CCO 2.0 GENERAL FEEDBACK SURVEY

Results and analysis

Draft 5-1-18

OVERVIEW

Survey Period: 3/15/2018-4/16/2018

Initiated survey: 2494
Completed survey: 1568 (62.9%)

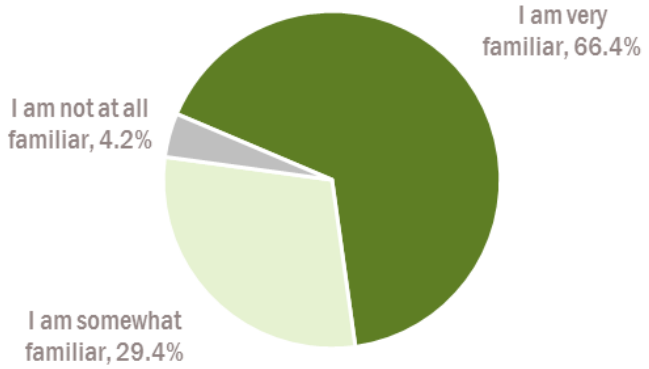
Group	n
Providers	598
Primary Care	187
Behavioral	336
Oral	26
Other	127
OHP Member/Family member	215
Non Member - Non Provider	809
Total	1568

Note: some respondents fell into more than one group, so total is greater than 1568.

Additional feedback provided:

	% providing feedback			
Topic Area	**All**	**Providers**	**Members**	**NM-NP**
	n=1568	n=598	n=215	n=809
VBP	49.6%	53.0%	49.3%	47.2%
SDoH	60.5%	58.7%	64.7%	60.7%
Behavioral Health	65.3%	69.1%	70.7%	61.2%
Sustainable Growth...	55.2%	57.7%	60.5%	52.5%

95.8% of all survey completers are **very familar** or **somewhat familiar** with CCOs



Familiarity with CCOs was similar across stakeholder groups.

Percent very familiar or somewhat familiar:
- Providers: **98.5%**
- OHP Member or family member: **94.4%**
- Non-Member & Non-Provider: **94.3%**

STAKEHOLDER GROUP & CCO AFFILIATION

Stakeholder Group*	n	%
Provider: Behavioral health provider (including mental health and addictive disorders)	336	21.4%
Represent a community-based organization	312	19.9%
General public	308	19.6%
OHP member and/or family of OHP member	215	13.7%
Government worker	209	13.3%
Contract with CCO	208	13.3%
Employed by a CCO	197	12.6%
Provider: Primary care provider	187	11.9%
Local public health	156	9.9%
Other CCO stakeholder (please specify)	151	9.6%
Advocacy organization	137	8.7%
Provider: Other health care provider	127	8.1%
CAC member	95	6.1%
Regional health equity coalition member	27	1.7%
Provider: Oral health provider	26	1.7%
Legislator	2	0.1%

*Note: Respondent may fall into more than one stakeholder group.

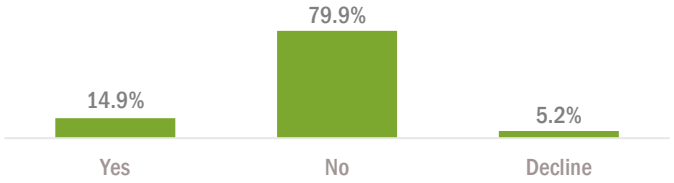
Of those who reported a CCO affiliation (n=944):

CCO*	n	%
All Care CCO	118	12.5%
Cascade Health Alliance	47	5.0%
Columbia Pacific	112	11.9%
Eastern Oregon	139	14.7%
FamilyCare	156	16.5%
Health Share of Oregon	299	31.7%
Intercommunity Health Network	116	12.3%
Jackson Care Connect	101	10.7%
PacificSource - Central	80	8.5%
PacificSource - Gorge	67	7.1%
PrimaryHealth of Josephine County	58	6.1%
Trillium Community Health Plan	177	18.8%
Umpqua Health Alliance	61	6.5%
Western Oregon Advanced Health	58	6.1%
Willamette Valley Community Health	144	15.3%
Yamhill Community Care	109	11.5%

*Note: Respondent may fall into more than one CCO group.

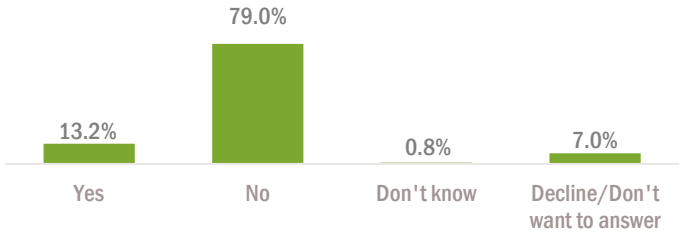
DEMOGRAPHICS

Language: Do you speak a language other than English in your home?

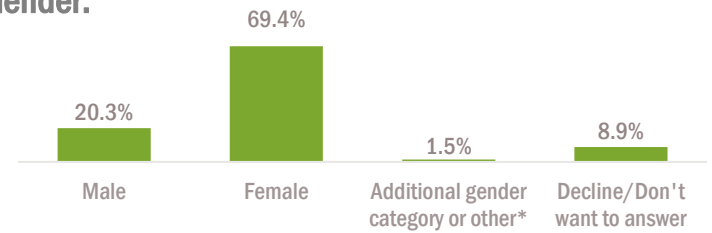


Disability: Do ANY of the following apply to you?

Deaf or serious difficulty hearing
Blind or serious difficulty seeing, even when wearing glasses
A physical, mental, or emotional condition limits your activities in any way

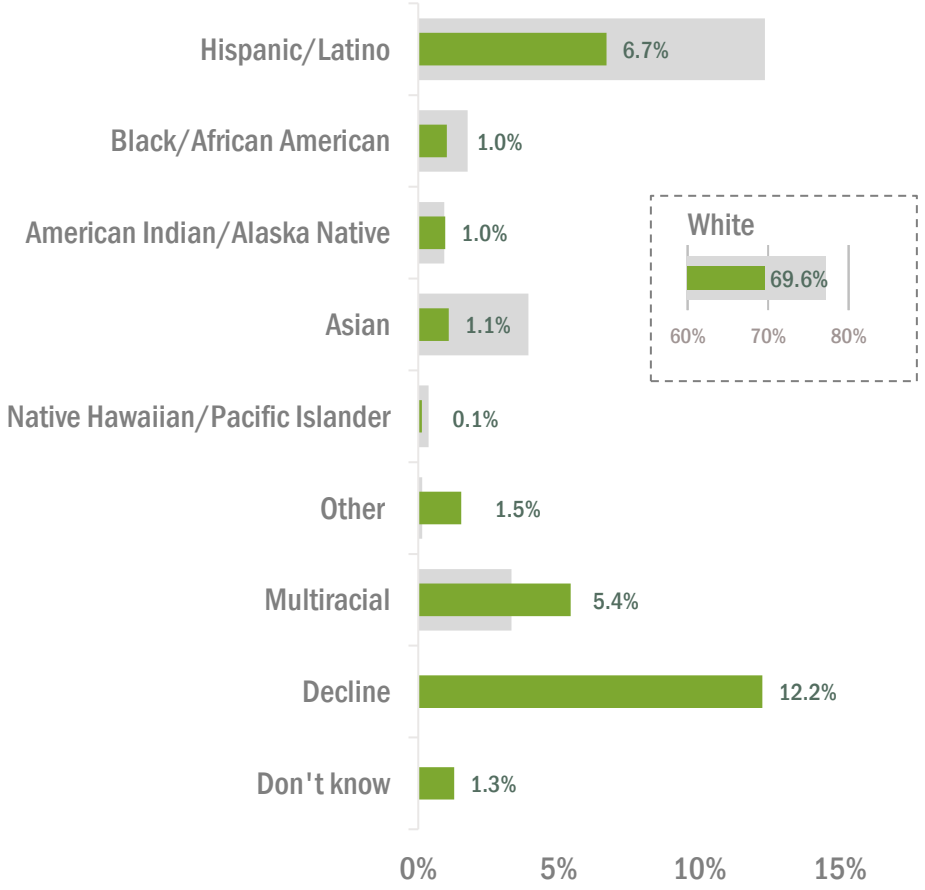


Gender:



*Additional categories include: Transgender (FTM; MTF), Genderqueer, and Other

Race/Ethnicity: Survey takers vs Population



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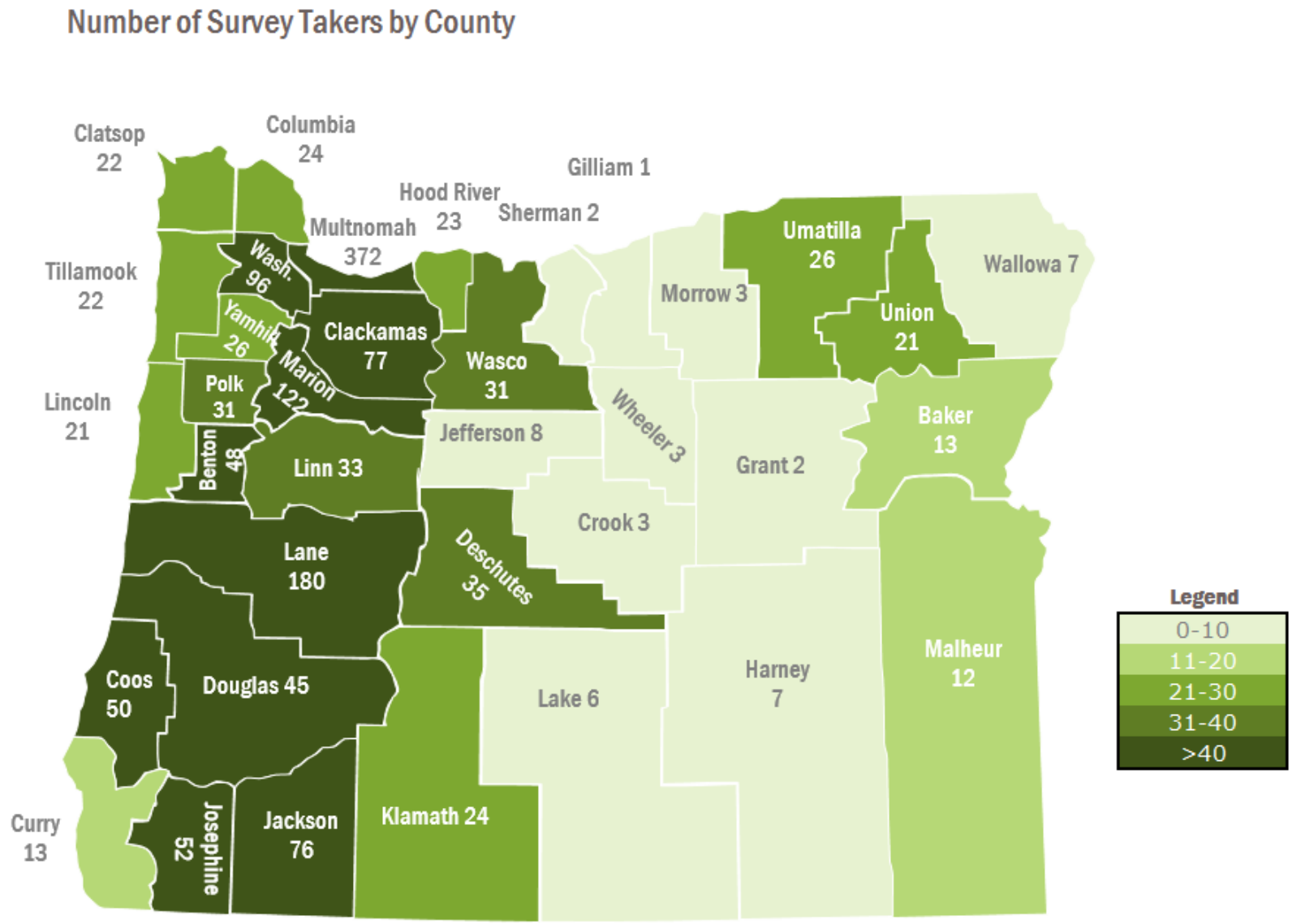

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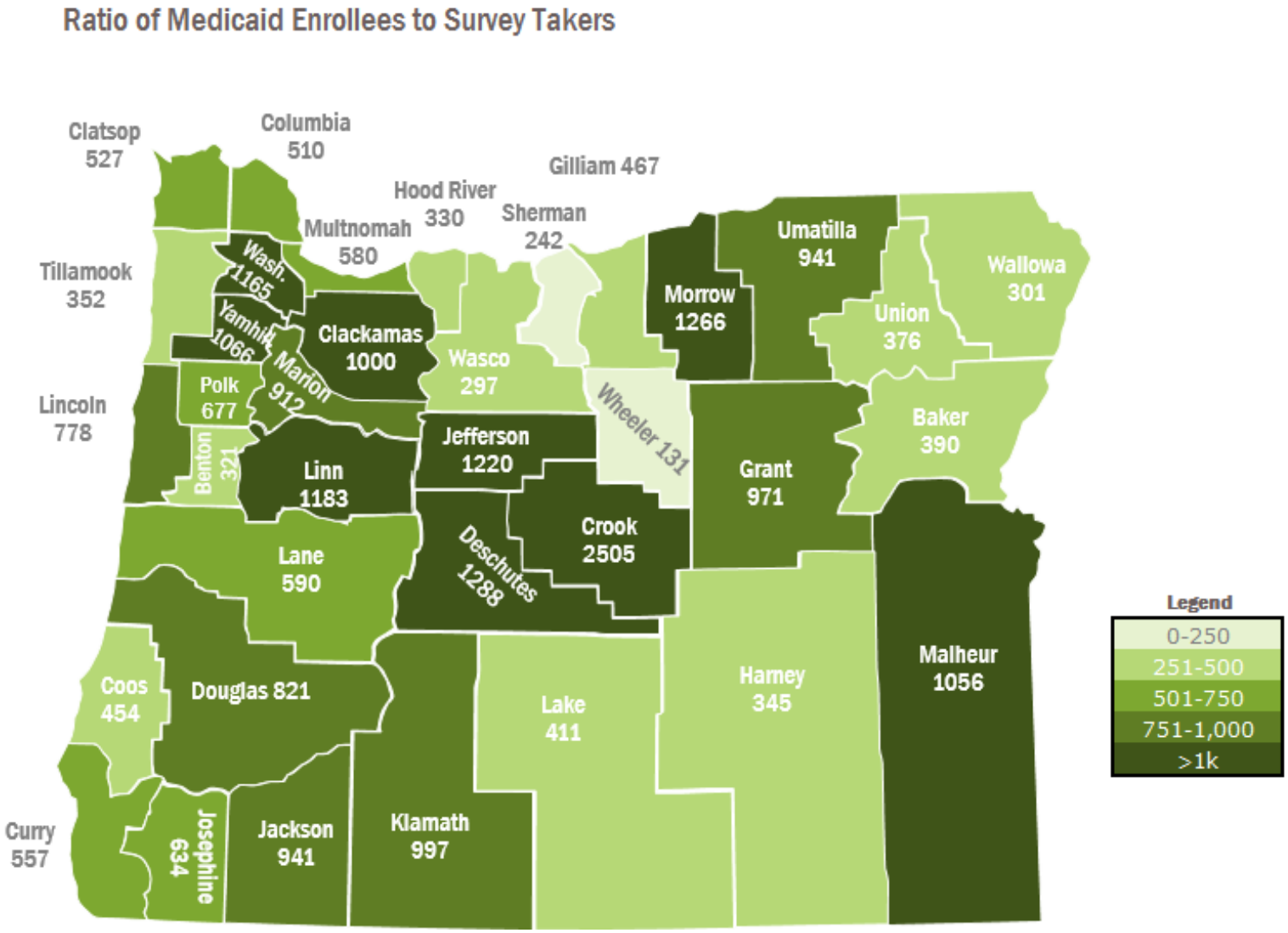
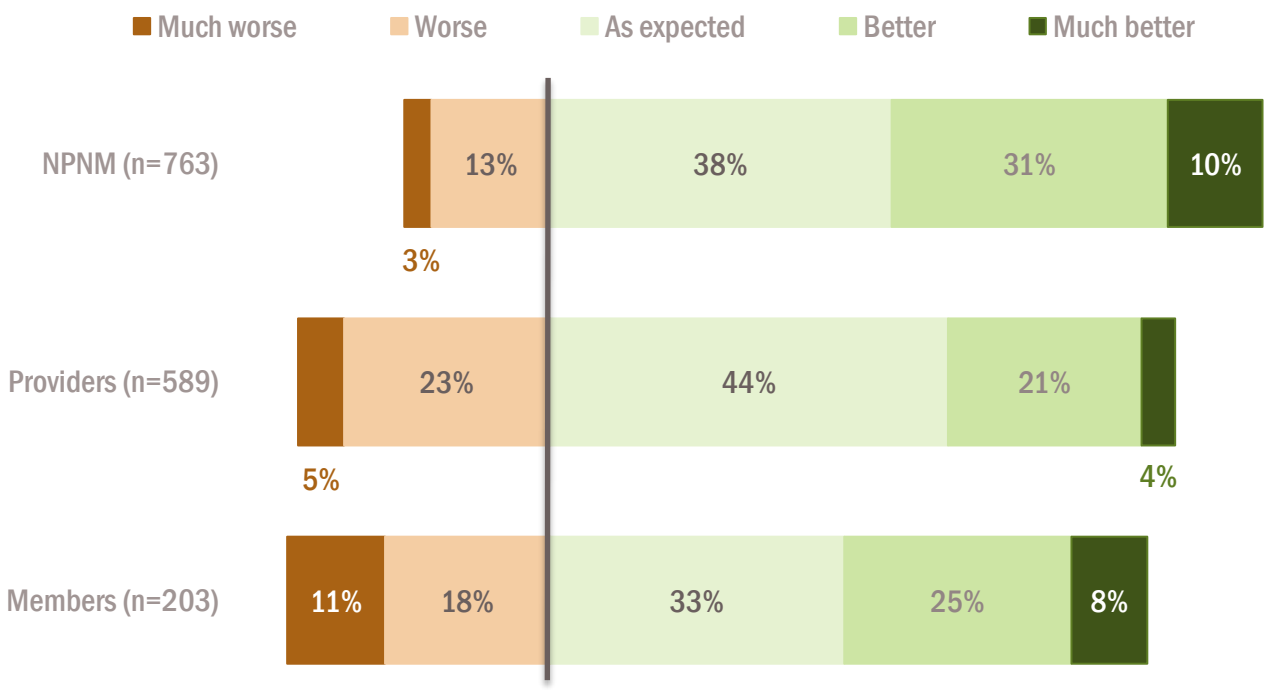


GENERAL CCO QUESTIONS

Have the CCOs met your expectations?

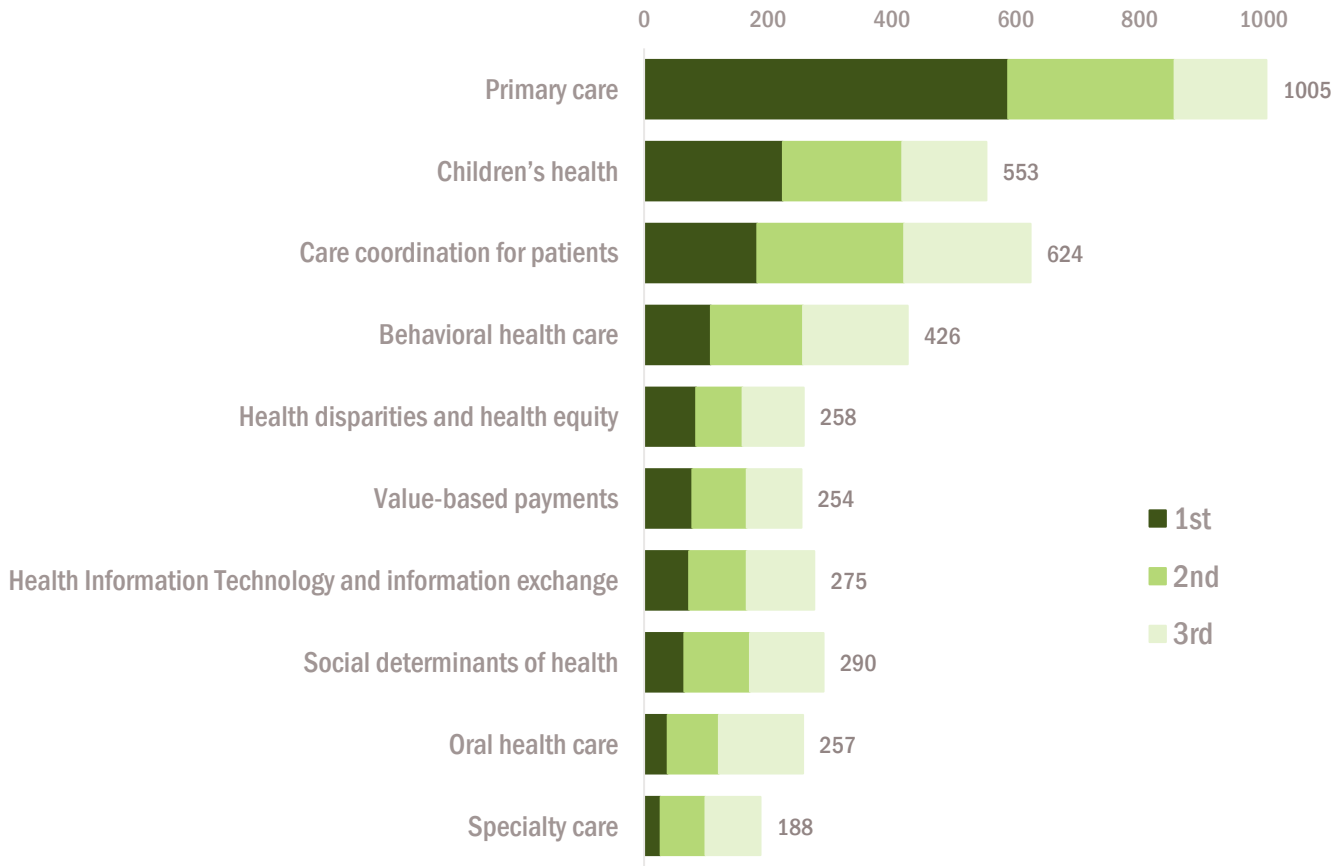
CCOs have done...



GENERAL CCO QUESTIONS (CONT)

In which of the following areas do CCOs work well?

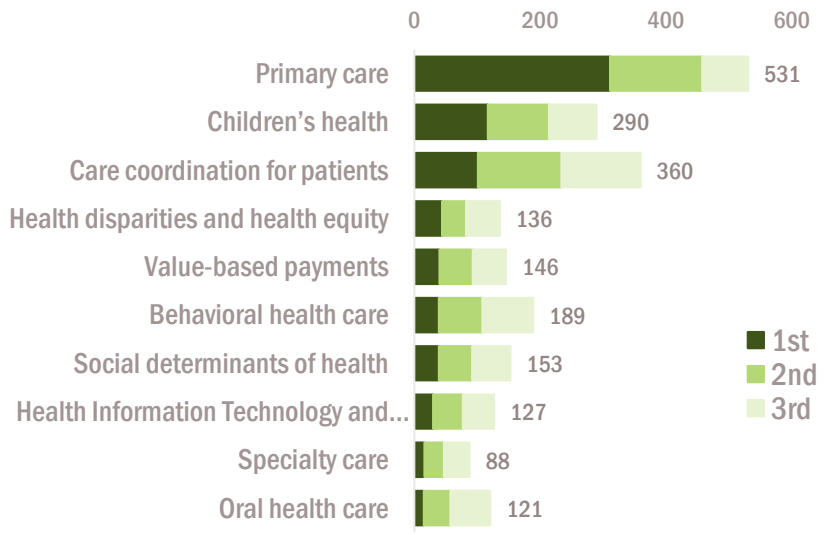
All survey takers:
1,005 (66.9%) respondents rank **primary care** as one of the top 3 areas that CCOs work well.



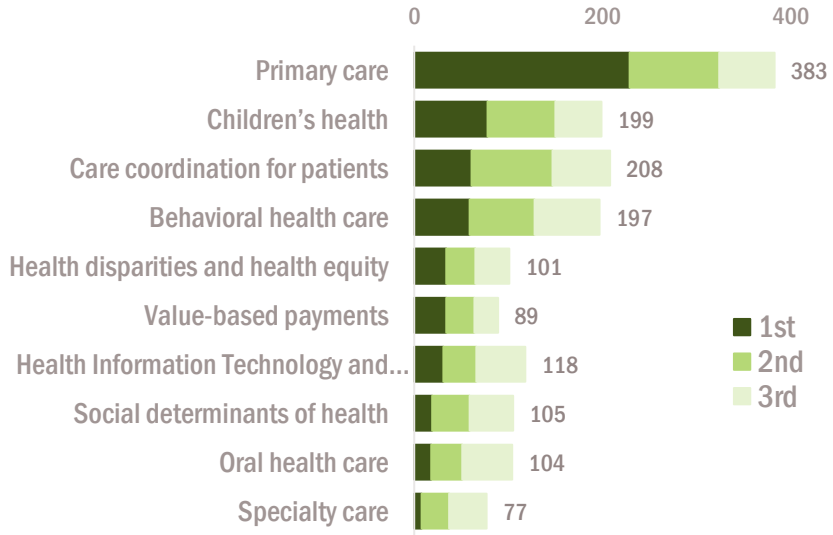
GENERAL CCO QUESTIONS (CONT)

In which of the following areas do CCOs work well?

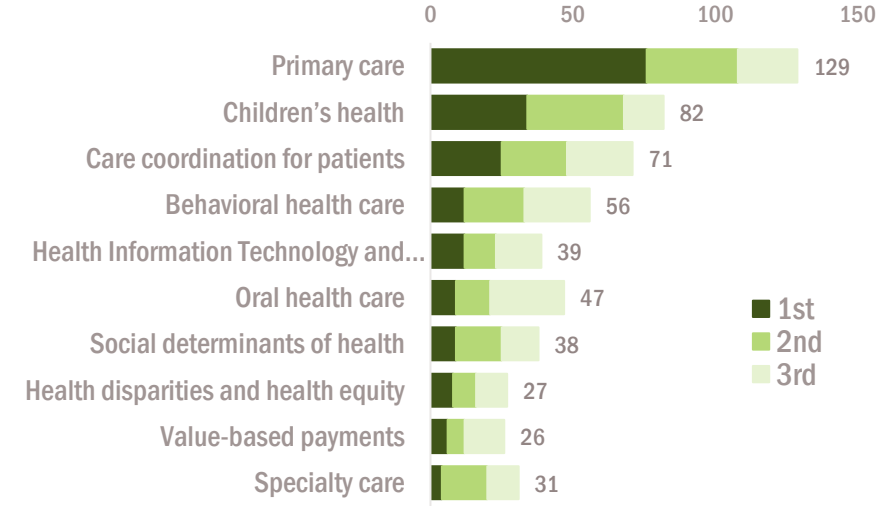
Non-member, non-providers:



Providers:



OHP members/family:



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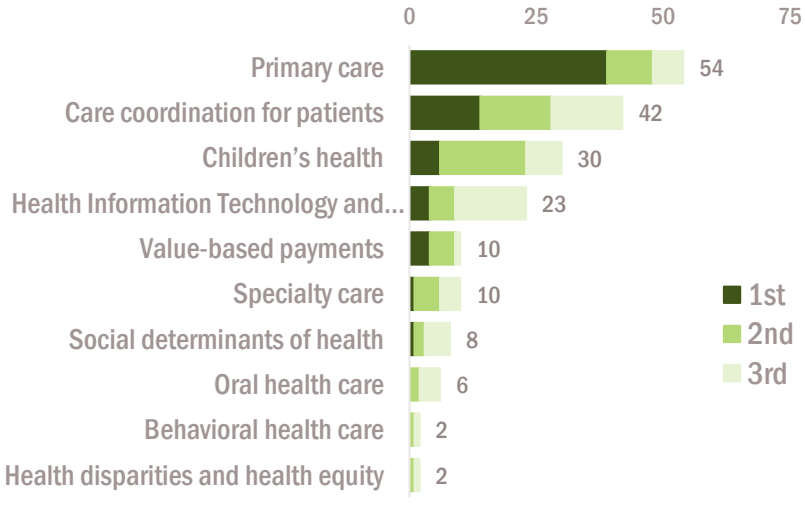
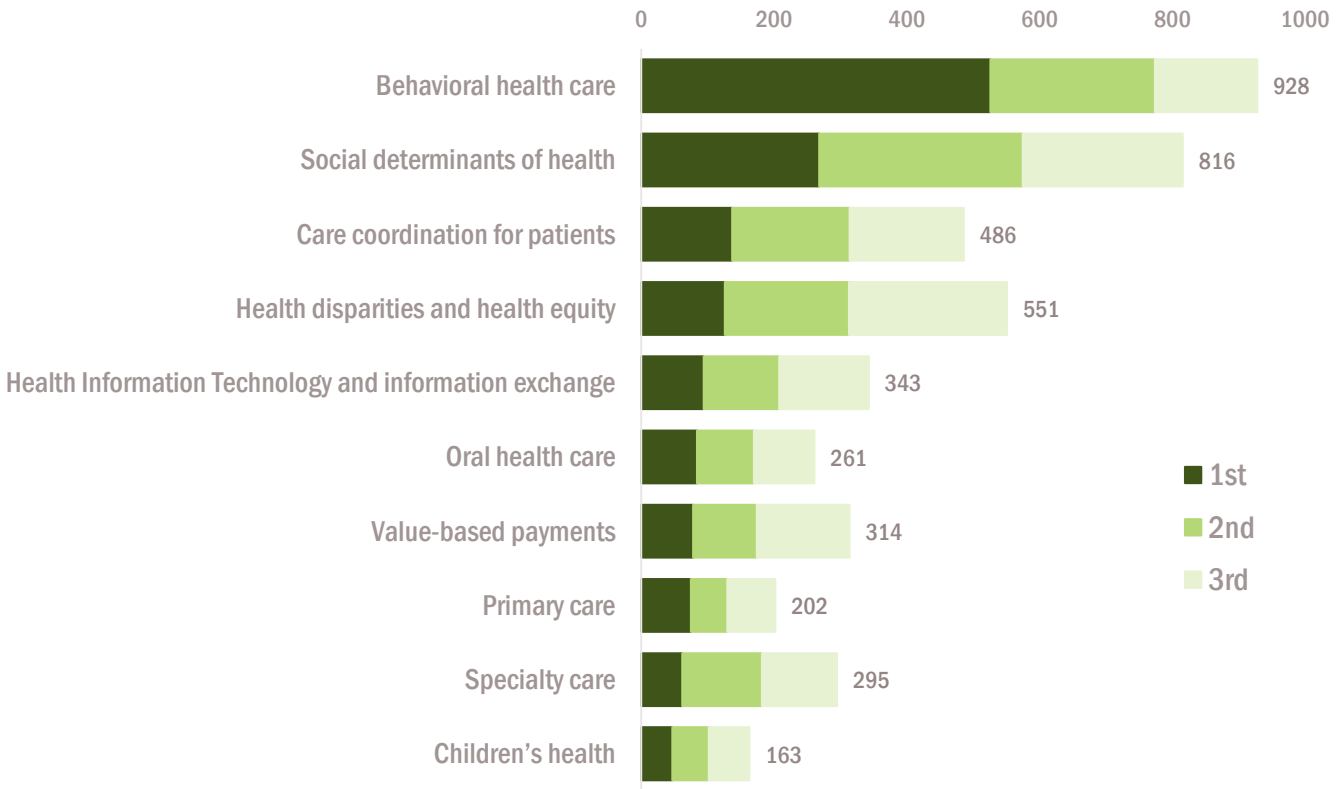


GENERAL CCO QUESTIONS (CONT)

Looking to the future of CCOs, or what we call CCO 2.0. Which of the areas need more attention and more work to improve?

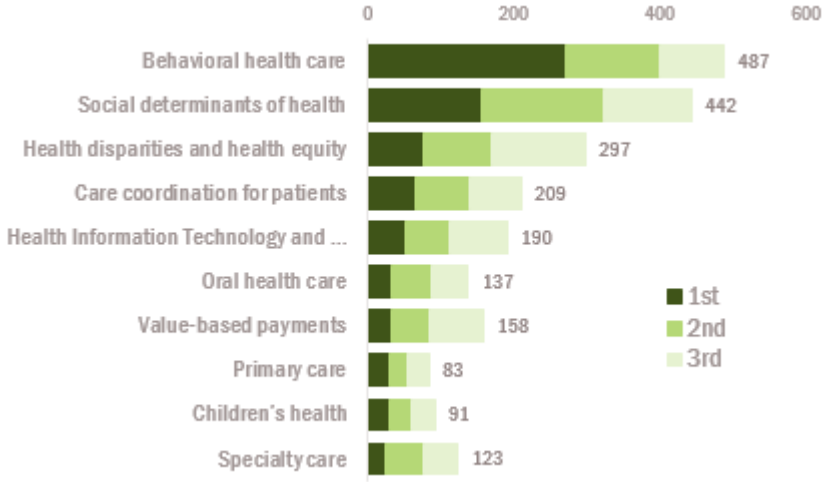
All survey takers:
928 (61.8%) respondents rank **behavioral health care** as one of the top 3 areas that needs attention.



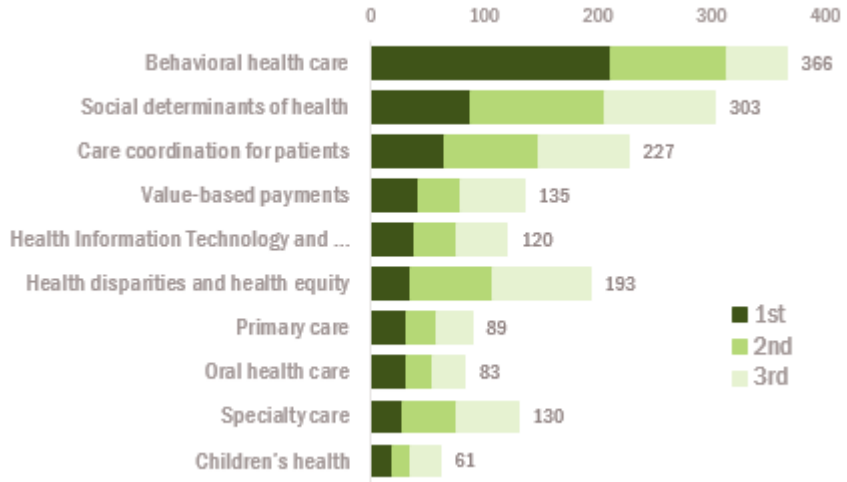
GENERAL CCO QUESTIONS (CONT)

… Which of the areas need more attention and more work to improve?

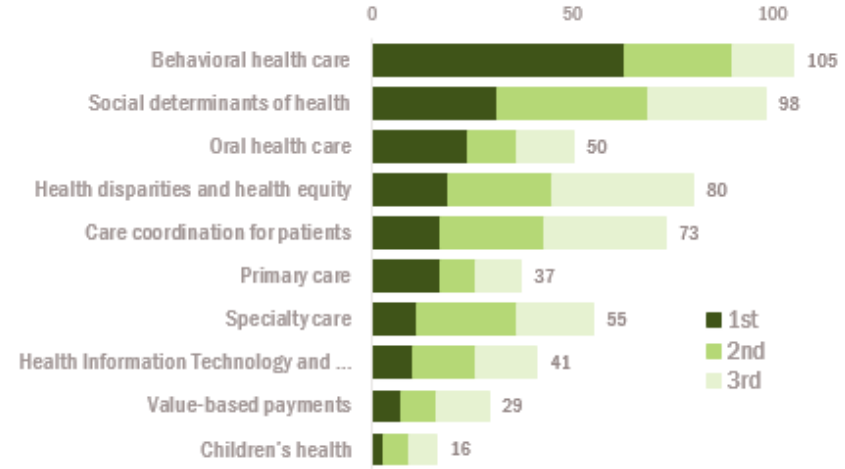
Non-member, non-providers:



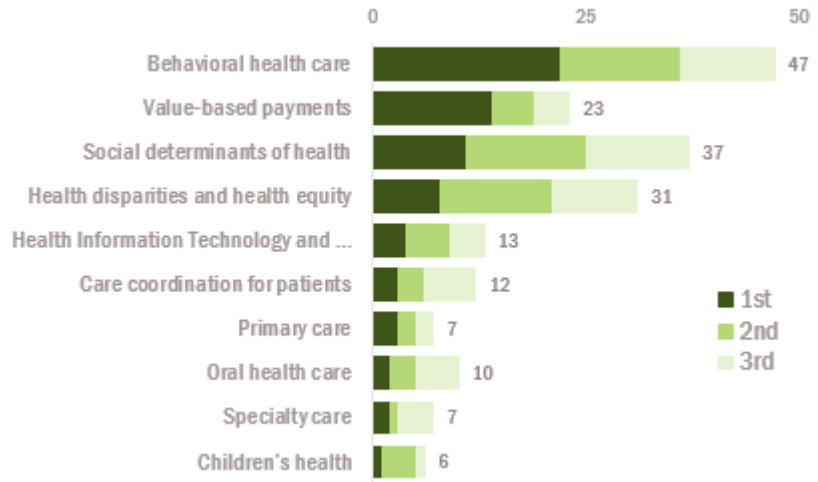
Providers:



OHP members/family:



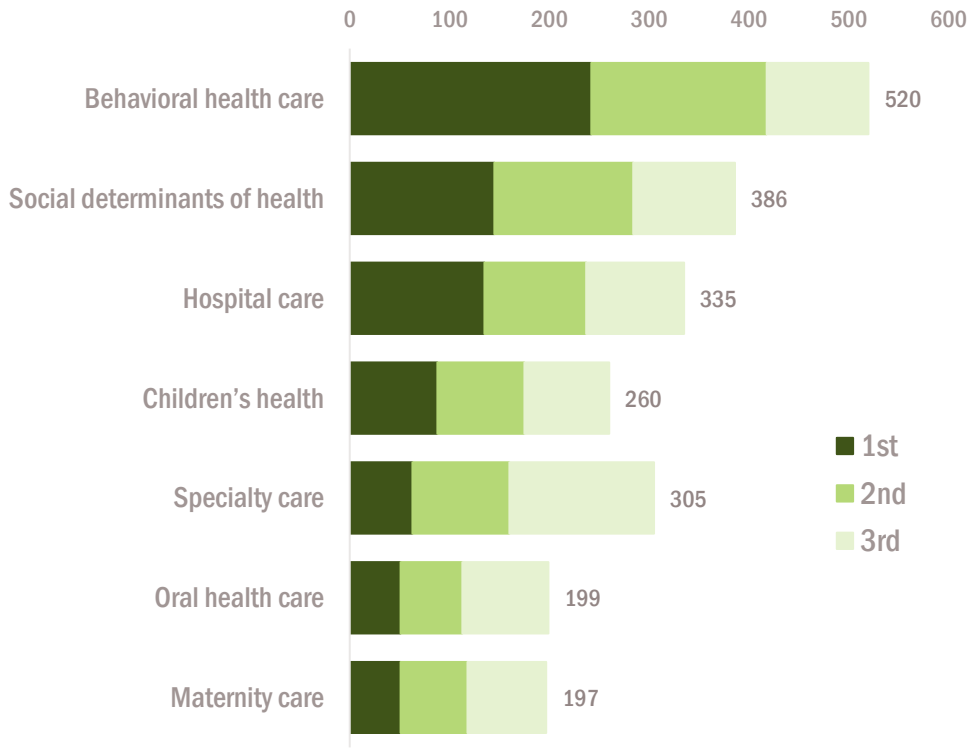
OHA staff:



VALUE-BASED PAYMENT (n=778)

In which of the following topic areas should CCOs use VBPs with their providers?

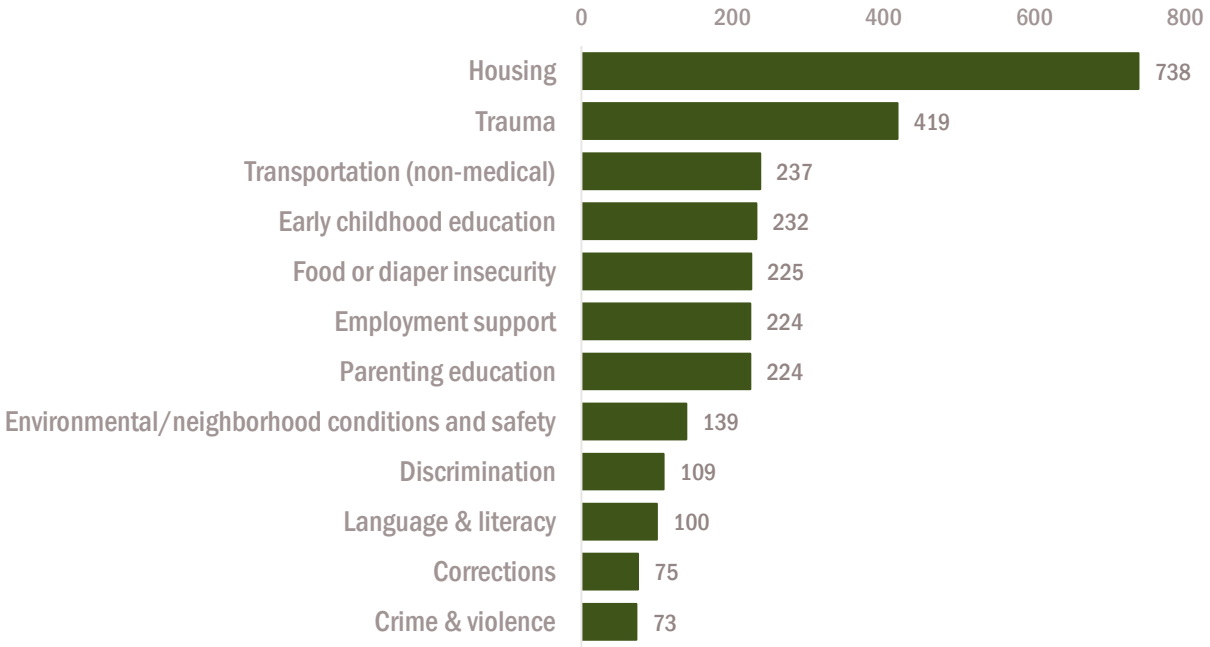
565 (66.8%) respondents rank **behavioral health care** as one of the top 3 areas that CCOs should use VBPs with their providers.



SOCIAL DETERMINANTS OF HEALTH & EQUITY (n=948)

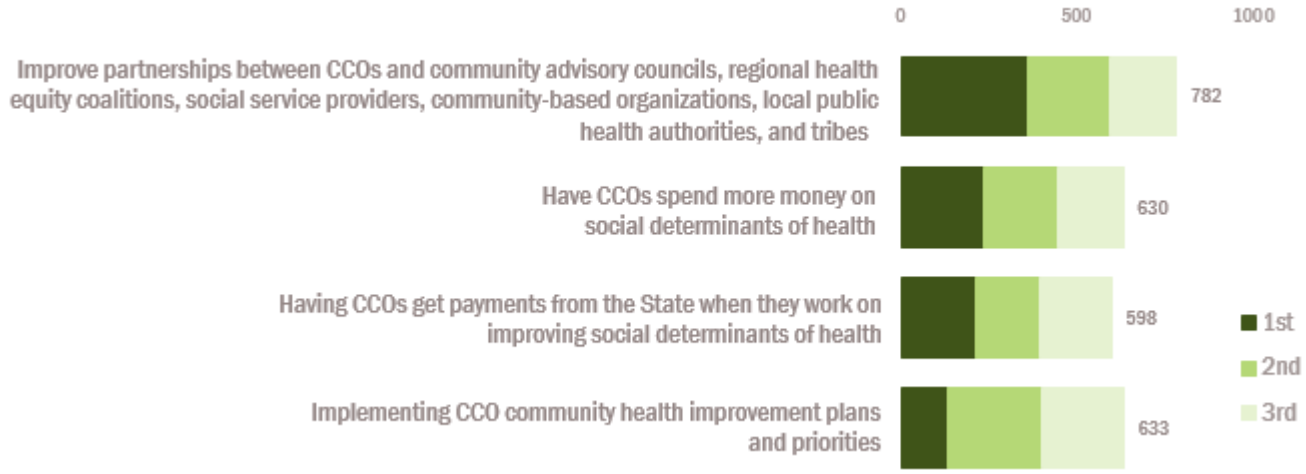
What are the top three most important area(s) of Social Determinants of Health and Equity that should be addressed in your community?

738 (72.7%) respondents rank **housing** as one of the top 3 areas of SDoH that should be addressed.

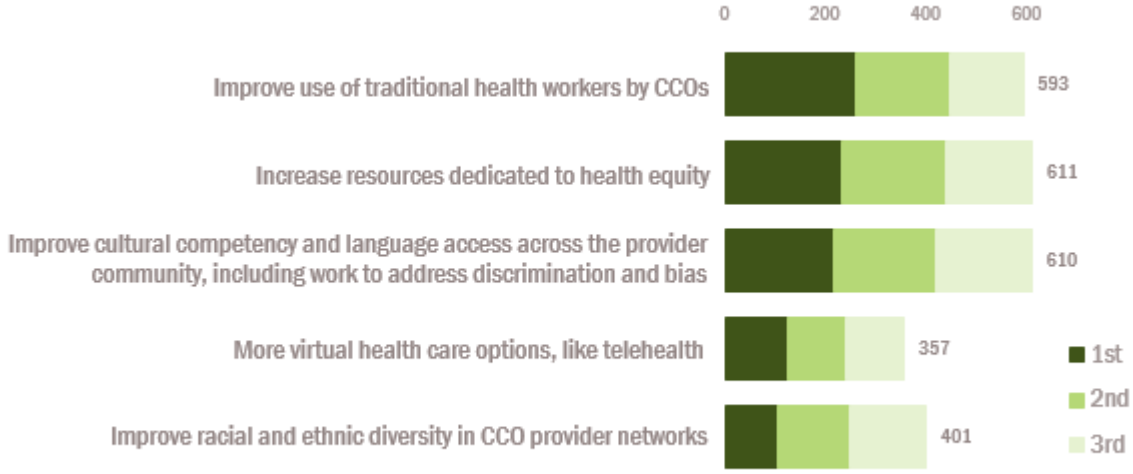


SOCIAL DETERMINANTS OF HEALTH & EQUITY (CONT)

What are the most important ways that CCOs could address the social determinants of health?

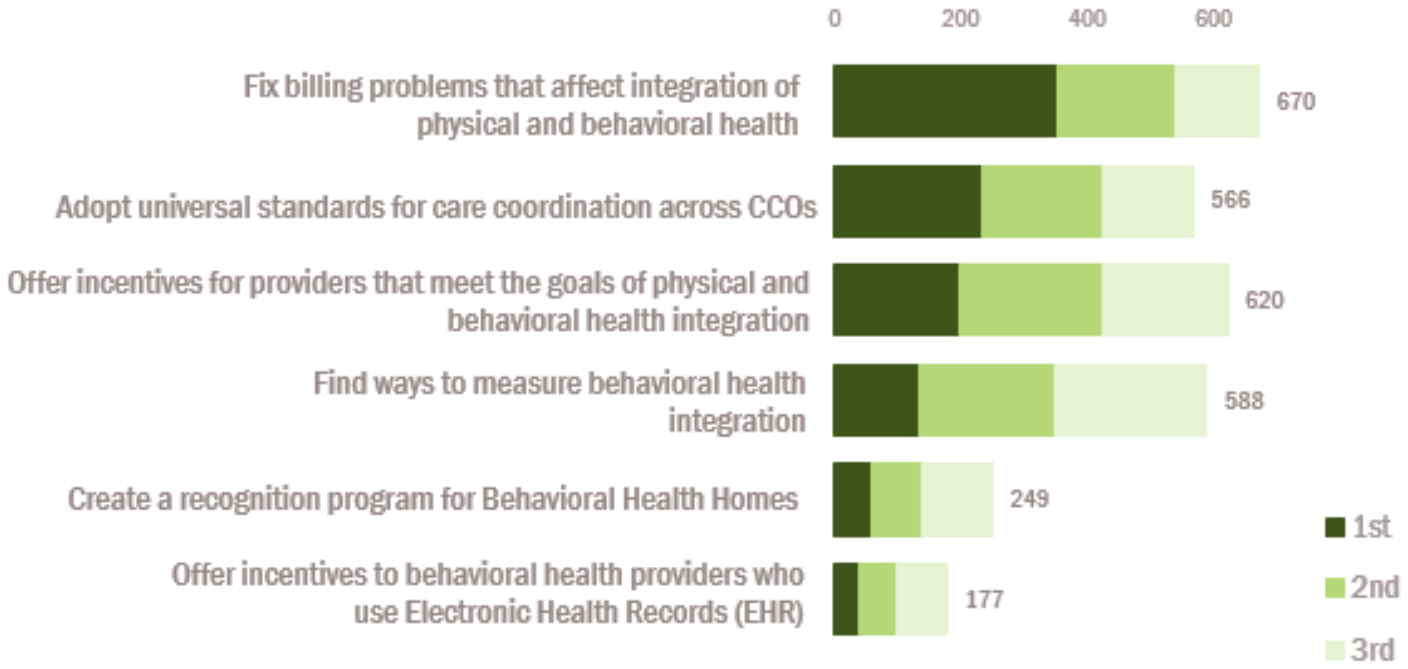


What are the most important ways that CCOs can address health disparities?



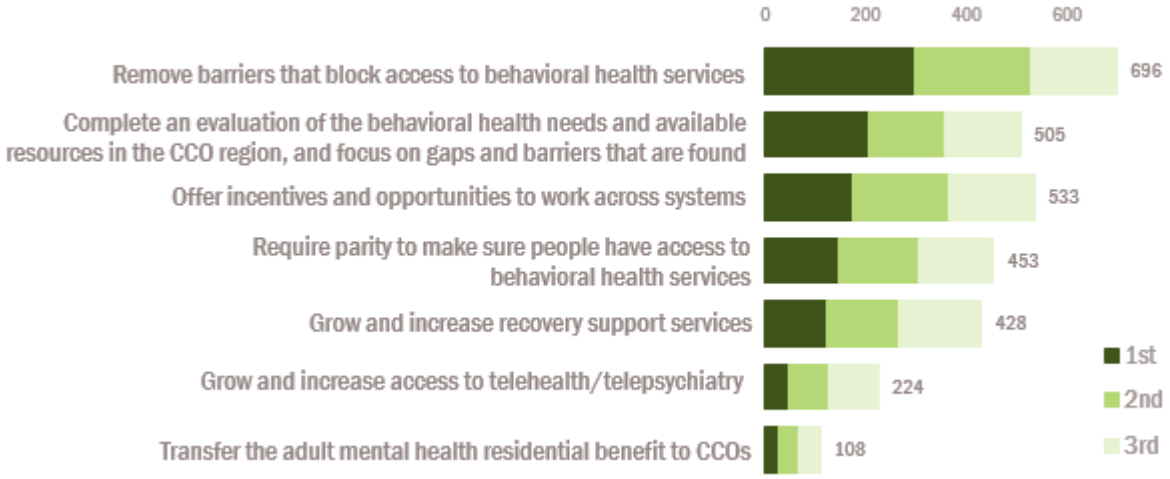
BEHAVIORAL HEALTH (n=1,024)

What can the state do to remove barriers to behavioral health, physical, and oral health integration within the CCO model?

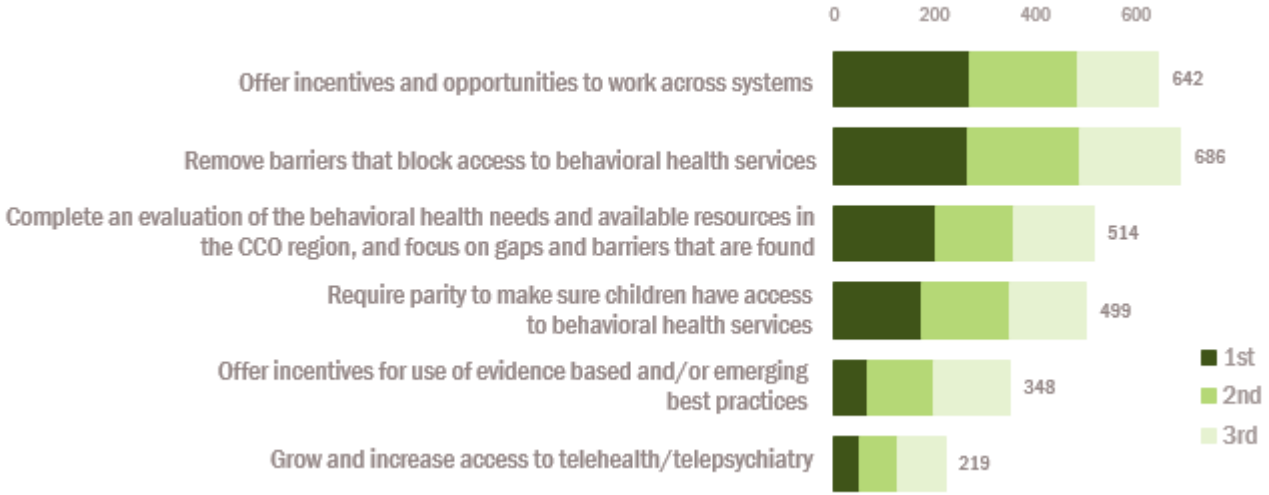


BEHAVIORAL HEALTH (CONT)

What can the state do to ensure all OHP members get the behavioral health care they need through the CCO model?

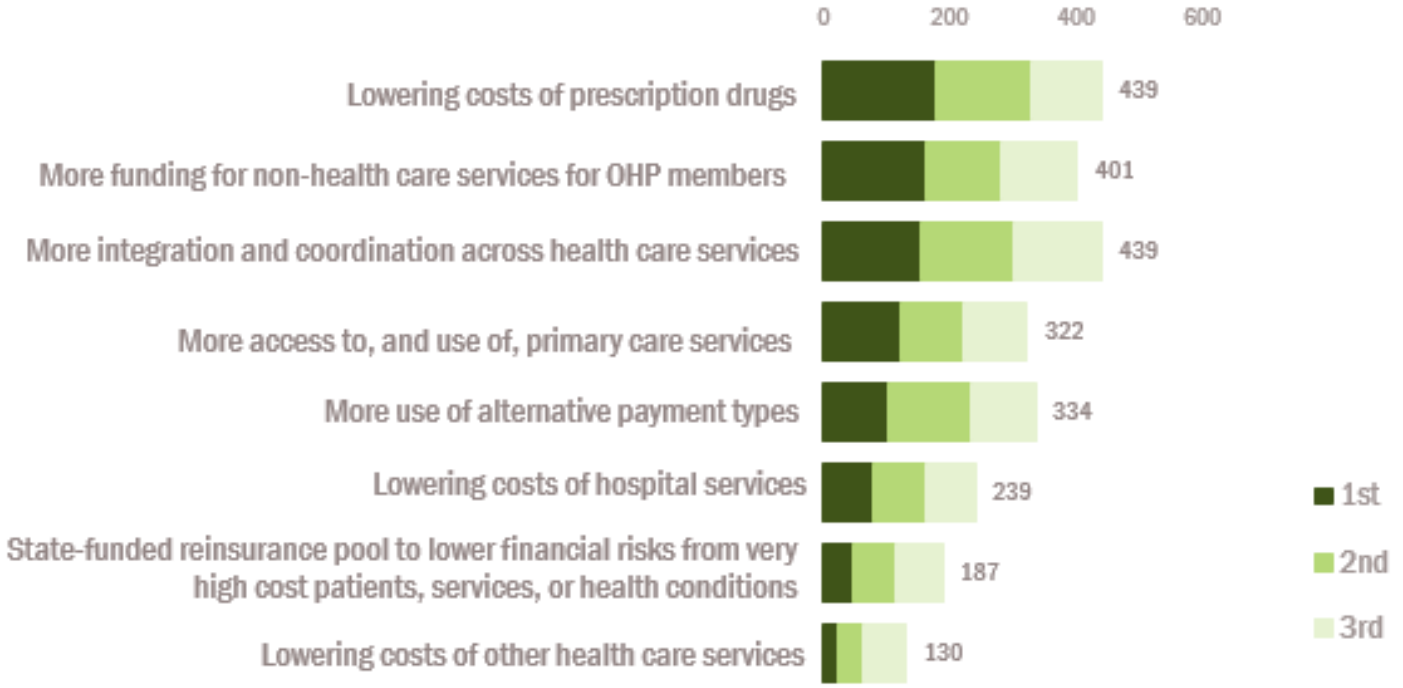


How do we ensure that children receive broad behavioral health services no matter where they live in Oregon?



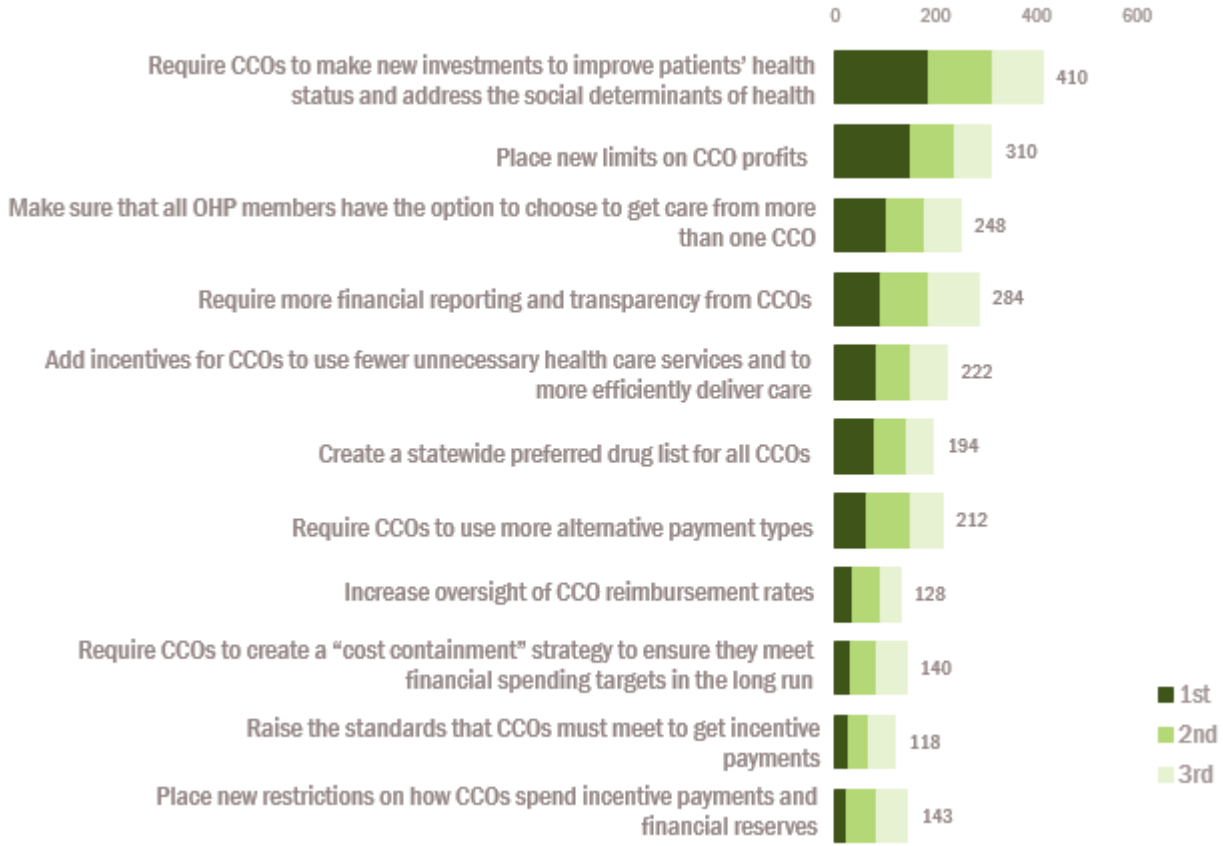
COST CONTAINMENT (n=866)

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



COST CONTAINMENT (CONT)

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



Survey Comments

Do you have anything else to add about how CCOs should improve in the future?

#	Topic/theme	EXAMPLE key words	# comments
1	**Cost and funding**	cost, funds, budget, flexible services, reimbursement, rates, HRS	226
2	**Behavioral health**	behavioral health, addictions, mental health, CCBHC	182
3	**Social determinants of health**	social determinants of health, education, transportation, housing, food, early learning	143
4	**Governance**	CAC, board, governance, general operations	134
5	**Metrics**	measures, incentive metrics, incentive payments	93
6	**Workforce**	traditional health workers, peers, access to care, shortage, training, providers	85
7	**Public health**	population health, community health improvement plan (CHIP), local public health (LPH)	71
8	**Coverage**	coverage, network adequacy, waiting period	54
9	**VBP**	value based payment, pay for performance, value	47
10	**Particular CCO**	named a specific CCO	40
11	**Equity**	disparities, race, ethnicity, cultural competency, equity, diversity	27
12	**Oral Health**	oral, dental, dentist	22
13	**Overall system**	choice, coordinated care model, administrative issues	19

A high-level summary of the open-ended survey responses is detailed on the following pages. For each topic identified, a brief description of the general content and themes of the answers is listed, as well as some example comments that are representative of the overall themes. Many of the comments and themes are cross-cutting and could apply to multiple topics.

1. Cost and Funding

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

- "**Protect the global budget concept** that was the foundation of developing the CCO concept. Allow communities to decide how to allocate and spend resources."
- "**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."
- "**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."
- "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."
- "**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."
- "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."

2. Behavioral Health

Integration is very important but isn't always working exactly as intended; billing is a challenge; access is a significant barrier.

- "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."

- "Serving in the behavioral health field for many years and running residential acute care facility as well as outpatient 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 CCO's need to develop a means to provide **universal access to treatment services for individuals involved with addition 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."
- "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."

3. Social Determinants of Health

This is a significant area in need of attention, support, partnership and investment; potential challenges with measurement.

- "We know that social determinants of health, specifically food insecurity, needs to be 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**."
- "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."
- "**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."
- "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."

4. Governance

Ideas and recommendations related to membership of the CCO board and Community Advisory Councils (CACs).

- "I would like to see that CCOs are mandated to have a **required number of consumer seats** on the board."
- "The public should be allowed and encouraged to attend CCO board meetings and the 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."
- "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."
- "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."
- "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."

5. Metrics

Recognition that the incentive measures work, but have other consequences too; suggestions for new or improved metrics; comments on how CCOs should use the funds earned from achieving the incentive measures.

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

6. Workforce

Challenges with adequate amount of existing workforce; utilization of all types of providers (e.g., THWs); training opportunities, especially related to trauma-informed care.

- "**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 alongside families and youth before they are in crisis."
- "**Promote excellence**. Training's on best practices are available across the system of providers in an equitable and cost effective manner."
- "We need to have **more peer to peer support on the Developmental Disabilities** level. Many parents are overwhelmed when there child gets a diagnosis, by no intervention for months, by the time they receive help they are in crisis mode."
- "**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."
- There also needs to be **payment equity** for other provider types (NP's, PA's, BH, etc.) and improved options to assist this population with some payment for technology related health care."

7. Public Health and Prevention

Opportunities related to increased support, investment and partnership related to prevention and population health activities.

- "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."

- "**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."

- "**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."

- 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.

8. Coverage

Comments addressed challenges with waiting periods, and contracting issues between CCOs and providers; importance of choice in provider and care; provider credentialing

- "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."

- "**CHOICE matters**. 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."

- "**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."

- "**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."

9. Value-based Payments

Comments were mixed across those who felt that this payment structure was the right direction, and those who felt that it was a challenge in practice and implementation.

- "**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."
- "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."
- "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**."
- "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."

10. Individual CCOs

Respondents identified success stories and challenges related to their own experiences, successful CCO programs and activities, and ideas for improvements.

- "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.
- "It would be **wonderful if my CCO could figure out how to pay providers in a timely manner**. For every mistaken denial on Explanation of Benefits (EOBs), clients have been notified and scared that they could no longer have services and have large bills to pay."
- "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, with regards to 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. 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."
- "**IHN-CCO has been an amazing leader** in SDoH, THW and peer-ran projects. GREAT JOB to IHN-CCO!"

11. Health Equity and Disparities

Diversity of providers; need for interpretation services and language access; ease of use and in system navigation; desire for culturally responsive care;

- "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!"
- "While savvy 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."**
- "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."

- "One thing that I didn't like when I found out I qualified for OHP and was assigned a CCO…was that 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**."
- "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."

12. Oral Health

Options and access to care; opportunities for better integration;

- "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."
- "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."
- "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."

13. Overall System

Administrative burden and reporting; overall number of CCOs; single-payer systems; non-profits and for-profits;

- "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."

- "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)."
- "**Fewer regional CCOs** (five in state) would seem prudent and more cost effective."
- "**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."
- "**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."
- "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."