



CCO Implementation Proposal

Public Comment Summary, Second Round

January 24, 2012

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

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PDF Book mark No.	Category	Organization or Person	Comment
18	Behavioral health	Recovery Advocates United	Mental and behavioral health consumers want to be included in health care reform. OHA should ensure peers are involved in the development of state-level policy.
24	Behavioral Health	Empower Oregon	Includes panel testimony and breakout group feedback from Empower Oregon's health care forum on January 17th on behavioral health and addictions services.
9	Behavioral health: Drugs	Estelle Womack	Concerned about not including the cost of mental health drugs in the overall budget.
8	Behavioral health: Families	Ron Sipress	The CCO plan pays little attention to families with children who have mental and emotional challenges. These families need to be actively involved in their care.
12	Behavioral health: Integration	Wendy Bourq Ransford (comment was representative of a handful)	It is vital to integrate behavioral health into the care of patients. Outcomes will improve drastically.
21	CCO Certification	Coos County	Counties should have an active voice in the certification process and on the governing board; Under ADR there should be a method to address the issue of overlapping CCOs in a given geographic area; the authority of the Community Advisory Council should be clarified.
11	CCO Criteria	Tom Jefferson	Allowing more than one CCO/county will significantly increase the complexity of managing budgets and could eliminate any efficiencies that are expected to be gained. Also, the proposal should address fraud audits.
16	CCO Criteria	Aisha Kudura	Great plan. How will patients be motivated to make changes in their own health? What will incentivize organizations to become CCOs? Will training be provided to build the community health worker workforce?
26	CCO Criteria	Northwest Health Foundation	The number of CCOs per region should be specifically limited to one. It should not be acceptable for patients to have to wait 6 to 8 weeks for appointments of to drive 50 miles to another city to see a provider. Recommend that OHA create an application review group. CCOs should have to articulate how major components of the health care delivery system are represented on governing boards. All consumer representatives should be members of the CAC. Clarify the intent of the language around community needs assessment.
27	CCO Criteria	Sean Riesterer	Want to second Felisa Hagins comments that there is not enough transparency or accountability. These two components need to be strengthened.

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31	CCO Criteria, governance	Judge Steven Grasty, Harney County Court	All health providers, individuals and entities should be part of the governing board for a CCO serving our county, or any other county. Partnerships between CCOs and mental health authorities should be strengthened. There needs to be more clarification regarding the global budget methodology, including inclusion and exclusion of funding. Counties should be part of the monitoring and oversight of financial reporting.
10	CCO Criteria: pain management	Michelle Underwood	A diagnostic support system would be extremely helpful in eliminating provider prejudice, something that is so human we cannot expect them to be without. This would help eliminate waste, and allow pain management to be better controlled and applied.
19	CCO Criteria: Transportation	Rand Stamm, Lane Transit District	The current human service transportation system is extremely effective and should continue to be an important aspect of the Medicaid system. There is no need to reinvent the wheel or to inadvertently disassemble an effective model.
30	County roles	Wasco County	Counties should have an active role in the selection of CCOs serving their communities, as well as a role in governance. Will programming currently provided by local government be maintained in the global budget? How will federal matching dollars be obtained if CCOs are not government bodies? Also, there should be assurances that CCOs do not result in cost shifting to counties.
21	Global Budget	Coos County	A preferred model for achieving Global Budget is to set the statewide budget on a per person, per month basis, and describe how it will be adjusted.
15	Governance	Mult. Alliance for Common Good (MACG)	One simple request: Require CCO boards to have at least a third of the members be from the community at large, including representation from low income and disadvantaged populations
17	Governance	Medicaid Advisory Committee	A CCO should have to define their community, so that they can adequately have a board makeup that reflects said community; The CAC member that sits on the board should be a Medicaid consumer.
20	Governance	Assoc. of Oregon Counties (AOC)	Add language that ensures counties will have a meaningful roll in CCO governance. Additionally, representatives from the counties should be appointed to the Technical Advisory Group that is to be convened.
29	Governance	Lane County	The "public" seat should have as much authority as the "private" seat on the CCO governing boards. We recommend language similar to what was in SB 204 (2011).

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25	Governance and Counties	Marion County	There needs to be stronger language outlining partnerships between CCOs and county governments. CCOs must have a meaningful roll in governance. Additionally, counties can be a good asset to CCOs by holding public hearings to gather key community input. Counties should be represented on CACs.
23	Governance and Criteria	Oregon Disabilities Commission	We urge a consistent, well-defined mandated partnership between OHA and the Oregon Disabilities Commission. The CAC member with a disability should be a mandated member of the CCO board. Each CCO should be required to have an ombudsperson. THE ODC should be included in discussions at both the local CCO level and the state level. Consumers must have a choice in the PCPCH.
32	Governance and Global Budget.	Jackson County	Jackson County would like to review and give input on all CCO applications covering Jackson County. Counties should be on governing boards; Jackson County supports the emphasis on partnerships between local mental health authorities and county government. Global budget issues must be carefully considered, especially regarding federal match dollars.
17	Health integration	Medicaid Advisory Committee	CCOs should have to emphasize delivery of preventive dental services. They should also conduct health screenings, including behavioral health, for members to assess individual care needs.
28	Implementation and Transition	Providence Health & Services	Flexibility, efficiency and standardized administration will be essential. Also, Section 9 - transition strategy has the potential to undo a lot of the transformation work due to its vagueness. It is essential that OHA defines transition criteria and early adopter incentives in statute.
22	Implementation Plan	Oregon Center for Public Policy	Multiple recommendations, including: the implementation plan should reference all relevant legislation; explicit CCO consumer protection obligations; promote accurate service determinations; OHA should strengthen the grievance process; increase accountability measures; OHA should monitor member access to providers; promote improved communication with members.
33	Innovation agents	Bob Dannenhoffer, DCIPA	I would propose a system that is a cross between the county agricultural extension agent and the original vision of the pre paid health plan coordinator. I would propose that each CCO has an "innovation agent."

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4	Lane County CCO	Wendy Lang	I work at Bethel Student Health Center in the Bethel School District. Our clinic has great potential to improve the health and education of children in this district; we have a fully functioning medical clinic; our mission is to increase the health of the children in the Bethel School District. We would like to see our services included in the Lane County CCO plan.
18	Metrics and Outcomes	Recovery Advocates United	Outcomes measurements and quality indicators should be the driving force behind reform. Metrics should guide service quality, workforce development, and the availability of evidence-based practices. Words throughout the proposal such as "encourage" or "recommend" are not definitive enough.
1	Non-discrimination	Oregon Chiropractic Association	CCOs must not be allowed to discriminate against any health care provider practicing within their scope, licensure or certification; Considering the current and increasing health care work force shortage, especially in primary care, Governor Kitzhaber has stated that Oregon will need all health care providers engaged in Oregon's health care reform; the chiropractic profession would submit that part of true health care reform includes moving away from out over-reliance on synthetic pharmacological agents.
6	Non-discrimination	Michael Gravett	Oregon has an opportunity to take a stance in the correction of a fragmented healthcare delivery system by drafting a plan that begins to truly coordinate medical care by providing coverage for a group of physicians philosophically and medically trained in the concept of "coordinated care."
13	Non-discrimination	American Massage Therapy Assoc.	Please include non-discrimination language regarding the use, availability, and reimbursement for those health professionals deemed important enough to our citizens to be licensed and entrusted to provide care for Oregonians.
14	Other	Edward Yanke	This is just another name for managed care, which did not work the first time.
5	Patients: cost savings	Melissa Kittrell	I've not seen anything in the CCO plans about how the reduction in costs will be passed down to the consumer. How will the steps taken in the next couple years lead to reducing health care costs and more money in the consumers' pockets.
7	Patients: non compliancy	Alma Smith	Families and patients need to be responsible for themselves in some meaningful way. They should help be a communicator with their doctors. One good manner of "health information exchange" is communication by the patient between providers.

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3	Prescription drug overuse	Vern Saboe	How is it that the Oregon Pain Management Commission recommends moving away from opioid narcotics for chronic recurrent lower back pain because of adverse events, but OHP will not pay for less invasive patient preferred intervention? There is a disconnect between what we say we are doing/what we wish to do and what we actually are doing.
2	Tribal Concerns and Suggestions	Northwest Portland Area Indian Health Board	Covers issues relating to tribal health care and CCOs, including alternative payment methodologies, mandatory enrollment, Indian health benefits package, options for providing specialty care, global budgets, and tribal consultation.

January 10, 2012

Oregon Health Policy Board

“Coordinated Care Organizations”

Concerns and recommendations by the Oregon Chiropractic Association

Vern Saboe, DC, DACAN, FICC, DABFP, FACO

Governor Kitzhaber has stated many times if we are going to substantively change health care in Oregon, we must significantly change how we deliver health care not just how we pay for it. Oregon’s coming “coordinated care organizations” must not be allowed to discriminate against any health care provider practicing within their scope, licensure, or certification. Additionally, CCOs must have both an adequate number of all provider types where possible as well as an adequate network of each provider type. The Governor has repeatedly supported this non-discrimination philosophy and considering the current and increasing health care work force shortage especially in primary care Governor Kitzhaber has stated that Oregon will need all health care providers engaged in Oregon’s health care reform.

Part of changing how we deliver health care in Oregon is moving way from our current crisis intervention model and moving toward a more preventative wellness model. This would include better monitoring of Oregonians with known chronic illnesses such as diabetes, heart disease, asthma, etc. to ensure they are being managed properly so they don’t fall into crisis and end up in the local ER. Moving away from a crisis interventional model would also mean routine screening of asymptomatic Oregonians in hopes of capturing early yet unrecognized disease, thereby getting those individuals under treatment before a health crisis develops.

The chiropractic profession would submit part of true health care reform must include moving away from our current and growing over-reliance on synthetic pharmacological agents. This year the “Centers for Disease Control” reported that 9 out of 10 poisonings in our country are related to abuse of prescription drugs, 40% being related to pain medications alone. There are a myriad of evidence based “natural remedies” that work and many drugs that don’t that come with considerable adverse events representing considerable direct and indirect costs in both economic and human terms. We have become a nation of “pill poppers,” approaching the four billion annual prescription purchases mark with a total direct cost estimated to reach \$500 billion by the year 2015 when Oregon’s universal health care system comes fully online. These direct drug costs do not include the annual indirect cost of treating consumers who suffer the estimated 2.2 million adverse drug events or side effects resulting in over 700,000 ER visits and 1 million hospitalizations. Nor does it include the cost of lost work capacity or lost work days, these economic costs are simply not sustainable and that which Oregon can ill afford. In human costs it has been shown that deaths due to in-hospital and out-patient adverse drug events total

“Coordinated Care Organizations”

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over 200,000 annually in this county, the equivalent of a Boeing 747-400 with 548 passengers on board crashing every single day. How long would it be before the FAA grounded all 747's after one crash? Certainly after the second crash, yet “air medicine” is allowed to continue to fly its “drug planes” day after day.

83% of Americans age 65 or older take at least one prescription drug daily, 75% take four and 11% take five daily. 1.6 million teenagers and children are prescribed at least two psychiatric drugs in combination with no clinical trials to show this is safe, yet 300,000 children under the age of 10 are prescribed two psychiatric drugs in combination. If we are going to improve the health of all Oregonians, increase their satisfaction and safety, as well as reduce the per capita cost of health care (The Triple Aim), Oregon's reform efforts must include at least some movement away from pharmacology.

Oregonians have made it clear they want equal access to complementary and alternative medical (CAM) providers who tend to utilize less invasive drugless therapies resulting in fewer adverse events. Studies by David Eisenberg, MD., director of Harvard Medical School's “Center for Alternative Medicine Research and Education,” at Beth Israel Deaconess Medical Center, and co-workers, have documented the dramatic increase in CAM use. Eisenberg and his colleagues documented that 42% of adults or 82 million Americans routinely used complementary medical therapies to treat their most common medical conditions. US consumers made an estimated 629 million office visits to complementary therapy providers exceeding the total number of visits to medical primary care physicians and spent an estimated \$27 billion out-of-pocket of complementary care. These statistics are now 14 years old (1997) with investigators estimating there has been an increase between 25% - 35% to date. This seems to be consistent with what Oregonians want, as evidenced by the November 10, 2011, Oregon Health Authority – Oregon Health Policy Board's “Bulletin.” On page two of the bulleting under “Oregon Statewide Community Meetings,” and “Comprehensive health care that meets the needs of the whole person is essential,” states, ***“There is a strong desire for the CCO system to include alternative providers such as naturopaths and chiropractors as well as mental health, home care, and dental services. Many saw these services as potential cost saving services and important for creating better health in the community.”***

Chiropractic physicians who wish to practice at the top of their licensure as our Governor has stated, we can and do perform more critical services than just treating common musculoskeletal complaints such as low back pain, neck pain, headache etc. We can and do offer more than simply “pounding down the high spots” in Oregonian's spines. Chiropractic physicians who choose to practice at the top of their licensure and clinical training currently can and do act as first contact portal of entry physician types.

“Coordinated Care Organizations”

Concerns and recommendations by the Oregon Chiropractic Association

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As first contact portal of entry physicians, we perform correlative and differential diagnoses and are trained to interpret X-ray, lab findings, conduct comprehensive physical examinations, conduct and/or order and interpret ancillary diagnostic studies (CT, MRI, S.P.E.C.T., etc) arriving at a clinical impression. Chiropractic physicians have the clinical training and skills to recognize pathophysiological conditions that require immediate or timely attention and know when to make the appropriate referral. This is especially true of frank life threatening pathology that can masquerade as a simple musculoskeletal complaint such as low back pain. As a consequence, in the midst of the current medical work force shortage the chiropractic profession is poised and ready to help fill this shortage and will provide needed services, not the least of which include semi-annual, “basic office diagnostics” and “well-person visits.” In short, chiropractic must be included in the coming “coordinated care organizations” and Oregon’s universal health care system as a “profession” not simply as a “service.”

So what might be the performance and outcomes if and when chiropractic and naturopathic physicians act in the capacity of first contact portal of entry physician types? The experiment has already been performed in the state of Illinois (2000-2007). In this 7-year prospective cost comparison study, consumers could select a chiropractic or naturopathic physician as their primary care physician or a medical doctor as their PCP. Investigators then followed these consumers for 7 years analyzing over 70,274 member-months. These investigators found in the chiropractic and naturopathic managed group the following significant savings, **85% reduction in drug costs, 62% reduction in MRIs and surgeries, 60.2% reduction in, in-hospital admissions, 59% reduction in hospital days** and with a **95% consumer satisfaction rating**. The 85% reduction in “drug costs” was for direct drug costs and did not include the sizeable indirect cost savings as a result of reduced adverse drug events which result in ER visits and hospitalizations or the cost savings due to reduced lost work days.

Returning to the realm of musculoskeletal conditions, namely spine related disorders, a great number of chiropractic physicians currently are known for and practice and function as primary care practitioners of the spine. Chiropractic physicians are best trained and skilled to perform spinal manipulation, the principle intervention we are known for. As a consequence, it is estimated chiropractors perform 94% of all spinal manipulation in the US. However, the chiropractic profession would submit there is currently a rather glaring disconnect between what we say we want here in Oregon versus what we are actually doing and the following is an example of what we as a state must change. The “State of Oregon Evidence-based Clinical Guidelines Recommendations for the Management of Low Back Pain” finalized December, 2011, recommends spinal manipulation as the only “nonpharmacologic therapy” for the first four weeks of an acute episode of lower back pain. In addition, the new State of Oregon Low Back Pain Guidelines also recommend acetaminophen (Tylenol) and non-steroidal anti-inflammatory drugs (NSAIDs), though the Oregon Health Plan (OHP) will not pay for “evidence-based” non-invasive spinal

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Concerns and recommendations by the Oregon Chiropractic Association

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manipulation, yet the state of Oregon recommends it will pay for multiple visits to the medical PCP and for prescription pain medications including narcotics?

Currently acetaminophen (e.g. Tylenol) is the leading cause of acute liver failure in the US with 140,000 poisonings, 56,000 ER visits, and 100 deaths yearly. Non-steroidal anti-inflammatory drugs (NSAIDs), are the second leading cause of peptic ulcers resulting in more than 100,000 hospitalizations at an estimated \$2 billion in additional costs and 17,000 deaths annually. Prescription opiates are an easy solution for medical physicians who prescribe them to patients as a supposed “quick fix” for back pain, with methadone leading the way which is likely at least in part, why Oregon is third in the nation for prescription narcotic abuse. According to Oregon’s state epidemiologist Katrina Hedberg, MD., between 1997-2007, hydrocodone sales increased 280%, oxycodone 866%, and methadone 1,293% and resulted in some 700 poisoning deaths between 2003-2007. 53% of drug overdoses in Oregon are associated with prescription opioids, an overall increase of 540% since 1999 and a 1,500% increase in deaths from methadone alone. Understandably the “Oregon Pain Management Commission” is recommending a paradigm shift in the way chronic recurrent pain is treated, strongly advocating that “holistic therapies” like chiropractic spinal manipulation replace prescription opiates as the dominant method of treatment.

Though a recent systematic review of cost-effectiveness of guidelines found no evidence for the cost-effectiveness of medications for acute, subacute, or chronic back pain, these dangerous medications continue to be prescribed are clearly adding direct and indirect costs to Oregon’s health care system. The Oregon Public Health Division revealed the number of treatment admissions for opioid use increased 130% between 1999-2005, however lost work capacity and/or lost work days must be added to these indirect costs. We agree with the Oregon Pain Management Commission that a change must be made and that prescription opiates are a costly and ineffective method of treating chronic recurrent back pain and are not resulting in good outcomes. This obvious disconnect between what the state of Oregon is recommending versus what it is doing will clearly not help us achieve “The Triple Aim” is certainly not an example of “value-based care.” As the chiropractic profession would say indeed, “**We Can Do Better.**” As a consequence, the coming Oregon coordinated care organizations must not be allowed to discriminate against any health care provider practicing within their scope licensure, or certification. Additionally, the CCOs must have both an adequate number of all provider types where possible as well as an adequate network of each provider type.

Sincerely,

Vern Saboe, DC, DACAN, FICC, DABFP, FACO

Oregon Chiropractic Association



**NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD**

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT VIA TELEFAX/EMAIL: (503) 947-2341 & ohpb.info@state.or.us

January 9, 2012

Oregon Health Policy Board
Eric Parsons, Chair
Lilian Shirley, Vice-Chair
500 Summer Street NE
Salem, OR 97301

Dear Mr. Parsons and Ms. Shirley:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638¹ tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. This includes all nine Tribes in the State of Oregon. We are writing to provide you with our comments and recommendations concerning the draft "CCO Implementation Proposal" to implement the requirements of HB 3650.

Our comments are intended for the second comment period that begins tomorrow, January 10, 2012, when the Oregon Health Fund Board convenes its meeting to begin consideration of an updated draft proposal to implement Coordinated Care Organizations (CCO). The recommendations included in the attached document represent the consensus views of all nine Oregon Tribes and the Native American Rehabilitation Association (NARA). These recommendations have been developed by Tribal leaders, health directors and NARA representatives in a series of meetings held over the past year.

We hope that you implement our recommendations as you finalize the CCO implementation plan and make recommendations to the Oregon Legislature. Our recommendations are included around five areas:

- Alternative Payment Methodologies and Global Budgets;
- Mandatory Enrollment;
- Indian Health Benefit Package;
- Options for providing specialty care, and;
- Tribal Consultation.

¹ A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

We believe that our recommendations will effectively integrate the Indian health system into the CCO process. Otherwise there will be complications that will need to be resolved, which will ultimately cost time and money and affect the quality of care that Indian people receive in the Medicaid program. We hope we can avoid these types of complications.

We welcome any questions you might have concerning our recommendations. We would also volunteer our organization to provide an overview to the OHFB on the Indian health system and its unique and complex set of federal laws that embody our recommendations. Please feel free to reach out to us if needed.

If you have any questions, feel free to contact Jim Roberts, Policy Analyst, at (503) 228-4185 or email at jroberts@npaihb.org. Thank you for your consideration!

Sincerely,

A handwritten signature in blue ink, appearing to read "Joe Finkbonner". The signature is fluid and cursive, with the first name "Joe" being more prominent.

Joe Finkbonner, RPH, MHA
Executive Director

cc: Bruce Goldberg, OHA Director
Judy Mohr Peterson, Medicaid Director
Jeanne Phillips, Deputy Director, Medical Assistance Programs
Nine Oregon Tribal Leaders & Health Directors
Jackie Mercer, Executive Director, NARA

Tribal Recommendations to Integrate the Indian Health Care Delivery System Into Oregon's Coordinated Care Organizations (H.B. 3650)

January 9, 2012

Executive Summary

House Bill 3650 establishes the Oregon Integrated and Coordinated Health Care Delivery system to replace managed care systems for Medicaid beneficiaries. The new system of Coordinated Care Organizations (CCOs) would be accountable for management of integrated and coordinated health care within a set global budget. The law requires the state to develop qualification criteria for CCOs, alternative payment methodologies, and to develop standards for patient centered primary care homes. The law also requires the state to adopt consumer and provider protections and to monitor and enforce these requirements.

CCO's may seem new to most, but not in the Indian health system. Since 1954 the Indian Health Service (IHS) has operated an integrated health care delivery model (primary care, behavioral health, and public health) that operates on a fixed (global) budget from Congress. Tribal health budgets are fixed funding that come via annual funding agreements with IHS that use a prioritized list of services to manage services to a population via the CHS program. CCO's service geography is similar to CHSDA health delivery regions. CCO reporting of quality and outcomes are comparable to IHS quality measures and reporting processes that are in place for Government Performance Results Act and Performance Assessment Rating Tool, which Tribes have utilized for years. Annual audits and accreditation also enhance quality outcomes. Thus, the objectives of CCOs are not new to the Indian health system. CCOs are delivery systems that Tribes will embrace if they effectively integrate our health care system.

On December 20th, Oregon Tribes and the NPAIHB met with State representatives to discuss the implementation of CCOs and how the changes might impact Tribal health programs. This dialogue allowed the opportunity to develop tribal recommendations for how CCOs can effectively integrate Indian health programs into the new CCO delivery system. The recommendations developed are around the following items:

- Alternative Payment Methodologies
- Mandatory Enrollment
- Indian Health Benefit Package
- Options for providing specialty care
- Global Budgets
- Tribal Consultation

The recommendations we provide are consistent with the Federal protections and requirements of IHS, Tribal and urban Indian operated health programs in Medicaid managed care organizations (MCOs). Medicaid MCOs refer to programs that coordinate, rationalize, and channel the delivery of care without being risk-based, and; also refers to care managed by organizations that assume full financial risk for the care managed. Medicaid MCOs in general are efforts to coordinate, rationalize, and channel the use of services to achieve desired access, service, and outcomes while controlling costs. These applications also

apply to Oregon's new CCOs and meet the CMS definitions of being managed care organizations. Thus, CCOs are used interchangeably with MCOs in our recommendations.

Background

The provision of health services to AI/AN people stems from a unique trust relationship between the United States and Indian Tribes. The Federal government's trust responsibility provides the legal justification and moral foundation for Indian specific health policymaking – with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population. It's important to underscore that when Congress passed the Affordable Care Act¹, there were a number of Indian specific protections included to promote the health reform goals for AI/AN people. Similar protections were included in the Recovery Act² that exempted AI/ANs from cost sharing in Medicaid and CHIP, Medicaid estate recovery and provided rights of reimbursement for Indian health providers from Medicaid managed care entities. This serves as an example of the policy precedence for Indian specific health policy making. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to AI/ANs—with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of Indian people.

The Indian health system in Oregon is a unique and complex system comprised of ten ambulatory care clinics and one urban program that is governed by unique laws, regulations and policies. The Indian health system consists of services provided by the Indian Health Service (an agency in the U.S. Department of Health and Human Services); programs operated by Indian tribes and tribal organizations through Indian Self-Determination and Education Assistance (ISDEAA) agreements, and; by urban Indian organizations that receive grant funding from IHS under Title V of the Indian Health Care Improvement Act.

These programs serve some of the poorest and most isolated populations in the state. Due to the severe and chronic underfunding of Indian health system, AI/ANs have limited access to health care services and suffer some of the highest rates of health disparities when compared to other population groups. Many beneficiaries served by the Indian health system live in remote or sparsely-populated reservation areas. The Indian health system was designed to reach these beneficiaries in their communities which have little, if any, other health infrastructure presence. Even in more populated areas, the Indian health system provides the most meaningful access to health care due to challenges of low income and cultural differences that make other health services essentially inaccessible.

These characteristics are what make the Indian health system unique and requires it to have a comprehensive focus. The IHS delivery system strives to be an integrated, a community-based system that emphasizes prevention and public health, delivers and purchases health care services, and provides the infrastructure for health improvements by building health facilities and sanitation systems. It also provides work force improvement through training, recruitment and retention of health personnel. This system is the health care home for the AI/AN people that it serves. The tribal leaders who direct it, and, increasingly, its workforce, are its users, as are their grandparents and their grandchildren, and it

¹ Patient Protection and Affordable Care Act, (P.L. 111-148), commonly referred to as the "Affordable Care Act".

² American Recovery and Reinvestment Act of 2009 (P.L. 111-5), commonly referred to as the "Recovery Act".

will be the health care home for their grandchildren's grandchildren. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

This is why it is important that the implementation of CCOs effectively integrate Indian health programs into their service model. The following recommendations can achieve this objective.

Measuring Health Quality and Reporting in the Indian Health System

The Indian health system strives to provide the best health care possible and is required by federal law to report annually on quality measures on its patients under the Government Performance and Results Act (GPRA). Other government health programs operated by the the Department of Veterans Affairs and the Department of Defense have to do the same. This means that all government health care programs are expected to improve the health of their patients with the money they get from Congress. Each year IHS includes its GPRA report card to Congress as part of the IHS budget submission. The GPRA report card tells Congress about the quality of care IHS is providing to its patients. The report card includes certain performance measures developed by IHS for the AI/AN patient population. For example, quality of care is measured by how well we are treating diabetes and heart disease. It also measures how well we are doing in preventing diseases like cancer, obesity, and HIV. Last year, IHS reported on 21 GPRA and three other clinical performance measures. The GPRA report is provided to the Office of Management and Budget (OMB) and Congress.

IHS programs also required to meet quality and accreditation standards for the purposes of participating in the Medicare, Medicaid and CHIP programs. To comply with this requirement IHS, Tribal and urban Indian programs are routinely accredited through such organizations as the Accreditation Association for Ambulatory Care or the Joint Commission Joint Commission on Accreditation of Health Care Organizations. This process requires Indian health programs to submit to a process in which their quality of care services and performance are measured against nationally-recognized standards. The accreditation process demonstrates that the Indian health system is committed to providing high-quality health care and that it has demonstrated that commitment by measuring up to the nationally-recognized standards.

IHS programs are required to comply with federal requirements for financial accountability. IHS programs must submit data for the purposes of the federal Program Assessment Rating Tool (PART), which measures budget and program performance so that the Federal government can achieve better results. A PART review helps identify a program's strengths and weaknesses to inform funding and management decisions aimed at making the program more effective. The PART therefore looks at all factors that affect and reflect program performance including program purpose and design; performance measurement, evaluations, and strategic planning; program management; and program results. This process includes a consistent series of analytical questions to measure programs over time it allows weakness to be identified so that improvements can be made to improve outcomes.

Tribes enter into legal binding contracts or compacts with the federal government under the Indian Self-Determination and Education Assistance Act (P.L. 93-638, "ISDEAA"), and; urban Indian programs enter into legal binding grant arrangements under Title V of the IHCA. In the course of carrying out these legally binding agreements with the Federal government, Tribes and urban programs must comply with the requirements of the Single Audit Act. Each IHS programs must complete the requirements of an OMB A-133 audit; which is a rigorous, organization-wide audit examination of funds that are received by

private, state and federal sources. Completion of this requirement demonstrates to the Federal government that the use of funds to provide health care is appropriately utilized. The audit is typically performed by an independent certified public accountant (CPA) and encompasses both financial and compliance components. Incomplete or irregular audits can jeopardize the funding that is received by IHS programs if corrective action is not taken and completed.

Recommendations:

1. Alternative payment methodologies and Global Budgets

H.B. 3650, Section 5, requires OHA to encourage CCOs to establish alternative payment methodologies that reward value and good health outcomes rather than volume and that limit increases in medical cost. CCOs shall also be encouraged to use payment structures other than fee-for-service that promote prevention, provide person-centered care and reward comprehensive care coordination. Providers and facilities may not charge, and CCOs may not reimburse for, services not covered by Medicare because they are related to health care acquired conditions.

This section also requires CCOs to reimburse Type A, Type B and rural critical access hospitals at cost until July 1, 2014. After July 1, 2014, OHA shall require CCOs to continue to reimburse specific hospitals at cost if the OHA determines that hospitals face sufficient financial risk. However, this section does not prohibit a CCO and a hospital from mutually agreeing to another method of reimbursement. The basis of this payment principle should be the same for the treatment of Indian health providers who serve similar populations and experience higher cost to provide care.

Tribal Recommendation:

HB 3650, Section 5 includes a requirement that CCOs must comply with federal requirements for payments to providers of the Indian health services, including but not limited to the payment protections of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C). Tribes recommend that the established Federal reimbursement process that uses the OMB encounter rate for IHS and Tribal programs and FQHC fee for service for urban health programs be maintained. IHS, Tribal and urban Indian health programs should not be subjected to any unnecessary certification or licensure requirements to participate in the CCO networks or as a condition of reimbursement.

In addition to the Section 5 exemption, there are federal requirements that protect the Indian health system for reimbursement and participation in the Medicaid program. The Indian Health Care Improvement Act (IHCIA or P.L. 94-437; amended as P.L. 111-148) contains such protections. The IHCIA at Section 206 stipulates that Indian health providers have a Federal right to receive reimbursement for the services they provide. Under Section 206, Indian health providers have the right to recover the "reasonable charges billed ... or, if higher, the highest amount any third party would pay for care and services furnished by providers other than governmental entities... "

The HHS Secretary has the responsibility under the Act to enforce this provision. If Indian health providers are not included in CCO plan networks, there may be more expensive transaction costs incurred by both the Indian providers and the CCO. Alternatively, if the requirement for Indian providers to be reimbursed by health plans is not effectively enforced, then the CCO may realize a potential windfall by collecting premiums or alternate resources for AI/AN enrollees – most likely

paid for with Federal dollars – and not making full payment for the health services their Indian enrollees receive from IHS and Tribal providers.

Additionally, the IHCIA at Section 408(a)(2), provides that Indian health programs are not required to obtain a license from the State as a condition of reimbursement by any Federal health care program so long as the Indian program meets “generally applicable State or other requirements for participation as a provider of health care services under the program.” A “Federal health care program” means “any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government,” including health insurance programs under chapter 89 of title 5; and any State health care program, which includes Medicaid, and CHIP, as well as any program receiving funds under certain other provisions of Federal law. Thus, the State or CCOs cannot require licensing in the State as a condition for network provider status nor as a condition for payment for services. Section 408 is as follows:

[a]ny requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the [Indian Health] Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law.

IHCIA Section 408 further states that “IHS, tribal and urban Indian organization programs shall be eligible for participation in any Federal health care program to the same extent as any other provider.” Consequently, federal law requires that tribal and urban health programs be offered participation in CCOs. Although tribal and urban programs are not required to participate, Section 408 mandates that states and CCO must offer to include all tribal and urban health programs within their provider networks.

In order address issues that might arise concerning reimbursement or participation of Tribal and urban programs in the networks of CCOs, the State should require CCOs to contract with IHS, Tribal or urban Indian providers using a contract addendum that sets forth federal rights and responsibilities similar to that used in the Medicare Part D program. This is also important to ensure that CCOs meet network adequacy and cultural competency requirements that are essential to providing and managing the care of AI/AN people. Use of a standard contract addendum will reduce legal and administrative uncertainty as CCOs seek to maintain compliance with all applicable federal laws.

2. Mandatory Enrollment

H.B. 3650, Section 27 and 28, requires that persons eligible for health services, which do not include Medicaid-funded long-term care for the purposes of this section, must enroll in a CCO, with several exceptions including: non-citizens; American Indian or Alaska Native beneficiaries; and other groups that OHA may exempt by rule (e.g. pregnant women in the third trimester). Mandatory enrollment does not apply to a person living in an area not served by a CCO or where the CCO’s provider network is inadequate, or PACE enrollees. In any area not served by a CCO but covered by a prepaid

managed care organization, a person must enroll with the managed care organization to receive any of the health services it offers.

There are a variety of reasons why and AI/AN may choose to exercise their option to opt out of being enrolled in a CCO. AI/ANs may prefer to continue to see providers they have an established relationship and that understand their needs and concerns and provides culturally appropriate care. There may be transportation or other economic constraints that prohibit them from receiving care other than through Indian programs. Or they may have job or educational related circumstances that result in relocation between cities and the reservation. Whatever the reason, there must be options for AI/AN who opt in and out of CCOs and requirements for CCOs to coordinate with Indian health programs to manage AI/AN clients access to care and to ensure that Indian health programs are reimbursed in a timely manner. Unless this happens it limit access to specialty care for AIAN patients that will result in negative health outcomes and an unintended consequence that discriminates against AI/ANs from being able to access specialty care.

Regardless, whether an IHS, Tribal or urban Indian health program is a participating provider in a CCO, it should be a requirement that any covered service rendered to a Medicaid patient should be reimbursed at the FFS rate or comply with the established federal requirements for payments to providers of Indian health services under the OMB encounter rate. The State should also establish procedures to make prompt and timely payment consistent with the rule for prompt payment of providers under Section 1932(a) of the Social Security Act. These payment requirements should also apply to any wrap-around payments from the State in accordance with ARRA, Section 5006 (42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C)).

Tribal Recommendations:

Since H.B. 3650 includes an exemption for AI/AN from mandatory enrollment the CCO system should be able to identify AI/AN beneficiaries and provide them with the an open card option similar to what is used in the OHP and IHS, Tribal and urban health programs should be eligible to be reimbursed on a FFS basis. The patient population that is eligible for this option would be any individual that is eligible to receive services through the Indian health system. HB 3650 defines AI/AN beneficiary consistent with the definition adopted by the Centers for Medicare and Medicaid Services (CMS) definition of "Indian" in its implementation of the Medicaid cost sharing protections enacted in Sec. 5006 of the Recovery Act (codified at 42 U.S.C. § 1396o(j)). This regulation, 42 C.F.R. § 447.1 - 447.50, broadly defines the term "Indian" consistent with the Indian Health Service's ("IHS") regulations on eligibility for IHS services.

We recommend that the state develop requirements to address the issues related to the relationship of shared patients between the Indian health system and CCOs. These requirements should address coordination and access to care for AI/AN patients, and; compliance with Medicaid prompt payment requirements to Indian health providers. The development such requirements should not be placed on IHS programs or CCOs, but should be the responsibility of the Oregon as the single state Medicaid agency. At a minimum these requirements should address AI/ANs enrolled in CCOs, who receive services from IHS, Tribal and urban Indian health programs and specialty care access for those for AI/ANs not enrolled in MCOs.

The State should require CCOs that enroll AI/ANs to treat any referral made by an IHS, Tribal or urban Indian health program to be treated as a participating primary care provider for the purposes

of receiving services from the CCOs network and for reimbursement of services provided by the Indian health system. Without such a requirement Indian health referrals will likely be refused service by the CCO network providers.

3. Indian health benefit package

H.B. 3650, Section 39, makes a conforming amendment to ORS 414.428, which is the regulation that provides an individual who is eligible for or receiving medical assistance and who is an AI/AN beneficiary shall receive the benefit package of health services described in ORS 414.707 if: (a) The Oregon Health Authority receives 100 percent federal medical assistance percentage for payments made by the authority for the health services provided as part of the benefit package described in ORS 414.707, or; “(b) The authority receives funding from the Indian tribes for which federal financial participation is available.

Tribal Recommendation:

Tribes have requested that the state explore options to exempt AI/AN from benefit reductions or explore alternatives to be able to provide optional services that have already been reduced in the Oregon Health Plan. We recommend that the State continue to work with Tribes and CMS in the development of waiver or state plan amendment (whichever is necessary) to allow implementation of Section 29. The requirements of Section 39 would make such services completely budget neutral to the State and provided needed services to address the health disparities that persist in Oregon’s tribal population.

4. Global Budgets

HB 3650, Section 13 requires the OHA develop—and the legislature to approve—a meaningful public process for CCO qualification criteria and a global budgeting process. It is noted that the draft report “CCO Implementation Proposal” for HB 3650 mentions that “all Medicaid dollars are in the global budgets” with the exception of long-term and mental health drugs. It is important to recognize that Oregon provides Tribes funding under its Medicaid plan for targeted case management (TCM) and out-stationed eligibility workers. Oregon operates a Tribal TCM program that provides Medicaid case management services to AI/ANs to assist eligible beneficiaries in obtaining medical and other services necessary for their treatment.³ The target group consists of individuals served by tribal programs, or receiving services from a federally-recognized Indian tribal government located in the State, and not receiving services from other Title XIX programs. The OHA also provides IHS, Tribal and urban programs reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices.⁴ Both of these programs are very important in providing outreach, enrollment and linkage activities for Indian people.

³ ORS 410-138-0610, Targeted Group - Federally Recognized Tribal Governments in Oregon.

⁴ ORS 410-146-0460, Compensation for Out-stationed Outreach Workers.

Tribal Recommendation: TCM and out-stationed eligibility workers are services that in most instances could not be performed on reservations by CCOs. Thus the funds provided to Tribes for these programs should be exempt from CCO global budget and continue to be received by Tribes under the State Medicaid plan. CCOs will likely lack the presence in Tribal communities to perform these services. IHS, Tribal and urban programs also carry these services out within their existing health programs that give them a distinct advantage in conducting these services. They are in the clinics and conducted with members of the community who understand the needs of the patients they serve.

5. Tribal Consultation

In recognition of the special relationship with tribal governments, the United States government has recognized the importance of Tribal consultation by reaffirming Executive Order 13175 to ensure regular and meaningful consultation and collaboration with tribal officials in Federal policy decisions that have tribal implications. In 1975, Oregon established the Legislative Commission on Indian Services (CIS) to improve services to Indian people by improving communication and coordination with Tribes. Following establishment of the Commission, the legislature overwhelmingly supported passage of SB 770, a bill that acknowledges and promotes government-to-government relations with Oregon Tribes. This establishes a foundation that the State and the legislature consult with Oregon Tribes in developing policies and implementing programs that will affect their interests.

Section 5006(e) of the Recovery Act codifies in statute, at section 1902(a)(73), the requirement that States utilize a process to seek advice on a regular, ongoing basis from designees of the Indian Health Programs and Urban Indian Organizations concerning Medicaid and CHIP matters having a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. The statute requires the solicitation of advice on an "on-going, regular basis". In order to assure the spirit of this obligation is fulfilled; CMS will require States to demonstrate that they have sought advice from designees of Indian Health Programs and Urban Indian Health Organizations throughout the process of developing state plan amendments, waiver requests, and demonstration projects. The "on-going, regular basis" requirement is intended to assure that the State has the benefit of substantive input and evaluation of impact from Indian Health Programs and Urban Indian Health Organizations during the proposal development process so that the State can meaningfully take this information into account.

Tribal Recommendation:

Tribes recommend that the State consult with Tribes over the final operational plan to implement CCOs where there are tribal implications that will affect the above recommendations and prior to the State's submission of the Medicaid State plan amendment or waiver request to implement CCOs. Tribes acknowledge that some of the State's Medicaid responsibilities could be subrogated to CCOs and that in these instances that State and CCOs must ensure that the tribal consultation process is adhered to when issues are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations.

6. Criteria for Coordinated Care Organizations

HB 3650, Section 5 sets forth the qualification criteria for CCOs including the governance structure, financial requirements, and components of health care delivery systems. Options to organize CCOs include community-based organizations, statewide organizations with community-based participation, a single corporate structure, or a network of providers organized through contractual relationships. In almost every instance the Oregon's Indian health care delivery system can meet all the requirements of these structures. Tribal and urban communities by their very nature are community based and their health clinics are their organizations that provide health care. Collectively they can coordinate to be statewide or become a single corporate structure and already include community participation. The Indian health system can also be formalized into a networked structure of providers through contractual relationships amongst itself or with other health system providers. While the benefits and challenges of becoming a CCO are not known by the Indian health system at this time, we would like to preserve the ability to become CCOs if it would be beneficial to our providers and patients.

Tribal Recommendations: We recommend that the qualification criteria to establish a CCO should not preclude the ability of IHS, Tribal and urban Indian health programs to become a CCO. We also recommend that the criteria for CCOs must require that they meet network adequacy requirements for providing care to AI/ANs located on Indian reservations and that there also be requirements for meeting cultural competency for providing care to all Oregonian populations.

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Ettinger Ari A

From: Vern Saboe <vsaboe@comcast.net>
Sent: Thursday, January 12, 2012 5:50 AM
To: OHPB.info@state.or.us
Subject: "Coordinated Care Organizations"

Categories: Public Input

If we are serious about transforming health care and addressing the workforce shortage and providing "value-based care" the CCOs must not be allowed to discriminate against any healthcare provider working within their scope, licensure, or certification. For example how is it that though the Oregon Pain Management Commission recommends moving away from opioid narcotics for chronic recurrent lower back pain for example because of all the adverse events, the new Oregon State Low Back Pain Guidelines recommend spinal manipulation as the only "drug-free" intervention, yet the Oregon Health Plan will not pay for this less invasive patient preferred (or at least my OHP patients) intervention? However, OHP will indeed pay for repeat visits to their medical PCP and for a myriad of prescriptions for various pain meds not the least of which are opioid narcotics? Is there not a disconnect between what we say we are doing or wish to do evidence based care/value-based care, vs. what we are doing?? Part of transforming healthcare in this great state must include moving away from all the pharmacology not the least of which are the narcotics yes? no?

Dr. Vern Saboe
Chiropractic physician
Albany

Ettinger Ari A

From: Lang, Wendy <wendy.lang@bethel.k12.or.us>
Sent: Thursday, January 12, 2012 9:44 AM
To: OHPB.info@state.or.us
Subject: School Based Health Centers and CCOs

Categories: Public Input

I am a nurse practitioner working in the Bethel Student Health Center in the Bethel School District. I believe our clinic has great potential to improve the health and education of the children in this district. We would like to see our services included in the Lane County CCO plan and would like to be included in the planning process where that seems helpful. We would also like you to keep us in mind during the planning and implementation of your new electronic medical record.

We have a fully functioning medical clinic and we provide health care to any child living in the district in need. Our mission is to increase the health of the children in the Bethel School district by removing financial and cultural barriers to health care. And to minimize the impact of health problems on their education . Since opening in April, 2011 we have had 342 visits with a wide range of diagnosis. We do well child care and risk assessment and intervention for infants, children and adolescents. We have a Spanish translator on site. We turn no child away because of inability to pay. We offer same day appointments.

Many of our patients qualify for the OHP Healthy Kids program but are not signed up for a variety of reasons. Some are signed up and have a PCP but have transportation issues so come to the clinic due to convenience. Some are homeless, estranged from their families and some are not citizens. We also have some privately insured patients that can't afford co-pays or have transportation difficulties.

We have a strong team approach including school nurses, counselors, teachers, and on site mental health workers from the Child Center. We collaborate with local pediatricians, PeaceHealth, PeaceHealth Labs, Slocum and Associates, Looking Glass, the Child Center and the Lane County Health department.

Wendy Lang, FNP

Bethel Student Health Center

1525 Echo hollow Road Suite A

Eugene, Oregon, 97402

541-607-1430

Ettinger Ari A

From: KITTRELL Melissa R
Sent: Thursday, January 12, 2012 10:03 AM
To: OHPB Info
Subject: Reduction in health care costs- will it be passed on to the consumer?
Attachments: TEXT.htm

Categories: Public Input

Hi,

It's great to anticipate saving State and Federal money with CCO's. That's the big picture. But I've not heard about these CCO's reducing health care costs and how the reduction in costs will be passed down to the consumer. The crisis with health care and insurance is that it is simply unaffordable with an outrageous price tag for the individual and the family. So, please explain the steps that the consumer would actually see in the next couple of years as these new CCO's are implemented that will illustrate reducing health care costs and more money in the pocket.

Melissa Kittrell
Oregon Health Plan
Human Services Specialist 3
Phone: 1-800-699-9075 ext. 30370
Fax: 503-373-0493

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Ettinger Ari A

From: Gravett, Michael W <mgravett@iuhealth.org>
Sent: Thursday, January 12, 2012 1:16 PM
To: OHPB.info@state.or.us
Subject: Oregon Health Plan

Categories: Public Input

Oregon Health Plan Representatives,

Often, when speaking about the future of how medicine and health care should look, I reference Oregon and the additional states that license physicians who have graduated from accredited medical schools with an ND/N-MD degree. The future of medicine, with Accountable Care on the horizon, lies in prevention, shared care and shared responsibility for ownership of the patient's care. An important role of the physician truly will be in mastering the care continuum in a coordinated effort to reduce all 30 day hospital readmissions in the US, reduce advancement of chronic disease and therefore reduce resource waste and redundancy. This is of critical importance with incidence of chronic disease and conditions on the rise. To complicate matters, chronic disease comorbidities are higher than in recent history;

- Proportion of Medicare Beneficiaries with 2 or more (multiple) Chronic Conditions: (CDC 'Behavioral Risk Factor Surveillance System' <http://www.cdc.gov/brfss>)
 - COPD 39%
 - Depression 26.1%
 - Diabetes 23.5%
 - Heart Failure 36.3%

Oregon has an opportunity to take a stance in the correction of a fragmented healthcare delivery system by drafting a plan that begins to truly coordinate medical care by providing coverage for a group of physicians philosophically and medically trained in the concept of 'coordinated care'.

"Providers need to increase care coordination and be jointly accountable for quality and resource use...there is no (current) incentive for providers to coordinate care. Each provider may treat one aspect of a patient's care without regard to what other providers are doing. There is a focus on procedures and services rather than on the beneficiary's total needs. This becomes a particular problem for beneficiaries with several chronic conditions and for those transitioning between care providers, such as at hospital discharge. Poorly coordinated care may result in patient confusion, over-treatment, duplicative service use, higher spending and lower quality of care." MedPAC Report to the Congress: Reforming the Delivery System

To eliminate insurance coverage for the ND/N-MD Licensed Physician in a legitimate practice of treating disease and improving health within a prescribed scope of primary care medicine is a statement that Oregon does not support a system of coordinated care and further promotes a fractured health care model where patients seeking whole health primary care must continue to live in a siloed medical world.

Dr. Michael W. Gravett, ND (NPI - 1710120050)
Statewide Cardiovascular Outreach Programs
Indiana University Health - Methodist
317.260.8245 (bb) - 317.962-1188 (o) - 317.312.8888 (pager)
mgravett@iuhealth.org
Discover the strength at www.iuhealth.org

Ettinger Ari A

From: Alma Smith <asmith@sopedcs.com>
Sent: Thursday, January 12, 2012 3:19 PM
To: ohpb.info@state.or.us
Subject: CCO Implementation

Categories: Public Input

As the board is addressing the pros and cons of the CCO's please take into consideration the ongoing problem of non compliant patients. As you know the OHA-OHPS has made the PCPs sole responsible for managing patient care and when non compliant patients are seen at another clinic without referrals the new clinic won't be paid and are required to write off their bill if no waiver is signed. The non compliant families need to be responsible for themselves and should be responsible for the treatment they received outside their PCP's office. Many of these patients seek treatment elsewhere and never inform the new providers of their eligibility until after they receive a bill. Once again the provider is out and the patient continues to do as they please. There must be a way that the non compliant patient be responsible for their choices and the providers either be reimbursed or bill the patient. Most physicians offices do not and should not have to look up every patient that comes thru their door. They're sole responsibility is to treat the patient or at least that is what they took their Oath.

Ask yourself WHY is medical care so expensive?? Well quite possibly because the State requires the providers to hire extra employees to do work that the non compliant patient won't take responsibility for.

Ettinger Ari A

From: Ron Sipress <ronsipress@gmail.com>
Sent: Friday, January 13, 2012 11:25 AM
To: ohpb.info@state.or.us
Cc: bill B; Bob Nikkel; bobfur; rlieberman; jamie farish; wendy markey; Mark Fisher (mfisher@columbiacare.org); heather hartman
Subject: Improving Children's Mental Health
Categories: Public Input

Good morning to, E Parsons,L Shirley,M Bonetto, E Brady, C Crespo, F Haggis.C Hofmann,J robertson, N Werner,
The initial formulation plans of the CCO's in Oregon pay little attention to families with children who have mental & emotional challenges.
Please help these family members become part of the decision making process.
I would be appreciated if you would keep me apprised of any progress in this direction.
Thanks you for your consideration.
Ron

--

Ron Sipress

Family Advocate

Supporting Children and Families
w/ mental and emotional challenges

Phone: 541-772-3636

ronsipress@gmail.com

Ettinger Ari A

From: Estelle Womack <ewrogue@gmail.com>
Sent: Friday, January 13, 2012 1:03 PM
To: OHPB.info@state.or.us
Subject: mental health drugs

Categories: Public Input

Public Input

I have deep concerns about not including the cost of mental health drugs (Page 31) in the overall cost in the budget. Mental health drugs are exceedingly expensive and their cost could blow a hole in the budget. This will led to mental health being limited, blamed and removed, or in some way penalized in the health care process.

Better to deal with a know factor than put off that decision.

Estelle Womack

1586 Rogue River Hwy

Gold Hill 97525

541 855 2584

Ettinger Ari A

From: Michelle Underwood <cantooconcepts@gmail.com>
Sent: Sunday, January 15, 2012 11:32 PM
To: OHPB.info@state.or.us
Subject: CCO public input - please read

Categories: Public Input

According to the statistics presented in the CCO document states that % of patients have a chronic illness. Sometimes illnesses are chronic because providers miss the causes due to personal prejudice, lack of experience with the condition, or just making the wrong diagnosis. When dealing with those on OHP due to disability that includes individuals who may have personality or mental health problems that make dealing with them or diagnosing them extremely difficult. Doctors are people too. To eliminate personal perception and to help reduce wasted time and testing I highly recommend that, along with electronic health records management, CCO organizations should use a diagnostic support system like NxOpinion. It is available for free or low cost to doctors who need it. If you made a case for serving the poor and disabled using their software they may allow OHP affiliated clinics the free access.

<http://www.robertsonhealth.com/>

<http://www.microsoft.com/presspass/features/2004/jan04/01-21NxOpinion.msp>

My second recommendation is that the CCO organizations be required to follow the recommendations of the Oregon Pain Commission and that each CCO have at least one provider thoroughly trained in pain management and that all patients given opiate medications be required to attend a training to help them learn to use the medication correctly while the treatment team works to reduce the need for them. CCO organizations should be barred from denying clinic access due to chronic pain (at least 90% of clinics refuse to accept new patients who have chronic pain) or limiting opiate prescriptions to some arbitrary mg/day standard since individual tolerances and needs vary greatly. An amount that would kill me barely stops my husband's pain. Direct observation is the only way to know if an amount is adequate, inadequate, or excessive.

As the wife of a man with a chronic condition I have seen the useless waste of medical resources doing the same process over and over because the new provider doesn't trust the judgement of the last provider. I have seen a single provider make a bad judgment that has followed from provider to provider causing years of delay in getting treatment that have left my husband permanently damaged and disabled. Because one doctor hated dealing with people with state medical coverage, he accused my husband of being a drug seeker and refused to honestly look for the cause of his intolerable pain, severe epididymitis, while he performed no less than three unnecessary kidney scopes, during the last one deliberately splitting the tube between his bladder and kidney to cause as much pain as he could to discourage any further attempts at drug seeking. When I pulled him from the hospital, against orders, and took him to another provider he instantly recognized the symptoms, from personal experience, and prescribed the antibiotics, steroids, etc. to cure the problem.

But, that one doctor's influence continued for years preventing my husband's severely damaged rotator cuffs from being diagnosed and treated until it was too late to treat them. Now he is in constant pain from the degeneration of his shoulder joint and the only treatment is a replacement he is too young to receive. Being a very stoic person and very driven he works out every day to keep his range of motion and rehabilitate his injuries. Unfortunately this gives the impression to new providers that his arm is fine, functional and that there should be no reason for pain treatment. It takes months of tests, new x-rays, mri, etc. before they finally realize

that it is force of will that allows him to move but in the meantime he is in severe pain and suffering that affects his sleep, causes TIAs, and who knows what other health repercussions. He has lost intelligence, lost his education, and spent the years our children were growing up in bed trying not to scream and convincing himself that he should continue fighting, that someday he will find someone who can fix whatever was wrong during the 15 years it took to get that first MRI showing the damage to his shoulder while every doctor told him there was nothing wrong with it and he was just addicted to drugs or had fibromyalgia or he was depressed or other insane diagnosis while stuffing NSAIDS that damaged his digestive system, SSRIs, and any number of non-opiate "therapies" that did nothing but make things worse.

We have found only three providers who would and could (due to administrative limitations on mg per day) treat his pain to the level necessary for him to regain his mental agility and be able to be moderately active, losing 60 pounds, but every change in insurance brings us back to zero where alternative therapies that have failed in the past, drugs he can't tolerate, and relaxation/mental skills he has already mastered are held out as the answer and he's again left to suffer without pain management.

We have encountered two types of providers: those that are willing to look for the cause until they found it, and those that were willing to treat the pain. Only once did we find a provider that was willing to do both, and he gave up looking for the cause after 18 months and turned to the "drug seeking behavior red flag" thinking because we weren't satisfied with just having adequate pain control - we want the cause eliminated so that the drugs will not be necessary anymore. Proper pain management must include both pain treatment and source identification and elimination.

I hope that the intentions shown in this document come to pass and are not used to pigeon-hole, trap, and abuse the poor and disabled. I see that it requires patient advocates but it has been our experience that patient advocates have well meaning hearts and no power to do anything to help. The board of medical examiner will discipline doctors who under-prescribe but only if another doctor will say that you should have been treated with a stronger medication/dose and doctors in the same system are reluctant, to say the least, to challenge or reverse the opinion of another member provider. It is too easy for a provider to cry "red flag" and wash their hands of a patient without accountability. I understand the problems with people who abuse the system but there are far more people being abused by it because of these few.

Sincerely,

Michelle Underwood

Ettinger Ari A

From: Jefferson, Tom (MD) <TJefferson@peacehealth.org>
Sent: Monday, January 16, 2012 10:47 AM
To: 'OHPB.info@state.or.us'
Subject: Public comment on Revised CCO Implementation Proposal

Categories: Public Input

Good morning,

I am helping to coordinate Peacehealth's response to CCOs, particularly in Lane County, but as I work at PeaceHealth system level, also am responding to questions that come from our health systems in Washington (Longview and Vancouver) that are being asked to participate in some ways to Oregon CCOs. Here are my high level comments:

1. The proposals and legislation are quiet on whether more than 1 CCO/county can be allowed. My guess is that this is intentional, to allow flexibility. However, I am sure that you recognize that allowing more than 1 CCO/county would, in my opinion, significantly increase the complexity of managing more than one bundled revenue streams and networks, causing possible confusion amongst providers, and eliminating any efficiencies that are expected to be gained, especially in the integration of behavioral and physical health. While it may make sense in Portland area to have more than 1 CCO (and I'm not even sure about that), I'm not sure it makes sense in a mature and collaborative market such as Lane County. It would be nice to have clarification here as far as intent, or at minimum a requirement that the multiple CCOs collaborate with each other in some way.
2. I am concerned that utilization and savings gains are based on M&R "well managed", AND a waiver or agreement from Medicare to share these for dual eligibles. Lots of ifs here, to achieve what I read as an 8.5% savings. I am not sure that M&R well managed has been applied to a dual eligible population, and would like clarification if it has (in other words, is there an established benchmark for best practice in dual eligibles subset population, in M&R database, or is best practice based on pure Medicaid including dual eligibles, or?). I would then recommend that these utilization targets would be shared specifically with County (not statewide) experience to allow for tailoring of approach; or, that the state budget or require M&R analysis for each county cohort, for those counties where historic utilization data exists.
3. Fraud audits. It is not clear to me from the documents whether returns from fraud will fall to the state, or to the CCO. Please clarify. I would recommend that audit returns come to the CCO, net a state administrative fee
4. I agree with Dr. Brown's testimony, which I summarize as
 - a. Request a federal waiver that allows mental health information to be passed more easily to physical health, otherwise the integration savings would be compromised
 - b. Require aggregate data sharing from public health
 - c. Cautions that fast tracking incentives may compromise provider led organizations to organize in time
 - d. Requests flexibility that governance allow formation of private non-profit, public corporation, or joint venture or other contractual relationship
 - e. Whatever is done will maximize federal match

Thank you for the opportunity to respond,

Tom Jefferson, M.D.
System Director, Clinical Effectiveness
Change Process Leader, Clinical Improvement Model
System Payor/Healthplan Strategy
PeaceHealth
770 E. 11th Ave.
Eugene, OR 97401

541-686-3730 (office)
541-510-4686 (cell)
tjefferson@peacehealth.org

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Ettinger Ari A

From: Wendy Bourg <drwendybourg@gmail.com>
Sent: Monday, January 16, 2012 4:37 PM
To: OHPB.info@state.or.us
Cc: jdf@juliefrederick.com
Subject: HB 3650 public comment

Categories: Public Input

To Whom It May Concern:

Thank you very much for your work on this bill and the development of an integrated care model for Oregonians.

I am writing to request that you include psychologists and the delivery of behavioral health care as integral parts of your CCO model. Psychologists are uniquely positioned to reduce health care costs by effectively teaching behavioral health to clients and then evaluating their work to ensure that it was helpful. Consider the following facts (I can provide references to support these claims if you would like to see them):

1. Research consistently shows that the quality of health care outcomes is significantly improved and the cost is significantly reduced with behavioral health integration.
2. Psychologists have specialized training and unique expertise to address the factors which lead to improved outcomes and reduced costs. As Governor Kitzhaber has said, if “we ... look at those factors which have the greatest influence on a person’s lifetime health status. ...we will find that fully 40 percent involve individual behavior and lifestyle choices.” (Medicaid Managed Care Conference, Oct 4, 2011) Psychologists are experts at facilitating behavior change, improving patient engagement and treatment compliance, and addressing co-morbid mental health issues in complex patients.
3. Psychologists are trained to be research-practitioners. From this unique training we have expertise in the evaluation of program outcomes and patient satisfaction, and the development and practice of evidence-based interventions.

--

Wendy Bourg Ransford, Ph.D. | Portland, OR 97210 | 2701 NW Vaughn St.,
Suite 350; 503.320.6996 office | 503.972.9806 fax

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QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

TO: Oregon Health Policy Board
OHPB.Info@state.or.us
FROM: American Massage Therapy Association Oregon
RE: Health Transformation
DATE: January 17, 2012

The American Massage Therapy Association of Oregon is the not-for-profit professional association created by massage therapists for massage therapists. AMTA-OR's primary goal is to develop and advance the art, science and practice of massage therapy in a caring, professional and ethical manner to promote the health and welfare of humanity. We currently have 1,154 members throughout Oregon.

We have been participating in ongoing conversation with our fellow Complimentary and Alternative Medicine colleagues, as well as with policymakers, in an effort to effect the important legislation on which you are currently working. We applaud your efforts and understand that the amount of information you must receive, analyze and include is immense. Hence, we will be brief and ask that you call our legislative representative should you have any questions we might answer: Cindy Robert, 503-260-3431.

While your work is to make health care in Oregon more efficient and efficacious and to extend its reach to Oregonians wider, that does not require making its practitioner possibilities smaller. The cost of health care nationally would not be as high if we encouraged citizens to take advantage of the full range of health care, rather than the most invasive and expensive. We must provide options and educate people on various ways to meet their health care needs in a preventive manner.

In addition, a transformation health care policy should not only embrace a spectrum of care, but also a sufficient number of practitioners within each specialty to meet the needs of the people. Understanding the economics of price control, we would not suggest *every* provider be included, but do advise *enough* be available to meet the demands placed on each Coordinated Care Organization.

Transformation will be hard and we know it is in the best hands with all of you. We just ask that you include non-discrimination language in the bill regarding the use, availability, and reimbursement for those health professionals deemed important enough to our citizens to be licensed and entrusted to provide care to Oregonians.

We look forward to helping you educate our citizens on the importance of integrated health care based on preventive care involving a spectrum of providers.

Ettinger Ari A

From: Edward Yanke <docy@gwhcpc.com>
Sent: Tuesday, January 17, 2012 12:58 PM
To: OHPB.info@state.or.us
Subject: cco

Categories: Public Input

This is just another name for managed care and capitation which did not work the first time. I see no evidence (and emphasis is on practicing evidenced based medicine) that this will be any different! It does not matter if the name is different.



To: Oregon Health Policy Board
From: MACG Health Care Action Team
Date: 17 January 2012
Re: CCO Implementation Proposal and Governance of CCOs.

Thank you for the opportunity to comment on the second draft of the CCO Implementation Proposal.

MACG's request: Require CCO boards to have at least a third of the members be from the community at large, including representation from low income and disadvantaged populations.

MACG has been involved in efforts to reform health care in Oregon since 2003. One of our major goals is to make sure that the voices of low-income consumers of health care are heard in the debates about reform.

We note that HB 3650 provides that each member of a CCO "Must be encouraged to be an *active partner* in directing the member's health care and services and *not a passive recipient* of care." (Section 8(1), emphasis added.)

We think it appropriate that you extend the idea of being an active partner in health care, and not a passive recipient, to the governance of CCOs in Oregon. The community served by a CCO, including low-income and disadvantaged peoples, needs to be an active participant in governing the CCO. We believe that this is essential and the current proposal does not currently meet this need.

We realize that you are constrained by the terms of HB 3650.

Section 4(o) provides that a CCO "governance structure" must be composed of:
(A) A "majority interest" representing the entities that share the financial risks,
(B) The "major components" of the health care delivery system, and

(C) The "community at large". The point of having the community at large is, in the language of Sec. 4(o)(C), "to *ensure* that the organization's decision-making is consistent with the values of the members and the community."

So the representatives of the "community at large" will be a minority. We suggest that a minority on a governing board is not in a position to *ensure* anything, especially not that the actual decisions of the majority reflect anyone's values.

What the community representative(s) can do is push, poke, and prod the financial representatives and delivery system representatives to engage in transparent decision-making, to be accountable for achieving the triple aim, and to work to understand the health care needs of the people to be served, as those people see their needs.

We appreciate that there is "no single governance solution", but we believe that OHPB and OHA should set some reasonable minimums for a governing board. It appears to us that there is only one minimum set in the Implementation Proposal, and



it is that at least one member of the Community Advisory Council (CAC) shall serve on the governing board (2nd draft, p. 18).

If our collective experience with governing boards is any guide, having one member of the community on a governing board will not accomplish much. The human dynamics of being alone on issues makes it difficult to sustain a pushing, poking and prodding stance while maintaining good working relationships with other board members. It is essential to have at least a third of the Board from the consumer voice representation to insure the community interest.

Our request is simple: require that CCO governing boards have a least **a third of the** members from the "community at large". Asking prospective CCOs to "articulate... How consumers will be represented..." (2nd draft, p. 18) is not sufficient.

Further, we request that OHPB provide some criteria for appointing members from the low-income and disadvantaged people who will, at least during the initial iteration, be served by the CCOs. Depending on who is appointed, the "community at large" does not always look after the folks who now rely on OHP.

Again, thank you for the opportunity to comment, and for your hard work on the Implementation Proposal.

Respectfully submitted,

MACG Health Care Action Team

Stan Ashenbrenner, *Lake Oswego United Methodist Church*

Catherine Bax, *St Andrew Catholic Church*

Bob Brown, *Havurah Shalom*

Delphine Busch, *Sisters of the Holy Name Associate*

Eric Carlson, *Lake Oswego United Methodist Church*

JulieAnn Edman, *Bethel Lutheran Church*

Jean Eilers, *SEIU Local 49*

Martin Heissler, *Kol Shalom*

Myra Himmelfarb, *Kol Shalom*

Alice McCarthy, *St Charles Catholic Church*

Sr Lucinda Peightal, *Sisters of the Holy Names*

Joe Stroud, *Parkrose United Methodist Church*

Jim Whittenburg, *Metanoia Peace Community*

Ettinger Ari A

From: Aisha Kudura <kuduraa@gmail.com>
Sent: Wednesday, January 18, 2012 11:25 AM
To: OHPB.info@state.or.us
Cc: Aisha Kudura
Subject: comments on CCO implementation proposal

Categories: Public Input

To whom it may concern,

I am writing in regards to the new CCO implementation proposal (<http://www.health.oregon.gov/OHA/OHPB/meetings/2012/2012-0110-cco.pdf>). Firstly, I wanted to thank the Oregon Health Policy Board and the Oregon Health Authority for providing the opportunity for public comment on this proposal. I feel it is very important for the community to be engaged in the review process and appreciate this opportunity. I was very impressed with this proposal overall and hope that my comments will be helpful. I approached my review from the perspective of a public health professional with a Masters degree in Public Health (emphasis in Community Health Education) and as a Certified Health Education Specialist (CHES). Below are my comments:

- 1) I would like to hear more about how patients will be motivated to make changes in their own health and engage in preventative healthcare services. For example, what model or theory will be used to promote and gauge behavior change?
- 2) I agree that rewarding CCOs with "better health" outcomes rather than volume of patients is a more beneficial plan. However I am still a little unclear how this will be measured (perhaps this is still being determined). For example, will a clinic with 100 obese patients be held to the same standard of improvement as a clinic with 5 obese patients? How will severe health disparities be accounted for in terms of expected improvement?
- 3) Perhaps more clarification on how prospective CCOs will be motivated to participate or apply to be a part of this new organization. What is the incentive or benefit to CCOs participating in this new structure?
- 4) The proposal mentions the use of community health workers--a practice that has been met with great success in other communities. How will community health workers be trained? For example, will training be provided through CCOs individually (training more specific to each community/region)? Or will training be provided more generally through the OHA and its partners?
- 5) Seeking input from underserved populations, as you mentioned, is an important step. How do you plan to seek input from these communities (e.g. through surveys, focus groups, Delphi panel, written input versus oral, etc.)? Who will conduct the outreach?
- 6) Regarding the use of electronic health information in terms of communication/outreach with patients: Many underserved populations lack consistent access to the internet. Will alternative methods of communication be provided to these patients? Will the health literacy of patients be taken into account somehow?

Overall, I appreciate all of the work that the OHA and other entities have done to address the health care crisis in the state of Oregon. I believe your plan has the potential to be very successful and help many Oregon residents. Thank you for all of your hard work and dedication.

Please do not hesitate to contact me if you have any further questions.

Sincerely,

Aisha Kudura, MPH, CHES

kuduraa@gmail.com

541-513-1451



Oregon

John A. Kitzhaber, Governor

Medicaid Advisory Committee

1225 Ferry Street SE, Ste. C

Salem, OR 97301

(503) 373-1779

FAX (503) 378-5511

January 16, 2012

Eric Parsons
Chair, Oregon Health Policy Board
Oregon Health Authority

Dear Mr. Parsons,

Thank you for the opportunity to provide feedback on the Oregon Health Authority's (OHA) current Coordinated Care Organization (CCO) Implementation Proposal. The Medicaid Advisory Committee (MAC) has reviewed the current proposal, as well as documents leading to its development, and has spent a great deal of time focused largely on the CCO criteria. The MAC's recommendations are specific to each of the criteria found in Section 5 and Appendix D of the proposal and are organized in this letter accordingly.

Governance Structure

The following language should be added to the initial baseline expectations:

- Given that the CCO must articulate how the governing board makeup reflects the community needs, the CCO must also clearly articulate how they define their community at large.
- The CCO must include at least one Medicaid consumer on its governing board.

The MAC would like to highlight that while the CCO model is initially being implemented within the Medicaid delivery system, it may expand to include other consumers of health care eventually.

Therefore, it is important to specifically identify inclusion of Medicaid recipients, as opposed to the broader terminology of "consumer" on all governing and advisory boards.

Community Advisory Council

The following language should be amended within the initial baseline expectations:

- A member of the Community Advisory Council, **who is also a Medicaid beneficiary**, sits on the governing board.

Further, the MAC recommends that the OHA take the following into consideration when reviewing and scoring CCO proposals:

- The following points are necessary for consumers to actively and meaningfully participate on a Community Advisory Council:
 - Recruitment, training and support of consumer-advocate should be ongoing activities, conducted by staff hired and/or trained specifically for these purposes.
 - Support includes consumer-advocate pre-meetings to discuss agenda, identify and practice speaking points; provide acronym lists and other decoding support.
 - Train professional committee members on valuing and facilitating consumer-advocate participation; assure the pace of the meeting supports consumer-advocate participation; take breaks.

- After hearing what the needs of the consumer participants are, compensate consumer-advocates for attendance and expenses.
- Assure that the consumer-advocate has an observable effect; identify that effect and regularly celebrate consumer-advocate participation.
- Ensure that there is a representative sample of the consumer population.
- Have applicants describe their plan for effective inclusion.
- Consider including substantial consumer involvement in all committees and workgroups as opposed to segregating the consumer input.
- Include clear expectations and opportunities for education and in-service prior to serving.

Dental Care Organizations

The following language should be added to the transformational expectations:

- CCOs must emphasize delivery of preventive dental services and describe the process that will be used to ensure that each member has a “dental home¹.”

Holistic Care through Primary Care Homes

The following language should be amended within the initial baseline expectations:

- CCO develops a process to conduct health screenings, **including behavioral health**, for members to assess individual care needs.

The following language should be added to the initial baseline expectations:

- CCO describes how it will identify and address special health care needs.

Transitional Care

The following language should be added to the initial baseline expectations:

- CCO develops a plan to address transitional care for members facing admission or discharge from Oregon State Hospital, acute psychiatric hospital, psychiatric residential treatment services (children and youth) and other intensive psychiatric services.

Thank you for the opportunity to collaborate on this monumental reform of health care delivery for Medicaid beneficiaries. We look forward to working with you in the future to ensure that all vulnerable populations have access to meaningful health coverage.

Sincerely,



Carole Romm, RN, MPA
Co-Chair
Medicaid Advisory Committee



Jim Russell, MSW
Co-Chair
Medicaid Advisory Committee

¹ The MAC recognizes that additional work needs to be conducted to identify how “dental homes” would be defined and identified. However, many of the goals for what a dental home would achieve are similar to the goals of patient-centered primary care homes, with a greater emphasis on oral health.

Re: Public Comment on CCO Proposal (HB 3650)

Dear Oregon Health Policy Board Members:

We, the undersigned, respectfully submit for the Oregon Health Policy Board's consideration the following observations and recommendations for the Coordinated Care Organization (CCO) proposal:

1. The plan addresses key elements of Oregon's Healthcare reform. The Council understands that out of this draft there will be a detailed implementation plan. We recommend that outcome measurements and quality indicators clearly drive reform. The measurements and indicators should guide service quality, workforce development, and the availability of consumer-identified, evidence-based practices.
2. We recommend health care savings and accountability to communities include a substantial role for local decision-making. Conversely, we need strong state leadership as health care transformation efforts extend to all. A balance should provide Oregonians with a clear and steady direction.
3. The draft plan uses the terms "encourage" or "recommend" when describing activities for the CCOs and general guidance for their functions. Consumers of mental health and addiction services prefer that State leadership use language that clarifies intent and assures specific action. It is important for leadership to be definitive when outlining issues regarding health disparities, governance, and other factors related to the establishment of a new health care program.
4. We recommend incentives be considered after CCOs develop appropriate outcome measures and methods for assessing quality. The processes should include substantial input from Oregon Health Plan (OHP) members and AMH advisory councils. The process is a public process with participation from recipients and providers of care. We recommend outcome measures and quality of care indicators be reported to payers, consumers, and other stakeholders.
5. We recommend the implementation plan describe strategies for the health care system to coordinate with social service entities. Linkages among housing, employment, childcare, general social

services, and health care are crucial for community wellness, prevention, and recovery.

6. Mental health and addiction services consumers want to be included in all aspects of health care reform, especially through the Oregon Consumer Advisory Council (OCAC). Statewide mental health and addiction services advocates and peer leaders want OHA to ensure peers are involved in the development of state-level policy, including the hiring of peers within state government.
7. We recommend the CCO implementation plan list major consumer behavioral health groups to increase the chance the groups' members be represented. Mental health and addiction services consumers are the vanguard of public sector health care consumer organizing. We further recommend consumer groups representing physical disabilities be listed.
8. Finally, we recommend the "Global Budget" is carefully monitored and a detailed plan for monitoring be described in the implementation plan. A distinction between covered and uncovered services and those that are funded needs to be made. In the first paragraph under Populations included in the Global Budget Calculations, percentages are used instead of total numbers. It is unclear why. Also, in the second paragraph under Service/Program Inclusion and Alignment, the third line states, "See Appendix C for a list of the services funded." Rather than using the term "funded", "covered" or "included" may be more accurate. We need a comprehensive list of covered services, and appendices need to correlate to the specific information referred to.

Thank you for your time and consideration of these critical and necessary components of which, we believe, a successful CCO model implementation will consist.

Respectfully yours,

Recovery Advocates United

Ettinger Ari A

From: STAMM Rand <Rand.Stamm@ltd.org>
Sent: Wednesday, January 18, 2012 2:48 PM
To: 'OHPB.info@state.or.us'
Subject: Comment With reference to the CCO Proposal

Categories: Public Input

While we applaud the recognition that transportation is an important part of access to appropriate and cost-effective medical care and needs to be planned for included in the budget, we feel that there is a lack of understanding about the extremely effective system currently in place to address this small but vital part of getting health care as a Medicaid enrollee in Oregon.

In 1994, under Governor Kitzhaber, DMAP, ODOT and local governments worked together to create a regional transportation brokerage model that operates and coordinates this and other types of human services transportation throughout Oregon. Working through local transit districts and other local government services DMAP has been able to achieve efficiency and an accountability structure for transportation. Under this model the current Transportation Brokerage system ensures clients use the most cost-effective appropriate transportation that meets their needs. Participants are screened to ensure eligibility, to determine the appropriate mode of transportation, and assign rides to the most cost-effective provider (be it a bus pass, a taxi trip, or a specialized vehicle). This has resulted in continually lower costs while meeting actual client needs. Transportation Brokerages have, over time, become more efficient as they have gained expertise, invested in infrastructure and personnel, worked in partnership with DMAP to streamline procedures, and worked with their provider networks to negotiate lower costs. Agreements with local providers ensure adequate training and safety of equipment used to transport people as well as other important policies and practices.

As brokerages continue to improve their efficiency, they can potentially further reduce costs. Brokerages continue to train staff, develop more advanced software, build stronger provider and community relationships, coordinate more human services transportation programs, and work in conjunction with DMAP to implement smarter, leaner policies. I encourage you to support and include reliance on the transportation brokerage network as part of planning for improved access to health care and medical services. There is no reason to reinvent the wheel or to inadvertently disassemble an effective model.

Rand Stamm
Human Services Transportation Specialist
Lane Transit District
Phone: (541) 682-3246
Cell: (541) 501-1149
FAX: (541)682-6111
Email: rand.stamm@ltd.org

LTD has a new mailing address! Please use: LTD, PO Box 7070, Springfield, OR 97475-0470



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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) appreciates the progress from the first draft to the second draft of the Implementation Proposal. A number of our concerns were addressed and we feel that there is a great deal more clarity in the current version. We would like to add the following recommendations:

Recommendations

Criteria/Governance

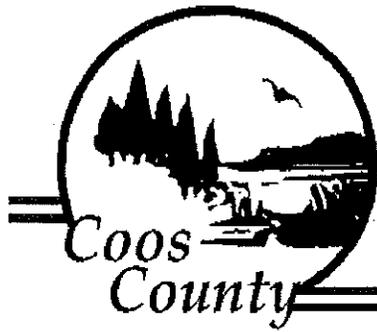
1. Add a sixth bullet to the **Coordinated Care Organization (CCO) Criteria** section under *Governance and organizational relationship* to read: **Counties shall have a meaningful role in governance of the CCO.** Counties are taking a financial risk and deliver services for CCOs. Additionally, the Medicaid funds the CCO uses are public dollars and having elected officials participating in the governance not only allows counties to have a governing role but will aide in public perception of the use of CCO funds.
2. OHPB and OHA should support an amendment to the CCO bill that includes language allowing counties 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.

Outcomes/Metrics

1. At the last OHPB meeting it was mentioned that CCO metrics will be established by a Technical Advisory Group. AOC recommends that representatives from the counties be appointed to the Technical Advisory Group. There are individuals employed by counties that have experience in both mental health and public health delivery systems. They can bring this unique expertise to the Advisory Group and provide insight into population health and behavioral health for the community.
2. 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@aacweb.org or 503-585-8351.



CAM PARRY, COMMISSIONER

250 No. Baxter Street, Coquille, Oregon 97423

(541) 396-3121 Ext. 281

FAX (541) 396-4861 / TDD (800) 735-2900

E-Mail: cparry@co.coos.or.us

Dear Oregon Health Authority Board Members,

Thank you for the opportunity to provide feedback on the January 10, 2012 draft CCO Implementation Proposal.

Background:

In Coos County there are currently two distinct County planning efforts working to address HB 3650 requirements. One is a local planning group led by Doctors of Oregon Coast South and has been meeting on a monthly basis since September. The second committee is the Board of Jefferson Behavioral Health (comprised of five county Commissioners) that has been exploring regional concerns regarding the integration of both physical health and mental health. These efforts are in their beginning stages and the overall end result is not apparent.

Coordinated Care Organization Certification Process:

Counties should have an active voice in the certification process. County government is responsible for the safety net of the community and therefore should be actively involved in determining the adequacy of the CCO's proposal to provide services that will meet the needs of the community, including how the safety net will remain intact.

Under "Alternative Dispute Resolution" there should be a method to address the issue of overlapping CCO's in a given geographic area. For example, if a County Mental Health department is in an area in which more than one CCO is attempting to establish services, is it "reasonable" for that mental health authority to accept the best offer? If so, what then happens to the competing CCO's if they are unable to acquire the mental health component necessary for their proposal? Will the local mental health authority be held liable for "unreasonably" refusing to partner with other competing CCO's? The term "unreasonably refuses" should be clearly defined so that the local mental health authority has the freedom to consider and accept the best partnership for the county without being held responsible for any potential litigation for refusal to sign partnerships with every CCO request.

Coordinated Care Organization Criteria:

Counties need to be included as key members of the governing body, not just advisory members. If a county does not share the financial risk as a major stake holder and acts in an advisory capacity only (Section 4(1)(i)), the County will be unable to ensure delivery of essential public and mental health services and functions. Additionally, if CCO's fail to provide essential mental and public health services the County will ultimately be responsible for the increase in jail admissions, homelessness, civil commitments and adverse health outcomes.

The Governance Board must have a structure in place that assures equitable representation and equitable authority for all board members. Because physicians and hospitals are the majority stake holders (in terms of financial risk), this can potentially exclude other "minor" players like county government. It is important to note that county government ultimately holds the highest level of risk if this program is not successfully implemented.

The definition of "consumer" should follow the federal definition for federally qualified health centers or Critical Access Hospital boards. A 'consumer' is a person actively receiving services.

Community Advisory Council:

The "authority" of the Advisory Board should be clarified. The risk of the advisory boards without clearly defined authority can have the unintended consequence of marginalizing minority stakeholders. This occurs in part due to a lack of real power within the organization and a lack of payment or other financial incentives to maintain an active presence (and clearly impacts the organization).

Partnerships:

Partnerships with the local mental health authority must be clearly articulated in a CCO application. It is imperative that the mental health safety net and community mental health needs are met. Additionally, when developing a Community Needs Assessment, the local mental health authority should be included in the partnerships with the local public health authority and the local hospitals in assessing community health disparities.

HB 3650 requires CCO's to have agreements with the local mental health authority "unless it can be shown why such arrangements would not be feasible". A similar process should be included for counties if a county does not elect to participate in a partnership with a particular CCO.

Global Budget Methodology Service/Program:

Coos County supports the input from AOCMHP January 3, 2012 letter describing recommendations for the CCO Implementation Proposal, pages 4 & 5:

" 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.

4. 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."

Accountability:

There should be performance measures that address how the County safety net system has been included in the CCO targeted outcomes, ie, reductions to jail recidivism, increase in use of prenatal care, reduction of homeless mentally ill, use of early interventions with newly diagnosed mentally ill youth, etc.

Financial Reporting Requirements to Ensure Against Risk of Insolvency:

Page 39, #8, "The proposal must include, but need not be limited to recommendations on" Under 'c' states, "The filing by a CCO of a statement of whether the organization or another entity, such as a state or local government agency or a reinsurer will guarantee the organization's ultimate financial risk" If county government has been excluded from being an "at risk" partner, why would OHA consider having local government guarantee a CCO's ultimate financial risk? If the CCO should then fail, what financial responsibility would local government be required to assume?

QHA Monitoring and Oversight:

Monitoring of CCO's should include, at a minimum, feedback from local government regarding outcomes related to the public safety system as well as public perception regarding the services provided by the CCO.

We would like to thank you for the opportunity you have provided for us to give feedback on draft CCO Implementation Proposal. We appreciate your willingness to hear our thoughts and concerns. We are also attaching our letter to Representative Thompson and members of the House Health Care Committee for your review.

Sincerely,



Cam Parry
Coos County Commissioner

Date: January 18, 2012

To: Oregon Health Policy Board Members
Bruce Goldberg, Director, Oregon Health Authority

From: Janet Bauer, Policy Analyst

Re: Assuring member benefits and other rights: comments on *Coordinated Care Organization Implementation Proposal* draft document

Thank you for the opportunity to comment on the draft document *Coordinated Care Organization Implementation Proposal* (1/10/12). It is our hope to see a successful transformation of Oregon's health care delivery system. Accordingly, we offer these comments with the aim of strengthening the implementation of HB 3650.

The recommendations we make here are limited to the proposed plan for protecting member rights to covered services and assuring that their grievances are adequately addressed. These comments do not represent a comprehensive review of the document.

While the draft proposal includes discussion of patient rights and accountability in assuring CCO success, those sections are not sufficiently developed to protect members' rights to covered services, guard against underutilization and assure that members have their concerns addressed through an established grievance process. These shortcomings put at risk key goals of health system transformation — building member trust, improving health and effectively addressing persistent health disparities.

Even as better care coordination stands to benefit members, the circumstances in which implementation will occur in Oregon will put members in a particularly vulnerable position. CCOs and their providers may not fully understand the package of benefits or rights of various OHP members. CCOs will operate under considerable fiscal constraints, creating a temptation to err toward denying care. The performance of the current OHP contractors (managed care organizations) in assuring members' rights to services has not been without deficiencies. And historically, the state's effort to monitor contractor responsibilities with respect to member rights has not always been adequate.

The implementation proposal should include well-developed consumer protections that anticipate CCO challenges and strive to prevent past contractor deficiencies. Such an approach would set the new system up for success in assuring member benefits and protecting other rights.

We recommend the following elements be included in the final proposal.

1. The implementation plan should reference all relevant legislation

Although each section of the draft proposal lists relevant legislative language, the document omits some provisions that pertain to member rights.

The following section of HB 3650 should be included in the proposal's Section 5, Coordinated Care Organization (CCO) Criteria; subsection, Patient Rights and Responsibilities:

Section 8(9): The authority shall: Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

The following section of HB 3650 should be included in Section 7, Accountability; subsection, OHA's Accountability in Supporting the Success of CCOs:

Section 8(3): Members and their providers and coordinated care organizations have the right to appeal decisions about care and services through the authority in an expedited manner and in accordance with the contested case procedures in ORS chapter 183.

2. The proposal should make explicit CCO consumer protection obligations

Current OHP contractors are required to carry out certain activities in assuring members' benefits and their positive experience of care. The implementation plan should explicitly state that *CCOs will comply with all consumer protection functions applicable to OHP contractors in state and federal law.*

In addition, we recommend striking language in Section 5, Coordinated Care Organization (CCO) Criteria; subsection, Patient Rights and Responsibilities, Engagement and Choice (page 20) as follows:

Member choices should be reflected in the development of treatment plans and member dignity will be respected. ~~Under this definition, enabling members will [to] be better positioned to fulfill their responsibilities as partners in the primary care team-at the same time that they are protected against underutilization of services and inappropriate denials of service.~~

The deleted language is illogical, casts speculation as fact and is inappropriate for an implementation proposal.

3. The proposal should spell out provisions that promote accurate service determinations and better notification of those decisions.

As demonstrated in the case of Oregon MCOs, OHP contractors sometimes fail to accurately determine whether services are covered and to appropriately notify members of such decisions. OHP contractors are required to cover the services contained in Oregon's Prioritized List of Health Services according to the benefit package associated with an enrollees' eligibility category. Currently, MCOs make service determinations and inform enrollees through a Notice of Action (NOA) letter. An independent review, however, has shown that service authorization processes by OHP contractors need improvement and that NOAs lack clarity and critical information.¹ Further, members are sometimes charged by providers for services wrongly believed not to be covered by OHP.

¹ Acumentra Health, "External Quality Review Annual Report, 2010-2011, Oregon Health Plan Managed Care Plans," September 2011.

The proposal should state that *OHA will monitor that CCOs are providing adequate NOAs in all cases where needed services are denied. OHA will also monitor that NOAs are complete, accurate and understandable to the member and that enrollees are not inappropriately charged for services by a provider.*

Please see Appendix A for a list of recommendations for improving service determinations.

4. The proposal should direct OHA to strengthen the grievance process

Currently, individuals with concerns that do not involve denials of service may lodge a complaint or “grievance” with their MCO. We recommend the proposal include the following statements to assure that members’ concerns are addressed.

- a) *OHA will adopt its own formal grievance rule so that members are able to file a grievance with OHA with adequate due process. This would allow members to file a grievance with OHA as an alternative to filing a grievance with the CCO, or file with OHA if they are not satisfied with the CCO’s response to a grievance.*
- b) *OHA will ensure that it has a grievance process available for all clients regarding all services provided. Doing this would address difficulties current OHP enrollees experience in having no recourse for some types of problems. For instance, there are no grievance rules for fee-for-service enrollees and none for clients having difficulties with medical transportation.*

5. The proposal should increase accountability measures

Effective OHA oversight of CCO consumer protection responsibilities is essential to ensuring that the new system does not perpetuate the deficiencies of the old one. While lax state oversight in the past left members subject to inaccurate denials without adequate recourse, recent efforts by OHA to better monitor contractors with respect to these matters bodes well for a strengthened system employing CCOs.

The following OHA oversight activities should be included in the implementation proposal to ensure members are protected.

- a) *OHA will collect data on CCO approvals, denials, appeals and grievances including number, service type and beneficiary characteristics (including race, primary language, gender and disability).*
- b) *Evaluation of a CCO’s service eligibility determination, appeals and grievance systems will be a part of regular CCO reviews.*
- c) *OHA will establish progressive sanctions for CCOs whose service determinations, appeals and grievances fall below minimum standards.*
- d) *Data and performance assessments with respect to CCO service determinations, appeals and grievances, as well as any progressive sanctions imposed, will be publicly available and posted on the agency website.*
- e) *OHA will make easily available to enrollees compliments, complaints and other performance-rating information about providers and clinics.*

6. The proposal's CCO criteria and outcome measures should include standards for CCO consumer protection responsibilities

To allow for accountability, the proposal should state that *OHA will establish minimum standards regarding CCO service determination, appeal and grievance procedures, and incorporate those standards into its criteria for selecting CCOs and monitoring their outcomes.*

Some MCOs have exhibited poor performance with respect to assuring member rights. Past MCO performance should be considered in the state's contracting with CCOs. To protect vulnerable CCO members, the proposal should state that *MCOs with a poor track record will be required to adequately demonstrate how they will address prior deficiencies before being awarded a CCO contract.*

7. The proposal should state that OHA will monitor member access to providers

Access to providers can be a problem for OHP enrollees. Therefore, the proposal should say that *OHA will monitor clients' experience in accessing providers.*

Please see Appendix B for recommendations for how OHA can better assure that members have access to providers.

8. The proposal should promote improved communication with members

Currently, OHP and its contractors are required to provide enrollees certain written information about how OHP works; the benefits they are entitled to; the appropriate ways to get various services; their rights to grievances, appeals and hearings procedures and other matters. While printed information conforms to legal requirements, it is not always an effective way to communicate with enrollees. Not all enrollees are able or likely to read printed material. Some may not understand the materials. Some have language barriers. Others are overwhelmed by the amount of written information provided. Therefore, additional steps should be taken by OHA and its contractors to improve member education to ensure that members are indeed aware of the grievance, appeals and hearings processes available to them and how to use them.

To improve communication with members, the proposal should include the statement that *OHA and its contractors will investigate how members learn and how information can be presented in a way that would make members receptive, likely to understand and act in the best interest of their health.*

9. The proposal should seek to ensure fairness in administrative hearings

OHP members can be at a disadvantage in terms of resources and knowledge when they exercise their right to a state administrative hearing. This can result in services being unfairly denied.

The proposal should state that *OHA will take steps to ensure that administrative hearings are fair to members.*

Please see Appendix C for recommendations for ensuring fair hearings.

Appendix A

Recommendations to improve the accuracy of service determinations and the quality of the NOAs

- a) CCO staff making benefit determinations must have the appropriate expertise to do the job. This requirement would prevent situations where staff make inaccurate determinations because they are unaware of the kind of information that has bearing on a case.
- b) CCOs should not deny service requests based on insufficient information from providers. If there is insufficient information to make a determination, the CCO (not the enrollee) should be responsible for gathering the information from the provider.
- c) Only designated CCO staff (not direct-service providers) should be permitted to make service determinations. Providers now may informally and inaccurately tell clients a needed service is not covered for them by OHP. Typically in these circumstances, the client is not sent a NOA, making it impossible for the client to initiate an appeal of the denial. OHA should collect data on the frequency of these occurrences.
- d) OHA should require and monitor that NOAs sent by CCOs are comprehensible to members, free of jargon and clearly identify the criteria used in making the denial.
- e) OHA should require CCOs to establish a process their providers must follow in billing clients for services that are not covered. In particular, the process must ensure that complete written waivers are in place before a provider provides a non-covered service at a cost to the member. OHA should consider requiring CCOs to certify that there is a waiver that meets standards before the provider may bill a member. This would address current circumstances where enforcement is insufficient and providers bill members without a waiver. Further, OHP should monitor that CCOs are enforcing standards for waivers. The waivers should fully disclose the service, the reason why the service is not covered and the charges. Charges should be set close to Medicare or Medicaid reimbursement rates rather than higher “usual and customary charges.”

Appendix B

Recommendations to ensure access to providers

- a) OHA should require CCOs to establish a means of monitoring whether their providers are treating OHP members the same as the other individuals served by the provider (a contract requirement). In particular, OHA should recommend strategies to gather information that would measure wait times for appointments.
- b) OHA should require CCOs to monitor whether providers refuse to serve some members and require CCOs to report to OHA providers found doing so. Doing this would help address existing problems in which providers refuse to serve some members that exhibit behavioral problems or are perceived to be inappropriately seeking addictive drugs. Service denials tend to occur among providers who are not accustomed or prepared to serve individuals with mental health, behavioral and addiction conditions. OHA should require CCOs to establish and carry out a plan to ensure the capacity of their providers to serve people with these conditions, or establish an alternate way for clients with special needs to get appropriate care. The goal should be to assist individuals in getting help for behavioral health conditions rather than blocking access to providers.
- c) OHA should extend the privileges given to individuals eligible for both Medicare and Medicaid by the legislature to those eligible for Medicaid only. HB 3650 allows “dual eligibles” to “ disenroll from a coordinated care organization that fails to promptly provide adequate service and: (a) to enroll in another coordinated care organization of their choice; or, (b) if another organization is not available, to receive Medicare- covered services on a fee-for-service basis.” The concerns of Medicaid-eligible individuals with respect to the health care delivery system are no less important than those eligible for Medicare. Therefore, all CCO members should be granted the same option to seek services elsewhere if necessary.

Appendix C

Recommendations to ensure members receive fair administrative hearings

- a) Standards for “good cause” for late hearing requests should conform to the Model Rules for Contested Cases standard for good cause. This would address current circumstances in which legitimate factors prevent members from submitting timely hearing requests and yet they are unable to get a hearing. More generally, OHA should strengthen the process for both eligibility and service denial issues by developing rules for them. Since it separated from DHS, OHA has not established its own rules for these functions, leaving members unclear about what they need to do to defend themselves.
- b) CCOs should be required to offer appropriate providers to testify at hearings on behalf of enrollees. Currently, hearings can be unfair to enrollees because MCOs typically have physician expert witnesses to represent their positions while members are unable to hire such witnesses, leaving members to make their case themselves without a comparable authoritative voice.

January 18, 2012

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

The Oregon Disabilities Commission (ODC) is a Governor appointed commission housed in the Department of Human Services. In order to carry out its mission, the commission:

- Identifies and hears the concerns of individuals with disabilities and uses the information to prioritize public policy issues which should be addressed; and
- Educates and advises the Department of Human Services, the Governor, the Legislative Assembly and appropriate state agency administrators on how public policy can be improved to meet the needs of individuals with disabilities.

We understand that healthcare transformation at both federal and state levels poses opportunities and challenges, as well as some potential unintended consequences. We urge a consistent, well-defined mandated partnership between the Oregon Health Authority (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 CCOs.

There is uniqueness in the scope of services provided individuals with disabilities that impact their health. There are exceptional challenges that must be faced by CCOs in many areas of development, implementation and monitoring of this new integrated approach to holistic health care for individuals 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 individuals with disabilities maintain the highest level of independence possible, to ensuring the use of innovative providers offering care in unconventional settings, etc.

The intersection between medical care and social supports, as often provided individuals with disabilities, is both vital to the success of the Triple Aim and difficult to master. There are vast differences in the modality of service delivery, control over the processes, determination of a “successful outcome” and even in the language used. For example, the disability community uses the word “access” to mean barrier-free usability by individuals with disabilities, In the health care context, it often refers to an individual'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. Individuals 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 large print, Braille or audio recording.

It is an overriding expectation that in rural areas no matter where the CCO is located, the CCO will have a robust grievance and complaint committee with local consumer input. It will include protection against retaliation. It is understood that the needs of the community are the needs of the consumers in the area. While appreciating the need to have local flexibility in the design and organization of a CCO, we urge the state to require that all CCOs are community-based non-profit organizations. Finally, we urge that language in the development and implementation of CCOs steer away from the terms “consumer” and “client” when referring to individuals served by CCOs. We suggest using a neutral term, “enrollee” as it is descriptive of these individuals.

Our recommendations:

1. Enrollees with disabilities play a major role in development and ongoing oversight of the new CCO in the following ways:
 - A. Community Advisory Council (CAC) member with a disability will be a mandated member of the CCO governing board
 - B. Enrollees must have an opt out option when

- C. Individual enrollees should be able to choose their Patient Centered Primary Care Home
2. The following items should be included in the final CCO Implementation Proposal, not left to the discretion of the developing CCOs:
 - A. A grievance/complaint system
 - B. A requirement that each CCO have an ombudsman that interacts with the state ombudsman
 - C. Non traditional healthcare workers need well defined job descriptions, training and staff development protocols
3. The Oregon Disability Commission should be included in discussions at both the local CCO level and the state level.

A discussion of each of ODC's recommendations, see below:

4. A robust Grievance/Complaint System:
 - Enrollees 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 Ombudsperson 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.
 - There should be measures in place to protect against any retaliation by a CCO against an enrollee who files a complaint or grievance.
5. Community Advisory Councils (CACs):
 - A majority of each CAC will be "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.
- 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 mandatory seat on each Community Advisory Council for an enrollee experiencing a disability.
 - 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 and held by the person on the CAC with a disability.
 - CAC Members must be knowledgeable about the broad population they are representing, engaged/active in health care 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 individuals with disabilities, this should be a defined linkage with the Oregon Disabilities Commission.
6. There must remain an Opt-Out mechanism, when resolution cannot be achieved between enrollee and CCO. Health care costs of the population of individuals with disabilities are more predictable than those of non-disabled populations (even down to the **individual** level). This creates troubling incentives for CCOs to control costs: CCOs may limit the enrollment (or increase disenrollment) of individuals whose health care costs are predictably above the payment rate made to the plan, or they may create barriers to meet the enrollee's health care needs (e.g., limiting access to qualified specialists often with whom they have developed long-standing relationships), are often problems seen. A parallel fee-for-service

opt-out system is a safety net for individuals with disabilities who may face such barriers in a CCO.

7. 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: most individuals with disabilities have a primary care physician knowledgeable about the individual's needs, and these individuals use medical offices and facilities that are accessible and provide cultural and language-appropriate services.
8. Every CCO must have an Ombudsperson, who then officially coordinates with the OHA Ombudsperson 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.
9. Non-traditional Healthcare Workers must have very explicit job descriptions and training. 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. These positions in the new system can be extremely valuable in meeting the Triple Aim, especially for individuals 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 1960s, on a cross-disability basis. Utilizing that well-established system could have tremendous benefit and should be further examined.

10. 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 exists 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 health care, 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. We recommend involving employment agency staff at the local level as part of the CAC and include a brief discussion about employment at each point of transformational change.

11. The ODC must be involved in all decisions and discussions. Although Oregon does not currently include long-term services and supports in the proposed CCOs, there needs 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 Home and Community-Based Services (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 seniors, but the primary issues requiring LTC services can vary greatly. Seniors might be planning which facility they will live in at the end of their life; 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.

In conclusion, we urge the involvement of individuals with disabilities and entities such as the State Independent Living Council and Oregon Disabilities Commission in every aspect of further design, development, contracting, implementation, training and monitoring within the new CCO model. Indeed, having the CCO application review process include disability advocates and experts in health needs and access issues would be an initial step toward this goal. 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.

On Behalf the Oregon Disabilities Commission

A handwritten signature in black ink that reads "Sherry Stock". The signature is written in a cursive, flowing style.

Sherry Stock, Chair

This public comment was provided by Empower Oregon which is a project of SEIU Local 503. Included is panel testimony from our forum on January 17th in Portland and Eugene as well as feedback from breakout sessions at the same forum on what should be kept, avoided, and added to mental health and addictions services in transformation.

If you have any questions please call Penny Ruff at 503-539-7108 or ruffp@seiu503.org.

Chalaina Connors

Chalaina Connors is a child abuse interviewer at CARES NW. She worked previously at the Morrison Child and Family Services, and prior to that worked at the Domestic Violence Resource Center. She holds a Master's degree in counseling psychology from Pacific University. She became a Licensed Professional Counselor for the State of Oregon in March of last year. She has been a volunteer with DanceSafe since 1999 and currently runs the Portland Chapter.

I've been working community mental health for the past five years. In that amount of I've seen a huge shift in the availability of funds, and the expectations for caseloads. This does not work. When therapists are forced to take on more than what is ethically appropriate. It effects the quality of services we can offer our clients and ultimately our clients suffer. For example when you're expected to take on at least six or seven hours a day of seeing clients how can you expect to be fully present for every one of those. I knew working in community mental health was tough work but our clients definitely need therapists who are experienced and not over worked so they can do the best job they can for their clients in the highest need.

I know the need is greater than the number qualified professionals that help but we need ways to reach more clients rather than the services we can bill for. I know that funding is not readily available and each year we get told of new and issues related to keeping agencies afloat. But I really feel that one of the services to be cut last should be the health and welfare of our children and people in general. If we can't be around to help our children become healthy individuals then who will be and what will the future hold.

Something beneficial for therapists would be having support from management. If we're not given appropriate feedback on the work we are doing with our clients this can be very discouraging. When we here nothing but the numbers it takes to keep the agency afloat we may lose sight of the good work we are doing and the lives that we are changing for the better. It also makes me sad to see the amount of turnover that takes place at community mental health agencies. I think that it is caused by the lack of support, pay, and the apathy about what kind of work this is. I know each year it feels like the normal cost of pay for a masters level therapist keeps dropping which makes it really difficult to appreciate the work that we do let alone paying off the cost of our student loans when the cost of higher education keeps skyrocketing each year as well.

Now I would like to talk about paperwork. I understand that documentation is very important. Luckily many agencies are switching to electronic medical records and I think this is absolutely wonderful and way more efficient and less time consuming. But I think that in some cases the programs that are designed to be more efficient can be very redundant and keep repeating some of the information that seems unnecessary. For example in an assessment for a new client is very important to gather all of the history information including previous diagnosis, family history, social/economic history, all kinds of medial relevance. But every year we are expected to do a reassessment and the program is designed to transfer a lot of the information over but sometimes with the programs you have to repeat a lot of the

information because it actually doesn't save what you did prior and so it is very redundant. It doesn't make sense to go through all these arbitrary steps to get things signed off for example.

For our yearly assessments we have to get them signed off by a psychiatrist and sometimes it can take months to track them down. Initially when we switched to electronic medical records a lot of the psychiatrists were unwilling to make the switch which created a lot of extra work and then it is the responsibility of the therapist to get it signed off because it shows up on our chart as not being completed which can be frustrating.

I don't think there is any quick solution but I feel that with more support from management and good feedback we can continue to provide the quality care we need to. Our clients ultimately need to be the number one focus in mind when we make changes because when we lose valuable clinicians because of budget cuts which creates more work for the remaining clinicians. This can lead to burnout and losing them as well. Of course if we had more funding and could hire more people, this would lower the burden on everyone and provide more balance for all.

Patricia Kennedy

Patricia Kennedy is a Family Advocate who lives in SE Portland. She has spent over 20 years caring for two children with mental health issues. Her oldest son, now 25, was diagnosed as a child with Asperger Syndrome, a form of Autism, and Obsessive-Compulsive Disorder. He is now living in a residential facility in Portland, recovering from a series of acute psychotic breaks triggered by the suicide of his brother, Patricia's youngest son, who died at age 20 after losing his struggle against severe depression and drug abuse.

Whenever I'm asked to think about how mental health services can be improved, my head starts to spin. I think about how my son was confined for days in a Portland Emergency Room on two occasions last year, once for 3 days, once for 5 days, waiting for a bed in a psychiatric unit to open up somewhere in the city. I think about how that would never happen to someone experiencing an acute physical illness.

I start to remember how my son once called the County Crisis Line because he realized he was becoming psychotic again, but didn't want to be hospitalized for a third time. He was told to call his caseworker. Well, it was after 5 pm on a Friday afternoon and she was long gone. He then went to an ER, asking if there was any place he could go just to talk with somebody. He was told there was a clinic in SE, but he didn't have the right insurance to go there. Recalling that day, I still feel anger over the way the Crisis Line passed my son off and how the ER got it wrong about which kinds of insurance that clinic in SE accepts.

I think about the time my son went to see a doctor about chronic back pain. Upon learning my son was on several medications, the doctor demanded "What do you take all this medication for?" When my son replied that he was there for his back pain and that he didn't want to talk about the reason for the meds, the doctor said "I can tell you why you take them. It's because you're Bi-Polar." When my son countered that he was not diagnosed with Bi-Polar Disorder, the doctor said "If you're not going to be honest you can just leave right now." And so, my son, left.

I start to recall how my son was cut with a knife by a man who was beating up a social worker at his residence. I think back to the first thing he said to me when I got to the hospital: "Nobody was doing anything. They just kept yelling 'Stop'. I had to help her." And so, I think how odd it is that, according to the social worker my son saved, staff is trained in CPR, but not in how to approach, engage and subdue. I think about the staff turnover and all the shift changes at my son's residence and how unsettling it is for him and the other residents there with paranoia.

A few weeks ago I went to an input session for consumers and family advocates on health care transformation at Multnomah County's Mental Health & Addiction Services Division. Here are some of the things that were mentioned

- Timely access to care and services
- Emphasis should be on preventive care
- Providers and staff need to be knowledgeable about insurance coverage, how the system works, where care is available and what resources are available.
- Increased communication through Electronic Health Records, but with more safeguards to assure that the records can only be accessed on a "need to know" basis.
- Providers need to be educated not to dismiss problems or downplay symptoms as due to someone's psychiatric diagnosis or addiction
- Primary care physicians need to know their limitations regarding mental health and addictions
- Peer support specialists need to be legitimate members of the team to help people with mental illness and with addictions engage in their own care and to coordinate services and help establish trust with providers and staff.
- Food, housing, safety and transportation are necessary for healthy outcomes

Thank you so much for listening.

Saige Gracie

Saige Gracie is a Senior Clinician at an Outpatient Program of Comprehensive Options for Drug Addiction aka CODA. She has nearly 10 years in social services caring for adolescents, elders, high risk homeless youth, and dual diagnosis populations. She is a member of SEIU Local 503's Board of Directors

So I figure the first thing we do when we look at a job we want to maybe be employed with, is the job description and say to ourselves that of the following criteria I think I can do that I think I can work these hours and provide these services and then you jump in and see how it goes. So what a job asks of us after three months is are you engaged how is this going, are you exhausted yet? The thing I am built for is providing social welfare to our population. About ten years ago when I was 18 or so I started volunteering with these groups that provide basic services like consoling and peer support and I think that stuck with me, still trying to figure out why that is. When I turned 25 or so I was an assistant supervisor on a dual diagnoses unit with teenage girls with severe mental illness and drug addiction. It was a lock down unit that required not only group and individual therapy but hands on redirection. I was there for about two years and it was probably an experience that will be with me for the rest of my life. There were time at that facility that went really well and there were times at that facility that

reminded me there is a world of change that needs to happen in this community Portland, Oregon, United States and a couple of them draw back to the original concept of the job description.

At no point do I recall having to look at a job description at that facility and think to myself I was going to have to find co-workers crying in the bathroom, at no point did I think to myself I was going to watch a systematic decline of a unit that was designed for therapy fall because of the pay scaled being so drastically different, at no point did I think to myself I would have to watch the only foundation the children ever had come out from underneath them because of funding cuts and budget cuts and the loss of belief and faith in a system that was set up to support them, at no point did I think I signed up to watch the decline in faith in the next generation that will follow me that will possibly provide absolutely essential elder services for myself. When we create a structure for social services ideally we would create a structure that we can sustain. Then, the situation that we have right now is that we have created a structure that we haven't funded, haven't set expectations for, and that we've watched suffer. So not only do we have the population of social workers who are stressed and traumatized but we have the outcome of that which is the population who relies on those services that's traumatized, that's disabled whether it be physically or emotionally and further traumatized by the decline of that consistency. If anything is to change for these services it is for them to be properly funded, create reasonable expectation for the social workers who provide these services and to put in the job description that at any point if you feel you can't provide these services this is exactly what we plan to do to support you because you are essential. At no point was that provided to me but we knew where to find it and it was from one another, these are the things not happening right now.

Dylan Ritchie

Dylan Ritchie is a self-pay consumer of Mental Health services in Portland, Oregon. He studied Public Health and Community Development at Portland State University, graduating in 2010. He has worked in many social services jobs dealing with issues affecting the LGBTQ spectrum and other economic and social minorities. He is currently a working artist at a local shoe repair shop and uninsured.

So what I am going to do is go over a very long and extensive history very quickly, I think you can keep up. I struggled with mental health issues pretty much my entire life; I have had PTSD my entire life. I had both parents try to kill me and that kind of leaves a mark on you. By fourteen I was fairly suicidal and began my decline and you would say entry into services but I didn't have services I had foster care. I emancipated myself when I was sixteen, I went to school full time, and I worked full time and I had no health insurance, I had never taken a psych med besides what my doctor gave me which is what my abusive mother told him to give me and that was it until I was nineteen.

Then I worked for the county for about a year before I had a full on psychotic break and lost my job, a month before I was union. I left that job and that town to come to Portland and go to school to study what I love which is social justice and public health and access. I was in my senior year at Portland state university when I had my next psychotic break. I thought fourteen was bad because I was in a coma in a bathtub for a week and I thought that was bad but this time I was much more together and much more adult and it was much more terrifying. I fortunately had school health insurance because I was a

fulltime student and an employee of the college but there are some interesting intricacies in how that insurance worked. I was getting my psychiatric services and medication through the student health center but as soon as I entered a hospital because I was suicidal there was really no other resource to go to at that point I lost my psychiatric coverage at my school. I have it in my documentation because I couldn't believe my psychiatrist telling me I couldn't see him even though I was there just about to finish school, I was a 3.9 student, he told me that any student who was dependent on health insurance who had any issue that jeopardized their full time attendance it was unethical for them to treat me because I could drop out at any minute and then I wouldn't have coverage. So in the meantime I didn't have any coverage and was attending school full time and began to spiral into large large amounts of medical debt that I am still dealing with. I had \$100,000 worth of bills that I either had written off to charity or have entered into a bankruptcy. I'm twenty-six years old, I pretty much can't work because of the damage that happened to my brain when I tried to commit suicide that year I had the last psychotic break. That year I spent about a year in the hospital and I went back to school but finished at a pretty slow pace and by the time I got out with my degree and that forty grand in debt I had a lot of memory issues and a lot of stress responses and a market change in personality I had to deal with on top of entering the job market. So I went to live with my step dad for a year in a place where there was no mental health coverage and literally have gone years of my life with absolutely no treatment. I have severe depression with psychotic breaks and I have PTSD. I make about \$400 a month and with that \$400 I am supposed to house myself, transport myself, pay for medication, somewhere in there see a counselor and then try to find a psychiatrist that will see me, usually I end up in the hospital first. The last time I needed care because I was having a psychotic break, I know I'm having them because I hallucinate; I was on a waiting list to see a psychiatrist, actually a psychiatric nurse practitioner since they are a little bit more affordable. If I was over thirty I wouldn't have qualified for the waiting list, I was in the hospital before they could see me; I was released from the hospital the day of my appointment so I could see them. I can't afford a counselor, I am fortunate to have my medication through Outside In right now and I'm trying to build a future, I don't have health insurance, access is one of the biggest issues I face. I've applied for OHP, I'm on that waiting list too. I've worked with the Department of Aging and Disabilities, I'm not old enough, I don't have a kid, and I work just enough that I am "not disabled." I fight with social security, I filled bankruptcy paperwork, and I work almost forty hours per week just trying to put my life together hoping I don't have another psychotic break.

Dr. Tobias Ryan

Dr. Tobias Ryan is a licensed clinical psychologist in independent practice. He practices across the lifespan, working with children, adults, couples and families. Dr Ryan has been practicing since 2007, when he graduated from Pacific University, and is a former clinician at Morrison Child and Family Services.

I'm really to be here especially because my journey with beginning trying to do some advocacy work with mental health really began with people I was exposed to in graduate school who told me that to provide really inclusive and competent services you have to get out of your office and go see what communities are doing in general to take care of problems outside of your office. I was encouraged to

do that and I started to do that and one of the first events I attended was in this room and I was ready to talk about paperwork, lack of support for clinicians and what I heard from people utilizing services or seeking services was that they couldn't get access and I heard that over and over again, this is a big room and it was a big circle and I heard that from person after person. I went home wondering how did this system evolve where here I am where I was actually chastised is one of my graduate course when I said I wanted to work part-time, pro-bono, for children who weren't receiving services anywhere else and the professor told me I had naïve and unrealistic expectations for how the world worked. I then went into the mental health field and I here this around the circle where I feel I was supposed to learn about what goes on outside of my office and people are saying they can't get into your office, just getting into your office would be nice but just getting access to you on a regular basis, what's wrong with that. I started to ask how we could evolve a system that makes it harder and harder for me to get access to people who need therapy or treatment and yet at the same time makes it harder and harder for people who want treatment to get access to providers. I don't think there's any shortage of providers, there was a group of people for instance who graduated with me in 2007 and there were 40-45 of them, that's 45 new doctors spread out into the world and there were concerns that they may be flooding the market because so many of them were graduating at the time.

So there's no shortage of providers so where's the disconnect? I think the disconnect the disconnect happens when we are emphasizing systems of administrations which are going to on the one hand were promised hold providers accountable for treatment they provide so they don't end up scamming on services and over billing and overcharging and at the same time managing the care of the other people so they don't remain in services and don't want to get better. I find over and over again that this viewpoint that admin is what's needed in order to be sure the providers don't abuse the system and consumers don't rely on the system overly just gets reinforced over and over again. There was this panel in Portland where we talked about the new CCO system and we came to this big group and one of the questions we were asked to address as tables was, what's the responsibility of consumers to get healthy? I'm just like I don't even want to answer this question I feel that there is this bias towards people who are like need to take charge of their treatment and get control and if they don't we are going to move on to the people who actually want to get better. So this system in the middle or this administrative system which I think is trying to keep me accountable and make sure my clients don't overly rely on me, really is what is creating more and more barriers for me.

So I'll give you a couple of concrete examples of this the first one is this week I do some work under Medicare in an assisted living facility for people who go into theses assisted living facilities and they stay in their rooms and they don't exit and then they become irritable and they yell at staff and they don't want their medication and then they start talking about just wanting to die, I wonder why I don't I die. My oldest client who is 95 continually asking me in session, why am I still alive? Why do keep going? And I remind him that he know all of this music and all of this history and all of these stories and he says oh yeah, there are still good things. I have to call the insurance company for clients on a regular basis and tell them and social isolation is detrimental to their health and I have to explain that I spent 45mins on the phone in one of my two days there doing just that. Just to get an authorization to keep working with a client who was I was already not getting paid for services because the authorization for services

expired. So that's an example of the administrative system blocking us out. She want me to come see her, I want to come see her, that's why I went to school, and I can't get to her because the system in the middle says call us first and tell us why you need to see her and then we'll give you ten weeks to see her and then after that you need to call us again.

So that's my first concrete example, my second concrete example is that I actually Morrison Child and family Services because I felt that the way the services were being provided was not actually responsive to children's actual needs. I had a conversation with a series of supervisors who told me that children didn't have the same expected levels of confidentiality that adults do so that they can be able to tell adults whatever the children said in session and I shouldn't have the expectation for that to be guarded. I decided I would leave for that reason. When I went into my own practice OHP sent me a twenty page document to fill out, in my practice where I don't have any benefits and need to make money to survive and buy food. When I finally sent in this form I went through this series of phone calls to get access to OHP clients. They told me I had been approve through this twenty page packet solely to give 1hr assessment session 1 time to people on OHP who were waiting for services. That's it, I could not see them on a regular basis, could not form relationships with them, I was supposed to asses them and turn in a report and that was it. That was the OHP contract I had just spent hours on the phone for.

My third example of this comes from this week when I have set aside time to prepare for session in my individual practice because this was something I was unable to do at Morrison child and Family Services because I needed to see patients all the time. So I set aside about 6hrs to do that, look over my cases see what's working look at the researching coming out. So I had this 6hrs last week and I used 5.5hrs of it on the phone with Insurance companies filling out HIPPA forms online, were talking about electronic medical records, this is supposed to make things streamlined and fast. There's is a 5 digit code called a payer ID that has been ruining my life for the last month, but the payer ID is different for all different types of people so I call the insurance company and they say I need to go through the local system and I call the local system and ask why aren't you guys approving this and they are like you have the wrong ID, client ID?, no org ID, what is that? So I spent 5hrs complete forms for 8 patients, help me out, 8 patients! So this middle system is not only making me accountable, it is not only keeping people from relying overly on the system it is keeping, its keeping people from getting into the system then it's keeping people from getting into the system and staying in the system because there is a strong desire on my part to do less and work more directly with people who coincidentally have enough money to pay their bill by themselves without the insurance company.

So I start to wonder if this is a consumer protection issue, why are there people who need the services not able to say, I am ready to authorize my doctor for 10 sessions and we'll see how my treatment is going after that. I don't like my diagnosis so I'm going to authorize this other doctor. But the people I work with don't have those kinds of power in choosing their own services. If I were going to change anything I would allow doctors to say you know you're wrong were going to do it this way, insurance company. And I would let patients say, you know I don't think my doctor is doing me wrong and we're going to keep with that with the co-pay I was promised with my plan. The co-pay is not difficult for me and I want this person added to my network so I get access to the co-pay I was promised when I signed up for this plan. Because as an out of network provider in a community where they are not accepting

new providers, the out of network cost is significantly higher than the co-pay they were promised when they got benefits at the job they were hired at or when they purchased this policy for themselves. Thank you very much for your time and attention.

Breakout Feedback:

Add

- More early crisis intervention
- Presumptive eligibility for Medicaid
- A nest egg or funding stream for paying for services when early crisis intervention is not covered by OHP/Medicaid – get people the services they need, worry about the funding later, saves money in the long run
- Residential services
- Better coordination of services
- Better access to care before need is acute
- Need to keep funding in system and add more
- Beer/liquor tax to fund A&D treatment
- Better access to community care after hospitalization
- Better crisis services
- Need to serve more people in the community
- Must share information between providers
- No wrong door to access care
- Better services available in rural communities
- Include preventative care – EASA (Early Assessment and Support Team) in Multnomah County as model
- Higher expectation for outcomes
- More peer support services
- More access to therapy, not just drugs
- Mental Health component to Addictions Centers/treatment
- Merge Mental Health and Addictions treatment
- Client centered treatment
- Encourage clients/patients own initiative
- Incentives to get off medications
- All providers for a single individual should communicate for the patients best treatment
- More community based services in poor neighborhoods
- Adequate pay for direct care staff – consistent with private providers
- Better working conditions for direct care staff – adequate paid time to meet administrative needs and to provide services – with appropriate support
- Electronic records that are compatible across public and private agencies
- Equal access to services for people on OHP
- Access to more prescribers for medications
- Make education and training for clinicians free or cheap in exchange for community work
- Centralized clearing house for medical records

- Consumer “smart cards” medical records
- More training/introduction for PCAs helping clients with mental health needs
- Additional pay with training
- Concentrated system for training prior to doing the work
- Coordinated trainings around the state for residential treatment
- More communication among different treatment settings
- Transparency with allocation of funding related to care provided
- More utilization of PCAs for activities of daily living and collaboration with case managers
- Utilize front line staff experience for better understanding of client conditions
- Utilize and create a treatment guide/mentor position to assist clients moving through the system
- Use our community services more often
- A more fluid spectrum of mental health treatments up and down the scale. Allocation transition between the case settings happen more early
- Transparency of info about client care
- Availability of opiate bridge drugs
- Treat the whole person
- Use housing services as a metric for CCOs
- Have strict accountability for services
- Use a series of risk issues to judge client health
- Use self-reporting from consumers in metrics
- Consumers should have individual choice
- Utilize peer specialists
- Have a “walk in their shoes” day for providers and OHPB members so they can see the difficulties in accessing services
- More simple forms
- More public forums

Avoid

- Making people have to access needed care at many different locations or organization
- Care being cost prohibitive
- Capitalizing services that are really needed
- Spending all our money on in-patient treatment
- Just diagnosis and drugs are not enough – real treatment must be available
- Don’t let the CCO set the rules
- Too high case loads or not enough time with patients
- Bureaucracy has too many layers
- Don’t turn people away, EVER
- Unequal services, treatment centers should not be separated from medical care

- Unequal prioritization of medical models
- Providers expected to give services beyond scope of their education or training
- Insurance companies making choices about medications
- Provider centered treatment
- Administrative costs of over 10% of funding
- Staff shortages that prevent consumers accessing services
- Underpayment of direct care providers
- Making so much paperwork or administrative oversight that consumers do not receive the services they need
- Electronic records that are bean-counter based and not direct care provider based
- Losing the consumer in the system
- Closer/more accessible services
- Hospital ER care, bigger problem in poorer areas
- Income disparities in services
- OHP recipients looked at as “lucky” to get experiences
- 8 or 6 session limit not based on client need
- Paperwork prioritized over services
- Too much time trying to find services
- High administrative costs
- Time not allowed for paperwork and preparation
- Stigma
- Confusing medical records
- Profit driven services
- CCO has to provide a full continuum of care
- Worker burnout/wage-theft
- Cooking the books for metrics
- Relying on patient independence
- Obstacles to training options for providers of mental health services
- Change for change’s sake
- Not following through on residential care setting inspections
- Mental health services in isolation

Keep

- Services available in community, which is cheaper than hospitalization
- Accountability of providers
- Electronic medical records/shared access to info

- Basic concept of CCO has some appeal: brings together treatment team centralizes care and resources
- Centralization of AMH and physical health records
- Caring, thoughtful, well trained direct care providers
- Accountability for direct care providers and administrators to provide care consistent with their ethical principles
- Not for profit status of providers
- Individual based treatment to meet the unique needs of each clients
- Maintain parity between mental health services and physical health care
- Peer supports are good but should be good jobs
- Access to housing to keep people stable
- Keep recovery mentors
- Need to keep county mental health services available to public
- Keep democratic control
- Social model for mental health – like case management, housing, support groups, social work.
- Peer support groups
- A community approach
- Open communication to county case managers and mental health providers
- At least current coverage elvels
- DHS case managers



Marion County
OREGON

(503) 588-5212
(503) 588-5237 - FAX

**BOARD OF
COMMISSIONERS**

Samuel Brentano
Janet Carlson
Patti Milne

January 18, 2012

Mr. Eric Parsons, Chair
Oregon Health Policy Board
500 Summer Street NE
Salem, OR 97301

RE: Draft Coordinated Care Organization (CCO) Implementation Proposal

Dear Mr. Parsons,

We appreciate the opportunity to comment on the draft Oregon Health Authority's Coordinated Care Organization Implementation Proposal.

Background - As of 2010, Marion County has a population of 315,335, is one of eight counties where 70% of the state's population resides, and where more than 64,000 residents are enrolled in the Oregon Health Plan. Marion County has fifteen years of experience collaborating with Willamette Valley Physicians (WVP) Health Authority on initiatives ranging from prenatal care and chronic health conditions to pain management and tobacco cessation. Our mental health and addictions system is a "hybrid" with some services provided by the county and other services provided through contracts with community providers.

CCO Development - The county, nonprofits, and other stakeholders have been participating in a series of meetings with officials from the WVP Health Authority in designing a Coordinated Care Organization (CCO) model for Marion County residents. Stakeholders also include three hospitals (Salem, Silverton, and Santiam Memorial), two federally qualified health centers, the Marion County Health Department, Mid Valley Behavioral Care Network, Capitol Dental Care Organization, and private providers represented by the WVP Health Authority. While many details remain to be worked out, stakeholders are engaging in good faith efforts to develop integrated delivery systems.

Governance - The issue of governance is of utmost importance to Marion County. We request additional policy language beyond "encouraging partnerships between CCO's, local mental health authorities and county government." We request that you consider language proposed by the Association of Oregon Counties stating, "Counties shall have a meaningful role in governance of the CCO." In order to meet our statutory requirements as the local public health and mental health authority, we would like to have the opportunity to engage in the governance of our local CCO providing input and influence. Some counties may desire to be a part of the decision making governance structure while others may not. As communities develop CCO's, counties should have the choice as to their level of engagement.

Under the outlined certification process, we would recommend adding the following bullet, "How the governing board represents the local public health and mental health authorities." Another concern is how to remedy the situation when counties are interested in a meaningful governance role and are not allowed to participate. We recommend that the CCO criteria specifically include a formal mediation process that can address conflicts.

Community Input - Another way county commissioners can be an asset to CCO's, is by holding public hearings to gathering key community input from various interest groups and citizens.

Community Advisory Council - We would like to comment on the suggestion of having county officials and hospital representatives sit on the Community Advisory Council (CAC), perhaps in lieu of a role in governance. The CCO Business Plan draft states, "Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority." While this seems an excellent way to ensure consumer "voice" in the CCO, it may not be an effective way of having hospitals and elected officials guide the CCO's course.

As the public health and mental health authorities of Marion County, the Board of Commissioners will continue to work with our regional partners and CCO's in order to:

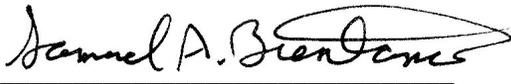
- Assure the health and well being of our constituents, particularly our most vulnerable;
- Coordinate mental health services with the local public safety system;
- Provide a 24-hour crisis response system for individuals regardless of insurance coverage;
- Increase access to physical health care and dental services for people with mental illness and addictions;
- Facilitate multi-system child and family support teams; and
- Work with Oregon State Hospital on patient coordination.

Thank you for the opportunity to provide input on the CCO Implementation Proposal. If we can be of further assistance, please contact us at 503-588-5212.

Marion County Commissioners



Janet Carlson, Vice Chair



Samuel A. Brentano, Commissioner

NORTHWEST HEALTH FOUNDATION

The Community's Partner for Better Health

January 17, 2012

To: Oregon Health Policy Board

From: Thomas Aschenbrener, President; Chris DeMars, Sr. Program Officer; Alejandro Queral, Program Officer

Re. Comments and suggestions to ***Coordinated Care Organization Implementation Proposal – January 10, 2012***

Northwest Health Foundation appreciates the work of the Oregon Legislature, the Oregon Health Authority and the Oregon Health Policy Board in developing and implementing a vision for an American health care system that is remarkable in scope. It is important to understand and acknowledge that our first efforts are critical steps toward creating momentum that will help us uncover and successfully address the inevitable problems that will arise as the process unfolds. If are committed to the Triple Aim and working with patients and providers, we will be successful in creating a system that will both improve the health of our population and be cost effective.

General Comments

From discussion at the work groups, a question remains as to whether there should be one CCO in a region or whether several CCOs are needed to promote competition. This question is not addressed in the Draft Implementation Proposal. We know that shifting from one insurance carrier to another, by both members and practitioners, produces redundant administrative costs that can run up the cost of health care by as much as 20 percent to 30 percent without providing any additional direct services. Moreover, allowing multiple CCOs per region would frustrate OHA's intent to have "a non-competitive Request for Applications (RFA) procurement process." In practice, multiple CCOs per region would also be difficult to implement because HB 3650 requires the CCO governance structure to include "the major components of the health care delivery system" §4(1)(o)(B). If multiple CCOs exist within a region, the same providers serving the region would have to be in the governance structure of each CCO. Finally, HB 3650 may implicitly preclude multiple CCOs per region: §1(5)(b) defines "Region" as "the geographical boundaries of the area served by a *coordinated care organization...*" (emphasis added). As such, one interpretation of the definition of "region" is that it limits the number of CCOs to one.

For these reasons, the recommendation is that the Draft Implementation Proposal specifically limit the number of CCOs per region to one (1).

There is real risk that CCOs will provide coverage, but fail to provide timely or meaningful access. It should not be acceptable for CCOs to have patients wait 6 or 8 weeks for appointments or to drive 50 or 70 miles to see a provider in another city. OHA should incorporate provisions in the Draft Implementation Proposal that allow it to monitor whether members are actually getting services in a timely and convenient manner.

Equity in access and culturally adequate care cannot be compromised. CCOs need to have the expectations laid out for equity, and systems in place for helping them achieve culturally adequate care as well as documenting the patient experience of equity. See specific comment in the “Community Needs Assessment” section below for more on this.

The selection and certification process of CCOs should be spelled out. Currently, OHA retains the power to evaluate and certify CCOs. We recommend that OHA create a review group with the same make-up as the recommended governance board to select the CCOs for certification.

Governing Board

CCOs would be required to articulate, among other things, “how the governing board includes members representing *major components* of the health care delivery system” (emphasis added). *Major components* is an undefined term. HB 3650 also fails to define the term but does define “health services.” *Major components of the health care delivery system* should be defined in such a way that avoids interpretations that equate providers of “health services” as “members representing major components of the health care delivery system.” Recommendation: A complete definition of “*major components of the health care delivery system*” should include public health interventions in community settings aimed at reducing chronic diseases and associated risk factors.

CCOs would also be required to articulate “[h]ow consumers will be represented *in the portion of the governing board* that is not composed of those with financial risk in the organization” (emphasis added) At the same time, the Draft Implementation Proposal calls for the formation of a Community Advisory Council (CAC), and recommends that “at least one member of the [CAC]... also serve on the governing board.” It is unclear whether the CAC is the same as “the portion of the governing board that is not composed of those with financial risk in the organization.”

Recommendation: clarify what is meant by “the portion of the governing board that is not composed of those with financial risk in the organization” and how this portion of the governing board differs from the CAC. Specifically, we recommend that the governing board be structured as 40% providers, 20% local public health, 20% local elected officials and 20% consumers.

Emphasis should also be given to how the governing board makeup reflects underserved communities, including ethnically diverse populations.

Community Advisory Council (CAC)

The Draft Implementation Proposal recommends that “at least one member of the [CAC] ... also serve on the governing board to ensure accountability for the governing board’s consideration of CAC policy recommendations. Following our recommendation that the governing board be structured as 40% providers, 20% local public health, 20% local elected officials and 20% consumers, we believe all consumer representatives should be members of the CAC. This would accomplish two things: (1) ensure mutual accountability between the CAC members also serving on the governing board; and (2) ensure that at least one member of the CAC attends governing board meetings in case of, for instance, scheduling conflicts.

Partnerships

The Draft Implementation Proposal states that:

HB 3650 encourages partnerships between CCOs and local mental health authorities and county governments in order **to take advantage of and support the critical safety net services** available through county health departments and other publicly supported programs (emphasis added).

Section 24 of HB 3650 does not limit such agreements to “critical safety net services” and in fact enumerates the public health services that would be authorized for payment in §24(1). Moreover, §24(3) requires the state to “[e]ncourage and approve agreements between coordinated care organization and publicly funded providers for authorization of and payment for services” provided through public health prevention programs such as “well-child care,” “prenatal care” and “school-based clinics,” among others. See HB 3650 §24(3)(a)-(f).

We recommend the Draft Implementation Proposal be amended so the language in this section reflects the intent and requirements under HB 3650.

Community Needs Assessment

The Draft Implementation Proposal recommends the development of a shared community needs assessment that “includes a focus on health equity issues and health disparities in the community.” This sentence is too vague: what does “a focus on health equity” mean in practical terms? This sentence should be reworded to read: “OHPB recommends that CCOs.....develop a shared community needs assessment and a *plan for reducing or eliminating health disparities in the community.*”

The Draft Implementation Proposal confounds two separate documents: (1) Community Needs Assessment, and (2) Health Improvement Plan. The former is called out by name whereas the latter is only implied in the first full paragraph on page 12: recommendation that “CCOs meaningfully and systematically engage representatives of critical population and community stakeholders to *create a plan for addressing community need...*” (emphasis added). The Draft Implementation Proposal should

spell out Health Improvement Plan by name, and recommend that the development of both documents be requirements for CCOs.

In defining the parameters of a Community Needs Assessment and developing a “*plan for addressing community need*” (emphasis added), the Draft Implementation Proposal references The Public Health Institute’s “Advancing the State of the Art in Community Benefit”¹ and a set of principles therein to serve as guidance for the development of a Community Needs Assessment (and by implication, a Health Improvement Plan). The second principle cited in the Draft Implementation Plan is “Emphasis on primary prevention.” In the context of HB 3650, the term “primary prevention” is most likely to be interpreted as “preventive medicine,” e.g. colorectal screenings. However, this principle, as defined in the Community Benefit document, is intended to include “moving beyond the provision of services and working directly with local residents to remove social, economic, and political obstacles to optimal health.”² The Draft Implementation Proposal should include a concrete definition of each principle in order to avoid a multitude of interpretations.

Alternatively, the definition of a Community Needs Assessment could be based on the “Standards and Measures” developed by the Public Health Accreditation Board, the national accrediting body for state, local and territorial health departments. PHAB defines a Community Needs Assessment as “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.”

Our recommendation is that OHPB adopt the Community Needs 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.

¹ Available at <http://www.phi.org/pdf-library/ASACB.pdf>

² ASACB at p. 8

Ettinger Ari A

From: Sean Riesterer <sriesterer@gmail.com>
Sent: Wednesday, January 18, 2012 4:53 PM
To: OHPB.info@state.or.us
Subject: Feedback re: Draft CCO Implementation Proposal for HB 3650

Categories: Public Input

Hello -

Overall I like to direction of this proposal. However I want to second and emphasize comments from Felisa Hagins in your last board meeting/work session regarding more specific criteria and consequences.

The current system is flawed significantly in that FCHPs are not held to high standards of transparency and accountability. Because of this, you have significant abuses of power and public monies and unnecessary waste (personal gains).

1. The certification and reporting process should require all CCO employees to disclose personal business entities/interests which receive payment or otherwise benefit from public monies directly or indirectly via the CCO.
2. The certification and reporting process should require all CCO's to disclose total compensation for employees across all related entities - i.e. IPA, FCHP OHP, Med Advantage, MEWA, TPA...
3. The certification, governance and reporting criteria should have specific requirements for structure, process and representation of a VALID community health needs assessment and engagement of beneficiaries, providers, community.
4. The certification criteria should be specific enough to require significant financial reserves for an entity responsible for population health, without suggesting that the State/OHA will be guarantor if a CCO's reserves prove insufficient.
5. The certification, alternative dispute resolution and progressive discipline should recognize the impact/lack of accountability of an FCHP/CCO as evidenced by the costs borne by beneficiaries, communities, providers and OHA by unusually high levels of denials, delays, appeals and/or legal actions.
6. The certification, governance and reporting criteria should require accountability for transparent benefit and claims processing - i.e. clear, published and accessible policies to be followed, reconciled and accountable to follow.

Thank you,

Sean



Comments on Jan. 10th draft of OHA's Coordinated Care Organization Implementation Proposal

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

Date: January 18, 2012

Providence Health & Services is committed to transforming the health care system through community based collaboration such as the Tri-County effort in the Portland metro area. We thank the Oregon Health Authority for another opportunity to comment on the Coordinated Care Organization Implementation Proposal.

As outlined in our previous comments, we believe the proposal must initiate a CCO structure that promotes two things. First, flexibility is required in order to meet the diverse community needs throughout the state. These needs will evolve as we refine the collaborative care model and identify best practices. Second, the CCO participation criteria must promote efficiency and standardized administration in order to ensure lasting, positive changes to the health care system. These core concepts are particularly important when we look at issues like governance, provider networks/patient-centered primary care teams, alternative dispute resolution, and work force expansion.

Outside these issues, there is one section in the current proposal that will have significant consequences on the success of CCOs – **Section nine, Implementation Plan – transition strategy**. Based on the vagueness of the current language, we believe that this section could potentially undo much of the innovative and transformative health care work that is occurring around the state.

Providence understands the desire to incent early adopters and reward existing MCOs that transition to CCO status, but incentives must be reasonable and not disadvantage or undermine new collaborative transformation efforts. We recommend that the OHA **define transition criteria and early adopter incentives in statute and provide detail around each incentive**. This would include specifics on eligibility for and definition of financial support incentives, enrollment incentives, flexibility incentives, and training incentives. There must be a level playing field with one set of criteria applicable to all CCOs – regardless of whether the CCO is created by a transitioning MCO or consists of a new collaboration seeking CCO status.

The health care system that exists today evolved to meet the needs of a different time and place. Transformation of care delivery at this time is crucial to achieving the triple aim and to improving the financial security of our state.



LIANE RICHARDSON

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

January 17, 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 both the first draft and second draft of the Coordinated Care Organization: Implementation Proposal document which the Oregon Health Policy Board developed in response to HB 3650 (2011).

Our second round of comment on this continues to express concern over the governance concept.

In the case of Lane County, we have invested sizable funds in development of health care infrastructure to serve traditionally underserved populations. This includes construction of two federally qualified health care structures and the creation of an insurance company that acts as a Mental Health Organization.

Given this investment, we have been very engaged with the development of a Coordinated Care Organization.

It would be our intent to have a seat at the decision making level of such an organization. In order for the "public" seat to have as much authority as the "private" seat, we will need language similar to what was in SB 204 (2011). And preferably, there would be a way to protect the public investment in such an organization, in the event that this transformation is not fully successful, for example due to federal changes that could be possible under a new administration or Congressional make up.

Sincerely,

Liane Richardson, Administrator

Coordinated Care Organization (CCO) Implementation Proposal

Comments made by the Wasco County Board of Commissioners to the Oregon Health Policy Board and the Oregon Health Policy Board

Background

Wasco County Public Health Director, Mental Health Director and Administrative Officer have been participating in local conversations regarding health care transformation. Meetings have been held with our Eastern neighbors as well as regional meetings including our neighbors to the west. Both local hospitals are attending, Commissioners and administrators from neighboring counties, local dentists, private primary care physicians, rural health clinic providers, the federally qualified health center serving the area. Not all rural health centers, County Commissioners and private providers are represented.

Feedback

The following feedback follows the Implementation Proposal organization and numbered items correspond to numbers used in the draft Proposal.

4. Coordinated Care Organization Certification Process

As both the Local Public Health Authority and the Local Mental Health Authority, County Commissioners have a responsibility to those who elected them locally.

Applications may not capture the entire picture of an entity applying for CCO status, and County Commissioners have the experience of local perspective. They should have an active role in the selection of CCO's serving their communities.

5. Coordinated Care Organization (CCO) Criteria

Again, with statutory responsibility, County Commissioners should also have a role in governance. This provides for local, public accountability to the people. It also allows for

assurance that the process is inclusive, and that services for indigent community members do not become unbearably burdensome for local governments.

Local governments also currently provide a significant amount of local dollars for public health and mental health services in some cases. It should not be expected that this commitment will continue if local governments have no place in the governance process.

Governing Board

The Implementation Proposal states:

OHPB recommends that, as part of the certification process, a CCO should articulate:

- . How individuals bearing financial risk for the organization make up the governing board's majority interest,
- . How the governing board includes members representing major components of the health care delivery system,
- . How consumers will be represented in the portion of the governing board that is not composed of those with financial risk in the organization; and
- . How the governing board makeup reflects the community needs and supports the goals of health care transformation.
- . What are the criteria and process for selecting members on the governing board, CAC and any other councils or committees of the governing board?

It is clear that many counties meet the criteria of the three statements in bold above. It is this county's view that based on the above, County officials must be included in CCO governance.

Community Advisory Council (CAC)

The Implementation Proposal also states:

HB 3650 requires that each CCO convene a Community Advisory Council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership. It further requires that the CAC

meets regularly to ensure that the health care needs of the consumers and the community are being met.

□

At least one member from the Community Advisory Council (chair or co-chairs) will also serve on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations. There must be transparency and accountability for the governing board's consideration and decision making regarding recommendations from the CAC.

It is this county's view that County officials should play a role in the Community Advisory Council.

Partnerships

Wasco County supports partnership between CCO's and Community Mental Health Agencies as is described in the implementation proposal.

6. Global Budget Methodology

Service/Program Inclusion and Alignment

It is unclear in the global budget methodology how programming currently provided by local government entities will be maintained for communities.

It is also unclear how federal matching dollars will be obtained if CCO's are not government entities. Also, some early childhood services provided by Local Public Health Agencies are included in the global budget of both the CCO's and the Early Learning Council. It is unclear how this work will be coordinated.

7. Accountability

At this time, there are no accountability measure to assure that the CCO is not resulting in cost shifting to County provided services. Not only would Local Mental Health and Public Health be impacted, but the possibility that without adequate care, some of those individuals successfully maintained in the community may fall into the public safety and corrections arenas. This would be an unacceptable cost shift for Counties. Accountability measures should be in place to measure such impacts.

8. Financial Reporting Requirements to Ensure Against Risk of Insolvency

We withhold comment on this section pending further study. On the surface the complexity of the financial reporting requirements seems to be burdensome - who will be reviewing them and making the determination of go or no go? Having a County guarantee financial stability risk of an independent organization over which a County has little or no control does not seem feasible. Administrative expenses should have some type of a cap or formula limit.

OHA Monitoring and Oversight

(Page 42...There is no mention of local government in the monitoring and oversight section.) Local governments will know best if the CCO is meeting the needs of the community.

Conclusion

Thank you for the opportunity to provide feedback and recommendations. For further information, please contact Tyler Stone, Administrative Officer Wasco County 541-506-2552.

□



HARNEY COUNTY COURT

Office of Judge Steven E. Grasty

450 North Buena Vista #5, Burns, Oregon 97720

Phone: 541-573-6356 Fax: 541-573-8387

E-mail: sgrasty@co.harney.or.us

Websites: www.co.harney.or.us ♦ www.harneycounty.org

Coordinated Care Organization (CCO) Implementation Proposal

Comments made by the Harney County Court to the Oregon Health Policy Board and the Oregon Health Policy Board.

Background

The Harney County Court has taken the lead locally to convene meetings to assure this VERY rural community (all of Harney County) is involved and informed in the process surrounding the CCO debate in Oregon. We have invited the County Wide Health District, the High Desert Medical Clinic, all primary care physicians and dentists, Hospice, Home Health and Public Health. These meetings have been well attended with all the previously listed entities having participated. One outcome already is a local focus of coordinated care for targeted individuals. We met once via video conference with Dr. Goldberg. It is the local desire to continue these meetings to stay informed and assure our inclusion in the CCO process.

The following feedback follows the Implementation Proposal organization and numbered items correspond to numbers used in the draft Proposal.

4. Coordinated Care Organization Certification Process

In the case of Harney County, county government provides public health service, hospice, home health and by statute are the mental health authority for the entire county, 10,228 square miles – eleven percent of the entire state. The process of certification should require/allow participation from county government to be a complete process and to insure all affected parties are at the table as CCO's are formed.

5. Coordinated Care Organization (CCO) Criteria

Below are several criteria cut from the draft implementation proposal. The Harney County Court believes that all health providers, individuals and entities should be part of the governing board for a CCO serving our county, or any other county. We also believe that this county fits the description of the three parts of the certification process highlighted in bold below. The county elected officials should be a part of every criteria and process for selecting members of a governing board for a CCO serving that county. As is well known in many areas of health delivery it is the Oregon county's that are doing many aspects of service delivery and we are well committed to this process. It is on that basis that county's should be an integral part of any CCO.

Governing Board

The Implementation Proposal states:

OHPB recommends that, as part of the certification process, a CCO should articulate:

- How individuals bearing financial risk for the organization make up the governing board's majority interest,**
- How the governing board includes members representing major components of the health care delivery system,**
- How consumers will be represented in the portion of the governing board that is not composed of those with financial risk in the organization; and
- How the governing board makeup reflects the community needs and supports the goals of health care transformation.**
- What are the criteria and process for selecting members on the governing board, CAC and any other councils or committees of the governing board?

Community Advisory Council (CAC)

The Implementation Proposal also states:

HB 3650 requires that each CCO convene a Community Advisory Council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership. It further requires that the CAC meets regularly to ensure that the health care needs of the consumers and the community are being met. At least one member from the Community Advisory Council (chair or co-chairs) will also serve on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations. There must be transparency and accountability for the governing board's consideration and decision making regarding recommendations from the CAC.

It is this County's view that partnerships such as the one between CCO's and mental health authority be strengthened. This is identified in the implementation plan and is supported by Harney County. We highly recommend county inclusion for the governing board of any CCO.

6. Global Budget Methodology

Service/Program Inclusion and Alignment. Harney County is concerned that the inclusion and in some cases the exclusion of programs will be further confused and complicated by the implementation plan not being clear of the budget process. The following is a short review of our confusion. Several of these programs are county administered and there are issues around how they are funded. Some state general funded programs are included in Appendix C and a couple of the public health programs require a government match to draw down federal funds. Which raises the question of whether a CCO is a government entity or ??? If not where will the government match come from? Finally, some of the public health programs are included in both Appendix C and the Early Learning Council. What are the implications of being listed in Appendix C and what impacts to budgets will inclusion on the list have?

7. Accountability

For several decades the State of Oregon has increasingly developed multiple accountability measures that have collectively reached a point where the cost of accounting for outcomes is a large share of the cost of the entire program. The Harney County Court strongly urges the use of measures that are minimal in requirements or

use data already being collected, as opposed to developing new one which create a work load which exceeds program delivery costs.

**8. Financial Reporting Requirements to Ensure Against Risk of Insolvency
OHA Monitoring and Oversight**

The county would recommend language in the plan for counties to be a part of monitoring and oversight. All Oregon County's have a solid track record of the oversight and assurance of financial integrity for our county's and health care programs like the mental health services. We are in a great position to assist in this vital role.

Conclusion

Thank you for the opportunity to provide feedback and recommendations. For further information, please contact Steve Grasty, Harney County Judge 541 573 6356.

Sincerely,

A handwritten signature in black ink that reads "Steven E. Grasty". The signature is written in a cursive, flowing style with a prominent initial "S" and "G".

Steven E. Grasty
Judge, Harney County Court

CCO BoC Response

Background: Jackson County has been closely watching the health care transformation process and is encouraged by the possibility of a more integrated system of care and the progress that has been made to date. The county wants to ensure that the proposed changes do not reduce access or compromise the quality of care for low income, County citizens and, in addition, does not have an adverse impact on community safety.

Jackson County has been part of several stakeholder groups and discussions in relation to CCO development. Jackson County has participated in conversations with Jefferson Regional Health Alliance, Jefferson Behavioral Health, and local Medicaid providers, including FQHC's and addictions treatment providers. In addition, the county has been part of community discussions with both MidRogue IPA and Care Oregon; the two MCO's who cover the majority of OHP members in this county. Multiple meetings have also occurred with individual providers and agencies. There has been broad representation from community stakeholders in these multiple dialogues. A meeting is being convened in early February to discuss the next steps in CCO development/implementation with leadership from the hospitals in Jackson County (Asante, Providence, Ashland Community Hospital); FQHC safety net clinics (La Clinica and Community Health Center); Mid Rogue IPA, Care Oregon, ODS; Prime Care; Jefferson Regional Health Alliance; Jackson County Health and Human Services (Mental Health and Public Health).

Jackson County welcomes this opportunity to provide feedback regarding the Coordinated Care Organization Implementation Proposal, dated January 10, 2012. The following feedback follows the order of the sections in the proposal.

CCO Certification: Jackson County would like to review and give input on all CCO applications covering Jackson County prior to certification being granted.

CCO Criteria: Counties appear to meet the criteria for inclusion on the governing board and should be considered as possible members. County government needs an independent voice in relation to CCO's acting in the county. This would not be provided solely by participation on the Community Advisory Council (CAC). In our county, MRIPA is proposing a commissioners' council to provide this voice and this seems to be a good idea. This model provides the opportunity for the commissioners to provide meaningful input, yet mitigates the concerns regarding assuming undue risk. We would recommend that in addition to the CAC, both a commissioners' council and a clinical advisory group (with provider membership) be established as three separate advisory bodies that give direct input to the governing board of the CCO. The governing board should include one representative from each of these advisory groups on the governing board. Anticipating multiple CCOs emerging in Jackson County, it is important to establish some form of county-wide CAC that is independent of any one CCO operating in the county, yet is advisory to all CCOs operating in that county. Such an advisory body would allow for more objective review and county-wide analysis of performance and outcomes.

Jackson County strongly supports the emphasis on "partnerships between local mental health authorities and county governments in order to take advantage of and support the critical safety net services available through county health departments and other publicly supported programs." We are glad that OHPB is directing OHA to review the applications "to ensure that the statutory requirements regarding county agreements are met." Jackson County would also like to be able to review the applications for our county in this regard and be able to give input to OHA prior to approval.

Jackson County has benefitted from the successful care coordination program developed through the Adult Mental Health Initiative and Wraparound services for children with severe emotional and behavioral disorders. An expectation that such program would continue to be funded should be part of the CCO criteria.

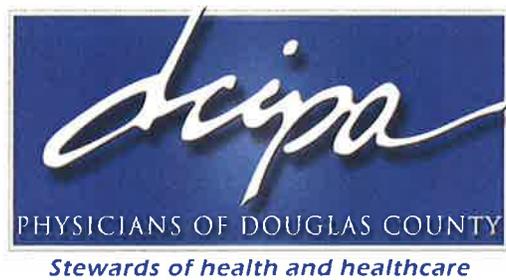
Global Budget: Careful analysis needs to be given to inclusion of programs currently funded through counties prior to inclusion in the non-capitated portion of the budget. In particular, it is important to ensure that the ability to draw down federal match is not reduced. Greater clarity is needed in regard to some programs currently under Public Health (Maternal Child Health/WIC) which have also been proposed to be moved under the Early Learning Council. Understanding that the exclusion of mental health drugs from the global budget is mandated by HB3650, Jackson County wants to register its strong opinion that these costs need to be included and statutory change towards that end should be pursued. At the very least mechanisms to allow for shared accountability for costs should be put into place.

Accountability: Jackson County wishes to receive regular reports regarding how well CCOs operating in the county are performing. It is envisioned that regular reports on health and performance outcomes would be received directly from the CCO and also from OHA. Reports from OHA should allow for comparison with other CCOs and other areas of the state.

Financial Reporting: Jackson County supports transparency in financial data and would like to receive regular financial reports and analysis for all CCOs operating in the county.

In general, Jackson County would like to be included in the monitoring and oversight functions of CCOs operating in the county. In addition the County would like to ensure that any problems emerging, for a county CCO that require assistance from OHA or any corrective actions, be reported to the county.

Once again, thank you for this opportunity to provide feedback in regard to the proposal.



January 20, 2012

Via email and US Postal Service

Oregon Health Policy Board
600 Summer Street NE
Salem, OR 97301
OHPB.Info@state.or.us

Dear OHP Board,

In planning for transformation of our health care system, we should actively consider our plans for regulatory reform and innovation. As Don Berwick has said, you won't get improvement just by hoping for it. Similarly, we won't get transformation simply by hoping for it.

The current MCO system is plagued by multiple layers of contact and regulation that cause unreasonable friction and squash hope for real innovation. I have asked our team to make a list of those at DMAP who have requested or demanded information. That number now tops 40 and with the incorporation of mental health and dental health into a CCO, we expect that over a hundred different people will be asking for information or seek to regulate. These requests or demands seem to be uncoordinated. We very frequently receive notes that are quickly withdrawn, need to be corrected or are duplicated requests.

It wasn't always this way. When the Oregon Health Plan began in the early 90's, each plan had a plan coordinator who acted as a liaison to the state. These early years were times of rapid evolution and there was a general feeling of cooperation. Although the health plan coordinator may currently exist in name, after over a year in my position at DCIPA, I have yet to meet and have had a single e-mail from our plan coordinator, in which I was asked to provide data that had previously been sent to the state.

Many small attempts at transformation have been met with rules or practices that discourage innovation. For example, the actuarial services unit is very comfortable with traditional fee for service encounters with a named patient and a definable service, but struggle with community health improvement efforts, bundled services, hospital capitation or other innovative payment structures that will be necessary to streamline and transform the system.

Similarly, the recent work groups have proposed additional layers of regulation and complexity that seem like a good idea, but will certainly increase friction and may well decrease or stifle transformation. For example, the patient centered primary care home task force came up with some good ideas, but their complex measurement systems will be a drag on the system.

In our journey to transformation, I would draw your attention to Atul Gawande's article on changing delivery systems. In this article, he describes the journey for transformation of the agricultural system

Oregon Health Policy Board
January 20, 2012
Page two

at the turn of the last century. He describes the use of county extension agents as catalysts for innovation. These agents had access to the best science about agricultural innovations and had access to very specialized expertise at agricultural colleges and the USDA. The agents would work with their local farmers to encourage enlightened experimentation and to learn from both successes and failures. In our health care transformation, we will need access to the best information about health care delivery systems. As many of the CCO's may be small and or rural, we will not have experts on staff. Without the sharing of information, the CCO's are likely to come up with what seem to be good ideas, but unless we know what has been tried in other areas, we may repeat doomed experiments. Although there is some movement towards learning collaboratives, I fear these will not be strong enough to get the transformation needed.

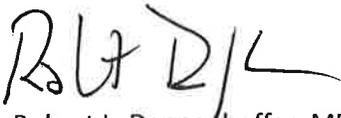
I would propose to eliminate duplication of requests and mandates, and improve transparency, that we adopt a system that is a cross between the county agricultural extension agent and the original vision of the pre-paid health plan coordinator. I would propose that each plan have an "**innovation agent**" co-located with the CCO. This "**innovation agent**" should work for the state and should be the plan's liaison for all information requests from the state. They should have direct access to the plan leaders. This person could review all complaints and actually meet with patients who have concerns.

At one of the task force meetings, we heard of the various complicated methods to ensure that the community advisory boards actually serve the function planned: I would suggest that this **innovation agent** actually attend those meetings to be sure that they are functioning as planned. An hour at the meeting will be more informative than any nicely written summary or action plan.

Perhaps most importantly, the dozen or so **innovation agents** throughout the state should have access to the very best information about health care transformation. For example, if our plan had a question about the best way to conduct a community needs assessment; our **innovation agent** might ask her cohorts to find the best practice. They should work closely with a university and the CMS center for innovation so that they have access to the very best information available.

Such a system would certainly be innovative. I would propose that early adopter CCO's be given the option of using this form of regulation and use of "**innovation agents**" as incentives for early adoption.

Sincerely,



Robert L. Dannenhoffer, MD
CEO DCIPA
541.464.4490
rdannenhoffer@dcipa.com

RLD/srp

Enclosures: DCIPA's OHP contacts list

Atul Gawande's article, "Getting There From Here"



January 18, 2012

Dear Oregon Health Policy Board Members,

Thank you for the opportunity to provide testimony concerning the Coordinated Care Organization (CCO) Implementation Proposal draft and for listening to our testimony over the last few months regarding the importance of including preventive reproductive health in health care transformation.

The Oregon Foundation for Reproductive Health has reviewed the newest draft of the CCO Implementation proposal and was very pleased to see **the inclusion of Women's Health as one of the service areas within the domain of CCO system performance accountability.** Within the CCO proposal, it is stated that CCO metrics will include both **core** and **transformational** measures of quality and outcomes. It is outlined in the CCO proposal that core measures will track both CCO performance and will encompass services that fall within the CCO global budget. We are very appreciative of the inclusion of Women's Health in the range of services included in the CCO global budgets.

The list of potential CCO Performance Measures listed in Appendix G does not include preventive reproductive health core measures. We recognize that the list is meant to show examples and may not be comprehensive at this time. However, we want to emphasize the importance of including preventive reproductive health measures in the CCO core performance measures such as **tracking rates of unintended pregnancy, contraception access/satisfaction with method, and folic acid supplementation prior to conception.**

Preventing unintended pregnancy and ensuring that all pregnancies are as healthy as possible will result in tremendous improvement in health outcomes and enormous cost savings. Medicaid is primarily a service to women, children and young families. It is critical that these outcomes be tracked as they are more relevant to this population than depression screening, hypertension and diabetes, as important as those conditions are. The sheer prevalence of women needing contraception and preconception care dramatically overshadow the prevalence of these other conditions, and family planning should be at the heart of preventive care in CCOs.

Thank you again for your partnership on this issue. We are confident that together we can make a difference in women's health in Oregon.

Oregon Foundation for Reproductive Health

PO Box 40472 Portland OR 97240 503-223-4510

Michele Stranger Hunter, Executive Director
Michele@prochoiceoregon.org

Helen Bellanca, MD, MPH, Medical Director
Helen@prochoiceoregon.org