Appendix A:

CCO 2.0 recommended policies and implementation expectations

Policy #1

Implement House Bill 4018: Require CCOs to spend portion of net income or reserves on social determinants of health (SDOH; including supportive 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 and health equity spending to, SDOH partners through a transparent process.

B) Require CCOs to designate role for community advisory council (CAC), and tribes and/or tribal advisory committee if applicable (see Policy 4, Part D), in directing and tracking/reviewing spending.

C) Years 1 and 2: Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the global budget rate methodology and seek to build in a specific amount of SDOH and health equity investment. This is 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 or reserves in social determinants of health and health equity.

   i. Require one statewide priority – housing-related supports and services – in addition to community priority(ies).

Dashboard

★	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**

Intended impact

Increased strategic spending by CCOs on social determinants of health and health equity/disparities. Decision-making is inclusive and consumer-informed.

Policy implementation considerations

- CCOs will be expected to engage tribes in this work and in decision-making processes about SDOH and health equity spending.
- Mandated by HB 4018; Part C 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: Policy option package (POP) is for a SDOH transformation analyst who would support a variety of SDOH work; could be applied to this policy option.
- Year 1 and 2 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, transformation and quality strategy (TQS), and 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:
- Oregon Health Policy Board (OHPB) 7/10/18: Support for statewide priority of housing-related supports and services.
- CCO 2.0 Survey and Medicaid Advisory Committee 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.

Policy implementation expectations

Initial baseline expectations

- CCO clearly articulates criteria for selecting the SDOH/HE partners it intends to direct SDOH/HE funding to through contract, memorandum of understanding (MOU), grant or other formal agreement (including housing partners to meet the statewide priority requirement).
- CCO demonstrates 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 for spending in addition to the statewide housing priority.
- CCO demonstrates that its expenditures (both to partners and other SDOH/HE spending) address the SDOH, health equity, health disparities, or population health policy and systems change as defined by OHA.

Transformational expectations

- CCO dedicates a percentage of its global budget to SDOH 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.

Examples of accountability

- Part C: 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, Transformation and Quality Strategy [TQS], CHP progress reports), including number of members served by SDOH/HE investments.
- OHA publishes annual data on CCOs' SDOH/HE spending.

Policy #2

Increase strategic spending by CCOs on health-related services (HRS) by**:**

A) Encouraging HRS community benefit initiatives to align with community priorities, such as those from the community health assessments (CHAs) and community health improvement plans (CHPs); and

B) Requiring CCOs' HRS policies to include a role for the community advisory councils (CACs) and tribes and/or tribal advisory committee if applicable (see Policy 4, Part D) in making decisions about how community benefit HRS investments are made.

Intended impact

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.

Policy implementation considerations

- No substantive contract changes for Part A ("encourage").
- Contract language change for Part B.
- 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.

Policy implementation expectations

Initial baseline expectations

- 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.

Transformational expectations

- CCO demonstrates that their HRS spending aligns with the CHA and CHP.
- CCO annually reports all HRS spending itemized with any evidence of return on investment.

Examples of accountability

- OHA publishes quarterly data on each CCO's HRS spending by category and as a percent of total member expenditures.
- OHA/CCO publishes CCO policies relating to HRS and CAC's role in HRS decisions.
- CCO includes community-based initiatives and explains CAC's role in deciding community-based initiatives.

Dashboard

	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**

Policy #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** by the Health Plan Quality Metrics Committee (HPQMC) and Metrics & Scoring (M&S) Committee for inclusion in the CCO quality pool

Dashboard

	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

Intended impact

Community partners are engaged and receive financial resources for their contributions to achieving incentive measures.

Robust and sustainable community-clinical linkages are in place for meeting incentive measures.

Metrics: CCO quality pool dollars are used to incentivize improvements in SDOH and health equity.

Policy implementation considerations

Part a:
- To be phased in after Year 1.
- Staff FTE for planning, tool development and ongoing technical assistance needed in Health Policy and Analytics (HPA) and Public Health Division (PHD); monitoring/compliance also needed.
- Recommended by the Public Health Advisory Board (PHAB).
- Support provided at CCO 2.0 road show forums.
- Pros:
  a) 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.
  b) Maintains local flexibility for CCOs to work with specific providers in their communities that meaningfully contribute to meeting incentive measures.
  c) May allow for better standardization of 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 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:
- Can be implemented in Year 1 with no additional resources.
- 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.

Policy implementation expectations

Initial baseline expectations

- 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 complies with OHA requirements for reporting CCO expenses related to incentive arrangements.

Transformational expectations

- CCO engages 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.
- CCO is a key convener in creating stronger community systems for addressing social determinants of health. This will include efforts to create trauma-informed systems.

Examples of accountability

- CCO submits policy for distributing quality pool dollars to clinical, non-clinical and public health providers.
- CCO reports expenses related to incentive payment arrangements.

Policy #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) the percentage of CAC comprised of Oregon Health Plan (OHP) consumers; 2) how the CCO defines their member demographics and diversity; 3) the data sources they use to inform CAC alignment with these demographics; 4) their intent and justification for their CAC makeup; and 5) an explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress;

B) Require CCOs to report CAC member representation alignment with CHP priorities (for example, public health, housing, education, etc.); and

C) Require CCOs to have two CAC representatives, at least one being an OHP consumer, on the 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.

Dashboard

	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**

Intended impact

CCOs have a representative CAC. This builds trust and relationship with members. Systems are designed with the OHP member in mind.

Policy implementation considerations

- 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).
- CCOs will not be required to use enrollment data to identify demographics; census data or other sources may be used.
- Health Systems Division (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.
- Pros: Supports better representation and meaningful engagement of consumers; 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 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 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.
- Requiring CCOs to have more than one CAC representative (Part C) on the board was included after interviews with key informants (primarily CAC coordinators).

Policy implementation expectations

Initial baseline expectations

- CCO identifies data sources it will use to analyze member demographics (could include enrollment data, American Community Survey data, or other sources).
- CCO demonstrates it has mechanisms, resources and community partnerships in place to support recruitment and engagement of diverse CAC members aligned with member demographics.
- CCO clearly articulates its criteria and process for engaging CAC representatives that align with CHP priorities.
- CCO shares plan for how it will meaningfully engage an OHP consumer(s) on CCO board.
- CCO describes its plan for how it will meaningfully engage tribes and/or a tribal advisory committee, if applicable.
- CCO meets reporting requirements and identifies barriers and challenges to CAC demographic alignment, which will inform tailored supports from OHA to assist CCO's progress toward a fully aligned CAC.
- Part B may be phased in after Year 1.

Transformational expectations

- CAC composition is reflective of Medicaid member demographics in the CCO service area.
- CCO decision-making is meaningfully informed by CAC members, and tribal advisory committee members if applicable, 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 and filled CAC seats and no lapses in 51% OHP consumer makeup of CAC.

Examples of accountability

- Reports include detailed information about CAC member composition and all components outlined in this policy option; reports posted publicly.
- CAC member satisfaction report/surveys. Surveys include inquiry about whether processes are trauma informed and meet the needs of members who have experienced trauma.

Policy #5

Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities by implementing the following:
  A) Require CCOs to develop 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.

Intended impact

Standardization of health equity infrastructure present in all CCOs.

CCO health equity expertise, capacity and infrastructure to facilitate adoption of measures to reduce health disparities.

Policy implementation considerations

RFA applicants:
  • Need to provide current organizational health equity infrastructure capacity (based on guidelines provided by OHA).
  • Need to commit to the designation of a "single point of accountability" for health equity and demonstrate allocation of resources for health equity activities.

In Year 1 all CCOs will:
  • Develop a health equity plan following OHA guidelines.
  • Designate a "single point of accountability" role.
  • Develop an organizational and provider network training and education plan based on "Cultural Responsiveness and Implicit Bias Fundamentals" guidance document provided by OHA.

In Year 2-5, all CCOs will:
  • Report increased capacity and leadership for health equity and cultural responsiveness, and the use of race, ethnicity, language and disability (REAL+D) and culturally and linguistically appropriate services (CLAS) in the organization and the provider network using TQS as a reporting mechanism.
  • Provide an outline of the general activities it will undertake to accomplish the goals and objectives outlined in the health equity plan over the course of three years for monitoring and TA.

General Timeline:
  • All strategies in this policy will be in contract and are set to begin **Year 1**. However, full implementation and completion of activities will vary and could be aligned with TQS to reduce administrative burden.

OHA role:
  • Provide a framework for the development of CCO health equity Infrastructure:
      a) OHA/Office of Equity and Inclusion (OEI)/Transformation Center (TC) to staff/lead a work group that will 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;

Dashboard

	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

How heavy is lift?	● ○ ○
How large is impact?	● ● ○

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	Requires legislation
	Recommendation for OHA
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✓	**Health equity impact assessment**
✓	**Potential to impact children**
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✓	**Increases transparency**

use of REAL+D data; workforce diversity; patient engagement using HIT tools; and organizational learning.

    c) OHA/OEI/TC to develop a guidance document on cultural responsiveness and implicit bias training fundamentals plan.

- 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 through CCO 2.0 will facilitate standardization and will improve OHA's ability to provide quality TA.
- Some CCOs have developed a strong organizational infrastructure for health equity, others have not; this represents an inequity that will be remedied in CCO 2.0.
- The development of CCO internal infrastructure and investment to coordinate and support CCO equity is necessary to ensure (a) CCOs around the state are moving in the same direction; (b) OHA, and OHPB and its Health Equity Committee have a conduit to connect with CCOs on health equity activities, build learning collaboratives, and provide guidance and technical assistance; and (c) health equity infrastructure will facilitate the deployment of health equity metrics once they are developed.
- The term "health equity infrastructure" refers to the organizational adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to community and member engagement; provision of quality and culturally responsive language access; organizational and provider network workforce diversity; Americans with Disabilities Act compliance and accessibility of CCO and provider network; Affordable Care Act 1557 compliance; CCO and provider network organizational training and development implementation of the CLAS Standards and non-discrimination policies; and other models, policies and practices that aim to advance health equity and eliminate inequities in health and health services that are avoidable, unnecessary and also unjust and unfair.
- In the development of CCOs' health equity infrastructure, OHA expects CCOs will:

    a) Meaningfully engage CACs and community partners in the development of CCO health equity infrastructure strategies, plans, policies and programs;

    b) Transform CCO organizational culture to make health equity a priority; and

    c) Institutionalize the health equity culture in all facets of the organizational structure.

Policy implementation expectations

Initial baseline expectations

- CCO provides information to OHA on its current organizational infrastructure to demonstrate its ability to implement health equity activities, including its capacity to collect and analyze REAL+D data.
- CCO develops a health equity plan, allocates necessary resources for health equity activities, and provides a timeline for implementing the plan's components.
- Potential components of the health equity plan include language access; workforce diversity; implementation of CLAS standards; collection and analysis of REAL+D; provider network accessibility; and meaningful community engagement.
- CCO designates a single point of accountability for health equity work. CCO develops an organizational and provider network training and education plan based on the Cultural Responsiveness and Implicit Bias Fundamentals guidance document provided by OHA.

Transformational expectations

- CCO ensures that its diverse member population receives the highest quality, culturally and linguistically appropriate health care from their provider network.

- 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 by, for example, incorporating health equity into their organizational structure, and being informed by the collection and use of REAL+D data.
- CCOs meaningfully engages CACs, providers and community partners in the development of CCO health equity infrastructure strategies, plans, policies and programs.

Examples of accountability

Year 1:
- CCO develops health equity plan following OHA guidelines.
- CCO designates a "single point of accountability" role.
- CCO develops an organizational and provider network training and education plan based on the Cultural Responsiveness and Implicit Bias Fundamentals guidance document provided by OHA.
- OHA develops appropriate monitoring, reporting and compliance process needed for all three strategies. This process could be aligned to current TQS process to reduce CCO administrate burden.

Year 2:
- CCOs potentially use TQS to report increased capacity and leadership for health equity and cultural responsiveness and the use of REAL+D and CLAS in the organization and the provider network.
- CCO provides an outline of the activities it will undertake to accomplish the goals and objectives outlined in the health equity plan over the course of three years for monitoring and technical assistance.

Policy #6

Implement recommendations of the Traditional Health Worker (THW) Commission:

A) Require CCOs to create a plan for integrating and utilizing 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 THWs affiliated with organizations listed under ORS 414.629 (note that Part D is also included under Policy 8 for CHAs/CHPs).

E) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for THW services.

Intended impact

Increases THW workforce by setting up a livable and equitable payment system.

Increases access to preventive, high-quality care beyond clinical setting and improves outcomes.

Increases access to culturally and linguistically diverse providers beyond clinical setting.

Dashboard

★	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**

Policy implementation considerations

- 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:
  a) Designate CCO liaison;
  b) Develop integration and utilization plan with metrics to track integration milestones with scores for progress; and
  c) Determine centralized standard reimbursement rates using the payment models grid created by the THW Commission Payment Model Committee.
- Builds upon THW services requirements already in contract.
- Recommended by the Department of Consumer and Business Services in its Report on Existing Barriers to Effective Treatment for and Recovery from Substance Use Disorders, Including Additions to Opioids and Opiates.
- Strong support came from health systems; health insurance carriers such as Providence, CareOregon and Kaiser; the Oregon Primary Care Association; and other community-based organizations and federally qualified health centers (FQHCs).
- Need to dedicate necessary resources to ensure policies are adequately and appropriately staffed, monitored and enforced.
  a) The integration and utilization plan fulfills the mandates established by the following legislation: House Bill 3650 (2011), House Bill 3311 (2011), Senate Bill 1580 (2012), House Bill 3407 (2013) and House Bill 2304 (2017).
  b) Literature shows improved health outcomes for consumers, which saves money for OHA

through Medicaid program savings. Positive return on investment will increase with increased number and utilization of THWs.

- Payment model grid contains a variety of pathways for THW payment including alternative payment methods; value-based payments such as bundling and per-member-per-month payments; fee-for-service; grants and contracts; Medicaid administrative; targeted case; and direct employment.

Policy implementation expectations

Initial baseline expectations

- 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 responsive 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 identifies a THW to participate in the CHA and CHP development process.
- CCO develops a payment rate and reimbursement plan across the board for all THWs.

Transformational expectations

- CCO's plan ensures that 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 THWs 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.

Examples of accountability

- Reporting to OHA includes 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 recruits 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 payments), and fully implements in-house payment structure and processes for all THWs. OHA provides system-level support to reduce billing barriers.
- Reporting includes number of THWs involved in CHA and CHP and how they are actively participating.

Policy #7

Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the community advisory council (CAC) and tribes, and/or tribal advisory committee if applicable (see Policy 4, Part D), connect to the CCO board

Intended impact

Transparency on fulfillment of statutory requirement.

Policy implementation considerations

- Transformation Center staff will monitor in a to be determined reporting method.

Policy implementation expectations

Initial baseline expectations

- 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.

Transformational expectations

- CCO demonstrates the engagement of its CAC by illustrating multiple feedback loops of CAC input that are integrated into a wide variety of areas of CCO decision-making.

Examples of accountability

- OHA publishes organizational structure information from CCOs.
- Reporting includes supplemental information about CAC role in decision-making (recommended policy #4).

Dashboard

	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**

Policy #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.

If a federally recognized tribe in a service area is developing a CHA or CHP, the CCO must partner with the tribe in developing the shared CHA and shared CHP priorities and strategies described above.

Ensure CCOs **include tribes and 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.

Intended impact

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.

Policy implementation considerations

- Contract changes and rule changes needed.
- Needs to be in contract for Year 1; work would phase in. CCOs would be required to meet these policy requirements with new CHAs and CHPs developed during the 2020–24 contract period (in the next CHA/CHP cycle; may differ by CCO).
- OHA could convene a work group in Year 1 of the contract to develop recommendations for addressing barriers to shared CHAs and shared CHP priorities and strategies. This would build upon the work of the 2014 OHA CHA/CHP alignment work group.
- Technical assistance provided by HPA and PHD.
- Staffing needs identified for monitoring and compliance within HSD.
- 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.
  - a) 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 from OHPB at 7/10 meeting.
  - a) 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

Dashboard

	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

and New York have implemented similar requirements. May result in statewide gains on health conditions.

- Including organizations that address SDOH and health equity: Recommended by the THW Commission (see Policy 2, Part D).
- Will ensure the voice of OHP consumers experiencing health disparities is included in the CHP/CHP process. May create a small limitation on local flexibility by prescribing the organizations to be involved.

Policy implementation expectations

Initial baseline expectations

- If CCO has an existing CHA/CHP in place, CCO clearly describes:
    a) Existing partnerships with local public health authorities (LPHAs), nonprofit hospitals and other CCOs that share the service area for the current CHA;
    b) Gaps in these partnerships;
    c) Steps the CCO will take to address these gaps prior to developing the next CHA;
    d) The tribes, THWs and organizations addressing social determinants of health and health equity that were involved in the development of the CHA and CHP; and
    e) 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/CHP describes existing partnerships with LPHAs, nonprofit hospitals, other CCOs that share the service area, organizations that address social determinants of health, tribes and THWs; 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, nonprofit hospitals, and any CCO that shares the service area.
- For any new CHP developed during the contract period, the CCO identifies and describes areas of alignment with at least two SHIP priorities, including which statewide strategies are being implemented.
- CCO makes progress toward CHP goals and demonstrates accountability through annual progress reports that include a description of the actions the CCO will take if goals are not being met.

Transformational expectations

- 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 nonprofit hospitals.
- The CHA/CHP partnership of CCOs, LPHAs and nonprofit 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 tribes, 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, which includes social determinants of health and trauma. 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.

Recommended Policies: Begin implementation in year 1

Examples of accountability

- 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):
  a) CCO demonstrates local partnership of LPHAs, nonprofit hospitals, tribes and other CCOs in the service area.
  b) CCO demonstrates accountability for making progress toward meeting CHP goals.
  c) CCO demonstrates alignment with SHIP priorities, including implementation of statewide strategies.
  d) CCO and partners demonstrate achievement of targets and goals in CHPs.
- SHIP annual progress reports also demonstrate improvements on priorities and strategies that are being implemented at the local level.

Policy #9

Require CCOs to submit their community health assessment (CHA) to OHA

Intended impact

Transparency and support of community partner efforts.

Policy implementation considerations

- Should be included in contract from Year 1. Would go into effect at first CHA cycle in 2020–2024 contract period (may differ by CCO).
- Monitoring is very straightforward (existing Transformation Center capacity).
- Origin of recommendation: OHA Transformation Center.
- Pros: Promotes transparency and can allow for improved technical assistance to CCOs.
- Cons: Would add a deliverable to CCO contract, but by rule CHA development is already required, so it should be easy for a CCO to submit their CHA to OHA to fulfill this requirement.

Policy implementation expectations

Initial baseline expectations

- CCO submits CHA by June 30 of the first year of the contract.

Transformational expectations

- Increased transparency about the health of communities and about how health priorities for the CHP are selected.
- CHA becomes a readily accessible data source for community partners or other organizations seeking to understand the health of the community.

Examples of accountability

- Year 1: CHA submissions demonstrate meeting baseline expectations based on OHA review.
- CHAs are posted online.

Dashboard

	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**

Policy #10

Increase CCOs' use of value-based payments (VBPs) with their contracted providers

Intended impact

Ensure all CCOs increase their use of VBPs.

Align with 1115 waiver requirement to achieve VBP target.

Provide financial support for Patient-Centered Primary Care Homes (PCPCHs) to implement and sustain a robust PCPCH model of care.

Each CCO will be responsible for meeting an annual VBP growth target, ensuring movement toward the 70% VBP goal in 2024.

Policy implementation considerations

RFA applicants need to:
- Provide details on how they would achieve a minimum of 20% VBP in LAN[1] category 2C ("pay-for-performance") or higher to be implemented Year 1 (2020).
- Provide details on their per-member, per-month (PMPM) VBP payments (LAN category 2A "foundational 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 and populations that intersect these communities.
- Demonstrate necessary information technology (IT) infrastructure for VBP reporting.

By Year 1 (2020), CCOs will:
- Be expected to achieve a 20% VBP target for LAN category 2C ("pay-for-performance") as reported in their RFA response;
- Implement a PCPCH VBP;
- Report VBP data via All Payer All Claims (APAC) database;
- Report supplemental VBP data and/or interviews.

By Year 2 (2021), CCOs will be required to implement new VBPs in at least two of the five care delivery focus areas with hospital and/or maternity care required in Year 2 or 3. The remaining care delivery focus areas include: children's health care, behavioral health and oral health. This allows CCOs to gain experience and develop more advanced VBPs in these areas.

By Year 5 (2024), CCOs will:
- Achieve 70% VBP goal.
- Add one new VBP in the remaining care delivery focus areas in Years 3–5 – successfully implementing

Dashboard

★	Fulfills state or federal mandate

Priority area:	**VPB**

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**

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[1] 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 The Alternative Payment Model Framework for categorizing VBPs that has become the nationally accepted method to measure progress in the adoption of VBPs.

VBPs in all five care delivery focus areas.

- Report complete encounter data with contract amounts and additional detail for VBP arrangements.

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 40–50% of CCOs' payments to providers were at least in category 2C/pay-for-performance (which is similar to the CCO incentive metric program).
- 70% VBP goal is sufficiently high to serve as a five-year VBP goal, but not so high that it would be unachievable.
- 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.

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.

Policy implementation expectations

Initial baseline expectations

- Ensure all CCOs increase their use of VBPs, in alignment with 1115 waiver requirement to achieve VBP target.
- RFA applicants will be required to:
    a) Provide details on how they would achieve a minimum of 20% VBP in LAN* category 2C ("pay-for-performance") or higher during Year 1 (2020).
    b) Provide details on their per-member, per-month (PMPM) VBP payments (LAN category 2A "foundational payments for infrastructure and operations") to Patient-centered Primary Care Homes (PCPCHs).
    c) 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; immigrants or refugees, people with complex health care needs and populations that intersect these communities.
    d) Demonstrate necessary information technology infrastructure for VBP reporting.
- Each CCO will need to meet annual VBP growth targets to ensure that all CCOs increase their use of VBPs.

Transformational expectations

- 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 (for example, increase their % in

3B/shared risk, or adopt a VBP to focus on behavioral health integration).

- CCOs' reporting to All Payer All Claims (APAC) database allows 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 above), provides an incredible opportunity to learn best practices, advance those best practices, and develop "safe-guards" where needed.

Examples of accountability

- By Year 1 (2020), CCOs will:
  a) Be expected to achieve a 20% VBP target for LAN category 2C ("pay-for-performance") as reported in their RFA response
  b) Implement a PCPCH VBP;
  c) Report VBP data via All Payer All Claims (APAC) database; and
  d) Report supplemental VBP data and/or interviews.
- By Year 5 (2024), CCOs will:
  a) Achieve 70% VBP goal;
  b) Participate in annual VBP interviews.
  c) Add Implement one new VBP in the remaining care delivery focus areas in Years 3–5 – successfully implementing VBPs in all five care delivery focus areas; and.
  d) Report complete encounter data with contract amounts and additional detail for VBP arrangements.

Policy #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 reward at the individual CCO level.**

Intended impact

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.

Policy implementation considerations

- Evaluation methodology implemented in 2020 (Year 1) but 2021 likely first year CCO amounts will be individually determined based on performance evaluation.
- Methodology to establish performance-based component of capitation rate needs to be finalized, and could benefit from cross-agency work group. Methodology will consider efficiency, effective HRS investment, and clinical value of services delivered.
- Methodology development needed in multiple phases and may evolve over time; additional OHA staff likely needed.
- Policy is required as part of our current 1115 waiver:
  - a) CCO-specific performance-based reward rates required by 2017 waiver renewal.
  - b) Waiver language specifically calls out goal of policy to motivate effective HRS use by CCOs, but additional evaluation tools are needed to evaluate CCO performance.
  - c) Methodology to inform CCO-specific rate components will be closely watched by stakeholders.
  - d) Evaluation and analysis may require additional staff beyond current capacity (similar structure to HPA metrics team).
  - e) OHA could strategically choose to include this program in legislation for the upcoming session.
  - f) Can be seen as more rigorous and formalized process to evaluate and achieve efficiency in managed care.
  - g) 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.

Policy implementation expectations

Initial baseline expectations

- OHA rate-setting methodology has new tools to:
  - a) Evaluate CCO efficiency, delivery of high-value health care services and cost-effective use of health-related services; and
  - b) Reward the highest performing CCOs.

Dashboard

★	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**

Transformational expectations

- 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:
  a) Improved health outcomes for members
  b) Lower overall 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.

Examples of accountability

- New publicly available measures are implemented:
  a) Efficiency measures
  b) Evaluation of CCO delivery of services with highest clinical-value
  c) Methodology for evaluating CCO use of HRS
- CCO-specific, performance-based components of capitation rates act as an incentive and accountability metric.

Policy #12

Incorporate measures of quality and value in any OHA-directed payments to providers (for example, 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

Intended impact

Providers are rewarded for improving value and quality of care, and metrics for CCOs and other providers are aligned and coordinated to achieve maximum impact.

Policy implementation considerations

- Implementation goal in 2020.
- Additional policy development needed to establish the quality and value metrics to be used and 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.
- Designed to meet CMS requirements related to passthrough funds that require OHA to move to a qualified directed payment process that includes quality and value.
- Policy involves hospital provider tax funds, which adds to complexity and visibility.
- OHA could strategically choose to include this program in legislation for the upcoming session, or as part of the budget process.
- Connects and builds on other policy options to expand CCO use of VBPs

Dashboard

★	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**

Policy implementation expectations

Initial baseline expectations

- The methodology for OHA-directed payments to hospitals incorporate measures of quality and value.

Transformational expectations

- 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 motivates 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 and CCOs that reduce disparities.

Examples of accountability

- Measures of quality and value may build on successes of previous Hospital Transformation Performance Program and should connect to CCO efforts to expand VBPs and efficiency metrics into hospital-based services.

Policy #13

Adjust the operation of the CCO quality pool allow consideration of expenditures in CCO rate development; this will 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

Intended impact

CCOs invest their quality pool earnings in a timely manner in the providers and partners who help achieve targeted metrics, and focus additional efforts on achieving targets to ensure maximum quality pool earnings.

Policy implementation considerations

- 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 flexibility 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 and clarification should seek to alleviate concerns.
- Moving quality pool inside rates allows 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).

Policy implementation expectations

Initial baseline expectations

- 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, distinct from any base payment the providers would have received absent quality incentive.

Dashboard

	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**

Transformational expectations

- 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 budget tied to performance.

Examples of accountability

- Increased visibility of CCO quality pool spending patterns helps hold CCOs accountable to their local communities.

Policy #14

Address increasing pharmacy costs and the impact of high-cost and new medications by increasing transparency of CCOs and their pharmacy benefit managers (PBMs)

Intended impact

Increased transparency of true pharmacy costs by addressing spread pricing, rebate transparency, and improved auditing features.

Reduced underlying pharmacy costs for CCOs through improved PBM contracting requirements.

Policy implementation considerations

- Transparency provisions likely implemented as broad requirements for how CCOs structure their PBM agreements.
- PBM contracts must provide for regular third-party market analysis to ensure CCOs are receiving competitive pricing.
- Oregon Prescription Drug Program (OPDP) could be an option for CCOs to comply with new PBM transparency requirements, but would not be mandatory for CCOs.
- Potential opposition from PBMs.
- OPDP currently meets pricing transparency and passthrough requirements being sought and is a viable PBM solution for CCOs if they choose.
- Policy option is similar to solutions being sought in other states in response to PBM pricing and passthrough policies.

Policy implementation expectations

Initial baseline expectations

- CCOs require their pharmacy benefit managers (PBMs) to:
    a) Provide pharmacy cost passthrough at 100%;
    b) Pass back 100% of rebates received to CCOs;
    c) Report administrative fees paid from CCO to PBM; and
    d) 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 third-party audits and market checks on an annual basis.

Examples of accountability

- Financial audits of CCO pharmacy networks (individual pharmacies) on amounts paid to them for claims processed by CCO's contracted PBM reconciled against amount PBM reports as paid to the CCO less fixed or expected administration fees charged by the PBM.
- Rebate passthrough reporting is demonstrated via periodic reporting by the PBM. This reporting takes place at a minimum of two times annually.

Dashboard

	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**

Policy #15

Address increasing pharmacy costs and the impact of high-cost and new medications by increasing alignment of fee-for-service (FFS) and CCO preferred drug lists (PDLs)

Intended impact

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.

Policy implementation considerations

- Implementation will take an incremental approach to strategically and partially align PDLs (starting with selected 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 to enable partnership between OHA and CCOs in phasing in alignment of specific drug classes.
- Ongoing pharmacy policy recommendations may be informed by task force created by House Bill 4005.
- 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 (specialty pipeline).

Dashboard

	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**

Policy implementation expectations

Initial baseline expectations

- CCO PDLs and coverage/prior authorization criteria are publicly posted and easily accessible for patients and prescribers.
- CCOs align selected segments of their PDLs with the Oregon Health Plan's fee-for-service PDL.

Transformational expectations

- Over time CCOs 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.

Examples of accountability

- CCOs submit PDLs for all classes to OHA in format required by OHA. CCOs provide updated version as changes are made.
- CCOs submit coverage criteria for all non-aligned PDL classes in format required by OHA. CCOs provide updated version as changes are made.
- OHA compiles CCO submissions and publishes the information to the OHA pharmacy website to improve practitioner and patient communications (to be updated monthly).

Policy #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

Intended impact

Increase solvency protection and reduce risks to the state and members of a CCO insolvency event; improve understanding of CCO finances.

Policy implementation considerations

- Use NAIC financial reporting templates and modify insurance regulations to fit unique CCO program including 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.
- Industry standard NAIC forms could replace much of OHA's current Exhibit L.
- Phase-in implementation may be needed since NAIC requires new standards that will require CCOs to adjust financial reporting.
    - a) If needed, CCOs may be allowed to continue to use GAAP accounting methodology for 1–2 years before being required to move to statutory accounting 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 reserve 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 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 of enhancing current exhibit L reporting tools could be equally administratively complex

Policy implementation expectations

Initial baseline expectations

- 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.

Examples of accountability

- CCO financial data is available in a publicly accessible manner.

Dashboard

	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**

Policy #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.

Intended impact

CCOs are fully accountable for members' behavioral health care.

Increase access to behavioral health services, decrease wait times, allow members provider choice, improve behavioral health outcomes for all Oregonians.

Policy implementation considerations

- 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 biennial implementation plan (BIP) 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 the CCO is responsible for ensuring there is an adequate provider network and members have access to behavioral health care. The CCO is responsible for outcomes.
- Pros: Clear owner of the behavioral health benefit for OHA and members.
- Cons: 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." National Alliance on Mental Illness, Children's Health Alliance and the Oregon Center for Children and Youth with Special Health Needs support elimination of carve-outs.

Policy implementation expectations

Initial baseline expectations

CCO clearly articulates plan for managing the behavioral health benefit, including:
- Resource utilization to ensure the behavioral health benefit is integrated in a way that is invisible to members and providers;
- 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), including provision of trauma-informed services;
- Policies and procedures for the behavioral health benefit for their entire region;
- Budget managed in a fully integrated way;

Dashboard

	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**

- Plan for annual evaluation of behavioral health spend and risk sharing;
- Behavioral health services are paid for in primary care and primary care is paid for in behavioral health, without pre-authorization;
- Multiple services are allowed within the same day at the same clinic; and
- No wait time for services.

Transformational expectations

- CCOs are 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.

Examples of accountability

- RFA response includes all items in the initial baseline expectations.
- OHA monitors the metrics identified in policy recommendation #17. Corrective action plans will be required if CCOs are not able to meet metrics.
- OHA will review MOU between CCO and community mental health provider – which includes conversations with relevant stakeholders.
- CCO ensures the local plan and CHP are collaborative plans that inform one another.

Policy #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 CCO's 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, implementing culturally responsive principles including trauma-informed practices, and meeting metrics

Intended impact

Increase integration, increase access, increase provider network, and decrease wait time.

Policy implementation considerations

- Transformation Center (TC) has contracted with a consultant to identify the metrics and a review proposal.
- CCOs should ensure providers integrate substance use disorder services in physical health settings in addition to mental health services.
- CCOs should plan to enhance culturally specific integrated services, including culturally specific behavioral health services in physical health settings.
- 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.
- OEI is involved in the work group tasked to identify metrics to ensure equity is taken into consideration.
- 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.

Policy implementation expectations

Initial baseline expectations

- Starting in Year 1, CCOs report on OHA identified behavioral health integration metrics on a regular basis.
- Starting in Year 2, CCOs report on OHA identified oral health integration metrics on a regular basis.

Transformational expectations

- 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.

Examples of accountability

- CCOs report on metrics, and OHA uses a scoring rubric.
- TA is available for CCOs that are not meeting the minimum score or that request additional TA.

Dashboard

	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**

Policy #19

CCOs identify actions for developing the medical, behavioral and oral health workforce. CCOs will:

- Report on the 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.
- Develop the health care 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 that can provide culturally and linguistically appropriate care, and trauma-informed practices, with attention to marginalized populations.
- Ensure current workforce completes a cultural responsiveness training in accordance with House Bill 2611

Intended impact

Increase workforce to ensure network adequacy for members throughout the lifespan and for all behavioral health services, (mental health and substance use disorder); increase access and outcomes for Oregonians.

Policy implementation considerations

- Starting in Year 1, CCOs will report on members in their network, the diversity and capacity of the workforce in their region, and the plan to meet the need of their members, including the capacity to provide needed services in a culturally responsive and trauma-informed manner.
- OHA will develop report and publish available data.
- Health Care Workforce (HCWF) Committee will continue to contribute to the development of these efforts.
- HPA and HSD will monitor compliance.
- This was first suggested in the HCWF Committee by a CCO medical director 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 CCOs and OHA (and potentially others).
- Some CCOs have this in place now but are 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 Primary Care Office cooperative agreement.
- Federally, HRSA requires states to maintain updated provider data.
- House Bill 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.

Dashboard

	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**

Policy implementation expectations

Initial baseline expectations

- In Year 1, CCOs report on members in their network, current workforce, and the plan to meet the need of their members.
- In Year 1, CCOs report on prevalence in their region of all health needs and begin working within their communities with local and state educational resources to develop an action plan to ensure the workforce is prepared to meet needs. All CCOs update these plans on an annual basis and identify how they are implementing them.
- OHA develops report and publishes available data.
- OHA monitors compliance.

Transformational expectations

- 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.
- CCO applicants understand the health care workforce needs for their area and have ideas for how to address those needs.
- CCOs ensure there is a sufficient and well-trained workforce to meet the needs of members. CCOs ensure culturally and linguistically appropriate, trauma responsive and trauma specific care available for all Oregonians.

Examples of accountability

- OHA sees a decrease in gaps among racial/ethnic groups in incentive and other existing metrics.
- Year 1 (2020) – Each CCO identifies 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 assesses CCOs' progress toward achieving the targets and look with the CCO at targets for Years 3–5.
- CCO includes trauma-specific care providers in the targets.

Policy #20

Require CCOs **utilize best practices to outreach to culturally specific populations**, including development of a diverse behavioral and oral health workforce that can provide culturally and linguistically appropriate care (including utilization of THWs)

Intended impact

Improve health outcomes for culturally specific populations.

Policy implementation considerations

- Guidelines and best practices are being developed by OEI.
- Technical assistance is recommended for implementation.
- Guidelines and best practices need to be developed by OHA (OEI and BH).
- Will require ongoing monitoring and TA.

Policy implementation expectations

Initial baseline expectations

- CCOs report in Year 1.
- CCOs reach out to populations experiencing gaps in care that contribute to oral health disparities.
- CCOs provide culturally and linguistically appropriate services to diverse populations using identified best practices.

Transformational expectations

- CCOs decrease the gaps in care that contribute to oral health disparities.
- Intake paperwork is accurately translated, with accessible interpreter services for intake, treatments and ancillary services.

Examples of accountability

- OHA sees 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 recommendation 19.
- Workforce diversity measures TBD.

Dashboard

	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**

Policy #21

Prioritize access for pregnant women and children ages birth through five years to health services, developmental services, early intervention, targeted supportive services, and behavioral health treatment.

- CCOs will ensure access to evidenced-based dyadic treatment and treatment that allows children to remain placed with their primary parent.
- CCOs will support providers in assessing for adverse childhood experiences (ACEs) and trauma, to develop individual services and support plans.
- For pregnant women, CCOs will support providers in screening for behavioral health needs and substance use prenatally and post-partum. CCOs will provide appropriate referrals and follow-up to referral.
- CCOs will prioritize access to substance use disorder (SUD) services for pregnant women, parents, families, and children, including access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services for parents and behavioral health screening and treatment for children

Dashboard

★	**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**

Intended impact

Improve health outcomes for children; CCOs level of services to children ages 0–5 will match the national percentages; increase support to families where substance use disorders are present.

Policy implementation considerations

- CCOs will collectively develop statewide early childhood criteria for behavioral health levels of care (outpatient, intensive outpatient, subacute and psychiatric residential treatment services).
- Services for young children are trauma responsive and/or trauma informed.
- Require an increased level of outpatient level of care for children 0–5 with indications of 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 would pay for mental health consultation in early learning settings for their network of providers.
- Fulfills a mandate of early learning hubs. Connects with recommendations of Governor's Children's Cabinet.
- Two or more ACEs is associated with poor kindergarten and behavioral outcomes.
- 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.
- Early identification and intervention 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.

Policy implementation expectations

Initial baseline expectations

- CCOs collectively develop statewide early childhood criteria for behavioral health levels of care (outpatient, intensive outpatient, subacute and PRTS).
- CCO provides an increased level of outpatient care for children birth through five with indications of 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.

Transformational expectations

- CCOs' level of services to children ages 0–5 will match the national percentages.
- CCO uses 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).
- CCOs and OHA's Children's Behavioral Health Unit collaborate to impact the workforce and quality of services.
- CCO services for young children are trauma responsive and/or trauma informed.
- CCOs require providers of physical health services to use evidence-based screening tools for depression and anxiety for expecting parents (parents/kinship caregivers, adoptive parents, and pregnant women).

Examples of accountability

OHA tracks the following:
- Data through Medicaid Management Information System (MMIS) assessment codes to monitor and report to CCOs their level of service as compared to national levels;
- TA and community participation on development of early childhood level of care;
- Use and impact of Help Me Grow's intervention on the community and share data with CCOs;
- Parent Child Interaction Therapy utilization with child welfare data (increase children stabilized, return home and reduce disruption and removal); and
- Parent Management and Training Oregon model implementation and usage, and connect with child welfare data (increase children stabilized, return home and reduce disruption and removal).

Policy #22

Implement risk-sharing with the Oregon State Hospital (OSH)

Intended impact

As CCOs assume risk, OHA anticipates increase in community care and decrease in hospitalizations.

Policy implementation considerations

- All CCOs will assume risk for members on OSH waitlist in year one.
- All CCOs will share limited risk for members in OSH by 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).
- Payment model will shift to OSH billing CCOs for members in OSH within five years.
- 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.

Policy implementation expectations

Initial baseline expectations

- In Year 1, all CCOs assume risk for members on OSH waitlist.
- By Year 2, all CCOs share limited risk for members in OSH (for example, 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).
- Within five years, payment model shifts to OSH billing CCOs for members in OSH.

Transformational expectations

- CCO members receive appropriate care in the appropriate setting. This will result in improved outcomes and lower costs.

Examples of accountability

- CCO members on OSH waitlist receive appropriate care in the appropriate setting of care (for example, acute care hospital or community setting).
- Each CCO has a contract in place with OSH following the same payment model.
- CCO members in OSH are discharged as soon as individual is ready to return to the community (Oregon Performance Plan indicator: discharge within 30 days of ready to transition).

Dashboard

	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**

Policy #23

Shift financial role for statewide HIT public/private partnership from OHA to CCOs to cover their fair share

Intended impact

CCOs are directly connected to cross-stakeholder efforts (such as Emergency Department Information Exchange and Prescription Drug Monitoring Program integration) to prioritize and improve HIT statewide.

Policy implementation considerations

- 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, and current CCOs have signed MOUs to participate that include transparency about taking on dues in 2020. CCOs are participating in HIT Commons efforts and have three seats on the HIT Commons Governance Board. OHIT manages this work.
- 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 $1,280 for the smallest CCO to $68,900 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

Dashboard

	Fulfills state or federal mandate

Priority area:	**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

Policy implementation expectations

Initial baseline expectations

- 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.

Examples of accountability

- MOU is signed, annual dues are paid.
- If elected, CCO representative regularly attends HIT Commons meetings and participates in HIT Commons work.
- If CCO fails to sign MOU, pay dues, and if elected, attend meetings and participate in HIT Commons work, a corrective action plan may be warranted.

Policy #24

Require CCOs to ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disturbances (SED), and individuals in medication-assisted treatment for SUD and incorporate the following:

- Develop standards for care coordination that are trauma informed and culturally responsive
- Enforce contract requirement for care coordination for all children in child welfare, state custody and other prioritized populations)
- Establish outcome measure tool for care coordination.

Intended impact

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.

Policy implementation considerations

- Starting in Year 1, 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 will develop standards and outcomes measure.
- Work would live within HSD. HPA Analytics would be involved for outcome measure.
- OHA received feedback that there are multiple care coordinators assigned and 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 support developing standards; Children's Health Alliance supports care coordination for child welfare and other prioritized populations.

Policy implementation expectations

Initial baseline expectations

- CCOs 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 develop statewide standards for care coordination and intensive care coordination. Standards include trauma responsive services.
- CCOs 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, individuals with intellectual and developmental disabilities and juvenile justice. This may include dual generation work when a caregiver's behavioral health is impacting a child's behavioral health.

Dashboard

	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

Transformational expectations

- Coordinators are identified and work with the individual to coordinate physical health, behavioral health, intellectual and developmental disability and ancillary services as needed.
- Care is coordinated and resources are used efficiently, improving outcomes for individuals and reducing cost.
- Services are delivered in a trauma informed or trauma responsive manner.
- Parents and children whose behavioral health impacts the other (for example, mothers with SUD and their children; caregivers with SPMI or untreated BH and their children) experience improved outcomes.
- Members have increased access to family supports through home visiting programs.

Examples of accountability

- CCOs increase number of individuals assigned to identified care coordinators over time.
- MHSIP Mental Health Statistical Improvement Project (adult survey) and Youth Services Survey can be used to evaluate care coordination satisfaction by families and consumers. Include items measuring whether services were trauma responsive/informed.
- CCOs use identified outcome measure tool.
- Care coordinators increase the number of families connected to appropriate services.

Policy #25

Develop mechanism to assess adequate capacity of services across the continuum of care

Ensure members have access to behavioral health services across the continuum of care

Intended impact

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.

Policy implementation considerations

- OHA will define continuum of care and network adequacy.
- CCOs will ensure a sufficient number of providers are available to provide care relative to the enrollees in the plan, providing consumers with the right care that includes all services in the benefit package, is provided across the continuum, is available within a reasonable distance, and is culturally and linguistically appropriate.
- Continuum of care for substance use disorder will include aftercare and ongoing recovery supports.
- Would sit in HSD.
- This is in current contract but has not been enforced.
- Likely 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.

Policy implementation expectations

Initial baseline expectations

- Starting in Year 1, CCOs report on network adequacy, based on prevalence for their region. Network adequacy includes the continuum of care for behavioral health, including SUD and opioid use disorder specific services.

Transformational expectations

- Every region has a full continuum of behavioral health services to meet the needs of the community.
- The full continuum of behavioral health services includes providers who can provide trauma-specific services.

Examples of accountability

- CCOs to monitor the behavioral health prevalence data for the region, and current provider network for the region.
- CCOs to develop plan to ensure adequate provider network, based on prevalence data.

Dashboard

★	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**

Policy #26

System of Care (SOC) to be fully implemented for the children's system

Intended impact

Child-serving systems and agencies collaborating in the SOC are working together for the benefit of children and families.

Policy implementation considerations

- Hold CCOs accountable to full implementation of existing model to ensure cross-system collaboration as well as services and supports that are youth and family driven, culturally and linguistically competent and community based.
- Clarify with CCOs and communities SOC governance roles and responsibilities as they relate to the broader statewide SOC infrastructure.
- Statewide SOC Steering Committee empowerment: State agencies (OYA/OHA/DHS/ODE) to fund the State SOC steering committee with existing general fund from each child-serving state agency for multi-agency needs and development of shared services and supports.
- The already-existing 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 of the local governance structure.

Policy implementation expectations

Initial baseline expectations

- State agencies to fund the State System of Care (SOC) Steering Committee with existing general fund from each child-serving state agency for multi-agency needs identified by local SOC governance structures.
- Starting in Year 1, CCOs are accountable to fully implement existing SOC model to demonstrate cross system collaborations that include SOC policies and collaborative funding models.
- CCOs have wraparound care coordinators who are fully trained, participate in coaching, and practice to fidelity standards in their work with wraparound.
- CCOs measure fidelity of their wraparound services using the Wraparound Fidelity Index – Brief Version (WFI-EZ).

Dashboard

	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

Transformational expectations

- CCOs have four levels of governance reflected within 2-4 working groups in their region.

Examples of accountability

- Data sharing agreements are in place to support SOC implementation and impact.
- CCO utilizes local governance structure to advance SOC concerns not resolvable locally to the state-level steering committee.
- Data tracking system identifies system impact of the SOC (i.e., children placed in out of home care or juvenile justice).
- CCOs provide utilization data (ED utilization, outpatient, etc.) to advisory councils.

Policy #27

Require wraparound is available to all children and young adults who meet criteria

Intended impact

Improve health outcomes for children and young adults.

Policy implementation considerations

- 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 while providing long-term cost savings.
- Meets requirements of House Bill 2144.

Policy implementation expectations

Initial baseline expectations

- Starting in Year 1, CCOs meet or exceed national average for fidelity implementation per WFI-EZ scores (fidelity tool/consumer survey).
- CCOs meet contractual expectations and their subcontractors meet requirements of wraparound OAR (in process, no number available).
- CCOs submit fidelity measurement scores from the WFI-EZ on a quarterly basis.
- OHA enforces existing contractual expectations. This will be critical to success.
- OHA ensures contract clarifies ages 0–25 for wraparound access.

Transformational expectations

- Wraparound is implemented to fidelity, children involved in wraparound services experience improved outcomes. This will result in future cost savings.

Examples of accountability

- CCO will administer the WFI-EZ after six months of enrollment.
- Wraparound care coordinators are trained in trauma-informed care principles.
- CCOs documented evidence of training and coaching participation by care coordinators and supervisors.

Dashboard

★	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

Policy #28

MOU between community mental health program (CMHP) and CCOs enforced and honored

Intended impact

Improved health outcomes and increased access to services through coordination of safety net services and CCO Medicaid services.

Policy implementation considerations

- 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 Association of Oregon Community Mental Health Providers

Policy implementation expectations

Initial baseline expectations

- Starting in Year 1, each CCO has MOU with CMHP.

Transformational expectations

- CCO has working relationship with each CMHP in the region, which will result in better coordinated behavioral health care in the region.

Examples of accountability

- The local plan is submitted by the CMHP. The local plan informs the CHP and the CHP informs the local plan. The CMHP and the CCO collaborate on the development of the CHP.
- The local plan and CHP include a plan for implementing trauma-informed service delivery.

Dashboard

	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**

Policy #29

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, integrated care management services and all services for evidence-based treatments (for example, wraparound, Parent-Child Interaction Therapy, Early Assessment and Support Alliance); and
- Examine equality in behavioral health and physical health reimbursement

Intended impact

Increase integration, increase access, and expand provider network.

Policy implementation considerations

- Implement in Year 1.
- 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 is completed in Year 1.
- 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 of 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 should be seamless to provider and patient; Oregon Medical Association supports reimbursement rates to support integration

Policy implementation expectations

Initial baseline expectations

- Implement in Year 1.
- OHA identifies codes and reimbursement rates.
- OHA reviews equality in reimbursement.
- CCOs reimburse for these services and expand provider network.
- OHA identifies appropriate codes and reimbursement rates.
- OHA reviews equality in reimbursement.

Transformational expectations

- Services are reimbursed in integrated settings, increasing integration.
- Providers can bill for services not previously allowed. Will improve outcomes as members will receive more flexible services.
- Reimbursement rates improve.

Dashboard

	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

Examples of accountability

- Improvements in integrated care metrics, such as the rate of members with diabetes who get an oral health evaluation.
- Internal OHA monitoring and compliance.

Policy #30

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; this will inform more aggressive targets in the future while providing CCOs with additional financial incentives to achieve spending targets in the form of shared savings arrangements

Intended impact

CCOs are held accountable for achieving spending growth targets, and targets reflect aggressive path to ensure costs grow at a sustainable rate.

Policy implementation considerations

- 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 (3 years, etc.).
- OHA is exploring rate methodology 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

Policy implementation expectations

Initial baseline expectations

- CCOs agree to meet sustainable growth targets.

Transformational expectations

- 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.

Examples of accountability

- CCO-specific growth trends posted publicly in a manner that allows comparison across regions and CCOs.

Dashboard

	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**

Policy #31

Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy with financial implications

Intended impact

Encounter data accurately reflects health care services provided to OHP enrollees.

Policy implementation considerations

- Implementation may be phased in with baseline data gathering and evaluation phase beginning Year 1 and enforcement and oversight beginning in Year 2+.
- Utilizes new resources added to the Program Integrity Provider Audit Unit from 2017–19 POP.
- Six of seven auditors funded in POP have already been hired.
- Intended to fulfil CMS requirements to ensure 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 would be necessary without this option.

Policy implementation expectations

Initial baseline expectations

- Implementation may be phased in.
- OHA uses data directly from providers to compare with CCO-level encounter data to add new accountability and oversight.
- Encounter data used in capitation rate development process increases in accuracy.

Examples of accountability

- OHA publishes results of CCO-specific findings to add layer of public accountability.
- Potential financial implications for CCOs if inaccuracies reach certain threshold or are not mitigated.

Dashboard

★	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**

Policy #32

Require CCOs support electronic health record (EHR) adoption across behavioral, oral and physical health contracted providers

Intended impact

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.

Policy implementation considerations

- Timing: This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers.
- OHA 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.
- 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.
- 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.
- CCOs are currently required by contract to support EHR adoption, and had been held accountable through an EHR adoption CCO incentive measure, which focused largely on physical health providers. The new policy option would build on CCOs' success in raising EHR adoption rates among contracted physical health providers by increasing attention to EHR adoption by behavioral and oral health providers. Like the current contracts, this policy option would not require that a provider adopt an EHR in order to contract with the CCO, nor would OHA set the targets for CCOs. Instead, CCOs would choose which targets to set and decide how best to remove barriers to EHR adoption. OHA would expect that CCOs would set targets keeping in mind their provider networks, and CCOs with more dispersed provider networks that may include many smaller providers (who may face greater barriers to EHR adoption) may set more modest targets.
- 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 to effectively use EHRs.
- Feedback: CCOs may face significant challenges to this if resources/incentives are not available.

Dashboard

	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**

Policy implementation expectations

Initial baseline expectations

- 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.

Transformational expectations

- All physical, behavioral and oral health providers adopt and use robust EHRs. Robust EHRs meet the latest Office of the National Coordinator (ONC) certification standards that are achievable based on the practice area.
- All patients can access their health information electronically via an EHR portal.

Examples of accountability

- CCO sets and reports on targets for percentage of providers adopting and using EHRs, broken out by provider type (physical, behavioral, oral).
- CCO sets and reports on targets for percentage of providers adopting and using 2015 Certified EHR Technology, broken out by provider type.

Policy #33

Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications

Intended impact

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 and coordination across physical, behavioral and oral health care.

Policy implementation considerations

- Timing: This would be a contractual obligation starting with 2020 contracts, adjusting current CCO contracts to specify BH, oral and physical providers.
- OHA 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.
- Consideration: 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 and physical.
- OHA is launching the HIE Onboarding Program that will support initial costs to connect key clinics (including BH, oral, physical) to community-based HIEs (currently, there is one contracted community-based HIE).
- Pro: Reduction in ED utilization. Increased health outcomes for members with complex care needs and mental illness. Increased care coordination between CCO and contracted clinics.
- Con: Providers may lack resources to participate in HIE or lack staff capacity to implement workflow changes needed.
- Feedback: 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.

Dashboard

	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**

Policy implementation expectations

Initial baseline expectations

- 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 increase contracted providers' access to HIE options. This policy option does not require providers to use any particular HIE option or tool, or any HIE at all. Choosing an HIE option is a business decision for the provider.
- CCOs extend access to HIE to behavioral and oral health providers.
- CCOs set targets keeping in mind their provider networks, and CCOs with more dispersed provider networks with many smaller providers (who may face greater barriers to technology use) may set more modest targets.
- CCOs use Oregon's statewide hospital event notifications system or other hospital event mechanisms to inform care coordination and population health management. CCOs have the option to use the statewide EDIE/PreManage tool, or any other tool or resource that provides hospital event notifications.
- CCOs ensure their contracted providers have access to timely hospital event notifications to help them manage populations and target interventions and follow up. CCOs have the option to provide access via the subscription to the statewide EDIE/PreManage tool, or any other tool or resource that ensures contracted providers have access to timely hospital event notifications.

Transformational expectations

- 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.

Examples of accountability

- CCO sets and reports on targets for percentage of providers health information exchange for care coordination, broken out by type of health information exchange, and type of provider (physical, behavioral, oral).
- CCO sets and reports on targets for percentage of providers with access to timely hospital event notifications broken out by type of provider (physical, behavioral, oral).
- CCO reports CCO rates of use of hospital event notifications (may be % of active users, days logged on to tool, etc.).

Policy #34

Require CCOs to demonstrate necessary information technology (IT) infrastructure for supporting VBP arrangements, including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and support contracted providers so they can effectively participate in VBP arrangements

Intended 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 manage financial risk and improve care.

Policy implementation considerations

- CCOs would be encouraged to take advantage of collaborative efforts related to data aggregation, electronic clinical quality measures, 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 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.
- Pro: Without data and HIT systems, CCOs cannot deliver on VBP. If CCOs are expected 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.
- Con: 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.
- Feedback: Multiple stakeholders expressed support for this – very important for moving into the future. This will be a heavy lift for some of the current CCOs, including obtaining clinical data. Some CCOs will likely need TA and support

Dashboard

	Fulfills state or federal mandate

Priority area:	**VBP/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**

Policy implementation expectations

Initial baseline expectations

- CCOs demonstrate they have the health IT tools necessary to:
    a) risk stratify populations and target interventions to ensure patients and communities receive the care they need to stay healthy;
    b) manage value-based payment (VBP) arrangements; and
    c) support contracted providers with VBP arrangements, for example, by providing CCO claims or cost data and information on provider performance on VBP metrics and which patients are attributed to the provider.
- If CCOs cannot demonstrate they have the health IT tools necessary, they provide a detailed roadmap of their plans to have such tools within the contract period.
- CCOs demonstrate their clinics with VBP arrangements have some HIT/data support in place.
- CCOs may collaborate on these efforts and/or leverage statewide or regional efforts.

Transformational expectations

- 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 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.

Examples of accountability

- Each CCO's HIT Roadmap (based on RFA response) includes milestones and monitoring to ensure CCO HIT and data capacity improve over time to support VBP.
- CCOs report (or OHA requests via survey from clinics) percentage of contracted providers with a VBP arrangement who have the data, tools and supports needed to manage their VBP arrangements.

Policy #35

Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources

Intended impact

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.

Policy implementation considerations

- 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 recommended policies that already existed in contract, but have not been achieved as intended and need strengthening or improved monitoring.
- 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.

Policy implementation expectations

Initial baseline expectations

- OHA develops compliance infrastructure and identifies gaps in monitoring, defines roles and responsibilities, and provides clear direction to CCOs on performance expectations.

Transformational expectations

- CCOs are actively engaged in identifying and remedying deficiencies with OHA support and technical assistance to ensure consistent implementation of policy goals as defined in the CCO contract.

Examples of accountability

- OHA develops a clearly defined escalation path for non-compliance with contract or program requirements.

Dashboard

★	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

Policy #36

Shift mental health residential benefit to CCOs

Intended impact

Improve health care for adults with SPMI.

Policy implementation considerations

- Supporting efforts needed (a work group, 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 needed (project manager and analysts).

Required in 1115 waiver

- Needs significant development.
- Kids' residential and SUD have already transitioned to CCOs. Mental health residential was scheduled in 2014 and a work group planned for transition, but it was postponed due to complexity and CCO and provider concerns.
- CareOregon supports.

Policy implementation expectations

Initial baseline expectations

- In Year 1, CCOs work with OHA as rate standardization is implemented and consider becoming early adopters to assure transitions are functional.
- In Year 2, OHA transfers the mental health residential benefit to CCOs.

Transformational expectations

- CCOs are responsible for the mental health residential benefit.

Examples of accountability

- Numbers of residential programs available in the CCO's benefit package.

Dashboard

★	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**

Policy #37

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

Intended impact

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.

Policy implementation considerations

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 are 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.

Dashboard

	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

Policy implementation expectations

Initial baseline expectations

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.

Transformational expectations

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.

Examples of accountability

- Patients with specified medical conditions have reduced cost and/or improved care delivery.
- CCO financial performance shows less volatility due to reinsurance costs being managed at the program level.

Policy #38

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

Intended impact

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.

Policy implementation considerations

- 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, a 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 is 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.
    a) CCOs raised concerns with increased reserve-holding requirements on the grounds they would reduce investment in local communities.
    b) Idea based on guaranty provisions in the insurance code.
    c) Provisions could lower required RBC thresholds for CCOs that could otherwise require increased reserves

Dashboard

	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

Policy implementation expectations

Initial baseline expectations

CCO requirements may be phased in:
- CCOs agree to meet RBC-based solvency standards.
- RBC-based solvency standards are evaluated for the Oregon Medicaid CCO program and ensure CCOs have adequate resources to maintain financial solvency.

Transformational expectations

Long-term:
- Program-wide CCO financial resources are available via a "Guaranty Fund" if a CCO is impaired or insolvent.

Examples of accountability

- CCO-specific RBC levels are publicly available.

Policy #39

Identify, promote and expand programs that integrate primary care in behavioral health settings (**Behavioral Health Homes**)

Intended impact

Improve health outcomes; increase access to BH and PH.

Policy implementation considerations

- 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.
- Association of Oregon Community Mental Health Providers supports.

Policy implementation expectations

Initial baseline expectations

- CCOs include behavioral health homes (BHHs) in their network to the greatest extent possible. CCOs assist providers within delivery system to establish BHHs.

Transformational expectations

- Behavioral health homes enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. This improves whole health outcomes for individuals.

Examples of accountability

- OHA has an implementation and compliance team, based on the PCPCH team, to monitor.

Dashboard

★	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

Policy #40

CCOs, with the support of OHA, to **require providers to implement trauma-informed care practices**

Intended impact

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.

Policy implementation considerations

- 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.
- House Concurrent Resolution (2017) directs state agencies to work together to become trauma informed. 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.

Dashboard

	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

Policy implementation expectations

Initial baseline expectations

- In Year 3, CCOs require subcontractors/providers of behavioral health services to receive training in trauma-informed approaches.
- CCOs require providers of behavioral health services to use screening and assessment of trauma to develop and inform Individual and service and support plans.
- CCOs require outcome-based tools for behavioral health services that reflect best/emerging practice.

Transformational expectations

- Increase number of providers and organizations using trauma-informed care principles.
- Reduce the impact of ACEs and trauma for all Oregonians.

Examples of accountability

- Subcontractors/providers implement standards of practice found at TIO.org.
- Subcontractors/providers submit training records.
- OHA and CCO audit providers' use of training, screening/assessment and outcome-based tools.

Policy #41

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

Intended impact

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 achieves the desired impact for our Medicaid population.

Policy implementation considerations

- 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 OHA 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 and support from CCOs or OHA may be needed 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

Dashboard

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

Policy implementation expectations

Initial baseline expectations

- If funding is approved, OHA develops and implements this incentive program.
- CCOs consult with communities and advise OHA about how to prioritize use of limited funds.

Transformational expectations

- All BH providers in Oregon have the robust EHRs and related HIT needed to engage in care coordination and VBP arrangements.

Examples of accountability

OHA will monitor the impact of this program by assessing the following types of information (not necessarily a CCO reporting requirement):

- Percentage of BH agencies with robust EHRs
- Percentage of BH agencies submitting data to the Measures and Outcomes Tracking System (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.

Policy #42

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 or urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (it does not require CCOs to add new providers to ensure telehealth is broadly available) but focuses on coverage.

Intended impact

Reduced barriers to telehealth services, better access to specialty and behavioral health care in frontier and rural areas, and reduced health disparities based on geographic location.

Policy implementation considerations

- The rule allowing for coverage of telemedicine services by CCOs is already in place and would need to be updated. HSD would lead this; OHIT could play a consultative role.
- This is a limited, technical fix intended to bring CCOs into alignment with telehealth coverage rules for private payers. Currently, private payers are required to cover telehealth services provided by a contracted provider if they would have covered the service if the contracted provider had provided the service in person. CCOs, in contrast, are currently allowed to cover telehealth services in that situation, but may deny coverage. Many CCOs have already aligned with private payer rules; this policy option would provide uniformity by requiring CCOs to cover telehealth services in the situation described above, just as private payers are required to do. Due to lack of clarity about this policy option, OHA will delay implementation to allow for further stakeholder engagement.
- Pros: Better access to care, reduced barriers for telehealth options, more consistency across CCOs.
- Cons: Some providers and patients lack the systems to engage in telemedicine consults through video. Some remote areas of Oregon lack the high-speed broadband capabilities that would enable telehealth.
- Feedback: 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 (for example, poverty) creating a hardship for members to access services in person. BH services are especially suited for telehealth approach and are used in Oregon in some rural areas. Concerns about patients needing a private setting when engaging with telehealth.

Dashboard

	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

Policy implementation expectations

Initial baseline expectations

- CCO would be required to cover services provided via telehealth if:
  - a) A CCO's contracted provider provides a service via telehealth* during an encounter, and
  - b) The CCO would cover that service if the contracted provider had provided the service in person during the encounter.
- CCOs are not expected to have specific levels of telehealth services available (for example, no network adequacy for telehealth specifically).
- If it is not clinically appropriate to provide the service via telehealth, CCOs are not required to cover the service.

Including asynchronous communication in some circumstances.

Examples of accountability

- Telehealth services are covered as required.
- If CCO fails to meet this requirement, technical assistance and/or a corrective action plan may be warranted.

Policy #43

Continue CCO role in using HIT for patient engagement and link to health equity

Intended impact

Patients better understand their health issues and treatment plans. Health disparities are addressed through targeted HIT-based programs that take into consideration member demographics, language, accessibility and literacy.

Policy implementation considerations

- Timing: This would be explored after Year 1, with the goal being to adjust current CCO contract requirements to align with the health equity plan process.
- Accountability mechanism will relate to the health equity plan. This has been a component of the TQS in the past.
- OHA TA could be useful.
- OEI would lead and OHIT would play a consulting role, and would seek to support CCO efforts around HIT for patient engagement where possible.
- Pro: Better patient engagement and health outcomes.
- Con: Some providers lack the systems to engage with their patients electronically. Some systems may lack the ability to support needed language and accessibility modifications.
- Feedback: Need support and guidance from OHA to help CCOs understand and leverage efforts in place (for example, PCPCH requires patient portals), 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.

Policy implementation expectations

Initial baseline expectations

- CCO identifies at least one initiative in its health equity plan that uses HIT to support patient engagement.
- CCO asks vendors for cultural and linguistic accessibility when discussing bringing on new tools for patient engagement (OHA is aware that accessible tools may not currently exist in the market; the requirement is simply to ask to demonstrate interest in such tools).

Transformational expectations

- Providers make patients' full records available to them; patients are aware of the availability and know how to access it through patient portals.
- High risk CCO members are engaged in their own care by using HIT apps and tools to work with their providers.
- HIT tools for patient engagement meet CCO members' cultural and linguistic needs.

Dashboard

	Fulfills state or federal mandate

Priority area:	**HIT/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

Examples of accountability

- Health equity plan contains an HIT component as required.
- Health equity plan includes attestation that CCOs will ask vendors about cultural and linguistic accessibility in tools.
- 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

Policies for future exploration

A. **Clinic-level health equity plans**. OHA should explore a model wherein providers identify disparities, and the health equity 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.

B. **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 the CCO's members because not all the CCO's dental contractors contract with the clinics. This creates a significant barrier to coordinated, patient-centered care.

C. **Health care interpretation incentives.** OHA should explore requiring CCOs to develop a system to incentivize or reimburse providers that use qualified or certified health care interpreters. As health care providers try to remain competitive and manage cost, offering them financial incentives for providing adequate language access services is necessary. It is unrealistic to expect health care organizations alone to shoulder the burden of providing the services, and it is a disincentive to the provision of language access services. Models for providing payment for language services include providing additional payments to health care organizations that take care of a disproportionate share of patients with limited English proficiency such as FQHCs, CHCs, MHCs, CAHs, CMHs and others

D. **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.

E. **Quality and appropriateness of language services.** OHA has encouraged CCOs to use certified and qualified interpreters. CCOs and provider networks have adopted different approaches to the provision of language services. To be able to meet the immediate language support needs, CCOs have contracted with telephonic or video-based interpreter services. These services may or may not use certified or qualified health care interpreters. In addition, members are not able to choose what modality of language services meets their needs. Some may prefer telephone or in-person interpretation for different types of encounters but may not be aware they can voice this preference when they present for care. Because video and telephone interpretation limits the ability to recognize and respond to emotional and physical cues, providers and members may find in-person interpretation more appropriate than remote interpreting, especially in complex, sensitive situations. Some aspects of enhancing this work are included in the health equity infrastructure policies (see Policy #5), but additional ongoing work will create a more robust system of culturally responsive language access.

Policies not recommended at this time

A. **COST:** Expand/revise existing risk corridor programs.
   This option is not being recommended because of the recommendation to examine in greater detail the idea of establishing a program-wide reinsurance program.

B. **COST:** Incentivize health care services with highest clinical value by rewarding their use in rate setting.
   This option has been incorporated as an aspect of variable profit implementation strategy.

C. **BH:** Develop a train-the-trainer investment in BH models of care.
   This option is not being recommended.

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 (funding, staff time, significant development, work groups, etc.)

Impact – In general, how much does this policy move the needle in achieving the goals of the coordinated care 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 model;** 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 B, the health equity impact assessment.

✓	**Health equity impact assessment**