



CCO Implementation Proposal

Public Comment Summary

January 5, 2012

For full text of each comment, please visit: www.oregon.gov/OHA/OHPB/meetings

PDF Book mark No.	Category	Organization or Person	Comment
2	Metrics: Women's reproductive health	Oregon Foundation for Reproductive Health	There is an important omission to the proposal: There are no core measures which address women's preventive reproductive health. This is a critical oversight, and one that needs remedying, specifically: 1) Unintended pregnancies should be tracked by CCOs as a Core Measure and an indicator of whether women are receiving the reproductive health services they need. 2) The percentage of women using contraception that meets their needs should be tracked by CCOs as a Core Measure, and routine assessment of women's contraceptive needs should be a standard in primary care. 3) The percentage of pregnant women who began taking folic acid prior to pregnancy should be tracked by CCOs as a Core Measure, and a marker of delivery of preconception service availability and prevalence.
23	Metrics: Chronic mental illness	Oregon Residential Provider Assoc.	Mental health is NOT a monolithic area of health care. Residential mental health serves the chronically and persistently mentally ill. See email for specific list of outcome measures.
8	Metrics: Smoking cessation	Colleen Hermann-Franzen, American Lung Assoc., Oregon	<ul style="list-style-type: none"> • Please keep "tobacco assessment and cessation" as one of the core metrics. • Please consider revising the categorization of "flu vaccination for pneumonia patients, aged 50 years or older" from a menu metric to a core metric. • Please consider updating the categorization of "rate of tobacco use among CCO members" from a developmental metric to a core metric.
37	Metrics: Care coordination	Assoc. of Ore. Comm. Mental Health Programs	There should be performance measures that address integration of care coordination between physical, behavioral and oral health.

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10	Metrics: Recovery Outcomes	Stephen McCrea	Hospital readmission rates are indeed an important outcome measure, but we need to go beyond that to things like employment, community activity, social relationships, etc. Quality of life outcomes, in essence. We should be in the business of improving people's lives, not simply keeping them from costing us more money.
16	Metrics: Equity	Multnomah County	Data collection should include health disparity related indicators, including community comparisons within the same service area.
16	Accountability	Multnomah County	CCOs should provide yearly information on salaries of top wage earners; streamline administrative requirements across the system
19	Accountability	Matt Borg	No where in the CCO proposal does it mention accountability on the part of the PATIENT.
17	Accountability	Oregon Primary Care Assoc.	CCOs need to be held accountable to the public. The CCO Implementation Plan should clearly indicate those elements that <u>must</u> be a part of the CCOs structure. The plan should also include a much more specific timeframe. Transparency is a must. Comments also include changes to the DRAFT Matrix of CCO Criteria.
21	Accountability	Oregon Medical Assoc.	Patient engagement is so important to the success of the CCO that we would like to see the addition of member incentives to prioritize healthy lifestyles.
27	Governance: Public representation	Liz Baxter, Community Leadership Council	The <u>majority</u> of the governance body should reflect and represent those people being served, rather than those with a financial risk. Another suggestion: consider using a modern "For-public-benefit" model rather than simply the outdated for-profit vs. not-for-profit.
3	Governance: Counties	Jan Kaplan, Curry County Health and Human Services Director	I would recommend that thought be given to including Counties statutorily within the 51% of risk bearing entities on any CCO governance structure. This is based on the concept that counties will bear significant financial risk to public dollars (both local and state) depending upon policies, decisions and performance of CCO's.

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4	Governance, Risk Adjusting	Ted Amann, Central City Concern	<p><u>CCO governance:</u></p> <ul style="list-style-type: none"> • The concept of "financial risk" needs to be broadly defined. I was disappointed to see that between the previous month's draft business plan and the more recent draft implementation plan the language that said this risk includes those with indirect risk was removed. I think you had it right the first time. • The governing board must reflect the community the CCO purports to serve. <p><u>Risk Adjusting:</u></p> <ul style="list-style-type: none"> • There must be a risk adjusting mechanism more robust than the current one that only includes age, sex, geography, and eligibility category.
16	Governance: Public representation	Multnomah County	Transparency is crucial; additional clarification is needed on how consumers without financial risk will be included in the CCO governing board; community engagement should extend beyond individuals, to whole communities.
22	Governance : Public representation	Mid-Valley Health Care Advocates	OHPB should require significant public representation on the CCO governing boards, as well as representation from public health.
31	Governance: Beneficiary representation	Oregon Health Action Campaign	CCO beneficiaries and their advocates should be directly represented in CCO governance bodies.
32	Governance: Counties	Liane Richardson, Lane County	Public entities should be better represented in governance. Forming a public-private partnership is not simple. To have a public entity with voting rights sit on an otherwise private board of directors may take legislative action and possibly face constitutional hurdles.
37	Governance: Counties	Assoc. of Oregon Counties	Counties share a financial risk in terms of contributing general funds and in terms of providing safety net services at risk of being overburdened by faltering CCOs. Counties should therefore be included on governing boards.

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21	Governance: Providers	Oregon Medical Assoc.	As currently defined, the structure does not allow for an equitable decision-making process to be established. No stakeholder should have an advantage over another. Physician membership should be ensured as part of the government structure.
28	Equity	Jennifer Valentine	More detail on ensuring adequate tracking and elimination of health disparities is essential, as is a mechanism of enforcement. This includes the importance of qualified interpreters, cultural competency training, best practice methodologies training, etc.
33	Equity	American Heart Assoc.	CCOs should ensure that the board makeup reflects underserved communities.
34	Equity	Josiah Hill Clinic	CCOs should ensure that the board makeup reflects underserved communities, seniors, people with disabilities, and people using mental health services. Ensure equal patient access through staffing and training protocols, and best practice sharing. CCOs falling behind in these outcomes must create an equity improvement plan.
35	Equity	211 Info	CCOs should ensure that the board makeup reflects underserved communities. Services should be located geographically as close as possible to members' residences.
38	Equity	Ore. Assoc. of Hospitals and Health Systems	CCOs must be tasked with making progress in the reduction of health disparities, however eliminating them altogether will require a concerted, collaborative effort that engages virtually every sector of the community.
25	Global budget: Actuarial soundness	Providence Health & Services	"Lowest cost estimate" is not an actuarially sound method. In the early development stages, focus should be on bending the cost curve. CCOs should be rewarded for hitting established targets, rather than the lowest cost estimate approach that effectively requires CCOs to bid and bet on the cost of caring for their population. Also, budgets must include risk adjustment.
37	Global Budget	Assoc. of Oregon Counties	Important that Medicaid funded programs do not lose funding because of fewer resources in the global budgets resulting in a loss of local or federal match.

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38	Global budget: Actuarial Soundness	Ore. Assoc. of Hospitals and Health Systems	The Proposal recommends setting the global budget capitation rate using a method similar to the problematic "lowest cost estimate" approach. It has minimal relationship to the principles of actuarial soundness and CMS describes it as highly unusual. It is not a valid way to build health plans with adequate provider networks. Also, we advocate for CCO Global Budgets to be all-inclusive.
17	Global budget: Account for social barriers	Oregon Primary Care Assoc.	CCO measurement and payment should account for psychological and social barriers to health. Without such accounting, providers who serve this challenging and costly population will be unfairly penalized. Additionally, global budgeting process should be guided by clear principles to avoid negative consequences for access, coverage of funding.
4	Fast track	Ted Amann, Central City Concern	I am concerned that the "fast track" from MCO to CCO that Rep. Freeman and Sen. Bates advocated for will be used as a way for existing organizations to get around the transformative demands of the new system. Also, the process for evaluating CCO applications should be as transparent as possible.
27	Fast track	Liz Baxter, Community Leadership Council	Current Medicaid MCOs should not be fast tracked -- we cannot transform while simultaneously staying the same. They should go through a transition phase, but should have to meet all CCO requirements before certification.
38	Fast track	Ore. Assoc. of Hospitals and Health Systems	There should not be a head start for Medicaid MCOs to the disadvantage of other would-be CCOs. We are concerned that fast track merely creates the illusion of transformation.
18	Choice	BJ Merriman	It is important that patients can have flexibility in choosing a doctor, clinic, dentist, etc. If someone is unsatisfied with the doctor they get, could they switch?
36	Choice	State Independent Living Council	Consumers must have a choice in their PCPCH; CCOs cannot have the power to assign.

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22	Best practices	Dr. Hsichao Chow	To ensure uniform, high quality care, best practices of all fields must be practiced. Such best practices must be continuously updated according to medical advancements. OHA should develop a division of Best Practices of Health Care (BPHC).
7	Incentives	Lori Karaian, Health Management Systems	Given the federal and CMS mandate, and the potential financial impacts, HMS recommends Oregon not only maintain payment integrity initiatives under the new CCO model, but maximize their use through proper incentive structures. It is important to maintain fiscal integrity. See email for more details -- pg. 15
20	Incentives	Cynthia Ross	I am concerned that there will not be sufficient financial incentives for a provider to treat members of a CCO.
23	Mental health	Oregon Residential Provider Assoc.	Mental health is NOT a monolithic area of health care. Residential mental health serves the chronically and persistently mentally ill.
9	Behavioral and Mental Health Services	Kelli Pellegrini	<p>I have been somewhat alarmed at the lack of clarity on Behavioral Health/Mental Health Service delivery. Specifically, I am concerned that in the new delivery model providers of Behavioral Health services will be lumped into a single category (psychologists, social workers, licensed professional counselors, and marriage and family therapists), with no differentiation in levels of education, license or expertise, which will not serve the needs of Oregonians well at all. In an effort to conserve resources and reduce costs, I believe that it may be tempting for the Oregon Health Authority to forward the notion that masters-level providers are the "same as" doctoral level providers. This would be a mistake, both in terms of quality of care and ultimately financially: Patients can't and won't get better if they are receiving inadequate treatment, which over time increases costs.</p> <p>Any aspect of CCO development that potentially compromises patient care in order to save money runs diametrically contrary to the stated goals of the OHA.</p>

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11	Peer support	Helen Lara, Mid-Valley Behavioral Care Network	Advocating that the Board understand the importance of having an <u>array</u> of peer services for people with mental health and substance abuse issues and to include funding opportunities for them in the future.
14	Peer support	Fred Abbe	In support of funding services provided by peer services.
36	People with disabilities	State Independent Living Council	Strongly urge a consistent, well-defined mandated partnership between OHA and the Oregon Disabilities Commission in the further development, implementation and monitoring of this vital system change. While system change will have an impact on everyone, it is vital that for people with disabilities that services and infrastructure, including knowledge and access to expertise, are in place and operational from the very beginning. Also, good employment supports, a robust grievance and complaint system and Ombudsperson.
16	Continuity of care	Multnomah County	Continuity of care must be considered during the application process.
16	Continuity of care	Multnomah County	Continuity of care must be considered during the application process. PCPCHs must develop in the proper settings. Oral health should be sufficient to assure access to preventive oral health services.
15	Deadlines	Carolynn Kohout	Essential that hard deadlines are created for implementation, otherwise, nothing will ever get done.
30	Food and nutrition	David McIntyre	The importance of diet and nutrition as a preventive, upstream health focus is increasingly acknowledged. This should be integrated into CCO care and education for patients, as it has been shown to generate enormous cost savings.
22	Transparency	Mid-Valley Health Care Advocates	OHA should ensure that public hearings are held on each CCO application.

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37	Comm. Needs assessment	Coalition of Local Health Officials	Important to have a community needs assessment that creates a planning process that fosters consistent engagement and collaboration and allows you to learn about the community as it changes, develops, and becomes sicker or more healthy. The five major areas of measurement should include: 1) data sources 2) demographics 3) health issues and population groups with health issues 4) continuing causes of issues 5) existing community assets.
250	Naturopathic Doctors	Over 250 emails	Over 250 emails were received relating to the importance of including non-discrimination language regarding the use, availability, proper reimbursement, etc. of Naturopathic Doctors, chiropractors, allopaths, and others that fall into the category of Complimentary and Alternative Medicine (CAM).
26	Dental	Willamette Dental Group	On page 16, it says a CCO must have formed a contractual relationship with a DCO in its area by 7/1/14. To ensure continuity of care, it should say that a CCO must contract with all DCOs that serve members of the CCO in the area where they reside by 7/1/14. If not handled correctly, Oregon is at risk of losing a successful dental delivery system built over time by investment of Oregon taxpayer dollars.
29	FQHCs	Yakima Valley Farm Workers Clinic	Important to ensure that CCOs include FQHCs and other safety net providers in their networks. A CCO should not be permitted to unreasonably refuse to contract with a licensed health care provider.
33	Tobacco and Obesity	American Heart Assoc.	Preventive benefits for tobacco use and obesity must be included in all Medicaid benefit plans, including smoking cessation benefits and preventive benefits for cardiovascular diseases and stroke.
37	Care coordination	Assoc. of Ore. Comm. Mental Health Programs	The population referred to as those with extensive care coordination needs should include individuals across the age spectrum with mental illness, addictions and co-occurring disorders. Half the high costs 10/70 population suffers from mental illness.

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15	Optical/glasses	Carolynn Kohout	Important for patients to have good optical options for care.
5	Advanced Directives	Amy Veatch, Oregon Health Decisions	How can/should Advanced Directives fit into CCOs?
6	Chronic Pain	Michelle Underwood	For patients with chronic pain, it is essential that providers have the ability and knowledge to help maintain an appropriate (not too small or too large) dosage of medicine. Systematic evaluation techniques should be put in place, as should "pain contracts" between doctor and patient. See email for more details, pg. 13
1	Hemophilia treatment	Hemophilia Foundation of Oregon	Hemophilia affects 20,000 people in the US, and approximately 400 in the state of Oregon. Most individuals with hemophilia receive care at hemophilia treatment centers (HTCs). Studies have shown that mortality and hospitalization rates are 40% lower for people who use HTCs than in those who do not, despite the fact that more severely affected patients are more likely to be seen in HTCs. Bleeding disorder patients need specialized health care that is best provided by federally funded hemophilia treatment centers (HTCs). It is critically important that people with hemophilia and other bleeding disorders have in-network access to HTC care through CCOs and QHPs offered in the exchanges. We ask that patients in CCOs/QHPs are not required to have copayments or coinsurances that are so high that patients will avoid getting needed factor replacement therapy. Patients with bleeding disorders must have access to the site of care that is determined by the patient and his/her physician. Continuity of Care: Patients who may find they need to switch enrollment between CCOs and QHPs must have protections in place so they do not have to seek reauthorization of services or treatments.
12	SAIF	Dean McAllister	SAIF would be a natural health care insurance provider for Oregon.

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13	Universal care	Claude and Lucy Thompson	Everyone, not just Medicaid, should be on the same health care system, that way everyone would have the same access.
25	General	Providence Health & Services	The plan must be: 1) flexible enough to create structures that work in individual communities, 2) efficient enough to make the changes that will have a lasting, positive impact, 3) capable of evolving as we discover the best structures to meet the Triple Aim.
24	General	South Coast Providers	We are concerned that the CCO Implementation Proposal leaves too much uncertainty, and often does not adequately elaborate on language already found in HB 3650. We understand the risk of being overly prescriptive, but a better balance must be found.

Ettinger Ari A

From: Marita Postma <marita@hemophiliaoregon.org>
Sent: Monday, December 12, 2011 12:32 PM
To: ohpb.info@state.or.us
Subject: Hemophilia Foundation of Oregon

Categories: Follow-up

Dear Members of the Oregon Health Policy Board:

Hemophilia Foundation of Oregon (HFO) appreciates the opportunity to comment on the draft CCO implementation proposal. HFO has provided programs and services which promote and support knowledge, health and advocacy for all people whose lives are affected by bleeding disorders for over four decades. We offer comments to ensure high quality health care for both Medicaid CCO and Health Insurance Exchange members who are affected by bleeding disorders such as hemophilia, Von Willebrand disease, and other blood clotting factor disorders.

Hemophilia is a rare, chronic bleeding disorder affecting 20,000 people in the US, and approximately 400 in the state of Oregon who infuse clotting factor replacement therapies to replace missing or deficient blood proteins. Most individuals with hemophilia receive care at hemophilia treatment centers (HTCs), which provide comprehensive, multi-disciplinary, patient-centered care for bleeding disorders and their long-term complications, including inhibitors, liver disease and HIV/AIDS. Studies have shown that mortality and hospitalization rates are 40% lower for people who use HTCs than in those who do not, despite the fact that more severely affected patients are more likely to be seen in HTCs.

It is HFO's understanding that in 2014, when Medicaid expands and the Health Insurance Exchange opens, patients may fall in and out of eligibility for Medicaid and then may move into a Qualified Health Plan (QHP) on the Exchange. Therefore, we have included many comments that would apply to both the CCOs and the QHPs.

Access to Hemophilia Treatment Centers for Medical Care

We greatly appreciate that Oregon recognizes the fact that those with chronic health conditions need additional focus. Bleeding disorder patients need specialized health care that is best provided by federally funded hemophilia treatment centers (HTCs). It is critically important that people with hemophilia and other bleeding disorders have in-network access to HTC care through CCOs and QHPs offered in the exchanges. As noted above, studies have shown that mortality and hospitalization rates are 40% lower for people who use HTCs than in those who do not. We also ask that access to HTCs does not require additional cost to patients in the form of increased copays.

Access to Therapies

Individuals with bleeding disorders must have access to the full range of medically necessary treatments (usually blood factor replacement therapy) that is appropriate for their condition. Decisions regarding which treatments are most suitable must be reserved for the physician in consultation with the individual patient. Without appropriate treatment, individuals face detrimental health outcomes. Furthermore, payers risk facing unnecessary costs from potential complications that arise from any limitations placed on the full range of therapies. Again, we ask that patients in CCOs/QHPs are not required to have copayments or coinsurances that are so high that patients will avoid getting needed factor replacement therapy.

Access to all Sites of Care

Patients with bleeding disorders must have access to the site of care that is determined by the patient and his/her physician. Because our patient population has the need for life-long treatment and not episodic care, it is important to take into consideration the site of care that works best for the patient – whether that be in the hospital, hospital outpatient department, a physician's office or in the home. Restricting treatment sites is a barrier to access to care.

Access to Specialty Pharmacy Providers

Bleeding disorders such as hemophilia are chronic disorders characterized by bleeding episodes that may occur spontaneously or after mild to severe trauma. The timing and severity of bleeding episodes are unpredictable, even for patients on regularly scheduled treatment. Providers of clotting factor replacement therapy must be able to effectively respond to varying frequency and dosing needs.

It is essential that any pharmacy provider dispensing clotting factor concentrates for home use provide services that meet several standards, including:

Provide the full range of available concentrates, including all available assays and vial sizes. Pharmacy providers must be able to provide all necessary ancillary supplies and appropriate hazardous waste disposal for administration of clotting factor. Some consumers of clotting factor concentrates require additional services, such as nursing services. Pharmacy staff must provide 24-hour emergency access including multilingual interpreters in case of emergency, and delivery. Timely emergency delivery of factor replacement therapy can prevent the need for costly emergency room visits.

Continuity of Care

Patients who may find they need to switch enrollment between CCOs and QHPs must have protections in place so they do not have to seek reauthorization of services or treatments. Comprehensive educational programs must be offered that will provide information about the potential implications of switching between plans.

Medical Necessity Determinations, Appeals, and Grievances Processes

HFO strongly agrees with the following recommendations previously provided by the National Health Council (NHC): Requirements for plans to use medical necessity criteria should be objective, clinically valid, and compatible with generally accepted principles of care. Furthermore, plan denials, based on lack of medical necessity, should explain in clear language the criteria used to make the determination. This should be uniform throughout the CCOs. We also request easy-to-access plan grievances processes and a system to track grievances and oversee plan responses to grievances filed.

Utilization Management without Discrimination

CCO and QHP utilization management practices should not impose unfair nor discriminatory requirements for plans, and they should disclose to all prospective and current members all utilization management techniques.

Thank you for the opportunity to provide input from the bleeding disorders community. HFO asks that you give the comments serious consideration and inclusion in the final proposal. I am happy to answer any questions you may have and would welcome further dialogue. I can be reached at:

503-209-7539

Sincerely,

Marita Postma

Executive Director

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December 15, 2011

Dear Oregon Health Policy Board Members,

Thank you for the opportunity to provide testimony concerning the Coordinated Care Organization (CCO) Implementation Proposal.

The Oregon Foundation for Reproductive Health recognizes and applauds the CCO workgroup and Oregon Health Policy Board's commitment to improving the affordability, quality, and efficiency of health care to ensure that Oregonians get the health services they need.

The Core Measures proposed by the Outcome, Quality and Efficiency Metrics Work Group include multiple screenings to be done on a routine basis in primary care, such as blood pressure screenings, tobacco use screenings, and depression screenings. It makes sense to do these types of screenings so that interventions can be done and costly medical complications can be avoided.

We noticed, however, an important omission. There are no core measures which address women's preventive reproductive health. This is a critical oversight, and one that needs remedying.

Women are more than half the population and more than two-thirds of the patients seen in primary care clinics. Most American women are fertile for about 35 years and desire (on average) 2 children. That means most women spend 30 years of their lives trying to avoid an unintended pregnancy, and the remainder of those years trying to optimize the health of their pregnancies. The pervasiveness and duration of this need (far greater than the other conditions which have Core measures) make a compelling case for routine screening for pregnancy intention in primary care. Knowing whether or not a woman desires to be pregnant would allow primary care providers to proactively provide two core prevention services: contraception and preconception care.

Unintended pregnancy

Oregon PRAMS (Pregnancy Risk Assessment and Monitoring System) Data from 2008 show that 49% of pregnancies in our state are unintended¹. According to Healthy People 2010 and 2020, unintended pregnancies lead to an increased likelihood of infant and maternal illness, and increase the likelihood of abortion. Women with unintended pregnancies are less likely to enter prenatal care early, or even receive prenatal care at all. They are also less likely to breastfeed and more likely to expose the fetus to harmful substances, such as tobacco or alcohol. They are more likely to be

¹ Oregon PRAMS 2008 <http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/9899q1list.aspx>

depressed and suffer from physical violence during pregnancy. The child of an unintended pregnancy is at greater risk for low birth weight, dying in its first year, being abused, and not receiving sufficient resources for healthy development². Unintended pregnancies disproportionately affect African American and Hispanic women, and are an important health disparity issue.

The adverse consequences of unintended pregnancies affect not only the children and families of these pregnancies, but also society as a whole through the increasing costs of health, education and social services. Prevention of unintended pregnancies can have profound economic impacts nationally, and has the potential to decrease the disparities in health among those of different socio-economic status. One study from California looked at prevention of unintended pregnancy by making contraception much more available to women. Each pregnancy that was avoided in this program saved the public sector \$6,557 in medical, welfare, and other social service costs for a woman and child from conception to age two and saved \$14,111 from conception to age 5³.

In Oregon in 2008, there were 34,000 unintended pregnancies. If even half of those were prevented, the state would save \$240 million. Nearly 48% of all deliveries in Oregon are paid for by Medicaid/OHP⁴. Preventing unintended pregnancy makes as much sense economically as it does for health reasons.

1. Unintended pregnancies should be tracked by CCOs as a Core Measure and an indicator of whether women are receiving the reproductive health services they need.

Contraception

Contraception is the most important preventive service offered to women in primary care, simply by the sheer prevalence and duration of the need. National data show that 98% of all women use contraception at some point in their lives, yet the contraceptive method that is best for them changes over time. Half of all unintended pregnancies are to women using no contraception, and another 45% are to women who have a contraceptive method, but use it inconsistently or incorrectly⁵.

As part of the federal Patient Protection and Affordable Care Act of 2010, the U.S. Department of Health and Human Services charged the Institute Of Medicine with reviewing which preventive services are important to women's health and well-being, and then recommending which services should be included in health care reform. One of the IOM's recommendations was a fuller range of contraceptive education, counseling, methods, and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes⁶.

Contraception is one of the most cost effective preventive services available. Oregon's Family Planning program states that its return on investment is 7 to 1. The aforementioned California study demonstrates that for every public dollar invested in contraception, the public sector saves \$4.30 in costs from conception to age 2, and \$9.25 in costs from conception to age 5. This is a powerful

² Healthy People 2010 and 2020, <http://www.healthypeople.gov>

³ Biggs MA, Foster DG, Hulett D, and Brindis C. (2010). *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007*, San Francisco, CA. Submitted to the California Department of Public Health, Office of Family Planning Division. April 2010. Bixby Center for Global Reproductive Health, University of California, San Francisco: San Francisco, CA

⁴ PRAMS 2008

⁵ Guttmacher Institute 2008 Contraception policy brief, www.guttmacher.org

⁶ Institute of Medicine Report <http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx>.

argument to include contraception services in the core standards of primary care, and assessment of contraception satisfaction as one of the Core Measures of CCOs.

- 2. The percentage of women using contraception that meets their needs should be tracked by CCOs as a Core Measure, and routine assessment of women's contraceptive needs should be a standard in primary care.**

Preconception care

Part of screening women for their pregnancy intentions involves identifying women who would like to become pregnant so that they can receive effective preconception services.

According to the CDC, about 30% of U.S. women have complications during pregnancy, and approximately 12% of babies born prematurely, 8% born with low birth weight, and 3% with major birth defects. The human and economic costs of poor pregnancy outcomes to families and society are enormous: each child born in the United States with a major disability leads to direct and indirect societal costs of more than \$1 million over his or her lifetime⁷.

There is evidence that improving women's health before pregnancy is important for optimizing pregnancy outcomes. Making preconception care services (including folic acid, vaccinations, and screening for health conditions and use of harmful medications and substances) more available to women would significantly improve maternal and infant outcomes, particularly for women at risk of adverse outcomes. Since nearly half of all pregnancies are unplanned, access to preconception health care services should be the norm for women during their reproductive years. Folic acid supplementation is a simple, effective means of preventing major birth defects, and yet according to PRAMS data in 2008, only 30% of Oregon women took folic acid daily before their most recent pregnancy. Creating a Core Measure regarding folic acid supplementation would encourage primary care providers to engage in other preconception counseling as well.

- 3. The percentage of pregnant women who began taking folic acid prior to pregnancy should be tracked by CCOs as a Core Measure, and a marker of delivery of preconception service availability and prevalence.**

And finally, since unintended pregnancy, access to contraception, and poor pregnancy outcomes are all health disparity issues, they should be included in the Community Health Assessments conducted by CCOs.

Thank you for your consideration of our perspective.

Oregon Foundation for Reproductive Health

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⁷CDC preconception health workgroup

<http://www.cdc.gov/ncbddd/preconception/documents/Workgroup%20Proceedings%20June06.pdf>

Ettinger Ari A

From: Michele Stranger-Hunter <michele@prochoiceoregon.org>
Sent: Thursday, December 15, 2011 2:29 PM
To: OHPB.Info@state.or.us
Subject: OFRH Testimony
Attachments: OFRH Written Testimony.doc; OHPB testimony.pdf

Dear Oregon Health Policy Board,

Thank you for the opportunity to provide testimony concerning the Coordinated Care Organization (CCO) Implementation Proposal.

The Oregon Foundation for Reproductive Health recognizes and applauds the CCO workgroups and Oregon Health Policy Board's commitment to improving the affordability, quality and efficiency of health care to ensure that Oregonians get the health services they need.

We noticed, however, an important omission in the preventive services you are tracking. There are no proposed Core measures which address women's preventive reproductive health. This is a critical oversight, and one that needs remedying.

We believe the Core Measures for CCOs should include measures of unintended pregnancy, contraceptive services and preconception care. And since unintended pregnancy, access to contraception and poor pregnancy outcomes are all health disparity issues, they should be included in the Community Health Assessments conducted by CCOs.

We have attached written testimony for your review.

Thank you for your time and consideration.

Sincerely,

Michele

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OHPB testimony: CCO metrics Oregon Foundation for Reproductive Health

Proposal: The Outcomes, Quality and Efficiency Metrics Work Group must ensure that women’s preventive reproductive health standards are included in CCO Core performance measures.

Proposed Core measures already include the following:

<u>Core measure</u>	<u>Prevalence in Oregon [1]</u>
• assessment of tobacco use	17.5% use tobacco
• blood pressure screening	25.8% with high blood pressure
• alcohol screening,	4.8% of men and 5.4% of women have heavy use
• diabetes care	6.8% with diabetes
• depression screening	4.7% with symptoms of major depression

While it is clear that these measures represent important primary care health concerns, the prevalence of these issues pale in comparison to the prevalence of the need for preventive reproductive health services. Women make up more than half of the population, and upwards of 70% of the patients in a primary care clinic. While most women desire only 2 children, they are fertile for 35 or more years of their lives. This means that most women spend 30 years trying to prevent an unintended pregnancy every month, and the remainder of those years trying to have a healthy pregnancy. **Preventive reproductive health is a core component of primary care for women, and needs to be represented in these core standards.** Preventive reproductive health issues include contraception and preconception care, with the goals of preventing unintended pregnancy and increasing the likelihood that all pregnancies are as healthy as possible.

<u>Proposed additions to Core measures</u>	<u>Prevalence in Oregon</u>
• assessment of unintended pregnancy	49% of all pregnancies in Oregon are unintended [2]
• contraception access/ satisfaction with method	98% of women use contraception at some time in their lives (US)[3] 95% of women with an unintended pregnancy were not using any method or were using a method inconsistently or incorrectly (US)[3]
• folic acid prior to conception	30% of Oregon women take folic acid daily before conception [2]

[1] Oregon Public Health Division website, public.health.oregon.gov, accessed December 1, 2011, [2] Oregon PRAMS data 2008, [3] Guttmacher Institute website, www.guttmacher.org, accessed December 1, 2011, data from 2008

Proposed additions to the Core performance measures table of the Outcomes, Quality and Efficiency Metrics Work Group

Metric	Domain	Alignment	Process measures	Outcome measures	Rationale
Percent of women age 18-50 with unintended pregnancies	Primary Care, prevention	HP 2020, AHRQ National Quality Measures Clearinghouse	% of prenatal patients with documentation of pregnancy intendedness	% reduction in rates of unintended pregnancy	Unintended pregnancies lead to worse outcomes for mother and infant, higher rates of preterm delivery, and substantial state health care costs. Almost half of all deliveries are paid for by Medicaid/OHP. This is a health disparity issue . Rates are higher for African Americans and Hispanics.
Percent of women age 18-50 taking folic acid daily before they become pregnant	Primary Care, prevention	HP 2020, USPSTF Grade A, AHRQ National Quality Measures Clearinghouse	% of prenatal patients with documentation of folic acid consumption prior to conception	% Increase in rates of folic acid consumption prior to conception	Folic acid is a simple, effective, inexpensive way to prevent birth defects. Also, this measure would encourage clinicians to ask about other health behaviors, screen for medical conditions and adjust medications as needed to maximize chances for a healthy pregnancy
Percent of women age 18-50 using contraception that meets their needs	Primary Care, prevention	HP 2020, IOM report, AHRQ National Quality Measures Clearinghouse HEDIS[1], Meaningful Use [2]	% of adult women screened for contraceptive needs	% increase in women using contraception that meets their needs	Contraception has been shown to prevent unintended pregnancy, especially when women have access to multiple methods to meet their needs as they change over time.

[1] Annual monitoring for patients on persistent medications, Adult Access to Preventive/Ambulatory Health Services

[2] Monitoring of persistent medications

Contact information: Oregon Foundation for Reproductive Health (503)223-4510
Michele Stranger Hunter, Executive Director (michele@prochoiceoregon.org)
Helen Bellanca, MD, MPH, Medical Director (helen@prochoiceoregon.org)

Ettinger Ari A

From: Jan Kaplan <kaplanj@co.curry.or.us>
Sent: Thursday, December 15, 2011 2:36 PM
To: OHPB.Info@state.or.us
Cc: George Rhodes
Subject: Comment on HB 3650- Governance

I would recommend that thought be given to including Counties statutorily within the 51% of risk bearing entities on any CCO governance structure. This is based on the concept that counties will bear significant financial risk to public dollars (both local and state) depending upon policies, decisions and performance of CCO's.

Jan Kaplan
Curry County Health & Human Services Director

Ettinger Ari A

From: Ted Amann <Ted.Amann@ccconcern.org>
Sent: Monday, December 19, 2011 1:49 PM
To: OHPB.Info@state.or.us
Subject: Public Comment - CCO Plan

Here are some comments & thoughts about the CCO Implementation Proposal and the most recent OHPB meeting:

- I believe this is a time for transformative (non-incremental) change in our health care delivery system. I was very disappointed in Rep. Freeman's comments to the Board that if he had it to do over again he would use the word "evolution" rather than "transformation." Many of us have actively engaged over the last 6 - 9 months because the process was billed as "transformation" and we believe the situation has hit a crisis point that requires wholesale changes. I urge the Board to stick to its transformative agenda and not put the brakes on now. Change is hard and it will make some people very uncomfortable, but that is not a good enough back away from what needs to be done.
- Regarding CCO governance, the concept of "financial risk" needs to be broadly defined. I was disappointed to see that between the previous month's draft business plan and the more recent draft implementation plan the language that said this risk includes those with indirect risk was removed. I think you had it right the first time. The organizations that have reserves to invest in a CCO have been using the people's money to create those reserves. Whether it is an MCO or a hospital system, public dollars and not-for-profit tax benefits have gone into those reserves. The last thing we need is a business-as-usual governing board made up of the same players that have been governing the current system.
- The governing board must reflect the community the CCO purports to serve.
- I am concerned that the "fast track" from MCO to CCO that Rep. Freeman and Sen. Bates advocated for will be used as a way for existing organizations to get around the transformative demands of the new system. The new standards for CCO's must be rigorously and uniformly applied if we are going to have real change. Otherwise the incentive will be to do as little change as possible, which will create minimal benefit to the system and the state.
- There must be a risk adjusting mechanism more robust than the current one that only includes age, sex, geography, and eligibility category. To have truly equitable allocation of scarce resources the global budgets for CCOs and their payment methodologies to their provider networks must also consider psychological and social barriers to health, and chronic disease burden. These are major cost drivers so to not include them in the financial planning is inappropriate. These factors must also be considered in evaluating performance data.
- The process for evaluating CCO applications should be as transparent as possible. Once a CCO has been certified/approved by the state the people have a right to know what claims, proposals, and promises that CCO has made. Transparency is essential if we are going to have accountability.

Thank you for the opportunity to provide input.

Ted Amann, MPH, RN
Director of Health System Development; FQHC Project Director
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Ettinger Ari A

From: Amy Veatch <amyveatch@msn.com>
Sent: Wednesday, December 21, 2011 1:40 PM
To: ohpb.info@state.or.us
Subject: Advance Directive and CCO
Attachments: KEYConversations Program and Trainings.pdf; KEYPG-Color Final-Sec.pdf

Dear OHPB member:

Liz Baxter, Executive Director of *We Can Do Better* and long-time board member of Oregon Health Decisions recommended that I talk with you as you prepare Coordinated Care Organizations.

As the state's resource for the Advance Directive, Oregon Health Decisions recently implemented a **new state-wide program called KEY Conversations™**. *KEY Conversations™* provides health care organizations with training and the coordinated materials they need **to help individuals better understand, discuss and document crucial medical decisions – before a crisis.**

Oregon Health Decisions provides organizations **materials to help educate and empower individuals to talk about end-of-life issues** and break down common barriers. In addition, organizations receive **training to implement a "turn-key" Advance Directive system** that meets State Statute, utilizes staff time effectively and most importantly, helps patients and individuals understand the importance of having a conversation with loved ones.

With successful implementation of *KEY Conversations™* materials, processes and training, health care organizations, medical providers, and the advance care planning communities will see an:

- Increased number of Oregonians with an effective Advance Directive,
- Improved communication between patients and health care providers,
- More effective use of health care resources,
- Increased public awareness of Advance Directives and their importance in directing an individual's end-of-life care.

After the holidays, I would appreciate meeting with you to show you Oregon's first Advance Directive DVD and corresponding materials to see if you are interested in incorporating *KEY Conversations™* materials and/or training into your coordinated care initiative. I look forward to talking with you.

Enclosed is an overview of the *KEY Conversations™* Program as well as an electronic preview of the *Advance Directive with the KEY Conversations™ Planning Guide* which I'd like to personally provide each of you when we meet. The Planning Guide is the centerpiece of the *KEY Conversations™* program.

Enjoy the holidays! My best,

Amy D. Veatch
Director of *KEY Conversations*
T| 503.550.5579
E| amyveatch@msn.com

Oregon Health Decisions
7451 SW Coho Ct. #101
Tualatin, OR 97062

Ettinger Ari A

From: Michelle Underwood <cantooconcepts@gmail.com>
Sent: Wednesday, December 21, 2011 11:08 PM
To: OHPB.Info@state.or.us
Subject: CCO Proposal Comments

What I have read so far is a very good start to transforming care of Oregonians in publicly funded programs. There are some issues that have not been addressed yet, but have been alluded to, in the draft proposal. There is a large population of individuals who receive OHP Standard or Medicaid/Medicare who are grossly underserved in the community; those whose disability includes chronic pain. Thankfully, I am not one of these patients but I have seen the torments and horrors faced by friends and family members who are. I have also seen the reasons that doctors feel the way they do, people who scam their providers for profit or recreation.

Almost all providers will refuse to begin seeing a person who has been treated for chronic pain (call around if you don't know this is true) and even those who agree to see them are suspicious, reluctant to prescribe adequate treatment or to try many different treatments to find the right one, and subject the patient to demeaning and often inequitable versions of "pain contracts" which are more a convenience for the provider in ridding themselves of patients than of any benefit to the patient.

Most providers feel inadequately equipped to know if they *should* prescribe, how much to prescribe, how to know if the patient is abusing the medication or using it for the wrong reason. Having an integrated (health and mental health) system will help reassure providers but it isn't enough. Systematic evaluation techniques, based on solid evidence and direct observation, should be put in place and can be augmented with medical technology. Pain contracts need to outline the rules that the provider will abide by, not just the patient, such as the evidence that would indicate that a reduction or discontinuation of pain medication is needed and a review or appeal process if the patient disagrees so their hope and future is not in the hands of one potentially arbitrary person. Rules and procedures for treating the pain of those with addictive personalities should also be included so these patients are not left to suffer or given more than they can handle. Rules and procedures need to be established to tell the difference between the two so that not every person in pain is treated like an addict, or worse, a liar, cheat, thief, and/or manipulative criminal.

The educational material put out by the Board of Medical Examiners is a good start too but it stops too short of enough information. There is so much work being done in the area of research and investigational techniques, not the least of which is the definition of "pain" itself. Pain is not a single entity, like illness is not a single entity. There are at least two pathways where pain is experienced: nociception and what can be termed as "suffering". In the system that registers suffering, physical and emotional pain can be experienced exactly the same way and both can be mitigated to a degree by non-medicinal methods. This is just one fact most people, including medical and mental health providers, don't know. Other definitions, like dependence, addiction, pseudo-addiction, abuse, tolerance, and intoxication are not commonly understood but have absolute definitions born out by research and objective evidence. Imaging is advancing in the ability to detect and measure nociception and suffering and is underutilized; as is plain old-fashioned observation. If you suspect that a patient is exaggerating the level of medication, have an antidote in hand and have them take the dose they say they need. Watch for signs of intoxication or overdose and also for signs that they are underestimating. Direct observation, accompanied by blood level and enzyme level testing, can objectively identify the minimal and optimal effective dose for anyone in a stable state of chronic pain. Care must be taken to ensure that the observed symptoms are not that of under-medication, the point just below effective dosage where the patient will appear rummy, sleepy, and/or less coherent that is actually remedied by increasing the dose slightly higher. Blood-pressure, respiration, pupil dilation, etc. must also be considered. A single, knowledgeable, experienced

anesthesiologist should be able to do the direct observation titration for enough patients to make it cost effective.

The terms narcotics, opiates, and opioid medications are used interchangeably without an understanding of the differences between them, nor the differences in their effects on the patients. Even the purpose and proper use of these medications can perplex the best intentions of providers and patients alike. Most assume that the purpose is to reach zero or one on the pain scale, it is not. Using them this way is what leads to addiction in susceptible individuals and dependence/tolerance in others. It also leads to further injury and aggravation of the underlying condition because the patient can't feel when they are pushing the limits of their physical abilities. Stretching the medications to the limits of their average effective time duration is also a poor use of the medication because it takes more medication to restore control, requires a higher blood concentration in the beginning of the cycle, and provides inadequate control during the last third to one quarter of that time interval. Using half the medication twice as often provides a more stable blood level and allows for more control over the balance between keeping some pain sensation and making it tolerable enough to function fully. The use of long acting medication during the night is essential if the pain is intense enough to disrupt the sleep cycles, even if it doesn't cause full arousal. Lack of sleep can reduce healing, lower the immune system, and lead to depression. It can also damage the prefrontal cortex and thalamus at a rate of 1.3 cm³ per year of untreated chronic pain. (<http://www.doctordeluca.com/Library/Pain/PainMedEmergency08c.pdf>)

I am not a medical professional but having a family member who was severely injured in ways that don't show on x-rays but cause pain in so many different places that providers assume he must be angling for something has caused me to look for answers on my own. All the information is there, especially with direct access to the medical research studies, readily available to anyone who looks persistently. Older studies of pain medications were based on drug addicts because it was assumed that addicts would not be any different from pain patients. More recent studies have proven this approach not only inaccurate but dangerously so. Studies of newborns have shown that untreated pain weakens the immune system and causes nerve and brain damage. Please, consider what I have said here seriously and take the steps necessary to both treat and protect those who are at the mercy of the medical profession; people who have complex injuries, illnesses, and disabilities that cause pain.

Sincerely,

Michelle Underwood
971-240-3537



December 23, 2011

To: Oregon Health Policy Board
Attention: Ari Ettinger
500 Summer Street NE
Salem, OR 97301

Re: HMS Comments on CCO Implementation Proposal

Health Management Systems (HMS) supports the goal of the Oregon Health Policy Board to reduce the cost and increase the quality of healthcare for its citizens. The implementation of such a large scale overhaul of the State's Medicaid system requires a thoughtful, coordinated approach – and we appreciate the opportunity to comment.

HMS Overview

HMS is the nation's leader in cost containment solutions for government-funded and commercial healthcare entities. Our clients include health and human services programs in more than 40 states; commercial programs, including over 150 Medicaid Managed Care plans; the Centers for Medicare and Medicaid Services (CMS); and Veterans Administration facilities. HMS helps these healthcare payers to ensure claims are paid correctly and by the responsible party. Overall, our services make the healthcare system better by improving access, impacting outcomes, containing costs, recovering dollars, and creating efficiencies. As a result of HMS's services, our clients collectively recover over \$1.8 billion annually, and save billions of dollars more by avoiding erroneous payments.

HMS in Oregon

In September 2011, the State of Oregon, Department of Human Services, Office of Payment Accuracy and Recovery (OPAR) signed a competitively procured contract with HMS to serve as the State's Recovery Audit Contractor (RAC) and provide third party liability (TPL) come-behind services. Under the terms of this contract, HMS will perform services mandated in Section 6411 of the federal Affordable Care Act, including identifying and recovering improper Medicaid overpayments and underpayments. HMS will also supplement the State's efforts in reviewing Medicaid claims to determine if another payer should have paid primary, known as Third Party Liability (TPL).

Oregon Health Transformation

Changes to the payment system may fundamentally change the incentives and ability to perform TPL and RAC federally mandated audit functions. As Oregon contemplates the structure of the CCOs, the following questions should be addressed:

How will these payment integrity activities be treated under the new system?

By federal and state law, the Medicaid program must conduct assertive and comprehensive payment integrity initiatives. Such initiatives include ensuring Medicaid is the payer of last resort as well as ensuring fiscal integrity through fraud, waste, and abuse identification and recovery activities. The institution of new payment methodologies under a CCO should maintain these principles. The Board should consider where the responsibility for performing these services lies within the new paradigm. Three potential models are outlined below:

Model	Description	Right to Recovery
Full Delegation	CCO has responsibility for performing all payment integrity functions	Held within the CCO
Partial Delegation	State serves as safety-net, coming behind the MCO after a designated time period.	Shared between State and CCO
State centralization	State maintains all responsibility	Given to the State

No matter what model is chosen, two items must be present. First, an incentive structure must be created that both requires and encourages the identification and prevention of improper payments. And second, the State must maintain audit rights to secure proper oversight.

How will payment integrity be incentivized, particularly in regard to the CMS RAC mandate?

The federally mandated Recovery Audit Contract requires states to hire a vendor, paid on a contingency fee, to identify and recover improper payments made to Medicaid providers. As per the federal requirement, in Oregon, the RAC will audit and identify overpayments and underpayments made to providers. However, under the CCO model, the state would not have paid the claim; it is the CCO that reimburses the provider. Given this, if the state is paying the contingency fee to the RAC for recovering overpayments from providers, but the CCO is "at-risk," who keeps the recovered funds that the RAC collects? Questions such as "How will the State benefit financially from the identification and recovery of overpayments?" and "How will these activities impact future capitated rates or global budgets?" need to be answered to avoid there being a disincentive to identify and recover improper payments, which of course, is an important function in keeping the program effective and sustainable. For example, there may be some concern that if successful recovery audit initiatives lower future rates, there will be a disincentive by the CCO to perform such activities. Depending on who benefits financially from payment integrity activities, how will it impact potential CCO incentive structures for quality and cost effectiveness? All of these questions impact the incentive structure of both the state and CCO in maximizing revenue from payment integrity activities. Ultimately, a RAC program must maintain an incentive structure that encourages both the CCO, in its day-to-day activities, and the State, in its oversight capacity, to identify, recover, and prospectively fix billing and payment errors.

How will these federal and CMS mandated activities be maintained for CCOs that move away from provider compensation through a fee-for-service system to an alternative payment methodology?

Given the desire to pay providers in ways that reimburse for quality rather than quantity, the State should discuss ways to ensure the continuation of payment integrity initiatives absent a paid claim. Is it possible for the CCO to overpay the provider in a capitated or global budget environment? It is estimated that ten percent of Medicaid recipients also have some commercial insurance coverage. If a recipient is simultaneously enrolled in private insurance and in Medicaid, will that impact the CCO capitation rate? How will the State or CCO coordinate benefits when one of the payers operate under an alternative methodology but the other does not? Can the CCO or state still seek payment from carriers for services that should have been provided by a private insurer? How will the integrity of payer of last resort status remain intact? It is unclear how the state will maintain CMS required payment integrity initiatives under this new paradigm.

HMS Recommendation

Given the federal and CMS mandate, and the potential financial impacts, HMS recommends Oregon not only maintain payment integrity initiatives under the new CCO paradigm, but maximize their use through proper incentive structures. Policy makers should give weight to the above considerations when designing payment systems for government-sponsored programs. Moreover, it is imperative that the State's contracts with the CCOs clearly define the responsibility and structure of payment integrity initiatives. Items that should be considered within the contracts include delegation of audit responsibilities, potential shared savings arrangements from payment integrity activities, and the specific rights of the state to audit the payments CCOs make to providers.

HMS strongly believes in the ideals of cost efficiency and quality within the health care system. Maintaining the fiscal integrity of programs through fraud, waste, and abuse efforts are a critical piece in meeting these goals. We look forward to engaging with you on this topic as you work towards a successful implementation of the CCO program. If you have any follow up questions, please do not hesitate to contact me.

Thank you again for the opportunity to comment.



Lori Karaian
Division Vice President, State Government Relations
P: 415-738-0758, E: LKaraian@hms.com

Ettinger Ari A

From: Colleen Hermann-Franzen <chermann@lungoregon.org>
Sent: Thursday, December 22, 2011 3:04 PM
To: OHPB.Info@state.or.us
Subject: Comments on draft CCO Proposal

Dear Members of the Oregon Health Policy Board,

My name is Colleen Hermann-Franzen and I am the Advocacy & Outreach Manager for the American Lung Association in Oregon. The Lung Association's mission is to save lives by improving lung health and preventing lung disease.

The Lung Association would like to thank you for all of your work. We strongly support your commitment to providing access to quality, affordable health care for all Oregonians and to improving population health. The Lung Association commends the Oregon Health Policy Board for their focus on evidence-based outcomes and prevention.

We have reviewed the draft Coordinated Care Organization (CCO) plan and the work of the CCO Outcomes, Quality and Efficiency Metrics Work Group. We are pleased to see that tobacco assessment and cessation is being considered as a "core measure" that would apply to all CCOs.

We believe the health of the whole community is protected when tobacco use is reduced. Tobacco use remains the leading cause of preventable death in Oregon, as well as the United States. We want to be a state where kids don't start smoking and adults who smoke have the resources to quit. By including tobacco prevention, education, and cessation as measured outcomes for Coordinated Care Organizations, we will see the savings necessary to make our health care system more affordable and sustainable.

CCOs need to do more than just treat tobacco-related illnesses; we must ensure that outcomes reflect tobacco prevention and cessation as core measures of success. Tobacco prevention and cessation programs not only save lives, but also offer economic benefits to states. A recent study by the American Lung Association (*Smoking Cessation: the Economic Benefits*, 2010) found a positive return on investment for states that invest in tobacco cessation services. For every \$1.00 Oregon spends on helping smokers quit, it has an average potential return on investment of \$1.32. Public education programs are another key element of creating a tobacco-free culture in our state, and should be sufficiently funded.

We encourage the board to use the tobacco cessation recommendations created by the "Helping Benefit Oregon Smokers" Project in 2011. The recommendations can be found at:
www.smokefreeoregon.com/smokefree-places/worksites.

We are also pleased to see that flu vaccination for elderly pneumonia patients is included as a metric. The American Lung Association & the Centers for Disease Control and Prevention recommend that anyone over the age of 6 months get an annual flu vaccine. On average, between 190,000 and 760,000 Oregon residents will suffer from influenza each year.

We also appreciate that there is still much work ahead. Further in the process, when the metrics are being finalized, we request your consideration of the following:

- Please keep “tobacco assessment and cessation” as one of the core metrics.
- Please consider revising the categorization of “flu vaccination for pneumonia patients, aged 50 years or older” from a menu metric to a core metric.
- Please consider updating the categorization of “rate of tobacco use among CCO members” from a developmental metric to a core metric.

Thank you for the opportunity to provide feedback on the draft CCO proposal.

Yours in health,
Colleen

Colleen Hermann-Franzen - Regional Advocacy & Outreach Manager



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Most deaths and hospitalizations from influenza occurs in babies, the elderly and people with weakened immune systems. But most flu transmissions come from young, healthy, unvaccinated children and adults. That's why it's recommended that EVERYONE over the age of six months be vaccinated against influenza. [Click here](#) to find a flu shot clinic near you.

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Fighting for Air

Ettinger Ari A

From: Kelli Pellegrini, PsyD <DrKelli@canby.com>
Sent: Monday, December 26, 2011 12:47 PM
To: OHPB.Info@state.or.us
Subject: CCO's and the role of psychologists

Dear Oregon Health Policy Board:

I am a licensed Clinical Psychologist practicing in Canby. I have been tracking with both interest and concern the development of CCO's in the State of Oregon. While I recognize that there are many details that remain unclear and will develop over time, I have been somewhat alarmed at the lack of clarity on Behavioral Health/Mental Health Service delivery.

Specifically, I am concerned that in the new delivery model providers of Behavioral Health services will be lumped into a single category (psychologists, social workers, licensed professional counselors, and marriage and family therapists), with no differentiation in levels of education, license or expertise, which will not serve the needs of Oregonians well at all. This would be the same as lumping medical care providers (physicians, physician assistants, and nurse practitioners) into a single category. Just as the level of expertise between a nurse practitioner and a physician are not the same, the level of expertise between a masters-level mental health professional is not the same as a psychologist. The level of expertise that a psychologist brings to Behavioral Health includes an indepth ability to assess (including testing), diagnose and treat not only the more common mental health disruptions (for example, mild depression and anxiety, adjustment disorders, etc), but also severe, complex and frequently multi-layered mental health disturbances (for example, Post-Traumatic Stress Disorder, severe mood disorders, bi-polar disorders, concomitant mental health and physical health disorders, etc).

In an effort to conserve resources and reduce costs, I believe that it may be tempting for the Oregon Health Authority to forward the notion that masters-level providers are the "same as" doctoral level providers. This would be a mistake, both in terms of quality of care and ultimately financially: Patients can't and won't get better if they are receiving inadequate treatment, which over time increases costs. Again, to draw a parallel to the medical domain, a nurse practitioner may recognize that a patient may have cancer ---- and it is a standard of care for the patient to then be referred to a physician for expeditious and appropriate diagnosis and treatment. Similarly, a licensed professional counselor may recognize that a client may have PTSD with suicidality ---- and within the new CCO model it should be a standard of care that the patient is referred to a psychologist for assessment, diagnosis and coordinated treatment.

Ideally, the OHA is seeking to create a model of excellence of care within the CCO's ----- which includes seeking to employ and retain providers who are at the top of their professions, practice at the top of the licenses, and provide patients with the best care available in Oregon. Just as it would not best serve Oregonians for CCO medical services to be provided by exclusively/predominately masters-level clinicians (or physicians who are either newly licensed and/or are otherwise willing to work at masters-level compensation due to less-than-stellar abilities), it would not best serve Oregonians for CCO behavioral health/mental health to be provided by exclusively/predominately masters-level clinicians (or psychologists who are either newly licensed and/or are otherwise willing to work at masters-level compensation due to less-than-stellar abilities).

I am very supportive of many of the underlying goals of the development of CCO's. I also see clearly that now is the time to create standards of excellence in all areas; standards that provide Oregonians with the best care possible. Any aspect of CCO development that potentially compromises patient care in order to save money runs diametrically contrary to the stated goals of the OHA.

Thank you for your time, and attention to my concerns.

Sincerely,
Kelli L. Pellegrini, Psy.D.
Licensed Clinical Psychologist
OR License 1436

Ettinger Ari A

From: stephen.t.mccrea@multco.us on behalf of Steve McCrea <smccrea@casahelpskids.org>
Sent: Thursday, December 29, 2011 9:06 AM
To: OHPB.Info@state.or.us
Subject: CCO Proposal

Categories: REAL CCO

I am happy to see all the hard work on the CCOs that has been accomplished in such a short time. I was very happy to see the specific inclusion of metrics to assess the availability of "non-traditional" healthcare workers (as in peer supporters and navigators).

However, as a mental health professional and an advocate, I have to admit to being disappointed with the sample outcome metrics submitted with the draft. For instance, you identify "hospital readmission rates" as a measure of performance quality. While this is an important measure and does relate to success of care, we want clients' success to be a lot more than avoiding rehospitalization! What about such measures as employment, involvement in meaningful community activities, vocational training, meaningful social relationships? These are the things that are the real measures of successful mental health intervention. We need to get beyond avoiding negative outcomes and look toward true RECOVERY OUTCOMES as our primary measures of success.

Similarly, at the very end, you give examples of levels of accountability, and on the micro level, identify "% patients showing improvement on clinically valid depression tool." Again, we're focusing on "making the bad go away." Why not look at what our depressed patient would want to be doing if they were not as depressed, and see if they are doing it? Could we not measure the PATIENT'S success in meeting their outcome goals? It has become clear that focusing on "symptom reduction" as our primary outcomes has led us to a system where we have increasing numbers of chronically ill patients. We need to reach beyond making people "less depressed" and shoot instead for helping people become MORE FUNCTIONAL in ways that are meaningful for them as individuals.

I really want to see the OHA write outcome and accountability measures that set a standard that our mental health services will IMPROVE PEOPLE'S LIVES, not simply keep them from costing us more money due to hospitalizations. The goal with a suicidal person is not to keep them from being suicidal - it should be to help them create sufficient meaning in their lives that suicide is no longer a viable alternative, because they have so much to live for. Real outcome measures have to do with QUALITY OF LIFE, not symptom reduction or avoidance of crisis events.

I hope this is helpful to your process.

--



Steve McCrea
CASA Supervisor
DIRECT 503.988.4175



Mid-Valley Behavioral Care Network

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December 29, 2011

Oregon Health Policy Board
Attn: Ari Ettinger
500 Summer St. NE
Salem, OR 97301

To Members of the Board:

I have been fortunate to work as the Consumer Affairs Specialist for Mid-Valley Behavioral Care Network, MVBCN, for the past 4 years. Part of my job responsibilities has been to work with Consumer Advocates as well as Consumer-run Organizations. Under our current leadership, MVBCN has dedicated 2.5% of their total Medicaid funds for Peer Delivered Services. We have been able to support 6 Consumer-run organizations in our region, including a self-help, drop-in center in each of our 5 counties and a regional organization that provides peer support and training to the counties in our region.

I am writing to advocate for the Board to understand the importance of having an array of peer services for people with mental health and substance abuse issues and to include funding opportunities for them in the future. I know that Peer Support Specialists hold a place of inclusion and importance in the healthcare transformation process but I must emphasize that this is only one aspect of peer support and getting good outcomes for recovery. We need an array of peer services, including self-help, drop-in centers, peer brokerages, warmline support and organizations that provide training and educational classes.

I am speaking from personal experience with a significant mental health diagnosis and as a recovering alcoholic as well. My recovery really began when I became involved with a self-help center and training in peer counseling. When I was able to participate with other peers in a safe environment and use my past experience to support and help others, my recovery began.

This is something that happens frequently when peers are able to spend time with each other. This is one reason why drop-in, self-help centers work very well. When they provide a safe environment, they not only are a place for people to attend but also provide a natural social environment that helps people to get out of their home and reduce isolation. It creates opportunity to be accepted and accountable to others. This is the same for warmlines and other programs that provide an avenue for peers to talk and learn together.

There are a number of drop-in, self-help centers around the state along with other peer programs and services. It is important that funding for them continue. They provide access to support for a great deal of people for many hours during the week and on weekends as well. If the funding for peer support is only going to be provided for Peer Support Specialists or Recovery Coaches within the system, Oregon will lose many valuable resources for people who can't always get the help they need from the system.

I strongly urge that funding for all peer support programs be included in the criteria for CCOs. I highly encourage that at least 1% of all mental health and substance abuse funding be dedicated to peer support which includes the variety of peer services that exist in Oregon already.

I do support the inclusion of Peer Support Specialists and Recovery Mentors or Coaches but not at the expense of the other peer programs that provide support and opportunities for recovery for peers. I cannot express how important it is to provide choices for people in recovery.

Maintaining funding for the array of peer supports and programs would be a wise use of limited funds because they impact a large number of people. In our region alone, our peer centers and programs serve an average of between 650-750 unique individuals a month. Those are just the OHP recipients that we serve. Now imagine that out of that number, 300-400 use these services on a weekly or even daily basis. Some of these programs operate on less than \$50,000 a year. These are not a luxury item when it comes to impacting people's lives. They provide a viable, cost-effective and effective resource for people who struggle to recover from not only from the stigma but the impact of having a mental health or substance abuse diagnosis.

Please consider these valuable resources when determining and creating criteria for peer services in this healthcare transformation.

Thank you,

Helen Lara
Consumer Affairs Specialist
hlara@mvpn.org
503-585-4992

December 29, 2011

Dear Sir or Madam

My public comments on the Healthcare are as follows: My own experience, personal and as an a small business owner indicate that all health care is paid for by rate payers or taxpayers and everyone has access to healthcare. My sister and husband, only one of many examples, are proof that all health care is paid for by ratepayers or taxpayers and everyone has access to healthcare. With no insurance or money my sister has had two episodes and treatment for non Hodgkins Lymphoma and congestive heart failure and her husband heart bypass surgery and a year later stints. Both received timely and good treatment at ratepayers expense. My sister is now covered by Medicaid and will receive treatment for breast cancer at taxpayer expense. I conclude it is sustainability ,cost and how we pay for healthcare that we must address. Therefore, I suggest, SAIF would be an entity with years of experience with health care insurance. SAIF would be a natural as healthcare insurance provider for Oregon. But necessarily, with equal contributions from employer and employee both need to be stakeholders for responsibilities sake and to maintain sustainability. Equal contributions would include small businesses, all public employee's taxpayer funded healthcare, Medicaid, Oregon Health Plan, Public Health department any and all taxpayer funded health care would be funneled through SAIF. SAIF or workman's comp would become healthcare insurance and unemployment insurance would cover any employee's who are unable to work due to injury. I believe there are numerous examples of Workman's Comp being gamed to cover healthcare issues not work related. There is no denying this merging would save money and create a large pool of funds. It also would accomplish the goal of coverage and cost reduction. Again we all have access to healthcare, health care is paid for by ratepayer or taxpayer, it is the sustainability, cost and how we pay for healthcare that we must address.

Sincerely

Dean McAllister

2515 Threemile Rd

The Dalles, Or 97058

Ettinger Ari A

From: Claude and Lucy Thompson <lucyjr@centurytel.net>
Sent: Thursday, December 29, 2011 2:58 PM
To: OHPB.Info@state.or.us
Subject: Oregon Health Policy

Categories: REAL CCO

While it is admirable to attempt to improve and keep in place a public health program, it is our belief that any system in place should be in place for everyone not just medicaid; by having the same health care system for everyone (including public officials) one would be assured of anyone having the same access.

Another major factor with the health care program (this also applies to school, college and other publicly assisted institutions) only legal citizens should be included. Many people may be sympathetic to plights of illegal aliens but it should not be too complicated to figure out that government is taxpayers and that working taxpayers cannot continue to support the whole world and carry the burden for everything. Also if a person is an illegal without green card or work visas, they are flat breaking the law; the rest of us are arrested if we break the law.

Everyone enrolled in health care should have some responsibility financially; seniors that are now on medicare have worked long worklives to qualify and paid into the program for years; there is no "free lunch"!

Sincerely,
Claude and Lucy Thompson

Ettinger Ari A

From: fred abbe <fabbe@charter.net>
Sent: Thursday, December 29, 2011 3:30 PM
To: OHPB.Info@state.or.us
Subject: peer services and input

Categories: REAL CCO

Peers should be funded to provide services as we see fit ,we have lived experience and great incentive and understanding to bring fellow sufferers out of illness to life.The establishment just wastes resources and basically most everything it does is done half ass backwards.Admit it wake up! Sincerely Fred Abbe a survivor inspite of the mental health establishment.I repeat WAKE UP!

Ettinger Ari A

From: EarthWindSpirit <earthwindspirit@juno.com>
Sent: Friday, December 30, 2011 6:49 AM
To: ohpb.info@state.or.us
Subject: Re: CCO Implementation Proposal Comments

Categories: REAL CCO

Coordinated Care Organization (CCO) implementation Proposal

I don't have notes indicating where the prior discussion of this document ended. I have a few comments anyway on material from the document beginning. The document I am working from is dated 12/8/11. The letters/words/punctuation **bolded** are to be added to this document.

The concern permeating my writing is there are no deadlines for any results. The nature of the human being is to not finish a required or suggested activity until a deadline is presented in no uncertain terms with significant consequences for non-compliance. Actualizing this understanding will help insure accomplishing HR 3650's goals.

Thank you for the opportunity to input. As I have much to learn about this developing system, current comments are mostly in the form of edits.

Sincerely,

Carolynn Kohout
SEIU 503, Local 99 (Homecare)
Finance Committee, District 1 Rep.
CAPE Member

Page 7

3. Opportunities for Achieving the Triple Aim:...

"patient-centered primary care homes", paragraph 1, line 5: an average reader would read these words and think they referred to a specific location with four walls in which a person lived. These words actually refer to a person or group of people who go into a home to assess and/or administer care. If this concept was worded "patient-centered primary care **in** homes" the concept would be crystal clear to the average reader.

“...community members’ physical health, addictions and mental health services,....” Paragraph 1, lines 2& 3: If one can’t see, then one’s physical health is impaired. I do not see anywhere optical/glasses assistance addressed.

Page 8

Paragraph 2, line 6: Spell out “FFS”. Other acronyms are spelled out.

Page 9

4. Coordinated Care ...

Paragraph 2, bullet point 3: “**CCO**” delete “s”

Paragraph 3: How does one eliminate over-costly programs where the same activity/service is offered by two or more CCO’s – both in which the same client can enroll in?

Page 10

Governance and organizational relationships

Bullet point 2: line 2 “but” not needed; line 3: “.membership, and...” [add comma after “membership”]
How regularly is the CAC to meet? It could meet once a year or monthly. This is a big difference.;

Bullet point 4: line 1: delete “are”. What about dental and optical organizations?

Page 11

Clinical Advisory Panel

Paragraph 1, line 1 “The OHPB requires” contradicts “...but would not require...”; line 2: “If,...” delete and write “When a ...”; line 3: delete “could”.

Partnerships: I do not see partnerships among dental and optical organizations. This is needed.

Page 12

Community Needs Assessment from prior page

Paragraph 1, line 6”: “The Public health Institute’s...” does not indicate if the below material is from a class, a paper, or who created the contents of the five bullet points.

Patient Rights and Responsibilities,...

Page 13

Bullet point 1, line 7-8: (E) Who are the providers of specialty care?; line 8: “are selected by CCOs...” appears to say that CCO selects clients. I understand clients select CCOs.

How is the system going to eliminate duplicative services, or is this wanted?

Regular paragraph 1, line 4: “...plans. Member...” is correct. “and” needs to be deleted

Bullet 1, line 2: “...how **their** approach... of **their** health...” delete “the” between “how” and “approach

Delivery System:..., Bullet 4, line 4: “Authority”.; page 14, bullet 5, line 1: Who is the Authority?

Page 15

Bullet 3, line 3: “...members are...”; Bullet 4, line 1: “if available” delete. Non-traditional providers need to be available.

Care Coordination

Bullet 3, line 2: “...communication **and wellness**.”

Paragraph 3, line 1: “...that CCO...”

Page 16

Bullet 1, line 4: Spell out “...EHR...”

Paragraph 1, line 3: How much time will the OHPB allow for work to occur in?

Care Integration

Bullet 2, line 2: “...any...”: What about already established relationships of clients?

Page 17

Payment Methodologies...

Bullet 1, line 1: “...shall **require**...” delete “encourage”, see Clinical Advisory Panel, page 11

Paragraph 1: Time frame? Needs to be relatively specific – otherwise there will not be compliance of all CCO’s in a reasonable time.

Page 18

Paragraph 1, lines 1, 2, 3: Delete “While...available”. This sentence contradicts next sentences in paragraph.

Health information Technology

Paragraph 1, line 1: “...requested...” needs to be stronger; line 4: “...suggests ...” should be “requests”; delete “...will need to...”; line 6: “...is at **a** different **stage** of...” delete “stages” – singular-plural agreement; line 8: “...improvement over **[how much?]** time.”

Electronic Health...

Bullet 3, line 1: delete “Consider” and start sentence with “Establish minimum...”; how much/long? “...over time.”

All need to properly mesh at a specific point.

Page 19

Paragraph 1, line 1: “CCOs should establish minimum...” delete “also consider establishing”; line 2: “...lab orders” need to be by a specific time.

Bullet 3: What about non-computer based/savvy clients?

Page 20

Populations Included...

Paragraph 1: What about those not in a fee for service group?

Service/Program...

Paragraph 2, line 4: “Funding and...” delete “Without exception” – extra words

Page 21

Global Budget...

Bullet 1, line 2: “...and dental care...” delete “if included,”

Bullet 2, line 1: “...programs, not...payments, as...” add commas

Paragraph 2, line 1: Initially, CCO...” delete “At least”

Modified Lowest...

Paragraph 1, line 1: "...approach, CCOs submit..." delete "potential" and "would"; line 2: "...data representing a ... and their benefit..." delete "that is representative" and "the"; line 3: "The OHPB... bidding. OHA..." delete "As previously mentioned" and "that"; line 4: "...will review...soundness, and **then** establish..." delete "would", add comma and "then"; line 5: "actuaries will use risk..." delete "would" and "a"

Paragraph 2, line 1: "In order ...OHA gathers..." delete "More specifically," and "would", add "gathers"; line 2: "... base cost, while..." add comma; line 3: "...data **will** indicate..." delete "would"

Page 22

Paragraph 1, line 2: "...will use ..." delete "would"; line 3: delete "in these new areas"

Paragraph 2, line 3: "...enacted..." – Is this the best word?

Paragraph 3, line 3: "...investigate including...into **the CDPS program.**; delete "the possibility of"

Process for Review...

Paragraph 1, line 1: "...contractors provide..." delete "to"; line 2: "...OHA no later than May __, 2012 ..." delete "not" and "the beginning of"; line 3: "...and **to** work..."; line 4: "...CCOs to.... If a CCO..." delete "potential" in both places; line 5: "...OHPB will not..." delete "does"

Review of Estimated...

Paragraph 1, line 2: "...documentation from the CCO is **to**..." delete "that" and "is capable of"

Page 23

Bullet 1: "Attain identified..." delete "Attaining"

Bullet 2: "Provide adequate..." delete "Providing"

Paragraph 1, line 1: "...soundness of the CCO at **the regional level**..." delete second "at" and "and region"

Blended Funding...

Paragraph 1, line 9: "...flexibly and **to** integrate..."; line 11: "... them **with** lower..." delete "and"

Paragraph 2: Over what time span will parties become efficient?

Quality Incentive...

Paragraph 1, line 3: "Initially metrics..." delete "So"; line 4: "After the first year, metrics..." delete "initial period"; line 5 "...to identify exceptional... who quality..." delete "determine" and "would"; line 6: When would an incentive program be developed?

Page 24

OHA's Accountability...

Bullet 4, line 1: "**(1)** Providing...; line 2: "...OHA **(2)** develop; line 3 & 4: "...innovations; **and (3)** support..." delete "should then"

CCO Accountability

Paragraph 1, line 3: "...on outcomes **and** quality..." delete "for"; line 4: "...process in..." delete "and"

Paragraph 2, line 2: "...members..." delete "of their"

Page 25

Accountability standards,...

Paragraph 1, line 5 & 6: "...including **(1)** technical assistance, **(2)** corrective action plans, **(3)** financial and non-financial sanctions, and **then (4)** non-renewal... their performance; to..."; line 7: "...plans and goals; and..." delete "However,"

Paragraph 2, line 1: "the Board..." delete "As with the reporting expectations"

Paragraph 3, line 2: "...expertise; use..."; line 3: "...baselines and set..." delete will

Specific areas...

Paragraph 1, line 5: "...transformation, but..."

Page 26

Line 5: "...will have a choice..." delete some"

Page 27

8. Financial Reporting...

Paragraph 1, line 1: spell out "DCBS"

Page 29

Bullet 5, line 2: "...state/write an annual..." delete "describe"; line 4: "...methodologies **wisdom/capacity**. Delete "implemented"

Bullet 6, line 3: "...CCO's (**including salaries of administrators and staff** or its..."

Bullet 7, line 5: "...insurance).

OHA Monitoring...

Paragraph 1, line 3: "...succeed, but..."; line 4: "...performance jeopardize members..." delete "are jeopardizing"; line 5: "...OHA becomes increasingly... time, if..." delete "would become"; line 6: "...guidelines **even though there is** increased ..." delete "with"

Page 30

Quality, access...

Paragraph 1, line 3: "...progressive and include:" delete "are" and "may"

Bullet 2: delete efforts

Monitoring of financial...

Paragraph 2, line 1: "**Ultimately**, if no remedy is **effective, the CCO losses its license and liquidates its...**" delete "The ultimate action... effective...feasible will be loss of licensure... liquidation of"

Public Disclosure...

Line 1: "...require public..." delete "the"

CCO Licensure

Line 1: "...category be..." delete "will"; line 3: "...from: (a) commercial insurers, (b) OHP..." single parenthesized letters get lost, as well as there are two full parenthesized acronyms in the paragraph, which help to diminish the single parentheses; line 5: "and (c) Medicare..."

Organizational Characteristics

Line 1: “OHPB **requires** CCOs to provide...” – the below either are or are not in contracts and need to be in this one.

Page 32

9. Implementation Plan

Bullet 2, lines 2-4: Rephrase material: Those eligible for both Medicare and Medicaid will need to be notified so they can enroll.

Bullet 3: Rephrase material: CCOs must provide flexibility in service delivery and administration first and foremost.

Transitional Provisions...

Lines 4-6: “...including **(1)** specific service offerings, **(2)** organizational structure, **(3)** patient-centered primary care **in** homes, **(4)** other system delivery reforms, **(5)** consumer protections, and **(6)** quality measures.” “in” within (3) reads logically for what it is trying to state; numbering items gives them importance and clarity as different actions/activities; in that they are spread over three lines, they do not ‘mush’ into fewer items than they are; line 5: delete “and” between “homes and “(4)”.

APPENDIX A:...

Page 1, Community Advisory Council, line 4: delete “but”; under Examples of Accountability... Bullet 2, lines 3-4: rephrase: “...recommendations of the Board meeting minutes”

Page 2

Person-centered Care: Examples of Accountability, Bullet 1 – spell out “CAHPS”

Page 3

Patient Engagement: Examples of Accountability Assessments, Bullet 1, line 2: “...level(s)

Member Access..., initial Baseline Expectations, Bullet 2: Who is a higher level of care needed for?

Page 4

Criteria from HB 3650

Bullet 3: This could create duplicative activity if consumer gets same service from two CCOs. Who is gatekeeper on this activity?

Bullet 4: Who/what are the “specialty care” providers?

Bullet 5: What number of years/months will it take for providers to pass or fail to meet objective quality standards? Who or what agency is to determine this?

Member and Care Team: Needs to be correlated with primary care in home team.

Examples of Accountability Assessments, Bullet 2, lines 1-2: “...Tier 3 (highest level) in relation to client capacity”

Page 6

Criteria From HB 3650

Navigating the System, line 11: Who is the “Authority”?

Accessibility”, Transformational Expectations, Bullet 1, line 4-5: “... and **includes** non-traditional...”; delete “inclusive”, which is less clear and legal jargon; Examples of Accountability...: Why none?

Page 7

Criteria From HB 3650, line 9: What is “ED”?

Learning Collaborative: Transformational Expectations and Examples of Accountability Assessments: Why none?

Patient Centered Primary Care in Homes, Transformational Expectations: Why none?; Examples of Accountability, Bullet 1, line 3: “...year 1, **year 2, year 3...**”

Page 8

Criteria From HB 3650, Health Equity:, paragraph 1, lines 1-3: “Health care services...disparities” cite where from; Initial Baseline Expectations, lines 6-8: Needs specifics; Transformational Expectations, Bullet 1: After how many months/years?; Bullet 2: After how many months/years?; Examples of Accountability Assessments: After how many months/years?

Alternative Payment Methodologies:, Examples of Accountability Assessments: Why none?

Page 9

Criteria From HB 3650, lines 1-2: How is the “...health outcomes and quality measures...” measured?; Bullet 2: At what rate for what outcomes will good performance be rewarded?; Bullet 4:

How will all of this be structured and actualized?; Initial Baseline Expectations: How will the quality of services be determined or measured?

Outcome and Quality Measures:, line 3: Who/what is the “Authority”?; initial Baseline Expectations, Bullet 1: What ratio/percentage is acceptable?; Transformational Expectations, lines 1-2: What does “...exceptional performance” mean?; Examples of Accountability Assessments, Bullet 3: “What percentage of need taken care of in first encounter” needs to be added.

Transparency:, Examples of Accountability Assessments: Why none?

Transparency:, Transformational Expectations: Why none?

APPENDIX C

Where is optical coverage?

Page 1

Spell out FFS

Page 2

Spell out CMHP, FCHPS; Addictions & Mental Health Programs, “Residential **Mental Health for Non-Forensic Children**

Page 3

Public Health, Babies First!, Descriptions, line 2: “...up to **age 5**,...” otherwise one is not sure if this refers to five children or a child of age 5; spell out MCM, LHD

Appendix E

Potential CCO Performance Measures: For what time frame?

Bullet 15: “Cancer screening” – over what time frame?

Bullet 17: “Fall risk screening” – give health condition parameters to include “younger” people. This is not specifically age-related. It is condition specific.

Bullet 19: Circle 2: Define time frame for “...quickly”

Bullet 27: “Health status improvement” – based on client or team?

Bullet 28: "Functional status improvement" - based on client or team?

Multnomah County

Public Comment on OHPB, CCO Implementation Proposal:

Multnomah County supports this effort, we are very interested in and currently working with many local partners to form a CCO that can best serve the residents of Multnomah County.

Part 3. Opportunities for Achieving the Triple Aim: Improving Health, Improving Health Care and Reducing Cost

It is crucial that the CCO accept the entire population in the area covered by the CCO (to avoid cherry-picking).

Part 5. Coordinated Care Organization (CCO) Criteria

In general Multnomah County agrees with the CCO Criteria.

Governance and organizational relationships

Section 4(1)(o)(A-C) We are pleased the criteria clearly includes the county in the governance structure. As a health care provider, local mental health authority, board of health and local public safety provider, the county shares the financial risk, is a major part of the health care delivery system and is part of the community at large. The county believes additional clarification is required on how consumers without financial risk will be included in the CCO Governing Board.

Section 4(1)(i)

To ensure a CCO is transparent and accountable as a public health care system, accountability assessments should be gathered from key community partners and stakeholders in addition to input from the community advisory council and member surveys.

The county asks that Quality Management Advisory Committees or Clinical Advisory Panels should also monitor services delivered. An advisory panel of stakeholders and those receiving services should oversee the quality of care and quality improvement initiatives for the community system of care operated by a CCO.

Community engagement should extend beyond individuals to whole communities so as to address not just personal lifestyle issues but also social determinants of health.

Section 24 (1-4) Multnomah County strongly agrees that CCOs be required to have written agreements with the local mental health authority, as the local mental health authority oversees the community mental health provider and safety net system of care. The Oregon Health Authority should work with CCOs to ensure that CCOs participate in funding and service delivery for the mental health crisis safety net.

12/29/2011

The community mental health program (CMHP) includes commitment services, emergency holds, and jail and hospital diversion programs. CCOs and the CMHP in each community should work together to coordinate these efforts.

Section 4(1)(k) Recommend that CCOs be required to demonstrate at regular intervals how they are engaging and educating members (per bullet points on page 13) and not just at the time of initial certification.

Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements

Section 4(1)(b): Continuity of care must be considered during the application process. CCOs should be required to document how the CCO will maintain continuity of care for existing patients.

Section 6(3): CCO partnerships and work with existing safety net providers is essential.

Patient-Centered Primary Care Homes

Page 14: In order to meet the population need and achieve the triple aim, patient-centered primary care homes must develop in those settings where consumers seek service – including primary care clinics and specialty behavioral health clinics.

Page 15: Community health workers and other non-traditional health workers should also provide culturally and linguistically appropriate assistance to members to obtain health care and the conditions needed for health and participate fully in their care.

Care Integration

Regarding the integration of Oral Health, the contractual relationship should be “with Dental Care Organization(s) sufficient to assure access to preventative oral health services for the members the CCO serves.”

Health Equity and Eliminating Health Disparities

Page 17: Data collection standards should include health disparity-related indicators.

First paragraph, second to last sentence: add phrase “individuals affected” to the “costs which are borne by the taxpayers...”

Second paragraph (and everywhere it’s mentioned): replace “reduce” disparities with “eliminate” disparities.

Payment Methodologies that Support the Triple Aim

Page 17: Support non-traditional health workers to work with communities to identify and solve their own most pressing health issues, by addressing the underlying social and structural causes of those issues.

Health Information Technology

Section 4(1)(g): While interoperability and electronic medical records are essential for a robust CCO and a healthy population, strong privacy protections must be in place and patients must understand how their private information will be used in this new environment and what security is in place.

Part 6. Global Budget Methodology

Section 13(2)(b): It's not clear how global budgeting will result in CCOs being held accountable for community health outcomes.

Part 7. Accountability

OHA's Accountability in Supporting the Success of CCOs

"Reducing and streamlining administrative requirements." All metrics and standards should be aligned across state, federal, and local systems (e.g. Uniform Data System (UDS), Centers for Medicaid and Medicare Services (CMS), Joint Commission data, and future CCO data).

CCO Accountability

Section 10(1): In order to ensure transparency, OHA should require publicly funded CCOs to provide yearly information on salaries of top wage earners in their organizations dedicated to CCO work.

Shared Accountability for Long Term Care

Rather than focusing on "problem" of long term care budget being excluded from the global budget, the proposal should consider this an opportunity to provide incentives for local collaboration and innovation in how to integrate long term care services and supports with primary and mental health care systems.

Proposal should include language to address potential cost shifting from health care to state hospital and jail utilization in addition to monitoring long term care utilization. Shared accountability should include long term care, state hospital and jail utilization monitoring.

Appendix A: Draft Matrix of Suggested CCO Criteria

Community Advisory Council: Inclusion of county government here is positive. Recommend including leaders of communities disproportionately affected by the disparities of that CCO's service area.

Dental Care Organization: Concerned that criteria may not lead to true integration of oral health with physical health from a patient perspective. One metric could be that all CCO enrollees have access to dental care or that a certain percentage of entire Medicaid/uninsured population have access.

Health Equity: The language here is stronger than in the proposal. There were also some great suggestions from a 10/3/11 letter from the Oregon Health Authority Office of Equity and Inclusion. Recommend adding language requiring CCOs to collect baseline health status information of majority of service area members to compare with communities experiencing health disparities within the same service area.

Adopt the measures layed out here in the Appendix and move them into the main document.

Appendix C: Example List of Programs That Could Be Included into CCO Global Budgets

Many programs included here are not currently operated or funded by Oregon Health Plan/Managed Care Organization/Mental Health Organization contractors. Recommend that decisions on which entities are included in the CCO global budget be made quickly as that will impact funding decisions at the local level.



Suggested Changes to the Coordinated Care Organization Implementation Plan

Submitted December 30, 2012

1. Each CCO's governance structure should reflect all who are taking financial risk.

We ask the OHPB to embrace a definition of "financial risk" that recognizes how many organizations will, in fact, be taking risk under a global budget that pools their many streams of funding. We see the premise of the CCOs as helping Oregon improve its present system, not simply perpetuating a broken business model. To that end --

Requested Changes to the Implementation Plan (*changes appear in bold, italics*):

Section 5, Page 10-11 – CCO Criteria

Governing Board --

- Modify the introductory paragraph to include the following:

“...there is no single governance solution, and there is risk in being too prescriptive beyond the statutory definition of a CCO governing board. ***However, the OHPB recognizes that, as a result of global budgeting, financial risk for each CCO will be shared broadly among many community organizations, as well as by the public in cases where the state subsidizes reinsurance.***”
- Modify OHPB's first two recommendation under this segment to state that "...a CCO should articulate":

“How ***all individuals and community organizations bearing risk for the solvency and viability of the organization are equitably represented among the governing board's majority interest.***”

“How the governing board includes members representing major components of the health care delivery system, ***including those that deliver care on the front line.***”

2. CCO measurement and payment structures should account for psychological and social barriers to health.

Without such accounting, the providers who serve this challenging and costly population will be unfairly penalized, and health disparities in our state will be exacerbated, leading to increased costs.

Requested Changes to the Implementation Plan (*changes appear in bold, italics*):

Section 2, Page 6 -- Existing Market Environment and Industry Analysis

“Target Population” and “Population Characteristics and Health Status”--

- Demographics data should ***provide detail on factors that lead to psychological and social barriers to health, as well as chronic disease data.***

Section 5 --CCO Criteria

Page 17 -- Health Equity and Eliminating Health Disparities --

- Add statement: ***The OHPB requires that CCOs use the Community Needs Assessment data to develop ways to measure and pay for psychological and social barriers to care.***

Page, 17 -- Payment Methodologies that Support the Triple Aim --

- Add a bullet: ***Accounts for psychological and social barriers to care in measurement and reimbursement.***

Section 6, Page 22-- Global Budget Methodology

Modified Lowest Cost Estimate Approach --

- In the fourth paragraph following the sentence: “For subsequent years... adjust payments...on member risk profiles under current CDPS process”. We ask that you add a sentence, ***“Upon approval of this Plan by the legislature, the OHA is directed to appoint a committee with broad community representation, to develop a risk adjustment methodology and a timeframe for doing so.”***
- Also, in the same paragraph, we ask that you expand the statement, “investigate the possibility of including pharmacy data and expanded demographic data..” to say, “investigate the possibility of including pharmacy data and expanded demographic data, ***including psychological and social barriers to health.***”

Section 7, Page 25-- Accountability

Measurement and Reporting Requirements --

- The implementation plan suggests that “...accountability measures for CCOs be phased in over time.” Again, we ask OHA to place a ***more specific timeline on this phase-in of measures, calling out specifically a timeline for incorporation of psychological and social factors into performance standards.***

3. The global budgeting process should be guided by clear principles to avoid negative consequences for access, coverage or funding.

The current CCO plan starts with a “presumption that all Medicaid dollars are in the global budget.” However, in some cases this “roll-in” may have unintended consequences. To prevent these unintended consequences, we ask that OHA establish clear principles of global budgeting.

Requested Changes to the Implementation Plan (*changes appear in bold, italics*):

Section 6, Page 20-21 -- Global Budget Methodology

Service/Program Inclusion and Alignment --

- Regarding the concept embedded in the paragraph beginning with, “On the remaining 13 percent...” We ask that this “exception” concept be applied to the entire global budget, and seek to insert a new paragraph that states:

“The OHA should evaluate the “roll-in” of all funding to the global budget and assess if the inclusion would cause:

- 1. Negative impacts on health outcomes by reducing available funding, access or quality.***
- 2. Loss or reduction of funding from non-state sources—for example, federal or local funding.***
- 3. Inefficiencies in the health delivery system, due to loss of efficient and effective handling at a statewide level.***

If any of the above statements are true, postponing, phasing-in or exempting inclusion of funding will be considered.”

4. Accountability needs to be ramped up.

We recognize that CCOs need flexibility, as one size will not fit all. However, CCOs also need to be held accountable to the public for management of such a significant amount of public dollars and achieving the triple aim in their communities.

Requirements of CCOs -- The Implementation Plan should clearly indicate those elements that must be a part of the CCO’s structure. Below you will find elements we believe to be the most critical to change. Please note, however, that throughout the document we believe the language needs to be stronger.

Requested Changes to the Implementation Plan:

Section 4, Page 9 -- CCO Certification Process

- “The OHPB does not favor a competitive bidding or Request for Proposals process. Instead, ~~it recommends~~ the Request for Applications **will** identify the criteria organizations must meet to be certified as a CCO.”

Section 5 --CCO Criteria

- Page 10, *Governing Board*:
 - ~~“The OHPB recommends~~ **As** part of the certification process, a CCO ~~should~~ **must** articulate.”
- Page 11, *Community Advisory Council*:
 - ~~“The OHPB recommends that~~ **At** least one member...”
- Page 12, *Community Needs Assessment*:
 - “In developing a needs assessment, ~~the Board recommends that~~ CCOs **will** meaningfully...”
- Page 13, *Patients’ Rights and Responsibilities, Engagement and Choice*:
 - ~~““The OHPB recommends~~ **Members** enrolled... In addition to any other consumer rights and responsibilities established by law, ~~the Board recommends that~~ CCOs be asked to **will** demonstrate how they will:

- Page 14, Patient-Centered Primary Care Homes:
 - “Building on this work, ~~The OHPB recommends that~~ CCOs **will** demonstrate...”
- Page 15-16, Care Coordination:
 - ~~“The OHPB recommends that~~ CCOs **will** demonstrate...”
 - ~~“The Board recommends that~~ CCOs **be required to will** describe...”
 - “As each CCO develops ~~the OHPB recommends it be~~ **will be** required to demonstrate:”
- Page 17, Health Equity and Eliminating Health Disparities
 - Include language directly from HB 3650, similar to all other sections.
 - “HB 3650 ~~encourages~~ **requires** CCOs and their associated providers...services delivery to ~~reduce~~ **eliminate** health disparities ... well-being of members. ~~The OHPB recommends that~~ CCOs **will** identify health disparities...”
- Page 17-18, Payment Methodologies that Support the Triple Aim
 - “The Board ~~recommends~~ **requires**...”
 - “Efforts to create incentives for evidence-based and best practices will ~~be expected to~~ increase health...”

Section 7 --Accountability

- Page 25, Accountability standards, monitoring and oversight
 - CCOs will ~~be expected to~~ assess their performance, to develop quality improvement plans...”
- Page 26, Annual review of CCO accountability metrics
 - ~~“The Board recommends that~~ OHA will establish an annual review process that ensures...”

Section 8 -- Financial Reporting Requirements to Ensure Against Risk of Insolvency

- Page 29, OHA Monitoring and Oversight
 - ~~“The OHPB recommends that~~ OHA **will** institute a system of progressive accountability...”
- Page, 30, Monitoring of financial solvency
 - If a CCO’s financial solvency is in jeopardy, ~~OHPB recommends that~~ OHA and DCBS **will** act as necessary to protect the public interest.”
- Page 31, Organizational Characteristics
 - ~~OHPB recommends that~~ CCOs **will** provide information *to the public* on corporate status...”

More Specific Timeframe -- Also, the plan should include a far more specific timeframe for the achievement of key CCO objectives. While we understand CCOs will need time to become fully successful, we must be keenly aware that the longer it takes, the higher the risk for the most vulnerable Oregonians.

Requested Changes to the Implementation Plan (*changes appear in bold, italics*)

Section 7, Page 25 -- Accountability

Measurement and Reporting Requirements --

- We believe that more stringent timelines are needed for the broader CCO development and reporting process. ***We ask the OHPB to appoint a committee with broad community representation to develop an appropriate timeline against which the OHA will hold all CCOs accountable.***

Section 6, Page 22 -- Global Budget Methodology

Modified Lowest Cost Estimate Approach --

- We applaud OHA for taking cautious steps and recommending that initial CCO global budget amounts be established for only one year. However, the timeframe reflected in the statement, “For subsequent years...” ***should be replaced with a more specific timeline and that timeline be developed by the “Risk Adjustment Committee” already suggested in this document in point 2, page 2.***

5. The CCO process should be highly transparent.

Creation of a Public Review Committee -- In order to balance the need for public accountability with the flexibility sought to support this CCO experiment, we strongly believe that the OHPB should request increased transparency. To that end, we ask that a public review committee be established to play an active role in the CCO certification process.

Requested Changes to the Implementation Plan (*changes appear in bold, italics*)

- We suggest that details regarding this ***newly established public review committee*** be included on page 9, Section 4: CCO Certification Process, as well as on pages 32-33, Section 9: Implementation Plan.
- ***This public review committee should be formed through a nomination process, similar to that of the CCO work groups.***
- ***The public review committee would form in April, to prepare for the review process.***
- ***The public review committee would provide feedback to the OHA on CCO applications, including recommended timelines for any modifications sought. This feedback would be provided to the CCO upon certification, with the requirement that it either be incorporated over an agreed upon period of time or a convincing reason be submitted as to why it could or should not be. The feedback would also be incorporated into evaluation proceedings to ensure accountability.***



OPCA Recommended Edits to Draft Matrix of CCO Criteria – December 30, 2011

(See Suggested Changes in **RED**)

Criteria from HB 3650	Initial Baseline Requirements	Transformational Requirements	Examples of Accountability Assessments
<p><u>Governance Structure:</u> Each CCO has a governance structure that includes:</p> <ul style="list-style-type: none"> • a majority interest consisting of the persons that share the financial risk of the organization • the major components of the health care delivery system, and -the community at large, to ensure that the organization's decision-making is consistent with the values of the members of the community 	<ul style="list-style-type: none"> • CCO clearly articulates selection criteria for governing members and assures transparency in governance—who the decision makers are, how decisions are made, what the actual decisions are (particularly regarding shared savings) and how decision-making reflects the recommendations of the Community Advisory Council. 	<ul style="list-style-type: none"> • Composition of governing board ensures that the CCO's decision-making is consistent with the values of the broad community as assessed by the Community Needs Assessment 	<ul style="list-style-type: none"> • Feedback from the CAC • Member experience or satisfaction surveys • Community Needs assessment confirms that CCO decision-making is consistent with community values. • Assessments confirm that shared savings distribution is clearly understood by the community at-large
<p><u>Community Advisory Council:</u> Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with</p>	<ul style="list-style-type: none"> • CCO establishes a CAC grounded in an assessment of community health needs and a process that assures the CAC reflects the diversity of the community. CAC members are selected by a community committee vetted by the 		<ul style="list-style-type: none"> • Community needs assessments confirm that the health care needs of the community are being met. • Attendance of CAC members at board

OPCA Recommended Edits to Draft Matrix of CCO Criteria – 12/30/11

<p>consumers making up the majority of the membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met</p>	<p>governing board. No more than .25 of selection committee members may represent the same interests as those who sit on the governing board.</p> <ul style="list-style-type: none"> • CCO employs best practice to support engagement and participation of members, including those facing barriers to participation. • CCO demonstrates transparently how they will collaborate with the CAC (remove governing board) on policy formulation and other decision-making affecting patient care and health outcomes, assuring collaboration from inception. • Composition of CAC ensures that the health needs of the population and the delivery of health care to the community are well understood. 		<p>meetings is reflected in meeting minutes.</p> <ul style="list-style-type: none"> • Board decisions as captured in publicly available minutes reflect full consideration of CAC recommendations.
<p><u>Nonprofit Agencies:</u> The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.</p>	<ul style="list-style-type: none"> • CCO plan and create reasonable timeline for developing and maintaining strong working relationships between local government agencies and other nonprofit agencies in the configuration of CCOs. • Letters of support for the 	<ul style="list-style-type: none"> • Strong working relationships exist, with real collaboration, as demonstrated through shared savings. 	<ul style="list-style-type: none"> • Letters of support from other organizations

OPCA Recommended Edits to Draft Matrix of CCO Criteria – 12/30/11

<p><u>Patient Engagement:</u> CCO operates in a manner that encourages patient engagement, activation, and accountability for the member's own health.</p>	<p style="color: red;">CCO are included in the initial application.</p> <ul style="list-style-type: none"> • CCOs will perform an upfront assessment of member's capacity for participating effectively in advocating and coordinating their own care. • CCO demonstrates how it will facilitate activation of its enrolled population, understanding to the greatest extent feasible, how the approach taken will take into consideration race, ethnicity, age, income, gender, housing status, mental illness, addiction, and other psychological and social barriers to health. • Plan for how to utilize OHA's clearinghouse of best practices for CCOs 	<ul style="list-style-type: none"> • CCO provides resources based on member's Patient Activation level (1, 2, 3 or 4). • CCO demonstrates they are training and engaging their providers to facilitate patient and family/caregiver's engagement. 	<ul style="list-style-type: none"> • CCO assesses members' activation levels • Activation improvement over time: X% of members improving by Y% in Z amount of time
<p><u>Member Access and Provider Responsibilities:</u> Members have access to a choice of providers within the CCO's network and providers in the network:</p> <ul style="list-style-type: none"> • work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members 	<ul style="list-style-type: none"> • CCOs must ensure that each provider or primary care team that is responsible for coordination of culturally appropriate care and transitions. • CCO team includes providers equipped to meet the needs of patients facing psychological and social barriers to health. • Ensure access to primary care 	<ul style="list-style-type: none"> • CCO (delete "will") ensures a breadth of providers capable of providing services across the continuum of care with a multidisciplinary, holistic and team approach. • CCO has established a workforce training program to ensure application of best practices in delivering socially, psychologically, and culturally 	<ul style="list-style-type: none"> • Community needs assessment results • Patient satisfaction surveys. • Provider satisfaction surveys.

OPCA Recommended Edits to Draft Matrix of CCO Criteria – 12/30/11

<ul style="list-style-type: none"> • are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history • emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication • are permitted to participate in networks of multiple CCOs • include providers of specialty care • are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards • work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members 	<p>where screenings can occur to determine if a higher level of care is needed.</p> <ul style="list-style-type: none"> • Ensure providers are working at the top of their license. 	<p>appropriate care.</p>	
<p><u>High Need Members:</u> Each CCO prioritizes</p>	<ul style="list-style-type: none"> • A substantial percentage of high risk members have an 	<ul style="list-style-type: none"> • CCO develops a system to identify and track high-risk members 	<ul style="list-style-type: none"> • Rate of avoidable hospitalizations

OPCA Recommended Edits to Draft Matrix of CCO Criteria – 12/30/11

<p>working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions</p>	<p>individualized care plan.</p> <ul style="list-style-type: none"> • CCO panels include providers equipped to meet the needs of patients facing psychological and social barriers to health. 	<p>and their outcomes, including avoidable ED visits and hospital admissions.</p> <ul style="list-style-type: none"> • Provider network capacities are adjusted to reflect changes in the need for and use of preventive services, remedial and supportive care, emergency care and hospital care. 	<ul style="list-style-type: none"> • Rate of non-emergency ED visits • Measures of patient engagement or patient activation • Measures of patient satisfaction
<p><u>Health Equity:</u> Health care services...focus on...improving health equity and reducing health disparities.</p> <p>Ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors.</p>	<p>CCO demonstrates an understanding of the diverse communities and health disparities in its service area (e.g. via a needs assessment) and describes an approach to eliminating these health inequities over time.</p> <ul style="list-style-type: none"> • CCO demonstrates how it will address disparities in the delivery of health care services and in health outcomes (access to care, quality of care, chronic disease management, care coordination, provider communication, etc.) and how they will ensure cultural competence. 	<ul style="list-style-type: none"> • CCO demonstrates meaningful and systematic engagement with critical populations in its community to create and implement plans for addressing health equity and health disparities. • CCO implements long term plans that incorporate innovation over time to eliminate disparities. Plan addresses disparities relating to race, ethnicity, age, income, gender, housing status, mental illness, addiction, and other psychological and social barriers to health. 	<ul style="list-style-type: none"> • Community needs assessment results • A comprehensive community oriented health equity plan. • Health outcomes demonstrate a narrowing health disparities gap, and by X date, indicate that disparities have been all but eliminated.

OPCA Recommended Edits to Draft Matrix of CCO Criteria – 12/30/11

<p><u>Alternative Payment Methodologies:</u> OHA encourage CCOs to use alternative payment methodologies that:</p> <ul style="list-style-type: none"> reimburse providers on the basis of health outcomes and quality measures instead of the volume of care hold organizations and providers responsible for the efficient delivery of quality care reward good performance limit increases in medical costs use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination 	<p>CCOs demonstrate how they will move from a predominantly fee-for-service system to alternative payment methods that: 1) base reimbursement on the quality rather than quantity of services provided, and 2) fairly compensate for the additional effort and time required of health care providers and their care teams to achieve satisfactory health outcomes in individuals facing psychological and social barriers to good health.</p>	<ul style="list-style-type: none"> CCOs [delete “will”] effectively implement alternative payment approaches to create incentives for evidence-based guidelines and best practices that [delete “will be expected to”] increase health care quality and patient safety, eliminate health disparities, and result in more efficient use of health care services. CCOs [delete “will”] build provider capacity to help restructure practices to be able to respond effectively to new payment incentives. CCOs fairly compensate for the additional effort and time required of health care providers and their care teams to achieve satisfactory health outcomes in individuals facing psychological and social barriers to good health. 	<ul style="list-style-type: none"> Provider satisfaction measures. Measures of health outcomes, including measures for patients facing psychological and social barriers to health.
<p><u>Outcome and Quality Measures:</u> Each CCO reports on outcome and quality measures identified by the Authority under Section 10 and participates in the All Payer All Claims data reporting system</p>	<ul style="list-style-type: none"> CCO reports an acceptable level of performance with respect to identified metrics, following a consistent schedule based on the effective date of each CCO’s contract. CCO submits APAC data in timely manner according to program specifications. 	<ul style="list-style-type: none"> CCO reports exceptional performance with respect to identified metrics. CCO uses a measurement system that accounts and adjusts, or stratifies, for psychological and social barriers to health. 	<ul style="list-style-type: none"> Patient experience of care Hospital readmission rates Access (e.g. time from CCO enrollment to first encounter, and type of encounter)

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<p><u>Transparency:</u> CCO is transparent in reporting progress and outcomes.</p>	<ul style="list-style-type: none"> • CCO outlines its plan to adopt a measurement system that accounts and adjusts, or stratifies, for psychological and social barriers to health. 	<ul style="list-style-type: none"> • CCO provides OHA with detailed quality, efficiency, and outcome data (not aggregate results). • CCO has performance feedback loop to contracted entities and providers. • CCO makes aggregate performance information available to members and to the public. • CCO makes funding allocation information available to the public. 	<ul style="list-style-type: none"> • HbA1C control • Etc. • Measurement system validly and reliably accounts and adjusts, or stratifies, for psychological and social barriers to health.
<p><u>Global Budget Methodology</u> Using a meaningful public process, the Oregon Health Authority shall develop...a global budgeting process for determining payments to CCOs and for revising required outcomes with any changes to global budgets.</p>	<ul style="list-style-type: none"> • CCO has system in place to provide timely performance and outcomes data to all stakeholders and the public. • CCO makes shared saving information available to the public. • CCO is transparent in reporting other decisions, as well, particularly those regarding payment, progress and outcomes. 	<ul style="list-style-type: none"> • CCO follows principles of global budgeting: <ul style="list-style-type: none"> • Funding of the global budget does not cause the loss or reduction of: 1) access or coverage for certain populations, or 2) payments from non-state sources 	<ul style="list-style-type: none"> • State's review of CCO budget indicates that principles are being followed.

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	<p>(federal, local, etc.).</p> <ul style="list-style-type: none">• Funding that is most efficiently and effectively handled at a statewide level is not included in the global budget.• Principles apply to all services that become part of the CCO.		
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Ettinger Ari A

From: BJ Merriman <bjm97338@gmail.com>
Sent: Saturday, December 31, 2011 5:59 PM
To: ohpb.info@state.or.us
Subject: Question re: CCO

Categories: REAL CCO

Happy New Year!

I think the new plan for converting the OHP to an administrative CCO format could be a smart move for Oregon if it will save money and improve service.

However, I do have a concern. A member's choices of providers are already somewhat limited by individual OHP plans and my hope is that members will have more flexibility in choosing which doctor, clinic, dentist, eye-care specialist, and most importantly which hospital they can use without losing coverage. For example, in our location, Salem Hospital is a little more local than the hospital in Corvallis, and if we prefer to go to the one in Corvallis, I hope we could have that choice. I think this extremely important. Also, if a member is unsatisfied with their primary care physician and wants to try a new doctor, will it be possible to choose or does the member have to stay with the same one to maintain coverage?

What information do you have regarding these issues?

Thank you,
Bj Merriman

Ettinger Ari A

From: Matt Borg <mattcyn@proaxis.com>
Sent: Monday, January 02, 2012 4:19 PM
To: OHPB.Info@state.or.us
Subject: Feedback on CCO proposal

Categories: REAL CCO

I applaud your effort in this work to achieve the so-called Triple Aim. However, I am concerned that the third aim of reduced cost will not be realized for two reasons: 1) no where in the CCO proposal is there any mention of any sort of accountability on the part of the patient, 2) the proposal creates an incredible bureaucracy centered around guaranteeing the outcome for the least common denominator. Regarding the first item, the patient appears to have no stake in the cost of their treatment, and hence would not be motivated to request itemization of service costs, or to request a list of options ranked according to cost, or be motivated to follow through with preventative measures or permanent life style modifications. As long costs are bundled up in cryptic codes which collect from some nebulous pool of money, the patients will remain disconnected from cost and the motivation will remain to collect additional dollars by manipulating billing codes. Regarding the second point, the cost of care of every individual must bear the administrative overhead of complying with regulations designed to insure that no individual falls through the cracks. The proposal is written with the tone that the patients are ignorant and have no accountability such that for health care purposes they must be treated as wards of the state independent of their individual capacity.

Best Regards,
Matt Borg

Ettinger Ari A

From: Cyndee Ross <rcyndee@gmail.com>
Sent: Monday, January 02, 2012 4:25 PM
To: OHPB.Info@state.or.us
Subject: Comments on CCO proposal

Categories: REAL CCO

Greetings,

I read with great interest the CCO proposal and thought that it would be of great help to the general public as reviewers and document drafters to have a series of at least 3 potential patients with a set of specific situations each, then to run them through the processes of the proposed CCO document to determine costs, health care treatments and final outcomes. A flow chart of this process would make for a graphic presentation of what is worded in 50 pages. "A picture is worth a 1,000 words".

At first thought with reading this CCO proposal is that patients have no accountability in the process that is concretely defined or accountable considering they are getting free taxpayer dollars for personal health services. Secondly, a large portion of the regulations and accountability are placed on the medical providers and the Health care facilities to perform to a predetermined standard. I am afraid that this would make these providers less inclined to help members of CCO unless there is a substantial financial gain from participating in this mandate, otherwise they may be forced out of business should the 'Capitate' find that funding or facilities is not adequate to handle the number of members in CCO. If funding or facilities were sporadic, then folks would be denied coverage and we'd be at the same point we are now. Patients have to know what their health costs are to minimize spending on unnecessary treatments, to budget their personal care and to be motivated to do preventative care.

Thank you for taking my considerations into review.
Cynthia Ross



MEMORANDUM

To: Chair Eric Parsons
Members of the Oregon Health Policy Board

From: Bryan Boehringer, OMA Government Affairs
Courtnei Dresser, OMA Government Affairs

Date: December 20, 2011

Re: Comments on the OHPB's Coordinated Care Implementation Proposal Dated 12/08/11

Thank you for the opportunity to provide comments on the Oregon Health Policy Board's Coordinated Care Organization Implementation Proposal. The Oregon Medical Association (OMA) appreciates the challenging work that has taken place to plan for and implement Coordinated Care Organizations (CCOs) in Oregon. We agree the current system is broken and that we need to do something to control costs and still provide top quality health care to Oregonians. We are cautiously optimistic that there may be an opportunity to improve the health care delivery system through better coordination of care. The integration of physical, dental, mental and behavioral health is an important step toward significantly improving the overall health of Oregonians, and we appreciate that provider and patient choice are incorporated in this proposal.

However, we remain concerned that the pace of these changes is overwhelming to our rank and file physicians who are struggling to understand the details and where they, as physicians, fit into these new organizations. Some of our members are feeling the pressure to start planning for a CCO without additional details about the physicians' role in coordinating care and feel their engagement with local efforts is limited. As we proceed forward with this plan, we must continue to engage physicians and other health care providers and ensure that this transformation is provider driven.

While the CCO Implementation Proposal does add some important details to the work that was begun in HB 3650, we still have questions and concerns about the current draft.

Governance and Global Budget

We continue to have concerns about the lack of definition contained in the proposal about the CCO governance structure. As currently defined, allocating the majority interest to those who share the "financial risk" does not allow for an equitable decision-making process to be established. We believe that no stakeholder should have an advantage over another. As part of the coordinated care team directly engaged with the patient, we feel it is imperative to have physician membership defined as part of the governance structure, rather than assume that a physician may be included in the broader

categorization of “health care delivery system”. Physicians and other health care providers will be responsible for providing quality care to the members in a CCO and they have a critical perspective on what will best ensure excellent care. If physicians are not equal partners in the governance structure, we are worried that patients’ health care needs will not be adequately represented.

We also remain concerned that the global budget and alternative payment discussions should reflect a fair representation of all stakeholders in the distribution of payments. Additionally, any new payment models that are used within CCOs need to be transparent to all participants, including providers and the public. The planning and implementation of payment reform models must include broad participation by providers.

We would also like to see more information and definition with regard to the “Clinical Advisory Panel” (CAP). The membership of the CAP should include a significant number of physicians. Furthermore, their scope of work and the scope of work of others on the CAP as well as the process for selection should be further defined.

Patient Engagement

We appreciate the patient choice that is reflected in the proposal, and would like to see additional detail about the role physicians, other health care providers and the informed patients will serve as the core decision makers for the member’s individual health.

The plan encourages CCO members to be active partners in directing their own health care and services. The requirements for patient engagement, however, seem to place a larger share of the responsibility on the CCO. Patient responsibility is such an important part of the success of the CCO that we would like to see the addition of member incentives to prioritize healthy lifestyles, and a greater emphasis on the member’s personal responsibility and expectations in managing their health care.

Flexibility and Technical Assistance

We appreciate that the proposal requires the Oregon Health Authority (OHA) to provide technical assistance and provide ‘learning collaboratives’ for CCOs as we implement reform. We continue to advocate for additional flexibility for rural areas and smaller/solo clinics to support their continued function and service to their communities. We also suggest that, given the aggressive timelines for implementing transformation in Oregon, we allow communities that are ready to go now proceed, while allowing flexibility in the timelines for those that may need more time. We should not punish those that are not ready to form or participate in CCOs, but instead should allow for delayed implementation in those communities that need to learn from the early starters.

Health Information Technology

We are pleased to see the proposed rules better reflect the readiness of Oregon communities, and the status ‘on the ground’ of Health Information Exchange in its implementation across the state. Timelines for integrating mental and dental health care into the members’ experience are more reasonable, yet the issue of integrating electronic health information exchange across all modalities of

care remains concerning. While it now looks promising that the state's Direct health information exchange, which is meant to enable health information exchange among stakeholders with email access, could be up and functional in 2012, bridge funding for the project remains at risk. We appreciate that HITOC conveyed feedback to the OHPB stipulating that efforts should meet the community where it is, but intent moving forward. We also appreciate the attention HITOC has given to phasing in the use of HIT that will increase value of care that would typically be out of reach of smaller and rural providers in a market based on volume.

Additionally, the OHA should use the implementation of CCOs as an opportunity to demand HIT interoperability across all CCOs so member's EHRs can flow within and between CCOs around the state. The OHA should also use this opportunity to demand administrative simplification across the CCOs to reduce the paperwork burdens on health care providers.

CCO Formation Due Process

It is critical that the process of forming and maintaining CCOs is equitable to all participants and potential participants. No physician should be forced to participate in a CCO if the terms of participation are inequitable or so difficult that the physician is not reasonably able to comply. For example, a CCO may believe a physician is necessary to implement the CCO, but require utilization or quality criteria that the physician cannot comply with because their electronic health record does not capture the necessary data. Physicians and other providers must have access to a fair process to raise and resolve these disputes. Just as patients should have the freedom to choose their physicians, physicians must have the freedom to choose with whom they contract.

Quality Metrics and Fair Process

We are also keenly interested in the development of the quality measures and how those measures are tied to provider payments. While we believe medicine needs to move in this direction, the current measures are imperfect, and are not always the best indicators of improved patient health. Additionally, physicians should have access to a fair process to raise concerns and resolve disputes regarding their evaluations pursuant to the quality and efficiency metrics, especially given that these criteria will be tied to payment and participation in the CCO. This will be a challenging process, and if not set up correctly, patients stand to lose.

Finally, the Metrics Technical Advisory Group must include physicians. Any efforts to define and measure clinical standards must include physician input and physician participation.

Care Coordination

We would also like to see additional detail on the coordination of care with specialty services. Specialty services will be an important part of the CCOs and how the details of how they will participate remain unclear for many of our specialty members.

Public Nature of the CCO/Liability Reform

CCOs are public entities and should be subject to the caps provided in the state Tort Claims Act. As providers of care to Medicaid and Medicare patients pursuant to state regulation and oversight, CCOs are essentially public entities. The fact that they rely on the “state action” exemption to the anti-trust laws further cements their status as public entities; to meet this exemption they must act pursuant to state direction. The Tort Claims cap is extended to other public entities for purposes of medical liability and should include CCOs as well. This medical liability reform would be a strong incentive for physicians to participate in CCOs and would be an essential step in bending the health care cost curve and mitigating the practice of defensive medicine. Indeed, we will not achieve the cost containment goals of CCOs without meaningful liability reform.

In closing, the Oregon Medical Association would like to express its appreciation for the opportunity to provide our initial comments on the Oregon Health Policy Board’s Coordinated Care Organization Implementation Proposal. With tight timelines, the OMA has solicited feedback on the proposal from our membership and as necessary, will be submitting relevant updates throughout the comment period.

The Oregon Medical Association is an organization of over 7,500 physicians, physician assistants, and medical students organized to serve and support physicians in their efforts to improve the health of Oregonians. Additional information can be found at www.theOMA.org.

Recommendation from Dr. Hsichao Chow, Corvallis Clinic
Member of Physicians for National Health Program and Mid-Valley Health Care Advocates
Dec. 30, 2011

The first of the Triple Aim Initiative, the central tenet of the Health Transformation in Oregon, is improvement of the health of the population. To achieve the best health of a population, uniformly high quality of care has to be delivered. To insure the uniformity of such high quality care, the best practices of all fields of health care should be readily available to all health care providers. Such best practices should also be continuously updated according to the advancement of medical science, to insure the most up-to-date best practices. However, the daunting task of maintaining such inventory of best practices that are constantly updated and revised is simply beyond the capability of any individual CCO.

We therefore, respectfully recommend the following:

1. Under the auspice of OHA, a division of Best Practices of Health Care (BPHC) be established and charged with the task of maintaining the inventory of best practices
2. BPHC then convenes experts in Oregon, and if necessary out-of-state experts in various fields of health care to form best practice panels of respective fields, e.g., Heart Care; Neurologic Care; Digestive Care, Musculoskeletal Care; etc.
3. Each best practice panel is charged to select and maintain, also gradually expand a list of best practices. Those best practices which have been published by reputable organizations or government agencies, such as NIH, various professional societies, and others, can be adopted without too much labor. For the majority of illnesses, however, there are no existing best practices. Participants of these panels will have to work them out according to their own research.
4. Formulation of new Best Practices must be undertaken with comprehensive research and vigorous deliberation.
5. Under the supervision of the OHA, these best practices can be rolled out to all CCOs to be adopted. There are various mechanisms for promulgating them.

Some examples are given below:

- a. Through the mandatory CME sessions of CCO
- b. Incorporated into the "library of orders" or templates in the EHR used in the CCO.
- c. Health care providers who adhere voluntarily to these best practices are given protection against malpractice litigation, which in the long run, will be the greatest incentive for the adoption of such practices.
- d. Financial incentives can also be assigned according to the diligence of utilizing such best practices.

6. In light of the time and labor required to compile and maintain such library of best practices, the participants must be contracted with adequate financial remuneration and appropriate recognition.

If this task can be successfully accomplished, the overall quality of health care can be elevated everywhere in Oregon, from the tertiary medical system like OHSU to the rural clinic in the mountainous region of the State. Within the foreseeable future, Oregon can be expected to be the leader in the best practices in the nation.

Ok January 2, 2012

To: Oregon Health Policy Board and Oregon Health Authority

From: Mid-Valley Health Care Advocates, Betty Johnson, Chr.

Re: Comments and Recommendations re Coordinated Care Organization Implementation Proposal

The Oregon Health Policy Board is to be commended for:

1. Its concerted efforts to encourage public participation in the entire transformation process.
2. Articulating “ the end goal of moving from fragmentation to organization and delivering the right care in the right place, at the right time, to patients who are fully engaged.”a very straightforward explanation.
3. Recognizing the unique nature of each Oregon community and its readiness to engage in transformation of health care delivery, allowing time to” develop capacity, relationships, systems...”.
4. Recommending that at least one member of the Community Advisory Council (chair or co-chairs) also serve on the CCO governing board to ensure accountability for the governing board’s consideration of CAC’s policy recommendations.(This has been an important Mid-Valley Health Care Advocates recommendation.)
5. Recommending focus on patient engagement in the design and implementation of care plans.
6. Requiring CCOs to describe HOW they will implement various elements of transformation to achieve coordination, integration, health equity .and utilize new payment methodologies to incentivize specific health outcomes.
7. Defining specific ways Oregon Health Authority will be accountable for providing technical assistance and support to CCOs as they implement transformation of the health care delivery system.
8. Recommending that OHA institute a system of progressive accountability to support the success of CCOs “but also **protects the public interest**”.
9. Recommending that Department of Consumer and Business Services insurance licensure rules regarding disclosure of information also apply to CCOs and that a new licensure category be established for CCOs by OHA and DCBS. (Disclosure of information is another recommendation from Mid-Valley Health Care Advocates.)
10. Providing guidelines for developing metrics which will be used to evaluate CCO achievement of its goals.

Mid-Valley Health Care Advocates submits the following recommendations to improve the Coordinated Care Organization Proposal :

1. **Accountability:** We strongly urge Oregon Health Policy Board to *require* significant public representation on the CCO governing boards. County government officials are elected by voters to represent their best interests and are accountable at each election cycle.
- 2 **Public health representation:** We propose that public health, as a major component of the health care delivery system, brings expertise and invaluable experience to the CCO partnership. Public health also provides essential knowledge and practical experience in conducting needs assessments so important to success of the CCOs.
- 3 **More specificity:** More specificity is needed to assist patients as well as CCOs to ensure active partnership in care planning and implementation. Defining terms such as “patient activation”, major components of the health care delivery system”, “patient choice”, “stakeholders” is essential. CCOs must also ensure availability of a full range of primary care providers e.g. medical doctors, nurse practitioners, naturopaths, chiropractors, doctors of osteopathy, etc.,. A full range of providers of auxiliary services is also required to facilitate choice and should include nutritionists, massage therapists, physical and occupational therapists .
4. **Expansion of Best Practices:** To insure the uniformity of high quality care , the best practices of all fields of health care should be readily available to all health care providers and should be continuously updated. Recognizing that this task is beyond the capacity of any individual CCO, Mid-Valley Health Care Advocates recommends the creation of Best Practices of Health Care under the auspices of the Oregon Health Authority, perhaps within the Office of Health Policy and Research, to serve as a resource to all Oregon CCOs.
See attachment written by Dr. Hsichao Chow, Corvallis Clinic, for further details on this recommendation.
5. **Global auditing process:** We request clearer definition of a “meaningful public process” in developing the global auditing process for determining payments to CCOs. In our on-going commitment to accountability and transparency, it is essential that at least minimum expectations are documented for CCOs and made known to the public.
6. **Mental Health drugs exclusion:** Please clarify the reasoning behind excluding mental health drugs from the global budget process. It would appear that excluding mental health drugs weakens the incentives for coordination and integration of services.
7. **“Stakeholders”:** **We want to emphasize that people directly affected by CCO decisions and policies, i.e. the public, are the most important stakeholders of all.** If stakeholder connotes only those with money and power, perhaps another term needs to be used that clearly includes every community member impacted by CCO decisions and policies.
8. **Public hearings:** We strongly recommend that OHA ensure that public hearings are held on each CCO application and that OHA consider public comments before any CCO application is certified.

Mid-Valley Health Care Advocates looks forward to your response to the above recommendations .



Oregon Residential Provider Association

“Promoting effective and efficient mental health residential services throughout the State of Oregon”

www.oregonrpa.org

December 19, 2011

To: Oregon Health Policy Board (OHPB)
From: Oregon Residential Providers Association
Re: Coordinated Care Organizations Business Plan
Cc: Dr. Bruce Goldberg

Dear OHPB Members:

Thank you for the opportunity to comment on the impending business plan and legislative framework the OHPB plans on submitting to the Legislature for their consideration during the 2012 legislative session. Your work as well as the work of countless stakeholders and policy makers is critical. We are sure you would agree that Oregon, indeed the nation, is at a crucial point with regards to health care; in both the delivery of services and the affordability of a quality health care system. As providers of residential mental health care in Oregon, we, the members of the Oregon Residential Provider Association (ORPA), are at the frontlines of the health care delivery system. We see, firsthand, the byproduct of a system fraught with inefficiencies, backwards incentives, and a poor payment structure. We hope we can give you some guidance in your decision making process to enhance the transformation business plan and future legislation.

ORPA is a state-wide, non-profit Association for providers of licensed community residential treatment programs for individuals with a psychiatric disability. The purpose of the Association is to ensure that the residential service system is a high quality, effective and integral component of the Oregon continuum of mental health care. In that capacity, and after reviewing the draft business plan, we see some significant omissions specifically in the area of mental health.

First and foremost, we believe expanding access to appropriate mental health treatment through outreach and engagement will lower costs and improve health throughout the health care system. Approximately 20% of the total population has a mental illness and 6% of all individuals with a mental illness have a severe and persistent mental illness. It has been noted in numerous OHPB meetings the devastating affect an untreated mental illness can have on the individual as well as the burden the illness has on various aspects of the health care safety net. It has long been known that most of the highest cost users of health care (from the emergency rooms to addictions providers) are those with mental illness. Treating the underlying mental illness can save lives and costs at numerous junctures in the health care delivery system.



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It is very important the OHPB as well as policy makers understand that **“mental health” is not a monolithic area of health care.** There are many different facets of mental health care and as such, we are including specific recommendations for residential mental health. Residential mental health serves the chronically mentally ill also known as severe and persistent mental illness (SPMI). The symptoms of individuals with SPMI, such as paranoia, may interfere with their ability to seek medical care until their medical condition becomes acute and requires more expensive emergency or inpatient treatment. Because of their inability to adequately address their own care and co-occurring addiction problems, people with SPMI have an average life span about 25 years shorter than the rest of the population. Behavioral and cognitive problems as a result of their mental illness interfere with the ability of individuals with SPMI to access medical services in traditional clinic settings, and they may best be served by bringing needed services to their place of residence.

Our recommendations below for more robust metrics reflect our belief that a more detailed approach to mental health is necessary to achieve the quality and cost saving goals we all hope to achieve through the formation of CCOs. It is through this detailed approach where the state can begin to achieve savings and where CCOs will truly be held accountable.

Finally, in addition to our recommendations it is important to keep in mind that treatment and recovery from mental illness is unlike other disease states or physical health problems. Successful treatment of a mental illness, and progress toward recovery from it, requires more than just medication therapy. Successful treatment must also include addressing co-occurring illnesses, skills training, lifestyle management, and the development of a trusting and caring relationship with those who provide the necessary care.

With that in mind, we recommend the Oregon Health Policy Board include in their business plan and their recommendations to the Legislature the following outcome and metric targets for coordinated care organizations:

Outcome and Metric Targets

- Psychiatric rehabilitation services consisting at least of skills training to address functional impairments resulting from a serious mental illness, which shall be furnished in any appropriate setting (including on-the-job-site or in the home)
- Reduction in suicides and attempts at suicide.
- Chronic Disease Self-management support for severe and persistent mental illness (SPMI).



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- At least one service designed to avoid institutional placement for chronic and serious mental disorders both for children and adults in order to ensure a sustainable, successful outcome (stability or remission) of a serious chronic condition.
- Reduction of long-term hospital stays for the chronically mentally ill through use of alternative residential care settings.
- Reduction of psychiatric visits to the ED.
- Increase in community tenure (days living outside of institutional settings) for those individuals with SPMI.
- Use of one or more evidence based practices for the treatment of individuals with SPMI, such as dialectic behavioral therapy, cognitive behavioral therapy, etc.

Once again, thank you for the opportunity to comment on your developing plan for Coordinate Care Organizations. If you have any questions or if you seek further information, please don't hesitate to contact us.

Sincerely,

Kevin McChesney, President
Oregon Residential Provider Association

January 3, 2012

Oregon Health Policy Board
500 Summer St. NE
Salem, Oregon 97301

(via email OHPB.Info@state.or.us)

Dear Oregon Health Policy Board Members,

Thank you for the opportunity to comment on the draft Coordinated Care Organization Implementation Proposal (CCO Implementation Proposal) under House Bill 3650. We support OHPB's work to "promote efficiency and quality improvements in an effort to reduce year-over-year cost increases while supporting the development of local accountability for the health of CCO members." We believe our community is well positioned to build on our already strong collaborative relationships in further realizing the OHPB's goals.

We understand that the CCO Implementation Proposal, when finalized, will be presented to the Legislative Assembly to fulfill the requirement set forth in Section 13 of HB 3650 which calls on the Oregon Health Authority (OHA) to develop, among other program components, "qualification criteria for coordinated care organizations" and "a global budgeting process for determining payments to coordinated care organizations." As further noted in Section 13, the proposed criteria and processes must be approved by the Legislative Assembly, before OHA may proceed with implementing the new coordinated care delivery system. This provision was included to insure that meaningful and necessary detail regarding the specifics of the coordinated care delivery system would be developed, providing for a clear and public understanding of the expected requirements and outcomes under the newly envisioned system.

We recognize the enormity of the task to develop a detail framework within a relatively short time frame and believe that the initial draft of the CCO Implementation Proposal provides a good starting point. However, the document needs to provide substantial additional detail in order to achieve the level of understanding necessary for providers to make an informed decision regarding participation in the new program. As the CCO delivery system is an "at-risk model" of care, meaning that CCO participating providers or organizations will be operationally and financially accountable within a global budget for the provision of services and achievement of outcomes, it is crucial that the criteria and processes for implementing and administering the program be clearly established in advance.

We find that the initial draft of the CCO Implementation Proposal often repeats or restates language already contained in HB 3650, without adding any further understanding regarding the criteria and processes that will be used by the OHA in implementing or administering the program. By example, this occurs frequently in Section 5, Coordinated

Care Organization Criteria, where each subsection contains bolded excerpts from Sections 4 through 13 of HB 3650, followed by a general restatement of those requirements and an indication that the CCO would be asked to describe, as part of the CCO application process, how they would address the corresponding provision of HB 3650. In most cases, no further significant guidance is provided, which if present would establish the needed objective criteria for determining if the CCO applicant's response is adequate and insure that OHA's evaluation of CCO applications, as well as ongoing administration of the program thereafter, is consistent and measured across all CCOs. As most of the CCO-required elements referenced in Sections 4 through 13 of HB 3650 are broad-based conceptual statements of principal, without the development of criteria and processes (as called for in Section 13 of HB 3650) there exists no framework for establishing the contractual scope of CCO responsibilities and accountability. Other examples, similar to this, occur throughout the document.

Similarly, the CCO Implementation Proposal makes reference on numerous occasions to the need to determine, at some future date, critical aspects of the program. We believe that Section 13 of HB 3650 was intended to provide the public with a higher level of certainty and comfort with regard to how the new CCO delivery system would be implemented and administered and that such clarity was intended to be provided currently, as part of the CCO Implementation Proposal, and not at some future date. By example, Section 10 of HB 3650 requires the OHA, through a public process, to "identity objective outcome and quality measures and benchmarks" to which CCO contractors will be held accountable. The interim HB 3650 workgroup on "Outcomes, Quality and Efficiency Metrics" was formed for this purpose. However, Section 7 of the draft CCO Implementation Proposal states that the "next stage of metrics development will be for the Board to establish a technical advisory group of experts from health plans and systems to build measure specifications, including data sources, and to finalize a reporting schedule." The identification of specific metrics and the related expected CCO contractual implications of achieving or failing to achieve an established level of performance should be clearly identified in advance in order for potential CCO providers or organizations to reasonably assess their ability to meet the performance requirements. Additionally, Section 8 of the draft CCO Implementation Proposal recommends that a new regulatory licensure category for CCOs be created by DCBS in collaboration with OHA. Connected to this new licensure category would be an array of yet to be determined financial reporting and solvency requirements, including the required levels of CCO capital investment. Again, a clear understanding of these specifics is critical in assessing potential CCO providers or organizations ability to participate in the new delivery system. Other examples, similar to these, occur throughout the document.

We recognize and appreciate the acknowledgement in the draft CCO Implementation Proposal that there is a potential risk in being too prescriptive when implementing a new program. We believe that the added clarity suggested above need not impair the flexibility of CCOs to innovate and invest in care that may decrease costs and achieve better

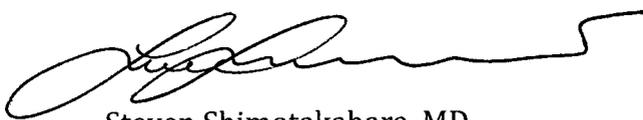
outcomes. By example, we suggest that the OHA look at the level of descriptive detail that accompanied the Centers for Medicare & Medicaid Services (CMS) discussion of criteria and processes for the Accountable Care Organization Shared Savings Program, the federal Medicare program with many similarities to Oregon's CCO model, both of which center on the Triple Aim goals of better health, better care and lower costs. While significantly more voluminous than the relatively brief current draft CCO Implementation Proposal, the CMS content provides a thorough understanding of the federal program's criteria and processes. Similarly, we would also recommend that OHA look not only at the existing CMS Medicare Advantage application to streamline the CCO application process, as noted in the draft CCO Implementation Proposal, but also to the ACO Shared Savings Program application process.

Section 6 of the draft CCO Implementation Proposal recommends "an overall global budget strategy that holds CCOs accountable for care costs but not enrollment growth". As you are aware, OHP enrollment is up over 30% in the past two years (November 2009 to November 2011), while at the same time program funding per individual and payments to providers have been cut to counter the higher enrollment. We are concerned about unrealistic expectations that a "transformed" delivery system can contain costs at the pace necessary to accommodate the recent and expected future enrollment increases, and that CCOs will, due to state budget constraints, be subject to funding adjustments to compensate for enrollment growth. Compared to other states, Oregon has a highly efficient health care delivery system and it will take considerable time and effort to achieve "budgeted" savings. We believe that medical liability reform will be a key component in achieving future savings. We encourage OHA to address these concerns in the next draft of the CCO Implementation Proposal.

Finally, we look forward to the sections of the draft CCO Implementation Proposal that are currently identified as "forthcoming".

We would be glad to discuss these comments further or provide any clarifications. If you have questions, please direct them to William Murray, CEO at North Bend Medical Center (tel: 541-266-1599 or email: william.murray@nbmconline.com). Thank you again for your leadership on health care transformation and for your consideration of our suggestions.

Sincerely,



Steven Shimotakahara, MD
Chairman
North Bend Medical Center, Inc.



Kathy Laird, RN
Chief Executive Officer
Waterfall Clinic



Dan Walsh
Administrator
Bay Clinic, LLP



Phil Greenhill
Chief Executive Officer
Southwest Oregon IPA, Inc.
Doctors of the Oregon Coast South (DOCS)

cc: Senator Joanne Verger
Senator Alan Bates
Representative Arnie Roblan



Comments on OHA Coordinated Care Organization Implementation Proposal

From: Michael Becker, Director of Government Affairs, Providence Health & Services – Oregon

Date: January 3, 2012

Thank you for the opportunity to offer comment on the Coordinated Care Organization Implementation Proposal. Providence Health & Services is committed to transforming the health care system as an essential part of achieving improved health outcomes for the poor and vulnerable and to improve the financial security of our state.

The current draft proposal generally follows a solid approach - defining the necessary outcomes and accountabilities, without constraining CCOs with inefficient, restrictive requirements. One key to this approach is ensuring that a community needs assessment, which includes data on equity issues and health disparities, guides the key components of each CCO. This would include: medical home/provider network structures, accountability for health equity, budget, and outcomes. Based on our experience with serving the diverse communities throughout Oregon, including the urban population in Portland and rural communities like Seaside and Hood River, we can assure you that one size does not fit all.

Providence understands the challenges we face and the hard, collaborative work that has to occur in the next 6 months in order to make this transformation successful. This can only happen by implementing a plan that is:

- Flexible enough to create structures that work in individual communities
- Efficient enough to make the changes that will have a lasting, positive impact
- Capable of evolving as we discover the best structures to meet the Triple Aim objectives

CCO Roles and Accountability

Health equity: Responsibility for managing health equity as a factor in reducing the financial impact on the health care system seems obvious, but will prove to be one of the most complex outcomes to meet and measure. Health equity goals and improvement measurements should be based on individual CCO needs assessments, not a standard set of expectations. The impact CCOs can have on long-term social and societal issues remains unknown and setting requirements that CCOs need to “demonstrate elimination of health disparities” will make it nearly impossible for CCOs to stay in compliance. Rather, the focus should include a requirement that each CCO have a plan to address disparities impacting health outcomes, by managing and coordinating with the organizations and experts specializing in those areas. Then each CCO should have a baseline established, and measure progress. Intractable social issues will never be eliminated, but we can measure CCO progress toward minimizing health disparities and addressing social issues.

OHA oversight and accountability targets: Providence supports a system that identifies targets specific to each population and holds CCOs accountable based on the identified needs in each region. An approach, similar to that outlined in the draft business plan, that phases in accountability targets and accounts for the complexity of each CCO population is essential to ensuring CCO success.

Governance

Providence supports a governance structure similar to the one outlined in the draft plan. Financial risk takers who will be responsible for CCO financial losses must have primary governance control. Representatives of the community/patient advisory council, the provider advisory council and county governments should also have representation on the board. Each CCO should be measured on how well their board facilitates an inclusive process and ensures a CCO is accomplishing expected outcomes as reflected in the community needs assessment.

Funding

Global budgets: The proposed global budget methodology needs some additional work in the following particulars:

- Using a "lowest cost estimate" approach for the initial CCO capitation rate setting is a methodology that has only a minimal basis in actuarial soundness, and is one that CMS has described it as highly unusual. This methodology also does not reflect a budget that represents the reality of CCO costs and gives no consideration to the initial investment of integrating providers and administering a shared collaborative organization.
- In the early developmental stages of CCOs the focus should be on bending the cost curve and meeting utilization, patient satisfaction and quality targets. CCOs operating through delivery systems and physicians, should be rewarded for hitting established targets, rather than using the lowest cost estimate approach that effectively requires CCOs to bid and bet on the cost of caring for their population.
- The foregone federal Medicaid matching funds create the potential for "shared savings" between CCOs/providers, the state and CMS. These funds could be used as the carrot in a global budget methodology. In the conversations with CMS on accessing shared savings, it should be clarified that the new CCO structure makes it possible to impact and flatten the rate of growth in future health care costs, but the changes are unlikely to reduce spending below current levels.
- The global budget methodology must also include risk adjustment of the populations served by CCOs, as well as risk adjustment reflecting the uninsured populations that will continue to exist in the CCO service areas. The CDPS and the MRX risk adjustment models are widely accepted, and Oregon has a history with these models (with some adjustments). It would be appropriate to update these models to reflect current data and adjustments to compensate for new drugs and procedures developed since the time these models were created nearly ten years ago.

CMS alignment with Medicare: Providence supports coordination with CMS, including the dual eligible population in the CCO structure. The CCO structure should be developed to support these populations, not expanded to include commercial and Medicare lives before this system is proven.

Long term care

CCO coordination with LTC should include incentives that foster alignment and development of a relationship between CCOs and long term care providers. As written, the section focuses primarily on avoidance of cost-shifting.

Efficiency

Alternative dispute resolution: With limited details it is difficult to comment on dispute resolution proposal. Providence recommends flexibility – allowing CCOs to create individualized processes that are appropriate, timely and efficient.

Transition incentives: Providence would like to see more detail around the proposed incentives. We understand the desire to incent early adopters and reward existing MCOs transitioning to CCO status, but these financial, enrollment and flexibility incentives must be reasonable and not work to the disadvantage those working to create CCOs in complex environments like the Portland metro area. In addition, a new collaborative CCO that includes more than one existing MCO should also qualify for the financial, enrollment and flexibility incentives. Finally, the incentives should be carefully crafted to encourage meaningful transformation in health care delivery, not business as usual under a new name.

Rural CCO considerations

Rural hospitals are a key to appropriate access to care in this state, and the business plan should allow sufficient flexibility to successfully implement CCOs in these communities. For example, smaller enrollment numbers and less opportunity for growth will mean that rural CCOs will face different risk factors requiring different risk adjustment requirements.

1/3/2012

Oregon Health Policy Board
500 Summer Street NE
Salem, OR 97301

Dear Oregon Health Policy Board:

Dental Care Organizations (DCOs) were formed to specialize and focus in the delivery of dental services to Oregon's Medicaid population. As a DCO, Willamette Dental Group believes that we, as well as the other DCOs, have been successful in this focus over the years, as evidenced through successful cost containment and delivery of services to help Oregon's most vulnerable achieve oral health.

DCO representatives have been actively involved in health system transformation, attending meetings from the early 2011 workgroups on concept through the present monthly workgroups designed to report a detailed plan of the CCO system to the legislature.

While oral health is scheduled to be integrated within the CCO framework, we believe the Implementation Proposal could provide more clarity regarding how OHP dental will transition to the new CCO model.

Specifically, we have the following three main concerns:

1. Dr. Goldberg recently stated that the state and federal funds for dental will not be included in the global payment to CCOs until 2014. On the other hand, HB 3650 seems to provide that CCOs may contract with dental subcontractors as soon as July 1, 2012. In this regard, CCOs and DCOs are working to "pair-up" in light of this uncertainty.
2. On page 16 of the CCO Implementation Proposal, in the second bullet point under Care Integration, it says "Oral Health: By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside". Despite that, there are virtual monopolies being arranged at this time between emerging CCOs (that may be the only CCO in a county) and a single DCO (where more than one DCO serves currently). This kind of business behavior, fueled by the uncertainty of the law and the lack of administrative rules, could lead to unintended consequences. To maintain continuity of care for OHP patients, the Implementation Proposal should clarify that CCOs must contract with all DCOs that serve members of the coordinated care organization in the area where they reside by July 1, 2014.

3. The DCO Grandfather provision of HB 3650 needs be clarified to ensure: (1) that dental funding will continue in its current form by contract between the State and each DCO until 7/1/14 or until a new CCO has contracts in place with all DCOs in its service area; (2) beginning thereafter, each qualified CCO must contract with every DCO with members in the CCO's service area; and (3) dental services must be funded by CCOs in the form of global payments to qualified DCOs in accordance with sound actuarial principles in light of dental coverage requirements and sound, historical, utilization data.

We believe that the transition from MCOs to CCOs is not intended to force patients to change dental providers, simply because the new CCO chooses to contract with only one of two DCOs in the area, or two of four DCOs in the area.

If not handled correctly Oregon is at risk of leaving behind the successful dental delivery system built over time by investment of Oregon taxpayer dollars. The DCOs have invested in physical plant, equipment, systems, and specialized training of personnel. These employees and investments as well as our continuing ability to support Medicaid dental service requirements are in jeopardy if the rules and funding change suddenly and in an unpredictable or unsustainable manner.

Thank you for your consideration.

Ettinger Ari A

From: Liz WCDB <liz@wecandobetter.org>
Sent: Tuesday, January 03, 2012 3:52 PM
To: OHPB.Info@state.or.us
Cc: community-leadership-council@googlegroups.com
Subject: Draft Plan for Coordinated Care Organizations
Attachments: HBRHeeradSabetiOct2011.pdf; ATT00001.htm

Categories: REAL CCO

To Members of the Oregon Health Policy Board:

We appreciate the time and effort that has gone into developing the draft implementation around CCOs, and acknowledge that you must be receiving extraordinary push and pull from diverse stakeholders that are trying to influence you as CCOs move toward legislative approval. On behalf of our Community Leadership Council (CLC) I am forwarding some additional comments.

Community Governance and Accountability

In 2011, the CLC identified Health Equity as one of its key policy priorities, and endorsed SB 97 as a result of that discussion. The population to be served initially by CCOs is both diverse and economically vulnerable and our concern about how the issues are addressed to meet this population's needs remains high.

We have worked with the Health Equity Policy Review Committee throughout 2011 and endorse their recommendations for changes and additions to the possible draft legislation, but there is one area that we would like to highlight. That is around community governance and accountability. We feel that the majority of the governance body should reflect and represent those people who are being served by the CCO.

If we understand the current recommendation correctly, the majority of the governance will be those who are taking the financial risk. We believe that the people who are going to be served by the CCO are also taking a great risk - often unacknowledged- and the governance should be weighted to reflect that.

For Profit versus Not For Profit

As we have stated to the OHPB in the past, we are very interested in new corporate models, and believe that a paradigm that pits for profit versus nonprofit needs to be replaced with one that reflects public or community benefit. Our colleague, Heerad Sabeti, recently published a paper in the Harvard Business Review that described the new For-Benefit model, and we feel it is applicable in this discussion. The full paper is attached, but Mr. Sabeti identifies core attributes for the for-benefit corporate form that is applicable and could shape the CCOs:

- **Social Purpose:** a core commitment to social purpose embedded in its organizational structure.
- **Business Method:** the organization can conduct any lawful business activity that is consistent with its social purpose and stakeholder responsibilities.
- **Inclusive Ownership:** the organization equitably distributes ownership rights among its stakeholders in accordance with their contributions.

- Stakeholder Governance: the organization shares information and control among stakeholder constituencies as they develop.
- Fair Compensation: the organization fairly compensates employees and other stakeholders in proportion to their contribution.
- Reasonable Returns: the organization rewards investors subject to reasonable limitations that protect the ability of the organization to achieve its mission.
- Social and Environmental Responsibility: the organization is committed to continuously improve its social and environmental performance throughout its stakeholder network.
- Transparency: the organization is committed to full, accurate assessment and reporting of its social, environmental and financial performance and impact.
- Protected Assets: the organization can merge with and acquire any organization as long as the resulting entity is also a social purpose entity. In the event of dissolution, the assets remain dedicated to social purposes and may not be used for the private gain of any individual beyond reasonable limits on compensation.

These attributes can apply whether the entity is for-profit or non-profit, and eliminates any assumptions one might have about the plusses of one direction over another. It reflects a social purpose that it is (or should be) at the heart of using public funds. We strongly encourage you to include these in your final recommendation before the legislature.

Current Medicaid Managed Care Plans

We listened with interest to the recommendations that current Medicaid MCOs be allowed to be fast-tracked into becoming CCOs. This concerns us, not because of any concern about Medicaid MCOs, but because we cannot have transformation and remain the same simultaneously. We urge the OHPB to allow Medicaid MCOs to be on their own track to become CCOs but that they be identified as something akin to apprentices, and that they must meet all the criteria before they can be certified as CCOs. They can be in a transition phase, or be acknowledged as moving towards certification, but they cannot simply be fast tracked and renamed. We mean this in no way to reflect poorly on the Medicaid MCOs, but rather to highlight that CCOs must indeed be transformative or they will fail. And we support a design that will be successful.

Thank you for the work you do on behalf of Oregonians.

Liz

Ettinger Ari A

From: Jennifer Valentine <jvalenti@stcharleshealthcare.org>
Sent: Tuesday, January 03, 2012 3:55 PM
To: OHPB.Info@state.or.us
Subject: Public comments on CCO Implementation proposal

Categories: REAL CCO

To Whom it may concern:

Comments for public comment period on CCO implementation proposal:

In general, the CCO implementation proposal seems to be weak on meeting the detail to address health equity provisions of HB 3650 adequately. The primary concern with the CCO Implementation Proposal is that it does not reflect the legislative language in HB 3650 (and HB 2009 - that created data reporting standards) related to the tracking and elimination of health disparities and the achievement of health equity through health systems transformation. In order to adequately see changes that HB3650 seeks, attention to detail on ensuring tracking and elimination of health disparities and ensuring there are adequate enforcement provisions for the Oregon Health Authority to provide technical assistance and support through the Office of Equity and Inclusion to assist CCO's in becoming learning organizations that strive to monitor and improve outreach and inclusion efforts for elimination of health disparities –more specific detail language similar to that in the original bill should be included in this proposal before it is made final. This also means that there should be stronger language to support use of qualified and certified interpreters in the CCO credentialing system by the State and ensure that CCOs understand global budgeting means they are expected to meet these linguistic standards in care and treatment of low-English proficiency and non-English proficiency populations. The HB3650 outlines a role for community organizations to be brought in to provide technical assistance to CCOs in learning how to better reach currently underserved communities with culturally appropriate interventions. The Oregon Health Authority should be charged with compiling and providing best practice documents to assist CCOs in learning methodologies that are emerging as best practice to achieve the population health outcomes and elimination of disparities desired in HB3650 language. The state should ensure that health equity is addressed by ensuring that underserved community liasons have a voice at state and local CCO levels to advise and provide needed feedback, as well as ensuring that data is tracked in ways that provide outcome data using demographic filters that have enough depth and breadth to provide more than superficial information. We should hope that transformation means that CCOs will move into proven best practice methodologies for address primary and secondary prevention in populations and working to address social determinants of health that impact health outcomes often more than health care services do in populations that have disproportionate affectation by health disparities. The state should consider restructuring public health services to work more closely with the CCOs to ensure that population-based health expertise can be brought to these organizations efficiently and avoid potential duplication by maintaining a seemingly separate set of services by public health outside the health services systems. Integration of public health in this way, could bring more significant cost savings to the overall system.

Best regards,

Jennifer Valentine
Cascades East AHEC
2500 NE Neff Rd.
Bend, OR 97701

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Yakima Valley Farm Workers Clinic

January 3, 2012

Ari Ettinger
Oregon Health Policy Board
500 Summer Street NE
Salem, OR 97301

RE: Coordinated Care Organization DRAFT Implementation Plan

Dear Mr. Ettinger:

Yakima Valley Farm Workers Clinic is among the largest providers of primary care for low-income and vulnerable Oregonians, serving more than 30,000 patients in Oregon each year. We applaud the Oregon Health Policy Board efforts reflected in the Coordinated Care Organization DRAFT Implementation Proposal document dated December 8th. We appreciate the input provided by OPCA and appreciate the opportunity to give this additional input that emphasizes our unique role as a Federally Qualified Health Center (FQHC).

Our primary concern at this point in the process is that FQHCs and other safety net providers in Oregon have the opportunity to fully participate in the transformed healthcare delivery system that is being planned for OHP enrollees. It is important that we have the opportunity to continue to offer patient-centered primary care for the patients we currently serve, should they choose to continue accessing our services. To that end, we appreciate that HB 3650 Section 4(1)(k)(D) and Section 9(8) appear to anticipate and protect the participation of FQHCs and other safety net providers that may qualify as patient-centered primary care homes. We support the general thrust of the Delivery System section of the CCO DRAFT Implementation Proposal (pages 13-15), and submit these two suggestions in an attempt to call attention to the role of the safety net.

1. In the bolded references to ***Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements (p 13-14)***

Add ► *Section 9(8): A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider.*

2. To OHPB recommendations under Patient-Centered Primary Care Homes (p 14-15)

Add ► How the CCO will ensure they are not unreasonably refusing to contract with existing safety net providers that may qualify as patient-centered primary care homes.

Thank you for the opportunity to submit these suggestions. We look forward to following the continued work of the Oregon Health Policy Board in implementing Coordinated Care Organizations in Oregon.

Sincerely,


Juan Carlos Olivares
Chief Executive Director

Central Administration
604 West 1st Avenue | Toppenish, WA 98948
Phone 509-865-5898 | Fax 509-865-4337 | www.yvfwc.com

A culture of caring | Nuestros Valores, su bienestar

Public Comment for CCO Proposal

David McIntyre

dmcintyre.pdx@gmail.com

Thank you for taking time to consider my comments on the Coordinated Care Organization Implementation Proposal. I am in full support of the work the OHPB is doing to ensure a healthy Oregon, and applaud the OHA and the PHPB for their diligence in this process.

My comments are centered on food and nutrition as they relate to the health of Oregonians. This area is of particular interest to me, as I am Co-Chair of the Portland Multnomah Food Policy Council, and Managing Director of the Natural Epicurean Culinary Academy: a plant-based, health-supportive culinary program.

The importance of diet and nutrition as a preventative, upstream health focus is increasingly acknowledged. The potential long-term healthcare cost savings associated with improved diets is tremendous. Simply encouraging healthy eating, however, is not enough. And the difficulties of learning how to teach patients to prepare healthful foods should not be underestimated.

The increasing role of community health workers, peer wellness specialists, and personal health navigators provides a great opportunity to get diet, nutrition, and, importantly, culinary education to the Oregonians who need it most. This group of health professionals can greatly reduce the inequity of healthy-cooking literacy by delivering culinary training in non-traditional settings such as community centers, faith centers, and in the home. The ability of this group to coordinate with physicians and other clinicians to bring nutritive assessment and training, *including culinary training*, to their patients will directly combat the causes of diabetes, obesity, and other diet-related diseases.

To be able to effectively do this, these community health workers will need training of their own. I suggest that competency standards be in place for this group's culinary teaching skills, and to have culinary training be a part of the credentialing procedure.

In short, I strongly believe that health-supportive culinary training should be an integral part of the preventative services provided to improve health and healthcare.

Thank you,

David McIntyre

dmcintyre.pdx@gmail.com

917-673-7927

Ettinger Ari A

From: WalterDawson <walter@ohac.org>
Sent: Tuesday, January 03, 2012 4:37 PM
To: OHPB.Info@state.or.us
Cc: jason@ohac.org
Subject: Public Comments for Draft Coordinated Care Organization (CCO) Implementation Proposal

Categories: REAL CCO

01/03/2012

Dear Oregon Health Policy Board:

The Oregon Health Action Campaign (OHAC) greatly appreciates the opportunity to provide public comment on the draft Coordinated Care Organization (CCO) Implementation Proposal. As you know, OHAC seeks to empower the consumer voice in the development of a health system that gives all Oregonians access to the care they need, when they need it, from providers of their choice at an affordable cost.

OHAC is pleased to know that the draft CCO proposal is flexible and seeks to accommodate the needs of the different communities in Oregon that will be served by the newly formed CCOs. Nonetheless, we believe the proposal could be strengthened in several respects. While we look forward to providing additional commentary after the full draft proposal is released after January 10th, at this time we would like to submit comments on the following three themes:

- **Governance**
- **Choice of Providers**
- **Accessibility**

Governance : OHAC is pleased to see that Section 4(1)(o)(C) outlines a role for the community in CCO governance. However, OHAC believes that, to ensure strong CCO acceptance and effectiveness, beneficiaries and their advocates should be directly represented in CCO governance bodies to represent their values, rather than just on community advisory councils.

Choice of Providers : The current proposal is ambiguous regarding the right of patients to choose their primary care provider within a CCO network. We hope the final proposal will clearly state that patients will be afforded this right.

Accessibility : Accessibility is a major issue for rural Oregonians who may not readily have access to health care providers. OHAC recommends that the draft's commitment to ensure that providers are available "as close as geographically possible" needs to be defined explicitly so that Oregonians participating in CCOs in rural areas are guaranteed reasonable access to nearby health care providers.

Again, OHAC greatly appreciate the opportunity to provide these comments on the draft Coordinated Care Organization Implementation Proposal.

Respectfully,

Jason McNichol, PhD Walt Dawson, MS

Executive Director Director of Policy

Oregon Health Action Campaign

503-914-6460

jason@ohac.org

walter@ohac.org



LIANE RICHARDSON

Lane County Administrator
liane.richardson@co.lane.or.us

January 3, 2012

Oregon Health Policy Board
Attention: Ari Ettinger
500 Summer Street NE
Salem OR 97301

To Whom It May Concern:

Thank you for the opportunity to comment on the draft Coordinated Care Organization: Implementation Proposal document which the Oregon Health Policy Board developed in response to HB 3650 (2011). Given that you intend for a second round of comments, we will limit our comment at this point to one overarching comment, and one specific comment:

Overarching comment

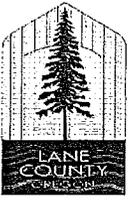
We appreciate the tone of the document and the repeated concern for the “risk in being too prescriptive”. It appears the Agency has recognized the best approach at this point is to encourage local collaboration and cooperation and is focusing on a well described vision and outcomes that will result from the establishment of CCO’s providing services across Oregon. Lane County’s efforts to date have pulled together 14 independent entities to prepare for health care transformation, and we think this can best succeed if local creativity is allowed to be maximized. Thus, the high level nature of this document is appreciated, as is the approach to developing clear criteria for CCO’s rather than turning this into a competitive process in which there are winners and losers.

Specific comment

In anticipating the success of CCO’s, perhaps nothing is more important than governance. We are concerned that this document suggests that “individuals” bearing financial risk make up the governing board’s “majority” interest. Lane County has previously testified for the potential need for legislative action to ensure that public entities may actually sit (with voting rights) on what appears to be a private board of directors (see attached testimony). We are concerned that even with the ability to sit on such a board, the majority is being predetermined to be those with financial risk for the organization. It will be very likely that the County would survive any kind of risk test, in that we have sizable investments in health care services, yet our interest in posting these as collaterals or putting them up as some sort of financial security for a system in which we are only a partner will be low. We believe this section needs additional attention.

Sincerely,

Liane Richardson, Administrator



FAYE HILLS STEWART

Lane County Commissioner
East Lane District
Faye.STEWART@co.lane.or.us

December 20, 2011

Senator Laurie Monnes Anderson, Chair
Senate Committee on Health Care, Human Services, and Rural Health Policy
900 Court St. NE, Room 453
Salem OR 97301

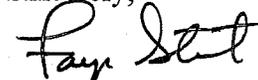
Dear Chair Monnes Anderson and Members of the Committee:

Lane County's involvement in seeking new models for the provision of health care services dates back to the inception of LaneCare in 1997, which we formed as a public insurance company in order to manage the mental health component of the Oregon Health Plan for Lane County. In 2010, we re-opened two federally qualified health care facilities to provide comprehensive services to serve the needs of patients that had outgrown our previous single facility. Most recently, we've been engaged with a suite of partners on discussions related to the formation of a community care organization (CCO).

The committee should know that the conversations in Lane County have borne substantial fruit. A total of 14 local organizations, both public and private, have agreed to seek federal funding to operationalize an organization to provide services in Lane County. The CCO will initially focus on strategies to develop alternative payment approaches, improved coordination of care, and enhance primary care medical homes to reduce costs for services delivered to the area's Medicaid recipients. The governance of this organization will be shared, and lead by the yet to be formalized Lane Health Policy Council. Our goal is for the CCO to achieve cost savings in the Medicaid population of 10% within 1 year (by October 2013).

In developing this structure, we have encountered a similar situation to the Central Oregon Health Council. That is, forming a public-private partnership is not simple. In order to have a public entity with voting rights sit on what is otherwise a private board of directors, it takes a specific change to the law, and even then may face constitutional hurdles. In fact, it took action by the Legislative Assembly in 2011 to allow for that organization to finalize its organizational structure. Senate Bill 983 was the initial vehicle for the effort, with the final language incorporated into Senate Bill 204. **It may well be that we'll need to ask the Legislature for a similar effort as we work towards the final organizational work in Lane County.**

Sincerely,


Faye Stewart



Oregon Health Policy Board Members
Comments on Coordinated Care Organization Implementation Draft Proposal

Stephanie Tama-Sweet, Director Government Relations
American Heart Association – Oregon
503-828-8448; stephanie.tama-sweet@heart.org
January 3, 2012

The American Heart Association's mission is to build healthier lives, free of cardiovascular diseases and stroke. As such, we urge each individual to make healthy choices on a daily basis; we also advocate for the establishment of communities where individuals have the opportunity to live a healthy life. We commend the work of the legislature, Oregon Health Policy Board, workgroup members and others for their emphasis on the triple aim of improving health, improving health care and reducing cost.

To realize the expected cost-savings and desired health outcomes we urge the following recommendations be included in the CCO/Transformation Proposal:

Evidence-based preventive benefits for tobacco use and obesity must be included in all Medicaid benefits plans.

Tobacco use remains the number one cause of preventable death in Oregon, killing 7,000 Oregonians every year. The obesity epidemic is quickly following tobacco use as a leading cause of death and disability. Oregon currently requires coverage of many preventive benefits including tobacco cessation and some obesity monitoring benefits but we could do more to cut down on costs and improve the health of CCO enrollees. We urge all Medicaid benefit plans and Patient-Centered Primary Care Homes to provide 100 percent of the United States Preventive Services Task Force (USPSTF) A and B recommended benefits¹. The following A and B benefits are currently not required in Oregon:

1. Smoking cessation benefits. Oregon currently requires Medicaid plans to provide smoking cessation benefits but the type and quality of benefit varies depending on the service provider. Cessation benefits should be expanded and standardized to include evidence-based coverage of pharmacotherapy and counseling at no – or minimal cost sharing.



2. Preventive benefits for cardiovascular diseases and stroke.
 - i. Dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
 - ii. Adult screening for obesity and offering intensive counseling and behavioral interventions for the obese.
 - iii. Screening for obesity in children and adolescents and offering or referring them to comprehensive, intensive behavioral interventions to promote improvement in weight status.

Ensure health equity is integrated throughout the health systems transformation.

1. Governance Structure (p10 of draft proposal):
 - a. Require CCOs to articulate how the governing board makeup reflects underserved communities, including ethnically diverse populations.
2. Health Equity and Eliminating Health Disparities (p17):
 - a. Require CCOs to demonstrate the elimination of health disparities by submitting quality improvement plans with performance-based results for addressing health equity outcomes.
3. CCO Accountability (p24-26):
 - a. Include progress toward eliminating health disparities as an accountability metric for CCOs. Report this progress to the legislative assembly on a regular basis.

CCO Performance Measures

We commend the OHPB for its inclusion of the following performance measures in the draft proposal and urge their inclusion in the final version: rate of tobacco use among CCO enrollees, obesity rate of CCO enrollees, cholesterol control for patients with coronary artery disease (CAD), cholesterol control for patients with diabetes, glucose control for diabetes and chronic disease self-management support.

Thank you for the opportunity to offer our comments.

ⁱ The USPSTF is an independent panel of experts in prevention and evidence-based medicine. USPSTF A and B recommendations are those that have the greatest amount of scientific evidence behind them. For more information see addition visit <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

FACTS

An Ounce of Prevention

Covering Preventive Services in the Medicaid Program

OVERVIEW

The 2010 Patient Protection and Affordable Care Act (“health reform”) emphasizes the importance of prevention as a means to improve the quality of life of Americans and increase the value of health services. One health reform provision emphasizes preventive services for the Medicaid population by giving states the option to provide Level A and B Recommendations of the U.S. Preventive Services Task Force (USPSTF) to Medicaid enrollees. Effective January 1, 2013, if states provide these prevention services without cost-sharing, they will be eligible for a 1% increase in the Federal Medical Assistance percentage (FMAP) for the services that they do offer.¹ This is intended to give states an incentive to provide preventive services to Medicaid beneficiaries.

WHAT IS THE USPSTF AND WHAT ARE LEVEL A & B RECOMMENDATIONS?

The USPSTF is an independent panel of experts in prevention and evidence-based medicine comprised of primary care providers such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists. The panel conducts scientific evidence reviews of a broad range of clinical preventive health care services, such as screening, counseling, and preventive medications, and develops recommendations for primary care clinicians and health systems. The USPSTF assigns one of five letter grades to each of its recommendations. A and B recommendations are those that have the greatest amount of scientific evidence behind them and there is significant certainty that the net benefit to patients is moderate or substantial. Examples of such services for cardiovascular disease and stroke include blood pressure monitoring, cholesterol testing and drug therapy, behavioral counseling for a healthy diet, obesity screening, and tobacco cessation programs. The comprehensive list for all A & B preventive services is wide-ranging.²

WHAT IS FMAP?

Medicaid is a federal/state partnership program that provides health benefits to certain low-income Americans, including children, their parents, pregnant women, the elderly and people with disabilities. Because Medicaid is a partnership, states and the

federal government each have a role paying for the program. The federal government gives each state a certain amount of matching dollars to assist states with Medicaid program expenditures. These matching dollars are referred to as Federal Medical Assistance Percentage (FMAP) payments, and the percentage of FMAP a state receives is based upon the state’s relative wealth (lower per capita income states receive higher FMAPs). By law, the federal FMAP payment is set at a minimum of 50 percent of Medicaid costs, to a maximum of 83 percent.³

WHY IS PREVENTION SO IMPORTANT

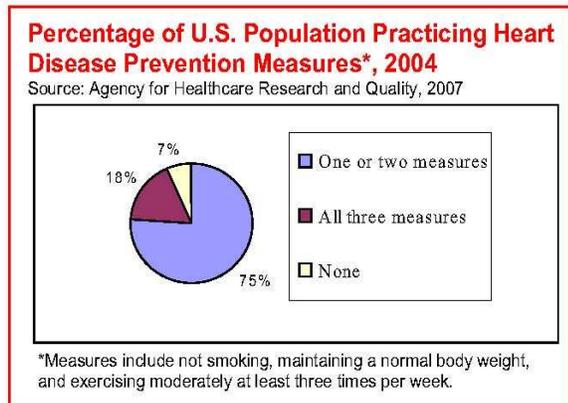
Cardiovascular disease (CVD), including heart disease and stroke, is the leading cause of death and disability in the U.S.⁴ Unfortunately, the disease process can start early in life and is influenced over time by lifestyle behaviors, the environments where people live, and modifiable risk factors, including smoking, overweight and obesity, physical inactivity, high blood pressure, elevated blood cholesterol, and Type 2 diabetes. In many instances, CVD can be prevented if individuals modify their risk factors for the disease. Recent studies support the link between minimizing risk factors and reducing chronic disease.

- Men and women who lower their risk factors may have 79-82% fewer heart attacks and strokes than those who do not reduce their risk factors.^{5,6}
- A recent review by USPSTF showed that counseling to improve diet or increase physical activity changed health behaviors and was associated with small improvements in weight, blood pressure, and cholesterol levels.⁷
- A recent study in Massachusetts showed that comprehensive coverage of tobacco cessation services in the Medicaid program led to reduced hospitalizations for heart attacks and a net savings of \$10.5 million or a \$3.07 return on investment for every dollar spent in the first two years. Savings likely will continue to increase as time goes on and the impact of quitting increases.⁸
- Even though chronic disease risk factors are becoming common even in young adults, there is not adequate screening and management for these risk factors.⁹
- Approximately 44% of the decline in U.S. age-adjusted CHD death rates from 1980-2000 can be attributed to improvements in risk factors including reductions in total blood cholesterol, sys-

tolic blood pressure, smoking prevalence, and physical inactivity. However, these reductions were partially offset by increases in obesity and diabetes prevalence.¹⁰

HOW ARE WE DOING?

Although we are placing a greater emphasis on prevention, we still have a long way to go to “walk the talk.” Only 18% of U.S. adults follow three important measures recommended by the American Heart Association for optimal health: not smoking, maintaining a healthy body weight, and exercising at moderate-vigorous intensity for at least 30 minutes, five days per week.¹¹



- In 2009, adult obesity rates rose in 28 states, and in more than two thirds of states, obesity rates exceed 25 percent of all adults.¹²
- The number of overweight pre-schoolers jumped 36% since 1999-2000.¹³ Nearly 12 million children and adolescents ages 6-19 are considered obese.¹ Sadly, one study has shown that obese children’s arteries resemble those of a middle-aged adult.¹⁴
- The percentage of high school students who smoke decreased over 29% from 1980 to 2006.¹ Still, 3,500 children age <18 try a cigarette for the first time and 1,100 get hooked each day.¹ An estimated 6.4 million of them can be expected to die prematurely as a result.¹⁵
- One in three U.S. adults has high blood pressure, but 36% do not have it under control.¹
- A sedentary lifestyle contributes to CHD. However, moderate-intensity physical activity, such as brisk walking, is associated with a substantial reduction in chronic disease.¹⁶ It is estimated that \$5.6 billion in heart disease costs could be saved if 10% of Americans began a regular walking program.¹⁷ Still, 36% of U.S. adults report that they do not do any vigorous physical activity.¹
- At least 65% of people with Type 2 diabetes die from some form of heart disease or stroke.¹ Unfortunately, diabetes prevalence increased 90 percent from 1995-1997 to 2005-2007 in the 33 states that tracked data for both time periods.¹⁸

- About 25.4 million Americans have diagnosed or undiagnosed diabetes and the prevalence of pre-diabetes in the adult population is nearly 37%. Diabetes disproportionately affects Hispanics, blacks, Native Americans and Alaskan Natives.¹
- Approximately 16% of U.S. adults have unhealthy total cholesterol levels of 200 mg/dl or higher. A 10% decrease in total blood cholesterol levels population-wide may result in an estimated 30% reduction in the incidence of CHD. Unfortunately, only half of the people who qualify for cholesterol lowering treatment are receiving it.¹

AHA ACTION PLAN

The American Heart Association supports coverage of comprehensive preventive benefits in private and public health insurance plans that incorporate all of the USPSTF A and B recommendations. The AHA will encourage states to cover these services and achieve the 1% federal payment increase. Comprehensive services meeting the A and B recommendations are wide-ranging, and include vaccinations, appropriate screenings, some counseling, and are listed at

<http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

¹ Public Laws 111-148 & 111-152. Patient Protection and Affordable Care Act. Section 4106.

² See USPSTF A and B Recommendations. August 2010. U.S. Preventive Services Task Force.

<http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>

³ Section 1905(b) of the Social Security Act.

⁴ Roger, V. et al., Heart disease and stroke statistics--2011 update: A report from the American Heart Association. *Circulation*. December 15, 2010.

⁵ Stampfer M.Hu FB, et al., Primary prevention of coronary heart disease in women through diet and lifestyle. *N Engl J Med*. 2000; 343: 16-22.

⁶ Gorelick PB. Primary prevention of stroke: Impact of healthy lifestyle. *Circulation*. 2008; 118:904-906.

⁷ Linn JS. et al., Behavioral Counseling to Promote Physical Activity and a Healthful Diet to Prevent Cardiovascular Disease in Adults. *Annals of Internal Medicine* 2010;153(11):736-750.

⁸ Land T, Rigotti NA, Levy DE, Paskowsky M, Warner D, et al. (2010) A Longitudinal Study of Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Hospitalizations for Cardiovascular Disease. *PLoS Med* 7(12): e1000375. doi:10.371/journal.pmed.1000375.

⁹ Kuklina, E.V. Prevalence of Coronary Heart Disease Risk Factors and Screening for High Cholesterol Levels Among Young Adults, United States, 1999–2006. *Annals of Family Medicine*. 2010. 8:327-333.

¹⁰ Ford E. Ajani U. Croft , et al., Explaining the decrease in U.S. deaths from coronary heart disease, 1980-2000. *New Engl J Med*. 2007; 356: 2388-2398.

¹¹ Soni A. Personal health behaviors for heart disease prevention among the U.S. adult civilian noninstitutionalized population. 2004. Statistical Brief #165, March 2007. Agency for Healthcare Research and Quality.

¹² Trust for America’s Health/Robert Wood Johnson Foundation. *F as in Fat: How Obesity Threatens America’s Future*. 2010.

¹³ Robert Wood Johnson Foundation/American Heart Association. *A Nation at risk: obesity in the United States. A statistical sourcebook*. 2005.

¹⁴ Raghuvveer G. et al., Obese kids’ artery plaque similar to middle-aged adults. AHA Scientific Sessions 2008. Abstract 6077.

¹⁵ Healthy Youth! Health Topics: Tobacco Use. Available at www.cdc.gov/HealthyYouth/tobacco/. Last reviewed November 7, 2007.

¹⁶ Hu FB. Et al., Physical activity and risk of stroke in women. *JAMA*. 2000; 283(22):2961-7.

¹⁷ U.S. Department of Health and Human Services. *Preventing Chronic Diseases: Investing Wisely in Health: Preventing Obesity and Chronic Diseases Through Good Nutrition and Physical Activity*. National Center for Chronic Disease Prevention and Health Promotion, 2005.

¹⁸ CDC. State-specific incidence of diabetes among adults – participating states. 1995-1997 and 2005-2007. *MMWR*. October 31, 2008; 57(43).

Ettinger Ari A

From: Charles McGee II <charles@jhillclinic.org>
Sent: Tuesday, January 03, 2012 4:57 PM
To: OHPB.Info@state.or.us
Subject: COORDINATED CARE ORG PROPOSAL
Attachments: COORDINATED CARE ORG RECOMMENDATIONS.doc

Categories: REAL CCO

To Whom These Bring Greetings;

The Josiah Hill III Clinic is very interested in providing feedback on how to ensure health equity is integrated in the Oregon Health Policy Board's draft Coordinated Care Organization proposal. Against this background, the below listed recommendations are forwarded for consideration:

I. Page 10, Governance and organizational relationships: We recommend adding the following legislative justification language:

Sec 2(2) The Oregon Health Authority shall seek input from groups and individuals who are **part of underserved communities, including ethnically diverse populations**, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.

We recommend adding the following language:

- How the governing board makeup reflects underserved communities, including ethnically diverse populations.

II. Page 13, Patient Rights & Responsibilities, Engagement, & Choice: We recommend adding the following language:

- Ensure equal patient access regardless of language, disability, culture through: staffing and training protocols (i.e. career path development to increase culturally-based providers, provider/staff workforce training on cultural and linguistic competency, and health literacy, etc.).
- Assess consumer satisfaction and share clear grievance procedures translated and offered through multimedia approaches.
- Ensure that providers are not working in isolation from underserved communities to develop best practices for culturally appropriate care and service delivery.

III. Page 17, Health Equity and Eliminating Health Disparities: We recommend adding the following legislative justification language:

Sec 19(1)(L) The authority shall: Implement policies and programs to expand the **skilled, diverse workforce** as described in ORS 414.018 (4)

Sec. 30(1)(a) Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:

(a) **Demographics, including race and ethnicity.**

(f) **Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.**

We recommend adding the following language:

OHA Office of Equity and Inclusion will serve as an additional resource to CCOs to ensure equal patient access regardless of language, disability, culture and improvement of health equity outcomes by connecting CCOs with technical assistance, especially as needs involve provider/staff workforce training on cultural and linguistic competency, health literacy, and career path development to increase culturally-based providers.

- CCOs will be required to demonstrate the elimination of health disparities by submitting quality improvement plans with performance-based results for addressing health equity outcomes and documentation for services (i.e. Certified Health Care Interpreters)
- CCOs need to describe processes they will be utilizing to collect community wisdom and experience with health care [& health], with links to implementation
- CCOs falling behind on expectations will be required to put together a specific health equity improvement plan and adopt benchmarks and measures.
- OHA will develop a system of incentives/disincentives for those that meet/fail to meet standard of care expectations related to health equity

IV. Page 18, Health Information Technology: We recommend adding the following legislative justification language from HB2009C:

Sec1201 (1) The Administrator of the Office for Oregon Health Policy and Research shall establish and maintain a program that requires reporting entities to report health care data for the following purposes:

(i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity.

(2) The Administrator of the Office for Oregon Health Policy and Research shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that:

(b) Establish the types of data to be reported under this section, including but not limited to: (C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards.

(4) The Administrator of the Office for Oregon Health Policy and Research shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.

Thank you for the consideration.

Faithfully,

Charles A. McGee, II, MEd.
Executive Director



January 3, 2012

To the Oregon Health Policy Board

Thanks for the opportunity to comment on this important aspect of the Coordinated Care Organization proposal. Generally, the goal of health equity is achievable by following best practices in designing health systems for underserved communities.

These are our comments on health equity:

- **Governance and organizational relationships:** We recommend additional language in Sec 2(2) emphasizing the need for input from underserved communities/ethnically diverse populations. It is important that the governing board reflects demographics of underserved communities, including ethnically diverse populations.
- **Patient rights and responsibilities:** We recommend the addition of language that will ensure equal patient access regardless of language, disability or culture. We further recommend that health care providers work with underserved communities to develop best practices that address culturally appropriate care and service delivery.
- **Delivery system:** We recommend language that ensures that services and supports will be located geographically as close as possible to members' residences. Geographic considerations will ensure culturally appropriate care and service delivery to reduce health disparities, which will improve members' health and well-being.
- **Workforce data collection:** Demographics must include race and ethnicity, and CCO must document plans for elimination of health disparities through quality-improvement plans.

Sincerely,

Liesl Wendt
Chief Executive Officer, 211info



January 3, 2012

Oregon Health Policy Board
Attention: Ari Ettinger
500 Summer Street NE
Salem, OR 97301

As the Oregon State Independent Living Council (SILC), we appreciate the opportunity to offer the following comments on the DRAFT Coordinated Care Organization Implementation Proposal. The SILC's charge is to assess the needs, monitor services, and work alongside people with disabilities, and those that provide services and supports to them, to obtain the greatest level of independence and self-sufficiency possible. Independence of course, encompasses nearly every aspect of an individual's life, with healthcare being a major component. Due to that fact, we have been following both the federal changes, as well as actively involved in our state's effort at healthcare system reform, and believe we bring a unique perspective to the effort and hope we can be more fully utilized as the future planning and execution of the CCOs model begins.

With both passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, referred to as the ACA, and Oregon's proposed Health Systems Transformation (HB3650), Medicaid for Oregonians is undergoing a substantial conversion. Along with some of the positive opportunities ahead, including the strong emphasis on person centered care, individualized planning, and coordination between medical and social supports, for people with disabilities, there also presents some complexities and fear-provoking unknowns. We believe for people with disabilities this is likely somewhat disproportionate often due to the need for increased and varied utilization of specialized care, opportunities for unconventional holistic services and supports to improve health, etc.

This substantial transformation at both levels, poses great opportunities and many challenges, as well as some potential unintended consequences. That is why our overarching comment is that we strongly urge a consistent, well-defined mandated partnership between OHA and the Oregon Disabilities Commission in the further development, implementation and monitoring of this vital system change. It is imperative that individuals with disabilities and their representatives be involved in policy development and decision making concerning the health care transformation including implementing and monitoring CCO's.

Transition from the current system to the CCO model will have an impact on all people involved in the healthcare system, but for many people with disabilities and chronic conditions, it is vital that there be the necessary infrastructure in place, including the knowledge and access to expertise in disability issues, to support the smooth transition for people who must rely on access to healthcare services, for their daily survival. Ensuring appropriate services are available to individuals with disability and chronic conditions is our primary concern. While “managed care” in many forms, grows in popularity across the US, with over 70% of all Medicaid beneficiaries enrolled in some form of such and does indeed provide States more flexibility to provide utilization management and increase budgeting stability, the consolidated set of Federal-CMS regulations require a strong focus on quality outcomes and access to care, with network adequacy and an external quality review component, 2 of the higher priorities and ones which we whole-heartedly agree.

Many disability advocates oppose a capitated payment system, because it’s fear by its very nature of cost containment, it may deprive people who need a lot of health care, of necessary services. We believe that there can be lessons learned from the few other states operating such, as well as creative solutions worked on together in Oregon, to better assure necessary services of high quality are provided people with disabilities. Some of the factors that need to be considered and/or put in place that come to our mind, include:

1. A robust Grievance/Complaint System:

- Consumers (Enrollees in the system) must play a major role in its development and eventually its monitoring to detect trends in certain areas of the states, in specific CCOs and in certain populations (this could be type and severity of disability, type of specialized needs, age, geographic location, etc.)
- Both the state level advisory committee to the OHA Ombuds Office and local Community Advisory Councils must have timely access to meaningful data and clearly defined processes to follow on issues they see represent trends
- Data must be transparent to the public
- The State must be a fair partner to CCOs, but also not hesitate to issue Corrective Action Plans, invoke sanctions or whatever is necessary, to meet the needs of the enrollees, and do so in a timely manner, when issues are identified and not timely resolved

2. Community Advisory Councils (CACs):

- A majority of each CAC will be “Consumers”. Consumers must be defined as “Enrollees” in the CCO and have a clearly defined mechanism for meaningful, informed and empowered interaction with the CCO’s Governing Board with their recommendations and the CCO’s response to such, publicly transparent;
- The idea that a minimum of one member of each CAC serve on the CCO’s governing board is a sound one, but this should be a mandatory seat.
- While appreciating the need for flexibility and community control of the governance and organizational structure of each CCO, because individuals with disabilities, traditionally experience increased need for health care,

- diversity in the type of specialized care and expertise of providers, etc. we strongly support a designated seat on each Community Advisory Council for an enrollee experiencing a disability.
- CAC Members must be knowledgeable about the broad population they are representing, engaged/active in healthcare issues, and have evident associations or defined methods of engaging with interested fellow enrollees. An official protection mechanism that these individuals are not merely token representatives, needs to be developed; in part this can be accomplished by a well-defined method of selection of members, outlined in the CCO application and contract.
 - CAC Members must have a formal linkage to entities outside the CCO, that can provide access to specialized expertise, mentorship and support, if needed, for them to be effective representatives ~ for people with disabilities, this should be a defined linkage with the Oregon Disabilities Commission.
3. There is uniqueness in the scope of services provided people with disabilities that impact their health. There are exceptional challenges in many areas of development, implementation and monitoring of this new integrated approach to holistic health care for people with disabilities of ALL ages and types, from how to actively engage enrollees in their own care, to developing performance measures, which reliably assess the performance in providing the array of medical and *related* services that are needed to help persons with disabilities maintain the highest level of independence possible, to ensuring the use of innovative providers offering care in unconventional settings, etc.
 4. The need to maintain the Fees for Services Opt-Out Provision: Because health care costs of the population of people with disabilities are more predictable than those of non-disabled populations, even down to the **individual** level, this can create situations where to maximize profitability, adopting business strategies to limit the enrollment (or increase disenrollment) of individuals whose health care costs are predictably above the payment rate made to the plan, stringency in the allocation of resources in meeting the healthcare needs (including access to qualified specialists often with whom they have developed long-standing relationships), are often problems seen. Recognizing the goal to reduce as much as possible, the number of people in Fee for Services, there must remain an Opt-Out mechanism, when resolution cannot be achieved between enrollee and CCO. We believe this is crucial for people with chronic conditions.
 5. Patient-Centered Primary Care Homes (PCPCH): Consumers must have a choice in their Patient-Centered Primary Care Homes. CCOs cannot have the power to just assign enrollees to a PCPCH. There are numerous considerations that must be factored in when an enrollee selects a PCPCH, including but not limited to: (1) A majority of people with disabilities already have a Primary Care Physician (GP or Specialist) that are very knowledgeable about their specific situation and have coordinated their care needs over a period of many years. Changing that relationship would be counter-productive to the outcome being sought: health provider and enrollee working together as a team to achieve improved health,

less duplication of services and reduced costs; (2) Accessibility, including lack of physical, communication and attitudinal factors, availability of accessible public transportation, etc.; (3) Culturally and language appropriate settings.

6. Every CCO should have an Ombudsperson, who then officially coordinates with the OHA Ombuds Office. This brings accountability full circle. This position on the CCO level should be staff to the CACs, which provides a certain level of autonomy to that body as well.
7. Non-traditional Healthcare Workers must have very explicit job descriptions. Using the concept of Exceptional Needs Care Coordinators (ENCCs) as an example, history has shown these individuals have an opportunity to make a remarkably, positive difference in the quality of care, timeliness of services, coordination of specialized care, reduction of paperwork and processes for both the provider and enrollee, and general systems access. Equally as often, some MCOs have not utilized this opportunity in the manner envisioned and have seen every customer service representative as having the ability to do the work of an ENCC. *This would be like assuming every doctor is trained and capable of performing brain surgery.* These positions in the new system can be extremely valuable in meeting the Triple Aim, especially for persons with disabilities. The use of "Peers" in this system should also be explored more fully. While there are references to such in the delivery of mental health services, Peer-delivered services and support, especially in the area of navigating systems, assisting individuals to be more empowered and fully engaged and much more have been the backbone of the success of the Independent Living movement since the 1960's, on a cross-disability basis and utilizing that well-established system could have tremendous benefit and should be further examined.
8. Role of Employment in Good Health: Research has shown that effective employment supports can be a very effective and a less-costly alternative to health care services. When capitated contracts with CCOs are being negotiated, an opportunity exist to engage in discussions about the benefits of providing these less-costly employment supports, such as work incentives counseling and supported employment, "in lieu of other services", such as comprehensive psychosocial rehabilitation, adult day health, or day treatment. While we're in the middle of broadening the traditional view of healthcare, looking more holistically at the needs of enrollees, we have an opportunity to save money while also advancing the economic condition of covered individuals. Benefits counseling, also called work incentives planning, is part of the employment decision-making process. Employment specialists ensure that people are offered comprehensive and personalized benefits planning, which includes information about how work may affect their benefits and about work incentives that is essential to informed choice.
9. Although Oregon does not currently include long-term services and supports in the proposed CCOs, there does need to be an ongoing discussion regarding the future of long-term services and the essential coordination between LTC and

CCOs. Although we were a strong and vocal proponent of excluding HCBS and other long-term services and supports from the design of the CCO model, we definitely support a close collaboration and want to be involved in the examination of how that coordination is defined and implemented. LTC services are as important to people with disabilities of any age, as they are to the aging population, but the primary issues requiring LTC services can vary greatly. Aging individuals might be planning which facility they will live in at the end of their life; while individuals with disabilities might be planning the assistance they will need in their homes or on their job or to participate in activities of life. It is important for both views of LTC to be included in all discussions.

10. The intersection between medical care and social supports, as often provide individuals with disabilities, while both vital to the success of the Triple Aim, can be difficult to master. There are vastly differences in the modality of service delivery, control over the processes, determination of a "successful outcome" and even in the language used. While the disability community uses the word "access" to mean barrier-free usability by people with disabilities, it means something different in the health care context, where it often refers to a person's ability to get the health care he or she needs. Access means being able to get good quality health care, without financial, geographical, cultural, or language barriers. People with disabilities need to be sure is it understood, that access also means things like wheelchair-accessible clinics, adjustable-height exam tables, sign language interpreting in medical settings, and written materials available in non-print formats such as Braille or audio recording.

In conclusion, we urge the involvement of persons with disabilities and entities such as the State IL Council and Oregon Disabilities Commission, in every aspect of further design, development, contracting, implementation, training and monitoring within the new CCO model. This will have benefits not only to the enrollees in the CCOs, but to the CCOs and the state. While many of us have been involved in various aspects of this endeavor, we feel a more focused, defined collaboration would benefit all involved and look forward to hearing from you to discuss this. Please don't hesitate to call us for technical assistance, support at consumer engagement or to further clarify any of our input.

Thank you for the opportunity to comment.



Tina Treasure, Executive Director



Ann Balzell, SILC Chairperson

Coordinated Care Organization (CCO) Implementation Proposal

Comments made by the Association of Oregon Counties (AOC) to the Oregon Health Policy Board and the Oregon Health Policy Board

The Association of Oregon Counties (AOC) recognizes the volume of work and tremendous progress made in the advancement of the creation of Coordinated Care Organizations (CCOs). The Implementation Proposal reflects a significant step forward and AOC believes that the Oregon Health Authority and Oregon Health Policy Board are moving on the right track. We appreciate the opportunity to provide the following feedback and recommendations.

Background

Counties contribute significantly to the health and well being of all Oregonians and the Triple Aim. By statute the counties serve as both the mental health and public health authorities. This means that counties provide a number of mental health programs such as outpatient treatment, residential treatment and crisis intervention. They also provide public health clinical services such as immunizations and maternal case management and community interventions around communicable disease and tobacco prevention. As a result, almost all counties contribute general funds to their public health programs and a majority of counties contribute county general funds to behavioral health programs. Please see the Association of Community Mental Health Programs' (AOCMHP) testimony for more details on behavioral health funding. In addition, counties' investment in the health system includes providing health services in county jails and some counties contribute general funds to provide primary care through federally qualified health centers (FQHC).

While each county provides core mental health and public health programs, individual counties also choose to provide a variety of additional programs based on community demand. There is more in common among the counties than there are differences. This investment of local resources in the core services reflects the dedication and commitment of the county commissioners to the health of their constituents and the Triple Aim.

CCO Criteria—Financial Risk

Part of the proposed criteria for becoming a CCO includes the governance structure, including “a majority interest consisting of persons that share the financial risk of the organization.” Simply looking through a financial contribution lens, counties clearly qualify as being at risk. Counties contribute general funds to supplement the community's needs thus strengthening the health system and furthering the Triple Aim.

However, looking through a different lens, it is clear that counties are at a financial risk in a different manner. Counties supply safety net and public safety services that could be overburdened if a CCO fails to meet their outcomes. If patients do not receive the preventative and mental health services they need, it is possible that they could create financial pressures on the safety net and public safety systems counties provide. It is because of these financial risks that counties need to be considered to be part of the governing body.

AOC recommends that a broader definition of “financial risk” should include potential impacts on needed county provided safety net and public safety services.

CCO Criteria—Governance

AOC recommends that counties have the opportunity to engage in the governance of the CCO based on a community by community basis. Some counties may choose to be part of the decision making governance structure while others may choose to only be a part of the community advisory council. As individual communities develop CCOs, counties should have a choice as to their level of engagement.

AOC recommends that CCOs also have the choice to use the same public-private governance and information sharing model developed for Central Oregon Health Council (COHC) in Senate Bill 204 (2011). COHC, acting as early adopters, have demonstrated the benefits of this type of agreement and all communities should have the opportunity to move this direction if they so desire.

One additional concern is how to remedy the situation when counties are interested in a meaningful role in governance and are not allowed to fulfill that role. AOC recommends that that the CCO criteria explicitly include a formal mediation process that can address conflicts in governance with the counties.

CCO Criteria—Community Needs Assessment

AOC concurs with the recommendations made by the Coalition of Local Health Officials (CLHO) in their written response to the Implementation Proposal.

Global Budget—Service/Program Inclusion and Alignment

AOC understands that the state is in the midst of a sea change in funding and administration of Medicaid programs. However, every effort must be made to prevent the erosion of important infrastructure for public health and mental health preventative services provided to consumers. These services directly contribute to the Triple Aim.

Some Medicaid funded programs, including Babies First! and CaCoon, require governmental contribution for federal match. AOC concurs with CLHO’s recommendation to look at the funding streams that are going into the global budget to see if there is going to be fewer resources in the “global budgets” because of a loss of local or federal match. For more details, please see CLHO’s response to the Implementation Proposal.

AOC understands the approach to including all Medicaid programs in the global budget but is concerned that some state general funded programs are included in Appendix C of the Implementation Proposal. AOC concurs with recommendations by AOCMHP regarding Program Inclusion and Alignment.

CCO Accountability

AOC recommends that the relationship between CCO performance and the public safety system be measured as one of the minimum expectations for accountability. If the transition to a CCO results in consistent increased pressures on the public safety system OHA should lay out steps toward progressive remediation.

Conclusion

Thank you for the opportunity to provide feedback and recommendations. For further information, please contact Human Services Policy Manger, Mark Nystrom, at mnystrom@ocweb.org or 503-585-8351.



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Addictions • Mental Health • Developmental Disabilities

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Coordinated Care Organization Implementation Proposal

Association of Oregon Community Mental Health Programs Comments

January 3, 2012

The Association of Community Mental Health Programs (AOCMHP), representing community mental health programs and mental health organizations, appreciates the opportunity to provide comments on the Coordinated Care Organization Implementation Proposal. We have inserted recommendations, questions and proposed language changes under each of the main sections and several of the subheadings in the CCO Implementation Proposal format. AOCMHP looks forward to working with the Oregon Health Authority and the Oregon Health Policy Board on further planning and implementation of the coordinated care organizations.

Opportunities for Achieving the Triple Aim: Improving Health, Improving Health Care and Reducing Cost

Our first global recommendation is to express clearly in Section 3, pages 7-8, that social determinants of health are the cornerstone of long term improved health, improved health care and reduction in cost.

Coordinated Care Organization Criteria

Governance and organizational relationships – Governing Board, Community Advisory Council, Clinical Advisory Panel, partnerships with LMHAs, health departments and county government

1. Insert the following additional bullet after “*The OHPB recommends that, as part of the certification process, a CCO should articulate: ...*”, p.10:
 - How the involved Counties will play a *meaningful role* in governance which reflects the financial risks borne by counties and the cost shifting that may occur to local public safety and social service systems if the governance approach is too narrow

2. In reference to the Community Advisory Council (CAC) Section, p. 11:

Individual CCOs should be encouraged to adopt innovative CAC models reflective of the particular community that are independent of the CCO to ensure objective review and analysis of performance and outcomes.

- One approach is to build independent CACs on the existing, statewide system of local boards of health. As stated in ORS 431.416, the local public health authority or health district shall assure activities necessary for the preservation of health...activities including but not limited to collection and reporting of health statistics...

3. In the Partnerships section, p. 11, we would suggest including the following overarching themes to be addressed in the agreements between CCOs and Local Mental Health Authorities:

- Target populations and overall system coordination should include individuals across the age spectrum with mental illness, addictions and co-occurring disorders.
- Mental health, addictions and public health prevention, screening and early intervention activities should be included throughout the system.
- Authorization, financing and reporting systems should be simple, flexible, and responsive to minimize administrative burden and enhance service delivery and access to care.
- Include joint financing and accountability for the local safety net.
- Outcome measures should also include the CCO's impact on local systems (jails and other criminal justice functions, child welfare, etc.).
- Identify point people for the CCOs, LMHAs and LPHAs.
- Clearly identify allowable administrative costs and functions.
- Outline how the sharing of protected health information will be facilitated and how access to data will be managed between entities on an individual and aggregate basis.
- Agreements should be informed of the need to:
 - Minimize the interruption in services to vulnerable populations;
 - Effectively transition current MHO functions including care coordination, claims processing, contracting, utilization management, and quality assurance. This may include sub-capitating any or all of the entire benefit management to the existing MHOs;

- Encourage the continued financing of the successful care coordination programs provided by counties for adults with serious mental illness and children with severe emotional disturbance (i.e., Adult Mental Health Initiative – AMHI and the Children’s Integrated Service Array/Wrap-around Programs.) These highly specialized programs will need to develop closer relationships with the primary health homes of their clients.

Furthermore, we would recommend adding a row in Appendix A between Governance and Community Advisory Council called “Partnering with county government”, to include specific criteria from Section 24 (4) of HB 3650, describing the role of local mental health authorities in working with CCOs. The Initial Baseline Expectation should be: “Statutory requirements regarding county agreements are met”.

Delivery System - Access, patient-centered primary care homes, care coordination, provider network requirements, care integration, alternative dispute resolution

Care Coordination

The target population referred to as those with intensive care coordination needs should include individuals across the age spectrum with mental illness, addictions and co-occurring disorders. Approximately half of the high needs, high costs 10/70 population suffers from mental illness.

On page 15 of the CCO Implementation Proposal, in the fourth bullet about access to non-traditional providers, the phrase “if available through the CCO...” appears, which indicates that a CCO might choose not to provide this service. The availability of navigators, peer wellness specialists, and community health workers should be guaranteed by CCOs whenever that is an indicated service. If it is not, how will members be informed of non-traditional services, such as peer coordination and intensive care coordination?

Care Integration

Health Information Technology – Electronic Health Records Systems (EHRs), Health Information Exchange (HIE)

Plans are needed for interoperability or interconnectedness among CCOs and OHA. As behavioral health providers did not receive the significant federal funds that have been allocated to improve physical health electronic records, CCOs should develop IT/EHR plans to enhance behavioral health capacity and to successfully integrate physical health and behavioral health records. OHA may need to pursue a waiver to 42 CFR Part 2 in order to lift the restrictions on the sharing of information by federally funded substance abuse providers.

Global Budget Methodology

AOCMHP has three areas of concern around Global Budget Development:

1. Perpetuation of Lowest Cost Estimate Exercise, page 21
2. Continuation of capitation methodology rather than Global Budget, page 22
3. Lack of connection between continued use of CDPS Risk adjusters and development of Quality Incentive Payments, page 23

1. Lowest Cost Estimate (LCE) was a concept given to MCOs in August 2011 as a means of allowing each MCO to define how they could absorb a 10.8% rate reduction for the year from October 1, 2011 through September 30, 2012. In order to maintain services, numerous MCOs drew down significant reserves and are spending them to support the delivery of services this year. A number of MCOs made this choice recognizing that they would not be in the MCO Business after CCOs are selected. The LCE was an effective way for the State to side step the need to determine if the reduced rates were actuarially sound.

Continuation of this process is problematic because it forces CCOs to inherit rates which are artificially low due to contributions of reserves from MCOs which were accrued over 15 years of operations and spent down in one year. Continuation of LCE also represents a de-coupling of future Global Budgets from actuarial soundness and such action should be fully discussed prior to implementation.

2. Although the term Global Budget does appear once on page 22, the term Capitation appears on numerous occasions thereafter. It appears that the current payment system is going to be perpetuated with its dependence on the submission of Encounter Data and billing for procedures as the underlying basis for rates, which change each year based upon historical billing and risk adjustment. This is a system in which no good deed goes unpunished and volume of services trumps quality of care or quality of health.

Much emphasis has been put on the need to have certainty of global budgets over a longer period of time to benefit both CCOs and the State. A preferred model for achieving Global Budget is to set the statewide budget on a per person, per month basis, describe how it will be adjusted with both risk adjusters and quality incentives simultaneously, apply this rate to each population assigned to a CCO with a defined COLA and review process.

3. Chronic Illness and Disability Payment (CDPS) - Risk adjusters are applied to rates to assure that those plans with the most sick people get more money to address the more complex needs of those individuals. They spread money disproportionately across plans and have been applied to FCHPs and MHOs with a large impact on rates that one MCO receives compared to another. Among MHOs, CDPS has resulted in one MHO receiving in excess of 30% more money per person, per month than another. The problem with CDPS applied to MHOs is that the adjustment is based on utilization of those served, rather than on the acuity of their whole membership.

Quality Incentive Payments are intended to reward CCOs that do a good job of keeping people well. If they are not implemented at the same time as CDPS, money will continue to migrate to those regions with the most sick people with no counterbalance for maintaining wellness or financial incentive for recovery from chronic illness. If CDPS is continued, its financial impact should match the opportunity for an equal financial impact that rewards wellness. It is hard to imagine a healthcare reform strategy which gives financial incentive to only those CCOs demonstrating that they continuously have more sick people year after year.

Service/Program Inclusion and Alignment

Twenty-six Oregon counties made county General Fund investments and in-kind contributions to their local behavioral health programs in the '09-'11 biennium, totaling approximately \$40,000,000, or 10% of Oregon's community-based behavioral health services. These dollars funded substance abuse prevention, treatment and recovery services, jail diversion, housing, child welfare and family services, mental health services and developmental disabilities services. In-kind county resources and dedicated levies are paying for buildings and utilities, technical support and county counsel services. One concern we have with CCOs administering part of the funding is the potential for fracturing the existing system by jeopardizing the continuation of funding and in-kind contribution.

AOCMHP endorses the concept of including funding and responsibility for children's mental health programs and other current services provided by mental health organizations in each CCO's global budget. In addition, AOCMHP supports the inclusion of National Drug Code classes 07 and 11 in CCO global budgets.

Lastly, AOCMHP members would like to work with OHA on reviewing **Appendix C** for clarity and accuracy.

Accountability

CCO Measurement and Accountability Plan – Measurement and reporting requirements, Accountability standards, Monitoring and oversight, Specific areas of CCO accountability metrics, Annual review of CCO accountability metrics

In general, there should be performance measures that address integration or care coordination between physical, behavioral and oral health. AOCMHP members would like to serve on the technical work group to establish a core set of metrics.

Because the comorbidity between medical and mental conditions is the rule rather than the exception, (RWJF Synthesis Report, "Medical disorders and medical comorbidity" February 2011), the subpopulation of people with diagnosed mental conditions should be identified as a sentinel population, and CCOs should be required to report services and health status for this specific population.

In addition to outcomes and performance measures, it is important to assess partnership capacity (i.e., between the CCO and the community stakeholders) so that the process can be

altered early on if the collaboration is not working. Robert Wood Johnson Foundation's Partnership Capacity Assessment resource list includes several links to tools to help evaluate system collaboration and to improve the viability and effectiveness of CCOs.

This concludes AOCMHP's comments to the Coordinated Care Organization Implementation Proposal. For questions or additional information, please contact Cherryl Ramirez, MPA, MPH, Executive Director, (503) 399-7201 or email: cramirez@aocweb.org.



January 3, 2012

To: Oregon Health Policy Board
Fr: Coalition of Local Health Officials
Re: Response to CCO Implementation Proposal

Background

The Coalition of Local Health Officials (CLHO) represents the 34 local health departments in Oregon, that work in concert to protect health of Oregonians at the local level.

CLHO appreciates the opportunity to comment on the draft Coordinated Care Organization (CCO) Implementation Proposal. As CCOs are established there will be many opportunities to integrate local health department interventions with primary care. Many communities are already engaged in these conversations locally.

Our goal is to make sure that while we boldly march into this new world of health transformation and work with new partners in improving the health of our communities we don't erode local public health infrastructure across the state. It is with this lens that CLHO requests consideration of three major areas in the design and development of Coordinated Care Organizations: Partnerships, Community Health Assessments/Health Equity and the Global Budget.

Partnerships

Counties are the Local Mental Health Authority and the Local Public Health Authority. Coordinated Care Organizations will need to develop agreements for mental health and "Point of Contact" public health services, as outlined in HB 3650. Many county programs run these two services out of the same department - under the guidance of a Health & Human Services Director. However, other counties have these services run in different departments and may need to be negotiated with two different people/departments within the county.

RECOMMENDATION:

Clarify in the CCO Implementation Proposal that there are agreements for certain Point of Contact services with county local public health departments AND written agreements with the Local Mental Health Authority.

Community Health Assessment/ Health Equity

CLHO is pleased to see that community health assessments are being included as an essential foundation from which the Coordinated Care Organization will build.



Community health assessments are an important look into the health needs of a community and many local health departments are working on these as they prepare for national accreditation. According to the Public Health Accreditation Board (PHAB), the national accrediting body for state, local and territorial health departments, “A community health assessment is a collaborative process of collecting and analyzing data and information for use in educating and mobilizing communities, developing priorities, garnering resources, and planning actions to improve the population’s health.” These assessments, done in collaboration with local partners should help provide the basis for preventative interventions and need for additional attention of risk factors within a community.

The community health assessment is the foundation for improving a population’s health and therefore there needs to be a standardized approach to conducting these assessments. This is not to say that there is a one-size fit for all communities but it must include the same pieces of information (as outlined in the standards and measures by the PHAB).

We are very concerned about the language in the health equity section of the CCO Implementation Proposal, “Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful.” This statement is contradictory to the purpose of the health assessment, which is to have a planning process that fosters consistent engagement and collaboration and allows you to learn about the community as it changes, develops, and become sicker or more healthy.

RECOMMENDATION

In order for there to be ensured consistency and collaboration and to avoid duplicative work, we recommend the following: adopt the community health assessment approach outlined in the Public Health Accreditation Board’s “Standards and Measures” which includes five major areas: 1.) data sources; 2.) demographics of a population; 3.) general description of health issues and specific descriptions of population groups with particular health issues; 4.) a description of contributing causes of community health issues and; 5.) a description of existing community or Tribal assets or resources to address health issues.

Align with the PHAB Standards and Measures, requirement that: “Health status disparities, health equity, and high health-risk populations must be addressed.” This is an essential component of community health assessments that must be a deliberate part of the plan for all partners working on assessments. .

Community Health Assessments should not “evolve” over time but should be done every three to five years to get a sense of how health issues in the community are changing and staying the same, and how populations are evolving.



Global Budget

CLHO understands the OHPB global budgeting approach and generally supports any approach that allows for innovation. However, CLHO recommends a review of the various proposed funding streams prior to implementation. Without a careful review, the global budget might actually lose resources and services to Medicaid clients. Currently there are Medicaid funding streams that are leveraged with local dollars acting as matching funds. Without careful review and planning, these funds, especially county general funds, could be lost. This could lead to a loss of services to the targeted population(s).

For example, the local health departments deliver a Targeted Case Management (TCM) Program called Babies First!/CaCoon. These two programs target infants and toddlers (ages 0-5) with social and/or medical risk factors and children with special health care needs (0-21 years of age).

In FY 2010/2011, the Babies First!/CaCoon TCM program generated roughly \$9 million dollars (\$500,000 in State general funds and more than \$2 million in County general funds leveraged an additional \$6.3 million in federal TCM dollars). These funds provided targeted case management services to approximately 10,000 children statewide. **The state and federal funds used for “Babies First!”/CaCoon appear in both the global budgets for the Coordinated Care Organizations and for the Early Learning Council and the resources are being duplicated in both systems.**

Many local health departments also participate in Medicaid Administrative Claiming (MAC). Federal funds are leveraged with a 50 percent match from county general funds. These funds are used to support a variety of local public health services and programs.

A global budget which encompasses Targeted Case Management and Medicaid Administrative Claiming raises a number of unanswered questions:

1. How can county general funds be used to leverage federal Medicaid dollars through a CCO rather than through DMAP?
2. Will other innovative funding opportunities be lost using a global budget approach?
3. Will local health departments retain their ability to serve high-risk Medicaid clients by leveraging revenue through TCM and MAC?

RECOMMENDATION:

Thoroughly review the global budget funding streams prior to implementation in order to prevent potential funding and service reductions to Medicaid clients.

Thank you for the opportunity to provide comment and feedback. If you have additional questions please contact Morgan Cowling, CLHO Executive Director, morgan@oregonclho.org.



Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

Submitted electronically

Jan. 3, 2011

Dear Dr. Goldberg,

On behalf of Oregon's 58 hospitals, we want to thank you for the opportunity to comment on the *Coordinated Care Organization Implementation Proposal: House Bill 3650 Health Care Transformation* document published in December 2011, and on related Coordinated Care Organization issues. Oregon hospitals support health transformation and want the development, implementation and operation of Coordinated Care Organizations to proceed successfully. We write you today to offer support for several key reform provisions and to suggest changes needed to improve Coordinated Care Organizations.

The Need for Actuarial Soundness in Funding CCOs

Oregon must fund care for our vulnerable populations using sound actuarial principles. This is an obligation our state may not discharge by handing off to another entity to set rates. All states are struggling with underfunding of public services. We hope Oregon's leaders avoid future challenges by adequately funding Medicaid.

The *Coordinated Care Organization Implementation Proposal* recommends setting the global budget capitation rate using a method similar to the problematic 'lowest cost estimate' approach taken to determine rates in the 2011-2013 biennium (Pg. 21). The process the Oregon Department of Medical Assistance Programs used for their 'lowest cost estimate' rate setting process has minimal relationship to the principles of actuarial soundness and Centers for Medicare and Medicaid Services leaders described it as highly unusual. Even if a health plan can get some subset of providers to work for a dictated price, this is not a valid way to build health plans with adequate provider networks.

One additional, specific concern about actuarial soundness centers around funding that targets a defined non-Oregon Health Plan population and is backed by finite resources (e.g. the state's breast and cervical cancer program). We are concerned that CCOs may be held responsible to care for everyone in that defined population, even when the financial resources are exhausted for the program. Safeguards should be put into place to protect CCO financial sustainability in this instance.

The Need to Maximize Federal Funding for Oregon's Medicaid Program

Starting in 2014, federal health care reform will bring 200,000 new Medicaid enrollees into the Oregon Health Plan. The cost of these new enrollees will be paid entirely by federal dollars for the first years. However, the federal government will only pay Medicaid providers at the state-set reimbursement rates in place at the time of this change. If Oregon's current low reimbursement rates are in effect our state will leave significant federal dollars on the table and add considerable stress, in the form of cost shift, to the Oregonians with private health insurance.

CCO Global Budgets Should Be All-Inclusive

We advocate full consolidation of Medicaid's varied funding streams into the global budget when establishing the global capitation rate. As a specific example, we advocate for the inclusion of the indigent mental health dollars into Coordinated Care Organizations within a two-year period. This strategy will improve care management and continuity of care for mental health clients population who due to "churn" frequently access both programs.

The Need for Equal Opportunity to Become a CCO

The proposed model for forming CCOs is inequitable in that it provides a head start for Medicaid Managed Care Organizations to the disadvantage of other would-be CCOs. We are concerned that the proposed fast track model of conversion for MCOs merely creates the illusion of transformation.

Preserving Rural Access to Hospital Care

As rural communities enter into Coordinated Care Organizations, we are supportive of employing reduced risk sharing requirements for CCOs with modest enrollment numbers, as suggested in the CCO implementation proposal (Pg. 29).

In addition, we implore state leaders to not underestimate the challenges rural hospitals must overcome to survive and thrive in the midst of profound change. Today's operating environment is similar to the one present during the 1980s and 1990s when 11 of Oregon's rural hospitals closed as a result of sweeping reimbursement changes under Medicare's Inpatient Prospective Payment System (IPPS). Oregon's rural hospitals need time to adjust to a new payment paradigm in order to ensure preservation of access to rural health services.

Pragmatism in Eliminating Health Disparities

Oregon hospitals are very supportive of efforts to eradicate health inequities in our communities; hospital leaders do and will serve as active partners in this vital endeavor. We also recognize that eliminating health disparities is a complex social problem requiring educational, social and economic changes beyond the purview of the health care system. Tackling inequitable distribution of power, money and resources and improving the daily living conditions of our vulnerable populations are key steps.

Coordinated Care Organizations must be tasked with making progress in reduction of health disparities. However, eliminating health disparities entirely will require a concerted, collaborative effort that engages virtually every sector of the community.

Hospitals Support Current CCO Governance Proposal

We support the language of HB 3560 and of the CCO implementation proposal pertaining to CCO governance. Decisions governing the CCO should be made by those who must fund the decision and those who bear the financial risk. A measured amount of community involvement -- such as the implementation proposal's suggestion that the Community Advisory Council Chair sit on the CCO governing board -- makes sense but should not dilute the majority interest. The state should use its contracting process to ensure its interests are being served. We also ask that the state encourage CCOs to move toward true clinical integration through implementation of equitable and transparent governance.

CCOs Should Meet Commercial Insurance Reserve Standards

Reserve requirements for Coordinated Care Organizations should mirror those imposed by the Oregon Department of Consumer and Business Services' Insurance Division on the commercial insurance industry, as suggested in the CCO implementation proposal (pg. 28). We support creation of a separate licensure category for CCOs, as suggested in the CCO implementation proposal (pg. 30), acknowledging the unique nature of these burgeoning health care entities.

Antitrust Protections Must be Strengthened

To reduce hesitation among providers entering into CCO contracts, we urge the removal of "per se" antitrust violation language from HB 3650 (strike Sect. 18 (1), lines 13-16).

We also would like to see the language on state oversight of antitrust-related issues strengthened in HB 3650, Section 18 (2) in the following way: "The Director of the Oregon Health Authority or the director's designee **may will** engage in appropriate state supervision..."

Incentives Should be Multi-Year

We support the use of meaningful and significant incentives tied to quality, service and affordability outcomes to help align provider and patient incentives for health. The state and CCOs should share financial risk and financial gain for care of CCO patients. We understand that contracts will be just one year long at first, and we urge the state to ultimately consider structuring incentives in a multi-year format, as the benefits of CCOs will accrue over many years.

Risk Adjustment Should Include Drug Data

We support use of current CDPS risk adjustment model and advocate the use of prescription drug data that is not included today. However, we recognize reliance on claims data will become less valid as new prevention efforts bear fruit and as we transition care to alternative settings and services. Medical claims will be the first to go if we are successful in transformation.

Extend Non-Economic Damage Medical Liability Tort Cap to CCOs

We support extending local governments' tort caps for non-economic damages in medical liability cases to CCOs.

Thank you for the opportunity to comment about this important CCO implementation plan. One final concern is that the pace of change required by this bill may not be realistic given where we are in the CCO development process. It is important to reform our health care system without damaging its infrastructure. Do not hesitate to contact me if you want to discuss the content of this letter, or if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Robin J. Moody". The signature is written in a cursive, flowing style.

Robin J. Moody
OAHHS Director of Public Policy
Mobile: 503-568-9291

Health Equity Recommendations for CCO Implementation Proposal

Section/ Page #	Recommended Language/Concept (Includes HB 3650 language, if any)
<p>Governance and organizational relationships /p10 <u>Governing Board</u> OHPB recommends that, as part of the certification process, a CCO should articulate:</p>	<p>We recommend adding the following legislative justification language:</p> <p>Sec 2(2) The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including racial/ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from cultural specific providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.</p> <p>We recommend adding the following language:</p> <p>How the governing board makeup reflects underserved communities, including ethnically diverse populations.</p>
<p>Patient Rights & Responsibilities, Engagement, & Choice/p 13</p>	<p>We recommend adding the following language:</p> <p>Ensure equal patient access regardless of language, disability, culture through: staffing and training protocols (i.e. career path development to increase culturally-based providers, provider/staff workforce training on cultural and linguistic competency, and health literacy, etc.) Assess consumer satisfaction and share clear grievance procedures translated and offered through multimedia approaches Ensure that providers are not working in isolation from racial/ethnic communities to develop best practices for culturally appropriate care and service delivery</p>

<p>Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements /p 13-16</p>	<p>We recommend adding the following legislative justification language:</p> <p>Sec 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.</p> <p>Sec 4(k)(G) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.</p> <p>Sec 20(4) 'Community health worker' means an individual who:</p> <ul style="list-style-type: none"> (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves; (d) Assists members of the community to improve their health and increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness; (e) Provides health education and information that is culturally appropriate to the individuals being served; <p>Sec 69(4)'Community health worker' means an individual who:</p> <ul style="list-style-type: none"> (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves; (d) Assists members of the community to improve their health and increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness;
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	<p>We recommend adding the following language:</p> <p>CCOs must specifically address how they will support clients moving off of coverage and into Health Insurance Exchange (HIE)</p> <p>Throughout CCO Implementation Proposal, We recommend replacing “certified health interpreters” with “qualified or certified health interpreters” language</p>
<p>Health Equity and Eliminating Health Disparities /p 17</p>	<p>We recommend adding the following legislative justification language:</p> <p>Sec 19(1)(L) The authority shall: Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4)</p> <p>Sec30(1)(a) Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:</p> <ul style="list-style-type: none"> (a) Demographics, including race and ethnicity. (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education. <p>We recommend adding the following language:</p> <p>OHA Office of Equity and Inclusion will serve as an additional resource to CCOs to ensure equal patient access regardless of language, disability, culture and improvement of health equity outcomes by connecting CCOs with technical assistance, especially as needs involve provider/staff workforce training on cultural and linguistic competency, health literacy, and career path development to increase culturally-based providers.</p>

	<p>CCOs will be required to demonstrate the elimination of health disparities by submitting quality improvement plans with performance-based results for addressing health equity outcomes and documentation for services (i.e. Certified Health Care Interpreters)</p> <p>CCOs need to describe processes they will be utilizing to collect community wisdom and experience with health care [& health], with links to implementation</p> <p>CCOs falling behind on expectations will be required to put together a specific health equity improvement plan and adopt benchmarks and measures.</p> <p>OHA will develop a system of incentives/disincentives for those that meet/fail to meet standard of care expectations related to health equity</p>
<p>Health Information Technology /p 18</p>	<p>We recommend adding the following legislative justification language from HB2009C:</p> <p>Sec1201 (1) The Administrator of the Office for Oregon Health Policy and Research shall establish and maintain a program that requires reporting entities to report health care data for the following purposes:</p> <ul style="list-style-type: none"> (i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity. (2) The Administrator of the Office for Oregon Health Policy and Research shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that: <ul style="list-style-type: none"> (b) Establish the types of data to be reported under this section, including but not limited to: (C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards. (4) The Administrator of the Office for Oregon Health Policy and Research

	<p>shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.</p>
<p>Accountability CCO Measurement and Accountability Plan/p24-26 <u>Specific areas of CCO accountability metrics</u></p>	<p>We recommend adding the following legislative justification language:</p> <p>Sec 2(3)(b) The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including: Progress toward eliminating health disparities;</p> <p>Sec10(2) Quality measures. The authority shall evaluate on a regular and ongoing basis key quality measures, including health status, experience of care and patient activation, along with key demographic variables including race and ethnicity, for members in each coordinated care organization and for members statewide.</p> <p>Sec30(1)(a) Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:</p> <ul style="list-style-type: none"> (a) Demographics, including race and ethnicity. (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education. <p>We recommend adding the following language:</p> <p>OEI staff, partners, and/or communities representing Oregon’s diversity, especially those impacted by health inequities, will bring a health equity lens to the work in the following groups:</p>

	<ul style="list-style-type: none"> • Incentives & Outcomes committee • Outcomes, Quality, and Efficiency Metrics workgroup • Technical advisory group of experts from health plans and systems <p><u>Specific areas of CCO accountability metrics</u> OEI staff/partners will provide consultation in accountability measures for CCOs as they relate to health equity in specific areas of: access, consumer engagement, health care delivery, and quality improvement. (See Appendix A for specific examples).</p>
<p>Delivery System /p 15</p>	<p>We recommend adding the following legislative justification language:</p> <p>Sec 4(k)(G) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.</p> <p>We recommend adding the following language:</p> <p>CCOs will demonstrate ability to partner with community and faith-based organizations, as made evident through letters of support of strong working relationships across communities.</p>
<p>Global Budget Methodology /p 20</p>	<p>We recommend adding the following legislative justification language:</p> <p>Sec29(2) The authority shall require each coordinated care organization, to the extent practicable, to offer patient centered primary care homes that meet the standards established in section 6 of this 2011 Act. The authority may reimburse patient centered primary care homes for interpretive services provided to people in the state's medical assistance programs if interpretive services qualify for federal financial participation. The authority shall require patient centered primary care homes receiving</p>

	<p>these reimbursements to report on quality measures described in ORS 442.210 (1)(c).</p> <p>We recommend adding the following language:</p> <p>The authority shall reimburse patient centered primary care homes for:</p> <ul style="list-style-type: none"> • Qualified or certified health care interpreter services • Non-traditional health workers (i.e. doula, community health workers, peer wellness specialists, and patient health navigators) <p>OEI staff/partners will provide consultation in global budget methodology for CCOs as they relate to health equity in specific areas of: access, consumer engagement, health care delivery, and quality improvement. (See Appendix B for specific examples).</p>
<p>Blended Funding for Individuals who are Dually Eligible for Medicare and Medicaid /p 23</p>	<p>We recommend adding the following language:</p> <p>Federal waivers should include provisions for Medicare and Medicaid as they relate to health equity in specific areas of: access, consumer engagement, health care delivery, and quality improvement. (See Appendix C for specific examples).</p>

Appendix A: Accountability-CCO Measurement and Accountability Plan

	Outcomes, Quality, and Efficiency
Access	<p># of limited English proficiency consumers</p> <p>Language audit to analyze demand for and provision of linguistically competent services</p> <p>Race/ethnicity data audit (based on Race, Ethnicity And Language [REAL] data standards)</p> <p># or % of comprehensive assessments for dual eligibles, by race, ethnicity and language</p> <p># and description of internal policies focused on health equity or provisions</p> <p>Wait time for access to health care interpreters</p>
Consumer Engagement	<p>Client/consumer representative advisory board members by race, ethnicity and language</p> <p>Consumer satisfaction and grievance linked to REAL data</p> <p># of community and faith based partnerships/ subcontracts</p> <p># of contract providers who are bi or multilingual or bi-cultural</p>
Health Care Delivery	<p>Providers, staff, volunteers, boards, advisory body demographics (race/ethnicity, LGBT/Homelessness)</p> <p>Cultural and linguistic competence measures</p> <p>Hours of cultural competence training</p> <p>Hours of Community Health Worker (CHW), Health Care Interpreter (HCI), and Doula utilization</p>
Quality Improvement	<p>Data sets cut by race, ethnicity, language, sexual orientation, etc.</p> <p>Wait time for access to (HCIs)</p> <p>Member satisfaction surveys with questions on cultural respect, linguistic access, etc.</p> <p>Specific health outcomes across the lifespan by race, ethnicity, language, sexual orientation, housing status, etc.</p> <p>From Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plans & systems survey:</p> <ul style="list-style-type: none"> ○ Provider communication composite ○ Customer service composite (treated with courtesy & respect) / Cut by race, ethnicity and language

Appendix B: Global Budget Methodology

	Outcomes, Quality, and Efficiency
Access	<p>Resources driven to highest risk clients</p> <p>Budget allocation for training, reimbursement of certified/qualified health care interpreters, community health workers, peer wellness specialists, etc.</p> <p>Resources for engaging in efforts to improve social determinants of health in CCO region</p> <p>Request to move from Community Engagement to Access: Subcontracts to specific partner organizations serving diverse populations.</p>
Consumer Engagement	<p>Outreach/engagement resources dedicated to specific communities</p> <p>Specific data collection efforts (focus groups, storytelling, marketing data (Social Determinants of Health-SDOHs))</p> <p>Subcontracts to specific partner organizations serving diverse populations.</p> <p>Have a transparent process for determining and distributing shared savings so their communities may participate or at least understand how these decisions are made and where the savings are being directed.</p>
Health Care Delivery	<p>Line items for nontraditional health care workers (CHWs, HCIs, Doulas)</p> <p>Subcontracting with telephonic and/or videoconference interpreter services/translation services/signage</p> <p>Incentives and pay differentials for providers/interns for culturally diverse backgrounds</p> <p>Requirement that with global budgeting providers will engage interpreters for patients global budgeting,</p> <p>Ensure diverse staffing that is able to engage populations in best practice/emerging practice approaches that seek to enhance health and reduce health disparities.</p> <p>Budgets include supporting the client’s personal choice of post long-term care support (in home care provider – family member, close friend, etc.)</p>
Quality Improvement	<p>Budget associated with QI efforts focused on eliminating health care disparities</p> <p>Establish a payment structure to reward the defined work of provider teams who help their patients achieve better health, while accounting for patients’ complex psychosocial factors as well as their complex medical factors.</p>

Appendix C: Federal Waivers for Medicare and Medicaid

	Outcomes, Quality, and Efficiency
Access	<p>Development of strong partnerships with Patient Centered Primary Care Homes (PCPCH), including migrant, homeless and community health centers</p> <p>Equitable enrollment in Medical Advantage and Special Needs Plans</p> <p>Mental/behavioral health literacy to address cultural barriers to services</p> <p>Linguistically appropriate information re: dual eligibility, CCO disenrollment if care is inadequate</p>
Consumer Engagement	<p>Clear and transparent grievance process described in multiple formats/flow charts</p>
Health Care Delivery	<p>Inclusion of families*** as part of health care team</p> <p>Self-management care process</p> <p>Treatment summaries in patient record include culture, literacy, social supports,</p> <p>*** “Family” means any person(s) who plays a significant role in an individual’s life. This may include a person(s) not legally related to the individual. Members of “family” include spouses, domestic partners, and both different-sex and same-sex significant others. “Family” includes a minor patient’s parents, regardless of the gender of either parent. Solely for purposes of visitation policy, the concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same sex parent, stepparents, those serving in loco parentis, and other persons operating in caregiver roles.</p>
Quality Improvement	<p>Transition plan after long term care – social supports included</p> <p>Assuring standardized assessment of needs is culturally and medically comprehensive</p> <p>Identification and enhancement of existing family, community and social supports and protective factors, as well as key challenges (including social determinants of health)</p> <p>Effective data sharing and appropriate utilization of race, ethnicity and language (REAL) data to identify potential and existing health disparities</p>