

# >> CCO 2.0 Recommendations of the Oregon Health Policy Board



# Executive summary

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

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

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

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

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

# CCO 2.0 Policy recommendations: The future of the Oregon Health Plan

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

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



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

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

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



## Increase value and pay for performance

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

Recommended policies will:

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



## Focus on social determinants of health and health equity

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

Recommended policies will:

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



## Maintain sustainable cost growth and ensure financial transparency

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

Recommended policies will:

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

## Conclusion

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

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

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

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

# Acknowledgments

The Oregon Health Authority Health Policy and Analytics Division, Health Systems Division, Office of Equity and Inclusion, Public Health Division and External Relations Division prepared this publication.




Oversight provided by the Oregon Health Policy Board.

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Please cite this publication as follows:

Oregon Health Authority Health Policy & Analytics Division. CCO 2.0 Recommendations of the Oregon Health Policy Board. Portland, OR. 2018 October.

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# CCO 2.0: Building on successes of Oregon's health system transformation

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

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

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

## Progress toward better health, better care and lower costs

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

- CCOs are locally governed.
- CCOs are accountable for the health outcomes of the communities they serve.
- Decisions are made through partnerships among:
  - » Health care providers
  - » Community members,
  - » OHP members, and
  - » Stakeholders in the health systems that have financial responsibility and risk.

CCOs have one integrated global budget for behavioral health (mental health and substance use) services, physical health and oral health care. CCOs have flexibility within their budgets to provide services outside traditional medical services. The goal of this flexibility is to meet the triple aim of better health, better care and lower costs for the population they serve. They have flexibility to support new models of care that are patient-centered and team-focused and reduce health disparities. CCOs coordinate services to focus on: prevention, chronic illness management and person-centered care.

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

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

Avoidable emergency department visits have decreased by more than 50 percent between 2011 and 2017

CCOs are also improving health care quality and other health indicators. This is especially true in the areas tied to incentive payments. For example, enrollment has increased in primary care homes. All CCOs met the threshold for the associated patient-centered primary care home incentive

metric in 2017. Developmental screenings from birth to three improved from just under 21 percent in 2011 to almost 70 percent in 2017. There has also been marked improvement on other OHA tracked quality measures. For example, avoidable emergency department visits decreased by over 50 percent from 2011 to 2017.

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

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

The evaluation found that total spending per member per month decreased relative to Washington Medicaid members.

The OHSU evaluation also identified eight recommendations to further health system transformation in the future, while continuing to build upon the existing foundation:

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

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

## Governor Brown identifies four areas for improvement

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

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

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

1. **Improve the behavioral health system and address barriers to the integration of care:**

Integrate behavioral, physical and oral health to allow patients to receive the right care at the right time and in the right place. Focus on behavioral health (mental health and substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.

## 2. **Increase value and pay for performance**

Reward providers' delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.

## 3. **Focus on the social determinants of health and health equity**

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

## 4. **Maintain sustainable cost growth and ensure financial transparency:**

Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

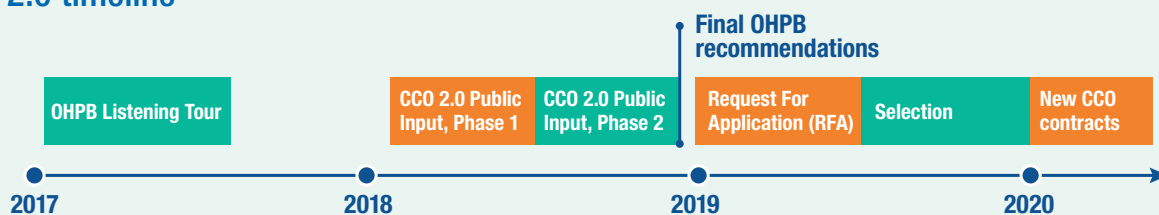
## Developing CCO 2.0 policy recommendations

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

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

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

### CCO 2.0 timeline



# Public engagement: Oregonians shape health transformation policies

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

Public engagement allows OHA to:

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

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

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

- Discussion at more than 25 health committee meetings
- Oregon Health Policy Board meeting updates and public testimony
- Presentations at more than 20 conferences and meetings
- Two formal tribal consultations
- Thirteen community advisory council meetings, hosted by OHA innovator agents
- Four public forum events across the state in April and May 2018 (200 participants)
- Ten public road show events across the state in June 2018 (more than 500 participants)

- Spanish-language forum in Woodburn, OR (100 participants)
- Spanish-language forums hosted by Mid-Columbia Health Equity Advocates (MCHEA) in Hood River and The Dalles (more than 40 participants)

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

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

## Community engagement strategies

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

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

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

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

# Public engagement impact on CCO 2.0 policy recommendations

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

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

## OHP members are highly satisfied with the program and with the health care they receive.

	Very satisfied	Somewhat satisfied	
Quality of health care	63%	27%	90%
Oregon Health Plan	64%	24%	89%

DHM research | OHA Oregon Health Plan member survey | August 2018

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

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

When feedback has supported modifying policies, OHA has carefully considered potential changes as well as the diverse viewpoints surrounding the policy. For example, health equity advocates and subject matter experts played a key role in reframing how OHA should approach issues of health equity. Embedded within a request that we adopt a framework of “cultural responsiveness” instead of defining the work as “cultural

competency” is an understanding that this work is ongoing. It is a process that understands we can never fully attain all the skills and views we need to work with culturally diverse clients. Instead, “responsiveness” assumes one has the openness to adapt to the cultural needs of those with whom they work, always seeking greater understanding of their culture, ethnicity, and language.

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

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

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



# Health equity impact assessment of the CCO 2.0 policy recommendations

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

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

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

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

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

# Policy recommendations: The future of the Oregon Health Plan

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

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

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

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

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

# Tribal consultation and meeting the health needs of tribal members

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

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

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

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

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

## Incorporating children's health needs into CCO 2.0 policies

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

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

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

### Key Strategies to Improve Children's Health

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

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

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

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

**Policy 27:** Require Wraparound services for all children and young adults who meet criteria.

# Accountability, contract monitoring and enforcement

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

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

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



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

## Vision

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

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

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

## Considerations

The current behavioral health system's functioning and operations are inconsistent across Oregon. As a result, OHPB has expressed that behavioral health is an immediate urgency to improve the health care system in Oregon. The 2016 Behavioral Health Collaborative, a group of 50 stakeholders convened to recommend a modern behavioral health system in Oregon, found "the behavioral health system continues to include fragmented financing,



carve-outs that prevent integration and efficiencies, siloed delivery systems, and services that fail to serve and exacerbate poor health outcomes.” The Behavioral Health Collaborative recommendations focused on workforce, standards of care and competencies, metrics, and health information technology. These recommendations are incorporated into CCO 2.0 behavioral health policy recommendations.

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

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

OHA also considered existing statewide plans and recommendations that addressed the needs of adults living with SPMI and SUDs. In 2012, to address the investigation of the State’s compliance with mandates for community mental health services to be sufficient to avoid unnecessary institutionalization of adults with SPMI, OHA entered into an agreement with the Civil Rights Division of the United States Department of Justice (USDOJ). This agreement with the USDOJ implements systemic changes to Oregon’s behavioral health system during health system transformation. Out of this agreement, in 2016 OHA issued the Oregon Performance Plan (OPP) to improve mental health services for adults living with SPMI. The main goals of the OPP are to reduce inappropriate institutionalization and strengthen the community behavioral health system. OPP priorities such as assertive community treatment services, mobile crisis services, linkages to services, discharges from the Oregon State Hospital, and reducing acute psychiatric care and emergency department readmissions helped inform the development of policy recommendations to ensure alignment.



In 2018, House Bill 4143 directed the Department of Consumer and Business Services (DCBS), with OHA, to study and report on existing barriers of effective treatment for and recovery from substance use disorders. OHA consulted on the resulting report and recommendations, which furthered clear alignment between the DCBS and CCO 2.0 policy recommendations. The most significant recommendation from the DCBS report is that substance use disorder be addressed as a chronic health condition, with ongoing care and services available to maintain recovery even when an individual is not actively using. Other recommendations include incentives to substance use disorder treatment providers in rural and underserved areas, increasing capacity within the full spectrum of services, and identifying and addressing issues of reimbursement equity.

The opioid epidemic continues to devastate families. Federal and state funding targets specific aspects of combating the opioid epidemic, and Oregon has added medication assisted treatment options in previously barren parts of the state. The CCO 2.0 policy

recommendations are designed to build on successes and increase access for individuals and families struggling with opioids. CCOs will be responsible for ensuring members have access to behavioral health services, including services to treat opioid use disorder. CCOs, in collaboration with local providers and Community Mental Health Programs (CMHPs), will ensure that adequately

The Oregon Health Plan needs a full continuum of care for behavioral health. This includes services from outpatient to inpatient or residential settings to withdrawal management and recovery support services for mental health and substance use disorder.

trained workforce, provider capacity, and comprehensive integrated services exist in the CCO region for individuals and families in need of opioid use disorder treatment and recovery services. CCOs will coordinate care with local hospitals, emergency rooms, oral health, law enforcement, emergency medical services, traditional health workers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their community.

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

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





- Prohibiting arrangements that fully sub-capitate and delegate the behavioral health benefit, and
- Increased support for health information technology and health information exchange.

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

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

## Policy recommendations

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

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

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

Community Mental Health Programs (CMHPs) are responsible for safety net and mobile crisis services, along with other key behavioral health services in the county. CCOs must



honor and enforce memorandums of understanding with the CMHPs. CCOs and CMHPs should work together, with OHP members, to develop the CCO community health improvement plan and the local mental health authority biennial implementation plan. These two plans should inform and complement one another.

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

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

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

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

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



behavioral health outcomes because of improved integration. The CCOs will report on these metrics as transparent integration goals.

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

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

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

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

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

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



of their workforce, and fairly assess the adequacy of the provider network to deliver effective care and treatment for members throughout the lifespan.

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

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

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

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



# Increase value and pay for performance

## Vision

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

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

## Considerations

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

Since Oregon first launched CCOs, significant work has occurred nationally to create a framework for health systems to move away from FFS toward VBP. Efforts to deliver person-centered care have been stymied nationally and in Oregon, to a large degree, by a payment system that is oriented toward paying for volume—as opposed to value—for



Value-based payments fundamentally change the way health care is delivered and better enable providers to invest in care that is focused on patient needs and health goals.

patients and caregivers. Previous payment reform efforts focused exclusively on capitating payments, without including a link to quality. These efforts, while often successfully containing costs, were generally unsuccessful in achieving the triple aim because they failed to ensure access to and quality of care was maintained.

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

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

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

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

OHA has developed the recommended VBP policy using the results of the Evaluation of Oregon’s 2012–2017 Medicaid Waiver (1), maturity assessment, CCO VBP Workgroup,



VBP provider survey, expert technical assistance provided by CMS, CCO 2.0 surveys and public engagement meetings.

## Policy recommendations

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

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

Each CCO applicant will be required to:

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

In 2020, each CCO will be expected to implement 20 percent of dollars using a VBP. In year two (2021), each CCO will be required to implement new VBPs in at least two of the five care delivery focus areas and one of the areas must be either hospital care or maternity care. A CCO may implement new VBPs in both hospital care and maternity care in 2021, but both must be implemented by year three (2022). In years three through five, CCOs will annually add one new VBP in the remaining care delivery focus areas, allowing them to gain experience and develop more advanced VBPs in these areas.



## Increase CCOs' support of Patient-Centered Primary Care Homes (PCPCHs) by requiring VBPs for PCPCH infrastructure and operations (Appendix A: Policy 10)

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

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

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

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

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





# Focus on social determinants of health and health equity

## Vision

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

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

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



## Considerations

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

- CCOs have reported minimal investment in health-related services, particularly those related to social determinants of health, in financial reports. However, current reporting has significant limitations.
- Based on CCO reporting, CCOs are investing in these areas, with a focus on housing and trauma or adverse childhood experiences, but data is self-report and limited.
- CCOs have partnered, to varying degrees with community partners that can support work related to health equity and social determinants of health, including Early Learning Hubs, local public health authorities, and Regional Health Equity Coalitions. CCOs have limited expectations in statute or contract related to these partnerships.
- While statewide workforce data is available, little is known about CCO employment or utilization of key providers such as traditional health workers and health care interpreters.
- Disparities in health outcomes and in access to quality of care related to race or ethnicity, disability, and behavioral health status are evident.

In developing and vetting the recommended policies, OHA received input through OHPB, stakeholders, and the public that reinforced the maturity assessment findings and strong support for social determinants of health and health equity as a significant area in need of attention, support, collaboration and spending. This includes placing additional emphasis on developing and strengthening partnerships with local public health authorities to improve population health. Feedback included a clear call for OHA to ensure explicit goals and strategies for addressing health inequities are in place and to recognize that it is as much a responsibility for OHA to support CCOs in this work as it is a mandate for CCOs.



Members and stakeholders also identified strategies to advance equitable and culturally and linguistically responsive health care by improving access to traditional health workers; collaboration and intentionality within workforce diversity efforts; and ensuring quality, accessible and meaningful language services for individuals with limited English proficiency.

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

- CCO SDOH and health equity initiatives should be driven by members and their communities, and funds should flow as much as possible to community partners doing the work, in alignment with the community health improvement plan;
- The community advisory councils should play a central role in decision-making related to social determinants of health and health equity spending;
- Public health and a focus on prevention should be emphasized in these efforts as key to promoting population health; and
- OHA should recognize potential challenges with measuring needs within the areas of social determinants of health and health equity and the impact of initiatives, such as collecting data via electronic health records.

About 50 percent of the factors that determine health outcomes are related to social determinants of health and health equity, while clinical care only accounts for 20 percent. *Source: County Health Rankings Model. University of Wisconsin Public Health Institute. 2014.*

## Policy recommendations

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

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

As a foundation for implementing these policy options, OHA is in the process of adopting standardized definitions of social determinants of health, health equity, and health disparities. This work intentionally elevates definitions and recommendations developed by the Medicaid Advisory Committee, the Public Health Advisory Board, and the Health Equity Committee of OHPB.



## Increase strategic spending by CCOs on social determinants of health, health equity and disparities in communities, including encouraging effective community partnerships (Appendix A: Policies 1, 2)

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

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

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

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

CCO partnerships with local public health agencies, hospital systems and tribes are critical to ensuring community health priorities and investments are aligned and impactful. A shared process for assessing community health needs and identifying interventions will reduce the burden on community members, local government and organizations who might otherwise participate in multiple similar processes. Alignment and collaboration also ensures resources within the community are directed toward achieving common goals.



## Strengthen meaningful engagement of tribes, diverse OHP members, and community advisory councils (Appendix A: Policies 1b, 2b, 4, 7)

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

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

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

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

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



# Maintain sustainable cost growth and ensure financial transparency

## Vision

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

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

## Considerations

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

- Oregon's program-wide 3.4 percent spending target is an important tool to ensure



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

- The OHSU waiver evaluation found that spending declined among CCO members compared to Washington Medicaid members, but spending on prescription drugs grew in both states, although may have grown more quickly in Oregon than in Washington. New policy interventions may be needed to rein in pharmacy costs.
- CCOs have substantial flexibility to deliver services to members within the constraints of the global budget. While that flexibility is critical to ensuring their success, new program-wide solutions may be necessary to achieve spending targets without compromising access to or quality of care for members.
- Technical assistance from OHA helps spread effective CCO practices and reduce costs. This resource is unique across state Medicaid programs and should remain a critical tool for improving CCO performance and maintaining access to care.
- Incentive payments to reward CCO performance have shown significant ability to motivate CCOs and their provider partners to achieve statewide benchmarks and/or improvement targets. Oregon should build on successes and maintain its commitment to pay for better quality care and health outcomes, which should help reduce health care costs in the long run.
- Improved data on CCO performance beyond incentive metrics, as well as comparable data across CCOs to better understand how CCOs achieve sustainable spending targets, will provide better opportunities to improve global budgeting and reduce costs.
- Improved transparency with existing CCO performance data, such as annual rates of growth, could be used to help address specific cost drivers like rising pharmaceutical costs.

Medicaid costs are expected to grow nationally at an average rate of 5.8 percent per year through 2026. Controlling costs in Oregon requires us to change the way we pay for and deliver care.<sup>2</sup>



- More efficient health care systems that invest in primary care services will help members to stay healthier. These services reduce the need for medical interventions that cost more later. For example, by managing chronic conditions members will require less urgent medical treatment or other more expensive health care services.
- Limiting growth in Oregon’s spending on Medicaid is as much an exercise in rate-setting as it is an effort to reduce underlying costs of health care services. While some interventions may reduce long-term costs or increase the quality of care delivered, they may also necessarily increase spending in the short-term.
- Policies to reduce spending and costs should also amplify policy interventions that:
  - » Improve quality and pay for value
  - » Address social determinants of health
  - » Improve health equity, and
  - » Ensure access to behavioral health care services at the right place and right time.

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

## Policy recommendations

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

OHA will institute additional contractual requirements for CCOs to meet sustainable rate of growth targets that are included in Oregon’s 1115 Medicaid Demonstration Waiver and set biennially by the Oregon legislature. However, because Oregon’s current Medicaid waiver expires in the middle of the next CCO contract period, the recommendations also direct the agency and board to examine ways to set more aggressive spending targets in





the future. These would be based on overall economic growth factors to ensure ongoing sustainability of the Oregon Health Plan. Setting more aggressive spending targets also requires new policies and tools to help OHA and the CCOs achieve the targets without sacrificing quality of or access to care for Oregon Health Plan members.

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

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

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

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

The next round of CCO contracts also provide an opportunity to incorporate measures of quality and value into payments made directly from OHA to health care providers, such as hospitals. Currently, hospitals pay an annual assessment that is used to increase hospital reimbursement rates as well as help fund the state's share of the cost of the Medicaid program. Beginning in 2020, the payments to hospitals made with these funds will begin to incorporate measures of hospital quality and the value of the care they provide. As



CCOs move towards implementing additional value-based payments, there will be new opportunities to align these measures and metrics across payers and systems.

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

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

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

CCOs in Oregon and Medicaid managed care plans nationally are increasingly resembling commercial health plans. Evidence of this can be seen by the many current CCOs affiliated with plans or companies that offer commercial products on the health insurance marketplace, have Medicare managed care plans (called Medicare Advantage), and offer products to employers. As a result, the CCO 2.0 policies change CCO reporting structures and OHA's oversight tools to more closely resemble reporting and oversight of these same commercial plans.



In particular, the policies require CCOs to report their financial situation to the state using insurance-industry standard reporting templates crafted by the National Association of Insurance Commissioners (NAIC). These reporting templates are crafted specifically for health insurance carriers, and several states already use the templates for their Medicaid managed care entities. The templates provide a more consistent look at CCO financial situations compared to current state-based Exhibit L reporting standards.

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

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

Finally, OHA will examine the feasibility and implementation of a program mirroring the commercial insurance code's "Guaranty Fund" to provide additional financial resources if a CCO becomes significantly financially impaired. Under this proposal, resources from stable CCOs would be temporarily used to help repair a CCO in financial stress, or to help OHA manage an insolvency event. This would allow solvency thresholds to be set at a slightly lower level and avoid requiring CCOs to over-capitalize reserve accounts in a manner that unnecessarily reduces CCOs resources to deliver health care services in their community.



## Use program purchasing power to align benefits and reduce costs with a focus on pharmacy costs (Appendix A: Policies 14, 15, 37)

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

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

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

# Next steps

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

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

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

# Endnotes

1. Oregon Health & Science University, Center for Health Systems Effectiveness. Evaluation of Oregon's 2012-2017 Medicaid Waiver. 2017, Dec 29. [cited 2018, Oct. 3]; Available from: <https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>
2. Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2017-2026: Forecast Summary. 2018, Feb. [cited 2018, Oct. 12]; Available from: [www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf)

# Appendices

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