January 13, 2025

To: Brenda Johnson, Oregon Health Policy Board Chair

From: Sarah D. Present MD, MPH, Public Health Advisory Board Chair

Subject: PHAB recommendations for 2027 CCO procurement

Dear Chair Johnson and Members of the Oregon Health Policy Board (OHPB),

Thank you for taking on the important work to collect and coordinate OHPB committee input for the 2027 CCO procurement.

The Public Health Advisory Board (PHAB) holds statutory responsibilities under ORS 431.123 to advise and make recommendations to Oregon Health Authority and OHPB on statewide public health policies and goals. This includes leading the last decade of work to modernize Oregon's public health system, and ensuring this work continues into the future. A modern public health system is one that focuses on upstream prevention, is prepared to respond to public health threats, and is accountable for improving health for all 4.2 million people in Oregon. Public health prevents and mitigates negative health outcomes that result in costly and preventable health care interventions.

On December 12, 2024 and January 9, 2025, PHAB members discussed their experiences working with CCOs and recommendations for opportunities to improve health outcomes through the next CCO procurement. These recommendations are listed below.

Enhance care coordination and case management between CCOs and local public health authorities (LPHAs)

With the next procurement, OHA should explore opportunities to enhance care coordination and case management between CCOs and LPHAs when they are serving the same member. This coordination will result in more efficient approaches to serving the individual and better outcomes as a result. For example:

Reportable communicable diseases: LPHAs have statutory requirements to provide case management for public health services including communicable disease control. LPHAs provide case management for people with restrictable diseases like tuberculosis (TB), serving people who may have complex health needs beyond the communicable disease diagnosis or who do not have the financial resources to isolate during treatment. As another example, LPHAs provide case management for people who are pregnant and who have syphilis to take all necessary steps to prevent congenital syphilis. Lack of coordination between CCO and LPHA case managers when working with people with complex health and social needs results in inefficiencies for the person needing services and duplication of work.

Childhood lead exposures: LPHAs provide case management and care coordination for families experiencing childhood lead exposures. Public health may go into a home to investigate when a child with high blood lead levels is identified. When high lead results come back for the household, public health may work with the CCO to try to identify any resources to help the family.

PHAB recommends that OHA explore the following types of options through the procurement to ensure and enhance communication and coordination of care coordination services:

- Ensuring that, for OHP members with a reportable disease with complex health needs, an assigned CCO case manager is required to work with the public health case manager.
- Identifying mechanisms for coordination for childhood lead exposures to try to provide needed resources to the family.
- Taking steps to ensure that contact information or best information for reaching hard to reach members is identified and provided to LPHAs for reportable disease case management.
- Investing in cross-sector educational opportunities for all parties to understand coordinated resources and care needed for communicable disease treatment and control.
- Ensuring that CCOs are able to connect members to housing assistance options for people who must vacate their homes due to high lead levels to prevent houselessness and further hazardous exposures. This could include providing

housing assistance through the CCO's HRS flexible spending program or other mechanisms.

Explore successful or innovative payment models for public health services that are being implemented locally and elevate these models as best practices at a statewide level.

Public health case management for complex cases often includes critical and costly interventions. Additionally, LPHAs often provide direct clinical services that would be covered if done withing a clinical setting. Existing fee-for-service (FFS) payment structures provide insufficient reimbursement for the services provided and do not fit with current billing infrastructure for most LPHAs. Case management occurs across many public health topics, including communicable and sexually transmitted diseases and maternal and child health. Below are two examples of promising payment models for tuberculosis and maternal and child health case management.

Tuberculosis: Managing a patient with TB may include daily visits for direct observation therapy either virtually or in person, and providing wraparound supports to make sure a person can stay in isolation in a healthful manner. Some CCOs have implemented per member per month (PMPM)-type payment models with LPHAs for these services, thereby ensuring that members receive complete and robust case management.

Maternal and child health case management: Some CCOs provide an LPHA with funding for the upstream prevention work public health provides for members, ensuring the needs of children and families are met and reducing the need for future costly interventions. This may be done through perinatal case management within LPHAs or through local Maternal and Child Health programs.

PHAB recommends that OHA explore opportunities to elevate and encourage the use of successful or innovative payment models to LPHAs for case management and direct services for populations that include large proportions of OHP members. This could include:

- Identifying successful local payment models for coordinated CCO and public health case management and elevating these models as best practices at the state level.

- Identifying barriers to implementing alternative payment models and solutions to those barriers.

Where possible, align CCO and public health metrics. Ensure that the CCO quality metrics program recognizes the contributions of public health prevention and direct services to achieving metrics.

Like CCOs, public health is accountable for improving health outcomes on priority health issues, with metrics used as a mechanism to demonstrate accountability for improvements over time. Increased effort is needed to align metrics at a statewide level and to foster coordination locally. Health improves when health care, public health and other partners align priorities and work together to address them.

As an example, some, but not all, LPHAs provide vaccinations. LPHAs may provide vaccines within a community where local providers cannot afford to provide vaccines and pharmacy capacity to vaccinate may be limited. In these communities, the LPHA may function as a safety net provider of vaccinations, but CMS reimbursement is insufficient to cover the costs of vaccinating OHP members. The resulting resource gap must be filled with public funds or grants, which is not sustainable.

All LPHAs have a statutory responsibility to assure access to vaccinations. To ensure access, LPHAs bring partners together and facilitate conversations to guarantee that the system makes immunizations available to the community. Through the Immunization Quality Improvement for Providers (IQIP) Program, some local public health authorities meet with health care providers to discuss opportunities to increase vaccine access and decrease barriers to vaccination. This is an evidence-based program for increasing childhood and adolescent vaccination rates.

For CCO metrics, many LPHAs have an important role in contributing to childhood and adolescent immunization rates, cigarette smoking prevalence and prenatal and postpartum care. Many CCOs provide funding to LPHAs for their contributions to meeting incentive metrics through grants, a flat amount to reflect public health contributions broadly or a proportional amount based on specific metrics. These decisions are made locally. CCOs are also required to report on how they disburse incentive dollars to health care and other partners.

PHAB recommends that OHA identify opportunities to align CCO and public health metrics and recognize the contributions of LPHAs to CCO quality incentive metrics. Opportunities include:

- Ensuring that public health metrics are reflected in OHPB conversations about metrics alignment, and opportunities for health care and public health coordination on shared metrics are identified at a statewide level.
- Identifying barriers to alignment and solutions to those barriers.
- Identifying innovative or successful local models for compensating LPHAs for contributions to meeting CCO quality incentive metrics and elevating those as best practices at a statewide level.

Streamline and simplify the process to change health plans when more than one option is available, including the role of community partners.

Community partners, as enrollment assistors, help Oregonians enroll in OHP and in their preferred plan when more than one option is available. When a person is enrolled in a CCO they may be randomly assigned to a health plan. If the member prefers a different plan, it takes time, resources and extra steps to switch plans, including for OHP assistors who work with members. It may also delay the initiation of care or interrupt current care with a provider with whom a member already has an established relationship.

Whenever possible, members should be assigned to the same health plan for physical, behavioral and dental health. This is essential for truly integrated care. As an example, a person with an eating disorder may be receiving mental health services through one CCO, but if a hospital admission needs to be made, it needs to happen under physical health which may be provided by a different plan. Other examples that would benefit from integrating behavioral and physical health care, include the provision of hearing aids and conducting neuropsychological testing, two areas that may be identified as a need by behavioral health, but must be ordered and covered by physical health.

All lines of care on one plan leads to increased availability of wraparound services to patients. Providers can better coordinate, which leads to better care and better outcomes.

PHAB recommends that OHA take steps to streamline and simplify enrollment processes for members and community partners who assist them. This may include:

- Creating options to allow people to self-select their plans rather than be automatically assigned.
- Taking all available steps to assign new members to the same plan for physical, behavioral and dental health.
- Invest in more supports for CCO navigation at the LPHA and CBO level to assist members in aligning care.

Consider the organization types that are eligible to serve as CCOs in Oregon and update governing board membership requirements.

PHAB requests that OHA consider the types of organizations that can be CCOs and whether OHA should continue to allow CCOs to operate as for-profit entities. OHA may consider requiring that CCOs are either non-profit organizations or, if CCOs maintain a for-profit status, certified B Corporations to ensure that healthcare dollars are reinvested in the community.

PHAB also strongly recommends that public health has formal representation on CCO governing boards with decision-making authority, in addition to current participation on advisory councils. Specifically, PHAB recommends that OHA add a local public health official under section (2)(o) of ORS 414.572, which specifies membership of CCO governing bodies.

Thank you again for the opportunity to provide this feedback. PHAB welcomes opportunities for further discussion about these recommendations with OHPB members.

Sincerely,

Sarah D. Present MD, MPH

Chair, Public Health Advisory Board

cc: Antonio Germann, Kirsten Isaacson, Chris DeMars, Naomi Adeline-Biggs