Coordinated Care Organization Procurement Findings and Recommendations Report

Issued by Oregon Health Policy Board

April 2025

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Executive summary

The Oregon Health Policy Board (OHPB) solicited oral and written feedback from Oregon Health Plan (OHP) members, caregivers, providers, community partners, community-based organizations, and members of OHPB committees on their experiences providing, accessing and receiving health care from Coordinated Care Organizations (CCOs). Feedback was collected from 158 respondents during two OHPB public Town Halls, through a publicly available online survey and from several public meetings of OHPB committees. OHPB also heard testimony from each CCO in a listening session reserved for CCOs specifically. The CCO testimony was considered as part of the OHPB recommendations but not included in the results of the analysis portion of this report.

Six observations emerged from feedback shared by respondents.

1. **Members receive better care when CCOs partner with communities.**
   When CCOs partner with community-based organizations and local agencies it creates opportunities for regional alignment and innovation in meeting unique community needs. Contracts and partnerships with local and community-based organizations expand access to health care and services and increase the network of providers for community specific services, including in rural areas and with culturally and linguistically specific/appropriate services.

2. **Unclear, complicated or inefficient requirements increase administrative burden and delay or limit care.**
   Providers expressed frustration and confusion around administrative requirements and processes that delay or limit their ability to provide care to members and to receive payment for care provided. Specific processes identified by respondents as burdensome included credentialing, referrals and prior authorizations, and billing. Some of the challenges described were greater when more than one CCO served the same region or when providers worked with more than one CCO.

3. **Payment rates and reimbursement models affect quality and availability of services.**
   Providers reported that reimbursement rates are not competitive and make it difficult to provide care and sustain their practices, particularly in oral health, behavioral health and children's health. Providers also shared concerns and impacts of payment models and mechanisms that increase administrative burden or disincentivize appropriate or cost-effective care.

4. **Gaps in service and provider availability make it difficult for members to access care.**
   Accessing and providing healthcare services throughout Oregon, and particularly in rural areas, emerged as a critical challenge for the full range of respondents.

Responses indicate that gaps in services disproportionately affect marginalized communities, including those requiring language assistance, those with complex health needs and those living in rural areas.

5. **Gaps in care coordination and case management impact members requiring complex care.**
   Respondents shared that care coordination and case management are often not happening for members who need these services. Many members who need care coordination services are not aware that these services exist or how to access them. When care coordination and case management are available, these services do not always meet members' needs. Opportunities for care coordination and case management are even more limited for members who need care and resources in languages other than English or need culturally specific services or facilities.

6. **Members struggle when services are unavailable or do not meet their needs.**
   Members struggle when services that should be covered are not available or are available but do not meet their needs. Some members reported feeling like they do not have autonomy over the care and services they receive. When they do not receive appropriate care, members and providers said they were unsure about what steps to take next.

In addition to these six observations, seven other areas of interest emerged from the feedback received from respondents. The first three align with the Governor's priorities for the next CCO procurement:

Behavioral health

Network adequacy, the lack of integration with physical health care, and care coordination were key themes related to behavioral health care. Challenges can be more acute for children and adults with complex needs, members with substance use disorders (SUD), people experiencing homelessness, members in rural areas, and people who need culturally or culturally or linguistically specific/appropriate care.

Children's health

Feedback referencing children's health highlighted difficulties in accessing care due to insufficient provider networks and lack of services or providers for children with complex medical care needs. Barriers to children's behavioral health care include long wait times and insufficient mental health providers and resources for children, especially for children with complex behavioral health needs.

Oral health

Most feedback related to oral health care was associated with payment models and low reimbursement rates. Providers also noted a lack of focus on prevention in oral health care, which can contribute to increased costs and less access to oral health care, particularly in rural areas.

Social determinants of health

Respondents shared challenges related to addressing social determinants of health (SDOH) for members. Respondents noted smaller provider offices may have a harder time contracting with CCOs and are unable to meet the administrative and reporting requirement of providing SDOH-related services.

Traditional Health Workers and peer support

Respondents shared that CCOs have been key partners in helping Traditional Health Workers (THWs) deliver culturally and linguistically specific care to communities. CCO investment in the THW workforce has increased community capacity and provided more options for the unique needs of communities in different parts of Oregon. Challenges include inconsistent billing and reimbursement processes, lack of resources for improving or expanding the THW workforce, low salaries for THWs, and a lack of integration of THWs into the health care system.

Rural areas

Feedback highlighted the lack of services and providers in rural areas, resulting in members having to travel long distances, using other resources that may not provide the level of care they needed, or not receiving care or support at all.

Network adequacy

Respondents noted network adequacy as a significant issue, especially for behavioral health, oral health, children's health, members with complex care needs, members who need culturally or linguistically appropriate services, and rural areas. Low reimbursement rates and inconsistent or burdensome administrative processes can exacerbate network adequacy gaps by reducing the number of available providers in CCO networks.

Throughout the six observations and seven additional areas of interest, respondents consistently identified two specific needs:

- Respondents want CCOs to adopt consistent standards across some processes to improve how providers deliver care and how members access care. Examples where CCOs could standardize processes include:
    - Credentialing
    - Authorization requests
    - Reimbursement rates

    - Care coordination
    - Case management
- Respondents want CCOs to take a localized approach when partnering with and facilitating care for specific communities in Oregon. Examples where CCOs could take a more local approach include:
    - Supporting rural communities
    - Culturally and linguistically specific/appropriate care
    - Traditional Health Workers
    - Local community programs
    - Youth and children's health care needs

OHPB Recommendations

OHPB appreciates the opportunity to provide recommendations for the procurement process. In the process of listening to the experiences of individuals and organizations who are part of Oregon's CCO program, we are reminded of the power of sharing. We are grateful and honored by each voice that contributed.

OHA staff and leadership were instrumental partners in this feedback effort. Their work included creating spaces for participation, removing barriers, coordinating across different departments for maximum value, and deeply listening, observing and compiling all that was heard in this report. This work takes time and commitment, for which we are filled with gratitude.

The Board's recommendations, based on the feedback we heard, are below.

1) **Establish a common framework for Health Equity Standards.** By January 1, 2030, all CCOs will have achieved National Council for Quality Assurance (NCQA) health equity accreditation. Collectively, these six NCQA standards address the following: workforce diversity, REALD/SOGI data collection, language access, practitioner network cultural responsiveness, culturally and linguistically appropriate services (CLAS), and quality improvement methods to eliminate inequities.

    1.a.) Ensure CCO partnerships with local organizations and agencies provide culturally and linguistically appropriate care, create opportunities for regional alignment, and innovate to meet community needs.

2) **OHA should increase alignment (minimize variation) across CCOs** and decrease provider administrative burden across the system by ensuring shared standard practices in the following areas:

    2.a.) Credentialing

    2.b.) Prior authorizations and coverage criteria

    2.c.) Data reporting alignment

3) **OHA should explore strategies to expand health care access**, including:

    3.a.) Improve payment rates across CCOs, especially rates for children, behavioral health, oral health, traditional health workers, and rural providers to expand access.

    3.b.) Incentivize access to care. OHA should explore and review alternative payment models to maximize access to care, especially around children and behavioral health to ensure positive incentives for timely access to care.

    3.c.) OHA should encourage alignment of payment models and billing processes across CCOs to reduce administrative burden and improve provider willingness to accept OHP patients, and improve more timely access to care.

3.d.) OHA should include accountability mechanisms for payment models and payment rates in CCO contracts, specifically around distribution of funds for culturally and linguistically specific care (i.e., enhanced rate).

3.e.) OHA should develop clear standards and statewide definitions for **network adequacy** and access to care for CCOs. Measures must be time-sensitive, updated quarterly, and reported publicly, with a defined path for public feedback. CCO's and OHA should collaboratively define improvement strategies if access to care doesn't meet the standard.

3.e.i.) Definitions and future standards to include the following provider types: primary care providers, primary care dentists, mental health providers, substance use disorder treatment providers, and specialty care providers.

3.e.ii.) Definitions and future standards to include timely access to care by provider type, specifically:

3.e.ii.(1). Acceptance rates for new OHP patients.

3.e.ii.(2). Timely availability to urgent care and same day access with an established provider.

3.e.ii.(3). Wait times for routine follow-up visits.

3.e.ii.(4). Travel time and distance to nearest available / open provider.

3.e.ii.(5). Timely access measured by telehealth vs. in person care.

3.e.iii.) Definitions and future standards to include variation in access: by age (children/adults) and by population type through use of REALD/SOGI data.

4) **CCOs and OHA should support workforce development**, including training, certification, and other workforce preparation and professional development opportunities, especially for Traditional Health Workers (THWs – i.e., Peer Support Specialists, Peer Wellness Specialists, Birth Doulas, Community Health Workers, and Personal Health Navigators).

4.a.) OHA should evaluate the intersection of workforce supply and network adequacy to identify targeted community improvement strategies.

5) **CCOs should reduce gaps in care coordination and case management** for members with medically complex needs. CCOs should provide more training and resources to case managers, so they can better support patients to navigate systems and services.

5.a.) OHA should improve definition of expectations around care coordination and case management in CCO contracts.

5.b.) OHA should establish baseline standards for CCOs that allows for performance transparency.

6) **CCOs should provide plain language communication** to members on how to access available support services (e.g., staff such as care coordinators, case managers, and THWs; and access to, for example, health-related services) that can help members resolve common and complex challenges they may experience when

navigating health services and member benefits. CCOs should publish clear communications to members about care coordination and case management services, especially for children with disabilities and complex needs.

Additional efforts and improvement areas

We also wanted to recognize that there are a multitude of efforts and improvement strategies underway that require bolstering or additional attention as we move into the next procurement process, whenever that may occur:

Local care, local inclusion, local decision-making control

It is clear from OHPB's community engagement work and data analysis, that members received better care when CCO's partner with communities. Therefore,

- OHA must determine a path forward to ensure community partnerships, coordinated community planning (CHA/CHIP), and community investments are transparent.
- An independently conducted community engagement / community satisfaction survey, owned by OHA, should inform future CCO community engagement improvement goals, performance improvement plans, and ultimately, the subsequent duration of individual CCO contracts.

Financial modeling

While not a primary focus of OHPB's community engagement, we did hear concerns expressed about the financial uncertainty of Medicaid rates, matching state/federal funding formulas, and deployment of Medicaid resources.

- OHA must stay vigilant in its assessment of the financial fragility of Oregon's CCO's, including the durability of ensuring protections and rapid actions are in place to intervene quickly if CCO's are financially fragile or at risk of closure.
- OHA must protect against shareholder wealth building or other profit motives in managing Medicaid resources and ensure Medicaid dollars are directed in areas that improve the member's experience, access, and quality of care.

We remain grateful for the opportunity to work with the Governor's Office, OHA, and all the individuals and organizations who collectively create and participate in Oregon's coordinated care program. Expectations for next steps follow our recommendations and we look forward to ongoing participation and partnership in improving Oregon's health care system, especially for the CCO delivery system. We share a collective vision around the importance of our roles, our impact, and our fierce resolve to engage in systems that ensure health equity. With that, we look to the future in the implementation of recommendations and improvements.

Next steps

OHPB to receive quarterly updates on all 6 CCO Procurement Recommendations, plus the recommendation for common health equity standards – 2025-2027.

If there is a delay in the procurement process, OHPB to receive updates on how the intervening time period is being used to make progress towards improving outcomes and efforts referenced in recommendations.

OHPB to receive bi-annual updates on application of holistic feedback: **local care, local inclusion, local decision-making control** and financial modeling. If legislative changes are needed, OHPB will collaborate with OHA to pursue progress towards said aims.

OHPB to share, via its public meetings, committee meetings, and through direct contacts, what was heard during this CCO Procurement Feedback effort and how and where it was applied. Communication will be focused on those who contributed feedback during this process, completing the important feedback loop.

The findings and recommendations in this report are unanimously supported by OHPB members:

Kirsten Isaacson, Chair
Antonio (Tony) Germann, Vice-Chair
Dr. Rosemarie Hemmings
Brenda Johnson
William (Bill) Kramer
Melina Moran
Peter Starkey

Introduction

Background

Description of request

On January 2, 2023, Governor Kotek directed OHPB to lead public engagement for the next Coordinated Care Organization (CCO) procurement with an eye toward member experience and access to care, as part of OHPB's 2023 - 2025 priority work (letter from Governor Kotek). At OHPB's October 1, 2024, annual strategic planning retreat, additional guidance on OHPB's role to lead procurement engagement was presented by the Governor's Office and OHA leadership (visit Appendix C: Sources for links to meeting recordings and associated documents).

A key reason the Governor selected OHPB to help inform the procurement process was because of its wide reach across Oregon, which would garner broad and diverse feedback. Over 250 people are involved in OHPB and its various committees, including members, providers, health system representatives and other partners.

Request objectives

The intent of the Governor's Office and OHA leadership ask of OHPB, its committees and the public was to gather input to understand the specific mechanisms, processes, policies and activities driving success in CCOs that could potentially serve as models for statewide replication, thus informing the procurement process.

OHPB was encouraged to consider how best to collaborate with its committees to obtain feedback. OHPB asked each committee to carve out time during a meeting between November 2024 to January 2025 for discussion and testimony. OHPB included a CCO Operational Snapshot Report review and direct discussion with CCOs to consider the CCO's perspectives on their performance. Finally, OHPB was encouraged to consider how to use its own space to solicit input.

The Governor's Office and OHA leadership asked OHPB to provide the procurement feedback received in a way that helps OHA use the information in procurement processes, including addressing the following questions:

- Is there a reasonable standard that could be set to achieve certain outcomes in these categories? What could that look like across all CCOs?
- How would the [OHA] procurement [team] ask CCOs to demonstrate their ability to achieve those outcomes?

This report fulfills the request for OHPB to solicit procurement feedback and send its findings and recommendations to the Governor's Office and OHA leadership.

OHPB's role and timeline

In their October 1, 2025, presentation, the Governor's Office and OHA leadership outlined specifics about OHPB's role and timeline; i.e., OHPB would review CCO performance reports, provide a platform for public testimony, share procurement guidance and recommendations and utilize its committees and public meeting spaces to share procurement updates. Below are the relevant slides on OHPB's role from the October 1 presentation.

The timeline depicted in these slides was pushed by three months due to a delay in the availability of the CCO Operational Snapshot report.

OHPB Role

Phase	Dates	OHPB Role	Activities
PHASE 1: Review Past Program Performance	2024 Q3-Q4	N/A	OHA review of CCO performance Examples: Access to Care, Network Adequacy, and Member Rights
PHASE 2: Develop Program Performance Snapshot	2024 Q4	Leader* Collaborator	OHA will develop a snapshot of CCO level performance and program overall **OHPB review of CCO Operational Snapshot Report**
PHASE 3: Set New Goals & Define Success	2025 Q1-Q2	Leader* Collaborator	OHA will begin designing the procurement by setting new performance goals in identified focus areas. **OHPB will provide insight from Phase 2 learnings** to help inform the goals and be a space for ongoing public discussion, including affirming direction of procurement

* Leader role is specific to activities described

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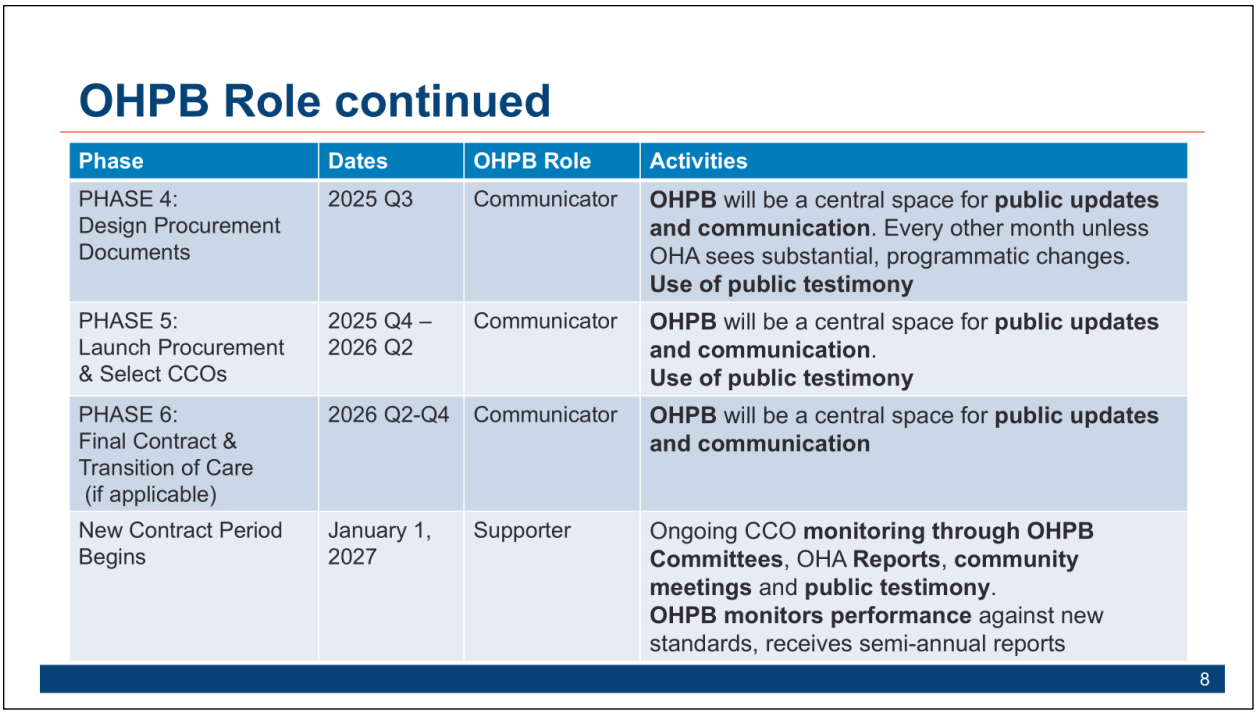

OHPB Role continued

Phase	Dates	OHPB Role	Activities
PHASE 4: Design Procurement Documents	2025 Q3	Communicator	**OHPB** will be a central space for **public updates and communication**. Every other month unless OHA sees substantial, programmatic changes. **Use of public testimony**
PHASE 5: Launch Procurement & Select CCOs	2025 Q4 – 2026 Q2	Communicator	**OHPB** will be a central space for **public updates and communication**. **Use of public testimony**
PHASE 6: Final Contract & Transition of Care (if applicable)	2026 Q2-Q4	Communicator	**OHPB** will be a central space for **public updates and communication**
New Contract Period Begins	January 1, 2027	Supporter	Ongoing CCO **monitoring through OHPB Committees**, OHA **Reports**, **community meetings** and **public testimony**. **OHPB monitors performance** against new standards, receives semi-annual reports

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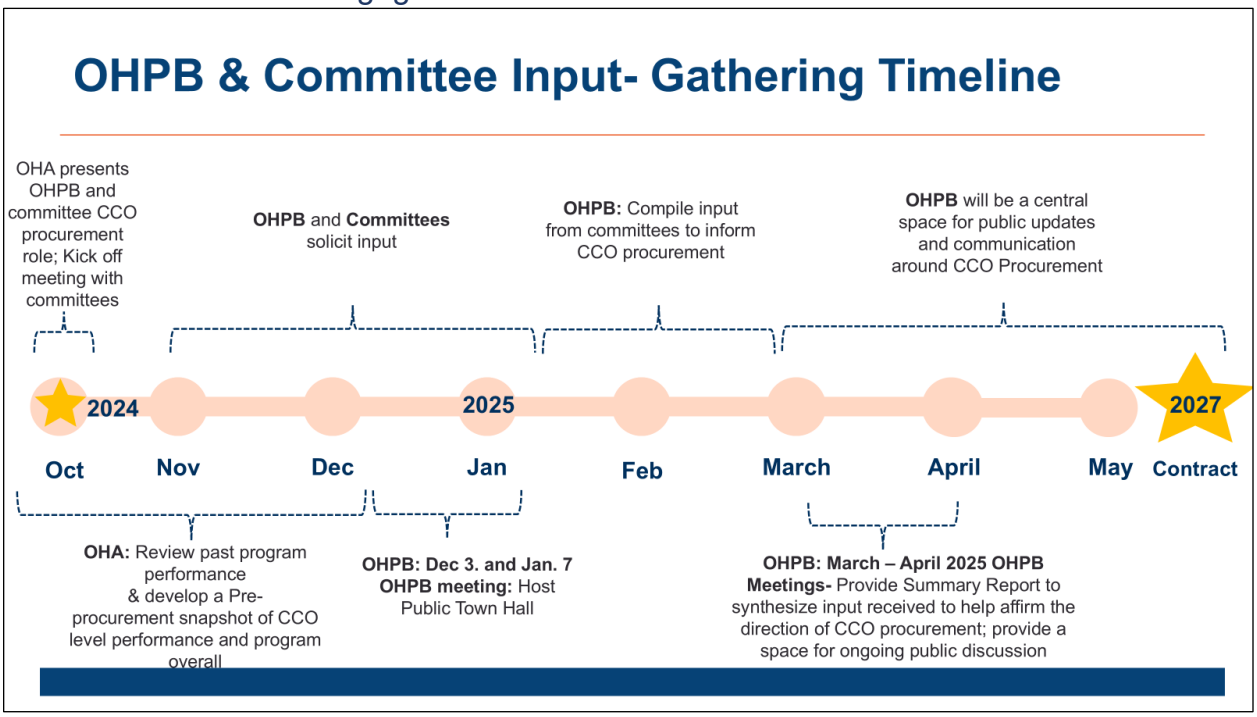
Procurement engagement

OHPB members Kirsten Isaacson, Tony Germann and Brenda Johnson volunteered to serve as the CCO procurement liaisons, helping strategize and guide OHPB's procurement engagement efforts.

On October 29, 2025, OHPB led a CCO procurement kick-off meeting to inform committee leadership and staff of the request from the Governor's Office and OHA leadership to solicit procurement feedback. At this meeting, OHPB procurement liaisons outlined a four-pronged approach for OHPB and its committees over the next several months to solicit procurement feedback from key audiences (more detail provided below). The timeline of the process, and detail on the four-pronged approach, are below.

OHPB and committee engagement timeline



Questions for key audiences

The slides below detail the questions the Governor's Office, OHA leadership and OHPB committees well-suited to support these efforts wanted to hear feedback on.

Questions to ask Committees

Committees to focus on gathering input from committee members or through public testimony, especially from.
OHP members, providers and community partners

Question 1	Intent	Potential Committees?
Where have **you seen successes in CCOs** as it relates to specific policy areas of interest? Examples: Health equity, access to care, children's health **What are the examples of good things, why do you think it's working well, and what can we learn from it?**	Understand not only where there are success stories, but specifically: • WHY they are occurring • HOW did they do it? • Is this scalable to all CCOs? • What would we look for that shows an organization's ability to do this core work successfully? Example: As it pertains to Health Equity: - Where have we seen sustained successes? - How can we replicate those successes to ensure CCOs are prepared to support health equity and address inequities for their members?	Medicaid Advisory Health Equity Oregon Health Policy Board

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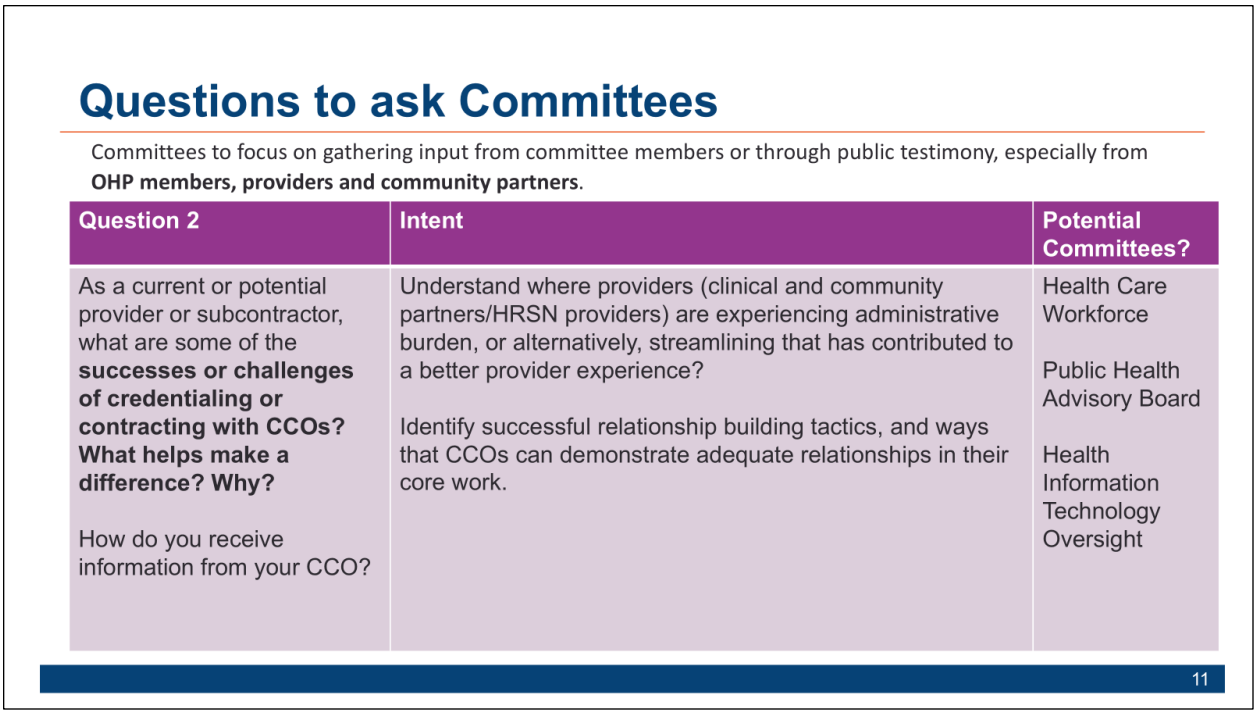

Questions to ask Committees

Committees to focus on gathering input from committee members or through public testimony, especially from **OHP members, providers and community partners**.

Question 2	Intent	Potential Committees?
As a current or potential provider or subcontractor, what are some of the **successes or challenges of credentialing or contracting with CCOs? What helps make a difference? Why?** How do you receive information from your CCO?	Understand where providers (clinical and community partners/HRSN providers) are experiencing administrative burden, or alternatively, streamlining that has contributed to a better provider experience? Identify successful relationship building tactics, and ways that CCOs can demonstrate adequate relationships in their core work.	Health Care Workforce Public Health Advisory Board Health Information Technology Oversight

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Key procurement topics

Three key focus areas for feedback were identified in the initial request of OHPB on October 1, 2024:

1. Supporting the success of children.
2. Convening behavioral health delivery across jurisdictions.
3. Social and environmental drivers of health.

OHPB and its committees welcomed feedback on all CCO procurement topics; in addition, those with experiences related to these priority topics were especially encouraged to share.

Four-pronged approach to OHPB collection of community feedback

OHPB and its committees conducted procurement feedback activities between late October 2024 and February 2025. To meet the request from the Governor's Office and OHA leadership, OHPB adopted a four-pronged engagement approach:

1. Public meetings to collect feedback through member discussions and public testimony.
2. CCO Feedback Town Halls hosted by OHPB on December 3, 2024, and January 7, 2025.
3. Online public survey (in English and Spanish).
4. CCO Listening Session hosted by OHPB on February 21, 2025.

Public meetings

During public meetings of the OHPB committees, seven of the OHPB committees dedicated specific time in their meeting or unique meetings to gather feedback on the

CCO procurement topics. The Medicaid Advisory Committee and the Public Health Advisory Board drafted written recommendations from the committee members. OHA committee staff were provided with a notetaking template to collect and categorize feedback data. The OHA team managing the feedback data reviewed, cleaned and prepared the data that had been entered into the template. They then categorized the data by key topics and themes as identified by the Governor's Office and OHA leadership in the original request and from the OHA procurement team throughout the procurement.

CCO feedback town halls

OHPB hosted two CCO Feedback town halls that were widely publicized through statewide media channels and existing OHPB and committee email distribution lists. Communications about the town halls were distributed in English and Spanish and directed those who were interested in sharing their experiences with CCOs to register online. The registration was also provided in English and Spanish and offered respondents the options to provide live oral testimony during the town hall, written comments, or both. Pre-registration helped OHA staff organize the town hall time and ensure all who wanted to provide oral testimony or written comments would be included. The live virtual (via Zoom) town halls on December 3, 2024, and January 7, 2025, provided closed captions and simultaneous Spanish interpretation to help increase accessibility and participation. Sixty-five people provided oral testimony and 40 people provided written comments for the two town halls. All town hall recording links, including oral comments and written comments, are in Appendix C.

Online public survey

OHPB offered an online survey in English and Spanish for those who wanted to share their experiences with CCOs to OHPB but could not participate in the town halls or attend an OHPB committee meeting. The surveys were hosted on OHPB's website from December 2024 to February 2025, distributed statewide through email distribution listservs managed by OHPB and OHA, shared through OHPB Committee networks and listservs, and announced during OHPB and Committee public meetings with links to both the English and Spanish surveys. The survey questions are in Appendix D. A total of 75 individuals completed the online survey.

CCO listening session

While the procurement feedback request did not include feedback solicitation from CCOs, OHPB felt it was important to hear CCO feedback as part of its process. On February 21, 2025, OHPB hosted a listening session for CCOs to provide oral and written testimony. All sixteen Oregon CCOs were invited. OHA staff emailed information and calendar invites to CCO leadership directly and through OHA's CCO Innovator Agents. All sixteen CCOs participated in the listening session and provided oral testimony. Each CCO was allocated a set amount of time to ensure equal distribution of time. A recording of the listening session and written materials from CCOs are in Appendix C.

About this report

Respondents and feedback sources

As described in the background section of this report, OHPB solicited oral and written feedback from OHP members, caregivers, providers, community partners, community-based organizations and OHPB committee members on their experiences providing, accessing and/or receiving health care from CCOs. Written and oral feedback was provided by 158 respondents during two OHPB Town halls, through a publicly available online survey, and from several public meetings of OHPB committees. Details about the respondents can be found in Appendix A.

The population sample used in the analysis of this report is not representative of the entire population of people who have interest in or are impacted by OHP or CCOs. Findings from this report only represent the voices of people who knew about the sessions and had the time and interest to provide feedback. Respondents self-identified as OHP members or caregivers of OHP members, providers, community partners, CCO representatives, or members of OHPB committees. The February 21, 2025, CCO listening session was not included in the analysis; however, CCO representatives did provide feedback through committees, and those comments have been included in the analysis. In addition, OHPB considered all feedback, including from the CCO listening session and other sources, when developing the recommendations in this report.

Analysis and reporting

Feedback and some information about the person providing the feedback, such as whether they were a service provider or an OHP member, was collected from written testimony and transcripts of oral testimony. Feedback from respondents was organized into general categories and, if appropriate, separated into distinct ideas. Within these categories, pieces of feedback were grouped by common issues or themes, which represent problems, successes, gaps and needs across people's experiences with health care, OHP and CCOs. This report analyzes the connections and relationships between these themes and groups themes with similar impacts, problems, successes and requests into "observations." Some issues raised in observations were further separated to accurately represent the voice or perspective; for instance, in some instances there are separate sections for member and provider perspectives within the same observation.

Within the sections, attention is called to issues that may have an impact on health equity. Health equity issues are identified based on OHA's definition of health equity. (1) Feedback that references impacts on health equity are highlighted in the "Equity Impacts" part of that section.

Quotes are included throughout the report to illustrate lived experience related to a particular topic. There are several considerations for quotes included in this report:

- If quotes referenced a specific person, provider, CCO or organization, the team anonymized the reference (e.g., using [CCO] instead of the CCO name). All other parts of quotes are preserved verbatim as shared with OHPB.
- Quotes are attributed to the voice that shared the feedback with OHPB. These "voice categories" are based on how respondents identified themselves in the survey or when registering to provide oral or written testimony. The following list represents different voice categories of respondents whose quotes are referenced in this report:
    - OHP member, parent, guardian or caregiver
    - Provider (CBO, Medicaid, mental health, or unspecified)
    - Community partner (referred to throughout this report as "community-based partner")
    - Survey respondent (voice unspecified)
- Some respondents self-identified their voice (e.g., oral health provider, parent, etc.) when providing feedback. In those cases, their quotes are attributed to their self-identified voice.

Observations overview

Similar or related themes identified in the feedback were organized into six sections or "observations" which highlight the relationships between themes that emerged in the feedback. The following table presents each observation and a brief description of the themes that it includes.

Observation	Description
Members receive better care when CCOs partner with communities.	Partnerships with local organizations and agencies create opportunities for regional alignment and innovation in meeting community needs. Contracts and partnerships with local and community-based organizations expand access to care, including culturally and linguistically appropriate services.
Unclear, complicated or inefficient requirements increase administrative burden and delay or limit care.	Providers expressed frustration and confusion around administrative requirements and processes. Respondents also shared complicated or inefficient billing and contracting processes. These requirements and tasks often delay or limit their ability to provide care to members and to receive payment for that care. These challenges were greater when more than one CCO served the same region or when providers worked with more than one CCO.

Observation	Description
Reimbursement rates and payment models affect quality and availability of services.	Providers said they struggle with low reimbursement rates and noted that payment models and mechanisms can increase administrative and financial costs of providing care, disincentivize appropriate or cost-effective care, and negatively impact the workforce.
Gaps in service and provider availability make it difficult for members to access care.	OHP members find it hard to access physical and behavioral health services, especially in rural areas of Oregon. When members do find care, they often experience long wait times, long drive times, or providers who are out-of-network or who don't accept OHP. Providers struggle to retain staff and maintain facilities to meet patient needs and are also frustrated by long wait times when they refer patients to specialists.
Gaps in care coordination and case management impact members requiring complex care.	Respondents shared examples and stories of how care coordination and case management are not happening for people who need it the most, and when these services are available, they do not meet members' needs.
Members struggle when services do not meet their needs.	Members struggle when services that should be available either aren't available or don't meet their needs. When members don't receive appropriate care, they are unsure about what they can or should do. Members report feeling like they don't have autonomy over their care and services they receive.

In addition to the six observations described in the table above, seven other areas of interest emerged from the feedback received from respondents (with the first three aligning with the Governor's priorities for the next CCO procurement): behavioral health, children's health, social determinants of health, oral health, Traditional Health Workers and peer support, rural areas and network adequacy.

Observation 1: Members receive better care when CCOs partner with communities

Partnerships with community-based organizations and local agencies create opportunities for regional alignment and innovation in meeting community needs. Contracts and partnerships with local and community-based organizations (CBOs) expand access to health care and services and increase the network of providers for community specific services, including culturally and linguistically specific/appropriate services (CLSS/CLAS). Respondents shared successes around addressing social determinants of health, particularly food access, and providing preventative services.

> "Since 2018, [our regional CCO] has supported two different programs at Food for Lane County, our local regional food bank, to help increase access to fresh produce in our community. These programs are the Veggie Rx program and the [CCO] Produce Plus program. The Veggie Rx program works with pregnant mothers who enroll in the Start Smart for Your Baby program. They receive CSA boxes with fresh produce from our youth farm delivered directly to them. This is huge because increasing general access to healthy foods and eliminating transportation barriers is really important. The other program, […] Produce Plus, provides free access to fresh, organic fruits and vegetables, generally at health clinics. There are 13 different locations across the county, serving between 4,000 and 5,000 people each month. These programs ultimately help get an extra 20,000 to sometimes 30,000 pounds of organic produce out into the community. The influence has been really amazing and great to see."
>
> - Community-based partner

Respondents reported that local partnerships and decision-making helped CCOs better serve members in their communities, avoid duplicating work that community partners are already engaging in and provide relevant care to their communities.

In some examples, CCOs actively participated in regional meetings, funded local initiatives and developed relationships in the community. CCOs provided grants for programs providing perinatal care coordination and for promoting child immunizations. Multiple providers noted relationships between CCOs and Traditional Health Workers (THWs) as improving community access to care.

> "CCOs have been key partners in expanding the [Traditional Health Worker] workforce in [our] County. They have accomplished this through several methods: Funding and contracting directly with [community-based organizations], THWs, and [local public health authorities] to expand THW capacity in the region; Intentional efforts to engage community partners in conversations that directly impact funding (e.g., HRSN benefits, 1115 waiver, [community health improvement plan]), Recognition that THWs are an essential workforce to

> advance [culturally and linguistically appropriate services] and address [social determinants of health and equity] for OHP members."
>
> - Community-based partner

CCOs funded trainings for CBO staff to become community health workers or certified as THWs. CCOs have worked with communities to reduce emergency room visits by improving access to preventative services, including establishing a primary care home for Tribal patients. CCOs also funded programs addressing community-level issues, such as free trash services in low-income communities.

Most feedback related to partnerships between local organizations and CCOs was positive; however, some feedback highlighted gaps in coordination, communication or both between CCOs and local organizations and providers. Members, providers and local partners want to see clear expectations for CCOs in partnering with local organizations and communities and to report out to communities. Community partners and providers want more investment in local communities to address children's health, behavioral health, transportation and social determinants of health.

> "OHA must clarify that, while there are statewide priorities and requirements around health care transformation, CCOs should also adapt their work in each community to align with local partners and priorities. There are robust networks of partners who have deep relationships in each community and understand local context and needs, and CCOs should align with these existing networks so we don't have duplicate work and can strengthen their support of local priorities."
>
> -Community-based partner

Equity impacts

There are health equity impacts when CCOs partner with local organizations and communities. Partnerships between CCOs and local community organizations can expand the network of providers in rural areas and with CLSS/CLAS. Many community-based organizations supporting these communities said funding from CCOs, relationships with CCO staff, health care navigation assistance and administrative support are beneficial to their work and allow them to better serve the communities they work with. Many of these organizations have existing relationships with the communities they serve and can have insight into community specific needs. Partners and providers would like CCOs to center equity when CCOs distribute funds to organizations.

> "We believe that commitment [to health equity] requires Oregon Health Authority support CCOs that are embedded within the regions where they make care available. As you all know, equity is not about deploying an equal amount of resource to each person; it is about meeting people where they are and addressing the unique conditions they face. For southern Oregon, that means recognizing the rural, dispersed, and economically diverse nature of our

communities. A blanket approach to healthcare provision does not meet the needs of our residents. . . Moreover, we must acknowledge that truly lifting all boats may require allocating resources in a manner that may not be equal and may not even seem efficient at first glance but rather is equitable. It means ensuring that those who face the greatest challenges are supported in ways that account for their unique needs. In our region, where access to healthcare is often more limited and where health disparities are more pronounced, it is essential that we invest in organizations that know the community, understand its challenges, and are committed to overcoming them."

-Community-based partner

Observation 2: Unclear, complicated or inefficient requirements increase administrative burden and delay or limit care

Providers expressed frustration and confusion around administrative requirements and processes that often delay or limit their ability to provide care to members and to receive payment for care provided. Specific processes identified by respondents as burdensome included credentialing, referrals and prior authorizations, and billing.

A CCO representative also acknowledged the need to decrease administrative burden for providers and standardize and streamline processes.

> "I know, for us at the CCO... any way that we can work towards improving that and really standardizing and streamlining processes as much as possible to decrease that administrative burden, I think, is important and decreasing duplication."
>
> - CCO representative

Some of the challenges described were greater when more than one CCO served the same region or when providers worked with more than one CCO. One respondent put it this way:

> "when there are multiple CCO's in one county the administrative burden that comes to both the county and any other agency that contracts with a CCO, is very high and burdensome. Separate entities with very different views and processes. I believe that these are duplicative in nature, with the end result wasting time, money and human resources. Any cost savings made by a reduction in these efforts could then be put back into the actual delivery, support and creation of the already mandated covered services."
>
> - Community-based partner

Credentialing

Definition
Each CCO coordinates care for specific OHP members in their region. Providers must apply to a CCO before they can provide care to OHP members who are part of that CCO. **Credentialing** is a part of this application process.

Medical, behavioral health, oral health and alternative care providers shared challenges with the credentialing process. Challenges reported by providers included a lack of clear instructions from CCOs on how to complete credentialing processes, inconsistent

requirements across CCOs, and long wait times for credentialing applications to be approved. These issues cause delays in patient care and reimbursement for care.

> "Each CCO has it's own credentialing process and requirements making it time consuming especially when you are trying to credential multiple providers."
>
> - Provider (mental health)

Referrals and prior authorization

Definition

Providers must submit requests and wait for approval from CCOs before referring a member to some specialists and for certain treatments, medications and procedures. This is called the **prior authorization** process.

Inconsistent coverage, different processes, delays in approving authorization requests and administrative requirements limit or delay care for members. Some providers shared that it takes additional time to submit requests and obtain approvals because CCOs have different interpretations of prior authorization and referral requirements.

One provider noted that coverage of some services also differs between CCOs, such as number of visits allowed, creating confusion and additional administrative burden for providers to verify coverage.

> "As someone who verifies coverage for patients, none of the provider portals give accumulators online for physical health benefits (how many visits are used for a calendar year) so we are calling again and again to check that status as to not end up with an unpaid visit that we are not legally allowed to bill the patient for. Although OHP Open Card's portal is outdated, we know what to expect as far as coverage, submission and no authorization."
>
> - Provider

A community partner shared they do not have staffing capacity to complete prior authorization forms, resulting in members paying out of pocket for prescriptions.

> "This is problematic because we receive prior authorization forms from OHP that we don't have the manpower to fill out, so patients are stuck paying for prescriptions out of pocket. There needs to be a system change because prior authorizations are so time consuming."
>
> - Community-based partner

Providers highlighted standardizing referral and prior authorization requirements or eliminating these processes as potential solutions for alleviating administrative burden.

> "I and the many folks in my clinic do this work because we believe in access to care. I like the CCO model because it feels personal and accessible, and I also believe that a little bit more standardization of authorization requirements & processes would benefit all parties involved. The administrative load would be lessened, our practitioners can continue to provide excellent care while also knowing that they will be compensated for their hard work, and most importantly, our patients can continue to receive accessible, excellent healthcare."
>
> - Provider (Medicaid)

> "I highly recommend that OHA explicitly do away with the archaic and unnecessary gatekeeping of referrals. And authorizations for care. They only serve to negatively impact patients delay essential care and create more work and cost on all sides."
>
> - Provider (Medicaid)

Billing

Two providers reported challenges with confusing or inefficient billing processes, noting inconsistent guidelines and the need to appeal and rebill to receive reimbursement.

> "Dental coverage decisions often rely on limited and inconsistent guidelines, and the lack of diagnostic codes for dental conditions complicates the process of determining medically necessary care. What is OHA's plan and timeline for developing additional guideline notes to address this gap? Will this process involve the Oral Health Advisory Panel (OHAP) or a separate workgroup?"
>
> - Oral health care provider

> "Probably the biggest concern is that when we submit claims for services rendered, we are forced to rebill and then appeal and then rebill again to receive payment. The prevailing Medicaid rates are not respected and the process to receive payments feels disrespectful when they pay at a lower rate than they should. A year ago, MODA was paying $100.00 a day for women's residential care, rather than the published rates."
>
> - Provider (Medicaid)

Observation 3: Reimbursement rates and payment models affect the quality and availability of services

Providers stated that low reimbursement rates impact their clinics and practices—from hiring, retention and facility maintenance to available services and appointments for OHP members. Payment models and mechanisms can increase administrative and financial costs of providing care, disincentivize appropriate or cost-effective care, and negatively impact the workforce.

Reimbursement rates

Definition

Providers care for patients and then bill the CCO or fee-for-service (FFS) afterwards to receive payment for the services they provided. The **reimbursement rate** is the amount the CCO or FFS will pay the provider for a specific service and are determined in advance.

Oral health, behavioral health and children's health providers as well as a community partner described challenges in delivering care and services when reimbursement rates are low. Providers reported hesitation to accept OHP, because low reimbursement rates make it difficult to provide care and sustain their practices. Providers may even drop OHP clients to prioritize patients with higher reimbursement rates.

> "Another critical concern is the ongoing issue of low reimbursement rates, which have made it increasingly difficult for dental providers to accept OHP members and maintain a sustainable practice. Oral diseases are largely preventable, yet the current medical model does not prioritize preventive care, resulting in deferred treatments and emergency visits that increase costs and strain the provider network."
>
> –Provider (dental)

Providers noted that reimbursement rates are not increasing with the increasing costs of providing care. In addition, health plans sometimes pay less than the established reimbursement rates. Providers may need to rebill or appeal to receive the full reimbursement rate, increasing costs and administrative burden.

Low reimbursement rates impact the ability to attract new providers, particularly for smaller practices. One provider said their practice could not afford to hire new behavioral health specialists due to low reimbursement rates. Another provider described how this also impacts oral health care:

> "The financial challenges posed by inadequate reimbursement are compounded by workforce shortages, which have been exacerbated by the COVID-19 pandemic. The increase in Medicaid coverage, combined with rising operational costs and declining reimbursement, has created a perfect storm that stresses an already fragile dental workforce."
>
> –Provider (dental)

Providers stated that low reimbursement rates can make it difficult to cover some services. For example, payment rates for immunizations and infectious disease care coordination do not cover providers' costs. The resulting gaps in services are sometimes filled by public health and community-based organizations working outside the Medicaid system and lacking the same access to funding and coordination for both providers and patients.

> "The payment rate for vaccine administration does not cover our costs."
>
> –Provider

Performance measures

Definition
Performance measures, including incentive metrics, set goals to improve the health of a group of patients. CCOs or providers can sometimes receive a financial reward or other incentives for meeting those goals.

Performance measures can increase the burden on providers. For example, providers shared that performance measures add administrative costs that are not covered by payments for services delivered to patients. One provider noted that the financial bonuses for meeting performance measures are unpredictable. Unpredictable funding and reward payments do not align with financial needs for providing care and, according to providers, can impact compensation and retention. One provider explained the impact of unpredictable financial incentives combined with low reimbursement rates:

> "One of the greatest difficulties with CCOs is reimbursement. Reimbursement is not increased proportionately to our increased expenses. Meeting measures requires additional staff, plus the cost of supplies, benefits, and wages has gone up significantly. While 'bonus' money from meeting measures is certainly helpful, it is impossible to budget for it, since we have no idea how much money the CCO will distribute. Also, receiving such a large percentage of pay in one lump sum means my physicians do not earn enough money to pay their personal bills during the first half of each year. This significantly impacts recruiting and retention.; OHA is requiring things of CCOs that are negatively impacting efforts to have a sufficient supply of providers, especially in rural areas."

–Provider (Medicaid)

Rewards may also not be as accessible to some providers. CCOs and providers in rural areas can have a more difficult time reaching incentive metrics. For example, small patient populations make it hard to provide care at scale. As another example, smaller practices have fewer staff, so the loss of one provider has an outsized impact.

One suggestion was to make information about CCO performance more easily available to members and communities.

Payment models

Definition
A **payment model** is a standardized approach to paying providers for the health care services they deliver to patients.

Note: In the feedback that OHPB received, respondents used various terms to describe payment models and mechanisms. Some respondents referred to specific payment models and mechanisms like fee-for-service (FFS), rate setting, capitation payments, Per Member Per Month (PMPM) payments, risk withholds and global budgets. At other times, respondents used terms broadly or interchangeably, such as business model, medical model, payment model and funding mechanism.

CCO payment models and mechanisms that are not tailored to local needs can have consequences for providers and members. For providers, payment models have a direct impact on the financial viability of their practices and ability to meet patient needs. For members, a mismatch can result in fewer providers to choose from due to strain on the provider network. Suggestions from respondents included requiring CCOs to adjust payment approaches to support local needs. For example, when there are more children in the regional population, CCOs should incentivize providers to see more pediatric patients. However, respondents noted that they receive lower payments when providing care to children even though administrative, staffing, facilities and other costs are the same as providing care to adults. This can impact the quality of care, referrals and willingness to have a high percentage of children in a clinic's patient population.

> "[The CCO's] contracting model underpays primary care providers for medical services. Per member per month payments for care delivered for children are lower than care for adults (by as much as 2/3 lower). The capitation model that [the CCO] forces on medical providers does not recognize that children - particularly those with chronic conditions and special healthcare needs often use 'acute or chronic care' services with their [primary care provider] (billed as

> ‘evaluation and management’ codes) to a greater extent than adults (who are generally referred to other specialists or behavioral health providers.”
>
> —Provider (Medicaid)

Other providers also reported that payment models have an impact on the quality and appropriateness of care. One concern was that payment models can incentivize fragmentation of care rather than care coordination or can encourage referrals to less qualified or more expensive care, including for children’s health, behavioral health and acute health issues (i.e., emergency care).

Providers shared concerns about specific payment mechanisms. One respondent said that rate setting based on previous utilization disincentivizes expansion and delivery of child health care and was concerned that risk withholds reduce payments for child immunizations. Another respondent said capitation payment models place too much burden on providers and create incentives to avoid costly patients. A provider described several impacts of their regional CCO’s payment model:

> “[The CCO’s] payment approach DOES prioritize preventive care, but due to the ‘capitation’ of all [emergency medicine] and telehealth visit codes (and the underpayment for the monthly PMPM for most children), they have created a problem for access to primary care for the children in [our region] who are covered by Medicaid. The payment/contracting policies create strong incentives to refer children for [Attention Deficit Hyperactivity Disorder] management to less qualified mental health [nurse practitioners], to refer more patients to specialist care though their problems should be manageable in a Primary Care Medical Home - particularly if there is access to Pediatric trained clinicians. There is also a strong disincentive to managing acute illnesses either with telemedicine (many parental concerns don't need an office visit) or an in-person visit with the [primary care physician]. The result is increased acute visit to [emergency departments] or urgent cares as a direct result of [the CCO’s] contracting approach.”
>
> –Provider (Medicaid)

Depending on how it is implemented, the PMPM payment model can help underfunded organizations offer essential health services or make it difficult for providers to offer care. In one example, a local partner said existing funding sources, like fee-for-service (FFS) and grants, were not enough to effectively provide case management for patients with infectious disease. So, they contracted with the regional CCO and used the PMPM model to successfully fund case management for these patients. Respondents also commented on the reporting burden associated with some payment models.

> “The CCO provides support for behavioral health (BH) and social determinants of health (SDoH) through per-member-per-month (PMPM) payments based on services provided and limited grant funding, e.g. for language access and BH

> projects on early childhood. The PMPM payments are, however, counterbalanced by burdensome reporting requirements and artificial 'engagement' thresholds that lead to box-checking rather than truly better care."
>
> –Survey respondent

Respondents shared suggestions related to global budgets. One respondent suggested providing global budgets specifically for children's health, so pediatric care is not in competition with adult care. The commenter also suggested requiring more transparent reporting on how global budgets are spent.

Equity impacts

Providers and community-based partners commented on how reimbursement rates and payment models can impact health equity, especially network adequacy for populations experiencing contemporary or historical injustices. Specific concerns were related to the workforce, Traditional Health Workers (THWs), behavioral health and rural areas.

Respondents asked for more transparency and parity around funding, contracting and reimbursement rates for providers and organizations serving communities with the greatest health disparities. Respondents noted that providers of color and organizations serving people of color may not be reimbursed at the same rates.

Respondents commented THWs are paid at low rates while also being the most diverse and representative of the communities they serve. In addition, funding for THWs is inconsistent.

> "It is imperative for CCOs to continue to invest and support the Traditional Health Worker workforce given important role they play in hard-to-reach communities that have been historically neglected and traumatized by our health and governmental systems. Through these key partnerships with Traditional Health Workers, systems such as CCOs and LPHAs, are able to reconnect with communities and support efforts that advance health equity and justice. It is also essential for the OHA to identify sustainable funding sources and support for this vital workforce through improved billing mechanisms, expanded low-cost training opportunities, support for continuing education, and basic infrastructure to support THWs."
>
> –Community-based partner

Respondents wanted to see more sustainable funding models and billing methods established for specific providers, like THWs and those providing culturally and linguistically specific/appropriate services (CLSS/CLAS). Suggested solutions included increasing payments for services, improving billing processes, and investing in infrastructure, like training, education and other supports.

Currently, access to behavioral health care does not meet the needs of Oregon communities, and people experiencing historical and contemporary injustices have more difficulty finding appropriate and timely care. Suggested solutions included allowing wraparound payments for behavioral health services and investing in the workforce.

Low reimbursement rates and administrative requirements attached to some payment models also have an outsized impact on rural providers who often operate smaller practices. Providers stated that these issues contribute to difficulties compensating, attracting and retaining providers in rural areas.

Observation 4: Gaps in service and provider availability make it difficult for members to access care

Network adequacy and access to care

Definition

Network adequacy means making sure people have access to health care providers and care is available where and when the patient needs it. Gaps in network adequacy indicate people cannot find or receive care when and where they need it. Importantly, it is a federal requirement that CCOs maintain a network of appropriate health care providers to ensure all covered services are available and accessible to members in a timely manner.

Accessing and providing health care services throughout Oregon, particularly in rural areas, emerged as a critical challenge for the full range of respondents. OHP members, parents, guardians and caregivers described their experiences with gaps in the availability of providers and services. Providers and community partners highlighted their struggles in meeting patient needs. Responses indicate that gaps in services disproportionately affect groups that have been economically and socially marginalized, including those requiring language assistance, those with complex health needs and those living in rural areas.

Member perspective: Gaps in service and provider availability

People trying to access care for themselves or an OHP member shared that it is hard to access physical and behavioral health services, especially in rural areas of Oregon. When they do find care, they often encounter other barriers like long wait times, long drive times, or providers who are out-of-network or who don't accept OHP.

Multiple respondents described experiencing long delays in accessing necessary health services, including primary and specialized care like behavioral or oral health care, with some people waiting months and even years to get appointments with providers. As a result, respondents reported struggling to get diagnoses, appropriate treatment and support services. For example, one parent shared that it took two years and multiple providers for their child with autism to get diagnosed and begin receiving supportive services. In another case a community partner shared that a youth passed away because they did not receive treatment for Type 1 diabetes. A member with complex medical needs reported that they use the emergency room regularly for their care because they cannot find a primary care physician in the state who will help them:

> "I also have been unable to find a primary care in the 10 years that I've been here. Not a single primary care physician will take my case because of the

> complexity. I had to get special permissions from the state of Washington and Oregon to keep a primary care in Washington that I had. And my care is all over the state and unfortunately parts of the country. It makes it extremely difficult to try to get any kind of coordination and so my care exists in a vacuum and I'm not the only one. There are other patients like me."
>
> – OHP member

Respondents described delays in accessing health-related social needs services post-discharge, like using flex funds to secure accommodations for people experiencing homelessness. This means members may not have access to a clean environment, bed and bathroom to support healing after they leave the hospital. In one case a CCO informed a community partner it would take up to 10 days for a decision:

> RE flex funds for hotel rooms for people leaving the hospital… they can't just go back to sleeping in the streets or a tent when they have a broken leg or hip or whatever the case may be. They have to have a clean environment with a bed and restroom. Our members when discharged from the hospital can't go back to being homeless… One member was on [OHP through a CCO]. They told me it would take up to 10 days for a decision on a room.
>
> –Community-based partner

Other members reported they could not access care timely enough or at all, because providers would not accept OHP:

> "There is only one point that I want to bring up as an opportunity for improvement. The super specialists such as Dermatology, Mental Health are really difficult to get into. We needed a term appointment for a funky rash. We can get into [provider] in February, making the appointment in August of Previous year. When we tried to find another provider, we failed completely. no one is taking OHP. We finally landed in a new practice with a [physician's assistant] but not until December (this is making appointment in August)."
>
> - OHP member, parent, guardian or caregiver

Members in rural regions may need to travel long distances to receive care, sometimes spending hours traveling to access appropriate services. This is true for people in a rural coastal area who lost access to the county's sole dialysis provider when the clinic closed with only 30 days' notice. Now, patients needing dialysis must travel to neighboring counties for critical care. For others, the availability of care does not guarantee it will be in a manner that meets their needs. Multiple types of respondents, including OHP members and community partners, reported a significant lack of CLSS/CLAS available to OHP members, limiting their access to appropriate care.

Provider perspective: Gaps in service and provider availability

The perspectives of providers and community-based partners reinforce the challenges shared by OHP members, parents, guardians and caregivers when it comes to the lack of available providers and services. Respondents described network adequacy issues in bigger cities, smaller cities and towns, and rural and coastal areas. One community-based partner said:

> "…when OHA talks about Universal Healthcare, they are really talking about Universal Health Insurance, as there are not enough Providers taking OHP patients."
>
> –Community-based partner

Another community-based partner said:

> "We work closely with [CCO]/[county], to do soft handoffs to the resources that OHP and Healthier Oregon patients qualify for with their benefits. One of the barriers is that there are not enough Providers for the number of insured individuals."
>
> –Community-based partner

Providers highlighted network adequacy issues across multiple service types—including primary care, mental health care, oral health care, physical therapy and pharmacy benefits—which suggests gaps in services and providers may be wide-ranging and not limited to a specific form of care. As a result, people may go without care, use costly temporary fixes (e.g., the emergency room), or wait for long periods of time to get the care they need.

> "It just seems like the CCO's idea of how every many doctors or alternative sorts of service providers they need is not matching up with service levels. Even to get to just a [primary care provider], most people are waiting for months to get in. It seems like there are a lot of issues with CCOs and I personally, either as a consumer or a provider, have not had very many successes with them at all…"
>
> – Provider

In addition to a lack of available care providers, network adequacy challenges shared by respondents also pointed to lack of facilities and resulting gaps in care. For example, a behavioral health provider commented on the need for additional long-term residential facilities for individuals to receive SUD treatment.

> "…definitely inadequate access to long-term residential facilities for people with substance use disorder. I think, currently, there's only 41, 47, maybe facilities in Oregon and that's a huge barrier. So, people leave, go to detox for two to five

> days, and then where do they go? Right, so putting them back into their environment where they came from isn't always successful, especially when they're wanting long term care."
>
> – Provider (mental health)

Another provider expressed concern around the lack of network adequacy and the impacts on children's behavioral health and children's oral health, particularly in rural areas. This provider called for these network adequacy gaps to be addressed in CCO contracts.

> "There is not enough network adequacy within CCOs for children's behavioral and dental health needs, which is the backbone of a contractual agreement to get a global budget. Through the system-level social-emotional health metric, we have CCO-reported data that starkly illuminates the lack of adequate behavioral services available for CCO-insured children. From the oral health metric, we have seen significant gaps in dental network adequacy for CCO-insured children, particularly in rural regions of the state. Reconciliation is needed for how the global budget is provided for fidelity behavioral and dental services."
>
> – Provider

A SUD provider called attention to the accessibility of pharmacy benefits as well as how, when one pharmacy closes, some members are transferred to another pharmacy that does not accept OHP, causing gaps in timely access to medications.

> "Having an assigned CCO that does not have pharmacy benefits at the dwindling available pharmacies. As pharmacy chains close patients are transferred to other pharmacies that may or may not take their type of OHP. This can cause a delay in care, return to use and patients risk withdrawal, overdose or even death. Every person deserves high quality care."
>
> – Provider (SUD)

Network adequacy and access issues also extend to nonmedical benefits that help people stay healthy, like housing, and services that help people access care, like transportation:

> "Housing supports and transportation services are desperately needed."
>
> – Provider (mental health)

> "[CCO] has only one provider in each county as the entire 'network' for the new housing benefits available under the state 1115 waiver…if a provider is unable to meet state requirements, we have no network in that area. This is currently the case in [our rural, coastal county]."

– County Commissioner and member of [CCO] Board of Directors

In addition to reinforcing the impact of gaps in services and providers on members, providers offered several reasons why they struggle to meet patient needs. Specifically, providers shared that they find it challenging to hire and retain staff, maintain facilities, accommodate the number of patients needing care, and are frustrated by long wait times when they refer patients to specialists. Some providers reported not having enough staff or facility space to help the amount of people who need care in their area. Others reported struggling to find caregiving services for members in rural areas.

> "And then lastly, trying to access caregiving needs for our dual eligible patients can be really difficult rurally."
>
> – Provider (Medicaid)

Network adequacy in rural areas

Respondents pointed to lack of access to health care in rural settings as especially problematic with people experiencing fewer or no choices for general or specialty care and long wait times. Additionally, rural areas may have fewer providers to begin with, which amplifies the impact of workforce shortages, facility closures and provider losses.

> "If you try to refer them for counseling services or any kind of psychiatric co management, the wait times are really, really, long, incredibly long for them to get in…And we're also having trouble with physical therapy access. And at least on the south coast, almost all the physical therapy offices currently will not accept our local CCOs payments, and so people can we're trying to manage their pain as best we can, but sometimes they might have a three to six month wait before they can even get into physical therapy for something that they really need. And then lastly, trying to access caregiving needs for our dual eligible patients can be really difficult rurally."
>
> – Provider (Medicaid)

> "Access to oral healthcare remains insufficient, particularly for low-income, rural, and underserved populations. The state's oral health delivery system continues to rely on a fragile workforce, greater disease acuity, and low utilization of services further exacerbates the problem. Those who seek care need more treatment than prevention."
>
> – Provider

Network adequacy problems for behavioral health services result in more use of costly emergency care.

> "…being in [coastal town], the biggest challenge is being in a rural area that does not have a lot of behavioral health resources and having patients coming to our emergency department who need a higher level of mental health care."
>
> – Provider

Respondents said that low reimbursement rates and lack of affordable housing prevent practices from attracting providers in regions where there are shortages, particularly for behavioral health services and in rural areas.

> "In addition, it is very difficult to attract new providers to the coast given the shortage of housing, at any price, for newcomers. Our hospital and other providers tell us about potential employees who accept a job offer only to turn it down a few weeks later when they cannot find housing. This is, unfortunately, not an isolated situation. These absences and unfilled vacancies create huge gaps in care for our members that are hard to overcome"
>
> –Community-based partner

Additionally, small practices may struggle to compete with clinics and health care systems offering higher salaries and incentives, especially for behavioral health providers.

> "Because [behavioral health] providers (especially ones with experience in primary care settings) are so hard to find, their salaries are climbing and outpacing our ability to afford them (the same can be said for physicians and non-physician primary care providers -- due to demand -- salaries have skyrocketed yet our reimbursement is stagnant). This will kill independent primary care offices like us. We will not be able to compete with the sign on bonuses and loan repayment offers that hospital-based clinics or FQHCs can afford to offer."
>
> –Provider (Medicaid)

Equity impacts

Gaps in services and provider availability disproportionately affect communities who are most impacted by health inequities. Members who require language access, members in rural areas, and members with disabilities or complex care needs have fewer providers to meet their specific needs.

> "…there's only one culturally specific residential facility. At this facility, they speak Spanish. There's Latinos working there, and it makes people feel comfortable. But with that, it's only for men, and so I think we need to see an increase for culturally specific care, because, I mean, I could speak for my ethnicity. There is a huge cultural component to substance use and huge barriers, and that are different than other ethnicities."
>
> – Provider (mental health)

Providers and members stated that those gaps are greater when care involves behavioral health and children's health services. Members and providers reported that these members may choose not to receive the care, or they experience long wait times if they do find an appropriate provider.

Suggestions from respondents

Respondents shared suggestions for improvement across two key areas: 1) Strengthening network adequacy and access to care and 2) Increase access to culturally and linguistically specific/appropriate services (CLSS/CLAS).

Strengthening network adequacy and access to care

Participant ideas for improving network adequacy and access to care revolved around finding and addressing root causes for long wait times and why some providers will not accept OHP. Improving funding was a common recommendation, such as providing funding for behavioral health and oral health care providers, particularly in underserved areas; improving compensation, training, and manageable caseloads for providers; and investing in Traditional Health Workers through sustainable funding, improved billing processes, low-cost training and continuing education, and infrastructure.

Additional ideas included increasing educational opportunities for providers supporting people with disabilities or people with substance use disorders (SUD) (i.e., prescribing medications for SUD) and offering things like travel vouchers and telehealth to help people access services they might not otherwise be able to reach. Some ideas involved collecting data to better understand and respond to issues with SUD care. Examples included identifying how many CCO providers and facilities treat substance use disorders and what treatments they provide, such as prescribing medications for opioid use disorder, intensive outpatient programs, and partial hospitalization.

Increasing access to culturally and linguistically appropriate care

Participant ideas for increasing access to CLSS/CLAS are related to improving network adequacy. This includes supporting and increasing the number of culturally and linguistically specific providers across Oregon communities, particularly in rural areas, and increasing interpretation and translation services beyond English and Spanish. To achieve this, respondents recommended specific actions to pursue with CCOs, like supporting CCOs in developing contracts with community-based and peer-led organizations who understand the needs of the communities they serve and increasing CCO partnerships with culturally specific clinics in rural communities.

Other ideas involved using data to better understand and improve access to CLSS/CLAS, including evaluating CCO processes and compliance with requirements to work with qualified or certified health interpreters. One suggestion was to evaluate compensation, recruitment and retention of health care interpreters as well as the

benefits and challenges of working with companies who provide language services versus hiring individual interpreters.

Respondents also recommended pursuing ways to develop a provider workforce that reflects the community at all levels, including among executives. Suggested solutions included developing long-term strategies—from early education to continuing education for professionals—to develop, recruit, and retain a diverse and bilingual/bicultural workforce.

Observation 5: Gaps in care coordination and case management impact members requiring complex care

Definition

Care coordination is the organization of a patient's care across multiple providers. (2) Oregon Administrative Rule further outlines care coordination as the act and responsibility of CCOs to deliberately organize a member's service, care activities and information sharing among all participants involved with a member's care according to the physical, developmental, behavioral, dental and social needs (including health-related social needs and social determinants of health and equity) of the member. (3)

Case management is a service offered by health care professionals to help people and their caregivers manage their health needs. This may include helping people get the care they need to manage a diagnosis, illness or injury, or connecting them to doctors, resources, and services. (4)

Community partners, providers, members and caregivers shared that care coordination and case management are often not happening for members who need these services. When care coordination and case management are available, the services do not always meet members' needs.

An OHP member describes the serious impacts that the lack of care coordination had on their health care experience and outcomes:

> "When I was dealing with brain tumors and severe illness, I was blamed for not providing enough information about my case. The CCO failed to gather records or follow up adequately with my doctor. As a result, critical care was denied, and I was left without back surgery or ongoing treatment for my rare disease. The lack of accountability and refusal to address their mistakes have had devastating effects on my health."
>
> –OHP member

Providers and community partners reported that many members who need care coordination services are not aware that these services exist or how to access these services.

> "When an extremely heavy utilizer—multiple chronic conditions, modifiable risk factors, frequent [emergency room] visits, several inpatient stays—tells me they have never had any care coordination I have to wonder if it's because that particular individual's experience is an exception or if [the] experience as described on the OHA website is not universally happening."
>
> –Community-based partner

> “I lead workshops on health care advocacy at a family camp for parents whose children are very medically involved. Some of the children also experience intellectual and developmental disabilities. In the last two workshops, I introduced the families to more than 15 helpful community resources, including CCO Care Coordination Services. I asked the parents to raise their hands if they had ever heard of Care Coordination services at their child’s CCO. In one workshop, there were 60 families present but only one raised their hand. In another workshop there were 20 families present. One raised their hand. They had heard of Care Coordination, but asked 'is that where they send a letter and tell you they can help? I didn’t really understand what that was about.’”
>
> – Provider (CBO)

Difficulty in accessing the care coordination and case management services can leave providers, members and caregivers with the burden of coordinating services on their own and finding what resources are available to them. As a result, providers, members, and caregivers try to find and coordinate services for themselves, but this can be difficult and is not always successful.

> “As a provider, my frustration is how do we know where to send our patients. We don't know and we have to put that burden on our [patients] and tell them, 'Please call your insurance company and ask what gastroenterologist is covered and then call around and ask if they're taking patients and then send me a message and then I'll send the referral.' So, administrative burden being a large barrier to access.”
>
> – Provider

Some respondents shared experiences of members turning to networks outside of CCOs, like peer support or community-based organizations, to find resources and address gaps in care coordination and case management. Members reported that peer networks provided more knowledgeable help in accessing or understanding available resources.

> “information is not readily available to clients. You are only aware of these service through your network of friends or family. You may also be able to get information related to these resources if you happen to have a very knowledgeable case worker. Not sure what their internal policies are around information sharing. I don’t know how they operate and I only call when I have a coverage related question. One customer service representative was very useful in connecting us to specific provider who was actually accepting new patients. It was just pure luck to have someone like her assist us”
>
> – OHP member, parent, guardian or caregiver

Members with complex medical and behavioral health needs and their caregivers reported struggling to access case management and care coordination services. This is due in part to the lack of integration between behavioral health care and primary care. Respondents called for integration of behavioral health services into the medical home model, so patients don't have to find behavioral health care on their own.

> "Ideally behavioral health would also be accessed within the medical home for easier access to behavioral health. Leaving it up to the patient to find their own behavioral health providers is difficult and leaves room for gaps in care..."
>
> - OHP member, parent, guardian or caregiver

> "For those with co-occurring conditions or complex needs, seamless integration between physical and mental health services is essential."
>
> - Provider (mental health)

Members with complex care needs often require services from specialists and other providers beyond what their primary care provider offers. One member shared that they found it easy to access care because specialists and other referrals were in the same health system as their primary care provider.

> "I have greatly enjoyed being able to access care at [CCO], as I saw them prior to becoming a OHP member. It is convenient to see my [primary care provider] and get referred to other specialists within [CCO]. It is also very easy and convenient to get my medications. I feel like this coordination helps prevent gaps in medical care."
>
> -OHP member

These gaps in care coordination and case management have real-life impacts on members. One member reported being unable to find a primary care physician for over ten years due to the complexity of their case and their need for specialized care outside of Oregon. A parent of a child with medical complexity did not receive caregiving referrals or care coordination after the child had spinal surgery. Another caregiver reported that, after the pediatrician specializing in developmental services left, they did not receive a referral to a new provider, and the child did not continue receiving services.

Providers requested more accountability for CCOs to meet case management requirements in CCO contracts. Respondents also asked for additional requirements for CCOs to publish clear communications about the availability of care coordination services, including for children with disabilities and complex health care needs. One provider suggested more training and resources for case managers, so they can better support patients navigating systems and services.

Equity impacts

Effective and accessible care coordination and case management are essential for children and adults with disabilities or complex medical needs. Not having these services means they are less likely to receive the health care they need or their care will be fragmented. When members have complex medical needs or disabilities that require many different types of services, there is a greater need for coordination among their providers.

Opportunities for care coordination and case management are even more limited for members who need care and resources in languages other than English or need culturally specific services or facilities.

Observation 6: Members struggle when services are unavailable or do not meet their needs

Members struggle when services that should be covered aren't available or are available but not meeting their needs. Members reported feeling like they do not have autonomy over the care and services they receive. When patients don't receive appropriate care, members and providers reported being unsure about what steps to take next.

Flex funds not being approved for housing

Flex funds are reportedly being denied for housing assistance for reasons that previously qualified, such as recovery housing, rental assistance and hotel rooms after a medical procedure. Some are being told that all housing flex fund requests transitioned to a new system on November 1, 2024, and that housing assistance is now only available for individuals with severe physical disabilities. Others are given conflicting guidance from their CCO and 211 regarding whether housing providers or treatment providers need to apply for the funds for the member. Based on the feedback there appears to be confusion between flex funds and the new HRSN housing benefit.

Recovery housing facilities and residential treatment providers reported similar experiences. Some facilities said they have started declining OHP members seeking housing using flex funds, leaving them without housing or treatment. Some organizations are considering shutting down some of their housing facilities because of the lack of funding.

Services available but not meeting needs

Some members said that certain covered services do not meet their actual needs. One member complained that the home modifications available are too limited and do not support the goal of independent living. Members and providers reported that non-emergency medical transportation is also difficult to obtain in specific circumstances, such as when a patient has a wheelchair or needs additional assistance during transport, or when a member is outside of their CCO's region.

> "We know that the contracts direct the CCO to have funding that follows the client, even when they are out of town participating in service. There is reluctance to provide transportation to medical and dental services, and, most often we need to access the emergency room instead of urgent care clinics so that they get paid."
>
> - Provider (Medicaid)

Additionally, the lack of American Sign Language interpreters and assistive technology during medical visits and at pharmacies prevents clear and accurate communication for

members who are Deaf or Hard of Hearing. Several respondents shared stories about people who were harmed by not having access to interpretation at pharmacies. Respondents would like to see incentives or requirements to install assistive technology and have live interpretation in exam rooms, clinics and pharmacies.

> “When a doctor has to have a very a deep discussions on a Deaf or Hard of hearing about their health deep conversation between the doctor and clients MUST LIVE IN PERSON… [video remote interpreting] do not always work why because interpreters do not know this Deaf person communication… Every Deaf person has different language needs… A deep conversation about cancer or other serious health issues must live interpreter!”
>
> -Community-based partner

One survey respondent noted that CCOs sometimes contract with companies that don't meet OHA’s standards. The respondent shared that CCOs are not hiring health care interpreters (HCIs) who do meet OHA standards. In addition, the respondent recommended compliance enforcement for HCIs and improvements in compensation, recruitment and retention.

> "We have been looking at data and having conversations with our community partners. One concern has been with the health care interpreters. Even though the number of health care interpreters trained and registered with OHA, few are being hired. Many CCO appointment that need interpretation services are being provided by a language service who may use staff not trained up to OHA standards and not on the registry. We should evaluate the process and compliance with use working with of qualified or certified health interpreters, including benefits and challenges to working with companies who provide language services versus hiring individual interpreters and the compensation, recruitment and retention of certified and qualified HCIs. From the rapid assessment of Oregon substance use disorder services in 2021-2022, interpretation and translation services were rarely available in languages other than Spanish during sessions for substance use disorders."
>
> - Survey Respondent

Autonomy over care

Members expressed frustration about not having enough control over decisions related to their own care. Some members shared frustration about providers that prioritize tests and services that they can bill for over the members’ needs. Other member expressed frustration that more restrictive or invasive treatments were prioritized over the less invasive or less costly treatments that they preferred. One member said they received recommendations for institutional living instead of corrective surgeries to restore their quality of life.

> “One occupational therapist even stated, ‘I work for the insurance company, not the patient.’ This attitude highlights a systemic misalignment of priorities that leaves patients like me without effective care.”
>
> – OHP member

Members and providers described not being able to get the treatment that the patient needed or that the doctor recommended, because the CCO either did not agree the treatment was necessary or required the patient to try other treatments first.

> “I know I have had some experience with the CCOs both as a community member, with denial of services, especially stuff like, ‘Oh, hey, you need a medication, this is not the first one that we've tried for you, but we have to get approval through the CCO.’ My husband recently got a denial letter saying that before he could try the current medication the doctor was trying, that he had to try other medications first, most of which on the list he had either tried or the CCO had denied. It's definitely been extremely frustrating for that. My own hysterectomy originally got denied because there were tests that weren't going to provide any more information or any additional help other than to be painful and to delay the process and my doctor actually had to go through a whole process for that. As a consumer, it felt like the CCO was saying, ‘You know, we don't trust your doctor to have your best interest at heart. You clearly are suffering and we also don't have your best interest at heart.’ I think from a consumer standpoint, that kinda feels like the insurance experience, whether it's the state or not, I think that's pretty universal for everybody.”
>
> - OHP member and committee member

Unclear next steps when members do not get appropriate care

When members are denied services or do not receive appropriate care, they struggle to find solutions and information about what to do next. Members have reported that they do not receive quick responses or solutions to complaints about their care. One member described continuously being denied services for her child, making repeated complaints and calls that did not correct the problem, and did not know what else to do.

Providers and community partners said they are unsure how CCOs are held accountable if CCOs are not providing the services they are supposed to or not meeting standards of care.

Equity impacts

Respondents identified equity impacts when services are unavailable or do not meet members' needs, particularly for people with disabilities, complex conditions or experiencing homelessness.

Non-emergency medical transportation often does not meet the needs of members with disabilities or complex medical conditions. These members often need additional support during transportation, which is not always available.

The lack of or denial of funds for housing impacts preventive care, treatment and recovery for members experiencing homelessness.

> "Because my entire career has been in a practice which serves ~80% uninsured and Medicaid recipients, I have long faced the impacts of inadequate financial resources on my patients' health. The presence of flex funds, the ability to get needs that do not obviously but clearly do indirectly impact the health of a patient has been very important in our practice. In a meaningful number of lives, this takes the sharp edge off of poverty."
>
> -Provider (CBO)

Additional areas of interest

The observations described above span across multiple areas of interest.

Behavioral health

Respondents mentioned behavioral health care as an area where there are big challenges, including with mental health care and treating substance use disorders (SUD). Key themes within this area were network adequacy, the lack of integration with physical health care, and care coordination. According to respondents, the challenges can be more intense for children and adults with complex needs, members with SUD, and people experiencing homelessness. Respondents also noted several successes related to telehealth, partnerships with CCOs, and SUD treatment.

Network adequacy

Members, parents/caregivers, providers, and community-based partners described challenges with accessing behavioral and mental health services. Members and caregivers shared their frustrations and experiences finding—or not finding—providers who accept OHP. Once they found an appropriate provider, multiple members described long wait times or needing to travel long distances to receive care. Multiple respondents said that finding behavioral and mental health care providers is most difficult in rural areas, for members who need culturally or linguistically specific services, and for members with complex conditions.

Respondents asked for funding, investment in the workforce, parity in reimbursement rates, accountability, and transparency to ensure services reflect OHP members culturally and linguistically. Providers noted challenges with credentialing and low reimbursement rates as barriers to providing culturally and linguistically specific/appropriate services (CLSS/CLAS).

> "They lack adequate access to non-white behavioral health providers, yet they continue to make it difficult to be in their network as a non-white provider. Additionally, getting payment when you do receive approval to provide behavioral care as out of network is challenging as they lose track of what they approved. Lack of concern for what access to care truly mean. The disregard for the need for cultural and linguistic care even when your population is overwhelmingly white."
>
> –Provider (mental health)

When members can't find timely care, they seek care elsewhere. A community-based partner observed that members with complex needs go to emergency rooms to access mental health care. One free clinic said a portion of their patient population are OHP members who could not receive timely care through OHP. Another commenter noted the lack of available beds for OHP members with acute mental health needs. These

patients then remain in health care settings that are unequipped to provide appropriate care. Providers in these settings may not be reimbursed for care provided while the member waits for an available bed. When asked about their experience with gaps in behavioral health care, one committee member said:

> "medical transportation for higher acuity mental health beds and the lack of beds available, which the patient gets stuck. Since there's not active medical decision-making being done, the transferring facility is on the hook for the patient care for a long time one on one supervision and other things. So, it's like a whole log jam a problem, and it ends up there's a lot of resources in that rural community that go towards this patient that are just solely on, just not reimbursed at all, and, and I don't know where the CCO comes into that, but like, it's hard all the way around for both the patient and provider."
>
> –Provider

In an environment where OHP members already struggle to find behavioral and mental health providers, respondents expressed concern and confusion that a recent policy change at their CCO further limits their options. Specifically, multiple OHP members and a provider commented on how their CCO is no longer allowing them to see associate behavioral health providers. (Associate behavioral health providers are behavioral health providers who have completed their education, have not yet received their own license, and are working under the supervision of another licensed practitioner.) Members described challenges finding providers and expressed distress that they will no longer be able to see the associate providers who meet their needs, including for culturally appropriate care.

> "The new proposed policy to block Associates from billing medicaid will dramatically affect clients like me in LIMITING the partnerships required to support improved access to behavioral health. This proposed policy represents a major breach in the fabric of mental health infrastructure. As a [CCO] member, I have fought for years to find and maintain a relationship with a therapist who fits my mental health needs. Taking away the sustainable option for these clinicians and all us clients who depend on their services is a totally unacceptable 'solution' to the funding/staffing gap faced by [community mental health programs]. BLOCK THE POLICY! This is totally unethical and unfair to burden the clients who depend on these services. Having received care at [a large behavioral health provider] in years prior, there is no way I would find services there to meet my needs today; my level of need is most appropriate for this space. I demand [the CCO] recognize the validity of that need and my right to access the behavioral health setting of my choosing."
>
> –OHP member, parent, guardian or caregiver

Expanding access and successes

Respondents did note successes and ways to increase access to care. In addition to continuing to allow associate behavioral health providers to bill for services, respondents identified telehealth as a way of expanding access to care. A community-based partner noted that telehealth can be essential for people with disabilities to access behavioral health care. A provider said their clinic successfully used telehealth to be available when and where members were ready to ask for support for SUD.

One member shared their positive experience becoming an OHP member after living out-of-state.

> "…I want to say really do appreciate your health plan buy in program because I do that as a person [with] disabilities. I had just moved back to Oregon and realized really how good it is in Oregon once you've been to another state, how many gifts there are here. grateful to have OHP mental health care. I wasn't allowed to have it in the past due to a mental health preexisting condition"
>
> –OHP member

Respondents also identified areas where they would like to see investment in behavioral health services. Multiple respondents noted the need for a sustainable funding model for crisis services. One provider encouraged investment in primary care to expand access to behavioral health services. Another request was for more funding for outreach and coordination of behavioral health care for children as well as education for their parents.

Impact on providers

Network adequacy problems in behavioral health care impact providers as well as members. A provider said that burnout in the mental health care workforce is compounded by a lack of resources. One member observed the impact on providers and how it impacted their care.

> "From the client perspective, private practice is a vital avenue for receiving care. Agencies do incredible work, but they are often overwhelmed by the sheer volume of community needs. As a former client of mental health services, I witnessed firsthand the lack of care and transparency that can occur when clinics are stretched too thin. Clients deserve options, and providers deserve the ability to work in environments where they can thrive and provide the best care possible."
>
> –OHP member, parent, guardian or caregiver

Providers reported struggling to deliver behavioral health services and to recruit new providers because of low reimbursement rates. One provider commented that reimbursement rates are not increasing with the increasing costs of providing care.

> "[W]e need better funding/reimbursement for behavioral health services. We have integrated clinical psychologists and social workers, but the amount of money we make off of claims/value-based contracts does not pay for their salaries. Because BH providers (especially ones with experience in primary care settings) are so hard to find, their salaries are climbing and outpacing our ability to afford them (the same can be said for physicians and non-physician primary care providers—due to demand—salaries have skyrocketed yet our reimbursement is stagnant). This will kill independent primary care offices like us. We will not be able to compete with the sign on bonuses and loan repayment offers that hospital-based clinics or FQHCs can afford to offer."
>
> –Provider

Multiple respondents suggested alternative payment models for behavioral health. One said that the Per Member Per Month (PMPM) model was largely working for their facility, but the reporting requirements increased the administrative burden without increasing the quality of care. Two providers mentioned improvements or changes to wrap payments for behavioral health care services as possible solutions.

> "In behavioral health, however, there's no option for capitated state wrap payments. This means we are stuck in a fee-for-service world, or we can have one wrap payment per day. When we provide best practice care where our clients see their psychiatrist, therapist, case manager, and attend a group meeting all on the same day, we see much lower reimbursements."
>
> –Provider

Providers specifically noted administrative burden as a barrier. Behavioral health providers who contract with multiple CCOs face an increased administrative burden because of differences between CCOs. These differences can also be confusing for members. Providers asked for streamlined processes and enhanced efforts to decrease administrative burden. A CCO representative noted that efforts to reduce the administrative burden in behavioral health have positive impacts on relationships between providers and CCOs.

Integration and care coordination

In addition to struggling to find behavioral health providers, members struggle with how behavioral health is not integrated into their overall care. Multiple respondents noted the lack of coordination between physical health and behavioral or mental health care. Two respondents also said this was a problem with pharmacy benefits, impacting access to medications for mental health conditions and substance use disorders.

> "However, I would like to express frustration with my ability to seek mental health/behavioral health care within my CCO. Prior to becoming an OHP member I had a psychiatrist and a therapist that I had been seeing for 5 years at [a private

> health insurer]. It was very disheartening to learn that [my CCO] does not allow you to get mental health care [within the health system], as then I was left to find a new psychiatrist and therapist. Having been with my therapist for 5 years, it was distressing to have to find a new one and go through the process of trying to find a good fit again. Unfortunately, it also appears that there are limited to no psychiatrists that take OHP insurance, instead leaving patients to seeing psychiatric nurse practitioners [NP] or PA's [physician's assistants]. While NP's and PA's have an important role in medicine, their limited educational training compared to a physician is evident when dealing with more complex mental health comorbidities. It was also very difficult and confusing to get my behavioral health medications set up as I did not realize my pharmacy was [with a specific health system]. Additionally, since my mental health prescriber is outside of [that health system], my PCP is not able to access their notes or easily collaborate on my health with them."
>
> –OHP member

The lack of integration with patients' overall care impacts OHP members with the highest need, such as children and adults with complex behavioral health conditions and members with SUD. These members and their caregivers are left to find behavioral health providers and services themselves, including during crises. Respondents also described not receiving care coordination to manage complex behavioral health conditions or to align care for behavioral and physical conditions. Respondents wanted to see behavioral health integrated into the medical home model, so patients don't have to find behavioral health care on their own and their care can be integrated with physical health care and pharmacy benefits.

> "It's challenging when patients are assigned to one CCO for behavioral health and a different one for physical health. This flies in the face of truly integrated care. Gave example of working to access care for people with eating disorders, who may be receiving mental health care through one CCO, but if a hospital admission is needed it needs to happen through a different CCO providing physical health coverage."
>
> –Provider (CBO)

Children

Parents and caregivers of children with developmental disabilities and behavioral health conditions also struggle to access and coordinate appropriate care for their children's complex needs. Parents and caregivers described challenges with getting timely diagnoses and a lack of care coordination.

> "So instead, my husband and I just continuously utilize everything we can to piecemeal. We utilize the highest level of supports available to severely disabled children. If there is something we have done it. And some days it's still not enough. The system is broken in a way that requires us members to just keep

> having to work extra. Freaking hard to get what we need to survive. Being the squeaky wheel, not taking no for an answer. It's so hard. And we're just getting very tired. But it's not like we can just give up. My kids rely on me."
>
> –OHP member, parent, guardian or caregiver

Local partnerships can improve behavioral health care access for children and families. One commenter noted that their partnership with the regional CCO has improved access to behavioral health services for children. Respondents wanted to see more CCO partnerships with schools and local organizations that serve youth and families to support children's wellness and behavioral health.

Treating substance use disorders

Providers and community-based partners commented on care and services to treat SUD. Issues include improving standards of care, the need for more services and facilities, and the need for housing during treatment as well as long-term sober housing. Respondents also noted successes.

Multiple providers commented on medication assisted treatment (MAT) for opioid use disorder (OUD). Observations included hesitancy among some providers as well as successes in clinics providing MAT. One provider said MAT could help reduce the need for long-term residential treatment. Multiple respondents wanted to see more education for providers on using MAT effectively. Another provider wanted assurances that primary care providers are screening for OUD before prescribing.

> "at [the hospital], I have led an educational program, and right now, we have at least more than 20 plus practitioners who are much more comfortable in prescribing Suboxone or Sublocare or whatnot for, as you know, for opioid use disorder under MAT [medication assisted treatment]. So maybe creating that awareness really helps reducing these numbers are people even needing residential facilities and can be managed in the communities much more stably, versus relying on these long-term residential facilities, because these are well, we all know, well tested treatments that's gaining lot of and there is a reason why DEA [Drug Enforcement Administration] has waived this requirement."
>
> –Provider

Providers and community partners noted successes in treating SUD. One provider commented on the importance of OHP coverage of naloxone to address overdoses. A provider noted that their clinic uses telehealth so patients with SUD can reach out whenever they are ready, wherever they are. CCO partnerships with local organizations have also generated successes. In one region, a CCO partnered with the community to expand opioid treatment, including MAT, and behavioral health services in primary care and other settings. In another region, a partner said the regional CCO worked with them to improve residential and outpatient SUD treatment.

> “The partnership between [the regional CCO] and [our detox clinic] has evolved into a vital support system for patients requiring withdrawal management at the 3.2WM level of care [a standard of care in which patients’ individual needs can be addressed]. This collaboration not only addresses the immediate needs of the patients but also demonstrates a shared commitment to enhancing the overall standard of care in withdrawal management, ultimately leading to better health outcomes for those in recovery.”
>
> –Provider

Housing and residential treatment facilities

Homelessness adds complications for patients being treated for substance use disorders (SUD) and other behavioral health conditions. Respondents identified a need for more long-term sober housing facilities as well as residential recovery centers providing CLSS/CLAS. Multiple providers said that Health-Related Services (HRS), also called flex funds, are no longer available to house members with behavioral health needs.

Respondents shared real life impacts and frustration related to the loss of HRS funds for housing for people with behavioral health, mental health and substance use conditions. A CCO told a community-based partner that mental health and SUD are no longer qualifying conditions for members to receive funding for housing. Three commenters from residential treatment and recovery facilities said their centers are struggling to provide care to OHP members because of the loss and denial of HRS funds. They said multiple facilities are now in danger of closing. At least two facilities were turning away OHP members because they were unhoused.

> “This sudden policy shift has placed our community in crisis. West Coast Sober Housing has had to turn away countless individuals seeking housing. Over 30 current residents are at immediate risk of losing their homes, and three months of services for over 20 residents are left unpaid. The ripple effects are devastating: outpatient treatment centers can no longer admit Medicaid clients because these individuals have nowhere to live. At this juncture, we are contemplating closing two of our seven sober homes, and we are hearing similar plans from other housing organizations across the Portland metro area. As a nonprofit accustomed to resilience and resourcefulness, we are used to pivoting when funding sources run dry. However, this time, there appears to be nowhere left to turn. Without access to Flex Funds for individuals with substance use disorders, Portland will face an unprecedented surge of houselessness”
>
> –Community-based partner

Children's health

Respondents shared challenges related to children's health services and children's behavioral health.

Children's health services

Some feedback referencing children's health highlighted difficulties in accessing care due to insufficient provider networks and lack of services and providers for children with complex care needs. For example, one respondent shared the challenges they experienced trying to find a new provider for their children after their family's pediatrician left:

> "My children were receiving developmental pediatrician services. Their pediatrician left. There wasn't one to take their place. And when they did have someone just basically doing diagnosis didn't provide any other services. I called [our CCO]. They had nowhere to refer us to. We even were offered a waiver to get those services provided outside of our network. But we couldn't get anywhere that was offering to take us because there was saving their visits for their in-house clients. Even if the provider had previously been a provider of my children's."
>
> - OHP member, parent, guardian or caregiver

A few respondents identified inaccurate administrative processes as causing barriers to accessing children's health services. A parent expressed how distressing it was for their family when their daughter repeatedly lost coverage. A provider shared they receive outdated information from their CCO and that services could be improved "if CCOs utilized real-time health information that was integrated into our electronic health record."

As mentioned in a previous section, one respondent noted how the global budget model can have a negative impact on children and families receiving services and suggested separate global budgets for children and adults as a possible solution.

> "A global budget requires even well-meaning CCOs to focus on populations that cost more money and will impact their global budget. This creates a focus on expensive adults. A solution is to create separate global budgets for children versus adults and then an enhanced rate for family units. There should be more transparent public reporting of how these global funds are spent, specific to the populations they are attributed to..."
>
> - Provider

While CCO representatives and some providers mentioned performance metrics as an area of increased administrative burden, one respondent noted the need for specific metrics focused on children's health.

> "... What is measured is what is focused on. Population metrics are needed to ensure a focus on the most vulnerable children. Data shows that quality healthcare for children and youth with special health care needs has not been achieved in the CCO model, even though healthcare is the last safety net for them. The disability designation in the state's priority focus on REAL D [race, ethnicity, language, disability data] only captures a very small proportion of children with special health care needs, as the criteria for disability and REAL D focuses on adult conditions and limitations.
> CCOs need evidence-based, clinically recommended aligned indicators of medical and social complexity, such as the child health complexity data, that can guide their population health needs in addition to using REAL D data. The state needs to provide CCOs with this actionable population health data, and quality metrics can then be stratified by available medical and priority social complexity indicators to guide efforts that will aim to eliminate health inequities for these most vulnerable populations of children."
>
> - Provider

Children's behavioral health services

Three respondents noted access issues for children's behavioral health services. These issues included long wait times to receive services, insufficient mental health resources for children, and lack of mental health providers for children, especially for children with complex behavioral health needs.

A few respondents also shared suggestions for areas of improvement. These suggestions included expanding children's wellness services through partnerships with local agencies and expanding behavioral health services for children in schools.

Social determinants of health

Respondents shared several challenges related to addressing social determinants of health (SDOH) for members. Respondents noted that smaller provider offices may have a harder time contracting with CCOs and may experience a lack of support in addressing SDOH. One survey respondent stated that the CCO support for SDOH through per-member-per-month payments, while helpful, came with burdensome reporting requirements that did not incentivize providing better care to members.

> "The CCO provides support for behavioral health (BH) and social determinants of health (SDoH) through per-member-per-month (PMPM) payments based on services provided and limited grant funding, e.g. for language access and BH projects on early childhood. The PMPM payments are, however, counterbalanced by burdensome reporting requirements and artificial "engagement" thresholds that lead to box-checking rather than truly better care.

> Finally, big picture, the CCO has taken the state mandates to address BH and SDoH and turned them into expectations from primary care providers, with contingent payments that have a high reporting burden. Without a much more substantial investment, primary care clinics like ours will not be able to make much meaningful progress on these fronts. I think money is well spent on expanding BH access through primary care. SDoH, however, would be much better address far upstream and by state agencies providing services. I would not recommend replicating this model without a 50% increase in funding."
>
> - Survey respondent

A community partner shared gaps in housing supports for patients discharged from hospital settings. Individuals that experience houselessness and receive treatment were discharged back onto the street and told it would take up to 10 days to receive a decision on a room. Another community partner shared struggles around connecting the houseless community to medicine, mental health counseling, community recovery and wellness living services.

> "Trying to connect the houseless community to medicine, mental health counseling; Community recovery and wellness living is a problem. Providing health services and housing not going well"
>
> - Community-based partner

Another community partner shared how a recent change in the area's only basic transit system, the local bus system, reduced operating hours and days for the community and surrounding rural area. This impacted community members that relied on that transit system for their daily lives and contributes to reduced access to care for that community.

> "For my local CCO, I know that under the social determinants of health transportation is one of those things that needs to be addressed. And in my community, we have one basic transit service, which is the bus system. It used to run six days a week from 6:30 in the morning until I believe 7:30 at night, and it serviced our whole community and even a little bit of rural community. And recently we've lost that service to now where it's only running Monday through Friday from 8:00 to 5:00. But the reason why I bring it up is because I would love if our local CCO or other CCOs could use some of that money to address those specific targets to what is it called, incentivize programs such as that as community programs to better all. I don't know, I don't want to say better all, but to overall be a benefit to our community and the people traveling to work, trying to make it to appointment, trying to drop their children off to daycare and stuff like that."
>
> - Community-based partner

A provider shared they received little feedback about the referral resource their CCO provided for when SDOH deficits are identified. The feedback they did receive was negative.

Some respondents shared successes around how CCOs have helped support local providers in addressing SDOH for their members. This includes expanding the traditional health worker workforce and supporting providers in meeting patients where they are with medical and SDOH care.

> "CCOs have been key partners in expanding the THW workforce in [our county]. They have accomplished this through several methods: Being key partners in advocating for better salaries and improved payment models and methods (including billing codes)."
>
> - Provider

Other community partners shared that CCOs have helped address SDOH issues in the community through financial support of local nutrition programs, allowing regional food banks to purchase healthy, nutritious food for health and social service clinics in the region. Another community partner shared that CCOs were very helpful in facilitating access to air conditioners, purifiers and other items to support the health-related social needs of community members.

> "[CCO] has provided financial support to FOOD For Lane County on an ongoing basis (a program called [CCO] Produce Plus) so that we can increase our produce purchases and provide fresh produce at health and social service clinics around the county. This program has been extremely popular for years and serves thousands of low-income families free, high quality organic produce to improve their health outcomes. The clinics that host these programs report excellent interactions with the community, and always ask for more produce. [CCO representative] built relationships with the food bank and specifically urged us to consider the people who are most impacted by disparate health outcomes while we did outreach to sites as potential future hosts."
>
> - Community-based partner

> "They have been very helpful in providing air conditioners, air purifiers and other things such as car seats."
>
> - Community-based partner

Oral health

While most feedback related to oral health and dental services was shared by providers, there was one OHP member who shared that they experienced dental providers not billing for a covered service while they were on OHP due to a qualifying pregnancy.

> “I have been pretty happy with my health coverage, particularly in comparison to private insurance, but several dental care providers did not even attempt to bill my insurance for a covered service. Whole molar root canals are not covered generally, I was on OHP due to a qualifying pregnancy which was unfortunately lost in a miscarriage so when the medical billers asked ‘are you pregnant’ the immediate answer was ‘no’ and I was too traumatized to go into further detail. a year later, I am a) still dealing with a bad root canal on that tooth and b) only just beginning to have financially recovered from that experience to try to have it addressed again.”
>
> - OHP member, parent, guardian or caregiver

Most oral health-related feedback from providers was associated with payment models and low dental reimbursement rates. One provider shared concern over the dental reimbursement rates for 2025 as compared to pre-COVID rates.

> “The 2025 dental reimbursement rates relative to pre- COVID or 2019 range from 0% to -15% are concerning, and they threaten to undermine the stability of the system. These rates include the State’s proposed Qualified Directed Payments of 6%.”
>
> - Provider

One provider noted that, while CCOs have a mission to focus on health promotion and prevention, there is a lack of focus on prevention in oral health care. This lack of focus on prevention in oral health care can contribute to increased costs and is particularly acute in rural areas.

> “Dentists in Oregon are deeply committed to serving their communities and improving the oral health of all Oregonians. However, [Oregon Dental Association] is troubled by the lack of investment in oral healthcare by the state. The mission of CCOs to focus on health promotion and prevention — ‘instead of just treating you when you get sick’ — does not adequately address the need for prevention in oral health. The saying ‘an ounce of prevention is worth a pound of cure’ holds especially true in oral healthcare, and investment in preventive services can reduce long-term healthcare costs, improve health outcomes, and enhance quality of life...”
>
> - Provider

While most of the oral health-related feedback consisted of challenges faced by providers, there were also a few successes shared by providers. These successes focused on the integration of oral health and oral health education in the medical clinic setting and preventative physical health education in the dental clinic setting.

> “Because, you know, we have medical and dental in our clinic, and we saw that, you know, we could train medical providers to provide oral health education and train them on applying florid varnish applications at well childcare visits”
>
> - Provider

> “And then in reverse, you know, we've trained our dental providers on HPV, education, vaccine education, and really trying to reiterate the importance of completing those vaccine series in order to help prevent problems down the future, you know, and for children. And just kind of, also in our clinic, we've been able to have medical, or excuse me, dental providers perform a 1c checks chair side, and really been able to highlight diabetic patients that had no idea that they were diabetic. And, you know, really being able to start that education with that patient, and the importance of how it affects their oral health care.”
>
> - Provider

Traditional Health Workers and peer support

Respondents shared successes and challenges related to how Traditional Health Workers (THW) support local communities by providing access to care to members.

Providers and community partners shared that CCOs have been key partners in helping THWs deliver culturally and linguistically specific care to communities. THW collaboration with CCOs has expanded vaccine access, advanced prevention efforts and supported climate resiliency. Ultimately, feedback suggested CCO investment in the THW workforce has increased community capacity and provided more options for the unique needs of community members in different parts of Oregon.

> “Over the past several years, THWs have been fundamental partners for [our county public health department] and integral to the wellbeing of [our] residents. THWs delivered culturally and linguistically responsive services and advanced health equity and justice before, during and after the COVID-19 pandemic and recovery period. THWs routinely support Community Health Improvement Plan (CHIP) implementation and are integral to Public Health Modernization plans. Across all these efforts, THWs have increased vaccination access (e.g., COVID-19, flu MPOX), advanced prevention efforts (e.g., harm reduction), supported communicable diseases work (e.g., HIV, tuberculosis), improved access to care and health literacy, and built community capacity in the areas of emergency preparedness and climate adaptation and resiliency.”
>
> - Community-based partner

> "CCO partnerships with local public health agencies have been essential for making this a reality. For example, [our CCO] recently awarded funding from Supporting Health for All through Reinvestment (SHARE) initiative for a project focused on building infrastructure to support THWs across the region. The

> majority of funding will be allocated to community-based organizations working on supporting communities to build climate resiliency across the Tri-County region. Additionally, CCO funding has supported [our county public health department's community health improvement plan (CHIP)] where THW are one of the key strategies to advance the CHIP priorities."
>
> - Community-based partner

Challenges shared by respondents include inconsistent billing reimbursement processes and lack of resources for improving or expanding the THW workforce. Providers shared that the THW workforce receives inconsistent funding and lower salaries compared to others in the public health profession but provide crucial services to members through their lived experiences and connection to the community. THWs also face increased risk of communicable diseases and other trauma when working closely with community members on a regular basis.

> "Despite this, the THW workforce faces immense challenges in workforce support and recognition and to sustainability. The THW workforce is composed primarily of women of color, immigrants and mixed immigrant status, trauma survivors and individuals who have historically been oppressed and discriminated against. These identities and lived experiences are a key to their positions as trusted community members, effective messengers, helpful navigators, and advocates for their community.
>
> However, this also means that THWs are exposed to direct and vicarious trauma through their work in the community and can be exposed to hazards such as communicable disease. THWs also receive some of the lowest salaries across the public health profession and often aren't recognized or integrated by medical providers and health systems. Many current THW programs are funded through grants or other inconsistent sources, making this a precarious profession despite THW's ever-present commitment to their communities."
>
> - Community-based partner
>
> "While the THW workforce has grown and advanced health equity in the region through these partnerships, there is continued need for the OHA to establish sustainable funding and billing methods for THWs and to build infrastructure to support this vital workforce."
>
> - Provider

Respondents shared that the THW workforce needs support to continue supporting communities. Providers shared a need for sustainable funding sources and billing mechanisms, expanded training opportunities, and infrastructure to help THWs better operate and continue serving as a conduit between CCOs and often hard-to-reach and historically neglected or traumatized communities.

> “It is imperative for CCOs to continue to invest and support the Traditional Health Worker workforce given important role they play in hard-to-reach communities that have been historically neglected and traumatized by our health and governmental systems. Through these key partnerships with Traditional Health Workers, systems such as CCOs and LPHAs, are able to reconnect with communities and support efforts that advance health equity and justice. It is also essential for the OHA to identify sustainable funding sources and support for this vital workforce through improved billing mechanisms, expanded low-cost training opportunities, support for continuing education, and basic infrastructure to support THWs.”
>
> - Provider

Rural areas

Respondents shared multiple challenges related to network adequacy in rural areas of Oregon. Respondents provided feedback about the lack of services or providers in rural areas, resulting in members having to travel long distances to find or receive the right care, having to use other resources that may not provide the level of care needed for the member’s needs, or not even receiving the care or support they need at all.

> “There is a real need for video remote interpreting (VRI) in pharmacies like Walmart, Fred Meyers, Safeway, and in rural pharmacies where Deaf live; it needs to be put in to save lives, we already had several Deaf people die because they did not understand their medication, Writing to Deaf or hard of hearing is NOT EFFECTIVE COMMUNICATION !
>
> We had a mother who son died because she had barriers from pharmacy hearing people ask questions to the pharmacy why can’t the Deaf and hard of hearing have that same rights? I been advocating for this for several years pharmacists refuse to because it cost money well how about if there a lawsuit against pharmacies by family members? Question is, can pharmacies afford a lawsuit? Cost way more than VRI. . . Thank you I hope number one on pharmacy to put in VRI it saves lives when there effective communication simple about medication they take to understand it from the pharmacy personal pharmacist. Side effects what to watch out for about medication. And Deaf and hard of hearing can communicate back to pharmacist”
>
> - Community-based partner

Other community partners and providers shared that high costs of living, funding gaps and inconsistent payment models and reimbursement rates make it difficult to staff for services in rural areas. In particular, the lack of providers and services in rural areas contribute to gaps in oral and behavioral health services for members in those areas.

"Insufficient redundancies and limited bench strength to draw from, coupled with small populations, make it exceedingly difficult to provide any care at scale, let alone to meet the important quality outcomes incentivized by OHA. The need for creative solutions can come into conflict with state fidelity requirements. The Quality Pool assumes strong foundations to drive year-over-year improvements, never acknowledging the large steps backwards that occur when one provider leaves, when one dental assistant position is unfilled, when – literally – we are 1/3rd of a child short of meeting the childhood immunization metric. These are the challenges and the reality of rural coastal communities. At [CCO], we are graced with a dedicated network of clinical and community safety net professionals. At [CCO], we do all we can to invest in capacity building, sustainable financial contracting models, and staff supports for population health programs, but the challenges faced in rural Oregon cannot be overstated."

- Community-based partner

Network adequacy

Respondents shared problems about and expressed needs to resolve network adequacy gaps across the state when providing services to members. In addition, inconsistent CCO processes such as the difficulty to credential with a CCO or different reimbursement rates create network adequacy gaps by reducing the number of available providers in CCO networks for members to find and receive care through.

“CCO's pay different reimbursement rates for procedures not equitable/ CCO's differ on extra services I recently learned from my child’s surgeon’s office manager, that CCO’s are allowed to pay different rates for procedures. I am referencing CCO’s in the Portland Metro area. My child needed a scar revision from a surgery this past year, we went in for a consult and told we would hear back from the surgery planner. We were then told they ended contracting with [CCO] because they pay less than other PDX area CCO’s for the same procedures. We would have to change my child’s CCO (meaning, altering and disrupting possible care team). This is not right or equitable, my child has complex health needs. The surgeon knows my child’s genetic conditions and risks and we felt safe with this surgeon; To think they broke the care Oregon contract encase they say they pay less is really unsettling. I had no idea this was allowed. I believed all CCO’s had a standard for payment. How is this equitable? I would like my child (adult child) to get support on this issue they still need the surgery and are discouraged they are forced to find a new surgeon, what are his options? He also has the same RCT as me (see below).”

- OHP member, parent, guardian or caregiver

Providers reported the length of time required to credential with a CCO, often three to six months, meant they were unable to see patients on OHP until the credentialing

process was complete or even declining OHP patients because the credentialing process was too complicated.

> “Regarding the comment on credentialing, when we hire a new dentist, it can take up to, like, three to six months to get them credentialed. The new dentist might be ready to start working but they're not able to see patients with OHP. I would like to have an expedited process for credentialing.”
>
> - Provider

> “Our biggest challenge right now is the wait time for our new providers to gain a Medicaid number which the CCO isn't able to process the CCO provider application without. It would be helpful to have a more clear way to start the process such as who to email or even an automated email that you could request that would send you all the required paperwork, including any updates. The time frame of onboarding a provider is delayed when the process takes a long time which really impacts our clients as we see birth to 18 and, especially for our under 5-year-old members if we are waiting 4-6 months that is a lot of time in their life they are lacking access to service.”
>
> –Provider

Other providers reported low reimbursement rates for services, such as immunizations, did not cover the costs associated with providing care. Providers that choose not to offer these services due to the higher costs reduce the number of providers available for communities and members to access these services through.

> “Public health works with a lot of mandates and requirements that are unfunded or insufficiently funded, that serve OHP populations...(Public health is the safety net for the safety net for immunizations. They must provide when local providers are unable/unwilling to provide vaccines, often due to cost barriers...”
>
> - Committee member

Some members reported that having complex care needs significantly increases their wait times for finding care and care coordination services. Other members reported having to wait months and even years to access primary, behavioral or oral health care services.

> “My son is getting behavioral health and support services is a super big challenge. It took us 2 years to get his diagnosis. The first time was through OHSU which was done by a person who was not qualified, we found out later and used old diagnostic criteria. They disqualified my son.
>
> He was later reevaluated by another clinic, and he is very autistic, which is not the term they use, but it's just been a challenge. There's a lot of waits for these little kiddos and they're all the COVID babies. We need a better system. We need some updated training on what autism looks like. How can we support it?”

- OHP member, parent, guardian or caregiver

Other members shared that doctors or providers do not accept patients with OHP. The reasons for this are unclear to members and they often struggle to find providers that both offer services to address the member's needs and accept OHP.

> "Most doctors would not accept my OHP. I have Chrons Disease and was needing infusions to manage it while on disability. It was very stressful to navigate all of this."

- OHP member

Respondents offered several suggestions to improve network adequacy across Oregon. Suggestions to improve the provider network included adjusting payment models based on local demographics, providing more training and resources to case managers, providing funding for behavioral health services in underserved areas, supporting culturally and linguistically specific providers, and supporting CCOs in developing local contracts with peer-led and community-based organizations.

Suggestions to improve how members find and access care included offering travel vouchers to help improve how members access care, especially in rural areas, resolving issues that cause providers to decline OHP or patients with OHP, expanding telehealth options for people with disabilities, integrating behavioral health into the medical home model so members do not have to find behavioral health care separately and publishing clear communications about care coordination services, especially for children with disabilities and complex needs.

Conclusions

Across the themes that emerged from this feedback two needs consistently surfaced and were explicitly stated by respondents:

- There are aspects of health care that respondents would like to see standardized across CCOs; and
- There are aspects of health care that respondents would like to be more responsive to regional or community needs.

Respondents want CCOs to standardize some processes to reduce administrative burden, make it easier and faster for providers to deliver care to members, ensure receiving and delivering services are equitable, and improve access care. Some examples of where respondents suggested CCOs could standardize processes include credentialing, authorization requests, reimbursement rates, care coordination and case management.

Respondents want CCOs to tailor some processes to regional or community-specific needs. They want communities to have a say in what care is needed and how they receive it, to have better information on how and where to get care, and to have the unique needs of communities addressed. Some examples where CCOs could take a more local approach include closing network adequacy gaps by partnering with local CBOs and CBOs that provide culturally and linguistically specific/appropriate services, meeting the unique needs of rural communities, improving funding and payment models for traditional health workers (THW), supporting local community agencies and local decision-making, and addressing the needs and gaps in children's health care.

Appendices

Appendix A. Respondent types

Table 1.
Respondents providing feedback self-identified as belonging to one of the following categories.

Respondents	#
Oregon Health Plan (OHP) member	43
OHP Parent, Guardian or Caregiver	7
Community Partner	37
Provider (CBO)	6
Provider (Medicaid)	12
Provider (Mental Health)	21
Provider (SUD)	3
Provider (other or Unknown)	18
CCO representative	3
Other or Unknown	15
Committees of the Board members	24
Total unique respondents*	158

*Some respondents submitted feedback more than once and self-identified in different categories. Committees of the board members are also counted in their self-identified category. Respondent total is adjusted for this overlap

Table 2.
Count of unique respondents by each method of engagement

Respondents	#
December Listening Session Oral Testimony	15
Dec Written Testimony	33
January Listening Session Oral Testimony	10
Jan Written Testimony	13
ONLINE survey	62
Committee Meeting Public Testimony	6

Appendix B. Definitions

Authorization, or prior authorization: Providers must submit requests and wait for approval from CCOs before referring a member to some specialists and for certain treatments, medications, and procedures. This is called the prior authorization process.

Care coordination: The organization of a patient's care across multiple providers. (2)

Case management: A service offered by health care professionals to help people and their caregivers manage their health needs. This may include helping people get the care they need to manage a diagnosis, illness or injury, or connecting them to doctors, resources, and services. (4)

Community-based organization (CBO): A nonprofit entity that serves those most in need and fills the gaps in traditional healthcare services.

Coordinated Care Organization (CCO): A network of all types of health care providers (physical health care, addictions and mental health care) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

Credentialing: Each CCO coordinates care for specific OHP members in their region. Providers must apply to a CCO before they can provide care to OHP members who are part of that CCO. Credentialing is a part of this application process.

Culturally and linguistically specific/appropriate services (CLSS/CLAS): Outpatient behavioral health services and/or residential substance use disorder services, supporting minoritized communities.

Fee-for-service (FFS), also called Open Card: Health care covered by the Oregon Health Authority (OHA). Members not enrolled in a coordinated care organization (CCO), are Open Card members because OHA pays for care. OHA covers any service not covered by the CCO.

Flex funds/Health-Related Services (HRS): Health-Related Services (HRS), also known as flex funds, are services that are not covered by OHP. CCOs can use flex funds to provide optional services to members to improve care delivery and overall member and community health and well-being.

Health equity: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity,

sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

- Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices. (1)

Health-Related Social Needs (HRSN) benefits: HRSN benefits are covered entitlements to help members stay healthy during times of greater need. Each HRSN benefit has different requirements for qualifying, and not all OHP members will qualify. For members who qualify, HRSN benefits help address social and economic needs, such as housing and nutrition, that affect a member's ability to maintain their health and well-being.

Network adequacy: Making sure people have access to healthcare providers and care is available where and when the patient needs it. Gaps in network adequacy indicate people cannot find or receive care when and where they need it. Importantly, CMS regulations define expectations for network adequacy as follows: Each managed care contractor must maintain a network of appropriate health care providers to ensure all services covered under the State plan are available and accessible to members in a timely manner.

Non-emergency medical transportation (NEMT): OHP pays for travel you need to get health care that OHP covers. This is called "non-emergent medical transportation" (NEMT). NEMT includes travel via taxi, bus or a local ride service to get health care services covered by OHP. It can also help pay for travel costs, such as gas, meals and lodging. NEMT is only for members with OHP Plus benefits.

Oregon Health Authority (OHA): The state agency responsible for administering and overseeing most of Oregon's health-related programs, including the Oregon Health Plan (Medicaid).

Oregon Health Plan (OHP): Oregon's medical assistance program. It provides health care coverage for people from all walks of life. This includes working families, children, pregnant adults, single adults and seniors.

Oregon Health Policy Board (OHPB): The policy-making oversight body for the Oregon Health Authority and its departmental divisions.

Payment model: A systemic approach to paying providers for the health care services that they deliver to patients.

Performance measures/metrics: Goals to improve the health of a group of patients, including incentive metrics. CCO or providers can sometimes receive a financial reward or other incentives for meeting those goals.

REALD and SOGI: REALD and SOGI are sets of standardized questions and data about a person's Race, Ethnicity, and Language, Disability (REALD) and Sexual Orientation, Gender Identity (SOGI).

Reimbursement rate: Providers care for patients and then bill the CCO afterwards to receive payment for the services they provided. The reimbursement rate is the amount the CCO will pay the provider for a specific service and are determined in advance through a contract with the CCO.

Social determinants of health (SDOH): The social, economic and environmental conditions in which people are born, grow, work, live and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.

Traditional Health Worker (THW): Trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members. THWs have historically provided person and community-centered care by bridging communities and the health systems that serve them, increasing the appropriate use of care by connecting people with health systems, advocating for health plan members, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health.

Appendix C. Sources

- March 4, 2025:
  - Preliminary Procurement Feedback Analysis Presentation to OHPB
  - CCO Operational Snapshot presentation update
  - CCO Operational Snapshot Final Report
  - OHPB meeting recording
- February 21, 2025 – CCO Listening Session
  - Meeting recording
  - CCO written comments – Eastern Oregon CCO and Trillium Community Health
  - Press release
- January 7, 2025 OHPB Town Hall
  - Press release to solicit member, provider, and community participation
  - Agenda
  - Meeting recording
  - Written feedback
  - Behavioral health associate provider written comments
- December 3, 2025 OHPB Town Hall
  - Press release to solicit member, provider, and community participation
  - Agenda
  - Meeting recording
  - Written feedback
- October 29, 2024 – OHPB and Committees: Procurement Collaboration Kick-Off Meeting
  - Meeting recording
  - OHPB request for Committee participation – presentation slides
- October 1, 2024 – Annual OHPB Strategic Planning Retreat
  - Meeting recording
  - Request from OHA and Governor's Office for OHPB to solicit procurement feedback – presentation slides
- January 2, 2024 – Governor Kotex letter to OHPB: 2024 – 2025 priority work areas
  - OHPB Priority Area Framework
- OHPB Committee Recommendation Letters
  - Public Health Advisory Board (PHAB) letter
  - Medicaid Advisory Committee (MAC) letter
- OHA Ombuds Program Reports
  - 2024 Ombuds 6-Month Report
  - 2023 Ombuds Year End Report

Appendix D: Online CCO Feedback Survey (English and Spanish)

OHPB CCO Feedback Survey

The Oregon Health Policy Board (OHPB) is gathering stories about people's Oregon Health Plan (OHP) successes, challenges and experiences with coordinated care organizations (CCOs). Experiences shared in this survey will inform the design of the next contract between the Oregon Health Authority (OHA) and CCOs.

Your feedback will help us better understand what drives CCO successes and help develop a model that we can use across the state in the next CCO contract.
OHPB wants to hear personal experiences and perspectives from Oregon Health Plan (OHP) members, caregivers, providers, and community partners.

OHPB is particularly interested to know more about CCO efforts regarding health care for children, care that goes beyond medical appointments to support social and environmental development (such as information about, or access to, air conditioning or housing programs), or behavioral health referrals or partnerships. For example, are there aspects that have helped improve care, communication or health outcomes?

Thank you for taking the time to provide your input.

QUESTIONS:

First and Last Name (optional)

Email (optional)

1) **I am sharing from my perspective primarily as a(n): (choose one)**
   a) Oregon Health Plan (OHP) member
   b) Parent, guardian, or caregiver for an OHP member
   c) Community-based organization representative
   d) Provider or provider organization (medical, dental, behavioral health or other)
   e) CCO representative
   f) Other (please explain)

1a- *(the next 2 open if 'provider' is clicked)* **What type of provider are you?**

- Community-based organization representative
- Primary care provider
- Primary care dentist
- Behavioral health provider
- Traditional Health Worker/Peer service provider
- Provider, other

1a part 2- What type of location do you work in (e.g., hospital, federally qualified health center, primary care clinic)? *(write in)*

1b- *(opens if 'other please explain' is clicked)* **Please describe your perspective.**

2) **The experience you are sharing is about which CCO? This survey will ask you questions about the CCO you select.**
   There will be an opportunity to share an experience with another CCO after clicking "submit" at the end of this form.

Advanced Health
AllCare CCO
Cascade Health Alliance
Columbia Pacific CCO
Eastern Oregon CCO
Health Share of Oregon
InterCommunity Health Network CCO
Jackson Care Connect
PacificSource - Central Oregon
PacificSource - Columbia Gorge
PacificSource - Lane
PacificSource - Marion/Polk
Trillium Community Health Plan - Southwest
Trillium Community Health Plan - Tri-county
Umpqua Health Alliance
Yamhill Community Care
Does not apply to one CCO

3) **Please share the experience you would like to highlight about the CCO you selected.**
   While we welcome any input, OHPB is particularly interested in knowing more about: services or partnerships that support children's wellness, partnerships to support improved access to behavioral health, how the CCO is providing care beyond medical appointments to support social and environmental support (such as housing programs, food assistance or other).

4) **Thinking about your response above, what factors do you think made this experience possible?**
   For example, is the experience a result of certain communication strategies? Have partnerships within or outside the healthcare system impacted your experience? OHPB is looking for models that can be replicated across the state to benefit more people. What do you think are the important parts of this experience that should be replicated or improved?

5) **Is there anything else about the CCO you selected that has made them successful that other CCOs can learn from? Is there anything else about them that you would like to share?**

Thank you for sharing your input!

Hit submit to complete. Once you submit, you will have the option to submit additional questions.

[pop up upon submission] Thank you for sharing your input! If you would like to submit an additional experience, please do so by clicking here:

[For Providers, skip to additional questions]

6) [For providers only] If you are a provider, are you interested in answering another few questions? *(if yes than move on, if no, then end)*

The intent of the provider-specific questions is to:

- Understand where providers are experiencing administrative burden, or alternatively, streamlining what has contributed to a better provider experience.
- Identify successful relationship building tactics, and ways that CCOs can demonstrate adequate relationships in their core work.

Questions for providers:

7) In your experience as a provider or provider organization, what are some of the successes or challenges of credentialing with CCOs? *[write in]*

8) In relation to your response above, what helps make a difference and why? *[write in]*

9) Have you experienced a success or challenge regarding communication between providers and CCOs

Encuesta de opinión sobre las CCO

La Junta de Políticas de Salud de Oregon (OHPB) está juntando historias sobre los éxitos, desafíos y experiencias de la gente con las organizaciones de coordinación de atención (CCO) del Plan de Salud de Oregon (OHP). Las experiencias compartidas en esta encuesta servirán para el diseño del próximo contrato entre la Oregon Health Authority (OHA) y las CCO.

Sus comentarios nos ayudarán a entender mejor lo que hace que las CCO tengan éxito y así desarrollar un modelo que podamos utilizar en todo el estado en el próximo contrato con las CCO.
La OHPB quiere escuchar las experiencias personales y perspectivas de los miembros del Plan de Salud de Oregon (OHP), proveedores de cuidados, proveedores y socios comunitarios.

Los miembros de la OHPB están especialmente interesados en saber más sobre los esfuerzos de las CCO relacionados con la atención médica de los niños, la atención que va más allá de las citas médicas para apoyar el desarrollo social y el medio ambiente (como información sobre aire acondicionado, programas de vivienda, o el acceso a ellos), o las referencias o colaboraciones relacionadas con la salud de la conducta. Por ejemplo, ¿hay aspectos que han ayudado a mejorar la atención, la comunicación o los resultados de salud?

Gracias por su tiempo.

PREGUNTAS:

Nombre y apellidos (opcional)

Correo electrónico (opcional)

10) Estoy compartiendo mi opinión, principalmente como: (elija una)

a) Miembro del Plan de Salud de Oregon (OHP)
b) Padre, tutor o cuidador de un miembro del OHP
c) Representante de una organización comunitaria
d) Proveedor u organización de proveedores (médica, dental, de salud de la conducta u otros)
e) Representante de una CCO
f) Otro (por favor, explique)

1a- *(las 2 siguientes se abren si se hace clic en "proveedor")* **¿Qué tipo de proveedor es usted?**

- Representante de una organización comunitaria
- Proveedor de atención primaria
- Dentista de atención primaria
- Proveedor de salud de la conducta
- Trabajador de la salud tradicional/Proveedor de servicios entre pares
- Proveedor, otro

1a parte 2- ¿En qué tipo de lugar trabaja (por ejemplo, hospital, centro de salud federal, clínica de atención primaria)? *(escriba su respuesta)*

1b- *(se abre si se hace clic en "otros, explique")* **Describa su perspectiva.**

11) **¿Sobre qué CCO es la experiencia que comparte? Esta encuesta le hará preguntas sobre la CCO que seleccione.**
Tendrá la oportunidad de compartir alguna experiencia con otra CCO después de hacer clic en "enviar" al final de este formulario.

Advanced Health
AllCare CCO
Cascade Health Alliance
Columbia Pacific CCO
Eastern Oregon CCO
Health Share of Oregon
InterCommunity Health Network CCO
Jackson Care Connect
PacificSource - Central Oregon
PacificSource - Columbia Gorge
PacificSource - Lane
PacificSource - Marion/Polk
Trillium Community Health Plan - Southwest
Trillium Community Health Plan - Tri-county
Umpqua Health Alliance
Yamhill Community Care
no se aplica a un cco

12) **Por favor, comparta la experiencia que le gustaría destacar sobre la CCO que ha seleccionado.**
Aunque agradecemos cualquier opinión, la OHPB está particularmente interesada en saber más acerca de: servicios o colaboraciones que apoyan el bienestar de los niños, las colaboraciones para apoyar un mejor acceso a la salud de la conducta, cómo la CCO está dando atención más allá de las citas médicas para apoyar el apoyo social y ambiental (como programas de vivienda, ayuda para comida u otros).

13) **Pensando en su respuesta anterior, ¿qué factores cree que hicieron posible esta experiencia**
Por ejemplo, ¿es la experiencia el resultado de determinadas estrategias de comunicación? ¿Han influido en su experiencia las colaboraciones dentro o fuera del sistema de salud? La OHPB está buscando modelos que puedan reproducirse en todo el estado para beneficiar a más personas. ¿Cuáles cree que son las partes importantes de esta experiencia que deberían reproducirse o mejorarse?

14) **¿Hay algo más sobre la CCO que ha seleccionado que haya hecho que tenga éxito y de lo que otras CCO puedan aprender? ¿Hay algo más sobre esa CCO que le gustaría compartir?**

Gracias por compartir su opinión.

Haga clic en “Enviar” para completar. Una vez enviado, tendrá la opción de enviar preguntas adicionales.

[pop up upon submission] Gracias por compartir su opinión. Si desea enviar una experiencia adicional, haga clic aquí:

[Para los proveedores, pase a las preguntas adicionales].

15) [Sólo para proveedores] Si es usted proveedor, ¿está interesado en responder a otras preguntas? *(si la respuesta es afirmativa, continúe; si es negativa, finalice la encuesta)*

El objetivo de las preguntas específicas para los proveedores es:

- Comprender en qué aspectos los proveedores tienen mucha carga administrativa o, alternativamente, optimizar lo que ha hecho la experiencia de los proveedores sea mejor.
- Identificar tácticas exitosas de fortalecimiento de relaciones, y formas en que las CCOs pueden demostrar relaciones adecuadas en su trabajo principal.

Preguntas para los proveedores:

16) Según su experiencia como proveedor u organización de proveedores, ¿cuáles son algunos de los éxitos o retos de obtener la acreditación con las CCO? *[escriba]*

17) En relación con su respuesta anterior, ¿qué ayuda a marcar la diferencia y por qué? *[escriba]*

18) ¿Ha experimentado algún éxito o reto en la comunicación entre proveedores y las CCO?

Appendix E. OHPB April 18, 2025, procurement recommendations table

Overall Recommendation: Establish a common framework for Health Equity Standards. By January 1, 2030, all CCOs will have achieved National Council for Quality Assurance (NCQA) health equity accreditation. Collectively, these6 NCQA standards address the following: workforce diversity, REALD/SOGI data collection, language access, practitioner network cultural responsiveness, culturally and linguistically appropriate services (CLAS), and quality improvement methods to eliminate inequities.

Recommendation 1 and 2: Informed by observations 1 and 2 – Community Partnerships and Streamlining Healthcare

OHPB Final Recommendations	April Observations (Slide #s)	March Observation
1) **Establish a common framework for Health Equity Standards.** By January 1, 2030, all CCOs will have achieved National Council for Quality Assurance (NCQA) health equity accreditation. Collectively, these six NCQA standards address the following: workforce diversity, REALD/SOGI data collection, language access, practitioner network cultural responsiveness, culturally and linguistically appropriate services (CLAS), and quality improvement methods to eliminate inequities. 1.a.) Ensure CCO partnerships with local organizations and agencies provide culturally and linguistically appropriate care, create opportunities for regional alignment, and innovate to meet community needs.	Members receive better care when CCOs partner with communities. (slides #13 – 20)	Local partnerships with communities improve local care.
2) **OHA should increase alignment (minimize variation) across CCOs** and decrease provider administrative burden across the system by ensuring shared standard practices in the following areas: 2.a.) Credentialing 2.b.) Prior authorizations and coverage criteria 2.c.) Data reporting alignment	Unclear, complicated or inefficient requirements increase administrative burden and delay or limit care. (slides #21 – 30)	Variations between CCOs causes challenges. Credentialing is difficult and complicated.

Recommendation 3 and 4: Informed by observations 3 and 4 – Payment models and Reimbursement Rates and Service and Provider Gaps

OHPB Final Recommendations	April Observations (Slide #s)	March Observation
3) OHA should explore strategies to expand health care access, including: 3.a.) Improve payment rates across CCOs, especially rates for children, behavioral health, oral health, traditional health workers, and rural providers to expand access. 3.b.) Incentivize access to care. OHA should explore and review alternative payment models to maximize access to care, especially around children and behavioral health to ensure positive incentives for timely access to care. 3.c.) OHA should encourage alignment of payment models and billing processes across CCOs to reduce administrative burden and improve provider willingness to accept OHP patients, and improve more timely access to care. 3.d.) OHA should include accountability mechanisms for payment models and payment rates in CCO contracts, specifically around distribution of funds for culturally and linguistically specific care (i.e., enhanced rate). 3.e.) OHA should develop clear standards and statewide definitions for **network adequacy** and access to care for CCOs. Measures must be time-sensitive, updated quarterly, and reported publicly, with a defined path for public feedback. CCO's and OHA should collaboratively define improvement strategies if access to care doesn't meet the standard. 3.e.i.) Definitions and future standards to include the following provider types: primary care providers, primary care dentists, mental health providers, substance use disorder treatment providers, and specialty care providers. 3.e.ii.) Definitions and future standards to include timely access to care by provider type, specifically: 3.e.ii.(1). Acceptance rates for new OHP patients. 3.e.ii.(2). Timely availability to urgent care and same day access with an established provider. 3.e.ii.(3). Wait times for routine follow-up visits.	Payment models and reimbursement rates affect quality and availability of services. (slides #31 – 45) Complicated and inefficient billing, contracting, and payment models decrease provider interest in serving OHP members, especially in areas with multiple CCO's in a service area.	

OHPB Final Recommendations	April Observations (Slide #s)	March Observation
3.e.ii.(4). Travel time and distance to nearest available / open provider. 3.e.ii.(5). Timely access measured by telehealth vs. in person care. 3.e.iii.) Definitions and future standards to include variation in access: by age (children/adults) and by population type through use of REALD/SOGI data.		
4) CCOs and OHA should support workforce development, including training, certification, and other workforce preparation and professional development opportunities, especially for Traditional Health Workers (THWs – i.e., Peer Support Specialists, Peer Wellness Specialists, Birth Doulas, Community Health Workers, and Personal Health Navigators). 4.a.) OHA should evaluate the intersection of workforce supply and network adequacy to identify targeted community improvement strategies.	Gaps in service and provider availability make it difficult for members to access care. (slides #46 – 61) OHP members find it hard to access physical and behavioral health services, especially in rural areas of Oregon. When members do find care, they often experience long wait times, long drive times, or providers who are out-of-network or don't accept OHP. Provider sites struggle to retain staff to meet patient needs, and providers are frustrated by long wait times when	Barriers to accessing or providing behavioral health services. Reduce barriers and expand scope of children's health care services.

OHPB Final Recommendations	April Observations (Slide #s)	March Observation
	they refer patients to specialists.	

Recommendation 5 and 6. Informed by observations 5 and 6 – Member complex needs and services not meeting needs

OHPB Recommendations	April Observations (Slide #s)	March Observation
5) CCOs should reduce gaps in care coordination and case management for members with medically complex needs. CCOs should provide more training and resources to case managers, so they can better support patients to navigate systems and services. 5.a.) OHA should improve definition of expectations around care coordination and case management in CCO contracts. 5.b.) OHA should establish baseline standards for CCOs that allows for performance transparency.	Gaps in care coordination and case management impact members requiring complex care. (slides #62 – 69) Care coordination and case management are not happening for people most in need; further, when these services are available, they do not adequately meet members' needs.	Gaps in care coordination and case management
6) CCOs should provide plain language communication to members on how to access available support services (e.g., staff such as care coordinators, case managers, and THWs; and access	Members struggle when services do	

OHPB Recommendations	April Observations (Slide #s)	March Observation
to, for example, health-related services) that can help members resolve common and complex challenges they may experience when navigating health services and member benefits. CCOs should publish clear communications to members about care coordination and case management services, especially for children with disabilities and complex needs.	not meet their needs. (slides #70 – 84) Members struggle when services that should be available either aren't available or don't meet their needs. When members don't receive appropriate care, they are unsure about what they can or should do. Members report feeling like they don't have autonomy over their care and services they receive.	

OHPB to receive quarterly updates on all 4 CCO Procurement Recommendations – 2025-2027.

Appendix F. Citations

1. Health Equity Plan Definitions [Internet]. Available from: https://www.oregon.gov/oha/EI/Pages/HEC%20Plan%20Definitions.aspx.
2. Care Coordination [Internet]. Available from: https://www.healthcare.gov/glossary/care-coordination/.
3. OAR 410-141-3500 Definitions [Internet]. Available from: https://oregon.public.law/rules/oar_410-141-3500.
4. Case Management At-A-Glance [Internet]. Available from: https://cmsa.org/case-management-at-a-glance/.
5. Health Equity Plan Definitions [Internet]. Available from: https://www.oregon.gov/oha/EI/Pages/HEC%20Plan%20Definitions.aspx.
6. Care Coordination [Internet]. Available from: https://www.healthcare.gov/glossary/care-coordination/.
7. OAR 410-141-3500 Definitions [Internet]. Available from: https://oregon.public.law/rules/oar_410-141-3500.
8. Case Management At-A-Glance [Internet]. Available from: https://cmsa.org/case-management-at-a-glance/.