1. Executive Summary

[Content in development]

2. CCO 2.0: Building on the Successes of Oregon's Health System Transformation

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

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

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

Progress Towards Better Health, Better Care, Lower Costs

There are multiple features that set Oregon's CCOs apart from typical managed care organizations that serve Medicaid members. CCOs are locally governed and accountable for the health outcomes of the communities they serve. Decisions are made through partnerships among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

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

Additionally, a portion of CCO global budgets are tied to performance and quality. In order to receive these funds, commonly referred to as the "quality pool," CCOs must meet performance or improvement targets on a set of 17 quality measures that are chosen by the Health Plan Quality Metrics Committee and the CCO Metrics & Scoring Committee.

Over the first five years of their contracts, CCOs have been successful at meeting the original goals of the Triple Aim[1]. Since 2013, the CCO program statewide has grown at a rate of 3.4% per member per year instead of the 5.4% per capita growth rate that was forecasted before Oregon's transformation of Medicaid. That has resulted in about $2.2 billion in avoided costs over the five-year period from 2013-2017.

CCOs have also been improving health care quality and other health indicators, especially in the areas tied to incentive payments. For example, there has been increased enrollment in primary care homes with all CCOs meeting the threshold for the associated patient-centered primary care home incentive metric in 2017, and developmental screenings from birth to three have improved from just under 21% in 2011 to almost 70% in 2017. There has also been marked improvement on other OHA tracked quality measures, such as avoidable emergency department visits that improved by over 50% from 2011 to 2017.

In addition, an evaluation of Oregon's 2012-2017 Medicaid 1115 waiver conducted by the OHSU Center for Health Systems Effectiveness found improved experience of care, self-reported health status, and a strong association with financial incentives and improvements in CCO metric performance. The evaluation found that total spending per-member, per month decreased relative to Washington Medicaid members.

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

1. Increase the portion of total CCO payments awarded for quality and access and raise the bar for rewards.
2. Require CCOs to report detailed data on value-based payment (VBP) arrangements.
3. Provide additional incentives and resources to increase electronic health record (EHR) functionality.
4. Inventory billing restrictions and regulations that impeded physical, behavioral and oral health care integration.
5. Create a "one-stop shop" where CCOs and other stakeholders can find information about health-related services (HRS)

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[1] Evaluation of the Oregon's 2012-2017 Medicaid Waiver, OHSU Center for Health Systems Effectiveness (www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf)

6. Require CCOs to report person-level data on use of health-related services
7. Require CCOs to commit one percent of their global budget to spending on social determinants of health (SDOH)
8. Evaluation options for limiting the growth of prescription drug spending.

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

Governor Brown Identifies Four Areas for Improvement

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

In 2016, prior to the release of the OHSU evaluation, the OHPB launched a listening tour to gather public input as the board and agency began planning for the procurement of the next CCO contracts. In September 2017, Governor Brown outlined her vision for improving care, increasing value, and containing costs in CCO 2.0 in a letter to the OHPB. Building on the board's previous work, she directed the board to provide recommendations for advancing Oregon's transformation efforts in four key areas:

1. **Improve the behavioral health system and address barriers to the integration of care**: Integrate behavioral, physical and oral health to allow patients to receive the right care at the right time in the right place. Focus on behavioral health services, with assurance that children with serious behavioral health care needs are addressed as a priority.
2. **Increase value and pay for performance:** Reward providers' delivery of patient-centered and high-quality care, and reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.
3. **Focus on the social determinants of health and health equity**: Build stronger relationships between CCOs and other sectors and align outcomes between health care and other social systems to improve health equity. Encourage a greater investment in prevention and the factors that affect our health outside the doctor's office.
4. **Maintain sustainable cost growth and ensuring financial transparency**: Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

Developing the CCO 2.0 Policy Recommendations

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

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

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

3. Public Engagement: Oregonians Shape Health Transformation Policies

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

Public engagement allows OHA to:

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

A critical aspect of the policy development work of the four policy area teams involved gathering public feedback at multiple points throughout the process. Each of the four CCO 2.0 policy area teams identified advocacy groups and subject-specific organizations to present draft policy options to and gather critical technical feedback. OHA heard directly from more than 800

Oregonians who participated in public meetings and forums held across the state in more than a dozen locations which were led by OHA Director Patrick Allen. Additionally, multiple surveys and online outreach tools were used to gather perspectives from a diverse cross-section of Oregonians.

The in-person approaches included the following (see appendix E):
- Discussion at more than 25 health committee meetings
- Oregon Health Policy Board meeting updates and public testimony
- Presentations at more than 20 conferences and meetings
- Two formal tribal consultations
- 13 community advisory council meetings, hosted by OHA innovator agents
- Four public forum events across the state in April and May 2018 (200 participants)
- Ten public road show events across the state in June 2018 (more than 500 participants)
- Spanish-language forum in Woodburn, OR (100 participants)

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

Community Engagement Strategies

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

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

The development of these relationships allowed OHA to better identify the diverse needs of cultural groups within member populations and develop strategies to engage them effectively. OHA developed a member-specific survey tool that sought feedback based on OHP member experiences, actively engaged Oregon tribes in tribal consultations and partnered with DHS's

Community Partner and Outreach Program to hold a culturally specific, Spanish language community meeting that drew nearly 100 attendees.

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

Public Engagement Impact on CCO 2.0 Policy Recommendations

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

In the on-line survey asking which areas need more attention and work to improve through CCO 2.0, respondents ranked behavioral health care and addressing social determinants of health at the top. (see appendix E). In the August phone survey, OHP members also identified improvements in these two areas as having the largest positive impact on their health care experiences. In addition, nearly two thirds of OHP members expressed they were very satisfied with the coverage they receive through OHP and an additional 24 percent reported being somewhat satisfied.

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

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

When feedback has supported modifying policies, OHA has taken careful consideration of potential changes as well as the diverse viewpoints surrounding the policy. For example, health

equity advocates and subject matter experts have played a key role in reframing how OHA should approach issues of health equity. Embedded within a request that we adopt a framework of "cultural responsiveness" instead of defining the work as "cultural competency" is an understanding that this work is ongoing, a process that understands we can never fully attain all the skills and views needed to work with culturally diverse clients. Instead, "responsiveness" assumes one has the openness to adapt to the cultural needs of those with whom they work, always seeking greater understanding of their culture, ethnicity, and language.

Additionally, OHA approached policies with clear plans to address common stakeholder concerns. For example, there has been stakeholder concern that value-based incentives should be meaningful enough to motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage. The OHA approach to specific VBP policies recognizes that financial incentives, by themselves, aren't sufficient to change provider behavior and achieve person-centered care. OHA plans to use additional, complimentary levers (such as promoting specific VBP model components that ensure provider flexibility) to transform the health care system.

Health Equity Impact Assessment of The CCO 2.0 Policy Recommendations

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

A Health Equity Impact Assessment (HEIA) is a tool that allows for the identification of how a program, policy or similar initiative will impact population groups in different ways. OEI took some key aspects of the HEIA tool and performed a desktop assessment, which involved a literature review, results of the CCO 2.0 public input process, and by feedback provided by the subject matter experts, culturally specific community-based organizations, the Medicaid Advisory Board, and by OHPB's Health Equity Committee.

The HEIA tool is intended primarily for application during the design phase of an initiative (pre-implementation). It is also a living document, with health equity impacts identified as the design of the initiative evolves. In this case, the assessment was introduced retrospectively as an evaluation tool to examine whether the policy option is capitalizing on available opportunities to improve health equity or whether they may potentially result in widening health disparities. The OEI CCO 2.0 desktop assessment intends to maximize positive impacts and reduce negative impacts that could potentially widen health disparities between

population groups. In identifying those impacts, recommendations were made to adjust the strategies, mitigate adverse impacts and maximize positive impacts of the policy.

Full details of the impact assessment are available (see appendix C), and assessed policies were marked either positive (potential for positive health equity impact), neutral (no positive or negative impact could be identified at this point), negative (potential for negative unintended health equity impact) or both, positive and negative. It is also a living document, with health equity impacts identified as the design of the initiative evolves. The assessment results directed OHA to areas where further development could capitalize on opportunities to improve health equity, even when the potential for a negative impact exists. An example of maximizing positive impact highlighted by the HEIA were instances that called for CCOs to strengthen community and tribal engagement and participation with the intent of giving communities a voice in matters that deeply affect them by strengthening community advisory councils and CCO partnerships. In the case of VBP, the assessment provided OHA with recommendations to mitigate potential negative impacts by elevating the need in the design and evaluation of payment models to include monitoring which groups or communities are benefiting from the model, and which may potentially be bearing the weight of unintended negative consequences

4. Policy Recommendations: The Future of the Oregon Health Plan

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

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

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

- CCOs should remain locally-governed, community-based organizations;
- The state and CCOs should work together to expand upon the flexibility and use of the global budget concept;

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

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

Accountability, Contract Monitoring and Enforcement

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

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

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

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

Vision:
In CCO 2.0, Oregon will improve behavioral health for Oregonians and remove the barriers that keep patients from receiving care in the right place at the right time. Where systems and needs align, we will extend these efforts to also improve integration of oral health. Children with serious emotional disturbances (SED) will have their needs addressed through system integration and access to appropriate services.

OHA has identified elements of an effective behavioral health system that meets the needs of all members:
- Services should be accessible;
- There should be no wait time for services;
- Consumers should have a choice in who they see for services;
- Services should be integrated;
- Consumers shall have their needs met without having to navigate the system; and
- Consumers receive the right services, at the right place, at the right time.

These elements are similar for oral health.

Considerations:
The current behavioral health system's functioning and operations are inconsistent across all of Oregon. The 2016 Behavioral Health Collaborative, a group of 50 stakeholders convened to recommend a modern behavioral health system in Oregon, found that "the behavioral health system continues to include fragmented financing, carve-outs that prevent integration and efficiencies, siloed delivery systems, and services that fail to serve and exacerbate poor health outcomes." The Behavioral Health Collaborative recommendations focused on workforce, standards of care and competencies, metrics, and health information technology. These recommendations are incorporated into CCO 2.0 behavioral health policy options.

Key themes heard from the OHPB include that behavioral health is a health emergency for Oregon. The OHPB also noted that ensuring seamless access to integrated behavioral health is a clear priority and that every member of the Oregon Health Plan should be able to access behavioral health treatments services within 24 hours. Children should receive extra focus to ensure access to social-emotional developmental services are available, including targeted behavioral health treatment.

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

1. Access, transitions between levels of care and navigating the system are cumbersome.

2. Administrative and billing barriers impeded integration efforts, created barriers to access and effective care in both Severe and Persistent Mental Illness (SPMI) and Substance Use Disorders (SUDS).
3. Physical health providers are not able to bill for behavioral health codes and the opposite is true as well.
4. Limited information sharing produces an additional barrier.
5. Workforce capacity was not robust enough to ensure access.
6. Rates for behavioral health services are insufficient, which leads to an underpaid workforce and high turnover.
7. Emergency Department issues are a result of broader access issues.
8. Data is insufficient to analyze the flow of services from assessment to delivery of care.

OHA staff developed policy options to address the issues identified above, with a focus on behavioral health integration, access to services and an adequate provider network. Fundamental to these concepts is clear accountability and responsibility for the behavioral health benefit by the CCOs. OHA vetted these policy options through a public input process and the following key behavioral health themes emerged:

- Access to a full continuum of care, including detox, residential, outpatient and recovery support services, throughout the state.
- Access to the appropriate level of care in a timely manner.
- Integration with primary care.
- Provider network adequacy, including culturally and linguistically appropriate services. A qualified behavioral health workforce includes peers.
- Reimbursement rates for behavioral health services are insufficient.
- Billing issues, including primary care unable to bill for behavioral health.
- Eliminate the sub-capitation and delegation of the behavioral health benefit.
- Need for more support around HIT and health information exchange.

Feedback from stakeholder groups and public comments were used to refine, and in some cases, revise the policy options. For example, stakeholders repeatedly asked for the elimination of the sub-capitation and delegation of the behavioral health benefit. Under CCO 1.0, CCOs may have fully sub-capitated, or "carved out", the behavioral health benefit. As a result, the behavioral health system was administered and provided in silos, with consequences including delayed authorizations, caps on behavioral health spending, diffuse accountability and members not receiving timely services. The original policy option asked for clear ownership of the behavioral health benefit. OHA staff revised the policy option to require CCOs to be accountable for the behavioral health benefit of their members and not fully transfer the benefit to another entity. This includes ensuring timely access to services and an adequate provider network. Fully eliminating the sub-capitation and delegation of the behavioral health benefit could have unintended consequences and destabilize the system; however, by strengthening contract language and accountability, the behavioral health system can reach the desired outcomes of members receiving the right services at the right place at the right time.

Additionally, stakeholders were concerned that requiring care coordination could create other workforce capacity concerns. The care coordination policy option was revised to require CCOs ensure a care coordinator is assigned to the most vulnerable behavioral health populations.

Although not highlighted in the Governor's letter, oral health integration emerged during the CCO 2.0 process as an important area of concern for OHA stakeholders, which suggests that policy options being considered to improve behavioral health may also improve administration of oral health care too. Among online survey respondents who are OHP members, family members or caretakers, oral health integration ranked as their third highest concern. Other stakeholders also mentioned the need to address oral health integration in CCO 2.0 listening sessions. There is a growing body of evidence that good oral health leads to improved overall health, better employment prospects, higher self-esteem, and greater self-sufficiency.

Policy Recommendations:

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

See appendix A for all policy recommendations.

Increase value and pay for performance

Vision:
Oregon has a long history of health system transformation, including efforts to move away from traditional volume-based health care payments to payments based on value that support positive member health outcomes and cost savings. In CCO 2.0, Oregon will make a significant move away from fee-for-service toward paying providers based on value.

OHA's value-based payment (VBP) policy option supports the triple aim of better care, better health and lower health care costs by:

- Rewarding providers' delivery of patient-centered, high-quality care
- Rewarding health plan and system performance
- Aligning payment reform with other state and federal efforts
- Ensuring consideration of health disparities and members with complex needs

Oregon's 1115 Medicaid waiver renewal also requires OHA to develop a plan—a VBP Roadmap—describing how the state, CCOs, and network providers will achieve an established VBP target by June 30, 2022.

Considerations:

During the period since Oregon first launched CCOs, significant work has occurred nationally to create a framework for health systems to move away from fee-for-service toward VBPs. Efforts to deliver person-centered care have been stymied, to a large degree, by a payment system that is oriented toward paying for volume—as opposed to value—for patients and caregivers. Previous payment reform efforts focused exclusively on capitating payments, without including a link to quality. These efforts, while often successfully containing costs, were generally unsuccessful in achieving the triple aim because they failed to ensure quality of care was maintained.

Over the past five years, the payment reform nomenclature has transitioned from the term "alternative payment models" toward VBP to signify the need for payments to reflect quality and outcomes. This has been adopted by the Health Care Payment Learning and Action Network (LAN), a national effort supported by CMS to accelerate VBP across markets. The LAN developed a "Framework" for categorizing VBPs that has become the nationally accepted method to measure progress on VBP adoption and is the framework Oregon will use to move from fee-for-service to VBPs.

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

The OHA maturity assessment (see appendix F) found that the use of VBPs varies by CCO. While CCOs use payment models beyond fee-for-service, they have less experience linking payment to quality; current reporting does not adequately capture CCO VBP activities; and the differences of geography, plan size and provider market power means a "one-size-fits-all" VBP approach will not work.

The proposed VBP policies have been informed by:

- OHA maturity assessment
- The Evaluation of Oregon's 2012-2017 Medicaid Waiver[2]
- CCO VBP Workgroup, established per the 1115 waiver VBP requirement, which met three times beginning February 2018
- VBP Provider Survey that targeted diverse providers in terms of geography and care delivery

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[2] Evaluation of the Oregon's 2012-2017 Medicaid Waiver, OHSU Center for Health Systems Effectiveness (www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf)

- OHA staff participation in technical assistance (TA) provided by CMS's Innovation Accelerator Program; national experts provided tools such as an environmental scan of Medicaid VBP efforts across the country[3]
- CCO 2.0 surveys and public engagement meetings

The proposed VBP policy and the planned implementation approaches broadly align with what OHA has heard from the OHPB and key stakeholders. Strategies to address common issues raised by stakeholders regarding the proposed VBP policy options include the following:

Metrics reporting should to be aligned, when possible, both within Medicaid and across payers. OHA plans to support payer alignment of provider metrics to ease administrative burden. OHA will work with national consultants to provide ongoing TA and will work through other avenues, such as the multi-payer Primary Care Payment Reform Collaborative, to seek metrics alignment across Medicaid and commercial payers.

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

Intentional strategies need to be put in place to ensure VBPs do not cause unintended, negative consequences for priority populations. To raise awareness and deter negative, unintended consequences, CCO applicants will be required to respond to specific questions in their RFA responses 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. CCOs will be required to respond 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 these priority populations. The Transformation Center will also engage with the Office of Equity and Inclusion in the development of technical assistance in areas that will address the health equity considerations brought up by the Health Equity Impact Assessment (see appendix C).

Policy Recommendations:

Realizing the vision of a transformed health system supported by increased adoption of VBP will require multi-sector, system-wide action and collaboration by payers and providers. CCO 2.0

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[3] Most states that have implemented VBP through their Medicaid managed care contracts have developed statewide goals with a focus on incrementally increasing the percentage of payments tied to VBP each contract year.

will move our health care system away from the fee-for-service model and help drive improvements to quality of care in key areas such as behavioral health and oral health. The following policies will reward CCO and provider performance and ensure health disparities and members with complex needs are considered.

The CCO VBP Roadmap is a key element toward ensuring partners are able to develop payment systems with the flexibility to ensure care focuses on the whole person and supports healthier communities.

<mark>See appendix A for all policy recommendations.</mark>

Focus on social determinants of health and health equity

Vision:
Health begins where we live, learn, work and play. From the beginning, Oregon's transformation vision has recognized that the health care system has a limited impact on overall lifelong health of Oregonians. There's also an increasing recognition that social determinants of health have a significant impact on health disparities.

In CCO 2.0, Oregon will address social determinants of health and improve health equity by building stronger partnerships between CCOs and other sectors, aligning outcomes, and creating incentives for CCOs to increase their investment in strategies to address social determinants of health, which will lead to improved outcomes, reduced costs, and improved health equity. CCOs will solidify their role as a convener and driver of social determinants of health and equity work in their community while also recognizing the assets and strengths of systems already in place.

Considerations:

Oregon's original health system transformation vision prioritized health equity and prevention work. Further, as health system transformation has progressed, there has been growing awareness both locally and nationally that social determinants of health, such as housing and education, have a greater impact on long-term health outcomes than health care services alone. Lessons learned regarding CCOs' experiences related to social determinants of health and health equity from the OHA maturity assessment (see appendix F) include the following:

- CCOs have reported minimal investment in health-related services (non-covered services that are 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), particularly those related to social determinants of health (SDOH), in financial reports. However, current reporting has significant limitations, including: CCOs focusing on services attributable to specific members, rather than community-level benefits; reports do not include investments outside of flexible service funds. Additional limitations include: CCOs' low use of health-related services may be attributable to lack

- of guidance/understanding on health-related services, and the time needed to develop/implement health-related services policies.
- Based on CCO reporting, CCOs are investing in areas of SDOH, with a particular focus on housing and trauma/adverse childhood experiences (ACEs). The data are limited to self-report and do not include information on actual financial investment, implementation, or results.
- CCOs have partnered, to varying degrees, with community partners that can support work related to health equity and SDOH, including Early Learning Hubs, local public health departments, and Regional Health Equity Coalitions. CCOs have limited expectations in statute or contract related to these partnerships.
- While statewide workforce data is available, little is known about CCO employment/utilization of key providers effective in addressing health disparities and SDOH, such as traditional health workers and health care interpreters.
- Disparities in health outcomes and in access to quality of care related to race/ethnicity, disability, and behavioral health status are evident.

The Oregon Health Policy Board expressed their support for focusing on social determinants of health and health equity to reach upstream and beyond the health care delivery system to support population health through CCO partnerships with local health authorities, other governmental agencies and community-based organizations. Board members believe that looking at the connecting points between disconnected systems to focus on addressing the social determinants of health and health equity is a foundational priority for Oregon's health system transformation.

Key themes heard from the Oregon Health Policy Board include: ensuring explicit goals and strategies for addressing health inequities are in place is crucial and that it is as much a responsibility for OHA to support CCOs in their work as it is a mandate for CCOs.

Board members stated that CCOs must place their members at the center of identifying solutions and ensure variable quality and access to services based on member language, race, or national origin does not exist. They also feel a stronger relationship between CCO Boards and Community Advisory Councils will enhance community driven changes.

Finally, Board members stated that, while access to adequate housing is a clear top priority for social determinants of health strategies, CCOs cannot solve this issue alone, and should partner with housing agencies to provide supportive housing services.

These lessons learned, themes from OHPB and feedback from community members and stakeholder engagement sessions have translated directly into policy recommendations for CCO 2.0, including policies related to equitable patient-centered care, mechanisms to address lack of transparency in CCOs' SDOH and heath equity spending, and policies related to fostering community engagement and addressing community needs. Additionally, as a foundation for implementing these policy options, OHA is in the process of adopting standardized definitions of social determinants of health, health equity, and health disparities. This work intentionally

elevates definitions and recommendations developed by the Medicaid Advisory Committee, the Public Health Advisory Board, and the Health Equity Committee of the Oregon Health Policy Board.

Themes heard through CCO 2.0 public input focused on SDOH and health equity include:
- Confirmation that SDOH and health equity is a significant area in need of attention, support, collaboration and spending.
- CCO SDOH and health equity initiatives should be community-driven, and funds should flow as much as possible to community partners doing the work in alignment with the community health improvement plan.
  - The community advisory council (CAC) should play a strong role in decision-making.
  - Public health and a focus on prevention are key to promoting population health.
- Health care should be equitable and culturally and linguistically responsive.
  - Strong support for the Traditional Health Workers model was expressed
  - Workforce diversity efforts are important, must be intentional, and must be grounded in collaboration.
  - The provision of quality, accessible and meaningful language services to individuals with limited English proficiency (LEP) is a key component of health equity.
- Potential challenges with measurement of social determinants of health and health equity need and impact of the CCO 2.0 initiatives in this area (e.g. challenges with collecting social determinants of health and health equity data via electronic health records).

Public input has informed all the social determinants of health and health equity policy options. For example, the development of a policy on CCO equity infrastructure, which initially required each CCO to have a dedicated health equity leadership position, evolved to incorporate critical public input. OHA heard that, while many CCOs have staff that are entirely dedicated to health equity activities, other CCOs do not. Public input indicated support for the idea of coordination and accountability of health equity at a CCO level, but also concern about taking away CCOs' staffing flexibility. As a result of this feedback, OHA staff modified the strategy from a dedicated position to a "single point of accountability with budgetary decision-making authority and health equity expertise." This change gives CCOs flexibility in achieving the purpose of the strategy—coordination and accountability for CCO health equity work—without being prescriptive about how CCOs realize this strategy.

Additionally, one policy option in CCO 2.0 sets a statewide spending priority for CCOs to invest in housing-related supports and services. This is in response to strong public input and need voiced for innovative approaches to addressing Oregon's housing crisis. Meanwhile, OHA is partnering with Oregon Housing and Community Services to expand supportive housing in the state. This is a key opportunity to leverage an increase in housing infrastructure in communities while expanding the housing-related services and supports that CCOs provide to complement this infrastructure.

Policy Recommendations:

OHA is working to ensure statewide transformation on social determinants of health and health equity while allowing CCOs flexibility to move this work forward using approaches that are informed by their communities. OHA also hopes to drive efforts on social determinants of health and health equity by setting clear expectations along with requirements for collaboration and transparency that allow OHA to assess where progress is being made and where support and technical assistance is needed from OHA to meet those expectations.

While CCOs must play a crucial role in addressing the social determinants of health and equity, they cannot do this work alone and should collaborate with and support local organizations and systems already involved in addressing the social factors that impact health. These partnerships can be reflected in OHA's partnerships with other state agencies.

See appendix A for all policy recommendations.

Maintaining sustainable cost growth and encouraging financial transparency

Vision:

With 94% of Oregonians insured, Oregon should focus on long term financial sustainability of the Oregon Health Plan by ensuring a high-quality system that operates within a budget the state can afford so that Oregonians across the state continue to have access to needed health care services. In CCO 2.0, Oregon will address major health care cost drivers with payment and rate-setting policies that incentivize the delivery of efficient, high-value, and high-quality health care (and health-related) services, and by effectively using the program's purchasing power and rate-setting methodology to reduce costs. We will utilize new data analysis tools to identify outlier costs and areas of opportunity for improved efficiency and continue to advance transparency and accountability throughout the health system by making information easily accessible to the public, members, and policymakers.

Considerations:

Oregon's efforts to limit growth in state and federal spending, on a per-member basis, is predicated on several factors, only some of which are targeted at influencing underlying health care costs. Key lessons learned were identified in the OHA maturity assessment (see appendix F) and throughout the policy development process. These findings should help Oregon build on successes and take additional steps to reduce the underlying costs of health care services in Oregon:

1. Oregon's program-wide spending target is an important tool to ensure spending growth remains sustainable. Oregon has experienced broad success achieving these targets on a program level, but data limitations complicate efforts to evaluate performance on a CCO-level or the success of specific CCO activities or interventions.

2. The OHSU waiver evaluation found that spending declined among CCO members compared to Washington Medicaid members, but also that spending on prescription drugs increased compared to Washington. New policy interventions may be needed to rein in pharmacy costs.

3. CCOs have substantial flexibility to deliver services to Oregon Health Plan (OHP) members within the constraints of the global budget. While CCO flexibility to be innovative in their care delivery is critical to ensuring their success, new program-wide solutions may also be necessary to ensure ongoing achievement of spending targets without compromising access to, or quality of, care for OHP members.

4. Technical assistance from the OHA helps spread effective CCO practices and reduce costs. This resource is unique across state Medicaid programs and should remain a critical tool for improving CCO performance and maintaining access to care.

5. Incentive payments to reward CCO performance have shown significant ability to motivate CCOs and their provider partners to achieve targeted performance and/or improvement goals. Oregon should build on successes and maintain its commitment to pay for better quality care and health outcomes, which should help reduce health care costs in the long run.

6. A more efficient health care system that invests in primary care services should help keep people healthier and reduce the need for more-costly medical interventions later. People who are properly managing chronic conditions will have less needs for urgent medical treatment and other health care services that are more expensive than primary care services.

7. Limiting growth in Oregon's spending on Medicaid is as much an exercise in rate-setting as it is an effort to reduce underlying costs of health care services. Some interventions that may reduce long-term costs or increase the quality of care delivered could increase spending in the short run. Policies to reduce spending and costs should not undermine, but rather should amplify policy interventions that improve quality and pay for value, that help address social determinants of health and improve health equity, and that ensure Oregonians access to behavioral health care services where and when they are needed.

Initially and throughout the policy development process, the OHPB has heard there was a need for more and better information to measure CCO performance beyond the metrics used for the quality incentive pool. OHPB members have specifically emphasized the value of comparing data across CCOs in order to better understand how CCOs achieve sustainable spending targets and thus improve global budgeting and reduce costs. Similarly, the Board highlighted opportunities to be more transparent with existing CCO performance data, such as annual rates of growth, with the intention of using the added transparency to help address issues like rising pharmaceutical costs. More CCO-specific information may also help identify best-practices so that CCOs' performance can be continuously improved in a collaborative and community driven process. Finally, the Board remains committed to achieving the sustainable growth targets and

directs the OHA to explore setting annual growth targets based on broad economic measures instead of the two-percent test to ensure the long-term sustainability of the program.

Community members and interested stakeholders also had opportunities to inform the policy development process on multiple occasions. The OHA team focused on sustainable spending and financial transparency convened two roundtable meetings with interested stakeholders to examine potential policy options in greater detail. These meetings were each three-hours long and offered attendees ample time to discuss the goals and vision of the CCO 2.0 process as well as the potential impact and other considerations related to the policy options under consideration.

The roundtable meetings were open to the public and advertised on the agency's CCO 2.0 website and at other public meetings and forums. In addition, agency staff reached out to dozens of potentially affected stakeholders to attend. Several current CCOs sent representatives, and other attendees included consumer advocates, academic researchers, representatives from non-CCO providers and health systems, and others.

During these meetings, stakeholders provide detailed input to the agency and offered both broad, goal-oriented thoughts on key policy proposals along with specific concerns and alternative proposals. In large part, the discussion at the roundtable meetings was focused ensuring that stakeholders understood the goals of the proposed ideas as well the agency's potential implementation strategies. Attendees raised concerns related to the overall difficulty of reducing health care costs and the value of data and assistance to help CCOs, providers, and other stakeholders to identify best practices to achieve this goal. Representatives from CCOs highlighted the importance of locally-driven decision making and the importance of CCO-flexibility to achieve broad goals, though many also acknowledged the need to address specific cost drivers such as pharmacy services.

Some attendees did raise concerns about specific proposals and whether they might reduce resources available to care for OHP patients or whether they would add new administrative costs to the provision of care. These concerns have been considered thoughtfully and policy options have been modified throughout the development process to attempt to mitigate concerns and to provide clear rationale for policy changes that caused concern. For instance, several CCOs raised concerns that significantly increasing reserve requirements for CCOs would tie up CCO resources and hinder their ability to deliver services and invest in their communities. While OHA is committed to ensuring that reserve requirements adequately reflect the risks CCOs and their risk-bearing partners face, OHA has also modified policy options in response to these concerns. The current recommendations seek to ensure financial security of the CCO program while also providing insolvency-mitigation tools that require less up-front reserve capitalization in order to ensure CCOs are able to make timely investments to meet the needs of their communities.

In many cases, the feedback received at the roundtable meetings and other forums provided agency staff with useful confirmation that policy options under development were examining the right issues. For instance, attendees highlighted the importance of addressing high-profile

cost drivers such as pharmacy and hospital services and confirmed the potential value of program-wide risk mitigation strategies such as a reinsurance program.

Policy Recommendations:

In order to ensure continued achievement of Oregon's sustainable growth targets, OHA is proposing a variety of CCO 2.0 policy recommendations that seek to address major health care cost drivers while increasing the share of CCO budgets tied to performance. In addition, the recommendations increase transparency and improve oversight to ensure financial transparency and accountability of the CCOs and of OHA. The recommendations also consider how changes to OHA's rate-setting policies and procedures could help contain spending growth in the long term.

==See appendix A for all policy recommendations.==

5. Next Steps

[Content in development]

6. Appendices
A. CCO 2.0 Recommended Policies
B. **CCO 2.0 Policy Implementation Expectations**
C. Draft Health Equity Impact Assessment
D. Coordinated Care Model Elements Crosswalk
E. Public input
- i.   PSU report on road show
- ii.   Summary of Woodburn community forum in Spanish
- iii.   Summary of two online surveys
- iv.   Summary of phone survey
- v.   List of all public meetings, including culturally specific outreach
- vi.   List of all formal letters/recommendations received

F. Maturity assessments
G. Timelines
H. Definitions