opportunity to increase access, enhance quality, and, indeed, offset costs, will be severely hampered. Of course, the funding must be coupled with significant accountability measures for BH providers -- something that will be difficult to do as providers have, for decades, functioned in a starved environment preventing investments in technology, data-driven processes, and science-based methods of care. It will be incumbent upon the leaders at the OHA, and the CCO community, to balance additional requirements for providers, with providers' ability to meet additional requirements.

Look, I strongly believe we are on the precipice of great change in Oregon's approach to BH via the CCOs. The opioid crisis, MH residential rate redesign, and a growing chorus at the Legislature and elsewhere that we need to act now, provides an opportunity to make significant change. It will take leaders in OHA, CCOs, the Legislature, AND the Governor's office to coordinate and place a high priority on this effort. Without that leadership, we will continue to do what we have done for the last 20 years -- produce a report that gathers dust on the shelf. The time for reports and studies and large, unwieldy workgroups are past us. Oregon has the data, they have the proof -- we just need to make it happen.

507 The way this survey was designed illustrates exactly what needs improvement. When CCO's were started, they were presented as being an excellent way to use an individual's insurance dollars to provide what THEY needed to improve their health. This is not happening, and just like the questions in this survey that say "do you want to provide more feedback about _?" and then give you a structured choice, the same happens with the insurance money.

I have been working primarily in mental health for the past 15 years in several different environments. There are many people who may need some medication or some case management, but really need therapy. Those people are not able to get both. If they are forced to go to a large community MH agency due to needing meds or case management, they have long waits between services and constant turnover of providers who don't know them. The CCO's should provide the option of having meds/case management at one location and a therapist at another location if that is what they need. OHP should have contracts with individual therapists that can meet the specific needs of a population. THIS would be an example of the original presentation of CCO's having the flexibility of providing individual members with what they need, rather than forcing them into a uniform system. Dictating the narrow window of choice to people who already have few choices due to low SES is not addressing social determinants of health.

508 Would like to have the administrative cost and burden of having multiple CCO's in a county looked at from a cost savings lens and for a reduction in member and provider confusions based on who the assigned CCO is.

509 For profit CCO's are in BUSINESS, not healthcare. The bottom line, not the patient, is all they care about. Our local CCO has added so many restrictions in the past six months that people are going without MORE THAN EVER. Have to use suboxone because you're finally in a position to try to get your life back? Don't come here, because even if you've demonstrated that you are able to reliably work a program, you are allowed to pick up only 7 days worth of medication at a time, AFTER a prior authorization has been filed, and your counselor has contacted the CCO. Because our CCO likes to induce anxiety and fear in patients who already have issues with this. These people are struggling with housing troubles, food scarcity, and poverty. And then, they have to struggle with the insurance company that is supposed to be there to help them. For profit is a terrible, terrible health care model. Stop hiring for profit groups for this type of health care model. They are only about themselves, not about their patients.

510 1. Get rid of them

if not #1 then

2. stricter oversight of the CCO's

3. MORE REAL Doctors not just physician assistants

511 Increase in providers across all specialties. Wait lists are too long.

512 CCO's need to focus on supporting primary care. Primary care works hard to fulfill quality metrics and have made it a part of delivering quality health care via data reporting, yet the incentives for improving care are not getting passed to the clinics. Where are the incentive payments going? Clinics are doing better and better, yet incentive payments are drastically reduced year to year with no transparency on why.

Without FamilyCare in the mix, already primary care is cutting staff and especially PCPs. How is that helping with access and helping primary care stay alive?

513 Create more transparent process for grant applications.

514 CCOs need to contract with more individual therapists, not just large MH organizations that already have waiting lists.

515 Adopt a PDL.

516 My work for Providence Health System directly supports the social determinants of health for patients. It is impariative that CCO's recognize and have the ability to provide flexible spending to address the social determinants of health that directly impact their health outcomes.

Many patients may be living pay check to pay check and dont anticipate an illness or injury that may impact their ability to return to work. Their livelihood instantly becomes at risk! I have whitnessed patients having no where to turn, no support system in place, and living in their car because they did not have any income coming in following their stroke, and having lost their apartment because of this. Patient's easily become evicted and that eviction then stays on the record for the next 5 years impacting their ability to gain housing again and increasing the homeless population.This is one example of many.

I have also seen patients far more engaged within the health system and connected to their care team when they are cared for as a whole person with more of a trauma informed approach. The care that needs to be provided needs to be community based, needs to consider the significant amount of barriers that impact ones ability to succeed in life due to significant trauma, abuse, neglect, disability, economic status, and race. There are significant inequities withing the health system that demand that we change the traditional approach to healthcare delivery.

517 It has been proven that if a member's basic needs are met, they are more likely to follow through with preventative care and health maintenance and are more able to absorb health teaching. Social Determinants of health are vital. As with Maslow, Basic needs have to be met before a person can move forward.

518 CCO's in my opinion need to work better with other CCO's to provide better Mental Health and Psychiatry services to all members, adults and children alike. With OHP and some CCO's requiring psychiatry evaluations for medication management, it is hard to find these services across the board. Psychologist are easy to find, but finding a Psychiatrist that will accept Oregon Health Plan and any CCO's is incredibly difficult.

519 The focus of CCO's and OHA should be to move to a non-profit model of CCO's. Ideally a non-profit Universal Healthcare System would be implemented overtime. There should be coordinated effort for preventative medicine and access to quality care across medical, mental and dental health. There should be a prescription drug preferred list across the board. There needs to be much more focus on care coordination. There must be transparency in the rate setting process with a priority given to keeping and achieving optimum health rather than on services preformed. Having a focus on community health which addresses fair and affordable housing, access to healthy foods, health literacy, early childhood intervention, mental health and addiction services, support for families, trauma and cultural sensitivity.

520 I have found the Washington County CCO to be more limiting of resources than helpful. They continue to implement more limitations on vital support programs such as Supported Employment programs by denying access to Outpatient services, denying access to DD clients receiving mental health services and potentially limiting SPMI level A clients from Supported Employment services. Working with them has been an effort in futility and they do not appear to take recommendations from local providers and continue to limit services in general through additional guidelines and limitations.

Working with CCO's is a frustrating experience all around and more input or oversight by the state could potentially help with this experience.

521 CCOs that can be classified as "for profit" have an incentive to limit access to care as a way of controlling cost in the "fee for service" model. Moving to alternative payments and requiring more transparency about the use of profits and reserves could be ways to make sure that taxpayer money does not leave the State.

522 The State infrastructure has not been sufficient to hold the CCO's accountable for their performance. Increased oversight is key.

There must be restrictions on how much money can be held in reserve/profits.

The administrative costs of the CCO's are too high.

Healthshare is not truly a CCO. The stakeholders have simply put an umbrella over the structure that existed prior to the creation of the CCO's that, for the most part, continues "business as usual" and increases administrative costs.

523 Providers need to have clear standards for how outcomes will be measured and what the standards will be for baseline performance expectations as well as exceptional performance that might earn incentives before more value-based payments are implemented.

CCOs need the flexibility to implement programs based on their regional needs and based on a range of conceptual approaches to health care. If every CCO is only allowed to do business one way, there is no point in having multiple CCOs.

Implement a behavioral health subcommittee for HERC.

524 CCO's should not be allowed to use federal and state tax monies that go into their accounts to provide bonuses to their provider members. Basically by denying services to their patients, they don't spend money needed on healthcare, and then they make bigger bonuses at the end of the year due to the reserves left over. When providers and the CCO decision makers know that their bonuses get bigger when they deny services compared to the fact that they get smaller bonuses when they pay for services, which do you think they are going to do? Denying care to patients to get bigger bonuses is ethically and morally wrong but that seems to be OK to the State of Oregon and its governmentally elected politicians and appointed representatives. Talk about the wolves helping each other to the benefits that the sheep are supposed to be getting!

Also it's high time that ALL meetings of the CCO's are made OPEN to the public. They are spending our tax dollars and we have no right to see what they are choosing to do with it? WRONG in so many ways!

525 For-profit CCOs are of concern for many reasons, beginning with their priorities of profit vs the Triple Aim. These are public funds, and are to be used for medical care for individuals who qualify for Medicaid. Transparency is essential, and rules regarding out of state for profit CCOs need to be established to protect Oregonians.

526 The CCO in Lane County has been spiraling downward in service to members and providers while pocketing literally millions of dollars meant to care for the citizens of the county. The state should be embarrassed of what it has been bullied into by the lobbyists and stakeholders of a for profit, out of state company at the expense of Lane County citizens who depend on Medicaid for their children's health care. With no transparency and seemingly little accountability, the last year and a half of Centene-run Trillium has appeared to many to just be a profiteering cash grab.

On the other hand, I have heard great things about the lengths to which Umpqua Health will go to take care of its constituents in Douglas County.

527 It appears that members bounce around between CCOs and regular Medicaid. It's difficult to maintain a balance and bill the appropriate entity correctly the first time. As we are strapped with unmanageable timely filing deadlines with these entities, it would only seem fair to reduce the changing of coverages to a minimum or extend our timely filing deadlines.

528 The process for updating patient PCP should be easier. The rules around mental health/behavioral health/primary care should be standardized and spelled out down to the claim detail.

529 No, I'm just grateful for the work that EOCCO does, Malheur county needs you desperately.

530 Need to hold CCOs accountable to provide state plan benefits (which may need to be clarified in contract). Need to provide clear parameters for spending on HRS so that they can make investments in this area confidently and track results and share learning with OHP. Quality/metric incentives tied to measures which are tied closely to the triple aim. This could be structured as an opportunity for them to "win big" on an investment, e.g. require spending of x% on HRS/equity but structure contracts so they get to keep any immediate or medium-long-term savings.

531 CCOs need to be the driver of creating/enhancing a partnership with the education sector. So many red flags of health can be identified through our educational sector. This needs to be mandated at the State level. It will not happen without direction from the top.

532 Require the CCOs to cover more health care costs for the OHP member. All the CCOs are a for PROFIT Mentality, have new facilities with state and federal money, yet are very strict with covering basic timely needs for OHP clients. Require CCOs to find and hold onto providers and specialists. Require CCOs to cover all the health care for the client, housing all the Medical, Dental and Mental Health together, not separate as they are. Require the providers contracted with the CCOs to not discriminate against OHP clients and treat them rudely. Have less CCOs covering more common service areas to reduce administration costs for the state.

533 No

534 The integration of Behavioral Health into Primary Care. Specifically removing barriers around the OARs and COA that create major barriers to implementing and paying for integrated behavioral health in primary care!

535 I just feel like the poorer (financially) a person is, the less health care on all scopes they receive. I feel the world in general outside the USA has evolved past this, and its time to catch up. When someone moves into the healthcare field they take an oath, and more often than not, that oath is being broken. It's time for change.

Value-Based Pay:

We recommend that CCO 2.0 should be increasingly coordinated with the OHA's Alternative Payment and Care Model (APCM, i.e. capitated Medicaid wrap payment to FQHCs). The Oregon APCM program has already begun a shift to increased accountability, which is an area highlighted by OHA as newer for CCO 2.0. We believe that an end goal should be more shared strategy, learnings, objectives, and alignment between CCO-based and APCM-based payment transformation efforts. This would also provide an improved measurement path by aligning quality measure requirements and reduce administrative costs associated with quality reporting.

Social Determinants of Health:

We recommend OHA focus on global budgeting at the CCO level to encourage cross-sector partnership (health and social services) to yield the outcomes sought. We also recommend OHA align strategies to address SDH with existing capabilities in the EHR. Regarding VBP focused on SDH, we question the ability to successfully incentivize outcomes by addressing SDH without more data to understand: collection of SDH data at the individual level, aggregation of SDH data across sectors at the individual level, addressing SDH in the health care setting. We believe that OHA needs to address this need for data systematically and recommend cross-sector partnership to gather individual-level SDH and outcome data. In response to the SDH policy options, we recommend focusing investment on infrastructure connecting social and health services in order to address SDH in two ways: 1) physical connection between social and health service organizations (e.g. embedding case workers in primary care, nurses in social service delivery sites) 2) electronic connection between social and health service organizations following national frameworks for data exchange. We believe in metric development to support addressing SDH but question the effectiveness of addition of SDH-specific metrics to CCO incentive metrics as an approach to addressing SDH without the above (e.g. addition of a screening metric).

Behavioral Health Integration:

We recommend OHA emphasize the need for data exchange and interoperability between behavioral/mental health and primary care. NAMI has found that patient outcomes improve when interoperability between behavioral/mental health and primary care increases. There are two specific areas we suggest OHA focus when emphasizing interoperability: 1) Working directly with behavioral/mental health providers to socialize and incentivize interoperability 2) Eliminate financial barriers to interoperability and support adoption of national interoperability standards.

Cost Containment:

We recommend OHA look to electronic methods of data exchange and care delivery to contain cost long-term as well as limit administrative burden associated with quality reporting by aligning quality-incentive programs and reporting where appropriate. We recommend measure alignment consider: feasibility of measurement in electronic systems, gaps in sector-specific measurement, and gaps in cross-sector measures at the CCO level.

537 The CCO model seems to be working. Let's invest in benchmarking what aspects are working well for each CCO (dependent upon the needs of the population being served) and what is not working well and then, invest in making improvements. I am a big supporter of efforts to complete Community Health Assessments and Community Health Improvement Plans. My background is in project management. I realize that "what gets measured, gets done". Addressing the health and wellness needs of Oregon residents is fundamental to the health of the economy of our state.

538 The CCO's have been in existence for 5 years. Healthcare has been transformed. Putting arbitrary rules in to make their work harder is not effective. Making it harder for them to offer incentives to providers does nothing to encourage and reward participation of providers in rural communities. Ask the CCO's what they need from the state to continue to be successful. Furthermore, what can the state do to ensure the CCO's continue to grow develop and be successful that does not include more regulations or unnecessary reporting.

539 CCOs need to contract directly with certified and qualified interpreters on the OHA list. They are spending too much money going through agencies which, in most cases, subcontract with interpreters. Because the interpreters are independent contractors, they often hold no professional or personal liability insurance and are not covered by agency insurance policies. It is unsafe for CCOs to allow such contractors in healthcare facilities. Furthermore, the contractors are often times so poorly compensated that skilled interpreters and those who are certified and qualified will not provide services for CCO contractors. Many of the interpreters currently providing services for CCOs have no training, no understanding of HIPAA or interpreter role boundaries, and may be causing more harm to patients than good. They also are not providing meaningful access to services. Why do CCOs insist on paying so much to agencies, instead of contracting with interpreters directly from the OHA list? If CCOs used interpreters from the list they could oversee quality control and safety, and save millions of dollars per year. They should follow a model used by the OJD, Oregon Public Defense Services and state Worker's Compensation Board and Worker's Compensation Division, who all allow interpreters to bill directly for services and prioritize hiring of certified and trained interpreters, as well as responsible use of state funds.

540 I have experience working and advocating for individuals with mental health disabilities all over Oregon. The most struggles I have had accessing services is Jackson County where there are two CCO's and the County overseeing the mental health care coordination. There is no communication, lack of education, and poor poor client care.

I am a legal guardian who has spoken with at least 3 other legal guardians who have a very difficult time with this county and in my opinion a lot of it is due to the break up of services between 3 organizations.

I would not recommend their business model to any county, it is NOT working for their mental health patients.

541 The private, for-profit and public transportation industries are struggling to meet the increase in non-medical transportation services in the urban and rural areas of Oregon. Not only are the Medicaid transportation benefit rules stringent, the cost of being a qualified transportation provider has significantly increased as the compliance requirements and insurance rates increase and the pool of qualified drivers shrink. Yet, Medicaid puts no funding into the capital costs for development and support of this critical resource that is key to bridging the health equity gap for most of the CCO's clients that have no other form of transportation to access their medical services. When will Medicaid and the Federal Transit Administration combine their funding and goals so that CCO's can rely on a stable network of public/private transit services that have accessible vehicles and transit amenities in more communities?

Another unmet need is transportation support at large health care facilities to assist with the boarding/unloading of people at their location and creative ways a how to provide an attendant during transport when care facility staff and family/friend are unavailable.

From the transportation provider prospective, there needs to be a better business model for NEMT brokerages contractors than driving competition for the lowest priced ride because it seems to quickly undermine established transportation providers or keeps revenue unstable so existing providers don't know whether to expand or contract their business. Instead, this approach favors the short-term, small fleet providers who are usually startups or hire independent contract drivers with little overhead yet ultimately lacks the capacity to handle growth, provide quality service, and long-term financial stability. While this initially may succeed in saving the NEMT contractor money on the cost of services, soon it also reduces the capacity of the brokerage to serve the volume of rides and results in poorer quality service or no service available for the CCO clients.

I have seen this approach create instability among the transportation providers which forces them to find alternative revenue or go out of business. This type of business model also discourages others to enter the business, so the NEMT has to find replacement providers. I feel there needs to be a review of the NEMT business management outcomes in order to truly see if they are serving the Medicaid and CCO goals. My hope is that this evaluation results in a more balanced relationship between brokerage contractor and transportation providers and a more reliable, growing resource for CCO clients and health care providers. When there is a reliable, well-managed, integrated transportation system that can serve both the NEMT and general public's transportation needs, I believe that the CCO will be able to help more health care providers meet and exceed their health equity benchmarks and other required outcomes.

Thank you for providing this survey opportunity.

542 For delegates of CCOs, it would be great if reporting requirements and metrics matched. As well as dataflow and processing. It would make things a lot easier on delegates if there could be one Health Insight Audit per delegate, instead of filling out differently formatted information requests for each CCO as they are being audited by Health Insight.

543 They should make more effort to use the existing, proven services rather than creating their own resources that might be inadequate for the most challenging patients. that would avoid duplicating the services, and would rely on providers that have proven to be able to achieve good outcomes. Clearly, investing in removing the social barriers to health would be a big step forward.

544 It is critical to take a deep look at for-profit entities putting money in the pockets of shareholders over investing in the health of the CCO members and population health in Oregon. It is challenging as a member of the safety net provider community to be told by the CCOs that there are dwindling or no resources to support care delivery to CCO members, while the CCOs/CCO parent companies continue to earn a profit that is not in turn invested back into the communities.

545 A better HSD leader at OHA that will actually hold CCO's accountable would be great!

546 Just to continue to work together and grow.

547 No, Not at this time

548 I work with passengers that are on OHP/Medicaid getting transportation to their doctors appointments in a very rural area of the state. I see and work with a very large amount of passengers that for one reason or another need a small amount of assistance getting to their appointments. Examples are a spouse on Medicare unable to drive and either a family member was not available or neighbor cancelled out on driving them to their appointment. I believe there should also be some funding that can help a person not on OHP/Medicaid get the transportation access that there OHP/Medicaid partners receive.

The very elderly who have worked all their lives and haven't asked or received any assistance might need a little to keep them from driving unsafe or missing appointments and then ending up in the Emergency Room. Or the dialysis patient that is so wiped out after their 4 hour treatment having to worry about getting back home, when home is 15 to 25 miles one way home.

I just really see the need for the "fall through the cracks" non OHP/Medicaid passenger. They need help as well.

549 CCOs should emphasize provision of health care in response to community identified needs. They should be nimble enough to respond to those needs and not take a "one size fits all" approach. As CCOs concentrate on improving access to quality health care, Public Health can concentrate on assuring a base level of public health as outlined in the Modernization manual. While CCOs and Public Health have many points of collaboration - OHA needs to assure Public Health is robustly supported for its duties.

550 Access to infant and toddler mental health services, and integration of infant and toddler mental health services into early childhood programs (like home visitng, Early Intervention, preschool, etc.)

551 Massages... Less Co pays

552 Make it easier to include alternative treatments. End Samaritan's monopoly on health care.

553 We need to have more peer to peer support on the Developmental Disabilities level. Many parents are overwhelmed when their child gets a diagnosis, by no intervention for months, by the time they receive help they are in crisis mode.

We also need to help parents of disabled kids work on addictions of their own. I see on a daily basis parents resorting to alcohol, medications, marijuana, and sex to deal with the overwhelming responsibilities of having a child with a disability.

554 I do not think CCO's should be run or owned by 'for profit' organizations.

I think addressing the social determinants is essential for a healthy population.

Given the staggering evidence about the long term effects of early life trauma on later health and well-being, it is imperative that we develop a strategy for supporting parents to be the parents they want to be.

555 Incentives to providers is a waste of funds. It has been proven time and again that there needs to be intrinsic rewards rather than extrinsic. Paying them to take more patients cuts the time they have for each patient. In turn this creates more people using the emergency departments to get problems solved that could have been resolved in an office visit. The incentives only give more money to the physicians but it does nothing to improve the care patients are receiving.

556 Provider availability especially for primary care and pain specialists.

557 As CCOs continue to evolve it will be interesting to see how the social determinants of health are expanded and funded. Housing and access to healthy food are both issues that Trillium is addressing in the Lane County community. Trillium also invests a defined amount in prevention by working with Lane County Public Health. This collaboration is important if the community is to prevent chronic disease due to obesity and tobacco use.

558 CCO's and local community partners such as hospitals and specialist offices need to learn to work as a team.

CCO's should focus more on preventative care measures such as behavioral health, housing, and childcare so future generations will be better off. As it stands the communities are still fighting to help current members overcome present situations due to past traumas. If we can work with our younger populations to help them and their families rise above their current circumstances, we would have a better chance at a more successful future community.

Housing is a huge deterrent for many new families interested in coming to the area. Businesses lose out on great candidates if they are unable to find housing for themselves or their families. Many families in the community cannot afford to buy homes and the rental industry is full to capacity. How can we expect our community to grow and become better if its' current member's are struggling to fulfill basic needs? The local CCO could be incentivized to create more housing for their members by the state if it is shown the statistical analysis for the lack of housing in their community. The highest utilizers of the CCO funds are those who are in need of housing and end up in the ER constantly so they can just meet their basic needs. Creating a temporary housing facility where members could stay for just a month or two before finding an alternative would make a big difference. Case workers could be placed in these facilities to assist with housing, behavioral health, and medical needs. The CCO's already have case workers that could travel to these facilities which would cut down on additional costs. Many communities have multiple empty buildings that could be redone to cut down cost of building a new facility. If cost is an issue, the CCO could look into working with the state to automatically use some of the member's current state benefits to help pay for their stay.

Or the state could look at simply working with current community members in the rental market to incentivize them to rent at lower costs/ rent to CCO members specifically. The main issues why renters won't current is the fact that they fear their properties will be vandalized or the tenant will skip out on rent. The CCO/state could be in charge of paying monthly rental bills and can contract with the rental owners that if property damage occurs, the CCO/state will pay for it from the member's social security benefits.

Or the state could work with members who are in need of housing and give them an option to work to clean up the community or other volunteer activities to better the community; in return they will get housing credits to help pay for monthly rent. This gives the member the ability to better their life, get housing, and gives them the motivation to work. If you don't incentivize the members to choose to better their own lives, they will never work towards a better future.

559 By paying primary care providers less than specialists, there are fewer PPOs in Oregon. All providers should be paid on a scale that is equitable.

Income inequity is the reason for most other inequities. All who are working should be able to fund their families with a single income. Government needs to become very active in making sure that corporations are paying their employees true living wages.

Health problems diminish with adequate income that affords the opportunity for healthy eating.

560 Cco's should cover their Patient regardless where they are at or traveling to when they are living their lives. Instead of only covering Primary Care treatment where they live.

561 Provide education and incentives for individuals to meet health goals like maintaining healthy weight and blood pressure.

Provide incentives for CCOs to use Peer Run Organizations to provide Peer Services and the ability to pay for Peer Services under a flexible treatment plan.

562 Yes, we have CCO's that are poorly integrated in this state. We need to better align integrated care within our own CCO's before we can expect our provider networks to do expected and improved care coordination. We need improved access to include new providers who want to work with and for OHP members. We also need to stop spending money on supports that don't work which may require incentives to improved care within the provider community. We spend high cost dollars on recidivism because discharge planning is poor related to housing and helping people re-integrate into the community through improved supported employment services which are extremely poor in Marion County. We spend more money on kicking people out of Oregon State Hospital and Institutions because of poor community resources and planning for these people.

563 CCOs should have more required common-practices. For example, how and when they require PAs, referral processes, and reimbursement rates (particularly for things like behavioral health services) should be the same across-the-board. These disparities make it difficult for providers to navigate, and it allows CCOs like AllCare to continue sacrificing member care for profit, while others like Jackson Care Connect thrive and, frankly, kick ass. There's a reason community partners love working with JCC and hate working with AllCare, and that needs to be brought to the state's attention.

564 CCO's need Critical Care Coordinators who are experienced ie ventilator use

CCO's need to COMMUNICATE with Service Coordinators state, county and CIIS and others who Provide supports for people who are enrolled in CCO's. At least for fee for service we can look up in MMIS and see where process is and descriptions of what else needs happen so help can be provided. Service Coordinators have no way to look to see what is happening with a request and CCO's don't call or even know CIIS exist.

565 all good

566 I am convinced that the key to overall cost containment is increased investments in the social determinants that drive health care disparities. Currently, it appears that the fact that most of these investments are classified as "administrative" expenses rather than member care is counterproductive to encouraging the necessary investments in social determinants. The bottom line should remain the Triple Aim with fewer restrictions on where investments are made to contain future costs.

567 Oregon needs to get smart and include chiropractic and acupuncture into their health coverage. Not only would it provide a very effective, drug free, option for pain treatment, but also boost our medical economy and free up our existing physicians from some of the on-going care for chronic pain and mobility issues that they are very limited in providing real options for in today's anti-opioid environment.

Secondly, find a path to making it OK for real, full time physicians with real offices and insurance to sign for medical marijuana cards. The industry itself is dying, but provides a great income and service to Oregon on monetary, commercial and medical levels. Clinics will soon not be able to provide these cards due to lack of financial viability after legalization in Oregon. Physicians, on the other hand, could sign off on the paperwork, and never physically 'prescribe' anything, other than the recommendation, whilst boosting their bottom line for these appointments and having an option to offer chronic pain patients that are in their office....as opposed to the toxic crap you are trying to replace opioids with. And the patients would not have to pay cash, out of pocket to have their OMMP paperwork signed, but it's still an 'office visit' for insurance purposes.

568 I think You're on the right track. I have had and still have a rare chronic pain condition that only affects 2% of the population. I was diagnosed about 15 years ago and was lucky to have had surgery. I was on disability all this time. If it wasn't for the Oregon Health Plan I would still be in wheelchair and using walkers. I will always be alternatively tabled, but I got another shot at enjoying my life instead of being bedridden. Keep up the good work!

569 I hear the term CCO constantly. Perhaps because I have employer supported health insurance I'm not as informed as to how CCO's operate and what services they provide, but it would be beneficial to understand more fully the scope of work CCO's perform in the community and across the state. My recommendation would be to provide better community awareness. By addressing more of the social determinants of health to prevent unnecessary use of health care, perhaps that would take care of itself. Better community connections and having a face in the community served would be very helpful as well.

570 Behavioral health options do not meet the needs of a diverse population. As a mental health provider, I have no good options to which I can refer clients who belong to marginalized groups and who have experienced severe trauma. I see many of them pro bono, which equates to "at a loss."

CCO's should emphasize making sure that members have access to appropriate, necessary care rather than emphasizing the denial of services.

Patients who smoke should not be denied immediate, urgent care unless there is a solid medical reason for the denial of this care.

An ombudsman should be established to assist patients in navigating appeals or other issues involving CCO's.

The current structures can result in low-income, marginalized individuals feeling that they are viewed as disposable, invisible, and undeserving of help.

571 Improve reimbursement for behavioral health services and services supporting the social determinants of health such as Behavioral Health Consultants in Primary Care settings, and community health workers/promotoras.

CCO's should be able to provide accurate and helpful data in order to address gaps and needs quickly.

572 Regarding drug and alcohol, there is a lot of room for improvement. Our local CCO does not know what is going on half the time with regard to other programs and the clients they serve. It's nearly impossible to get someone into a mommy and me program, let alone a regular in-patient facility.

573 They need to be available to child welfare agencies, foster parents, and other supports involved with child welfare.

Really get in and do something. Not to just talk about it or try to facilitate a meeting (anyone can do that!). Not waste time by just stating what is already obvious.

574 quicker turn times on PA's.

More accessibility to behavioral health specialist.

We need more providers, especially in specialty care.

575 If CCO's are to address the more global picture of healthcare (for example social determinants, trauma, health equity,) it will be necessary for them to have more flexibility in spending with a true global budget. This would of course require more oversight of spending and more accountability for outcomes, but traditional restraints on healthcare spending will not adequately address these issues.

576 I feel that CCOs could and should be devoting more resources and energy to the social determinants of health and integration of non-traditional services. Behavioral health is a great investment for the population that CCOs serve, and additional integrated services should be examined like nutrition counseling provided by a Registered Dietitian. There is currently a limited infrastructure for billing and provision of nutrition counseling in clinics. Additionally, the SDoH impact health and access to services SO MUCH - if someone does not have reliable transportation, they cannot make their visits with their provider, cannot pick up their medications, etc. If we want to be a progressive state that truly provides equitable health care, we cannot keep ignoring and undervaluing the social determinants of health.

577 Health care should be non-profit.

578 Our CCO works with WIC Program, Head Start, schools and other programs to provide much-needed dental assessments and services to children who would not otherwise have access and who would have big dental problems in school years. This is a great example of an excellent collaboration.

579 CCO's in rural counties need to have a Coordinated Integrated Network set up, and it should be a top priority. There is a large amount of financial waste and risk to patients when up-to-date health records cannot be attained by PCP's, emergency rooms, and urgent cares. Allowing CCO's to continue to put this off is irresponsible and costs the state more each year.

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- 580** CCOs need better integration with IHS and Tribally-operated healthcare clinics and systems in the State. Partner with Tribes to ensure that Tribal members have equal access to services. Work with Tribes to ensure that CCO practitioners receive training and information to help them develop cultural competence with the Tribes and Tribal members they serve.
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- 581** There should be increased coordination with community and public health programs. Childhood obesity should be addressed in all PCPCHs. More self-management programs and not waiting until patients are diagnosed with chronic diseases - more prevention programs - no just pamphlets. Medical assistants are not trained enough to handle complex patients. Bring more educated staff into PCPCHs.
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- 582** There should be limits on CCO's profits and they all should all be not-for-profits. The one in Eugene made obscene profits for their shareholders when they sold it.
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- 583** CCOs should ensure that they provide a open market place for providers so that specific services are not all provided by one local agency especially if the need is not being met.
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- 584** My experience as a frontline human service worker and administrative staff at a non-profit in Lane County has left me very concerned with what seems to be a lack of oversight of the CCOs at both the county and state levels. There has been no clear resolution to the clear examples of profit taking that happened when the local CCO was sold a few years ago. I know that some of that profit came from the cutting of key services in our community which saved millions and thus made the CCO look even more valuable on paper. Additionally, the embedding of County staffers/administration in the local CCO has led to much confusion about where allegiances of some county staff are and has left many local providers concerned about how this impacts the ability of the County to provide unbiased oversight and regulation of the local CCO. Further unnerving is the current confusion around reserve levels of for-profit CCOs and the potential for legal loopholes to allow for the CCO to suddenly shut down and walk away with massive amounts of public dollars with no recourse. Many believe that all CCOs should become non-profits in the near future. Even more individuals would like to see immediate fiscal transparency and open meetings/records policies enforced at both the state and local levels. Many local providers would like to see the past issues around the sale of our local CCO in Lane county be addressed openly by government agencies at every level and their findings be openly shared with the public. Ideally, all the issues I have listed should be handled in the same way if the public is ever going to regain trust in our current CCO model.
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- 585** I believe that all treatments should be longer than 3 months and that the aftercare should be more intense for each person leaving residential treatments.
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- 586** I work in a Residential Program in rural eastern Oregon. CCOs are now making our clients return home by taking the Greyhound. This is a huge risk to the client's relapse potential. It is ridiculous to assume that this is in any way shape of form a "safe" method of travel for a person returning home after being in a residential program.
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587 More focus on preventative care & health education. Allow CCOs to refer to alternative care providers if standard practices are repeatedly failing - then providing incentives on outcomes for providers who research & take alternative action toward health resolution. Cover alternative care prescribed by providers. Do not penalize providers because a patient hasn't met a specific health marker at a specific time. This causes providers to fire clients. Address illiteracy and language barriers so patients are properly informed. Integrate all medical records so all providers can access patient records and treat patient with full history instead of only current conditions. This prevents repeat tests & experimenting with similar drugs. Require patients to read the pharmaceutical info sheet on a prescription BEFORE the medicine is dispensed. This will save a lot of money as often the medicine comes with a warning the provider is unaware of & the medicine cannot be used & cannot be returned. Provide better coverage for dental care as it affects overall health matters & costs more money later on. Require better dental care providers so the work you're paying for gets done right the first time instead of a patient returning 3 times to accomplish one task. Promote a plant based lifestyle & offer education as to how it directly benefits health. Provide incentives to doctors & CCOs who teach a plant based lifestyle to patients. Thanks for all you do - much appreciated.

588 Two of the issues that I see are lack of transparency and communication, especially from a claims perspective. If the state expects healthcare organizations to expand access and provide better quality of care, these become difficult goals to achieve when they don't get paid for legitimate services.

It is difficult to locate policies regarding payment of services and/or the enrollment and credentialing of providers. For instance, one CCO I work with does not follow some of the state OHA policies, but has their own set of standards, i.e., they won't credential or enroll providers based on the OHA Medicaid effective date, but only on the first of the month following the effective date. So if a provider starts on the second of the month, that provider can't bill this CCO until 29 days after OHA's effective date. Therefore, clinicians are giving "free" services during this time. It would be ideal, if all CCO's had the same requirements for credentialing using the effective OHA date.

Also, CCOs should be required to provide TPL information to the state, the same as providers. It's difficult, from a billing perspective, when MMIS shows no TPL, but the CCO denies a claim, stating there is a TPL. Especially for young adults, covered under their parents under ACA. Many times the patient and parents don't live in close proximity (ie. the patient is in Oregon and the parent is in Texas) and the patient is unaware of the TPL. When questioned, the CCO can't provide enough information to bill the TPL, making it impossible to receive payment.

And like many large organizations, the communication between departments of a CCO seems to be lacking. And it is increasingly difficult to get a "live person" who will take responsibility and follow up to resolve issues. If CCO's want to have a positive impact on patient's lives and expand their business, they must be more open and accessible to the clinicians providing treatment.

589 My experience with CCO's (IHN) has been they create barriers in order to not spend the money that has been allocated for care and that money then becomes profit. They change titles and phone numbers of staff so you can't access the people you need to access in order to acquire a service. IHN has the highest paid CEO and the worst outcomes. CCO's need incentives to work in the best interest of the people they serve.

590 In the northern eastern part of state provide qualified employees or insist on experience. It appears that individuals getting their first position or working toward certification are in majority of positions.

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- 591** Some people can afford to pay a small co-pay to see a doctor. Consider it.
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- 592** Hearing services should be included for seniors. Seniors with hearing problems are being taken advantage of by providers over charging for hearing aids.
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- 593** We have a housing crisis. Period. If families don't have shelter and opportunity to eat, this severely impacts their ability to function. Like Maslow's hierarchy. It is imperative that base needs be met and we travel up from there.
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- 594** Regulations against hospital over-billing will allow CCOs to put more financial incentive into the hands of preventive-care providers like PCP, BH and dental providers. Nation-wide, Medicaid recipients face discrimination due to lower payments for routine/preventive services. This discrimination leads to lower rates of access to pre-emergency services. Health disparity is readily alleviated by preventing hospital/facility control of governmental healthcare expenditures.
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- 595** Population health driven methodologies need to drive the creation of new CCO's, particularly in areas of the state where the population density is the greatest. This means perhaps a CCO dedicated exclusively to pediatric services to better align the outcomes of that CCO with the services they are paying for and supporting.
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- 596** More effective and accessible behavioral health
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- 597** We need to teach people to accept personal responsibility for their self-destructive and community-destructive choices. We need to focus health education on living lives of meaning, personal contribution, striving for adding value to our communities, to avoid self-destructive choices, and to act responsibly with our time and talents. We need less selfish, with our behaviors and focus on helping each other.
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- 598** I'm 32 years old I have struggled with addiction and mental health for many years I have multiple years in recovery and I have no idea what ccos is.
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- 599** Through all of this, the key thing missing is PATIENT ACCOUNTABILITY. Nowhere have I seen or heard anything that holds the patient accountable for making their appointments, taking their meds, getting their weight at goal, smoking cessation, drug cessation, following up on mental health as needed, etc. Along with that is the need to make patients pay SOMETHING for the services they receive. Too often, patients are ungrateful at best, and downright abusive of the system at worst, because they have no "skin in the game" and therefore are not good stewards of resources, personnel, time, etc. You will not fix a broken medical system unless / until you hold ALL users of that system accountable.
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- 600** I believe CCO's need to develop a means to provide universal access to treatment services for individuals involved with addiction issues. This is a unique component of behavioral health care and has a clear need for addiction related metrics. People should not have to die while waiting to get into residential treatment or even outpatient services. Thousands of individuals die each year, and for the most part, these deaths were totally preventable
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- 601** One thing that I didn't like when I found out I qualified for OHP and was assigned a CCO, was the amount of time it took me to get my health information card from my CCO. In addition, they just randomly assigned me a PCP without asking me if I already have a PCP in the community that was accepted by the health plan, nor did their selection factors in areas of expertise for my health conditions and LGBTQ identity.
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- 602** I think there needs to be an increase in recovery resources for patients who struggle with opioids and decreasing use, primarily chronic conditions/pain patients. I do not believe that medication assisted treatment is the only option, and I would like to see more access to alternative therapies, such as acupuncture, chiropractic (good practitioners not sub par), accupressure, warm water therapies, massage, CBT and/or ACT groups, mindfulness and yoga, tai chi. Right now, CCOs pay for medical treatment and those options are very NARROW. There are so many other ways to decrease opioid addiction and more holistic means. However, who will pay for this? Our patients certainly do not have the funds to access alternative treatments.
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- 603** Great start, good model with the 16 or so CCO's but need a lot more on Behavioral Health, Mental Health, Addictions, Coordination of Care between CCO's and within CCO's, Specialty Care, Public Health/ Social Determinants of Health and Health Equity.
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- 604** No
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- 605** CCOs should be receiving incentives to put money into policy, systems, and environmental changes as well as community-based programming that aims to reduce health care costs to the state long-term. And there should be more opportunities to share promising practices among CCOs directly rather than through Innovator Agents.
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- 606** Addiction is a unique component of Behavioral Health, and the CCO 2.0 model should adopt clear addiction related metrics.
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- 607** To include more wrap around care for behavioral health issues such as addiction.
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- 608** When a goal is to provide equity of service and quality of service, when CCOs seem to only contract with low cost public programs (behavioral health) to get volume of treatment episodes and ignore higher cost treatment that appear to have higher quality of services, it appears to be rhetoric over policy.
- Most of the OARs for behavioral health have nothing to do about quality of treatment or health and safety. They appear to set up the stage for OHA to be punitive instead of fostering a system of high quality of care. The OHA should look at best practices before issuing new OARs and get off the punitive aspect of site reviews if we want to improve our delivery system, that includes working with CCOs.
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- 609** Addiction is a unique component of Behavioral Health. There is growing need for clear addiction related metrics.
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- 610** I am very concerned about Trillium CCO's stated plan to move to a capitated payment model for behavioral health services. This will hurt consumers by incentivizing behavioral health providers to provide limited services.
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- 611** Really a national issue of the need for affordable and excellent medical and behavioral health care for everyone. CCO's payment rates may not be sustainable forcing some CCO's to close and interrupt the formation of close relationships with primary care providers and the patients they serve.
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- 612** CCO's are working hard, payers are working to keep up and provide key data and while there has no doubt been disruption in the provider networks it has not been equitable. The next wave of improved outcomes for Oregonians will need providers to massively innovate new ways of increasing care. The innovation must come from the hospitals, clinics and other medical/mental health providers as no other section (CCO or Payors) will have as much impact as what comes from those we trust the most. If the fantastic health care workers can rally towards something new, CCO's will be there to help.
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613 In rural areas the CCO's are not fulfilling their role when it comes to Mental Health. When there is a very strong biased and stigma toward the current CCO, and there is no brand change or visual improvements the state is putting their resources into a program the community does not trust. I have many families who refuse the only services available to them in the county because of past experiences of mistrust, and they desperately need and want services.

614 Allow 1.0 to work before we put new requirements on 2.0

615 I'd like the CCO in my area (Tillamook County) to understand that we need options for our behavioral health care. I can go to my primary care provider and see a social worker there for therapy, but they're not paid for it because, according to my CCO/GOBHI, the only mental health provider in my entire county is Tillamook Family Counseling. I want to get my care at my primary care clinic, they are professional and skilled and it's better care than what I could get at TFCC. Why doesn't the CCO understand that?

In my CCO, I have a number of options for who I see for primary care but I only have 1 option for who I see for counseling. How is that reasonable? If you want to address barriers to treatment or barriers to improved health, let me get counseling at my primary care clinic.

616 HIRE MORE DOCTORS!!

617 I just don't understand why a dental patient of mine getting coverage through the Oregon Health Plan has different benefits and/or payor than the next patient. For example, an adult dental patient with Capitol Dental as their payor can only receive one preventative cleaning annually. Yet, that same adult patient could call OHP, switch their payor to CareOregon, and receive two cleanings annually. This is all funded through the state, so to reduce employee waste and processing time, why can't we have one payor? You could take those funds and put them back into the healthcare. Neighborhood Health Center is my employer and we are trying to be innovative/comprehensive with our care and would love to see more organization and services covered for patients by eliminating unnecessary insurance processing companies (CCO's).

618 I recommend setting caps for services and care. Regulating the maximum amount that a patient can be charged for services, along with having more available options/choices for their care and for whom to perform services is the key. This drives costs down (due to competition) and promotes employment & economic growth. These methods need to be adapted nationally, so that healthcare in general can be affordable not just for patients, but for companies and government agencies that are paying for these services, so that their personal & business budgets can afford the overall costs.

619 Working as the Clinical Director for a non-profit community mental health center, I found that in order to keep the doors open, we had to focus on certain areas of reimbursement, such as family therapy. However, it was very clear from the beginning that the majority of our clients did not have the basic needs met (housing, food, employment, benefits, transportation, etc) that they would need to feel secure and engage in therapy. A good system would make sure that all needs were met through proper integration of services.

Additionally, there is not enough emphasis on co-occurring work and as such, not enough communication and collaboration between addictions and mental health. If we want to provide quality care, we look at best practices, which is the treatment of addictions and mental health simultaneously by a single clinician OR a treatment team model.

There is a lot of competition for billing in the community, rather than emphasis on meeting the needs of the community. While every center is a business, at times, it felt as though the goal was to treat as many people as possible rather than provide quality care. This may have been a result of the specific place that I worked and am curious what other agencies experienced.

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- 620** more mental health facilities! More beds and more screenings done on children and adults!
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- 621** I see the biggest improvement right now as the ride to care transportation system. This system is failing its clients and leading to big funding losses for every health care institution due to patients missing appointments due to the ride not showing up and subsequently being kicked out for missing appointments several times. I would suggest making a real time phone application where clients can request and track rides similar to the way ride share apps are set up, the hardest part is that clients spend several hours of their day waiting and have little to no recourse when a ride does not show up on time which leads to late cancelling and productivity loss.
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- 622** no
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- 623** CCO's should not be for profit, as it creates a conflict of interest - making money, saving money on care, limiting access to care - we see it in Lane County with Trillium/Centene.
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- 624** I majority of the counties in Oregon are now are Federally designated as having Behavioral Health workforce shortages.
Will OHA step up and take leadership on this issue?
Without enough trained workers to do the work - access to behavioral health services throughout Oregon will remain at an all time low.
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- 625** The State needs to support the CCOs in containing costs by limiting hospital reimbursement rates for Type A/B and DRG hospitals. The CCOs aren't funded enough to pay the current rates.
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- 626** More education to the public about what CCOs are and what they do. All I know is a lot of money/resources have gone into them and one recently shut down. I haven't seen the benefit of our tax dollars. I'm not saying there hasn't been a benefit, I'm saying, I don't know what that is.
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- 627** Add people with disabilities and those living in remote areas as targeted disparities experiencing inequitable service.

Increase the amount of mental health therapy available to CCO members. My friend was suicidal and yet only able to access a therapist for 30 minutes a week. That is insufficient and not proactive care.
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- 628** Our community needs better and additional mental health services. CH&W does not offer what we need. CWS is told over and over how there are no services for our kids who need residential treatment. Child who need residential services are being sent out of state to get the care they need which isolates them from their families and does NOT promote health and wellbeing.
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- 629** 1. Increase use of Health Information Exchanges to improve integration of care.

2. Use of alternative service deliveries for SPMI population such as medically enhanced ACT teams, mobile detox teams for in-home opioid replacement.

3. Use alternative payment methods such as Pay-for-Success for behavioral health care.

4. Increase parity of behavioral health rates with physical health rates so providers can stabilize workforce.

5. Increase the services that are reimbursed i.e. care coordination, transportation, etc for SPMI population.

6. Require CCOs to address deficit of qualified behavioral health workers through workforce development initiatives.
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- 630** Again, the CCOs need to make the case that the Social Determinants of Health are health care issues, and we should be able to receive Medicaid match for housing and other vital needs.
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631 CCO's should work on prevention of higher needs. Make CCO's responsible for costs of members needing institutional placement - State Hospital/Non-skilled Nursing Facility stays.

632 This survey really does not allow for us to address all of the issues in our community. No one thing is worse than the other when it comes to needs in the community. Those needs are individually based. not all OHP members need housing, but have trauma. Not all clients need education but need housing, not all clients have trauma but need housing. CCOS are doing a terrific job with the implementation of CHW or THW. They need to be used on a wider basis, education for all level of client's needs to be more easily accessible. The hotline that members call to change their address or ask a question needs to be improved. Member's sometimes spend hours on the phone just to get hung up on or not get anywhere. If CCO's were given the power to do things small like that(change of address, reinstate services etc) It would eliminate a huge gap that clients have created by OHP for them to receive services.

633 The CCO model is completely inappropriate for Oregon and should be dismantled. I have three main reasons for this:

1. Some CCO's are for-profit and are more interested in their bottom line and shareholders than the wellness of our community.
2. Different CCO's offer different incentives and programs that don't exist in other regions. A regional approach allows for some innovation, I guess, but it creates inequity.
3. CCO's waste FTE and money lobbying the state. This is unacceptable.

I appreciate that the OHA is considering how to make this model better for Oregonians, but strongly suggest doing away with the model and returning the management of care and payment to the state to ensure that funds are used transparently and equitably.

634 I think a competitive market can have some benefits. CCOs are more likely to invest in SDOH services directly at the member level for activities and services that improve wellness and provide stability.

Whether or not, it is a CCO investment, or otherwise, housing is a huge barrier and cost driver in the healthcare system, so at some level this needs to be addressed.

We must stop fee for service payment models. The reality is, in terms of population health, it is unsustainable and incongruent with the Triple AIM. This means providers will make less, AND with these payment models, we must build in utilization and quality metrics.

A more significant investment needs to be made into prevention, specifically; unplanned pregnancies and more accessible birth control -- even incentivized birth control if we wish to sustain OHP as it is today.

Oversight/regulation on prescriptions and prescription costs.

635 Care coordination for children placed out of county for treatment services. More mental health beds, CCO help in obtaining more foster homes, making getting services easier for foster parents to obtain, not be an obstacle they have to overcome to help these fragile children.

636 Focus more on effective coordination or integration within the health care system rather than on things not within their control such as housing, food, employment, etc.

637 It would be helpful if the CCO managed care plans were more consistent in things like how patients can access care. I like the idea of more patient education on how to utilize their plan, the need for referrals etc on the front end.

638 Allow better access to speciality care provider with adequate reimbursement. Many specialist refuse CCO patients

639 The definition of Coordinated Care Organization (CCO) as a Community-governed organization does not hold true in all areas of our state.

I don't believe our CCO is community-governed when it is 'owned' by a For Profit corporation based out of our state. Not only governing from out of state but new to the working of Mental Health/Behavioral Health services as well.

Their billing system was a disaster from the take-over. Local providers were not paid for services for months and some had to take a 'loan' from the corporation to keep their doors open until the billing could be cleaned up. These billing issues were across all providers in our county! Issues continue to this day.

Transparency is non-existent. Input into structural developments is minimal at best.

I very much believe that the CCO award (and trust) should NOT be given to a "For Profit" entity when we in the community are "Not for Profit" providers working to provide services to a low-income Medicaid population.

How can they improve? Limit the awards to NOT FOR PROFIT LOCAL applicants.

640 The state should continue efforts to improve alignment and to incentivize cooperation between CCOs and Early Learning Hubs.

641 Add more care by complementary or alternative provider types in coordination with more traditional provider types. A different view of health and how to attain or recoup it can assist the overall picture. Focusing on just traditional type care lessens the potential value that could be attained with help from other provider types.

642 Quit making patients go to two or three doctors before you approve the care they really need. You waste time and money making us go through more tests that cost a fortune. Believe the doctor when they say the patient needs to see a specialist.

643 Expend more effort in the transportation and counseling areas for their patients.

Provide onsite tobacco cessation counseling. Many of the Medicaid patients seem to be tobacco users and do not have the tools or resources to help them quit.

644 In general, the CCO's have been given large goals and allowed to meet them in whichever way they see fit. While this had lead to some innovation it has also created more work and an inability to consistently identify what CCO's are doing to improve the health of OHP members. There should be more guidance and consistency in what CCO's are required to do including what services they cover. Best practices should be found and shared freely among the CCO's and they should not be seen as in competition with each other for patients and dollars. Every CCO should actively work with the state to improve the health or the clients that they serve without a profit incentive. Public dollars need to be spent in the best and most efficient way possible to ensure the best possible outcomes for the population being served.

645 CCOs should be required to increase behavioral rates - especially residential addiction treatment services. And, the accompanying health supports (housing, employment, peer, family counseling and more) need to be covered. CCOs must take money to do this from the physical health side. Addressing the addiction issues will drive down the costs of physical care.

CCOs should be required to invest in rates for Medicaid providers so that we can pay a competitive wage and don't continue to lose good staff to higher wage positions with counties, CCOs themselves, or private sector. With the behavioral health workforce shortage, many providers have positions opens for months on end because the lack of workforce coupled with noncompetitive wage.

CCOs should be required to have rate parity for mental health and addictions due to the fact that the same level of qualified staff are providing services. Addictions rates do not cover the cost of care (even in an environment where wages are below market).

646 Ensure that "cost containment" and "Value-based" do not equate to shorter physician visits, or paying more for specialty care. Focus on prevention by attending to small matters before they become larger (more expensive) matters.

647 There should be an easier process for getting authorizations for different CCO's. I don't think a CCO should deny an authorization for an out of panel provider just because they members CCO has changed.

648 I think CCO's are a waste of money all together. All you do is take the money that could be paid directly to providers. I have watched the care my family receives go down hill for the last 4 years. I can not get any prescriptions I need. My son has had 3 surgeries with little to no physical therapy afterward. All your 'care' does is tell 'us' that we are not important. You tell us on one hand to take responsibility for our health....but then you wont cover any services. You send us surveys with predetermined answers....how is that equitable?

My mental health is worse because of CCO's. My physical health is worse because of CCO's. My life is worse because you have a nice, cushioned job.

649 Know your patients and their needs.

650 More coordination with community partners around health and health related outcomes.

651 Housing = healthcare

652 Look at existing strong HIV system of care and usage of medical case management model. Consider reimbursing case management services to support this model which has great success in engaging OHP members with significant barriers and improving their overall health outcomes.

It is imperative that CCOs address social determinants of health and provide support (financial and otherwise) to improve these as they have a direct impact on client outcomes and engagement in care (housing, food, etc).

653 Survey their patients/clients/consumers n staff to get on-the-ground input on ways to improve and implement same.

654 Have a true care coordinating program.

All health providers need to communicate with each other regarding each individual.

Each individual should be assigned a care coordinate to help them. Lots won't need it, but all the others that need this service will benefit greatly.

655 We need to make it easier for ohp clients to change CCOs and manage reapplications, etc in multiple languages. The 800 number in Salem is often inaccessible and huge wait times and that is a huge client issue that continues to be unaddressed. The burden shouldn't be so high on clients to switch CCOs (especially when changes are often due to state errors, autoreassigns to incorrect plan, etc). Ongoing problems with this issue often results in interrupted primary care, addiction treatment and other critical services.

656 I don't think that it's the job of CCOs to pay for health equity or the social determinants of health.

657 Communities would be better served if CCOs were more transparent about how public dollars are used and if board and board committee meetings were open to public comment and public scrutiny. Also incentives would be well used if targeted not only to clinical settings, but to systems supports (e.g prevention and community based work) or if CCOs were required to invest in community benefit activities that were aligned with community health improvement plans developed in partnership with the local public health department. Requiring an investment in population based prevention would be a good strategy, especially when targeted at social determinants of health and equity.

658 So far the model is working and I hope we continue it.

659 It's been a great experiment and we are fortunate in the southern region of the state that the level of collaboration between those who are charged with the "social determinants of health" was strong and has become stronger with the CCO vision and projected outcomes, along with financing they bring to leverage positive change.

660 I was surprised to learn that our CCO (Trillium) does not want leadership staff to publicize the rates for reimbursement to line staff, nor even to middle management. I also can't find policies on their site that clearly state what various clinicians can bill for various services. It seems like they're just not transparent enough to allow behavioral health staff to figure things out & make decisions that help the financial condition of our agencies, and it even feels like a barrier to care for our clients.

Additionally, an "expedited" credentialing request now takes something like 30 days by Trillium which seems debilitating to our agency. There's an expectation for us to see more & more clients, and expand our capacity - and when we have licensed clinicians who are ready & able to begin seeing clients and helping our community, we're held up by the CCO? That seems woefully negligent, on the CCO's part. My sense is they operate like an insurance company akin to BC/BS or Aetna - where the insured members have resources - when in reality, the clients we are trying to serve are underserved and consequently have limited resources. WE are their resource. But, we can't help them because their insurance provider is slow.

More feedback has to do with potential ways to lower costs and improve BH access: CCOs could potentially increase BH rates so that community-based BH providers can (a) pay staff at the same level as a primary care or hospital setting and (b) expand capacity to ensure quick access to services. This increase could be based on the predicted savings in medical costs. It could also come from a bigger push towards integration. The promise of integrated care isn't playing out as we'd hoped. For example, funding is still kept in separate categories.

Another idea that was discussed amongst my colleagues was to potentially require CCO funding for supports that help clients achieve recovery in both mental health and addictions (examples include telephonic therapy, post-discharge maintenance, dual diagnosis/co-occurring services for all levels, employment and housing support, family counseling by time instead of session, multifamily counseling and education, basic needs vouchers, service plan development, time for documenting and supervision of outcome work, no show and travel codes, residential care requiring medical services, etc.).

Lastly, a suggestion made by my team of colleagues was to potentially require OHA and CCOs to reduce administrative burden for providers while at the same time helping providers to increase the pool of well-trained behavioral health candidates with higher levels of education. One step could be requiring CCOs to standardize payment models and allowable codes across the state.

661 continue to encourage and incentivize integration of clinical pharmacy services to help reduce overall drug costs and improve clinical outcome measures.

662 The problem is not the CCO's. It is that OHA is absent in contributing to solving many of the problems affecting healthcare in Oregon, such as out of control drug pricing, continual additions to covered services that CCO's must cover, and a complete lack of any accountability from providers. OHA cannot reasonably expect each CCO to police FWA activity if they will not back up CCO attempts to monitor and sanction providers.

If OHA does not step up to partner with CCO's on solving problems, and instead continues to offer no help while continually auditing, monitoring and overseeing CCO's with repeated "reviews" and regulation, then OHP is doomed.

663 Require CCO's to contract with and adequately compensate "proven providers" as evidenced through their national accreditation, licensing and certifications. CCO's contract with too many providers with no accreditation and limited expertise in delivering behavioral health services. Build the capacity of proven providers and stop building capacity by contracting with new, unaccredited and unproven providers.

664 I think now that we've seen many different models of how a CCO can be structured and operated, we know what works best and what doesn't. OHA has quality metric results and financials along with provider and patient feedback to combine into recommendations about which CCO models and strategies are most successful and which ones have created/maintained barriers to quality care. It is time to pull lessons learned to create additional structure/requirements around the CCOs to move into CCO 2.0 so we can continue improving the health and wellbeing for all Oregonians.

Thank you for the opportunity to provide feedback!

665 This is very poorly done. First--each CCO has different strengths and/or weaknesses so just asking about a generic CCO begs the question: Is MY CCO doing well how can THEY improve. Second--the entire premise is that there are enough providers--medical and/or non-traditional--in the CCO/State/entire Nation; and there are not. No CCO can "fix" that without "stealing" from another and that just lessens the strength of that other CCO. And third--the answers are going to differ whether one is an OHP person and/or professional/provider (and, yes, there are a couple that I know who are both), a person over 65, a Vet, a person underage, etc. Access to services that are not there or that are limited affect everyone in the system; you can't force providers to provide services to a certain group--not without losing even more providers.

What a disappointed and biased (and not equitable) survey. (And I'm sure it will be used to change an entire system over the next few years--without any acknowledgement of the basic issues.)

666 Stay on the path designed for this work - outcomes, experience and affordability. Remain committed to the models we have designed and are working - primary care medical home, quality incentive programs for primary care and hospitals, and value based care payments.

Mental health integration, quality and overall financial improvement is completely dependant on Oregon Counties stepping up to to the work that needs to be done - or, handing over the money they receive to provide services and fully integrating services with CCOs.

667 To lower costs and improve BH access, CCOs should be required to increase BH rates so that community-based BH providers can (a) pay staff at the same level as a primary care or hospital setting and (b) expand capacity to ensure quick access to services. This increase could be based on the predicted savings that would come on the physical health side. It could also come from a bigger push towards integration. The promise of integrated care isn't playing out as we'd hoped. For example, funding is still kept in separate categories.

Paying for supports that help clients achieve recovery (examples include telephonic therapy, post-discharge maintenance, dual diagnosis/co-occurring services for all levels, employment and housing support, family counseling w/o patient, multifamily counseling and education, basic needs vouchers, service plan development, time for documenting and supervision of outcome work, no show and travel codes, residential care requiring medical services, etc.).

Requiring OHA and CCOs to reduce administrative burden while helping us to increase the pool of well-trained behavioral health candidates with higher levels of education. One step could be requiring CCOs to standardize payment models and allowable codes across the state.

Support culturally specific providers to achieve more equity and reduce disparities.

668 Currently, there is not a good plan or analysis of where the actual versus perceived needs of behavioral healthcare gaps in services. The CCOs are asking for more capacity from providers without the data needed to help expand the system in ways that will actually meet the community need.

Also, the expansion is being demanded of providers without the financial supports or resources to then increase capacity. There is a "build it and they will come...maybe" attitude that is difficult to plan for and strategically address. Also, the reimbursement rates for services, even as stated by leadership within CCOs do not actually cover the costs of services and therefore agencies are expected to fund raise to close the financial gap. Operating from a place where the expectation is lower than cost reimbursement is not sustainable either short or long term. There are not sustainable services at the appropriate levels hence youth and adults being stuck in emergency rooms for days (or weeks) since the appropriate services are not available. There is not a plan in place to determine where within the behavioral health service area which services need expansion and also no plan on how to help increase capacity.

There is also no continuity between the CCOs in operations, billing, authorizations, and services offered. As a state wide provider, this creates a challenge in learning and understanding the 15 very distinct culture and processes of the 15 CCO's in the state. While we understand the need for unique service arrays based on location, there should be basic service delivery that is the same state wide. This also impacts families that move and lose services due to shifting from one CCO to the next. A family with BlueCross can access similar services and have similar expectations regardless of region. However, medicaid families are not allowed the same experience. This is most evident in community based services for youth and adult services.

669 It is not reasonable to require the CCOs to do more, provide more services, and improve quality with less funding. The State needs to reduce expenses in other areas in order to sustain funding levels for quality programs and those CCOs that are meeting and exceeding benchmarks.

670 We do nothing about Juvenile Diabetes in our county. There is no warm handoff between Portland and our rural community in Southern Oregon. There needs to be education and supplies available for Parents and their child that has been diagnosed with diabetes.

In addition, we have no mental health services for our children in Southern Oregon. Why aren't we working with the schools and setting up programs to ensure our kids are safe in the school environment. Why aren't we teaching our parents and providing them resources for to assist them with behavioral health services?

We spend more time worrying about reimbursement to providers and making sure we collect data on OHP encounters to ensure the CCO gets paid and our providers get paid, we forget about the quality of care to the OHP beneficiary and provide NO PREVENTION EDUCATION. We leave all of that up to other Not for Profits in our area.

671 Work closer with local trusted OHP-Cerified Community Partners who assist Oregonians in enrolling in coverage an navigating CCOs. Hear their suggestions and value them. These partners have strong connections with their clients and OHP/CCO members and many times they share direct feedback with their OHP-certified partner.

672 In my experience, working with Trillium has been a better experience since the CCO is in place.

673 I believe that CCOs are doing the best they can to assist members with their health. I think the biggest problem is that the social determinants are sometimes the biggest barriers to health, and if CCOs could spend time and money to assist with those issues, costs and high stress, complex needs would go down over time.

674 Decrease overall administrative costs in the healthcare system; simplify and standardize payment methodologies across sectors. A good start would be a Primary Care Trust model with single access and payment methodology for all primary care.
Social determinant of health funding should not be "medicalized" and flow directly through CCO's; it will cost more in the end.

675 CCO's (Healthshare) needs to step up and start providing for their most vulnerable kids in foster care. They have almost no involvement with the most medically fragile children in child welfare who are receiving in home services through other programs because of their lack of involvement. Almost all foster children in hotels belong to Healthshare who has little involvement in getting these high behavioral needs into appropriate programs and services....which are VERY lacking.

Mental Health Services for kids across the state are in crisis, causing our kids to be in crisis.

More focus on coordinated care across the health care/mental health care continuum.

On the ground, in home care coordination is needed for our medically fragile kids who are home with families rather than phone communication. And actual care coordination needs to happen rather than putting the responsibility on the parent or foster parent to contact the coordinator. A respite program needs to be developed for these families who are under a great deal of stress caring for these children with limited in-home services. CCO's need to step up and provide and coordinate these in-home services.

676 The CCO should make it easier (i.e. Require) OHP members to get a PCP, so the emergency room is not used as a PCP. It's far to convenient for OHP members to go to the emergency for services that can be gotten at their doctors office or walk in clinic. There needs to be some "skin in the game" so to speak if OHP members choice to use the ER for non-ER services.

677 keep data. on everything

678 Oregon Health Authority should invest additional resources into non-emergency medical transportation as a cost-saving strategy for global CCO budgets. NEMT is the one social determinant that CCOs are funded and equipped to address. NEMT has been shown by multiple studies to be cost saving for specific health conditions and highly cost effective for others. Funding for NEMT should be expanded to allow for growth in utilization of NEMT services so that more members are able to access preventive services.

679 We spend a lot of money on things and don't get anything in return. We have lower readmission rates and lower admission rates but cost keep climbing.

We need to negotiate for lower costs of things, like labs, x-rays and drugs. I as a physician want to give my patients the things they think they need. We need the CCO's and insurances to set guidelines. Limit those meds that are too expensive. Make that preferred list public and easy to access. Streamline the prior-auth procedure. Make sure that we spend time with the patient.

680 Use more Chiropractors, Acupuncturists, Massage Therapists, Homeopathic, Herbalists, Frequency Therapy, etc. as preventive care providers. They too are licensed by the state and should be included in a patients list of choices. Traditional medicine doesn't work for everyone all the time. We need to look for new and better ways to manage our health issues. Doing things the same old way and expecting a new outcome is lunacy. Think more outside the old box you are stuck in and there will be a much bigger reward.

681 The CCO system has been a "money pit" for Oregon. The "For-Profit" status of a CCO has corrupted many of them and the patients and taxpayers have suffered. There has been no real accountability for these organizations and they have spent millions of dollars on bonuses, incentives, and salaries for their executives.

If the State is not willing to actually "manage" the CCOs, then the next election may not be as favorable as the last one. If the State cannot see this coming, then they are blind to it, or taking their own share of the profits that are paid to take care of the underprivileged!!

682 CCOs should stick around and "model" CCO's should be identified to determine operational procedures.

There should be more transparency around where Medicaid dollars go and the percent of profit that goes to the community.

A percentage of CCO profits should automatically go to local public health organizations as general funding to help decrease funding silos and promote PH Modernization. Another percentage should be allocated to non-profits promoting health and the social determinants of health.

683 Focus more on the social determinants of health, food, housing, employment, education, health improvement through coaching, opportunities to engage around healthy activities and less focus on paying/spending for traditional healthcare services like doctor's visits both primary and specialty, clinic visits and hospitals.

684 It would help to develop accountability criteria that is applied to the consumer. An example is addressing the problem of people intentionally using hospital emergency rooms when nearby clinics are available. While provider accountability is important there is little to encourage the "patient" to take responsibility for changing lifestyle and usage behaviors and thereby controlling healthcare costs.

685 Living in Eastern Oregon there is high turnover in providers. Continuity of care should be high priority especially in behavioral health and primary care.

686 CCO's should require patients to have a primary care provider. Patients are going to specialists too much and obtaining high dollar treatments that commercially covered patients cannot afford personally. Consider capping what can be spent for each patient so they consider where their "dollars" are being spent. Creates accountability for the patient.

687 Overall, I believe the concept of coordinated care is great and I see healthcare providers working diligently to assist mbrs in accessing care; however, I would like to see far more education/information on a healthy diet/exercise and meditation/mindfulness practices to help mbrs prevent common, preventable conditions/diseases and far less dependence on prescription meds.

Not sure there is a whole lot that can be done w/ the substance abuse issue since the drugs are so readily available and the resistance to change is so difficult to treat. The sever mentally ill require far more assistance than I think the outpatient community can effectively treat and I would like to see far more structured community settings/homes for these people providing them with a safe environment.

I do not like the value based incentives as doctors can only do so much - individuals need to step up to the plate and start accepting responsibility for their unhealthy habits and start to make better choices. When one is making strides towards a healthier lifestyle, he/she is far better prepared to contribute more to society and a healthier community.

Overall, I believe we have to work towards a single payer system so that everyone has access to BASIC healthcare and not to have to worry about being able to afford healthcare. Those of us who are working and have to pay for our healthcare do resent those on Medicaid who get most, if not all, care - dental/vision/dme for free - I believe EVERYONE should have to pay SOMETHING towards their healthcare because then people have some skin in the game and will value their health and the care they receive. I also think we have to really evaluate the types of care we will pay for and possibly cut out some medical procedures that only a few benefit from but that are prohibitively expensive. Basically, we have to promote self health responsibility.

688 CCOs have been invaluable to my family and our needs. I think they are doing a great job, but more locations in the valley should accept OHP. There are quite a few providers that won't.

689 The CCO model is wonderful, but it seems to be leaving the under and un-insured behind. When working on projects and partnering in the community the goals need to be for all people, not just ohp members. We have a lot of work to do and burning bridges and turning our backs on the rest of the population is not an effective way to get work done.

The more lived experience we have involved in making choices and planning the better.

Consistency and communication.

690 Greatly expand the number of beneficiaries who have an assigned health home and plan for coordinated care and social supports including housing.

691 Access to all types of care including chiropractors, acupuncture, naturopathic physicians

692 Addiction is the largest cost driver for CCO's and yet there are no metrics for measuring addiction, it has the lowest re-imburement rates, has the virtually no standards of care.

693 All CCOs should be required to dedicate a percentage of their funding to support prevention/health promotion.

694 CCOs should lead the discussion on reducing costs for end of life care, something we need to shift across the entire country if we are to make a dent in healthcare expenditures.

The State is prone to quarterly and annual monitoring of outcomes which works well for hospital care and perhaps some focused speciality care but which is not good for primary and behavioral healthcare. Lifestyle change, dealing with longterm traumas, and undoing lifelong patterns that have impacted a patient's health can often not be done in a couple of months. We need longer-term monitoring of provider effectiveness for these long-term chronic issues.

695 We need to consider oral health an equally valuable piece of the delivery system. Oral health impacts overall health and should be legitimized as such.

The Authority needs to take the stance of elevating oral health in our system of care and then raise our expectations of the CCOs and dental providers with regard to service delivery, care coordination and compliance.

696 The Community Advisory Councils do not work as envisioned. Perhaps there is room for more redesign of the model to get the right kind of community guidance for delivery of services.

697 There are not enough primary care provider options in my area. I live on the border of 2 counties and have taken my children to a provider in Lincoln County for 10 years. Due to the this CCO being VERY difficult to work with and receive payments from, I am no longer able to take them to that provider. I had to change to a provider in Tillamook County and they are not ideal, difficult to get into be seen, farther from my home and work, and not very good providers.

698 Very frustrating experiences in rural area with turnover of staff, staff who aren't well trained or no specialty training for youth who have experienced sex abuse or deep trauma. Feels like CCO's "toss the potato" with Child Welfare on difficult children who might have to be in a hotel for placement. Very frustrating e-mails of "It's a behavior issue, not mental health. We can't help you-sorry."

699 A lot of the CCO's follow along with OHA guidelines but when guidelines are not clear it creates confusion for providers as well as the CCO's trying to figure out the rules just so they can establish there own guidelines.

700 CCOs should not be allowed to split physical and mental health funding and risk. There is overlap on where services are being provided with more mental health care being provided by primary care providers. CCOs who carve out physical and mental health to different entities are causing the system to be more complex then it needs to be and increasing barriers to care.

701 In rural Eastern Oregon, by far the biggest barrier for OHP clients I work with is realistic access to services. In some cases, there is one provider in any given location that actually takes EOCCO coverage. We have to send kids 2 hours away to get them pediatric dental treatment when their dental home is unable/unwilling to treat them with anything above minimum basic care (prox), silver fluoride). One trip is required for a referral evaluation, and then one for treatment months later, and then another for post follow up. Even though there are medical transport options available, families have to take three days off work. Reimbursement for gas and lodging doesn't work. The system is really clunky and we hate to even offer it because it requires so much work, has taken months to receive reimbursement, and hasn't always gone through. These are families do not have the financial resources for this, and then instead go without getting their kids necessary treatment.

Also, they do not have a choice in primary dental home with EOCCO where we are. There is one option in each town. Therefore if they are not satisfied with the care they receive, feel judged or shamed when they miss appointments or something, they are under the impression that they have no options, and then tend just not to go back.

Also, in our program we often see children for the first time when they have dental screenings with us. These are also many families who have not enrolled them in OHP or have let coverage lapse. Then they are screened and found to have immediate need for treatment, it takes a really long time to get them covered in order for a dental home to even see them. If this doesn't need to be the case, providers (AND RECEPTIONISTS!) need to be better educated on assisting the family right off the bat in getting them in as quickly as possible so they can start process of evaluating and referring out to pedontist (2 hours away and three months out in scheduling).

702 Why are CCOs allowed to give millions of dollars away to their shareholders? Why doesn't OHA report this?

703 Housing first. It's evidenced-based, it works.

Increase mental health services. Spending weeks in the ED waiting for a psych bed is an absurd cost. Repeat ER trips because there are so few psychiatrists willing to see juveniles (and they can't get medication management elsewhere) are expensive.

Increase residential d/a treatment for families and incentivize wraparound MH/trauma services as part of d/a treatment.

704 Not At This Time

705 I feel that to get the best quality care in a state of emergency, a person must go to Eugene in order to receive that. Mercy Medical Center has been responsible for many tragic occurrences in the health of our community. Non-emergency experience at Mercy is hit and miss, but is definitely not outstanding. I found myself and friends entirely surprised to see Mercy's national rating. Mercy does bring in a large amount of money, so perhaps their influence through finances landed them their rating. It is, for those on OHP, one of few limited options in our area for care so there are many patients because it's simply all we have. But most I've ever talked to in my life time have had far more negative experiences than positive and I've experienced the negative impact as well within my own family circle. I've also witnessed bad health outcomes lawsuits fall through because of the astronomical amount of money backing Mercy. Being a person with great insurance, at this point, I steer clear of Mercy at all costs but have had to go there for labs a few times.

I do feel that the merge between ADAPT and Compass Behavioral Health has been incredibly beneficial within our community. The correlation between mental health and addiction as well as the consideration of trauma being a major influencing factor for those struggling is something that has been a long time coming. Of course those things tie together and I feel that ADAPT/Compass simply gets it and want to help people. They are striving to become a very well rounded provider.

Ultimately Douglas County has lots of room for growth but I also believe we are growing right now and improving. I have witnessed it happen.

706 The Oregon Health Authority seems to currently operate on the myth that they "can do all things for all people." This has no credibility nor capacity to sustain. It takes many organizations and it is unfortunate OHA wants to pursue this goal at the expense of basic health services our patients need. The OHA is not a housing, transportation, or employment division---no different than schools and colleges cannot tackle these issues at the expense of education for students. The mission could be restarted to put greater emphasis on primary and behavioral health. Give the appropriate agencies already in place permission to pursue their major work.

The second myth is that health care professionals are responsible for patient health improvements. It is not true that office doctoring, documentation, prescriptions to treat symptoms improve health services. Patients have the primary role and, thankfully, are supported by the medical team. The awarding of incentives for basic doctoring such as patient intakes from blood pressure to diabetes to whatever appears to have run its course: are protocols in place now that we should not award people and organizations for doing what they are supposed to do in the first place?

Some places in Oregon have no Coordinated Care Organizations, as in reality there is absolutely no transparency, including who serves on the boards. Monopolies do exist. I understand this is changing, however the OHA must accept responsibility to assure that going forward CCO's are required to allow other major provider organizations such as FQHC's, to be involved in program planning and have access to data including financials. "To those who have had much given in taxpayer dollars, much should be expected in transparency and accountability."

All this to say, also, I am proud of the progress that has been made and proud of physicians who are truly dedicated to helping patients. The path ahead will be made more clear because of this progress and my hopes are for a sharper focus on core services, transparency, and true community stakeholder participation. And, I hope we will work to allow patients to experience their own accomplishments and joy that only comes from accepting responsibility for their own daily health needs. The patient in the center of their health is the future.

707 In Lane County, our local CCO (Trillium) was bought by Centene. Since then, primary care doctors have had difficulty finding specialists to accept their referrals. Specialist group practices have told us they have difficulty negotiating contracts and getting reimbursed for services already provided.

Individual Trillium members have difficulty finding primary care physicians. Sometimes they are assigned to a PCP on paper but have never met their doctor. Wait lists to establish care are often long. There should be more oversight of the number of OHP members who have not met their PCP. Many people use Urgent Care in the absence of a PCP.

There should be a cap on how much profit a CCO can make. Any revenue after that cap should be directed to social determinants of health or service capacity building.

There is a shortage of psychiatrists and psychiatric mental health nurse practitioners in Lane County. It is very difficult for new patients to get seen. The shortage is not the CCO's fault, but there should be some sort of tracking and improvement plan.

The use of prior authorizations to slow down healthcare spending is harming patient care. Legitimate PA requests get bounced back to providers multiple times, delaying patient access to medications and services. Medical practices spend so much money on staff time to work on prior authorizations and the CCOs have staff on their end doing the same thing. I would like to see information about the delays and costs of PAs. I would like to see that system be more efficient.

708 CCO's do not work well in small rural communities. In Klamath County all that has happened is that people are restricted to seeing very few providers who cannot meet the needs of the many. KBBH is the CMHP and cannot meet the growing the needs of the behavioral health patients it is supposed to serve. People are suffering, people are dying and people are getting sicker and sicker. The community monopoly restricts and limits services. This is a bad model. The State of Oregon needs to spend some money and time researching what is happening in small rural communities rather than expanding on something that is not working. One size does not fit all. Let the data speak for itself!

709 The answer is not to provide an infinite amount of care and subsidy, but rather to focus on the most important care, education, and to hold CCO's (providers) accountable for holistic risk sharing agreements, bundled care, and value based benefits, instead of allowing any fee for service.

710 Why are they building brand new buildings for administration instead of using the money for patient care?

711 Increased access to psychiatric services for children and primary care providers that can also prescribe psychotropic medications and/or have access to psychiatrists for consultation and guidance around prescribing. Flexibility in billing for mental health services so providers can do more thorough assessments and meet with kids/families multiple times per week if needed and in multiple settings.

712 I would definitely suggest the need for interpreters is lacking and should be worked on, along with dental. so many people are on OHP but have such a hard time getting in to be seeing.

713 I would like to see all CCOs operate as non-profits. I would also like to see them have minimum requirements for number or percentage of practicing community physicians on their boards of directors.

714 Ensure that clinical systems (e.g. FQHCs) have access to and regularly receive member/patient level data from their CCOs. Emergency department utilization data is one that comes to mind.

Lead the way in bringing health literacy issues to light and start the conversation at a deeper level so that we can better understand what's needed. I think this would really help enhance the health equity and disparities work.

715 I think it's important for Oregon to re-evaluate allowing CCOs to be for profit, and allowing large corporations to take over. Local control is extremely important to meet the needs of the local communities. For profit corporations and out of state for profit corporations should not be allowed to contract with the state.

716 Remove the for profit organizations involved with them.

717 Rural care and Behavioral Health are tow areas the CCOs have failed miserably at.

718 work harder on coordinating coverage with children in care to make sure no child is turned away when first coming into custody because the foster parents medical card isn't "active" despite having all appropriate paperwork. These children often have immediate medical needs and to caseworker's knowledge the documentation provided is sufficient to make dr appointments.

719 Access to early education for children on the fringes of opportunity.

Provide on site assistance for children experiencing behavior regulation challenges. Provide on site evaluations and therapies where helpful.

720 CCOs should not be for profit

721 Increase use of THW's, including Peer Support Specialists (behavioral health) and peer programs. Increase support, both policy and program wise, of peer programs and have clear, comprehensive information and training available to clinical CEOs, other management and staff regarding the rules, and importance, of peer services and programs.

Allow the use and billing of Community Health Worker roles within behavioral health settings.

722 EOCCO is a CCO covering much of Oregon that is owned in part by GOBHI. GOBHI is a trade organization protecting the interests of its providers (former county mental health agencies that privatized to get away from public control in the 2000s) who in fact sit on the GOBHI board. This results in a complete monopoly of Medicaid behavioral health treatment by a highly bureaucratic system with no real quality control or oversight. The fox is guarding the henhouse with results one might expect. I cannot even begin to describe how terrible "public" mental health treatment is in eastern Oregon. GOBHI has blocked integration of mental healthcare into primary care through limiting funding and creating unnecessary workarounds. GOBHI has become highly adept at paperwork and appearance largely at the cost of patient care.

I have been watching the deterioration of medicaid mental health care in eastern Oregon for many years. It has been like watching a motor vehicle accident in slow motion.

GOBHI refuses to pay me to see mental health patients despite having perhaps the highest qualifications in eastern Oregon. They are all about control and resent my complaints about quality.

It will take outside pressure to change this horrible system.

723 CCOs need to continue to work to provide coordinated service across all providers. There still seems to be a struggle with this aspect of the CCOs.

724 Medical records need to be easier for providers to get clinical information out of quickly, and better integrated across clinics.

CCOs should encourage providers to participate in community interventions focused on parent education and legislative advocacy, to expand the scope of our practice beyond the clinic, so we can more effectively achieve better health outcomes.

725 Much greater oversight of the CCOs, transparency regarding leadership/policies of CCOs, ensure that profit is not the driving factor in CCO decision-making. CCOs need to be committed to the goals of improving the health of Oregonians and their communities.

726 Would like to see CCOs build capacity in already existing services and established professionals that live and raise families in the communities, rather than recreate systems and exclude or duplicate already established professional agencies, professions and services.

727 Hire more people of color.

728 I am VERY concerned that this survey does not appear to include upstream substance abuse prevention. My CCO appears quite checked out on any community-level policy initiatives which could significantly impact the risky behaviors exhibited by large percentages of the population. Our governor just declared alcohol and drug addiction to be a statewide emergency...I'm not seeing any mention of substance abuse prevention strategies tied to policy change around alcohol, marijuana, tobacco, etc. This is a serious oversight. When speaking about social determinants of health, please consider that the policies embedded in the fabric of our societies, or the lack thereof, can be driving these disparities and inequities.

While I agree that there are significant social determinants of health, I DO NOT AGREE that the CCOs (essentially professionals tied to medical clinics/hospitals) should be holding the purse strings for funding initiatives designed to change the social determinants of health: employment, housing, education, etc. What do doctors and other medical professionals know about operating successful programs to positively impact any of these social determinants of health? PLEASE don't put this group in charge of distributing funds for these initiatives - give the money to professionals who will use best practices and research to guide those projects!

I do think that medical professionals can/should champion these efforts, but I don't see how their stewardship of the resources will result in best practice solutions. I'm already seeing the funding available in my community get focused on clinical settings RATHER than on community-level initiatives which change community norms and foster wellness at a societal level. If you're going to have clinicians involved in improving the social determinants of health, you'll need to provide clear and firm direction to leverage those resources OUT of the clinic and into the community.

If you want/need to reduce costly interventions in medical clinics/hospitals then multiple SYSTEMS (not just clinic-based systems) must be redesigned for HEALTH PROMOTION and risky behavior PREVENTION. This takes multi-sector coalition work to create "collective impact". Require this approach, have a well-trained community organizer in a "backbone" organizations as a requirement, and require that these initiatives be connected to the local Health Equity Coalitions, tobacco and alcohol/other drug prevention coordinators who are already doing multi-sector work in each community. Require the community organizer/back-bone organization to use the Collective Impact Model - it's a thing - look it up. Use it. It works for complex societal issues which can't be fixed in a clinic or hospital setting. It takes commitment to multi-year strategies, so get ready to invest in 5-20 year initiatives.

I'm greedy - I don't simply want to prevent death. I want to prevent the life-altering, ripple-generating ills which negatively impact the lives that are being prolonged by better healthcare.

729 Perhaps several of the smaller CCOs should merge in an effort to reduce overhead by spreading those costs across larger patient populations.

Health Share may have served its purpose....new governing models for the Portland area CCO need to be explored to assure that we are not duplicating capabilities that may already exist already in the organizations who currently bear the financial risk.

730 All of the CCO's seem to have money to spare. How can this continue? Care is being cut. Supplies are being cut. Yet many CCO's are paying executives extreme amounts of money and building new high priced office buildings. What is going on?

731 X

732 n/a

733 Ensure that the governance structures and members truly reflect a broad cross section of the CCO's community, not just a rubber stamp of providers' perspectives and priorities.

734 CCO's that administer Medicaid benefits should NEVER be for-profit corporations like Trillium (Centene) who make fortunes for share holders via the poorest citizens of Lane County. How did Oregon find itself in the position of making money for wealthy businesses off of the health crises of the poorest and most vulnerable people in our state? Please reverse this unacceptable practice for the integrity and well being of the state's physical, mental, moral and ethical health.

735 Reduce the cost associated with housing inmates (city and county facilities) by eliminating jail sentences for persons whose ONLY crime is possession (for personal use) of controlled substances and addiction issues. They need treatment not jail. In WA county simple possession of Meth is a Felony.

So even if the person can obtain appropriate substance abuse treatment (many insurance providers support only 30 days of inpatient treatment and that is not enough for most addicts), they are shackled with a Felony charge, once they start to build up their lives again. Which can be a barrier to employment

There sentence could be mandatory drug treatment.

The monies saved through the criminal housing system could be used to help pay for In and Out patient treatment. Meth and Heroin addiction is at an unbelievable level in Oregon and is/will get worse without significant intervention.

736 We need to try and have incentives to keep costs down for the taxpayers of our society and make families accountable for their health and well being and become more self sufficient and not burden others heavily by raising health care costs to others with health care, medicare or Medicaid. More education needs to be granted making it equitable and less burdensome on the taxpayers of today. Those who work and are Seniors seem to suffer the most as taxpayers trying to survive from those who live off the system pragmatically which is unfair.

737 Gaps/needs/barriers assessment that involves the community voice from consumers and also representative agencies such as Probation/Parole, Schools, Child Welfare.

Telehealth is good, but should not replace office visits.

CCO's need to be concerned with the financial viability of their providers and what they are able to pay their employees/contractors. There should be more employment and not more contractors.

More ways for consumers to choose their providers - therefore - able to work with private providers in the community in small to very small agencies.

Focus on mobile service providers for mental health.

Focus on the relationship work that families need to be healthy. This involves Perpetrators of Violence who tend to need a focused type of Mental Health to reduce violence. Also, children who have had abuse and have unstable behaviors - making it difficult for anyone to take care of them. Mobile services help ensure they will get the service.

738 I would like to see changes in the referral process. I feel that Pt's are pushed out from receiving quick care in some situations because they first have to get a referral. For Example, if a child injures a knee playing football at 4PM and there is an orthopedic clinic across the street with a same day opening, the Pt should be able to access that care immediately vs. calling a PCP that does not have an opening for a day or two and then place a referral that may take a day or two and then see the Ortho provider two days later.

739 We need quality mental health coverage. Not time limited, but based a persons actual needs. We need more mental health beds for youth to help stabilize them.

740 No

741 CCOs need to work on pre-discharge patient coordination of services.

742 All of items you've listed are good goals.

Putting much more emphasis on mental health - and bringing the discussion out into the open early on, will do much to save lives and improve overall health care.

743 There are some challenges with CCO networks and public health departments. CCOs should be required to reimburse all LPHAs for services rendered whether they are in-network or out-of-network. For example, the residential treatment center in Baker County receives patients from all over the state, and Baker County Health Department provides services including reproductive health services and immunizations to patients while they are at the treatment center. BCHD is providing valuable and cost-effective services yet only being reimbursed by EOCCO due to where BCHD is located. This is not sustainable for BCHD.

744 More standardization across CCOs should be required by OHA in terms of drug formularies, what's covered, rates to providers.

CCOs should get together and leverage their power to negotiate better rates for drugs and with hospitals.

OHA is pushing stuff for which there is NO evidence. What's the evidence for increased use of VPBs? Just using them more isn't going to be effective. There are ways they need to be set up that make them effective. Same with SDOH. Is there any evidence that addressing SDOH by healthcare companies leads to any positive outcomes? What's the evidence that addressing some (like housing) is more,less effective than another like nutrition? OHA is just charging ahead and requiring these concepts without evidence for what works and doesn't work. It's the wrong way to go.

745 Accelerate infrastructure, incentives, and resources dedicated to addressing SDOH. Housing, transportation, non-billable emotional health/trauma-informed services for kids in particular.

Look at Bailit report around value-based payments for kids. Need to improve overall rates for primary care for kids, pilot an APM around care coordination/SDOH work for kids in schools that would put RNs and CHWs working with parents, school staff, pediatric PC/BH providers. So much care happening for kids "in the spaces" between traditional primary care, mental health, school health services that is not reimbursable.

746 1) CCOs across the state are so varied; there needs to be more consistency

2) the local employees in clinics are so far from CCO metrics that when I present metrics information to them they are seeing it for the first time. After CCOs being around for this long, the local clinic-level people should know what goals have been set in front of them; they should be involved in the solutions.

3) I was on FamilyCare in the interim between jobs. When I became privately insured quickly, I attempted to get off FamilyCare which proved impossible. I was told I couldn't cancel it. Some assigned provider received payment for me, but I never used FamilyCare. I remained on their mailing list for two years. As a college graduate making nearly \$90K a year I could not figure out the thick re-enrollment packet that was mailed to me. Although I didn't plan to reapply, I looked the packet over and had no clue how anyone can fill it out.

747 Additional investment in public health

748 The State should be holding CCOs accountable to things in their contracts that they refuse or fail to do. We do not seem to hold them accountable to anything. They seem to tell us what to do and how to do it and we react. We seem afraid of what they will say or do so we back off when they get upset. We are not acting like the authority. We are acting like they are in charge and we work for them. They should read their contract and commit to doing everything that is required and then, once they sign, they should know that we will hold them accountable.

749 The current level of care determinations for children's behavioral health are made based on imminent risk of harm. While we must provide services to keep everyone safe when there is a risk of harm to self or others, I suggest that the level of care determination criteria also include long term risk of poor outcomes in physical health, mental health, academic functioning and activities of daily living. If we made this change, young children's behavioral health services would be funded by the CCOs at similar rates to older children.

CCOs have concentrated on and had the most success with controlling adult physical health costs. However, many CCOs have fallen far short on providing effective behavioral health services to children, especially for the youngest children.

Those preschool children who are being asked to leave child care and early learning settings due to mental health and behavioral problems will grow up to be bigger children who are more expensive and more difficult to treat. If we do not provide effective behavioral health services to families of our youngest citizens, then we will never contain the costs of older children who need higher levels of care.

The scientific evidence is very clear. We need to provide coordinated and evidence based treatment and supports to families at the first point of problems starting to develop, which is best done when their children are under 6 years old and their brains are developing faster than they ever will again.

750 If CCOs are going to change it must be for the better of the future for all Oregonians. Road blocks to basic mental and behavioral health have to be removed. An assessment or measurements of what those needs are must be implemented. Ensuring our children come first, their health, overall is and should be the highest priority. All Oregonians needs to be defined, if we are truly going to say ALL Oregonians than it must be just that, no discrimination. Incentive programs to me means that providers are given a reward for not being discriminative. This money should be put back into the community to allow other programs to be implemented.

751 I wish they would work to improve patient health without worrying so much about their bottom line.

752 My specialty is in oral health integration, so here are my suggestions for that in the short-term:

1. Require an oral health integration position at each CCO. Most of the focus has been on behavioral health integration, but it is time to devote some resources to oral health integration
2. Require CCOs to report all oral health data by contracted provider (DCO or dental provider) and by race, ethnicity and disability when possible. OHA was able to get DCO-level data before oral health was integrated in the CCOs, but is now not possible.

Long-term suggestions:

3. Require CCOs to contract with medical providers and patient-centered primary care homes to incorporate oral health into well-child visits.
 4. Require CCOs to ensure their contracted dental providers (DCO or dental provider) provide services to pregnant women and young children 0-5. Some dentists still refuse to serve pregnant women and children until age 3 or 4.
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753 Increase the amount of oversight on CCO financial reporting. There is little evidence to support the current volume of CCOs in our state, especially when OHA pays for 3 executive-level positions for each, despite the fact that many of them already combine administrative functions and submit combined financial reports. Conduct audits of the administrative expenses being allocated to the OHP book of business, most plans have a private and Medicare advantage line of business, and without increased scrutiny it is very likely that expenses are being allocated to OHA that should not be entirely the state's to pay.

Consider making certain policy goals into deliverables, instead of layering multiple incentives on top of the existing rates to encourage a contractually bound vendor to perform to expectations.

Most importantly: CCOs are distinct entities and each one performs differently. It is difficult to evaluate the performance of "all CCOs", since they have varying governance structures, payment systems, provider networks, and different levels of oversight and management of public money. Some are high performers and embody the goals of the CCO project, others benefit from the lack of OHA oversight into their operations, and we owe it to the high performers to hold the rest accountable for their actions.

754 CCOs need to have transparency about quality improvement. We need to reinstate or begin a monthly discussion about behavioral health across CCOs medical/behavioral health directors and the units in OHA that address children and their families or adults (including physical health, behavioral health, dental, interpersonal violence, child welfare etc.) in order to better coordinate services as a system of care

We need to actually enforce the contract.

We need to have a quick resolve as well as a regular complaint process. The quick resolve needs to not include 2-3 layers within OHA and a paper 3day response expectation.

Care coordinators should NOT be financial gatekeepers for the CCO. This should be a separate function. Care coordinators also should NOT be responsible for enforcing subcontracts with community providers.

Every family member should be offered peer delivered services (adult, family and youth) and not have to intuit that the services is available or what it can provide.

We need to eliminate the reimbursement rules and services rules that separate physical from behavioral health, for example, a pediatrician should be able to provide support services(including peer delivered services) for behavioral health when the child has diabetes, major surgery, developmental delays, traumatic/internal head injury etc.

CCOs should contribute to the cost of maintaining children's ombudspersons and adult behavioral health ombudspersons in a unit in addition to the OHP ombudsperson.

There should be a state level system of care committee that resolves barriers to the continuity of care . This should be tied in to the various state level consumer advisory councils (OCAC, CSAC, SACSE, CSAG etc) and CCO advisory committee and regional systems of care committee.

755 Require CCOs to not only participate in, but engage with the HIT Commons.

756 I believe the concept is a great one. I would like to see more equality in things. I understand that addiction is a disease and people can get pretty much free treatment. Cancer is also a disease and it bankrupts people. Why is chemo not free like methadone is? People need to be more accountable for their health.

757 Require the CCOs to report the exact amount they pay their panel providers. Require CCOs to audit their panel providers and report those findings to Office of Program Integrity. Require the CCOs report in detail how much money they recover from panel providers.

758 All of the CCOs should be required to meet and adhere to CMS regulations. Conflicts occur when the "rules for enrollment" differ from fee for service enrollments. The CCO model has impacted the care for many Oregonians, but for the minority of clients that remain on open card they are finding it more and more difficult to find providers that will care for them. This is due to the low reimbursement fees that these providers are paid on the fee for service side vs the CCO pay schedule. All Oregonians should have the best care available to them regardless of whether or not they are in a CCO. The CCOs are making huge profits while the fee for service providers often aren't paid enough to cover their administrative costs. In my opinion these inequities are found in the behavioral health and oral health services.

759 CCOs should be held accountable in the way they work with their CAC, CBOs, and other community partners. CCOs should also be mandated to integrate Health Equity into their organization and should not be treated as a separate program. OHA should ensure it gets elevated, and of course, for that OHA should elevate health equity and have an agency wide Health Equity Plan. We can't ask CCOs to work on health equity when OHA does not do it. Current efforts are siloed.

760 I think CCOs need more opportunities (requirements?) to share innovative ideas and successes.

761 Current state: Zero accountability for CCOs when they fail to meet contract standards and inconsistent application of standards.

Future state: Clear standards, consistent application of standards, clear process for and criteria for OHA to evaluate whether standards are met, and clear corrective action direction from the state to CCOs.

Current state: 15 versions of EVERY CCO contract deliverable x # CCO deliverables = huge administrative burden

Future state: 1 version of each CCO contract deliverable x 15 CCO x # CCO deliverables = manageable administrative burden

Current state: CCOs and their subcontractors (BH, dental, pharmacy) develop, design and issue dozens of required member notices and materials. Content is often incorrect, inconsistent, non-compliant with CFR, OAR and Contract. OHA is required to review and approve all notices and materials.

Future state: 1 version of required member notices template and materials template. OHA developing, designing and issuing to CCOs, for CCOs to use, improves consistency of communication to members. OHA would only be responsible for ensuring 1 template per notice/material type was correct and compliant with OAR and CFR.

General feedback:

1. HSD should work to align quality and compliance oversight. OHA quality oversight activities should be based on similar data points for CCO vs FFS. Currently, agency runs separate and distinct process (often through different units in HSD), using different data, for CCO vs FFS. Lack of consistency in process and data collected makes it impossible to compare quality, access, and timeliness of FFS vs CCOs member experience in multiple sectors. OHP members are all OHA's members, whether they are currently in a CCO or FFS, and OHA should treat them as such. It should not matter if a member is in a CCO or in FFS, OHA should have consistent oversight of the quality, access and timeliness of the services provided.

2. HSD should consider what tasks associated with Medicaid it performs for the CCOs and what tasks it asks CCOs to perform. When CCOs are unable to perform a function, or perform it poorly, the impression within Agency is that HSD will take on that work. Yet, OHA pays CCO billions in capitated dollars to perform this work. Where is the analysis on the part of OHA to determine when this is appropriate use of tax payer funds vs double paying for an activity?

762 In order to mitigate risk to the agency there needs to be sound oversight over the CCO contracts. There needs to be a concerted effort toward monitoring and overseeing the deliverables and outcomes that CCO's are charged with providing and firm incentives and penalties need to be in place and enforced as necessary to ensure compliance and delivery of this needed Medicaid program.

763 I believe as the CCO's bargain to obtain more populations in their enrollment that they be required to expand their Provider panels to include additional Providers. I know of a family recently transferred to CareOregon after the FamilyCare issue and were told the only PCP's and Mental Health providers were Clackamas County Public/Mental Health. That is not acceptable especially given the fact that Cover All Kids, House Bill 3391 and TPL and Foster Children intend to be enrolled into CCO's in the very near future.

764 I think it is critical that the state hold the funds for risk vs. the CCOs themselves.

Meetings should be public.

CCOs should be not-for-profit only.

765 OHA should improve its strategic approach towards improving the health care system, including higher-level strategic alignment to leverage the CCO model with concurrent efforts like public health modernization and other policy work.

766 What is missing from this discussion is any kind of data and analysis from OHA. What's worked well in the past 5 years with each of these areas? Where is the evidence for which parts of SDOH to address (for example – does addressing housing have a bigger impact than addressing nutrition?) Also what's been shown to work either in the state or nationally? Look at pilot programs that showed results on patient outcomes. Where is all of that analysis? It seems, at least from the outside, that all of this CCO 2.0 is being done without taking that into consideration. There is lots of information in the CCO Transformation Plans and TQS reports, let's actually use some of vs just collecting it.

767 Partnering with community to decrease social determinants will need state financial assistance

768 Being transparent in how they work with community partners. So many stories from the field about being unsure of how to apply to the CCO for grants, how to get involved with the CCO, how to partner effectively.

Overall, having CCOs focus on prevention of health issues by investing in young children and families and working effectively with non-health partners to meet families' needs is the way to go. Isn't prevention what health system transformation is actually about?

769 We need much a much faster CCO enrollment process. if Integrated Eligibility in ONE functions according to plan we will have larger volumes of patients dis enrolling and re enrolling on a regular basis. We really need a 24-48 hour re-enrollment process, not something that takes 2-3 weeks.

CCO's need to be responsible to educating clients on what a CCO is and how it works--most clients have no idea, and are completely confused about how their health care is managed. The feel intimidated, confused and anxious--which increases health care disparity.

770 Please ensure that CCO's are informed that within each county there is at least one provider providing gambling treatment services and that all CCO contractors should be screening for this disorder and making appropriate referrals to free treatment options.

771 Utilize CHW to do more outreach and education in communities and have early access to peer support, especially family peer support , to help individuals and families understand how to access and negotiate the type of care they need, including not using clinical services when community support and self-care would work as effectively.

CCOs should give back to OHA the quality improvement function so there is more evident training, use of System of Care principles and oversight of services delivery.

772 There is no oversight, no accountability and no incentive for the CCO's to want to do better. They complained loud enough and OHA caved. They were granted the ability to force the members to complete an appeal prior to going to hearing. I didn't know that we were in the business of creating road blocks for our members. We already had this system in place, we had concerns, we asked leadership to listen to those concerns so we could explain why it didn't work and it didn't even fall on deaf ears, we were never given the opportunity to at least help the decision makers make an informed decision. Through the hearing process it was well known that many of the CCO's were not reviewing cases properly, yet they were not held accountable for their actions. Now, again, the CCO's have no oversight. The only way that the CCO's can improve is for our leadership to allow HSD staff to hold the CCO's to the contracts that they sign. The only way that the CCO's will improve is to have to answer to why they do not follow the rules they are contractually obligated to follow. The CCO's have a contract with the State of Oregon, not the other way around. Why is it that we let the CCO's dictate SO much? We need to do right by our members. Have we lost sight of that? I often think so. I hear the "oh poor CCO" song too much these days. What about the member who isn't being served by the CCO who decides they don't want to follow the rules? Why isn't that an issue? How long do we put these and other issues on the back burner? Put a pin in it? Move it to the "parking lot"? When does compliance get addressed, I mean really addressed? Are we waiting until 2020 to do that?

773 Require CCOs to cover clinical care at any local public health authority authorized clinic (physical, behavioral, dental).

774 I am not aware of any CCO's having patient advocates or navigators. The population that is served by Medicaid and Medicare doesn't always understand the system or may not have access to technology. Sometime the best way to serve these vulnerable populations is to have a real live person help them answer their questions or help them navigate the services.

775 Require that every CCO operating in Oregon be non-profit rather than for profit. The non-profit requirement needs to also include that executive compensation be restricted to less than \$100K per year with no bonuses or other performance incentives.

Each CCO needs to be required to make public its efficiency percentages, i.e., how much money is spent on actual healthcare and healthcare related activities compared to administrative and operation costs. Any CCO that posts a less than 90% efficiency rate should be subject to immediate forensic auditing from an independent auditing firm, at the CCO's expense and with oversight provided by the Secretary of State's office, that does not have ties to any person within the CCO or to an employee of the State. CCOs that repeatedly operate at a less than 90% efficiency rate need to be subject to; a) fines totaling the amount spent by the CCO for expenditures other than healthcare that caused the CCO to perform at less than a 90% efficiency for the first offense, b) a probationary period and additional fines levied against the CCO for the second offense, and an immediate dismissal and contract cancellation of the CCO for the third offense.

Additionally, CCOs need to be barred from participating in lobbying and from hiring others to lobby on their behalf with regards to legislative sessions and contract negotiations:

<https://www.thelundreport.org/content/profit-ccos-muscle-greenlick%E2%80%99s-reform-bill-away-house-floor>
