# Appendix H:

# CCO 2.0 Definitions

**CCO 2.0 Policy Development – Glossary and Definitions**

***Adult mental health residential:*** A facility that provides mental health treatment in a residential setting (long-term, overnight care).

***Alternative payment***: Payments made to health care providers (such as clinics, hospitals, doctors, nurses and others) that pay for a wider range of services than the usual "fee for service" payments. Value-based-payments are one method of alternative payment.

***Behavioral health:*** Mental health and addictive disorders such as problem gambling and/or substance use disorders.

***Behavioral health homes:*** Behavioral Health Homes (BHH) are health homes for individuals with behavioral health conditions (mental health and/or substance use disorder). BHHs integrate physical health into behavioral health to provide effective person-centered care for individuals with complex needs.

***Capitation rate or payments:*** Capitation refers to the per-member / per-month payments that OHA makes to the CCOs to deliver and coordinate services for OHP members. CCOs receive different capitation rates for enrollees depending on their age, eligibility category, and other information. Capitation payments form the basis of the CCO revenue and does not dictate specifically how much money a CCO must spend on a specific OHP member or collection of members.

***Community advisory councils (CACs):*** Community advisory councils advise their CCO about community health issues and include Medicaid members and other community members.

***Coordinated care organization (CCO):*** Coordinated Care Organizations are community- governed organizations that bring together physical, behavioral and dental health providers to coordinate care for people on the Oregon Health Plan. CCOs receive fixed monthly payments from the state to coordinate care and financial incentives that reward outcomes and quality. CCOs also have the flexibility to address their members' health needs outside traditional medical services. This model is designed to improve member care and reduce taxpayer costs.

***CCO 2.0****:* A reference to the vision and process being used by the state to design the next phase of coordinated care organizations. This process includes policy analysis, research, development, public input and discussion, as outlined on the CCO 2.0 website: www.oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx

***Care coordination:*** Deliberate organizing of patient care activities and sharing information among all of the participants concerned with a patient's care to facilitate appropriate delivery of effective integrated health care service.

***Community health assessment (CHA):*** Health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

***Community health improvement plans (CHPs):*** 5-year plans to address community health issues, needs, and priorities.

***Cost containment strategy:*** The state's or a CCO's goals or activities that try to control or reduce overall spending on health care services.

***Cultural responsiveness:*** The capacity to respond to the issues of diverse communities. Cultural responsiveness requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual.

***Culturally competent services:*** Services that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities whose members identify as having particular cultural or linguistic affiliations by virtue of their providers do not make assumptions on the basis of an individual's actual or perceived abilities, disabilities or traits whether inherent, genetic or developmental including: race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration/refugee status, marital status, socio-economic status, veteran's status, sexual orientation, gender identity, gender expression, gender transition status, level of formal education, physical or mental disability, medical condition or any consideration recognized under federal, state and local law.

***Evidence-based or emerging best practices:*** Concepts or strategies that use fact-based information when designing programs and policies.

***Fee-for-service (FFS):*** Payments to health care providers for delivering a specific service to a specific patient.

***Health Care Payment Learning and Action Network (LAN):*** A national effort partially funded by CMS to accelerate VBP adoption by states and the commercial insurance market. They developed a "Framework" for categorizing VBPs that the Oregon Health Authority will use to measure progress in the adoption of VBPs.

***Health disparities:*** Differences in health status and outcomes between populations.

***Health equity:*** Means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination.

***Health information exchange (HIE):*** The electronic movement of health care information between two or more organizations.

***Health information technology (HIT):*** Refers to a wide range of products and services – including software, hardware, and infrastructure – designed to collect, store and exchange health care information.

***Health-related services (HRS):*** Non-covered services offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being.

***Incentive metrics:*** The specific set of performance measures included in the Quality Incentive Program, used to evaluate CCO performance and distribute funding from the Quality Pool. Metrics are chosen annually by the Metrics & Scoring Committee to measure CCO performance related to access to care, the quality of care they deliver, and patient and community health outcomes. Through the Quality Incentive Program, CCOs achieve financial rewards if they meet specific performance benchmarks or improvement targets.

***Integration***: When behavioral health, physical health, and/or oral health providers work together as a team.

***OHP member:*** The Oregon Health Plan (OHP) is our state Medicaid program. It provides health care coverage for low-income Oregonians from all walks of life. This includes working families, children, pregnant women, single adults, seniors and more. Most OHP members get their care through a CCO.

***Oral health:*** Refers to healthy teeth, dental care, and a disease-free mouth.

***Parity:*** The Mental Health Parity and Addiction Equity Act of 2008 requires insurance to provide the same level of benefits for behavioral health as they do for medical/surgical care.

***Physical health****:* Refers to the medical care provided for an individual's general health and well-being, not including behavioral health (mental health and substance use disorder) and oral health (dental). For example, health care services delivered by a primary care provider, such as a well-child visit or services to treat physical ailments, delivered at hospitals or other clinics.

***Population health policy and systems change:*** Interventions that occur outside a clinical setting and are intended to shift health outcomes collectively for a group of individuals. Policy change refers to changes to rules or procedures within the community or the organization. Systems change refers to changes to infrastructure within the community or the organization. Examples include interventions intended to improve access to healthy and affordable housing within the community, or reduce use of harmful products such as tobacco and sugary drinks, which may include pricing strategies.

***Preferred drug list (PDL):*** A set of prescription drugs that are given preferential pricing and access based on their efficacy, safety, cost effectiveness and other factors. Currently CCOs (and health carriers generally) set their own PDLs based on negotiations with pharmaceutical companies, which may differ from the PDL used by OHA for Fee-For Service enrollees.

***Provider networks:*** The list of providers who contract with an organization to provide services.

***Providers:*** Someone who delivers health care, like a doctor or a nurse.

***Quality incentive program:*** The program administered by OHA to provide financial incentives to reward CCO performance on a set of access, quality and outcome metrics ("incentive metrics") selected annually by the Metrics & Scoring Committee. Through this program, CCOs achieve financial rewards if they meet specific performance benchmarks or improvement targets. Funding for the program comes from the Quality Pool.

***Quality pool:*** The funding pool for the Quality Incentive Program, used to pay CCOs based on their performance on incentive measures chosen by the Metrics & Scoring Committee. In the first CCO contract period, the quality pool was funded with a bonus payment above their capitation rates. The size of the quality pool is calculated based on funding availability within the OHP budget set by the Oregon Legislature.

***Recognition program:*** A way of identifying and rewarding programs and organizations for meeting certain targets, outcomes, or standards of performance.

***Recovery support services:*** Incorporates social, legal and other services to assist individuals and families working towards recovery from mental health and addictive issues.

***Regional health equity coalitions:*** Community groups that work to increase health equity in their communities.

***Reimbursement rates:*** Payments made to health care providers (clinics, pharmacies, hospitals, and others) for delivering services to patients.

***Reinsurance:*** A type of insurance product used by insurers to protect against costs associated with very high claims. Health insurers typically purchase reinsurance from private reinsurance carriers, but states are increasingly considering broader reinsurance programs in Medicaid and commercial markets to reduce cost volatility and increase affordability.

***Social determinants of health equity:*** Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies, and political systems, both historical and current. Institutionalized racism is one example.

***Social determinants of health (SDOH):*** The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Some examples are poverty, access to housing, transportation, and neighborhood safety.

***Sustainable rate of growth:*** The Oregon Health Plan (OHP) operates under a targeted, annual fixed rate of growth in an effort to control and contain costs across the program. The target growth rate in Oregon's current 1115 Medicaid waiver is 3.4%. However, the Oregon Legislature also sets a biennial growth target for the state portion of the budget that is evaluated against the rate of growth, and this may be different than the target in the 1115 waiver.

***System of Care (SOC):*** A coordinated network of services and supports, including education, child welfare, public health, primary care, pediatric care, juvenile justice, mental health treatment, substance use treatment, developmental disability services and any other services and supports to the identified population that integrates care planning and management across multiple levels, that is culturally and linguistically competent, that is designed to build meaningful partnerships with families and youth in the delivery and management of services and the development of a supportive policy and management infrastructure.

***Telehealth/telepsychiatry:*** Telehealth is the delivery of medical, health and education, or dental assessment and oral health care services using telecommunications. Telepsychiatry is the delivery of psychiatric assessment and psychiatric care through telecommunications.

***Traditional health workers (THWs):*** THWs help individuals in their communities by providing physical and behavioral health services. There are five types of THWs: doulas, peer-support specialists, peer-wellness specialists, personal health navigators, and community health workers. A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

***Trauma informed care (TIC):*** An approach, based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff.

***Value-based-payment (VBP)***: A strategy to pay health care providers for quality outcomes and value, rather than quantity or volume of services provided.

***Wraparound***: A definable, team-based planning process involving a Member 0-17 years of age (or Members who continue receiving Wraparound services from 18-25 years of age) and the Member's family that results in a unique set of community services, and services and supports individualized for that Member and family to achieve a set of positive outcomes.