Community Advisory Council (CAC)
MINUTES

Date: Monday, May 8, 2017
Location: Willamette Health Center, Albany

Council representatives and others at the table:
CAC Chair: Ellen Franklin;
Benton: Karen Douglas (Liaison), Lisa Pierson, Michael Volpe, Stretch McCain, Tyra Jansson;
Lincoln: Paul Virtue, Patricia Neal,; Rebecca Austen (Liaison);
Linn: Catherine Skiens, Frank Moore, Judy Rinkin;
Local Chairs: Dick Knowles (Linn), Paul Virtue (Lincoln);
Presenters: **Kelley Kaiser**, IHN-CCO CEO; **Rebekah Fowler**, CAC Coordinator; **Carla Jones**, IHN-CCO Reimbursement Manager; and **Jenna Bates**, IHN-CCO Transformation Manager.
Absent: Richard Sherlock; George Matland

CALL TO ORDER

Ellen Franklin, CAC Chair, called the meeting to order at 1:00.

INTRODUCTIONS, ANNOUNCEMENTS, & APPROVAL OF AGENDA & MINUTES

- Introductions & Welcome
  - Housekeeping: Restrooms, Acronyms & Glossary
- Chair announcement: Ellen Franklin presented Frank Moore with a clock engraved with appreciation for his leadership on the CAC these past 5 years. Frank expressed that in his 42 years in this field, this advisory council has had the most influence and worked the hardest and that is why he has invested so much time.
- Mental Health Awareness day is being planned for the evening of the 20th at the Corvallis library.
- **ACTIONS:** Council to approved present *Agenda* and *Meeting Minutes* from previous meeting **(Attachment)** (Pat, Frank). (Frank, Karen).

LOCAL ADVISORY COMMITTEES TO THE CAC

Ellen Franklin lead a discussion of local advisory committees and how they can assist the CAC with responding to healthcare service and system transformation issues.

Ellen said that we all want more, quality involvement at the community level. Through experience, we've seen that the local advisory committees are best suited to discussing and processing issues before forwarding them to the CAC.

The CAC doesn't have time at its meetings to discuss and respond to issues brought up by the public. Therefore, the public will be encouraged to attend local meetings and to make public comments there.

Rebekah Fowler, CAC Coordinator, said that by feeding things up from the grassroots level to the CAC, we should all be better able to nurture issues through to a good result rather than having issues thud at introduction due to lack of time and preparation or struggle and fizzle out without resolution.

Lisa made the point local meetings may need to change to accommodate more public input. She also made the point that each local committee should have a point person who could work on addressing the individual issues right away. Ellen said that, complaints and grievances should be made for individual cases so the system will know that there's a problem and be able to address it for that individual.

Rebekah said that the local committees should work on systemic issues, not individual issues, so she will work on the pathways for how to handle individual issues that get brought forward so people who have an individual service issue can be directed to the appropriate resource.

PUBLIC ANNOUNCEMENTS

Ten minutes to be equally divided amongst those who signed up to announce an upcoming healthcare related event.

Purpose: The Council will be informed of upcoming healthcare events. Members of the public interested in providing other types of input to the CAC are encouraged bring such issues to a Local Advisory Committee meeting.

IHN-CCO UPDATE

Kelley Kaiser, IHN-CCO CEO, provided an IHN-CCO update **(Attachment)**

InterCommunity Health Network CCO

May 2017 CAC report
Operations Report

IHN-CCO Total Enrollment

As of April 2017	53,981
Benton	12,020
Linn	29,635
Lincoln	12,326

Highlights

March 28, 2017

CMS approves 2017 rates for Oregon's CCOs

SALEM—Today the Centers for Medicare & Medicaid Services (CMS) approved the Oregon Health Authority's Coordinated Care Organization (CCO) contracts and capitation rates for 2017. Today's approval by CMS finalizes the 2017 rates for all 16 CCOs that contract with the state of Oregon to manage and deliver health care to Oregonians on the Oregon Health Plan (OHP), the state's Medicaid insurance program. OHA pays these capitation rates to CCOs on a monthly basis to cover OHP members for physical, behavioral and oral health services.

"Oregon has been successful at bending the cost curve and saving over $1.4 billion since 2012 with the coordinated care model," said Lynne Saxton, Director of the Oregon Health Authority. "This is largely because of our commitment to using global budgets and maintaining a sustainable rate of growth. Today's approval by CMS is validation that our CCO rates are actuarially sound and that Oregon's CCOs can continue providing quality care for Oregon Health Plan members."

The rates approved today show that Oregon is on track to meet its cost containment rate of 3.4 percent, with an aggregate 2017 rate increase of 3.2 percent. The 2017 rates take into account several factors, including differences in regional costs, population disease risk and hospital reimbursement. Oregon has pledged to maintain this sustainable rate of growth through 2022 as part of its renewed Medicaid waiver.

High Dollar Cases: IHN-CCO has **0** cases over $300,000 as of March, 2017

NEWS RELEASE

March 16, 2017

Media Contact:

Chris Pair, 503-559-5938

Report Details Drastic Impact of Republican Health Care Plan on Oregon

(Salem, OR) — Today, Governor Kate Brown released a report that details the impact to Oregon of the American Health Care Act (AHCA), which is currently being considered in Congress. Last week, the Governor called on the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to analyze the impact the legislation would have on the lives of Oregonians.

"It's clear from today's report that the legislation being considered in Congress would only take Oregon backwards," said Governor Brown. "Any legislation that would threaten to triple Oregon's uninsured rate, create more burden on the state budget, and risk the loss of over 23,000 jobs in Oregon should not even be a consideration. I call upon Oregon's congressional delegation to oppose this legislation that will hurt Oregonians from every walk of life and in every corner of our state."

Today, OHA and DCBS released their findings that demonstrate the ways the AHCA would fundamentally change health care in Oregon and affect the health care reforms implemented through the ACA and through Oregon's innovative Oregon Health Plan (OHP) since 1994. After analyzing data to determine the impact on Oregon, OHA and DCBS find that this legislation will:

- **Reduce coverage**: As many as 465,000 Oregonians will lose health coverage, including approximately 80,000 next year. Oregon's uninsured rate will triple from 5 percent to more than 15 percent.
- **Reduce federal funding**: To maintain Medicaid enrollment, we estimate the AHCA would shift $190 million in costs to Oregon starting in 2020 approaching $1 billion in 2023. The cumulative cost shift would be $2.6 billion over the next six years.
- **Reduce economic activity**: The AHCA risks the loss of more than 23,300 health care jobs that were created in Oregon after the ACA was implemented.

Additionally, the report released today demonstrates the ways the AHCA will reshape the lives of Oregonians in 10 areas:

Low-income working Oregonians and families struggling to make ends meet: Threatens the state's ability to continue serving the approximately 1 million Oregonians currently covered under the OHP and Medicaid expansion – as many as 375,000 OHP members could lose coverage by 2023. It would fundamentally alter the Medicaid system in Oregon by shifting the cost burden to the state. Today, nearly 4 in 10 adults on OHP who are under 65 are working.

Oregonians with individual insurance plans: Lowers costs for young adults and mid- to high-income earners, while increasing costs for seniors and low-income enrollees. Repeals the requirement for everyone to have insurance.

Older adults and people with serious chronic illness: Increases premiums for older adults between 50 and 64. The bill allows insurers to set premiums five times higher than

younger adults for the same coverage in the individual market. The bill would also eliminate cost-sharing reductions. Many Oregonians with serious chronic illnesses will see higher premium costs and deductibles, putting health insurance out of reach for the many Oregonians who have been able to get health coverage under the Affordable Care Act.

Women and family planning: Restricts provider options and threatens access to family planning and preventative and wellness services for more than 51,000 Oregon women who use Planned Parenthood for cancer screenings, contraception, and STD counseling and screening. The bill also prevents the use of federal tax credits for plans that cover abortions. Nearly all Oregon individual plans currently provide abortion coverage; there is limited time to establish stand-alone abortion coverage by Jan. 1, 2018.

Oregonians with disabilities: Eliminates the 6 percent in federal matching funds and $150 million per year in Oregon for home- and community-based long-term care for vulnerable Oregonians who need community-based long-term care services and support. Affects 65,000 Oregonians including approximately 7,500 children and 18,000 adults with intellectual and developmental disabilities.

Rural Oregon: Rural Oregon has seen the greatest gains in coverage due to the expansion of Medicaid under the ACA. Rural Oregon is likely most severely affected by losses in coverage. The health care system for rural Oregon, and its infrastructure, will be severely undermined by this legislation – jeopardizing access to care and the ability of many communities to continue to recover from the recession.

The Affordable Care Act helped stabilize the finances of many rural Oregon hospitals and helped many of them improve their financial stability. These same hospitals are at risk of seeing rising uncompensated care costs due to rising uninsured individuals. Additionally, any further withdrawal of carriers from markets in Oregon will likely disproportionately impact rural communities.

Oregon's health systems: Oregon's Medicaid system currently contains costs to a growth rate of 3.4 percent. The AHCA disrupts decades of Oregon's innovative reforms and undermines rural health, hospitals, and public health. This will lead to more complexity and uncertainty for a health system that is just beginning to stabilize from the last round of national health reform – without ensuring better care, better health or lower costs to state taxpayers.

With the uninsured rate likely to triple in Oregon under the proposed plan, hospitals will see higher rates of uncompensated care, which have fallen to historic lows since the ACA was implemented. The legislation eliminates the Prevention and Public Health Fund, which helps local communities address the Zika virus, provides immunization to children, addresses teen suicide, and helps prevent chronic diseases.

Oregon's insurance market: Uncertainty about who will enroll under the AHCA may further disrupt the individual insurance market.

Oregon Taxpayers and the state budget: Converting Medicaid to per-capita caps and eliminating Medicaid expansion will lead to a massive transfer of cost from the federal government to the states, on top of the existing state budget shortfall due to reductions in federal funding under the ACA and other factors. The federal reductions proposed by the

AHCA would cost Oregon $2.6 billion in revenue by 2023. Oregon is already contending with a budget gap, resulting from the planned reduction in the federal match under the ACA. Additional cuts would force the state to pull back on coverage and benefits.

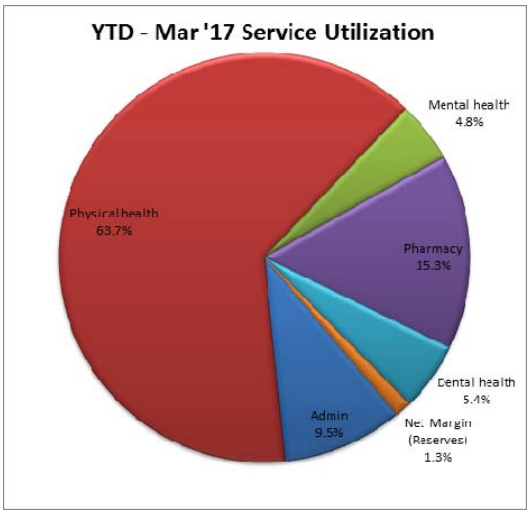
Economic impact: Following implementation of the ACA, Oregon added 23,300 health care jobs, which are at risk under the AHCA. The loss of $2.6 billion in federal Medicaid funding between 2020 and 2023 would slow economic activity in Oregon. We expect these losses to drain more than $500 million in direct health spending from the Oregon economy.

A full copy of the report can be found at 95PercentOregon.com.

Transformation

Other Transformational topics:

1. Transformation
    a. 2016 Metrics update
        i. At this point we believe we are meeting 13 of the 17 metrics we will need ot meet one of the CAHPs metrics in order to receive the full allotment of dollars. These are of course estimates as the final report is not available from the OHA yet.
    b. 2017 Metrics – Developing a monthly process for reporting with providers that addresses provider workflow. Dashboard will be available next month.
    c. DST – Summary of approach and process (Information received at the last CAC meeting)



Judy Rinkin asked about educating people about when to go to the Emergency Department and when it is appropriate to go elsewhere. Kelley said that they are working on education like this. She said the ED cannot turn someone away. They can do follow-up after the visit

and tell them about other resources.

Lisa said that mental health services cannot be accessed in her county without going to the ED first. She said that it takes 2-3 months to get an appointment with her PCP. She said that she was told that she had to wait 3 months to get test results because her doctor was the only one who could give her the results.

Mike said that there continues to be long waits to get access to oral health. Kelley said that IHN is working with the 4 Dental Care Organizations (DCO)

Paul said that he filed a complaint with one of the DCOs and then complained to IHN so they would be aware of the issue.

OREGON HEALTH AUTHORITY (OHA) UPDATE

Joell Archibald, OHA Innovator Agent, provided a State update (HANDOUT)

Joell updated the CAC on Innovation Café, a Health Equity Webinar, A public Health Modernization webinar, Quality Pool Metrics, Oregon's unintended pregnancy rate and the One Key Question Initiative.

Regarding OHP enrollment, the State has initiated a contract to begin outreach on outbound calls to remind people to reapply for their benefits.

COMMUNITY ENGAGEMENT PROJECT UPDATE

Ellen Franklin led a discussion of how the local advisory committees are doing with the Community Engagement project. Lincoln County Representatives shared experiences with the interviews they've conducted so far.

Rebecca Austen said they had about 21 people come up to their table and 16 were interviewed. Her feedback was that the interview format and process took a long time. Some people got tired of the questions.

Gary Lahman said that Samaritan had a health fair, but it was an older group and most were Medicare members. He said his lesson learned was to go where the "fish" are. He wants to think about targeting the right events. He said he needs clarification on the approval process.

Rebekah said that requests to do events should be emailed to her so she can forward that to the RPCMG.

Lisa said that she last year did the Benton County Fair but didn't have a booth. They would like a booth.

Rebekah said that she'd like to have venues sent to her in writing via email so she can forward that to the RPCMG for them to be aware of where the local advisory committees will be participating. Frank said it's not so much for approval as to be aware of what's happening. Also, if the event was primarily political, that could raise red flags.

Stretch said that the Jamboree is coming to Sweet Home.

Paul would like to see more diversity brought to the community engagement project. Frank said that we can get it translated. Rebecca Austen is working on having them translated. Rebekah Fowler said that if interviews are conducted in Spanish, we'll also need someone to translate the interviews for data entry.

ISSUE BRIEF

Ellen Franklin led a discussion of the BLAC's Searchable Provider List Issue Brief **(Attachment).** *"The Benton Local Advisory Committee (BLAC) requests that IHN-CCO provide members with a provider list that is easily accessible, meets the best practices outlined by the Center for Medicaid/Medicare Services (CMS), and that can be searched by all of the following criteria: area, type of provider (MD, MS, MSW, LPC, LCSW, etc.), specialty (family medicine, internal medicine, psychiatry, counseling, etc.), licensing status, whether the provider accepts patients directly and caseload status (accepting/not accepting new IHN patients). We further request regular updates as to the progress of this request and its estimated date of delivery."*

Kelley said that IHN is working on creating a searchable provider list.

Rebekah said that a project manager at IHN has reached out and asked if CAC members are interested in testing the searchable website.

Frank said that this is an important issue and we need to recognize that it's an enormous undertaking.

Paul is concerned that the CMS letter isn't a requirement. He feels that Kelley already responded. Pat and Frank are concerned about the level of detail being required of IHN for the searchable database.

Lisa asked to change it to make a request of IHN-CCO to provide a report on the feasibility of creating a searchable provider list as CMS guidelines outlined.

ACTION: Lisa Pierson moved that the CAC request that IHN report on the feasibility of developing a searchable provider list for the website that is easily accessible and can be searched for by the following criteria: geographical area, type of provider specialty, licensing status, whether the provider accepts patients directly and caseload status. The

CAC requests regular updates as to the progress of this request and its estimated date of delivery. Pat seconded; Paul and Stretch abstained; Frank voted against.

LIAISON UPDATES

The CAC Liaisons reported on Local Advisory Committee activities since the previous CAC meeting.

Dick Knowles reported for George Matland (Linn). The Linn Local Advisory Committee discussed political advocacy policy for the local advisory committee. They are planning community engagement for May 18 at the Heart to Heart fair. They also have some summer events planned. They would also like more diversity and are thinking about bringing in Spanish speakers to help with the effort.

Karen Douglas of the Benton Local Advisory Committee (BLAC) reported that they have an open chair position. They will be voting at the next BLAC meeting on the nominations that are due this Friday. They are planning on an engagement event.

Rebecca Austen of the Lincoln County Coordinated Healthcare Committee (CHAC) reported that they had a discussion with how to make the Lincoln Local Advisory Committee meetings able to receive and process public comments.

2017 CHIP PROGRESS REPORT

Rebekah Fowler, CAC Coordinator, presented the 2017 IHN-CCO CHIP Progress Report (Attachment). Ellen Franklin will facilitate a vote of the CAC.

- ACTION: CHIP Progress Report adoption vote

Paul thanked Rebekah Fowler for her work on the report and expressed appreciation for pulling this data together over the years. Lisa Pierson concurred.

Rebecca Austen pointed out where an asterisk should be moved on Table 9.

ACTION: Paul moved that the CAC adopt the CHIP Progress Report, Frank seconded. All in favor. None opposed nor abstained. The motion carried.

IHN-CCO TRANSFORMATION – ALTERNATIVE PAYMENT METHODOLOGY (APM) WORKGROUP PRESENTATION

Carla Jones, Reimbursement Manager & Jenna Bates, Transformation Manager, IHN-CCO present on how Alternative Payment Methodologies are transforming care **(Handout)**

To move healthcare into rewarding good outcomes rather than just providing more

services, Alternative Payment Methodologies or Models are being created to pay providers for having healthier patients.

- ***Alternative Payment Models*** are a form of payment based, at least in part, on achieving good outcomes rather than just being paid for providing a service (fee-for-service)
- ***Fee-for-service*** is a form of payment where services are unbundled and paid for separately. In health care, it gives an incentive for healthcare providers to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.

NEXT CAC MEETING AGENDA ITEMS

Ellen Franklin & Rebekah Fowler request agenda items for the future CAC meetings to be scheduled as time permits.
Future presentations include:

- IHN-CCO Transformation and pilot project presentations
- IHN-CCO Website
- RHA, how are CHAs and CHIPs being aligned
- Are there providers who are against APMs. Paul said some providers are leaving practice because of APMs.

MEETING ADJOURNMENT

- Ellen Franklin adjourn the meeting at 4:00
- Next CAC: July 10, 1:00-4:00, 4077 SW Research Way, Corvallis

Acronyms and Definitions

Acronyms

APM – Alternative Payment Methodology
CAC – Community Advisory Council
CCC – Communication Coordination Committee (subcommittee of the CAC)
CCO – Coordinated Care Organization (Medicaid services)
CEAP – Community Engagement Action Plan
CEO – Chief Executive Officer
CHA – Community Health Assessment
CHIP – Community Health Improvement Plan
CMS – Center for Medicaid/Medicare Services (Federal)
DCO – Dental Care Organization
DST – Delivery System Transformation Steering Committee, IHN-CCO, tasked with the IHN-CCO Transformation Plan & pilot projects

FQHC – Federally Qualified Health Center
HIA – Health Impact Area (in the CHIP)
IHN-CCO – InterCommunity Health Network CCO
OHA – Oregon Health Authority (State of Oregon, oversees Medicaid)
OHP – Oregon Health Plan (Medicaid)
O&I – Outcomes & Indicators (in the CHIP Addendum)
PCPCH – Patient Centered Primary Care Home or a Medical Home
SHS – Samaritan Health Services

Definitions

- ***Addendum:*** something added; *especially* a section added to the original document
- ***Alternative Payment Models*** are a form of payment based, at least in part, on achieving good outcomes rather than just being paid for providing a service (fee-for-service)
- ***Determinants of health*** are "the range of personal, social, economic, and environmental factors that influence health status.
- ***Fee-for-service*** is a form of payment where services are unbundled and paid for separately. In health care, it gives an incentive for healthcare providers to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.
- ***Epidemiologist:*** a person who studies the patterns, causes, and effects of health and disease conditions in defined populations. It is the cornerstone of public health, and shapes policy decisions and evidence-based practice by identifying risk factors for disease and targets for preventive healthcare.
- ***Health disparities:*** Differences in access to, or availability of, services is a health disparity. **Health status disparities** refer to the differences in rates of disease and disabilities between different groups of people, such as those living in poverty and those who are not.
- ***Indicators***: measurements or data that provide evidence that a certain condition exists or certain results have or have not been achieved. They can be used to track progress.
- ***Liaison:*** a person who helps groups to work together and provide information to each other. CAC liaisons share information between the CAC and a local advisory committee.
- ***Oregon Health Authority:*** The state agency tasked with reforming healthcare. It hold contracts with the Coordinated Care Organizations and with Public Health Agencies.
- ***Outcomes***: results or changes, including changes in knowledge, awareness, skills opinions, motivation, behavior, decision-making, condition, or status.
- ***Social Determinants of Health:*** the conditions in which people are born, grow, live, work, & age. Examples include availability of resources to meet daily needs (e.g., safe housing and local food markets; access to educational, economic, and job opportunities; healthcare services; quality of education and job training. Some of these the CCO or its partners have the ability to impact.