Appendix E: CCO 2.0 public input –

i. Oregon consensus report on community meetings

CCO 2.0 Public Engagement Process
June 2018 Community Engagement Road Show Report
Executive Summary

In June 2018, OHA convened a series of community engagement events across Oregon aiming to tell the story of the Oregon Health Plan, build statewide buy-in on the vision of where the Plan is going in the next five years, get a temperature check that the agency is headed in the right direction, and collect community input on a suite of policy changes which would directly impact the next five years of services that OHP members receive. The feedback from this particular round of community meetings is intended to inform the Oregon Health Policy Board's (OHPB's) near term decisions (Fall 2018) with respect to a suite of policy options under consideration. Five 'big ideas' were presented to the communities:

- Improve behavioral health
- Address social determinants of health,
- Reduce health care costs,
- Pay for better health, and
- Strengthen transparency and accountability.

OHA expressed a commitment to ongoing engagement with their communities for continuous improvement of the OHP. They used this particular process to inform the public and gauge level of support for the specific policy options described above. **The findings in this report, developed by Oregon Consensus, reflect the feedback heard at the 10 in-person community meetings held in June 2018.** Oregon Consensus provided neutral, third party note taking at the events.

Generally, per feedback on written forms as well as dialogue at the events, there was no push back from participants as to OHA's areas of focus. Across the events, themes emerged at multiple events about key health areas OHA should focus on:

- The importance of integrating mental and behavioral health (and a key role for CCOs in resourcing/providing a warm handoff from primary care to these services)
- Better integration of oral health
- Focus on preventative care especially for children
- Provide access to primary care/specialty care in rural areas
- CCOs have a role to help address disparities especially in housing and transportation
- More coverage for alternative care and traditional health workers
- OHA should negotiate drug prices at a national level to keep costs down.

Consistent themes also emerged about coordination and delivery of services:

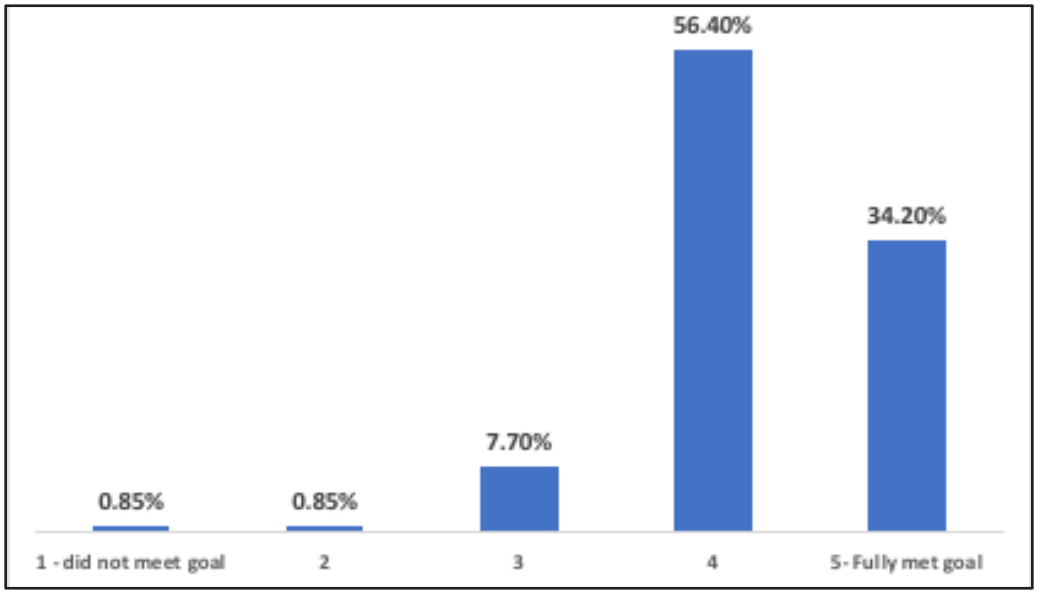
- Increase support for challenges with health information technology and health information exchange to make coordinated care easier
- Standardize successes (particularly innovations) across CCOs,
- Increase support for collaboration with other resources (i.e. helping patients connect with other resources and navigate other systems) across all social sectors
- Increase/improve bilingual and culturally appropriate care for members

- Involve more community members in advisory and engagement capacities for building transparency and assisting continuous improvement of the OHP.
- Educate and empower patients within the system will support the whole person and help reduce overall costs.

Participants also provided feedback to OHA about the community engagement process. The results are summarized in the graphs below. Generally, OHA met its goal of building understanding about the 5 big ideas; participants felt that they were asked and were able to provide useful feedback; and overall feel satisfied that they have opportunities to provide feedback to OHA to help improve the Oregon Health Plan.

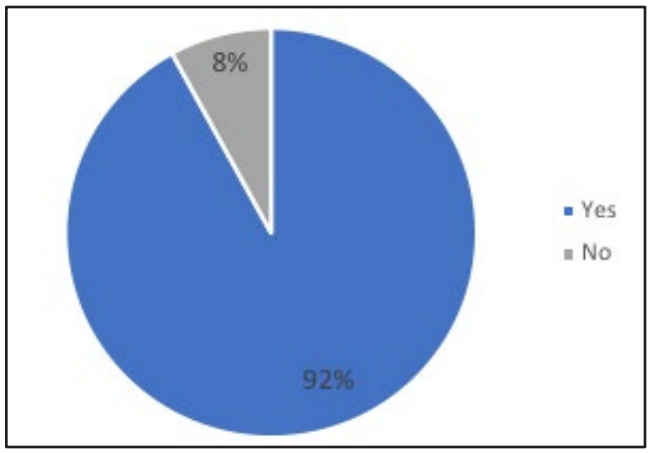
Goal: Build understanding about the 5 big ideas for the Oregon Health Plan.

How well did OHA meet this goal?



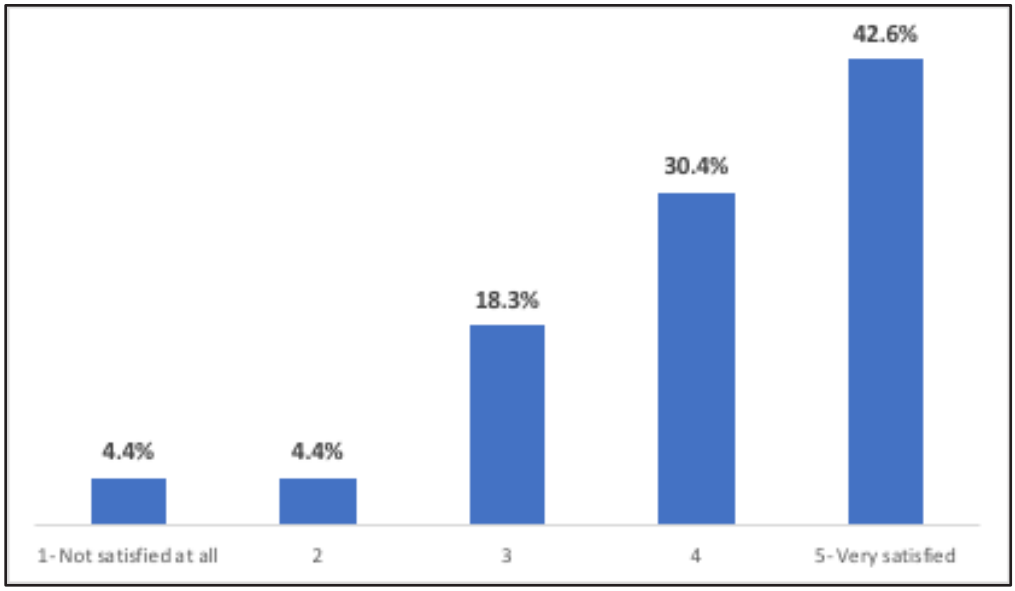
Goal: Get a temperature check about whether we are headed in the right direction.

Did you feel you were asked to provide useful feedback?

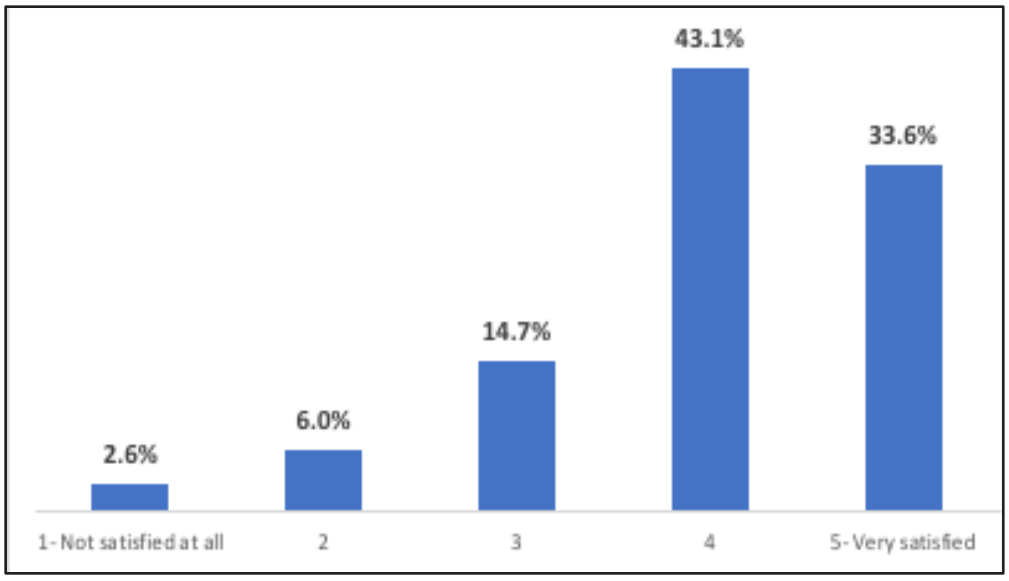


Goal: Hear meaningful feedback from OHP members, healthcare providers and other people about the 5 big ideas.

How well did you feel OHA did to give you a chance to provide your response to these ideas?



Process review: How satisfied are you with opportunities to provide input to OHA to improve OHP?



Appendix E: CCO 2.0 public input –

ii. Summary of Woodburn community forum in Spanish

DHS Oregon Department of Human Services
SELF-SUFFICIENCY PROGRAMS
Community Partner Outreach Program

Oregon Health Authority

On August 21, 2018, a community forum was held at Chemeketa Community College in Woodburn. The entire meeting was conducted in Spanish with English interpretation available. The meeting's focus was to hear directly from the Latino community about their experience using both the Oregon Health Plan and the coordinated care organization system.

CCO 2.0 Community Forum en español

Overview

The Oregon Health Authority partnered with the Department of Human Service's Community Partner Outreach Program to gather feedback on the future of the Oregon Health Plan from Spanish-speaking OHP members. Approximately 100 community members, community partners and support staff participated in this historic event. The community welcomed this gathering and recommended holding similar forums throughout the state.

Over 300 comments and ideas were shared by community members regarding improvements they would like to see with the Oregon Health Plan and our health care system in general. The following is a list of common themes that arose:

- Both Spanish language and culturally appropriate services provided by bi-cultural providers are necessary to support the health of our community.
- Attendees didn't know about all the available benefits of OHP, including transportation services. This information should be easier to understand, access, and sent in the language preferred.
- Members asked to be engaged through videos, audio, and phone conversations instead of only written communication. Text messaging or an OHP app was suggested.
- Friendly and welcoming service is important on the phone and in person. Wait times are too long, and timely appointments are hard to schedule.
- Services for the entire family are needed. Parents feel left out of available resources.
- Access to women's health, reproductive health care, and pregnancy-related care like doula services is essential.

About CPOP

DHS's Community Partner Outreach Program (CPOP) develops and maintains partnerships to address barriers that affect health coverage access for Oregon's most vulnerable and hard-to-reach populations. They train, certify and provide on-going support to approximately 300 organizations that employ more than 1,000 OHP-certified community partners serving every county in Oregon. Through culturally and linguistically responsive community-driven efforts, CPOP serves as the bridge between the community and the state. Their equity-based outreach strategies help advance Oregon's triple aim of better care, better health, and lower costs.

Our Community Partners

Our network includes community-based nonprofits, OHP providers, county health departments, hospital systems, and other valued stakeholders across Oregon. A special thank you to City of Woodburn, Interface Network, Legacy Health, Mano a Mano, Northwest Human Services, Willamette Family Medical Center and all of our volunteers for their tremendous efforts to help ensure the success of this forum.

Additional Community Member Feedback

Communication

- More in-person, Spanish language meetings are desired. Telephone wait times are long. Occasionally you are disconnected after waiting on hold or manually disconnected while talking to a representative. Face-to-face assistance is important.
- Written communication is overwhelming and difficult to understand. If in-person education isn't available, videos explaining how OHP works would be helpful. Smartphones are common and can be used to watch or listen in multiple formats.
- Improved communication to OHP members and health care providers is necessary. OHP members need to know what benefits are available and how to access them. It would also help if providers knew about benefits and community resources. There is miscommunication about immigration rules, what services are covered and what the role of CCOs are.

Services

- More bi-lingual and bi-cultural mental health services are needed. Mental health triaging using a scale similar to the commonly used pain scale would be helpful. Services for both adults and children are necessary.
- Value-based payments are a good idea. Quality is better than quantity. More time is desired with providers during the scheduled visit not more scheduled visits.
- OHP-covered doula services are desired. Adding this service would have both cultural and cost-saving benefits.

Other Health Factors

- Undocumented parents don't have the same access to health care as children now do. Adults with immigration barriers feel left out or that they don't "count" in society.
- Housing is too expensive and at times not suitable for living. Mold and other environmental concerns are present.
- To encourage healthy actvities, CCOs could provide vouchers for sports or recreation centers.
- Covered alternatives to medication are highly desired; acupuncture, yoga, swim therapy, naturopathy, etc.

Plus /Delta

At the end of the meeting, attendees were asked what they liked and what could be improved. This is what they said:

- I appreciate the time taken to come and listen to us in our language. We feel heard and valued.
- New information learned about free rides, complaint process, rights and other resources.
- This felt like a safe space.
- Do this more often, in more places, in Spanish.
- Do this for other cultures so that they can have the same access we had today.
- Keep us informed about the results to see if we actually made a difference or if the state was just checking off a box. We want to know that we made an impact.
- Childcare was available.
- Delicious, self-serve Mexican food.
- History was made tonight. I've never experienced an all Spanish meeting like this one; deserves a round of applause.

For questions or additional information, please contact Maria Vargas (971) 283-1955; maria.vargas@dhsoha.state.or.us.

Appendix E: CCO 2.0 public input –

iii. Summary of two online surveys

CCO 2.0 GENERAL FEEDBACK SURVEY #1

Results and analysis

5-1-18

OVERVIEW

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

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

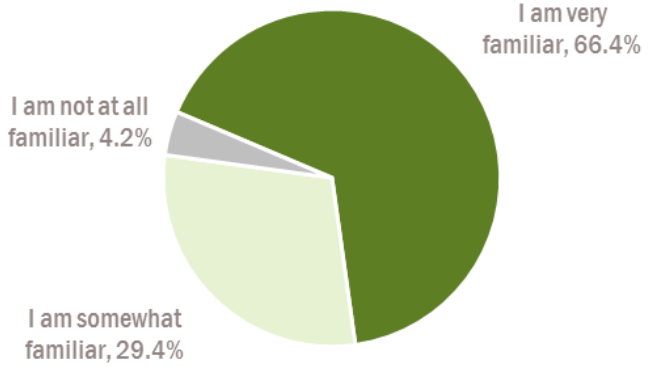
Group	n
Providers	598
Primary Care	187
Behavioral	336
Oral	26
Other	127
OHP Member/Family member	215
Non Member - Non Provider	809
Total	1568

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

Additional feedback provided:

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

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



Familiarity with CCOs was similar across stakeholder groups.

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

STAKEHOLDER GROUP & CCO AFFILIATION

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

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

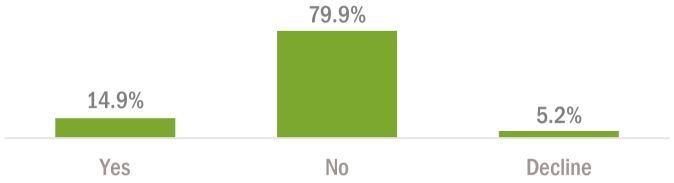
Of those who reported a CCO affiliation (n=944):

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

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

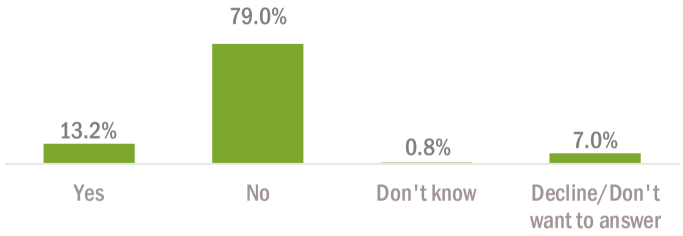
DEMOGRAPHICS

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

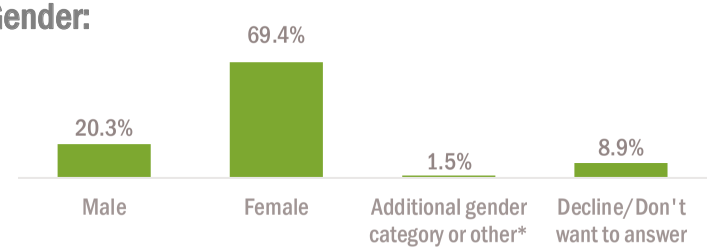


Disability: Do ANY of the following apply to you?

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

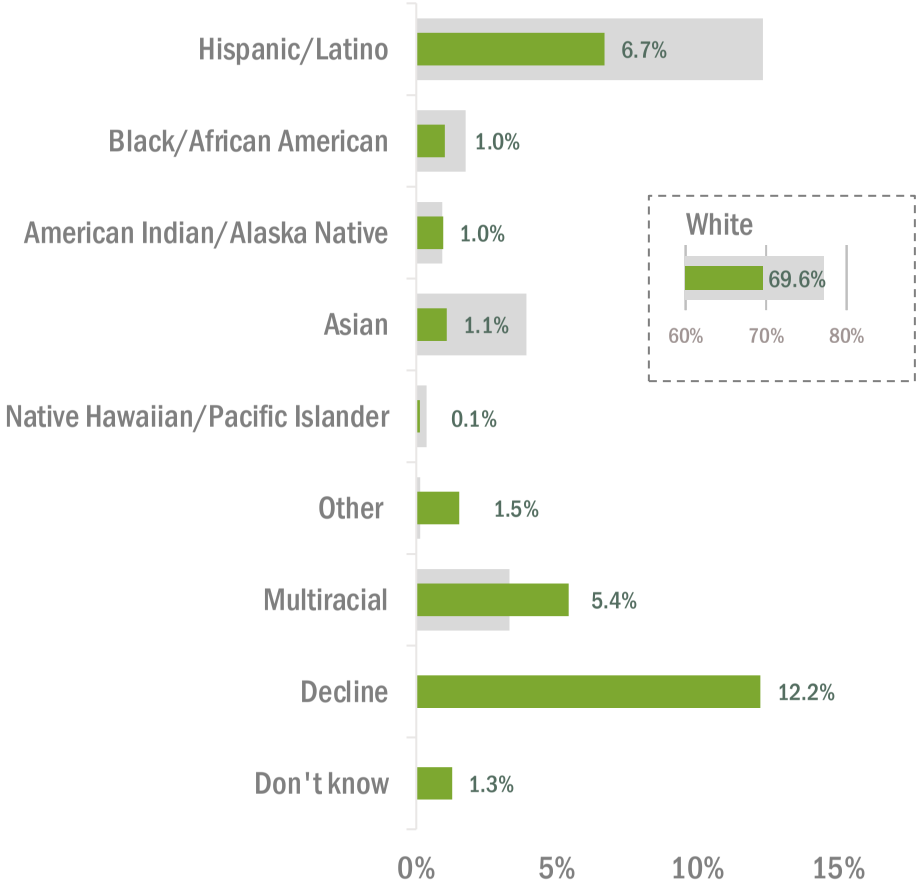


Gender:

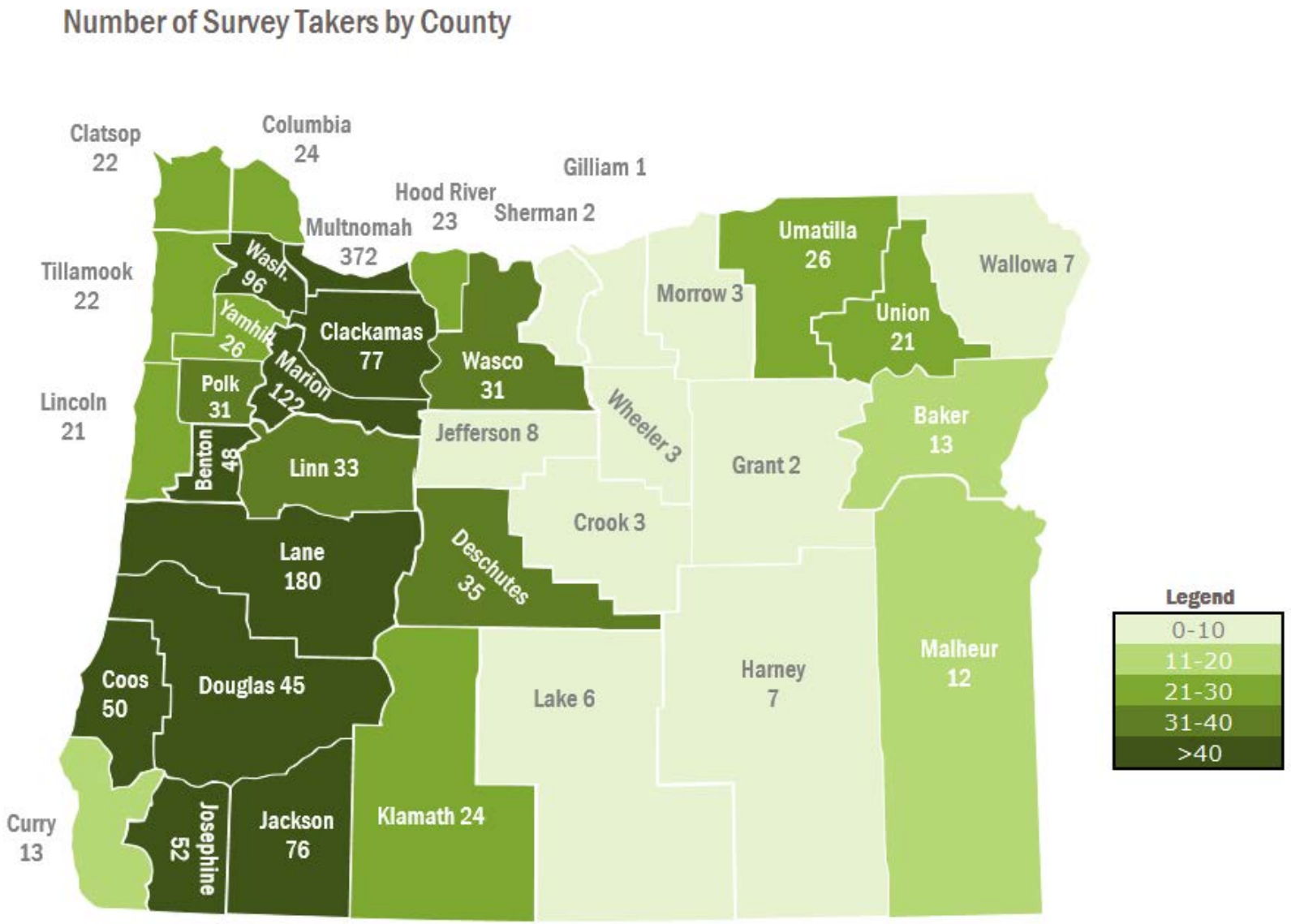


*Additional categories include: Transgender (FTM; MTF), Genderqueer, and Other

Race/Ethnicity: Survey takers vs Population



GEOGRAPHIC DISTRIBUTION



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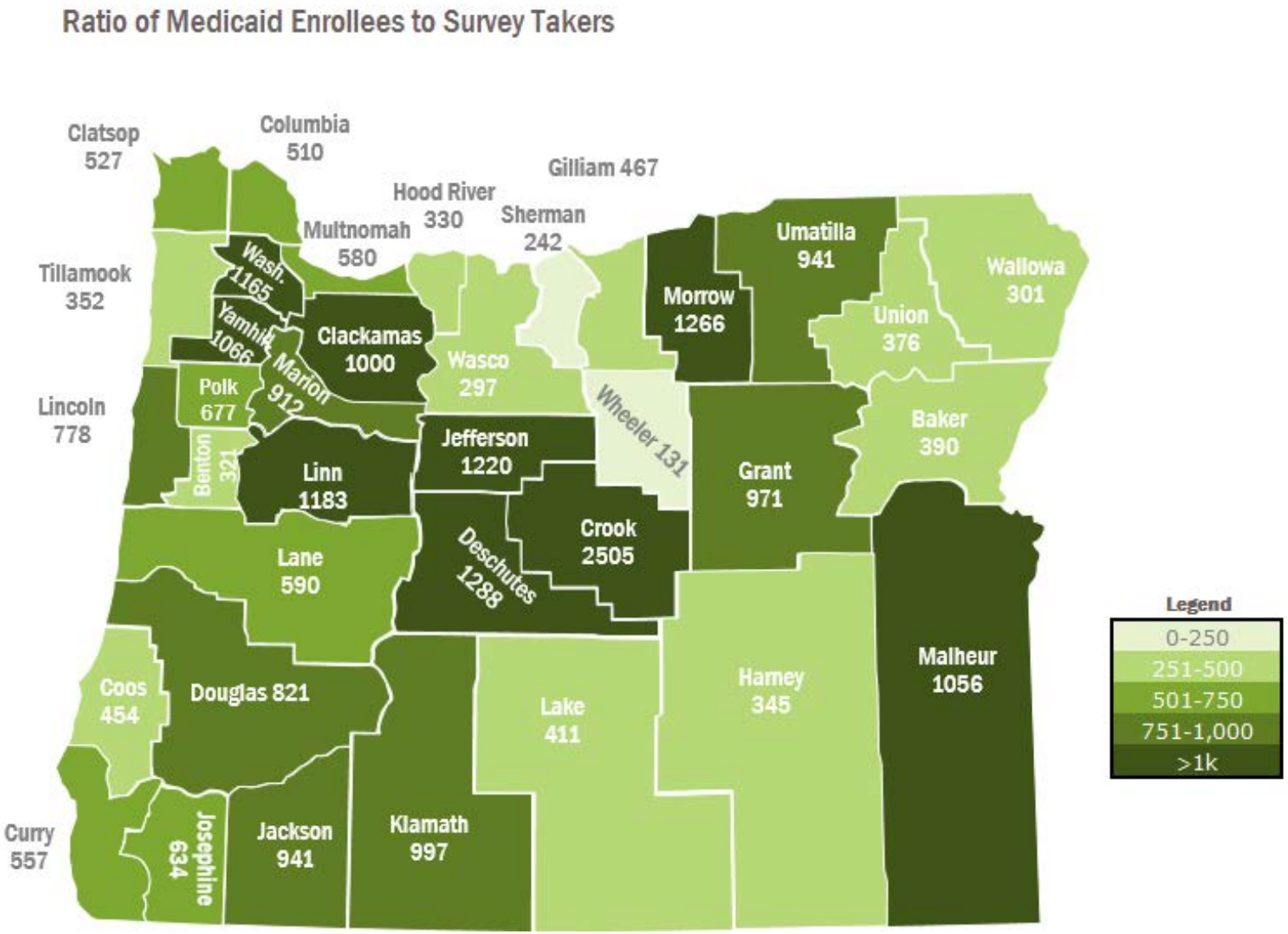
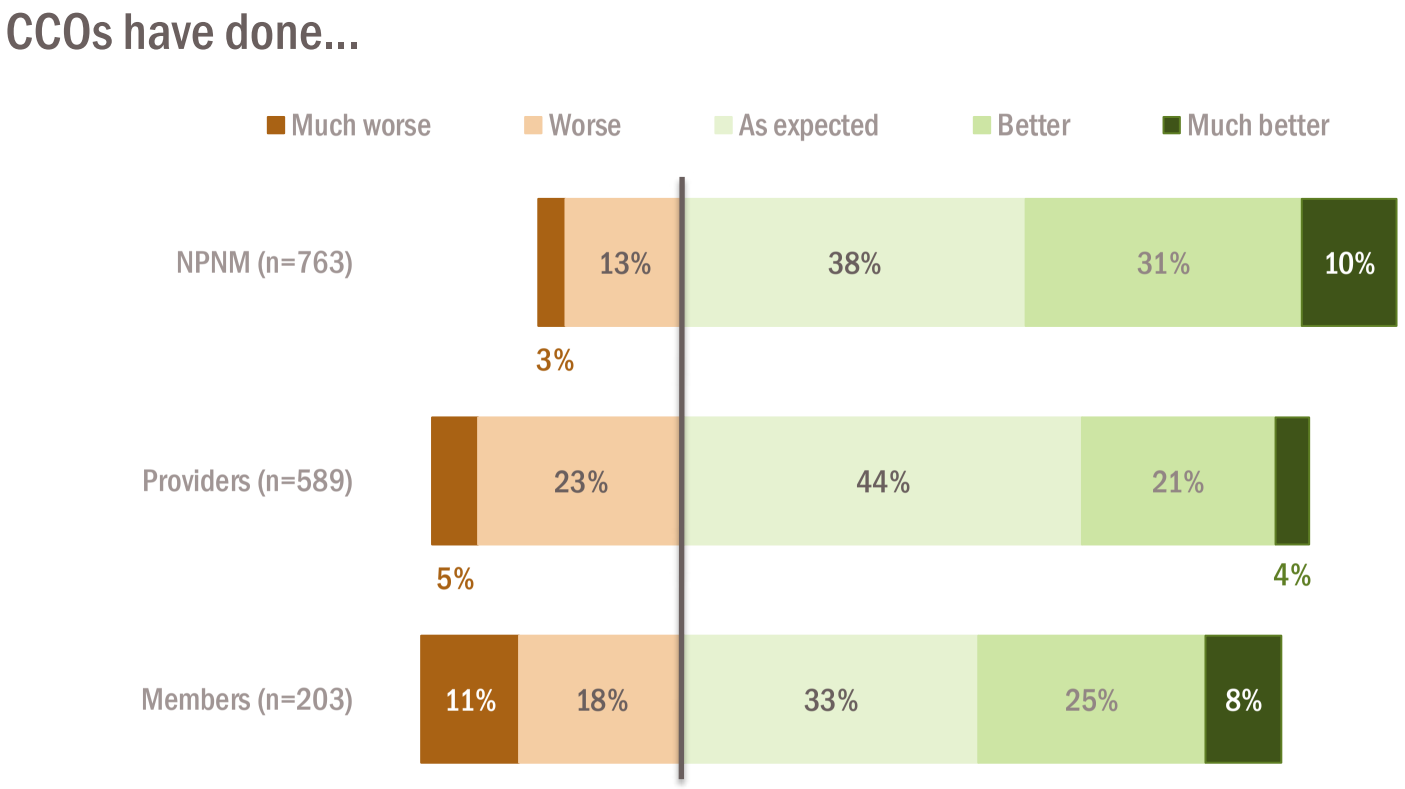


GENERAL CCO QUESTIONS

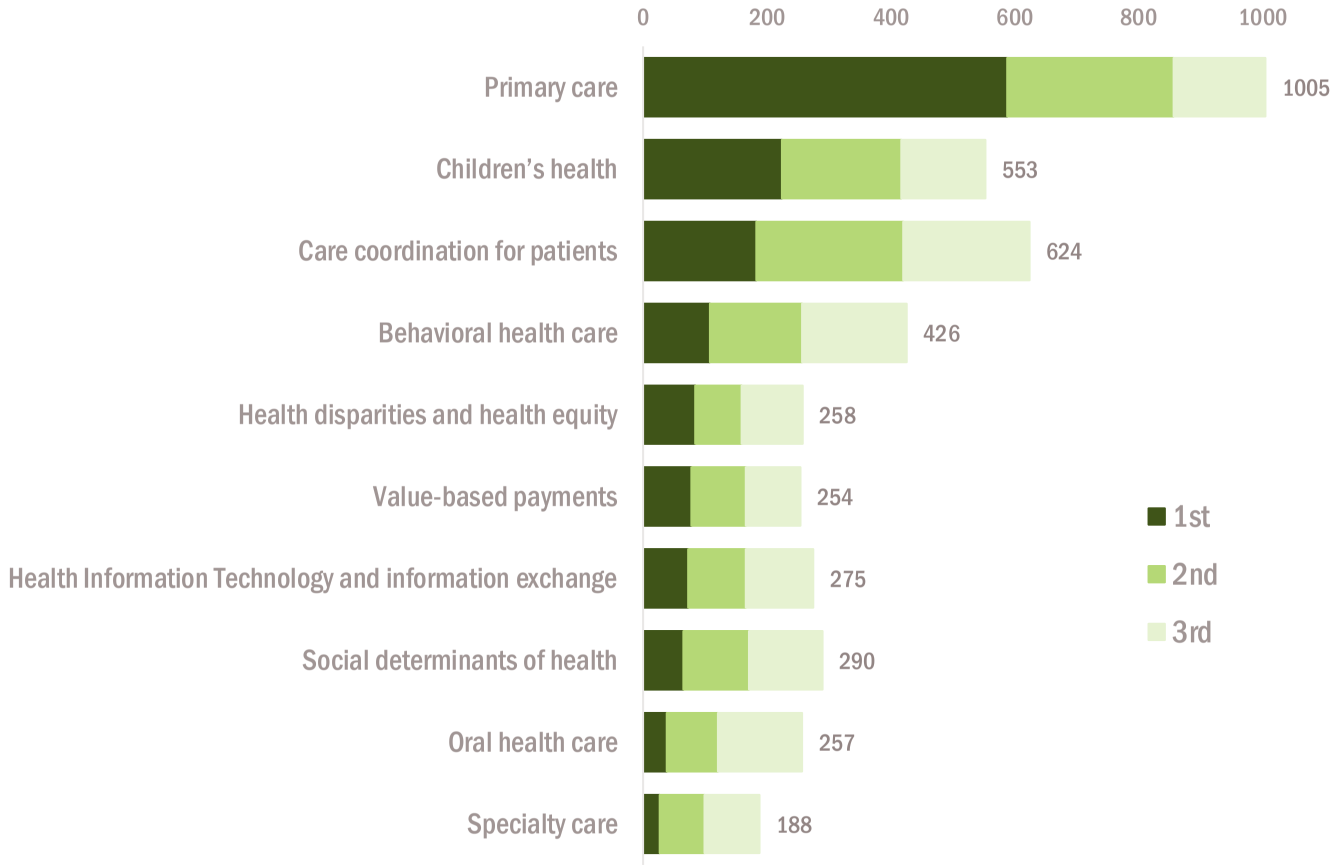
Have the CCOs met your expectations?



GENERAL CCO QUESTIONS (CONT)

In which of the following areas do CCOs work well?

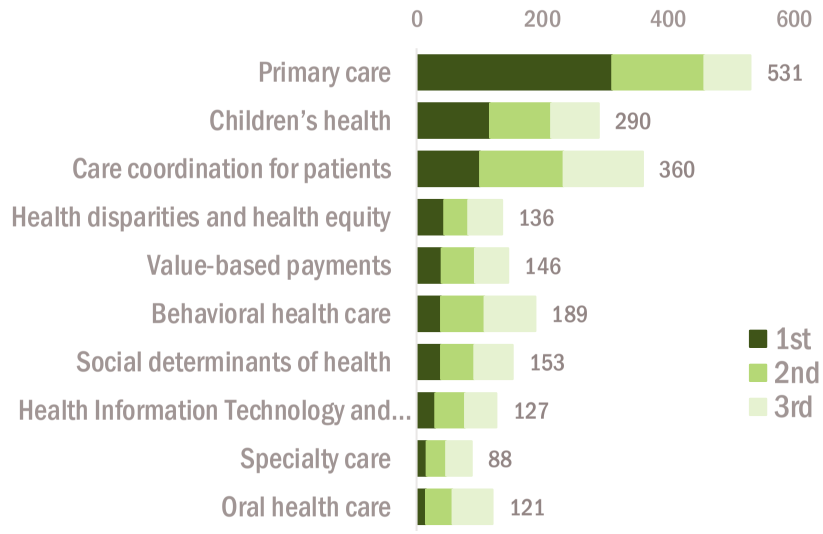
All survey takers:
1,005 (66.9%) respondents rank **primary care** as one of the top 3 areas that CCOs work well.



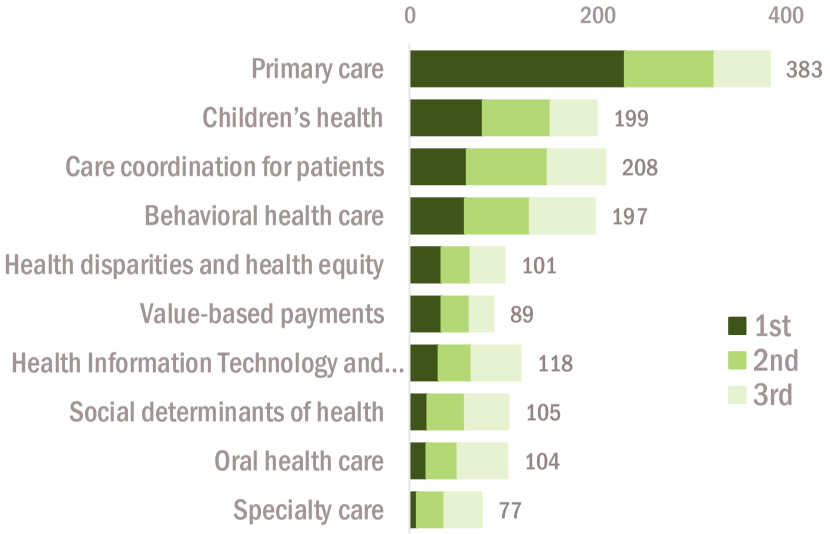
GENERAL CCO QUESTIONS (CONT)

In which of the following areas do CCOs work well?

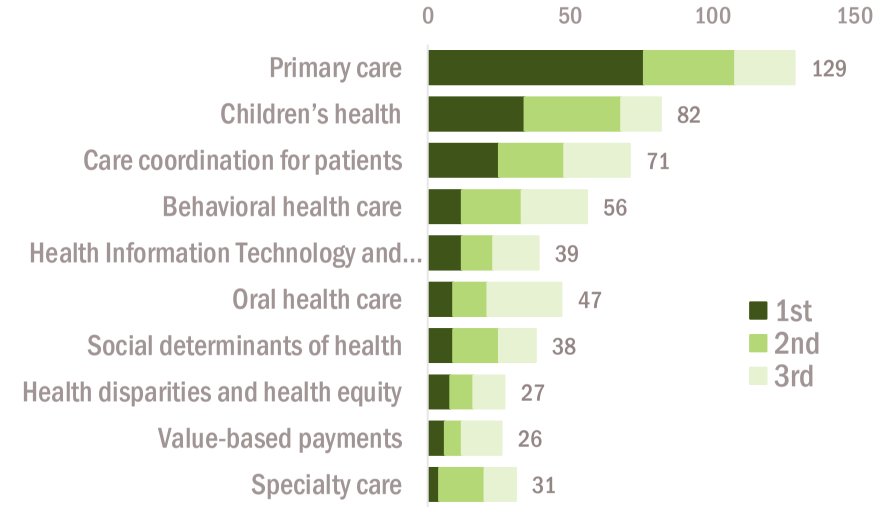
Non-member, non-providers:



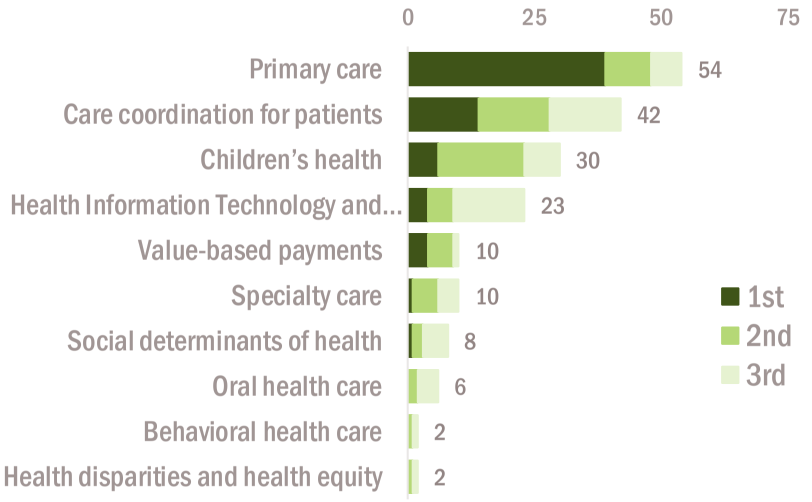
Providers:



OHP members/family:



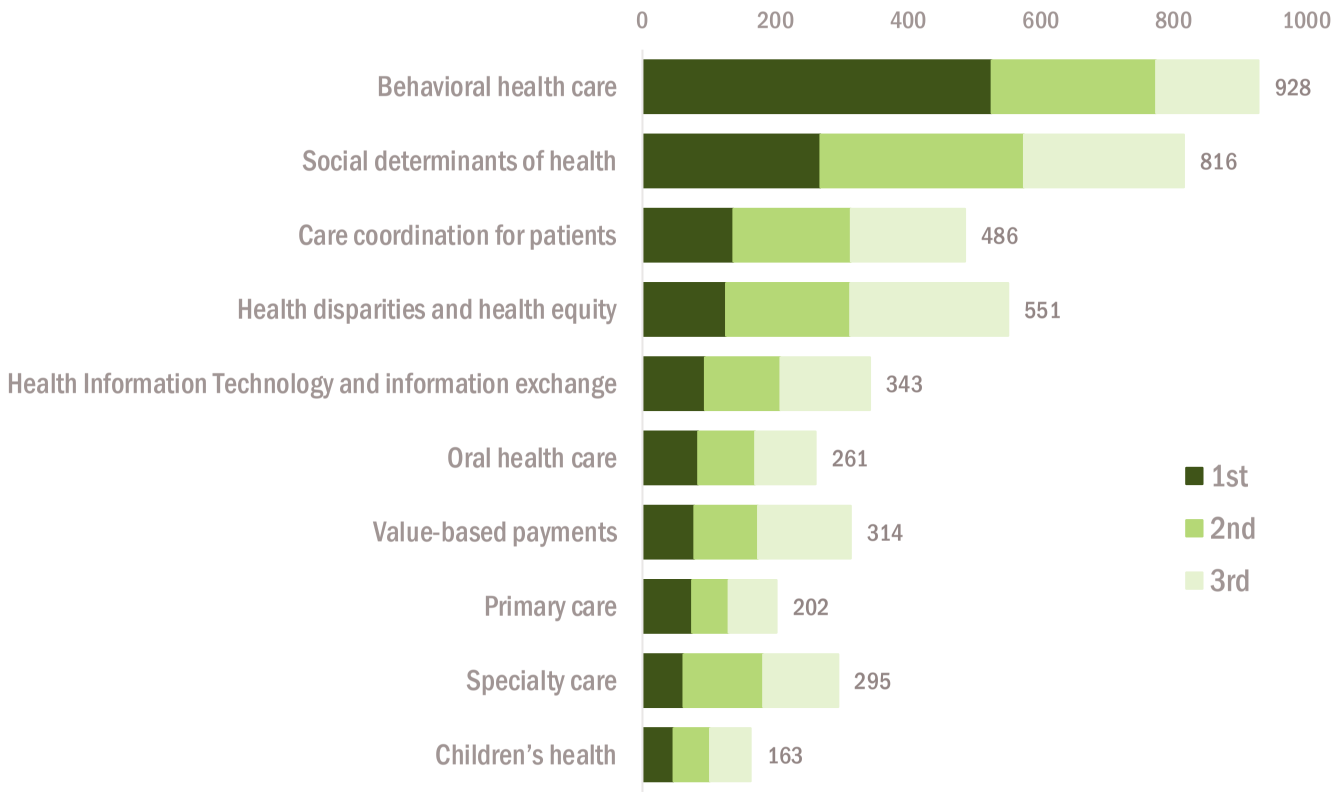
OHA staff:



GENERAL CCO QUESTIONS (CONT)

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

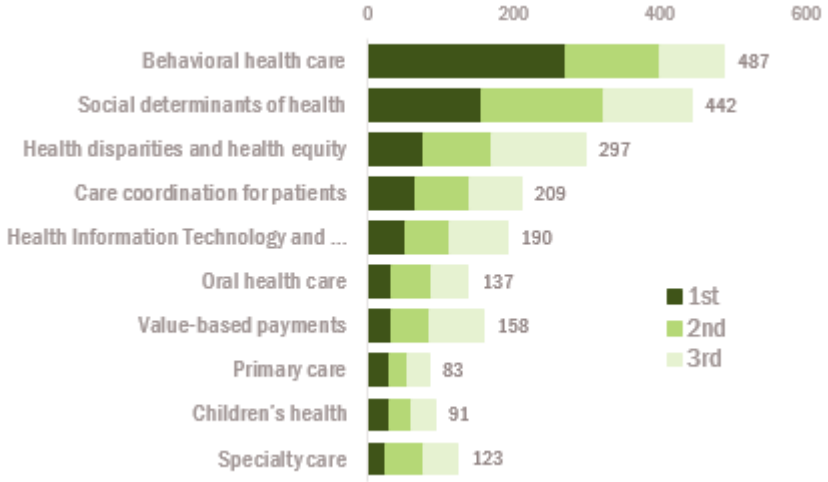
All survey takers:
928 (61.8%) respondents rank **behavioral health care** as one of the top 3 areas that needs attention.



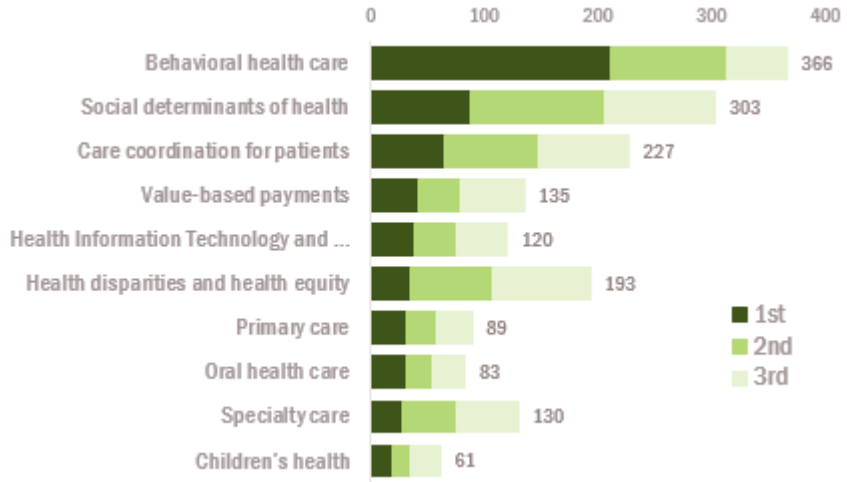
GENERAL CCO QUESTIONS (CONT)

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

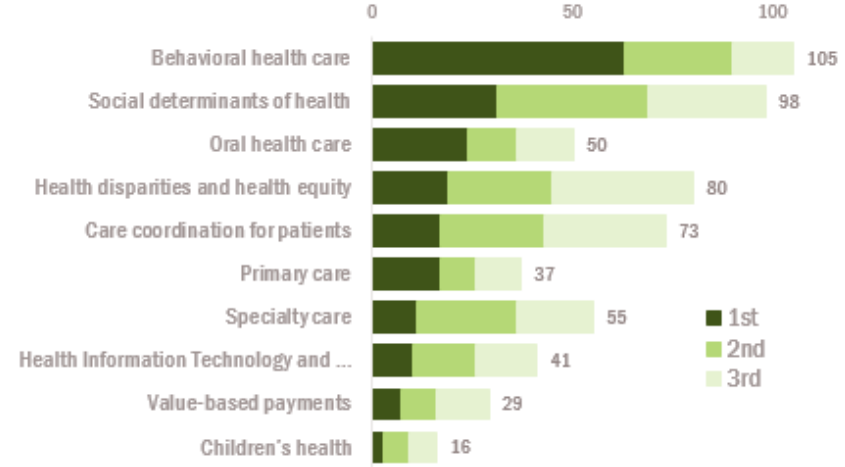
Non-member, non-providers:



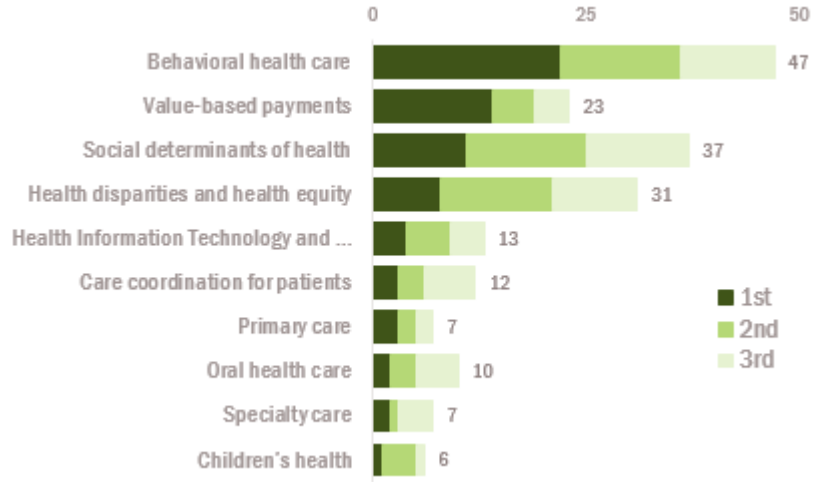
Providers:



OHP members/family:



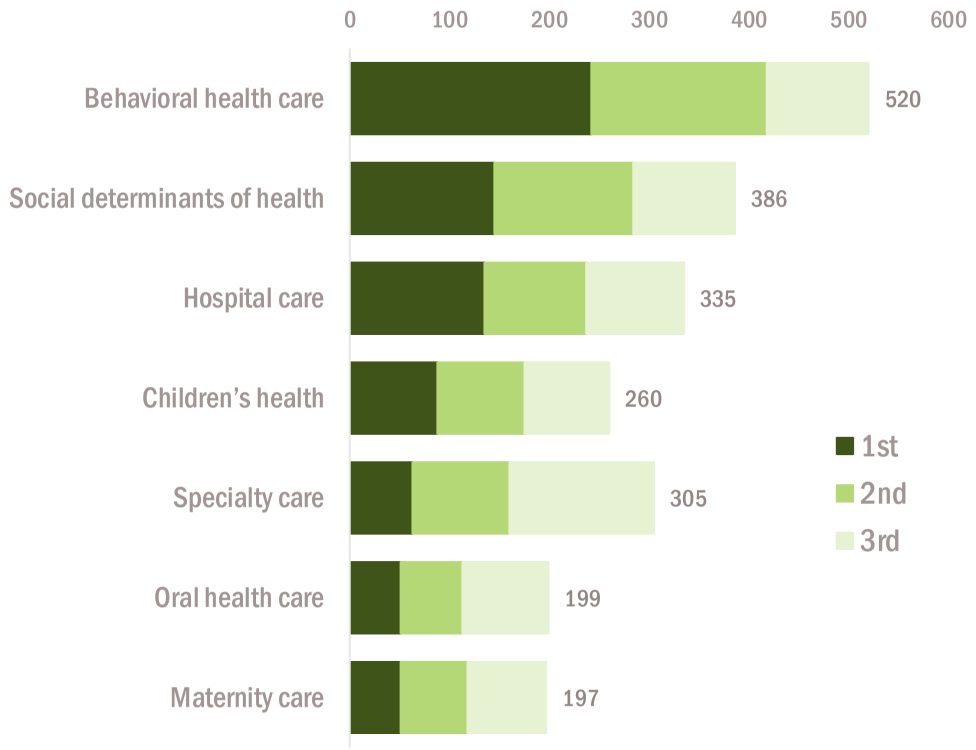
OHA staff:



VALUE-BASED PAYMENT (n=778)

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

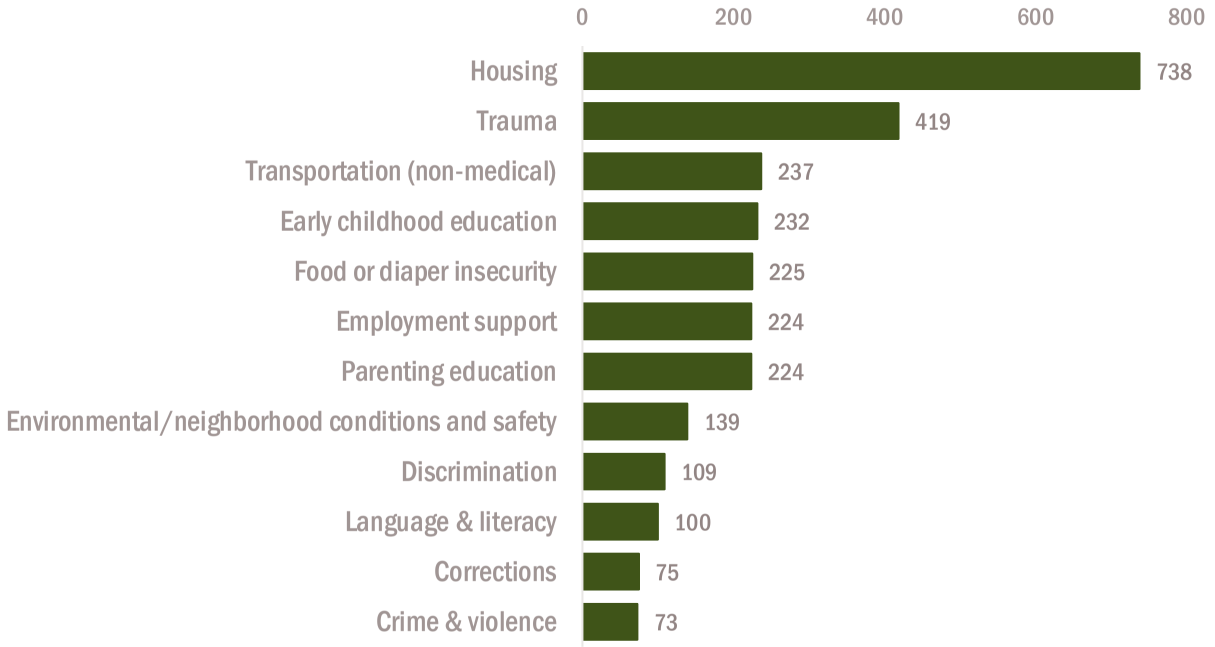
565 (66.8%) respondents rank **behavioral health care** as one of the top 3 areas that CCOs should use VBPs with their providers.



SOCIAL DETERMINANTS OF HEALTH & EQUITY (n=948)

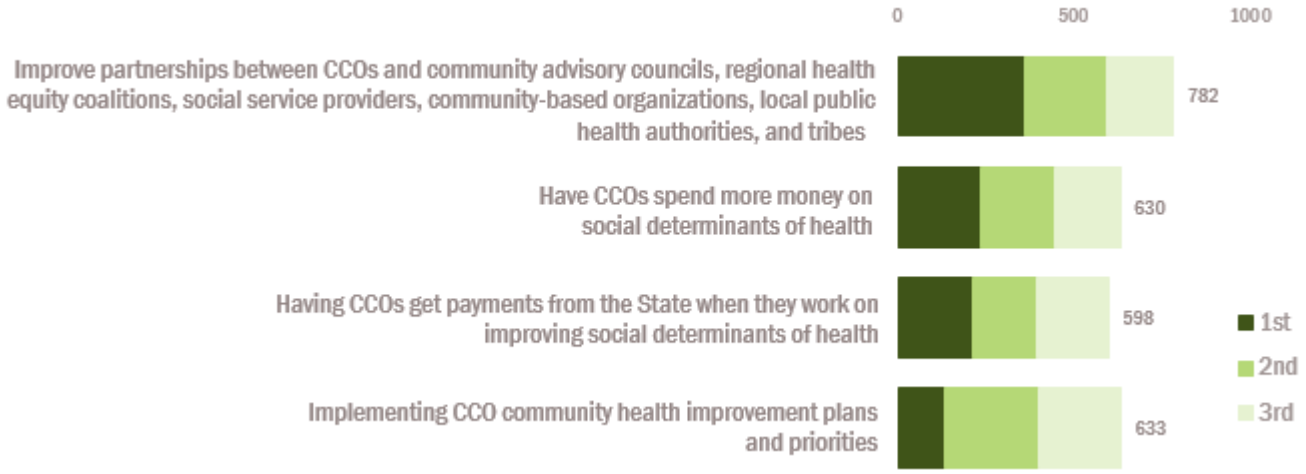
What are the top three most important area(s) of Social Determinants of Health and Equity that should be addressed in your community?

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

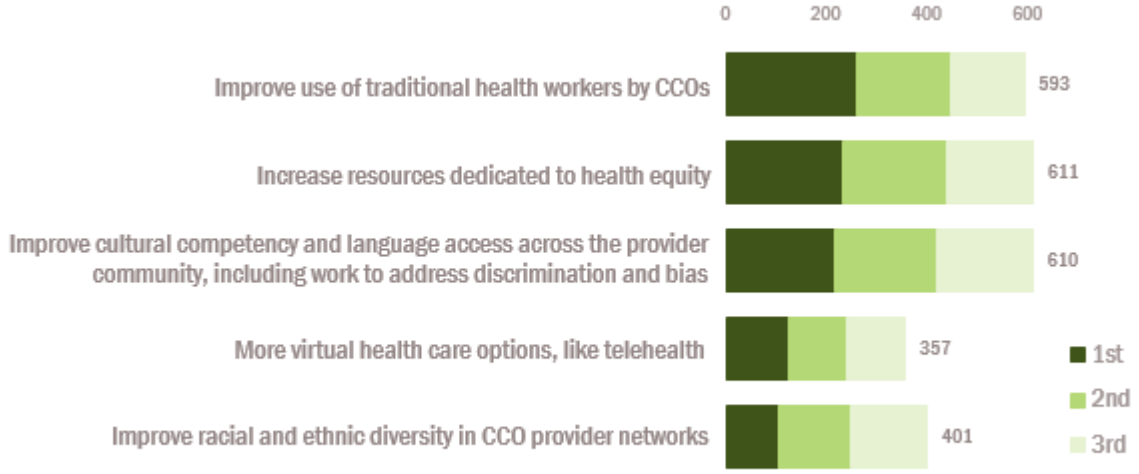


SOCIAL DETERMINANTS OF HEALTH & EQUITY (CONT)

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

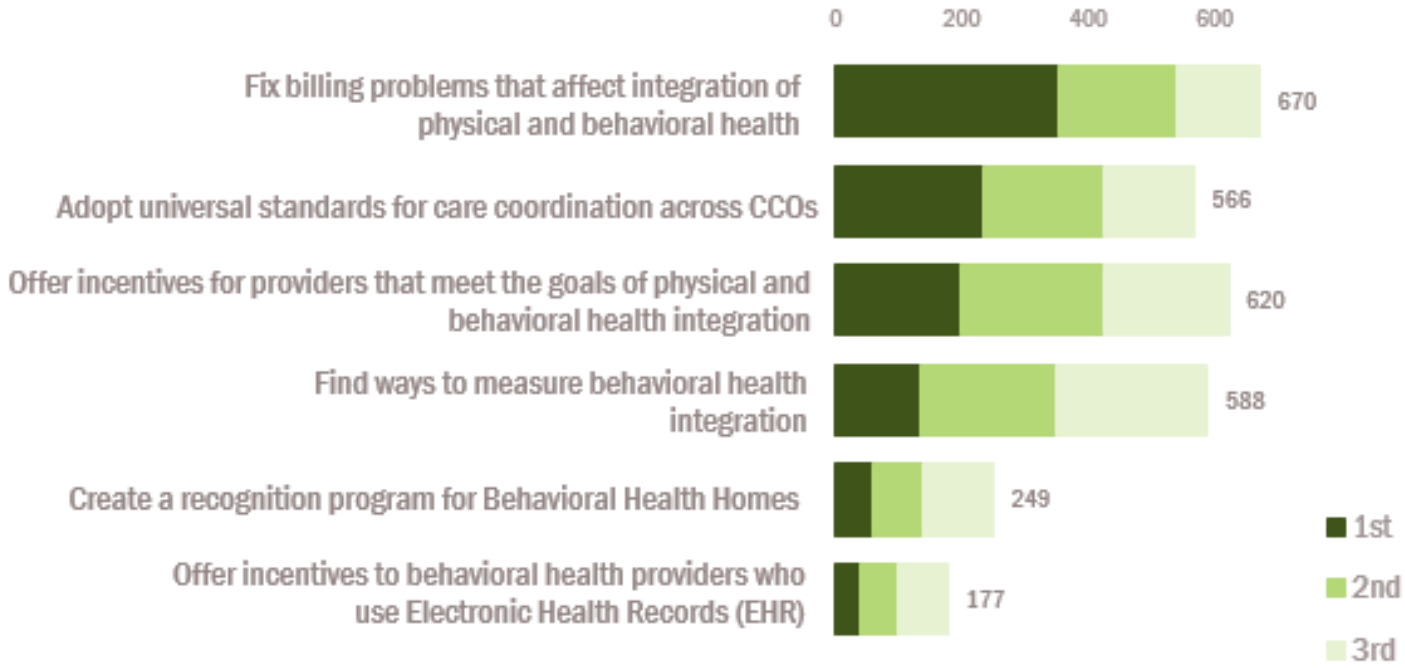


What are the most important ways that CCOs can address health disparities?



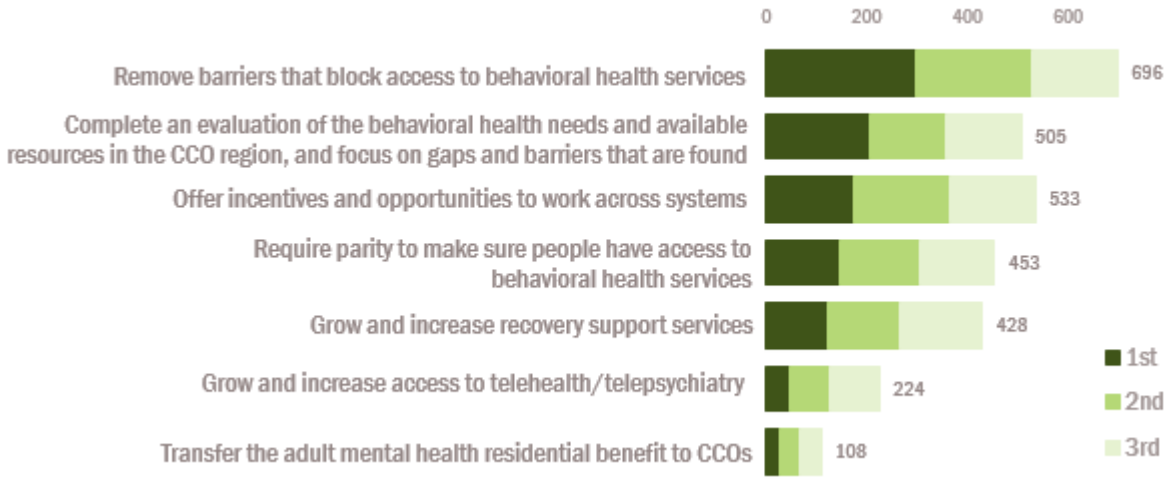
BEHAVIORAL HEALTH (n=1,024)

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

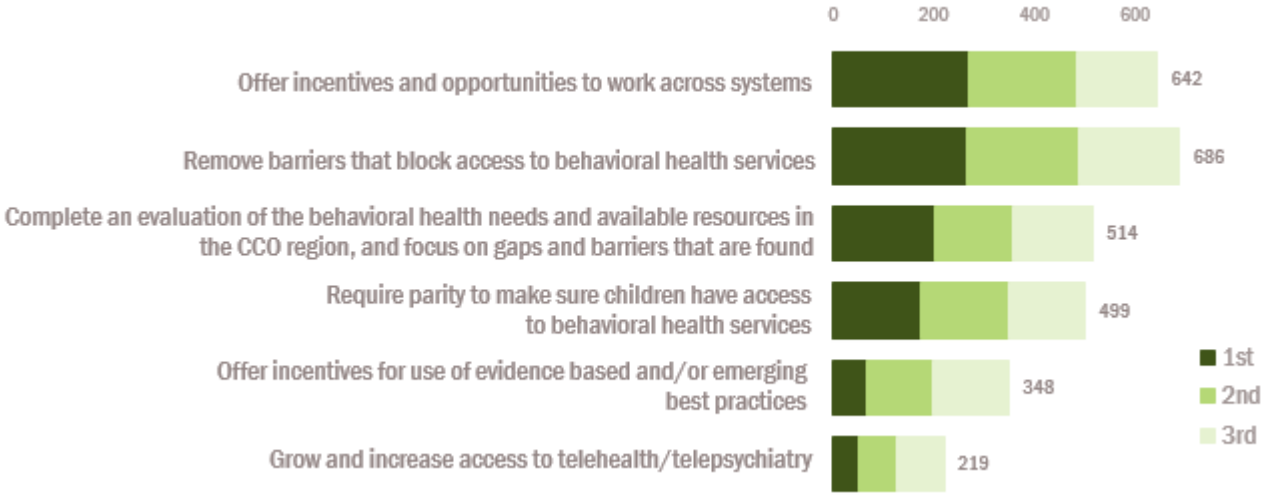


BEHAVIORAL HEALTH (CONT)

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

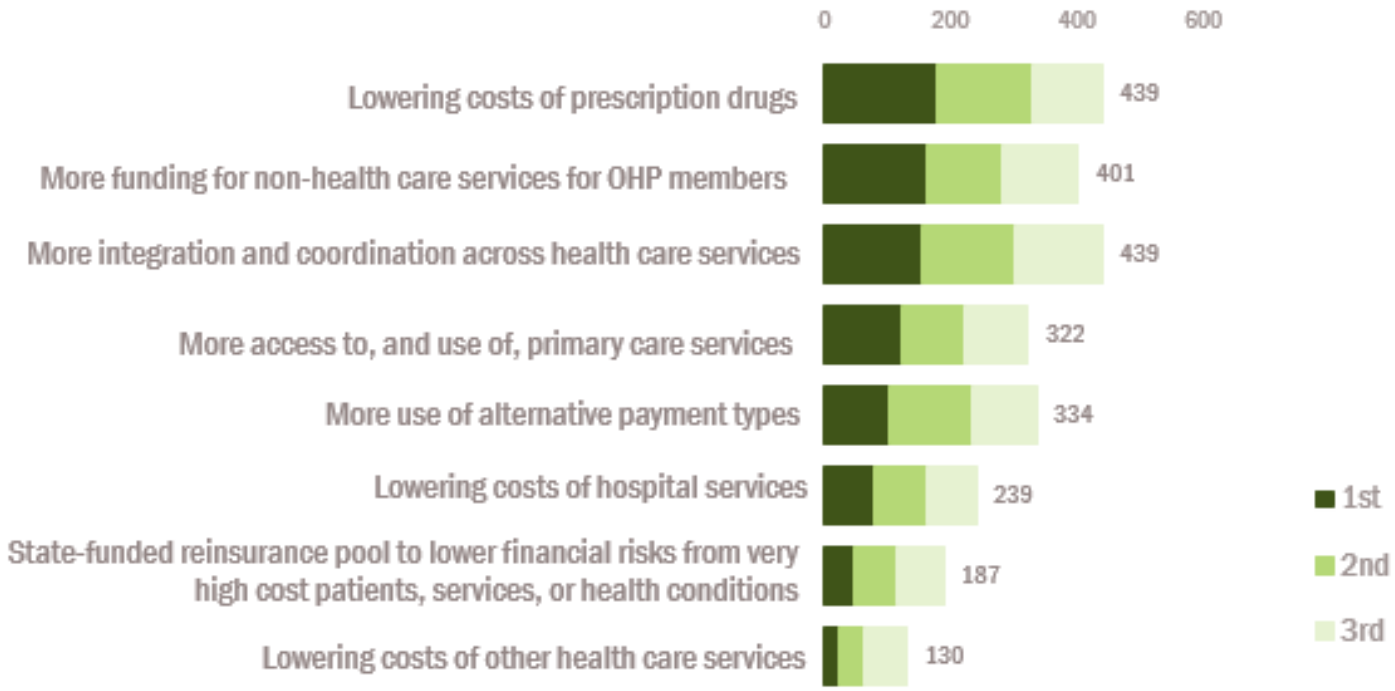


How do we ensure that children receive broad behavioral health services no matter where they live in Oregon?



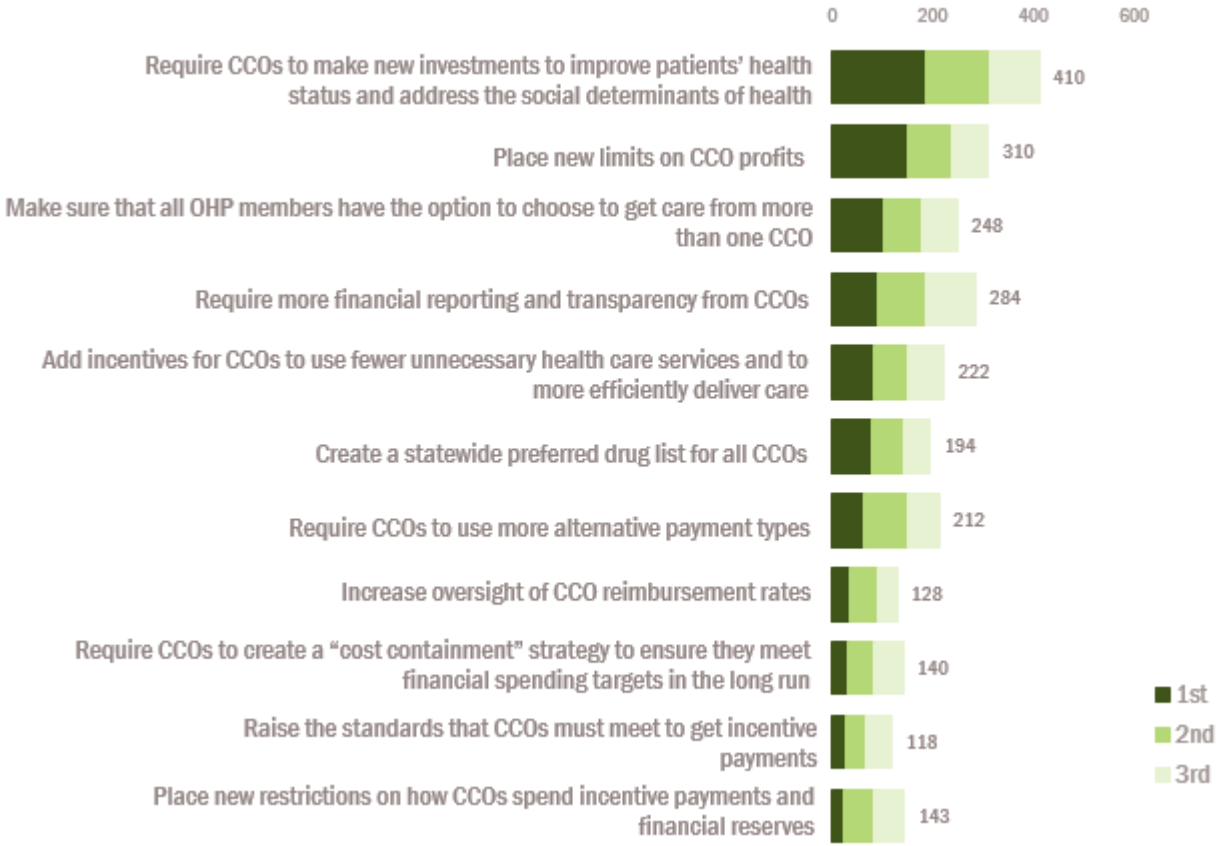
COST CONTAINMENT (n=866)

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



COST CONTAINMENT (CONT)

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



Survey Comments

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

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

A high-level summary of the open-ended survey responses is detailed on the following pages. For each topic identified, a brief description of the general content and themes of the answers is listed, as well as some example comments that are representative of the overall themes. Many of the comments and themes are cross-cutting and could apply to multiple topics. Full survey comments are available on the CCO 2.0 website: https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

1. Cost and Funding

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

- "**Protect the global budget concept** that was the foundation of developing the CCO concept. Allow communities to decide how to allocate and spend resources."
- "**Be a leader nationally on pharmaceutical costs**. Bring the costs down and make sure that essential treatments are available regardless of income. Example, HEP C."
- "**Use market share to drive down costs of care**- including specialty physician and leadership salaries- as well as pharmaceuticals and supplies. Medical systems are all top heavy while the patients and taxpayers bear the brunt of financing that top. Health care is not suitable for a pure capitalist business model; the goal should not be to maximize profit over equity and accessibility of care. Period."
- "We recommend OHA **focus on global budgeting at the CCO level to encourage cross-sector partnership** (health and social services) to yield the outcomes sought. We also recommend OHA align strategies to address SDH with existing capabilities in the EHR."
- "**Improve reimbursement** for behavioral health services and services supporting the social determinants of health such as Behavioral Health Consultants in Primary Care settings, and community health workers/promotoras."
- "Incentives would be well used if targeted not only to clinical settings, but to **systems supports** (e.g., prevention and community based work) or if CCOs were required to invest in community benefit activities that were aligned with community health improvement plans developed in partnership with the local public health department."

2. Behavioral Health

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

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

- "Serving in the behavioral health field for many years and running residential acute care facility as well as outpatient programs, I have found that **many CCO members cannot receive mental health services due to there being a deficiency in providers and long wait times** at community mental health agencies. I have personally tried to become a panel provider for CCOs only to be told that their provider panel was closed to private providers. This is confusing and frustrating as I have frequent calls from people who belong to local CCOs, but cannot find any openings in community mental health and no open providers."

- "I believe CCO's need to develop a means to provide **universal access to treatment services for individuals involved with addition issues**. This is a unique component of behavioral health care and has a clear need for addiction related metrics. People should not have to die while waiting to get into residential treatment or even outpatient services."

- "Behavioral health has been in crisis for decades and we can put money on the fire, but it will never go out until we change the structure of the flawed system. You can pour water in a leaky bucket and you will never have enough water. We need to build the social and health support people need as they need them and **not force them into a crisis system that does not meet their needs.** They need to care for the whole person, not just the diagnosis."

3. Social Determinants of Health

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

- "We know that social determinants of health, specifically food insecurity, needs to be addressed out here in Frontier Rural Oregon and if we are not able to continue to look at the "whole health" of the person, then we should just stop having LCAC meetings and working on CHIP plans **if we are not going to be able to implement anything new that is not necessarily tied directly to an incentive measure**."

- "With the overwhelming amount of research on ACEs and research connecting parenting and children's early relationships with parents and caregivers as one of the strongest protective factors, **CCOs have an opportunity to help normalize parenting education** and to make these supports part of every family's health care plan."

- "**Difficult to measure outcomes of social determinants of health in the short term.** These are long term improvements that may show results in 10-20 years as we support children and families, see less trauma/poverty/housing and food insecurity and have better adult health outcomes, more productive adults and better parenting in next generation."

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

4. Governance

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

- "I would like to see that CCOs are mandated to have a **required number of consumer seats** on the board."
- "The public should be allowed and encouraged to attend CCO board meetings and the community advisory committee meetings." **Members of the CCO board should be well known to the public** and approachable by the public. The board members are fiduciary agents for the public in the use of Medicaid money."
- "I would like to see more incentive **payments go to Community Advisory councils** to carry out projects in communities, as they represent the best change for collaboration and cross organization work, which I feel is vital to truly lowering cost and improving community health."
- "Still too many conflicts of interest in board structures and contracts. **Add contracting/legal expertise to OHA** and build in safeguards for due process for patients and service providers when conflicts arise."
- "I feel strongly about **oversight and requirements for CCOs profits and salary structure** within the organizations; most seem to pay themselves well and then refuse to pass appropriate payments on to providers."

5. Metrics

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

- "The incentive metrics seem like pretty low-hanging fruit in some cases. We **need to push CCOs harder** for better outcomes/lower cost."
- "When CCO's are offered incentives to pay particular attention to one outcome it **often creates an overload in another area**. For example, when CCO's were incentivized on developmental screens for children it increased the number of children screened and referred for services but no increase was given to those providing the services. The incentives should be reinvested into the community-based organization providing the service to help meet the new increased demand."
- "Any incentives given should have a percentage that **must be reinvested in an area that was impacted** by that focus."

6. Workforce

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

- "**Increase funding, hiring and commitment to peer support** across physical and behavioral health care. Do not limit it to the adult system of mental health and addictions but to move to a more proactive approach by providing youth and family peers to work alongside families and youth before they are in crisis."
- "**Promote excellence**. Training's on best practices are available across the system of providers in an equitable and cost effective manner."
- "We need to have **more peer to peer support on the Developmental Disabilities** level. Many parents are overwhelmed when there child gets a diagnosis, by no intervention for months, by the time they receive help they are in crisis mode."
- "**Trauma informed care** - one of the biggest missed opportunities in our health care system is related to unaddressed trauma, and misunderstandings about how many Oregonians came to experience such significant healthcare issues to begin with. Our health, behavioral health, and other practitioners such as social workers, case managers and others need new approaches that are grounded in trauma informed practice principles. Otherwise, we will keep putting a 'bandaid' on the real wounds Oregonians experience, and continue to treat symptoms rather than the person."
- There also needs to be **payment equity** for other provider types (NP's, PA's, BH, etc.) and improved options to assist this population with some payment for technology related health care."

7. Public Health and Prevention

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

- "More evidence based (guided) early prevention and intervention efforts. **Early efforts are impactful in the long term** across all metrics. Those that would impact mental and physical health outcomes by focusing on prenatal, maternity, and early childhood pay back dividends in reduced care costs for adolescents and adults."

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

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

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

8. Coverage

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

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

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

- "**The credentialing of providers needs to be more streamlined**. DMAP will credential our providers in a very timely manner, but our CCO takes 2-3 times as long. We have providers on staff (3 currently) who have been with us since Dec. 2017 and they still aren't credentialed. How can we provide access to our patients when the CCO won't expedite or timely credential the providers? We are remote, access is limited in the surrounding 50 mile radius, and our providers can't get credentialed."

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

9. Value-based Payments

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

- "**Stay on the path designed for this work - outcomes, experience and affordability**. Remain committed to the models we have designed and are working - primary care medical home, quality incentive programs for primary care and hospitals, and value based care payments."
- "The answer is not to provide an infinite amount of care and subsidy, but rather to **focus on the most important care,** education, and to hold CCO's (providers) accountable for holistic risk sharing agreements, bundled care, and value based benefits, instead of allowing any fee for service."
- "As solo providers are added to the system, I hope that CCO's increase understanding that the case-rate model does not work when you're not seeing hundreds of clients per week. **A fee-for-service model is much more appropriate in smaller practices**."
- "Ensure that when payment is made through Value Based Payment methodologies the CCO has **a way to measure the effectiveness** of the program. Encourage experimentation, but ensure there is a control group for comparison and that there are methods to measure whether the program is a success in containing costs and improving patient outcomes."

10. Individual CCOs

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

- "Coordination between providers, hospitals and the CCO plan, for example the Central Oregon model with Pacific Source, St. Charles Hospital System and the providers under the Central Oregon IPA **have shown success by working together to improve the lives of this population.** Other areas of the state could learn from them.
- "It would be **wonderful if my CCO could figure out how to pay providers in a timely manner**. For every mistaken denial on Explanation of Benefits (EOBs), clients have been notified and scared that they could no longer have services and have large bills to pay."
- "I have been very **pleased by how my CCO has performed with regard to specialty care and preventive care.** I have been less impressed with the performance of primary care providers, with regards to wellness care (which is almost the only use). In the area of this CCO, the primary (close to a monopoly) care provider (clinics, hospital, urgent care) provider has been unable to retain medical personnel so there is zero continuity of care, in terms of seeing the same provider for well person care or the occasional other care I've received. Again the specialty care I've received via outside practitioners has been fine and I am grateful that I have had OHP coverage when I needed it. The CCO helped make that happen and it happened with a minimum amount of stress re: coverage, payment, etc."
- "**IHN-CCO has been an amazing leader** in SDoH, THW and peer-ran projects. GREAT JOB to IHN-CCO!"

11. Health Equity and Disparities

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

- "I have found it **very challenging in finding doctors who are non-white**. Is there a program which offer incentives for medical personnel with racial or ethnic backgrounds? I have mentioned this in the past, and it seems to fall on "deaf ears". This is the 21st century.... let's act like it!"
- "While savvy in navigating systems, it took numerous phone calls and a total of 8 hours on hold to make a simple change (adult son experiencing disability no longer had private insurance coverage). I can't imagine what that would be like for a parent unable to take time off work, spoke a language other than English, or that was not able to access online resources. **There must be a way to make simple transactions...simple."**
- "CCO 2.0 should **address the health care disparities**, utilize the knowledge gained in understanding the connection between the SDoH and health outcomes (continue to do so). However, the current payment structure does not address this area. In our region, we are

collaborating with other CCOs and using best practices to take advantage of 'economies of scale'. It concerns me for our communities that there would be drastic changes to a model of care that has proven successful for everyone involved."

- "One thing that I didn't like when I found out I qualified for OHP and was assigned a CCO…was that they just randomly assigned me a PCP without asking me if I already have a PCP in the community that was accepted by the health plan, nor did their selection factors in areas of **expertise for my health conditions and LGBTQ identity**."
- "CCOs need to **contract directly with certified and qualified interpreters on the OHA list**. They are spending too much money going through agencies which, in most cases, subcontract with interpreters. Because the interpreters are independent contractors, they often hold no professional or personal liability insurance and are not covered by agency insurance policies."

12. Oral Health

Options and access to care; opportunities for better integration;

- "I also would like to see **better options for dental care** than just pulling problem teeth- again there is a lot of evidence that toothless grins decrease jobs, housing opportunities, and mental health."
- "CCOs need to work on **improving the integration of oral health care**. If oral health integration cannot be one of the top priorities, it must be included in the other work to contain costs, use value-based payments effectively, and address equity. And, although the focus of behavioral health integration is integration with physical health, there is also room to increase integration of oral health and behavioral health."
- "Oral Care is also something that desperately needs to be improved. In the decade+ I've worked w/ clients on Medicaid, I've seen abysmal practices where **insurance only seems to cover pulling teeth**. When I've seen clients get denied housing and jobs due to poor oral health (e.g., missing and/or rotted teeth) for years, it's very frustrating for them and for their helpers such as myself."

13. Overall System

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

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

- "Please **stop allowing individual CCOs to have different standards and rules for covered benefits**. Please standardize the titles and functions of Exceptional Needs Care Coordinators. Please standardize language across handbooks. Please make up consumer information about ENCCs/ICMs. Please don't hide phone numbers of ENCCs (be more transparent with how to reach and utilize them)."
- "**Fewer regional CCOs** (five in state) would seem prudent and more cost effective."
- "**Prohibit for-profit enterprises from owning/operating CCO's.** This is ethically, operationally, and organizationally disastrous for the recipients of OHP and the taxpayers of Oregon."
- "**Consolidation of CCOs to make the CCOs larger** & give the CCOs more "market power" (to negotiate lower prices from providers) may deliver additional value to taxpayers in Oregon. Also, Medicaid beneficiaries in Oregon (outside of Portland) do not have a choice of what Medicaid plan they wish to enroll in."
- "One thought is to have **ONE CCO be responsible to serve all children experiencing foster care** throughout the State (like Colorado) to assure that children's needs are met regardless of their placement location."

CCO 2.0 General Feedback Survey #2

Results and Analysis

8-1-18

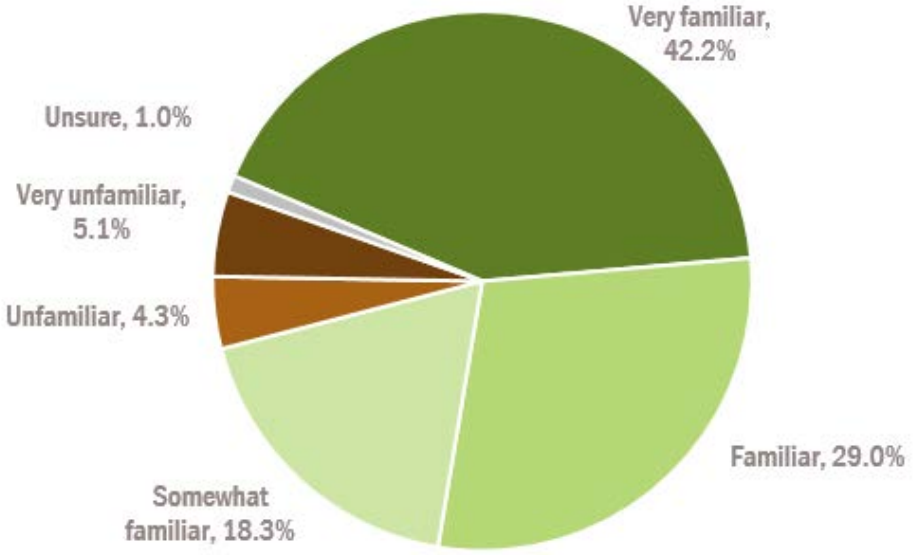
Survey Overview

- Survey was open 6/18/18 to 7/1/18.
- English and Spanish versions were available online.

Initiated survey: 523
Completed survey: 393 (75.1%)

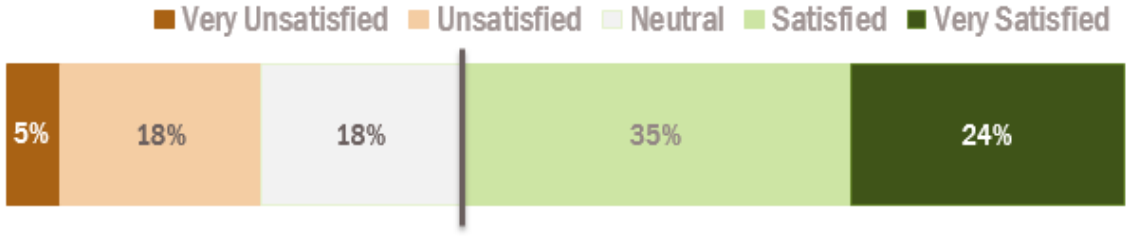
OHP Member : n=123

89.6% of all survey completers are at least somewhat familiar with CCOs



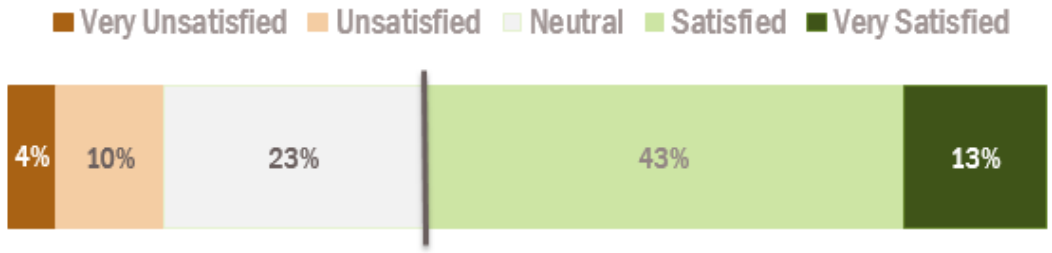
OHP & CCO Satisfaction

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?



59.3% 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?



55.7% are very satisfied or satisfied

Oregon Health Authority

Stakeholders

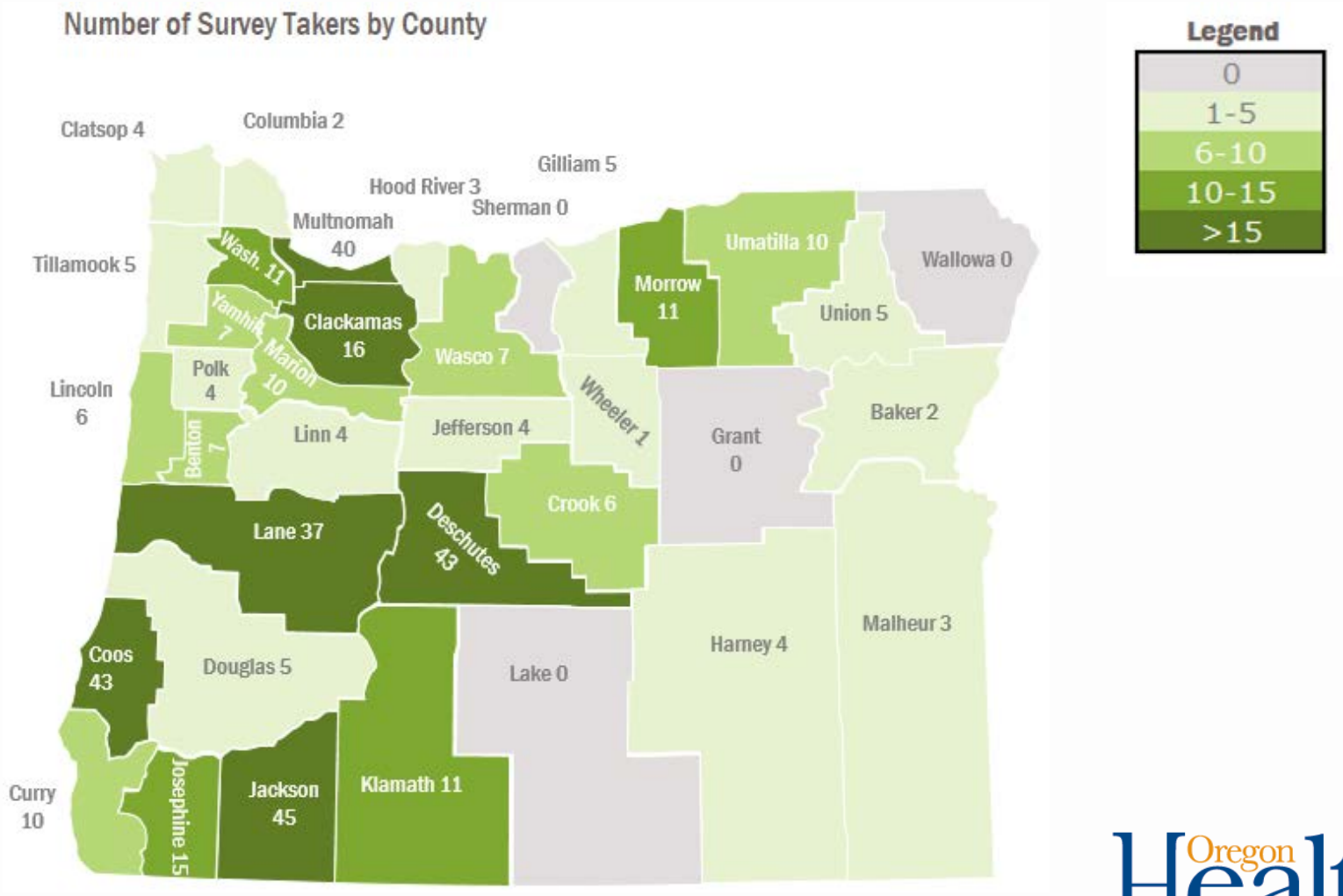
Stakeholder Group*	%
General public	27.8%
Represent a community-based organization	27.5%
OHP member and/or family of OHP member	25.4%
Local public health	21.0%
Provider: Other health care provider	14.8%
Contract with CCO	13.3%
CAC member	11.2%
Employed by a CCO	10.7%
Government worker	9.5%
Advocacy organization	8.9%
Provider: Primary care provider	8.9%
Other CCO stakeholder (please specify)	6.8%
Provider: Oral health provider	6.5%
Provider: Behavioral health provider (including mental health and addictive disorders)	5.9%
Regional health equity coalition member	3.0%
Legislator	0.0%

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

CCO*	n	%
Advanced Health, LLC	48	12.2%
All Care CCO	40	10.2%
Cascade Health Alliance	11	2.8%
Columbia Pacific	14	3.6%
Eastern Oregon	37	9.4%
FamilyCare	13	3.3%
Health Share of Oregon	31	7.9%
Intercommunity Health Network	17	4.3%
Jackson Care Connect	30	7.6%
PacificSource - Central	42	10.7%
PacificSource - Gorge	14	3.6%
Primary Health of Josephine County	11	2.8%
Trillium Community Health Plan	32	8.1%
Umpqua Health Alliance	4	1.0%
Willamette Valley Community Health	14	3.6%
Yamhill Community Care	11	2.8%
Not a member / No CCO affiliation	100	25.4%
Unsure	18	4.6%

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

Geographic Distribution



Demographics

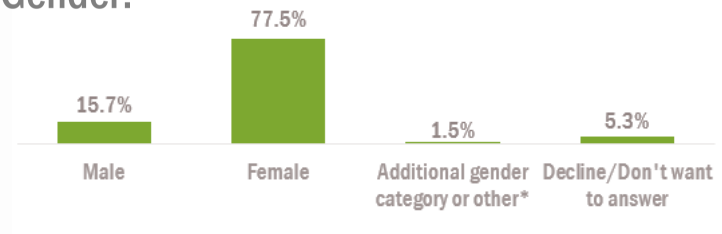
98.5% speak English well or very well

Average 48.2 years of age

Disability:

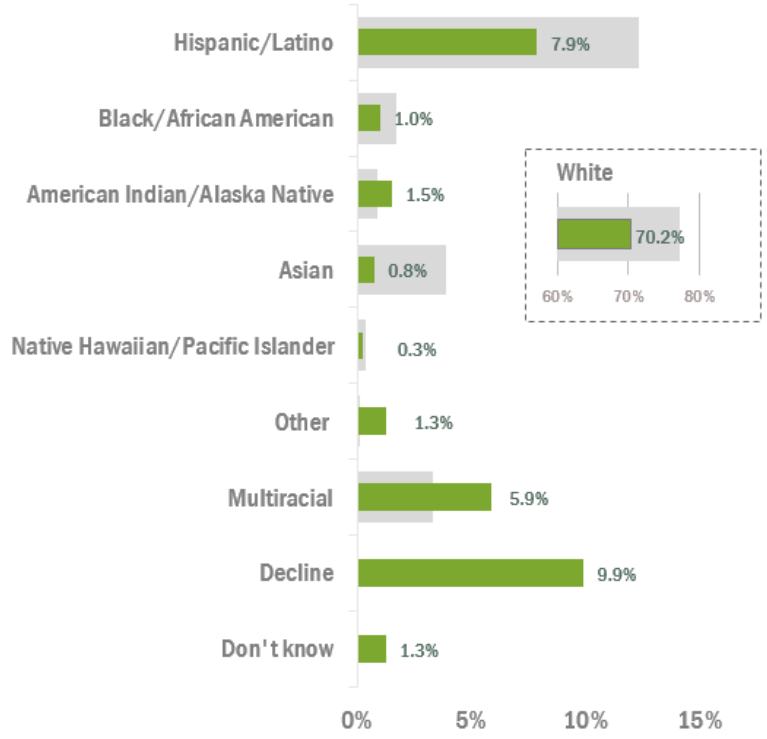
- Deaf or serious difficulty hearing: 2.5%
- Blind or serious difficulty seeing: 1.8%
- Difficulty walking or climbing stairs: 8.4%
- Difficulty dressing or bathing: 2.5%
- Difficulty concentrating/decision making: 5.6%
- Difficulty doing errands alone: 4.3%

Gender:



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

Race/Ethnicity: Survey takers vs Population



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

- **191** respondents provided additional open response feedback.

Policy Options

Community Involvement:

"CCOs are managed locally and have boards and committees of people that guide their work. Some people say CCOs need more members of the local community on their boards.

"OHP should make CCOs include more community members – including people who get OHP – on their boards and advisory committees. CCOs should also have to include the type of people who live in the communities they serve. For example, people of the same age, race or ethnicity, or income range. CCOs should take these steps, even if it means changing some of the people who serve on these boards and committees today.

"What kind of impact do you think this would have?"

Value Based Payment:

"Today, most doctors and other providers are paid based on the number of times they see a patient or the services they provide. Some CCOs pay health care providers more money if they improve care or get better results for patient's health.

"Over the next five years, CCOs should be required to pay more health care providers to improve the care OHP members get, instead of paying them for number of visits and services they provide. This would mean providers may have to change the way they do business.

"What kind of impact do you think this would have?"

Oregon Health Authority

Policy Options

Sustainable Growth:

CCOs are designed to help the Oregon Health Plan save money by connecting people to care that costs less and reduces the need for more expensive services. An example would be doctor visits that help you avoid the emergency room. The money saved helps the state of Oregon give more people health care. It also means the state can spend more for schools, public safety and other vital services.

Over the next five years, the Oregon Health Plan should lower the rate that costs are increasing, so the state of Oregon has more money for health care, education and other services. This could mean CCOs might have to offer members less costly medications, do more to reduce services that are not medically needed, or reduce payment rates for doctors and other health care providers.

"What kind of impact do you think this would have?"

Social Determinants of Health:

"Most of the things that change our health happen outside the doctor's office. For example, things like where we live, what we eat, if we have enough to eat, and if we have access to transportation can help or harm our health. We call these things "social factors."

"The Oregon Health Plan should require coordinated care organizations to spend a larger part of their budgets to help OHP members with housing, food and other supports that have an impact on health, even if it means the CCOs have somewhat less money for other health care services.

"What kind of impact do you think this would have?"

Policy Options

Behavioral Health:

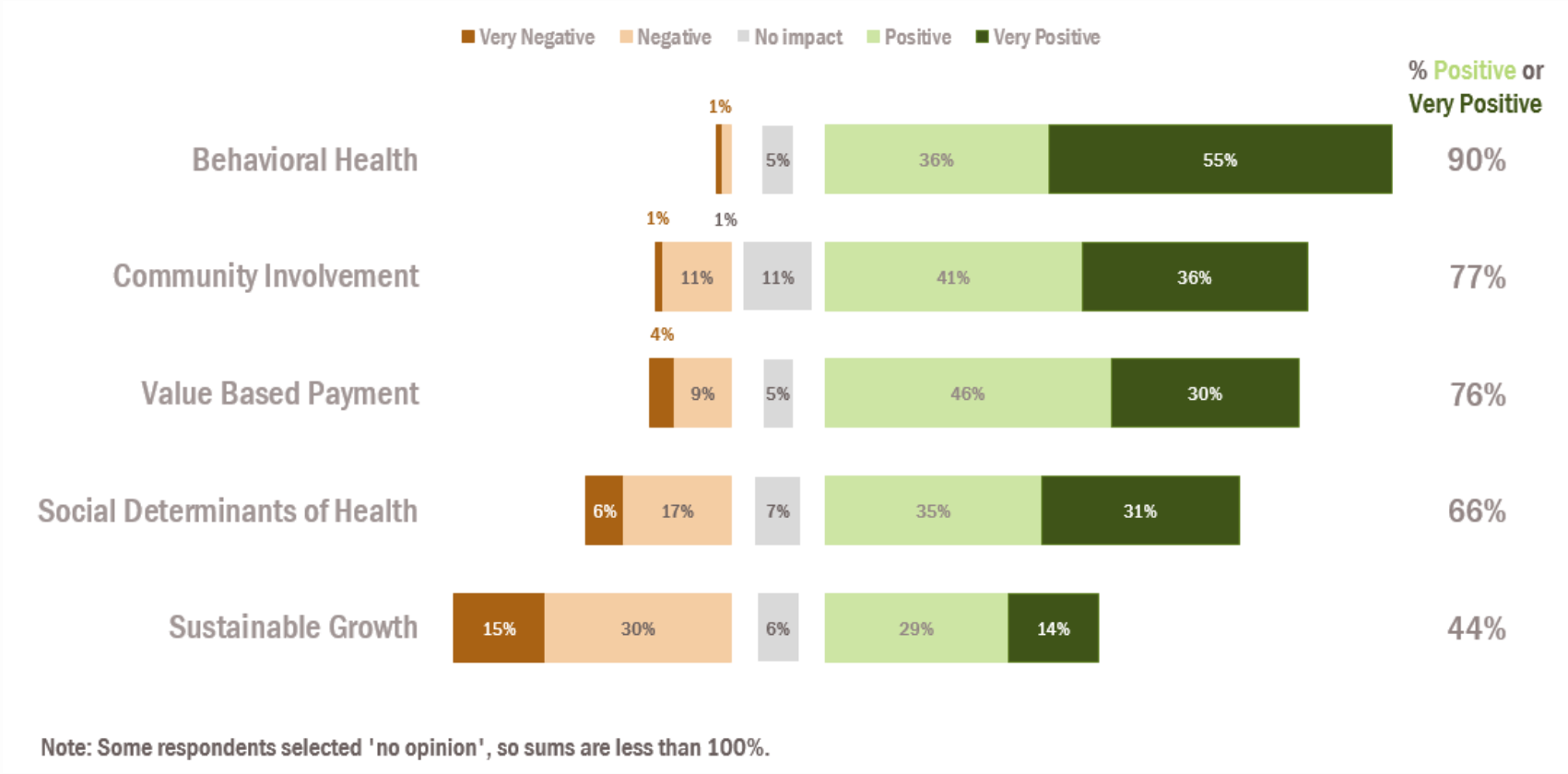
"The Oregon Health Plan should do more to get doctors and other providers to work together to help members who need mental health and addiction services. OHP might do this even if it means paying providers more money for the time it takes to coordinate care.

"What kind of impact do you think this would have?"

Oregon Health Authority

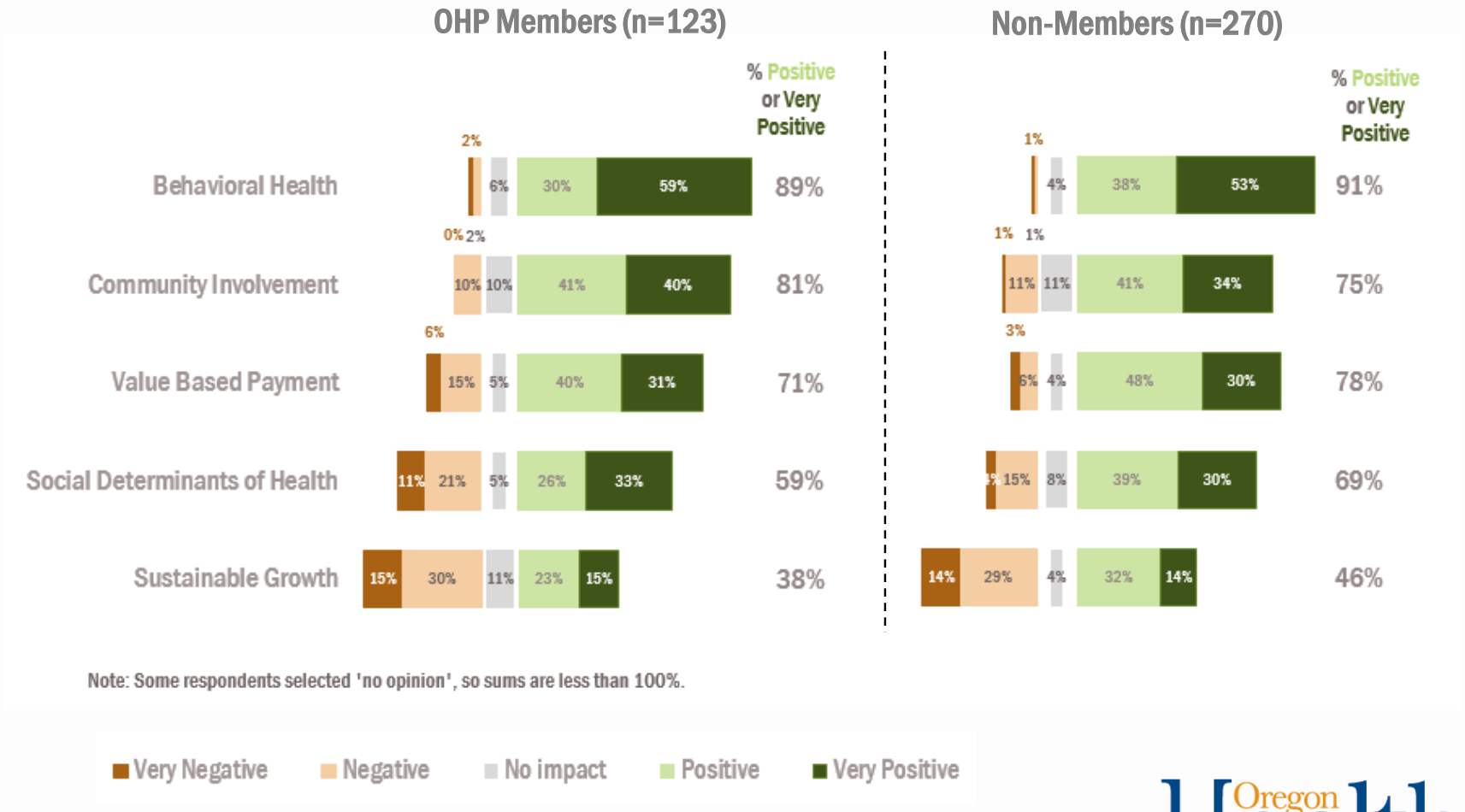
Policy Options

What kind of impact do you think this would have?



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

Policy Options



Survey Comments

Is there anything else you'd like to share with us about these ideas to improve the Oregon Health Plan?

Theme	EXAMPLE keywords	# of comments
Cost and funding	cost, funds, budget, flexible services, reimbursement, rates	52
Governance	CAC, board, governance, general operations	50
Social determinants of health	social determinants of health, education, transportation, housing, food	30
Behavioral health	behavioral health, addictions, mental health, CCBHC	28
Oral health	dental, oral, dentist	26
Alternative care	alternative care, alternative, traditional	26
Coverage	coverage, network adequacy, waiting period,	24
Public health	population health, community health improvement plan (CHIP)	23
Value-based payment	value based payment, pay for performance, value	22
Personal	(personal complaint or issue)	13
Workforce	traditional health workers, PSS, access to care	11
Particular CCO	(named a specific CCO)	9
Metrics	measures, incentive metrics, incentive payments	7

Full survey comments are available on the CCO 2.0 website:
https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

Appendix E: CCO 2.0 public input –

iv. Summary of OHP member phone survey

Oregon Health Authority
Oregon Health Plan Member Survey

August 2018

Research Purpose

- Assess member satisfaction with health care
- Measure support for CCO 2.0 policies to complement community outreach
- Determine most effective messengers

Methodology

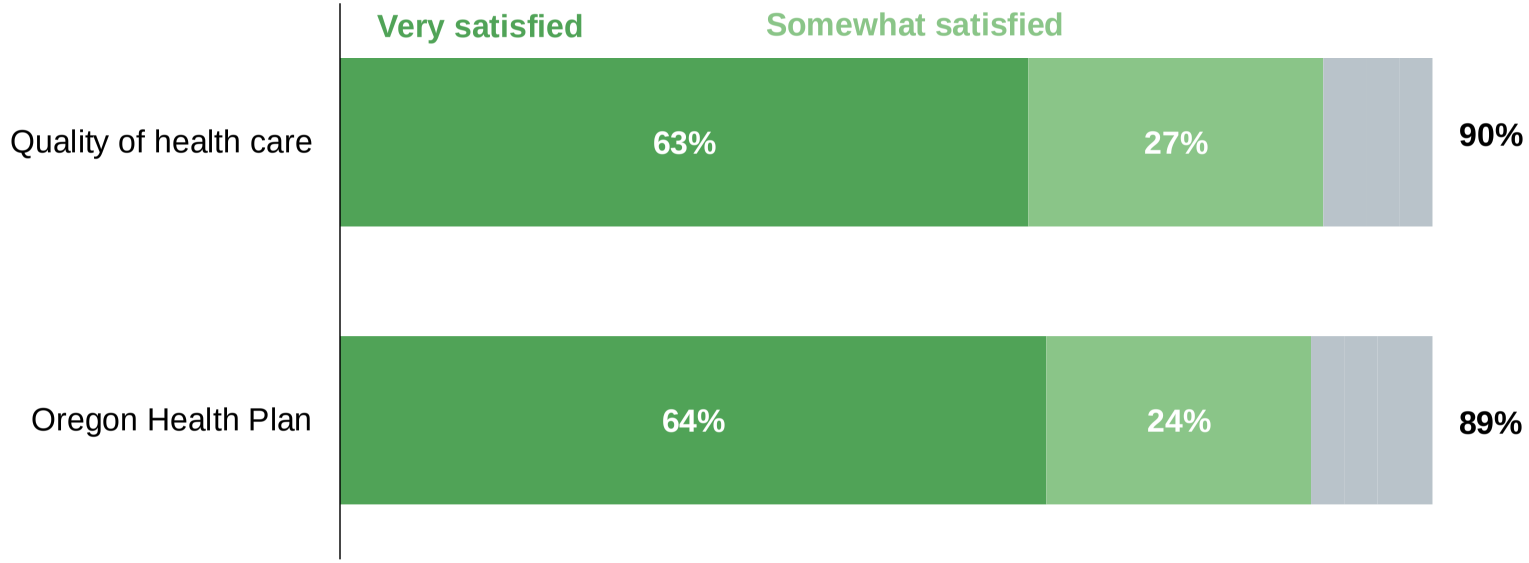
- Telephone survey of 401 OHP members
  - 348 interviews conducted in English
  - 14 Spanish, 14 Vietnamese, and 28 Russian
- Conducted August 22–27, 2018; 12 minutes to complete
- Respondents contacted from a list of OHP members
- Margin of error ±4.9%
- Due to rounding, some totals may differ by ±1 from the sum of separate responses

Key Takeaways

- OHP members are highly satisfied with their health care, and they trust OHP for information about health
- Members have some concerns about access to care and the ability to easily find and choose providers
- There is strong support for some CCO 2.0 proposals, but those that may limit the number of providers in Oregon are less popular

Satisfaction

OHP members are highly satisfied with the program and with the health care they receive.



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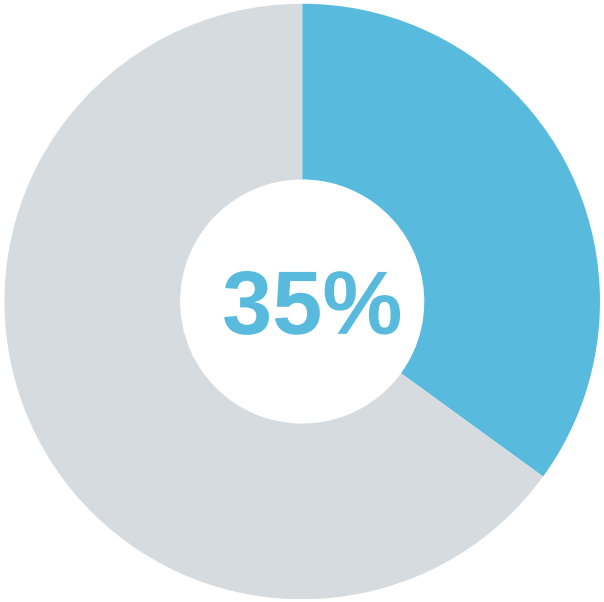
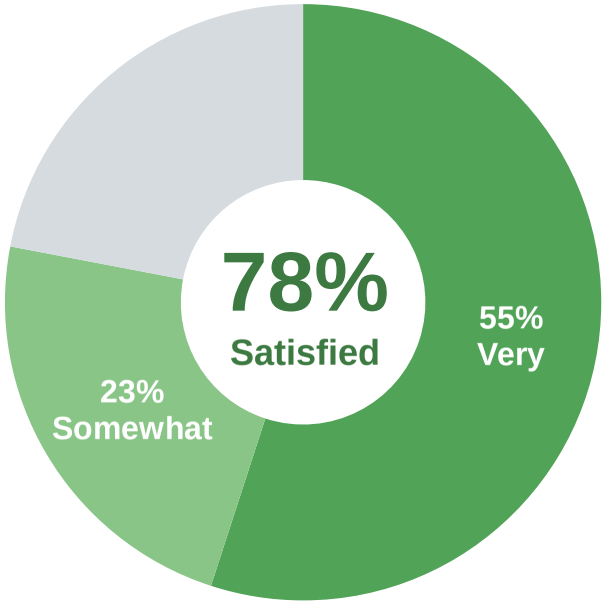
Many respondents are unfamiliar with CCOs.



Not sure what a CCO is

Those who are familiar with CCOs are highly satisfied.



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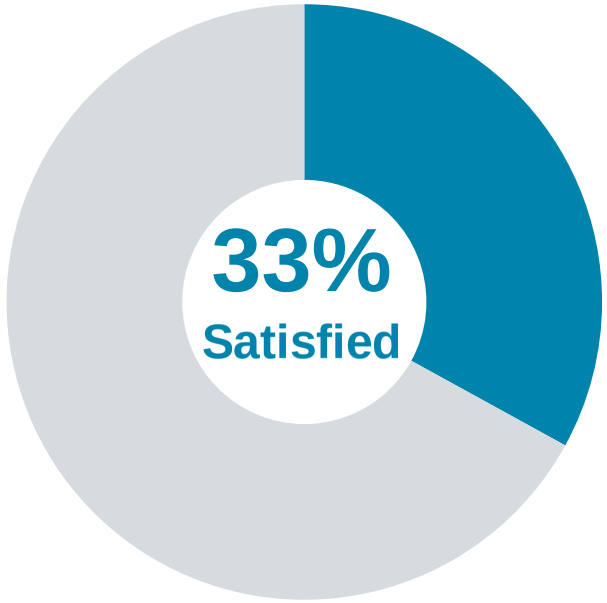
Many members wouldn't change OHP. Those who had suggestions pointed to choice, access, and coverage.



Top Suggestions for Improvement

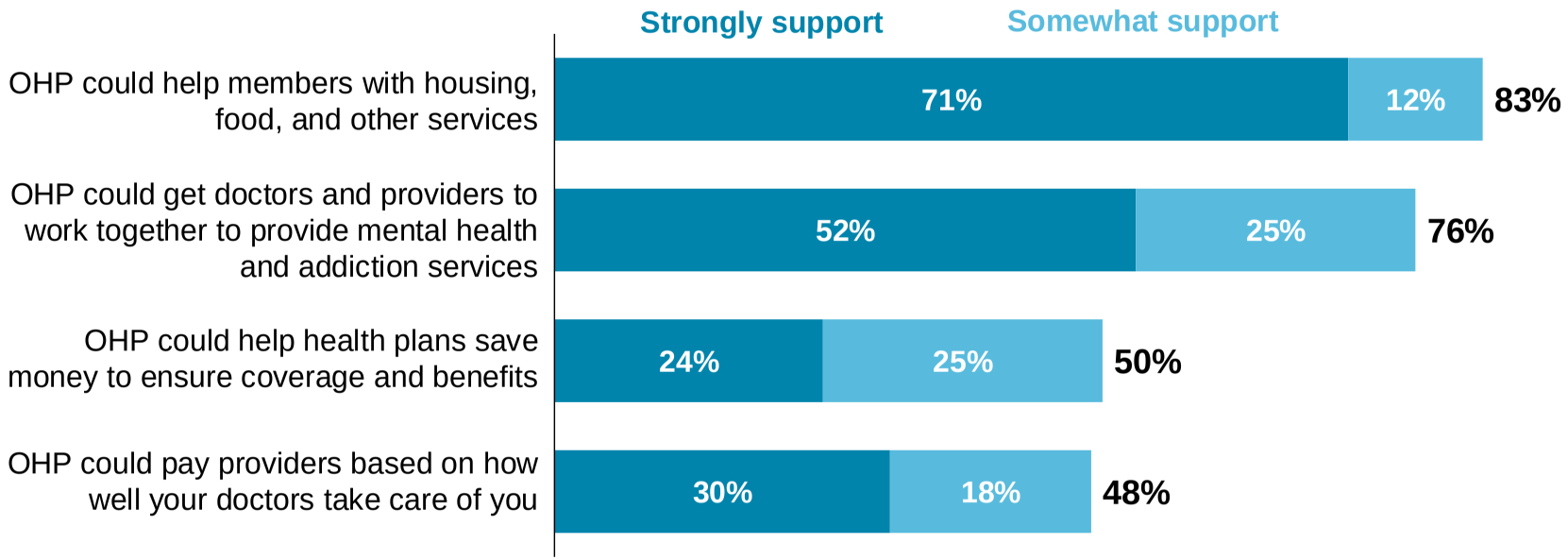
23% Expand coverage (dental, vision, Rx, and more)

12% Wait times in office and on phone

10% Improve access and choice of provider

Health care improvements

There is stronger support for improved mental health care and addressing social determinants of health.



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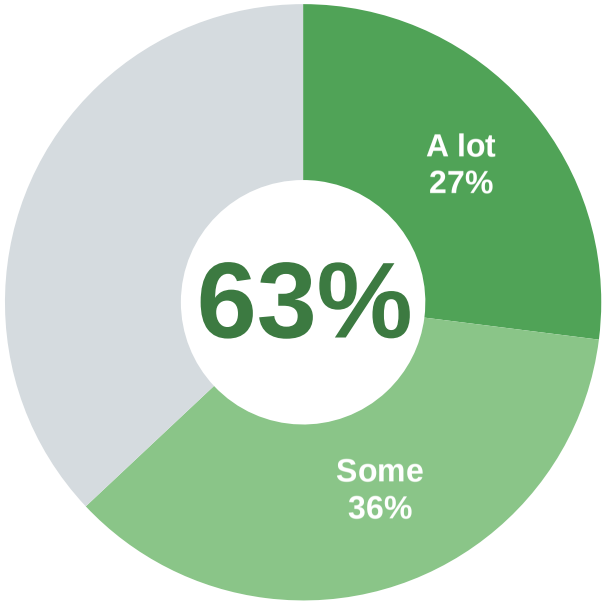
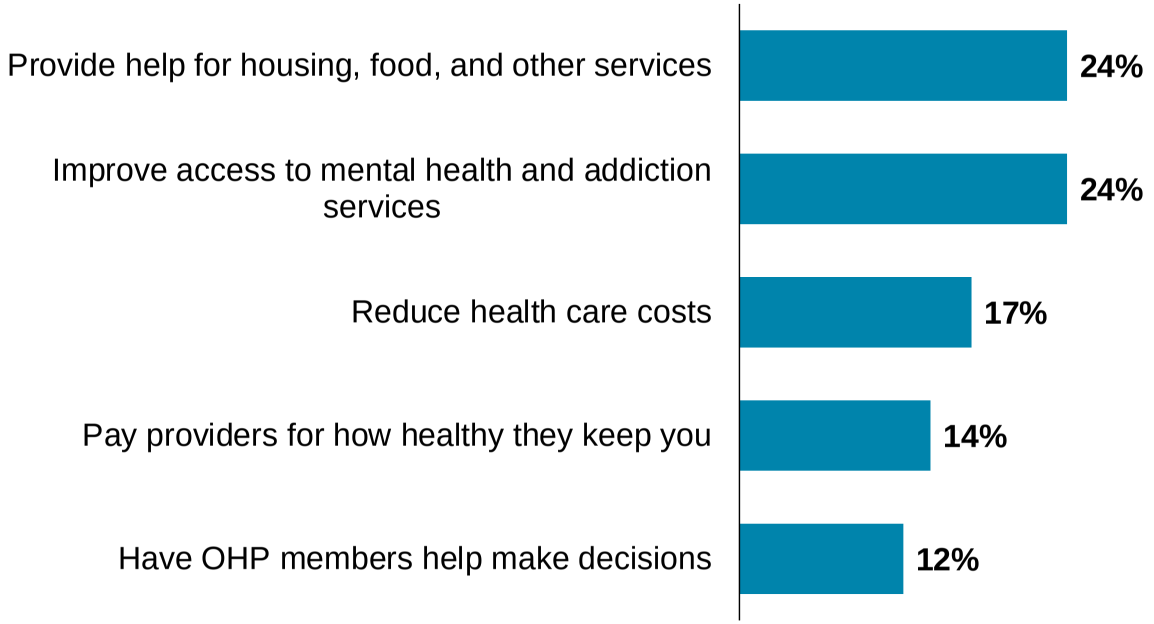
Two-thirds of OHP members think having more representation on CCO board could improve health.



Overall, members prioritize mental health and addiction care, and help for things like food and housing.



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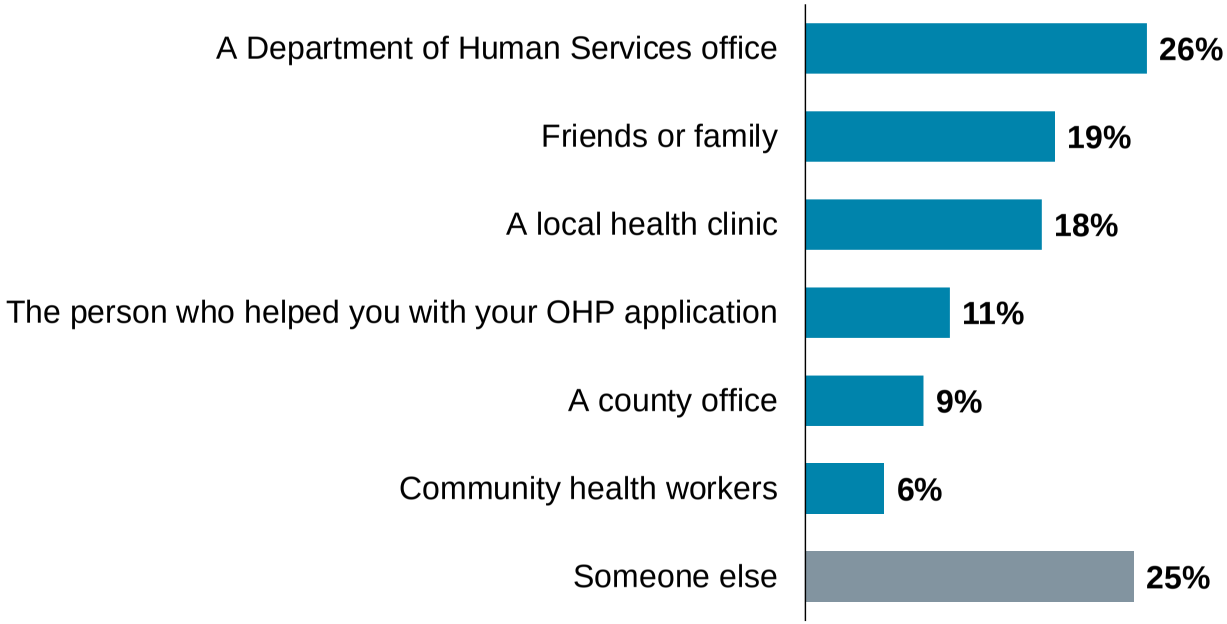
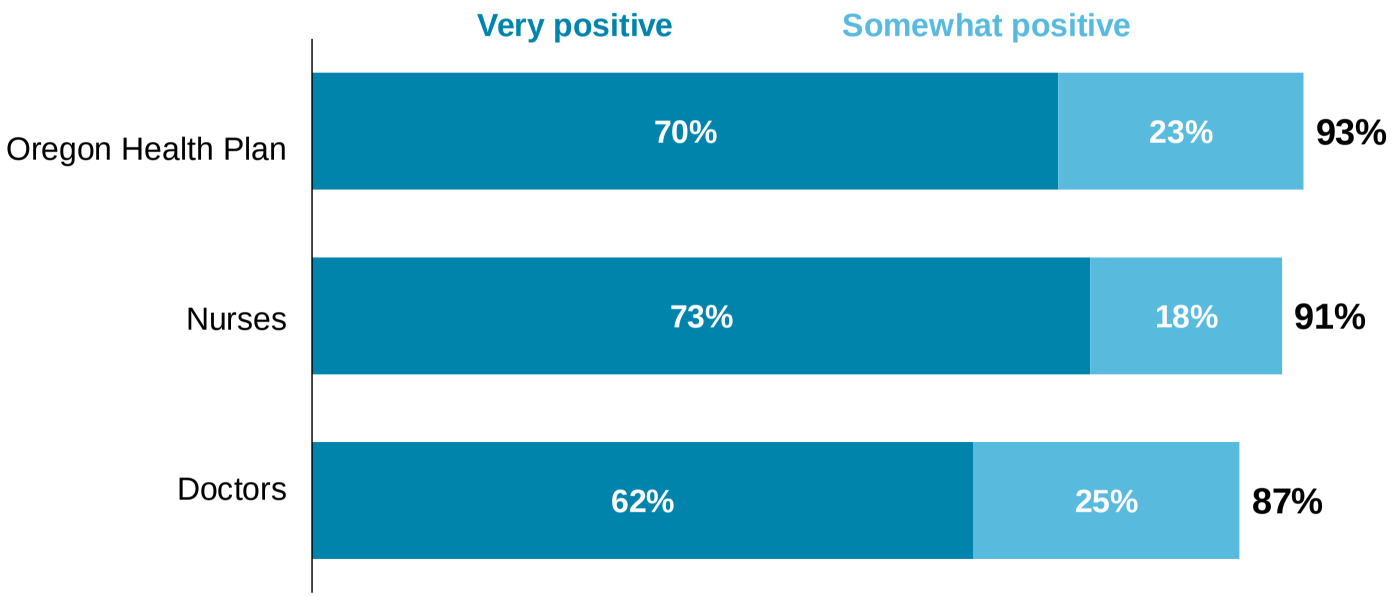
Messengers

Members often turn to a DHS office for information about OHP, but many are relying on other sources.



Members trust OHP. They have positive impressions of the program and of their providers.



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Appendix E: CCO 2.0 public input –

v. Public meetings list, including culturally specific outreach

CCO 2.0 Public Meetings List

October 2018	
10/15/2018	Oregon Health Policy Board
September 2018	
9/18/2018	The Dalles Community Forum in Spanish
9/14/2018	Tribal & OHA meeting
9/13/18	Hood River Community Forum in Spanish
9/4/2018	Oregon Health Policy Board
August 2018	
8/21/2018	Woodburn Community Forum in Spanish
8/10/2018	Tribal & OHA meeting
8/7/2018	Oregon Health Policy Board
July 2018	
7/30/2018	CCO Leadership & OHPB Joint Public Meeting
7/19/2018	CCO 2.0 Health IT Policy Options Webinar
7/10/2018	Oregon Health Policy Board
June 2018	
6/28/2018	Statewide Road Show: Henley Elementary School, Klamath Falls
6/27/2018	Statewide Road Show: Red Lion Hotel, Coos Bay
6/27/2018	Statewide Road Show: Astoria Armory, Astoria
6/26/2018	Statewide Road Show: OSU LaSells Steward Center, Corvallis
6/25/2018	CCO 2.0 Health IT Policy Options Webinar
6/21/2018	Statewide Road Show: Madison High School, Portland
6/20/2018	Statewide Road Show: Central Oregon Community College, Bend
6/19/2018	Statewide Road Show: Eastern Oregon Trade Center, Hermiston
6/19/2018	Statewide Road Show: Treasure Valley Community College, Ontario
6/18/2018	Statewide Road Show: Hood River Inn, Hood River
6/8/2018	Tribal & OHA Meeting
6/5/2018	Oregon Health Policy Board
May 2018	
5/22/2018	CCO2.0 Financial Policy Stakeholder Roundtable
5/17/2018	Public Health Advisory Board
5/17/2018	CCO Public Leadership Meeting
5/11/2018	Tribal & OHA Meeting
5/11/2018	CCO2.0 Public Forum, Medford
5/10/2018	Addictions & Mental Health Planning & Advisory Committee
5/2/2018	Healthcare Workforce Committee
5/1/2018	Oregon Health Policy Board CCO 2.0 update
April 2018	
4/30/2018	CCO Financial Framework & Sustainability: Stakeholder Roundtable Webinar
4/28/2018	Public Forum: Woodburn
4/27/2018	Children's System Advisory Committee

4/25/2018	Medicaid Advisory Committee
4/23/2018	Traditional Health Workers Commission
4/21/2018	Public Forum: The Dalles
4/19/2018	CCO Leadership Meeting
4/19/2018	Public Health Advisory Meeting
4/19/2018	Primary Care Payment Reform Collaborative
4/17/2018	CAC Learning Collaborative Special Event
4/16/2018	Health Equity Committee
4/13/2018	Oregon Alliance of Children's Programs
4/13/2018	Oregon Academy of Family Physicians
4/12/2018	CCO Value-based payments workshop
4/11/2018	Oregon Consumer Advisory Council
4/11/2018	Tribal & OHA Meeting
4/9/2018	Quality & Health Outcomes Committee
4/9/2018	Oregon Health Policy Board
4/5/2018	Allies for a Healthier Oregon
4/5/2018	Health Information Technology Oversight Council
4/2/2018	Association of Counties
March 2018	
3/27/2018	OHA Ombuds Advisory Council
3/8/2018	Addictions & Mental Health Planning Advisory Council
3/6/2018	Oregon Health Policy Board
3/1/2018	Tribal & OHA meeting
3/1/2018	Quality & Health Outcomes Committee

Appendix E: CCO 2.0 public input –

vi. List of formal letters and recommendations received

CCO 2.0 Formal Letters and Recommendations Received

CCO 2.0 letters and recommendations are listed here and available in full on the CCO 2.0 website (www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx).

1. AllCare Health (submitted August 8, 2018)
2. AllCare Health (submitted September 10, 2018)
3. AllCare Health (submitted September 4, 2018)
4. Alliance for Culturally Specific Behavioral Health Providers (submitted October 5, 2018
5. Association of Oregon Community Mental Health Programs (submitted May 1, 2018)
6. Association of Oregon Counties, Oregon Coalition of Local Health Officials, and Association of Oregon Community Mental Health Programs (submitted May 1, 2018)
7. CareOregon (submitted May 5, 2018)
8. Cascadia Behavioral Healthcare (submitted September 10, 2018)
9. CCO Oregon (submitted August 27, 2018)
10. CCO Oregon Pharmacy Workgroup (submitted September 26, 2018)
11. Children's Health Alliance (submitted June 4, 2018)
12. Clackamas, Multnomah, and Washington Counties (submitted September 4, 2018)
13. Clackamas, Washington, and Multnomah Counties (submitted September 17, 2018)
14. Coalition for a Healthy Oregon COHO (submitted August 7, 2018)
15. Coalition of Local Health Officials (submitted May 1, 2018)
16. Confederation of Oregon School Administrators (submitted July 9, 2018)
17. Early Childhood Partners (submitted September 10, 2018)
18. FamilyCare (submitted September 28, 2018)
19. Four Rivers Early Learning Hub (submitted September 18, 2018)
20. Health Care for all Oregon, Action HCAO (submitted July 10, 2018)
21. Health Equity Committee (submitted September 7, 2018)
22. Health Information Technology Oversight Council (submitted May 25, 2018)
23. Health Share (submitted September 7, 2018)
24. Healthcare Workforce Committee (submitted May 11, 2018)
25. InterCommunity Health Network CCO (submitted May 29, 2018)
26. Lines for Life (submitted September 11, 2018)
27. Lines for Life, Dwight Holton (submitted September 11, 2018)
28. Marion County Board of Commissioners (submitted June 18, 2018)
29. Medicaid Advisory Committee (submitted April 25, 2018)
30. National Alliance on Mental Illness, Oregon NAMI (submitted June 15, 2018)
31. OCHIN (submitted April 13, 2018)
32. OCHIN (submitted July 31, 2018)
33. OHPB Health Equity Committee - Behavioral Health (submitted June 13, 2018)
34. OHPB Health Equity Committee - SDOH/HE (submitted June 13, 2018)
35. OPERA and ORPA (submitted September 10, 2018)
36. Oregon Center for Children & Youth with Special Health Needs – Veggie RX working group (submitted May 7, 2018)

37. Oregon Community Food Systems Network Veggie Rx (submitted July 6, 2018)
38. Oregon Community Health Workers Association (submitted September 7, 2018)
39. Oregon Department of Human Services (submitted May 14, 2018)
40. Oregon Food Bank (submitted August 10, 2018)
41. Oregon FosterYouth Connection (submitted September 5, 2018)
42. Oregon GME Consortium (May 25, 2018)
43. Oregon Health Equity Alliance (submitted August 27, 2018)
44. Oregon Medical Association (submitted May 1, 2018)
45. Oregon Prevention Education & Recovery Association OPERA (submitted June 1, 2018)
46. Oregon Primary Care Association (submitted August 1, 2018)
47. Oregon Primary Care Association (submitted August 10, 2018)
48. Oregon Primary Care Association (submitted September 19, 2018)
49. Pacific Source (submitted July 31, 2018)
50. Providence Health & Services (submitted May 29, 2018)
51. Public Health Advisory Board (submitted February 15, 2018)
52. Southern Oregon Success (submitted May 11, 2018)
53. Trillium Community Health Plan (submitted May 18, 2018)
54. Yakima Valley Farm Workers Clinic (submitted September 10, 2018)