**MINUTES OF THE MEETING**
**OF THE BOARD OF DIRECTORS OF**

**Eastern Oregon Coordinated Care Organization, LLC**

**(EOCCO)**

**December 12, 2019**
**St. Anthony Hospital, Pendleton, Oregon**

**BOARD MEMBERS PRESENT:** Catie Brenaman, Dennis Burke, Jeremy Davis, Larry Davy, Renee Grandi, Diane Kilkenny, Robin Richardson, Mike Smith and Christopher Zadeh.

Carlos Olivares and Harold Geller attended via telephone.

**OTHERS PRESENT:** Bill Dwyer, Dave Evans, Nick Gross, Debra Florence, Sean Jessup, Moda/ODS Community Health. Dr. Chuck Hofmann, EOCCO clinical consultant. Bob Seymour, Grande Ronde Hospital. Bob Houser, Morrow County Health District. Charles Tveit, Lake District Hospital. Troy Soenen, GOBHI. Derek Daly, Blue Mountain Hospital District. Dan Grigg, Harney District Hospital. Allison Myers and Oralia Mendez, OSU Center for Health Innovation. Glenn Davis, Yakima Valley Farm Workers Clinic.

Marilyn McGaffin, Moda/ODS Community Health, Estela Gomez, EOCCO Innovator Agent, and Ray Gibbons attended via telephone.

**WELCOME AND INTRODUCTION:** Mr. Richardson welcomed everyone to the meeting and announced that EOCCO had been awarded a new five year contract by OHA to continue its work serving Eastern Oregon. Mr. Richardson noted that several of the smaller, rural CCOs were only awarded single year contracts and would remain under a high level of regulatory scrutiny by the OHA in the coming year. He further offered that the requirements under CCO 2.0 are significantly more prescriptive and extensive than the previous CCO contract.

**CALL TO ORDER:** Mr. Richardson called the regular session of the meeting to order.

**APPROVAL OF MINUTES:** Upon a motion by Dr. Grandi and seconded by Mr. Smith, the Board unanimously approved the minutes of the meeting of the Board on October 17, 2019.

**OREGON HEALTH AUTHORITY UPDATE:** Ms. Gomez reviewed the contents of her Oregon Health Authority Innovator Agent Update, a copy of which was provided to the Board in advance of the meeting. She announced that there was a new CCO operations officer from Deschutes health system. She offered that the Oregon Health Authority (OHA) would be releasing additional provider resources to help providers understand the changes under the new CCO 2.0 requirements. She advised that the reports on children health complexity with state, county and CCO level data were available.

Ms. Gomez explained that the contents of the CCO guidance document regarding the community health assessment plan and policies and procedures. She noted that links to the documents are included in her report.

Ms. Gomez advised that there would be an upcoming webinar for Community Advisory Councils (CAC) regarding the new CCO contract and rule changes affecting them. Many of the CACs responded that some of the new requirements stemming from the contract and rule changes may not be feasible or possible. She noted that CACs may attend the meeting to better understand the draft rules which were not yet final.

Ms. Gomez offered that a new program was now available from the Public Health Division. Providers can refer their patients who meet the WIC requirements to the WIC program to help streamline enrollment.

Mr. Richardson inquired as to whether only staff or staff and board members can attend the meeting. Ms. Gomez noted that she would inquire as to the attendance options.

**FINANCIAL UPDATES:** Mr. Evans presented the EOCCO's balance sheet as of October 31, 2019. He explained that the decrease in cash was the result of the distribution in January. Mr.

Evans continued on to note that the change in the investment strategy has resulted in approximately 6% return on investment. He continued on to note that liabilities had gone up as a result of increased per member per month costs.

Mr. Evans moved on to the P&L statement explaining that revenue was up but the medical loss ratio (MLR) was at 91.4%. Mr. Evans explained that this was consistent with the financial forecasts and accounted for the rate hold in 2018 and rate decrease in 2019. Mr. Burke asked if the MLR target of 85% is different under the CCO 2.0 requirements. Mr. Evans responded that the 85% target was consistent with original requirements and remains unchanged for CCO 2.0.

Mr. Evans advised that he may bring EOCCO's investment advisor to the February 2020 Board meeting to go into detail on the investment portfolio. He will walk through the 2020 forecast and explain what, if any, additional amounts he would recommend moving into restricted reserves from unrestricted reserves. Mr. Evans detailed the investment portfolio components and the performance of each.

Mr. Jessup explained the 2020 rates for all CCOs were included in the Board packet. He noted that EOCCO's new rate accounts for the higher prevalence of cost-based hospitals and out-of-network utilization given eastern Oregon's geography. Mr. Jessup reminded the Board that OHA was now including the Incentive Measure funds premium that accounts for part of the rate increase. He further clarified that OHA would continue to hold the amounts for the incentive payment but EOCCO's overall rate increase includes this in the total.

Mr. Jessup explained that the HRA pass through process would sunset in 2019. OHA added additional dollars into the rates to account for the DRG hospitals at 80% of Medicare rates. As EOCCO has primarily cost based hospitals, the additional premium rate is not anticipated to affect EOCCO as much as other urban area CCOs. Mr. Jessup noted that OHA would do a mid-year rate adjustment based on the risk profile of

the CCOs as a result of new CCOs and member attributions to those CCO's.

Mr. Richardson congratulated EOCCO for hitting the quality and cost metrics for 2019. He informed the Board that OHA announced the preliminary payment projections which indicate that EOCCO is expected to receive approximately $2 million less than in previous years. Mr. Richardson advised that the leadership team would be engaging in high level conversations with OHA regarding the reduction in payments given that all metrics were met.

Dr. Grandi and Mr. Davis questioned Mr. Jessup and Mr. Richardson about the assignment process and the expected impacts in 2020. Dr. Grandi also asked about why Medicaid members still remained on open card. Mr. Jessup explained the various reasons why a member may remain on open card and noted that there will always be a portion of membership on open card as a result.

**COST & UTILIZATION UPDATE:**

Mr. Dwyer presented comparative data across the CCOs. He walked through a high-level comparison of spending by category. Based on the data, as expected, EOCCO had higher costs per member per month on services compared to other CCO's. He noted that the totals were reflective of CY2018 costs. He explained that hospital spend accounts for 45% of medical costs. After some additional analysis, Mr. Dwyer noted that EOCCO had significantly higher emergency room costs than any other CCO. Further, he explained that, while EOCCO has reduced the number of ER visits, EOCCO's cost per visit remains higher than other CCOs. He clarified that the additional emergency room costs were not fully attributable to the general reasons why costs tend to be higher in eastern Oregon. Dr. Grandi asked some clarifying questions regarding the changes in utilization and costs. Mr. Tviet added that, in most of the eastern Oregon geographies, there was a lack of availability of all hours walk-in clinics or urgent care clinics. He asked if this would be a factor driving up emergency room costs as members did not have a lower cost, more appropriate alternative. Mr. Burke noted that increased PCP, all hours walk-in clinic and

urgent care availability would significantly decrease emergency room costs at his hospital specifically. Mr. Hofmann asked Mr. Dwyer to analyze the emergency room utilization on weekends versus weekdays to see if this hypothesis could explain some of the discrepancy. Mr. Houser inquired as to whether there were coding options to identify visits where PCP care would be appropriate but not available. Mr. Hofmann noted that this had been previously investigated but it was not permissible under federal and state regulations.

Mr. Dwyer continued through his presentation, explaining the assumption that EOCCO was anticipated to have some of the highest costs for non-emergent medical transportation services but that the data indicates otherwise. EOCCO was not reported as either the highest on costs or frequency of use. He noted HealthShare was the highest in a smaller, denser geography. Ms. Brenaman noted that some counties are dealing with a shortage of drivers which could be an explanation as to why EOCCO's costs were lower. Mr. Burke noted that many hospitals like his have invested heavily in non-emergent medical transportation services that would not be billed through EOCCO in claims encounters. These programs were a home-grown solution to the access problem. As a result, these investments were not accounted for in the EOCCO's non-emergent medical transportation claims data.

Mr. Dwyer walked the Board through the changes over the year in per member per month costs for various utilization categories. He explained that costs and utilization for emergency room and inpatient were going down while PCP costs and utilization were going up which reflects the significant and ongoing investment in PCP initiatives. He noted that specialty drug and general pharmacy spending was trending upward, which was anticipated given the increasing costs of life saving medications. He continued on to demonstrate that the lab/radiology had gone up by approximately 14%, which was unexpected and concerning. He noted that the bulk of the spending consisted of urine drug analysis claims from Millennia Labs. Dr. Grandi noted that drug

testing was required when members are on certain drugs and that testing was very expensive. Mr. Hofmann noted that the Clinical Advisory Panel had already started digging into the unexpected claims trend to identify ways to control urine drug analysis spending. Mr. Davis requested that more provider specific data be provided to determine where within the system the bulk of the spend was occurring. He noted that, without additional clarification on the data, it was challenging to take actionable steps.

Mr. Dwyer noted that the overall claims trend continues to go down consistent with EOCCO's goals. He explained that over 70% of members did not have an emergency room visit and that this trend had remained stable this year. Further, he explained 19% of EOCCO's spend was for PCP care. He noted that OHA used its own definition to categorize what visits were included in the PCP spend but, even with OHA's definition, EOCCO's was very high even when compared to commercial investment rates.

Mr. Tviet asked if there was a way to get this level of comparative data with other CCOs to have a better idea of how EOCCO was performing in comparison.

**COMMUNITY HEALTH WORKER UPDATE:**

Mr. Richardson provided a background on EOCCO's partnership with the Community Health Worker (CHW) program. Mr. Richardson reminded the Board that EOCCO had voted during its summer Board meeting to continue to fund the innovative program. He introduced Ms. Myers and Ms. Mendez who were in attendance from the Center for Health Innovation. Ms. Myer's thanked the EOCCO for its continued support of the college and the CHW program. CHI was launched in 2018 and Ms. Myers explained the center and its work. She included a list of the programs by the CHI in her presentation, provided to the Board in advance of the meeting.

Ms. Mendez described the CHW program history. To date, 12 sessions of the program were delivered to 115 students around the state of Oregon. CHI developed continuing educational courses and curricula to help CHWs post-program completion. Ms. Mendez described some details on her

background and her roles in her community of Nyssa. Ms. Mendez shared a story about the impact a CHW had on an individual as well as a community. She thanked the Board for its renewed support of the CHW training program and noted that it had been renewed by OHA through July 2022. Additionally, Ms. Mendez explained that an in-person training day has been added to the program and two virtual sessions. The online resources remain the same as well as the program the goals.

Ms. Mendez explained that interested individuals are reaching out to obtain materials and schedule programs in their own communities. She advised there has been some interest in training high school students in Harney county. She also noted that she spoke with Ms. Kilkenny about potentially offering the program in other eastern Oregon counties.

Ms. Kilkenny explained that CHWs were key components to spreading healthcare in underserved communities. She noted that health happens in the home and the community and CHWs were a key resource to bridging the gap between the doctor's office and the home. Ms. Myers noted that CHI was seeking to broaden its reach in the community and provide more data on the benefits and effects of CHWs on health outcomes. Mr. Tviet asked how the program deals with the issue of wages for program graduates. Ms. Mendez noted that the new trainees generally seek opportunities at the hospitals and normally receive entry level salaries. Mr. Richardson asked to what Ms. Myers attributes the record enrollment in the most recent session. She explained that the EOCCO staff have been helpful in getting the word out as well as the partnership with PACE. Dr. Grandi inquired as to how the new requirements around Social Determinants of Health (SDoH) under CCO 2.0 would affect program enrollment. She noted that one of the most effective ways to address SDoH in the clinics and hospitals would be to engage with CHWs.

Mr. Hofmann asked if there was any data on the tenure of CHWs. He noted that, anecdotally, once the CHW are trained and work for a period of time, it led

to interest in other healthcare related fields such as nursing. Ms. Mendez advised that data on this topic was not currently available, but CHI was developing an evaluation to help track CHW career progression. Ms. Brenaman noted that New Mexico has been using and studying CHWs. Some information may be available from studies there. Ms. Kilkenny noted that focusing the CHW pipeline to health care professional was a way to increase access in eastern Oregon. Mr. Jessup thanked Ms. Myers and her team in defending the online portion of the program that has been so important for individual access in eastern Oregon. Mr. Jessup noted the new CCO 2.0 THW representative would be connected and available to the CHI.

**ADMINISTRATIVE SERVICE AGREEMENT AMENDMENTS:**

Ms. Florence explained the need to update EOCCO's administrative service agreements with its subcontractors to ensure the agreements conformed to the CCO 2.0 contract requirements. Mr. Richardson advised that the administrative service agreements, upon updating, would be back to the Board for approval.

Upon a motion by Mr. Davis and seconded by Dr. Grandi, the Board unanimously approved amending EOCCO's administrative service agreements to comply with the CCO 2.0 requirements.

**NEW BOARD SUBCOMMITTEES:**

Mr. Gross explained that under CCO 2.0 several new Board committees were required. Mr. Gross presented the two draft committee charters, one for the Compliance Committee and the other for the CAC Selection Committee. He described the purpose of the two committees and requested Board members volunteer by the end of the year for participation on one or both committees. He requested that a minimum of two Board members participate on the Compliance Committee. He noted that the Compliance Committee would meet quarterly with its report sent to the full Board on its activities.

Upon a motion by Dr. Grandi and seconded by Ms. Kilkenny, the Board unanimously approved the formation of and charter for the Compliance Committee.

In regard to the CAC Selection Committee, Mr. Gross explained the historic method for selecting and appointing members to EOCCO's LCACs and CAC was very flexible. He explained that Ms. Brenaman shall be a member, with a commissioner and Diane as Board representatives. Mr. Hofmann noted that the process should be made consistent with the historic process to the extent possible as it had worked well in the past.

Upon a motion by Ms. Brenaman and seconded by Mr. Houser, the Board unanimously approved the formation of and charter for the CAC Selection Committee.

**CONFLICT OF INEREST POLICY AND ATTESTATION:**

Mr. Gross explained the Conflict of Interest policy and requested that all Board members and Officers fill out the form. He offered to collect them at the conclusion of the meeting if individuals were ready to turn them in. Mr. Tviet asked if anyone beside the officers and Board members should complete the form. Mr. Gross advised that it was not required. Mr. Gross advised that anyone who needed more time to fill out his/her COI form could email them to Mr. Gross and Mr. Jessup at a later date.

**EOCCO CLINICAL UPDATE:**

Mr. Hofmann advised that the draft 2020 quality bonus payment methodology would be presented to the Board for approval at the next meeting in February.

Mr. Hofmann explained multiple PCP training opportunities available through ECHO/ORPRIN. He provided details on the various programs and requested Board members circulate with the information with any providers who may be interested to increase visibility and participation.

Mr. Hofmann noted that grant funding recommendations will be presented at the February meeting. Mr. Hofmann described the highlights of the recent provider summit and noted that it received a warm reception in the community. He noted that Dr. Kitzhaber spoke highly of the event and Dr. Kitzhaber's presentation was incredibly well received.

**PUBLIC COMMENT:** Ms. Brenaman advised that the next regional CAC meeting will not occur due to insufficient attendance.

**INFORMATIONAL REPORTS & UPDATES:** Mr. Jessup walked through the reports that were provided in advance of the meeting.

**ADJOURN:** There being no further business, the meeting was adjourned.

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Assistant Secretary