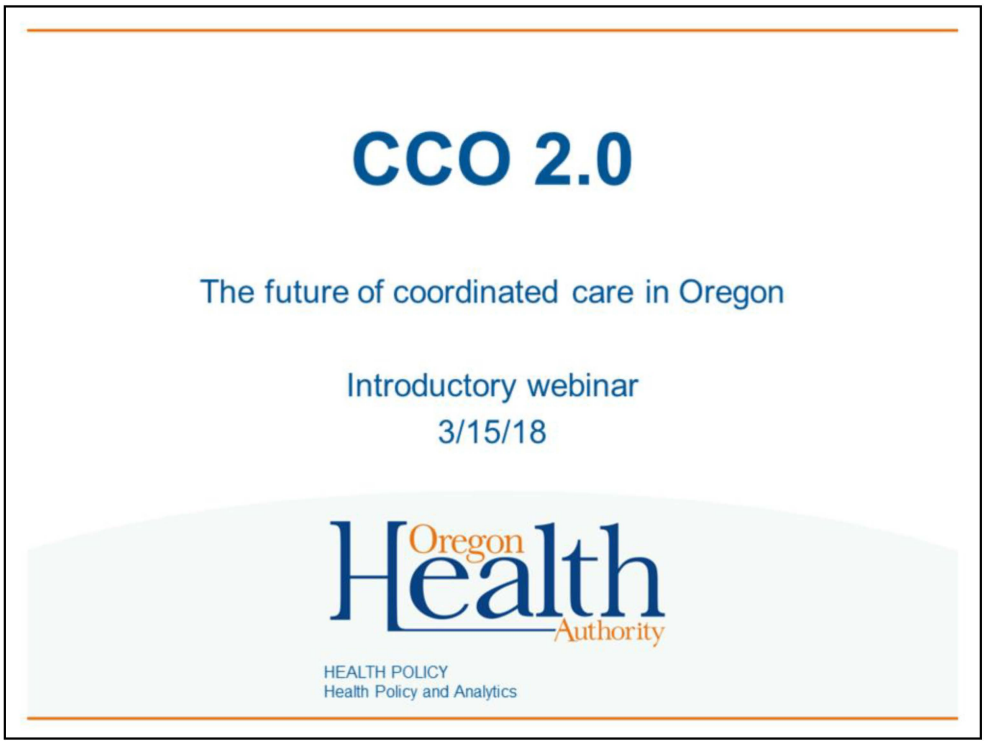


Speaking:

Jeremy Vandehey, OHA Acting Director of Health Policy and Analytics Division
Steph Jarem, OHA Office of Health Policy

A note on language and accessibility

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

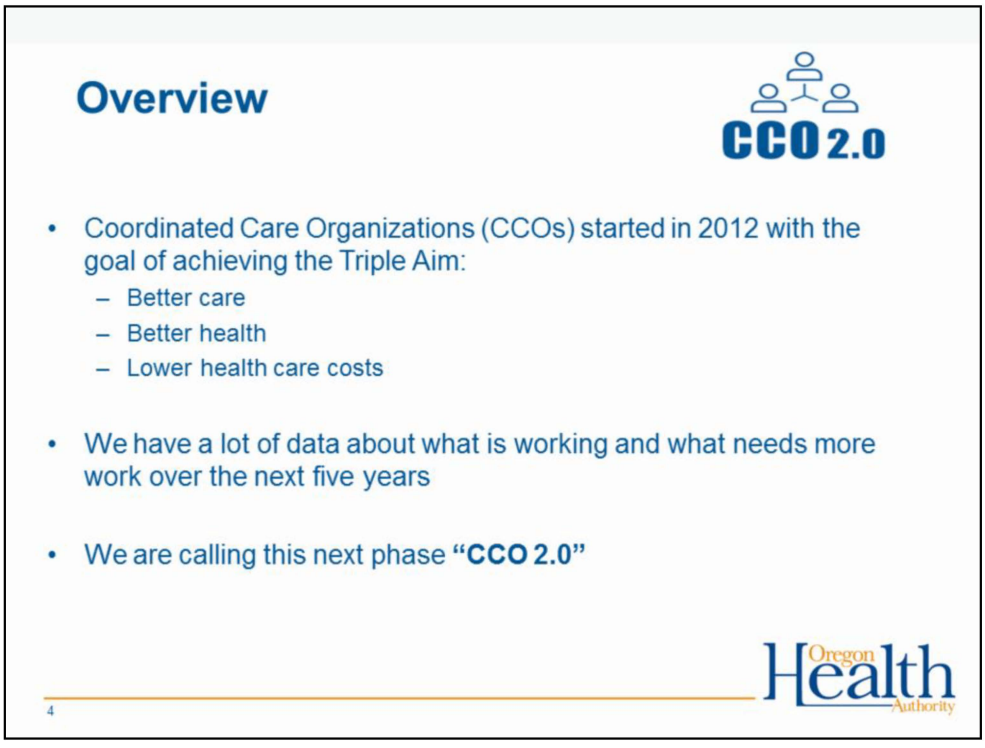
- *Sign language and spoken language interpreters*
- *Written materials in other languages*
- *Braille*
- *Large print*
- *Audio and other formats*

If you need help or have questions, please contact: Stephanie Jarem at 971-273-6844 or through email at CCO2.0@state.or.us. If assistance is needed for a meeting, please contact at least 48 hours prior to any meetings.

Oregon Health Authority

Table of Contents

- Overview
- Brief history of health system transformation
- Understanding coordinated care organizations (CCOs)
- What is working in CCO 1.0?
- CCO 2.0
  - Governor's vision
  - Timeline
  - Topic Areas
  - Public engagement opportunities



We now have more than five years of experience with the CCO model.

The CCO 2.0 contracts will start in 2020, but we want to hear from you now to help inform the contract and continue health transformation in Oregon.

Why is this important?

- One in four Oregonians, or nearly one million people now receive health coverage through the Oregon Health Plan (Medicaid).
- Most are members of a CCO.

- Oregon's Medicaid budget is about $14 billion, this accounts for 19 percent of the state's budget. This is taxpayer money and you should have a say in how it is spent.
- This is one of the largest procurements in the state.

Oregon Health Authority

Who is leading this work?

- The Oregon Health Authority (OHA)
- The Oregon Health Policy Board (OHPB)
  - Governor appointed nine-member board
  - Serves as the policy-making and oversight body for OHA
  - The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health

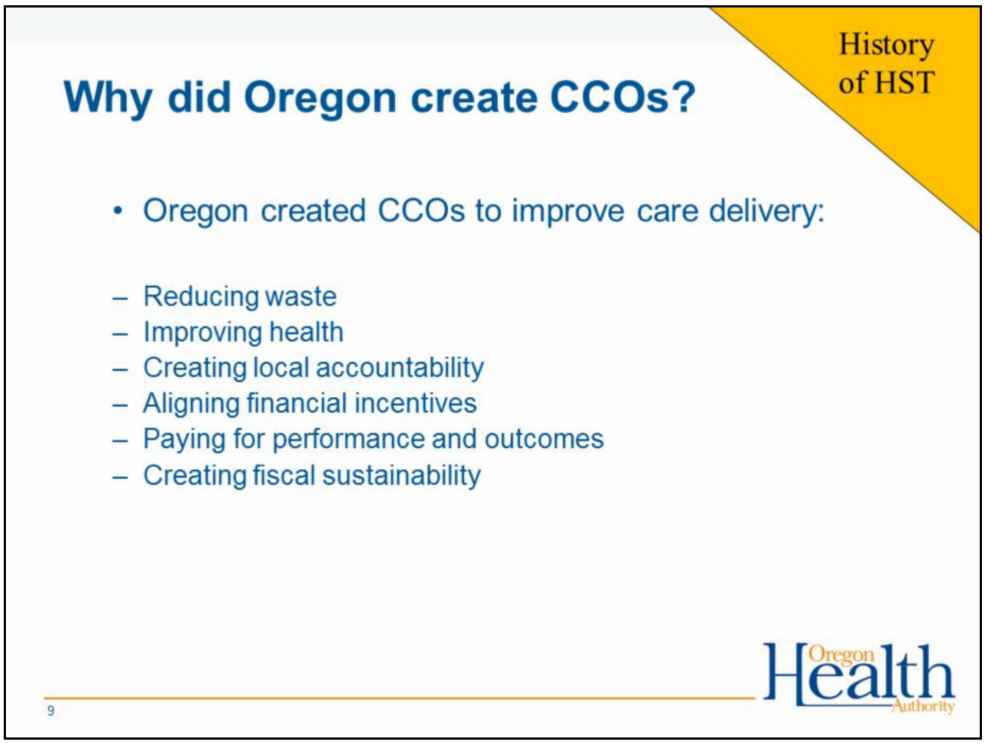
A little history of health system transformation (HST)

The system was fragmented and didn't coordinate or integrate care for patients. The state contracted separately for physical health, behavioral health and oral health services meaning patients had to navigate the complex system and no system had an incentive to coordinate care to lower costs.

High health care costs were unsustainable. A fragmented system encouraged more care rather than better care and improved health.

Many countries around the world spend

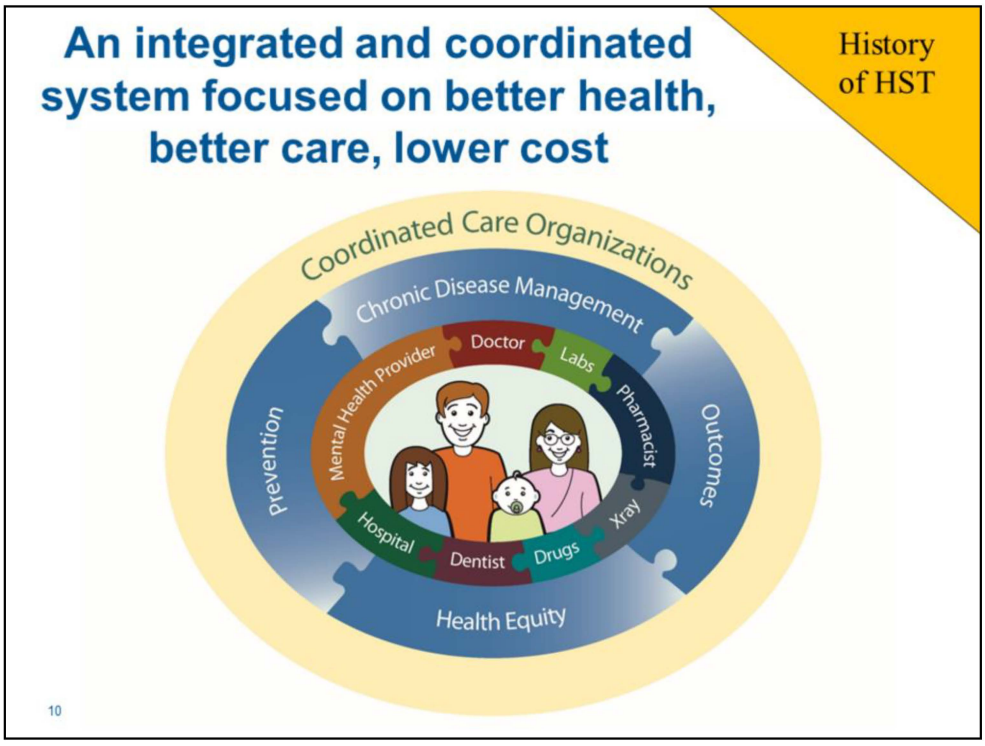
between 9% and 11% of their gross domestic product (GDP) on health care but between 1980 and 2013 that rose to about 17-18% in the United States, which tracks with Oregon's budget. When we're spending more money on health care, just like when families and businesses are spending more money in health care, that leaves fewer financial resources for other critical investments like housing and education.



In 2011 the state was faced with a pretty significant budget challenge including within Medicaid.

Traditionally we've balanced the Medicaid budget and tight times by through cuts – either through cutting eligibility or benefits or provider rates – and the challenge with all three of those options is they ultimately result in less access. When there's less access to the care that people need they end up in the emergency room which is the most expensive point-of-service and the only part of the system that has to provide coverage. Those costs are then passed on the rest of us.

So, we decided to pave a fourth path forward and really look at ways to improve the delivery of care so that it would reduce waste in the system, improve the health of population, create local accountability, align financial incentives, pay for performance and outcomes and create fiscal sustainability.



We called the new system a Coordinated Care Model.

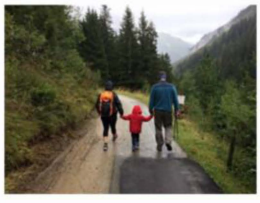
Rather than the fragmented disarray of puzzle pieces that made up the old system, Oregon's coordinated care organizations would bring together all parts of the health system to work together in an integrated and coordinated way that put patients at the center and coordinated high quality care for them.

Learning more about coordinated care organizations (CCOs)

Understanding CCOs

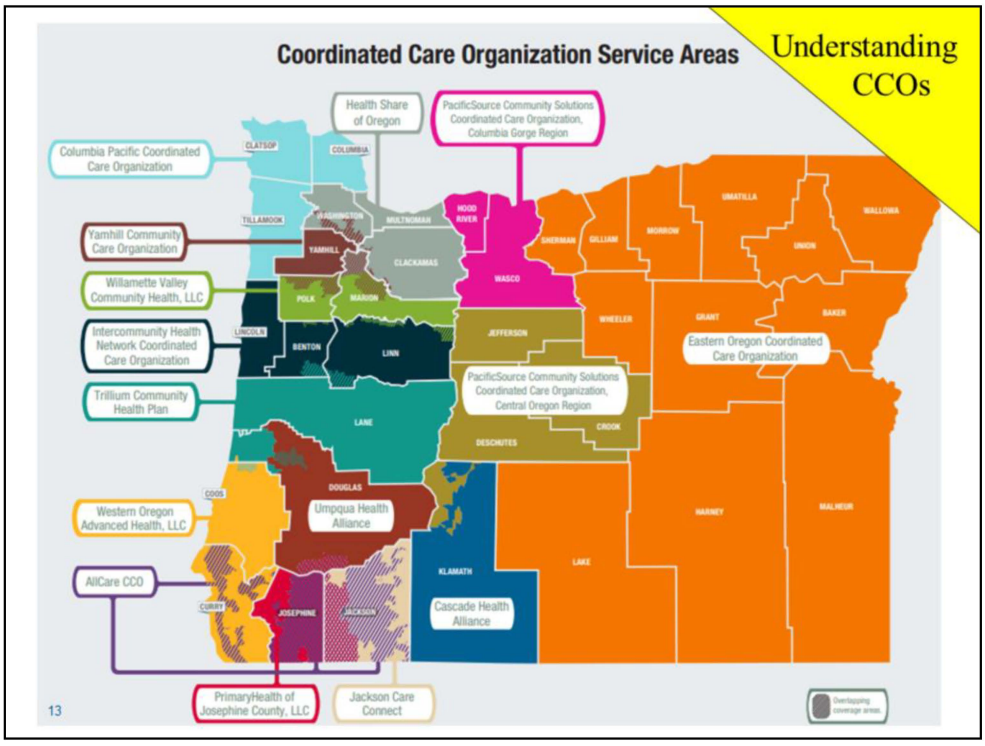
What is a CCO?

- Coordinated Care Organizations are **community-governed organizations** that bring together **physical, behavioral** and **dental** health providers to coordinate care for people on the Oregon Health Plan.
- CCOs receive fixed **monthly payments** from the state to coordinate care and **financial incentives** that reward outcomes and quality.
- CCOs also have the **flexibility** to address their members' health needs outside traditional medical services. This model is designed to improve member care and reduce taxpayer costs.



➢ The first CCOs started doing business in Oregon in 2012.

Oregon Health Authority



There are now 15 CCOs caring for nearly one million Oregonians. This map shows the service areas of all of the CCOs.

You can explore the map online: https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/le8116.pdf

Global budgets: CCOs are paid a "global budget" for all physical, oral, and behavioral health care for their members. CCOs are expected to stay within this budget while also improving quality and outcomes by focusing on prevention.

Sustainable costs: Oregon has committed that spending on global budgets will not increase more than 3.4 percent per year.

Budget Flexibility: CCOs have the flexibility to hire their own providers, conduct innovative quality improvement programs, and to spend money on health-related services like transportation, housing and education.

Understanding CCOs

CCOs can also earn incentive payments for improving quality

- The state rewards CCOs through an incentive pool. CCOs can earn money for meeting or exceeding targets on 17 quality measures. These include:
  - patient centered primary care home enrollment
  - cigarette smoking prevalence
  - colorectal cancer screening
  - childhood immunization status
  - controlling high blood pressure
  - application of dental sealants for kids
  - depression screening and follow-up
  - health assessments for kids in foster care

CCO incentive metrics reports and payments are available online

Oregon Health Authority

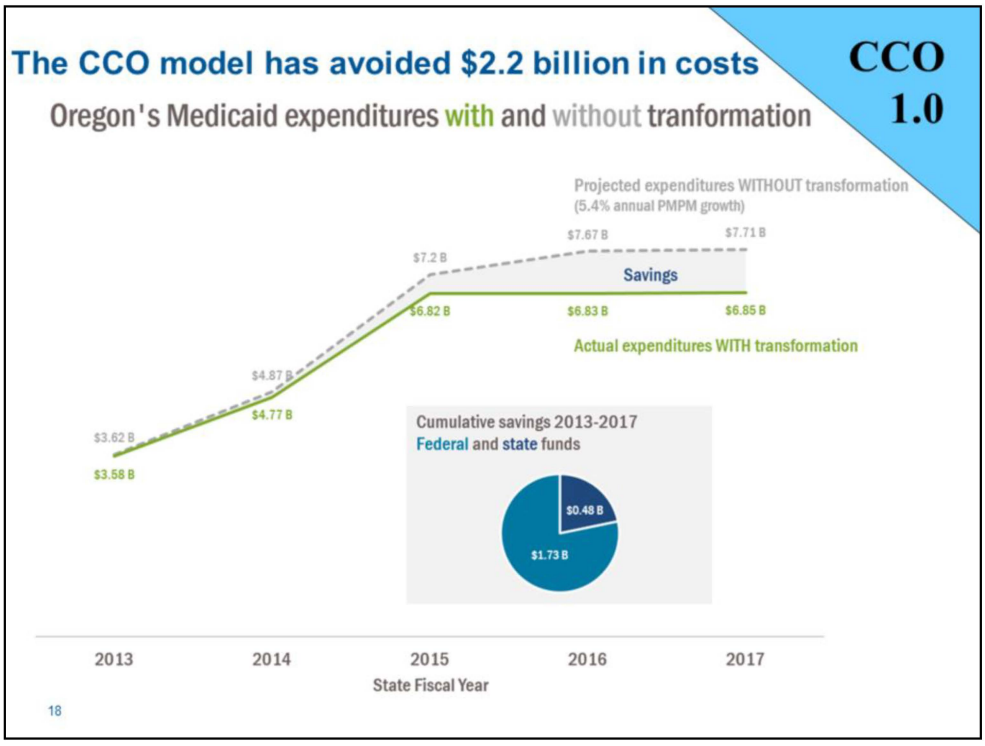
What do we know about CCO 1.0?

What is working in CCO 1.0?

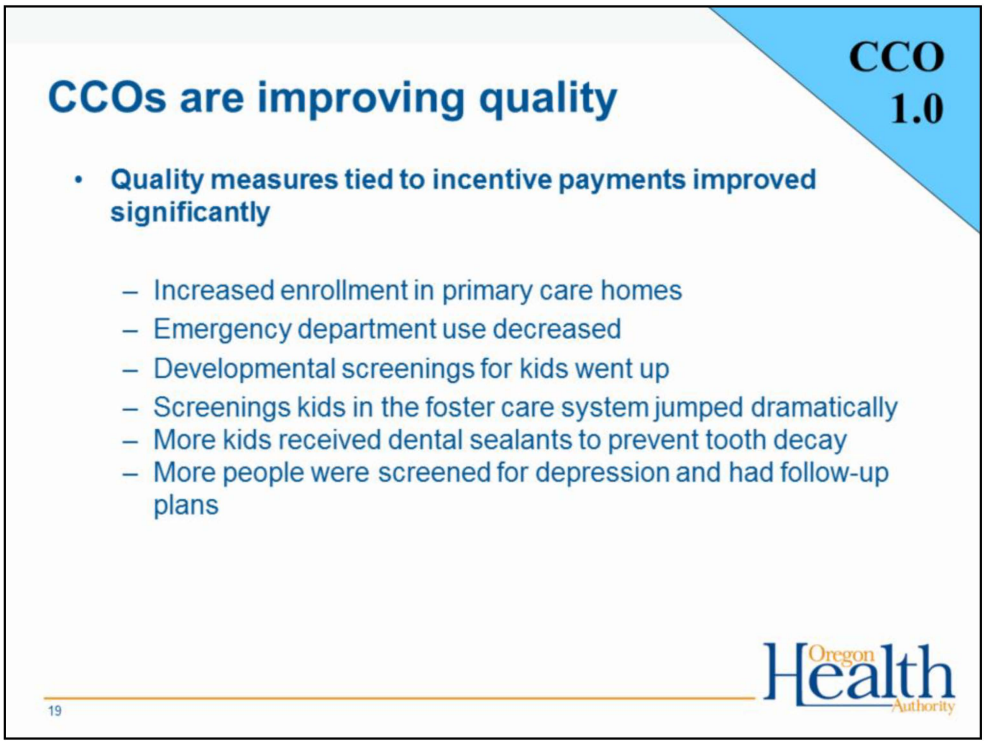
CCO 1.0

- CCOs have reduced cost growth
- CCOs are improving quality
- CCOs are improving member health

Oregon Health Authority



Since 2013, the CCO model has grown at a rate of 3.4% instead of the 5.4% that we would have expected without transformation. That has resulted in about $2.2 billion in avoided costs over that five year period.



More people were enrolled in primary care homes, which means better care coordination and a consistent care team

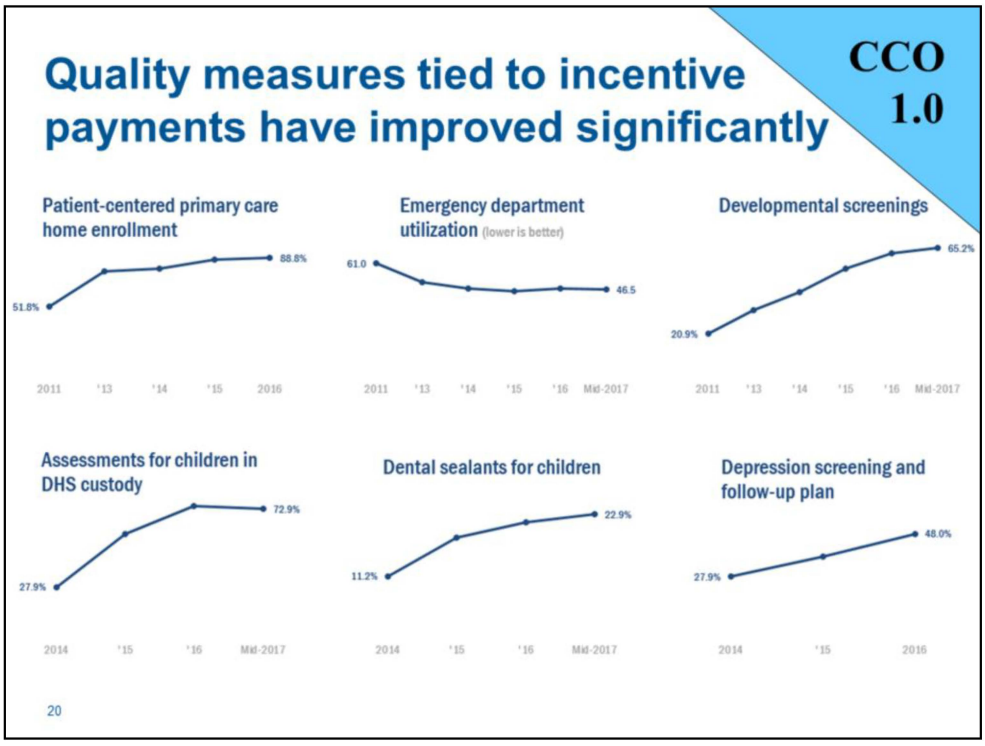
Emergency department use went down as members were getting care in primary care setting

Developmental screenings for kids went up, ensuring earlier treatment

Screenings kids in the foster care system jumped dramatically with better care for this vulnerable population

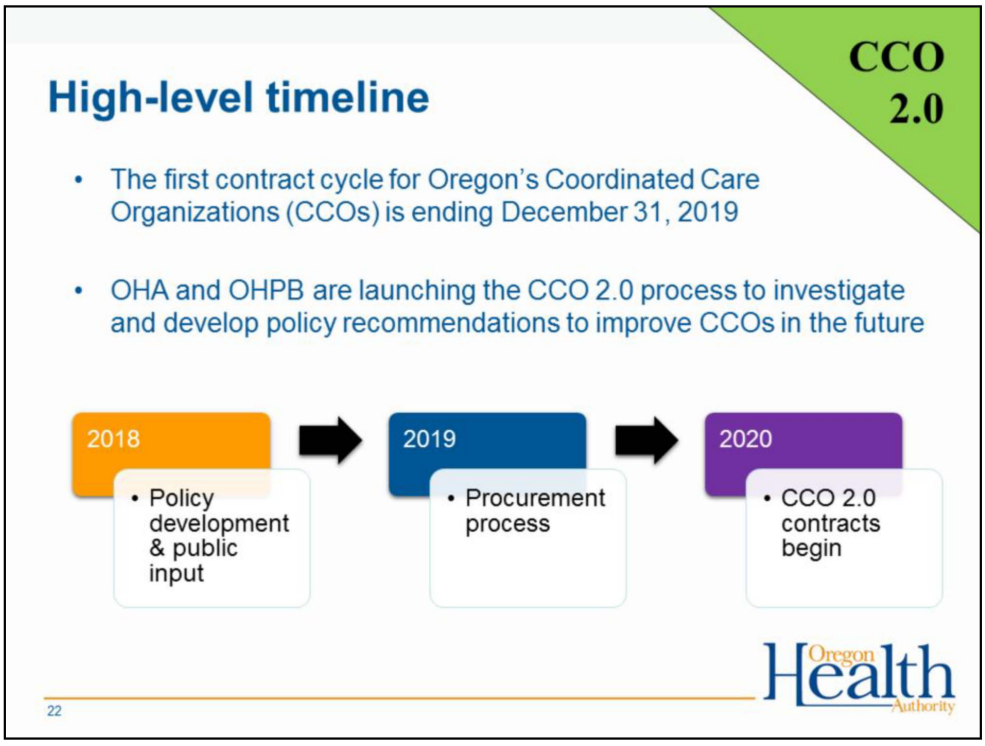
More kids received dental sealants to prevent tooth decay

More people were screened for depression and had follow-up plans which ensures better mental health care

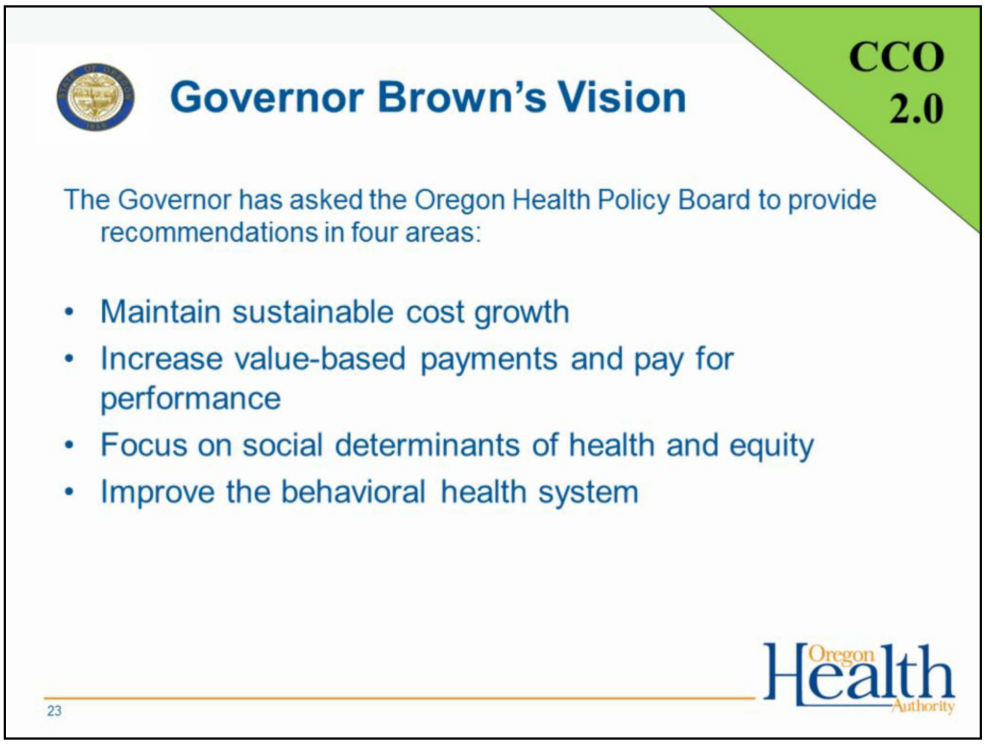


More information on improvements to quality based on measures tied to incentive payments.

What will CCOs look like in the future?



This timeline ensures that the next contracting cycle capitalizes on the health care transformation progress made by CCOs



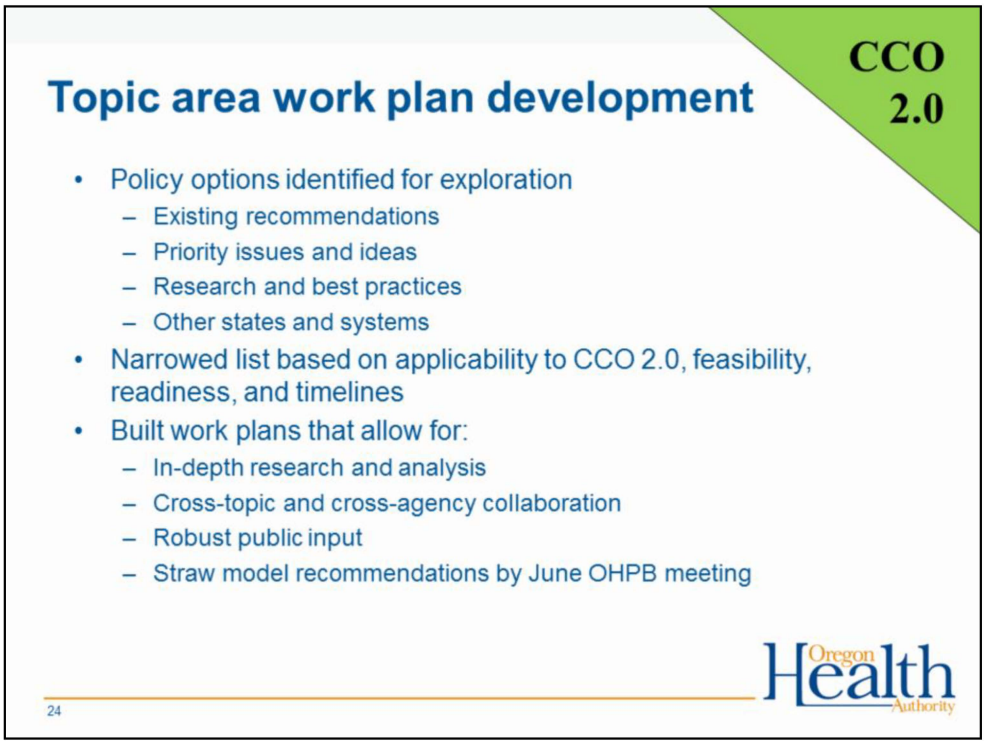
Governor's vision: in the next phase of transformation CCOs will

Integrate behavioral health and ensure patients receive the right care at the right time

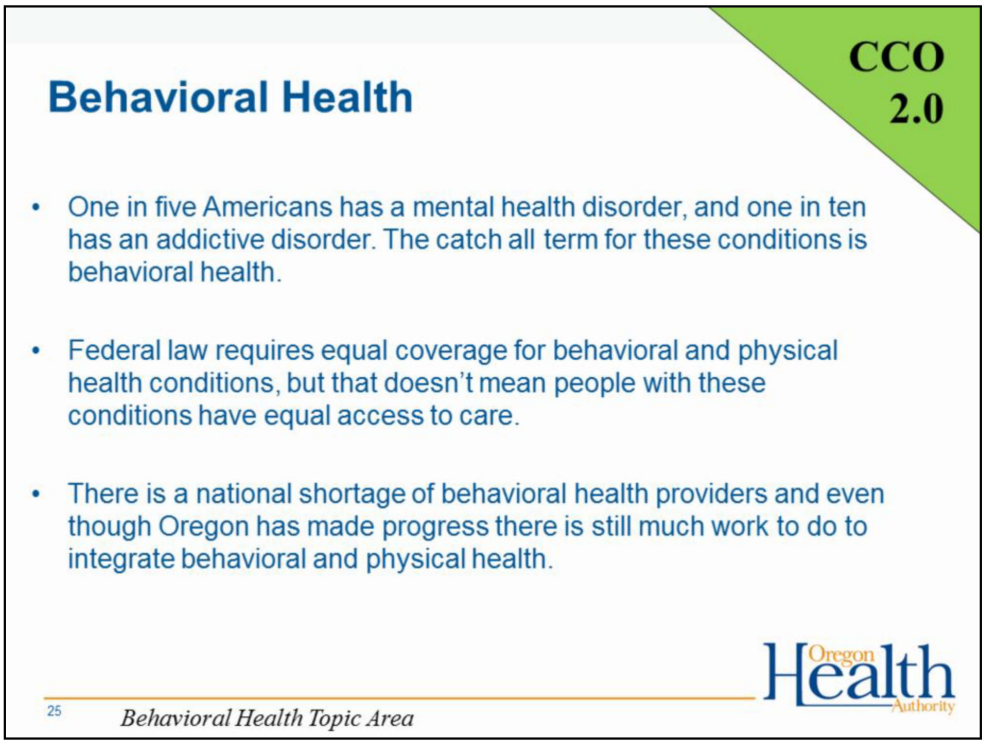
Move from focusing on health care to focusing on other systems that impact health and equity. Only 10-15% of what impacts health happens in the doctor's office.

Further increase quality and reduce disparities, and pay providers for value rather than volume of care.

Continue to operate within a sustainable budget that contains cost.



OHA established teams focused on each of the four areas highlighted by the Governor, and each team has developed a work plan. These work plans were shared with the Oregon Health Policy Board (OHPB) at their March meeting.



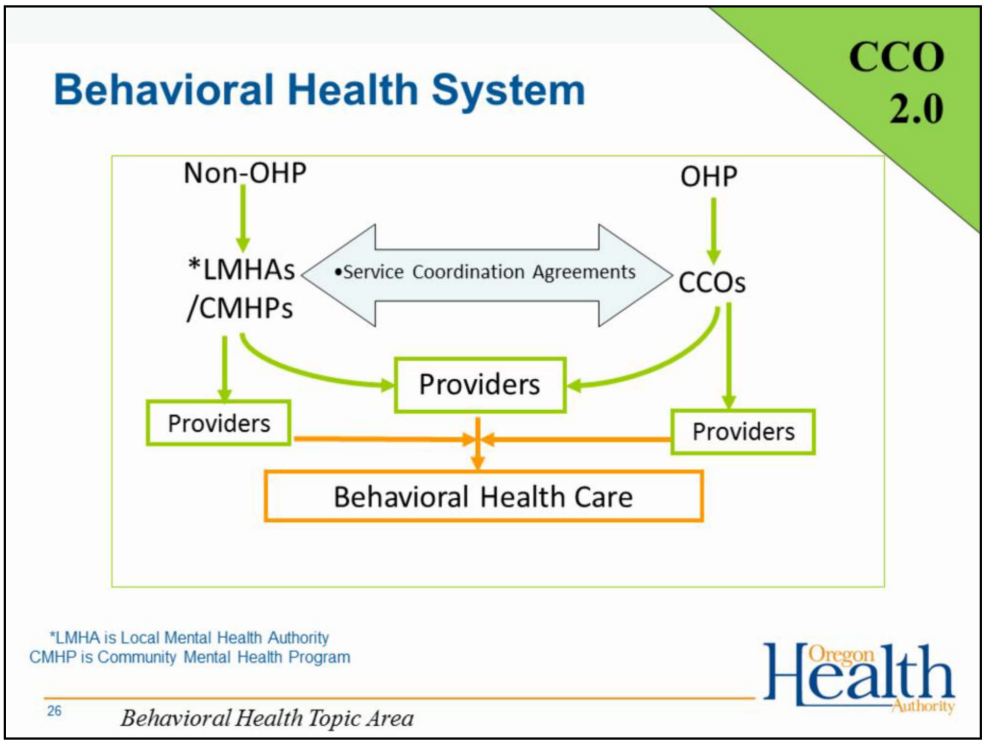
Oregonians who struggle with behavioral health – mental health challenges and addictive disorders, face barriers every day to getting the services and support they need.

The behavioral health system continues to include fragmented financing, carve-outs that prevent integration, and a siloed delivery system.

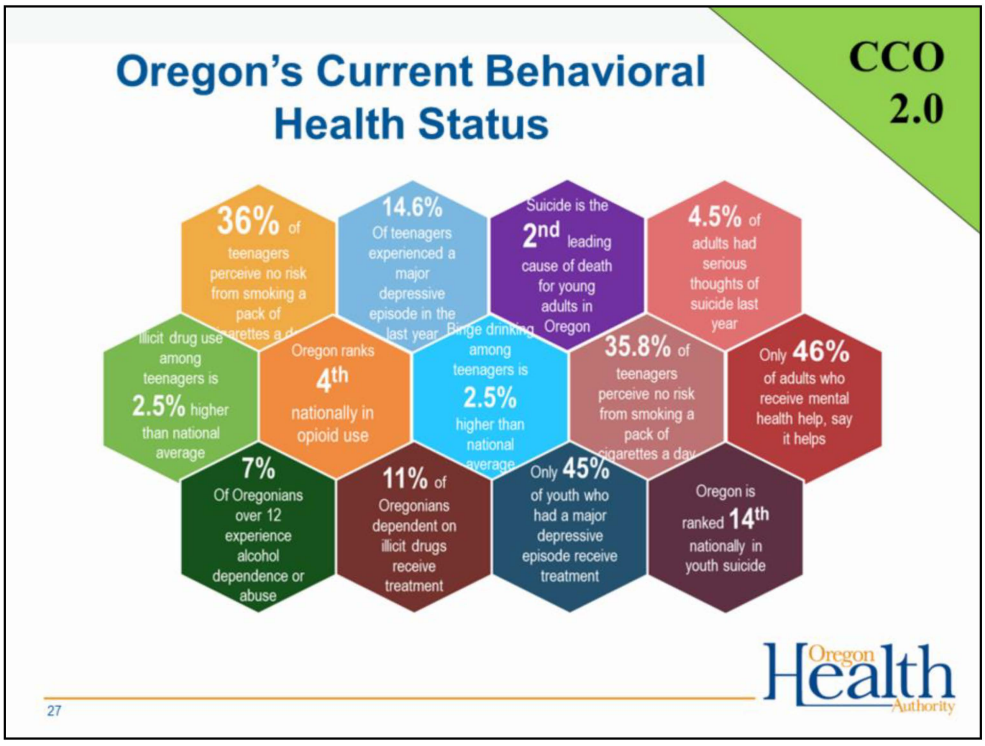
Access to specialty and general behavioral health services does not meet the needs of all Oregonians in the right place at the right time and in a culturally and linguistically specific manner.

Coordination between systems, such as criminal justice, human services, health and education is insufficient.

Social determinants of health, including insufficient housing, education, employment and transportation, create barriers to behavioral health resources.

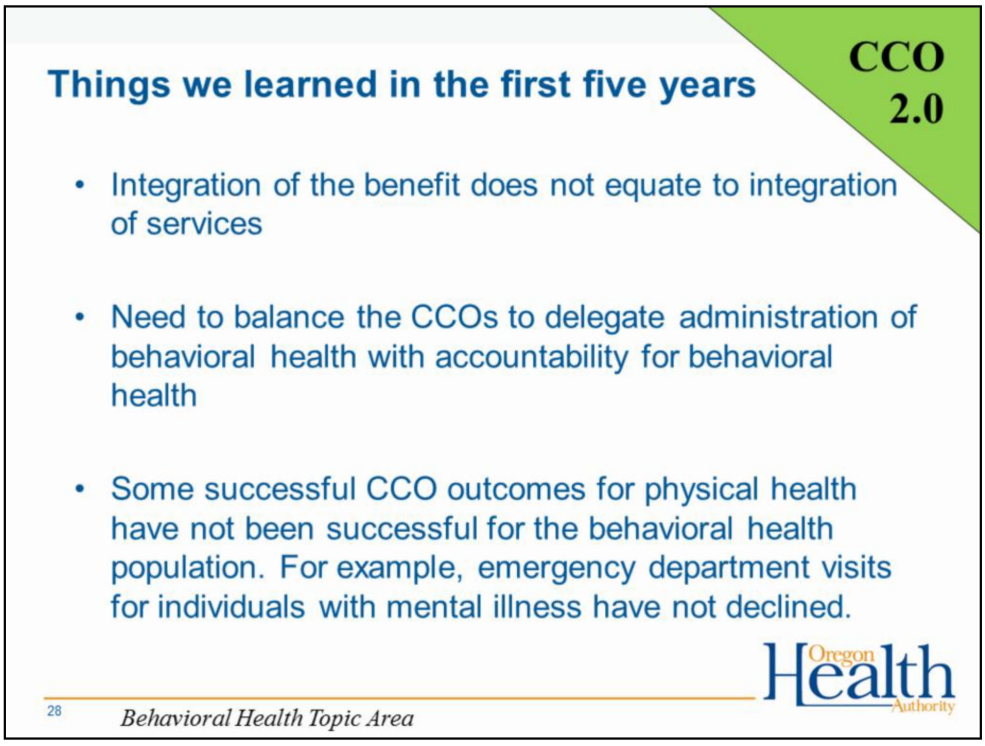


CCOs have service coordination agreements with Community Mental Health Programs (CMHPs). CCOs may contract with the CMHP to provide services, or they may contract directly with other behavioral health service providers. CMHPs either provide behavioral health services or contract with other providers in the community to provide the services.

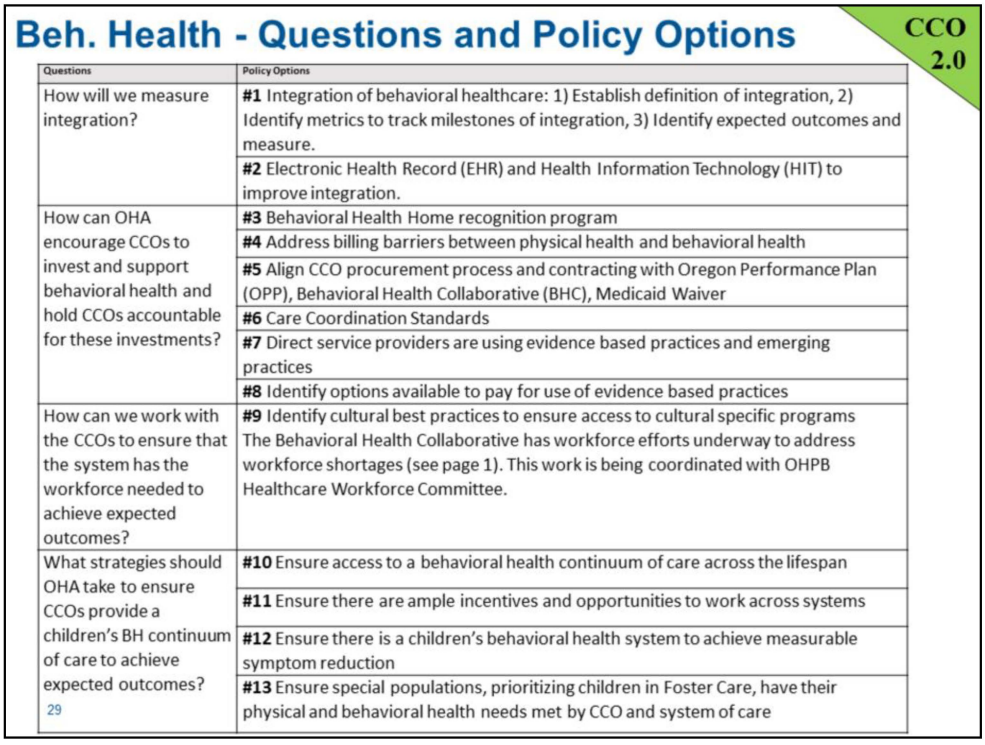


Data shows that consumers are not currently receiving sufficient or consistent behavioral health services throughout Oregon.

We have ample opportunity for improvement.



Since the inception of the Affordable Care Act, there has been an increase in people receiving behavioral health services. However, what we have learned in the past five years is that the integration of the benefit doe not result in integration of services. And while we have seen improvements in physical health outcomes, such as a reduction in the number of emergency department visits, we have not seen a reduction in emergency department visits for people with mental illness. What we need to see is behavioral health services truly integrated with physical and behavioral health services.



Beh. Health - Questions and Policy Options

CCO 2.0

Questions	Policy Options
How will we measure integration?	**#1** Integration of behavioral healthcare: 1) Establish definition of integration, 2) Identify metrics to track milestones of integration, 3) Identify expected outcomes and measure.
	#2 Electronic Health Record (EHR) and Health Information Technology (HIT) to improve integration.
How can OHA encourage CCOs to invest and support behavioral health and hold CCOs accountable for these investments?	**#3** Behavioral Health Home recognition program
	#4 Address billing barriers between physical health and behavioral health
	#5 Align CCO procurement process and contracting with Oregon Performance Plan (OPP), Behavioral Health Collaborative (BHC), Medicaid Waiver
	#6 Care Coordination Standards
	#7 Direct service providers are using evidence based practices and emerging practices
	#8 Identify options available to pay for use of evidence based practices
How can we work with the CCOs to ensure that the system has the workforce needed to achieve expected outcomes?	**#9** Identify cultural best practices to ensure access to cultural specific programs The Behavioral Health Collaborative has workforce efforts underway to address workforce shortages (see page 1). This work is being coordinated with OHPB Healthcare Workforce Committee.
What strategies should OHA take to ensure CCOs provide a children's BH continuum of care to achieve expected outcomes?	**#10** Ensure access to a behavioral health continuum of care across the lifespan
	#11 Ensure there are ample incentives and opportunities to work across systems
	#12 Ensure there is a children's behavioral health system to achieve measurable symptom reduction
	#13 Ensure special populations, prioritizing children in Foster Care, have their physical and behavioral health needs met by CCO and system of care

29

In September 2017, Governor Brown asked the Oregon Health Policy Board to focus on behavioral health when considering the future or Coordinated Care Organizations. The Governor's request included the following:

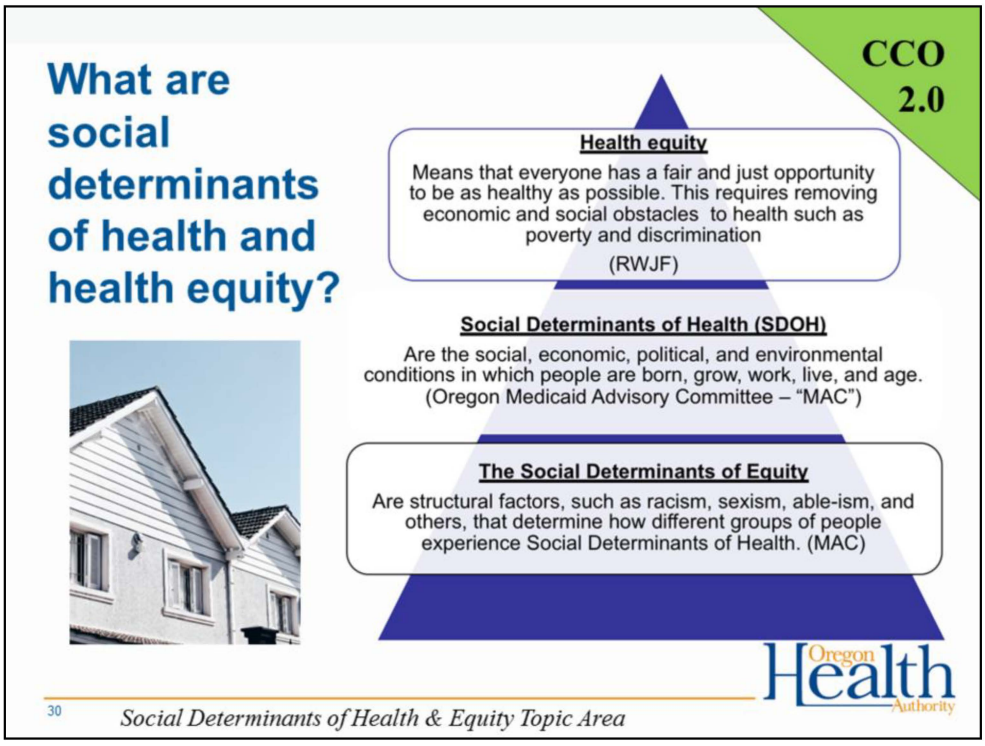
1. Reduce Emergency Department utilization
2. Increase access to community based behavioral health care; and
3. Children with behavioral health needs are a priority

In order to fulfill the Governor's request, behavioral health must be fully integrated into the CCO model. We have developed the following questions to move us forward with this work.

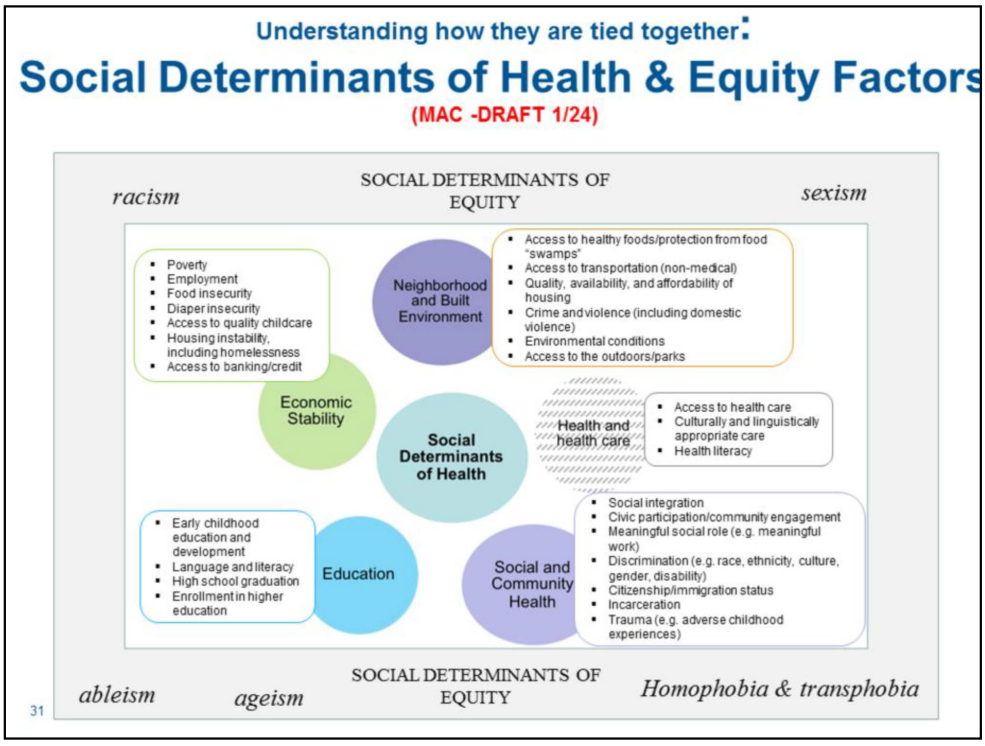
1. How will we measure integration? In order to know that we are successful in integrating the behavioral health system, we must identify meaningful measures. We also need the technology, including Electronic Health Record and Health Information Technology. By investing in technology for behavioral health providers, we expect increased care coordination and support for integrated physical, behavioral and oral healthcare.
2. How can we encourage investment in behavioral health and hold CCOs accountable for these investment? Our current behavioral health system is

fragmented and siloed. Addressing billing barriers between physical and behavioral health, and aligning contracts will improve access to behavioral health care for all Oregonians.

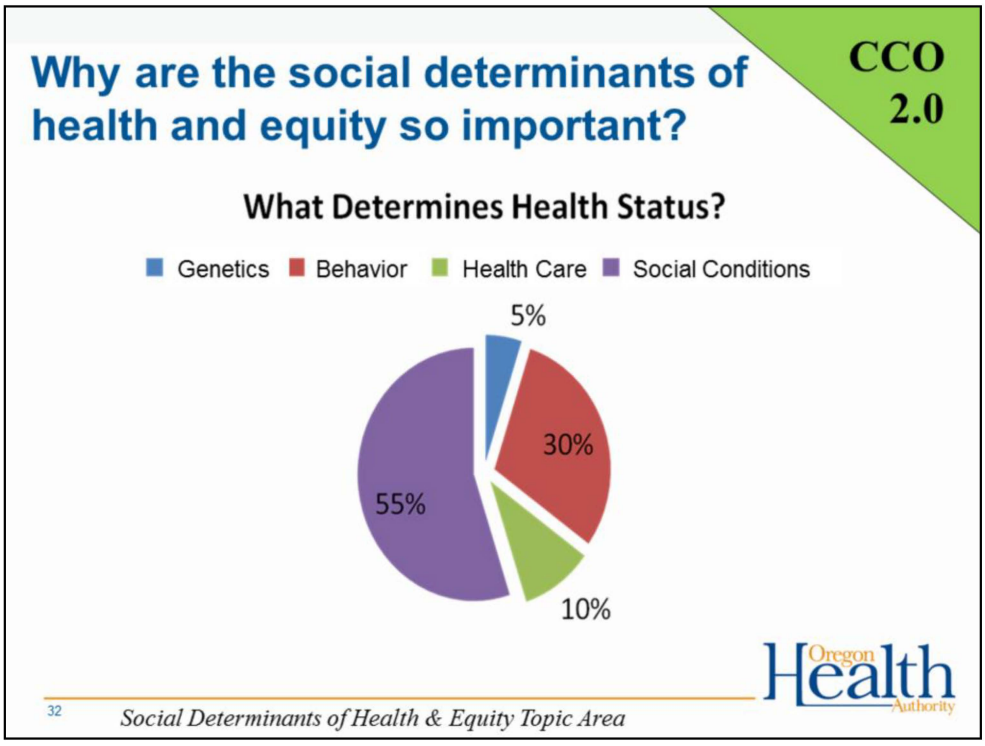
3. How can we ensure that they system has the workforce to achieve expected outcomes? The Oregon Health Authority is assessing the current behavioral health workforce. Once this assessment is complete, we will develop and implement a recruitment and retention plan. This work will be complete March 31, 2019. Meanwhile, we must ensure that we have culturally and linguistically appropriate services for all Oregonians.
4. How do we ensure that children receive comprehensive behavioral health services no matter where they live in Oregon? There must be a full continuum or care across the entire lifespan. This means prevention, early intervention, treatment, residential care and ongoing recovery support services



- One of our primary goals for the next five years of Coordinated Care Organizations is to increase health equity in the health care system.
- Health equity is about fairness and social justice. It means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination
- Another term for obstacles like poverty and discrimination is the "social determinants of health"
- The social determinants of health are the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age.
- Social determinants of health aren't fairly distributed in communities. Policies and structural factors like racism, sexism, age-ism, and others mean that certain groups face more factors like poverty and other social determinants of health than others. These structural factors are also called "the social determinants of equity"



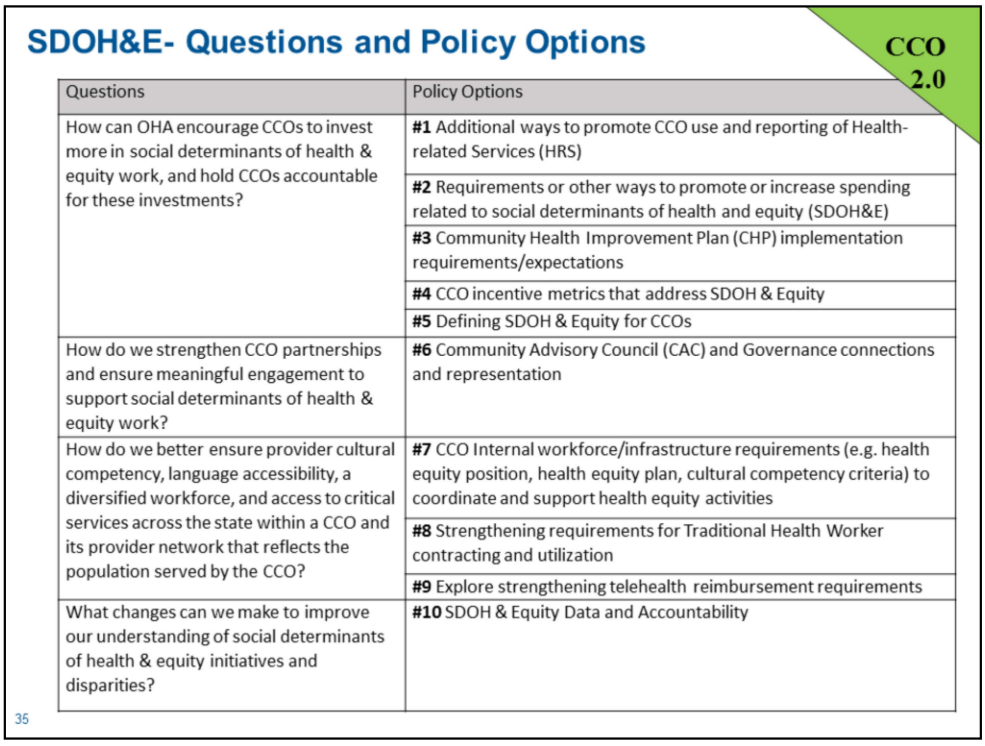
- This image shows how the social determinants of equity, like racism and sexism, are connected to the social determinants of health, like poverty and employment.
- This graphic also shows the different social, political, and environmental conditions we mean when we say the social determinants of health
- Oregon's Medicaid Advisory Committee, a stakeholder advisory group to OHA and Department of Human Services, is coming up with a definition of social determinants of health and equity for Oregon CCOs. This graphic is the draft definition.



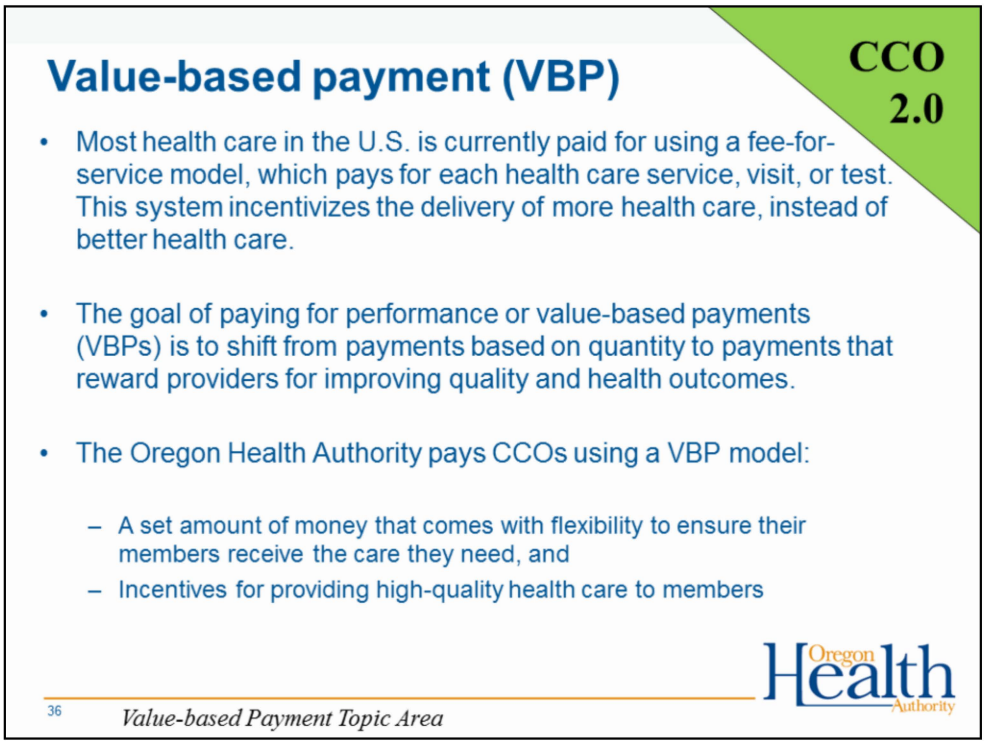
- Health care is important, but the medical care we get only determines about 10% of our health.
- Social and environmental conditions – or the social determinants of health – actually make a much bigger difference in how healthy we are.
- In order to keep transforming the health care system and help Medicaid members improve their health, we need to expand the work that health care partners do to impact social determinants.

- When we looked at the last five years of CCOs, we saw that CCOs are already starting to do work to address the social determinants of health, especially in areas related to housing and addressing trauma, including trauma during childhood. However, there's more work we can do.
- When we looked at CCO financial reports, we saw that CCOs weren't reporting high investments in health-related services, which is a flexible part of a CCOs budget that can be used to provide services that might address a person's social service needs, like transportation needs or the need for healthy food. There are lots of reasons we saw these low investments, including a lack of understanding about how CCOs could use these services.
- We saw that CCOs had partnerships with community partners that could support work related to social determinants of health and equity. Some had more and some had less, and the types of partnerships (whether they had a formal contract, or worked on a shared plan together) varied.

- When we looked at health care access and health outcome data, we saw disparities, especially related to race/ethnicity. However, the data that we have on race/ethnicity has limitations.
- And, when we looked at the workforce, we saw that we need to know much more about how CCOs are using certain providers like traditional health workers (e.g. community health workers) and health care interpreters. Yet, we know that these type of workers can make a big difference in helping address the social determinants of health and equity.



- Based on these lessons learned, we are considering the following policy questions and policy options:
- How do we encourage CCO investment in social determinants of health and health equity?
    - In other words, how do we require or otherwise encourage CCOs to spend more of their funds in these areas?
- How do we ensure that CCOs have a culturally and linguistically competent workforce that reflects the population they serve?
- How do we strengthen CCO partnerships with community partners that support work in SDOH and equity?
- How can we improve our understanding and get better data around the social determinants of health and equity?

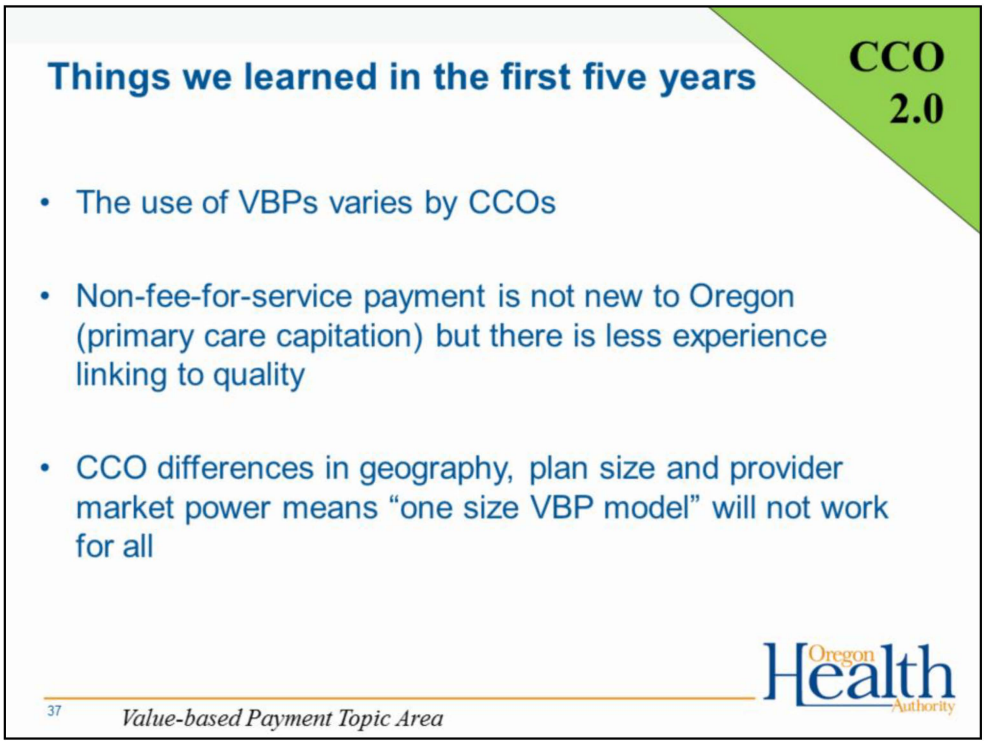


Most entities that pay for health care, such as health insurance companies, paid for health care using a model called "fee-for-service," which pays for each health care service, visit, or test a patient receives.

The goal of paying for performance or value-based payments is to move away from payments that are based solely on quantity of services delivered to payments that reward providers for improving quality of care and better health outcomes for the patients they see.

In other words, value-based payment is not just about moving away from fee-for-service payments, but it must also include a link to quality of care.

The Oregon Health Authority pays CCOs using a value-based payment model. Specifically, it pays CCOs a set amount of money—which we call a "global budget"—that gives CCOs flexibility to ensure their members receive the care they need. CCOs also receive financial rewards for providing high-quality health care to their members. These payments are tied to CCOs' performance on 17 incentive metrics.

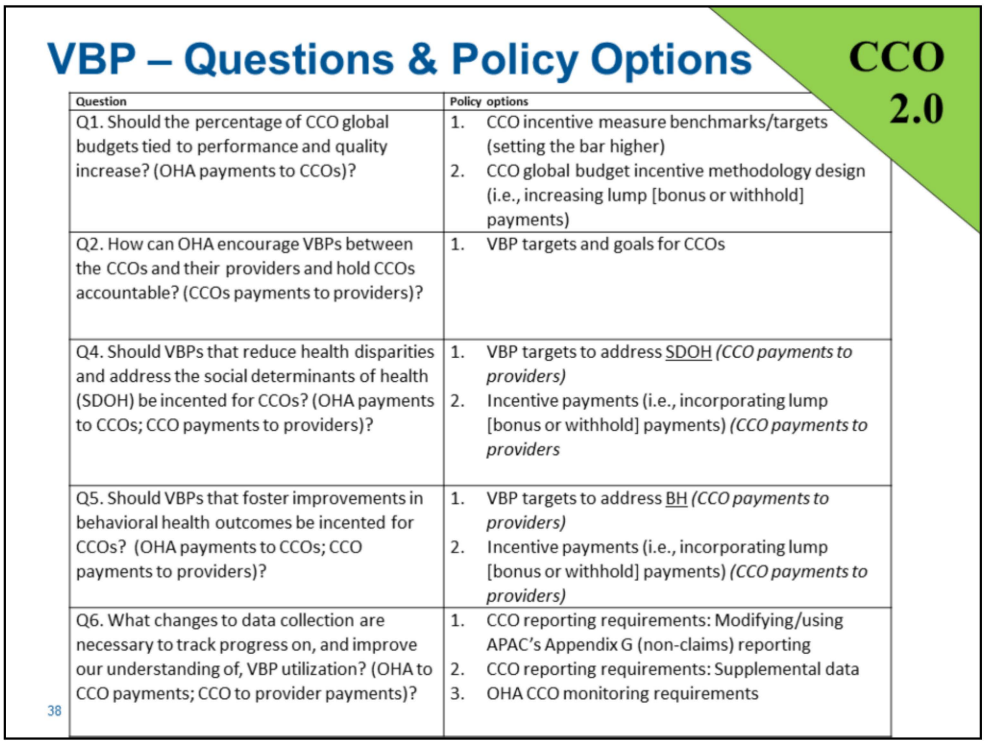


Value-based payments in Oregon's Medicaid program can exist at two different levels of Oregon's Medicaid program. First are payments from OHA to CCOs, the payment we refer to as a "global budget,' as I just explained. The second are payments between CCOs and their contracted health care providers.

Through information collected from CCOs over the first five years, we learned that all CCOs have non-fee-for-service arrangements with their providers. However, there is less experience linking these payments to quality of care, which would make them value-based payments.

Unique characteristics within CCOs, including differences in their geography, number of members, and provider market power means "one value-based payment model" will not work for all CCOs.

The goal of CCO 2.0 is to increase the degree to which value-based payments are used between CCOs and their providers, encouraging a health care delivery system that rewards quality and better health outcomes. We're also investigating ways to enhance the OHA to CCO value-based payment model.



The goal of CCO 2.0 is to increase the degree to which value-based payments are used between CCOs and their providers –for a health care delivery system that rewards quality and better health outcomes. We're also investigating ways to enhance the OHA to CCO value-based payment model.

Specific questions that are being considered as part of CCO 2.0 include:

- Should the percentage of CCO global budgets tied to performance and quality increase? (OHA payments to CCOs)?

For these next two questions, note that OHA is in the process of developing a "value-based payment Roadmap," which is a requirement of our 1115 Medicaid waiver, that will include value-based payment targets for CCOs. This Roadmap will be folded into the CCO 2.0 process.

- How can OHA encourage VBPs between the CCOs and their providers and hold CCOs accountable? (CCOs payments to providers)?
- Should VBPs that reduce health disparities and address the social determinants of health (SDOH), and foster improvements in behavioral health outcomes be incented for CCOs? (OHA payments to CCOs; CCO payments to providers)?

And Finally,

- What changes to data collection are necessary to track progress on, and improve our understanding of, VBP utilization?

Sustainable Spending & Cost Containment

CCO 2.0

- Ensuring the fiscal sustainability of the Oregon Health Plan is critical to Oregon's efforts to make sure that Oregonians have access to high quality health care services they need.

- The Coordinated Care Model aims to control health care spending NOT by reducing access to health care services, but instead by investing in primary care, paying for value, and improving health outcomes to reduce health care costs in the long run.

CCO 2.0

Cost growth is a challenge

- The nation spent $3.3 trillion on health care in 2016, or more than $10,000 per person.
- We have reduced the growth in health care spending in Oregon, but we need to continue this trend with focus on:
  - containing prescription drug spending,
  - holding CCOs financially accountable
  - adjusting financial incentives to reward CCOs for improving quality over quantity.

- Oregon's sustainable spending targets provide an important tool to help the state and its CCO partners control annual spending growth.
- CCO flexibility within constraints from global spending limits provide incentives for CCOs and providers to be innovative in care delivery while information sharing and technical assistance from the State helps spread effective CCO practices and reduce costs while maintaining robust access to health care services for members.
- Incentive payments based on CCO performance help motivate CCOs and their provider partners to achieve performance goals that indicate better quality care and patient health outcomes.
- Increased investment in primary care services help improve care for patients while reducing costs to the health care system – as indicated by ROI calculations for Oregon's patient centered primary care homes.

Cost – Questions& Policy Options

CCO 2.0

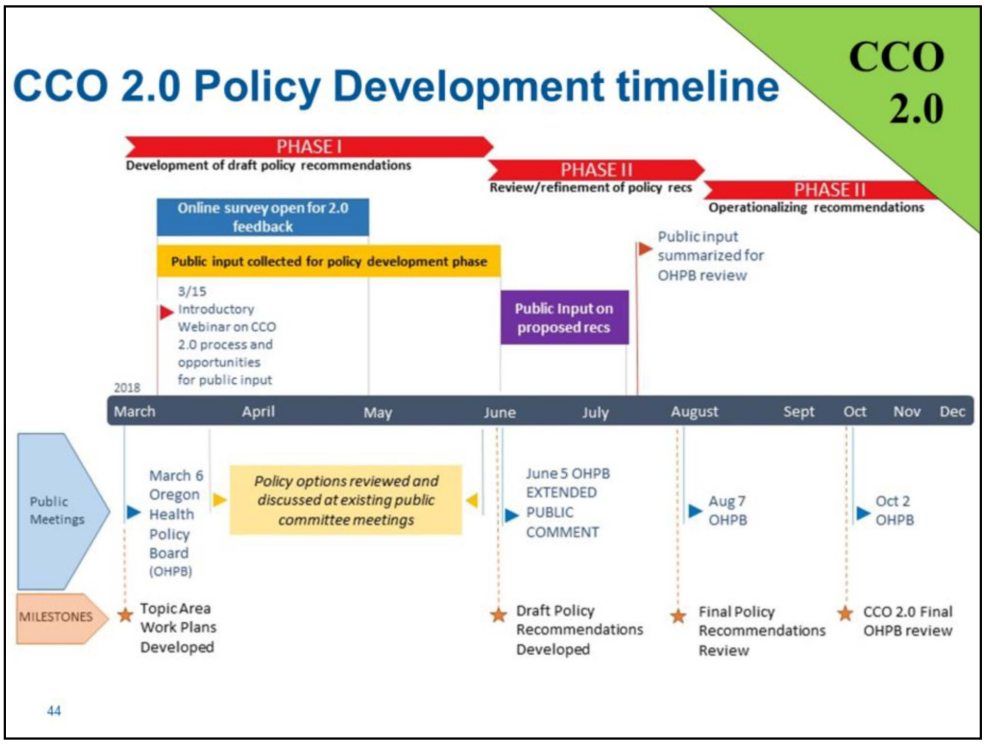
Questions	Policy Options
Is 3.4% still the right target for the entirety of the CCO contract period?	**#1** Evaluation of 3.4% Sustainable Growth Rate Target and Ongoing Review
What cost drivers threaten continued achievement of sustainable growth (3.4%) in future years?	**#2** Evaluate Cost Drivers and Propose Cost Containment Strategies for CCO 2.0
What cost drivers warrant additional analysis & focus to help OHA and CCO partners continue to meet Legislative and waiver-driven growth targets?	**#3** Driving cost containment & sustainability in CCO 2.0
	#4 Explore a reimbursement threshold (Min/Max)
What strategies could OHA pursue to increase CCO financial accountability while preserving adequate CCO flexibility to operate within global budget?	**#5** Improve encounter data requirements and validation
	#6 Improve financial oversight and reporting requirements
	#7 Evaluate & adjust requirements related to solvency, reserves and capacity
	#8 Explore revisions to the medical cost definition
	#9 Review & modify quality pool structure & funding
	#10 Create payment structure that aligns with and promotes policy goals of CCO 2.0 (i.e. SDoH investment, etc.)
	#11 Develop program-wide strategies to manage risk and high/outlier costs
	#12 Develop a process to build a variable profit margin in the CCO rates based on efficiency and quality
	#13 Move to two-year rebasing for rate development

42

Based on these lessons learned, we are considering the following policy questions and policy options.

How can you get involved?

Oregon Health Authority



We are dividing this work into three phases.

Phase 1 will focus on the development of draft policy recommendations. This is the phase where we will be exploring and investigating policy options to better understand if they work for Oregon and for CCOs. This is also the time for you to bring forward any ideas you have about how to improve CCOs in the future. We want to make sure we have plenty of time to discuss and learn along the way. Some of the opportunities for public input during this phase include:

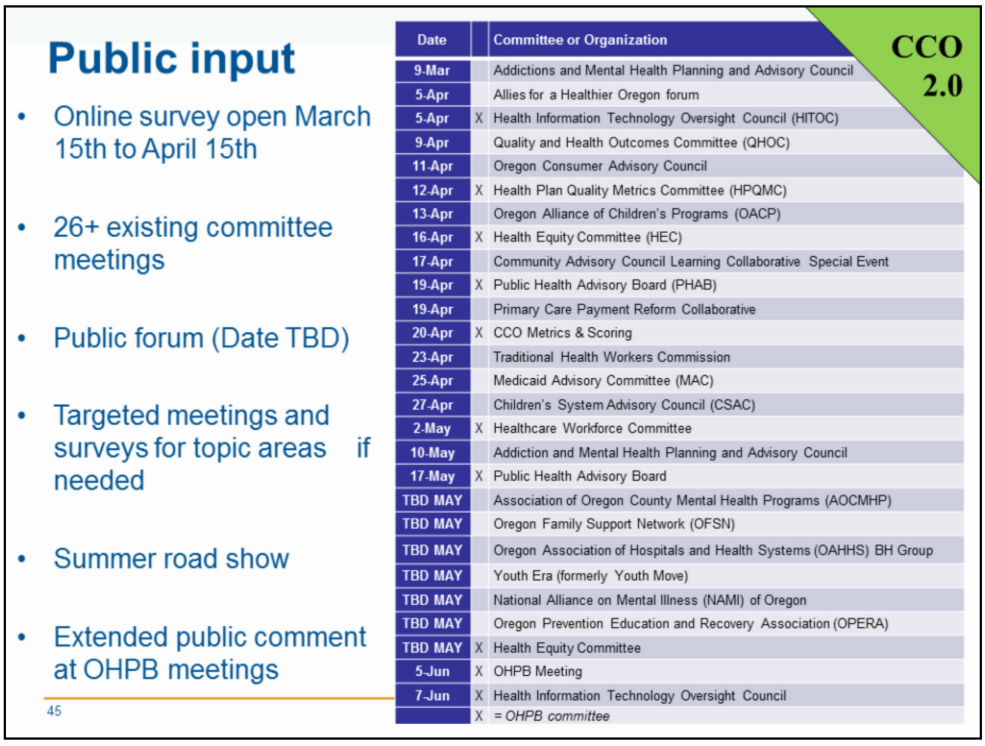
- Taking the survey
- Attending one of the committee meetings
- Participating in a public forum (date to be announced)
- Emailing us your ideas at CCO2.0@state.or.us
- Attending an OHPB meeting and providing public testimony
- Inviting OHA/OHPB to come speak at your event

Phase 2 will focus on reviewing and refining the policy ideas and recommendations. A straw model (early first draft) of the recommendations

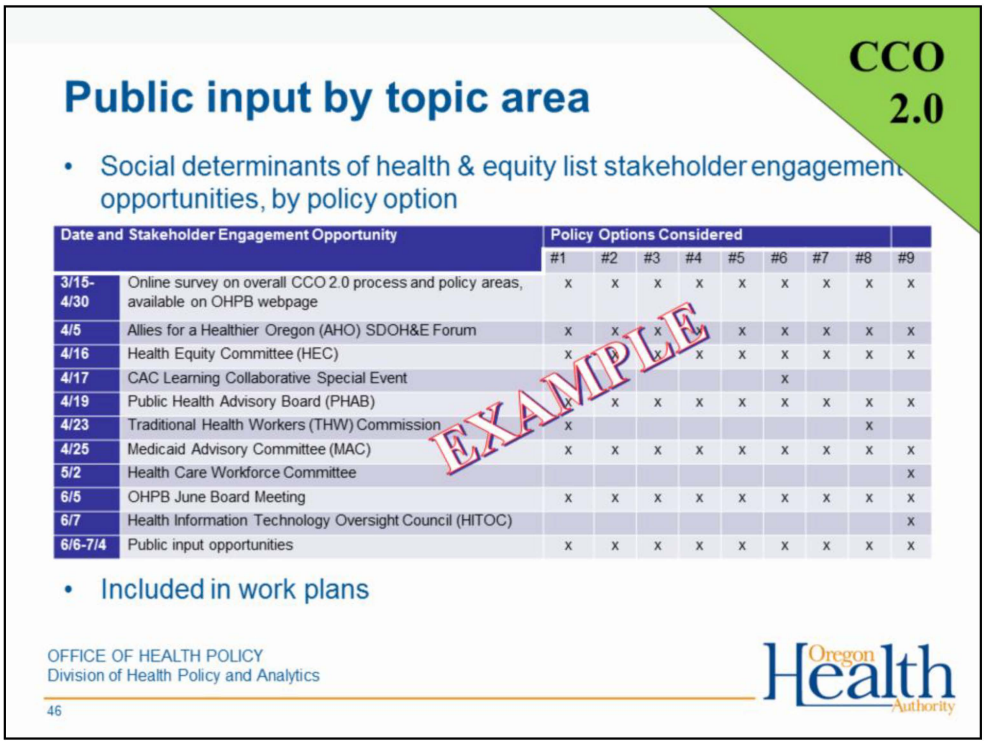
that have been explored in the first phase will be shared at the OHPB meeting in June. Opportunities for public input during this phase include:

- Taking another survey
- Attending a road show event, which will be held around the state during the last two weeks of June
- Emailing us feedback at CCO2.0@state.or.us
- Attending an OHPB meeting and providing public testimony

Phase 3 will focus on operationalizing and finalizing the recommendations. This stage will likely incorporate more than just CCO recommendations, and will also provide context as to how OHA will implement any of the anticipated changes.



This provides a glimpse into the public meeting schedule that you can follow online at our website.



Date and	Stakeholder Engagement Opportunity	Policy Options Considered								
		#1	#2	#3	#4	#5	#6	#7	#8	#9
3/15-4/30	Online survey on overall CCO 2.0 process and policy areas, available on OHPB webpage	x	x	x	x	x	x	x	x	x
4/5	Allies for a Healthier Oregon (AHO) SDOH&E Forum	x	x	x	x	x	x	x	x	x
4/16	Health Equity Committee (HEC)	x	x	x	x	x	x	x	x	x
4/17	CAC Learning Collaborative Special Event						x			
4/19	Public Health Advisory Board (PHAB)	x	x	x	x	x	x	x	x	x
4/23	Traditional Health Workers (THW) Commission	x							x	
4/25	Medicaid Advisory Committee (MAC)	x	x	x	x	x	x	x	x	x
5/2	Health Care Workforce Committee									x
6/5	OHPB June Board Meeting	x	x	x	x	x	x	x	x	x
6/7	Health Information Technology Oversight Council (HITOC)									x
6/6-7/4	Public input opportunities	x	x	x	x	x	x	x	x	x

This slide explains how to track specific policy options.

Each topic area is looking at specific policy options. In the example here, the social determinants of health and equity topic area is currently exploring 9 policy options. We built this table into each of the work plans so you can see where each of the policy options will be discussed. For example, if you wanted to hear the discussion on policy option 5, you would realize that you don't need to attend the May 2nd Health Care Workforce Committee meeting as it will NOT be discussed at that meeting.

CCO 2.0

Online survey

- Open from March 15 to April 15 to the general public
- Goal: include feedback during policy development phase from anyone interested without requiring attendance at a meeting
- Format:
  - Mostly multiple choice
  - 3-5 general questions
  - 2-3 questions per topic area
  - Open-ended opportunity for general feedback, suggestions and ideas

Oregon Health Authority

CCO 2.0

Key links

- CCO 2.0 webpage:
  - http://www.oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx
- Public meetings schedule:
  - http://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-meetings.aspx
- Please take our survey!
- More questions? Email CCO2.0@state.or.us

Oregon Health Authority

CCO 2.0

Thank you!

Oregon Health Authority