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

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

#	Time	Item	Presenter	Purpose
1	8:30	Welcome, Minutes Approval, Calendar Review	Zeke Smith, Chair	Action
2	8:40	Public Testimony		
3	9:00	OHA Report	Pat Allen, OHA Director	Informational & Discussion
4	9:10	CCO 2.0: CCO 1.0 & Health System Transformation CCO 2.0: Procurement	Jeremy Vandehey, OHA Director Health Policy & Analytics	Discussion
5	9:35	CCO 2.0: Input Process & Themes	Stephanie Jarem, OHA, Policy Analyst	Discussion & Update
6	10:15	Break		
7	10:20	CCO 2.0: Impact Framework	Stephanie Jarem, OHA, Policy Analyst	Informational
6	10:30	CCO 2.0: Impact and Analysis	Chris DeMars, OHA Transformation Center Director Leann Johnson, OHA Office of Equity and Inclusion Director Chelsea Guest, OHA Actuarial Unit Manager Mike Morris, OHA Behavioral Health Administrator	Discussion
10	11:45	CCO 2.0: Final Report Framework & Reflections	Chair Smith	Discussion
12	12:00	Adjourn		

Next meeting:
August 7, 2018

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DRAFT June 5, 2018
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Item	
OHPB video and audio recording To view the video, or listen to the audio link, of the OHPB meeting in its entirety click here. Agenda items can be reviewed at time stamp listed in the column below.	
Welcome and Call To Order, Chair Zeke Smith Present: Board members present: Chair Zeke Smith, Vice-Chair Carla McKelvey, David Bangsberg, Brenda Johnson, John Santa The Board voted to approve the May minutes.	
OHA Report: Reorganization, Jeremy Vandehey, OHA Jeremy gave a brief update on the re-org and a few changes within the agency. One change was to the name of Dana Hargunani's group. It is now known as the Delivery System Innovation group, another change is the creation of a Deputy Director position for Behavioral Health Division. All members present voted to approve the reorganization.	Part 1 00:20:59
CCO 2.0: Behavioral Health Policy Option Review Session, Mike Morris, OHA, Jackie Fabric, OHA Mike Morris and Jackie Fabrick gave an overview of the work being done in Behavioral Health and how it connects with CCO 2.0. The Board requested more information regarding the sequencing and modeling of some recommendations. They discussed how to operationalize and ensure contract enforcement vs. new contract requirements.	Part 1 00:38:20
CCO 2.0: SDOH and Health Equity Policy Option Review Session, Chris DeMars, OHA, Leann Johnson, OHA, Amanda Peden, OHA Chris, Leann and Amanda gave an overview of how the work they are doing connects to CCO 2.0. The Board discussed CCO spending on medical services, health related service and what is needed to "push transformation" in a viable manner. The Board also discussed the need for clear expectations, actions, and connections to	Part 1 01:42:07

Oregon Health Policy Board
DRAFT June 5, 2018
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resources as well appreciation for recommendations to improve utilization of traditional health workers.	
CCO 2.0: Cost Policy Option Review Session, Laura Robison, OHA, Chelsea Guest, OHA, Tim Sweeney, OHA Tim gave a brief overview of the policy development as it related to CCO 2.0 and cost and Chelsea discussed policy options. The Board asked that high cost drugs continue to be a priority and posed questions regarding CCO administrative costs and redundancy as well as appropriate risk adjustments. The Board also asked about factors unique to Oregon which drive costs as opposed to national trends and how total cost of care can be accounted for. The Board prioritized recommendations which increase transparency and monitoring and discussed parameters applied when a CCO service area changes as well as noting the importance of quality pool payments and cautioned against possible adverse impacts driven by changes to that program.	Part 2 00:00:17
CCO 2.0: VBP Policy Option Review Session, Chris DeMars, OHA, Lisa Krois, OHA, Zachary Goldman, OHA Chris gave an update on work being done on Value Based Payment and CCO 2.0. The Board discussed specialty care as a component of VBP design as well as network adequacy and spreading the VBP and the CCO model to broader markets. The Board noted the importance of telehealth and asked about growing the percent of CCO budgets driven by quality pool dollars.	Part 2 01:00:57
Health Plan Quality Metrics Committee: Measure Selection, Kristen Dillon, M.D., HPQMC Chair, Shaun Parkman, HPQMC Vice-Chair Kristen and Shaun gave an overview of the scope and charge of the Health Plan Quality Metrics Committee. They discussed the progress the committee has made and what is next for the committee. They presented the committees measure set for review and discussion by the Board and all members listed as present voted to approve the measures as presented.	Part 2 01:49:08
Public Testimony	Part 1

Jonathan Eames testified on behalf of OPERA representing in and out patient drug rehabilitation providers. He noted the association has submitted a letter for the Board's review and noted issues with rehabilitation workforce, behavioral health system funding, structural barriers to behavioral health investments and incentive metrics. Kevin Fitts testified about the OHA reorganization and asked that consumer voices be heard in policy development and service provision. He asked how consumer groups fit into behavioral health reorganization. Bruce Thompson spoke about the need for improved connections between public health and CCOs to address SDOH&HE. He asked why CCOs duplicate Community Health Assessments and formulate Community Health Improvement Plans which aren't aligned. He noted the need for strengthened and enhanced connections between public health and CCOs to meet the goals of the triple aim. Silas Halloran-Steiner from AOCMHP testified regarding the association's willingness to help identify solutions that meet community needs. He noted the roll of mental health providers and cited a letter submitted to the Board regarding recommendations for CCO 2.0, including working to eliminate carve outs around state hospital billing, contract and service agreement mandates, the USDOJ Performance Plan, prevention and promotion based investments and the importance of local control and flexibility. Ann Kasper testified about OHA's reorganization, she shared concerns about the behavioral health organization and noted the need for clear rolls and accountabilities. She shared concerns about Unity Behavioral Health Center and asked that consumer voices be elevated. She noted the need for less people in Unity rooms and concerns with prescription adherence and sexual assault. She noted issues with language access at the state hospital, specifically Somali and relayed issues with consumer and family care. She noted the need for improved refugee care. Kaha Mohomed testified about her daughter's care at the state hospital. She noted appreciation for the care team directing her daughter's treatment. She noted issues with reaching her daughter by telephone and language barriers.	00:03:49 & 01:42:07

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Adjourn

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2018 OHPB CALENDAR

DRAFT

Updated 7/3/18

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

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

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
August 7, 2018	• Workforce Composition Promising Strategies & Presentation on Evaluation of Health Provider Incentives • High Cost Drugs • CCO 2.0 Development	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Hospital Financial Report	Workforce Financial Incentives Evaluation Report, due to interim health committees of the Leg. Assembly every 2 years, first due Sep. 2018. OHA report to OHPB re: Status of Doulas in Oregon Sep. 2018
September 11, 2018	• Action Plan for Health update • CCO 2.0 Finalization	• Engage stakeholders and community partners • Measure progress	-WF composition report	
October 2, 2018 **OUT OF AREA MEETING: HOOD RIVER (tentative)**	• Workforce Provider Incentive Program Update • Engaging Stakeholders & Partners Discussion • CCO 2.0 Finalization	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Oregon Health Insurance Survey Fact Sheets	
November 6, 2018	• Behavioral Health Collaborative Report • Primary Care Collaborative Update	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		Primary Care Collaborative Report

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

OHPB Committee Digest

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

Public Health Advisory Board

The PHAB has provided content and input on OHA's Public Health Modernization Report, which OHA will submit to Legislative Fiscal Office by June 30, 2018. This report includes the 2019-21 local public health authority funding formula which PHAB has been working on for the last six months. The PHAB adopted minor changes to the active transportation accountability measure.
The PHAB is continuing to hear from each of the eight regions funded by the 2017-19 public health modernization investment to gain a better understanding of the systems changes underway to improve communicable disease control and address communicable disease-related health disparities.

COMMITTEE WEB SITE: https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx
STAFF POC: Kati Moseley, Katarina.Moseley@dhsoha.state.or.us

Behavioral Health Collaborative

OHA, in partnership with a diverse group of stakeholders, will launch an RBHC in the Metro Portland tri-county area. OHA has convened a small group of stakeholders to meet several times over the summer to plan for the September launch. The planning group includes Health Share CCO, BH Directors from the three counties, child and adult providers, consumers, peers, and culturally specific organizations.

Communication detailing this work has been sent to the BHC participants and workgroups and OHPB and committees.

OHA and stakeholders are exploring risk sharing options for the OSH civil commitment population to be incorporated into the 2020 CCO contracts. Work to identify possible models will take place over the summer with financial modeling to take place in the fall and winter.

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

Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative convened on April 19, 2018. Agenda topics of note included: review of the work plan and timeline for developing Primary Care Transformation Initiative implementation strategy from the Collaborative; *Primary Care Spending Report in Oregon* presentation followed by a discussion about how the report can inform the Primary Care Transformation Initiative;

CCO 2.0 value-based payment and behavioral health presentation and discussion; and presentation on three options for evaluating the Primary Care Transformation Initiative followed by small group discussion. In May and June the workgroups will convene to draft a proposed Initiative implementation strategy for Collaborative review and discussion at the July meeting.

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

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

Healthcare Workforce Committee

The Healthcare Workforce Committee met on May 2. Key items of activity include:

CCO 2.0
Most of the May meeting was spent hearing from OHA staff on policy options related to CCO 2.0. Based on information shared and discussion, the Committee sent a letter to Pat Allen and Zeke Smith offering the recommendation that in the procurement process to determine who will serve as CCOs, applicants be required to include plans for:

- Developing the healthcare workforce pipeline for their areas;
- Participating in and facilitating the current and future training for the health professional workforce in their areas;
- Supporting health professionals following their initial training; and
- Encouraging local talent to return to their home areas to practice medical, oral and/or behavioral health.

The Committee also recommended that ongoing reporting requirements for those that become CCOs include reports on the capacity and diversity of the medical, oral and behavioral health workforce within their geographical area and network.

Increasing the Diversity of the Healthcare Workforce
The Committee has begun to consider promising solutions for increasing the diversity of the healthcare workforce, and has formed a workgroup that includes the involvement of the Health Equity Committee. The Committee will send a report later this year to the Board on this topic.

Behavioral Health Workforce
Members of the Committee are working with OHA staff to present a response to the Farley Center on the skills and competencies required for the behavioral health workforce of the future.

Upcoming Meeting and Work
The next meeting of the Committee will take place on July 11. At that time there will be continued discussion of strategies to increase the diversity of the healthcare workforce, a presentation on labor market needs and trends from the Employment Department on the healthcare workforce. Also, committee leadership and OHA staff are continuing to work with the Oregon Medical Board on license renewal surveys, and OHA is working with Oregon Health and Science University to support the launch

of the HOW-TO Program, to provide training grants to increase the supply and diversity of the healthcare workforce in Oregon.

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

Health Plan Quality Metrics Committee

The Health Plan Quality Metrics Committee (HPQMC) presented to the Oregon Health Policy Board on June 5th with a progress report on the committee's work to date. This included an overview of the finalized measure set of 51 quality measures across six domains, potential gaps in the measures menu, and plans for future work.

The Committee acknowledged that the current measure menu is heavily concentrated in prevention and early detection, with fewer measures addressing specialty care and health system integration and transformation. Other areas the Committee identified for near term focus include health equity, access to telehealth and other alternatives to face-to-face visits, obesity and upstream influences, and behavioral health. The aligned measure set is available online.

At the June 14th regular meeting, the committee reelected Committee Chair, Kristen Dillon, MD, and Committee Vice-chair, Shaun Parkman, for another one-year term. Also at this meeting, the committee debriefed Year 1 processes and outcomes and began planning for future work to refine the measures menu.

The committee next meets on Thursday August 9, 2018 by webinar only.

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

Metrics & Scoring Committee

In June the Metrics and Scoring Committee heard a presentation on statewide areas for quality improvement, and continued discussions on selecting the 2019 CCO incentive measure set. These discussions included reviewing feedback from a survey of the CCO metrics Technical Advisory Group, comprised of representatives of the CCOs and other partners, and discussion of OHA staff recommendations. The Committee will make final decisions on the 2019 measure set at its next meeting on July 20th.

In addition, the final report on CCO incentive measure program performance for 2017 was published on 26 June, and is available here: https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/2017-CCO-Metrics-Report.pdf. The Committee will review this report at its July meeting.

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

Health Information Technology Oversight Council

HITOC's June meeting featured discussion of CCO 2.0 policy options from the value-based payment and behavioral health workgroups and revisited the HIT policy options being developed for CCO 2.0. HITOC will sponsor a series of public meetings to get input on the HIT policy options beginning on June 27th. HITOC also approved the charter for the network of networks advisory group, which will begin foundational work to support statewide health information exchange, and discussed a proposed federal rule that would change elements of the CMS Meaningful Use Program. HITOC's next meeting is on August 2nd.

Meeting schedules, information, and materials are available online at https://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/HITOC-Meetings.aspx.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/OHIT-HITOC/
Committee POC: Francie Nevill, Francie.j.nevill@dhsoha.state.or.us

Medicaid Advisory Committee

On May 31, 2018, the MAC submitted to the OHA a second set of recommendations aimed at how OHA can support and hold CCOs accountable for addressing the social determinants of health, in line with the committee's recommendations.

The next work product of the MAC will be a housing-specific guide on health-related services, to be developed in collaboration with OHA. The MAC will be working with OHA to develop a guide that builds on feedback from the Statewide Supportive Housing Strategy Workgroup, its survey, and follow up interviews with CCOs regarding work in the social determinants of health, and the evidence base around housing and health.

The MAC released a recruitment announcement in June to replace several members whose terms expire in 2019 or fill existing vacancies. The application deadline for interested individuals is August 15th. Specifically, OHA and the Governor's office are seeking people with the following backgrounds or qualifications:

- Individuals from all parts of the state and from diverse backgrounds, including people of color, LGBTQ individuals, women, and people with disabilities
- Individuals covered by the Oregon Health Plan (OHP), including one OHP member with a disability
- Members of health care consumer groups that include Medicaid recipients such as a coordinated care organization (CCO) consumer advisory group (CAC)
- A member of one of Oregon's federally recognized tribes
- Persons associated with health care organizations, including providers of all types, but especially behavioral health and traditional health workers (like community health workers)
- Members of the general public

The recruitment announcement can be found here: https://www.oregon.gov/oha/HPA/HP/Documents/MAC%20Recruitment%20notice__June2018.pdf

COMMITTEE WEBSITE: http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx
COMMITTEE POC: Tim Sweeney, Timothy.D.Sweeney@dhsoha.state.or.us

Health Equity Committee

HEC Feedback to OHA and OHPB on CCO 2.0

The Committee had the opportunity to provide direct feedback during the month of June to the Social Determinants of Health and Health Equity and Behavioral Health policy workgroups. On June 13th, co-chairs Michael Anderson-Nathe and Carly Hood-Ronick submitted feedback on behalf of the committee to Director Allen and Chair Smith in both areas. Health Equity Committee feedback can be found here: https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

Committee Governance
During the June meeting, the Committee had a chance to hear back from workgroups on the work done to date:

#1 Recruitment
This workgroup asked for a copy of the strengths and demographics of current committee members to determine gaps that may need to be filled. OEI indicated they could send application information from those who had previously applied to the workgroup for recruiting.

#2 Strategic Plan Development/Work plan
This group shared a draft of the workplan template they are developing and options for supporting workgroups in developing plans for HEC work in 2019. They planned to meet with co-chairs outside of meeting time to discuss.

#3 Policy and Advocacy
No updates at this time – group has not developed yet.

#4 Data and Metrics
Carly Hood-Ronick and Michael Anderson-Nathe, HEC Co-Chairs indicated they will be meeting with OHA to discuss this soon. Derick Du Vivier, MD., HEC member, will support this workgroup as well.

#5 Training and Technical Assistance – One committee member indicated interest in this workgroup but no updates were shared in June.

Additionally, the co-chairs shared a set of deliverables they hope to focus on for the remainder of the year to ensure the committee is well-positioned for the new year. These include: ongoing feedback/engagement with CCO 2.0; fully filling the HEC committee seats; and ensuring all workgroups have a dedicated workplan for 2019.

July's meeting will include an educational component on REAL-D status.

COMMITTEE WEBSITE: https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

COMMITTEE POC: Maria Castro, Maria.Castro@dhsoha.state.or.us

Statewide Supportive Housing Strategy Workgroup

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

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

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

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

Measuring Success Committee

At the June 6th Measuring Success meeting, the committee continued its discussion of long-term outcomes and measures for an Early Learning System dashboard. Toward that effort, members heard a presentation from OHA regarding the health system's role in kindergarten readiness. A variety of OHA metrics were reviewed that pertained to early childhood, the strategy for OHA creating a CCO incentive measure on the health aspects of kindergarten readiness was discussed, and the concept and measurement of a health complexity measure were presented. The committee will continue the task of identifying final and intermediate outcomes and measures for an ELS dashboard at its next meeting on August 1st.

COMMITTEE WEBSITE: N/A
COMMITTEE POC: Thomas George, Thomas.George@state.or.us

CCO 2.0 Policy Development
Feasibility & Impact Analysis
Oregon Health Policy Board meeting 7/10/18

Topic Areas and Proposed Goals

Governor Brown asked the Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) to provide recommendations for the next phase of health system transformation (CCO 2.0) in four areas:

- Maintain sustainable cost growth
- Increase value-based payment and pay for performance
- Focus on the social determinants of health and equity
- Improve the behavioral health system

To date (September 2017 to June 2018), the policy work has focused on these four topic areas. In June 2018, the OHPB asked that OHA consider the overlapping themes and the broader goals of the coordinated care model, in an effort to better define the expectations of future CCOs.

One of the basic principles of the policy development process has been to build on the foundation that has been set thus far in Oregon's health system transformation. OHA's policy team utilized and refined the six strategic goals for the coordinated care model (CCM) first developed in 2012, while taking into account the four priorities of the governor and the potential opportunities for improvement in the future.

By transitioning to the larger goals of the overall model, the work moving forward can also more accurately capture policy opportunities in areas beyond the Governor's priorities that support improved health and health care, such as oral health and the healthcare workforce.

The six goals of the Coordinated Care Model include:

1. Partnering with communities to support health and health equity
2. Providing equitable, patient-centered care
3. Measuring performance and efficiency
4. Paying for outcomes and value
5. Financial sustainability and strategic investment (sustainable rate of growth)
6. Transparency and accountability in price and quality

To note: The Coordinated Care Model (CCM), as referenced above, provides the general structure and goals for overall health system transformation. These goals could be applied across the entire system and are not exclusive to Coordinated Care Organizations (CCOs).

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments
SDOH = Social determinants of health HIT = health information technology OH = Oral health

Analysis Process

Policy options that were presented at the June 5, 2018 Oregon Health Policy Board (OHPB) meeting were first assessed by policy subject matter experts on the following criteria:

- whether the policy was fulfilling a state or federal requirement;
- connection to other policies and topic areas;
- inclusion in current contract;
- if legislation would be needed;
- any additional development needed;
- potential to reduce health disparities;
- whether the policy corrected a process or identified an outcome;
- potential impact on health system, OHA, and provider costs;
- impact on procurement process;
- risks; and,
- timelines.

That information was then broadly utilized to estimate overall:

Feasibility – In general, how heavy is the "lift" for this this policy across the system?

	Generally easy/straightforward to implement, little to no additional work or resources required; is already part of the plan/expectation
	Requires moderate increase in staff time, resources, development, or funding; could face some challenges
	Will be a challenge to implement and will require new resources (e.g., funding, staff time, significant development, workgroups, etc.)

Impact – In general, how much does this policy move the needle in achieving the goals of the model?

	Plays a supporting role, offers some clarity or direction; will have a small impact on business practices
	Medium impact; policy will strengthen Oregon's direction and we'll see some type of effect across the state
	Fundamental to moving the needle in this area of the CCM, significant impact or transformational

Within each goal listed below, policies have been divided into:

1. Policies that are new concepts (i.e., new or different funding, programs, payment models, structures, etc.)
2. Policies that build on and strengthen current concepts (i.e., further clarity in contracts, increased accountability, spreading best practices, supporting and strengthening successful policies)

Note: Policies are NOT listed in priority order.

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

Goal #1: Partnering with communities to support health and health equity

When providers, payers, consumers and the community work together, improving health becomes a team effort. CCOs are part of a larger community focused on improving health and ensuring that everyone has a fair and just opportunity to be as healthy as possible. This goal focuses on leveraging partnerships and sharing responsibility for improving the overall community's health (including the social determinants of health).

Implementation of the policies below will likely impact members of the Oregon Health Plan (OHP) through system improvements like efforts to address the social determinants of health in their communities (e.g., transportation, education, housing, environment), shared community-wide alignment around needs and priorities, and strengthening the role and representation of the Community Advisory Council.

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
Policies that are new concepts				
1	*Implement HB 4018: Require CCOs to spend portion of savings on SDOH, population health policy and systems change & health equity/health disparities, consistent with the CCO community health improvement plan (CHP) a) Require CCOs to hold contracts with and direct portion of required SDOH&HE spending to SDOH partners through transparent process b) Require CCOs to designate role for CAC Years 1 & 2 infrastructure grants: State provide two years of "seed money" to help CCOs meet spending requirement on SDOHE in partnership with community SDOH and CHP providers *Consider:* Require one statewide priority – housing-related supports and services – in addition to community priority(ies)	SDOH / Health Equity	● ● ○	● ● ●
2	Require CCOs develop best practices to outreach to culturally specific populations, including development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs)	BH/OH	● ● ●	● ● ●

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
Policies that build on and strengthen current efforts				
3	Increase strategic spending by CCOs on health-related services by: a) Encouraging HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans and b) Requiring CCOs' HRS policies to include a role for the CAC in making decisions about how community benefit HRS investments are made.	SDOH / Health Equity	● ● ○	● ● ○
4	Encourage CCOs to share financial resources with non-clinical and public health providers for their contributions to incentive measures, through clarifying the intent that CCOs offer aligned incentives to both clinical AND non-clinical providers with quality pool measure areas • Encourage adoption of SDOH, health equity, and population health incentive measures to the Health Plan Quality Metrics Committee and Metrics & Scoring Committee for inclusion in the CCO quality pool	SDOH / Health Equity	● ● ○	● ● ○
5	Strengthen Community Advisory Council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers through the following: a) Require CCOs to align CAC member composition with demographics of Medicaid members in their communities, report to OHA, and explain barriers to and efforts to increase alignment; b) Require CCOs to align CAC member representation alignment with CHP priorities (e.g. public health, housing, etc.) and percentage of CAC comprised of OHP consumers, c) Require CCOs have two CAC representatives, at least one being an OHP consumer, on CCO board.	SDOH / Health Equity	● ● ○	● ● ○
6	Require each CCO to develop shared CHAs and shared CHP priorities and strategies with local public	SDOH / Health Equity	● ● ○	● ● ●

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments
SDOH = Social determinants of health HIT = health information technology OH = Oral health

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
	health authorities, non-profit hospitals, and with any CCO that shares a portion of its service area a) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need. b) Ensure CCOs include organizations that address the social determinants of health and health equity in the development of the CHA/CHP, including THWs affiliated with organizations listed under ORS 414.627.			
7	Shift financial role for statewide HIT public/private partnership from OHA to CCOs to cover their fair share	HIT	● ○ ○	● ● ●
8	Require CCOs utilize best practices to outreach to culturally specific populations (BH)	BH	● ● ●	● ● ●

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

Goal #2: Providing equitable, patient-centered care

The model is built on the use of evidence-based best practices to manage and coordinate care, centered around the patient and the patient's family. This includes concepts such as better integrated behavioral, physical, and oral health care that improves the patient's experience and outcomes and maximizes efficiency. Many of the policies below aim to support increased adoption of the best practices and experiences of CCOs during the first contracting period.

Oregon Health Plan members should see improved access to care, more streamlined communication between health care providers, additional standardization across providers and CCOs in some areas, and more structure around children's behavioral health.

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
Policies that are new concepts				
1	Develop an incentive program to support behavioral health providers' investments in electronic health records (Feasibility depends on 2019 legislative session	BH	● ○ ○ Or ● ● ●	● ● ●
2	*Identify, promote and expand programs that integrate primary care in behavioral health settings (Behavioral Health Homes)	BH	● ● ○	● ● ○
3	Clear ownership of BH benefit by the CCO	BH	● ● ○	● ● ○
4	Require CCOs to ensure a care coordinator is identified for individuals with Severe and Persistent Mental Illness (SPMI) and for children with Serious Emotional Disturbances (SED), and incorporate the following: • Develop standards for care coordination • Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD) • Establish outcome measure tool for Care Coordination Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD)	BH	● ● ○	● ● ○

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
5	CCOs identify plans for the medical, behavioral and oral health workforce including their efforts to: • Develop the healthcare workforce pipeline in their area; • Develop and support a diverse workforce who can provide culturally and linguistically appropriate care, with attention to marginalized populations • Ensure current workforce completes a cultural competency training in accordance with HB 2611 • Participate in and facilitate the current and future training for the health professional workforce in their area • Support health professionals following their initial training; and • Encourage local talent to return to their home areas to practice	Work-force	● ● ●	● ● ●
6	Require CCOs report on capacity and diversity of the medical, behavioral and oral health workforce within their geographical area and provider network. CCOs must monitor their provider network to ensure parity with their membership.	Work-force	● ○ ○	● ● ○
7	Require BH outcome measures or metrics for research based practices • Update OHAs recommended BH clinical practices • Incentivize use of BH best practices and emerging practices, including: ○ Development of a Train the Trainer investment in BH models of care ○ Supporting providers in utilizing ACEs score, outcome based tools and/or trauma screening tools to develop individual service and support plans	BH	● ● ○	● ● ○
8	Prioritize access to BH early intervention (0-5) and BH prevention services for children	BH	● ● ○	● ● ○

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
9	Develop incentives for CCOs to meet the complex health needs of children and young adults	BH	●●●	●●○
Policies that build on and strengthen current efforts				
10	Require CCOs support EHR adoption across behavioral, oral and physical health contracted providers	BH	●●○	●●○
11	Require CCOs ensure behavioral, oral and physical health contracted providers have access to technology that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications	BH	●●○	●●○
12	*Develop mechanism to assess network adequacy services across the continuum of care. Require CCOs ensure gaps in the continuum of care are addressed and that consumers have access to a diverse provider network	BH	●●●	●●●
13	System of Care to be fully implemented for the children's system	BH	●●○	●●●
14	Require Wraparound is available to all children and young adults who meet criteria	BH	●○○	●●○
15	CCOs, with the support of OHA, to incentivize providers to implement trauma informed care practices	BH	●●●	●●○
16	Continue CCO role in using HIT for patient engagement and link to health equity	BH	●●○	●●○
17	Standardize CCO coverage for telehealth services	BH	●○○	●●○
18	Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities by implementing the following: a) Require CCOs to adopt a Health Equity plan to institutionalize organizational commitment to health equity,	SDOH/ Health Equity	●○○	●●●

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments
SDOH = Social determinants of health HIT = health information technology OH = Oral health

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
	b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and c) Require an organization-wide cultural responsiveness and implicit bias training fundamentals training plan and timeline for implementation.			

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

Goal #3: Measuring performance and efficiency

Performance measurement that's consistent across health systems improves performance and accountability, while easing providers' reporting burden. Alignment also helps ensure more meaningful analysis across the system in areas like access, quality, patient satisfaction, service utilization and cost.

These policies should help Oregon Health Plan (OHP) members experience better quality of care and improved health by having providers and CCOs focus on improving efficiency, communication, and coordination of care, especially related to high-value services and outcomes.

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
Policies that are new concepts				
1	Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting	BH	● ● ●	● ● ○
2	*Evaluate efficiency and total costs of care to establish variable profit margins based on CCO performance	Cost	● ● ○	● ● ○
3	Report VBP data via All Payer All Claims (APAC) database, supplemental data and /or interviews and require complete encounter data with contract amounts and additional detail for VBP arrangements.	VBP	● ● ○	● ● ●
Policies that build on and strengthen current efforts				
4	Identify metrics to track milestones of BH and OH integration with physical health care by completing an active review of each CCOs plan to integrate services that incorporates a score for progress • OHA to refine definitions of BH and OH integration and add to the CCO contract • Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics	BH/OH	● ○ ○	● ● ●
5	* Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting	VBP	● ● ○	● ● ○

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

Goal #4: Paying for outcomes and value

Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. This method of reimbursing providers is referred to as "value-based payments" (VBPs). The goal of increased use of VBPs is to incentivize delivery system reform that focuses on *value* instead of volume of care delivered, *rewarding* providers for a combination of *high-quality care, positive member health outcomes* and *cost savings.*

Oregon Health Plan members who receive care from a provider being reimbursed through a VBP will likely notice improvements in their care that result in better health outcomes and overall patient experience.

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
Policies that are new concepts				
1	Develop payment methodologies to reimburse for warm handoffs, impromptu consultations and integrated care management services	BH	● ● ○	● ● ●
2	*Shift mental health residential benefit to CCOs	BH	● ● ●	● ● ○
3	*Assess capacity management of behavioral health residential settings	BH	● ● ○	● ● ○
4	Examine equality in behavioral health and physical health reimbursement	BH	● ● ○	● ● ●
5	Incentivize health care services with highest clinical value by rewarding their use in rate setting	COST	● ● ○	● ● ○
6	*Increase the portion of hospital payments that are based on quality and value • Incorporate quality and value measures in calculating reimbursement to hospitals (includes CCO and OHA directed payments).	COST	● ○ ○	● ● ○
7	Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development in order to: a) Align incentives for CCOs, providers, and communities to achieve quality metrics b) Create consistent reporting of all CCO expenses related to medical costs, incentive arrangements, and other	COST	● ● ○	● ● ○

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
	payments regardless of funding source (Quality Pool or global budget)			
8	Require CCOs to implement one VBP focused on these key care delivery focus areas and potentially develop more robust VBP requirements in later years: a) Primary care b) Behavioral health integration c) Oral health integration d) Specialty care e) Hospitals f) Children's health care g) Maternity care	VBP	● ● ●	● ● ●
9	*Require CCO-specific VBP targets in support of achieving a statewide VBP goal	VBP	● ● ●	● ● ●
Policies that build on and strengthen current efforts				
10	*Implement recommendations of the THW Commission, including the following: a) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for THW services b) Require CCOs to create a plan for integration and utilization of THWs. c) Require CCOs to integrate best practices for THW services in consultation with THW commission d) Require CCOs to designate a CCO liaison as a central contact for THWs e) Identify and include THW affiliated with organizations listed under ORS 414.627 (Note that d. is also included under Policy Option #30 for CHAs/CHIPs)	SDOH / Health Equity	● ● ○	● ● ●
11	Require CCOs to develop Patient-centered Primary Care Home VBPs (i.e., payments based on PCPCH tier level)	VBP	● ● ○	● ● ○

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments
SDOH = Social determinants of health HIT = health information technology OH = Oral health

Goal #5: Financial sustainability and strategic investment (sustainable rate of growth)

Bending the cost curve is a vital component of the coordinated care model – and one that strengthens all other principles. Part of bending the overall rate of growth is ensuring that CCOs are supported in remaining financially sustainable and that financial decisions are made strategically.

Notably, containing costs at the CCO or state level should not be achieved by cutting benefits to Oregon Health Plan members.

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
Policies that are new concepts				
1	Establish a statewide reinsurance pool for CCOs administered by OHA to spread the impact of low frequency, high cost conditions and treatments across entire program	COST	● ● ●	● ● ●
2	Address increasing pharmacy costs and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers, aligning CCO PDLs based on recommendations from outside analysis and additional OHA/OHPB guidance, and revising 340 b pricing to consider overall fiscal impact on system and not just 340b entities	COST	● ● ○	● ● ○
3	Enhance current financial reporting tools	COST	● ● ○	● ● ○
4	Create a statewide reserve pool in addition to CCO-specific reserve requirements in the event of an insolvency	COST		● ● ○
Policies that build on and strengthen current efforts				
5	Ongoing evaluation of Oregon's sustainable spending target based on national trends and emerging data and setting more aggressive targets in future years, potentially increase CCO	COST	● ● ○	● ○ ○

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
	accountability to target by adding provisions to contract			
6	Shared-savings arrangements for achievement of lower-than-targeted spending growth	COST	● ○ ○	● ○ ○
7	Expand / revise existing risk corridor programs	COST	● ○ ○	● ○ ○
8	Implement risk-sharing with the state hospital (Behavioral Health Collaborative recommendation)	BH	● ● ●	● ● ●

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments SDOH = Social determinants of health HIT = health information technology OH = Oral health

Goal #6: Transparency and accountability in price and quality

Data that are readily available, reliable, and clear helps patients and the public understand how their health plan functions. This goal incorporates better reporting around VBPs, community health assessments, costs and organizational structures.

With access to data, patients can be more engaged and share responsibility in their health care decisions.

#	Policy	Priority Area	How heavy is the lift?	How large of an impact?
Policies that are new concepts				
53	Publish CCO data on VBPs	VBP	● ● ○	● ● ○
Policies that build on and strengthen current efforts				
54	Require CCOs to submit their community health assessment (CHA) to OHA	SDOH / Health Equity	● ○ ○	● ○ ○
55	Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the Community Advisory Council connects to the CCO board	SDOH / Health Equity	● ○ ○	● ○ ○
54	*Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy (AZ Model) with financial implications	COST	● ○ ○	● ○ ○

*= Required policy BH = Behavioral health Cost = cost containment VBP = value-based payments
SDOH = Social determinants of health HIT = health information technology OH = Oral health

Oregon Health Policy Board

July 10, 2018

Agenda

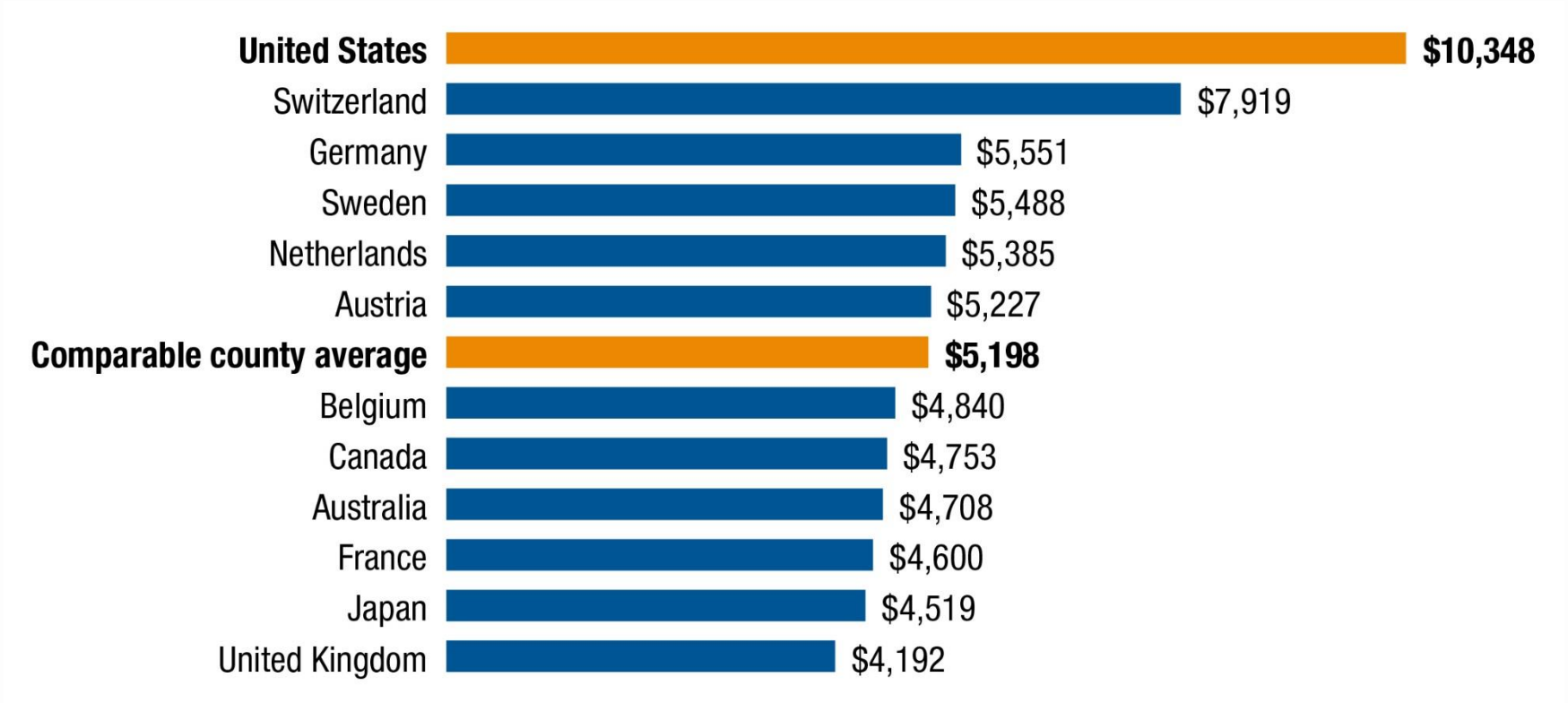
- CCO 1.0 and Health System Transformation
- CCO 2.0 Input Process & Themes
- CCO 2.0 Feasibility and Impact Analysis Framework
- CCO 2.0 Final Report Framework & Reflections

CCO 1.0 and Health System Transformation (HST)

The US spends **twice as much on health care** as other wealthy countries.

Total health expenditures per capita

U.S. dollars, PPP adjusted, 2016



Source: Source: U.S. data are from the 2016 National Health Expenditures Account. Comparable country data are from OECD (2017), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). DOI: 10.1787/health-data-en (Accessed on March 19, 2017)

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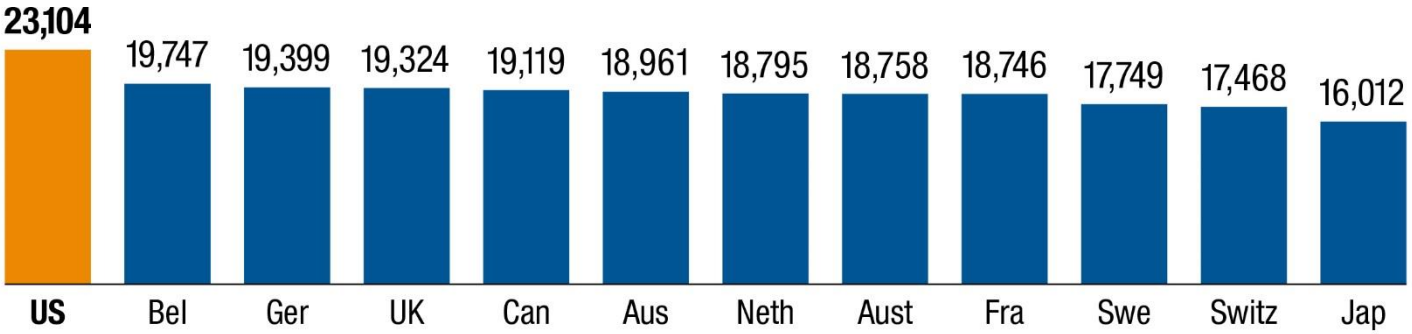
For all that spending…

We often don't get better outcomes and we aren't healthier.

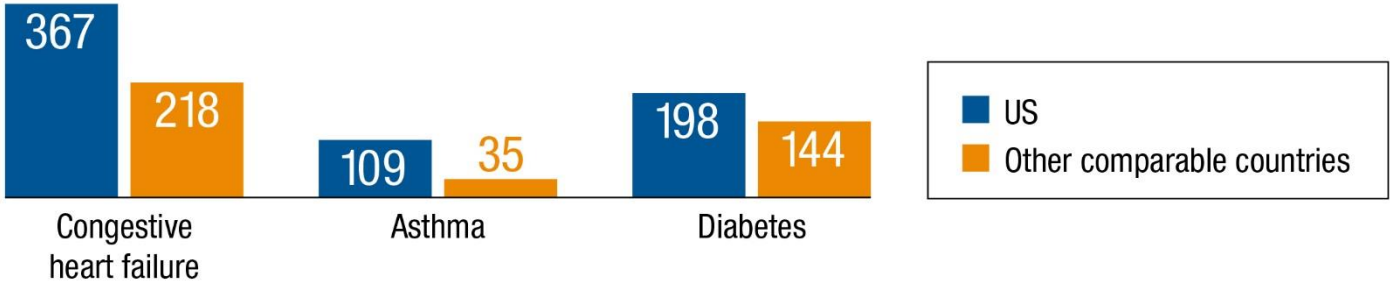
Disease burden is higher

Age standardized disability adjusted life year (DALY) rate per 100,000 population, 2015



Hospital admissions for preventable diseases are higher

Age standardized hospital admission rate per 100,000 population for asthma, congestive heart failure, hypertension, and diabetes, ages 15+, 2012



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Oregon's answer: Coordinated care organizations (CCOs)

2012: New CCOs replace fragmented system

OHA created CCOs to improve care delivery in the Oregon Health Plan.

- Improve health
- Reduce waste and costs
- Create local accountability
- Align financial incentives
- Pay for better quality and better health
- Coordinate care
- Maintain sustainable spending
- Measure performance

Oregon Health Authority

Goals of Oregon's Coordinated Care Model

Other aspects:

- Local
- Community-based
- Global budget
- Integration of care
- Flexibility

Oregon Health Authority

Health transformation results

1 Better health

CCO members who report better health: ↑13 percentage points
(59% to 72%, 2011–2015)

2 Better care

Avoidable ER use in Oregon: ↓50 percent
(2011–2016)

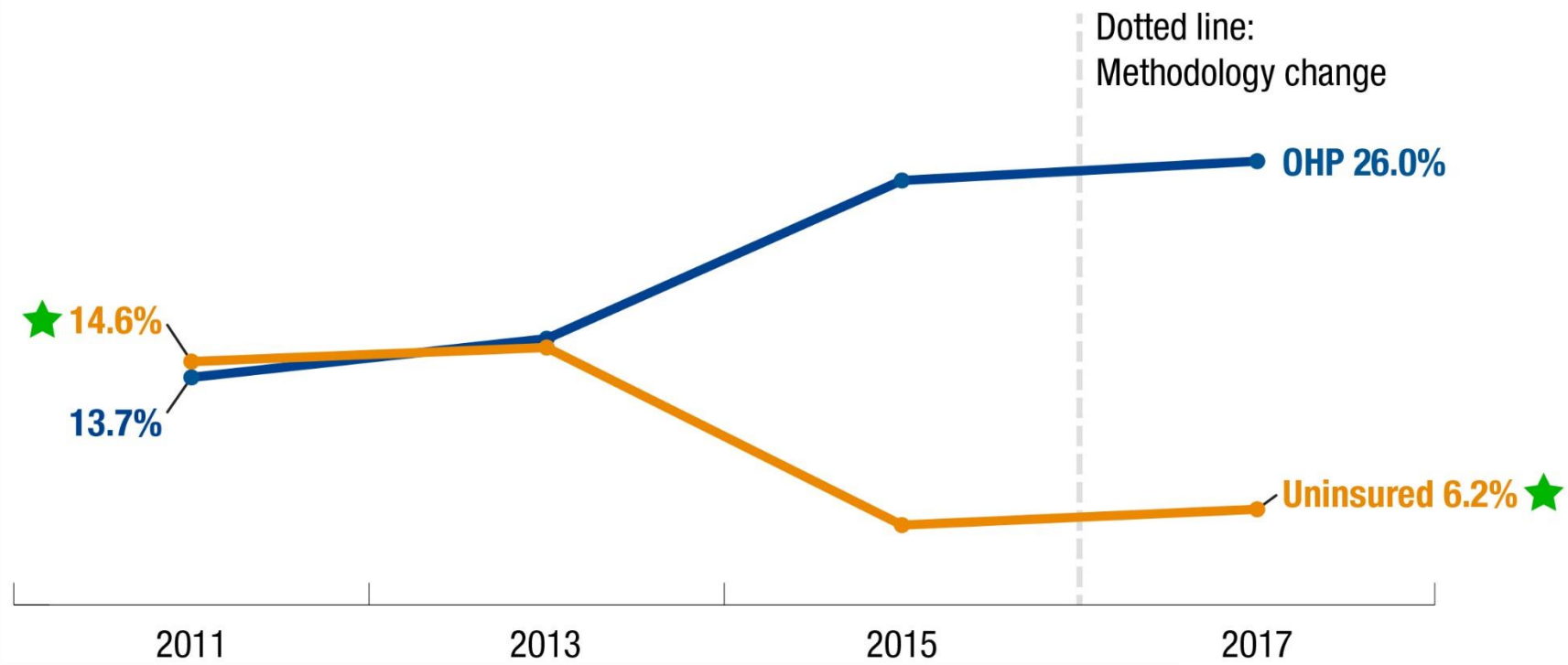
3 Lower costs

Taxpayers save: $2.2 billion
(2012–2017)

Authority

Success: Expanded coverage

The percent of Oregonians without insurance dropped ten percentage points with the ACA expansion (that's about 400,000 people)



Looking ahead: Challenges and opportunities

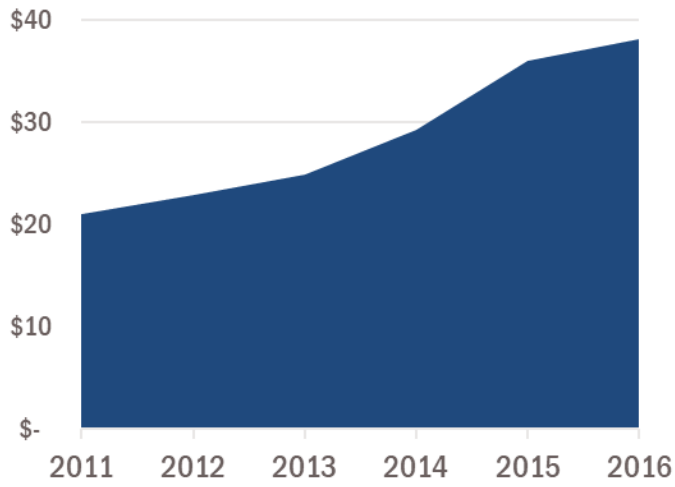
The nation spent **$3.3 trillion** on health care in 2016, or **more than $10,000 per person**.

We have reduced the growth in Medicaid spending in Oregon, but there's more work to do:

- Health care still unaffordable for many.
- Disparities persist.
- Rising prescription drug spending (see graph on right).
- Still mostly paying for quantity regardless of quality.
- Expand focus to transformation in other markets.

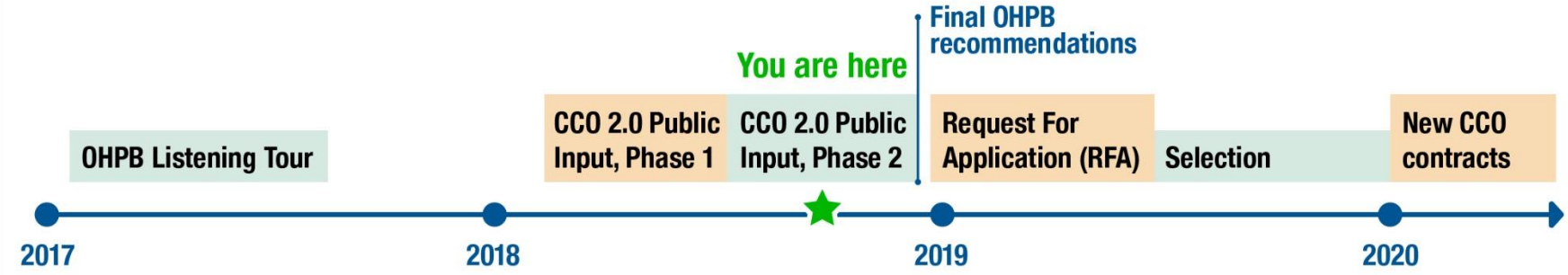
Pharmacy expenditures

All Payer All Claims, figures in $ billions



Authority

CCO 2.0 timeline



CCOs will be selected through a Request for Application (RFA) process

- Only current CCOs and companies with an existing Oregon “footprint” can apply
- Considering asking applicants to apply for regions with an option for current CCOs to apply for their current service area

Oregon Health Authority

CCO 2.0 Input Process & Themes

How is public input used?

Public input and feedback helps OHA/OHPB understand:

- What is working in CCOs and should remain
- What isn't working and needs improvement
- New ideas that should be considered
- How issues should be prioritized

Public input can be reflected in contract language, and can also impact OHA business practices or a long-term vision of CCOs

CCO 2.0 Public Forums and Road Show

Engaging communities in the future of the Oregon Health Plan (Road Show)

CCO 2.0 public input opportunities to date

In-person

- Discussion at 25+ health committee meetings
- Oregon Health Policy Board meeting updates/public testimony
- Presentations at 20+ conferences and meetings
- 2 formal tribal consultations
- 13 Community Advisory Council meetings, hosted by IAs
- April/May public forums (4 events)
- June road show (10 locations)

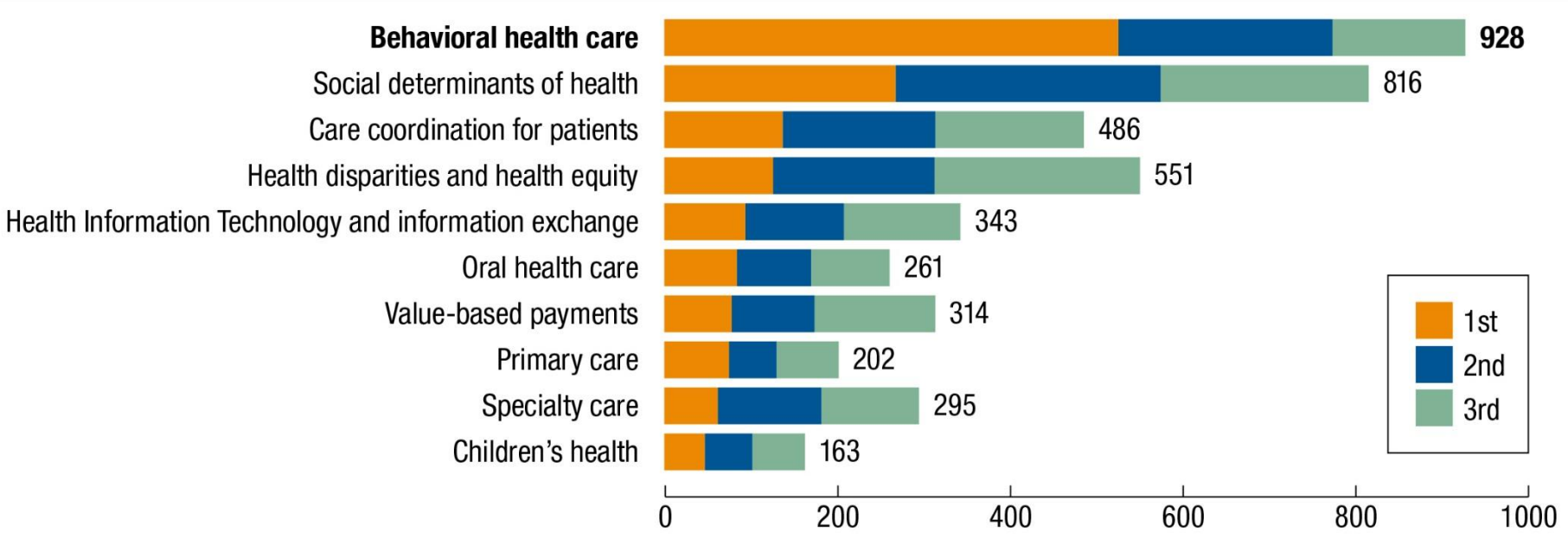
Online

- **Currently open** online survey (mirrors the road show experience)
- March/April online survey (1568 respondents)
- Emails to CCO 2.0
- 25 letters/comments from organizations (posted online)

What we've heard: Top OHP priorities

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

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



March/April Survey on CCO 2.0 Open-ended comments/themes

#	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

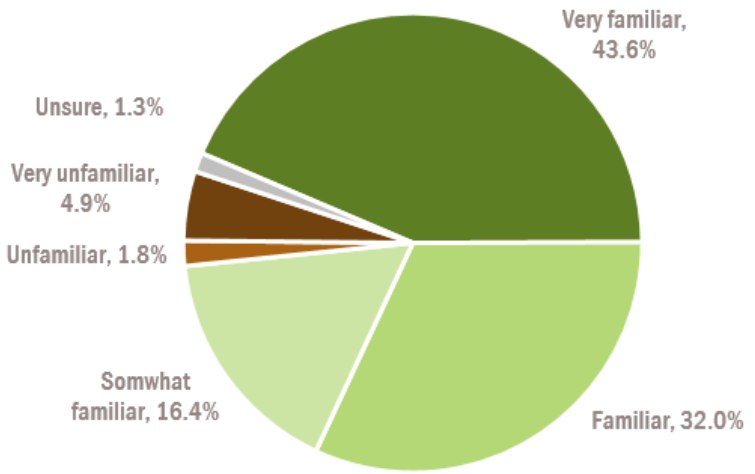
June/Aug Survey preview – overview

- Survey is open 6/18/18 to 8/1/18.
- Data in these slides pulled on 7/2/18 for previewing purposes only.
- English and Spanish versions are available online.

Initiated survey: 315
Completed survey: 225 (71.4%)

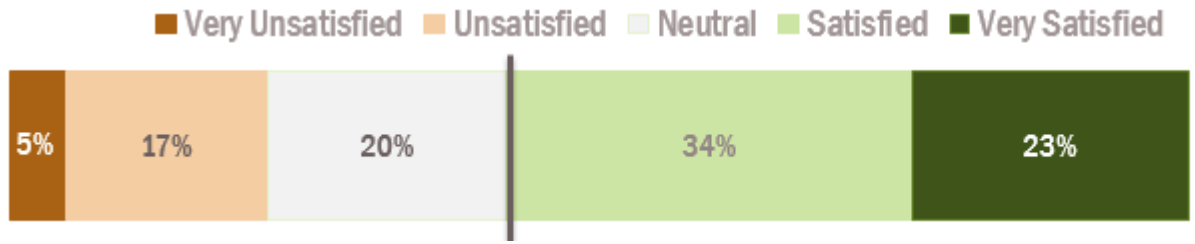
OHP Member : n=64

92.0% of all survey completers are at least somewhat familiar with CCOs



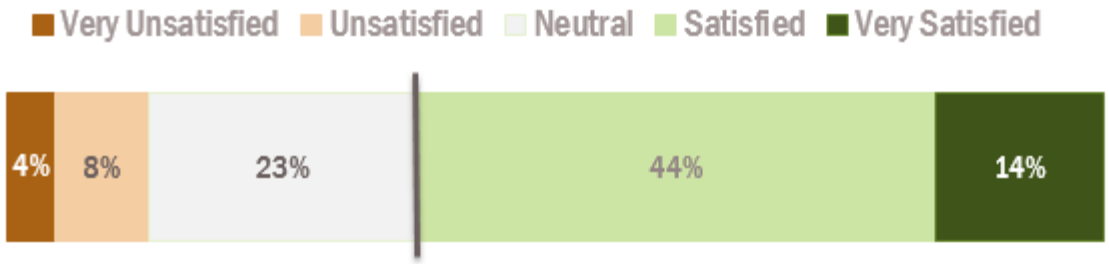
Survey #2 preview – satisfaction

If you are a member of the Oregon Health Plan, how satisfied are you with the Oregon Health Plan care and services it provides members it covers for health care?



57.8% are very satisfied or satisfied

Based on what you know about CCOs, how satisfied are you with the job they are doing to serve OHP members?



58.2% are very satisfied or satisfied

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Survey #2 preview – stakeholders

Stakeholder Group*	%
Represent a community-based organization	32.4%
Local public health	24.1%
General public	22.4%
OHP member and/or family of OHP member	19.4%
Employed by a CCO	15.9%
Provider: Other health care provider	15.9%
Contract with CCO	15.3%
CAC member	12.4%
Government worker	10.0%
Advocacy organization	8.2%
Provider: Primary care provider	7.6%
Provider: Behavioral health provider (including mental health and addictive disorders)	6.5%
Other CCO stakeholder (please specify)	6.5%
Provider: Oral health provider	4.1%
Regional health equity coalition member	4.1%
Legislator	0.0%

*Note: Respondent may fall into more than one stakeholder group. Question not included on survey until 6/22/18.

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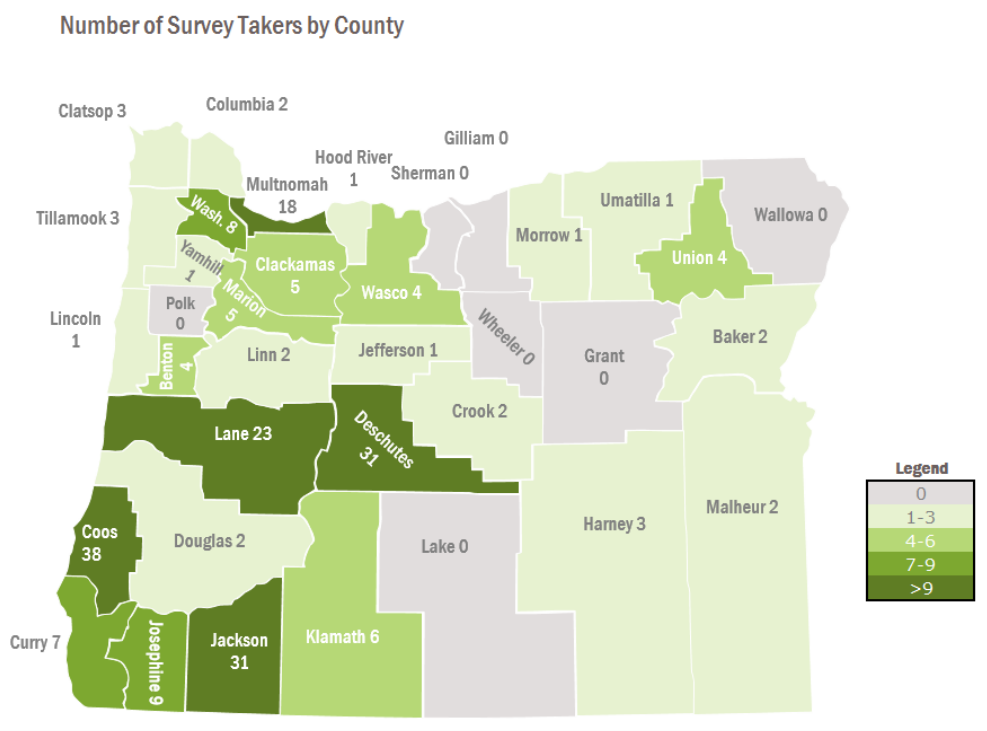
Survey #2 preview – stakeholders

CCO*	n	%
Advanced Health, LLC	43	18.7%
All Care CCO	28	12.0%
Cascade Health Alliance	9	3.6%
Columbia Pacific	9	3.6%
Eastern Oregon	11	4.4%
FamilyCare	7	2.7%
Health Share of Oregon	12	4.9%
Intercommunity Health Network	6	2.2%
Jackson Care Connect	22	9.3%
PacificSource - Central	26	11.1%
PacificSource - Gorge	9	3.6%
Primary Health of Josephine County	8	3.1%
Trillium Community Health Plan	22	9.3%
Umpqua Health Alliance	4	1.3%
Willamette Valley Community Health	4	1.3%
Yamhill Community Care	4	1.3%
Not a member / No CCO affiliation	58	25.3%
Unsure	10	4.0%

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



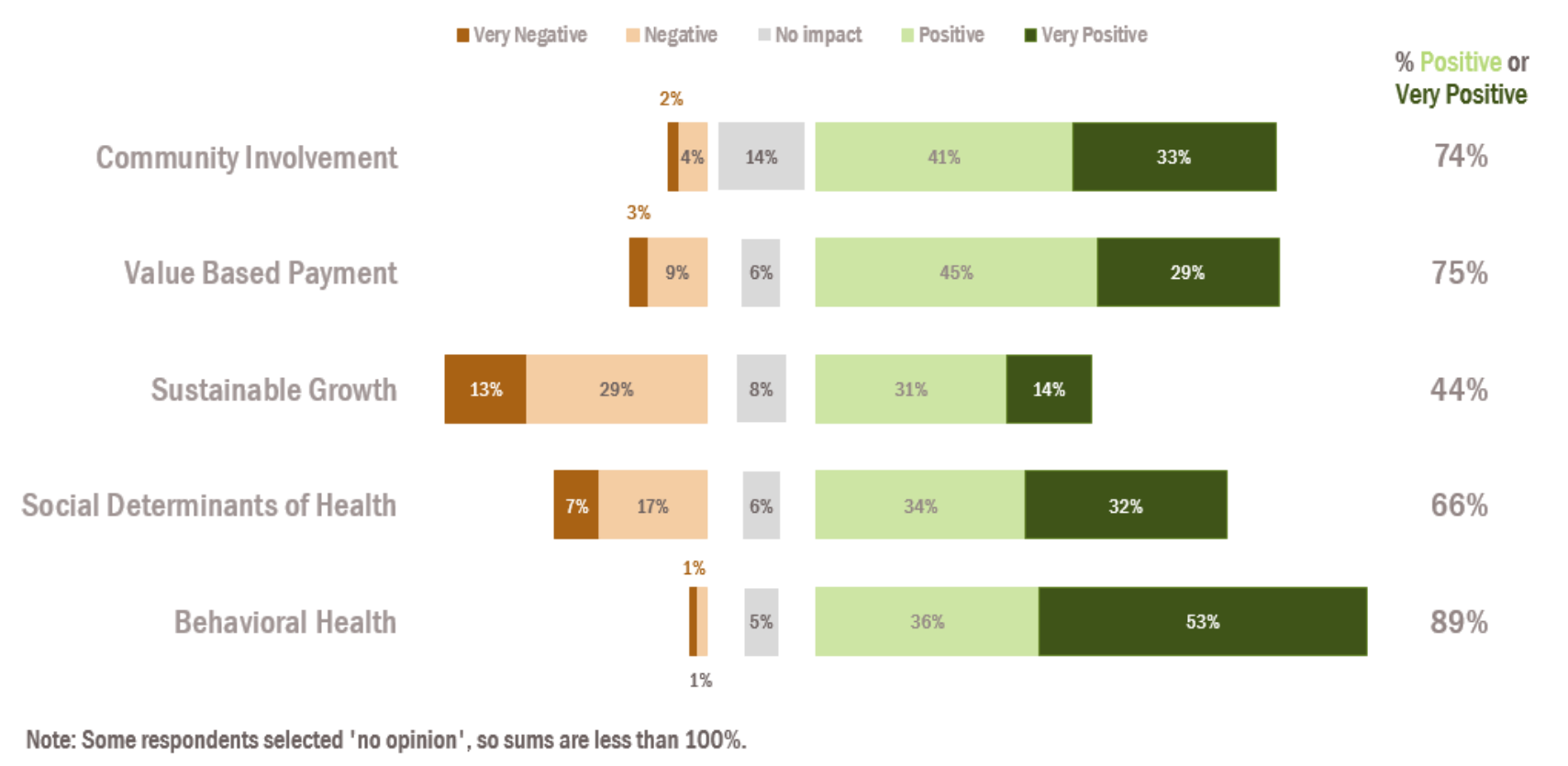
Survey #2 preview – Policy Options

- Respondents were asked to give feedback related to 5 policy options:

  - Community Involvement
  - Value Based Payment
  - Sustainable Growth
  - Social Determinants of Health
  - Behavioral Health

Survey #2 preview – Policy Options

What kind of impact do you think these policies would have?



Note: Some respondents selected 'no opinion', so sums are less than 100%.

The five big ideas are the right priorities

- Improve behavioral health
- Address the social factors that affect health and reduce health disparities
- Reduce health care costs
- Pay for better health
- Strengthen transparency and accountability

….With the addition of oral health

Improve behavioral health

Big idea:

Require CCOs to make sure members have immediate access to mental health and addiction services (behavioral health) without having to navigate the system on their own.

Community feedback:

- There is continued strong support for behavioral health as a focus area.
- We need to break down the silos between physical health and behavioral health, remove billing obstacles, and encourage outcome-based payments.
- Providers should be as diverse as the communities they serve.

Address the social factors that affect health and reduce health disparities

Big idea:

Give more OHP members help with housing, food insecurity, transportation and other supports that promote good health. Require CCOs to do more to ensure better health for everyone in the community.

Community feedback:

- CCOs can't do this work alone. There is strong support for CCOs to work with nonprofits, schools, public health, etc. to leverage resources, align efforts, and measure progress.
- Traditional health workers can play a key role in improving health equity.
- OHP members desire culturally competent care and care in their primary language.

Reduce health care costs

Big idea:

Keep OHP costs in line with overall cost-of-living increases. (Today, Oregon's goal is to keep OHP costs below health care inflation, which is higher.)

Community feedback:

- Prescription drugs should be a priority area for OHA to address; leverage the state's purchasing power.
- Community members understood the need to contain costs but expressed concerns about the potential of limiting access to providers.

Oregon Health Authority

Pay for better health

Big idea:

More health care providers are paid for improving member health and cost savings, instead of the number of visits or services they provide. This is called ‘value-based payment.’

Community feedback:

- There was support for getting away from fee for service but concerns about the complication of the switch to value-based payments, especially if this change is not happening across markets.

Strengthen transparency and accountability

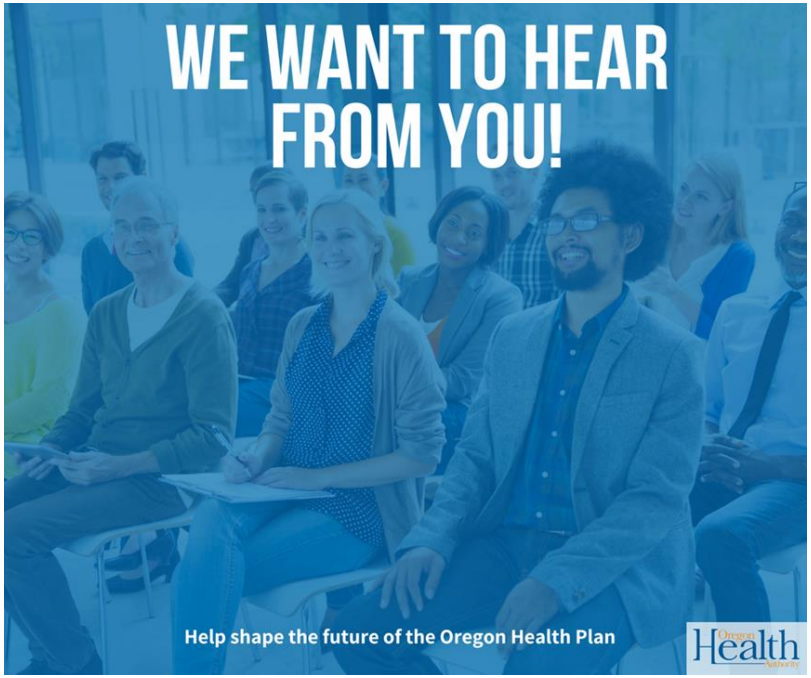
Big idea:

Ensure CCOs are more accountable to OHP members and their communities.

Community feedback:

- Community members want the CCOs to remain locally accountable with the flexibility to focus on the needs of their service area.
- CACs and community engagement are highly valued. CACs should reflect the communities served, and CCOs should make it easier for OHP members to engage and participate in CACs.
- OHA should continue to share information about CCOs in ways that are accessible and understandable to the general public.

Next steps: On-going OHP member engagement

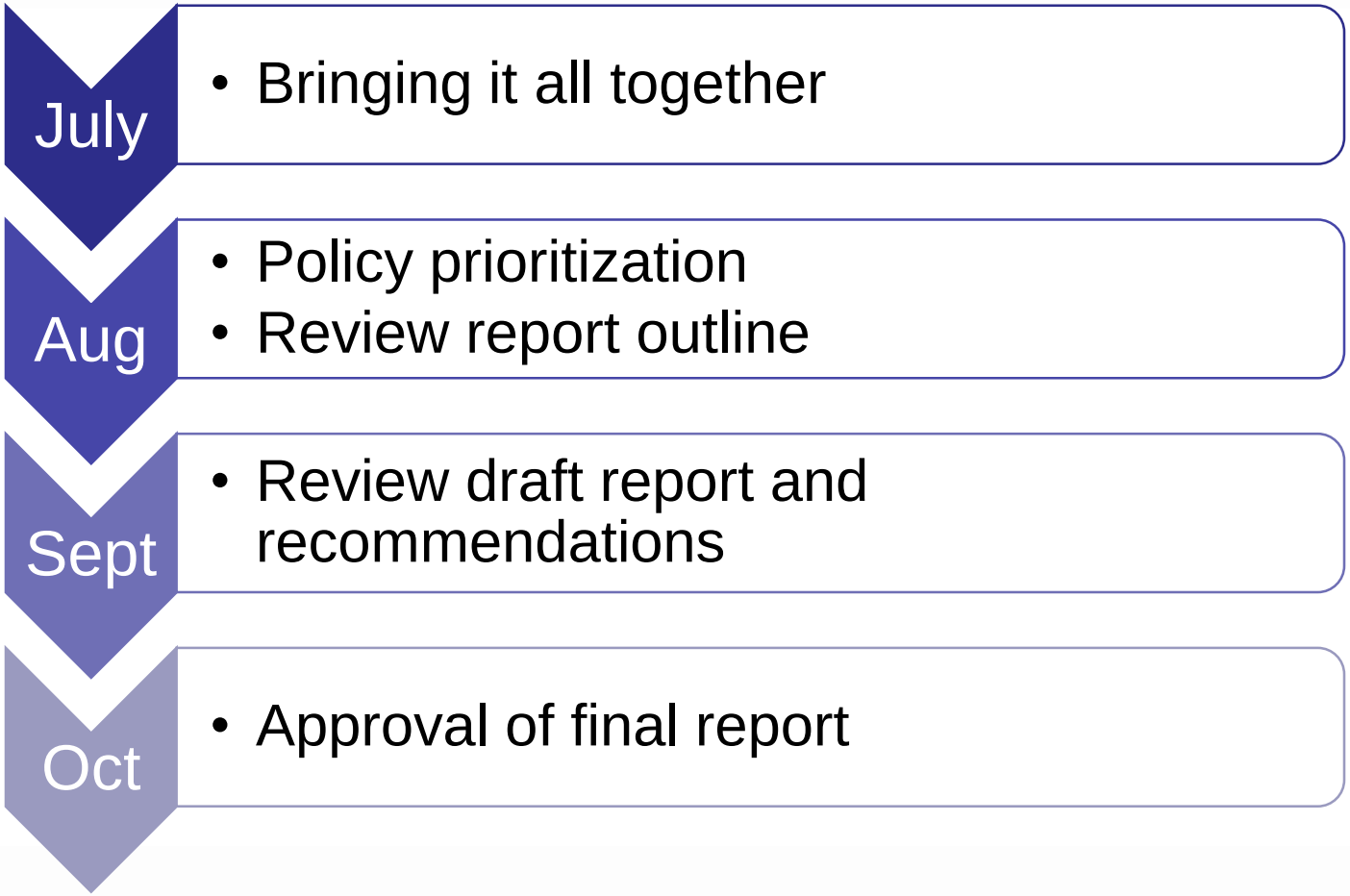


July to September

- Spanish-language forum
- Co-sponsoring outreach events with culturally-specific organizations
- Phone survey to a representative sample of OHP members

Feasibility and Impact Analysis

CCO 2.0 and OHPB: The big picture



Goals of the Coordinated Care Model

1. Partnering with communities to support health and health equity
2. Providing equitable, patient-centered care
3. Measuring performance and efficiency
4. Paying for outcomes and value
5. Financial sustainability and strategic investment (sustainable rate of growth)
6. Transparency and accountability in price and quality

Feasibility and Impact Analysis - Process

Step 1: Assessment of…

- whether the policy was fulfilling a state or federal requirement;
- connection to other policies and topic areas;
- inclusion in current contract;
- if legislation would be needed;
- any additional development needed;
- potential to reduce health disparities;
- whether the policy corrected a process or identified an outcome;
- potential impact on health system, OHA, and provider costs;
- impact on procurement process;
- risks; and,
- timelines.

Feasibility and Impact Analysis - Process

Step 2: Overall estimation of…

- **Feasibility – In general, how heavy is the "lift" for this this policy across the system?**

● ○ ○	Generally easy/straightforward to implement, little to no additional work or resources required; is already part of the plan/expectation
● ● ○	Requires moderate increase in staff time, resources, development, or funding; could face some challenges
● ● ●	Will be a challenge to implement and will require new resources (e.g., funding, staff time, significant development, workgroups, etc.)

- **Impact – In general, how much does this policy move the needle in achieving the goals of the model?**

● ○ ○	Plays a supporting role, offers some clarity or direction; will have a small impact on business practices
● ● ○	Medium impact; policy will strengthen Oregon's direction and we'll see some type of effect across the state
● ● ●	Fundamental to moving the needle in this area of the CCM, significant impact or transformational

SDOH/Health Equity Deeper dive – Statewide Priorities

- NEED: Direction on whether OHA should include policy options that set statewide priorities, or should we remove these in favor of entirely local control/flexibility?

- CONSIDERATION: Statewide priorities may be an effective mechanism for gaining momentum and leveraging resources more efficiently. But these could detract from a CCO's ability to focus on community priorities.

- POLICIES:
  - (Page 3) Require one statewide priority – housing-related supports and services – plus community priority(ies)
  - (Page 5) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need.

SDOH/Health Equity Deeper Dive - CACs

- NEED: Direction needed on how to ensure Community Advisory Councils (CACs) are representative and whether this option should move forward

- CONSIDERATION: Concerns have been expressed about requiring potential CAC members to disclose personal information in order to meet CAC member composition requirements. Concerns from CCOs about ability to recruit to meet these requirements (esp in rural areas or in areas with overlapping CCOs)

- POLICIES (page 4):
  - Require CCOs to align CAC member composition with demographics of Medicaid members in their communities, report to OHA, and explain barriers to and efforts to increase alignment
  - Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, etc.) and percentage of CAC comprised of OHP consumers

SDOH/Health Equity Deeper Dive – Shared CHAs and CHPs

- NEED: Confirmation/direction on policies related to shared community health assessments (CHAs) and community health improvement plans (CHPs)

- CONSIDERATIONS: Significant feedback from road show and partners that a shared CHA/CHP would improve alignment; could be challenges in implementation and accomplishment of the task

- POLICIES (page 4-5)
  - Require each CCO to develop shared CHAs and shared CHP priorities and strategies with local public health authorities, non-profit hospitals, and with any CCO that shares a portion of its service area
  - Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need.
  - Ensure CCOs include organizations that address the social determinants of health and health equity in the development of the CHA/CHP, including THWs affiliated with organizations listed under ORS 414.627.

Deeper dive - VBPs

- NEED: Confirmation on overall direction of VBP policy options in order to ensure increased VBP adoption occurs within CCOs and their providers, as well as across all Oregon payers
- CONSIDERATIONS: These VBP policy options will require transitions within the health care delivery system for both payers and their providers delivering care to Oregon Health Plan members. OHA intends to closely partner with, and provide support for, CCOs and their providers to ensure the success of VBP implementation and advancement across the state.

- POLICIES (page 12):
  - Require CCO-specific VBP targets in support of a statewide VBP goal
  - Require CCOs to develop Patient-centered Primary Care Home (PCPCH) VBPs
  - Require CCOs to implement VBPs in key care delivery focus

Cost Deeper Dive – Variable Profit by CCO

- NEED: Confirmation/direction of 1115 waiver provisions calling for OHA to vary CCO profits to reward CCOs identified as high performing
- CONSIDERATIONS: The 1115 Waiver directs OHA to vary the profit load by CCO depending on their efficiency and performance as a tool to reward CCOs that reduce per capita growth. OHA is still developing potential methodologies to evaluate CCOs in order to incentivize effective HRS use and other activities that improve quality, reduce costs, and improve efficiency.
- POLICIES (page 10 & 11):
  - Evaluate efficiency and total cost of care on CCO performance
  - Incentivize health care services with highest clinical value

Cost Deeper Dive – Quality Payments

- NEED: Confirmation/direction on the intention to continue to grow the amount of money CCOs receive for quality as a percent of the global budget.
- CONSIDERATIONS: The quality pool is currently close to maxing out as an incentive/bonus, proposed revisions would allow for more room to pay CCOs in incentives, risk-sharing arrangements and/or increased SDoH investment. Proposed policies also achieve several policy goals related to transparency and encourage timely CCO investment in their communities.
- POLICIES (page 11 & 14):
  - Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development
  - Shared-savings arrangement for achievement of lower-than-targeted spending growth

BH Deeper Dive – Clear ownership of the BH benefit by CCOs

- NEED: Guidance: should we focus on outcomes or process?
- CONSIDERATIONS: The CCO currently delegates all authority for the BH benefit. What this can mean for members is: limited provider network, limited access, long wait times, and no choice in providers. Additionally, Members are not able to transition seamlessly between levels of care due to delays in authorizations, confusion or disagreement over who is responsible for the member.
- POLICIES (page 6):
  - Include clear process guidelines and expectations in the RFA including plans to integrate budget and ensure members have access to timely and comprehensive behavioral health services. Resource OHA to enforce moving forward.
  - Increase process and outcome metrics associated with behavioral health delivery (Only one BH incentive metric for 2019.)

CCO 2.0 Final Report Framework & Reflections

CCO 2.0 Final Report Framework

Final report draft outline:

- Vision of CCO 2.0
- Goals of the coordinated care model
- Prioritized policy recommendations, including:
  - Any sequencing needed
  - Contract changes needed in year 1
  - Legislation or support needed from Legislature and Governor
  - Operational changes for OHA
- Appendices:
  - Additional goals and opportunities that have surfaced through this process (not necessarily CCO 2.0)
  - Promising policies that need additional development work
  - Housekeeping changes to contracts

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

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

Thank you!

Oregon Health Authority