# TRI-COUNTY MENTAL HEALTH BOARD
## MEETING AGENDA

**Tuesday, November 26, 2018 – 11:00 A.M. to 2:00 P.M.**

*MCCFL – Computer Lab: 1610 Woods Court – Hood River*

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
<th>Action or Discussion</th>
</tr>
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<tbody>
<tr>
<td>11:00-11:15 AM</td>
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<tr>
<td>11:15 – 11:30 AM</td>
<td>Community Meeting</td>
<td>Board</td>
<td>Discussion</td>
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<tr>
<td>11:30 – 11:35 AM</td>
<td>Approval of Meeting Minutes – September 11, 2018</td>
<td>Board</td>
<td><em>(Action)</em></td>
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<tr>
<td>11:45 – 11:55 AM</td>
<td>Public Comment</td>
<td>Public</td>
<td>Discussion</td>
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<tr>
<td>11:50 – 12:10 AM</td>
<td>Additional Agenda Items:</td>
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<tr>
<td>12:10 – 12:30 PM</td>
<td>New Building</td>
<td>Valerie Bellus</td>
<td>Discussion</td>
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<td></td>
<td>● Report</td>
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<tr>
<td>12:30 – 1:00 PM</td>
<td>Fiscal Report</td>
<td>Mel Heuberger</td>
<td>Discussion</td>
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<td></td>
<td>● October Financials</td>
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<td>1:00 – 2:00 PM</td>
<td>Executive Directors Report:</td>
<td>Barb Seatter</td>
<td>Discussion/Update</td>
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<td>● CCO 2.0 – Oregon Health Summary, and AOCMHP Letters</td>
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<td>● Association of Oregon Counties MOU</td>
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<td>● Legislative Priorities – Gov. Brown Letter</td>
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<td>● 2019 Pacific Source Timeline</td>
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<td></td>
<td>● CGHC Presentation – Performance Metrics</td>
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**PLEASE NOTE:** This Agenda is subject to last minutes changes. The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Angie Millard at [541] 296-5452, x8130.

Next Meeting: **Tuesday, December 11, 2018**

*MCCFL – Annex C*

425 E 7th

The Dalles, OR 97058
Tri-County Mental Health Board
Draft Meeting Minutes: September 11, 2018

IN ATTENDANCE:
- Wasco County Commissioner Scott Hege
- Hood River County Commissioner Karen Joplin
- Sherman County Commissioner Tom McCoy
- Barb Setter MCCFL Executive Director
- Al Barton MCCFL Deputy Director
- Holly Thompson MCCFL QI Supervisor
- Monique Adams MCCFL Clinical Services Manager
- Angie Millard, MCCFL Executive Assistant

GUESTS:

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>KEY DISCUSSION POINTS</th>
<th>ACTION/TASK/DECISION LOG</th>
<th>RESPONSIBLE PARTY</th>
<th>DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY MEETING</td>
<td>Everyone participated in the community meeting</td>
<td></td>
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</tr>
<tr>
<td>APPROVAL OF MEETING MINUTES</td>
<td>The August 14, 2018 Tri-County Mental Health Board Meeting Minutes were approved as</td>
<td>Motion: Commissioner Hege</td>
<td></td>
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<tr>
<td></td>
<td>written and Presented at 11:14 AM</td>
<td>Second: Commissioner Joplin</td>
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</tr>
<tr>
<td></td>
<td>Approval: Unanimous</td>
<td>Approve: Unanimous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRUST DEED TENNESON PROPERTY</td>
<td>The Trust Deed Tenneson Property document was approved as written and presented at</td>
<td>Motion: Commissioner Hege</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11:26 AM</td>
<td>Second: Commissioner Joplin</td>
<td></td>
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<tr>
<td></td>
<td>Barb presented to document to previously sent to members. Members discussed the</td>
<td>Approve: Unanimous</td>
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</tbody>
</table>
document details agreeing that it was acceptable.

<table>
<thead>
<tr>
<th>PUBLIC COMMENT</th>
<th>There were no public comments.</th>
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</thead>
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<thead>
<tr>
<th>ADDITIONS TO AGENDA:</th>
<th>Quality Improvement</th>
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</table>

**Quality Improvement**

Holly presented the QI work plan that included results for Q1, and some results for Q2. The following measurements were discussed:

- **Access**
  - Children’s Access/Open Access
- **Urgent/Emergent Access**
- **FIT**
- **Crisis Services**
- **Supported Employment**
- **Integrated Care**
- **IDD**
- **SUD/DUII**
- **Outcomes**
- **Clinical Compliance**

Members discussed the requirements for each metric in detail with explanations from Holly, Barb, Al & Monique. Holly reported on improvements in results between Q1 and Q2. Members discussed challenges, and changes recently made to processes to help improve service results that could be seen as early as Q3 that includes retaining Ramona to prepare for an upcoming audit.

<table>
<thead>
<tr>
<th>Fiscal Report</th>
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**July 2018 Financial Report**

Mel presented the July 2018 financial statement. Mel gave detailed information on all differences compared to budgeted amounts. Revenue shortfalls were reported for
CCBHC due to lack of medical billing services. Other revenue shortfalls including expected funds from GOBHI for the DD Regional Transition that were not realized. Staff shortfalls have contributed to budget differences in both expenses, and revenues due to billable services. Mel reported the 1915i revenue is below budgeted amounts due to payment lagging, but it will catch up. Mel reported that contract income is up slightly as they were able to bill some more of the RFPs/charge more expenses to that income. Mel reported a reduction in facilities expenses vs budgeted amounts stating that this included equipment that has not yet been purchased, and building maintenance/repairs that are currently taking place. Mel reported that capital loss had an improvement as it did not have as much of a loss as budgeted. Mel reported that assets are reducing due to expenditures on the new building which is to be expected. Mel stated that the financial auditors will be on site starting on the 24th.

### EXECUTIVE REPORT

<table>
<thead>
<tr>
<th><strong>NORCOR TERMINATION</strong></th>
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<tbody>
<tr>
<td><strong>NORCOR Termination:</strong> Barb inquired whether members had any questions about the termination. Barb reported that Brian sent a letter to request termination with an effective date of 8/31/18. Barb reported that contract terms required a 30 day written notice for termination, but they were allowed to terminate earlier without penalties, but were charged for accrued vacation time for the staff members involved. Barb reported their computer connection to Cerner/MCCFL has been terminated as a result, and communications with NORCOR are now limited.</td>
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<table>
<thead>
<tr>
<th><strong>STAFFING</strong></th>
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<tbody>
<tr>
<td><strong>Staffing:</strong> Al reported that higher numbers in departures have been seen and as a result the data collected by HR has been carefully looked at. Reasons for departure are varied but do have one common factor being too much paperwork. Al reported that part of the employee retention piece from the strategic plan includes a paperwork reduction committee. Barb reported that we have put allot of pressure on staff due to many recent changes/requirements and we are trying to streamline wherever possible which includes looking at the EHR system. Barb and Al reported that they have been conduction a series of brown bag meeting in hopes of opening up communications with staff. Al concurred that staff have dealt with allot of major changes between the new building, CCBHC, &amp; FIT &amp; loss with departing staff. Barb pointed out that our turnover rate is not out of line for the average, but still finds it...</td>
</tr>
</tbody>
</table>
PACIFICSOURCE HOSPITALIZATION WITHHOLD

PacificSource Hospitalization Withhold: Barb reported that there is currently discussions taking place with PacificSource about the claims paid to Next Door for day treatment. Barb reported that she did send out a letter on this and has had a conversation Peter McGarry. Barb showed the members the actual letter sent, and confirmed that a copy of the letter will also be sent out to CGHC. Barb reported that Next Door has been informed by PacificSource that their waiver has run out and to stop all future claims. Members discussed the situation, and Barb confirmed that a conversation had taken place with Peter at PacificSource who did admit that he has not given this the attention that it deserves. Barb stated that she has requested an explanation of these payments in writing. Commissioner Joplin asked if the funds going to Next Door could potentially take away funding for services for individuals in our area. Barb confirmed that yes it could reduce funds available.

Meeting adjourned at 1:30 PM
| NEXT MEETING | October 9th 2018 11:00 AM – 2:00 PM |
For the Three Months Ending September 30, 2018

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>Year-to-Date</th>
<th>Variance to Budget</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHP Revenue</td>
<td>541,988</td>
<td>581,026</td>
<td>(39,037)</td>
<td>1,780,914</td>
<td>1,743,077</td>
<td>37,837</td>
</tr>
<tr>
<td>Other State Revenue</td>
<td>218,780</td>
<td>199,840</td>
<td>18,940</td>
<td>510,819</td>
<td>540,037</td>
<td>(29,218)</td>
</tr>
<tr>
<td>CCBHC</td>
<td>653,773</td>
<td>312,290</td>
<td>341,483</td>
<td>666,611</td>
<td>426,870</td>
<td>239,741</td>
</tr>
<tr>
<td>Contract Income</td>
<td>177,074</td>
<td>176,985</td>
<td>99</td>
<td>704,276</td>
<td>839,533</td>
<td>(135,257)</td>
</tr>
<tr>
<td>Client Fees/Private Pay</td>
<td>68,557</td>
<td>53,389</td>
<td>15,168</td>
<td>205,184</td>
<td>160,168</td>
<td>45,016</td>
</tr>
<tr>
<td>County Revenue</td>
<td>3,681</td>
<td>3,681</td>
<td>0</td>
<td>10,380</td>
<td>17,796</td>
<td>(7,416)</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>12,888</td>
<td>20,714</td>
<td>7,826</td>
<td>66,566</td>
<td>181,302</td>
<td>(114,716)</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>1,673,062</td>
<td>1,347,926</td>
<td>325,136</td>
<td>3,944,770</td>
<td>3,908,782</td>
<td>35,988</td>
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<table>
<thead>
<tr>
<th>Expenses</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Wages/Earning</td>
<td>566,252</td>
<td>706,940</td>
<td>140,689</td>
<td>1,750,144</td>
<td>2,011,839</td>
<td>261,795</td>
</tr>
<tr>
<td>Benefits/OPE</td>
<td>229,395</td>
<td>312,885</td>
<td>83,290</td>
<td>706,593</td>
<td>879,829</td>
<td>173,236</td>
</tr>
<tr>
<td>Total Personnel</td>
<td>795,647</td>
<td>1,019,826</td>
<td>223,978</td>
<td>2,456,737</td>
<td>2,891,769</td>
<td>435,032</td>
</tr>
<tr>
<td>Contracted Services</td>
<td>123,441</td>
<td>115,161</td>
<td>(8,280)</td>
<td>347,797</td>
<td>364,354</td>
<td>16,558</td>
</tr>
<tr>
<td>Contracted Providers</td>
<td>124,345</td>
<td>104,788</td>
<td>(19,557)</td>
<td>347,076</td>
<td>332,365</td>
<td>(14,713)</td>
</tr>
<tr>
<td>Facilities &amp; Equipment</td>
<td>34,882</td>
<td>39,261</td>
<td>4,380</td>
<td>109,220</td>
<td>141,961</td>
<td>32,740</td>
</tr>
<tr>
<td>Program Expenses</td>
<td>7,471</td>
<td>8,505</td>
<td>1,034</td>
<td>27,434</td>
<td>32,840</td>
<td>5,406</td>
</tr>
<tr>
<td>Communications</td>
<td>4,789</td>
<td>6,214</td>
<td>1,425</td>
<td>18,371</td>
<td>18,641</td>
<td>270</td>
</tr>
<tr>
<td>OHP Management Fees</td>
<td>6,533</td>
<td>6,349</td>
<td>(184)</td>
<td>18,930</td>
<td>18,046</td>
<td>357</td>
</tr>
<tr>
<td>Insurance</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>61,702</td>
<td>58,000</td>
<td>(3,702)</td>
</tr>
<tr>
<td>Training</td>
<td>4,073</td>
<td>6,568</td>
<td>2,496</td>
<td>13,776</td>
<td>19,793</td>
<td>6,017</td>
</tr>
<tr>
<td>Travel &amp; Mileage</td>
<td>2,599</td>
<td>2,140</td>
<td>(459)</td>
<td>7,265</td>
<td>6,420</td>
<td>(845)</td>
</tr>
<tr>
<td>Advertising &amp; PR</td>
<td>3,362</td>
<td>2,500</td>
<td>(862)</td>
<td>7,446</td>
<td>7,500</td>
<td>56</td>
</tr>
<tr>
<td>Client Write-Offs</td>
<td>14,463</td>
<td>2,050</td>
<td>(12,413)</td>
<td>33,167</td>
<td>6,150</td>
<td>(27,017)</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>10,591</td>
<td>9,736</td>
<td>(855)</td>
<td>61,841</td>
<td>41,015</td>
<td>(20,826)</td>
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<tr>
<td>Non-Operating Expenses</td>
<td>427</td>
<td>366</td>
<td>(61)</td>
<td>1,221</td>
<td>24,914</td>
<td>23,693</td>
</tr>
<tr>
<td>Total Materials &amp; Services</td>
<td>336,975</td>
<td>303,638</td>
<td>(33,337)</td>
<td>1,055,006</td>
<td>1,072,988</td>
<td>17,992</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>1,132,622</td>
<td>1,323,263</td>
<td>190,641</td>
<td>3,511,743</td>
<td>3,964,767</td>
<td>453,024</td>
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Net Income Before Capital Outlay and Bad Debt:

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</thead>
<tbody>
<tr>
<td>Outlay and Bad Debt</td>
<td>540,440</td>
<td>24,662</td>
<td>515,778</td>
<td>433,027</td>
<td>(55,985)</td>
<td>489,012</td>
</tr>
<tr>
<td>Capital Outlay</td>
<td>278,803</td>
<td>841,274</td>
<td>562,471</td>
<td>1,382,438</td>
<td>1,633,560</td>
<td>251,122</td>
</tr>
<tr>
<td>Net Gain(Loss) after Capital</td>
<td>261,637</td>
<td>(816,612)</td>
<td>1,078,249</td>
<td>(949,411)</td>
<td>(1,689,545)</td>
<td>740,134</td>
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Net Gain(Loss) after G&A:

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<tbody>
<tr>
<td></td>
<td>261,637</td>
<td>(816,612)</td>
<td>1,078,249</td>
<td>(949,411)</td>
<td>(1,689,545)</td>
<td>740,134</td>
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Report: P&L Monthly Agency Summary
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<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td><strong>REVENUE:</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>OHP Revenue</td>
<td>586,612</td>
<td>652,314</td>
<td>541,988</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,760,914</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>112,611</td>
<td>179,227</td>
<td>218,780</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>510,919</td>
</tr>
<tr>
<td>CBMC</td>
<td>13,744</td>
<td>(907)</td>
<td>653,773</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>668,611</td>
</tr>
<tr>
<td>Contract Income</td>
<td>290,654</td>
<td>236,538</td>
<td>177,074</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>704,276</td>
</tr>
<tr>
<td>Client Fees/Private Pay</td>
<td>73,076</td>
<td>63,551</td>
<td>69,557</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>205,184</td>
</tr>
<tr>
<td>County Revenue</td>
<td>2,011</td>
<td>8,370</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10,380</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>13,315</td>
<td>40,383</td>
<td>12,888</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>66,586</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>1,092,233</td>
<td>1,179,475</td>
<td>1,673,062</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3,944,770</td>
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<tr>
<td><strong>EXPENSES:</strong></td>
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</tr>
<tr>
<td>Wages/Earning</td>
<td>586,356</td>
<td>597,496</td>
<td>568,252</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,750,144</td>
</tr>
<tr>
<td>Benefits/OPE</td>
<td>241,979</td>
<td>235,219</td>
<td>229,395</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>706,583</td>
</tr>
<tr>
<td><strong>Total Personnel</strong></td>
<td>828,375</td>
<td>832,715</td>
<td>795,647</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,458,737</td>
</tr>
<tr>
<td>Contracted Services</td>
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<td>123,441</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Travel &amp; Mileage</td>
<td>2,438</td>
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<td>0</td>
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<td>0</td>
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<td>7,265</td>
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<td>Non-Operating Expenses</td>
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<td>427</td>
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<td><strong>Total Materials &amp; Services</strong></td>
<td>390,685</td>
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<td>336,975</td>
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<td>1,055,006</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td>1,219,060</td>
<td>1,160,061</td>
<td>1,132,622</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
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<td>3,611,743</td>
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<td><strong>Net Income Before Capital</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outlay and Bad Debt</td>
<td>(126,827)</td>
<td>19,414</td>
<td>540,440</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>433,027</td>
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<tr>
<td>Capital Outlay</td>
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<td>836,275</td>
<td>278,803</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1,382,438</td>
</tr>
<tr>
<td><strong>Net Gain/(Loss) after Capital</strong></td>
<td>(394,187)</td>
<td>(816,861)</td>
<td>251,837</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(949,411)</td>
</tr>
<tr>
<td><strong>Net Gain/(Loss) after G&amp;A</strong></td>
<td>(394,187)</td>
<td>(816,861)</td>
<td>261,637</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(849,411)</td>
</tr>
</tbody>
</table>

Report: P&L Monthly Agency Summary
### Mid-Columbia Center for Living

For the Three Months Ending September 30, 2018

<table>
<thead>
<tr>
<th></th>
<th>September Fiscal Yr 2019</th>
<th>August Fiscal Yr 2019</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Checking Accounts</td>
<td>$1,179,179</td>
<td>$1,040,476</td>
<td>$138,703</td>
<td>13.33%</td>
</tr>
<tr>
<td>Local Gvt Pool/Pool Reserve</td>
<td>$4,531,736</td>
<td>$5,063,552</td>
<td>($531,816)</td>
<td>-10.60%</td>
</tr>
<tr>
<td>Accounts Receivable - Client/3rd Party</td>
<td>$197,036</td>
<td>$209,520</td>
<td>($12,484)</td>
<td>-5.96%</td>
</tr>
<tr>
<td>Accounts Receivable - Contracts</td>
<td>$39,839</td>
<td>$79,255</td>
<td>($39,416)</td>
<td>-49.73%</td>
</tr>
<tr>
<td>Other Accounts Receivable</td>
<td>$809,713</td>
<td>$583,297</td>
<td>$226,416</td>
<td>38.82%</td>
</tr>
<tr>
<td>Pre-paid (Deposits)</td>
<td>$15,548</td>
<td>$15,548</td>
<td>$0</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$6,773,050</td>
<td>$6,991,647</td>
<td>($218,597)</td>
<td>-3.13%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LIABILITIES AND EQUITY:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>$467,673</td>
<td>$993,286</td>
<td>($525,613)</td>
<td>-52.92%</td>
</tr>
<tr>
<td>Miscellaneous Payables</td>
<td>$1,543,228</td>
<td>$1,529,844</td>
<td>$13,384</td>
<td>0.87%</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td>$213,263</td>
<td>$176,901</td>
<td>$36,362</td>
<td>20.55%</td>
</tr>
<tr>
<td>Payroll Liabilities</td>
<td>($2,171)</td>
<td>$2,195</td>
<td>($4,367)</td>
<td>-198.92%</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>$2,221,992</td>
<td>$2,702,226</td>
<td>($480,234)</td>
<td>-17.77%</td>
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<tr>
<td>Beginning Fund Balance</td>
<td>$5,500,469</td>
<td>$5,500,469</td>
<td>$0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Change In Fund Balance</td>
<td>($949,411)</td>
<td>($1,211,048)</td>
<td>$261,637</td>
<td>-21.60%</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td>$4,551,058</td>
<td>$4,289,421</td>
<td>$261,637</td>
<td>6.10%</td>
</tr>
<tr>
<td><strong>Total Liab &amp; Equity</strong></td>
<td>$6,773,050</td>
<td>$6,991,647</td>
<td>($218,597)</td>
<td>-3.13%</td>
</tr>
</tbody>
</table>
### Mid-Columbia Center for Living

#### For the Three Months Ending September 30, 2018

<table>
<thead>
<tr>
<th></th>
<th>September Fiscal Yr 2019</th>
<th>September Fiscal Yr 2018</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Checking Accounts</td>
<td>$1,179,179</td>
<td>$660,343</td>
<td>$518,836</td>
<td>78.57%</td>
</tr>
<tr>
<td>Local Govt Pool/Pool Reserve</td>
<td>$4,531,736</td>
<td>$4,644,347</td>
<td>($112,612)</td>
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<tr>
<td>Accounts Receivable - Client/3rd Party</td>
<td>$197,036</td>
<td>$377,444</td>
<td>($180,409)</td>
<td>-47.80%</td>
</tr>
<tr>
<td>Accounts Receivable - Contracts</td>
<td>$39,839</td>
<td>$90,703</td>
<td>($50,865)</td>
<td>-56.08%</td>
</tr>
<tr>
<td>Other Accounts Receivable</td>
<td>$809,713</td>
<td>$1,071,303</td>
<td>($261,589)</td>
<td>-24.42%</td>
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<tr>
<td>Pre-paid (Deposits)</td>
<td>$15,548</td>
<td>$15,548</td>
<td>$0</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$6,773,050</strong></td>
<td><strong>$6,859,689</strong></td>
<td><strong>($86,638)</strong></td>
<td><strong>-1.26%</strong></td>
</tr>
</tbody>
</table>

<p>| | | | | |
|                      |                          |                          |            |          |
| <strong>LIABILITIES AND EQUITY:</strong> |                          |                          |            |          |
| Accounts Payable     | $467,673                 | $131,400                 | $336,273   | 255.92%  |
| Miscellaneous Payables | $1,543,228              | $1,106,133               | $437,095   | 39.52%   |
| Other Current Liabilities | $213,263                 | $634,102                 | ($420,839) | -66.37%  |
| Payroll Liabilities  | ($2,171)                | ($6)                     | ($2,164)   | 28851.60% |
| <strong>Total Liabilities</strong> | <strong>$2,221,992</strong>           | <strong>$1,871,628</strong>           | <strong>$350,364</strong> | <strong>18.72%</strong> |
| Beginning Fund Balance | $5,500,469              | $4,705,680               | $794,789   | 16.89%   |
| Change In Fund Balance | ($949,411)            | $282,381                 | ($1,231,792) | -436.22% |
| <strong>Total Equity</strong>     | <strong>$4,551,058</strong>           | <strong>$4,988,061</strong>           | <strong>($437,003)</strong> | <strong>-8.76%</strong> |
| <strong>Total Liab &amp; Equity</strong> | <strong>$6,773,050</strong>           | <strong>$6,859,689</strong>           | <strong>($86,638)</strong> | <strong>-1.26%</strong> |</p>
<table>
<thead>
<tr>
<th></th>
<th>October</th>
<th></th>
<th>Variance</th>
<th></th>
<th></th>
<th>Variance</th>
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<td></td>
<td>Actual</td>
<td>Budget</td>
<td>to Budget</td>
<td>Actual</td>
<td>Budget</td>
<td>to Budget</td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>OHP Revenue</td>
<td>589,300</td>
<td>611,026</td>
<td>(21,726)</td>
<td>2,370,214</td>
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<tr>
<td>Other State Revenue</td>
<td>108,951</td>
<td>199,840</td>
<td>(90,889)</td>
<td>619,770</td>
<td>739,877</td>
<td>(120,107)</td>
<td>(16%)</td>
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<td>CCBHC</td>
<td>25,845</td>
<td>57,290</td>
<td>(31,445)</td>
<td>692,456</td>
<td>484,160</td>
<td>208,296</td>
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<td>207,256</td>
<td>211,985</td>
<td>(4,730)</td>
<td>911,532</td>
<td>1,051,516</td>
<td>(139,987)</td>
<td>(13%)</td>
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<td>Client Fees/Private Pay</td>
<td>199,918</td>
<td>53,389</td>
<td>146,528</td>
<td>405,102</td>
<td>213,558</td>
<td>191,544</td>
<td>90%</td>
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<td>3,681</td>
<td>(3,681)</td>
<td>10,380</td>
<td>21,476</td>
<td>(11,096)</td>
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<td>Other Revenue</td>
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<td>20,714</td>
<td>29,194</td>
<td>116,484</td>
<td>202,016</td>
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<td>23,251</td>
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<td></td>
<td></td>
<td></td>
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<td>607,336</td>
<td>44,902</td>
<td>2,312,578</td>
<td>2,619,275</td>
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<td>12%</td>
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<tr>
<td>Benefits/OPE</td>
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<td>262,743</td>
<td>39,523</td>
<td>929,824</td>
<td>1,142,572</td>
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<td>3,761,848</td>
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<td>Contracted Services</td>
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<td>112,961</td>
<td>6,991</td>
<td>453,767</td>
<td>477,315</td>
<td>23,548</td>
<td>5%</td>
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<td>Contracted Providers</td>
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<td>122,788</td>
<td>(2,802)</td>
<td>472,668</td>
<td>455,153</td>
<td>(17,515)</td>
<td>(4%)</td>
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<tr>
<td>Facilities &amp; Equipment</td>
<td>38,332</td>
<td>60,261</td>
<td>21,929</td>
<td>147,553</td>
<td>202,222</td>
<td>54,669</td>
<td>27%</td>
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<tr>
<td>Program Expenses</td>
<td>14,203</td>
<td>14,647</td>
<td>444</td>
<td>41,636</td>
<td>47,487</td>
<td>5,851</td>
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<tr>
<td>Communications</td>
<td>8,477</td>
<td>6,214</td>
<td>(2,263)</td>
<td>26,848</td>
<td>24,855</td>
<td>(1,993)</td>
<td>(8%)</td>
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<tr>
<td>OHP Management Fees</td>
<td>6,556</td>
<td>6,349</td>
<td>(207)</td>
<td>25,246</td>
<td>25,395</td>
<td>149</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
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<td>0</td>
<td>0</td>
<td>61,702</td>
<td>58,000</td>
<td>(3,702)</td>
<td>(6%)</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>12,047</td>
<td>6,668</td>
<td>(5,479)</td>
<td>25,823</td>
<td>26,361</td>
<td>538</td>
<td>2%</td>
<td></td>
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<tr>
<td>Travel &amp; Mileage</td>
<td>3,404</td>
<td>2,140</td>
<td>(1,264)</td>
<td>10,669</td>
<td>8,560</td>
<td>(2,109)</td>
<td>(25%)</td>
<td></td>
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<tr>
<td>Advertising &amp; PR</td>
<td>4,128</td>
<td>2,500</td>
<td>(1,628)</td>
<td>11,573</td>
<td>10,000</td>
<td>(1,573)</td>
<td>(16%)</td>
<td></td>
</tr>
<tr>
<td>Client Write-Offs</td>
<td>7,777</td>
<td>2,050</td>
<td>(5,727)</td>
<td>40,944</td>
<td>8,200</td>
<td>(32,744)</td>
<td>(399%)</td>
<td></td>
</tr>
<tr>
<td>Other Expenses</td>
<td>6,954</td>
<td>8,736</td>
<td>1,782</td>
<td>68,795</td>
<td>49,751</td>
<td>(19,044)</td>
<td>(38%)</td>
<td></td>
</tr>
<tr>
<td>Non-Operating Expenses</td>
<td>508</td>
<td>366</td>
<td>(143)</td>
<td>1,729</td>
<td>25,279</td>
<td>23,550</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Total Materials &amp; Services</td>
<td>333,947</td>
<td>345,580</td>
<td>11,632</td>
<td>1,388,953</td>
<td>1,418,578</td>
<td>29,625</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Total Expenses</td>
<td>1,119,601</td>
<td>1,215,659</td>
<td>96,058</td>
<td>4,631,355</td>
<td>5,180,426</td>
<td>549,071</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Net Income Before Capital Outlay and Bad Debt</td>
<td>61,576</td>
<td>(57,733)</td>
<td>119,309</td>
<td>494,592</td>
<td>(113,718)</td>
<td>608,310</td>
<td>535%</td>
<td></td>
</tr>
<tr>
<td>Capital Outlay</td>
<td>280,057</td>
<td>704,830</td>
<td>424,774</td>
<td>1,662,495</td>
<td>2,338,390</td>
<td>675,895</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Net Gain(Loss) after Capital</td>
<td>(218,481)</td>
<td>(762,563)</td>
<td>544,082</td>
<td>(1,167,903)</td>
<td>(2,452,108)</td>
<td>1,284,205</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Net Gain(Loss) after G&amp;A</td>
<td>(218,481)</td>
<td>(762,563)</td>
<td>544,082</td>
<td>(1,167,903)</td>
<td>(2,452,108)</td>
<td>1,284,205</td>
<td>52%</td>
<td></td>
</tr>
</tbody>
</table>
### Mid-Columbia Center for Living

**For the Month Ending October 31, 2018**

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OHP Revenue</td>
<td>586,612</td>
<td>652,314</td>
<td>541,988</td>
<td>589,300</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,370,214</td>
</tr>
<tr>
<td>Other State Revenue</td>
<td>112,811</td>
<td>179,227</td>
<td>218,760</td>
<td>108,951</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>619,770</td>
</tr>
<tr>
<td>CCBHC</td>
<td>13,744</td>
<td>(607)</td>
<td>653,773</td>
<td>25,845</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>682,456</td>
</tr>
<tr>
<td>Contract Income</td>
<td>290,654</td>
<td>236,538</td>
<td>177,074</td>
<td>207,256</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>911,532</td>
</tr>
<tr>
<td>Client Fees/Private Pay</td>
<td>73,076</td>
<td>63,551</td>
<td>68,557</td>
<td>199,918</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>405,102</td>
</tr>
<tr>
<td>County Revenue</td>
<td>2,011</td>
<td>8,370</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10,380</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>13,315</td>
<td>40,368</td>
<td>12,858</td>
<td>49,108</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>116,494</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>1,092,233</td>
<td>1,179,475</td>
<td>1,673,062</td>
<td>1,181,177</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5,125,947</td>
</tr>
</tbody>
</table>

| **EXPENSES:**        |          |          |           |           |          |          |         |          |       |       |     |      |         |
| Wages/Earning        | 586,396  | 597,496  | 566,252   | 562,434   | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 2,312,578|
| Benefits/OPE         | 241,979  | 235,219  | 220,407   | 223,220   | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 929,924  |
| **Total Personnel**  | 828,375  | 832,715  | 796,658   | 785,654   | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 3,242,402|
| Contracted Services  | 114,384  | 109,972  | 123,441   | 105,970   | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 453,787  |
| Contracted Providers | 123,035  | 99,697   | 124,345   | 125,590   | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 472,688  |
| Facilities & Equipment | 32,926  | 41,513   | 34,882    | 38,332    | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 147,553  |
| Program Expenses     | 10,304   | 9,659    | 7,471     | 14,203    | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 41,038   |
| Communications        | 6,515    | 7,067    | 4,789     | 8,477     | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 26,848   |
| OHP Management Fees  | 6,185    | 5,972    | 6,533     | 6,556     | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 25,246   |
| Insurance            | 61,702   | 0        | 0         | 0         | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 61,702   |
| Training             | 4,303    | 5,400    | 4,073     | 12,087    | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 25,923   |
| Travel & Mileage     | 2,436    | 2,228    | 2,599     | 3,404     | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 10,668   |
| Advertising & PR     | 1,430    | 2,653    | 3,362     | 4,128     | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 11,573   |
| Client Write-Offs    | 6,050    | 11,754   | 14,463    | 7,777     | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 40,944   |
| Other Expenses       | 20,156   | 31,024   | 10,591    | 9,564     | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 65,796   |
| Non-Operating Expenses | 456     | 338      | 427       | 508       | 0        | 0        | 0       | 0        | 0     | 0     | 0   | 0    | 1,729    |
| **Total Materials & Services** | 350,685 | 327,346 | 336,975 | 333,947 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,386,953 |
| **Total Expenses**   | 1,219,060| 1,160,081| 1,132,833 | 1,119,601 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4,631,355 |
| Net Income Before Capital Outlay and Bad Debt | (126,827) | 19,414   | 540,429   | 81,576    | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 404,592 |
| Capital Outlay       | 267,361  | 836,275  | 540,429   | 81,576    | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,662,495 |
| **Net Gain(Loss) after Capital** | (394,187) | (816,661) | 281,526 | (218,481) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,167,903) |
| **Net Gain(Loss) after G&A** | (394,187) | (816,661) | 281,526 | (218,481) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,167,903) |

Report: P&L Monthly Agency Summary
Mid-Columbia Center for Living

For the Four Months Ending October 31, 2018

<table>
<thead>
<tr>
<th>ASSETS:</th>
<th>October Fiscal Yr 2019</th>
<th>September Fiscal Yr 2019</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and Checking Accounts</td>
<td>$581,974</td>
<td>$1,179,168</td>
<td>($597,194)</td>
<td>-50.65%</td>
</tr>
<tr>
<td>Local Govt Pool/Pool Reserve</td>
<td>$4,810,221</td>
<td>$4,531,736</td>
<td>$278,486</td>
<td>6.15%</td>
</tr>
<tr>
<td>Accounts Receivable - Client/3rd Party</td>
<td>$265,086</td>
<td>$197,036</td>
<td>$68,050</td>
<td>34.54%</td>
</tr>
<tr>
<td>Accounts Receivable - Contracts</td>
<td>$47,791</td>
<td>$39,839</td>
<td>$7,953</td>
<td>19.96%</td>
</tr>
<tr>
<td>Other Accounts Receivable</td>
<td>$823,193</td>
<td>$809,713</td>
<td>$13,479</td>
<td>1.66%</td>
</tr>
<tr>
<td>Pre-paid (Deposits)</td>
<td>$15,548</td>
<td>$15,548</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$6,543,813</td>
<td>$6,773,039</td>
<td>($229,226)</td>
<td>-3.38%</td>
</tr>
</tbody>
</table>

| LIABILITIES AND EQUITY: | | | | |
| Accounts Payable | $432,192 | $467,673 | ($35,481) | -7.59% |
| Miscellaneous Payables | $1,528,779 | $1,543,228 | ($14,449) | -0.94% |
| Other Current Liabilities | $249,625 | $213,263 | $36,362 | 17.05% |
| Payroll Liabilities | $651 | ($2,171) | $2,822 | 129.97% |
| **Total Liabilities** | $2,211,247 | $2,221,992 | ($10,746) | -0.48% |
| Beginning Fund Balance | $5,500,469 | $5,500,469 | 0 | 0.00% |
| Change In Fund Balance | ($1,167,903) | ($949,422) | ($218,481) | 23.01% |
| **Total Equity** | $4,332,566 | $4,551,047 | ($218,481) | -4.80% |
| **Total Liab & Equity** | $6,543,813 | $6,773,039 | ($229,226) | -3.38% |
Mid-Columbia Center for Living  
For the Four Months Ending October 31, 2018

<table>
<thead>
<tr>
<th></th>
<th>October Fiscal Yr</th>
<th>October Fiscal Yr</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019</td>
<td>2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASSETS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and Checking Accounts</td>
<td>$581,974</td>
<td>$790,263</td>
<td>($208,289)</td>
<td>-26.36%</td>
</tr>
<tr>
<td>Local Govt Pool/Pool Reserve</td>
<td>$4,810,221</td>
<td>$4,560,129</td>
<td>$250,092</td>
<td>5.48%</td>
</tr>
<tr>
<td>Accounts Receivable - Client/3rd Party</td>
<td>$265,086</td>
<td>$372,090</td>
<td>($107,004)</td>
<td>-28.76%</td>
</tr>
<tr>
<td>Accounts Receivable - Contracts</td>
<td>$47,791</td>
<td>$80,431</td>
<td>($32,640)</td>
<td>-40.58%</td>
</tr>
<tr>
<td>Other Accounts Receivable</td>
<td>$823,193</td>
<td>$1,089,211</td>
<td>($266,019)</td>
<td>-24.42%</td>
</tr>
<tr>
<td>Pre-paid (Deposits)</td>
<td>$15,548</td>
<td>$15,548</td>
<td>$0</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$6,543,813</strong></td>
<td><strong>$6,907,672</strong></td>
<td><strong>($363,860)</strong></td>
<td><strong>-5.27%</strong></td>
</tr>
<tr>
<td>LIABILITIES AND EQUITY:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>$432,192</td>
<td>$222,345</td>
<td>$209,847</td>
<td>94.38%</td>
</tr>
<tr>
<td>Miscellaneous Payables</td>
<td>$1,528,779</td>
<td>$1,123,054</td>
<td>$405,725</td>
<td>36.13%</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td>$249,625</td>
<td>$652,276</td>
<td>($402,651)</td>
<td>-61.73%</td>
</tr>
<tr>
<td>Payroll Liabilities</td>
<td>$651</td>
<td>$1,052</td>
<td>($401)</td>
<td>-38.14%</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>$2,211,247</strong></td>
<td><strong>$1,998,727</strong></td>
<td><strong>$212,519</strong></td>
<td><strong>10.63%</strong></td>
</tr>
<tr>
<td>Beginning Fund Balance</td>
<td>$5,500,469</td>
<td>$4,705,680</td>
<td>$794,789</td>
<td>16.89%</td>
</tr>
<tr>
<td>Change In Fund Balance</td>
<td>($1,167,903)</td>
<td>$203,265</td>
<td>($1,371,168)</td>
<td>-674.57%</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td><strong>$4,332,566</strong></td>
<td><strong>$4,908,945</strong></td>
<td><strong>($576,379)</strong></td>
<td><strong>-11.74%</strong></td>
</tr>
<tr>
<td><strong>Total Liab &amp; Equity</strong></td>
<td><strong>$6,543,813</strong></td>
<td><strong>$6,907,672</strong></td>
<td><strong>($363,860)</strong></td>
<td><strong>-5.27%</strong></td>
</tr>
</tbody>
</table>
**Compare PPS1 Rates and Review of Cap Wrap**

2017 to October 31, 2018

<table>
<thead>
<tr>
<th>Initial Calculation of PPS-1 Rate FY 2016</th>
<th>Subsequent Calculation of PPS-1 Rate Apr 2017 to Mar 2018</th>
<th>Change PPS-1 Estimated to Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trial Balance Costs FY2016</strong></td>
<td>$12,454,261</td>
<td><strong>Trial Bal Costs Apr to Mar</strong></td>
</tr>
<tr>
<td>Reclassifications of DDDREC (unrelated CCBHC Costs)</td>
<td>(1,837,885)</td>
<td>Reclassifications</td>
</tr>
<tr>
<td>Adjustments for Capital and Depreciation</td>
<td>76,653</td>
<td>Adj for Cap &amp; Depr</td>
</tr>
<tr>
<td>Anticipated Costs of Adding 66 FTE</td>
<td>8,746,478</td>
<td></td>
</tr>
<tr>
<td>Direct Costs (Rent, Ins., Office Salaries, Furniture, Legal, Communication, Janitorial, etc.)</td>
<td>(3,026,059)</td>
<td><strong>Indirect Costs</strong></td>
</tr>
<tr>
<td>Total Direct Cost of CCBHC Services</td>
<td>$16,413,448</td>
<td><strong>Total DC of CCBHC Serv.</strong></td>
</tr>
<tr>
<td>Indirect Costs related to CCBHC (89.9% of Indirect Costs)</td>
<td>$2,721,339</td>
<td><strong>Indirect to CCBHC (85.9%)</strong></td>
</tr>
<tr>
<td><strong>Total Estimated Costs of CCBHC Services to Start</strong></td>
<td>$19,134,787</td>
<td><strong>New Costs of CCBHC Serv</strong></td>
</tr>
<tr>
<td>Daily Visits based upon 136,638 units of Service in FY2016</td>
<td>38,936</td>
<td>Daily Visits Apr17 to Mar18</td>
</tr>
<tr>
<td>Additional Visits based upon adding 66 people</td>
<td>9,253</td>
<td></td>
</tr>
<tr>
<td>More Visits added because Oregon thought rate too high</td>
<td>8,205</td>
<td></td>
</tr>
<tr>
<td><strong>Total Estimated Visits for CCBHC DY1</strong></td>
<td>$56,394</td>
<td><strong>Visits Apr 17 to Mar 18</strong></td>
</tr>
<tr>
<td>Unadjusted PPS-1 Rate Calculated initially (Cost per Visit)</td>
<td>$339.31</td>
<td><strong>PPS-1 Apr17 to Mar18</strong></td>
</tr>
<tr>
<td>Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period</td>
<td>1.2%</td>
<td><strong>MEI Adj</strong></td>
</tr>
<tr>
<td><strong>PPS-1 Rate per visit submitted to Oregon for DY1</strong></td>
<td>$343.38</td>
<td><strong>PPS-1 DY1 Actual</strong></td>
</tr>
<tr>
<td><strong>PPS-1 Rate Settled on after Oregon Actuarial Review</strong></td>
<td>$322.40</td>
<td></td>
</tr>
<tr>
<td>Adjustments to PPS-1 Rate due to Inpatient Services</td>
<td>$320.69</td>
<td></td>
</tr>
<tr>
<td>PPS-1 Rate for DY2 adjusted for MEI Index</td>
<td>$326.91</td>
<td></td>
</tr>
<tr>
<td>Adjustments to PPS-1 Rate DY2 due to Inpatient Services</td>
<td>$325.18</td>
<td></td>
</tr>
</tbody>
</table>

**Review of Cap Wrap Calculation DY1 and DY2**

<table>
<thead>
<tr>
<th>Sep 2017 (Qtr 2 Apr to Jun Activity)</th>
<th>Dec 2017 (Qtr 3 Jul to Sep Activity)</th>
<th>Mar 2018 (Qtr 4 Oct to Dec Activity)</th>
<th>Jun 2018 (Qtr 1 Jan to Mar Activity)</th>
<th>Sep 2018 (Qtr 2 Apr to Jun Activity)</th>
<th>Dec 2018 (Qtr 3 Jul to Sep Activity)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Encounters</strong></td>
<td>8,845</td>
<td>7,262</td>
<td>12,406</td>
<td>13,696</td>
<td>12,963</td>
</tr>
<tr>
<td>Accepted Encounters by PCS an GOBHI</td>
<td>6,542</td>
<td>5,844</td>
<td>5,614</td>
<td>6,427</td>
<td>6,164</td>
</tr>
<tr>
<td>Unduplicated Visits</td>
<td>5,586</td>
<td>4,735</td>
<td>4,817</td>
<td>5,588</td>
<td>6,053</td>
</tr>
<tr>
<td><strong>PPS-1 Rate</strong></td>
<td>$322.40</td>
<td>$322.40</td>
<td>$322.40</td>
<td>$325.18</td>
<td>$325.18</td>
</tr>
<tr>
<td>Gross Cap Wrap Revenue</td>
<td>$1,800,926</td>
<td>$1,526,564</td>
<td>$1,553,001</td>
<td>$1,817,106</td>
<td>$1,968,315</td>
</tr>
<tr>
<td>CCO and Medicare Claims</td>
<td>$5,342</td>
<td>$5,812</td>
<td>$3,590</td>
<td>$5,644</td>
<td>(7,818)</td>
</tr>
<tr>
<td>Capitation Received HRC and WASCO (in Quarter)</td>
<td>$1,351,657</td>
<td>$1,329,151</td>
<td>$1,359,604</td>
<td>$1,392,318</td>
<td>$1,372,421</td>
</tr>
<tr>
<td><strong>Less Adjustment for Rate Recalculation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approx Income Received from Cap Wrap Payment</strong></td>
<td>$443,927</td>
<td>$191,601</td>
<td>$189,807</td>
<td>$393,312</td>
<td>$633,076</td>
</tr>
</tbody>
</table>

* In Quarter ending Dec 2018 (Activity Jul to Sep) we received an additional Net Settlement of 2017 Merit Performance $429,204 less Claims Still owed of ($143,121)
** Rate for DY1 went down by $1.71 due to removal of Inpatient Services in PPS-1 Calc
MCCFL
Estimated Calculation of COLA Costs Jan thru June 2019
No Cola was budgeted in FY2019, Incentives were budgeted at $171,052 or $1,192 per employee
As of October 2018, over the last 12 months, CPI-U increased 3.5 Percent in the West Region, USA. In 2017, Portland Area CPI-U increased 3.9 percent. BLS is no longer calculating a Portland Area index.

Proposals for COLA Wage Increase at Jan 1, 2019.

<table>
<thead>
<tr>
<th></th>
<th>Budget FY2019</th>
<th>Actual Wages thru October Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At 2.0%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages FY2019 Less DD Region</td>
<td>$ 7,407,557.00</td>
<td>$ 6,937,734.00</td>
</tr>
<tr>
<td>COLA at 2.0% Jan to June 2019</td>
<td>$ 74,075.57</td>
<td>$ 69,377.34</td>
</tr>
<tr>
<td>Increased FICA Costs Jan to June 2019</td>
<td>$ 5,666.78</td>
<td>$ 5,307.37</td>
</tr>
<tr>
<td>Increase PERS Costs Jan to June 2019</td>
<td>$ 10,776.73</td>
<td>$ 10,093.22</td>
</tr>
<tr>
<td>Increase to Wages and Benefits Jan to June 2019</td>
<td>$ 90,519.08</td>
<td>$ 84,777.93</td>
</tr>
<tr>
<td><strong>Estimated Wages FY2019 with 2.0% COLA</strong></td>
<td>$ 7,481,632.57</td>
<td>$ 7,007,111.34</td>
</tr>
<tr>
<td><strong>At 2.5%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages FY2019 Less DD Region</td>
<td>$ 7,407,557.00</td>
<td>$ 6,937,734.00</td>
</tr>
<tr>
<td>COLA at 2.5% Jan to June 2019</td>
<td>$ 92,594.46</td>
<td>$ 86,721.68</td>
</tr>
<tr>
<td>Increased FICA Costs Jan to June 2019</td>
<td>$ 7,083.48</td>
<td>$ 6,634.21</td>
</tr>
<tr>
<td>Increase PERS Costs Jan to June 2019</td>
<td>$ 13,470.91</td>
<td>$ 12,616.52</td>
</tr>
<tr>
<td>Increase to Wages and Benefits Jan to June 2019</td>
<td>$ 113,148.85</td>
<td>$ 105,972.41</td>
</tr>
<tr>
<td><strong>Estimated Wages FY2019 with 2.5% COLA</strong></td>
<td>$ 7,500,151.46</td>
<td>$ 7,024,455.68</td>
</tr>
<tr>
<td><strong>At 3.0%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages FY2019 Less DD Region</td>
<td>$ 7,407,557.00</td>
<td>$ 6,937,734.00</td>
</tr>
<tr>
<td>COLA at 3.0% Jan to June 2019</td>
<td>$ 111,113.36</td>
<td>$ 104,066.01</td>
</tr>
<tr>
<td>Increased FICA Costs Jan to June 2019</td>
<td>$ 8,500.17</td>
<td>$ 7,961.05</td>
</tr>
<tr>
<td>Increase PERS Costs Jan to June 2019</td>
<td>$ 16,165.10</td>
<td>$ 15,139.83</td>
</tr>
<tr>
<td>Increase to Wages and Benefits Jan to June 2019</td>
<td>$ 135,778.63</td>
<td>$ 127,166.89</td>
</tr>
<tr>
<td><strong>Estimated Wages FY2019 with 3.0% COLA</strong></td>
<td>$ 7,518,670.36</td>
<td>$ 7,041,800.01</td>
</tr>
<tr>
<td><strong>At 3.5%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages FY2019 Less DD Region</td>
<td>$ 7,407,557.00</td>
<td>$ 6,937,734.00</td>
</tr>
<tr>
<td>COLA at 3.5% Jan to June 2019</td>
<td>$ 129,632.25</td>
<td>$ 121,410.35</td>
</tr>
<tr>
<td>Increased FICA Costs Jan to June 2019</td>
<td>$ 9,916.87</td>
<td>$ 9,287.89</td>
</tr>
<tr>
<td>Increase PERS Costs Jan to June 2019</td>
<td>$ 18,859.28</td>
<td>$ 17,663.13</td>
</tr>
<tr>
<td>Increase to Wages and Benefits Jan to June 2019</td>
<td>$ 158,408.40</td>
<td>$ 148,361.37</td>
</tr>
<tr>
<td><strong>Estimated Wages FY2019 with 3.5% COLA</strong></td>
<td>$ 7,537,189.25</td>
<td>$ 7,059,144.35</td>
</tr>
</tbody>
</table>

As of October 2018, over the last 12 months, CPI-U increased 3.5 Percent in the West Region, USA. In 2017, Portland Area CPI-U increased 3.9 percent. BLS is no longer calculating a Portland Area index.
## MCCFL
### Review of Salaries and Benefits
#### December 2016 to October 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>579,890</td>
<td>592,322</td>
<td>591,904</td>
<td>597,192</td>
<td>599,307</td>
<td>595,821</td>
<td>585,569</td>
<td>584,940</td>
<td>582,611</td>
<td>592,148</td>
<td>584,052</td>
<td>593,418</td>
<td>588,063</td>
<td>584,679</td>
<td>595,511</td>
<td>606,799</td>
<td>596,902</td>
<td>703,520</td>
<td>586,396</td>
<td>597,496</td>
<td>566,252</td>
<td>562,434</td>
</tr>
</tbody>
</table>

| **Budget** |
| Salaries | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 | 611,427 |

| **Actual Less (000)** |
| Salaries | 580 | 592 | 597 | 599 | 596 | 586 | 585 | 583 | 592 | 584 | 593 | 588 | 585 | 596 | 587 | 607 | 597 | 704 | 586 | 597 | 566 | 562 |

| **Budget Less (000)** |
| Salaries | 611 | 611 | 611 | 611 | 611 | 611 | 611 | 611 | 611 | 646 | 646 | 646 | 646 | 646 | 646 | 646 | 646 | 646 | 646 | 653 | 653 | 707 | 607 |
| Benefits | 246 | 246 | 246 | 246 | 246 | 246 | 246 | 246 | 246 | 281 | 281 | 281 | 281 | 281 | 281 | 281 | 281 | 281 | 281 | 284 | 284 | 313 | 263 |

| **Act Labor Le** |
| 819 | 814 | 823 | 831 | 829 | 822 | 812 | 823 | 816 | 831 | 820 | 821 | 835 | 818 | 839 | 838 | 863 | 840 | 964 | 828 | 832 | 795 | 785 |
| **Budget Labe** |
| 857 | 857 | 857 | 857 | 857 | 857 | 857 | 857 | 857 | 927 | 927 | 927 | 927 | 927 | 927 | 927 | 927 | 927 | 927 | 927 | 927 | 937 | 937 | 1,020 | 870 |
Consumer Price Index, Portland – Second Half 2017

Area prices were up 1.4 percent over the past six months, up 3.9 percent from a year ago

Prices in the Portland Area, as measured by the Consumer Price Index for All Urban Consumers (CPI-U), increased 1.4 percent in the second half of 2017, the U.S. Bureau of Labor Statistics reported today. (See table A.) Assistant Commissioner for Regional Operations Richard Holden noted that this latest six-month increase was influenced by higher prices for shelter and medical care. (Data in this report are not seasonally adjusted. Accordingly, six-month-to-six-month changes may reflect seasonal influences.)

Over the last 12 months, the CPI-U rose 3.9 percent. (See chart 1 and table A.) Energy prices increased 7.1 percent, largely the result of an increase in the price of gasoline. The index for all items less food and energy advanced 4.1 percent over the year. (See table 1.)

Food

Food prices increased 0.8 percent in the second half of 2017. (See table 1.) Prices for food away from home increased 1.0 percent, and prices for food at home increased 0.6 percent for the same period.

Over the year, food prices increased 1.8 percent. Prices for food away from home increased 4.0 percent since a year ago, and prices for food at home edged up 0.1 percent.
Energy
The energy index increased 2.7 percent since the first half of 2017. The increase was mainly due to higher prices for gasoline (4.6 percent). Prices for electricity increased 0.3 percent, and prices for natural gas service inched up 0.1 percent for the same period.

Energy prices advanced 7.1 percent over the year, largely due to higher prices for gasoline (12.6 percent). Prices paid for electricity advanced 0.9 percent, but prices for natural gas service moved down 1.3 percent during the past year.

All items less food and energy
The index for all items less food and energy rose 1.4 percent in the latest six-month period. Higher prices for medical care (2.6 percent) and shelter (2.5 percent) were partially offset by lower prices for recreation (-1.9 percent) and apparel (-1.1 percent).

Over the year, the index for all items less food and energy advanced 4.1 percent. Components contributing to the increase included shelter (7.0 percent), medical care (6.0 percent), and household furnishings and operations (1.6 percent). Partly offsetting the increases were price declines in apparel (-2.7 percent), education and communication (-1.3 percent), and recreation (-1.1 percent).

Table A. Portland CPI-U semi-annual and annual percent changes (not seasonally adjusted)

<table>
<thead>
<tr>
<th>Month</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Semi-annual</td>
<td>Annual</td>
<td>Semi-annual</td>
<td>Annual</td>
<td>Semi-annual</td>
<td>Annual</td>
</tr>
<tr>
<td>First Half</td>
<td>1.2</td>
<td>2.5</td>
<td>1.3</td>
<td>2.2</td>
<td>1.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Second Half</td>
<td>0.9</td>
<td>2.1</td>
<td>1.5</td>
<td>2.8</td>
<td>1.2</td>
<td>2.3</td>
</tr>
</tbody>
</table>

This release marks the final publication of the Portland-Salem Consumer Price Index series.

Consumer Price Index Geographic Revision for 2018
In January 2018, BLS will introduce a new geographic area sample for the Consumer Price Index (CPI). As part of the new sample, the index for this area will be discontinued. The first indexes using the new structure will be published in February 2018. Additional information on the geographic revision is available at: www.bls.gov/cpi/additional-resources/geographic-revision-2018.htm.

Technical Note
The Consumer Price Index (CPI) is a measure of the average change in prices over time in a fixed market basket of goods and services. The Bureau of Labor Statistics publishes CPIs for two population groups: (1) a CPI for All Urban Consumers (CPI-U) which covers approximately 89 percent of the total population and (2) a CPI for Urban Wage Earners and Clerical Workers (CPI-W) which covers 28 percent of the total population. The CPI-U includes, in addition to wage earners and clerical workers, groups such as professional, managerial, and technical workers, the self-employed, short-term workers, the unemployed, and retirees and others not in the labor force.
The CPI is based on prices of food, clothing, shelter, and fuels, transportation fares, charges for doctors' and dentists' services, drugs, and the other goods and services that people buy for day-to-day living. Each month, prices are collected in 87 urban areas across the country from about 6,000 housing units and approximately 24,000 retail establishments--department stores, supermarkets, hospitals, filling stations, and other types of stores and service establishments. All taxes directly associated with the purchase and use of items are included in the index.

The index measures price changes from a designated reference date (1982-84) that equals 100.0. An increase of 16.5 percent, for example, is shown as 116.5. This change can also be expressed in dollars as follows: the price of a base period "market basket" of goods and services in the CPI has risen from $10 in 1982-84 to $11.65. For further details see the CPI home page on the Internet at www.bls.gov/cpi and the BLS Handbook of Methods, Chapter 17, The Consumer Price Index, available on the Internet at www.bls.gov/opub/hom/homch17_a.htm.

In calculating the index, price changes for the various items in each location are averaged together with weights that represent their importance in the spending of the appropriate population group. Local data are then combined to obtain a U.S. city average. Because the sample size of a local area is smaller, the local area index is subject to substantially more sampling and other measurement error than the national index. In addition, local indexes are not adjusted for seasonal influences. As a result, local area indexes show greater volatility than the national index, although their long-term trends are quite similar. **NOTE: Area indexes do not measure differences in the level of prices between cities; they only measure the average change in prices for each area since the base period.**

The Portland-Salem, OR, WA metropolitan area covered in this release consists of Clackamas, Columbia, Marion, Multnomah, Polk, Washington, and Yamhill Counties in the State of Oregon and Clark County in the State of Washington.

Information in this release will be made available to sensory impaired individuals upon request. Voice phone: (202) 691-5200; Federal Relay Service: (800) 877-8339.
Table 1. Consumer Price Index for All Urban Consumers (CPI-U): Indexes for semiannual averages and percent changes for selected periods Portland-Salem, OR-WA (1982-84=100 unless otherwise noted)

<table>
<thead>
<tr>
<th>Item and Group</th>
<th>2nd half 2016</th>
<th>1st half 2017</th>
<th>2nd half 2017</th>
<th>Percent change to 2nd half 2017 from-</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1st half 2017</td>
</tr>
<tr>
<td><strong>Expenditure category</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All items</td>
<td>251.710</td>
<td>258.055</td>
<td>261.621</td>
<td>3.9</td>
</tr>
<tr>
<td>All items (1967=100)</td>
<td>736.903</td>
<td>755.477</td>
<td>765.918</td>
<td>-</td>
</tr>
<tr>
<td>Food and beverages</td>
<td>232.822</td>
<td>235.531</td>
<td>236.525</td>
<td>1.6</td>
</tr>
<tr>
<td>Food</td>
<td>234.769</td>
<td>237.074</td>
<td>238.886</td>
<td>1.8</td>
</tr>
<tr>
<td>Food at home</td>
<td>215.919</td>
<td>214.855</td>
<td>216.046</td>
<td>0.1</td>
</tr>
<tr>
<td>Food away from home</td>
<td>265.226</td>
<td>272.942</td>
<td>275.753</td>
<td>4.0</td>
</tr>
<tr>
<td>Alcoholic beverages</td>
<td>213.679</td>
<td>220.467</td>
<td>213.220</td>
<td>-0.2</td>
</tr>
<tr>
<td>Housing</td>
<td>262.228</td>
<td>271.955</td>
<td>278.079</td>
<td>6.0</td>
</tr>
<tr>
<td>Shelter</td>
<td>312.818</td>
<td>326.375</td>
<td>334.669</td>
<td>7.0</td>
</tr>
<tr>
<td>Rent of primary residence</td>
<td>314.295</td>
<td>327.628</td>
<td>332.248</td>
<td>5.7</td>
</tr>
<tr>
<td>Owners' equiv. rent of residences(1)</td>
<td>325.023</td>
<td>339.175</td>
<td>348.091</td>
<td>7.1</td>
</tr>
<tr>
<td>Owners' equiv. rent of primary residence(1)</td>
<td>325.023</td>
<td>339.175</td>
<td>348.091</td>
<td>7.1</td>
</tr>
<tr>
<td>Fuels and utilities</td>
<td>262.894</td>
<td>266.703</td>
<td>268.961</td>
<td>2.3</td>
</tr>
<tr>
<td>Household energy</td>
<td>204.951</td>
<td>205.832</td>
<td>206.452</td>
<td>0.7</td>
</tr>
<tr>
<td>Energy services</td>
<td>251.943</td>
<td>252.429</td>
<td>253.127</td>
<td>0.5</td>
</tr>
<tr>
<td>Electricity</td>
<td>299.251</td>
<td>301.129</td>
<td>302.087</td>
<td>0.9</td>
</tr>
<tr>
<td>Utility (piped) gas service</td>
<td>155.421</td>
<td>153.186</td>
<td>153.366</td>
<td>-1.3</td>
</tr>
<tr>
<td>Household furnishings and operations</td>
<td>105.048</td>
<td>106.024</td>
<td>106.726</td>
<td>1.6</td>
</tr>
<tr>
<td>Apparel</td>
<td>126.708</td>
<td>124.727</td>
<td>123.341</td>
<td>-2.7</td>
</tr>
<tr>
<td>Transportation</td>
<td>219.120</td>
<td>228.257</td>
<td>231.246</td>
<td>5.5</td>
</tr>
<tr>
<td>Private transportation</td>
<td>223.478</td>
<td>230.249</td>
<td>235.863</td>
<td>5.5</td>
</tr>
<tr>
<td>Motor fuel</td>
<td>215.924</td>
<td>232.403</td>
<td>243.201</td>
<td>12.6</td>
</tr>
<tr>
<td>Gasoline (all types)</td>
<td>217.892</td>
<td>234.579</td>
<td>245.400</td>
<td>12.6</td>
</tr>
<tr>
<td>Gasoline, unleaded regular(2)</td>
<td>214.414</td>
<td>230.677</td>
<td>241.302</td>
<td>12.5</td>
</tr>
<tr>
<td>Gasoline, unleaded midgrade(2)(3)</td>
<td>188.367</td>
<td>203.476</td>
<td>212.958</td>
<td>13.1</td>
</tr>
<tr>
<td>Gasoline, unleaded premium(2)</td>
<td>207.417</td>
<td>224.017</td>
<td>234.411</td>
<td>13.0</td>
</tr>
<tr>
<td>Medical care</td>
<td>531.392</td>
<td>548.762</td>
<td>563.254</td>
<td>6.0</td>
</tr>
<tr>
<td>Recreation(4)</td>
<td>109.339</td>
<td>110.304</td>
<td>108.182</td>
<td>-1.1</td>
</tr>
<tr>
<td>Education and communication(4)</td>
<td>114.882</td>
<td>112.746</td>
<td>113.411</td>
<td>-1.3</td>
</tr>
<tr>
<td>Other goods and services</td>
<td>474.017</td>
<td>474.724</td>
<td>478.280</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Commodity and service group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Items</td>
<td>251.710</td>
<td>258.055</td>
<td>261.621</td>
<td>3.9</td>
</tr>
<tr>
<td>Commodities</td>
<td>175.305</td>
<td>177.202</td>
<td>177.421</td>
<td>1.2</td>
</tr>
<tr>
<td>Commodities less food &amp; beverages</td>
<td>147.438</td>
<td>148.940</td>
<td>148.774</td>
<td>0.9</td>
</tr>
<tr>
<td>Nondurables less food &amp; beverages</td>
<td>181.847</td>
<td>184.607</td>
<td>185.642</td>
<td>2.1</td>
</tr>
<tr>
<td>Durables</td>
<td>110.644</td>
<td>110.948</td>
<td>109.702</td>
<td>-0.9</td>
</tr>
<tr>
<td>Services</td>
<td>328.749</td>
<td>339.628</td>
<td>346.616</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Special aggregate indexes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All items less medical care</td>
<td>239.088</td>
<td>244.967</td>
<td>248.096</td>
<td>3.8</td>
</tr>
<tr>
<td>All items less shelter</td>
<td>227.889</td>
<td>231.246</td>
<td>232.849</td>
<td>2.2</td>
</tr>
<tr>
<td>Commodities less food</td>
<td>149.794</td>
<td>151.517</td>
<td>151.049</td>
<td>0.8</td>
</tr>
<tr>
<td>Nondurables less food</td>
<td>205.991</td>
<td>208.704</td>
<td>209.710</td>
<td>1.8</td>
</tr>
<tr>
<td>Nondurables less food</td>
<td>183.230</td>
<td>186.310</td>
<td>186.641</td>
<td>1.9</td>
</tr>
<tr>
<td>Services less rent of shelter(1)</td>
<td>353.409</td>
<td>360.250</td>
<td>365.316</td>
<td>3.4</td>
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<tr>
<td>Services less medical care services</td>
<td>313.836</td>
<td>324.034</td>
<td>330.361</td>
<td>5.3</td>
</tr>
<tr>
<td>Energy</td>
<td>210.410</td>
<td>219.359</td>
<td>225.244</td>
<td>7.1</td>
</tr>
<tr>
<td>All items less energy</td>
<td>258.442</td>
<td>264.668</td>
<td>268.100</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Note: See footnotes at end of table.
Table 1. Consumer Price Index for All Urban Consumers (CPI-U): Indexes for semiannual averages and percent changes for selected periods Portland-Salem, OR-WA (1982-84=100 unless otherwise noted) - Continued

<table>
<thead>
<tr>
<th>Item and Group</th>
<th>Semiannual average indexes</th>
<th>Percent change to 2nd half 2017 from-</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2nd half 2016</td>
<td>1st half 2017</td>
</tr>
<tr>
<td>All items less food and energy</td>
<td>264.916</td>
<td>271.976</td>
</tr>
</tbody>
</table>

Footnotes
(1) Index is on a December 1982=100 base.
(2) Special index based on a substantially smaller sample.
(3) Indexes on a December 1993=100 base.
(4) Indexes on a December 1997=100 base.
- Data not available.
Consumer Price Index, West Region — October 2018

Area prices were up 0.4 percent over the past month, up 3.5 percent from a year ago

Prices in the West Region, as measured by the Consumer Price Index for All Urban Consumers (CPI-U), rose 0.4 percent in October, the U.S. Bureau of Labor Statistics reported today. (See table A.) The October increase was influenced by higher prices for gasoline, household furnishings and operations, and shelter. (Data in this report are not seasonally adjusted. Accordingly, month-to-month changes may reflect seasonal influences.)

Over the last 12 months, the CPI-U increased 3.5 percent. (See chart 1 and table A.) Energy prices jumped 12.8 percent, largely the result of an increase in the price of gasoline. The index for all items less food and energy advanced 3.0 percent over the year. (See table 1.)

**Chart 1. Over-the-year percent change in CPI-U, West region, October 2015–October 2018**

![Chart showing percent change in CPI-U for West region](chart)


**Food**

Food prices edged up 0.2 percent for the month of October. (See table 1.) Prices for food at home advanced 0.3 percent, and prices for food away from home rose 0.2 percent for the same period.
Over the year, food prices advanced 2.0 percent. Prices for food away from home advanced 3.2 percent since a year ago, and prices for food at home increased 0.9 percent.

Energy
The energy index advanced 1.6 percent over the month. The increase was mainly due to higher prices for gasoline (2.7 percent). Prices for electricity rose 0.8 percent, but prices for natural gas service decreased 5.0 percent for the same period.

Energy prices jumped 12.8 percent over the year, largely due to higher prices for gasoline (22.6 percent). Prices paid for electricity rose 0.8 percent, but prices for natural gas service decreased 4.8 percent during the past year.

All items less food and energy
The index for all items less food and energy advanced 0.3 percent in October. Higher prices for household furnishings and operations (1.4 percent), new and used motor vehicles (0.9 percent), apparel (0.7 percent), and shelter (0.2 percent) were partially offset by lower prices for education and communication (-0.1 percent).

Over the year, the index for all items less food and energy advanced 3.0 percent. Components contributing to the increase included shelter (4.0 percent) and medical care (2.7 percent). Partly offsetting the increases was a price decline in apparel (-0.7 percent).

Table A. West Region CPI-U monthly and annual percent changes (not seasonally adjusted)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>0.3</td>
<td>1.7</td>
<td>0.3</td>
<td>1.7</td>
<td>-0.3</td>
<td>0.7</td>
<td>0.5</td>
<td>2.6</td>
<td>0.5</td>
<td>2.5</td>
<td>0.5</td>
<td>3.1</td>
</tr>
<tr>
<td>February</td>
<td>0.8</td>
<td>2.0</td>
<td>0.4</td>
<td>1.3</td>
<td>0.6</td>
<td>0.9</td>
<td>0.1</td>
<td>2.1</td>
<td>0.6</td>
<td>3.0</td>
<td>0.5</td>
<td>3.1</td>
</tr>
<tr>
<td>March</td>
<td>0.4</td>
<td>1.5</td>
<td>0.6</td>
<td>1.5</td>
<td>0.8</td>
<td>1.1</td>
<td>0.2</td>
<td>1.5</td>
<td>0.3</td>
<td>3.1</td>
<td>0.4</td>
<td>3.2</td>
</tr>
<tr>
<td>April</td>
<td>0.0</td>
<td>1.3</td>
<td>0.3</td>
<td>1.8</td>
<td>0.3</td>
<td>1.0</td>
<td>0.5</td>
<td>1.8</td>
<td>0.3</td>
<td>2.9</td>
<td>0.4</td>
<td>3.2</td>
</tr>
<tr>
<td>May</td>
<td>0.2</td>
<td>1.3</td>
<td>0.6</td>
<td>2.3</td>
<td>0.8</td>
<td>1.2</td>
<td>0.5</td>
<td>1.5</td>
<td>0.2</td>
<td>2.6</td>
<td>0.5</td>
<td>3.5</td>
</tr>
<tr>
<td>June</td>
<td>0.1</td>
<td>1.5</td>
<td>0.1</td>
<td>2.3</td>
<td>0.0</td>
<td>1.1</td>
<td>0.2</td>
<td>1.6</td>
<td>0.0</td>
<td>2.5</td>
<td>0.2</td>
<td>3.6</td>
</tr>
<tr>
<td>July</td>
<td>0.0</td>
<td>1.9</td>
<td>0.1</td>
<td>2.3</td>
<td>0.3</td>
<td>1.3</td>
<td>0.1</td>
<td>1.4</td>
<td>0.1</td>
<td>2.5</td>
<td>0.1</td>
<td>3.6</td>
</tr>
<tr>
<td>August</td>
<td>0.1</td>
<td>1.5</td>
<td>-0.1</td>
<td>2.1</td>
<td>-0.1</td>
<td>1.3</td>
<td>0.0</td>
<td>1.5</td>
<td>0.2</td>
<td>2.7</td>
<td>0.2</td>
<td>3.6</td>
</tr>
<tr>
<td>September</td>
<td>0.2</td>
<td>1.3</td>
<td>0.1</td>
<td>2.0</td>
<td>-0.2</td>
<td>1.0</td>
<td>0.3</td>
<td>2.0</td>
<td>0.5</td>
<td>2.9</td>
<td>0.3</td>
<td>3.4</td>
</tr>
<tr>
<td>October</td>
<td>-0.1</td>
<td>0.9</td>
<td>-0.6</td>
<td>2.0</td>
<td>0.0</td>
<td>1.1</td>
<td>0.3</td>
<td>2.3</td>
<td>0.3</td>
<td>2.9</td>
<td>0.4</td>
<td>3.5</td>
</tr>
<tr>
<td>November</td>
<td>-0.4</td>
<td>1.3</td>
<td>-0.6</td>
<td>1.7</td>
<td>-0.2</td>
<td>1.5</td>
<td>-0.2</td>
<td>2.3</td>
<td>0.0</td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>0.0</td>
<td>1.8</td>
<td>-0.5</td>
<td>1.3</td>
<td>-0.1</td>
<td>1.8</td>
<td>0.0</td>
<td>2.5</td>
<td>0.1</td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The November 2018 Consumer Price Index for the West Region is scheduled to be released on December 12, 2018

Technical Note
The Consumer Price Index (CPI) is a measure of the average change in prices over time in a fixed market basket of goods and services. The Bureau of Labor Statistics publishes CPIs for two population groups: (1) a CPI for All Urban Consumers (CPI-U) which covers approximately 93 percent of the total population and (2) a CPI for Urban Wage Earners and Clerical Workers (CPI-W) which covers 29 percent of the total population. The CPI-U includes, in addition to wage earners and clerical workers, groups such as professional, managerial, and technical workers, the self-employed, short-term workers, the unemployed, and retirees and others not in the labor force.
The CPI is based on prices of food, clothing, shelter, and fuels, transportation fares, charges for doctors' and dentists' services, drugs, and the other goods and services that people buy for day-to-day living. Each month, prices are collected in 75 urban areas across the country from about 5,000 housing units and approximately 22,000 retail establishments--department stores, supermarkets, hospitals, filling stations, and other types of stores and service establishments. All taxes directly associated with the purchase and use of items are included in the index.

The index measures price changes from a designated reference date (1982-84) that equals 100.0. An increase of 16.5 percent, for example, is shown as 116.5. This change can also be expressed in dollars as follows: the price of a base period "market basket" of goods and services in the CPI has risen from $10 in 1982-84 to $11.65. For further details see the CPI home page on the Internet at www.bls.gov/cpi and the BLS Handbook of Methods, Chapter 17, The Consumer Price Index, available on the Internet at www.bls.gov/opub/hom/homch17_a.htm.

In calculating the index, price changes for the various items in each location are averaged together with weights that represent their importance in the spending of the appropriate population group. Local data are then combined to obtain a U.S. city average. Because the sample size of a local area is smaller, the local area index is subject to substantially more sampling and other measurement error than the national index. In addition, local indexes are not adjusted for seasonal influences. As a result, local area indexes show greater volatility than the national index, although their long-term trends are quite similar. **NOTE: Area indexes do not measure differences in the level of prices between cities; they only measure the average change in prices for each area since the base period.**

The West Region covered in this release is comprised of the following thirteen states: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Information in this release will be made available to sensory impaired individuals upon request. Voice phone: (202) 691-5200; Federal Relay Service: (800) 877-8339.
Table 1. Consumer Price Index for All Urban Consumers (CPI-U): Indexes and percent changes for selected periods West (1982-84=100 unless otherwise noted)

<table>
<thead>
<tr>
<th>Item and Group</th>
<th>Indexes</th>
<th>Percent change from-</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Items</td>
<td>264.395</td>
<td>265.105</td>
</tr>
<tr>
<td>All items (December 1977=100)</td>
<td>427.380</td>
<td>428.528</td>
</tr>
<tr>
<td>Food and beverages</td>
<td>260.098</td>
<td>260.238</td>
</tr>
<tr>
<td>Food</td>
<td>259.839</td>
<td>259.955</td>
</tr>
<tr>
<td>Food at home</td>
<td>246.873</td>
<td>246.457</td>
</tr>
<tr>
<td>Cereals and bakery products</td>
<td>259.020</td>
<td>258.351</td>
</tr>
<tr>
<td>Meats, poultry, fish, and eggs</td>
<td>258.828</td>
<td>255.646</td>
</tr>
<tr>
<td>Dairy and related products</td>
<td>225.159</td>
<td>225.997</td>
</tr>
<tr>
<td>Fruits and vegetables</td>
<td>325.125</td>
<td>328.324</td>
</tr>
<tr>
<td>Nonalcoholic beverages and beverage materials</td>
<td>171.246</td>
<td>171.372</td>
</tr>
<tr>
<td>Other food at home</td>
<td>211.715</td>
<td>210.942</td>
</tr>
<tr>
<td>Food away from home</td>
<td>276.720</td>
<td>277.520</td>
</tr>
<tr>
<td>Alcoholic beverages</td>
<td>260.135</td>
<td>260.600</td>
</tr>
<tr>
<td>Housing</td>
<td>288.932</td>
<td>289.398</td>
</tr>
<tr>
<td>Shelter</td>
<td>332.959</td>
<td>333.957</td>
</tr>
<tr>
<td>Rent of primary residence(1)</td>
<td>351.431</td>
<td>353.140</td>
</tr>
<tr>
<td>Owners’ equiv. rent of residences(1)(2)</td>
<td>349.126</td>
<td>350.400</td>
</tr>
<tr>
<td>Fuel and utilities</td>
<td>306.943</td>
<td>301.933</td>
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<tr>
<td>Household energy</td>
<td>263.985</td>
<td>257.487</td>
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<tr>
<td>Energy services(1)</td>
<td>266.349</td>
<td>259.548</td>
</tr>
<tr>
<td>Electricity(1)</td>
<td>294.006</td>
<td>288.745</td>
</tr>
<tr>
<td>Utility (piped) gas service(1)</td>
<td>218.282</td>
<td>206.671</td>
</tr>
<tr>
<td>Household furnishings and operations</td>
<td>128.378</td>
<td>129.206</td>
</tr>
<tr>
<td>Apparel</td>
<td>116.614</td>
<td>120.996</td>
</tr>
<tr>
<td>Transportation</td>
<td>219.235</td>
<td>219.326</td>
</tr>
<tr>
<td>Private transportation</td>
<td>215.011</td>
<td>214.985</td>
</tr>
<tr>
<td>New and used motor vehicles(3)</td>
<td>100.683</td>
<td>99.368</td>
</tr>
<tr>
<td>New vehicles</td>
<td>145.903</td>
<td>145.885</td>
</tr>
<tr>
<td>New cars and trucks(3)(4)</td>
<td>101.334</td>
<td>101.315</td>
</tr>
<tr>
<td>New cars(4)</td>
<td>143.377</td>
<td>143.667</td>
</tr>
<tr>
<td>Used cars and trucks</td>
<td>135.579</td>
<td>130.452</td>
</tr>
<tr>
<td>Motor fuel</td>
<td>271.188</td>
<td>273.994</td>
</tr>
<tr>
<td>Gasoline (all types)</td>
<td>269.963</td>
<td>272.802</td>
</tr>
<tr>
<td>Gasoline, unleaded regular(4)</td>
<td>267.197</td>
<td>270.063</td>
</tr>
<tr>
<td>Gasoline, unleaded midgrade(4)(5)</td>
<td>257.208</td>
<td>259.277</td>
</tr>
<tr>
<td>Gasoline, unleaded premium(4)</td>
<td>263.377</td>
<td>265.956</td>
</tr>
<tr>
<td>Motor vehicle insurance(6)</td>
<td>841.012</td>
<td>847.893</td>
</tr>
<tr>
<td>Medical Care</td>
<td>494.151</td>
<td>495.094</td>
</tr>
<tr>
<td>Medical care commodities</td>
<td>358.085</td>
<td>382.609</td>
</tr>
<tr>
<td>Medical care services</td>
<td>528.357</td>
<td>530.461</td>
</tr>
<tr>
<td>Professional services</td>
<td>354.203</td>
<td>354.466</td>
</tr>
<tr>
<td>Recreation(3)</td>
<td>114.002</td>
<td>113.933</td>
</tr>
<tr>
<td>Education and communication(3)</td>
<td>137.172</td>
<td>138.175</td>
</tr>
<tr>
<td>Tuition, other school fees, and child care(6)</td>
<td>1,433.387</td>
<td>1,457.206</td>
</tr>
<tr>
<td>Other goods and services</td>
<td>436.312</td>
<td>437.335</td>
</tr>
</tbody>
</table>

**Commodity and Service Group**

| All Items | 264.395  | 265.105  | 266.195  | 3.5       | 0.7       | 0.4       |
| Commodity | 185.265  | 185.784  | 187.076  | 3.2       | 1.0       | 0.7       |

Note: See footnotes at end of table.
Table 1. Consumer Price Index for All Urban Consumers (CPI-U): Indexes and percent changes for selected periods West (1982-84=100 unless otherwise noted) - Continued

<table>
<thead>
<tr>
<th>Item and Group</th>
<th>Indexes</th>
<th>Percent change from-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commodities less food &amp; beverages........</td>
<td>147.891</td>
<td>148.525</td>
</tr>
<tr>
<td>Nondurables less food &amp; beverages ...</td>
<td>195.806</td>
<td>198.314</td>
</tr>
<tr>
<td>Nondurables less food, beverages, and apparel ..........</td>
<td>251.316</td>
<td>252.441</td>
</tr>
<tr>
<td>Durables ..................................</td>
<td>105.123</td>
<td>104.306</td>
</tr>
<tr>
<td>Services..................................</td>
<td>337.754</td>
<td>338.639</td>
</tr>
<tr>
<td>Rent of shelter(2)........................</td>
<td>354.490</td>
<td>355.560</td>
</tr>
<tr>
<td>Transportation services ....................</td>
<td>318.229</td>
<td>320.048</td>
</tr>
<tr>
<td>Other services ..........................</td>
<td>352.039</td>
<td>353.861</td>
</tr>
</tbody>
</table>

Special aggregate indexes:

| All items less medical care | 253.881 | 254.579 | 255.646 | 3.6 | 0.7 | 0.4 |
| All items less food ........ | 265.282 | 266.086 | 267.246 | 3.7 | 0.7 | 0.4 |
| All items less shelter....... | 237.558 | 238.155 | 239.469 | 3.2 | 0.8 | 0.6 |
| Commodities less food ........ | 152.071 | 152.706 | 154.166 | 3.9 | 1.4 | 1.0 |
| Nondurables .................. | 228.376 | 229.819 | 231.381 | 4.4 | 1.3 | 0.7 |
| Nondurables less food .......... | 200.694 | 203.099 | 205.317 | 6.9 | 2.3 | 1.1 |
| Nondurables less food and apparel...... | 251.851 | 252.912 | 256.007 | 9.2 | 1.7 | 1.2 |
| Services less rent of shelter(2) | 354.242 | 354.992 | 356.282 | 3.2 | 0.6 | 0.4 |
| Services less medical care services.. | 324.408 | 325.212 | 326.014 | 3.7 | 0.5 | 0.2 |
| Energy ............................ | 272.425 | 271.577 | 275.834 | 12.8 | 1.3 | 1.6 |
| All items less energy ........ | 266.010 | 266.840 | 267.708 | 2.9 | 0.6 | 0.3 |
| All items less food and energy .... | 267.873 | 268.827 | 269.737 | 3.0 | 0.7 | 0.3 |
| Commodities less food and energy commodities | 138.970 | 139.347 | 140.104 | 0.3 | 0.8 | 0.5 |
| Energy commodities .............. | 275.826 | 278.696 | 286.234 | 22.3 | 3.8 | 2.7 |
| Services less energy services ........ | 343.230 | 344.541 | 345.495 | 3.8 | 0.7 | 0.3 |

Footnotes
(1) This index series was calculated using a Laspeyres estimator. All other item stratum index series were calculated using a geometric means estimator.
(2) Indexes on a December 1982=100 base.
(3) Indexes on a December 1997=100 base.
(4) Special index based on a substantially smaller sample.
(5) Indexes on a December 1993=100 base.
(6) Indexes on a December 1977=100 base.
- Data not available

Regions defined as the four Census regions. West includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

NOTE: Index applies to a month as a whole, not to any specific date. Data not seasonally adjusted.
CCO 2.0 Recommendations of the Oregon Health Policy Board
Executive summary

Over the past five years, Oregon’s unique coordinated care model has made progress on the triple aim goals of better health, better care and lower costs. The Oregon Health Plan (OHP) is the source of health coverage for nearly one million Oregonians, the Oregon Health Plan (OHP) and its 15 coordinated care organizations (CCOs) have improved access to primary care, reduced costly emergency room visits, and saved the state an estimated $2.2 billion dollars in avoided health care costs.

Despite these successes, there is more work to do to ensure all Oregonians can be as healthy as possible. To guide the next five years of the Oregon Health Plan, the Oregon Health Authority (OHA) worked in partnership with the Oregon Health Policy Board (OHPB), policymakers, stakeholders and OHP members to bring forward new ideas. These ideas address the gaps and challenges that persist in our health care system. We are calling this next phase of health care transformation “CCO 2.0.”

To support CCO 2.0 policy development and fulfill our commitment to transparency, OHA sought significant public input. Thousands of Oregonians took part through:

- OHPB meetings
- Stakeholder meetings and presentations
- Public forums
- Online surveys and
- A phone survey of OHP members.

Throughout the yearlong process, OHP members and other stakeholders issued support for the policy direction. They also expressed satisfaction with Oregon’s coordinated care system. In addition, the Office of Equity and Inclusion (OEI) performed a health equity impact assessment (HEIA) on CCO 2.0 policies to find out how they may affect population groups in different ways.
CCO 2.0 Policy recommendations: The future of the Oregon Health Plan

OHA’s CCO 2.0 policy recommendations build on Oregon’s strong foundation of health care innovation and seek to make improvements based on best practices and evidence, as well as stakeholder and community input. To tackle Oregon’s biggest health problems Governor Kate Brown directed OHPB to focus on four key areas:

1. Improve the behavioral health system
2. Increase value and pay for performance
3. Focus on social determinants of health and health equity, and

**Improve the behavioral health system and address barriers to access to and integration of care**

These policies make CCOs more accountable for developing a person-centered mental health and substance use disorder (behavioral health) system that OHP members can count on, no matter who they are or where they live. Together, the policies aim to remove barriers between behavioral, physical and oral health. These policies will help all members receive the right care, at the right time and in the right place. Policies will:

- Require CCOs be fully accountable for the behavioral health benefit
- Assess capacity of comprehensive services
- Address prior authorization and network adequacy issues that limit member choice and timely access to providers
- Use metrics to incentivize behavioral health and oral health integration
- Expand programs that integrate primary care into behavioral health settings
- Require CCOs to support electronic health record adoption and access to electronic health information exchange
- Develop a diverse and culturally responsive workforce, and
- Ensure children have behavioral health needs met with access to appropriate services.
Increase value and pay for performance

Over the next five years, CCOs will make a significant move away from fee-for-service payments toward paying providers based on value. The proposed CCO 2.0 policies will reward providers and health systems for delivering patient-centered and high-quality care. OHA will ask CCOs to develop value-based payments (VBPs) to improve health outcomes in the areas of: hospital care, maternity care, behavioral health, oral health and children’s health care.

Recommended policies will:

- Increase CCOs’ use of VBPs with providers:
  - Require annual, CCO-specific VBP growth targets
  - Achieve a 70 percent VBP goal by 2024
- Increase CCOs’ support of Patient-Centered Primary Care Homes (PCPCHs):
  - Require VBPs for PCPCH infrastructure and operations
- Provide technical support and align payment reforms with other state and federal VBP efforts

Focus on social determinants of health and health equity

From the beginning, Oregon’s coordinated care model recognized that many things affect our health outside of the doctor’s office. Over the next five years, CCOs will increase their investments in strategies to address social determinants of health and health equity. CCOs will build stronger relationships with members, nonprofit organizations, hospitals, schools, and local public health departments. CCOs will align goals at the state and local level to improve health outcomes and advance health equity. OHA will develop measurement and evaluation strategies to increase understanding of spending in this area and track outcomes.

Recommended policies will:

- Increase strategic spending by CCOs on social determinants of health, health equity and disparities in communities, including encouraging effective community partnerships
- Increase CCO financial support of non-clinical and public health providers
- Align community health assessment and community health improvement plans to increase impact
- Strengthen meaningful engagement of tribes, diverse OHP members, and community advisory councils (CACs)
- Build CCOs’ organizational capacity to advance health equity
- Increase the integration and use of traditional health workers (THWs)
Maintain sustainable cost growth and ensure financial transparency

The Oregon Health Plan must remain a high-quality system that operates within a budget the state can afford. That way, Oregonians can continue to have access to the health care services they need. To support sustainability, CCO 2.0 policies address the major cost drivers currently in the system. OHA will also identify areas where CCOs can increase efficiency, improve value and decrease administrative costs.

Recommended policies will:

- Strengthen current financial incentives
- Set up new tools to evaluate and reward CCOs for improving health outcomes and containing costs
- Ensure program-wide financial stability and program integrity through improved reporting and strategies to manage a CCO in financial distress
- Use program purchasing power to align benefits and reduce costs with a focus on pharmacy costs

Conclusion

OHA plays an important role in creating the conditions for CCO and health transformation success. Program flexibility allows CCOs to meet the unique needs their communities. However, OHA also has a responsibility to conduct effective oversight of the program. This ensures that members across the state receive the care they deserve. OHA is developing the internal structures necessary to improve oversight and compliance infrastructure inside the agency, increase enforcement of new and existing requirements, and clarify the performance expectations for CCOs.

Oregon has been a leader in health reform since the early 1990s. This was when the state established the Oregon Health Plan and prioritized list of health services. The goal has always been to provide evidence-based, high-value care for Medicaid members.

CCO 2.0 policy recommendations continue to set Oregon apart as a leader in health care transformation. Most importantly, they:

- Address disparities our health care system
- Increase a focus on issues outside the doctor’s office that impact health
- Improve access to high quality physical, behavioral, and oral health care
- Change the way we pay for health care,
- Increase transparency, and
- Ensure the financial stability of OHP so Oregonians can continue to access the care they’ve come to rely on.
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CCO 2.0: Building on successes of Oregon’s health system transformation

Community-governed coordinated care organizations (CCOs) bring together physical, behavioral and dental health providers to coordinate care for people on the Oregon Health Plan, or Medicaid. Oregon first established CCOs across the state in 2012 to transform health care delivery in the state. These new organizations were created to reduce waste in the system, improve the health of the community, provide local accountability, align financial incentives, pay for performance and outcomes, and ensure fiscal sustainability. While other states have made adjustments to their Medicaid programs, Oregon’s efforts transform the entire system. These efforts are a national model for health care reform.

Today, one in four Oregonians, or nearly one million people, receive health coverage through the Oregon Health Plan (Medicaid), and most are members of a CCO. The first contracts for CCOs will end Dec. 31, 2019. Therefore, there is an opportunity to: build upon our successes, address challenges and persisting gaps in the system, and explore the possibilities for the next phase of health system transformation, which we are calling “CCO 2.0.”

The CCO 2.0 policy recommendations in this report build on Oregon’s strong foundation of health care innovation and seek to make modifications and improvements based on best practices, evidence, and stakeholder and community input.

Progress toward better health, better care and lower costs

Multiple features set Oregon’s CCOs apart from typical managed care organizations that serve Medicaid members:

- CCOs are locally governed.
- CCOs are accountable for the health outcomes of the communities they serve.
- Decisions are made through partnerships among:
  - Health care providers
  - Community members,
  - OHP members, and
  - Stakeholders in the health systems that have financial responsibility and risk.
CCOs have one integrated global budget for behavioral health (mental health and substance use) services, physical health and oral health care. CCOs have flexibility within their budgets to provide services outside traditional medical services. The goal of this flexibility is to meet the triple aim of better health, better care and lower costs for the population they serve. They have flexibility to support new models of care that are patient-centered and team-focused and reduce health disparities. CCOs coordinate services to focus on: prevention, chronic illness management and person-centered care.

A portion of CCO global budgets are tied to performance and quality. To receive these funds, commonly referred to as the “quality pool,” CCOs must meet performance or improvement targets on a set of 17 quality measures. The Health Plan Quality Metrics Committee and the CCO Metrics and Scoring Committee chooses the measures.

Over the first five years of their contracts, CCOs have been successful at meeting the original goals of the triple aim. (1) Since 2013, the CCO program statewide has grown at a rate of 3.4 percent per member per year. Before Oregon’s transformation of Medicaid, the forecast was for a growth rate of 5.4 percent. The result has been about $2.2 billion costs avoided over the five-year period from 2013 to 2017.

CCOs are also improving health care quality and other health indicators. This is especially true in the areas tied to incentive payments. For example, enrollment has increased in primary care homes. All CCOs met the threshold for the associated patient-centered primary care home incentive metric in 2017. Developmental screenings from birth to three improved from just under 21 percent in 2011 to almost 70 percent in 2017. There has also been marked improvement on other OHA tracked quality measures. For example, avoidable emergency department visits decreased by over 50 percent from 2011 to 2017.

An evaluation of Oregon’s 2012–2017 Medicaid 1115 waiver conducted by the Oregon Health & Science University (OHSU) Center for Health Systems Effectiveness found:

- Improved experience of care
- Improved self-reported health status, and
- A strong association between financial incentives and improvements in CCO metric performance.

The evaluation found that total spending per member per month decreased relative to Washington Medicaid members.
The OHSU evaluation also identified eight recommendations to further health system transformation in the future, while continuing to build upon the existing foundation:

1. Increase the portion of total CCO payments awarded for quality and access and raise the bar for rewards.
2. Require CCOs to report detailed data on value-based payment arrangements.
3. Provide additional incentives and resources to increase electronic health record functionality.
4. Inventory billing restrictions and regulations that impeded physical, behavioral and oral health care integration.
5. Create a “one-stop shop” where CCOs, OHP members, and other stakeholders can find information about health-related services.
6. Require CCOs to report person-level data on use of health-related services.
7. Require CCOs to commit one percent of their global budget to spending on social determinants of health.
8. Evaluate options for limiting the growth of prescription drug spending.

The findings and recommendations from the OHSU evaluation were used to help OHA identify gaps in the health care system and to inform CCO 2.0 policy development.

**Governor Brown identifies four areas for improvement**

The Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for OHA. OHPB is responsible for policy recommendations that will set the vision for the next phase of health transformation through the Oregon Health Plan and direct contract development for the next five-year CCO contracts.

In 2016, prior to release of the OHSU evaluation, OHPB launched a listening tour to gather public input. This took place as the board and agency began to plan to procure the next CCO contracts. In September 2017, in a letter to OHPB, Governor Brown outlined her vision to improve care, increase value and contain costs in CCO 2.0.

To build on the board’s previous work, she directed the board to provide recommendations to advance Oregon’s transformation efforts in four key areas:

1. **Improve the behavioral health system and address barriers to the integration of care:**
   Integrate behavioral, physical and oral health to allow patients to receive the right care at the right time and in the right place. Focus on behavioral health (mental health and substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.
2. **Increase value and pay for performance**
   Reward providers’ delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.

3. **Focus on the social determinants of health and health equity**
   Build stronger relationships between CCOs and other sectors. In addition, align outcomes between health care and other social systems to improve health equity. Encourage a greater investment in prevention and the factors that affect our health outside the doctor’s office.

4. **Maintain sustainable cost growth and ensure financial transparency:**
   Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

**Developing CCO 2.0 policy recommendations**

Upon receiving Governor Brown’s direction, OHPB and OHA organized CCO 2.0 policy development efforts to align with the four key areas. This organization allowed small, cross-agency policy area teams to focus their efforts to better understand the successes of the first CCO contract cycle and where improvements could be targeted.

The CCO 2.0 policy development process was kickstarted at the OHPB January 2018 retreat. There, the board members reviewed “maturity assessments” in each of the four key policy areas. OHA conducted these maturity assessments (see Appendix F) and captured the history, context, data, lessons learned and new policy opportunities for OHA to explore in the CCO 2.0 process. The OHSU evaluation results, OHA’s 2017–2019 Action Plan for Health, and the board’s 2016 public listening tour informed OHA’s maturity assessments.

From February through August, OHA and OHPB traveled the state, attended meetings, conducted presentations and issued surveys with the intent of hearing from experts, partners and stakeholders, OHP members and other interested individuals. This input was used to further develop policies for inclusion into the next round of contracts. The contracts will be awarded in June 2019 and begin Jan. 1, 2020.
Public engagement: Oregonians shape health transformation policies

Ensuring meaningful community engagement is part of OHA’s culture and practice. OHA considers community members to be essential partners in our work. We understand that meaningful engagement in the process by those most affected by an issue allows for concerns to be adequately addressed, builds community capacity, establishes transparency and creates better outcomes.

Public engagement allows OHA to:

1. Receive input and feedback from local communities
2. Educate the community about OHA’s work and how that work may affect the community
3. Develop relationships with local communities and ensure transparency
4. Identify the most relevant ways of communicating to the broader community about an issue or OHA’s work
5. Ensure that community concerns are heard, understood, incorporated and addressed

A critical aspect of the policy development work of the four policy area teams involved gathering public feedback at multiple points throughout the process. Each of the four CCO 2.0 policy area teams identified advocacy groups and subject-specific organizations to present draft policy recommendations to and gather critical technical feedback. OHA heard directly from more than 800 Oregonians who participated in public meetings and forums held across the state in more than a dozen locations, which were led by OHA Director Patrick Allen. Additionally, multiple surveys and online outreach tools were used to gather perspectives from a diverse cross-section of Oregonians.

The in-person approaches included the following (see Appendix E):

- Discussion at more than 25 health committee meetings
- Oregon Health Policy Board meeting updates and public testimony
- Presentations at more than 20 conferences and meetings
- Two formal tribal consultations
- Thirteen community advisory council meetings, hosted by OHA innovator agents
- Four public forum events across the state in April and May 2018 (200 participants)
- Ten public road show events across the state in June 2018 (more than 500 participants)
• Spanish-language forum in Woodburn, OR (100 participants)
• Spanish-language forums hosted by Mid-Columbia Health Equity Advocates (MCHEA) in Hood River and The Dalles (more than 40 participants)

Online and phone approaches included the following (see Appendix E):

• Online survey with 1,568 respondents
• Online survey that mirrored the June 2018 road show events with 393 respondents
• Emails directly to the CCO 2.0 state email address
• 38 letters and comments from organizations that are posted online
• Phone surveys in August to a representative sample of 400 OHP members in English, Spanish, Russian and Vietnamese

Community engagement strategies

OHA’s policy area teams partnered with the Office of Equity and Inclusion and the External Relations Division to support a transparent and inclusive public engagement process. OHA sought input from subject matter experts and community partners to inform the development of the CCO 2.0 public engagement plan and to determine the purpose and scope of community engagement efforts. OHA prioritized gathering input from OHP members and worked to ensure that public meetings were held in geographically diverse locations.

Public forums took place in accessible venues. OHA also provided language interpretation services and food to attendees. All public forum materials were developed with plain language considerations. The materials were translated into Spanish, with additional languages translated upon request. In organizing these events, OHA partnered with culture-specific community-based organizations, Regional Health Equity Coalitions, and the Community Partner and Outreach Program. In some cases, these partners acted as the conveners.

The development of these relationships allowed OHA to better identify the diverse needs of cultural groups within member populations and develop strategies to engage them effectively. OHA developed a member-specific survey that sought feedback based on OHP member experiences. OHA also actively engaged Oregon tribes in tribal consultations. In addition, OHA partnered with the Department of Human Services’ Community Partner and Outreach Program to hold a culturally specific, Spanish-language community meeting. This meeting drew nearly 100 attendees.

These strategies and partnerships can be used to inform future OHA community engagement plans. OHA is committed to ongoing engagement with community organizations and OHP members to build member and community trust and ensure that our policies and services are responsive to the diverse needs of our communities.
Public engagement impact on CCO 2.0 policy recommendations

Throughout the policy development process, OHA has connected with a diverse audience of OHP members, community members, and other stakeholders to receive formal recommendations, public comments and OHP member specific feedback. This critical information has been used to modify the policy recommendations to ensure they are informed by a wide array of Oregonians and improve the state’s coordinated care system.

In the online survey asking which areas need more attention and work to improve through CCO 2.0, respondents ranked behavioral health care and addressing social determinants of health at the top (see Appendix E). In the August phone survey, OHP members also identified improvements in these two areas as having the largest positive impact on their health care experiences. In addition, eighty-nine percent of OHP members expressed they were satisfied or very satisfied. Nearly two-thirds were very satisfied with the coverage they receive through OHP.

This general satisfaction with OHP and Oregon’s coordinated care system was also heard at the statewide in-person public events. When identifying areas in need of improvement, participants confirmed the four policy priority areas were the right areas to focus on. Attendees provided support for the overall direction of CCO 2.0 policy development. They reiterated strong support for improving the integration of behavioral health care and CCOs’ role in partnering with community organizations, schools and local public health authorities to address disparities in health, housing and transportation (see Appendix E).

Oregonians spoke to challenges in accessing medical and behavioral health providers. This includes those who are culturally responsive and speak the languages of communities they serve. They expressed support for keeping CCOs locally governed and accountable with the flexibility to focus on the needs of their communities. Community members also emphasized the importance of improving care coordination through electronic health records and the need to continue to focus on the integration of oral health.

When feedback has supported modifying policies, OHA has carefully considered potential changes as well as the diverse viewpoints surrounding the policy. For example, health equity advocates and subject matter experts played a key role in reframing how OHA should approach issues of health equity. Embedded within a request that we adopt a framework of “cultural responsiveness” instead of defining the work as “cultural
“competency” is an understanding that this work is ongoing. It is a process that understands we can never fully attain all the skills and views we need to work with culturally diverse clients. Instead, “responsiveness” assumes one has the openness to adapt to the cultural needs of those with whom they work, always seeking greater understanding of their culture, ethnicity, and language.

Another important conversation with stakeholders centered around the repeated stakeholder ask for the elimination of the sub-capitation and delegation of the behavioral health benefit. Under CCO 1.0, CCOs may have fully sub-capitated, or “carved out,” the behavioral health benefit. As a result, the behavioral health system was administered and provided in silos. Consequences include delayed authorizations, caps on behavioral health spending, diffuse accountability and members not receiving timely services. OHA changed the policy from requiring CCOs to clearly own the behavioral health benefit to requiring CCOs be accountable for the behavioral health benefit of their members and not fully transfer the benefit to another entity. This includes ensuring timely access to services and an adequate provider network. Fully eliminating the sub-capitation and delegation of the behavioral health benefit could have unintended consequences, harm exiting relationships and destabilize the system. However, by strengthening contract language to require CCOs be responsible and accountable, the behavioral health system can reach desired outcomes of members receiving the right services at the right place and at the right time.

Additionally, OHA approached policy recommendations with clear plans to address common stakeholder concerns. For example, stakeholders have concerns that value-based incentives should be meaningful enough to motivate providers to invest in and adopt new approaches to care delivery. At the same time, incentives should not subject providers to financial and clinical risk they cannot manage. The OHA approach to specific value-based payment (VBP) policies recognizes financial incentives, by themselves, are not sufficient to change provider behavior and achieve person-centered care. OHA plans to use additional, complementary levers (such as promoting specific VBP model components that ensure provider flexibility) to transform the health care system.

Within sustainable cost growth, several CCOs raised concerns that significantly increasing reserve requirements for CCOs would tie up CCO resources and hinder their ability to deliver services and invest in their communities. While OHA is committed to ensuring that reserve requirements adequately reflect the risks CCOs and their risk-bearing partners face, OHA has also modified policy recommendations in response to these concerns. The current recommendations seek to ensure financial security of the CCO program while also providing insolvency-mitigation tools that require less up-front reserve capitalization to ensure CCOs can make timely investments to meet the needs of their communities.
Health equity impact assessment of the CCO 2.0 policy recommendations

OHA’s Office of Equity and Inclusion (OEI) has been an active participant in the CCO 2.0 process of policy analysis and development, research, public input, and discussion. In July, OHPB directed OHA to ensure an equity lens is applied to all the policy recommendations in collaboration with OHPB’s Health Equity Committee.

A health equity impact assessment (HEIA) is a tool that helps identify how a program, policy or similar initiative will impact population groups in different ways. OEI took some key aspects of the HEIA tool and performed a desktop assessment, which involved a literature review, results of the CCO 2.0 public input process, and feedback provided by:

- Subject matter experts
- Culturally specific community-based organizations
- The Medicaid Advisory Board, and
- OHPB’s Health Equity Committee.

The HEIA tool is intended primarily for application during the design phase of an initiative (pre-implementation). It is also a living document, with health equity impacts identified as the design of the initiative evolves. In this case, the assessment was introduced retrospectively as an evaluation tool to examine whether the policy recommendations capitalize on available opportunities to improve health equity or whether they may potentially widen health disparities. In identifying those impacts, recommendations were made to adjust the strategies, mitigate adverse impacts and maximize positive impacts of the policies during development and implementation.

Full details of the impact assessment are available (see Appendix B), and assessed policies were initially flagged as either positive (potential for positive health equity impact), neutral (no positive or negative impact could be identified at this point), negative (potential for negative unintended health equity impact) or both, positive and negative. It is also a living document, with health equity impacts identified as the design of the initiative evolves. The assessment results directed OHA to areas where further development could maximize positive impact to improve health equity, even when the potential for a negative impact exists. In the case of VBP, the assessment provided OHA with recommendations to address potential negative impacts by elevating the need in the design and evaluation of payment models to include monitoring which groups or communities are benefiting from the model, and which may potentially be bearing the weight of unintended negative consequences. As policy options changed, and mitigation plans were incorporated into the policies, the content of the HEIA evolved, and recommended policies reflect those changes. The resulting changes to the policies led to policy development and implementation considerations that use a health equity lens and aim to prevent potential negative impacts while maximizing positive impacts.
Policy recommendations: The future of the Oregon Health Plan

Oregon is well-positioned to continue as a national leader in health transformation. Oregon has been recognized as a leader in health reform since the early 1990s when the state established the Oregon Health Plan and prioritized list of health services to provide evidence-based, high-value care for Medicaid members. Yet, despite the gains Oregon has made in outcomes, quality and cost-savings, Oregon’s health transformation still has room to grow. Today, as in other states, too many Oregonians experience health problems rooted in social conditions, such as lack of adequate housing and nutrition. Too many Oregonians struggle with untreated mental illness or substance use disorders. Too many resources are still spent on costly acute interventions or low-value services, rather than more effective and efficient preventive and primary care.

The CCO 2.0 policy recommendations leverage the lessons learned in the first five years of Oregon’s coordinated care experiment to write the next chapter of Oregon’s health transformation story by tackling these underlying health care challenges.

The vision for the future of coordinated care and the Oregon Health Plan has been shaped by the following values:

- CCOs should remain locally governed, transparent, community-based organizations;
- The state and CCOs should work together to expand upon the flexibility and use of the global budget concept;
- Local flexibility is key to statewide transformation;
- Integration of behavioral, oral and physical health care must remain a priority;
- Focusing on children requires distinct approaches from how care is delivered for adults but is crucially important to any long-term health and well-being improvements in the state; and
- Everyone should have a fair and just opportunity to be as healthy as possible.

Culturally and linguistically appropriate services are key elements in the work of eliminating health disparities and advancing health equity.

Grounded in these values and guided by experience and the best available evidence, the following policy recommendations are the result of more than a year of work by OHPB and OHA and reflect the input of thousands of Oregonians.
Tribal consultation and meeting the health needs of tribal members

In Oregon, there are 34,346 tribal members who receive coverage through OHP. Among those tribal members, 52.6 percent are open card (fee for service) and 47.4 percent are part of a CCO. To improve access to health care that is culturally responsive and enhance the social, physical, behavioral and oral health of tribal members, as well as to address health disparities experienced by tribal members, OHA must meaningfully consult with tribal leadership.

During the policy development process, OHA actively engaged with Oregon’s nine federally-recognized tribes. OHA presented to the tribes at the monthly government-to-government tribal and state agencies meetings and held an informational webinar that provided time for clarification and questions. To ensure information exchange, mutual understanding, and informed decision-making on behalf of the tribes and OHA, the agency followed its Tribal Consultation and Urban Indian Health Program Confer Policy.

OHA engaged in individual consultations with the Confederated Tribes of Grand Ronde, Warm Springs, and Umatilla Reservation. OHA also held a collective consultation in August open to all tribes during the final stages of policy development. The collective consultation included representatives from:

- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes, Coquille Indian Tribe
- Confederated Tribes of Warm Springs
- Confederated Tribes of Grand Ronde
- Confederated Tribes of the Umatilla Indian Reservation
- Native American Rehabilitation Association, and
- Northwest Portland Area Indian Health Board.

In response to direction gathered during consultation, OHA updated policy options to include clear and prioritized inclusion of the tribes in all community engagement processes. Collectively, we have also worked to ensure elements from Oregon’s 2012–2017 Medicaid Waiver (Attachment I) are a priority as we develop the CCO 2.0 contract language. These elements include requirements for contracting with and ensuring network adequacy for Indian Health Care Providers (IHCP), more effective care coordination for tribal members, and opportunities for tribal and IHCP participation, and review and feedback for the CCO community health assessments and community health improvement plans. Additionally, at the request of tribes, OHA will begin work to create a path for one or more Indian Managed Care Entities to serve tribal Medicaid members in Oregon.
Incorporating children’s health needs into CCO 2.0 policies

The Governor’s Children’s Cabinet and the Early Learning Council are developing long term, cross-sector plans for improving early childhood outcomes and family stability in Oregon. The vision of Governor Brown’s Children’s Agenda is that “all Oregon children living in poverty have pathways to rise to the middle class and achieve their full potential.” The Children’s Agenda states that, “To accomplish this, we must focus on reducing poverty and supporting family stability by using a two-generation approach that supports both vulnerable kids and their families.” The Oregon Health Authority is working toward this vision in CCO 2.0 by blending together strategies across the coordinated care system to improve the health and wellbeing of children and families across the state and working in conjunction with other state agencies to ensure a continuum of supports for families.

In 2016, 85 percent of Oregon children living in or near poverty were served by OHP or the Children’s Health Insurance Program (CHIP) and 38 percent of all Oregon children were covered by OHP or CHIP. Crucial to improving outcomes for these children is a focus on and investment in upstream prevention, which sets the trajectory for lifelong health and reduction in chronic disease, which in turn leads to sustainable reductions in healthcare costs.

Multiple policies in CCO 2.0 are designed to improve child and family outcomes (see Appendix C) by addressing key factors that impact maternal, child and family health. These include strategies to prevent and address the behavioral health issues that destabilize families and impede children’s readiness for kindergarten strategies that enhance care coordination for families of children and youth with special health care needs; payment strategies to improve delivery of maternity and pediatric care; and policies that drive CCOs’ work to improve the social and environment context in which our most vulnerable Oregonians live.

Key Strategies to Improve Children’s Health

Policy 1: Require CCOs to spend a portion of the net income or reserves on social determinants of health and health equity or health disparities, which can be directed at supports for families with young children.

Policy 10: In years three through five of the CCO 2.0 contracts, each CCO will implement new value-based payments (VBPs) in five care delivery focus areas, two of which are maternity care and children's health care.

Policy 21: Prioritize access to behavioral health services and early intervention for pregnant women, parents, families and young children to prevent poor long-term outcomes and reduce costs.

Policy 26: Require System of Care to be fully implemented for the children’s system

Policy 27: Require Wraparound services for all children and young adults who meet criteria.
Accountability, contract monitoring and enforcement

Achieving the policy objectives of CCO 2.0 requires a strong operational foundation with clearly defined performance expectations and a system to monitor compliance with all contract provisions. While some flexibility allows CCOs to meet the unique needs their communities, OHA also has a responsibility to conduct effective oversight of the program to ensure members across the state receive the care they deserve.

State audits and program reviews have highlighted the need for improved enforcement of contract provisions, and new federal rules that increase the requirements for state monitoring and oversight of CCOs go into effect this year. This includes drafting contract language that clearly defines expectations and deliverables, providing technical assistance if needed, and utilizing enforcement mechanisms when necessary to achieve those outcomes. It also means developing more prescriptive guidance in areas where stakeholders have expressed concern about barriers to access or inconsistency.

To support this effort, OHA is developing the internal structures necessary to set the standard for accountability throughout the health care delivery system and to consistently apply that standard to all providers. Through improvements to the monitoring and compliance infrastructure inside the agency, increased enforcement of new and existing requirements, and clarifying the performance expectations for CCOs, OHA plays an important role in creating the conditions for CCO and health transformation success.
Improve the behavioral health system and address barriers to access to and integration of care

Vision

Behavioral health encompasses mental health and substance use disorder services for individuals and families throughout the lifespan. Creating an effective behavioral health system that meets the needs of all members requires:

• Integrated and accessible services without wait times
• Member choice in who they see for services, and
• A system that meets members’ needs without having to navigate a complicated system.

In CCO 2.0, Oregon will improve behavioral health for Oregonians and remove the barriers that keep patients from receiving care in the right place at the right time. Where systems and needs align, we will extend these efforts to improve integration of oral health. Children with serious emotional disturbances (SED) will have their needs addressed through system integration and access to appropriate services. Members impacted by the opioid epidemic will experience more access to medication assisted treatment, traditional health workers, and timely access to treatment.

Considerations

The current behavioral health system’s functioning and operations are inconsistent across Oregon. As a result, OHPB has expressed that behavioral health is an immediate urgency to improve the health care system in Oregon. The 2016 Behavioral Health Collaborative, a group of 50 stakeholders convened to recommend a modern behavioral health system in Oregon, found “the behavioral health system continues to include fragmented financing,
carve-outs that prevent integration and efficiencies, siloed delivery systems, and services that fail to serve and exacerbate poor health outcomes.” The Behavioral Health Collaborative recommendations focused on workforce, standards of care and competencies, metrics, and health information technology. These recommendations are incorporated into CCO 2.0 behavioral health policy recommendations.

Additional issues negatively impacting the behavioral health system were identified in the OHA maturity assessment (see Appendix F):

- Access, transitions between levels of care and navigating the system are cumbersome.
- Administrative and billing barriers impede integration efforts and create barriers to access and effective care in both severe and persistent mental illness (SPMI) and substance use disorders (SUDs).
- Physical health providers are not able to bill for behavioral health codes, and the opposite is true as well.
- Limited information sharing produces an additional barrier.
- Workforce capacity is not robust enough to ensure access.
- Rates for behavioral health services are insufficient, which leads to an underpaid workforce and high turnover.
- Emergency department issues are a result of broader access issues.
- Data is insufficient to analyze the flow of services from assessment to delivery of care.

OHA also considered existing statewide plans and recommendations that addressed the needs of adults living with SPMI and SUDs. In 2012, to address the investigation of the State’s compliance with mandates for community mental health services to be sufficient to avoid unnecessary institutionalization of adults with SPMI, OHA entered into an agreement with the Civil Rights Division of the United States Department of Justice (USDOJ). This agreement with the USDOJ implements systemic changes to Oregon’s behavioral health system during health system transformation. Out of this agreement, in 2016 OHA issued the Oregon Performance Plan (OPP) to improve mental health services for adults living with SPMI. The main goals of the OPP are to reduce inappropriate institutionalization and strengthen the community behavioral health system. OPP priorities such as assertive community treatment services, mobile crisis services, linkages to services, discharges from the Oregon State Hospital, and reducing acute psychiatric care and emergency department readmissions helped inform the development of policy recommendations to ensure alignment.
In 2018, House Bill 4143 directed the Department of Consumer and Business Services (DCBS), with OHA, to study and report on existing barriers of effective treatment for and recovery from substance use disorders. OHA consulted on the resulting report and recommendations, which furthered clear alignment between the DCBS and CCO 2.0 policy recommendations. The most significant recommendation from the DCBS report is that substance use disorder be addressed as a chronic health condition, with ongoing care and services available to maintain recovery even when an individual is not actively using. Other recommendations include incentives to substance use disorder treatment providers in rural and underserved areas, increasing capacity within the full spectrum of services, and identifying and addressing issues of reimbursement equity.

The opioid epidemic continues to devastate families. Federal and state funding targets specific aspects of combating the opioid epidemic, and Oregon has added medication assisted treatment options in previously barren parts of the state. The CCO 2.0 policy recommendations are designed to build on successes and increase access for individuals and families struggling with opioids. CCOs will be responsible for ensuring members have access to behavioral health services, including services to treat opioid use disorder. CCOs, in collaboration with local providers and Community Mental Health Programs (CMHPs), will ensure that adequately trained workforce, provider capacity, and comprehensive integrated services exist in the CCO region for individuals and families in need of opioid use disorder treatment and recovery services. CCOs will coordinate care with local hospitals, emergency rooms, oral health, law enforcement, emergency medical services, traditional health workers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their community.

OHA vetted its policy recommendations through OHPB and a public input process, as well as through the OHA Office of Equity and Inclusion’s HEIA, all of which supported the maturity assessment results and raised key additional behavioral health themes. These additional themes included improving access to a full continuum of care, including:

- Withdrawal management, residential, outpatient and recovery support services
- Addressing culturally and linguistically appropriate services through network adequacy

The Oregon Health Plan needs a full continuum of care for behavioral health. This includes services from outpatient to inpatient or residential settings to withdrawal management and recovery support services for mental health and substance use disorder.
• Prohibiting arrangements that fully sub-capitate and delegate the behavioral health benefit, and

• Increased support for health information technology and health information exchange.

In addition to behavioral health focused themes, integration themes included addressing challenges with oral health integration to improve members’ ability to manage chronic conditions like diabetes and gum disease and ensuring children with SED have access to integrated and appropriate services.

OHA staff developed recommended policies to address the issues identified, with a focus on integration of care across the care continuum, access to services and an adequate provider network. Fundamental to these concepts is clear accountability and responsibility for the behavioral health benefit by the CCOs.

**Policy recommendations**

CCO 2.0 will build on existing successes to shape a consistent, person-centered behavioral health system throughout Oregon. The recommended policies will support development of a behavioral health system that works for everyone by requiring CCOs be fully accountable for the behavioral health benefit, addressing billing barriers, and improving health information technology for behavioral health providers. Improving the integration of behavioral health with oral and physical health will lead to better health outcomes and lower costs through increased coordination of care and a stronger, accountable health system.

**Require CCOs be fully accountable for the behavioral health benefit (Appendix A: Policies 17, 28)**

The public input process highlighted the need for clear ownership of the behavioral health (mental health and substance use disorder) benefit. The current process is not working and has led to difficulty with authorizations and unanswered questions, resulting in members not receiving services in a timely manner. The policy recommendations require CCOs be accountable for the behavioral health benefit, which ensures that members have access to an adequate provider network, receive timely access to the full continuum of care and access effective treatment. Full accountability for the behavioral health benefit should result in integration of the benefit at the CCO level. By eliminating silos at the administration and benefit level, funding and services will integrate improving whole health for members.

Community Mental Health Programs (CMHPs) are responsible for safety net and mobile crisis services, along with other key behavioral health services in the county. CCOs must
honor and enforce memorandums of understanding with the CMHPs. CCOs and CMHPs should work together, with OHP members, to develop the CCO community health improvement plan and the local mental health authority biennial implementation plan. These two plans should inform and complement one another.

Assess capacity of comprehensive services and address prior authorization and network adequacy issues that limit member choice and access to providers (Appendix A: Policies 17, 19, 25)

The Oregon Health Plan needs a full continuum of care for behavioral health. This includes services from outpatient to inpatient or residential settings to withdrawal management and recovery support services for mental health and substance use disorder, which must incorporate opioid treatment and recovery services. CCOs must ensure that all members have access to the full continuum of care, including an adequate workforce to deliver these services. In order to fully understand and address gaps in services, OHA will develop clear definitions of network adequacy and the appropriate tools for assessment.

Additionally, cumbersome and limited prior authorizations prevent individuals from receiving the care they need when they need it. Contracts that delegate the behavioral health benefit to one entity in a region limit the provider network. CCOs must be fully accountable for services by actively taking responsibility for ensuring seamless access to all covered benefits. To do such, CCOs will develop proactive solutions to prior authorization and benefit issues and work collaboratively to resolve workforce and network adequacy issues. CCOs will be required to review their region’s network of providers and ensure it is sufficient enough to meet the needs of all members, including children and older adults. This will create a more transparent, effective and responsive behavioral health system.

Use metrics to incentivize and measure the outcomes of behavioral health and oral health integration (Appendix A: Policy 18) and expand programs that integrate primary care into behavioral health settings (Policy 39)

Integration of behavioral health, physical health and oral health will increase access to care and improve outcomes. OHA staff will identify metrics to provide goals for CCOs to improve behavioral health and oral health outcomes. The metrics will capture integration at the CCO level and treatment system level. They will also enable OHA to monitor and enforce accountability for the behavioral health benefit and help OHA better understand the limitations of integration of the oral health benefit. OHA will also be able to track
behavioral health outcomes because of improved integration. The CCOs will report on these metrics as transparent integration goals.

In addition, the creation of behavioral health homes will enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. Sixty-eight percent of adults diagnosed with mental health conditions have one or more chronic physical conditions. Behavioral health homes integrate physical health into behavioral health to provide effective person-centered care for individuals with complex needs. Health homes models result in decreased emergency department visits, reduced hospital admissions, reduced homelessness, and fewer withdrawal management visits. Behavioral health homes reduce stigma for individuals that have been reluctant to seek services in the health care system. Implementing the behavioral health homes program will address the health needs of the whole person and improve whole health outcomes.

Require CCOs to support electronic health record adoption and access to electronic health information exchange (Appendix A: Policies 32, 33, 41)

To achieve integration, health information technology (HIT), including electronic health records (EHR) and electronic health information exchange (HIE), must be available for providers, including behavioral health providers, who currently face a “digital divide” in access to HIT. CCOs will be required to establish targets for increasing EHR adoption by physical, oral and behavioral health providers and work with key providers to reduce barriers to EHR adoption. OHA will seek incentive funds to help support provider EHR adoption.

CCOs will also support behavioral health providers’ access to HIE for care coordination, including but not limited to ensuring that physical, oral and behavioral health providers have access to timely hospital event notifications to help them manage populations and target interventions and follow-up. Finally, CCOs will be required to use hospital event notifications to inform care coordination and population health management.

Develop a diverse and culturally responsive workforce (Appendix A: Policies 19, 20)

OHP members and stakeholders have asked OHA and OHPB to prioritize the development of a well-trained, trauma-informed, culturally and linguistically responsive workforce. Three complementary policy options address this issue, with responsibility shared between the OHA and CCOs. CCOs will submit plans for developing their workforce, provide regular reporting on the capacity and diversity
of their workforce, and fairly assess the adequacy of the provider network to deliver effective care and treatment for members throughout the lifespan.

**Ensure children have their behavioral health needs addressed with access to appropriate services (Appendix A: Policies 21, 26, 27, 40)**

Many of the behavioral health policy options will positively impact the children’s system; however, additional focused work must be done. CCOs’ play a critical role in advancing recommendations by existing stakeholder groups who are examining the needs for children’s continuum of care such as:

- Children and Youth with Specialized Needs
- Children’s System of Care
- Behavioral Health Collaboratives
- Children’s System Advisory Committee, and
- Other advisory and provider groups.

These policies ask CCOs, with the support of OHA, to require providers to implement trauma-informed care practices, utilize adverse childhood experiences screening, and prioritize services for children from pregnancy through age five. Additionally, by strengthening requirements and infrastructure for services that work (for example, The Children’s System of Care and Wraparound Initiative) the new behavioral health system will ensure needs are met for all children, youth and young adults and their families.
Increase value and pay for performance

Vision

By serving as a foundational strategy for advancing health system transformation, value-based payment (VBP) fundamentally changes the way health care is delivered through new payment models that encourage patient-centered, population-based care. In CCO 2.0, CCOs will make a significant move away from fee-for-service (FFS) payment toward paying providers based on value. This will lead the way for new, innovative payment models across Oregon’s health system by:

• Rewarding providers’ delivery of patient-centered, high-quality care;
• Rewarding health plan and system performance;
• Aligning payment reform with other state and federal efforts;
• Supporting providers’ focus on patient care rather than administrative tasks; and
• Ensuring consideration of health disparities and members with complex needs.

Considerations

The OHA maturity assessment (see Appendix F) of the first five years of CCOs found that the use of VBP varied by CCO; CCOs have used payment models beyond FFS, but they have less experience linking payment to quality; current reporting does not adequately capture CCO VBP activities; and differences in geography, plan size and provider market power means a “one-size-fits-all” VBP approach will not work. Based on a preliminary data collection, OHA estimates that approximately 40 to 50 percent of all CCOs’ payments to providers were in the form of a VBP.

Since Oregon first launched CCOs, significant work has occurred nationally to create a framework for health systems to move away from FFS toward VBP. Efforts to deliver person-centered care have been stymied nationally and in Oregon, to a large degree, by a payment system that is oriented toward paying for volume—as opposed to value—for
patients and caregivers. Previous payment reform efforts focused exclusively on capitating payments, without including a link to quality. These efforts, while often successfully containing costs, were generally unsuccessful in achieving the triple aim because they failed to ensure access to and quality of care was maintained.

Over the past five years, the commonly used payment reform language has transitioned from the term “alternative payment models” (APMs) toward VBP to signify the need for payments to reflect quality and outcomes. The Health Care Payment Learning and Action Network (LAN), a national effort supported by the Centers for Medicare and Medicaid Services (CMS) to accelerate VBP across markets, developed a framework for categorizing VBPs that has become the nationally accepted method to measure progress on VBP adoption. OHA will use the LAN framework to categorize and track VBP use across Oregon.

Changing how care is paid for is a critical component of moving to an affordable, sustainable health system. Payment models within the VBP framework are configured to incentivize value by ensuring activities that enhance patient-centered care (for example, care coordination) are compensated appropriately. VBPs better enable providers to invest in care delivery that is more focused on patient needs and health goals. Changes in payment are necessary to drive delivery system transformation and ensure that health care costs reflect appropriate and necessary spending.

Oregon’s 1115 Medicaid Demonstration Waiver renewal requires OHA to advance CCOs’ use of VBP by ensuring CCOs use VBP arrangements, structured to improve quality and manage cost growth, in their contracts with their network providers. OHA has used the CCO 2.0 process to inform the development of a VBP Roadmap that describes how the state, CCOs and their contracted providers will achieve this goal, while maintaining flexibility to ensure care focuses on the whole person and supports healthier communities.

The VBP policy option that forms the foundation of the VBP Roadmap encompasses a comprehensive package of complementary strategies that not only increase CCOs’ use of VBPs with providers over the five-year period, they move CCOs along the VBP continuum to more advanced VBP models that give providers increased flexibility to provide the care their members need.

OHA has developed the recommended VBP policy using the results of the Evaluation of Oregon’s 2012–2017 Medicaid Waiver (1), maturity assessment, CCO VBP Workgroup,
VBP provider survey, expert technical assistance provided by CMS, CCO 2.0 surveys and public engagement meetings.

Policy recommendations

Realizing the vision of a transformed health system supported by increased adoption of VBP will require multi-sector, system-wide action and collaboration by payers and providers. CCO 2.0 will move Oregon’s health care system away from an unsustainable fee-for-service model to sustainable payment models that reward efficiency and drive improvements in quality of care in key areas such as behavioral health and oral health.

Increase CCOs’ use of VBP with providers by requiring annual VBP growth targets to achieve a 70 percent VBP goal by 2024 (Appendix A: Policy 10, 34)

Each CCO applicant will be required to:

1. Have a plan to spend at least 20 percent of dollars in year one using a VBP model that at least pays for performance on quality metrics (like the CCO incentive metrics program).
2. Provide details on per-member, per-month (PMPM) VBP payments to PCPCH clinics.
3. Respond to specific questions that address how their VBP models will not negatively affect priority populations, including:
   a. Racial, ethnic and culturally-based communities
   b. LGBTQ people
   c. People with disabilities
   d. People with limited English proficiency
   e. Immigrants or refugees
   f. People with complex health care needs, and
   g. Populations at the intersection of these categories.
4. Demonstrate they have (or intend to acquire) the health information technology infrastructure necessary to support VBP reporting.

In 2020, each CCO will be expected to implement 20 percent of dollars using a VBP. In year two (2021), each CCO will be required to implement new VBPs in at least two of the five care delivery focus areas and one of the areas must be either hospital care or maternity care. A CCO may implement new VBPs in both hospital care and maternity care in 2021, but both must be implemented by year three (2022). In years three through five, CCOs will annually add one new VBP in the remaining care delivery focus areas, allowing them to gain experience and develop more advanced VBPs in these areas.
Increase CCOs’ support of Patient-Centered Primary Care Homes (PCPCHs) by requiring VBPs for PCPCH infrastructure and operations (Appendix A: Policy 10)

CCOs will be required to make “infrastructure and operations” payments to Patient-Centered Primary Care Homes (PCPCHs), based on PCPCH tier level. These per-member, per-month VBPs allow for advancement and sustainability of the PCPCH model, which a 2016 evaluation showed have achieved better health outcomes and cost savings. These VBPs, which can support staff and activities that are not reimbursed through traditional FFS, allow for advancement and sustainability of the PCPCH model.

Provide technical support and align payment reforms with other state and federal VBP efforts

OHA plans to provide support for VBP implementation in the several areas of need identified through the CCO 2.0 public input process. For example, metrics reporting should to be aligned, when possible, both within Medicaid and across payers. OHA will support CCO and other payer alignment of metrics to ease providers’ administrative burden. OHA will work with national consultants to provide ongoing technical assistance and will work through other avenues, such as the multi-payer Primary Care Payment Reform Collaborative, to seek metrics alignment across Medicaid and commercial payers.

Intentional strategies need to be put in place to ensure VBPs do not cause unintended, negative consequences for priority populations. The Transformation Center will work with the Office of Equity and Inclusion to develop technical assistance in areas that will address the health equity considerations brought up by the health equity impact assessment (see Appendix B).

Additionally, expansion of VBP needs to include more than Medicaid to successfully transform the delivery system. OHA recognizes that adoption of VBP will be accelerated through alignment of payment approaches across the public and private sectors, which will ensure broader dissemination of meaningful financial incentives that reward providers who deliver higher-quality and more affordable care. OHA plans to extend the VBP Roadmap to other payers, including the Public Employees’ Benefit Board (PEBB), the Oregon Educators Benefit Board (OEBB), and commercial payers participating in the Primary Care Payment Reform Collaborative, and expects CCOs to be part of the collaborative process to align efforts across these markets.
Focus on social determinants of health and health equity

Vision

Health begins where we live, learn, work and play. Oregon’s transformation vision is rooted in the fact that the health care system has a limited impact on overall lifelong health of Oregonians. To truly achieve health for all people in Oregon – and not just the absence of disease – the health care system and its partners need to focus equally on the factors that affect health outside the clinic walls. There’s also an increasing recognition that social determinants of health such as housing and education have a significant impact on health disparities.

Because of Oregon’s largely rural and frontier geography, a focus on improving the social determinants of health is particularly critical. Oregon’s rural and frontier communities, and especially racial and ethnic minorities in these communities, are often disproportionately impacted by social determinants such as poverty, lack of housing, lack of transportation and challenges accessing care.

In CCO 2.0, Oregon will address social determinants of health and improve health equity by building stronger partnerships between CCOs, their members and communities, and other sectors, including with local public health agencies, aligning outcomes, and creating incentives for CCOs to increase their investments in this area. CCOs will solidify their role as a convener and driver of social determinants of health and equity work for interventions intended to improve the health of the entire community while also recognizing the assets and strengths of systems already in place. Through these efforts, CCOs will ensure robust, sustainable community systems and strong clinical community linkages. Additionally, this community-driven focus on health disparities and the social factors contributing to those disparities will help lead to decreased inequities between rural and urban communities across the state.
Considerations

Oregon’s original health system transformation vision prioritized health equity and prevention work. As one part of this commitment, CCOs have been given the budget flexibility to make investments in “health-related services.” Health-related services are non-covered services offered as a supplement to covered benefits under Oregon’s Medicaid State Plan to improve care delivery and overall member and community health and well-being. However, expenditures in health-related services are not enough to significantly move the dial towards a more equitable health system. CCOs can use additional spending and partnership strategies to impact population health, the social determinants of health and health equity. Lessons learned regarding CCOs’ experiences in this area from the OHA maturity assessment (see Appendix F) include the following:

• CCOs have reported minimal investment in health-related services, particularly those related to social determinants of health, in financial reports. However, current reporting has significant limitations.

• Based on CCO reporting, CCOs are investing in these areas, with a focus on housing and trauma or adverse childhood experiences, but data is self-report and limited.

• CCOs have partnered, to varying degrees with community partners that can support work related to health equity and social determinants of health, including Early Learning Hubs, local public health authorities, and Regional Health Equity Coalitions. CCOs have limited expectations in statute or contract related to these partnerships.

• While statewide workforce data is available, little is known about CCO employment or utilization of key providers such as traditional health workers and health care interpreters.

• Disparities in health outcomes and in access to quality of care related to race or ethnicity, disability, and behavioral health status are evident.

In developing and vetting the recommended policies, OHA received input through OHPB, stakeholders, and the public that reinforced the maturity assessment findings and strong support for social determinants of health and health equity as a significant area in need of attention, support, collaboration and spending. This includes placing additional emphasis on developing and strengthening partnerships with local public health authorities to improve population health. Feedback included a clear call for OHA to ensure explicit goals and strategies for addressing health inequities are in place and to recognize that it is as much a responsibility for OHA to support CCOs in this work as it is a mandate for CCOs.
Members and stakeholders also identified strategies to advance equitable and culturally and linguistically responsive health care by improving access to traditional health workers; collaboration and intentionality within workforce diversity efforts; and ensuring quality, accessible and meaningful language services for individuals with limited English proficiency.

Additional key themes emerged that informed the CCO 2.0 direction for health equity and SDOH policies:

- **CCO SDOH and health equity initiatives should be driven by members and their communities, and funds should flow as much as possible to community partners doing the work, in alignment with the community health improvement plan;**

- **The community advisory councils should play a central role in decision-making related to social determinants of health and health equity spending;**

- **Public health and a focus on prevention should be emphasized in these efforts as key to promoting population health; and**

- **OHA should recognize potential challenges with measuring needs within the areas of social determinants of health and health equity and the impact of initiatives, such as collecting data via electronic health records.**

**Policy recommendations**

Statewide transformation on social determinants of health and health equity requires CCO collaboration with local organizations and systems who are already addressing the social factors that impact health and the flexibility to use approaches that are informed by local communities.

OHA will drive efforts statewide by setting clear expectations along with requirements for collaboration and transparency. This will allow OHA to assess where progress is being made and where support and technical assistance are needed to meet those expectations.

As a foundation for implementing these policy options, OHA is in the process of adopting standardized definitions of social determinants of health, health equity, and health disparities. This work intentionally elevates definitions and recommendations developed by the Medicaid Advisory Committee, the Public Health Advisory Board, and the Health Equity Committee of OHPB.
Increase strategic spending by CCOs on social determinants of health, health equity and disparities in communities, including encouraging effective community partnerships (Appendix A: Policies 1, 2)

Passed during the 2018 session, HB 4018 requires CCOs to spend a portion of their net income or reserves on social determinants of health and health equity. This spending should be directed to community efforts and partnerships and CACs will play a role in the transparent decision-making process.

To encourage CCO and community efforts to address social determinants of health and health equity, OHA will seek to designate a funding structure for this spending in the first two years of the work. In community after community, OHA heard a desire for CCOs to play a role in working with stakeholders to find innovative approaches to addressing Oregon’s housing crisis. In response, CCOs will be expected to make housing-related services and supports a spending priority. While CCOs cannot solve this issue alone, partnering with housing agencies to increase supportive housing services aligns with OHA’s own partnership with Oregon Housing and Community Services to expand supportive housing in the state. This is a key priority for OHA and an opportunity to leverage an increase in housing infrastructure in communities while expanding the housing-related services and supports that CCOs provide to complement this infrastructure.

Increase CCO financial support of non-clinical and public health providers and align community health assessment and community health improvement plans to increase impact (Appendix A: Policies 3, 6d, 8, 9)

CCOs should share financial resources with public health and non-clinical providers who help them achieve their metrics goals, in addition to health care providers. This ensures sustainability of the strong clinical-community linkages necessary to address the social factors that affect health. Additionally, a shift toward more incentive metrics with a focus on the social determinants of health, health equity and population health will increase the effect of shared financial resources.

CCO partnerships with local public health agencies, hospital systems and tribes are critical to ensuring community health priorities and investments are aligned and impactful. A shared process for assessing community health needs and identifying interventions will reduce the burden on community members, local government and organizations who might otherwise participate in multiple similar processes. Alignment and collaboration also ensures resources within the community are directed toward achieving common goals.
Strengthen meaningful engagement of tribes, diverse OHP members, and community advisory councils
(Appendix A: Policies 1b, 2b, 4, 7)

Consumers must be meaningfully included in designing and making decisions about the health systems that serve them. CCOs will be expected to develop community advisory councils that are representative of the communities they serve; ensure OHP members are actively included on CCO boards; meaningfully engage tribes in their service areas, along with other local governmental bodies; and build trusted relationships with these and other key partners to improve health outcomes and address health disparities. OHA and CCOs will work to improve collection and use of demographic information such as Race, Ethnicity, Language and Disability (REAL+D) data, which allows for a better understanding of health disparities and supports robust engagement of populations impacted by disparities.

Build CCOs’ organizational capacity to advance health equity
(Appendix A: Policy 5)

CCOs must integrate health equity through all aspects of their work, including their internal operations, staffing, policies, and processes. These policy recommendations ensure robust internal infrastructure, progress on health equity implementation throughout the contract period, and standardization of health equity infrastructure across the CCO system. These policies will also drive implementation of consistent methods for collecting and reporting health data, such as standardization provided by the adoption of REAL+D. These strategies will help CCOs and the communities they serve to better understand and address the nature of health problems in populations experiencing health disparities.

Increase the integration and use of Traditional Health Workers
(Appendix A: Policy 6)

The Traditional Health Worker workforce is widely recognized as crucial to ensuring increased access to culturally and linguistically responsive health services. THW services are often available outside of clinical settings, reducing barriers to access for populations experiencing health disparities. Additionally, THWs play important roles in connecting OHP members with social and community services and other resources that impact their health. CCOs will be expected to build equitable payment systems for the THW workforce and work closely with the THW Commission to effectively integrate THWs into their networks.
Maintain sustainable cost growth and ensure financial transparency

Vision

With 94 percent of Oregonians insured, Oregon should focus on long-term financial sustainability of the Oregon Health Plan by ensuring a high-quality system that operates within a budget the state can afford so that Oregonians continue to have access to health care services they need. Currently, inefficient spending and misaligned incentives are playing a role in driving increased costs.

In CCO 2.0, Oregon will address these and other health care cost drivers with payment and rate-setting policies that incentivize the delivery of efficient, high-value, and high-quality health care services, and by effectively using the program’s purchasing power and rate-setting methodology to reduce costs. New analytical tools will allow OHA to better measure CCO efficiency and the costs associated with inefficient or unnecessary care and to incorporate this information into the capitation rate methodology. These tools will enhance OHA’s ongoing efforts to evaluate and consider the reasonableness of CCO administrative expenses in developing capitation rates. OHA will also continue to advance transparency and accountability throughout the health system by making information easily accessible to the public, members and policymakers.

Considerations

Oregon’s efforts to limit growth in state and federal spending on a per-member basis are based on several factors, only some of which are targeted at influencing underlying health care costs. Key lessons learned about maintaining sustainable cost growth were identified in the OHA maturity assessment (see Appendix F) and reinforced throughout the policy development process, including OHPB meetings, stakeholder and public feedback:

• Oregon’s program-wide 3.4 percent spending target is an important tool to ensure
spending growth remains sustainable. The target is improving transparency and forcing dialogue about cost drivers in the system that did not exist before CCOs. Oregon has experienced broad success achieving these targets on a program level, but data limitations complicate efforts to evaluate performance on a CCO level or the success of specific CCO activities or interventions.

- The OHSU waiver evaluation found that spending declined among CCO members compared to Washington Medicaid members, but spending on prescription drugs grew in both states, although may have grown more quickly in Oregon than in Washington. New policy interventions may be needed to rein in pharmacy costs.

- CCOs have substantial flexibility to deliver services to members within the constraints of the global budget. While that flexibility is critical to ensuring their success, new program-wide solutions may be necessary to achieve spending targets without compromising access to or quality of care for members.

- Technical assistance from OHA helps spread effective CCO practices and reduce costs. This resource is unique across state Medicaid programs and should remain a critical tool for improving CCO performance and maintaining access to care.

- Incentive payments to reward CCO performance have shown significant ability to motivate CCOs and their provider partners to achieve statewide benchmarks and/or improvement targets. Oregon should build on successes and maintain its commitment to pay for better quality care and health outcomes, which should help reduce health care costs in the long run.

- Improved data on CCO performance beyond incentive metrics, as well as comparable data across CCOs to better understand how CCOs achieve sustainable spending targets, will provide better opportunities to improve global budgeting and reduce costs.

- Improved transparency with existing CCO performance data, such as annual rates of growth, could be used to help address specific cost drivers like rising pharmaceutical costs.

Medicaid costs are expected to grow nationally at an average rate of 5.8 percent per year through 2026. Controlling costs in Oregon requires us to change the way we pay for and deliver care.²
• More efficient health care systems that invest in primary care services will help members to stay healthier. These services reduce the need for medical interventions that cost more later. For example, by managing chronic conditions members will require less urgent medical treatment or other more expensive health care services.

• Limiting growth in Oregon’s spending on Medicaid is as much an exercise in rate-setting as it is an effort to reduce underlying costs of health care services. While some interventions may reduce long-term costs or increase the quality of care delivered, they may also necessarily increase spending in the short-term.

• Policies to reduce spending and costs should also amplify policy interventions that:
  » Improve quality and pay for value
  » Address social determinants of health
  » Improve health equity, and
  » Ensure access to behavioral health care services at the right place and right time.

The policy development process also underscored the importance of addressing high-profile cost drivers, especially those over which CCOs have limited influence over unit price, such as pharmacy and cost-based hospital services, and confirmed the potential value of risk mitigation strategies such as a reinsurance program. The recommended policies will help Oregon build on successes and take additional steps to reduce the underlying costs of health care services in Oregon.

Policy recommendations

OHA expects CCOs to operate efficiently in their delivery of clinical and supportive services and in their administrative expenses. To ensure continued achievement of Oregon’s sustainable growth targets, CCO 2.0 will address major health care cost drivers while increasing the share of CCO budgets tied to performance. In addition, OHA will increase transparency and improve oversight to ensure financial transparency and accountability of the CCOs and of OHA. The recommended policies also consider how changes to OHA’s rate setting policies and procedures could help contain spending growth in the long term.

OHA will institute additional contractual requirements for CCOs to meet sustainable rate of growth targets that are included in Oregon’s 1115 Medicaid Demonstration Waiver and set biennially by the Oregon legislature. However, because Oregon’s current Medicaid waiver expires in the middle of the next CCO contract period, the recommendations also direct the agency and board to examine ways to set more aggressive spending targets in
the future. These would be based on overall economic growth factors to ensure ongoing sustainability of the Oregon Health Plan. Setting more aggressive spending targets also requires new policies and tools to help OHA and the CCOs achieve the targets without sacrificing quality of or access to care for Oregon Health Plan members.

**Strengthen current financial incentives and set up new tools to evaluate and reward CCOs for improving health outcomes and containing costs (Appendix A: Policies 11, 12, 13, 30)**

One of the central goals of the coordinated care model is to create financial incentives that push the health care system to deliver higher-value, higher-quality, and more efficient care to patients. In the first phase of CCOs, OHA established a quality incentive pool to make a portion of CCO payments dependent on their achievement on selected metrics that measure performance in a variety of ways. CCO 2.0 will build on this policy to introduce new financial incentives for CCOs to improve performance and in the next phase of CCOs OHA will continue to review and enhance Oregon’s capitation rate methodology to advance the global budget concept and improve CCO performance and efficiency.

One key provision in the 2017 renewal of Oregon’s 1115 Medicaid demonstration waiver rewards CCOs if their performance, efficiency, and use of health-related services causes their spending on covered health care services to grow more slowly than the growth target, or even decline. Under the current rate development methodology, a CCO achieving a flat or negative rate of growth could see their global budget from the state fall on a per-member basis, which creates a disincentive for CCOs to reduce underlying health care costs.

Under this proposal, OHA and its actuarial partners will develop a methodology to evaluate performance at a CCO level to set CCO-specific capitation rates. High performing CCOs that are reducing their underlying health care costs will receive the highest rewards, which could eventually amount to a few percentage points in their capitation rates, depending on their achievement. This would ensure CCOs have the resources to maintain effective health-related services programs that enable Oregonians to improve their health while also reducing underlying use of the health care system.

The next round of CCO contracts also provide an opportunity to incorporate measures of quality and value into payments made directly from OHA to health care providers, such as hospitals. Currently, hospitals pay an annual assessment that is used to increase hospital reimbursement rates as well as help fund the state’s share of the cost of the Medicaid program. Beginning in 2020, the payments to hospitals made with these funds will begin to incorporate measures of hospital quality and the value of the care they provide. As
CCOs move towards implementing additional value-based payments, there will be new opportunities to align these measures and metrics across payers and systems.

OHA is continuing to evolve the rate methodology to advance the global budget concept that is intended to reward efficiency, quality, and upstream investments that reduce costs. This includes shifting the funding of the existing quality incentive pool from an add-on payment to a withhold of a portion of the global budget. The capitation rate development process will address the shift of the quality pool funding structure to avoid reducing the overall size of the pool and increase the share of CCO global budgets that is tied to CCO performance. As a result, transparency related to CCO expenditures of quality pool revenue will also improve. Moving the pool inside the global budget will also incentivize CCOs to not hold on to their quality pool earnings but invest them on programs and provider incentives in their community. This will also allow OHA to use add-on payments outside the global budget for additional purposes, such as rewarding efficiency and investments in social determinants of health and health equity (Appendix A: Policy 1) and other future policy proposals.

**Ensure program-wide financial stability and program integrity through improved reporting and strategies to manage a CCO in financial distress (Appendix A: Policies 16, 30, 38, 31)**

Ensuring financial stability and solvency of the Oregon Health Plan broadly, and the CCO program specifically, is a critical responsibility for OHA. CCOs and their risk-accepting health system partners are responsible for delivering health care services to more than 1 million Oregonians. Ensuring those members have access to the health care services they need requires that CCOs and their partners remain financially stable. OHA must have a clear picture of every CCO's financial situation and an array of oversight tools to manage potential changes in CCO participation, whether the changes are related to financial solvency or other CCO business decisions.

CCOs in Oregon and Medicaid managed care plans nationally are increasingly resembling commercial health plans. Evidence of this can be seen by the many current CCOs affiliated with plans or companies that offer commercial products on the health insurance marketplace, have Medicare managed care plans (called Medicare Advantage), and offer products to employers. As a result, the CCO 2.0 policies change CCO reporting structures and OHA’s oversight tools to more closely resemble reporting and oversight of these same commercial plans.
In particular, the policies require CCOs to report their financial situation to the state using insurance-industry standard reporting templates crafted by the National Association of Insurance Commissioners (NAIC). These reporting templates are crafted specifically for health insurance carriers, and several states already use the templates for their Medicaid managed care entities. The templates provide a more consistent look at CCO financial situations compared to current state-based Exhibit L reporting standards.

One component of the NAIC reporting structure includes a move to a Risk-Based Capital (RBC) standard for evaluating CCO financial solvency. RBC is the industry-standard template for commercial health insurance carriers, including Medicare Advantage Plans operated by CCOs and their parent companies. Compared to current statutorily-set solvency standards, RBC solvency standards are a more accurate measure of insurance carriers’ financial assets that could be called upon if their expenses exceed revenue for a period.

OHA will ensure program integrity by increasing efforts to validate CCO encounter data. Encounter data validation studies will allow OHA to compare CCO claims data to provider-level charting data. Comparing a sample of claims to provider charts would add an additional layer of oversight. It would also help Oregon comply with federal rules that require states to increase their efforts to validate the claims data submitted by their managed care contractors.

Finally, OHA will examine the feasibility and implementation of a program mirroring the commercial insurance code’s “Guaranty Fund” to provide additional financial resources if a CCO becomes significantly financially impaired. Under this proposal, resources from stable CCOs would be temporarily used to help repair a CCO in financial stress, or to help OHA manage an insolvency event. This would allow solvency thresholds to be set at a slightly lower level and avoid requiring CCOs to over-capitalize reserve accounts in a manner that unnecessarily reduces CCOs resources to deliver health care services in their community.
**Use program purchasing power to align benefits and reduce costs with a focus on pharmacy costs (Appendix A: Policies 14, 15, 37)**

These recommended policies propose to better use program-wide purchasing power. OHA proposes a statewide reinsurance program to better manage the financial risks and costs associated with low-frequency high cost health conditions or events. Implementing a reinsurance program requires a financial analysis first to determine its feasibility and to develop specific program details. This would include details like the threshold or “attachment point” at which claims would qualify for reinsurance. In the short-term, such a program should reduce rate volatility and increase predictability for CCOs (and in particular for smaller CCOs), while in the long-term it could provide OHA with new tools to better manage and reduce the costs associated with rare, but expensive conditions.

OHA will also use its purchasing power to reduce state costs associated with pharmacy services and better align the pharmacy benefit across the state. This includes increasing the alignment of individual CCO preferred drug lists (PDLs) with the statewide PDL for the fee-for-service (FFS) portion of the Oregon Health Plan. A recent third-party analysis found there is already a significant alignment of PDLs across CCOs and with the FFS program. The analysis also found that aligning PDLs in several additional classes of drugs could yield financial savings while better aligning benefits. Initially, CCOs may be asked to align a few additional classes of drugs with the fee-for-service PDL. Over time, CCOs and OHA will work together to target other alignment opportunities that could be beneficial to the state and to CCOs, as well as improved care for OHP members.

OHA aims to increase transparency related to CCO agreements with their Pharmacy Benefit Managers (PBMs). CCOs will be required to enter into “no-spread” contracts with their PBMs that provide for a full pass-through of any rebates received and ensure that CCOs are not charged a higher cost than the PBM reimburses to the dispensing pharmacy. Currently, several states are examining and implementing similar requirements for their managed care entities and their PBMs agreements structure. While CCOs would not be required to utilize the Oregon Prescription Drug Program as their PBM, it would remain an option for all CCOs to comply with the transparency and “no spread” requirements of the policies.
Next steps

OHPB is in charge of adopting final policy recommendations to improve the Oregon Health Plan and CCOs. These recommendations are based on an extensive engagement process with OHA subject matter experts, OHP members, stakeholders and the public. Once adopted by OHPB, OHA will begin to develop the request for applications (RFAs) and contract language based on the policy recommendations.

While policy recommendations may note implementation timelines or phased-in approaches, OHA must implement carry out policies within OHA budget and capacity constraints. Also, policies must be within state or federal statutory constraints.

OHA will develop the RFA and contract language. At the same time, OHA will begin to develop rates, legislative concepts and rule amendments to align with recommended policies. OHA intends to release the RFA in January 2019. OHA will award contracts in June 2019. New CCO contracts will be implemented in January 2020.

Endnotes


Appendices

A. CCO 2.0 recommended policies and implementation expectations
B. CCO 2.0 Health equity impact assessment
C. CCO 2.0 and children’s health
D. Coordinated care model elements crosswalk to policy recommendations
E. CCO 2.0 public input
   i. Oregon consensus report on community meetings
   ii. Summary of Woodburn community forum in Spanish
   iii. Summary of two online surveys
   iv. Summary of OHP member phone survey
   v. Public meetings list, including culturally specific outreach
   vi. List of formal letters and recommendations received
F. CCO 1.0 maturity assessments
G. CCO 2.0 timelines
H. CCO 2.0 definitions
Appendix A:

CCO 2.0 recommended policies and implementation expectations
Appendix A: CCO 2.0 recommended policies and implementation expectations

CCO 2.0 Recommendations of the Oregon Health Policy Board

Recommended Policies: Begin implementation in year 1

Policy #1
Implement House Bill 4018: Require CCOs to spend portion of net income or reserves on social determinants of health (SDOH; including supportive population health policy and systems change) and health equity/health disparities, consistent with the CCO community health improvement plan (CHP)

A) Require CCOs to hold contracts or other formal agreements with, and direct a portion of required SDOH and health equity spending to, SDOH partners through a transparent process.

B) Require CCOs to designate role for community advisory council (CAC), and tribes and/or tribal advisory committee if applicable (see Policy 4, Part D), in directing and tracking/reviewing spending.

C) Years 1 and 2: Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the global budget rate methodology and seek to build in a specific amount of SDOH and health equity investment. This is intended to advance CCOs’ efforts to address their members’ SDOH and establish their internal infrastructure and processes for ongoing reinvestment of a portion of net income or reserves in social determinants of health and health equity.
   i. Require one statewide priority – housing-related supports and services – in addition to community priority(ies).

Intended impact
Increased strategic spending by CCOs on social determinants of health and health equity/disparities. Decision-making is inclusive and consumer-informed.

Policy implementation considerations

- CCOs will be expected to engage tribes in this work and in decision-making processes about SDOH and health equity spending.
- Mandated by HB 4018; Part C is not required but strongly recommended by OHA staff.
- HPA and actuarial staff to develop investing guidelines, additional requirements, and reporting and monitoring strategy.
- TA and compliance needed.
- NOTE: Policy option package (POP) is for a SDOH transformation analyst who would support a variety of SDOH work; could be applied to this policy option.
- Year 1 and 2 spending amounts contingent on OHA’s 2020 budget and 3.4% growth cap.
- Builds toward 2012–2017 waiver evaluation recommendation #7: Require CCOs to commit one percent of their global budget to spending on social determinants of health.
- Spending must align with CCO CHP priorities, transformation and quality strategy (TQS), and waiver.
- Pros: May encourage spending on health-related services as key mechanism to track investments in SDOH; may encourage additional spending on SDOH within the global budget.
- Cons: Could reduce funds flowing to clinical providers.
Recommended Policies: Begin implementation in year 1

- Feedback:
- Oregon Health Policy Board (OHPB) 7/10/18: Support for statewide priority of housing-related supports and services.
- CCO 2.0 Survey and Medicaid Advisory Committee survey ranked housing as a top priority for SDOH work.
- Agency partnerships: OHA is partnering with Oregon Housing and Community Services to expand supportive housing in the state, and there are opportunities to leverage this partnership to increase housing infrastructure in communities while expanding the housing-related services and supports that CCOs provide to complement this infrastructure.

Policy implementation expectations

Initial baseline expectations

- CCO clearly articulates criteria for selecting the SDOH/HE partners it intends to direct SDOH/HE funding to through contract, memorandum of understanding (MOU), grant or other formal agreement (including housing partners to meet the statewide priority requirement).
- CCO demonstrates it has mechanisms in place to track and report SDOH/HE expenses and outcomes of spending, including for funds directed to SDOH/HE partners.
- CCO provides a policy demonstrating the CAC’s role in tracking, reviewing and making decisions regarding SDOH/HE spending.
- CCO may choose to select 1-2 community priorities for spending in addition to the statewide housing priority.
- CCO demonstrates that its expenditures (both to partners and other SDOH/HE spending) address the SDOH, health equity, health disparities, or population health policy and systems change as defined by OHA.

Transformational expectations

- CCO dedicates a percentage of its global budget to SDOH and health equity spending.
- CCO focuses its SDOH/HE spending on families with children under age 5.
- CCO demonstrates impacts on racial/ethnic disparities as a result of SDOH/HE spending.

Examples of accountability

- Part C: CCO submits to OHA its spending priorities and how it has chosen to implement the housing spending priority; CCO demonstrates how selected priorities and spending plans align with CHP.
- CCO reports SDOH/HE expenditures and outcomes to OHA (financial reporting, Transformation and Quality Strategy [TQS], CHP progress reports), including number of members served by SDOH/HE investments.
- OHA publishes annual data on CCOs’ SDOH/HE spending.
Appendix A: CCO 2.0 recommended policies and implementation expectations

**Policy #2**

**Increase strategic spending by CCOs on health-related services (HRS)** by:

A) Encouraging HRS community benefit initiatives to align with community priorities, such as those from the community health assessments (CHAs) and community health improvement plans (CHPs); and

B) Requiring CCOs’ HRS policies to include a role for the community advisory councils (CACs) and tribes and/or tribal advisory committee if applicable (see Policy 4, Part D) in making decisions about how community benefit HRS investments are made.

**Intended impact**

SDOH spending is aligned in communities and across various SDOH spending strategies. Community resources are used more efficiently. Decision-making is inclusive and consumer-informed.

**Policy implementation considerations**

- No substantive contract changes for Part A (“encourage”).
- Contract language change for Part B.
- OHA to develop guidance, FAQs to ensure clarity on HRS requirements.
- Builds toward 2012–2017 waiver evaluation recommendation #5: Create a “one-stop shop” where CCOs and other stakeholders can find information about health-related services.
- Pros: Leverages existing work and other SDOH spending requirements.
- Cons: Competing priorities for investment.

**Policy implementation expectations**

**Initial baseline expectations**

- CCO submits policies describing how community benefit investment decisions will be made, including but not limited to the types of entities that will be eligible for funding, how entities may apply for funding, and the process for how funding will be awarded.
- CCO clearly articulates the CAC’s role regarding HRS community-benefit initiatives in this policy.

**Transformational expectations**

- CCO demonstrates that their HRS spending aligns with the CHA and CHP.
- CCO annually reports all HRS spending itemized with any evidence of return on investment.

**Examples of accountability**

- OHA publishes quarterly data on each CCO’s HRS spending by category and as a percent of total member expenditures.
- OHA/CCO publishes CCO policies relating to HRS and CAC’s role in HRS decisions.
- CCO includes community-based initiatives and explains CAC’s role in deciding community-based initiatives.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Policy #3

A) **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

B) **Encourage adoption of SDOH, health equity, and population health incentive measures** by the Health Plan Quality Metrics Committee (HPQMC) and Metrics & Scoring (M&S) Committee for inclusion in the CCO quality pool

**Intended impact**

Community partners are engaged and receive financial resources for their contributions to achieving incentive measures.

Robust and sustainable community-clinical linkages are in place for meeting incentive measures.

Metrics: CCO quality pool dollars are used to incentivize improvements in SDOH and health equity.

**Policy implementation considerations**

Part a:

- To be phased in after Year 1.
- Staff FTE for planning, tool development and ongoing technical assistance needed in Health Policy and Analytics (HPA) and Public Health Division (PHD); monitoring/compliance also needed.
- Recommended by the Public Health Advisory Board (PHAB).
- Support provided at CCO 2.0 road show forums.
- **Pros:**
  - a) Sets expectation that CCOs assess contributions of non-clinical and public health providers in achieving incentive measures — in addition to clinical providers — and pay for these contributions accordingly.
  - b) Maintains local flexibility for CCOs to work with specific providers in their communities that meaningfully contribute to meeting incentive measures.
  - c) May allow for better standardization of how non-clinical and public health providers are included in quality pool payment structures.
- **Cons:** As written, this policy option “encourages” rather than “requires,” which may lead to inconsistent approaches. However, there are concerns about requiring quality pool payments to a single provider type, which may have unintended consequences by setting a precedent for similar requirements for other provider groups. Also, federal waiver concerns have been identified related to requiring incentive payments to specific providers.

Part b:

- Can be implemented in Year 1 with no additional resources.
- Current statute doesn’t allow OHA to require that either HPQMC or M&S take up specific measures or categories of measures. However, both committees are committed to this work.

**Dashboard**

<table>
<thead>
<tr>
<th>Priority area</th>
<th>SDOH / Health Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>How heavy is lift?</td>
<td>🌒🌒🌒〇</td>
</tr>
<tr>
<td>How large is impact?</td>
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</tr>
</tbody>
</table>

- Fulfills state or federal mandate
- 2019 POP planned
- Requires legislation
- Recommendation for OHA
- Exists in contract; needs strengthening or improved monitoring
- Health equity impact assessment
- Potential to impact children
- May require OHA TA support
- Increases transparency
Policy implementation expectations

Initial baseline expectations

- Part A may be phased in after Year 1.
- CCO demonstrates it has policies and procedures for distributing quality pool dollars to clinical, non-clinical and public health providers for their contributions to achieving incentive measures, including SDOH, health equity and population health incentive measures. Must include the criteria used for determining payments and the process for distributing financial resources.
- CCO complies with OHA requirements for reporting CCO expenses related to incentive arrangements.

Transformational expectations

- CCO engages in robust, sustainable clinical–community partnerships developed to meet incentive measure targets.
- CCO demonstrates standard, transparent approaches for determining the contributions of non-clinical and public health providers and for distributing quality pool dollars to support these contributions.
- CCO is a key convener in creating stronger community systems for addressing social determinants of health. This will include efforts to create trauma-informed systems.

Examples of accountability

- CCO submits policy for distributing quality pool dollars to clinical, non-clinical and public health providers.
- CCO reports expenses related to incentive payment arrangements.
Policy #4

Strengthen community advisory council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers through the following:

A) Require CCOs to report on CAC member composition and alignment with demographics of Medicaid members in their communities, including: 1) the percentage of CAC comprised of Oregon Health Plan (OHP) consumers; 2) how the CCO defines their member demographics and diversity; 3) the data sources they use to inform CAC alignment with these demographics; 4) their intent and justification for their CAC makeup; and 5) an explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress;

B) Require CCOs to report CAC member representation alignment with CHP priorities (for example, public health, housing, education, etc.); and

C) Require CCOs to have two CAC representatives, at least one being an OHP consumer, on the CCO board.

D) OHA is exploring adding a recommendation that CCOs use a tribal advisory committee rather than simply ensuring tribal representation on the CAC. Development of this policy option is occurring through ongoing collaboration with Oregon’s nine federally recognized tribes.

E) OHA is exploring implementation options for a requirement that CCOs have a designated tribal liaison per 1115 Waiver Attachment I: Tribal Engagement and Collaboration Protocol. This is also occurring through ongoing collaboration with Oregon’s nine federally recognized tribes.

Intended impact

CCOs have a representative CAC. This builds trust and relationship with members. Systems are designed with the OHP member in mind.

Policy implementation considerations

- Part B to be implemented in Year 2 or later.
- Due to need for legislative change, other components of this policy may need to be implemented in Year 2 of contract (TBD; pending confirmation with procurement team).
- CCOs will not be required to use enrollment data to identify demographics; census data or other sources may be used.
- Health Systems Division (HSD) work needed to ensure better demographic data of CCO enrollment.
- Transformation Center capacity for TA and receiving and reviewing reports.
- Need to define OHP consumer.
- Pros: Supports better representation and meaningful engagement of consumers; potential benefit to recruitment/retention (elevate CAC due to role on board – Part C).
Recommended Policies: Begin implementation in year 1

- **Cons:** Potential recruitment and retention challenges (including possible resistance to CAC members reporting their own demographic information to their CAC/CCO); enrollment data issues/complexity (can use demographic data from American Community Survey or other sources as needed); possible concern with information privacy and how much of that info is shared with the federal government.
- Requiring alignment with communities came from interest from numerous stakeholders in supporting more diversity and better representation, but this specific policy option as worded did not come directly from CACs.
- Requiring CCOs to have more than one CAC representative (Part C) on the board was included after interviews with key informants (primarily CAC coordinators).

**Policy implementation expectations**

**Initial baseline expectations**

- CCO identifies data sources it will use to analyze member demographics (could include enrollment data, American Community Survey data, or other sources).
- CCO demonstrates it has mechanisms, resources and community partnerships in place to support recruitment and engagement of diverse CAC members aligned with member demographics.
- CCO clearly articulates its criteria and process for engaging CAC representatives that align with CHP priorities.
- CCO shares plan for how it will meaningfully engage an OHP consumer(s) on CCO board.
- CCO describes its plan for how it will meaningfully engage tribes and/or a tribal advisory committee, if applicable.
- CCO meets reporting requirements and identifies barriers and challenges to CAC demographic alignment, which will inform tailored supports from OHA to assist CCO's progress toward a fully aligned CAC.
- Part B may be phased in after Year 1.

**Transformational expectations**

- CAC composition is reflective of Medicaid member demographics in the CCO service area.
- CCO decision-making is meaningfully informed by CAC members, and tribal advisory committee members if applicable, and CCO demonstrates this in its reporting.
- CAC members report feeling meaningfully engaged and empowered in their roles on the CAC and CCO board.
- CCO has systems in place that ensure constant representation and filled CAC seats and no lapses in 51% OHP consumer makeup of CAC.

**Examples of accountability**

- Reports include detailed information about CAC member composition and all components outlined in this policy option; reports posted publicly.
- CAC member satisfaction report/surveys. Surveys include inquiry about whether processes are trauma informed and meet the needs of members who have experienced trauma.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

Policy #5

Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities by implementing the following:

A) Require CCOs to develop a health equity plan, including culturally and linguistically responsive practice, to institutionalize organizational commitment to health equity;
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 fundamentals training plan and timeline for implementation.

Intended impact

Standardization of health equity infrastructure present in all CCOs.

CCO health equity expertise, capacity and infrastructure to facilitate adoption of measures to reduce health disparities.

Policy implementation considerations

RFA applicants:

- Need to provide current organizational health equity infrastructure capacity (based on guidelines provided by OHA).
- Need to commit to the designation of a “single point of accountability” for health equity and demonstrate allocation of resources for health equity activities.

In Year 1 all CCOs will:

- Develop a health equity plan following OHA guidelines.
- Designate a “single point of accountability” role.
- Develop an organizational and provider network training and education plan based on “Cultural Responsiveness and Implicit Bias Fundamentals” guidance document provided by OHA.

In Year 2-5, all CCOs will:

- Report increased capacity and leadership for health equity and cultural responsiveness, and the use of race, ethnicity, language and disability (REAL+D) and culturally and linguistically appropriate services (CLAS) in the organization and the provider network using TQS as a reporting mechanism.
- Provide an outline of the general activities it will undertake to accomplish the goals and objectives outlined in the health equity plan over the course of three years for monitoring and TA.

General Timeline:

- All strategies in this policy will be in contract and are set to begin Year 1. However, full implementation and completion of activities will vary and could be aligned with TQS to reduce administrative burden.

OHA role:

- Provide a framework for the development of CCO health equity Infrastructure:
  a) OHA/Office of Equity and Inclusion (OEI)/Transformation Center (TC) to staff/lead a work group that will develop health equity plan guidelines for CCOs.
  b) OHA/OEI/TC to develop “single point of accountability” role expectations that relate to prioritization of health equity; engagement with the community; health disparities work;
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

- use of REAL+D data; workforce diversity; patient engagement using HIT tools; and organizational learning.
- OHA/OEI/TC to develop a guidance document on cultural responsiveness and implicit bias training fundamentals plan.

- CCO 1.0 maturity assessment showed that lack of detailed tracking mechanisms and data related to health equity contributed to the challenge of understanding how CCOs have impacted these areas over the last five years. The infrastructure proposed through CCO 2.0 will facilitate standardization and will improve OHA’s ability to provide quality TA.
- Some CCOs have developed a strong organizational infrastructure for health equity, others have not; this represents an inequity that will be remedied in CCO 2.0.
- The development of CCO internal infrastructure and investment to coordinate and support CCO equity is necessary to ensure (a) CCOs around the state are moving in the same direction; (b) OHA, and OHPB and its Health Equity Committee have a conduit to connect with CCOs on health equity activities, build learning collaboratives, and provide guidance and technical assistance; and (c) health equity infrastructure will facilitate the deployment of health equity metrics once they are developed.
- The term “health equity infrastructure” refers to the organizational adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to community and member engagement; provision of quality and culturally responsive language access; organizational and provider network workforce diversity; Americans with Disabilities Act compliance and accessibility of CCO and provider network; Affordable Care Act 1557 compliance; CCO and provider network organizational training and development implementation of the CLAS Standards and non-discrimination policies; and other models, policies and practices that aim to advance health equity and eliminate inequities in health and health services that are avoidable, unnecessary and also unjust and unfair.
- In the development of CCOs’ health equity infrastructure, OHA expects CCOs will:
  a) Meaningfully engage CACs and community partners in the development of CCO health equity infrastructure strategies, plans, policies and programs;
  b) Transform CCO organizational culture to make health equity a priority; and
  c) Institutionalize the health equity culture in all facets of the organizational structure.

Policy implementation expectations

Initial baseline expectations

- CCO provides information to OHA on its current organizational infrastructure to demonstrate its ability to implement health equity activities, including its capacity to collect and analyze REAL+D data.
- CCO develops a health equity plan, allocates necessary resources for health equity activities, and provides a timeline for implementing the plan’s components.
- Potential components of the health equity plan include language access; workforce diversity; implementation of CLAS standards; collection and analysis of REAL+D; provider network accessibility; and meaningful community engagement.
- CCO designates a single point of accountability for health equity work. CCO develops an organizational and provider network training and education plan based on the Cultural Responsiveness and Implicit Bias Fundamentals guidance document provided by OHA.

Transformational expectations

- CCO ensures that its diverse member population receives the highest quality, culturally and linguistically appropriate health care from their provider network.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

- All CCO and provider network programs, community partnerships, priorities, policies and activities have solid and consistent health equity components that go beyond the use of an equity lens by, for example, incorporating health equity into their organizational structure, and being informed by the collection and use of REAL+D data.
- CCOs meaningfully engages CACs, providers and community partners in the development of CCO health equity infrastructure strategies, plans, policies and programs.

Examples of accountability

Year 1:
- CCO develops health equity plan following OHA guidelines.
- CCO designates a “single point of accountability” role.
- CCO develops an organizational and provider network training and education plan based on the Cultural Responsiveness and Implicit Bias Fundamentals guidance document provided by OHA.
- OHA develops appropriate monitoring, reporting and compliance process needed for all three strategies. This process could be aligned to current TQS process to reduce CCO administrate burden.

Year 2:
- CCOs potentially use TQS to report increased capacity and leadership for health equity and cultural responsiveness and the use of REAL+D and CLAS in the organization and the provider network.
- CCO provides an outline of the activities it will undertake to accomplish the goals and objectives outlined in the health equity plan over the course of three years for monitoring and technical assistance.
Policy #6

Implement recommendations of the Traditional Health Worker (THW) Commission:

A) Require CCOs to create a plan for integrating and utilizing THWs.
B) Require CCOs to integrate best practices for THW services in consultation with THW Commission.
C) Require CCOs to designate a CCO liaison as a central contact for THWs.
D) Identify and include THWs affiliated with organizations listed under ORS 414.629 (note that Part D is also included under Policy 8 for CHAs/CHPs).
E) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for THW services.

Intended impact

Increases THW workforce by setting up a livable and equitable payment system.

Increases access to preventive, high-quality care beyond clinical setting and improves outcomes.

Increases access to culturally and linguistically diverse providers beyond clinical setting.

Policy implementation considerations

- All activities will be in contract beginning in Year 1; expectation for implementation/completion varies by activity.
- CCOs will work with THW Commission, OEI and HSD to:
  a) Designate CCO liaison;
  b) Develop integration and utilization plan with metrics to track integration milestones with scores for progress; and
  c) Determine centralized standard reimbursement rates using the payment models grid created by the THW Commission Payment Model Committee.
- Builds upon THW services requirements already in contract.
- Recommended by the Department of Consumer and Business Services in its Report on Existing Barriers to Effective Treatment for and Recovery from Substance Use Disorders, Including Additions to Opioids and Opiates.
- Strong support came from health systems; health insurance carriers such as Providence, CareOregon and Kaiser; the Oregon Primary Care Association; and other community-based organizations and federally qualified health centers (FQHCs).
- Need to dedicate necessary resources to ensure policies are adequately and appropriately staffed, monitored and enforced.
  b) Literature shows improved health outcomes for consumers, which saves money for OHA.

Dashboard

- Fulfills state or federal mandate
- Priority area: SDOH / Health Equity
- How heavy is lift? 3 3 0
- How large is impact? 3 3 3
- 2019 POP planned
- Requires legislation
- Recommendation for OHA
- Exists in contract; needs strengthening or improved monitoring
- Health equity impact assessment
- Potential to impact children
- May require OHA TA support
- Increases transparency
Recommended Policies: Begin implementation in year 1

through Medicaid program savings. Positive return on investment will increase with increased number and utilization of THWs.

- Payment model grid contains a variety of pathways for THW payment including alternative payment methods; value-based payments such as bundling and per-member-per-month payments; fee-for-service; grants and contracts; Medicaid administrative; targeted case; and direct employment.

Policy implementation expectations

Initial baseline expectations

- CCO describes the components of its comprehensive integration and utilization plan for THWs, including benchmarks, milestones and timelines. The plan should ensure that each CCO member is an active partner in their own health care and services and not a passive recipient of care.
- CCO describes how it will integrate best practices for THW service delivery to ensure 1) recruitment and retention of diversified workforce that is culturally and linguistically responsive to the population served by the CCOs, and 2) measurable best practice standards and metrics are created to promote THW program fidelity and effectiveness.
- CCO clearly articulates how it will create a dedicated liaison position for coordinating workforce, payments, utilization, supervision, service delivery, and member accessibility to THW services.
- CCO clearly describes its plans for establishing sustainable payment rates for THWs.
- CCO identifies a THW to participate in the CHA and CHP development process.
- CCO develops a payment rate and reimbursement plan across the board for all THWs.

Transformational expectations

- CCO’s plan ensures that THWs are part of the member’s care team to provide and assist in services navigation, access to culturally and linguistically responsive care/providers, community connection and social support that impacts the member’s health care and service needs.
- CCO consistently utilizes THW best practices to be proactive in educating health care providers, consumers and administrators about the members’ health care needs and the culturally responsive interventions and supports available through a culturally responsive workforce.
- CCO THW liaison position effectively acts as the “hub” for THWs, consumers and the community within the CCO health care system, and this is demonstrated in CCO reporting.
- CCO meaningfully engages THWs during the CHA and CHP development process.
- CCO implements centralized reimbursement/ payment rates for all THWs to be efficiently utilized in all health care settings and ensures that payments are not contingent upon health outcomes.

Examples of accountability

- Reporting to OHA includes benchmarks, milestones and targets that measure impacts such as: increases in recruitment and retention of THW workforce, improvements in access to THW services, increases in engagement of THWs in member care teams and increases in members assigned to THWs as appropriate for the members’ health needs.
- CCO recruits THW liaison and begins measuring: encounters between consumers and THWs; THW-related improvements in health outcomes by race, ethnicity, primary language; THW-related reductions in the rate of non-emergent ED visits; increases in patient engagement with THWs; and utilization by THW type with a plan to address transitions in care within the delivery system.
Recommended Policies: Begin implementation in year 1

- CCO develops and publishes payment guidelines (which include value-based payments such as bundling and per-member-per-month payment, as well as fee-for-service payments), and fully implements in-house payment structure and processes for all THWs. OHA provides system-level support to reduce billing barriers.
- Reporting includes number of THWs involved in CHA and CHP and how they are actively participating.
Policy #7

Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the community advisory council (CAC) and tribes, and/or tribal advisory committee if applicable (see Policy 4, Part D), connect to the CCO board

Intended impact

Transparency on fulfillment of statutory requirement.

Policy implementation considerations

- Transformation Center staff will monitor in a to be determined reporting method.

Policy implementation expectations

Initial baseline expectations

- CCO clearly articulates relationship between CAC and CCO board, including CAC participation on the CCO board and other CCO committees, and CCO staff participation on the CAC.
- CCO clearly articulates relationship between CAC, CCO board and tribal advisory council, if applicable.
- CCO provides a visual organizational chart demonstrating these connections.

Transformational expectations

- CCO demonstrates the engagement of its CAC by illustrating multiple feedback loops of CAC input that are integrated into a wide variety of areas of CCO decision-making.

Examples of accountability

- OHA publishes organizational structure information from CCOs.
- Reporting includes supplemental information about CAC role in decision-making (recommended policy #4).

Dashboard

<table>
<thead>
<tr>
<th>Fulfills state or federal mandate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority area: SDOH / Health Equity</td>
</tr>
<tr>
<td>How heavy is lift?</td>
</tr>
<tr>
<td>How large is impact?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2019 POP planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires legislation</td>
</tr>
<tr>
<td>Recommendation for OHA</td>
</tr>
<tr>
<td>Exists in contract; needs strengthening or improved monitoring</td>
</tr>
<tr>
<td>✓ Health equity impact assessment</td>
</tr>
<tr>
<td>Potential to impact children</td>
</tr>
<tr>
<td>May require OHA TA support</td>
</tr>
<tr>
<td>✓ Increases transparency</td>
</tr>
</tbody>
</table>
Policy #8

Require CCOs to partner with local public health authorities, non-profit hospitals, and any CCO that shares a portion of its service area to develop shared CHAs and shared CHP priorities and strategies.

A) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need.

If a federally recognized tribe in a service area is developing a CHA or CHP, the CCO must partner with the tribe in developing the shared CHA and shared CHP priorities and strategies described above.

Ensure CCOs include tribes and 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 414.629.

Intended impact

Improved population health outcomes through CHA and CHP collaboration and investment.

CHAs and CHPs that reflect the needs and priorities of the entire community.

Reduced burden for community members due to streamlined community assessment and planning processes.

Policy implementation considerations

• Contract changes and rule changes needed.
• Needs to be in contract for Year 1; work would phase in. CCOs would be required to meet these policy requirements with new CHAs and CHPs developed during the 2020–24 contract period (in the next CHA/CHP cycle; may differ by CCO).
• OHA could convene a work group in Year 1 of the contract to develop recommendations for addressing barriers to shared CHAs and shared CHP priorities and strategies. This would build upon the work of the 2014 OHA CHA/CHP alignment work group.
• Technical assistance provided by HPA and PHD.
• Staffing needs identified for monitoring and compliance within HSD.
• Shared CHAs and shared CHP priorities and strategies: Recommended by the Public Health Advisory Board. Supported by OHPB at June meeting. Supported during road show forums.
  a) Likely to reduce burden on community members who are asked to participate in multiple health assessments. Will reflect the needs of entire community, beyond Medicaid. Challenges with shared CHP development can be addressed through implementation and contractual requirements.
• SHIP priority alignment: Recommended by OHA staff. Support from OHPB at 7/10 meeting.
  a) High level of alignment currently between CHPs and 2015–19 SHIP. All CCOs could meet requirement with 2015–19 SHIP priorities (note there will be a new SHIP for 2020–24). This policy option would require CCOs to implement statewide strategies for shared priorities. Ohio
and New York have implemented similar requirements. May result in statewide gains on health conditions.

- Including organizations that address SDOH and health equity: Recommended by the THW Commission (see Policy 2, Part D).
- Will ensure the voice of OHP consumers experiencing health disparities is included in the CHP/CHP process. May create a small limitation on local flexibility by prescribing the organizations to be involved.

**Policy implementation expectations**

**Initial baseline expectations**

- If CCO has an existing CHA/CHP in place, CCO clearly describes:
  a) Existing partnerships with local public health authorities (LPHAs), nonprofit hospitals and other CCOs that share the service area for the current CHA;
  b) Gaps in these partnerships;
  c) Steps the CCO will take to address these gaps prior to developing the next CHA;
  d) The tribes, THWs and organizations addressing social determinants of health and health equity that were involved in the development of the CHA and CHP; and
  e) Gaps in involvement of SDOH/HE organizations and how the CCO will meaningfully engage these organizations in developing the next CHA and CHP.
- A CCO that does not have a current CHA/CHP describes existing partnerships with LPHAs, nonprofit hospitals, other CCOs that share the service area, organizations that address social determinants of health, tribes and THWs; gaps in existing partnerships; and the steps the CCO will take to meaningfully engage these organizations when it develops its first CHA and CHP.
- CCO identifies the CHP priorities and strategies currently being implemented by the CCO and LPHAs, nonprofit hospitals, and any CCO that shares the service area.
- For any new CHP developed during the contract period, the CCO identifies and describes areas of alignment with at least two SHIP priorities, including which statewide strategies are being implemented.
- CCO makes progress toward CHP goals and demonstrates accountability through annual progress reports that include a description of the actions the CCO will take if goals are not being met.

**Transformational expectations**

- CHP is a single community document describing community health improvement priorities (note that CCOs, hospitals and LPHAs may document their strategies toward those goals in separate documents).
- In regions with aligned service areas, the CHP is fully shared by CCOs, LPHAs and nonprofit hospitals.
- The CHA/CHP partnership of CCOs, LPHAs and nonprofit hospitals has a governance structure that is responsible for allocating resources to CHP priorities, overseeing shared metrics, and is the accountable body for meeting targets and goals.
- Inclusion of tribes, organizations that address social determinants of health, and THWs in developing the CHA and CHP shifts focus in CHA/CHP to the root causes of poor health and health disparities, which includes social determinants of health and trauma. Consumer voice is demonstrated in development of community priorities and improvement strategies.
- CCO demonstrates investment of a percentage of its global budget in implementing CHP priorities to meet CHP goals.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

Examples of accountability

- Year 1, and annually: CHA/CHP submissions and annual progress reports demonstrate meeting baseline expectations based on OHA review.
- Upon submission of new CHA and CHP (timeline will vary for CCOs):
  a) CCO demonstrates local partnership of LPHAs, nonprofit hospitals, tribes and other CCOs in the service area.
  b) CCO demonstrates accountability for making progress toward meeting CHP goals.
  c) CCO demonstrates alignment with SHIP priorities, including implementation of statewide strategies.
  d) CCO and partners demonstrate achievement of targets and goals in CHPs.
- SHIP annual progress reports also demonstrate improvements on priorities and strategies that are being implemented at the local level.
Policy #9

Require CCOs to submit their community health assessment (CHA) to OHA

Intended impact

Transparency and support of community partner efforts.

Policy implementation considerations

• Should be included in contract from Year 1. Would go into effect at first CHA cycle in 2020–2024 contract period (may differ by CCO).
• Monitoring is very straightforward (existing Transformation Center capacity).
• Origin of recommendation: OHA Transformation Center.
• Pros: Promotes transparency and can allow for improved technical assistance to CCOs.
• Cons: Would add a deliverable to CCO contract, but by rule CHA development is already required, so it should be easy for a CCO to submit their CHA to OHA to fulfill this requirement.

Policy implementation expectations

Initial baseline expectations

• CCO submits CHA by June 30 of the first year of the contract.

Transformational expectations

• Increased transparency about the health of communities and about how health priorities for the CHP are selected.
• CHA becomes a readily accessible data source for community partners or other organizations seeking to understand the health of the community.

Examples of accountability

• Year 1: CHA submissions demonstrate meeting baseline expectations based on OHA review.
• CHAs are posted online.
Appendix A: CCO 2.0 recommended policies and implementation expectations

CCO 2.0 Recommendations of the Oregon Health Policy Board

Recommended Policies: Begin implementation in year 1

**Policy #10**

**Increase CCOs’ use of value-based payments (VBPs) with their contracted providers**

**Intended impact**

Ensure all CCOs increase their use of VBPs.

Align with 1115 waiver requirement to achieve VBP target.

Provide financial support for Patient-Centered Primary Care Homes (PCPCHs) to implement and sustain a robust PCPCH model of care.

Each CCO will be responsible for meeting an annual VBP growth target, ensuring movement toward the 70% VBP goal in 2024.

**Policy implementation considerations**

RFA applicants need to:

- Provide details on how they would achieve a minimum of 20% VBP in LAN\(^1\) category 2C (“pay-for-performance”) or higher to be implemented Year 1 (2020).
- Provide details on their per-member, per-month (PMPM) VBP payments (LAN category 2A “foundational payments for infrastructure and operations”) to PCPCHs.
- Respond to specific questions that address how their VBP models will not negatively impact priority populations, including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and populations that intersect these communities.
- Demonstrate necessary information technology (IT) infrastructure for VBP reporting.

By Year 1 (2020), CCOs will:

- Be expected to achieve a 20% VBP target for LAN category 2C (“pay-for-performance”) as reported in their RFA response;
- Implement a PCPCH VBP;
- Report VBP data via All Payer All Claims (APAC) database;
- Report supplemental VBP data and/or interviews.

By Year 2 (2021), CCOs will be required to implement new VBPs in at least two of the five care delivery focus areas with hospital and/or maternity care required in Year 2 or 3. The remaining care delivery focus areas include: children’s health care, behavioral health and oral health. This allows CCOs to gain experience and develop more advanced VBPs in these areas.

By Year 5 (2024), CCOs will:

- Achieve 70% VBP goal.
- Add one new VBP in the remaining care delivery focus areas in Years 3–5 – successfully implementing

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\(^1\) The Health Care Payment Learning and Action Network (LAN) is a national effort partially funded by CMS to accelerate VBP adoption by states and the commercial insurance market. They developed The Alternative Payment Model Framework for categorizing VBPs that has become the nationally accepted method to measure progress in the adoption of VBPs.
Appendix A: CCO 2.0 recommended policies and implementation expectations

### Recommended Policies: Begin implementation in year 1

VBPs in all five care delivery focus areas.

- Report complete encounter data with contract amounts and additional detail for VBP arrangements.

### VBP targets

- Statewide goal of CCO VBP to providers is aligned with the 1115 waiver requirement.
- Preliminary data collection of CCO VBP data indicates approximately 40–50% of CCOs’ payments to providers were at least in category 2C/pay-for-performance (which is similar to the CCO incentive metric program).
- 70% VBP goal is sufficiently high to serve as a five-year VBP goal, but not so high that it would be unachievable.
- Potential development of CCO VBP collaborative to align efforts and share tools to lead this work in their communities. The CCO VBP collaborative could evolve into a multi-payer collaborative in later years.

#### PCPCH VBP

- Supports staff and activities not reimbursed through fee-for-service.
- Operationalized via PMPM payments based on PCPCH tier level.
- Requires the use of a VBP to invest in PCPCHs, which a 2016 evaluation showed have achieved better health outcomes and cost savings.
- Allows for advancement and sustainability of the PCPCH model.
- PCPCH VBP requires payments that fit in LAN category 2A, which are foundational payments for infrastructure and operations but are not counted toward achieving the CCO VBP target.
- Aligned with CPC+ payment methodology, a national CMS, multi-payer primary care payment reform program.

### Policy implementation expectations

#### Initial baseline expectations

- Ensure all CCOs increase their use of VBPs, in alignment with 1115 waiver requirement to achieve VBP target.
- RFA applicants will be required to:
  - a) Provide details on how they would achieve a minimum of 20% VBP in LAN* category 2C (“pay-for-performance”) or higher during Year 1 (2020).
  - b) Provide details on their per-member, per-month (PMPM) VBP payments (LAN category 2A “foundational payments for infrastructure and operations”) to Patient-centered Primary Care Homes (PCPCHs).
  - c) Respond to specific questions that address how their VBP models will not negatively impact priority populations, including racial, ethnic and culturally based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; immigrants or refugees, people with complex health care needs and populations that intersect these communities.
  - d) Demonstrate necessary information technology infrastructure for VBP reporting.
- Each CCO will need to meet annual VBP growth targets to ensure that all CCOs increase their use of VBPs.

#### Transformational expectations

- PCPCH VBP provides financial support to sustain a robust PCPCH model of care and supports staff/activities not reimbursed through FFS.
- CCO VBP learning collaborative to align efforts and share tools to lead this work in their communities. The CCO VBP collaborative could evolve into a multi-payer collaborative in later years.
- CCOs can advance in model sophistication or care delivery focus areas (for example, increase their % in
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

3B/shared risk, or adopt a VBP to focus on behavioral health integration).

- CCOs’ reporting to All Payer All Claims (APAC) database allows for comparing CCO VBP progress over time, across CCOs and across the health system.
- CCOs’ responses to a standardized set of questions within their annual VBP interviews on steps they have taken to ensure their VBPs have not had unintended, negative consequences for priority populations (including those previously identified above), provides an incredible opportunity to learn best practices, advance those best practices, and develop “safe-guards” where needed.

Examples of accountability

- By Year 1 (2020), CCOs will:
  a) Be expected to achieve a 20% VBP target for LAN category 2C (“pay-for-performance”) as reported in their RFA response
  b) Implement a PCPCH VBP;
  c) Report VBP data via All Payer All Claims (APAC) database; and
  d) Report supplemental VBP data and/or interviews.

- By Year 5 (2024), CCOs will:
  a) Achieve 70% VBP goal;
  b) Participate in annual VBP interviews.
  c) Add Implement one new VBP in the remaining care delivery focus areas in Years 3–5 – successfully implementing VBPs in all five care delivery focus areas; and.
  d) Report complete encounter data with contract amounts and additional detail for VBP arrangements.
Policy #11
Evaluate CCO performance with tools to evaluate CCO efficiency, effective use of health-related services (HRS), and the relative clinical value of services delivered through the CCO. Use evaluation to set a performance-based reward at the individual CCO level.

Intended impact
Improved delivery of benefits to CCO members including more efficient use of medical services, increased delivery of high-value services and increased use of HRS that improves member health.

Policy implementation considerations
- Evaluation methodology implemented in 2020 (Year 1) but 2021 likely first year CCO amounts will be individually determined based on performance evaluation.
- Methodology to establish performance-based component of capitation rate needs to be finalized, and could benefit from cross-agency work group. Methodology will consider efficiency, effective HRS investment, and clinical value of services delivered.
- Methodology development needed in multiple phases and may evolve over time; additional OHA staff likely needed.
- Policy is required as part of our current 1115 waiver:
  a) CCO-specific performance-based reward rates required by 2017 waiver renewal.
  b) Waiver language specifically calls out goal of policy to motivate effective HRS use by CCOs, but additional evaluation tools are needed to evaluate CCO performance.
  c) Methodology to inform CCO-specific rate components will be closely watched by stakeholders.
  d) Evaluation and analysis may require additional staff beyond current capacity (similar structure to HPA metrics team).
  e) OHA could strategically choose to include this program in legislation for the upcoming session.
  f) Can be seen as more rigorous and formalized process to evaluate and achieve efficiency in managed care.
  g) Could result in base data exclusions of inefficiencies.
- NOTE: Policy option now incorporates policy option to provide rewards for care with higher clinical value in rate-setting process.

Policy implementation expectations
Initial baseline expectations
- OHA rate-setting methodology has new tools to:
  a) Evaluate CCO efficiency, delivery of high-value health care services and cost-effective use of health-related services; and
  b) Reward the highest performing CCOs.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

Transformational expectations

- CCOs increase investments in programs and systems that improve the care delivery system and increase access to health-related services.
- Improved CCO efficiency leads to:
  a) Improved health outcomes for members
  b) Lower overall programmatic costs
- CCO investments in programs and services that increase efficiency and utilization of high-value services benefit populations experiencing health disparities and inequities.
- New transparency increases public accountability for CCOs.

Examples of accountability

- New publicly available measures are implemented:
  a) Efficiency measures
  b) Evaluation of CCO delivery of services with highest clinical-value
  c) Methodology for evaluating CCO use of HRS
- CCO-specific, performance-based components of capitation rates act as an incentive and accountability metric.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Policy #12

Incorporate measures of quality and value in any OHA-directed payments to providers (for example, hospital payments) or OHA reimbursement policies and align measures with CCO metrics

Example: Qualified directed payments made directly to hospitals are based in part on quality and value

Intended impact

Providers are rewarded for improving value and quality of care, and metrics for CCOs and other providers are aligned and coordinated to achieve maximum impact.

Policy implementation considerations

• Implementation goal in 2020.
• Additional policy development needed to establish the quality and value metrics to be used and their impact on specific payment streams.
• Alignment across CCOs and hospital quality metrics is key to CCO 2.0.
• Implementation of quality/value metrics should build on HTPP experience.
• Requires policy development coordination between HPA, Finance and HSD.
• Designed to meet CMS requirements related to passthrough funds that require OHA to move to a qualified directed payment process that includes quality and value.
• Policy involves hospital provider tax funds, which adds to complexity and visibility.
• OHA could strategically choose to include this program in legislation for the upcoming session, or as part of the budget process.
• Connects and builds on other policy options to expand CCO use of VBPs

Policy implementation expectations

Initial baseline expectations

• The methodology for OHA-directed payments to hospitals incorporate measures of quality and value.

Transformational expectations

• CCOs and OHA align payment methodologies and their incorporation of quality and value to amplify their ability to motivate performance improvements.
• Connecting quality and value with financial incentives motivates continued improvement in a key goal of the triple aim: improve care.
• OHA-directed payments and methodologies are increasingly aligned with CCOs’ efforts to increase use of value-based payments.
• Metrics measuring quality and value consider health disparities and reward providers and CCOs that reduce disparities.

Dashboard

Fulfills state or federal mandate

Priority area: COST

How heavy is lift? 🌑🌑🌑🌑

How large is impact? 🌒🌒🌒🌒

2019 POP planned

Requires legislation

Recommendation for OHA

Exists in contract; needs strengthening or improved monitoring

Health equity impact assessment

Potential to impact children

May require OHA TA support

Increases transparency
Recommended Policies: Begin implementation in year 1

Examples of accountability

- Measures of quality and value may build on successes of previous Hospital Transformation Performance Program and should connect to CCO efforts to expand VBPs and efficiency metrics into hospital-based services.
Policy #13

Adjust the operation of the CCO quality pool allow consideration of expenditures in CCO rate development; this will align incentives for CCOs, providers and communities to achieve quality metrics.

Create consistent reporting of all CCO expenses related to medical costs, incentive arrangements, and other payments regardless of funding source (quality pool or global budget).

Intended impact

CCOs invest their quality pool earnings in a timely manner in the providers and partners who help achieve targeted metrics, and focus additional efforts on achieving targets to ensure maximum quality pool earnings.

Policy implementation considerations

- 2020 capitation rates would reflect the quality pool as being funded by a withhold of capitation payments instead of as a bonus.
- Adjusting the operation to a withhold allows OHA the flexibility to increase the percentage of payments to CCOs that are tied to quality and value.
- Requires policy development coordination between HPA, Finance and HSD.
- Some CCOs have expressed concern that their failure to achieve quality pool earnings in one year effectively limits their rates for the following year – additional methodology development and clarification should seek to alleviate concerns.
- Moving quality pool inside rates allows creation of bonus funding methodology for social determinants of health funding.
- Creates consistent reporting of all CCO expenses related to medical costs, incentive arrangements and other payments regardless of funding source (global budget or quality pool).

Policy implementation expectations

Initial baseline expectations

- Considering quality pool spending within rate development adds a new layer of transparency to CCO spending patterns related to the quality pool and allows OHA to increase the portion of the CCO’s global budget tied to quality and value.
- CCOs clearly report all quality or incentive payments to providers, distinct from any base payment the providers would have received absent quality incentive.
Transformational expectations

- CCOs use quality pool revenues to make timely investments in their communities and the partners that help them achieve targeted metrics.
- Moving quality pool funds inside the rate development process provides extra incentive for CCOs to meet benchmarks and thus help motivate performance improvement at the CCO level.
- Funding the quality pool through a withhold allows OHA to increase the share of CCO global budget tied to performance.

Examples of accountability

- Increased visibility of CCO quality pool spending patterns helps hold CCOs accountable to their local communities.
Policy #14

Address increasing pharmacy costs and the impact of high-cost and new medications by increasing transparency of CCOs and their pharmacy benefit managers (PBMs)

Intended impact

Increased transparency of true pharmacy costs by addressing spread pricing, rebate transparency, and improved auditing features.

Reduced underlying pharmacy costs for CCOs through improved PBM contracting requirements.

Policy implementation considerations

- Transparency provisions likely implemented as broad requirements for how CCOs structure their PBM agreements.
- PBM contracts must provide for regular third-party market analysis to ensure CCOs are receiving competitive pricing.
- Oregon Prescription Drug Program (OPDP) could be an option for CCOs to comply with new PBM transparency requirements, but would not be mandatory for CCOs.
- Potential opposition from PBMs.
- OPDP currently meets pricing transparency and passthrough requirements being sought and is a viable PBM solution for CCOs if they choose.
- Policy option is similar to solutions being sought in other states in response to PBM pricing and passthrough policies.

Policy implementation expectations

Initial baseline expectations

- CCOs require their pharmacy benefit managers (PBMs) to:
  a) Provide pharmacy cost passthrough at 100%;
  b) Pass back 100% of rebates received to CCOs;
  c) Report administrative fees paid from CCO to PBM; and
  d) Require reporting from PBM on pharmacy-paid amounts at claim level.
- Require transparent “no-spread” arrangements between CCOs and PBMs.
- CCOs require PBMs to agree via contract to third-party audits and market checks on an annual basis.

Examples of accountability

- Financial audits of CCO pharmacy networks (individual pharmacies) on amounts paid to them for claims processed by CCO’s contracted PBM reconciled against amount PBM reports as paid to the CCO less fixed or expected administration fees charged by the PBM.
- Rebate passthrough reporting is demonstrated via periodic reporting by the PBM. This reporting takes place at a minimum of two times annually.
Appendix A: CCO 2.0 recommended policies and implementation expectations

CCO 2.0 Recommendations of the Oregon Health Policy Board

**Policy #15**

**Address increasing pharmacy costs** and the impact of high-cost and new medications by increasing alignment of fee-for-service (FFS) and CCO preferred drug lists (PDLs)

**Intended impact**

Increased alignment of PDLs provides new tools to OHA and CCOs to reduce pharmacy costs and ensure consistent access to pharmacy services for members across CCOs.

**Policy implementation considerations**

- Implementation will take an incremental approach to strategically and partially align PDLs (starting with selected drugs/classes and building on experience over time).
- Initial alignment requirements will be built on over time with input and cooperation from CCOs beginning in the 2.0 contract period.
- Varied opinion within CCO community on value/impact of proposed PDL policy.
- External report recommends aligning targeted drug classes.
- Specifics of alignment strategies may best be finalized after CCO contracts are awarded to enable partnership between OHA and CCOs in phasing in alignment of specific drug classes.
- Ongoing pharmacy policy recommendations may be informed by task force created by House Bill 4005.
- Implementing a flexible reinsurance program in CCO 2.0 may help support this policy.
- Policy could consider complementary approaches to limit costs and uncertainty associated with new pharmaceutical products (specialty pipeline).

**Policy implementation expectations**

**Initial baseline expectations**

- CCO PDLs and coverage/prior authorization criteria are publicly posted and easily accessible for patients and prescribers.
- CCOs align selected segments of their PDLs with the Oregon Health Plan’s fee-for-service PDL.

**Transformational expectations**

- Over time CCOs work with OHA to significantly increase alignment of CCO PDLs (and coverage criteria) across highly utilized drug classes to improve intrastate portability of the Medicaid program.

**Examples of accountability**

- CCOs submit PDLs for all classes to OHA in format required by OHA. CCOs provide updated version as changes are made.
- CCOs submit coverage criteria for all non-aligned PDL classes in format required by OHA. CCOs provide updated version as changes are made.
- OHA compiles CCO submissions and publishes the information to the OHA pharmacy website to improve practitioner and patient communications (to be updated monthly).
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

Policy #16

Enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated risk-based capital (RBC) tool to evaluate carrier solvency

Intended impact

Increase solvency protection and reduce risks to the state and members of a CCO insolvency event; improve understanding of CCO finances.

Policy implementation considerations

- Use NAIC financial reporting templates and modify insurance regulations to fit unique CCO program including supplemental CCO-specific schedules.
- Use RBC tool to evaluate CCO solvency.
- Work with DCBS to build a financial oversight framework that leverages the insurance code.
- Reporting framework requirements targeted for implementation in Year 1.
- Industry standard NAIC forms could replace much of OHA’s current Exhibit L.
- Phase-in implementation may be needed since NAIC requires new standards that will require CCOs to adjust financial reporting.
  a) If needed, CCOs may be allowed to continue to use GAAP accounting methodology for 1–2 years before being required to move to statutory accounting principles; which is standard for health insurance carriers.
- RBC thresholds need to be set for Medicaid if this tool is used to assess financial risk and reserve levels.
- NAIC reports cover a two-year period and requires a five-year historical data period – OHA will need to decide the reporting timing for both the RFA and the five-year contract.
- Potential impact to OHA and DCBS oversight capacity to increase the “lift” score.
- Approach is consistent with larger trends in Medicaid managed care to more closely resemble the commercial insurance world.
- Could facilitate the spread of the coordinated care model to non-Medicaid sectors.
- Alternative of enhancing current exhibit L reporting tools could be equally administratively complex

Policy implementation expectations

Initial baseline expectations

- CCOs report financial information to OHA using NAIC financial reporting templates (Health Annual Statement).
- CCOs submit supplemental reports to OHA for necessary information not part of NAIC templates.

Examples of accountability

- CCO financial data is available in a publicly accessible manner.
Policy #17

Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity. This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.

Intended impact

CCOs are fully accountable for members’ behavioral health care.

Increase access to behavioral health services, decrease wait times, allow members provider choice, improve behavioral health outcomes for all Oregonians.

Policy implementation considerations

- OHA will develop monitoring and compliance protocol.
- OHA will monitor the metrics identified in the next policy option. Corrective action plans will be required if CCOs are not able to meet metrics.
- The biennial implementation plan (BIP) and CHP must be collaborative plans that inform one another.
- Monitoring and compliance should be in HSD.
- Integration of the behavioral health benefit should promote delivery of the behavioral health benefit. This means the CCO is responsible for ensuring there is an adequate provider network and members have access to behavioral health care. The CCO is responsible for outcomes.
- Pros: Clear owner of the behavioral health benefit for OHA and members.
- Cons: Current CCOs may not have the expertise or infrastructure.
- This policy was developed from feedback regarding what is not currently working. Many stakeholders have called for the elimination of carve-outs; however, that may have unintended consequences.
- Oregon Academy of Family Physicians states that carve-outs “if allowed to exist at all in the future — should not be allowed for primary care behavioral health services.” National Alliance on Mental Illness, Children’s Health Alliance and the Oregon Center for Children and Youth with Special Health Needs support elimination of carve-outs.

Policy implementation expectations

Initial baseline expectations

CCO clearly articulates plan for managing the behavioral health benefit, including:

- Resource utilization to ensure the behavioral health benefit is integrated in a way that is invisible to members and providers;
- The full behavioral health benefit is available to members (accessible, timely, within a reasonable distance and inclusive of a full range of treatment and recovery options), including provision of trauma-informed services;
- Policies and procedures for the behavioral health benefit for their entire region;
- Budget managed in a fully integrated way;
**Recommended Policies: Begin implementation in year 1**

- Plan for annual evaluation of behavioral health spend and risk sharing;
- Behavioral health services are paid for in primary care and primary care is paid for in behavioral health, without pre-authorization;
- Multiple services are allowed within the same day at the same clinic; and
- No wait time for services.

**Transformational expectations**

- CCOs are fully accountable for services by actively taking responsibility for ensuring seamless access to all covered benefits. This will create a transparent, effective and responsive behavioral health system.
- CCOs ensure processes and structures are in place to ensure there is a coordinated behavioral health system.

**Examples of accountability**

- RFA response includes all items in the initial baseline expectations.
- OHA monitors the metrics identified in policy recommendation #17. Corrective action plans will be required if CCOs are not able to meet metrics.
- OHA will review MOU between CCO and community mental health provider – which includes conversations with relevant stakeholders.
- CCO ensures the local plan and CHP are collaborative plans that inform one another.
**Policy #18**

**Identify metrics to track milestones of behavioral health (BH) and oral health (OH) integration** with physical health care by completing an active review of each CCO’s 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, implementing culturally responsive principles including trauma-informed practices, and meeting metrics

**Intended impact**

Increase integration, increase access, increase provider network, and decrease wait time.

**Policy implementation considerations**

- Transformation Center (TC) has contracted with a consultant to identify the metrics and a review proposal.
- CCOs should ensure providers integrate substance use disorder services in physical health settings in addition to mental health services.
- CCOs should plan to enhance culturally specific integrated services, including culturally specific behavioral health services in physical health settings.
- HSD and HPA will collaborate: HPA will monitor and pull data; the review will sit in HSD for compliance; TC will provide TA.
- Behavioral health has not consistently been integrated by the CCOs. This will be a lever to ensure CCOs integrate services, for OHA to measure progress and to target technical assistance.
- OEI is involved in the work group tasked to identify metrics to ensure equity is taken into consideration.
- Children's Health Alliance supports and recommends that measurement recognizes appropriate measures for pediatric population; Oregon Medical Association supports quality incentive metrics for integration; Trillium supports.

**Policy implementation expectations**

**Initial baseline expectations**

- Starting in Year 1, CCOs report on OHA identified behavioral health integration metrics on a regular basis.
- Starting in Year 2, CCOs report on OHA identified oral health integration metrics on a regular basis.

**Transformational expectations**

- CCOs increase the level of behavioral health integration, resulting in integrated and coordinated health care for all Oregonians.
- OHA has a method to measure the level of integration of each CCO.

**Examples of accountability**

- CCOs report on metrics, and OHA uses a scoring rubric.
- TA is available for CCOs that are not meeting the minimum score or that request additional TA.
Policy #19

CCOs identify actions for developing the medical, behavioral and oral health workforce. CCOs will:

- Report on the 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.
- Develop the health care workforce pipeline in their area by participating in and facilitating the current and future training for the health professional workforce. This includes encouraging local talent to return to their home areas to practice and supporting health professionals following their initial training.
- Develop and support a diverse workforce that can provide culturally and linguistically appropriate care, and trauma-informed practices, with attention to marginalized populations.
- Ensure current workforce completes a cultural responsiveness training in accordance with House Bill 2611.

**Intended impact**

Increase workforce to ensure network adequacy for members throughout the lifespan and for all behavioral health services, (mental health and substance use disorder); increase access and outcomes for Oregonians.

**Policy implementation considerations**

- Starting in Year 1, CCOs will report on members in their network, the diversity and capacity of the workforce in their region, and the plan to meet the need of their members, including the capacity to provide needed services in a culturally responsive and trauma-informed manner.
- OHA will develop report and publish available data.
- Health Care Workforce (HCWF) Committee will continue to contribute to the development of these efforts.
- HPA and HSD will monitor compliance.
- This was first suggested in the HCWF Committee by a CCO medical director while the committee was looking at challenges of collecting data on workforce capacity.
- This policy can contribute to the development of a shared accountability model for the adequacy of the health care workforce in the state between CCOs and OHA (and potentially others).
- Some CCOs have this in place now but are not reviewed/supported by OHA; for others, asking for this will help them better think through questions of access.
- Every state is required to develop a needs analysis as part of the Primary Care Office cooperative agreement.
- Federally, HRSA requires states to maintain updated provider data.
- House Bill 3261 requires a biennial needs assessment.
- Need to consider whether “area” is only a CCO’s provider network or a geographic area served in part by the CCO.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Recommended Policies: Begin implementation in year 1

Policy implementation expectations

Initial baseline expectations

- In Year 1, CCOs report on members in their network, current workforce, and the plan to meet the need of their members.
- In Year 1, CCOs report on prevalence in their region of all health needs and begin working within their communities with local and state educational resources to develop an action plan to ensure the workforce is prepared to meet needs. All CCOs update these plans on an annual basis and identify how they are implementing them.
- OHA develops report and publishes available data.
- OHA monitors compliance.

Transformational expectations

- CCOs lead the way in the collaborative and creative development of the necessary medical, oral and behavioral health workforce to serve individuals in their communities.
- CCO applicants understand the health care workforce needs for their area and have ideas for how to address those needs.
- CCOs ensure there is a sufficient and well-trained workforce to meet the needs of members. CCOs ensure culturally and linguistically appropriate, trauma responsive and trauma specific care available for all Oregonians.

Examples of accountability

- OHA sees a decrease in gaps among racial/ethnic groups in incentive and other existing metrics.
- Year 1 (2020) – Each CCO identifies a targeted number of FTE and a targeted range of diversity for medical, oral and behavioral health care providers by the end of the following year.
- At end of Year 2, OHA assesses CCOs’ progress toward achieving the targets and look with the CCO at targets for Years 3–5.
- CCO includes trauma-specific care providers in the targets.
## Policy #20

Require CCOs **utilize best practices to outreach to culturally specific populations**, including development of a diverse behavioral and oral health workforce that can provide culturally and linguistically appropriate care (including utilization of THWs)

### Intended impact

Improve health outcomes for culturally specific populations.

### Policy implementation considerations

- Guidelines and best practices are being developed by OEI.
- Technical assistance is recommended for implementation.
- Guidelines and best practices need to be developed by OHA (OEI and BH).
- Will require ongoing monitoring and TA.

### Policy implementation expectations

#### Initial baseline expectations

- CCOs report in Year 1.
- CCOs reach out to populations experiencing gaps in care that contribute to oral health disparities.
- CCOs provide culturally and linguistically appropriate services to diverse populations using identified best practices.

#### Transformational expectations

- CCOs decrease the gaps in care that contribute to oral health disparities.
- Intake paperwork is accurately translated, with accessible interpreter services for intake, treatments and ancillary services.

### Examples of accountability

- OHA sees a decrease in gaps among racial/ethnic groups in incentive and other existing metrics.
- Outreach leads to changes in capacity and diversity of the workforce that are included in the report required for recommendation 19.
- Workforce diversity measures TBD.

## Dashboard

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<td>Health equity impact assessment</td>
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**Recommended Policies: Begin implementation in year 1**

**Policy #21**

*Prioritize access for pregnant women and children ages birth through five years* to health services, developmental services, early intervention, targeted supportive services, and behavioral health treatment.

- CCOs will ensure access to evidenced-based dyadic treatment and treatment that allows children to remain placed with their primary parent.
- CCOs will support providers in assessing for adverse childhood experiences (ACEs) and trauma, to develop individual services and support plans.
- For pregnant women, CCOs will support providers in screening for behavioral health needs and substance use prenatally and post-partum. CCOs will provide appropriate referrals and follow-up to referral.
- CCOs will prioritize access to substance use disorder (SUD) services for pregnant women, parents, families, and children, including access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services for parents and behavioral health screening and treatment for children.

**Intended impact**

Improve health outcomes for children; CCOs level of services to children ages 0–5 will match the national percentages; increase support to families where substance use disorders are present.

**Policy implementation considerations**

- CCOs will collectively develop statewide early childhood criteria for behavioral health levels of care (outpatient, intensive outpatient, subacute and psychiatric residential treatment services).
- Services for young children are trauma responsive and/or trauma informed.
- Require an increased level of outpatient level of care for children 0–5 with indications of ACEs and high complexity due to one or more of the following: multi-system involvement, two or more caregiver placements within the past six months, moderate to severe behavior challenges, at risk of losing current caregiver placement, or school or daycare placement.
- CCOs would pay for mental health consultation in early learning settings for their network of providers.
- Fulfills a mandate of early learning hubs. Connects with recommendations of Governor’s Children’s Cabinet.
- Two or more ACEs is associated with poor kindergarten and behavioral outcomes.
- Trauma-informed approaches must be a foundation on which other services are conducted.
- Recommendation in the OHA-DHS Continuum of Care proposal that state agencies pursue trauma-informed approaches.
- Early identification and intervention prevents poor long-term outcomes and reduces costs.
- Currently social-emotional screening is needed to identify children with problems interfering with kindergarten readiness and issues related to early behavioral health intervention needs.

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Policy implementation expectations

Initial baseline expectations

- CCOs collectively develop statewide early childhood criteria for behavioral health levels of care (outpatient, intensive outpatient, subacute and PRTS).
- CCO provides an increased level of outpatient care for children birth through five with indications of ACEs and high complexity due to one or more of the following: multi-system involvement, two or more caregiver placements within the past six months, moderate to severe behavior challenges, at risk of losing current caregiver placement, or school or daycare placement.

Transformational expectations

- CCOs’ level of services to children ages 0–5 will match the national percentages.
- CCO uses quality, evidence-based practices that have high results for this age group and school age children that did not get access to parent-child interaction therapy (PCIT).
- CCOs and OHA’s Children’s Behavioral Health Unit collaborate to impact the workforce and quality of services.
- CCO services for young children are trauma responsive and/or trauma informed.
- CCOs require providers of physical health services to use evidence-based screening tools for depression and anxiety for expecting parents (parents/kinship caregivers, adoptive parents, and pregnant women).

Examples of accountability

OHA tracks the following:

- Data through Medicaid Management Information System (MMIS) assessment codes to monitor and report to CCOs their level of service as compared to national levels;
- TA and community participation on development of early childhood level of care;
- Use and impact of Help Me Grow’s intervention on the community and share data with CCOs;
- Parent Child Interaction Therapy utilization with child welfare data (increase children stabilized, return home and reduce disruption and removal); and
- Parent Management and Training Oregon model implementation and usage, and connect with child welfare data (increase children stabilized, return home and reduce disruption and removal).
Appendix A: CCO 2.0 recommended policies and implementation expectations

Policy #22

Implement risk-sharing with the Oregon State Hospital (OSH)

Intended impact

As CCOs assume risk, OHA anticipates increase in community care and decrease in hospitalizations.

Policy implementation considerations

- All CCOs will assume risk for members on OSH waitlist in year one.
- All CCOs will share limited risk for members in OSH by year two (e.g., CCO projects number of beds they will use, pays monthly amount to OSH based on projection, settlement at the end of the year; details of the model are in development).
- Payment model will shift to OSH billing CCOs for members in OSH within five years.
- Work will ultimately sit in HSD.
- Behavioral Health Collaborative recommendation.
- This will advance the Oregon Performance Plan by facilitating community placement for individuals transitioning from Oregon State Hospital.
- May pose challenges in Multnomah County for hospitals regarding utilization review.
- CCO and CMHP support; AOCMHP supports; Care Oregon supports.

Policy implementation expectations

Initial baseline expectations

- In Year 1, all CCOs assume risk for members on OSH waitlist.
- By Year 2, all CCOs share limited risk for members in OSH (for example, CCO projects number of beds they will use, pays monthly amount to OSH based on projection, settlement at the end of the year; details of the model are in development).
- Within five years, payment model shifts to OSH billing CCOs for members in OSH.

Transformational expectations

- CCO members receive appropriate care in the appropriate setting. This will result in improved outcomes and lower costs.

Examples of accountability

- CCO members on OSH waitlist receive appropriate care in the appropriate setting of care (for example, acute care hospital or community setting).
- Each CCO has a contract in place with OSH following the same payment model.
- CCO members in OSH are discharged as soon as individual is ready to return to the community (Oregon Performance Plan indicator: discharge within 30 days of ready to transition).
Policy #23
Shift financial role for statewide HIT public/private partnership from OHA to CCOs to cover their fair share

Intended impact
CCOs are directly connected to cross-stakeholder efforts (such as Emergency Department Information Exchange and Prescription Drug Monitoring Program integration) to prioritize and improve HIT statewide.

Policy implementation considerations
- **Timing:** This would be an attestation in the RFA and contractual obligation starting with 2020 contracts. The only change needed is for CCOs to take over paying the HIT Commons dues that OHA is currently paying on their behalf. A dues schedule has already been established, and current CCOs have signed MOUs to participate that include transparency about taking on dues in 2020. CCOs are participating in HIT Commons efforts and have three seats on the HIT Commons Governance Board. OHIT manages this work.
- **Pro:** HIT Commons continues to support CCO and Medicaid objectives and is informed about the needs of Oregonians across the state. Ensuring CCO participation will demonstrate value to other stakeholders and help ensure the HIT Commons maintains sufficient participation for effective governance of statewide HIT initiatives.
- **Con:** Some CCOs may prefer to focus on local HIT initiatives in the future.
- **Consideration:** 2018 dues range from $1,280 for the smallest CCO to $68,900 for the largest. Dues are paid using FMAP-eligible funds.
- **Feedback:** Stakeholders have had little feedback other than requesting information about the dues – this has been non-controversial

Policy implementation expectations
Initial baseline expectations
- CCO signs MOU as a participant in the HIT Commons and pays dues according to the dues structure established by the HIT Commons.
- If elected, CCO representative fills one of the three CCO seats on the HIT Commons (nominations by CCO CEOs).
- As HIT Commons participants, CCOs are eligible to participate in HIT Commons efforts; for example, accessing HIT Commons services, participating on a committee, or attending a learning collaborative.

Examples of accountability
- MOU is signed, annual dues are paid.
- If elected, CCO representative regularly attends HIT Commons meetings and participates in HIT Commons work.
- If CCO fails to sign MOU, pay dues, and if elected, attend meetings and participate in HIT Commons work, a corrective action plan may be warranted.
Appendix A: CCO 2.0 recommended policies and implementation expectations

CCO 2.0 Recommendations of the Oregon Health Policy Board

Policy #24

Recommend CCOs to ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disturbances (SED), and individuals in medication-assisted treatment for SUD and incorporate the following:

- Develop standards for care coordination that are trauma informed and culturally responsive
- Enforce contract requirement for care coordination for all children in child welfare, state custody and other prioritized populations
- Establish outcome measure tool for care coordination.

Intended impact

Increase access to behavioral health services, allow members provider choice. Improve health outcomes. Ensure care coordination is efficient and impactful for the highest risk members.

Policy implementation considerations

- Starting in Year 1, CCOs will ensure care coordinators are identified to work with the individual to coordinate physical health, mental health, intellectual and developmental disability and ancillary services as needed.
- OHA will develop standards and outcomes measure.
- Work would live within HSD. HPA Analytics would be involved for outcome measure.
- OHA received feedback that there are multiple care coordinators assigned and there needs to be coordination or role clarification.
- Oregon Center for Children and Youth with Special Health Needs supports with a call-out for those transitioning from pediatric to adult systems; Trillium supports with call-out for families; Children’s Health Alliance and Oregon Center for Children and Youth with Special Health Needs support developing standards; Children’s Health Alliance supports care coordination for child welfare and other prioritized populations.

Policy implementation expectations

Initial baseline expectations

- CCOs ensure individuals diagnosed with severe and persistent mental illnesses or serious emotional disorders are assigned to a care coordinator who works with the individual to complete a care plan that meets their individual needs and personal goals.
- CCOs and OHA develop statewide standards for care coordination and intensive care coordination. Standards include trauma responsive services.
- CCOs ensure individuals in state custody are assigned to a care coordinator who works with the individual to complete a care plan that meets their individual needs and personal goals using best practice working with children in foster care, individuals with intellectual and developmental disabilities and juvenile justice. This may include dual generation work when a caregiver’s behavioral health is impacting a child’s behavioral health.

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Transformational expectations

- Coordinators are identified and work with the individual to coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services as needed.
- Care is coordinated and resources are used efficiently, improving outcomes for individuals and reducing cost.
- Services are delivered in a trauma informed or trauma responsive manner.
- Parents and children whose behavioral health impacts the other (for example, mothers with SUD and their children; caregivers with SPMI or untreated BH and their children) experience improved outcomes.
- Members have increased access to family supports through home visiting programs.

Examples of accountability

- CCOs increase number of individuals assigned to identified care coordinators over time.
- MHSIP Mental Health Statistical Improvement Project (adult survey) and Youth Services Survey can be used to evaluate care coordination satisfaction by families and consumers. Include items measuring whether services were trauma responsive/informed.
- CCOs use identified outcome measure tool.
- Care coordinators increase the number of families connected to appropriate services.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Policy #25

Develop mechanism to assess adequate capacity of services across the continuum of care

Ensure members have access to behavioral health services across the continuum of care

Intended impact

Provide a full continuum of behavioral health, medical and oral health services throughout the state. Ensure members have access to a provider network. Will improve health outcomes.

Policy implementation considerations

- OHA will define continuum of care and network adequacy.
- CCOs will ensure a sufficient number of providers are available to provide care relative to the enrollees in the plan, providing consumers with the right care that includes all services in the benefit package, is provided across the continuum, is available within a reasonable distance, and is culturally and linguistically appropriate.
- Continuum of care for substance use disorder will include aftercare and ongoing recovery supports.
- Would sit in HSD.
- This is in current contract but has not been enforced.
- Likely understanding of “adequate capacity” will expand and evolve from what it was understood to be in CCO 1.0. Fulfills a federal requirement to identify mental health shortages.
- Further development needed, especially around compliance.

Policy implementation expectations

Initial baseline expectations

- Starting in Year 1, CCOs report on network adequacy, based on prevalence for their region. Network adequacy includes the continuum of care for behavioral health, including SUD and opioid use disorder specific services.

Transformational expectations

- Every region has a full continuum of behavioral health services to meet the needs of the community.
- The full continuum of behavioral health services includes providers who can provide trauma-specific services.

Examples of accountability

- CCOs to monitor the behavioral health prevalence data for the region, and current provider network for the region.
- CCOs to develop plan to ensure adequate provider network, based on prevalence data.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Policy #26
System of Care (SOC) to be fully implemented for the children’s system

Intended impact
Child-serving systems and agencies collaborating in the SOC are working together for the benefit of children and families.

Policy implementation considerations
- Hold CCOs accountable to full implementation of existing model to ensure cross-system collaboration as well as services and supports that are youth and family driven, culturally and linguistically competent and community based.
- Clarify with CCOs and communities SOC governance roles and responsibilities as they relate to the broader statewide SOC infrastructure.
- Statewide SOC Steering Committee empowerment: State agencies (OYA/OHA/DHS/ODE) to fund the State SOC steering committee with existing general fund from each child-serving state agency for multi-agency needs and development of shared services and supports.
- The already-existing SOC governance infrastructure was launched in 2014 and continues to mature and develop. OHA contractually requires CCOs to have local SOC structures in place, and these have been developed and maintained with consultation from PSU System of Care Institute. The institute is funded jointly through an interagency agreement between DHS–Child Welfare, OHA and PSU.
- Pros: SOC is already established, needs fine tuning for some CCOs/areas.
- Cons: Difficulty getting system partners to the table, lack of blended funding hampers efforts.
- Much national research exists documenting cost savings.
- HB2144 Youth Wraparound Initiative names system partners.
- This will reflect values and principles of the local governance structure.

Policy implementation expectations
Initial baseline expectations
- State agencies to fund the State System of Care (SOC) Steering Committee with existing general fund from each child-serving state agency for multi-agency needs identified by local SOC governance structures.
- Starting in Year 1, CCOs are accountable to fully implement existing SOC model to demonstrate cross system collaborations that include SOC policies and collaborative funding models.
- CCOs have wraparound care coordinators who are fully trained, participate in coaching, and practice to fidelity standards in their work with wraparound.
- CCOs measure fidelity of their wraparound services using the Wraparound Fidelity Index – Brief Version (WFI-EZ).

Dashboard
- Fulfills state or federal mandate
- BH
- How heavy is lift? 🌑🌑🌑🌑
- How large is impact? 🌒🌕🌕🌕
- 2019 POP planned
- Requires legislation
- Recommendation for OHA
- Exists in contract; needs strengthening or improved monitoring
- Health equity impact assessment
- Potential to impact children
- May require OHA TA support
- Increases transparency
Transformational expectations

- CCOs have four levels of governance reflected within 2-4 working groups in their region.

Examples of accountability

- Data sharing agreements are in place to support SOC implementation and impact.
- CCO utilizes local governance structure to advance SOC concerns not resolvable locally to the state-level steering committee.
- Data tracking system identifies system impact of the SOC (i.e., children placed in out of home care or juvenile justice).
- CCOs provide utilization data (ED utilization, outpatient, etc.) to advisory councils.
Policy #27

Require wraparound is available to all children and young adults who meet criteria

Intended impact

Improve health outcomes for children and young adults.

Policy implementation considerations

- Require CCOs to meet national average for fidelity implementation per WFI-EZ scores (fidelity tool/consumer survey).
- Enforcement of existing contractual expectations will be critical to success.
- Work would sit in HSD.
- This was in the CCO contract but not enforced. Enforcement will be critical to success.
- Pros: Wraparound is documented to improve outcomes for children and families while providing long-term cost savings.
- Meets requirements of House Bill 2144.

Policy implementation expectations

Initial baseline expectations

- Starting in Year 1, CCOs meet or exceed national average for fidelity implementation per WFI-EZ scores (fidelity tool/consumer survey).
- CCOs meet contractual expectations and their subcontractors meet requirements of wraparound OAR (in process, no number available).
- CCOs submit fidelity measurement scores from the WFI-EZ on a quarterly basis.
- OHA enforces existing contractual expectations. This will be critical to success.
- OHA ensures contract clarifies ages 0–25 for wraparound access.

Transformational expectations

- Wraparound is implemented to fidelity, children involved in wraparound services experience improved outcomes. This will result in future cost savings.

Examples of accountability

- CCO will administer the WFI-EZ after six months of enrollment.
- Wraparound care coordinators are trained in trauma-informed care principles.
- CCOs documented evidence of training and coaching participation by care coordinators and supervisors.
**Policy #28**

**MOU between community mental health program (CMHP) and CCOs enforced and honored**

**Intended impact**

Improved health outcomes and increased access to services through coordination of safety net services and CCO Medicaid services.

**Policy implementation considerations**

- Enforcement would sit in HSD.
- The CCOs have the MOUs but not all have been fully implemented.
- Would result in coordination of safety net services in each region.
- Supported by Association of Oregon Community Mental Health Providers

**Policy implementation expectations**

**Initial baseline expectations**

- Starting in Year 1, each CCO has MOU with CMHP.

**Transformational expectations**

- CCO has working relationship with each CMHP in the region, which will result in better coordinated behavioral health care in the region.

**Examples of accountability**

- The local plan is submitted by the CMHP. The local plan informs the CHP and the CHP informs the local plan. The CMHP and the CCO collaborate on the development of the CHP.
- The local plan and CHP include a plan for implementing trauma-informed service delivery.
Appendix A: CCO 2.0 recommended policies and implementation expectations

Policy #29

Identify and address billing system and policy barriers to integration:
- Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting;
- Develop payment methodologies to reimburse for warm handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, wraparound, Parent-Child Interaction Therapy, Early Assessment and Support Alliance); and
- Examine equality in behavioral health and physical health reimbursement

Intended impact
Increase integration, increase access, and expand provider network.

Policy implementation considerations
- Implement in Year 1.
- Work to be completed in HSD with technical assistance through the Transformation Center.
- Will require HSD Medicaid staff to complete. This position is currently vacant. OHA will work with a consultant to ensure work is completed in Year 1.
- Work groups have submitted recommendations to OHA.
- This will allow providers to bill from integrated settings.
- Will increase access and expand the provider network.
- Payment methodologies will allow for provision of full continuum of behavioral health services.
- Oregon Academy of Family Physicians supports all BH in integrated PC be reimbursed; Children’s Health Alliance supports BH to be billable in PC for all services provided and should be seamless to provider and patient; Oregon Medical Association supports reimbursement rates to support integration

Policy implementation expectations
Initial baseline expectations
- Implement in Year 1.
- OHA identifies codes and reimbursement rates.
- OHA reviews equality in reimbursement.
- CCOs reimburse for these services and expand provider network.
- OHA identifies appropriate codes and reimbursement rates.
- OHA reviews equality in reimbursement.

Transformational expectations
- Services are reimbursed in integrated settings, increasing integration.
- Providers can bill for services not previously allowed. Will improve outcomes as members will receive more flexible services.
- Reimbursement rates improve.
Examples of accountability

- Improvements in integrated care metrics, such as the rate of members with diabetes who get an oral health evaluation.
- Internal OHA monitoring and compliance.
Policy #30

**Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts**

Connect contractual requirements to ongoing evaluation of Oregon’s sustainable spending target based on national trends and emerging data; this will inform more aggressive targets in the future while providing CCOs with additional financial incentives to achieve spending targets in the form of shared savings arrangements.

**Intended impact**

CCOs are held accountable for achieving spending growth targets, and targets reflect aggressive path to ensure costs grow at a sustainable rate.

**Policy implementation considerations**

- Include a contract requirement with enforcement options requiring CCOs to achieve current and future sustainable rate of growth targets.
- RFA language will clarify spending targets set by waiver and legislature are a CCO deliverable.
- OHA process developed to evaluate current spending targets and inform spending target(s) in future waiver renewals.
- OHA has achieved program-wide spending targets in the first five years.
- Connects OHA’s waiver commitment to CCO contracts.
- OHA may choose to allow CCOs to meet the target over a rolling period (3 years, etc.).
- OHA is exploring rate methodology tools to help meet sustainable growth targets, such as setting multi-year capitation rates for CCOs.
- Shared savings arrangement provides clarity to CCOs that program-wide savings will be reinvested into program.
- Similar to initial funding build-up of quality pool

**Policy implementation expectations**

**Initial baseline expectations**

- CCOs agree to meet sustainable growth targets.

**Transformational expectations**

- CCOs reduce annual growth rates and enable reinvestment of savings into CCO program.
- Multi-year capitation rates provide new tools to help CCO program meet sustainable growth targets.
- New data and analytical tools enable more aggressive growth targets in future years to ensure overall sustainability of program.

**Examples of accountability**

- CCO-specific growth trends posted publicly in a manner that allows comparison across regions and CCOs.
Appendix A: CCO 2.0 recommended policies and implementation expectations

CCO 2.0 Recommendations of the Oregon Health Policy Board

Policy #31

Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy with financial implications

Intended impact

Encounter data accurately reflects health care services provided to OHP enrollees.

Policy implementation considerations

- Implementation may be phased in with baseline data gathering and evaluation phase beginning Year 1 and enforcement and oversight beginning in Year 2+.
- Utilizes new resources added to the Program Integrity Provider Audit Unit from 2017–19 POP.
- Six of seven auditors funded in POP have already been hired.
- Intended to fulfill CMS requirements to ensure encounter data is “complete and accurate” and to ensure it reflects services provided to patients.
- Capacity being added to provider audit unit related to prior POP.
- Alternative ways to meet federal requirements would be necessary without this option.

Policy implementation expectations

Initial baseline expectations

- Implementation may be phased in.
- OHA uses data directly from providers to compare with CCO-level encounter data to add new accountability and oversight.
- Encounter data used in capitation rate development process increases in accuracy.

Examples of accountability

- OHA publishes results of CCO-specific findings to add layer of public accountability.
- Potential financial implications for CCOs if inaccuracies reach certain threshold or are not mitigated.

Dashboard

Fulfills state or federal mandate

Priority area: COST

How heavy is lift? 🌒 ☀️ ☀️ ☀️

How large is impact? 🌒 ☀️ ☀️ ☀️

2019 POP planned

Requires legislation

Recommendation for OHA

 Exists in contract; needs strengthening or improved monitoring

 Health equity impact assessment

 Potential to impact children

 May require OHA TA support

 Increases transparency
Policy #32

Require CCOs support electronic health record (EHR) adoption across behavioral, oral and physical health contracted providers

Intended impact

Behavioral and oral health providers adopt and use EHRs more effectively and at higher rates, allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements.

Policy implementation considerations

- **Timing:** This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers.
- **OHA** would expect CCOs to evaluate current EHR adoption rates and opportunities, set targets and report on progress – phased over 5 years.
- **OHA TA** could be useful.
- Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO needs for data on EHR adoption where possible.
- CCOs’ primary care providers successfully increased EHR adoption with federal incentive payments. This policy option would build on that success. This will be most helpful if BH EHR incentives (POP requested) are available as well.
- CCOs are currently required by contract to support EHR adoption, and had been held accountable through an EHR adoption CCO incentive measure, which focused largely on physical health providers. The new policy option would build on CCOs’ success in raising EHR adoption rates among contracted physical health providers by increasing attention to EHR adoption by behavioral and oral health providers. Like the current contracts, this policy option would not require that a provider adopt an EHR in order to contract with the CCO, nor would OHA set the targets for CCOs. Instead, CCOs would choose which targets to set and decide how best to remove barriers to EHR adoption. OHA would expect that CCOs would set targets keeping in mind their provider networks, and CCOs with more dispersed provider networks that may include many smaller providers (who may face greater barriers to EHR adoption) may set more modest targets.
- **Pro:** Encouraging and supporting the adoption of EHRs capable of information exchange and connecting to health information exchange tools and services would support increased care coordination and improve patient care.
- **Con:** Providers may lack resources to invest in EHRs or lack staff capacity to implement workflow changes needed to effectively use EHRs.
- **Feedback:** CCOs may face significant challenges to this if resources/incentives are not available.

Dashboard

- **Fulfills state or federal mandate**
- **Priority area:** BH/HIT
- **How heavy is lift?**
- **How large is impact?**
- 2019 POP planned
- Requires legislation
- Recommendation for OHA
- **Exists in contract; needs strengthening or improved monitoring**
- **Health equity impact assessment**
- Potential to impact children
- **May require OHA TA support**
- **Increases transparency**
Recommended Policies: Begin implementation in year 1

Policy implementation expectations

Initial baseline expectations

- CCOs establish targets for EHR adoption, focusing on each provider type (physical, behavioral and oral health).
- CCOs work with their key contracted providers to remove barriers to EHR adoption and use.

Transformational expectations

- All physical, behavioral and oral health providers adopt and use robust EHRs. Robust EHRs meet the latest Office of the National Coordinator (ONC) certification standards that are achievable based on the practice area.
- All patients can access their health information electronically via an EHR portal.

Examples of accountability

- CCO sets and reports on targets for percentage of providers adopting and using EHRs, broken out by provider type (physical, behavioral, oral).
- CCO sets and reports on targets for percentage of providers adopting and using 2015 Certified EHR Technology, broken out by provider type.
Policy #33

*Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology* that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications

**Intended impact**

Behavioral, oral and physical health providers have the information needed to deliver better care, patients get the right care at the right time, and costly hospital use is reduced.

Increasing the adoption of HIE among priority providers in support of priority populations will support care coordination and improve patient care, particularly around integration and coordination across physical, behavioral and oral health care.

**Policy implementation considerations**

- Timing: This would be a contractual obligation starting with 2020 contracts, adjusting current CCO contracts to specify BH, oral and physical providers.

- OHA would expect CCOs to evaluate current HIE use and opportunities, set targets and report on progress – phased over 5 years.

- OHA TA could be useful. OHA is currently supporting TA for hospital event notifications related to the CCO disparity metric.

- Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIE where possible.

- Consideration: OHA currently financially supports PreManage directly for CCOs on a voluntary basis (all CCOs are now using PreManage either directly or through regional HIE), and nearly all CCOs are paying to extend PreManage to their key clinics, including BH, oral and physical.

- OHA is launching the HIE Onboarding Program that will support initial costs to connect key clinics (including BH, oral, physical) to community-based HIEs (currently, there is one contracted community-based HIE).

- **Pro**: Reduction in ED utilization. Increased health outcomes for members with complex care needs and mental illness. Increased care coordination between CCO and contracted clinics.

- **Con**: Providers may lack resources to participate in HIE or lack staff capacity to implement workflow changes needed.

- **Feedback**: Interest in sharing costs or leveraging OHA financial support to help CCOs in this area; OHA can support education/TA for HIE and for SUD info-sharing policies; concerns about this requirement going beyond adoption of PreManage and requiring CCOs to support multiple HIE platforms, which would have less utility for providers.

- Consideration of all partners that need to be in HIE including families, caregivers, SDOH entities, jails, etc.
Policy implementation expectations

Initial baseline expectations

• CCOs support contracted physical, behavioral and oral health providers’ access to electronic health information exchange options to connect disparate care providers for care coordination.
• CCOs increase contracted providers’ access to HIE options. This policy option does not require providers to use any particular HIE option or tool, or any HIE at all. Choosing an HIE option is a business decision for the provider.
• CCOs extend access to HIE to behavioral and oral health providers.
• CCOs set targets keeping in mind their provider networks, and CCOs with more dispersed provider networks with many smaller providers (who may face greater barriers to technology use) may set more modest targets.
• CCOs use Oregon’s statewide hospital event notifications system or other hospital event mechanisms to inform care coordination and population health management. CCOs have the option to use the statewide EDIE/PreManage tool, or any other tool or resource that provides hospital event notifications.
• CCOs ensure their contracted providers have access to timely hospital event notifications to help them manage populations and target interventions and follow up. CCOs have the option to provide access via the subscription to the statewide EDIE/PreManage tool, or any other tool or resource that ensures contracted providers have access to timely hospital event notifications.

Transformational expectations

• CCOs and contracted physical, behavioral and oral health providers have access to comprehensive electronic patient data needed to support coordinated care and population health efforts.

Examples of accountability

• CCO sets and reports on targets for percentage of providers health information exchange for care coordination, broken out by type of health information exchange, and type of provider (physical, behavioral, oral).
• CCO sets and reports on targets for percentage of providers with access to timely hospital event notifications broken out by type of provider (physical, behavioral, oral).
• CCO reports CCO rates of use of hospital event notifications (may be % of active users, days logged on to tool, etc.).
Policy #34

Require CCOs to demonstrate necessary information technology (IT) infrastructure for supporting VBP arrangements, including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and support contracted providers so they can effectively participate in VBP arrangements.

Intended impact

CCOs are better able to achieve population health outcomes at lower costs. Providers engaging in VBP contracts have the information and support needed from the CCO to manage financial risk and improve care.

Policy implementation considerations

- CCOs would be encouraged to take advantage of collaborative efforts related to data aggregation, electronic clinical quality measures, and other VBP data needs. In their RFA response, CCOs would show they meet an initial minimum and explain how, during the first year of the contract, they will ensure they have sufficient HIT capabilities for VBP and population health management.
- Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIT where possible.
- OHA should consider TA/support for CCOs in this area – possibly through Transformation Center/TA Bank and/or OHIT.
- **Pro**: Without data and HIT systems, CCOs cannot deliver on VBP. If CCOs are expected to become more sophisticated around VBP in 2.0, they must have the skills and systems to do so. Ability to use clinical data/metrics is critical to moving toward triple aim.
- **Con**: CCOs face challenges in getting and using clinical data – may need HIE strategy to help with this. Some providers may lack the capability to use CCO data effectively. Possible proliferation of systems across CCOs and payers.
- **Feedback**: Multiple stakeholders expressed support for this – very important for moving into the future. This will be a heavy lift for some of the current CCOs, including obtaining clinical data. Some CCOs will likely need TA and support.

Dashboard

| Fulfills state or federal mandate | ☑ |
| Priority area: | VBP/HIT |
| How heavy is lift? | ☯ ☯ ☯ |
| How large is impact? | ☯ ☯ ☯ |
| 2019 POP planned | ☑ |
| Requires legislation | ☑ |
| Recommendation for OHA | ☑ |
| **Exists in contract; needs strengthening or improved monitoring** | ☑ |
| **Health equity impact assessment** | ☑ |
| **May require OHA TA support** | ☑ |
| **Increases transparency** | ☑ |
Policy implementation expectations

Initial baseline expectations

• CCOs demonstrate they have the health IT tools necessary to:
  a) risk stratify populations and target interventions to ensure patients and communities receive the care they need to stay healthy;
  b) manage value-based payment (VBP) arrangements; and
  c) support contracted providers with VBP arrangements, for example, by providing CCO claims or cost data and information on provider performance on VBP metrics and which patients are attributed to the provider.
• If CCOs cannot demonstrate they have the health IT tools necessary, they provide a detailed roadmap of their plans to have such tools within the contract period.
• CCOs demonstrate their clinics with VBP arrangements have some HIT/data support in place.
• CCOs may collaborate on these efforts and/or leverage statewide or regional efforts.

Transformational expectations

• Individuals at risk for poor outcomes are identified and interventions are targeted and monitored to improve outcomes.
• All contracted providers engaging in VBP arrangements with CCOs have the data, IT tools and supports needed to manage their VBP obligations.
• All CCOs have the data, IT tools and supports needed to manage their VBP arrangements and support the increased expectations around VBP.

Examples of accountability

• Each CCO’s HIT Roadmap (based on RFA response) includes milestones and monitoring to ensure CCO HIT and data capacity improve over time to support VBP.
• CCOs report (or OHA requests via survey from clinics) percentage of contracted providers with a VBP arrangement who have the data, tools and supports needed to manage their VBP arrangements.
Policy #35

Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources.

Intended impact

Streamline and enhance OHA’s capacity for contract management and compliance.

Increase understanding of CCO effectiveness and provide improved support to CCOs over contract issues.

Policy implementation considerations

- TBD – would require assessment of current resources and possible reallocation of existing capacity and/or new capacity.
- In addition to monitoring, tracking and ensuring compliance with CCO 2.0 policies, this team would be tasked with oversight of recommended policies that already existed in contract, but have not been achieved as intended and need strengthening or improved monitoring.
- Enhancing compliance around CCO contracts is a natural next step from CCO 1.0 – during the first contract, CCOs were building new businesses and the priority was around ensuring the model was successful. CCO 2.0 provides an opportunity to increase accountability around actual contractual obligations.
- State audits and program reviews have highlighted that OHA’s compliance monitoring needs significant improvement. Additionally, new federal managed care rules went into effect in 2018 that increase requirements for state compliance monitoring.

Policy implementation expectations

Initial baseline expectations

- OHA develops compliance infrastructure and identifies gaps in monitoring, defines roles and responsibilities, and provides clear direction to CCOs on performance expectations.

Transformational expectations

- CCOs are actively engaged in identifying and remediing deficiencies with OHA support and technical assistance to ensure consistent implementation of policy goals as defined in the CCO contract.

Examples of accountability

- OHA develops a clearly defined escalation path for non-compliance with contract or program requirements.
Policy #36

Shift mental health residential benefit to CCOs

Intended impact
Improve health care for adults with SPMI.

Policy implementation considerations
- Supporting efforts needed (a work group, additional development, standing up of new reports, etc.)
- Rate standardization is in process. Review of rates must be completed in one year and must precede transition of the benefit.
- HSD resources needed (project manager and analysts).

Required in 1115 waiver
- Needs significant development.
- Kids’ residential and SUD have already transitioned to CCOs. Mental health residential was scheduled in 2014 and a work group planned for transition, but it was postponed due to complexity and CCO and provider concerns.
- CareOregon supports.

Policy implementation expectations

Initial baseline expectations
- In Year 1, CCOs work with OHA as rate standardization is implemented and consider becoming early adopters to assure transitions are functional.
- In Year 2, OHA transfers the mental health residential benefit to CCOs.

Transformational expectations
- CCOs are responsible for the mental health residential benefit.

Examples of accountability
- Numbers of residential programs available in the CCO’s benefit package.
**Policy #37**

**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.

**Intended impact**

OHA has the flexibility and tools necessary to better manage patients with high-cost conditions, which will better enable OHA and CCOs to control program-wide costs of these patients.

**Policy implementation considerations**

Staff recommends establishing this reinsurance pool for CCO 2.0 subject to a detailed financial analysis and the legislative budget process.

- Initial study needed to assess financial viability, benefits, and costs of a state-backed reinsurance pool.
- Additional policy development ongoing related to potential need for legislation and the type of federal sign-off needed.
- Timeframe for implementation is Year 2+. Implementation could be phased in and program modified over several years based on experience.

Initial phase of implementation would be OHA responsibility.

- Legislation and budget authority are needed to fully launch program.
- Helps fulfil goals of keeping OHP clients in CCOs and not open card.
- Short-term benefits include spreading risk across CCOs and mitigating CCO risk associated with low-frequency, high-cost patients.
- Long-term benefits could include reduced costs from using program-wide purchasing power and better aligning PDLs.
- Connects to rate setting – removing catastrophic claims from rate-setting reduces rate volatility, especially for small CCOs.
- DCBS received 1332 waiver to establish a reinsurance program for private carriers that could be a resource.

**Policy implementation expectations**

**Initial baseline expectations**

Program implementation phased in:

- CCOs are better protected from unforeseen and unavoidable costs associated with high-cost patients and high-cost medical conditions.
- A program-wide reinsurance pool assists the rate setting process and reduces the volatility of rates associated with some patients.
Recommended policies: Begin implementation Years 2–5

**Transformational expectations**

Long-term expectations after fully phased in:

- OHA uses program-wide purchasing power to reduce costs associated with some high-cost treatments and/or patients.
- Program-wide reinsurance costs decline over time as program ramps up and purchasing power is leveraged; savings benefit CCOs and state taxpayers instead of private reinsurers.

**Examples of accountability**

- Patients with specified medical conditions have reduced cost and/or improved care delivery.
- CCO financial performance shows less volatility due to reinsurance costs being managed at the program level.
Policy #38

Ensure continued CCO solvency by establishing solvency thresholds at a level that adequately considers the financial risks CCOs face and strengthening OHA’s solvency regulation tools

Intended impact

Members, providers and OHA are better protected from insolvency risk. RBC thresholds ensure CCOs hold adequate financial resources to protect against insolvency. Additional solvency regulation tools, similar to those available to DCBS, would allow OHA to prevent or meliorate insolvency events.

Policy implementation considerations

- Consider increases to CCO reserves over the five-year contract.
- RBC option is connected to proposed move to NAIC reporting standards.
- As an alternative to increasing reserve requirements, a guaranty fund could add a safeguard by drawing on CCO resources if a CCO is impaired or insolvent.
- Granting OHA administrative and judicial tools for dealing with financially impaired CCOs, similar to those of DCBS, could allow OHA to rehabilitate a CCO nearing insolvency.
- CCO insolvency would be highly disruptive to members and providers and could expose OHA to risk of having no CCO in an area.
- RBC thresholds need to be set for Medicaid carriers (CCOs) if this tool is used to assess financial risk and reserves levels.
- Policy option is connected to potential for NAIC/RBC requirements to increase required reserves for CCOs.
- OHA lacks the tools that DCBS possesses to intervene with a financially weak CCO. A “guaranty fund” mechanism could allow for rehabilitation of an impaired CCO, or spread the losses of an insolvent one, without requiring advance capitalization.
  a) CCOs raised concerns with increased reserve-holding requirements on the grounds they would reduce investment in local communities.
  b) Idea based on guaranty provisions in the insurance code.
  c) Provisions could lower required RBC thresholds for CCOs that could otherwise require increased reserves

Dashboard

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<th>Fulfills state or federal mandate</th>
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<tbody>
<tr>
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<td>How heavy is lift?</td>
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<td>How large is impact?</td>
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<td>Potential to impact children</td>
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<tr>
<td>✔ May require OHA TA support</td>
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<tr>
<td>Increases transparency</td>
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Policy implementation expectations

Initial baseline expectations

CCO requirements may be phased in:
- CCOs agree to meet RBC-based solvency standards.
- RBC-based solvency standards are evaluated for the Oregon Medicaid CCO program and ensure CCOs have adequate resources to maintain financial solvency.

Transformational expectations

Long-term:
- Program-wide CCO financial resources are available via a “Guaranty Fund” if a CCO is impaired or insolvent.

Examples of accountability
- CCO-specific RBC levels are publicly available.
Policy #39
Identify, promote and expand programs that integrate primary care in behavioral health settings (Behavioral Health Homes)

Intended impact
Improve health outcomes; increase access to BH and PH.

Policy implementation considerations
- Standards and ORS were completed under SB 832.
- Would require hiring 3 FTE.
- Work would be within PCPCH program in HPA.
- SB 832 created the BHH, but there was no funding to implement.
- This would enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. This will improve whole health outcomes for individuals.
- Association of Oregon Community Mental Health Providers supports.

Policy implementation expectations

Initial baseline expectations
- CCOs include behavioral health homes (BHHs) in their network to the greatest extent possible. CCOs assist providers within delivery system to establish BHHs.

Transformational expectations
- Behavioral health homes enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. This improves whole health outcomes for individuals.

Examples of accountability
- OHA has an implementation and compliance team, based on the PCPCH team, to monitor.

Dashboard

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<th>Priority area:</th>
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✔ 2019 POP planned
✔ Requires legislation
Recommendation for OHA
 Exists in contract; needs strengthening or improved monitoring
✔ Health equity impact assessment
✔ Potential to impact children
✔ May require OHA TA support
Increases transparency
**Policy #40**

CCOs, with the support of OHA, to require providers to implement trauma-informed care practices

**Intended impact**

Improve health outcomes for all Oregonians; increase number of providers and organizations adopting trauma-informed care principles; reduce the impact of ACEs and trauma for all Oregonians.

**Policy implementation considerations**

- Create OHA-wide trauma-informed approach policy.
- In Year 3, CCOs will require subcontractors/providers to receive training in trauma-informed care approaches.
- CCOs will require providers of behavioral health services to use screening and assessment of trauma to develop and inform individual service and support plans.
- Work to sit in HSD and HPA.
- House Concurrent Resolution (2017) directs state agencies to work together to become trauma informed. Oregon is a national leader in trauma awareness and trauma-informed approach.
- Trauma Informed Oregon in full support of this policy.
- Legislation may be needed.
- Many CCOs are already implementing.
- Requires planful, thoughtful, coordinated response.

**Policy implementation expectations**

**Initial baseline expectations**

- In Year 3, CCOs require subcontractors/providers of behavioral health services to receive training in trauma-informed approaches.
- CCOs require providers of behavioral health services to use screening and assessment of trauma to develop and inform Individual and service and support plans.
- CCOs require outcome-based tools for behavioral health services that reflect best/emerging practice.

**Transformational expectations**

- Increase number of providers and organizations using trauma-informed care principles.
- Reduce the impact of ACEs and trauma for all Oregonians.

**Examples of accountability**

- Subcontractors/providers implement standards of practice found at TIO.org.
- Subcontractors/providers submit training records.
- OHA and CCO audit providers’ use of training, screening/assessment and outcome-based tools.

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**Dashboard**

Fulfills state or federal mandate

Priority area: BH

How heavy is lift? ☀️曜曜

How large is impact? ☀️曜曜

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Policy #41

Develop an incentive program to support behavioral health providers’ investments in electronic health records and other related HIT (feasibility depends on 2019 legislative session)

Intended impact

If OHA is able to implement an incentive program, the result would be BH providers have better EHRs allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements. CCO participation in prioritizing BH providers for these incentives helps ensure the funding is targeted well and achieves the desired impact for our Medicaid population.

Policy implementation considerations

- **Timing**: Following 2019 legislative session – if OHA is successful in getting POP/funding approved.
- **Likely process** would include leveraging CCO input through an existing work group (CCO HIT Advisory Group [HITAG]) on development and oversight of the incentive program, as well as a CCO engagement process to identify high priority BH providers. Ideally OHA would make incentives available in early–mid 2020.
- **OHIT** would staff this program and the CCO HITAG/CCO engagement.
- **Pro**: BH providers are incentivized to improve their HIT to support integration and care coordination. CCO involvement is needed to ensure OHA understands local community needs when making decisions about priority providers; incentive dollars make a bigger impact.
- **Con**: Providers may lack staff capacity to implement workflow changes needed for effective use of EHRs. Technical assistance and support from CCOs or OHA may be needed to be effective.
- **Feedback**: Strong support among BH providers for incentive program, which would help close the “digital divide” that behavioral health providers face. These providers have been largely left out of federally funded programs that support EHR adoption and use.
Recommended policies: Begin implementation Years 2–5

Policy implementation expectations

Initial baseline expectations

- If funding is approved, OHA develops and implements this incentive program.
- CCOs consult with communities and advise OHA about how to prioritize use of limited funds.

Transformational expectations

- All BH providers in Oregon have the robust EHRs and related HIT needed to engage in care coordination and VBP arrangements.

Examples of accountability

OHA will monitor the impact of this program by assessing the following types of information (not necessarily a CCO reporting requirement):

- Percentage of BH agencies with robust EHRs
- Percentage of BH agencies submitting data to the Measures and Outcomes Tracking System (MOTS) from their EHRs (or percentage of Medicaid members receiving BH care whose data is submitted to MOTS from an EHR)
- Percentage of BH agencies providing data from their EHR electronically as part of sharing information for care coordination
- Percentage of BH agencies reporting that they have the data, IT tools and supports needed to participate in VBP arrangements.
**Policy #42**

Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in person, regardless of a patient’s geographic setting (rural or urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (it does not require CCOs to add new providers to ensure telehealth is broadly available) but focuses on coverage.

**Intended impact**

Reduced barriers to telehealth services, better access to specialty and behavioral health care in frontier and rural areas, and reduced health disparities based on geographic location.

**Policy implementation considerations**

- The rule allowing for coverage of telemedicine services by CCOs is already in place and would need to be updated. HSD would lead this; OHIT could play a consultative role.
- This is a limited, technical fix intended to bring CCOs into alignment with telehealth coverage rules for private payers. Currently, private payers are required to cover telehealth services provided by a contracted provider if they would have covered the service if the contracted provider had provided the service in person. CCOs, in contrast, are currently allowed to cover telehealth services in that situation, but may deny coverage. Many CCOs have already aligned with private payer rules; this policy option would provide uniformity by requiring CCOs to cover telehealth services in the situation described above, just as private payers are required to do. Due to lack of clarity about this policy option, OHA will delay implementation to allow for further stakeholder engagement.
- **Pros:** Better access to care, reduced barriers for telehealth options, more consistency across CCOs.
- **Cons:** Some providers and patients lack the systems to engage in telemedicine consults through video. Some remote areas of Oregon lack the high-speed broadband capabilities that would enable telehealth.
- **Feedback:** Multiple stakeholders expressed support for telehealth. Some input that the policy should be flexible to allow exceptions for services not clinically indicated for telehealth, and that quality of telehealth services should be monitored. Telehealth services are frequently needed when there are transportation barriers, or other SDOH-related issues (for example, poverty) creating a hardship for members to access services in person. BH services are especially suited for telehealth approach and are used in Oregon in some rural areas. Concerns about patients needing a private setting when engaging with telehealth.

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**Dashboard**

- **Fulfills state or federal mandate**
- **Priority area:** BH/HIT
- **How heavy is lift?** 🌒🌒〇〇
- **How large is impact?** 🌒〇〇〇
- **2019 POP planned**
- **Requires legislation**
- **Recommendation for OHA**
- **Exists in contract; needs strengthening or improved monitoring**
- ✔️ **Health equity impact assessment**
- ✔️ **Potential to impact children**
- ✔️ **May require OHA TA support**
- **Increases transparency**
Policy implementation expectations

Initial baseline expectations

- CCO would be required to cover services provided via telehealth if:
  a) A CCO’s contracted provider provides a service via telehealth* during an encounter, and
  b) The CCO would cover that service if the contracted provider had provided the service in person during the encounter.
- CCOs are not expected to have specific levels of telehealth services available (for example, no network adequacy for telehealth specifically).
- If it is not clinically appropriate to provide the service via telehealth, CCOs are not required to cover the service.

*Including asynchronous communication in some circumstances.

Examples of accountability

- Telehealth services are covered as required.
- If CCO fails to meet this requirement, technical assistance and/or a corrective action plan may be warranted.
Policy #43

Continue CCO role in using HIT for patient engagement and link to health equity

Intended impact

Patients better understand their health issues and treatment plans. Health disparities are addressed through targeted HIT-based programs that take into consideration member demographics, language, accessibility and literacy.

Policy implementation considerations

- **Timing:** This would be explored after Year 1, with the goal being to adjust current CCO contract requirements to align with the health equity plan process.
- **Accountability mechanism** will relate to the health equity plan. This has been a component of the TQS in the past.
- **OHA TA** could be useful.
- **OEI** would lead and **OHIT** would play a consulting role, and would seek to support CCO efforts around HIT for patient engagement where possible.
- **Pro:** Better patient engagement and health outcomes.
- **Con:** Some providers lack the systems to engage with their patients electronically. Some systems may lack the ability to support needed language and accessibility modifications.
- **Feedback:** Need support and guidance from OHA to help CCOs understand and leverage efforts in place (for example, PCPCH requires patient portals), not sure how to incentivize members to use HIT. Some patients have multiple patient portals, which can be onerous and confusing. Patient control of their own health information is important – including the ability to correct information.

Policy implementation expectations

Initial baseline expectations

- CCO identifies at least one initiative in its health equity plan that uses HIT to support patient engagement.
- CCO asks vendors for cultural and linguistic accessibility when discussing bringing on new tools for patient engagement (OHA is aware that accessible tools may not currently exist in the market; the requirement is simply to ask to demonstrate interest in such tools).

Transformational expectations

- Providers make patients’ full records available to them; patients are aware of the availability and know how to access it through patient portals.
- High risk CCO members are engaged in their own care by using HIT apps and tools to work with their providers.
- HIT tools for patient engagement meet CCO members’ cultural and linguistic needs.
Examples of accountability

- Health equity plan contains an HIT component as required.
- Health equity plan includes attestation that CCOs will ask vendors about cultural and linguistic accessibility in tools.
- CCO engages in OHA TA as needed to better understand the potential and scope of HIT for patient engagement or if HIT component of health equity plan is inadequate.
Policies for future exploration

A. **Clinic-level health equity plans.** OHA should explore a model wherein providers identify disparities, and the health equity workplan is generated at the clinic level (with CCO/OHA guidance). This is a multi-year approach to addressing health disparities at the clinic level (model from Minnesota). Providers are engaged at the clinic level to identify what they see as the greatest health disparities within their practice (Year 1), to create a plan for measuring those health disparities (Year 2), and to measure and report on those disparities and create plans for reducing the disparities (Year 3). This type of model could potentially be tied to or inform CCO health equity plans in the future.

B. **Dental care organizations.** CCOs should explore how their contracts with various dental care organizations or other providers of dental care inhibit their ability to provide integrated oral health care to members. Several CCOs work with clinics with co-located oral health care that cannot provide dental care to all the CCO’s members because not all the CCO’s dental contractors contract with the clinics. This creates a significant barrier to coordinated, patient-centered care.

C. **Health care interpretation incentives.** OHA should explore requiring CCOs to develop a system to incentivize or reimburse providers that use qualified or certified health care interpreters. As health care providers try to remain competitive and manage cost, offering them financial incentives for providing adequate language access services is necessary. It is unrealistic to expect health care organizations alone to shoulder the burden of providing the services, and it is a disincentive to the provision of language access services. Models for providing payment for language services include providing additional payments to health care organizations that take care of a disproportionate share of patients with limited English proficiency such as FQHCs, CHCs, MHCs, CAHs, CMHs and others

D. **Oral health policy.** OHA should explore developing an oral health policy recommendation parallel to the one that requires CCOs to be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity, including ensuring an adequate provider network, timely access to services, and effective treatment.

E. **Quality and appropriateness of language services.** OHA has encouraged CCOs to use certified and qualified interpreters. CCOs and provider networks have adopted different approaches to the provision of language services. To be able to meet the immediate language support needs, CCOs have contracted with telephonic or video-based interpreter services. These services may or may not use certified or qualified health care interpreters. In addition, members are not able to choose what modality of language services meets their needs. Some may prefer telephone or in-person interpretation for different types of encounters but may not be aware they can voice this preference when they present for care. Because video and telephone interpretation limits the ability to recognize and respond to emotional and physical cues, providers and members may find in-person interpretation more appropriate than remote interpreting, especially in complex, sensitive situations. Some aspects of enhancing this work are included in the health equity infrastructure policies (see Policy #5), but additional ongoing work will create a more robust system of culturally responsive language access.
Policies not recommended at this time

A. **COST:** Expand/revise existing risk corridor programs.
   *This option is not being recommended because of the recommendation to examine in greater detail the idea of establishing a program-wide reinsurance program.*

B. **COST:** Incentivize health care services with highest clinical value by rewarding their use in rate setting.
   *This option has been incorporated as an aspect of variable profit implementation strategy.*

C. **BH:** Develop a train-the-trainer investment in BH models of care.
   *This option is not being recommended.*
Dashboard Legend

### Feasibility – In general, how heavy is the “lift” for this policy across systems?

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<th>Symbols</th>
<th>Description</th>
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<tr>
<td>☀️ ☀️ ☀️ ☀️</td>
<td>Generally easy/straightforward to implement; little to no additional work or resources required; is already part of the plan/expectation.</td>
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<tr>
<td>☀️ ☀️ ☀️ ☀️</td>
<td>Requires moderate increase in staff time, resources, development or funding; could face some challenges.</td>
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<tr>
<td>☀️ ☀️ ☀️ ☀️</td>
<td>Will be a challenge to implement and will require new resources (funding, staff time, significant development, work groups, etc.)</td>
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### Impact – In general, how much does this policy move the needle in achieving the goals of the coordinated care model?

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<tr>
<td>☀️ ☀️ ☀️ ☀️</td>
<td>Plays a supporting role, offers some clarity or direction; will have a small impact on business practices.</td>
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<tr>
<td>☀️ ☀️ ☀️ ☀️</td>
<td>Medium impact; policy will strengthen Oregon’s direction and we’ll see some type of effect across the state.</td>
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<tr>
<td>☀️ ☀️ ☀️ ☀️</td>
<td>Fundamental to moving the needle in this area of the model; significant impact or transformational.</td>
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The health equity impact assessment check mark indicates the policy was assessed for a health equity impact. Further details on the result of that assessment are available in Appendix B, the health equity impact assessment.

✔️ | Health equity impact assessment
Appendix B:

CCO 2.0 Health equity impact assessment
CCO 2.0: Infusing equity throughout the policy development and implementation process

The Oregon Health Authority (OHA) is a state government leader in carrying out both internal and external programs that apply equity, diversity and inclusion principles. OHA’s Office of Equity and Inclusion (OEI) leads, advises and oversees strategic initiatives that equip OHA to meet the needs of Oregon’s increasing cultural and linguistic diverse population and underrepresented populations.

OEI has been an active participant in the state-wide process to design the next phases of work in health systems transformation and coordinated care organizations (CCOs). This process, per direction by the Oregon Health Policy Board (OHPB) at their July 2018 meeting an assessment of the health equity impact, includes:

- Policy analysis
- Research
- Development, and
- Public input and discussion.

A Health Equity Impact Assessment (HEIA)\(^1\) It is a tool that indicates how a program, policy or similar initiative will impact population groups in different ways. OEI took some key aspects of the HEI tool and performed a desktop assessment informed by:

- Literature review
- Results of the CCO 2.0 public input process, and by
- Feedback provided by the subject matter experts (SME), culturally specific community-based organizations (CBOs), the Medicaid Advisory Board (MAC), and by the OHPB’s Health Equity Committee (HEC).\(^2\)

The HEIA tool is intended primarily for application during the design phase of an initiative (pre-implementation). It is also a living document, with health equity impacts identified as the design of the initiative evolves. The current version may not reflect new changes in the policy options due to time constraints. However, the HEIA will be updated again once all changes are in place, prior to the OHPB’s October 2018 meeting.

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\(^1\) Conducting a Health Equity Impact Assessment (HEIA): MOHLTC tool  
https://www.nccmt.ca/knowledge-repositories/search/146

\(^2\) CCO 2.0 recommendations https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx
Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018

The desktop assessment is an evaluation tool that looks back to examine whether each policy option is capitalizes on opportunities to improve health equity or whether each policy will result in widening health disparities.

The HEIA has five primary purposes:\n
1. Help identify potential unintended health impacts (positive or negative) of a planned policy, program, or initiative on vulnerable or marginalized groups within the general population.
2. Help develop recommendations as to what adjustments to the plan may mitigate negative impacts as well as maximize positive impacts on the health of vulnerable and marginalized groups.
3. Embed equity across an organization’s existing and prospective decision-making models, so that it becomes a core value and necessary criterion to be weighed in all decisions.
4. Support equity-based improvements in program or service design, i.e., through considerations such as "How must this program be adjusted to meet the needs of specific populations?"
5. Raise awareness about health equity as a catalyst for change throughout the organization, so decision-makers develop "stretch goals" through considerations, such as:
   - How can we include more people in this program, especially people often missed?
   - What are the systemic barriers potentially impacting the opportunity for equitable health outcomes?
   - Are we effective, in including people facing the greatest disparities and addressing inequities?

CCO 2.0 Policy options Health Equity Impact Assessment process

Early in August 2018, OHPB directed OHA to work with the Health Equity Committee (HEC) and ensure an equity lens was applied to each policy option presented. The committee had the opportunity to engage in the CCO 2.0 earlier in the policy development process. At the HEC April 2018 OHA policy staff presented the Social Determinants of Health and Behavioral Health Policy Options meeting. The Committee provided a list of recommendations to the policy team.

Given the timing of the request from OHPB, OEI staff was only able to perform a desktop assessment of policy options that presented new strategies for Year 1 and Year 2+ for CCO 2.0. HEC members had the opportunity to submit further comments.

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3 The Health Equity Impact Assessment (HEIA) Tool, and Workbook updated in 2012 by the Ontario Ministry of Health and Long-Term Care (MOHLTC) in partnership with the public health sector and health service providers.

4 Health Equity Committee Recommendations on Social Determinants of Health and Health Equity and Behavioral Health Recommendations (June 2018)
https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx
Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018

The intention of the initial OEI CCO 2.0 desktop assessment performed in early August was to help CCO 2.0 the policy team maximize the positive impacts of each policy option and reduce unintended negative consequences that could potentially widen health disparities between population groups. In identifying those impacts, recommendations were made to:

• Adjust the strategies
• Mitigate adverse impacts, and
• Maximize positive results of the policy.

The desktop assessment of the policy options sought answers to the following questions:

• What is the intent behind this policy or strategy?
• Who benefits and who does not?
• If there is potential for unintended consequences, what are the mitigation strategies?
• Are there critical recommendations for implementation based on the public input that should be highlighted?

Based on the desktop assessment, if a particular strategy was highlighted with potential for unintended negative consequences on health equity, the Topic Area Teams (TAT) working on that policy option was asked to provide mitigation measures. In the assessment, and to ensure clarity, OEI staff used the definition for health equity in the CCO 2.0 Policy Development Glossary and Definitions document available on the CCO 2.0 website. The definition states “Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination.”

OEI shared a draft of the HEIA with policy leads of each CCO 2.0 TAT early in the process. OEI saw this as an opportunity to engage from the beginning with policy teams in critical dialogue about policies and strategies and bring an equity and inclusion perspective to the internal CCO 2.0 policy development process. Beyond helping identify unintended health equity impacts of decision-making (positive and negative) on specific populations, the exercise proved helpful in accomplishing the following:

1. Better ensuring equity at all steps of the policy development process, including considering equity in the policy implementation phase; and
2. Building capacity and raise awareness about health equity throughout OHA as an organization.

The process itself provided opportunities for inclusion and for learning the languages of equity fostering shared understanding and greater collaboration.

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Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018

In September 2018, Health Equity Committee Co-chairs submitted additional feedback based on their analysis of CCO 2.0 Policy Recommendations Straw Proposal presented to the Oregon Health Policy Board (OHPB) on Aug. 7, 2018. They also shared with OHPB that they had provided input on the Health Equity Impact Analysis conducted by OEI and were in full support of the analysis.

As stated before, as policy options continued to adjust, the HEIA was updated to ensure alignment with the policy development process every step of the way. As the process for policy development ends, the HEIA continues to evolve. This recently updated version of the HEIA will be presented to OHPB in their October 2018 meeting and includes “equity considerations for policy analysis” and “equity considerations for policy implementation.”

Stakeholder feedback pointed out that the CCO 2.0 policy proposals had the potential to advance (or inhibit) equity depending on how they were implemented. However, “policy options alone cannot achieve equity, and rather it is through the implementation of policy options where true transformation can be realized.” OEI decided then to widen the scope of the HEIA adding, “Equity considerations for implementation.”

HEIA impact and major themes

The Health Equity Impact desktop assessment performed in the CCO 2.0 policy development process was informed by available literature, stakeholder feedback and community input. It is important to note that the review process itself had to be adapted to be able to respond in flexible and timely ways to the needs of the project team. In other words, even though, CCO 2.0 policy options have been assessed for their impact on health equity continuously, the extent this initial review could be expected to inform subsequent activities is limited. Future steps related to CCO 2.0 will have to include a separate mechanism for looking at the potential health equity impact of the items proposed.

The desktop equity impact assessment identified three significant themes in the policy options development and implementation: Changing policy development

- HEIA provided the opportunity to elevate and discuss policy options with an equity lens. For instance, the Value-Based Payment TAT had developed a mitigation plan to ensure that CCO implemented payment models that did not have unintended consequences for priority populations and those with complex health care needs. The HEIA had further questions about the

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6 Health Equity Committee Co-Chairs Recommendations to OHPB. September 7th, 2018 https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx
mitigation plans, since from an equity perspective, there is a need for reassurance that members that need more complex care, or those who require extra resources such as Limited English Proficiency (LEP), will not be left behind. The process provided the VBP TAT an opportunity to address these additional concerns and enriched the planning process.

**Consolidating understandings of equity**
Agreement among policy team that the HEIA was able to bring potential health equity impacts to the fore of the policy development and ensure health equity items were addressed in each version of the CCO 2.0 straw models.

**Enabling discussion of alternatives**
The HEIA was able to help TATs consider different ways of achieving policy options objectives. The addition of the HEIA as an essential step of the policy development allowed for formality in the process of generating alternatives that address health inequities and ensure health equity is considered earlier in the formulation of policy options.

**How to read the assessment**
In the initial HEIA shared with OHPB in September 2018, policy options were marked:
- Positive (potential for positive health equity impact)
- Neutral (no positive or negative effect could be identified at this point)
- Negative (potential for negative unintended health equity impact), or
- Both, positive and negative.

All policy options with the potential for unintended negative effects on health equity were flagged. Every policy flagged triggered a mitigation plan from TATs. Mitigation plans were added to the first version of the HEIA, and then, the policy options narrative. The HEIA intended to provide a quick visual to decision makers, not to halt a policy from developing but, to request a deeper dive into their development. As policy options changed, and mitigation plans were incorporated into the policies, the content of the HEIA evolved. Straw models reflected those changes.

This version of the HEIA includes all the recommended policy options for year 1 and Years 2-5. In this version, OEI recognizes the need to assess health equity impacts on policy development and implementation.

Equity considerations on policy implementation are vital. In this step policies work through those responsible for the implementation of the service or strategy and their interactions with the intended beneficiaries of those changes. Implementation is not just the mechanical and straightforward transfer of policy intent into practice. In some cases, under the column “considerations
for policy implementation” CCO 2.0 TATs added details around policy implementation that resulted from the initial HEIA version. Those details are easily identifiable as they reflect the process of implementing and achieving the policy objective (See policies 1-11). In other cases, this version of the HEIA contains equity considerations for policy implementation that aim to guide OHA and CCOs on certain implementation aspects of the policy using an equity lens.

### Recommended policies year 1

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<tr>
<th>#</th>
<th>Policy</th>
<th>Equity considerations for policy development</th>
<th>Equity considerations for policy implementation</th>
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<tbody>
<tr>
<td>1</td>
<td>Implement HB 4018: Require CCOs to spend a portion of net income or reserves on social determinants of health (SDOH) (this includes supportive population health policy and systems change), and health equity and health disparities, consistent with the CCO community health improvement plan (CHP)</td>
<td>CCOs and OHA should consider that communities may not always have sufficient service capacity or supply to meet SDOH need. However, through SDOH spending, CCOs can increase capacity among community partners. This policy requires careful understanding of availability of SDOH supports and capacity to meet the needs of the CCO service area. In addition, it is important to ensure that the policy is sufficiently flexible to allow spending to be used to build the infrastructure and capacity needed to address SDOH. OHA should consider potential use of integrated information technology, to formally coordinate services between health care, public health and social service organizations.</td>
<td>Implementation of this policy will include a mechanism to measure the impact of SDOH investment in the community. OHA will also explore options for implementation to include sharing of best practices. Technical assistance (TA) from OHA is also needed to build understanding among the health care provider network regarding SDOH referrals, screening, etc. CCOs should strongly consider that any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities. At implementation, CACs and other community groups such as Regional Health Equity</td>
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<td></td>
<td>will seek to build in a specific amount of SDOH and Health Equity investment intended to advance CCOs’ efforts to address their members’ SDOH and establish their internal infrastructure and processes for ongoing reinvestment of a portion of net income or reserves in social determinants of health and health equity.</td>
<td>Note that policies that improve the overall social and economic well-being of individuals and families will reverberate across a varied range of health outcomes and help to achieve health equity.</td>
<td>Coalitions, should be engaged at every step, to help inform policy and increase transparency. In addition, when implementing this policy, CCOs should consider adding public education components at the community level to educate the public about the importance of the social determinants of health. This strategy could be used to bolster member and community empowerment and shared decision making. CCOs will be expected to engage tribes in this work and in decision-making processes about SDOH and health equity spending.</td>
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<td>2</td>
<td>Increase strategic spending by CCOs on health-related services (HRS) by:</td>
<td>Consumer perspectives, in this case, the CAC, can assist in making health information more balanced and relevant to patients, and provide the opportunity to listen to the diversity of consumer voices.</td>
<td>At implementation, OHA plans to provide TA opportunities for CCOs to share lessons learned and best practices. As general consideration that could be applied to many of the current recommended policy options for CCO 2.0 about community engagement process is that it is best practice that those processes should be designed to meet unique community needs. OHA should consider developing a framework for CCOs on community engagement. A framework can</td>
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<td></td>
<td>• Encouraging HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans; and</td>
<td></td>
<td>include a role for the CAC and tribes or Tribal Advisory Committee if applicable (see policy #4d) in making decisions about how</td>
</tr>
<tr>
<td>Community Benefit HRS Investments are Made. Community benefit HRS investments are made.</td>
<td>Help guide CCO community engagement activities and ensure that critical considerations about health equity and SDOH are consistently and meaningfully being utilized. OHA will consider providing TA to CCOs on implementation plans for HRS community benefits and inviting community organizations that CCOs have included as part of their community engagement plans to participate.</td>
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| **a)** 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. | Sharing CCO financial resources with non-clinical and public health providers would support the sustainability of many programs that depend on grant funding to survive. “Clarifying the meaning of health equity can bring actors a step closer to identifying and promoting policies and practices that are likely to reduce inequities.”  
Performance measurement is an essential yet underused tool for advancing health equity. Measurement allows the monitoring of health disparities and assessment of the level to which Social Determinants of Health, Health Equity, and other key terms will be defined in the CCO contract. This policy option “encourages” rather than “requires.” This is due to concerns around federal waiver restrictions regarding requiring incentive payments to specific providers. In addition, there are concerns about requiring quality pool payments to a single provider type, which may have unintended consequences by setting a precedent for similar requirements for other provider groups. |
| **b)** Encourage adoption of SDOH, health equity and population health incentive measures to the Health Plan Quality Metrics Committee (HPQMC) and Metrics & Scoring (M&S) |  |

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<tr>
<th>Committee for inclusion in the CCO quality pool</th>
<th>Interventions known to reduce disparities should be employed. Performance measures can also enable stakeholders to assess the impact of interventions known to reduce disparities. Moreover, measures can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality.</th>
<th>Operational definitions will support the development of objectives and specific targets, determine priorities for the use of limited resources and support measurement of progress. OHA should consider that SDOH, population health and health equity incentive measures must include provider motivation in their design.</th>
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| **Strengthen community advisory council (CAC) and CCO partnerships and ensure meaningful engagement of diverse consumers through the following:**  
  a) Require CCOs to report on CAC member composition and alignment with demographics of Medicaid members in their communities, including:  
    1. The percentage of CAC comprised of OHP consumers  
    2. How the CCO defines their member demographics and diversity  
    3. The data sources they use to inform CAC alignment with these demographics  
    4. Their intent and justification for their CAC makeup, and | Meaningful community engagement and representation of consumers, public health, community-based organizations and local and tribal government in the CCO governance is critical to health systems transformation in Oregon. From an equity perspective, many of the communities and members have not historically had a voice in the planning and implementing of the programs and services they use. Decision-making structures must be able to create opportunities for community leaders to participate. In addition, community leaders must receive support, so they can represent their communities appropriately. OHA must ensure expectations for progress in meaningful community engagement are met. | At implementation, OHA will provide CCOs with an operational definition of meaningful community engagement. In addition, OHA will consider developing a framework for community engagement to be used in the process of policy development and implementation. A framework can help guide CCO community engagement activities and ensure that critical considerations about health equity and the SDOH are consistently and meaningfully being used. CCOs will be expected to demonstrate that it has mechanisms, resources and community partnerships in place to support recruitment and engagement of diverse CAC members. CCOs will also be expected to describe their plans for how they will meaningfully engage... |
5. An explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress
   
   a) Require CCOs to report CAC member representation alignment with CHP priorities (e.g., public health, housing, education, etc.) and,
   
   b) Require CCOs to report CAC member representation alignment with CHP priorities (e.g., public health, housing, education, etc.) and,
   
   c) Require CCOs have two CAC representatives, at least one being an OHP consumer, on CCO board.
   
   d) OHA is exploring adding a recommendation that CCOs use a Tribal Advisory Committee rather than simply ensuring tribal representation on the CAC. Development of this policy option is occurring through ongoing collaboration with Oregon’s nine Federally Recognized Tribes.
   
   e) OHA is exploring implementation options for a requirement that CCOs have a designated Tribal Liaison per 1115 Waiver Attachment I, “Tribal Engagement and Collaboration Protocol.” This is also occurring through ongoing collaboration with Oregon’s nine Federally Recognized Tribes. OHA is exploring implementation clear, and that reporting and tracking mechanisms to track the fulfillment of those expectations provide the information necessary for targeted TA to support improvements in demographic alignment and meaningful engagement.
   
tribes or a Tribal Advisory Committee, if applicable.

CCOs will be provided with guidance and clarity that inclusive decision-making structures require:
   • Transparency
   • Power balance
   • Diversity
   • Intersectionality
   • Equal decision-making authority
   • Inclusion early in the process
   • Attention to power or hierarchy dynamics
   • Acknowledgment of historical or ongoing abuse and discrimination
   • Honoring tribal consultation, and
   • Recognition that community-based organizations have limited bandwidth and resources to dedicate to committee participation if they are not provided additional resources.

OHA will consider ways to encourage that CCOs’ support for robust representation requires commitment to long-term financial support, ongoing training, TA, and support; and a platform for collaboration.
<table>
<thead>
<tr>
<th>Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities by implementing the following:</th>
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<tbody>
<tr>
<td>a) Require CCOs to develop a health equity plan, including culturally and linguistically responsive practice, to institutionalize an organizational commitment to health equity,</td>
</tr>
<tr>
<td>b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and</td>
</tr>
<tr>
<td>c) Require organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation.</td>
</tr>
<tr>
<td>OHA has clarified that the intent of this policy option is not to silo the equity work being done by CCOs. Health Equity Plans must include an organizational approach to health equity. Embedding equity as an organizational goal means equity is present in every policy and every decision.</td>
</tr>
<tr>
<td>This policy should build on existing equity infrastructure at a CCO and community level. It intends to develop and standardize coordination and accountability in all CCOs.</td>
</tr>
<tr>
<td>The work on equity at a CCO level should be driven by CCO leadership in close collaboration with the community being served. CACs are a critical partner in this work. Based on community feedback the following must be addressed intentionally: Public input provided areas that would benefit from a more coordinated approach to health equity and culturally responsive infrastructure.</td>
</tr>
<tr>
<td>The health equity infrastructure policy option will establish a clear vision for CCOs to follow, with deliverables, timelines, and clearly defined objectives and outcomes.</td>
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<tr>
<td>OHA will allow CCOs flexibility to meet organizational, service area, community, and member needs.</td>
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<tr>
<td>OHA will provide guidance on areas of focus for health equity plans. The intent is to encourage CCOs to include elements around the advancement of health equity through service delivery; use of Race Ethnicity Language and Disability data standards (REAL-D); criteria for organizational and provider network cultural responsiveness; workforce diversity; community and member engagement, etc. In developing the plans, CCO should include realistic and achievable evaluation measures, benchmarks and milestones.</td>
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<tr>
<td><strong>Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018</strong></td>
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<tr>
<td>7</td>
<td>Require CCOs share with OHA (to be shared publicly) a <strong>clear organizational structure that shows how the Community Advisory Council, and tribes or Tribal Advisory Committee if applicable (see policy #4d) connects to the CCO board.</strong></td>
<td>This policy should go beyond the demonstration of an organizational structure. It should require that CCOs share with OHA and the public strategies in place to ensure CAC full participation on the CCO board, including their process for inclusive CAC decision making. For implementation consideration see Policy Option #4.</td>
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<td></td>
<td>Require CCOs to partner with local public health authorities, non-profit hospitals, and any CCO that shares a portion of its service area to <strong>develop shared Community Health Assessments (CHAs) and shared CHP priorities and strategies.</strong></td>
<td>OHA should establish clear expectations in the development of shared CHA and CHP priorities and strategies. CCOs should demonstrate the ability to develop the connections and relationships in the community necessary to advance community-driven work in SDOH (e.g., community-based organizations, tribes, social service organizations, public health, etc.). OHA will ensure the voice of consumers experiencing health disparities are included in the CHA and CHP planning process.</td>
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<tr>
<td></td>
<td>under Policy Option 8 for CHAs and CHPs) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for traditional health workers (THW) services.</td>
<td>CCOs have a role in increasing the THW workforce by setting up a livable and equitable payment system and that ensures sustainability. The incorporation of the THW must be done with fidelity, and it must not be left to interpretation. The development of relationships between CCOs and the THW Commission is critical for effective implementation of the model in the CCO service delivery.</td>
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<tr>
<td>9</td>
<td><strong>Require CCOs to submit their community health assessment (CHA) to OHA</strong></td>
<td>Public reporting, transparency, and accountability are essential tools for advancing health equity. This supports a process which is open and inclusive, allowing for a traceable path to data and results. Promotes transparency and can allow for improved technical assistance to CCOs. CCOs will have the opportunity to share their CHA with a wide variety of community partners.</td>
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<tr>
<td>10</td>
<td><strong>Increase CCOs’ use of value-based payments (VBP) with their contracted providers</strong></td>
<td>OHA should take into consideration underserved patient populations to help improve value-based care for everyone (Families USA report) OHA should require CCOs to consider racial inequality, ethnicity, sex, sexual orientation, English language proficiency, immigration status, patient income, and Support VBPs developed as another tool to improve and provide flexibility in the way care is delivered to better serve the diverse needs of OHP members. OEI and the Transformation Center will collaborate on developing and providing CCOs VBP technical assistance.</td>
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geographic disparities when designing and implementing VBPs.

Proposed VBP policies should allow flexibility to CCOs to implement most appropriate VBP models within the most appropriate settings. Safety-net and small community providers face different challenges than large, urban providers. This approach will allow for transitions in payment models at the right level and pace within each community.

OHA will require CCOs applicants to:
- Respond to specific questions in their RFA application that address how their VBP models will not negatively impact “priority populations,” including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and members with complex health care needs, as well as populations at the intersections of these groups.

OHA will require CCOs to:
- Respond to a standardized set of questions within their annual interviews on steps they have taken to ensure their VBPs have not had unintended, negative consequences for “priority populations” and members with complex health care needs. This question set, as well as the questions within the RFA will be developed in partnership with OEI.
- Report lessons learned, and strategies used to prevent unintended, negative consequences for these populations in their VBP arrangements, potentially as part of their TQS VBP submission (need CMS approval for this change).
| Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018 |
|---------------------------------------------------------------|---------------------------------------------------------------|
| **11** Evaluate CCO performance with tools to evaluate CCO efficiency, effective use of health-related services (HRS), and the relative clinical value of services delivered through the CCO. Use evaluation to set a performance-based reward at the individual CCO level. | While these tools may not be able to identify health disparities, it is safe to say that within the healthcare system, every area is responsible to adopt approaches that will make achieving health equity a high priority and tailor solutions for that purpose. |
| **12** Incorporate measures of quality & value in any OHA-directed payments to providers (e.g., hospital payments) or OHA | Cost TAT has identified that there is a potential equity impact depending on metrics used to measure quality and value. |

<p>| | ethnicity data will provide valuable information to inform VBP policies in future years. |
| | OHA has reviewed all proposed VBP policy options with a trauma-informed lens. |
| | At implementation, the methodology to evaluate CCO performance should consider CCO success in reducing health disparities to the extent possible. |
| | OHA will ensure that data collection for evaluation measurement identifies and accurately captures representation of diverse population groups and emerging subpopulations. In addition, care should be taken to ensure that the measures do not create incentives that effectively penalize CCOs with larger populations of people affected by disparities or that undermine CCO efforts to improve health equity. |
| | As this policy option is implemented over time, it is important to monitor its impact on health equity and health disparities and to continue to refine the methodology as needed to improve health equity. |
| | At implementation, OHA should consider the repercussions of the use of metrics of quality and value that could penalize institutions that |</p>
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<th>Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018</th>
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<tr>
<td><strong>reimbursement policies and align measures</strong> with CCO metrics</td>
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<td>Example: qualified directed payments made directly to hospitals are based in part on quality and value</td>
</tr>
<tr>
<td>Metrics measuring quality and value related to OHA-directed payments should consider ways to ensure that hospitals (or other provider types) are making equitable improvements in quality and value and could consider financial incentives for reductions in health disparities or other measurable improvements in health equity.</td>
</tr>
<tr>
<td>are most likely to care for populations affected by disparities and affected by social determinants of health.</td>
</tr>
<tr>
<td>Would the use of measures of quality and value impact organizations such as safety-net providers or critical access hospitals? Evaluations will also need to be conducted over sufficiently long-time periods to identify any unintended consequences, such as long-term effects on vulnerable populations.</td>
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| **Adjust the operation of the CCO Quality Pool** to allow consideration of expenditures in CCO rate development to: |
| - Align incentives for CCOs, providers, and communities to achieve quality metrics |
| Create consistent reporting of all CCO expenses related to medical costs, incentive arrangements, and other payments regardless of funding source (quality pool or global budget) |
| Spending patterns should be monitored to ensure no negative unintended consequences takes place. |
| It is important to make clear that this policy recommendation does not affect the set of metrics chosen by the Metrics & Scoring Committee to determine CCO quality pool earnings. It is unclear whether this policy will change how CCOs spend their quality pool earnings, though spending patterns should be monitored to identify any populations that are positively or negatively affected this is important to ensure that interventions do not increase population health inequities. |

| **Address increasing pharmacy costs** and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers |
| Pharmacy is an integral component of patient care. Also, management of this benefit has significant downstream effects on health outcomes and cost of care. Bringing transparency to the benefit is important to support all patient populations. |
| No equity considerations for implementation identified. |

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<th></th>
<th>Address increasing pharmacy costs and the impact of high-cost and new medications by increasing alignment of FFS and CCO PDLs</th>
<th>Increasing the alignment of pharmacy benefits across the state will minimize variability and will make the benefit easier to navigate for patients, especially for members who transition between CCOs. Increasing clarity and consistency within CCO prior authorization and coverage criteria will make the pharmacy benefit easier for patients and providers to navigate.</th>
<th>As CCO preferred drug lists are increasingly aligned over time, OHA and its partners should include a comprehensive equity analysis to identify any populations that are positively or negatively affected by CCO PDL policies. This is important to ensure that interventions do not increase population health inequities.</th>
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<tr>
<td>15</td>
<td>Enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk-Based Capital (RBC) tool to evaluate carrier solvency</td>
<td>No equity considerations for development identified.</td>
<td>No equity considerations for implementation identified.</td>
</tr>
<tr>
<td>16</td>
<td>Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity. This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.</td>
<td>Current CCOs may not have the expertise or infrastructure for the behavioral health benefit. Current CCOs may not have the expertise or infrastructure for the behavioral health benefit. Public input and OEI suggest that barriers like benefit limits or requirements for preauthorization should be addressed. The BH TAT has addressed this by clarifying that ownership of the benefit must include responsibility for pre-authorizations. The</td>
<td>Equity considerations for implementation of this recommendation will be directly impacted by other policy options. The BH TAT is aware of these considerations and will address in the workforce, continuum of care and outreach to culturally specific populations recommendations. CCOs in collaboration with OHA should identify gaps between community need and existing mental health services, including services that are not available at all or not accessible to specific populations because of geography, language, financing, or other barriers.</td>
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</table>
use of pre-authorizations will be monitored through policy option 18 and through compliance.

Other equity considerations are included in BH policy options but have direct impact on the success of this recommendation. The BH TAT is aware of these considerations and is addressing them in the workforce recommendation. They include: the BH provider network is deficient, especially in rural and frontier Oregon. The situation is critical if we account for a diverse provider network.

OHA, CCOs and other stakeholders, including communities will address provider network deficiencies to maximize positive impact of this policy.

Member provider choices are minimal with specific populations. Tribes, LGBTQ and LEP, are of concern. OEI suggests elevating this issue and addressing it throughout alignment with CCO 2.0 workforce policy development and implementation.

Public input and OEI suggest that barriers like benefit limits or requirements for preauthorization should be addressed.

In the workforce and network adequacy the following elements are also addressed.

CCOs in collaboration with OHA should identify gaps between community need and existing mental health services, including services that are not available at all or not accessible to specific populations because of geography, language, financing, or other barriers.

CCOs should assess if there are existing services sufficient in quantity and quality to meet community need.

If there are existing services not accessible to specific populations because of geography, language, financing, or other barriers. If there are services that are currently unavailable or unavailable in sufficient quantity that would better meet the needs of the community

CCOs should take inventory of culturally specific services provided by culturally specific agencies. For this work, CCOs should engage with CACs, Regional Health Equity Coalitions, culture specific community-based organizations, etc.
Another barrier that should be addressed is language and culturally responsive behavioral health services.

**Identify metrics to track milestones of behavioral health (BH) and oral health (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, culturally responsive principles including trauma informed practices, and meeting metrics

CCOs should have the ability to organize oral, behavioral, and physical health services in ways that better support integration.

CCOs should streamline documentation requirements to truly support integrated care.

CCOs should plan to enhance culturally specific integrated services, including culturally specific mental health services in physical health care settings.

The CCOs have not consistently integrated behavioral health. This will be a lever to ensure CCOs integrate services, for OHA to measure progress and to target technical assistance.

CCO plans to integrate BH and OH should consider the following first:

There are barriers for timely access to services, language access and accessibility, appropriateness of services, and follow-through in each system. Disparities exist.

Service delivery should aim to be culturally and linguistically appropriate; responsive to the community; committed to addressing social determinants of health; focused on language access services and be fully accessible for all members, patients, and clients.

**CCOs identify actions for the development of the medical, behavioral and oral health workforce**. CCOs will:

- Report on the 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

CCOs reporting on capacity and diversity of the medical, behavioral and oral health workforce and provider network must include language access (bilingual providers, or bilingual staff); provider use of certified and qualified healthcare interpreters; provider use of phone language services and provider accessibility

Language in this policy option should move CCOs further than “reporting” alone on capacity and diversity of the medical, behavioral and oral health workforce within their geographical area and provider network.

Language should include enforcement to ensure CCOs are required to look at parity.
ensure parity with their membership.

- Develop the healthcare workforce pipeline in their area by participating in and facilitating the current and future training for the health professional workforce. This includes encouraging local talent to return to their home areas to practice and supporting health professionals following their initial training;
- Develop and support a diverse workforce who can provide culturally and linguistically appropriate care, trauma informed practices, with attention to marginalized populations; and
- Ensure current workforce completes a cultural responsiveness training in accordance with HB 2611.

(ADA compliance- This is a federally mandated requirement)

CCOs should monitor the items mentioned above and develop technical assistance as part of their quality improvement processes.

Important to note that the health care system should consider the distribution of providers within an area and between urban and rural areas as a matter of equitable access to care. The overall health care workforce needs to grow to meet demand, must be more ethnically and racially diverse, better distributed geographically, and inclusive of a broader array of jobs—from primary care providers to mid-level providers, to community health workers and peers.

OHA should require CCOs to develop a plan on how to diversify their workforce to reflect the demographic composition of the community at all levels and incentivize network providers to do the same. A more diverse health care workforce can also help improve outreach and engagement with communities of color and other communities that experience health inequities.

and develop action plans for addressing any gaps identified.

OHA should develop a process to assess the meaning of diversity in provider composition continually.

As health outcomes by emerging populations (e.g., LGBTQ) evolve, it's critical the provider mix reflect those served.

CCOs should maintain accurate and up-to-date network provider directories that are easily accessible to patients.

CCO employment recruitment and retention plans and strategies are intentionally designed to attract a workforce to the organization that is reflective of the populations served.

At implementation, CCOs can support the development of the healthcare workforce by:

- Advocating for more robust integration of health equity and social determinants of health in clinical training to develop a better understanding of how these issues factor into the direct clinical care of patients.

Increasing the diversity of traditional health care providers and health system leaders by supporting the expansion of pipeline
| 20 | Require CCOs **utilize best practices to outreach to culturally specific populations**, including the development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs) | BH OHA is currently working on a project, in collaboration with OEI and other stakeholders that will identify best practices in culturally and linguistically appropriate care or service provision of behavioral health services. As CCOs integrate, BH special attention should be provided to prioritize addressing the need for cultural responsive and implicit bias training in the BH workforce. | On the implementation of this policy option, consultation with policy team leading this work, THW Commission or OHA Equity and Inclusion Division are strongly advised. Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities. |

CCOs can support the development and expansion of partnerships and resources to address workforce diversity. Programs and other supports and incentives for students and providers from underrepresented groups and expanding opportunities for training in underserved areas. Working with local school districts, universities and community colleges, healthcare professional boards and community leaders and organizations, CCOs can develop a blueprint for:

1. Increasing diversity of the workforce,
   and

2. Making the existing workforce culturally responsive.

Promoting the sustainable use and integration of THWs and similar community care team members.

**Promoting the use and integration of mid-level providers into care teams.**
### BH system is behind on addressing language access needs of the population already. Hiring practices must have language and culture as critical recruitment considerations even for front office staff.

A more comprehensive approach should take place that encompasses BH organizations in addition to addressing BH care delivery.

Adoption of CLAS as a framework to guide BH work on health equity is recommended.

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<table>
<thead>
<tr>
<th>Priority Access for Pregnant Women and Children Ages Birth Through Five Years to Health Services, Developmental Services, Early Intervention, Targeted Supportive Services, and Behavioral Health Treatment</th>
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<td><strong>21</strong></td>
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<tr>
<td>- CCOs will ensure access to evidenced-based dyadic treatment and treatment that allows children to remain placed with their primary parent.</td>
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<tr>
<td>- CCOs will support providers in assessing for adverse childhood experiences (ACEs) and trauma, to develop individual services and support plans.</td>
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<tr>
<td>- For pregnant women, CCOs will support providers in screening for CCOs have experience working with early learning and intervention and should capitalize on that existing relationship to ensure health services are equitable, family-centered and culturally and linguistically responsive.</td>
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<tr>
<td>- CCOs should recognize that primary care behavioral health delivery looks different in pediatric care settings. CCO collaboration with schools and early learning is fundamental.</td>
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<tr>
<td>- The focus should include addressing the BH needs of children and youth with specialized health needs.</td>
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At implementation, the following should be taken into consideration:

Need for parental awareness about services available, types of support offered and their benefits. Information needs to be provided in a timely manner, and in a culturally and linguistically appropriate way.

Parental understanding of the critical importance of the early years, and of the home environment for learning and development, with targeted support and tailored strategies for families.

OHA and CCOs should ensure that services and interventions are available in a range of different languages.
### Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018

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<th>Behavioral health needs and substance use prenatally and postpartum. CCOs will provide appropriate referrals and follow-up to referral. • CCOs will prioritize access to substance use disorder (SUD) services for pregnant women, parents, families, and children, including access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services for parents and behavioral health screening and treatment for children.</th>
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<tr>
<td></td>
<td>Focus on BH workforce with pediatric expertise. Concern over behavioral health scarcity of services. In many Oregon communities, children must leave their homes and receive care someplace else. Many factors influence the underutilization of behavioral health services by parents and children, including stigma, cost, cultural barriers, access to and regional distribution of providers, and a shortage of child and adolescent psychiatrists.</td>
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<td></td>
<td>Mixed eligibility for health insurance within families is likely to be common due to differences in parental or spousal employment and documentation status. Regardless, those parents should be included in the interventions and treatment plans. Based on public input provided in culture-specific events, interventions that address children must have a parent education component and support. Literacy, language, and cultural needs must be addressed.</td>
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<th>Implement risk-sharing with the Oregon State Hospital (Behavioral Health Collaborative recommendation)</th>
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<tr>
<td>22</td>
<td>Implement risk-sharing with the state hospital (Behavioral Health Collaborative recommendation), in a way that is consumer driven and where equity considerations are met. As CCOs assume risk OHA anticipates an increase in community care and a decrease in hospitalizations.</td>
</tr>
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<td></td>
<td>Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.</td>
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<th>Shift financial role for statewide HIT public and private partnership from OHA to CCOs to cover their fair share</th>
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<td>23</td>
<td>Increasing CCO investment and participation in the HIT Commons will promote health equity by creating more opportunities for the HIT Commons to hear</td>
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<td></td>
<td>No equity considerations for implementation identified.</td>
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| 24 | 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 those in medication assisted treatment for SUD and incorporate the following:  
• Develop standards for care coordination that reflect principles that are trauma informed and culturally responsive.  
• Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (intellectual and developmental disabilities).  
Establish outcome measure tool for care coordination. | Individuals with severe and persistent mental illness (SPMI) require more intensive support to effectively address the complexity of their needs.  
OHA should require CCOs to address the importance of cultural and linguistic competencies in the design and implementation of care coordination approaches. Focus care coordination efforts that consider the impact of race, ethnicity, language access, and other community factors, support engagement and effective transitions. | Any initiatives developed with the intent of fulfilling objectives of this policy option at implementation should include a comprehensive equity analysis to identify any populations that are positively or negatively affected; this is important to ensure that interventions do not increase population health inequities. |
|---|---|---|---|
| 25 | Develop mechanism to assess adequate capacity of services across the continuum of care.  
Ensure members have access to behavioral health services across the continuum of care. | Communities provide different types of treatment programs and services for children and adolescents with mental illnesses. The complete range of programs and services is referred to as the continuum of care. Not every community has every type of service or program on the continuum. This is a concern. | Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities. |
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<tr>
<th></th>
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<th>From an equity perspective, the development of assessments on network capacity and continuum of care must include language and accessibility capabilities. Cultural and linguistic competence in the delivery of mental health services for racial and ethnic minority populations</th>
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<tr>
<td>26</td>
<td>System of Care to be fully implemented for the children’s system</td>
<td>Systems of care are broad, flexible array of evidence-informed services and support for defined populations, in this case, children. Implementation of SOC in children must include culturally and linguistically appropriate services, screenings, care coordination to be &quot;fully implemented.&quot; Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.</td>
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<tr>
<td>27</td>
<td>Require Wraparound is available to all children and young adults who meet criteria</td>
<td>Wraparound is unique from typical service delivery strategies, in that it provides a comprehensive, holistic, and youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. Use of equity lens at the implementation of policies these population should be required. CCOs and OHA should ensure diverse community representation in all collaborative efforts to plan, implement and oversee Wraparound as a community process. Community partnerships should be in place to ensure access to needed support and services and that those services are culturally and linguistically appropriate.</td>
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<tr>
<td>28</td>
<td>MOU between CMHP and CCOs enforced and honored</td>
<td>No equity considerations for development identified. No equity considerations for implementation identified.</td>
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</table>
| Page | Identify and address billing system and policy barriers to integration:  
| - Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting  
| - Develop payment methodologies to reimburse for warm handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, Wraparound, PCIT, EASA)  
| - Examine equality in behavioral health and physical health reimbursement | Without a dedicated funding stream for coordination, it is difficult to bridge [separate] systems, including billing. Among the barriers to accessing care that. Implementing new billing and claims systems for non-traditional providers.  
| Consider changes in legislation and regulations regarding scope of practice, licensing, prescribing, and supervision to allow more mid-level providers to practice at their highest level and facilitate integration.  
| Exchange of physical and behavioral health diagnosis and treatment information among providers is a pillar of integrated care. Two issues make this especially difficult concerning behavioral health services: lack of information technology and constraints on sharing behavioral health data across practices and agencies  
| Special considerations to children’s physical and behavioral health needs at integration. | Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.  
| Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts | Oregon CCOs will address social determinants of health and continuing to the path of adopting value-based payments. Risk adjustment is the standard solution for leveling the payment playing field so that providers are fairly compared to each other by adjusting for patient | Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.  
<p>| Connect contractual requirements to ongoing evaluation of Oregon’s |</p>
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<tr>
<th>#</th>
<th>Recommendation</th>
<th>Sustainability Spending Target</th>
<th>Factors that are out of their control and research indicates that adjusting for social risk is a path that needs to be explored.</th>
<th>When social risk factors are not accounted for in performance measurement and payment in the health care system, achieving performance benchmarks may be more difficult for providers disproportionately serving socially at-risk populations owing to the influence of social risk factors.</th>
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<tr>
<td>31</td>
<td>Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy with financial implications</td>
<td>No equity considerations for development identified.</td>
<td>No equity considerations for implementation identified.</td>
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<tr>
<td>Requirement</td>
<td>Recommendation</td>
<td>Notes</td>
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| Require CCOs support EHR adoption across behavioral, oral and physical health contracted providers | “EHR adoption is not a goal in and of itself, but a pathway towards reducing historical health disparities.”¹²  
EHRs and other HIT tools that are successfully integrated into clinical workflow have the potential to improve patient safety and quality of care while helping to eliminate health disparities.  
EHRs are also foundational to participation in many kinds of electronic health information exchange (HIE), which can help to support care coordination for patients with complex medical and social needs.  
OHA should be intentional supporting the adoption of EHRs and other innovative HIT tools for providers who treat underserved populations |  
OHA should ensure that targets for EHR adoption and the methods that CCOs use to support EHR adoption are driven by CCO’s knowledge of community needs by allowing CCOs to choose targets and methods.  
CCOs should give careful attention to issues of EHR certification requirements to avoid the potential for unintended consequences for behavioral health providers, as there are few certified products that meet their needs.  
However, it is important to prioritize adoption of EHRs that can track language, sexual orientation, gender identity and social risk factors.  
CCOs should plan for technical assistance to support the collection and documentation of comprehensive patient demographic data. |

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<tr>
<th>Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018</th>
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<td><strong>33</strong></td>
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</table>
Identify, promote and expand programs that integrate primary care into behavioral health settings (Behavioral Health Homes)

At implementation, the following needs to be taken into consideration:

Language barriers decrease the odds of using behavioral health services, therefore for behavioral health homes, the integration of primary care in behavioral health settings must include teams that are culturally and linguistically responsive to the needs of individuals seeking care and to the needs of the community.

Current workforce shortages and the need for a culturally and linguistically responsive workforce in behavioral health prove that this intervention may be appropriate for certain groups but not for all.

1) The acceptability and use of behavioral health services are impacted by cultural attitudes, beliefs, and practices.
2) The current science base around psychiatric diagnosis and treatment.

While research suggests that integrated models of behavioral health services (that is, models that involve colocation of primary care and behavioral health services and collaborative care models in physical health care settings) are most effective in improving mental health outcomes for racial and ethnic minorities and reducing disparities, continuous access to care through practical convenience and privacy, which is particularly important for individuals who may refrain from seeking services because of culturally-based stigma about mental health problems and services.

Receiving mental health services in physical health care settings is thought to reduce barriers to access through practical convenience and privacy, which is particularly important for individuals who may refrain from seeking services because of culturally-based stigma about mental health problems and services.

However, continuity of care is important for all patients, but it is especially critical for those with complex chronic conditions.
| CCOs, with the support of OHA, to require providers to implement trauma-informed care practices | Trauma-informed care practices involve both organizational and clinical changes that have the potential to improve patient engagement and health outcomes. CCOs and OHA should not focus only on health care providers but in the implementation of broad changes across their organizations to address trauma. Another consideration is that traditional payment systems present significant barriers to implementing a trauma-informed approach. The integration of behavioral health and primary care services, which provide coordinated care and a whole-person treatment is derived from research primarily involving European-origin populations; and 3) ethnic and minority communities face many increasing challenges around mental illness and substance use, such as lower access to services and evidence-based treatments, higher burdens of morbidity, and a multitude of social determinant stressors. |

Creating a Trauma-Informed Approach to Care means engaging patients in organizational planning for the implementation of trauma-informed practices. OHA and CCOs should ensure that training and education components are developed to create a safe environment and to prevent secondary traumatic stress in staff. OHA and CCO should support providers by engaging referral sources and partnering with organizations. The timing of screenings should be carefully considered to reduce the risk of racial and ethnic bias.

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14 ISSUE BRIEF Key Ingredients for Successful Trauma-Informed Care Implementation (2016) Christopher Menschner and Alexandra Maul, Center for Health Care Strategies.
<table>
<thead>
<tr>
<th>Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018</th>
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<tbody>
<tr>
<td><strong>41 Develop an incentive program to support behavioral health providers’ investments in electronic health records and other, related HIT. (Feasibility depends on 2019 legislative session)</strong></td>
</tr>
<tr>
<td>CCOs and OHA should ensure that health care professionals participating in the CCO provider network are proficient in trauma screening and know how to conduct appropriate follow-up discussions with patients that are sensitive to their cultural and ethnic characteristics (e.g., language, cultural concepts of traumatic events).</td>
</tr>
<tr>
<td><strong>41</strong> Develop an incentive program to support behavioral health providers’ investments in electronic health records and other, related HIT. (Feasibility depends on 2019 legislative session)</td>
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<td>CCOs and OHA should ensure that health care professionals participating in the CCO provider network are proficient in trauma screening and know how to conduct appropriate follow-up discussions with patients that are sensitive to their cultural and ethnic characteristics (e.g., language, cultural concepts of traumatic events).</td>
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<tr>
<td>According to the literature, healthcare providers would invest more of their resources to integrating behavioral and physical health information to improve their population health initiatives were the resources available.</td>
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<td>Without proper investment and support to BH providers investments in technology, integration is hard to imagine.</td>
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<tr>
<td>Stakeholders, like OHA and CCOs and community-based organizations must work together and use health IT tools to create connections between social and behavioral healthcare organizations and the primary care system to develop a better understanding of patient’s challenges and needs.</td>
</tr>
<tr>
<td>Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in-person, regardless of a patient’s geographic setting (rural, urban). Coverage would include asynchronous communications if there is limited ability to use video conferencing. This proposal does not address the availability of telehealth services (i.e., does not require CCOs to add new providers to ensure telehealth is broadly available), but focuses on coverage.</td>
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<tr>
<td>This is a limited technical fix intended to bring CCOs into alignment with telehealth coverage rules for private payers. Currently, private payers are required to cover telehealth services provided by a contracted provider if they would have covered the service if the contracted provider had provided the service in-person. CCOs, in contrast, can choose to cover telehealth services in that situation, but may also deny coverage. Many CCOs have already aligned with private payer rules; this policy option would provide uniformity by requiring CCOs to cover telehealth services in the situation described above, just as private payers are currently required to do.</td>
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<tr>
<td>Due to widespread lack of clarity about this policy option, OHA will delay implementation to allow for further stakeholder engagement and policy development. OHA may also engage in a broader discussion about building telehealth capacity, which is outside the scope of this policy option. Broadband capabilities that would enable telehealth in some areas in Oregon and its impact on quality and reimbursement should be addressed at implementation.</td>
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<tr>
<td>Continue CCO role in using HIT for patient engagement and link to health equity</td>
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<td>CCOs should consider that HIT has a role in patient engagement and such initiatives could be part of the health equity plan.</td>
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<td>CCO should ask vendors for cultural and linguistic accessibility when discussing bringing on new tools for patient engagement (OHA is aware that accessible tools may not currently exist in the market; the requirement is simply to ask to demonstrate interest in such tools)</td>
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<tr>
<td>OHA should ensure health equity plan guidelines include a HIT component for patient engagement.</td>
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<tr>
<td>OHA and CCOs should work together on addressing the need for better IT tools that are culturally and linguistically responsive.</td>
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Appendix C:

CCO 2.0 and children’s health
CCO 2.0 and Children’s Health

Health in the earliest years of life – starting with a mother’s health before pregnancy – has lifelong impacts on well-being. Early childhood is a unique and critical window of opportunity to set a positive trajectory for a child’s long-term health. In the first few years after birth, a child’s brain forms more than one million new neural connections every second. Early childhood brain development is impacted by numerous factors, including the social determinants of health. Research on adverse childhood experiences (ACEs) also demonstrates that early life exposure to negative events, trauma, and family instability increases the likelihood of poor health later in life and creates barriers to educational success.

Additionally, large disparities in health outcomes exist across Oregon’s child population, with state and national data demonstrating that children of color and children in poverty fare worse, overall, than white children and those of higher socioeconomic status. Early childhood disparities exist across numerous areas of health and well-being, from infant and maternal mortality to oral health status to ACEs, trauma and toxic stress. Prominent disparities exist in other domains with strong implications for early childhood health, including access to basic needs like food, diapers, and safe and stable housing. Children and youth with special health care needs and their families also face significant barriers in accessing health care and other supportive services.

Investment in early childhood services and maternal and child health is a proven strategy to improve health outcomes and contain health care costs, as well as creating notable returns on investment in education costs, workforce productivity, crime reduction, and reduced burden on safety net services. Evidence also shows the most effective interventions to support healthy early childhood development are those that support parent-child connections and family stability, impacting two generations – for it is difficult to sustain positive impacts on children without addressing the needs of their caregivers.

As stated in Healthy People 2020, improving the well-being of mothers, infants, children and families is a critical public health goal. The health and well-being of these populations determine the health and well-being of today’s citizens as well as the next generation. It can also predict future opportunities and challenges for communities and health care systems. CCO 2.0 offers a unique opportunity for the Oregon Health Authority and the coordinated care model to positively impact the trajectories of our youngest Oregonians’ lives through health system transformation strategies and policies.

CCO 2.0 policies impacting children’s health

Staff have strategically considered how each CCO 2.0 policy will impact children and families, including implementation options at the CCO level for maximum impact on child outcomes. Included in the CCO 2.0 policies are strategies to prevent and address the behavioral health issues that destabilize families and impede children’s readiness for kindergarten; payment strategies to improve delivery of maternity and pediatric care; and policies that drive CCOs’ work to improve the social and environmental context in which the most vulnerable Oregonians live.
Overall, 26 out of 43 CCO 2.0 policies were determined to have a potential to positively impact children. These are noted in the “Dashboard” section in Appendix A: CCO 2.0 Recommended Policies and Implementation Expectations and listed in Table 1 below. In addition, some key examples of how these policies are intended to impact children and families are provided here:

**Policy 1** includes a proposed strategy to build into the CCOs’ global budget rate methodology a specific amount of spending to advance members’ social determinants of health and health equity. This includes a statewide priority of CCO spending on housing-related supports and services, including opportunities and encouragement to partner with community housing entities and capitalize on state efforts toward permanent housing for low-income families. CCOs can further leverage this opportunity by focusing their spending on families with young children and can complement these investments with strategic use of health-related services (policy 2) to provide parenting supports, as well as meet childcare and transportation needs to enhance families’ access to health care services.

**Policy 10** requires that in years three through five of the CCO 2.0 contracts, each CCO will implement new value-based payments (VBPs) in five care delivery focus areas, two of which are maternity care and children’s health care. Maternity care VBPs offer promise in delivering higher-quality, cost-effective care through promoting care coordination and flexibility in types of services, providers and care settings. This is especially important for at-risk populations that have lower utilization of prenatal care and higher rates of adverse birth outcomes. In addition, through their children’s health care VBPs, CCOs will begin to develop payment models that address social determinants of health (including trauma related to adverse childhood experiences), thus supporting long-term positive health outcomes.

**Policy 21** prioritizes access to behavioral health services and early intervention for pregnant women, parents, families and young children to prevent poor long-term outcomes and reduce costs. CCOs can ensure children and families have access to evidence-based treatment approaches for families that help children with symptoms of emotional disorders. Additionally, CCOs will be expected to prioritize access to substance use disorder services for pregnant women, parents, families and their children to provide the best outcomes for young children and their caregivers. CCOs can improve outcomes for new families by ensuring mothers continue to have access to behavioral health services, including traditional health workers. CCO 2.0 will require that behavioral health services are accessible and available to all members throughout their lifespan (policy 25) and CCOs will ensure care coordinators are identified for families of children and youth with special health care needs (policy 24).

Integrating oral health care in the primary care setting offers an excellent way to set up children for a lifetime of improved oral health, which has significant impacts on academic success and overall well-being. This integration is supported through a variety of CCO 2.0 policies including policy 10, which encourages oral health integration through value-based payment, and policy 18, which drives measurement of integration of behavioral and oral health into physical health care.

Teledentistry is a key strategy for expanding access to oral health care in frontier/rural areas and reducing geographic disparities in access and outcomes. Policy 42 standardizes coverage for telehealth services, including teledentistry. This can be especially important for children
receiving care in school settings from expanded practice dental hygienists who may rely on electronic consultation with dentists.

**Policy 33** requires CCOs to ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology. Electronic HIE for care coordination offers significant benefits to families and caregivers of children, especially those with complex medical needs. It can eliminate the need to fax, mail or hand-carry medical records when seeing a new specialist, ensure all members of the child’s care team can access the child’s up-to-date health information at appointments, and provide real-time notifications to care team members that the child is being seen at the emergency department (ED) to facilitate follow-up – or even allow care team members to reach out to the family before they leave the ED.

OHA will also implement a policy from the 2017 Medicaid waiver renewal (policy 11) that will reward CCOs for delivering efficient care and encourage care delivery with the highest clinical value. This policy should provide CCOs additional incentive to increase the availability of health-related services for children and their families and should build on other policy options that more directly encourage CCOs to improve delivery of behavioral health services and address social determinants of health. Embedded in this policy are new data and analytical tools that should help CCOs and OHA better identify CCO success and areas for improvement, which should in turn improve the system’s ability to serve children and their families covered by OHP.

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<tr>
<th>#</th>
<th>Focus area</th>
<th>Policy</th>
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<tr>
<td>1</td>
<td>Social Determinants of Health and Health Equity</td>
<td><strong>Implement House Bill 4018: Require CCOs to spend portion of net income or reserves on social determinants of health (SDOH; including supportive population health policy and systems change) and health equity/health disparities, consistent with the CCO community health improvement plan (CHP)</strong>&lt;br&gt;A. Require CCOs to hold contracts or other formal agreements with, and direct a portion of required SDOH and health equity spending to, SDOH partners through a transparent process.&lt;br&gt;B. Require CCOs to designate role for community advisory council (CAC), and tribes and/or tribal advisory committee if applicable (see Policy 4, Part D), in directing and tracking/reviewing spending.&lt;br&gt;C. <strong>Years 1 and 2:</strong> Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the global budget rate methodology and seek to build in a specific amount of SDOH and health equity investment. This is intended to advance CCOs’ efforts to address their members’ SDOH and establish their internal infrastructure and processes for ongoing reinvestment of a portion of net income or reserves in social determinants of health and health equity.&lt;br&gt;i. <strong>Require one statewide priority</strong> – housing-related supports and services – in addition to community priority(ies).</td>
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<td>Social Determinants of Health and Health Equity</td>
<td><strong>Increase strategic spending by CCOs on health-related services</strong> (HRS) by:&lt;br&gt;A. Encouraging HRS community benefit initiatives to align with community priorities, such as those from the community health assessments (CHAs) and community health improvement plans (CHPs); and</td>
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<tr>
<td></td>
<td>Social Determinants of Health and Health Equity</td>
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| **3** | **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.  
**B. Encourage adoption of SDOH, health equity, and population health incentive measures** by the Health Plan Quality Metrics Committee (HPQMC) and Metrics & Scoring (M&S) Committee for inclusion in the CCO quality pool. |   |
| **4** | **Strengthen community advisory council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers** through the following:  
A. Require CCOs to report on CAC member composition and alignment with demographics of Medicaid members in their communities, including: 1) the percentage of CAC comprised of Oregon Health Plan (OHP) consumers; 2) how the CCO defines their member demographics and diversity; 3) the data sources they use to inform CAC alignment with these demographics; 4) their intent and justification for their CAC makeup; and 5) an explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress;  
B. Require CCOs to report CAC member representation alignment with CHP priorities (for example, public health, housing, education, etc.); and  
C. Require CCOs to have two CAC representatives, at least one being an OHP consumer, on the CCO board.  
D. OHA is exploring adding a recommendation that CCOs use a tribal advisory committee rather than simply ensuring tribal representation on the CAC. Development of this policy option is occurring through ongoing collaboration with Oregon’s nine federally recognized tribes.  
E. OHA is exploring implementation options for a requirement that CCOs have a designated tribal liaison per 1115 Waiver Attachment I: Tribal Engagement and Collaboration Protocol. This is also occurring through ongoing collaboration with Oregon’s nine federally recognized tribes. |   |
| **5** | **Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities** by implementing the following:  
A. Require CCOs to develop a health equity plan, including culturally and linguistically responsive practice, to institutionalize organizational commitment to health equity;  
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 fundamentals training plan and timeline for implementation. |   |
### Social Determinants of Health and Health Equity

**Implement recommendations of the Traditional Health Worker (THW) Commission:**

A. Require CCOs to create a plan for integrating and utilizing THWs.

B. Require CCOs to integrate best practices for THW services in consultation with THW Commission.

C. Require CCOs to designate a CCO liaison as a central contact for THWs.

D. Identify and include THWs affiliated with organizations listed under ORS 414.629 (note that Part D is also included under Policy 8 for CHAs/CHPs).

E. Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for THW services.

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**Social Determinants of Health and Health Equity**

Require CCOs to partner with local public health authorities, nonprofit hospitals, and any CCO that shares a portion of its service area to develop shared CHAs and shared CHP priorities and strategies.

If a federally recognized tribe in the CCO’s service area is developing a CHA or CHP, the CCO must partner with the tribe in developing the shared CHA and shared CHP priorities and strategies described above.

A. Require that CHPs address at least two state health improvement plan (SHIP) priorities, based on local need.

Ensure CCOs include tribes and 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 414.629.

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### Value-based Payment

**Increase CCOs’ use of value-based payments (VBP) with their contracted providers**

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### Cost

Evaluate CCO performance with tools to **evaluate CCO efficiency, effective use of health-related services (HRS), and the relative clinical value of services** delivered through the CCO. **Use evaluation to set a performance-based reward at the individual CCO level.**

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### Behavioral Health

**Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity.** This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.

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### Behavioral Health

**Identify metrics to track milestones of behavioral health (BH) and oral health (OH) integration** with physical health care by completing an active review of each CCO’s 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, implementing culturally responsive principles including trauma-informed practices, and meeting metrics.
<table>
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<tr>
<th>19</th>
<th>Behavioral Health</th>
<th><strong>CCOs identify actions for developing the medical, behavioral and oral health workforce.</strong> CCOs will:</th>
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<tr>
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<td>• Report on the 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.</td>
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<td>• Develop the health care workforce pipeline in their area by participating in and facilitating the current and future training for the health professional workforce. This includes encouraging local talent to return to their home areas to practice and supporting health professionals following their initial training.</td>
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<td>• Develop and support a diverse workforce that can provide culturally and linguistically appropriate care, and trauma-informed practices, with attention to marginalized populations. Ensure current workforce completes a cultural responsiveness training in accordance with House Bill 2611.</td>
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<tr>
<td>20</td>
<td>Behavioral Health</td>
<td>Require CCOs <strong>utilize best practices to outreach to culturally specific populations,</strong> including development of a diverse behavioral and oral health workforce that can provide culturally and linguistically appropriate care (including utilization of THWs).</td>
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<tr>
<td>21</td>
<td>Behavioral Health</td>
<td><strong>Prioritize access for pregnant women and children ages birth through five years</strong> to health services, developmental services, early intervention, targeted supportive services, and behavioral health treatment.</td>
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<td>• CCOs will ensure access to evidenced-based dyadic treatment and treatment that allows children to remain placed with their primary parent.</td>
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<td>• CCOs will support providers in assessing for adverse childhood experiences (ACEs) and trauma, to develop individual services and support plans.</td>
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<td>• For pregnant women, CCOs will support providers in screening for behavioral health needs and substance use prenatally and post-partum. CCOs will provide appropriate referrals and follow-up to referral.</td>
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<td>• CCOs will prioritize access to substance use disorder (SUD) services for pregnant women, parents, families, and children, including access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services for parents and behavioral health screening and treatment for children.</td>
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<td>22</td>
<td>Behavioral Health</td>
<td>Implement risk-sharing with the Oregon State Hospital (OSH)</td>
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<td>24</td>
<td>Behavioral Health</td>
<td>Require CCOs to <strong>ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disturbances (SED), and individuals in medication-assisted treatment for SUD</strong> and incorporate the following:</td>
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<tr>
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<td>• Develop standards for care coordination that are trauma informed and culturally responsive</td>
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<td>• Enforce contract requirement for care coordination for all children in child welfare, state custody and other prioritized populations)</td>
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<td>• Establish outcome measure tool for care coordination.</td>
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<td>Category</td>
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<tr>
<td>25</td>
<td>Behavioral Health</td>
<td>Develop mechanism to assess adequate capacity of services across the continuum of care</td>
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<td>Ensure members have access to behavioral health services across the continuum of care</td>
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<tr>
<td>26</td>
<td>Behavioral Health</td>
<td>System of Care (SOC) to be fully implemented for the children’s system</td>
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<tr>
<td>27</td>
<td>Behavioral Health</td>
<td>Require wraparound is available to all children and young adults who meet criteria</td>
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<tr>
<td>28</td>
<td>Behavioral Health</td>
<td>MOU between community mental health program (CMHP) and CCOs enforced and honored</td>
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<td>29</td>
<td>Behavioral Health</td>
<td>Identify and address billing system and policy barriers to integration:</td>
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<td>• Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting;</td>
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<td>• Develop payment methodologies to reimburse for warm handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, wraparound, Parent-Child Interaction Therapy, Early Assessment and Support Alliance); and</td>
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<td>• Examine equality in behavioral health and physical health reimbursement.</td>
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<td>33</td>
<td>Behavioral Health/Health Information Technology</td>
<td>Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications</td>
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<td>35</td>
<td>All</td>
<td>Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources</td>
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<tr>
<td>39</td>
<td>Behavioral Health</td>
<td>Identify, promote and expand programs that integrate primary care in behavioral health settings (Behavioral Health Homes)</td>
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<tr>
<td>40</td>
<td>Behavioral Health</td>
<td>CCOs, with the support of OHA, to require providers to implement trauma-informed care practices</td>
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<td>42</td>
<td>Behavioral Health/Health Information Technology</td>
<td>Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in person, regardless of a patient’s geographic setting (rural or urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (it does not require CCOs to add new providers to ensure telehealth is broadly available) but focuses on coverage.</td>
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**Linkages to other system work to support children and families**

In 2018, Governor Brown’s Children’s Agenda includes a set of priorities that impact the health and well-being of young children and their families; CCO 2.0 aligns with many of these priorities. The Governor’s Agenda priorities includes supporting pregnant and postpartum women who experience substance use disorder so they can effectively parent, parent-child centered behavioral treatments, and community-based family and parent support programs such as parenting education and Relief Nursery services. In addition, multi-prong strategies are being considered around housing and sheltering specifically for families with young children,
affordable high-quality early care and education services for children 0–3 and quality preschool for children ages 3 to kindergarten entry.

One of the key strategies prioritized in the Governor’s Children’s Agenda is supporting home visiting programs for new parents and their children, intervening early to put families on a pathway to success. Home visiting is an upstream prevention strategy used to support parents in providing safe, nurturing and supportive environments for their children. Home visiting programs include voluntary, structured visits by trained professionals to provide parenting education on a wide variety of topics including feeding and sleeping; building a strong attachment; guidance with navigating other community services; screenings for child development milestones, maternal depression and intimate partner violence; and referrals to community supports such as early intervention, counseling, food and clothing, and rental assistance. Evidence shows that the top five benefits of home visiting are: mothers and babies are healthier, children are better prepared for school, children are safer, families are more self-sufficient, and for every $1 spent on home visiting programs, $5 of savings from reduced health care and welfare services spending.

CCOs can leverage this priority by investing in, supporting and partnering closely with home visiting programs in their regions to ensure families with young children have the supports they need to be healthy, connect with other services, and ensure family stability and on-track child development. Local public health agencies, tribal health agencies, early learning entities and community-based organizations implement evidence-based and evidence-informed programs such as Nurse-Family Partnership, Healthy Families Oregon, Babies First! and Early Head Start. Across the state, these programs stand ready to work with CCOs on coordinating and implementing this effective community-based service for families of young children.

**Community partnership opportunities**

In addition to opportunities to support home visiting programs, CCOs’ work to impact early childhood should include partnerships with a wide variety of entities, including but not limited to parenting support programs, childcare and preschool programs, Relief Nurseries and early learning hubs. By engaging and supporting these community-based experts within the early learning system, CCOs can help build strong community systems to ensure Oregon’s youngest children and their families are fully supported for good health outcomes and readiness for school.

Senate Bill 902 (2015) requires that CCOs and their community advisory councils partner with early learning and youth development programs for developing their community health improvement plans (CHPs) to the extent practicable. Community health assessments (CHAs) and CHP development are key areas for collaboration and partnership with early childhood partners, and to date many CCOs’ CHPs include priorities and strategies related to maternal and child health. Following the increasing focus and urgency around child health throughout the state, CCO 2.0 policies driving alignment of CHA and CHP development across multiple entities in a region can emphasize and direct resources to this work in new and efficient ways.
**Child health measure development**

Concurrently with CCO 2.0, a variety of work is underway at the Oregon Health Authority in support of children’s health measurement. The Children’s Institute, in collaboration with OHA and with technical expertise from the Oregon Pediatric Improvement Partnership (OPIP), continues to convene the Health Aspects of Kindergarten Readiness Technical Workgroup. The purpose of this group is to explore development of potential CCO incentive metrics to impact school readiness for children on the Oregon Health Plan.

OHA also continues its partnership with OPIP to develop new system-level approaches for identifying children with “health complexity,” including children with a combination of both medical and social complexity factors. OPIP, through its partnership with OHA, Kaiser Permanente NW, and CCOs, will support the distillation, development and dissemination of leanings from this work, including case management approaches for children with health complexity that can meaningfully applied by CCOs.

The Metrics and Scoring Committee, which is responsible for identifying outcome and quality measures for the CCOs, continues to highlight early childhood health in its selected measures, including a focus on postpartum care, developmental screening, childhood immunizations, dental sealants for children, and adolescent well-visits.
Appendix D:

Coordinated care model elements crosswalk to policy recommendations
The Coordinated Care Model’s six elements, as utilized in CCO 2.0, support the OHA goal of meeting the triple aim of better health, better care and lower costs:

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

**For full policy details, see Appendix A:**
Policy Recommendations and Implementation Expectations
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?

![Bar graph showing goal metness](image)

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

Did you feel you were asked to provide useful feedback?

![Pie chart showing feedback](image)
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
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.

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 ongoing 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.
Appendix E: CCO 2.0 public input – ii. Summary of Woodburn community forum in Spanish

**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 activities, 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.
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%)

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>598</td>
</tr>
<tr>
<td>Primary Care</td>
<td>187</td>
</tr>
<tr>
<td>Behavioral</td>
<td>336</td>
</tr>
<tr>
<td>Oral</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>127</td>
</tr>
<tr>
<td>OHP Member/Family member</td>
<td>215</td>
</tr>
<tr>
<td>Non Member - Non Provider</td>
<td>809</td>
</tr>
<tr>
<td>Total</td>
<td>1568</td>
</tr>
</tbody>
</table>

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

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

I am very familiar, 66.4%
I am somewhat familiar, 29.4%
I am not at all familiar, 4.2%

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%

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>% providing feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>n=1568</td>
</tr>
<tr>
<td>VBP</td>
<td>49.6%</td>
</tr>
<tr>
<td>SDoH</td>
<td>60.5%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>65.3%</td>
</tr>
<tr>
<td>Sustainable Growth...</td>
<td>55.2%</td>
</tr>
</tbody>
</table>
## STAKEHOLDER GROUP & CCO AFFILIATION

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

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

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

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

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

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

- Yes: 14.9%
- No: 79.9%
- Decline/Don't want to answer: 5.2%

**Disability**: Do ANY of the following apply to you?

- Deaf or serious difficulty hearing: 13.2%
- Blind or serious difficulty seeing, even when wearing glasses: 0.8%
- A physical, mental, or emotional condition limits your activities in any way: 7.0%

**Race/Ethnicity: Survey takers vs Population**

- Hispanic/Latino: 6.7%
- Black/African American: 1.0%
- American Indian/Alaska Native: 1.0%
- Asian: 1.1%
- Native Hawaiian/Pacific Islander: 0.1%
- Other: 1.5%
- Multiracial: 5.4%
- Decline: 12.2%
- Don't know: 1.3%

*Additional categories include: Transgender (FTM; MTF), Genderqueer, and Other*
Appendix E: CCO 2.0 public input – iii. Summary of two online surveys

CCO 2.0 Recommendations of the Oregon Health Policy Board

GEOGRAPHIC DISTRIBUTION

Number of Survey Takers by County
Appendix E: CCO 2.0 public input – iii. Summary of two online surveys

CCO 2.0 Recommendations of the Oregon Health Policy Board
GENERAL CCO QUESTIONS

Have the CCOs met your expectations?

CCOs have done...

<table>
<thead>
<tr>
<th></th>
<th>Much worse</th>
<th>Worse</th>
<th>As expected</th>
<th>Better</th>
<th>Much better</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPNM (n=763)</td>
<td>13%</td>
<td>38%</td>
<td>31%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Providers (n=589)</td>
<td>23%</td>
<td>44%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members (n=203)</td>
<td>11%</td>
<td>18%</td>
<td>33%</td>
<td>25%</td>
<td>8%</td>
</tr>
</tbody>
</table>

CCO 2.0 Recommendations of the Oregon Health Policy Board

CCO 2.0 General Feedback Survey 1 – Results
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.
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.
Appendix E: CCO 2.0 public input – iii. Summary of two online surveys

CCO 2.0 Recommendations of the Oregon Health Policy Board

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:

<table>
<thead>
<tr>
<th>Area</th>
<th>Non-member, non-providers</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health care</td>
<td>497</td>
<td>366</td>
</tr>
<tr>
<td>Social determinants of health</td>
<td>442</td>
<td>303</td>
</tr>
<tr>
<td>Health disparities and health equity</td>
<td>297</td>
<td>227</td>
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<tr>
<td>Care coordination for patients</td>
<td>209</td>
<td>135</td>
</tr>
<tr>
<td>Health Information Technology and …</td>
<td>190</td>
<td>120</td>
</tr>
<tr>
<td>Oral health care</td>
<td>137</td>
<td></td>
</tr>
<tr>
<td>Value-based payments</td>
<td>158</td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Children’s health</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Specialty care</td>
<td>123</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area</th>
<th>OHP members/family</th>
<th>OHA staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health care</td>
<td>106</td>
<td>47</td>
</tr>
<tr>
<td>Social determinants of health</td>
<td>50</td>
<td></td>
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<tr>
<td>Oral health care</td>
<td>50</td>
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<tr>
<td>Health disparities and health equity</td>
<td>80</td>
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<tr>
<td>Care coordination for patients</td>
<td>73</td>
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<tr>
<td>Primary care</td>
<td>37</td>
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<tr>
<td>Specialty care</td>
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<tr>
<td>Health Information Technology and …</td>
<td>41</td>
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<tr>
<td>Value-based payments</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Children’s health</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>
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?

1. Improve partnerships between CCOs and community advisory councils, regional health equity coalitions, social service providers, community-based organizations, local public health authorities, and tribes
   - 1st: 782
   - 2nd: 630
   - 3rd: 598

2. Have CCOs spend more money on social determinants of health
   - 1st: 630
   - 2nd: 598
   - 3rd: 633

3. Having CCOs get payments from the State when they work on improving social determinants of health
   - 1st: 598
   - 2nd: 630
   - 3rd: 782

4. Implementing CCO community health improvement plans and priorities
   - 1st: 633
   - 2nd: 782
   - 3rd: 630

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

1. Improve use of traditional health workers by CCOs
   - 1st: 593
   - 2nd: 610
   - 3rd: 611

2. Increase resources dedicated to health equity
   - 1st: 611
   - 2nd: 593
   - 3rd: 610

3. Improve cultural competency and language access across the provider community, including work to address discrimination and bias
   - 1st: 610
   - 2nd: 593
   - 3rd: 611

4. More virtual health care options, like telehealth
   - 1st: 357
   - 2nd: 401
   - 3rd: 610

5. Improve racial and ethnic diversity in CCO provider networks
   - 1st: 401
   - 2nd: 357
   - 3rd: 610
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?

- Fix billing problems that affect integration of physical and behavioral health (670 responses)
- Adopt universal standards for care coordination across CCOs (566 responses)
- Offer incentives for providers that meet the goals of physical and behavioral health integration (620 responses)
- Find ways to measure behavioral health integration (588 responses)
- Create a recognition program for Behavioral Health Homes (249 responses)
- Offer incentives to behavioral health providers who use Electronic Health Records (EHR) (177 responses)
**BEHAVIORAL HEALTH (CONT)**

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

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove barriers that block access to behavioral health services</td>
<td>696</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete an evaluation of the behavioral health needs and available resources in the CCO region, and focus on gaps and barriers that are found</td>
<td>505</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offer incentives and opportunities to work across systems</td>
<td>533</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Require parity to make sure people have access to behavioral health services</td>
<td>453</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grow and increase recovery support services</td>
<td>428</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grow and increase access to telehealth/telepsychiatry</td>
<td>224</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer the adult mental health residential benefit to CCOs</td>
<td>108</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>1st</th>
<th>2nd</th>
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<tr>
<td>Offer incentives and opportunities to work across systems</td>
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<td></td>
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<tr>
<td>Remove barriers that block access to behavioral health services</td>
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<tr>
<td>Complete an evaluation of the behavioral health needs and available resources in the CCO region, and focus on gaps and barriers that are found</td>
<td>514</td>
<td></td>
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<tr>
<td>Require parity to make sure children have access to behavioral health services</td>
<td>499</td>
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<td></td>
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<tr>
<td>Offer incentives for use of evidence based and/or emerging best practices</td>
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<td></td>
<td></td>
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<tr>
<td>Grow and increase access to telehealth/telepsychiatry</td>
<td>219</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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?

- Lowering costs of prescription drugs: 439
- More funding for non-health care services for OHP members: 401
- More integration and coordination across health care services: 439
- More access to, and use of, primary care services: 322
- More use of alternative payment types: 334
- Lowering costs of hospital services: 239
- State-funded reinsurance pool to lower financial risks from very high cost patients, services, or health conditions: 187
- Lowering costs of other health care services: 130

The diagram shows the number of responses for each option, with the most important areas highlighted in darker shades.
COST CONTAINMENT (CONT)

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

- Require CCOs to make new investments to improve patients’ health status and address the social determinants of health: 410 votes
- Place new limits on CCO profits: 310 votes
- Make sure that all OHP members have the option to choose to get care from more than one CCO: 248 votes
- Require more financial reporting and transparency from CCOs: 284 votes
- Add incentives for CCOs to use fewer unnecessary health care services and to more efficiently deliver care: 222 votes
- Create a statewide preferred drug list for all CCOs: 194 votes
- Require CCOs to use more alternative payment types: 212 votes
- Increase oversight of CCO reimbursement rates: 128 votes
- Require CCOs to create a “cost containment” strategy to ensure they meet financial spending targets in the long run: 140 votes
- Raise the standards that CCOs must meet to get incentive payments: 118 votes
- Place new restrictions on how CCOs spend incentive payments and financial reserves: 143 votes
## Survey Comments

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

<table>
<thead>
<tr>
<th>#</th>
<th>Topic/theme</th>
<th>EXAMPLE key words</th>
<th># comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cost and funding</td>
<td>cost, funds, budget, flexible services, reimbursement, rates, HRS</td>
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<td>2</td>
<td>Behavioral health</td>
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<tr>
<td>3</td>
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<tr>
<td>4</td>
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<td>CAC, board, governance, general operations</td>
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<tr>
<td>5</td>
<td>Metrics</td>
<td>measures, incentive metrics, incentive payments</td>
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<td>6</td>
<td>Workforce</td>
<td>traditional health workers, peers, access to care, shortage, training, providers</td>
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<td>Public health</td>
<td>population health, community health improvement plan (CHIP), local public health (LPH)</td>
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<td>8</td>
<td>Coverage</td>
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<td>9</td>
<td>VBP</td>
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<tr>
<td>10</td>
<td>Particular CCO</td>
<td>named a specific CCO</td>
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<td>11</td>
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<td>disparities, race, ethnicity, cultural competency, equity, diversity</td>
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<td>Oral Health</td>
<td>oral, dental, dentist</td>
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<tr>
<td>13</td>
<td>Overall system</td>
<td>choice, coordinated care model, administrative issues</td>
<td>19</td>
</tr>
</tbody>
</table>

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 CCOs 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.
Appendix E: CCO 2.0 public input – iii. Summary of two online surveys

CCO 2.0 General Feedback Survey 1 – Results

- “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?

- Very Unsatisfied: 5%
- Unsatisfied: 18%
- Neutral: 35%
- Satisfied: 24%
- Very Satisfied: 18%

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?

- Very Unsatisfied: 4%
- Unsatisfied: 10%
- Neutral: 23%
- Satisfied: 43%
- Very Satisfied: 13%

55.7% are very satisfied or satisfied
### Stakeholders

<table>
<thead>
<tr>
<th>Stakeholder Group*</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>General public</td>
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<tr>
<td>Represent a community-based organization</td>
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<tr>
<td>OHP member and/or family of OHP member</td>
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<td>Contract with CCO</td>
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<tr>
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<td>Advocacy organization</td>
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<td>Provider: Primary care provider</td>
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<td>Provider: Oral health provider</td>
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<tr>
<td>Provider: Behavioral health provider (including mental health and addictive disorders)</td>
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<td>Regional health equity coalition member</td>
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*Note: Respondent may fall into more than one stakeholder group. Question not included on survey until 6/22/18.

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<td>4</td>
<td>1.0%</td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>14</td>
<td>3.6%</td>
</tr>
<tr>
<td>Yamhill Community Care</td>
<td>11</td>
<td>2.8%</td>
</tr>
<tr>
<td>Not a member / No CCO affiliation</td>
<td>100</td>
<td>25.4%</td>
</tr>
<tr>
<td>Unsure</td>
<td>18</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

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

Number of Survey Takers by County

Legend

- 0
- 1-5
- 6-10
- 10-15
- >15
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%

Race/Ethnicity: Survey takers vs Population

*Additional categories include: Transgender (FTM; MTF), Genderqueer, and Other
**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?”
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?”
Policy Options

What kind of impact do you think this would have?

<table>
<thead>
<tr>
<th>Category</th>
<th>Very Negative</th>
<th>Negative</th>
<th>No Impact</th>
<th>Positive</th>
<th>Very Positive</th>
<th>% Positive or Very Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>1%</td>
<td>5%</td>
<td>36%</td>
<td>55%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Community Involvement</td>
<td>1%</td>
<td>11%</td>
<td>11%</td>
<td>41%</td>
<td>36%</td>
<td>77%</td>
</tr>
<tr>
<td>Value Based Payment</td>
<td>4%</td>
<td>9%</td>
<td>5%</td>
<td>46%</td>
<td>30%</td>
<td>76%</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>6%</td>
<td>17%</td>
<td>7%</td>
<td>35%</td>
<td>31%</td>
<td>66%</td>
</tr>
<tr>
<td>Sustainable Growth</td>
<td>15%</td>
<td>30%</td>
<td>6%</td>
<td>29%</td>
<td>14%</td>
<td>44%</td>
</tr>
</tbody>
</table>

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

### OHP Members (n=123)

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Very Negative</th>
<th>Negative</th>
<th>No Impact</th>
<th>Positive</th>
<th>Very Positive</th>
<th>% Positive or Very Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>2%</td>
<td>6%</td>
<td>30%</td>
<td>59%</td>
<td>1%</td>
<td>89%</td>
</tr>
<tr>
<td>Community Involvement</td>
<td>0%</td>
<td>2%</td>
<td>10%</td>
<td>41%</td>
<td>1%</td>
<td>81%</td>
</tr>
<tr>
<td>Value Based Payment</td>
<td>5%</td>
<td>15%</td>
<td>40%</td>
<td>31%</td>
<td>1%</td>
<td>71%</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>5%</td>
<td>11%</td>
<td>21%</td>
<td>35%</td>
<td>1%</td>
<td>59%</td>
</tr>
<tr>
<td>Sustainable Growth</td>
<td>15%</td>
<td>30%</td>
<td>11%</td>
<td>23%</td>
<td>15%</td>
<td>38%</td>
</tr>
</tbody>
</table>

### Non-Members (n=270)

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Very Negative</th>
<th>Negative</th>
<th>No Impact</th>
<th>Positive</th>
<th>Very Positive</th>
<th>% Positive or Very Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>4%</td>
<td>38%</td>
<td>38%</td>
<td>53%</td>
<td>1%</td>
<td>91%</td>
</tr>
<tr>
<td>Community Involvement</td>
<td>3%</td>
<td>11%</td>
<td>11%</td>
<td>41%</td>
<td>1%</td>
<td>75%</td>
</tr>
<tr>
<td>Value Based Payment</td>
<td>4%</td>
<td>4%</td>
<td>48%</td>
<td>39%</td>
<td>3%</td>
<td>78%</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>3%</td>
<td>13%</td>
<td>8%</td>
<td>39%</td>
<td>8%</td>
<td>69%</td>
</tr>
<tr>
<td>Sustainable Growth</td>
<td>14%</td>
<td>29%</td>
<td>4%</td>
<td>32%</td>
<td>14%</td>
<td>46%</td>
</tr>
</tbody>
</table>

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

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

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

Full survey comments are available on the CCO 2.0 website: [https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx](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
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.
OHP members are highly satisfied with the program and with the health care they receive.

- **Quality of health care**: Very satisfied 63%, Somewhat satisfied 27% (90% total)
- **Oregon Health Plan**: Very satisfied 64%, Somewhat satisfied 24% (89% total)

DHM RESEARCH | OHA OREGON HEALTH PLAN MEMBER SURVEY | AUGUST 2018
Many respondents are unfamiliar with CCOs.

35% Not sure what a CCO is
Those who are familiar with CCOs are highly satisfied.

- 55% Very Satisfied
- 23% Somewhat Satisfied
- 78% Satisfied
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
There is stronger support for improved mental health care and addressing social determinants of health.

<table>
<thead>
<tr>
<th>Description</th>
<th>Strongly support</th>
<th>Somewhat support</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHP could help members with housing, food, and other services</td>
<td>71%</td>
<td>12%</td>
</tr>
<tr>
<td>OHP could get doctors and providers to work together to provide mental health and addiction services</td>
<td>52%</td>
<td>25%</td>
</tr>
<tr>
<td>OHP could help health plans save money to ensure coverage and benefits</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>OHP could pay providers based on how well your doctors take care of you</td>
<td>30%</td>
<td>18%</td>
</tr>
</tbody>
</table>

DHM RESEARCH | OHA OREGON HEALTH PLAN MEMBER SURVEY | AUGUST 2018
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.

- Provide help for housing, food, and other services: 24%
- Improve access to mental health and addiction services: 24%
- Reduce health care costs: 17%
- Pay providers for how healthy they keep you: 14%
- Have OHP members help make decisions: 12%
Members often turn to a DHS office for information about OHP, but many are relying on other sources.

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Department of Human Services office</td>
<td>26%</td>
</tr>
<tr>
<td>Friends or family</td>
<td>19%</td>
</tr>
<tr>
<td>A local health clinic</td>
<td>18%</td>
</tr>
<tr>
<td>The person who helped you with your OHP application</td>
<td>11%</td>
</tr>
<tr>
<td>A county office</td>
<td>9%</td>
</tr>
<tr>
<td>Community health workers</td>
<td>6%</td>
</tr>
<tr>
<td>Someone else</td>
<td>25%</td>
</tr>
</tbody>
</table>
Members trust OHP. They have positive impressions of the program and of their providers.

![Bar chart showing responses to OHP trust and impressions]

- **Oregon Health Plan**:
  - Very positive: 70%
  - Somewhat positive: 23%
  - Total: 93%

- **Nurses**:
  - Very positive: 73%
  - Somewhat positive: 18%
  - Total: 91%

- **Doctors**:
  - Very positive: 62%
  - Somewhat positive: 25%
  - Total: 87%
Appendix E: CCO 2.0 public input –

v. Public meetings list, including culturally specific outreach
## CCO 2.0 Public Meetings List

### October 2018
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/15/2018</td>
<td>Oregon Health Policy Board</td>
</tr>
</tbody>
</table>

### September 2018
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/18/2018</td>
<td>The Dalles Community Forum in Spanish</td>
</tr>
<tr>
<td>9/14/2018</td>
<td>Tribal &amp; OHA meeting</td>
</tr>
<tr>
<td>9/13/18</td>
<td>Hood River Community Forum in Spanish</td>
</tr>
<tr>
<td>9/4/2018</td>
<td>Oregon Health Policy Board</td>
</tr>
</tbody>
</table>

### August 2018
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/21/2018</td>
<td>Woodburn Community Forum in Spanish</td>
</tr>
<tr>
<td>8/10/2018</td>
<td>Tribal &amp; OHA meeting</td>
</tr>
<tr>
<td>8/7/2018</td>
<td>Oregon Health Policy Board</td>
</tr>
</tbody>
</table>

### July 2018
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/30/2018</td>
<td>CCO Leadership &amp; OHPB Joint Public Meeting</td>
</tr>
<tr>
<td>7/19/2018</td>
<td>CCO 2.0 Health IT Policy Options Webinar</td>
</tr>
<tr>
<td>7/10/2018</td>
<td>Oregon Health Policy Board</td>
</tr>
</tbody>
</table>

### June 2018
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/28/2018</td>
<td>Statewide Road Show: Henley Elementary School, Klamath Falls</td>
</tr>
<tr>
<td>6/27/2018</td>
<td>Statewide Road Show: Red Lion Hotel, Coos Bay</td>
</tr>
<tr>
<td>6/27/2018</td>
<td>Statewide Road Show: Astoria Armory, Astoria</td>
</tr>
<tr>
<td>6/26/2018</td>
<td>Statewide Road Show: OSU LaSells Steward Center, Corvallis</td>
</tr>
<tr>
<td>6/25/2018</td>
<td>CCO 2.0 Health IT Policy Options Webinar</td>
</tr>
<tr>
<td>6/21/2018</td>
<td>Statewide Road Show: Madison High School, Portland</td>
</tr>
<tr>
<td>6/20/2018</td>
<td>Statewide Road Show: Central Oregon Community College, Bend</td>
</tr>
<tr>
<td>6/19/2018</td>
<td>Statewide Road Show: Eastern Oregon Trade Center, Hermiston</td>
</tr>
<tr>
<td>6/19/2018</td>
<td>Statewide Road Show: Treasure Valley Community College, Ontario</td>
</tr>
<tr>
<td>6/18/2018</td>
<td>Statewide Road Show: Hood River Inn, Hood River</td>
</tr>
<tr>
<td>6/8/2018</td>
<td>Tribal &amp; OHA Meeting</td>
</tr>
<tr>
<td>6/5/2018</td>
<td>Oregon Health Policy Board</td>
</tr>
</tbody>
</table>

### May 2018
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/22/2018</td>
<td>CCO2.0 Financial Policy Stakeholder Roundtable</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Public Health Advisory Board</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>CCO Public Leadership Meeting</td>
</tr>
<tr>
<td>5/11/2018</td>
<td>Tribal &amp; OHA Meeting</td>
</tr>
<tr>
<td>5/11/2018</td>
<td>CCO2.0 Public Forum, Medford</td>
</tr>
<tr>
<td>5/10/2018</td>
<td>Addictions &amp; Mental Health Planning &amp; Advisory Committee</td>
</tr>
<tr>
<td>5/2/2018</td>
<td>Healthcare Workforce Committee</td>
</tr>
<tr>
<td>5/1/2018</td>
<td>Oregon Health Policy Board CCO 2.0 update</td>
</tr>
</tbody>
</table>

### April 2018
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/30/2018</td>
<td>CCO Financial Framework &amp; Sustainability: Stakeholder Roundtable Webinar</td>
</tr>
<tr>
<td>4/28/2018</td>
<td>Public Forum: Woodburn</td>
</tr>
<tr>
<td>4/27/2018</td>
<td>Children’s System Advisory Committee</td>
</tr>
</tbody>
</table>

Appendix E: CCO 2.0 public input – v. Public meetings list, including culturally specific outreach
CCO 2.0 Recommendations of the Oregon Health Policy Board
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/25/2018</td>
<td>Medicaid Advisory Committee</td>
</tr>
<tr>
<td>4/23/2018</td>
<td>Traditional Health Workers Commission</td>
</tr>
<tr>
<td>4/21/2018</td>
<td>Public Forum: The Dalles</td>
</tr>
<tr>
<td>4/19/2018</td>
<td>CCO Leadership Meeting</td>
</tr>
<tr>
<td>4/19/2018</td>
<td>Public Health Advisory Meeting</td>
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<tr>
<td>4/19/2018</td>
<td>Primary Care Payment Reform Collaborative</td>
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<tr>
<td>4/17/2018</td>
<td>CAC Learning Collaborative Special Event</td>
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<tr>
<td>4/16/2018</td>
<td>Health Equity Committee</td>
</tr>
<tr>
<td>4/13/2018</td>
<td>Oregon Alliance of Children’s Programs</td>
</tr>
<tr>
<td>4/13/2018</td>
<td>Oregon Academy of Family Physicians</td>
</tr>
<tr>
<td>4/12/2018</td>
<td>CCO Value-based payments workshop</td>
</tr>
<tr>
<td>4/11/2018</td>
<td>Oregon Consumer Advisory Council</td>
</tr>
<tr>
<td>4/11/2018</td>
<td>Tribal &amp; OHA Meeting</td>
</tr>
<tr>
<td>4/9/2018</td>
<td>Quality &amp; Health Outcomes Committee</td>
</tr>
<tr>
<td>4/9/2018</td>
<td>Oregon Health Policy Board</td>
</tr>
<tr>
<td>4/5/2018</td>
<td>Allies for a Healthier Oregon</td>
</tr>
<tr>
<td>4/5/2018</td>
<td>Health Information Technology Oversight Council</td>
</tr>
<tr>
<td>4/2/2018</td>
<td>Association of Counties</td>
</tr>
<tr>
<td>March 2018</td>
<td></td>
</tr>
<tr>
<td>3/27/2018</td>
<td>OHA Ombuds Advisory Council</td>
</tr>
<tr>
<td>3/8/2018</td>
<td>Addictions &amp; Mental Health Planning Advisory Council</td>
</tr>
<tr>
<td>3/6/2018</td>
<td>Oregon Health Policy Board</td>
</tr>
<tr>
<td>3/1/2018</td>
<td>Tribal &amp; OHA meeting</td>
</tr>
<tr>
<td>3/1/2018</td>
<td>Quality &amp; Health Outcomes Committee</td>
</tr>
</tbody>
</table>
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](http://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)
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)
14. Coalition for a Healthy Oregon COHO (submitted August 7, 2018)
15. Coalition of Local Health Officials (submitted May 1, 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)
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)
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)
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<td>Oregon Community Food Systems Network Veggie Rx (submitted July 6, 2018)</td>
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<td>Oregon Community Health Workers Association (submitted September 7, 2018)</td>
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<td>Trillium Community Health Plan (submitted May 18, 2018)</td>
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<td>Yakima Valley Farm Workers Clinic (submitted September 10, 2018)</td>
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Appendix F:

CCO 1.0 Maturity Assessments
CCO 1.0 Maturity Assessments

The Oregon Health Authority (OHA) led CCO 1.0 maturity assessments to capture the history, context, data, lessons learned and new policy opportunities for OHA to explore in the CCO 2.0 process. These assessments were completed in the following four areas and full assessments are available online.

1. **Sustainable Spending:**
   https://www.oregon.gov/oha/OHPB/CCODocuments/Maturity%20Assessment%20of%201.0%20-%20Spending%20Costs%20FULL.pdf

2. **Paying for Value:**
   https://www.oregon.gov/oha/OHPB/CCODocuments/Maturity%20Assessment%20of%201.0%20-VBP%20FULL.pdf

3. **Health Equity and Social Determinants of Health:**
   https://www.oregon.gov/oha/OHPB/CCODocuments/Maturity%20Assessment%20of%201.0%20-SDOHE%20FULL.pdf

4. **Behavioral Health:**
   https://www.oregon.gov/oha/OHPB/CCODocuments/Maturity%20Assessment%20of%201.0%20-BH%20FULL.pdf
Appendix G:

CCO 2.0 Timelines
Appendix G: CCO 2.0 Timelines

CCO 2.0 Recommendations of the Oregon Health Policy Board

Phase 1
Development of draft policy recommendations
- Input collected for policy development
- 3/15 Introductory Webinar on CCO
- Online survey open for 2.0 feedback
- March 6 Oregon Health Policy Board (OHPB)
- March 20 OHPB

Phase 2
Review/refinement of policy recommendations
- Policy options reviewed and discussed at existing public committee meetings
- Policy proposal straw model
- June 5 OHPB
- Extended Public Comment

Phase 3
Operationalizing recommendations
- Tribal Webinars: CCO 2.0 Policy
- Member Survey
- Individual 1:1 tribal consultations
- Aug 7 OHPB
- Sep 11 OHPB
- Oct 15 OHPB

Milestones
- Topic area work plans developed
- Review of policy options
- Policy proposal straw model
- CCO 2.0 Final report approval
Appendix H:

CCO 2.0 Definitions
CCO 2.0 Policy Development – Glossary and Definitions

**Adult mental health residential:** A facility that provides mental health treatment in a residential setting (long-term, overnight care).

**Alternative payment:** Payments made to health care providers (such as clinics, hospitals, doctors, nurses and others) that pay for a wider range of services than the usual “fee for service” payments. Value-based-payments are one method of alternative payment.

**Behavioral health:** Mental health and addictive disorders such as problem gambling and/or substance use disorders.

**Behavioral health homes:** Behavioral Health Homes (BHH) are health homes for individuals with behavioral health conditions (mental health and/or substance use disorder). BHHs integrate physical health into behavioral health to provide effective person-centered care for individuals with complex needs.

**Capitation rate or payments:** Capitation refers to the per-member / per-month payments that OHA makes to the CCOs to deliver and coordinate services for OHP members. CCOs receive different capitation rates for enrollees depending on their age, eligibility category, and other information. Capitation payments form the basis of the CCO revenue and does not dictate specifically how much money a CCO must spend on a specific OHP member or collection of members.

**Community advisory councils (CACs):** Community advisory councils advise their CCO about community health issues and include Medicaid members and other community members.

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

**CCO 2.0:** A reference to the vision and process being used by the state to design the next phase of coordinated care organizations. This process includes policy analysis, research, development, public input and discussion, as outlined on the CCO 2.0 website: www.oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx

**Care coordination:** Deliberate organizing of patient care activities and sharing information among all of the participants concerned with a patient’s care to facilitate appropriate delivery of effective integrated health care service.

**Community health assessment (CHA):** Health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

**Community health improvement plans (CHPs):** 5-year plans to address community health issues, needs, and priorities.
**Cost containment strategy:** The state’s or a CCO’s goals or activities that try to control or reduce overall spending on health care services.

**Cultural responsiveness:** The capacity to respond to the issues of diverse communities. Cultural responsiveness requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual.

**Culturally competent services:** Services that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities whose members identify as having particular cultural or linguistic affiliations by virtue of their providers do not make assumptions on the basis of an individual’s actual or perceived abilities, disabilities or traits whether inherent, genetic or developmental including: race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration/refugee status, marital status, socio-economic status, veteran’s status, sexual orientation, gender identity, gender expression, gender transition status, level of formal education, physical or mental disability, medical condition or any consideration recognized under federal, state and local law.

**Evidence-based or emerging best practices:** Concepts or strategies that use fact-based information when designing programs and policies.

**Fee-for-service (FFS):** Payments to health care providers for delivering a specific service to a specific patient.

**Health Care Payment Learning and Action Network (LAN):** A national effort partially funded by CMS to accelerate VBP adoption by states and the commercial insurance market. They developed a “Framework” for categorizing VBPs that the Oregon Health Authority will use to measure progress in the adoption of VBPs.

**Health disparities:** Differences in health status and outcomes between populations.

**Health equity:** Means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination.

**Health information exchange (HIE):** The electronic movement of health care information between two or more organizations.

**Health information technology (HIT):** Refers to a wide range of products and services – including software, hardware, and infrastructure – designed to collect, store and exchange health care information.

**Health-related services (HRS):** Non-covered services offered as a supplement to covered benefits under Oregon’s Medicaid State Plan to improve care delivery and overall member and community health and well-being.
**Incentive metrics:** The specific set of performance measures included in the Quality Incentive Program, used to evaluate CCO performance and distribute funding from the Quality Pool. Metrics are chosen annually by the Metrics & Scoring Committee to measure CCO performance related to access to care, the quality of care they deliver, and patient and community health outcomes. Through the Quality Incentive Program, CCOs achieve financial rewards if they meet specific performance benchmarks or improvement targets.

**Integration:** When behavioral health, physical health, and/or oral health providers work together as a team.

**OHP member:** The Oregon Health Plan (OHP) is our state Medicaid program. It provides health care coverage for low-income Oregonians from all walks of life. This includes working families, children, pregnant women, single adults, seniors and more. Most OHP members get their care through a CCO.

**Oral health:** Refers to healthy teeth, dental care, and a disease-free mouth.

**Parity:** The Mental Health Parity and Addiction Equity Act of 2008 requires insurance to provide the same level of benefits for behavioral health as they do for medical/surgical care.

**Physical health:** Refers to the medical care provided for an individual's general health and well-being, not including behavioral health (mental health and substance use disorder) and oral health (dental). For example, health care services delivered by a primary care provider, such as a well-child visit or services to treat physical ailments, delivered at hospitals or other clinics.

**Population health policy and systems change:** Interventions that occur outside a clinical setting and are intended to shift health outcomes collectively for a group of individuals. Policy change refers to changes to rules or procedures within the community or the organization. Systems change refers to changes to infrastructure within the community or the organization. Examples include interventions intended to improve access to healthy and affordable housing within the community, or reduce use of harmful products such as tobacco and sugary drinks, which may include pricing strategies.

**Preferred drug list (PDL):** A set of prescription drugs that are given preferential pricing and access based on their efficacy, safety, cost effectiveness and other factors. Currently CCOs (and health carriers generally) set their own PDLs based on negotiations with pharmaceutical companies, which may differ from the PDL used by OHA for Fee-For Service enrollees.

**Provider networks:** The list of providers who contract with an organization to provide services.

**Providers:** Someone who delivers health care, like a doctor or a nurse.

**Quality incentive program:** The program administered by OHA to provide financial incentives to reward CCO performance on a set of access, quality and outcome metrics (“incentive metrics”) selected annually by the Metrics & Scoring Committee. Through this program, CCOs achieve financial rewards if they meet specific performance benchmarks or improvement targets. Funding for the program comes from the Quality Pool.
**Quality pool:** The funding pool for the Quality Incentive Program, used to pay CCOs based on their performance on incentive measures chosen by the Metrics & Scoring Committee. In the first CCO contract period, the quality pool was funded with a bonus payment above their capitation rates. The size of the quality pool is calculated based on funding availability within the OHP budget set by the Oregon Legislature.

**Recognition program:** A way of identifying and rewarding programs and organizations for meeting certain targets, outcomes, or standards of performance.

**Recovery support services:** Incorporates social, legal and other services to assist individuals and families working towards recovery from mental health and addictive issues.

**Regional health equity coalitions:** Community groups that work to increase health equity in their communities.

**Reimbursement rates:** Payments made to health care providers (clinics, pharmacies, hospitals, and others) for delivering services to patients.

**Reinsurance:** A type of insurance product used by insurers to protect against costs associated with very high claims. Health insurers typically purchase reinsurance from private reinsurance carriers, but states are increasingly considering broader reinsurance programs in Medicaid and commercial markets to reduce cost volatility and increase affordability.

**Social determinants of health equity:** Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies, and political systems, both historical and current. Institutionalized racism is one example.

**Social determinants of health (SDOH):** The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Some examples are poverty, access to housing, transportation, and neighborhood safety.

**Sustainable rate of growth:** The Oregon Health Plan (OHP) operates under a targeted, annual fixed rate of growth in an effort to control and contain costs across the program. The target growth rate in Oregon’s current 1115 Medicaid waiver is 3.4%. However, the Oregon Legislature also sets a biennial growth target for the state portion of the budget that is evaluated against the rate of growth, and this may be different than the target in the 1115 waiver.

**System of Care (SOC):** A coordinated network of services and supports, including education, child welfare, public health, primary care, pediatric care, juvenile justice, mental health treatment, substance use treatment, developmental disability services and any other services and supports to the identified population that integrates care planning and management across multiple levels, that is culturally and linguistically competent, that is designed to build meaningful partnerships with families and youth in the delivery and management of services and the development of a supportive policy and management infrastructure.
**Telehealth/telepsychiatry:** Telehealth is the delivery of medical, health and education, or dental assessment and oral health care services using telecommunications. Telepsychiatry is the delivery of psychiatric assessment and psychiatric care through telecommunications.

**Traditional health workers (THWs):** THWs help individuals in their communities by providing physical and behavioral health services. There are five types of THWs: doulas, peer-support specialists, peer-wellness specialists, personal health navigators, and community health workers. A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

**Trauma informed care (TIC):** An approach, based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff.

**Value-based-payment (VBP):** A strategy to pay health care providers for quality outcomes and value, rather than quantity or volume of services provided.

**Wraparound:** A definable, team-based planning process involving a Member 0-17 years of age (or Members who continue receiving Wraparound services from 18-25 years of age) and the Member’s family that results in a unique set of community services, and services and supports individualized for that Member and family to achieve a set of positive outcomes.
October 22, 2018

Pat Allen, Director, Oregon Health Authority

Dear Pat:

I am providing comments on behalf of the Association of Community Mental Health Programs (AOCMHP) on proposed service areas for CCOs in the 2020-2025 contract period. As you know, CCOs contract with CMHPs for direct behavioral health services and local system management, which contributes to the safety net and the health of the whole community. We strongly support defining service areas by counties, both allowing single-county service areas and groups of adjacent counties, and not allowing new applicants to propose serving a portion of a county. Consequently, we do not support more than one CCO per county for the following reasons:

- Considering OHA’s main priorities and values guiding the service area approach, CCOs need to be aligned with single or multi-county-based early learning hubs and to initiate or strengthen MOUs with LPHAs/LMHAs/CMHPs for local system planning and management. Multiple CCOs in the same county make it difficult to navigate the local system, to assure standardized, value-based care/payment and cost containment, and to maintain consistent service delivery expectations within a county.

- We highly value public health system stewardship and transparency, necessitating a governance structure with meaningful roles for local leadership (LPHA, LMHA, CMHP, CAC), which all have statutory authority in county-level jurisdictions.

- We support OHA efforts to strengthen accountability for CCO investments into longer term population health at the community level, such as prenatal and early childhood interventions, behavioral health services in schools, and evidence-based prevention efforts across the lifespan.

- We support more investment in safety net and capacity-based services, including 24/7 crisis services (similar to police, fire, and other first responders, which also have county-based service areas), and these investments align with the county structure.

Thank you for the opportunity to provide comments.

Sincerely,

Cheryl L. Ramirez
Director, AOCMHP
Dear Oregon Health Policy Board Members,

The Association of Oregon Community Mental Health Programs (AOCMHP), representing the public behavioral health system and safety net, strongly supports Policy Recommendation #10 to increase CCOs’ use of value-based payments (VBP) with their contracted providers. While we fully endorse the use of VBP and infrastructure development in PCPCHs to move from fee for service (FFS) to VBP, we strongly believe that investing in integrated care and infrastructure development in behavioral health homes is essential to enable our whole health care system to use VBPs wherever people choose to go for their health care. As behavioral health system improvement is a priority area for the Governor and a care delivery focus area for OHA, we should move forward in both health home models, integrating care between the two to help CCOs, CMHPs, community health centers (CHCs) and other health system partners to get to the VBP targets in the policy recommendation.

Moving to VBP is not without its challenges, many of which are articulated in OHA’s policy recommendation narrative. Some of the most critical hurdles for the behavioral health system to clear include the following:

- Integration is not incentivized as evidenced by coverage deficits, insufficient and denial of payments in both primary and behavioral health care settings.
- Infrastructure development in the behavioral health system is far behind the physical health system due to historical underfunding and lack of parity in federal and state policy (e.g., HITECH Act exclusion, Mental Health Parity and Addictions equity enforcement problems, etc.). Integrated electronic health records and data management systems, along with a few key metrics, are integral for VBP to be successful.
- Workforce development, both investing in training and fair pay for the mental health and addictions treatment workforce, is critical to strengthening and sustaining the behavioral health system as an equal partner to physical health.

When considering the move to VBP, it is critically important to understand that community-based behavioral health care has been historically underfunded, along with social services, and is shrinking as a percentage of total healthcare spending. In order for the move to VBP to be successful, the rates cannot be less than the current FFS rates, which are already inadequate to sustain the safety net. Additionally, the behavioral health system must be able to share in the savings that behavioral health services bring to the medical system to continue investments to help people get jobs, go to school and graduate, find stable housing, and stay out of jail and hospitals. We would add that when CCOs use value-based payments that allow for flexibility
between encounterable and non-encounterable services to achieve outcomes, they should be held harmless from negative impacts on rate setting in the future based on the move away from a FFS focus.

And now a word about our 12 Certified Community Behavioral Health Clinics (CCBHCs): CCBHCs are Oregon’s first statewide attempt at initiating behavioral health homes (BHHs) through a federal demonstration pilot under an agreement between SAMHSA and OHA to pay CCBHCs a Medicaid wrap rate for an array of services and specified target population, a similar arrangement OHA has with CHCs. We strongly support Policy Recommendation #39 to identify, promote and expand programs that integrate primary care in behavioral health settings (BHHs), but we are concerned that the two-year CCBHC demo will be dismantled in March 2019, without a concrete plan to allocate State general funds needed to maintain the match after the demo is concluded. It does not make sense to tear down the infrastructure and reduce the workforce that has been built up over the last two years to help BHHs/CCBHCs integrate care, improve access, and contribute to better health outcomes for their communities, only to attempt to resurrect the effort two years later (through CCO 2.0 Year 2 policy recommendation). We commit to working with OHA to find a way to sustain and expand CCBHCs across the state as the best way of moving toward an integrated and value-based care system. Whether we sustain the current CCBHC demo or begin again in 2021, we also recommend tailoring the number of primary care service hours provided in behavioral health homes to the size of the population served by each behavioral health home.

Thank you for the opportunity to provide comments on value-based payment and integrated care.

Sincerely,

Cherryl L. Ramirez
Director, AOCMHP
1. Oregon Health Authority 2019-21 Budget Request and Policy Option Packages:
   - 408 – Continuation of Mental Health Funding (backfilling SEs that were funded by marijuana tax revenue in 17-19): $16,039,052
     - Note: The funding gap will either be covered by this POP or by a legislative concept to remove the sunset from SB 1555; Either way, this does not represent an increase for Counties and CMHPs in addiction prevention, early intervention and treatment unless there is advocacy for adherence to the original language referendum to allocate cannabis tax revenue on top of existing prevention and treatment funding to make real progress in addiction recovery and prevention.
   - 413 – Behavioral Health Funding Shortfall (in tobacco tax revenues): $9,132,500
   - 402 – Expand Behavioral Health Services, including suicide intervention and prevention, in schools for children and youth; develop adult suicide prevention, intervention and postvention plan: $13,103,059
   - 403 – Intensive In-Home Behavioral Health Services: $6,575,316
   - 410 – Aid & Assist misdemeanor defendants – intermediate placement options (LC 383): $7,612,914
   - 411 – Behavioral Health System investments (LC 364 – Behavioral Health Homes) and (LC 368 – MH Clinical Advisory Group on pharmaceuticals): $5,530,100
   - 414 – MOTS/COMPASS System modernization and completion (or other data management system): $6,739,793

2. Department of Human Services 2019-21 Budget Request and Policy Option Packages:
   - 102 – IDD 100% Workload Model (restore CDDP and Brokerage funding back to 100% workload FTEs at 95% equity)
   - 126 – Workforce Expansion and Development (Direct Support Professionals)
   - 118 – IDD Data Management System (statewide, centralized I/DD client system across 47 CMEs for intake, eligibility, enrollment, case management assessment, person centered planning and monitoring, adult protective services and other functions)
Public Safety/Criminal Justice

3. **Workgroup to Decriminalize Mental Illness** - Civil Commitment criteria expansion (LC 814) and extending length of holds (LC 749)

4. **Behavioral Health Justice Reinvestment Initiative** — Recommendations from Council of State Governments through grant with Criminal Justice Commission (LC not completed yet; Governor’s Task Force is being formed to create LC)

5. **Aid & Assist (.370) process improvement** (OSH) — Stakeholder group is opting for a more systemic approach (to be conceptualized on 10/10)

6. **Disability Rights Oregon Concepts** — Protect the confidentiality of social and medical records for adults placed under the PSRB; Assure a defendant’s notification of the effects of a guilty except for insanity plea; Update Community Mental Health Services Bill of Rights to expand definition of “Program” beyond CMHPs to other providers.

Children

7. **School Safety Task Force** — Support youth suicide prevention efforts; Support bullying and harassment prevention efforts; Statewide implementation of Threat Assessment system; Promote statewide school safety tip line (LC modified from HB 2812-2 in 2017)

8. **Suicide Prevention/Mental Health Promotion and Service Provision in or connected to Schools (multiple efforts)** — Basic Rights Oregon (suicide prevention regulations and protocols for schools); Student Success Committee Recommendations (Includes Oregon Safe and Effective Schools for All Students Advisory Committee; Governor’s Children’s Cabinet; Confederation of Oregon School Administrators; Oregon Education Association; Oregon Task Force on School Safety – see #7; Oregon Business Council; and Educator Advancement Council); and POP 402 in OHA Budget; Suicide prevention stakeholders are preparing a legislative advocacy one-pager

9. **Children with Specialized Needs Workgroup (Governor’s Child Welfare Platform)** — Crisis and transition services: community services, in-home supports, therapeutic foster care, face-to-face; Regional assessment programs; Stabilize residential care; Better data; Strengthen system of care at state and local levels.
This Memorandum of Understanding, dated __________, 2018, by and between the ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS, of Salem, Oregon, (hereinafter referred to as "AOCMHP") and the ASSOCIATION OF OREGON COUNTIES, of Salem, Oregon, (hereinafter referred to as "AOC"), for the mutual considerations and benefits of the parties, provided for as follows:

AOC and AOCMHP agree to engage in ongoing communication in a timely manner concerning matters of mutual interest.

A. AOC agrees to:

- Encourage and support Commissioners to develop working relationships and ongoing communication with their local Community Mental Health Programs (CMHPs) and to be informed of the main policy and budget issues concerning their role as Local Mental Health Authorities (LMHA’s).
- Develop relationships with state and federal administrators, elected officials, and staff to advocate and develop bipartisan support for community mental health, addictions, and developmental disability policy and funding priorities.
- Write effective and concise issue briefs in conjunction with AOCMHP for commissioners on key community mental health system policy, including but not limited to the LMHA role.
- Provide testimony and respond to requests in conjunction with AOCMHP to State Legislature, including Legislative Fiscal Office, Legislative Counsel, Committee Administrators, and Legislators. Mobilize and support commissioners and advocates to attend hearings, contact legislators, impact media, and provide testimony.
- Provide education and communication on community mental health system policy issues for commissioners through in-person meetings, emails, policy briefs, and the AOC newsletter.
- Attend AOCMHP monthly and quarterly meetings, and Legislative and other committee meetings as needed, schedule and staffing permitting.
- Conduct joint field visits with AOCMHP staff to help develop positive working relationships with local mental health directors and County Commissioners, schedule permitting.
- Include AOCMHP as a voting member of the AOC Health and Human Services Steering Committee.

B. AOCMHP agrees to:
- Encourage and support their members to share policy and budget positions and communicate regularly with their local County Commissioners.
- Help lead policy discussions and provide program technical information at monthly AOC Health and Human Services Steering Committee meetings.
- Advise on AOC positions for key policy and legislative initiatives pertaining to community mental health, addictions and developmental disabilities systems.
- Provide state legislative and administrative advocacy on health and human services issues relating to mental health, addictions, and developmental disabilities systems.
- Provide education and communication on community behavioral health and developmental disabilities systems for County Commissioners at the AOC Annual Conference, the County College, and other events as needed, schedule permitting.
- Support the growth of skills, knowledge and professionalism among CMHP directors across the state through activities such as “CMHP director orientation” and formal/informal mentoring, understanding that Commissioners have a vested interest in having high quality, effective local leaders who benefit and grow through their membership in AOCMHP.
- Represent the community-based mental health and developmental disabilities systems, both in Oregon and nationally, through leadership on the National Association of County Behavioral Health and Developmental Disabilities Directors, and on the National Association of Counties Board of Directors.
- Partner with AOC policy managers and other staff on special initiatives when it fits within the strategic focus of AOCMHP’s annual plan. (e.g., Stepping Up Initiative, Mental Health Justice Reinvestment).

(KMM) C. When AOCMHP and AOC differ on policy positions, representatives of each association agree to actively participate in a specific meeting, hosted by a mutually agreed upon facilitator, to review and refine each association’s communication strategy. Each association agrees to be candid and clear on their position, provide evidence of impacts of their position, and share their respective strategy for communicating with the Legislature. At the meeting’s conclusion, emphasis will be placed on collaborative development of inclusive talking points, with the goals of minimizing confusion for lawmakers and focusing on areas of agreement and common interest.

(Cherryl) C. When AOCMHP and AOC differ on policy positions, representatives of each association agree to meet to review and refine their communication strategies with the Legislature to ensure collaborative development of inclusive talking points, with the goals of minimizing confusion for lawmakers and focusing on areas of agreement and common interest.

D. This agreement may be amended at any time by mutual agreement of the parties. Any such changes to this original agreement shall be done in writing and signed by both parties.

By: ______________________________  By: ______________________________
Mike Eliason                      Cherryl Ramirez
Dear Governor Brown,

On behalf of the Association of Oregon Community Mental Health Programs (AOCMHP), I would like to express our support for the Oregon Health Authority budget request, including the proposed policy option packages. I have listed AOCMHP’s highest priorities below, ranked in order of greatest need for our community mental health system. Community mental health programs (CMHPs) operate and manage the local behavioral health system, providing the safety net for their communities. Many CMHPs provide direct services, while others contract out to local behavioral health providers.

Our top two priorities, POPs 408 and 413, would keep our local delivery system at current service level. Without this funding our behavioral health system will experience cuts. Additionally, while marijuana access and use continues to rise, POP 408 would not represent an increase for CMHPs in addiction prevention, early intervention and treatment. In order to make real progress in addiction recovery and prevention, additional current cannabis tax revenue needs to be allocated on top of existing prevention and treatment funding:

- 408 – Continuation of Mental Health Funding (backfilling SEs that were funded by marijuana tax revenue in 17-19): $16,039,052
- 413 – Behavioral Health Funding Shortfall (in tobacco tax revenues): $9,132,500

The next two priorities are aligned with our focus on prevention and early intervention, keeping kids in school and at home. AOCMHP staffs the Alliance to Prevent Suicide and facilitates suicide prevention and mental health promotion trainings across the state, which are key components of POP 402. AOCMHP also has a seat on the School Safety Task Force, which is introducing a suicide and bullying prevention legislative concept, and is in partnership with other groups advocating for student mental health supports working with the Joint Committee on Student Success. CMHPs are also responsible for overseeing or providing in-home behavioral health services, and POP 403 is aligned with our mission and value to keep kids with their families and in their home communities if at all possible, rather than placing them in out of county or out of state treatment facilities:

- 402 – Expand Behavioral Health Services, including suicide intervention and prevention, in schools for children and youth; develop adult suicide prevention, intervention and postvention plan: $13,103,059
- 403 – Intensive In-Home Behavioral Health Services: $6,575,316

Our other top priority focuses on people with behavioral health disorders who are involved in the criminal justice system. CMHPs, supported by OHA, and in partnership with local Public Safety systems, work to divert people from jail and the Oregon State Hospital through community restoration, housing and intensive services. As the funding is very limited to do this work, we support POP 410 to help us keep Aid & Assist defendants in their communities if at all possible:
• 410 – Aid & Assist misdemeanor defendants – intermediate placement options (LC 383): $7,612,914

As Oregon’s first version of behavioral health homes, we strongly encourage the continuation and expansion of Certified Community Behavioral Health Clinics (CCBHCs) after the federal demonstration project ends on March 31, 2019. CCBHCs are showing great progress in integrated care and supporting the behavioral health needs of their communities. Defunding the CCBHCs would be counter to Oregon Health Authority’s priority recommendation for CCO 2.0 to invest in behavioral health homes to improve bidirectional integrated care and to ensure access to care for people whose primary care needs are best met at a community mental health center. Nine out of 12 of the CCBHCs in Oregon are also CMHPs. We support POP 411 that would provide additional investments for Behavioral Health Homes:

• 411 – Behavioral Health System investments (LC 364 – Behavioral Health Homes) and (LC 368 – MH Clinical Advisory Group on pharmaceuticals): $5,530,100

Lastly, in order to truly measure our behavioral health system’s effectiveness, move to value-based care and payment, and to enable us to make course corrections when needed, we must be able to rely on non-Medicaid data in addition to Medicaid data to tell the whole story, especially the essential safety net and cross system work that does not show up in encounter-based claims. Whether MOTS is modernized or OHA moves to a different data management system, this is essential for statewide behavioral health system improvement.

• 414 – MOTS/COMPASS System modernization and completion (or other data management system): $6,739,793

Thank you for your consideration and for your prioritization of behavioral health and children’s well-being as key focus areas.

Sincerely,

Cherryl L. Ramirez
Director, AOCMHP
Fixing Healthcare in America
Design/Build Workshop

Today’s Format

• Part 1: Dale’s Environmental Scan
  • Discussion Topic
  • My Prediction
  • AOCMHP as the Focus Group
  • Repeat

• Part 2: Design Workshop
  • Review of our 2016 Work
  • AOCMHP Charting a Course to the Future
Part 1 Discussion Topics

1. What’s Going on with National Healthcare Reform?
2. What’s Going on in the Private Sector?
3. What’s Going on in BH Nationally?
4. What’s Going on in Oregon?

My High Level Predictions

• The rate of change in the private healthcare sector is going to accelerate dramatically.
• The public section health and behavioral health systems will fall 5 – 10 years behind the curve.
• Every AOCMHP member needs understand what’s coming, carefully read their local tea leaves, and decide how and when to jump into the future. If you jump too early or too late, you will be toast.
• The AOCMHP itself needs to both lead the membership on positioning the organization to be where the puck is going, and support each member in their individual trajectories into the future.
What’s Going on with National Healthcare Reform?

Fixing Healthcare is a Top Priority

Percent who say each of the following issues is “very important” in making their decision about who to vote for Congress this year:

- Health care: 71%
- The economy and jobs: 64%
- Gun policy: 60%
- Immigration: 55%
- Tax cuts and tax reform: 53%

The 2018 Midterms Are All About Health Care

As the impact of Trump’s attack on Obamacare becomes clear to voters, Democrats are going all-in on Medicare for All.

By SARAH JONES | July 20, 2018
The ACA is still standing... And Expanding
Alternative Payment Models are Stumbling

Difficult to keep up with the proliferation of increasingly complex APMs.
Practices that have invested in APMs haven’t changed patient care.
It often costs more to manage to APMs than the incentive payment.
The AMA, the AHA and other trade groups are calling for a slow down in the transition to value-based payments.
Healthcare Information Technology is Stumbling

Physicians are spending 2 hours of computer work for every 1 hour of patient time... resulting in an epidemic level of clinician burnout.

So, here’s where we are with physicians: a third of the 954,000 physicians are looking for an exit strategy. The rest are looking for a career option where they are respected, compensated well and provided the tools to practice sans administrative hassles and paperwork. They are closely watching the disruptors like Amazon, Apple, Walmart, CVS, Walgreens, Optum and others hoping new opportunities will emerge.

• Physician Discontent: Have we Reached their Tipping Point? (Paul Keckley, 10/30/2018)
Election 2020: Fix the Health Insurance and Delivery System…

And if we don’t do a better job fixing what’s under the hood, we will fail!

My Predictions

• The current wave of Value-Based Purchasing will be come to known as Managed Care 2.0.
  • Technocratic initiatives to “control” clinician behavior because they can’t be trusted on their own to achieve better health, better care and better cost.

• This wave will eventually be rejected in the same way that Managed Care 1.0 blew out of the private insurance market.

• Forward thinking healthcare leaders will figure this out early and attempt to rethink how metrics and payments are used.

• If enough leaders figure this out, we may be able to prevent the workforce from bolting and save the system.

• If not, “Houston we have a problem!”
What would you add to my National Healthcare Reform scan?

What are your elephants in the living room? Anything like mine?

How do we deal with payors mandating Managed Care 2.0?

What’s Going on in the Private Sector?
The Ecosystem is Radically Changing

1. **Large legacy hospital healthcare systems** are in major acquisition mode in order to gain larger market share.
2. **Health Plans** are attempting to reinvent themselves and move horizontally and vertically throughout the ecosystem.
3. **Large non-healthcare firms** (not generally part of the healthcare industrial complex) are coming on the scene.

And all of this is very relevant to everyone in this room!

---

Health for a Better World

Every day, 119,000 compassionate caregivers serve patients and communities through Providence St. Joseph Health, a national, Catholic, not-for-profit health system, comprising a diverse family of organizations and driven by a belief that health care is a human right. Rooted in the founding missions of the Sisters of Providence and the Sisters of St. Joseph of Orange, courageous women ahead of their time who brought health care and other social services to the American West when it was still a rugged, untamed frontier, we share a singular commitment to improve the health of all.
• Health Plans are using their enormous resources to reinvent themselves.

• The New Optum:
  – Disease management
  – Wellness programs
  – Clinical Decision Support
  – Collaborative Care
  – Financial Services
  – Primary Care
  – Reporting and Insight
Aetna/CVS Merger

$69 billion deal
CVS: 9,700 pharmacies and 1,100 Minute Clinics
New Front Door
Medical version of Apple’s Genius Bar

“Patients will be able to go to a local CVS in between doctor visits for glucose level monitoring, counseling on how and when to use medications and advice on weight loss programs and better dietary habits.”
Collectively, Amazon, Berkshire Hathaway and J P Morgan have 1.2 million employees. They believe that the medical industrial complex can’t fix the problems they created.

Instead they are using an Amazon approach to target 3 types of waste: 1) high administrative costs, 2) high prices, and 3) improper healthcare utilization.

If they’re successful, they will share their work for free.
### ABJ’s Healthcare Venture: Functional Matrix

#### Individual Health Jobs-To-Be-Done

<table>
<thead>
<tr>
<th>Corporate Jobs-To-Be-Done</th>
<th>Fix Me When I’m Broken</th>
<th>Keep Me As Healthy As Possible</th>
<th>Help Me Make Smarter Lifestyle Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Design</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Care</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Wellness</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Incentives</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Purchasing Healthcare</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episodic</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corporate Wellness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diet</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>End-of-Life Care &amp; Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End-of-Life Care &amp; Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Who’s reinventing health benefits? One of the most hated companies in the U.S.**

Comcast is among a handful of employers declaring progress in reaching a much-desired goal: keeping health-care costs flat. Some consider the cable company to be “the most interesting and creative employer when it comes to health-care benefits.”

*The Seattle Times*
The Comcast Story

- 225,000 employees, $1.3 billion annual healthcare spend.
- In the last 5 years, their health care costs have increased only 1% per year (vs 3-10% for other big companies).
- Key Strategies:
  1. Shunned insurance companies as the source for ideas.
  2. Lowered deductible to $250 per year.
  3. **Accolade**: makes Navigators available for any employee.
  4. **Grand Rounds**: offers second opinions on helping employees find a doctor.
  5. **Doctor on Demand**: access to a doctor via cellphone.
  6. **Brightside**: help employees manage their finances.

My Prediction

- “Healthcare is 100 times more complicated than any other problem I’ve tried to wrap my brain around.” (Clayton Christensen, Disruptive Innovation guy)
- The private sector will get to the fix faster than the private sector.
- Politics and Regulations will result in the public sector continuing to struggle.
- Both sectors will get to the fix faster if they can cross pollinate in meaningful ways.
What are you already doing that should go on this “innovation list”?

Are any of these emerging innovations relevant to your community?

What do you think about my prediction that the private sector will get there first?

What’s Going on in BH Nationally?
The New Mexico Story

New Mexico, Chapter 1

• June 2013
  – State-hired Public Consulting Group's audit sampling found that 15 large CMHCs had $42,500 in overbillings that were also possible Medicaid fraud.
  – PCG extrapolated the overbillings to $36 million over a 3.5 year period, froze all billings and demanded payback.
New Mexico, Chapter 2

- 2nd Half 2013 - 2014
  - Lawsuits are filed while payments continue to be frozen.
  - Most of the 15 local CMHCs go out of business.

New Mexico, Chapter 3

- 2015-2016
  - 15 of the 15 NM CMHCs cleared of fraud, only $1.16M in overbillings, but it's too late.
  - New Mexico asks the state’s FQHCs to take over the programs and staff from the departing Arizona CMHCs.
New Mexico, Chapter 4

• 2017-2018
  – Currently, the majority of New Mexico’s BH services are being provided by FQHCs, bringing more federal funding into the state.

TRUTH OR CONSEQUENCES
Sierra Vista Hospital
800 East 9th Avenue
Truth or Consequences, NM 87901

FARMINGTON
La Familia/Namaste
626 East Main Street
Unit 5
Farmington, NM 87401

ARTESIA
Presbyterian Medical Services (PMS)
Artesia Health Resources
1105 Memorial Drive
Artesia, NM 88210

SANTA FE
Christus Saint Vincent Reg Med Center
Behavioral Health Unit
455 Saint Michaels Drive
Santa Fe, NM 87505

ALBUQUERQUE
La Familia Inc
DBA La Familia/Namaste
2600 Wellesley Drive NE
Albuquerque, NM 87107

LAS CRUCES
El Paso VA Healthcare System
Las Cruces Clinic
1635 South Don Roser Drive
Las Cruces, NM 88011

SILVER CITY
Gila Regional Medical Center
1313 East 32nd Street
Silver City, NM 88061

The MultiCare Story

CARE WHERE YOU ARE, WHEN YOU NEED IT

Multicare Virtual Care gives you anytime access to a doctor through your computer, phone or mobile app. It’s an affordable option for quality medical care. →
Good Samaritan Hospital acquired one of the 3 Tacoma area mental health centers in the late 1990s

Then Good Sam merged with MultiCare in 2006

In 2017 MultiCare acquired Navos, one of the largest CMHCs in Seattle

In early 2018 the 2nd Tacoma mental health center came into the fold

Community Psychiatric Clinic to Merge with Navos

In June, Navos, a wholly-owned affiliate of MultiCare and our behavioral health partner, and Community Psychiatric Clinic (CPC), a well-established behavioral health organization based in Seattle, announced plans to combine and merge operations under the Navos name. We are excited to welcome CPC to the greater MultiCare family. Learn more about this upcoming merger.

My Prediction

• Mergers to achieve Economies of Scale (horizontal integration) and Vertical Integration are going to affect every corner of the delivery system.
• MH/SUD/BH Provider Organizations will be swept up in this next phase of Mergers and Acquisitions.
• Oddball New Mexico added credence to the FQHC/CMHC consolidation model that will become the rule, not the exception.
• There will be very few free standing MH/SUD/BH Provider Organizations left standing.
Is any of this happening in your community?

Will any of this come to your community?

What do you think about my predictions?

What’s Going on in Oregon?
CCO Narrative 1: “Doing great, keep going”

• 1 million + members on the Oregon Health Plan.
• > 90% receive care through a CCO.
• 94% of Oregon’s providers see OHP members.
• Oregon is meeting the commitment to reduce spending growth by 2% per year.
• Most CCOs earning their Incentive Payments.

CCO Narrative 2: “We’re not improving fast enough”

• Health Reform in the Affordable Care Act era is made up of “halfway technologies”.
• Example
  – The iron lung was invented to treat individuals with polio
  – It addressed the symptoms, not the underlying problem
  – In contrast to the polio vaccine, which was a full technology
• All of the exciting health reform work going on in Oregon fits into the category of “halfway technologies”. (Mitch Greenlick)

• While Oregon is touted as the most successful state in the country in terms of Medicaid reform, succeeding in
• It’s not doing enough to create a shift from a Sick Care System to a true Health System
What’s Your Assessment?

CCO Narrative 1: “Doing great, keep going”
- 1 million + members on the Oregon Health Plan.
- > 90% receive care through a CCO.
- 94% of Oregon’s providers see OHP members.
- Oregon is meeting the commitment to reduce spending growth by 2% per year.
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- All of the exciting health reform work going on in Oregon fits into the category of “halfway technologies.”
  (Mitch Greenlick)

BH Narrative 1: “We have a Plan to fix BH; It’s called CCO 2.0”

Improve the behavioral health system and address barriers to access to and integration of care

1. Require CCOs be fully accountable for the behavioral health benefit
2. Assess capacity of comprehensive services
3. Address prior authorization and network adequacy issues that limit member choice and timely access to providers
4. Use metrics to incentivize behavioral health and oral health integration
5. Expand programs that integrate primary care into behavioral health settings
6. Require CCOs to support electronic health record adoption and access to electronic health information exchange
7. Develop a diverse and culturally responsive workforce, and
8. Ensure children have behavioral health needs met with access to appropriate services.
BH Narrative 2: Tinkering with a dramatically underfunded system… fits the definition of tinkering.

- Tinker (v)
  Attempt to repair or improve something in a casual or desultory way, often to no useful effect.

<table>
<thead>
<tr>
<th>Oregon Health Plan Members</th>
<th>Youth</th>
<th>Adults</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>409,752</td>
<td>640,426</td>
<td>1,050,178</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Need</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members Served</td>
<td>63,100</td>
<td>255,900</td>
<td>319,000</td>
</tr>
<tr>
<td>Unserved Gap</td>
<td>12,400</td>
<td>147,000</td>
<td>160,000</td>
</tr>
<tr>
<td>Mental Health Gap %</td>
<td>20%</td>
<td>58%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Use Disorders</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder Need</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members Served</td>
<td>9,600</td>
<td>121,800</td>
<td>131,400</td>
</tr>
<tr>
<td>Unserved Gap</td>
<td>6,000</td>
<td>80,700</td>
<td>86,700</td>
</tr>
<tr>
<td>Substance Use Disorder Gap %</td>
<td>63%</td>
<td>60%</td>
<td>66%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unserved Gap</td>
<td>12,400</td>
<td>147,000</td>
<td>160,000</td>
</tr>
<tr>
<td>Average Cost per Person</td>
<td>$2,800</td>
<td>$1,000</td>
<td>$1,200</td>
</tr>
<tr>
<td>Cost to Close the Gap</td>
<td>$14,700,000</td>
<td>$162,200,000</td>
<td>$196,900,000</td>
</tr>
<tr>
<td>FTEs Needed to Close the Gap</td>
<td>269</td>
<td>1,340</td>
<td>1,609</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Use Disorders</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unserved Gap</td>
<td>6,000</td>
<td>80,700</td>
<td>86,700</td>
</tr>
<tr>
<td>Average Cost per Person</td>
<td>$1,850</td>
<td>$1,335</td>
<td>$1,400</td>
</tr>
<tr>
<td>Cost to Close the Gap</td>
<td>$11,200,000</td>
<td>$107,600,000</td>
<td>$118,800,000</td>
</tr>
<tr>
<td>FTEs Needed to Close the Gap</td>
<td>82</td>
<td>806</td>
<td>888</td>
</tr>
</tbody>
</table>

**What’s Your Assessment?**

BH Narrative 1: “We have a Plan to fix BH; It’s called CCO 2.0”

- Improve the behavioral health access to and integration of:
  - Require CCOs be fully accountable for behavioral health care services.
  - Assess capacity of comprehensive services.
  - Address prior authorization and network choice and timely access to providers.
  - Use metrics to incentivize behavioral health care services.
  - Expand programs that integrate primary and behavioral health care services.
  - Develop a diverse and culturally resonant behavioral health workforce.
  - Ensure children have behavioral health care services.

BH Narrative 2: Tinkering with a dramatically underfunded system… fits the definition of tinkering.

- Tinker (v)
  Attempt to repair or improve something in a casual or desultory way, often to no useful effect.
My Assessment

1. **Oregon Needs Your Help** and the system won’t get to where it needs to without your leadership as Payors, Protectors, Preventers and Policy Makers (the subject of the next section).

2. **Global Budgets** at the State and CCO Level must include population-based funding pools that are based on projected demand, clear identification of Gaps, and clear strategies to close those gaps.

3. **Integration Efforts** will not sufficiently move the whole health outcomes needle for persons with BH disorders without achieving all 3 types of integration:
   - **Clinical Integration**: MH, Medical, Oral Health clinicians are part of the same care team in the same setting, working from common workflows.
   - **Financial Integration**: The money and financial risk for success or failure is under the same roof.
   - **Structural Integration**: The care team works for the same organization.

4. **BH Provider Organizations** will not be adequately funded for the foreseeable future and will need to be subsidized (like Primary Care) through mergers with large health systems or with FQHC mergers (tapping into their PPS Rates).

5. **The Jury is Still Out** on whether CMHPs as Providers and their MH/SUD Networks are seen as high performing behavioral health service delivery organizations (next section).

**Thoughts? Comments?**

---

**Part 2: Design Workshop**

- Review of our 2016 Work
- AOCMHP Charting a Course to the Future
2016 Work

- Remember when we began work on a Next Generation CMHP initiative (before we were swamped with CCBHCs)?

- **Governance:** How can the CMHPs be first movers in bringing clarification to the role of the CMHP and the role of the CCO?

- **Payor:** How can CMHPs that are payors serve as a model of a “supportive payment and regulatory system”?

- **Provider:** How can CMHPs demonstrate “being great places to get care and great places to work”?

---

2016 Work

- **What we completed:**
  - Next Generation Workplan
  - Functions Matrix
  - 6-page Analysis
  - CMHP Readiness Assessment (created but not completed)

- Let’s review each of piece and discuss their relevance for today and tomorrow.

---

[Diagram of Oversight and Mobilization, Local MH Authority Responsibilities, System Transformation, Core Services]
An outcomes driven performance measurement system that supports the provision of high quality Behavioral Health services as well as the CCO’s Quality Incentive Metric Performance, Community Health Assessment, and Community Health Improvement Plan shall be developed, implemented, and monitored. Performance measurement deliverables will span the categories of Data and Tracking, Services, and Systems.

The Performance Measurement Program shall include a withhold, a portion of the aggregate capitation payment (not including administrative component of sub-cap payment), to provide performance incentives related to deliverables specified as "performance measures". This amount will be retained by Health Plan and paid out to the CMHP annually for any successfully completed deliverables at the amount noted herein. Final performance estimates will be calculated five (5) months following the end of the calendar year ending December 31st to allow for adequate claims and encounter data run-out. Final performance incentive payment will be calculated and paid approximately eight (8) months after year end.

*Performance Measurement report submissions must be clearly labeled, legible and submitted to the appropriate parties with a request of receipt.*

[PERFORMANCE MEASURES START ON NEXT PAGE]
<table>
<thead>
<tr>
<th>#</th>
<th>Measure</th>
<th>Intention</th>
<th>Criteria</th>
<th>Target</th>
<th>Source</th>
<th>Reporting Frequency</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>QIM: DHS 60</td>
<td>Children going into DHS custody are a high risk population and require timely assessment of mental health and service needs.</td>
<td>Follow OHA QIM criteria</td>
<td>Cumulative rate will meet the CCO-level State established improvement target for “mental, physical, and dental health assessments for children in DHS custody” QIM measure.</td>
<td>OHA; PS</td>
<td>Annually</td>
<td>20%</td>
</tr>
<tr>
<td>2</td>
<td>Completion of Child and Adolescent Needs and Strengths Assessment (CANS) for members receiving Wraparound services</td>
<td>To support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.</td>
<td>Members enrolled in Wraparound services.</td>
<td>100% of members enrolled in Wraparound services will have at least one CANS completed while receiving Wraparound services. CANS Assessments must be entered into the state approved data system for consideration.</td>
<td>PS encounter data using a list of wraparound enrolled members provided by MCCFL. MCCFL will code CANS Assessments using H2000.</td>
<td>Annually Report by January 15, 2019</td>
<td>15%</td>
</tr>
<tr>
<td>3</td>
<td>Engagement / Retention: Feedback Informed Treatment (FIT)</td>
<td>Increase therapeutic alliance and engagement in treatment to improve outcomes.</td>
<td>ORS/SRS</td>
<td>Complete an end-of-year analysis/summary of FIT implementation including successes, challenges, and supporting data.</td>
<td>MCCFL Self Report</td>
<td>Annually Report by January 15, 2019</td>
<td>15%</td>
</tr>
<tr>
<td>4</td>
<td>Emergency Department Visits for Behavioral Health Reasons</td>
<td>To decrease emergency department visits for Members with a behavioral health history and to reduce inpatient behavioral health/SUD admissions.</td>
<td>Written plan and evidence it was developed collaboratively with hospitals and larger primary care practices.</td>
<td>To develop and implement a plan by September 30, 2018 with the two hospitals in the Gorge CCO service area to reduce ED utilization and inpatient behavioral health/SUD admissions.</td>
<td>MCCFL Self Report</td>
<td>Report by September 30, 2018</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Integrated Care/ CCBHC: CCBHC Certification</td>
<td>CCBHC criteria</td>
<td>MCCFL will meet and sustain the CCBHC criteria by April 30, 2018</td>
<td>MCCFL OHA certification report</td>
<td>Annually Report by May 15, 2018</td>
<td>10%</td>
<td></td>
</tr>
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<td>---------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Outcomes: Patient Satisfaction Survey</td>
<td>Assess overall level of patient satisfaction with CMHP services.</td>
<td>Conduct an annual Patient Satisfaction Survey</td>
<td>To achieve 100% implementation, report results, and report any recommendations from board of directors or advisory council.</td>
<td>MCCFL Self Report</td>
<td>Annually Prior to December 31, 2018</td>
<td>10%</td>
</tr>
<tr>
<td>6</td>
<td>Annual Report to Columbia Gorge Health Council</td>
<td>To keep the CCO governing body and other representatives informed of changes in the program.</td>
<td>Create an annual report with input from health council clinical advisory panel.</td>
<td>MCCFL to present a report to the health council or subcommittee no less than annually.</td>
<td>MCCFL Self Report</td>
<td>Annually Prior to December 31, 2018</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Note:** Documentation for measures above must be submitted to Health Plan by 11:59 PM PST of the date specified or by December 31, 2018 in each measure above to the following: analytics@pacificsource.com, ralph.summers@pacificsource.com.