Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
1	**Implement HB 4018: Require CCOs to spend portion of savings on SDOH, population health policy and systems change, and health equity/health disparities, consistent with the CCO community health improvement plan (CHP)** a) Require CCOs to hold contracts or other formal agreements with and direct a portion of required SDOH/HE spending to SDOH partners through a transparent process b) Require CCOs to designate role for CAC in directing and tracking/reviewing spending. c) **Years 1 & 2:** Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the global budget rate methodology and will seek to build in a specific amount of SDOH/HE investment intended to advance CCOs' efforts to address their members' SDOH and establish their internal infrastructure and processes for ongoing reinvestment of a portion of net income and reserves in social determinants of health and health equity. d) **Require one statewide priority** – housing-related supports and services – in addition to community priority(ies)	★ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●● ✓ **2019 POP planned** Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**	Increased strategic spending by CCOs on social determinants of health and health equity/disparities. Decision-making is inclusive and consumer-informed.	• Mandated by HB 4018; 1c is not required but strongly recommended by OHA staff. • HPA and actuarial staff to develop investing guidelines, additional requirements, and reporting and monitoring strategy • TA and compliance needed NOTE: POP is for a SDOH Transformation Analyst that would support a variety of SDOH work; could be applied to this policy option.	• Spending amounts contingent on OHA's 2020 budget and 3.4% growth cap. • Builds toward 2012-2017 waiver evaluation recommendation #7: *Require CCOs to commit one percent of their global budget to spending on social determinants of health.* • Spending must align with CCO CHP priorities, TQS, waiver • Pros: May encourage spending on health related services as key mechanism to track investments in SDOH; May encourage additional spending on SDOH within the global budget • Cons: Could reduce funds flowing to clinical providers • Feedback: o OHPB 7/10/18: Support for statewide priority of housing-related supports and services o CCO 2.0 Survey and MAC survey ranked housing as a top priority for SDOH work • Agency partnerships: OHA is partnering with Oregon Housing and Community Services to expand supportive housing in the state, and there are opportunities to leverage this partnership to increase housing infrastructure in communities while expanding the housing-related services and supports that CCOs provide to complement this infrastructure.
2	**Increase strategic spending by CCOs on health-related services by:** a) Encouraging HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans; and b) Requiring CCOs' HRS policies to include a role for the CAC in making decisions about how community benefit HRS investments are made.	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●○ 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment**	SDOH spending is aligned in communities and across various SDOH spending strategies. Community resources are used more efficiently. Decision-making is inclusive and consumer-informed.	• No substantive contract changes for 2a ("encourage") • Contract language change for 2b • OHA to develop guidance, FAQs to ensure clarity on HRS requirements	• Builds toward 2012-2017 waiver evaluation recommendation #5: *Create a "one-stop shop" where CCOs and other stakeholders can find information about health-related services* • Pros: Leverages existing work and other SDOH spending requirements • Cons: Competing priorities for investment

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#	Policy	Dashboard	Intended impact	Implementation	Considerations
		✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**			
3	a) **Encourage CCOs to share financial resources with non-clinical and public health providers** for their contributions to incentive measures, through clarifying the intent that CCOs offer aligned incentives to both clinical AND non-clinical providers with quality pool measure areas b) **Encourage adoption of SDOH, health equity, and population health incentive measures** to the Health Plan Quality Metrics Committee and Metrics & Scoring Committee for inclusion in the CCO quality pool	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Increases transparency	Community partners are engaged and receive financial resources for their contributions to achieving incentive measures. Robust and sustainable community-clinical linkages in place for meeting incentive measures. *Metrics:* CCO quality pool dollars are used to incentivize improvements in SDoH and health equity.	Part a to be phased in after Year 1. • Staff FTE for planning, tool development and ongoing technical assistance needed in HPA and PHD; monitoring/compliance also needed. Part b can be implemented in Year 1 with no additional resources.	**Part a:** • Recommended by the Public Health Advisory Board (PHAB) • Support provided at road show forums. • Pros: o Sets expectation that CCOs assess contributions of non-clinical and public health providers in achieving incentive measures - in addition to clinical providers - and pay for these contributions accordingly. o Maintains local flexibility for CCOs to work with specific providers in their communities that meaningfully contribute to meeting incentive measures. o May allow for better standardization for how non-clinical and public health providers are included in quality pool payment structures. • Cons: As written, this policy option "encourages" rather than "requires," which may lead to inconsistent approaches. However, there are concerns about requiring quality pool payments to a single provider type, which may have unintended consequences and by setting a precedent for similar requirements for other provider groups. Also, federal waiver concerns have been identified related to requiring incentive payments to specific providers. **Part b:** Current statute doesn't allow OHA to require that either HPQMC or M&S take up specific measures or categories of measures. However, both committees are committed to this work.
4	**Strengthen community advisory council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers** through the following: a) Require CCOs to report on CAC member composition and alignment with demographics of Medicaid members in their communities, including: 1) How the CCO defines their member demographics and diversity, 2) The data sources they use to inform CAC alignment	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●○	CCOs have a representative CAC. This builds trust and relationship with members. Systems are designed with the member in mind.	Part b to be implemented in Year 2 or later **Due to need for legislative change, other components of this policy may need to be implemented in Year 2 of contract** (TBD; pending confirmation with procurement team).	• Pros: Supports better representation and meaningful engagement of consumers; reporting requirements can be added to the TQS; potential benefit to recruitment/retention (elevate CAC due to role on board – part C) • Cons: Potential recruitment and retention challenges (including possible resistance to CAC members reporting on their own demographic information to their CAC/CCO); enrollment data issues/complexity (can use demographic data from American Community Survey or other sources as needed); possible

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#	Policy	Dashboard	Intended impact	Implementation	Considerations
	with these demographics, 3) Their intent and justification for their CAC makeup, 4) An explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress, 5) The percentage of CAC comprised of OHP consumers, b) Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, education, etc.) and, c) Require CCOs have two CAC representatives, at least one being an OHP consumer, on CCO board. d) OHA is exploring adding a recommendation that CCOs use a Tribal Advisory Committee rather than simply ensuring tribal representation on the CAC. Development of this policy option is occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes. e) OHA is exploring implementation options for a requirement that CCOs have a designated Tribal Liaison per 1115 Waiver Attachment I, "Tribal Engagement and Collaboration Protocol." This is also occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes.	2019 POP planned ✓ **Requires legislation** Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**		• HSD work needed to ensure better demographic data of CCO enrollment • Transformation Center capacity for TA and receiving and reviewing reports • Need to define OHP consumer	concern with information privacy and how much of that info is shared with the federal government • Requiring alignment with communities came from interest from numerous stakeholders in supporting more diversity and better representation, but this specific policy option as worded did not come directly from CACs. • Part C - Requiring CCOs to have more than one CAC representative on the board was included after interviews with key informants (primarily CAC coordinators).
5	**Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities** by implementing the following: a) Require CCOs to adopt a Health Equity plan, including culturally and linguistically responsive practice, to institutionalize organizational commitment to health equity, b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and c) Require an organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation.	Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ● ○ ○ How large is impact? ● ● ○ 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring	Standarization of health equity infrastructure present in all CCOs. CCO health equity expertise, capacity and infrastructure to facilitate adoption of measures to reduce health disparities	• All strategies in this policy option will be in contract and set to begin on Year 1. Excpectations for full implementation and completion of activities have the potential to be flexible. • Current work led by OEI and future guidance from Health Equity Committee will provide a framework for the development of CCO Health Equity Infrastructure guidance: a) OHA/OEI/TC to staff/lead a work group that will	• CCO 1.0 maturity assessment showed that lack of detailed tracking mechanisms and data related to health equity contributed to the challenge of understanding how CCOs have impacted these areas over the last five years. The infrastructure proposed on CCO 2.0 will facilitate standarization and will ease the provision of TA by OHA. • Some CCOs have developed a strong organizational infrastructure for health equity, others have not; this represents an inequity that will be remedied on CCO 2.0. • The development of CCO internal infrastructure and investment to coordinate and support CCO equity is neccesary to ensure a) CCOs around the state are moving in the same direction; b) OHA and OHPB have a conduit to connect with CCOs on health equity activities, build learning collaboratives, and provide guidance and technical assistance; c) Health Equity infrastructure will

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		✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**		develop health equity plan guidelines for CCOs. b) OHA/OEI/TC to develop "single point of accountability" role expectations that relate to prioritization of health equity; engagement with the community; health disparities work; use of REAL-D data; workforce diversity; and, organizational learning. OHA/OEI/TC to develop Cultural Responsiveness and Implicit bias training fundamentals plan guidance document. c) Plan would continue CCO role in using HIT for patient engagement • OHA/OEI/TC/Quality will develop appropiate monitoring and compliance processs needed for all strategies.	facilitate the deployment of health equity metrics once they are developed. • The term "Health equity infrastructure" refers to the adoption and use of culturally and linguistically responsive models, policies and practice including and not limited to community and member engagement; provision of quality language access, workforce diversity, ADA compliance and accessibility of CCO and provider network, ACA 1557 compliance, CCO and provider network organizational training and development, implementation of the CLAS Standards, non-discrimination policies etc. • The HIT for patient engagement component would promote patient engagement and health outcomes, although some providers lack the systems to engage with their patients electronically. Some systems may also lack the ability to support needed language and accessibility modifications. Stakeholders have expressed that they need support and guidance from OHA to help CCOs understand and leverage efforts in place (e.g., PCPCH requires patient portals), and are not sure how to incentivize members to use HIT. Some patients have multiple patient portals – which can be onerous and confusing. Patient control of their own health information is important – including the ability to correct information.
6	**Implement recommendations of the THW Commission:** a) Require CCOs to create a plan for integration and utilization of THWs. b) Require CCOs to integrate best practices for THW services in consultation with THW commission c) Require CCOs to designate a CCO liaison as a central contact for THWs d) Identify and include THW affiliated with organizations listed under ORS 414.629 (Note that d. is also included under Policy Option 8 for CHAs/CHPs) e) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for traditional health workers (THW) services.	★ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●● 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment**	Increases THW workforce by setting up a livable and equitable payment system; Increases access to peventive, high-quality care beyond clinical setting and improves outcomes Increases access to culturally and linguistically diverse providers beyond clinical setting.	All activities will be in contract beginning in Year 1; expectation for implementation/completion varies by activity. CCOs will work with THW Commission, OEI and HSD to: • Designate CCO liaison • Develop integration/ utilization plan with metrics to track integration milestones w/score for progress • Determine centralized/ standard reimbursement rates for reimbursement utilizing the Payment Models Grid created by the THW	• Builds upon THW services requirements already in contract. ○ Strong support came from health systems , health insurance carriers such as Providence, Care Oregon, Kaiser, OPCA and other CBOs, FQHCs ○ Need to dedicate necessary resources to ensure policies are adequately and appropriately staffed, monitored, and enforced. ○ The integration and utilization plan fulfills the mandates established by the following legislation: HB 3650 (2011), HB 3311 (2011), SB 1580 (2012), HB 3407 (2013)) & HB 2304 (2017). ○ Literature shows improved health outcome for consumers, which, in return, saves money for OHA through Medicaid programs. Positive return on investment with increased number and utilization of THWs • Payment Model Grid contains a variety of pathways for THW payment including APM; value-based payment such as bundling and per-member-per-month payment; Fee for Service,

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		✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**		Commision Payment Model Committee	Grants/Contracts, Pathways, Medicaid administrative, targeted case and direct employement.
7	Require CCOs share with OHA (to be shared publicly) a **clear organizational structure that shows how the Community Advisory Council connects to the CCO board**	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ● ○ ○ How large is impact? ● ○ ○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ☐ Potential to impact children ☐ May require OHA TA support ✓ **Increases transparency**	Transparency on fulfillment of statutory requirement	Transformation Center staff: Monitoring in TQS	Reporting can be added to the Transformation and Quality Strategy (TQS)
8	Require CCOs to partner with local public health authorities, non-profit hospitals, and any CCO that shares a portion of its service area to **develop shared CHAs and shared CHP priorities and strategies.** a) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need. Ensure CCOs **include organizations that address the social determinants of health and health equity in the development of the CHA/CHP,** including THWs affiliated with organizations listed under ORS 414.629.	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ● ● ○ How large is impact? ● ● ● ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring	Improved population health outcomes through CHA and CHP collaboration and investment. CHAs and CHPs that reflect the needs and priorities of the entire community. Reduced burden for community members due to streamlined community assessment and planning processes.	• Contract changes and rules changes needed. • Needs to be in contract for year one; work would phase in. CCOs would be required to meet these policy requirements with new CHAs and CHPs developed during the 2020-25 contract period (i.e. next CHA/CHP cycle; may differ by CCO) • OHA could convene a workgroup in Year 1 of the contract to develop recommendations for addressing barriers to shared CHAs and shared CHP priorities	• **Shared CHAs and shared CHP priorities and strategies:** Recommended by the Public Health Advisory Board. Supported by OHPB at June meeting. Supported during road show forums. o Likely to reduce burden on community members who are asked to participate in multiple health assessments. Will reflect the needs of entire community, beyond Medicaid. Challenges with shared CHP development can be addressed through implementation and contractual requirements. • **SHIP priority alignment:** Recommended by OHA staff. Support voiced by OHPB at 7/10 meeting. o High level of alignment currently between CHPs and 2015-19 SHIP. All CCOs could meet requirement with 2015-19 SHIP priorites (note there will be a new SHIP for 2020-24). This policy option would require CCOs to implement statewide strategies for shared priorities. Ohio and New

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		✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Increases transparency		and strategies. This would build upon the work of the 2014 OHA CHA/CHP alignment work group. • Staff FTE for technical assistance would sit in HPA and PHD. • Staff FTE for monitoring and compliance in HSD.	York have implemented similar requirements. May result in statewide gains on health conditions. • **Including orgs that address SDOH and health equity:** Recommended by the THW Commission (see policy option 2-2d) o Will ensure the voice of consumers experiencing health disparities into the community health assessment and planning process. May create a small limitation on local flexibility by prescribing the organizations to be involved.
9	**Require CCOs to submit their community health assessment (CHA) to OHA**	☐ Fulfills state or federal mandate Priority area: **SDOH / Health Equity** How heavy is lift? ●●○ How large is impact? ●●● ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ☐ Potential to impact children ☐ May require OHA TA support ✓ **Increases transparency**	Transparency and support of community partner efforts.	• Should be included in contract from Year 1. Would go into effect at first CHA cycle in 2020-2025 contract period (may differe by CCO) • Monitoring is very straightforward (existing Transformation Center capacity)	• Origin of recommendation: OHA Transformation Center • <u>Pros</u>: Promotes transparency and can allow for improved technical assistance to CCOs • <u>Cons</u>: Would add a deliverable to CCO contract, but by rule CHA development is already required so it should be very easy for a CCO to submit their CHA to OHA to fulfill this requirement.
10	**Increase CCOs' use of value-based payments (VBP) with their contracted providers**	★ Fulfills state or federal mandate Priority area: **VPB** How heavy is lift? ●●● How large is impact? ●●●	**Ensure all CCOs increase their use of VBPs** Aligns with 1115 Waiver requirement to achieve VBP target **VBP Policy Option summary**: Provide financial support for Patient-	**RFA Applicants:** • Need to provide details on how they would achieve a minimum of 20% VBP in primary care in LAN category 2C ("pay-for-performance") or higher during year one (2020). • Need to provide details on their per-member, per-month (PMPM) VBP payments (i.e., LAN category 2A "foundational	*<u>The Health Care Payment Learning and Action Network</u> (LAN) is a national effort partially funded by CMS to accelerate VBP adoption by states and the commercial insurance market. They developed a "<u>Framework</u>" for categorizing VBPs that has become the nationally accepted method to measure progress in the adoption of VBPs. Increasing CCOs' use of VBP will entail two complementary strategies: • Infrastructure payments for PCPCHs (LAN category 2A); and

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		✓ **2019 POP planned** Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** Increases transparency	centered Primary Care Homes (PCPCH) to implement and sustain a robust PCPCH model of care. Each CCO will be responsible for meeting annual VBP growth target calculated with their own baseline VBP data. This will ensure that all CCOs increase their use of VBPs.	payments for infrastructure and operations") to PCPCHs. • Respond to specific questions that address how their VBP models will not negatively impact priority populations, including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees. • Demonstrate necessary information technology (IT) infrastructure for VBP reporting, **By year 1, CCOs will (2020):** • Implement a PCPCH VBP • Report VBP data via All Payer All Claims (APAC) database • Report supplemental VBP data and /or interviews • Be expected to achieve a one-year VBP growth target tied to the statewide VBP goal and the CCO's baseline data for LAN category 2C ("pay-for-performance") and LAN category 3B ("shared savings and downside risk") as reported in their RFA response. At end of the one-year period, OHA will assess CCOs' progress toward meeting VBP growth targets and establish CCO-specific growth targets for years two–five. **By year 2, CCOs will** be required to implement two VBPs focused on key care delivery focus areas listed below.	• Achievement of VBP goal for all CCO payments (LAN category 2C and higher) **PCPCH VBP** • Supports staff and activities not reimbursed through fee-for-service. • Operationalized via PMPM payments based on PCPCH tier level. • Requires the use of a VBP to invest in PCPCHs, which a 2016 evaluation showed have achieved better health outcomes and cost savings. • Allows for advancement and sustainability of the PCPCH model. • PCPCH VBP requires payments that fit in LAN category 2A—which are foundational payments for infrastructure and operations— but are not counted toward achieving the CCO VBP target. • Aligned with CPC+ payment methodology, a national CMS, multi-payer primary care payment reform program. **VBP Targets** • Statewide goal of CCO VBP to providers is aligned with the 1115 waiver requirement. • Preliminary data collection of CCO VBP data indicates approximately 50% of CCOs' payments to providers were at least in category 2C/pay-for-performance (which is similar to the CCO incentive metric program). • Statewide VBP goal is sufficiently high to serve as a statewide goal, but not so high that it would be unachievable. • Each CCO's progress will apply to the 70% statewide VBP goal progress. • Potential development of CCO VBP collaborative to align efforts and share tools to lead this work in their communities. The CCO VBP collaborative could evolve into a multi-payer collaborative in later years.

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				• Behavioral health • Oral health • Hospitals • Children's health care • Maternity care **By year 5, CCOs will (2024):** • Implement the remaining three care delivery focus areas. • Contribute to 70% statewide VBP goal. • Report complete encounter data with contract amounts and additional detail for VBP arrangements.	
11	Evaluate CCO performance with tools to **evaluate CCO efficiency, effective use of health-related services (HRS), and the relative clinical value of services** delivered through the CCO. **Use evaluation to set a performance-based profit at individual CCO level.**	★ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●○ How large is impact? ●●○ ✓ **2019 POP planned** Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**	Improved delivery of benefits to CCO members including more efficient use of medical services, increased delivery of high-value services and increased use of HRS that improves member health	• Evaluation methodology implemented in 2020 (year 1) but 2021 likely first year CCO profits will be individually determined based on performance evaluation • Methodology to establish performance-based profit needs to be finalized, and could benefit from cross-agency workgroup. Methodology will consider efficiency, effective HRS investment, and clinical value of services delivered. • Methodology development needed in multiple phase and additional OHA staff likely needed	**Policy is required as part of our current 1115 waiver** • CCO-specific profit margins required by 2017 waiver renewal • Waiver language specifically calls out goal of variable profit to motivate effective HRS use by CCOs, but additional evaluation tools likely needed • Methodology to inform CCO-specific profit levels will be closely watched by stakeholders • Evaluation and analysis may require additional staff beyond current capacity (similar structure to HPA metrics team) • OHA could strategically choose to include this program in legislation for the upcoming session • Can be seen as more rigorous & formalized process to evaluate and achieve efficiency in managed care • Could result in base data exclusions of inefficiencies NOTE: Policy option now incorporates policy option to provide rewards for care with higher clinical value in rate-setting process.
12	**Incorporate measures of quality & value in any OHA-directed payments to providers** (e.g. hospital payments) or OHA reimbursement policies and **align measures** with CCO metrics	★ Fulfills state or federal mandate Priority area: **COST**	Providers are rewarded for improving value and quiality of care, and metrics for CCOs and other providers are	• Implementation goal in 2020 • Additional policy development needed to establish the quality & value metrics to be used and	• **Designed to meet CMS requirements** related to pass-through funds that require OHA to move to a Qualified Directed Payment (QDP) process that includes quality/value

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	Example: qualified directed payments made directly to hospitals are based in part on quality and value	**How heavy is lift?** ●○○ **How large is impact?** ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**	aligned and coordinated to achieve maximum impact	their impact on specific payment streams • Alignment across CCOs and hospital quality metrics is key to CCO 2.0 • Implementation of quality / value metrics should build on HTPP experience • Requires policy development coordination between HPA, Finance, and HSD	• Policy involves hospital provider tax funds which adds to complexity & visibility • OHA could strategically choose to include this program in legislation for the upcoming session, or as part of the budge process • Connects and builds on other policy options to expand CCO use of VBPs
13	**Adjust the operation of the CCO Quality Pool** to allow consideration of expenditures in CCO rate development to: • Align incentives for CCOs, providers, and communities to achieve quality metrics **Create consistent reporting of all CCO expenses** related to medical costs, incentive arrangements, and other payments regardless of funding source (quality pool or global budget)	☐ Fulfills state or federal mandate **Priority area:** **COST** **How heavy is lift?** ●●○ **How large is impact?** ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**	CCOs invest their quality pool earnings in a timely manner on the providers and partners who help achieve targeted metrics, and focus additional efforts on achieving targets to ensure maximim quality pool earnings	• 2020 capitation rates would reflect the quality pool as being funded by a withhold of capitation payments instead of as a bonus • Adjusting the operation to a withhold allows OHA the flexiblity to increase the percentage of payments to CCOs that are tied to quality and value • Requires policy development coordination between HPA, Finance, and HSD	• Some CCOs have expressed concern that their failure to achieve quality pool earnings in one year effectively limits their rates for the following year – additional methodology development / clarification should seek to alleviate concerns • Moving quality pool inside rates allows for creation of bonus funding methodology for social determinants of health funding • Creates consistent reporting of all CCO expenses related to medical costs, incentive arrangements and other payments regardless of funding source (global budget or quality pool)
14	**Address increasing pharmacy costs** and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers	☐ Fulfills state or federal mandate **Priority area:** **COST**	Increased transparency of true pharmacy costs by addressing spread pricing, rebate transparency, and	• Transparency provisions could be implemented as broad requirements for how CCOs	• Potential opposition from PBMs • OPDP is a viable PBM solution for CCOs as it currently meets pricing transparency and pass through requirements being sought.

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		How heavy is lift? ●●○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**	improved auditing features. Reduced underlying pharmacy costs for CCOs through improved PBM contracting requirements	structure their PBM agreements • Oregon Prescription Drug Program could be a path for implementation if CCOs choose it as a their PBM	• Policy options similar to solutions being sought in other states in response to PBM pricing and pass-through policies
15	**Address increasing pharmacy costs** and the impact of high-cost and new medications by: increasing alignment of FFS and CCO PDLs	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**	Increased alignment of PDLs provides new tools to OHA and CCOs to reduce pharmacy costs and ensure consistent access to pharmacy services for members across CCOs	• Implementation will take an incremental approach to strategically and partially align PDLs (ie, starting with slected drugs / classes and building on experience over time) • Initial alignment requirements will be built on over time with input and cooperation from CCOs beginning in the 2.0 contract period.	• Varied opinion within CCO community on value/impact of proposed PDL policy • External report recommends aligning targeted drug classes • Specifics of alignment strategies may best be finalized after CCO contracts are awarded so as to enable partnership between OHA and CCOs in phasing in alignment of specific drug classesOngoing pharmacy policy recommendations may be informed by task force created by HB 4005 (in 2018 session) • Implementing a flexible reinsurance program in CCO 2.0 may help support this policy • Policy could consider complementary approaches to limit costs and uncertainty associated with new pharmaceutical products (i.e. specialty pipeline)
16	**Enhance financial reporting and solvency evaluation tools** by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC)	☐ Fulfills state or federal mandate	Increase solvency protection and reduce risks to the state and members of a CCO	• Use NAIC financial reporting templates and modify insurance regulations to fit unique CCO program including	• Industry standard NAIC forms could replace much of OHA's current Exhibit L

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
	and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency	**Priority area: COST** How heavy is lift? ● ● ● How large is impact? ● ● ○ ✓ **2019 POP planned** 　Requires legislation 　Recommendation for OHA 　Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** 　Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**	insolvency event; improve understanding of CCO finances	supplemental CCO-specific schedules; • Use RBC tool to evaluate CCO solvency • Work with DCBS to build a financial oversight framework that leverages the insurance code • Reporting framework requirements targeted for implementation in year 1	• Phase-in implementation may be needed since NAIC requires new standards that will require CCOs to adjust financial reporting. 　o If needed, CCOs may be allowed to continue to use GAAP accounting methodology for 1-2 years before being required to move to Statutory Accountint Principles; which is standard for health insurance carriers. • RBC thresholds need to be set for Medicaid if this tool is used to assess financial risk and reserves levels. • NAIC reports cover a two-year period and requires a five-year historical data period – OHA will need to decide the reporting timing for both the RFA and for the five-year contract. • Potential impact to OHA and DCBS oversight capacity to increase the "lift" score. • Approach is consistent with larger trends in Medicaid managed care to more closely resemble the commercial insurance world. • Could facilitate the spread of the Coordinated Care Model to non-Medicaid sectors. • Alternative is to enhance current exhibit L reporting tools.
17	**Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity.** This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.	Fulfills state or federal mandate **Priority area: BH** How heavy is lift? ● ● ○ How large is impact? ● ● ○ ✓ **2019 POP planned** ✓ **Requires legislation** 　Recommendation for OHA 　Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children**	CCOs fully accountable for members' BH care. Increase access to BH services, decreased wait times, allow members provider choice, improve behavioral health outcomes for all Oregonians	• OHA will develop monitoring and compliance protocol • OHA will monitor the metrics identified in the next policy option. Corrective action plans will be required if CCOs are not able to meet metrics. • The local plan and CHP must be collaborative plans that inform one another. • Monitoring and compliance should be in HSD	• Integration of the behavioral health benefit should promote delivery of the behavioral health benefit. This means that the CCO is responsible for ensuring there is an adequate provider network, that members have access to behavioral health care, and that the CCO is responsible for outcomes. • <u>Pros</u>: Clear owner of the behavioral health benefit for OHA and member • <u>Cons</u>: Current CCOs may not have the expertise or infrastructure • This policy was developed from feedback regarding what is not currently working. Many stakeholders have called for the elimination of carve-outs; however, that may have unintended consequences. • Oregon Academy of Family Physicians states that carve outs "if allowed to exist at all in the future - should not be allowed for primary care behavioral health services;" NAMI, Children's Health Alliance and the Oregon Center for Children and Youth with Special Health Needs support elimination of carve-outs.

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		✓ **May require OHA TA support** ✓ **Increases transparency**			
18	**Identify metrics to track milestones of behavioral health (BH) and oral health (OH) integration** with physical health care by completing an active review of each CCOs plan to integrate services that incorporates a score for progress • OHA to refine definitions of BH and OH integration and add to the CCO contract • Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ● ○ ○ How large is impact? ● ● ● 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**	Increase integration, increase access, increase provider network, decrease wait time	• Transformation Center (TC) has contracted with a consultant to identify the metrics and a review proposal • HSD and HPA will collaborate: HPA will monitor and pull data; the review will sit in HSD for compliance; TC will provide TA	• Behavioral health has not consistently been integrated by the CCOs. This will be a lever to ensure CCOs integrate services, for OHA to measure progress and to target technical assistance. • Children's Health Alliance supports and recommends that measurement recognizes appropriate measures for pediatric population; Oregon Medical Association supports quality incentive metrics for integration; Trillium supports.
19	Require **CCOs report on capacity and diversity of the medical, behavioral and oral health workforce** within their geographical area and provider network. CCOs must monitor their provider network to ensure parity with their membership.	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ● ● ○ How large is impact? ● ● ○ 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment**	Increase workforce to ensure network adequacy; increase access and outcomes for Oregonians	• Starting in year one, CCOs will report on members in their network, current workforce, and the plan to meet the need of their members. • OHA will develop report and will publish available data. • OHA to monitor compliance.	• This was first suggested in the HCWF by the Medical Director of a CCO while the committee was looking at challenges of collecting data on workforce capacity • This policy can contribute to the development of a shared accountability model for the adequacy of the health care workforce in the state between the CCOs and OHA (and potentially others) • Best practices in this area can be reviewed to help with developing the forms and review process

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**			
20	Require CCOs **utilize best practices to outreach to culturally specific populations**, including development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs)	Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●● 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**	Improve health outcomes for culturally specific populations	• Guidelines and best practices being developed by OEI • Technical assistance recommended for implementation	• Guidelines and best practices need to be developed by OHA (OEI and BH) • Will require ongoing monitoring and TA
21	**Prioritize access for children ages birth** through five years to health services, developmental services, Early Intervention and targeted supportive services, and Behavioral health/mental health treatment.	Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring	Improve health outcomes for children; CCOs level of services to 0-5 children will match the national percentages	• CCOs to collectively develop statewide early childhood criteria for behavioral health levels of care (outpatient, intensive outpaticent, subacute and PRTS). • Require an increased level of outpatient level of care for children 0-5 with indications of Adverse Childhood Events (ACEs) and high complexity due to one or more of the following: multi system involvement, 2 or more caregiver placements within the past six months, moderate to severe behavior challenges, at risk of losing current	• Fulfills a mandate: early learning hubs. Connects with recommendations of Governor's Children's Cabinet. • Two or more ACEs is associated with poor kindergarten and behavioral outcomes • Intervening early prevents poor long-term outcomes and reduces costs • Currently social-emotional screening is needed to identify children with problems interfering with kindergarten readiness and issues related to early behavioral health intervention needs

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** Increases transparency		caregiver placement, or school or daycare placement • CCO's would pay for Mental Health Consultation in early learning settings for their network of providers	
22	Implement risk-sharing with the Oregon State Hospital (Behavioral Health Collaborative recommendation)	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●● 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**	As CCOs assume risk we anticipate increase in community care and decrease in hospitilizations	• All CCOs will assume risk for members on OSH waitlist in year one. • Payment model will shift to OSH billing CCOs for members in OSH in year two. • All CCOs will share limited risk for members in OSH in year two (e.g., CCO projects number of beds they will use, pays monthly amount to OSH based on projection, settlement at the end of the year; details of the model are in development). • Work will ultimately sit in HSD	• Behavioral Health Collaborative recommendation • This will advance the Oregon Performance Plan by facilitating community placement for individuals transitioning from Oregon State Hospital • May pose challenges in Multnomah County for hospitals regarding utilization review • CCO and CMHP support; AOCMHP supports; Care Oregon supports
23	Shift financial role for statewide HIT public/private partnership from OHA to CCOs to cover their fair share	☐ Fulfills state or federal mandate Priority area: **HIT** How heavy is lift? ●○○ How large is impact? ●●● 2019 POP planned Requires legislation Recommendation for OHA	CCOs are directly connected to cross-stakeholder efforts (such as EDIE and PDMP Integration) to prioritize and improve HIT statewide	Timing – this would be an attestation in the RFA and contractual obligation starting with 2020 contracts. The only change needed is for CCOs to take over paying the HIT Commons dues that OHA is currently paying on their behalf. A dues schedule has already been established, current CCOs have signed MOUs to participate that includes transparency about taking on dues in 2020, and CCOs are participating in HIT Commons efforts and have 3 seats on the HIT Commons	• Pro: HIT Commons continues to support CCO and Medicaid objectives and is informed about the needs of Oregonians across the state. Ensuring CCO participation will demonstrate value to other stakeholders and help ensure the HIT Commons maintains sufficient participation for effective governance of statewide HIT initiatives. • Con: Some CCOs may prefer to focus on local HIT initiatives in the future. • Consideration: 2018 dues range from $1,300 for the smallest CCO to $70,100 for the largest. Dues are paid using FMAP-eligible funds. • Feedback: Stakeholders have had little feedback other than requesting information about the dues – this has been non-controversial.

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** Potential to impact children May require OHA TA support Increases transparency		Governance Board. OHIT manages this work.	
24	Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in-person, regardless of a patient's geographic setting (rural, urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (i.e., does not require CCOs to add new providers to ensure telehealth is broadly available), but focuses on coverage.	☐ Fulfills state or federal mandate Priority area: **BH/HIT** How heavy is lift? ●○○ How large is impact? ●●○ 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** Potential to impact children ✓ **May require OHA TA support** Increases transparency	Reduced barriers to telehealth services, better access to specialty and behavioral health care in frontier/rural areas, and reduced health disparities based on geographic location	• The rule allowing for coverage for telemedicine services by CCOs is already in place and would just need to be updated. HSD would lead this, OHIT could play a consultative role. • Timing – this would be a contractual obligation starting with 2020 contracts, could decide to phase in (e.g., expectations that CCOs have coverage in their networks no later than end of year 1).	• <u>Pros</u>: Better access to care, reduced barriers for telehealth options, more consistency across CCOs • <u>Cons</u>: Some providers and patients lack the systems to engage in telemedicine consults through video. Some remote areas of Oregon lack high-speed broadband capabilities that would enable telehealth. • <u>Feedback</u>: Multiple stakeholders expressed support for telehealth. Some input that the policy should be flexible to allow exceptions for services not clinically indicated for telehealth, and that quality of telehealth services should be monitored. Telehealth services are frequently needed when there are transportation barriers, or other SDOH related issues (e.g. poverty) creating a hardship for members to access services in person. BH services are especially suited for telehealth approach and used in Oregon in some rural areas. Concerns about patients needing a private setting when engaging with telehealth.
25	**CCOs identify actions for the development of the medical, behavioral and oral health workforce** including their efforts to: • Develop the healthcare workforce pipeline in their area by participating in and facilitating the current and future training for the health professional workforce. This includes encouraging local talent to return to their home areas to practice and supporting health professionals following their initial training; • Develop and support a diverse workforce who can provide culturally and linguistically	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●● 2019 POP planned Requires legislation	Increase workforce to ensure network adequacy; increase access and outcomes for Oregonians	• Health Care Workforce Committee will continue to contribute to the development of these efforts • HPA and HSD to monitor compliance	• HCWF, HEC and THW support; recommendation directly offered by HCWF; Dr. McKelvey contributed to the list to include in the plan. • Some CCOs have this in place now but not reviewed/supported by OHA; for others, asking for this will help them better think through questions of access. • Every state is required to develop a needs analysis as part of the PCO cooperative agreement. • Federally, HRSA requires states to maintain updated provider data.

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
	appropriate care, with attention to marginalized populations; and • Ensure current workforce completes a cultural competency training in accordance with HB 2611.	☐ Recommendation for OHA ☐ Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**			• HB 3261 requires a biennial needs assessment. • Need to consider whether "area" is only a CCO's provider network or a geographic area served in part by the CCO.
26	**Require CCOs to ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI) and for children with serious emotional disturbances (SED),** and incorporate the following: • Develop standards for care coordination • Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD) Establish outcome measure tool for care coordination	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ✓ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ✓ **Potential to impact children** ✓ **May require OHA TA support** ☐ Increases transparency	Increase access to behavioral health services, allow members provider choice. Improve health outcomes. Ensure care coordination is efficient and impactful for the highest risk members.	• Starting in year one, CCOs will ensure care coordinators are identified to work with the individual to coordinate physical health, mental health, intellectual and developmental disability and ancillary services as needed. • OHA to develop standards and outcomes measure. • Work would live within HSD. HPA Analytics would be involved for outcome measure. •	• Feedback we received indicated there are multiple care coordinators assigned and that there needs to be coordination or role clarification. • Oregon Center for Children and Youth with Special Health Needs supports with a call out for those transitioning from pediatric to adult systems; Trillium supports with call out for families; Children's Health Alliance and Oregon Center for Children and Youth with Special Health Needs supports developing standards; Children's Health Alliance supports for care coordination for child welfare and other prioritized populations. •
27	**Develop mechanism to assess adequate capacity of services across the continuum of care.** Ensure members have access to services across the continuum of care.	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●● ☐ 2019 POP planned ☐ Requires legislation	Provide a full continuum of behavioral health, medical and oral health services throughout the state. Ensure members have access to a provider network. Will improve health outcomes.	• Need to develop or adopt mechanism. OHA to define continuum of care and network adequacy. • Would sit in HSD.	• This is in current contract but has not been enforced. • Likely our understanding of "adequate capacity" will expand and evolve from what it was understood to be in CCO 1.0. Fulfills a federal requirement to identify mental health shortages. • Further development needed, especially around compliance.

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		☐ Recommendation for OHA ✓ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ✓ **Potential to impact children** ✓ **May require OHA TA support** ✓ **Increases transparency**			
28	**System of Care to be fully implemented for the children's system**	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ✓ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ✓ **Potential to impact children** ☐ May require OHA TA support ☐ Increases transparency	Improve health outcomes for children through a system of care	• Hold CCOs accountable to full implementation of existing model to ensure cross system collaboration. • Statewide Systems of Care (SOC) Steering Committee empowerment: State agencies (OYA/OHA/DHS/ODE) to fund the State System of Care steering committee with existing general fund from each child serving state agency for multi-agency needs and development of shared services and supports. • Clarify with CCOs and communities the advisory council roles and responsibilities as they relate to the broader System of Care governance structure.	• The already-existing System of Care (SOC) governance infrastructure was launched in 2014 and continues to mature and develop. OHA contractually requires CCOs to have local SOC structures in place and these have been developed and maintained with consultation from PSU System of Care Institute. The institute is funded jointly, through an interagency agreement between DHS – Child Welfare, OHA and PSU. • Pros: SOC is already established, needs fine tuning for some CCOs/areas. • Cons: Difficulty getting system partners to the table, lack of blended funding hampers efforts. • Much national research exists documenting cost savings. • HB2144 Youth Wraparound Initiative names system partners. • This will reflect values and principles to the local governance structure.
29	Require **Wraparound is available to all children and young adults who meet criteria**	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation	Improve health outcomes for children	• Require CCOs to meet national average for fidelity implementation per WFI-EZ scores (fidelity tool/consumer survey) • Enforcement of existing contractual expectations will be critical to success • Work would sit in HSD	• This was in the CCO contract but not enforced. Enforcement will be critical to success. • Pros: Wraparound is documented to improve outcomes for children and families; long-term cost savings, and improvement in health outcomes for families. • HB2144

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		☐ Recommendation for OHA ☑ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ☑ **Potential to impact children** ☐ May require OHA TA support ☐ Increases transparency			
30	**MOU between CMHP and CCOs enforced and honored**	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●○○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☑ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ☑ **Potential to impact children** ☐ May require OHA TA support ☑ **Increases transparency**	Improved health outcomes and increased access to services through coordination of safety net services and CCO Medicaid services	• Enforcement would sit in HSD	• The CCOs have the MOUs but not all have been fully implemented • Would result in coordination of safety net services in each region • Supported by AOCMHP
31	Identify and address billing system and policy barriers to integration: • Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting • Develop payment methodologies to reimburse for warm handoffs, impromptu consultations and integrated care management services • Examine equality in behavioral health and physical health reimbursement	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●○○ How large is impact? ●●● ☐ 2019 POP planned ☐ Requires legislation	Increase integration, increase access, expand provider network	• Implement in year one. • Work to be completed in HSD with technical assistance through the Transformation Center.	• Will require HSD Medicaid staff to complete. This position is currently vacant. OHA will work with a consultant to ensure work completed in year one. • Work groups have submitted recommendations to OHA. • This will allow providers to bill from integrated settings. • Will increase access and expand the provider network. • Payment methodologies will allow for provision on full continuum of behavioral health services. • Oregon Academy of Family Physicians supports all BH in integrated PC be reimbursed; Children's Health Alliance supports BH to be billable in PC for all services provided and

Recommended policies: Begin implementation in year 1

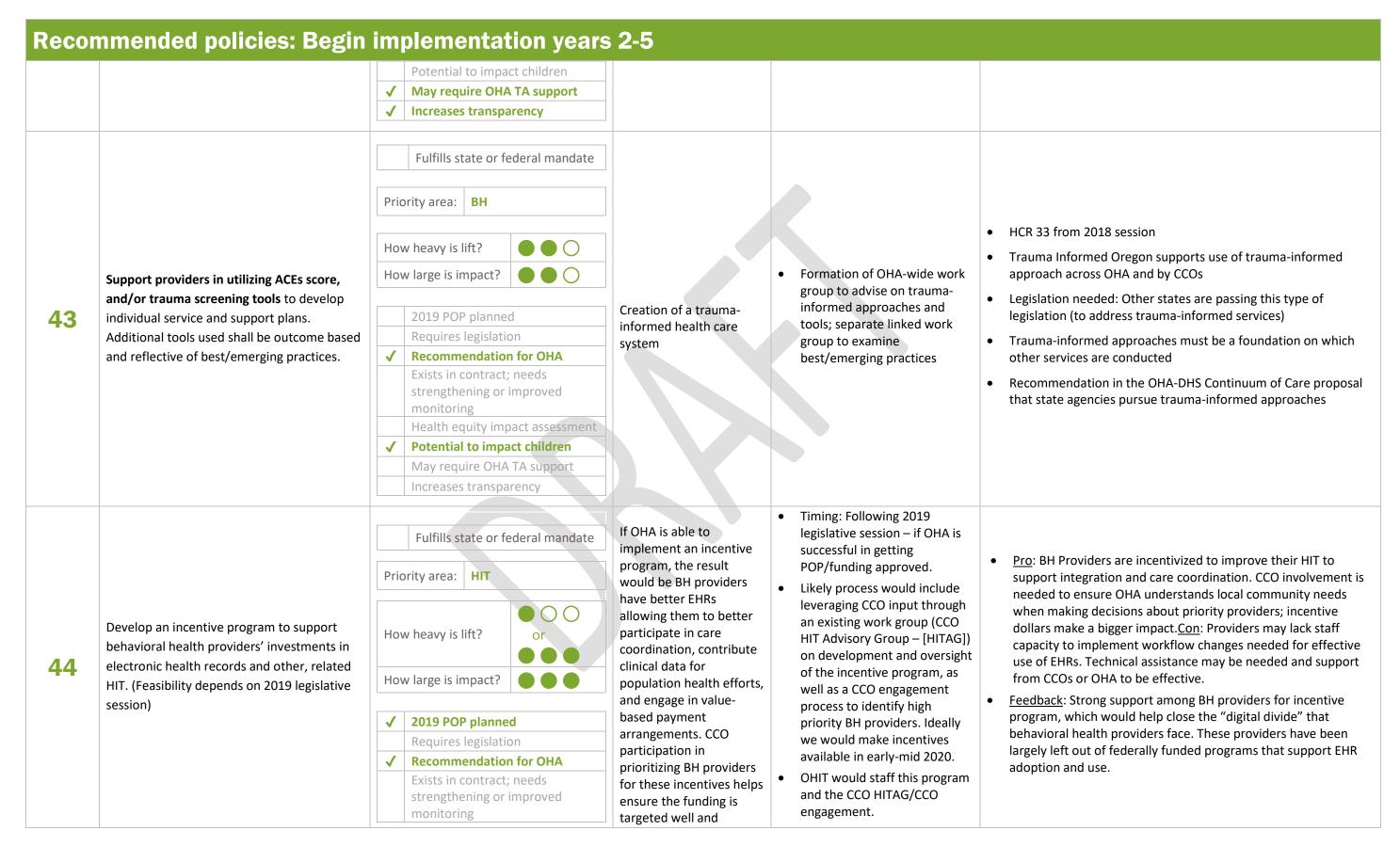| #	Policy	Dashboard	Intended impact	Implementation	Considerations
		✔ **Recommendation for OHA** 　Exists in contract; needs strengthening or improved monitoring 　Health equity impact assessment ✔ **Potential to impact children** 　May require OHA TA support 　Increases transparency			should be seamless to provider and patient; Oregon Medical Association supports reimbursement rates to support integration
32	**Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts** Connect contractual requirements to ongoing evaluation of Oregon's sustainable spending target based on national trends and emerging data to inform more aggressive targets in future while providing CCOs with additional financial incentives to achieve spending targets in the form of shared savings arrangements	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●○○ How large is impact? ●○○ 　2019 POP planned 　Requires legislation 　Recommendation for OHA ✔ **Exists in contract; needs strengthening or improved monitoring** 　Health equity impact assessment 　Potential to impact children ✔ **May require OHA TA support** ✔ **Increases transparency**	CCOs are held accountable for achieving spending growth targets and targets reflect aggressive path to ensure costs grow at a sustainable rate	• Include a contract requirement with enforcement options requiring CCOs to achieve current and future sustainable rate of growth targets • RFA language will clarify spending targets set by waiver and legislature are a CCO deliverable • OHA process developed to evaluate current spending targets and inform spending target(s) in future waiver renewals	• OHA has achieved program-wide spending targets in the first five years • Connects OHA's waiver commitment to CCO contracts • OHA may choose to allow CCOs to meet the target over a rolling period (i.e., 3 years, etc.) • OHA exploring rate methodological tools to help meet sustainable growth targets, such as setting multi-year capitation rates for CCOs • Shared savings arrangement provides clarity to CCOs that program-wide savings will be reinvested into program • Similar to initial funding build-up of quality pool
33	**Require CCOs support EHR adoption across behavioral, oral and physical health contracted providers**	☐ Fulfills state or federal mandate Priority area: **BH/HIT** How heavy is lift? ●●○ How large is impact? ●●○ 　2019 POP planned 　Requires legislation	Behavioral and oral health providers adopt and use EHRs more effectively and at higher rates, allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements.	• Timing – This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers. • We would expect CCOs to evaluate current EHR adoption rates and opportunities, set targets and report on progress – phased over 5 years. • OHA TA could be useful.	• Consideration: CCOs' primary care providers successfully increased EHR adoption, with federal incentive payments. This policy option would build on that success. This will be most helpful if BH EHR Incentives (POP requested) are available as well. • Pro: Encouraging and supporting the adoption of EHRs capable of information exchange and connecting to health information exchange tools and services would support increased care coordination and improve patient care. • Con: Providers may lack resources to invest in EHRs or lack staff capacity to implement workflow changes needed for effective use of EHRs.

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		☐ Recommendation for OHA ✓ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**		• Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO needs for data on EHR adoption where possible.	• <u>Feedback</u>: CCOs may face significant challenges to this if resources/incentives are not available.
34	**Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange technology** that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications	☐ Fulfills state or federal mandate Priority area: **BH/HIT** How heavy is lift? ●●○ How large is impact? ●●○ ☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ✓ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ☐ Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**	Behavioral, oral and physical health providers have the information needed to deliver better care, patients get the right care at the right time, and costly hospital use is reduced Increasing the adoption of HIE among priority providers in support of priority populations will support care coordination and improve patient care, particularly around integration/coordination across physical, behavioral, and oral health care.	• Timing – This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers. • We would expect CCOs to evaluate current HIE use and opportunities, set targets and report on progress – phased over 5 years. • OHA TA could be useful. OHA is currently supporting TA for hospital event notifications related to the CCO Disparity metric. • Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIE where possible. •	• <u>Consideration</u>: OHA currently financially supports PreManage directly for CCOs on a voluntary basis (all CCOs are now using PreManage either directly or through regional HIE), and nearly all CCOs are paying to extend PreManage to their key clinics, including BH, oral, physical. When PreManage subscription ends through the state for CCOs (end of 2019), CCOs have the option to continue with the PreManage tool at their own cost. • OHA is launching the HIE Onboarding program that will support initial costs to connect key clinics (including BH, oral, physical) to approved HIEs (only one is approved at this time). • <u>Pro</u>: Reduction in ED utilization. Increased health outcomes for members with complex care needs and mental illness. Increased care coordination between CCO and contracted clinics • <u>Con</u>: Providers may lack resources to participate in HIE or lack staff capacity to implement workflow changes needed • <u>Feedback</u>: Interest in sharing costs or leveraging OHA financial support to help CCOs in this area, OHA can support education/TA for HIE and for SUD info sharing policies, concerns about this requirement going beyond adoption of PreManage and requiring CCOs to support multiple HIE platforms, which would have less utility for providers. • Consideration of all partners that need to be in HIE including families, caregivers, SDOH entities, jails, etc.
35	**Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting,** including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and manage VBP data. This would include a demonstration that the CCO can work with electronic clinical quality measure data.	☐ Fulfills state or federal mandate Priority area: **VBP/HIT** How heavy is lift? ●●○ How large is impact? ●●○	CCOs are better able to achieve population health outcomes at lower costs. Providers engaging in VBP contracts have the information and support needed from the CCO to	• CCOs would be encouraged to take advantage of collaborative efforts related to data aggregation, eCQMs, and other VBP data needs. In their RFA response, CCOs would show they meet an initial minimum and explain how, during the first year of the	• <u>Pro</u>: Without data and HIT systems, CCOs cannot deliver on VBP. If we expect CCOs to become more sophisticated around VBP in 2.0, they must have the skills and systems to do so. Ability to use clinical data/metrics is critical to moving toward triple aim. • <u>Con</u>: CCOs face challenges in getting and using clinical data – may need HIE strategy to help with this. Some providers may lack the capability to use CCO data effectively. Possible proliferation of systems across CCOs and payers.

Recommended policies: Begin implementation in year 1

#	Policy	Dashboard	Intended impact	Implementation	Considerations
		☐ 2019 POP planned ☐ Requires legislation ☐ Recommendation for OHA ☑ **Exists in contract; needs strengthening or improved monitoring** ☐ Health equity impact assessment ☐ Potential to impact children ☑ **May require OHA TA support** ☑ **Increases transparency**	manage financial risk and improve care.	contract, they will ensure they have sufficient HIT capabilities for VBP and population health management. • Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIT where possible. • OHA should consider TA/ support for CCOs in this area – possibly through Transformation Center/TA Bank and/or OHIT.	• <u>Feedback</u>: Multiple stakeholders expressed support for this – very important for moving into the future. This will be a heavy lift for some of our current CCOs, including obtaining clinical data. Some CCOs will likely need TA and support.
36	Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources.	★ Fulfills state or federal mandate Priority area: **ALL** How heavy is lift? ●●● How large is impact? ●●● ☐ 2019 POP planned ☐ Requires legislation ☑ **Recommendation for OHA** ☐ Exists in contract; needs strengthening or improved monitoring ☐ Health equity impact assessment ☑ **Potential to impact children** ☑ **May require OHA TA support** ☐ Increases transparency	Streamline and enhance OHA's capacity for contract management and compliance Increase understanding of CCO effectiveness and provide improved support to CCOs over contract issues	• TBD – would require assessment of current resources and possible reallocation of existing capacity and/or new capacity.	• In addition to monitoring, tracking, and ensuring compliance with CCO 2.0 policies, this team would be tasked with oversight of policy options 34–45 above, which have already existed in contract but have not been achieved as intended. • Enhancing compliance around CCO contracts is a natural next step from CCO 1.0 – during the first contract, CCOs were building new businesses and the priority was around ensuring the model was successful. CCO 2.0 provides an opportunity to increase accountability around actual contractual obligations • State audits and program reviews have highlighted that OHA's compliance monitoring needs significant improvement. Additionally, new federal managed care rules went into effect in 2018 that increase requirements for state compliance monitoring

Recommended policies: Begin implementation years 2-5

#	Policy	Dashboard	Intended impact	Implementation	Considerations
37	**Shift mental health residential benefit to CCOs**	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●● How large is impact? ●●○ 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** Potential to impact children ✓ **May require OHA TA support** ✓ **Increases transparency**	Improve health care for adults with SPMI	• Supporting efforts (need for a workgroup, additional development, standing up of new reports, etc.) • Rate standardization is in process. Review of rates must be completed in one year and must precede transition of the benefit. • HSD resources (PM and analysts)	**Required in 1115 waiver** • Needs significant development • Kids residential and SUD have already transitioned to CCOs. MH res was scheduled in 2014 and a work group planned for transition, but was postponed due to complexity and CCO and provider concerns. • CareOregon supports
38	**Establish a statewide reinsurance pool** for CCOs administered by OHA to spread the impact of low frequency, high cost conditions and treatments across entire program	Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●● How large is impact? ●●● ✓ **2019 POP planned** ✓ **Requires legislation** Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment** Potential to impact children	OHA has the flexibility and tools necessary to better manage patients with high-cost conditions, which will better enable OHA and CCOs to control program-wide costs of these patients	**Staff recommends establishing this reinsurance pool for CCO 2.0 subject to a detailed financial analysis** and the Legislative Budget process • Initial study needed to assess financial viability, benefits, and costs of a state-backed reinsurance pool • Additional policy development ongoing related to potential need for legislation and the type of federal sign-off needed • **Timeframe for implementation is year 2+.** Implementation could be phased in and program modified over several years based on experience.	**Initial phase of implementation would be OHA responsibility.** • Legislation and budget authority needed to fully launch program • Helps fulfil goals of keeping OHP clients in CCOs and not open card • Short term benefits include spreading risk across CCOs and mitigating CCO risk associated with low-frequency, high-cost patients • Long term benefits could include reduced costs from using program-wide purchasing power and better aligning PDLs • Connects to rate setting – removing catastrophic claims from rate-setting reduces rate volatility, especially for small CCOs • DCBS received 1332 waiver to establish a reinsurance program for private carriers that could be a resource

Recommended policies: Begin implementation years 2-5

		✓ **May require OHA TA support**			
		Increases transparency			

39	**Ensure continued CCO solvency** by establishing solvency thresholds at a level that adequately considers the financial risks CCOs face and strengthening OHA's solvency regulation tools	Fulfills state or federal mandate
		
		Priority area: **COST**
		
		How heavy is lift? ●●●
		How large is impact? ●●●
		
		2019 POP planned
		✓ **Requires legislation**
		Recommendation for OHA
		Exists in contract; needs strengthening or improved monitoring
		✓ **Health equity impact assessment**
		Potential to impact children
		✓ **May require OHA TA support**
		Increases transparency
			Members, providers and OHA are better protected from insolvency risk. RBC thresholds ensure CCOs hold adequate financial resources to protect against insolvency. Additional solvency regulation tools, similar to those available to DCBS, would allow OHA to prevent or meliorate insolvency events	• Consider increases to CCO reserves over the five year contract
				• RBC option is connected to proposed move to NAIC reporting standards
				• As an alternative to increasing reserve requirements, Guaranty Fund could add a safeguard by drawing on CCO resources if a CCO is impaired or insolvent
				
				Granting OHA administrative and judicial tools for dealing with financially impaired CCOs, similar to those of DCBS, could allow OHA to rehabilitate a CCO nearing insolvency
					• CCO insolvency would be highly disruptive to members and providers and could expose OHA to risk of having no CCO in an area.
					• RBC thresholds need to be set for Medicaid carriers (CCOs) if this tool is used to assess financial risk and reserves levels.
					• Policy option connected to potential for NAIC/RBC requirements to increase required reserves for CCOs
					• OHA lacks the tools that DCBS possesses to intervene with a financially weak CCO. A "guaranty fund" mechanism could allow for rehabilitation of an impaired CCO, or spread the losses of an insolvent one, without requiring advance capitalization.
					  o CCOs raised concrens with increased reserve-holding requirements on the grounds they would reduce investment in local communities
					  o Idea based on guaranty provisions in the insurance code
					  o Provisions could lower required RBC thresholds for CCOs that could otherwise require increased reserving

40	Identify, promote and expand programs that integrate primary care in behavioral health settings (**Behavioral Health Homes**)	★ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●● ✓ **2019 POP planned** ✓ **Requires legislation** Recommendation for OHA Exists in contract; needs strengthening or improved monitoring ✓ **Health equity impact assessment**	Improve health outcomes; increase access to BH and PH	• Standards and ORS were completed under SB 832 • Would require hiring 3 FTE • Work would be within PCPCH program in HPA	• **SB 832 created the BHH**, but there was no funding to implement • This would enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. This will improve whole health outcomes for individuals • AOCMHP supports

Recommended policies: Begin implementation years 2-5

		✓ **Potential to impact children** ✓ **May require OHA TA support** Increases transparency			
41	CCOs, with the support of OHA, to **require providers to implement trauma-informed care practices**	Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ 2019 POP planned Requires legislation Recommendation for OHA Exists in contract; needs strengthening or improved monitoring **Health equity impact assessment** ✓ **Potential to impact children** ✓ **May require OHA TA support** Increases transparency	Improve health outcomes for all Oregonians; increase number of providers and organizations adopting trauma informed care principles; reduce the impact of ACEs and trauma for all Oregonians	• Create OHA-wide trauma-informed approach policy. • In year 3, CCOs will require subcontractors/providers to receive training in trauma informed care approaches. • CCOs will require providers of behavioral health services to use screening and assessment of trauma to develop and inform individual service and support plans • Work to sit in HSD and HPA	• HCR 33 • Oregon is a national leader in trauma awareness and trauma-informed approach • Trauma Informed Oregon in full support of this policy • Legislation may be needed • Many CCOs are already implementing • Requires planful, thoughtful, coordinated response
42	**Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy** (AZ Model) with financial implications	★ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●○○ How large is impact? ●●○ 2019 POP planned Requires legislation Recommendation for OHA ✓ **Exists in contract; needs strengthening or improved monitoring** Health equity impact assessment	Encounter data accurately reflects health care services provided to OHP enrollees	• Implementation may be phased in • Utilizes new resources added to the Program Integrity Provider Audit Unit from 17-19 POP • Five of seven auditors funded in POP have already been added	• Intended to fulfil CMS requirements to ensure that encounter data is "complete and accurate" and to ensure it reflects services provided to patients • Capacity being added to provider audit unit related to prior POP • Alternative ways to meet federal requirements necessary without this option

Recommended policies: Begin implementation years 2-5

	Potential to impact children
	✓ **May require OHA TA support**
	✓ **Increases transparency**

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Support providers in utilizing ACEs score, and/or trauma screening tools to develop individual service and support plans. Additional tools used shall be outcome based and reflective of best/emerging practices.

	Fulfills state or federal mandate
Priority area:	**BH**
How heavy is lift?	● ● ○
How large is impact?	● ● ○
	2019 POP planned
	Requires legislation
✓	**Recommendation for OHA**
	Exists in contract; needs strengthening or improved monitoring
	Health equity impact assessment
✓	**Potential to impact children**
	May require OHA TA support
	Increases transparency

Creation of a trauma-informed health care system

- Formation of OHA-wide work group to advise on trauma-informed approaches and tools; separate linked work group to examine best/emerging practices

- HCR 33 from 2018 session
- Trauma Informed Oregon supports use of trauma-informed approach across OHA and by CCOs
- Legislation needed: Other states are passing this type of legislation (to address trauma-informed services)
- Trauma-informed approaches must be a foundation on which other services are conducted
- Recommendation in the OHA-DHS Continuum of Care proposal that state agencies pursue trauma-informed approaches

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Develop an incentive program to support behavioral health providers' investments in electronic health records and other, related HIT. (Feasibility depends on 2019 legislative session)

	Fulfills state or federal mandate
Priority area:	**HIT**
How heavy is lift?	● ○ ○ or ● ● ●
How large is impact?	● ● ●
✓	**2019 POP planned**
	Requires legislation
✓	**Recommendation for OHA**
	Exists in contract; needs strengthening or improved monitoring

If OHA is able to implement an incentive program, the result would be BH providers have better EHRs allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements. CCO participation in prioritizing BH providers for these incentives helps ensure the funding is targeted well and

- Timing: Following 2019 legislative session – if OHA is successful in getting POP/funding approved.
- Likely process would include leveraging CCO input through an existing work group (CCO HIT Advisory Group – [HITAG]) on development and oversight of the incentive program, as well as a CCO engagement process to identify high priority BH providers. Ideally we would make incentives available in early-mid 2020.
- OHIT would staff this program and the CCO HITAG/CCO engagement.

- Pro: BH Providers are incentivized to improve their HIT to support integration and care coordination. CCO involvement is needed to ensure OHA understands local community needs when making decisions about priority providers; incentive dollars make a bigger impact. Con: Providers may lack staff capacity to implement workflow changes needed for effective use of EHRs. Technical assistance may be needed and support from CCOs or OHA to be effective.
- Feedback: Strong support among BH providers for incentive program, which would help close the "digital divide" that behavioral health providers face. These providers have been largely left out of federally funded programs that support EHR adoption and use.

Recommended policies: Begin implementation years 2-5

		Health equity impact assessment	achieves the desired impact for our Medicaid population.	
		Potential to impact children		
		May require OHA TA support		
	✓	**Increases transparency**		

Not recommended at this time or for future exploration

Policy	Dashboard		Intended impact	Implementation	Considerations
Expand/revise existing risk corridor programs **This option is not being recommended as a result of recommendation to examine in greater detail the idea of establishing a program-wide reinsurance program**	Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ● ● ○ How large is impact? ● ○ ○ Equity TBD – OEI/HEC 2019 POP planned Requires legislation Potential to impact children May require OHA TA support ✓ **Could have flexible timeline** Increases transparency		Additional use of risk corridors not a formal component of recommendations	No new proposals for risk corridors	Risk corridors remain a tool at OHA's discretion in the next 5-year contract period.

Not recommended at this time or for future exploration

Policy	Dashboard	Intended impact	Implementation	Considerations
Incentivize health care services with highest clinical value by rewarding their use in rate setting **This option has been incorporated as aspect of variable profit implementation strategy**	☐ Fulfills state or federal mandate Priority area: **COST** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☑ **Potential to impact children** ☑ **May require OHA TA support** ☐ Could have flexible timeline ☐ Increases transparency	CCOs focus additional energy on moving providers to deliver health care services with higher clinical value and reduce provision of low-value care	• Phased-in approach preferred • Formal work group (possibly a HERC subcommittee?) needed to evaluate services for placement on a high or low-value list. • Clinical-value could be used as part of methodology informing CCO-specific variable profit levels	• Policy option can be viewed as a next step for Oregon's prioritized list to further shift the system to providing evidence based, high-value services to patients (Benefits 2.0). • Phasing in the development of a high and low value list could ease concerns from CCOs about pushing too hard too fast. • OHA could strategically choose to include this program in legislation for the upcoming session.
Development of a Train the Trainer investment in BH models of care	☐ Fulfills state or federal mandate Priority area: **BH** How heavy is lift? ●●○ How large is impact? ●●○ Equity: TBD – OEI/HEC ☐ 2019 POP planned ☐ Requires legislation ☑ **Potential to impact children** ☑ **May require OHA TA support** ☑ **Could have flexible timeline** ☐ Increases transparency	Increase in BH providers trained in evidence-based practices; improved outcomes	• Formation of a Statewide Train the Trainer Model and/or Training Initiative (less expensive) for 5–10 evidence-based practices (that address two generation clinical models) for the Oregon Mental Health Community targeting clinical needs throughout the state. • OHA to provide initial financial and "lift" investment (1-2 FTE, Transformation Center?) to coordinate and roll out trainings for providers.	Would require funding and position authority. May be considered for a future POP.
Quality and appropriateness of language services. CCOs and provider networks have adopted different approaches to the provision of language services. Some of them,	For future exploration			

Not recommended at this time or for future exploration

Policy	Dashboard	Intended impact	Implementation	Considerations
although able to meet the immediate language support need, such as the use of telephonic or video-based interpreter services, are not responsive culturally, as many members express that would prefer in-person interpreters. Some aspects of this are included in the health equity infrastructure policies, but additional ongoing work will create a more robust system of culturally responsive language access				
Health care interpretation. OHA should explore requiring CCOs to develop a system to incentivize or reimburse providers (FQHCs, CHC, MHCs, CAHs, CMH, etc.) that use Qualified or certified health care interpreters.	For future exploration			
Dental care organizations. CCOs should explore how their contracts with various dental care organizations or other providers of dental care inhibit their ability to provide integrated oral health care to members. Several CCOs work with clinics with co-located oral health care that cannot provide dental care to all of the CCO's members because not all of the CCO's dental contractors contract with the CCO's clinic. This creates a significant barrier to coordinated, patient-centered care.	For future exploration			
Oral health policy. OHA should explore developing an oral health policy recommendation parallel to the one that requires CCOs to be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity, including ensuring an adequate provider network, timely access to services, and effective treatment.	For future exploration			
Clinic-level health equity plans. OHA should explore a model wherein providers identify disparities, and the workplan is generated at the clinic level (with CCO/OHA guidance). This is a multi-year approach to addressing health disparities at the clinic level (model from Minnesota). Providers are engaged at the clinic level to identify what they see as the greatest health disparities within their practice (year 1), to create a plan for measuring those health disparities (year 2), and to measure and report on those disparities, and create plans for reducing the disparities (year 3). This type of model could potentially be tied to or inform CCO health equity plans in the future.	For future exploration			

Dashboard Legend

Feasibility – In general, how heavy is the "lift" for this policy across systems?

●○○	**Generally easy/straightforward to implement**; little to no additional work or resources required; is already part of the plan/expectation.
●●○	**Requires moderate increase in staff time**, resources, development, or funding; could face some challenges.
●●●	**Will be a challenge to implement** and will require new resources (e.g., funding, staff time, significant development, workgroups, etc.)

Impact – In general, how much does this policy move the needle in achieving the goals of the model?

●○○	**Plays a supporting role, offers some clarity or direction**; will have a small impact on business practices.
●●○	**Medium impact**; policy will strengthen Oregon's direction and we'll see some type of effect across the state.
●●●	**Fundamental to moving the needle in this area of the CCM;** significant impact or transformational.

The health equity impact assessment check mark indicates the policy was assessed for a health equity impact. Further details on the result of that assessment are available in Appendix C, the draft health equity impact assessment.

✓	**Health equity impact assessment**

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#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
1	**Implement HB 4018: Require CCOs to spend portion of savings on SDOH, population health policy and systems change, and health equity/health disparities, consistent with the CCO community health improvement plan (CHP)** a) Require CCOs to hold contracts or other formal agreements with and direct a portion of required SDOH/HE spending to SDOH partners through a transparent process b) Require CCOs to designate role for CAC in directing and tracking/reviewing spending. c) **Years 1 & 2:** Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the global budget rate methodology and will seek to build in a specific amount of SDOH/HE investment intended to advance CCOs' efforts to address their members' SDOH and establish their internal infrastructure and processes for ongoing reinvestment of a portion of net income and reserves in social determinants of health and health equity. d) **Require one statewide priority** – housing-related supports and services – in addition to community priority(ies) **SDOH/HE**	• CCO clearly articulates criteria for selecting the SDOH/HE partners it intends to direct SDOH/HE funding to through contract, MOU, grant or other formal agreement (including housing partners to meet the statewide priority requirement) • CCO demonstrates that it has mechanisms in place to track and report SDOH/HE expenses and outcomes of spending, including for funds directed to SDOH/HE partners. • CCO provides a policy demonstrating the CAC's role in tracking, reviewing, and making decisions regarding SDOH/HE spending. • CCO may choose to select 1-2 community priorities in addition to the statewide spending priority. • CCO will be responsible for demonstrating that its expenditures (both to partners and other SDOH/HE expenditures) address the social determinants of health, health equity, health disparities, or population health policy and systems change as defined by OHA.	• CCO dedicates a percentage of its global budget to social determinants of health and health equity spending. • CCO focuses its SDOH/HE spending on families with children under age 5. • CCO demonstrates impacts on racial/ethnic disparities as a result of SDOH/HE spending.	• Years 1 and 2: CCO submits to OHA its spending priorities and how it has chosen to implement the housing spending priority; CCO demonstrates how selected priorities and spending plans align with CHP. • CCO reports SDOH/HE expenditures and outcomes to OHA (financial reporting, TQS, CHP progress reports), including number of members served by SDOH/HE investments. • OHA publishes annual data on CCOs' SDOH/HE spending.
2	**Increase strategic spending by CCOs on health-related services by:** a) Encouraging HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans; and Requiring CCOs' HRS policies to include a role for the CAC in making decisions about how community benefit HRS investments are made. **SDOH/HE**	• CCO submits policies describing how community benefit investment decisions will be made, including but not limited to the types of entities that will be eligible for funding, how entities may apply for funding, and the process for how funding will be awarded. • CCO clearly articulates the CAC's role regarding HRS community-benefit initiatives in this policy.	• CCO demonstrates that their HRS spending aligns with the CHA and CHP. • CCOs annually report all HRS spending itemized with any evidence of return on investment.	• OHA publishes quarterly data on each CCO's HRS spending by category and as a percent of total member expenditures. • All CCO policies relating to HRS and CAC's role in HRS decisions are published. • CCO must include community-based initiatives and explain CAC's role in deciding community-based intiatives in the Tranformation and Quality Strategy reports.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
3	a) **Encourage CCOs to share financial resources with non-clinical and public health providers** for their contributions to incentive measures, through clarifying the intent that CCOs offer aligned incentives to both clinical AND non-clinical providers with quality pool measure areas b) **Encourage adoption of SDOH, health equity, and population health incentive measures** to the Health Plan Quality Metrics Committee and Metrics & Scoring Committee for inclusion in the CCO quality pool **SDOH/HE**	• Part a may be phased in after Year 1 • CCO demonstrates it has policies and procedures for distributing quality pool dollars to clinical, non-clinical and public health providers for their contributions to achieving incentive measures, including SDOH, health equity and population health incentive measures. Must include the criteria used for determining payments and the process for distributing financial resources. • CCO must comply with OHA requirements for reporting CCO expenses related to incentive arrangements.	• CCO is engaged in robust, sustainable clinical-community partnerships developed to meet incentive measure targets. • CCO demonstrates standard, transparent approaches for determining the contributions of non-clinical and public health providers and for distributing quality pool dollars to support these contributions. • Stronger community systems for addressing social determinants of health are created with the CCO as a key convener.	• CCO submits policy for distributing quality pool dollars to clinical, non-clinical and public health providers. • CCO reports expenses related to incentive payment arrangements.
4	Strengthen community advisory council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers through the following: a) Require CCOs to report on CAC member composition and alignment with demographics of Medicaid members in their communities, including: 1) How the CCO defines their member demographics and diversity, 2) The data sources they use to inform CAC alignment with these demographics, 3) Their intent and justification for their CAC makeup, 4) An explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress, 5) The percentage of CAC comprised of OHP consumers, b) Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, education, etc.) and, c) Require CCOs have two CAC representatives, at least one being an OHP consumer, on CCO board. d) OHA is exploring adding a recommendation that CCOs use a Tribal Advisory Committee rather than simply ensuring tribal representation on the CAC. Development of this policy option is occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes. e) OHA is exploring implementation options for a requirement that CCOs have a designated Tribal Liaison per 1115 Waiver Attachment I, "Tribal Engagement and Collaboration Protocol." This is also occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes. **SDOH/HE**	• CCO identifies data sources it will use to analyze member demographics. • CCO demonstrates it has mechanisms, resources and community partnerships in place to support recruitment and engagement of diverse CAC members. • CCO clearly articulates its criteria and process for engaging CAC representatives that align with CHP priorities. • CCO describes its plan for how it will meaningfully engage an OHP consumer(s) on CCO board. • CCO will be responsible for meeting reporting requirements and identifying barriers and challenges to CAC demographic alignment, which will inform tailored supports from OHA to assist CCOs in progressing toward a fully aligned CAC. • Part b may be phased in after Year 1.	• CAC composition is reflective of Medicaid member demographics in the CCO service area. • CCO decision-making is meaningfully informed by CAC members, and CCO demonstrates this in its reporting. • CAC members report feeling meaningfully engaged and empowered in their roles on the CAC and CCO board. • CCO has systems in place that ensure constant representation/filled CAC seats and no lapses in 51% OHP consumer makeup of CAC.	• TQS reports to include detailed information about CAC member composition and all components outlined in this policy option. • CAC member satisfaction report/surveys.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
5	**Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities** by implementing the following: a) Require CCOs to adopt a Health Equity plan, including culturally and linguistically responsive practice, to institutionalize organizational commitment to health equity, b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and c) Require an organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation. **SDOH/HE**	• CCO provides a baseline health equity plan, demonstrates its ability to implement health equity activities, and clearly articulates how it will dedicate necessary resources and a timeline for implementation. In addition to other components, the CCO must identify at least one initiative in its health equity plan that uses HIT to support patient engagement. • CCO provides criteria for how it will select and designate a single point of accountability for health equity work. • CCO describes how it will incorporate and promote National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care as a tool to eliminate/reduce racial and ethnic health disparities, including the CAC's role in ongoing member engagement to ensure appropriate language access. • CCO describes how it will use data to monitor and evaluate the impact of CLAS on health equity and outcomes to inform service delivery. • CCO describes how, with provider network and through community partnerships (including with public health organizations), it systematically collects and uses data on race, ethnicity and primary language to improve the quality of care for diverse populations. • CCO will be responsible for joining state and local efforts to ensure the health care workforce reflects the population served. • CCO will be responsible for developing and deploying a cultural responsiveness and implicit bias training plan and a timeline for its implementation.	• CCO ensures that its diverse member population receives the highest quality culturally and linguistically appropriate health care. • All CCO and provider network programs, community partnerships, priorities, policies and activities have solid and consistent health equity components that go beyond the use of an equity lens. • CCOs consistently engage clinical and non-clinical providers, members, community-based organizations, and others in health equity promotion efforts, including the application of solutions that directly address the social determinants of health. • For HIT: Providers make patients' full records available to them, patients are aware of the availability and know how to access it through patient portals, and high risk CCO members are engaged in their own care by using HIT apps and tools to work with their providers.	• In Year 1, CCO designates its single point of accountability for health equity work and begins implementation of cultural responsiveness and implicit bias training plan. • In Year 1, TQS reports include information on implementation of the health equity plan, training plan, and efforts to reduce health disparities. • External quality review implemented as necessary. • For HIT: Health equity plan contains an HIT component as required, and CCO engages in OHA TA as needed to better understand the potential and scope of HIT for patient engagement or if HIT component of health equity plan is inadequate

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
6	**Implement recommendations of the THW Commission:** a) Require CCOs to create a plan for integration and utilization of THWs. b) Require CCOs to integrate best practices for THW services in consultation with THW commission c) Require CCOs to designate a CCO liaison as a central contact for THWs d) Identify and include THW affiliated with organizations listed under ORS 414.629 (Note that d. is also included under Policy Option 8 for CHAs/CHPs) e) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for traditional health workers (THW) services. **SDOH/HE**	• CCO describes the components of its comprehensive integration and utilization plan for THWs, including benchmarks, milestones and timelines. The plan should ensure that each CCO member is an active partner in their own health care and services and not a passive recipient of care. • CCO describes how it will integrate best practices for THW service delivery to ensure 1) Recruitment and retention of diversified workforce that is culturally and linguistically responsiveness to the population served by the CCOs and 2) Measurable best practice standards and metrics are created to promote THW program fidelity and effectiveness. • CCO clearly articulates how it will create a dedicated liaison position for coordinating workforce, payments, utilization, supervision, service delivery, and member accessibility to THW services. • CCO clearly describes its plans for establishing sustainable payment rates for THWs. • CCO will be responsible for identifying a THW to participate in the CHA and CHP development process. • CCO will be responsible for developing a payment rate and reimbursement plan across the board for all THWs	• CCO's plan ensures that the THWs are part of the member's care team to provide and assist in services navigation, access to culturally and linguistically responsive care/providers, community connection and social support that impacts the member's health care and service needs. • CCO consistently utilizes THW best practices to be proactive in educating health care providers, consumers and administrators about the members' health care needs and the culturally responsive interventions and supports available through a culturally responsive workforce. • CCO THW liaison position effectively acts as the "hub" for THWs, consumers and the community within the CCO health care system, and this is demonstrated in CCO reporting. • CCO meaningfully engages THW voice during the CHA and CHP development process. • CCO implements centralized reimbursement/ payment rates for all THWs to be efficiently utilized in all health care settings and ensures that payments are not contingent upon health outcomes.	• Reporting to OHA to include benchmarks, milestones and targets that measure impacts such as: Increases in recruitment and retention of THW workforce, improvements in access to THW services, increases in engagement of THWs in member care teams and increases in members assigned to THWs as appropriate for the members' health needs. • CCO completes the recruitment of THW liaison and begins measuring encounters between consumers and THWs; THW-related improvements in health outcomes by race, ethnicity, primary language; THW-related reductions in the rate of non-emergent ED visits; increases in patient engagement with THWs; and utilization by THW type with a plan to address transitions in care within the delivery system. • CCO develops and publishes payment guidelines (which include value-based payments such as bundling and per-member-per-month payment, as well as fee for service), and fully implements in-house payment structure and processes for all THWs. OHA provides system-level support to reduce billing barriers. • Reporting to include # of THWs involved in CHA and CHP and how they are actively participating.
7	Require CCOs share with OHA (to be shared publicly) a **clear organizational structure that shows how the Community Advisory Council connects to the CCO board** **SDOH/HE**	• CCO clearly articulates relationship between CAC and CCO board, including CAC participation on the CCO board and other CCO committees, and CCO staff participation on the CAC. • CCO clearly articulates relationship between CAC, CCO board and Tribal Advisory Council, if applicable. • CCO provides a visual organizational chart demonstrating these connections.	• CCO demonstrates the value of CAC voice by illustrating multiple feedback loops of CAC input that are integrated into a wide variety of areas of CCO decision-making.	• OHA publishes organizational structure information from CCOs. • TQS reporting to include supplemental information about CAC role in decision-making (policy option #4).

8	Require CCOs to partner with local public health authorities, non-profit hospitals, and any CCO that shares a portion of its service area to **develop shared CHAs and shared CHP priorities and strategies.** a) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need. Ensure CCOs **include organizations that address the social determinants of health and health equity in the development of the CHA/CHP,** including THWs affiliated with organizations listed under ORS 414.629. **SDOH/HE**	• CCO clearly describes: o Existing partnerships with local public health authorities (LPHAs), non-profit hospitals and other CCOs that share the service area for the current CHA; o Gaps in these partnerships; o Steps the CCO will take to address these gaps prior to developing the next CHA; o The THWs and organizations addressing social determinants of health and health equity that were involved in the development of the CHA and CHP; and o Gaps in involvement of SDOH/HE organizations and how the CCO will meaningfully engage these organizations in developing the next CHA and CHP. • A CCO that does not have a current CHA shall describe existing partnerships with LPHAs, non-profit hospitals, other CCOs that share the service area, organizations that address social determinants of health, gaps in existing partnerships, and the steps the CCO will take to meaningfully engage these organizations when it develops its first CHA and CHP. • CCO identifies the CHP priorities and strategies currently being implemented by the CCO and LPHAs, non-profit hospitals, and any CCO that shares the service area. • For any new CHP developed during the contract period, the CCO must identify and describe areas of alignment with at least two state health improvement plan priorities, including which statewide strategies are being implemented. • The CCO will be responsible for making progress toward CHP goals and demonstrate accountability through annual progress reports that include a	• CHP is a single community document describing community health improvement priorities (note that CCOs, hospitals and LPHAs may document their strategies toward those goals in separate documents) • In regions with aligned service areas, the CHP is fully shared by CCOs, LPHAs and non-profit hospitals. • The CHA/CHP partnership of CCOs, LPHAs and non-profit hospitals has a governance structure that is responsible for allocating resources to CHP priorities, overseeing shared metrics, and is the accountable body for meeting targets and goals. • Inclusion of organizations that address social determinants of health, and THWs, in developing the CHA and CHP shifts focus in CHA/CHP to the root causes of poor health and health disparities; consumer voice is demonstrated in development of community priorities and improvement strategies. • CCO demonstrates investment of a percentage of its global budget in implementing CHP priorities to meet CHP goals.	• Year 1, and annually: CHA/CHP submissions and annual progress reports demonstrate meeting baseline expectations based on OHA review. • Upon submission of new CHA and CHP (timeline will vary for CCOs): o CCO demonstrates local partnership of LPHAs, non-profit hospitals and other CCOs in the service area. o CCO demonstrates accountability for making progress toward meeting CHP goals. o CCO demonstrates alignment with SHIP priorities, including implementation of statewide strategies. o CCO and partners demonstrate achievement of targets and goals in CHPs. • SHIP annual progress reports will also be used to demonstrate improvements on priorities and strategies that are being implemented at the local level.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
		description of the actions the CCO will take if goals are not being met.		
9	**Require CCOs to submit their community health assessment (CHA) to OHA** **SDOH/HE**	• CCO must submit CHA by June 30 of the first year of the contract.	• Increased transparency about the health of communities and about how health priorities for the CHP are selected. • The CHA will become a readily accessible data source for community partners or other organzations seeking to understand the health of the community.	• Year 1: CHA submissions demonstrate meeting baseline expectations based on OHA review. • CHAs will be posted online.

| 10 | Increase CCOs' use of value-based payments (VBP) with their contracted providers

VBP | **Ensure all CCOs increase their use of VBPs**, in alignment with 1115 Waiver requirement to achieve VBP target.

RFA Applicants:

• Need to provide details on how they would achieve a minimum of 20% VBP in primary care in LAN* category 2C ("pay-for-performance") or higher during year one (2020).
• Need to provide details on their per-member, per-month (PMPM) VBP payments (i.e., LAN category 2A "foundational payments for infrastructure and operations") to Patient-centered Primary Care Homes (PCPCH).
• Respond to specific questions that address how their VBP models will not negatively impact priority populations, including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees.
• Demonstrate necessary information technology (IT) infrastructure for VBP reporting,

Each CCO will be responsible for meeting annual VBP growth target calculated with their own baseline VBP data. This will ensure that all CCOs increase their use of VBPs.

*The Health Care Payment Learning and Action Network (LAN) is a national effort partially funded by CMS to accelerate VBP adoption by states and the commercial insurance market. They developed a "Framework" for categorizing VBPs that has become the nationally accepted method to measure progress in the adoption of VBPs. | • PCPCH VBP provides financial support to sustain a robust PCPCH model of care and supports staff/activities not reimbursed through FFS.
• CCO VBP learning collaborative to align efforts and share tools to lead this work in their communities. The CCO VBP collaborative could evolve into a multi-payer collaborative in later years.
• CCOs can advance in model sophistication or care delivery focus areas (e.g., increase their % in 3B/shared risk, or adopt a VBP to focus on behavioral health integration).
• CCOs reporting to APAC will allow for comparing CCO VBP progress over time, across CCOs and across the health system.
• CCOs' responses to a standardized set of questions within their annual VBP interviews on steps they have taken to ensure their VBPs have not had unintended, negative consequences for priority populations (including those previously identified in the column to the left), provides an incredible opportunity to learn best practices, advance those best practices, and develop "safe-guards" where needed.
• CCOs' responses to a standardized set of questions within their annual VBP interviews on steps they have taken to ensure their VBPs have not had unintended, negative consequences for priority populations (including those previously identified in the column to the left), provides an incredible opportunity to learn best practices, advance those best practices, and develop "safe-guards" where needed. | **By year 1, CCOs will:**
• Implement a PCPCH PMPM payment by PCPCH tier level (LAN category 2A).
• Implement at least 20% of primary care payments in the form of a VBP in LAN category 2C or higher.
• Achieve a 1-year VBP growth target tied to the statewide VBP goal and the CCO's baseline data for category 2C ("performance-based incentive payments") and category 3B ("shared risk") as reported in their RFA response.
• Report VBP data to All Payer All Claims (APAC) database.
• Participate in annual CCO VBP interviews, including responses to a standardized set of questions on steps they have taken to ensure their VBPs have not had unintended, negative consequences for priority populations.

At end of the 1-year period, OHA will assess CCOs' progress toward meeting growth targets and establish CCO-specific growth targets for years 2–5.

By year 2, CCOs will be required to implement two VBPs focused on key care delivery focus areas listed below.
• Behavioral health
• Oral health
• Hospitals
• Children's health care
• Maternity care

By year 5, CCOs will (2024):
• Implement the remaining three care delivery focus areas.
• Contribute to 70% statewide VBP goal.
• Report complete encounter data with contract amounts and additional detail for VBP arrangements. |

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
11	Evaluate CCO performance with tools to **evaluate CCO efficiency**, **effective use of health-related services (HRS), and the relative clinical value of services** delivered through the CCO. **Use evaluation to set a performance-based profit at individual CCO level.** **Cost**	• OHA rate-setting methodology has new tools to: o Evaluate CCO efficiency, delivery of high-value health care services and cost-effective use of health-related services; and o Reward the highest performing CCOs.	• CCOs increase investments in programs and systems that improve the care delivery system. and increase access to health-related services • Improved CCO efficiency leads to: o Improved health outcomes for members o Lower overal programmatic costs • CCO investments in programs and services that increase efficiency and utilization of high-value services benefit populations experiencing health disparities and inequities. • New transparency increases public accountability for CCOs.	• New publicly available measures: o Efficiency measures o Evaluation of CCO delivery of services with highest clinical-value o Methodology for evaluating CCO use of HRS • CCO-specific profit loads act as an incentive and accountability metric.
12	**Incorporate measures of quality & value in any OHA-directed payments to providers** (e.g. hospital payments) or OHA reimbursement policies and **align measures** with CCO metrics Example: qualified directed payments made directly to hospitals are based in part on quality and value **Cost**	• The methodology for OHA-directed payments to hospitals will incorporate measures of quality and value.	• CCOs and OHA align payment methodologies and their incorporation of quality and value to amplify their ability to motivate performance improvements. • Connecting quality and value with financial incentives will motivate continued improvement in a key goal of the triple aim: improve care. • OHA-directed payments and methodologies are increasingly aligned with CCOs efforts to increase use of value-based payments. • Metrics measuring quality and value consider health disparities and reward providers/CCO that reduce disparities.	• Measures of quality and value may build on successes of previous HTPP program and should connect to CCO efforts to expand VBPs and efficiency metrics into hospital-based services.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
13	**Adjust the operation of the CCO Quality Pool** to allow consideration of expenditures in CCO rate development to: • Align incentives for CCOs, providers, and communities to achieve quality metrics **Create consistent reporting of all CCO expenses** related to medical costs, incentive arrangements, and other payments regardless of funding source (quality pool or global budget) **Cost**	• Considering Quality Pool spending within rate development adds a new layer of transparency to CCO spending patterns related to the quality pool and allows OHA to increase the portion of the CCO's global budget tied to quality and value. • CCOs clearly report all quality or incentive payments to providers, as distinct from any base payment the providers would have received absent quality incentive.	• CCOs use quality pool revenues to make timely investments in their communities and the partners that help them achieve targeted metrics. • Moving quality pool funds inside the rate development process provides extra incentive for CCOs to meet benchmarks and thus help motivate performance improvement at the CCO level. • Funding the quality pool through a withhold allows OHA to increase the share of CCO global budgets that is tied to performance.	• Increased visibility of CCO quality pool spending patterns helps hold CCOs accountable to their local communities.
14	**Address increasing pharmacy costs** and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers **Cost**	• CCOs require their pharmacy benefit managers (PBMs) to: o Provide pharmacy cost pass through at 100% o Pass back 100% of rebates received to CCOs o Report administrative fees paid from CCO to PBM o Require reporting from PBM on pharmacy-paid amounts at claim level • Require transparent "no-spread" arrangements between CCOs and PBMs. • CCOs require PBMs to agree via contract to 3rd party audits and market checks on an annual basis.	•	• Financial audits for CCO pharmacy networks (i.e., individual pharamcies) on amounts paid to them for claims processed by CCO's contracted PBM can be compared and reconciled against what PBM is reporting as paid amount to the CCO less, fixed or expected adminstration fees charged by the PBM. • Rebate passthrough reporting must be demonstrated via periodic reporting by the PBM. This reporting should take place at a minimum of two times annually.
15	**Address increasing pharmacy costs** and the impact of high-cost and new medications by: increasing alignment of FFS and CCO PDLs (based on recommendations from outside analysis and additional OHA/OHPB guidance) **Cost**	• CCO PDLs and coverage/prior authorization criteria will be publicly posted and easily accessible for patients and prescribers. • CCOs will be responsible for aligning selected segments of their Preferred Drug Lists (PDLs) with the Oregon Health Plan's fee-for-service PDL.	• Over time CCOs will work with OHA to significantly increase alignment of CCO PDLs (and coverage criteria) across highly utilized drug classes to improve intrastate portability of the Medicaid program.	• Require CCOs to submit PDLs for all classes to OHA in format required by OHA. CCO will be required to provide updated version as changes are made. • Require CCOs to submit coverage criteria for all non-aligned PDL classes in format required by OHA. CCO will be required to provide updated version as changes are made. • OHA compiles CCO submissions and publishes the information to the OHA pharamcy website to improve practitioner and patient communications (to be updated monthly).

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
16	**Enhance financial reporting and solvency evaluation tools** by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency **Cost**	• CCOs report financial information to OHA using NAIC financial reporting templates (Health Annual Statement). • CCOs submit supplemental reports to OHA for necessary information not part of NAIC templates.	•	• CCO financial data is available in a publicly accessible manner.
17	**Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity.** This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities. **BH**	• CCO clearly articulates plan for managing the behavioral health benefit, including: o Resource utilization to ensure the behavioral health benefit is integrated in a way that is invisible to members and providers; o The full behavioral health benefit is available to members (accessible, timely, within a reasonable distance and inclusive of a full range of treatment and recovery options); o Policies and procedures for the behavioral health benefit for their entire region; o Budget managed in a fully integrated way; o Plan for annual evaluation of behavioral health spend and risk sharing; o Behavioral health services are paid for in primary care and primary care is paid for in behavioral health, without pre-authorization; o Multiple services are allowed within the same day at the same clinic; and • No wait time for services.	• CCOs must be fully accountable for services by actively taking responsibility for ensuring seamless access to all covered benefits. This will create a transparent, effective and responsive behavioral health system. • CCOs ensure processes and structures are in place to ensure there is a coordinated behavioral health system.	• RFA response should include all items in the initial baseline expectations. • OHA will monitor the metrics identified in the next policy option. Corrective action plans will be required if CCOs are not able to meet metrics. • Review of MOU between CCO and community mental health provider – which includes conversations with relevant stakeholders. • Ensure that the local plan and CHP are collaborative plans that inform one another.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
18	**Identify metrics to track milestones of behavioral health (BH) and oral health (OH) integration** with physical health care by completing an active review of each CCOs plan to integrate services that incorporates a score for progress • OHA to refine definitions of BH and OH integration and add to the CCO contract • Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics **BH**	• Starting in year one, CCOs report on OHA identified behavioral health integration metrics on a regular basis. • Starting in year two, CCOs report on OHA identified oral health integration metrics on a regular basis.	• CCOs increase the level of behavioral health integration, resulting in integrated and coordinated health care for all Oregonians. • OHA has a method to measure the level of integration of each CCO.	• CCOs will be required to report on metrics, and OHA will use a scoring rubric. • Technical assistance will be available for CCOs that are not meeting the minimum score or that request additional TA.
19	Require **CCOs report on capacity and diversity of the medical, behavioral and oral health workforce** within their geographical area and provider network. CCOs must monitor their provider network to ensure parity with their membership. **BH**	• In year one, CCOs will report on members in their network, current workforce, and the plan to meet the need of their members. • OHA will develop report and will publish available data. • OHA to monitor compliance.	• CCOs lead the way in the collaborative and creative development of the necessary medical, oral, and behavioral health workforce to serve individuals in their communities. • CCOs will ensure there is a sufficient and well-trained workforce to meet the needs of members. CCOs will ensure culturally and linguistically appropriate care available for all Oregonians.	• OHA will see a decrease in gaps among racial/ethnic groups in incentive and other existing metrics. • Year 1 (2020) – Each CCO will be expected to identify a targeted number of FTE and a targeted range of diversity for medical, oral and behavioral health care providers by the end of the following year. • At end of year 2, OHA will assess CCOs' progress toward achieving the targets and look with the CCO at targets for years 3–5.
20	Require CCOs **utilize best practices to outreach to culturally specific populations**, including development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs). **BH**	• CCOs to report in year one. • CCOs will reach out to populations experiencing gaps in care that contribute to oral health disparities. • CCOs will provide culturally and linguistically appropriate services to diverse populations using identified best practices.	• CCOs will decrease the gaps in care that contribute to oral health disparities. • Intake paperwork is accurately translated, accessible interpreter services for intake, treatments and ancillary services.	• OHA will see a decrease in gaps among racial/ethnic groups in incentive and other existing metrics. • Outreach leads to changes in capacity and diversity of the workforce that are included in the report required for policy change 23. • Workforce diversity measures TBD.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
21	**Prioritize access for children ages birth** through five years to health services, developmental services, Early Intervention and targeted supportive services, and Behavioral health/mental health treatment. **BH**	• CCOs to collectively develop statewide early childhood criteria for behavioral health levels of care (outpatient, intensive outpaticent, subacute and PRTS). • Require an increased level of outpatient level of care for children birth through five with indications of Adverse Childhood Events (ACEs) and High complexity due to one or more of the following: multi system involvement, two or more caregiver placements within the past six months, moderate to severe behavior challenges, at risk of losing current caregiver placement, or school or daycare placement •	• CCOs level of services to children ages 0–5 will match the national percentages. • Use of quality, evidence-based practices that have high results for this age group and school age children that did not get access to parent-child interaction therapy (PCIT). • Collaboration between CCOs and OHA's Children's Behavioral Health Unit to impact the workforce and quality of services. •	• OHA to track APAC data through MMIS Assessment codes (E/M and CPT/HCPCS) to monitor and report to CCOs their level of service as compared to national levels. • TA and community participation on development of EC level of care. • Track use and impact of Help Me Grow's intervention on the community and share data with CCOs. • Track PCIT utilization with Child Welfare data (increase children stabilized, return home and reduce disruption and removal). • Track PMTO implementation, usage and connect with Child Welfare data (increase children stabilized, return home and reduce disruption and removal).
22	Implement risk-sharing with the Oregon State Hospital (Behavioral Health Collaborative recommendation) **BH**	• All CCOs will assume risk for members on OSH waitlist in year one. • Payment model will shift to OSH billing CCOs for members in OSH in year two. • All CCOs will share limited risk for members in OSH in year two (e.g., CCO projects number of beds they will use, pays monthly amount to OSH based on projection, settlement at the end of the year; details of the model are in development).	• CCO members will receive appropriate care in the appropriate setting. This will result in improved outcomes and lower costs.	• CCO members on OSH waitlist receive appropriate care in the appropriate setting of care (e.g., acute care hospital, community setting). • Each CCO has a contract in place with OSH following the same payment model. • CCO members in OSH will be discharged as soon as individual is ready to return to the community (Oregon Performance Plan indicator: discharge within 30 days of ready to transition).
23	Shift financial role for statewide HIT public/private partnership from OHA to CCOs to cover their fair share **HIT**	• CCO signs MOU as a participant in the HIT Commons and pays dues according to the dues structure established by the HIT Commons. • If elected, CCO representative fills one of the three CCO seats on the HIT Commons (nominations by CCO CEOs). • As HIT Commons participants, CCOs are eligible to participate in HIT Commons efforts, for example, accessing HIT Commons services, participating on a committee, or attending a learning collaborative.	•	• MOU signed, annual dues are paid. • If elected, CCO representative regularly attends HIT Commons meetings and participates in HIT Commons work. • If CCO fails to meet this requirement, a corrective action plan may be warranted.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
24	Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in-person, regardless of a patient's geographic setting (rural, urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (i.e., does not require CCOs to add new providers to ensure telehealth is broadly available), but focuses on coverage. **BH/HIT**	• CCO will cover services provided via telehealth in the following situations: ○ A CCO's contracted provider provides a service via telehealth* during an encounter, and ○ The CCO would cover that service if the contracted provider had provided the service in person during the encounter. • CCOs would not be expected to have specific levels of telehealth services available (e.g., no network adequacy for telehealth specifically). • If it is not clinically appropriate to provide the service via telehealth, CCOs would not be required to cover the service. **Including asynchronous communication in some circumstances.*		• Telehealth services are covered as required. • If CCO fails to meet this requirement, technical assistance and/or a corrective action plan may be warranted.
25	**CCOs identify actions for the development of the medical, behavioral and oral health workforce** including their efforts to: • Develop the healthcare workforce pipeline in their area by participating in and facilitating the current and future training for the health professional workforce. This includes encouraging local talent to return to their home areas to practice and supporting health professionals following their initial training; • Develop and support a diverse workforce who can provide culturally and linguistically appropriate care, with attention to marginalized populations; and • Ensure current workforce completes a cultural competency training in accordance with HB 2611**.** **BH**	• In year one, CCOs report on prevalence in their region for all health needs and begin working within their local communities with local and state educational resources to develop an action plan to ensure the workforce is prepared to meet needs. All CCOs will be expected to update these plans on an annual basis and identify how they are implementing them.	• CCOs lead the way in the collaborative and creative development of the necessary medical, oral and behavioral health workforce to serve individuals in their communities. • The ability of CCO applicants to understand the health care workforce needs for their area and have ideas for how to address those needs is critical to the success of being able to provide access to care and critical to the success of them as a CCO	• Year 1 (2020) – Each CCO will be expected to identify a targeted number of FTE and a targeted range of diversity for medical, oral and behavioral health care providers by the end of the following year. • At end of year 2, OHA will assess CCOs' progress toward achievement of the targets and look with the CCO at targets for years 3–5.

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
26	**Require CCOs to ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI) and for children with serious emotional disturbances (SED),** and incorporate the following: • Develop standards for care coordination • Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD) • Establish outcome measure tool for care coordination **BH**	• CCOs to ensure individuals diagnosed with severe and persistent mental illnesses or serious emotional disorders are assigned to a care coordinator who works with the individual to complete a care plan that meets their individual needs and personal goals. • CCOs and OHA to develop statewide standards for care coordination and intensive care coordination. • CCOs to ensure individuals in state custody are assigned to a care coordinator who works with the individual to complete a care plan that meets their individual needs and personal goals using best practice working with children in foster care and juvenile justice.	• Coordinators are identified and work with the individual to coordinate physical health, mental health, intellectual and developmental disability and ancillary services as needed. • Improved outcomes for individuals and reduced cost as a result of care being coordinated and resources used efficiently.	• Number of individuals with identified care coordinators increases over time. • MHSIP and YSS-F surveys can be used to evaluate care coordination satisfaction by families and consumers. • Use of identified outcome measure tool.
27	**Develop mechanism to assess adequate capacity of services across the continuum of care.** Ensure members have access to services across the continuum of care. **BH**	• Starting in year one, CCOs will report on network adequacy, based on prevalence for their region. Network adequacy will include the continuum of care for behavioral health, including SUD and OTP specific services.	• Every region will have a full continuum of behavioral health services to meet the needs of the community. . •	• Behavioral health prevalence data for the region. • Current provider network for the region. • Plan to ensure adequate provider network, based on prevalence data. •
28	**System of Care to be fully implemented for the children's system** **BH**	• State agencies (OYA/OHA/DHS/ODE) to fund the State System of Care Steering Committee with existing general fund from each child-serving state agency for multi-agency needs and development of shared services and supports. • Starting in year one, hold CCOs accountable to full implementation of existing model to demonstrate cross system collaboration. OHA to provide TA. • CCOs will have care coordinators who are fully trained, participating in coaching, and practicing to fidelity standards in their work with wraparound within the system of care. Supervisors will also be trained and participating in coaching. • CCOs will measure fidelity of their wraparound services.	• CCOs will have four levels of governance reflected within 2-4 working groups in their region.	• Funding occurs through an IGA. • Data sharing agreements in place to support System of Care implementation and impact. • Documented and utilized state level policy and procedure from local CCO areas through their governance structure to the state level steering committee. • Tracking system to identify system impact of the System of Care (i.e., children placed in out of home care or juvenile justice).

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
29	Require **Wraparound is available to all children and young adults who meet criteria** BH	• Starting in year one, require CCOs to meet or exceed national average for fidelity implementation per WFI-EZ scores (fidelity tool/consumer survey). • CCOs will meet contractual expectations and their subcontractors will meet requirements of wraparound OAR (in process, no number available). • CCOs will administer fidelity measurements periodically and fund these efforts. • Enforcement of existing contractual expectations will be critical to success. • Ensure contract clarifies 0-25 age for wraparound access.	• As wraparound is implemented to fidelity, there will be improved outcomes for children involved in wraparound services. This will result in future cost savings.	• Fidelity measurements through WERT (University of Washington) for Team Observation Measure (TOMS), wraparound facilitation and community support are available; CCOs should use at least two of these • Evaluation of satisfaction by youth and families with CCO/delegate administration of wraparound • Fidelity measurements periodically (at present they are done once) • Documented evidence of training, and coaching participation by care coordinators and supervisors
30	**MOU between community mental health provider (CMHP) and CCOs enforced and honored** BH	• Starting in year one, each CCO must have MOU with CMHP.	• CCO has working relationship with each CMHP in the region, which will result in better coordinated behavioral health care in the region.	• The local plan (biennial implementation plan or BIP) will be submitted by the CMHP. The Local Plan will inform the CHP and the CHP will inform the Local Plan. The CMHP and the CCO will collaborate on the development of the CHP.
31	Identify and address billing system and policy barriers to integration: • Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting • Develop payment methodologies to reimburse for warm handoffs, impromptu consultations and integrated care management services • Examine equality in behavioral health and physical health reimbursement BH	• Implement in year one. • OHA to identify codes and reimbursement rates. • OHA to review equality in reimbursement. • CCOs required to reimburse for these services and to expand provider network. • OHA to identify appropriate CDT codes and reimbursement rates. • OHA to review equality in reimbursement.	• Increase integration by allowing for services to be reimbursed in integrated settings. • Improved outcomes as providers will be able to bill for services that are not currently allowed. Will improve outcomes as members will receive more flexible services. • Improve reimbursement rates • Improved outcomes as providers will be able to bill for services that are not currently allowed. Will improve outcomes as members will receive more flexible services. • Improve reimbursement rates	• To be developed as part of accountability and monitoring plan. • Improvements in metrics of integrated care, such as the rate of members with diabetes who get an oral health evaluation. • Internal OHA monitoring and compliance. • Improvements in metrics of integrated care, such as the rate of members with diabetes who get an oral health evaluation • Internal OHA monitoring and compliance

#	Policy	Initial baseline expectations	Transformational expectations	Examples of accountability or assessment tools
32	**Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts** Connect contractual requirements to ongoing evaluation of Oregon's sustainable spending target based on national trends and emerging data to inform more aggressive targets in future while providing CCOs with additional financial incentives to achieve spending targets in the form of shared savings arrangements **Cost**	• CCOs agree to meet sustainable growth targets.	• CCOs reduce annual growth rates and enable reinvestment of savings into CCO program. • Multi-year capitation rates provide new tools to help CCO program meet sustainable growth targets. • New data and analytical tools enable more aggressive growth targets in future years to ensure overall sustainability of program.	• CCO-specific growth trends posted publicly in a manner that allows comparison across regions and CCOs.
33	**Require CCOs support EHR adoption across behavioral, oral and physical health contracted providers** **BH/HIT**	• CCOs establish targets for EHR adoption, focusing on each provider type (physical, behavioral and oral health). • CCOs work with their key contracted providers to remove barriers to EHR adoption and use.	• All physical, behavioral and oral health providers adopt and use robust EHRs. Robust EHRs would meet the latest ONC certification standards that are achievable based on the practice area. • All patients are able to access their health information electronically via an EHR portal.	• Percentage of providers adopting and using EHRs, broken out by provider type • Percentage of providers using an EHR that provides an enabled patient portal • Percentage of patients accessing portal data (broken out by physical, behavioral and oral health)
34	**Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange technology** that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications **BH/HIT**	• CCOs support contracted physical, behavioral and oral health providers' access to electronic health information exchange options to connect disparate care providers for care coordination. • CCOs use Oregon's statewide hospital event notifications system or other hospital event mechanisms to inform care coordination and population health management. • CCOs ensure their contracted providers have access to timely hospital event notifications to help them manage populations and target interventions and follow up.	• CCOs and contracted physical, behavioral and oral health providers have access to comprehensive electronic patient data needed to support coordinated care and population health efforts.	• Percentage of providers adopting and using health information exchange, broken out by type of health information exchange, and type of provider (physical, behavioral, oral) • Percentage of providers with access to timely hospital event notifications, and percentage actively using notifications, broken out by type of provider (physical, behavioral, oral) • Reporting about how CCOs are using hospital event notifications (what are the use cases being addressed) and CCO rates of active use of hospital event notifications (may be % of active users, days logged on to tool, etc.)

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35	**Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting,** including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and manage VBP data. This would include a demonstration that the CCO can work with electronic clinical quality measure data. **VBP/HIT**	• CCOs demonstrate they have the health IT tools necessary to: o risk stratify populations and target interventions to ensure patients and communities receive the care they need to stay healthy; o manage value-based payment (VBP) arrangements, including sharing with providers data on patient attribution, patient risk scoring, CCO claims or cost data, and provider performance; and o analyze and manage electronic clinical quality metric data and claims-based metrics (as a component of VBP arrangements). • Or provide a detailed roadmap of their plans to have such tools within the contract period • CCOs demonstrate that their primary care clinics with VBP arrangements have some HIT/data support in place. • CCOs may collaborate on these efforts and/or leverage statewide or regional efforts.	• Individuals at risk for poor outcomes are identified and interventions are targeted and monitored to improve outcomes. • All contracted providers engaging in VBP arrangements with CCOs have the data, IT tools and supports needed to manage to their VBP obligations. • All CCOs have the data, IT tools and supports needed to manage their VBP arrangements and support the increased expectations around VBP.	• HIT Roadmap for each CCO (based on RFA response) includes milestones and monitoring to ensure that CCO HIT and data capacity improve over time to support VBP. • Percentage of contracted providers with a VBP arrangement who have the data, tools and supports needed to manage their VBP arrangements – this can be reported by CCO and/or requested via survey from clinics.
36	Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources. **All**	•	•	•
37	**Shift mental health residential benefit to CCOs** **BH**	• In year one, CCOs work with OHA as rate standardization is implemented and consider becoming early adopters to assure transitions are functional. • In year two, transfer the mental health residential benefit to CCOs.	• CCOs will be responsible for the mental health residential benefit.	• Numbers of residential programs available in the CCO's benefit package

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38	**Establish a statewide reinsurance pool** for CCOs administered by OHA to spread the impact of low frequency, high cost conditions and treatments across entire program **Cost**	Program implementation phased-in: • CCOs are better protected from unforeseen and unavoidable costs associated with high-cost patients and high-cost medical conditions. • A program-wide reinsurance pool assists the rate setting process and reduces the volatility of rates associated with some patients.	Long-term expectations after fully phased-in: • OHA uses program-wide purchasing power to reduce costs associated with some high-cost treatments and/or patients. • Program-wide reinsurance costs decline over time as program ramps up and purchasing power is leveraged; savings benefit CCOs and state taxpayers instead of private reinsurers.	• Reduced cost and/or improved care delivery of patients with specified medical conditions. • CCO financial performance shows less volatility due to reinsurance costs being managed at the program-level.
39	**Ensure continued CCO solvency** by establishing solvency thresholds at a level that adequately considers the financial risks CCOs face and strengthening OHA's solvency regulation tools **Cost**	CCO requirements may be phased in: • CCOs agree to meet RBC-based solvency standards. • RBC-based solvency standards will be evaluated for the Oregon Medicaid CCO program and ensure CCOs have adequate resources to maintain financial solvency	Long-term: • Program-wide CCO financial resources are available via a "Guaranty Fund" in the event that a CCO is impaired or insolvent.	• CCO-specific RBC levels are publicly available.
40	Identify, promote and expand programs that integrate primary care in behavioral health settings (**Behavioral Health Homes**) **BH**	• CCOs include in their network, to the greatest extent possible, BHHs. CCOs to assist providers within delivery system to establish BHHs.	• Behavioral health homes would enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. This will improve whole health outcomes for individuals.	• OHA will have an implementation and compliance team, based on the PCPCH team, to monitor.
41	CCOs, with the support of OHA, to **require providers to implement trauma-informed care practices** **BH**	• In year 3, CCOs will require subcontractors/providers of behavioral health services receive training in trauma informed approaches. • CCOs will require providers of behavioral health services to use screening and assessment of trauma to develop and inform Individual and service and support plans. • CCOs to require outcome-based tools for behavioral health services that reflect best/emerging practice.	• Increase number of providers and organizations using trauma informed care principles. • Reduce the impact of ACEs and trauma for all Oregonians.	• Standards of Practice found at TIO.org • Training records • OHA and CCO audit of providers' use of training, screening/assessment and outcome-based tools
42	**Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy** (AZ Model) with financial implications **Cost**	• Implementation may be phased in • When implemented, OHA will use data directly from providers for comparison with CCO-level encounter data to add new accountability and oversight.		• OHA publishes results of CCO-specific findings to add layer of public accountability. • Potential financial implications if inaccuracies reach certain threshold or are not mitigated.

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43	**Support providers in utilizing ACEs score, and/or trauma screening tools** to develop individual service and support plans. Additional tools used shall be outcome based and reflective of best/emerging practices. **BH**	• Internal OHA work group to direct trauma informed approach within OHA to better support CCOs/providers. Move to CCO contract in year 3+.	• Identify impact of trauma on treatment, improved outcomes for individuals receiving services.	• Monitored as part of compliance review
44	Develop an incentive program to support behavioral health providers' investments in electronic health records and other, related HIT. (Feasibility depends on 2019 legislative session) **HIT**	• If funding is approved, OHA develops and implements this incentive program. Expectation for CCOs: CCOs consult with communities and advise OHA about how to prioritize use of limited funds.	• All BH providers in Oregon have the robust EHRs and related HIT needed to engage in care coordination and VBP arrangements.	• Percentage of BH agencies with robust EHRs • Percentage of BH agencies submitting data to MOTS from their EHRs (or percentage of Medicaid members receiving BH care whose data is submitted to MOTS from an EHR) • Percentage of BH agencies providing data from their EHR electronically as part of sharing information for care coordination • Percentage of BH agencies reporting that they have the data, IT tools and supports needed to participate in VBP arrangements