Appendix B:

CCO 2.0 Health equity impact assessment

CCO 2.0: Infusing equity throughout the policy development and implementation process

The Oregon Health Authority (OHA) is a state government leader in carrying out both internal and external programs that apply equity, diversity and inclusion principles. OHA's Office of Equity and Inclusion (OEI) leads, advises and oversees strategic initiatives that equip OHA to meet the needs of Oregon's increasing cultural and linguistic diverse population and underrepresented populations.

OEI has been an active participant in the state-wide process to design the next phases of work in health systems transformation and coordinated care organizations (CCOs). This process, per direction by the Oregon Health Policy Board (OHPB) at their July 2018 meeting an assessment of the health equity impact, includes:

- Policy analysis
- Research
- Development, and
- Public input and discussion.

A Health Equity Impact Assessment (HEIA)[1] It is a tool that indicates how a program, policy or similar initiative will impact population groups in different ways. OEI took some key aspects of the HEI tool and performed a desktop assessment informed by:

- Literature review
- Results of the CCO 2.0 public input process, and by
- Feedback provided by the subject matter experts (SME), culturally specific community-based organizations (CBOs), the Medicaid Advisory Board (MAC), and by the OHPB's Health Equity Committee (HEC).[2]

The HEIA tool is intended primarily for application during the design phase of an initiative (pre-implementation). It is also a living document, with health equity impacts identified as the design of the initiative evolves. The current version may not reflect new changes in the policy options due to time constraints. However, the HEIA will be updated again once all changes are in place, prior to the OHPB's October 2018 meeting.

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[1] Conducting a Health Equity Impact Assessment (HEIA): MOHLTC tool https://www.nccmt.ca/knowledge-repositories/search/146

[2] CCO 2.0 recommendations https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018

The desktop assessment is an evaluation tool that looks back to examine whether each policy option is capitalizes on opportunities to improve health equity or whether each policy will result in widening health disparities.

The HEIA has five primary purposes[3]:

1. Help identify potential unintended health impacts (positive or negative) of a planned policy, program, or initiative on vulnerable or marginalized groups within the general population.
2. Help develop recommendations as to what adjustments to the plan may mitigate negative impacts as well as maximize positive impacts on the health of vulnerable and marginalized groups
3. Embed equity across an organization's existing and prospective decision-making models, so that it becomes a core value and necessary criterion to be weighed in all decisions.
4. Support equity-based improvements in program or service design, i.e., through considerations such as "How must this program be adjusted to meet the needs of specific populations?"
5. Raise awareness about health equity as a catalyst for change throughout the organization, so decision-makers develop "stretch goals" through considerations, such as:
    - How can we include more people in this program, especially people often missed?
    - What are the systemic barriers potentially impacting the opportunity for equitable health outcomes?
    - Are we effective, in including people facing the greatest disparities and addressing inequities?

CCO 2.0 Policy options Health Equity Impact Assessment process

Early in August 2018, OHPB directed OHA to work with the Health Equity Committee (HEC) and ensure an equity lens was applied to each policy option presented. The committee had the opportunity to engage in the CCO 2.0 earlier in the policy development process. At the HEC April 2018 OHA policy staff presented the Social Determinants of Health and Behavioral Health Policy Options meeting. The Committee provided a list of recommendations to the policy team.[4]

Given the timing of the request from OHPB, OEI staff was only able to perform a desktop assessment of policy options that presented new strategies for Year 1 and Year 2+ for CCO 2.0. HEC members had the opportunity to submit further comments.

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[3] The Health Equity Impact Assessment (HEIA) Tool, and Workbook updated in 2012 by the Ontario Ministry of Health and Long-Term Care (MOHLTC) in partnership with the public health sector and health service providers.

[4] Health Equity Committee Recommendations on Social Determinants of Health and Health Equity and Behavioral Health Recommendations (June 2018) https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

The intension of the initial OEI CCO 2.0 desktop assessment performed in early August was to help CCO 2.0 the policy team maximize the positive impacts of each policy option and reduce unintended negative consequences that could potentially widen health disparities between population groups. In identifying those impacts, recommendations were made to:

- Adjust the strategies
- Mitigate adverse impacts, and
- Maximize positive results of the policy.

The desktop assessment of the policy options sought answers to the following questions:

- What is the intent behind this policy or strategy?
- Who benefits and who does not?
- If there is potential for unintended consequences, what are the mitigation strategies?
- Are there critical recommendations for implementation based on the public input that should be highlighted?

Based on the desktop assessment, if a particular strategy was highlighted with potential for unintended negative consequences on health equity, the Topic Area Teams (TAT) working on that policy option was asked to provide mitigation measures. In the assessment, and to ensure clarity, OEI staff used the definition for health equity in the CCO 2.0 Policy Development Glossary and Definitions document available on the CCO 2.0 website. The definition states *"Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination."*[5]

OEI shared a draft of the HEIA with policy leads of each CCO 2.0 TAT early in the process. OEI saw this as an opportunity to engage from the beginning with policy teams in critical dialogue about policies and strategies and bring an equity and inclusion perspective to the internal CCO 2.0 policy development process. Beyond helping identify unintended health equity impacts of decision-making (positive and negative) on specific populations, the exercise proved helpful in accomplishing the following:

1. Better ensuring equity at all steps of the policy development process, including considering equity in the policy implementation phase; and
2. Building capacity and raise awareness about health equity throughout OHA as an organization.

The process itself provided opportunities for inclusion and for learning the languages of equity fostering shared understanding and greater collaboration.

[5] CCO 2.0 Policy Development Glossary. Health Equity Definition. https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

Appendix B: CCO 2.0 Health Equity Impact Assessment – September 26, 2018

In September 2018, Health Equity Committee Co-chairs submitted additional feedback based on their analysis of CCO 2.0 Policy Recommendations Straw Proposal presented to the Oregon Health Policy Board (OHPB) on Aug. 7, 2018. They also shared with OHPB that they had provided input on the Health Equity Impact Analysis conducted by OEI and were in full support of the analysis.

As stated before, as policy options continued to adjust, the HEIA was updated to ensure alignment with the policy development process every step of the way. As the process for policy development ends, the HEIA continues to evolve. This recently updated version of the HEIA will be presented to OHPB in their October 2018 meeting and includes "equity considerations for policy analysis" and "equity considerations for policy implementation."

Stakeholder feedback pointed out that the CCO 2.0 policy proposals had the potential to advance (or inhibit) equity depending on how they were implemented. However, "policy options alone cannot achieve equity, and rather it is through the implementation of policy options where true transformation can be realized. "[6] OEI decided then to widen the scope of the HEIA adding, "Equity considerations for implementation."

HEIA impact and major themes

The Health Equity Impact desktop assessment performed in the CCO 2.0 policy development process was informed by available literature, stakeholder feedback and community input. It is important to note that the review process itself had to be adapted to be able to respond in flexible and timely ways to the needs of the project team. In other words, even though, CCO 2.0 policy options have been assessed for their impact on health equity continuously, the extent this initial review could be expected to inform subsequent activities is limited. Future steps related to CCO 2.0 will have to include a separate mechanism for looking at the potential health equity impact of the items proposed.

The desktop equity impact assessment identified three significant themes in the policy options development and implementation:
Changing policy development

- HEIA provided the opportunity to elevate and discuss policy options with an equity lens. For instance, the Value-Based Payment TAT had developed a mitigation plan to ensure that CCO implemented payment models that did not have unintended consequences for priority populations and those with complex health care needs. The HEIA had further questions about the

[6] Health Equity Committee Co-Chairs Recommendations to OHPB. September 7th,2018 https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx

mitigation plans, since from an equity perspective, there is a need for reassurance that members that need more complex care, or those who require extra resources such as Limited English Proficiency (LEP), will not be left behind. The process provided the VBP TAT an opportunity to address these additional concerns and enriched the planning process.

Consolidating understandings of equity
Agreement among policy team that the HEIA was able to bring potential health equity impacts to the fore of the policy development and ensure health equity items were addressed in each version of the CCO 2.0 straw models.

Enabling discussion of alternatives
The HEIA was able to help TATs consider different ways of achieving policy options objectives. The addition of the HEIA as an essential step of the policy development allowed for formality in the process of generating alternatives that address health inequities and ensure health equity is considered earlier in the formulation of policy options.

How to read the assessment

In the initial HEIA shared with OHPB in September 2018, policy options were marked:

- Positive (potential for positive health equity impact)
- Neutral (no positive or negative effect could be identified at this point)
- Negative (potential for negative unintended health equity impact), or
- Both, positive and negative.

All policy options with the potential for unintended negative effects on health equity were flagged. Every policy flagged triggered a mitigation plan from TATs. Mitigation plans were added to the first version of the HEIA, and then, the policy options narrative. The HEIA intended to provide a quick visual to decision makers, not to halt a policy from developing but, to request a deeper dive into their development. As policy options changed, and mitigation plans were incorporated into the policies, the content of the HEIA evolved. Straw models reflected those changes.

This version of the HEIA includes all the recommended policy options for year 1 and Years 2-5. In this version, OEI recognizes the need to assess health equity impacts on policy development and implementation.

Equity considerations on policy implementation are vital. In this step policies work through those responsible for the implementation of the service or strategy and their interactions with the intended beneficiaries of those changes. Implementation is not just the mechanical and straightforward transfer of policy intent into practice. In some cases, under the column "considerations

for policy implementation" CCO 2.0 TATs added details around policy implementation that resulted from the initial HEIA version. Those details are easily identifiable as they reflect the process of implementing and achieving the policy objective (See policies 1-11). In other cases, this version of the HEIA contains equity considerations for policy implementation that aim to guide OHA and CCOs on certain implementation aspects of the policy using an equity lens.

Recommended policies year 1

#	Policy	Equity considerations for policy development	Equity considerations for policy implementation
1	Implement HB 4018: Require CCOs to spend a portion of net income or reserves on social determinants of health (SDOH) (this includes supportive population health policy and systems change), and health equity and health disparities, consistent with the CCO community health improvement plan (CHP) a) Require CCOs to hold contracts or other formal agreements with and direct a portion of required SDOH or HE spending to SDOH partners through a transparent process b) Require CCOs to designate a role for CAC, and tribes or the Tribal Advisory Committee if applicable (see policy #4d) in directing and tracking and reviewing spending. c) Years 1 and 2: Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the global budget rate methodology and	CCOs and OHA should consider that communities may not always have sufficient service capacity or supply to meet SDOH need. However, through SDOH spending, CCOs can increase capacity among community partners. This policy requires careful understanding of availability of SDOH supports and capacity to meet the needs of the CCO service area. In addition, it is important to ensure that the policy is sufficiently flexible to allow spending to be used to build the infrastructure and capacity needed to address SDOH. OHA should consider potential use of integrated information technology, to formally coordinate services between health care, public health and social service organizations.	Implementation of this policy will include a mechanism to measure the impact of SDOH investment in the community. OHA will also explore options for implementation to include sharing of best practices. Technical assistance (TA) from OHA is also needed to build understanding among the health care provider network regarding SDOH referrals, screening, etc. CCOs should strongly consider that any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities. At implementation, CACs and other community groups such as Regional Health Equity

	will seek to build in a specific amount of SDOH and Health Equity investment intended to advance CCOs' efforts to address their members' SDOH and establish their internal infrastructure and processes for ongoing reinvestment of a portion of net income or reserves in social determinants of health and health equity. Investment intended to advance CCOs' efforts to address their members' SDOH and establish their internal infrastructure and processes for ongoing reinvestment of a portion of net income and reserves in social determinants of health and health equity.	Note that policies that improve the overall social and economic well-being of individuals and families will reverberate across a varied range of health outcomes and help to achieve health equity.	Coalitions, should be engaged at every step, to help inform policy and increase transparency. In addition, when implementing this policy, CCOs should consider adding public education components at the community level to educate the public about the importance of the social determinants of health. This strategy could be used to bolster member and community empowerment and shared decision making. CCOs will be expected to engage tribes in this work and in decision-making processes about SDOH and health equity spending.
2	Increase strategic spending by CCOs on health-related services (HRS) by: • Encouraging HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans; and Requiring CCOs' HRS policies to include a role for the CAC and tribes **or** Tribal Advisory Committee if applicable (see policy #4d) in making decisions about how	Consumer perspectives, in this case, the CAC, can assist in making health information more balanced and relevant to patients, and provide the opportunity to listen to the diversity of consumer voices.	At implementation, OHA plans to provide TA opportunities for CCOs to share lessons learned and best practices. As general consideration that could be applied to many of the current recommended policy options for CCO 2.0 about community engagement process is that it is best practice that those processes should be designed to meet unique community needs. OHA should consider developing a framework for CCOs on community engagement. A framework can

	community benefit HRS investments are made. community benefit HRS investments are made.		help guide CCO community engagement activities and ensure that critical considerations about health equity and SDOH are consistently and meaningfully being utilized. OHA will consider providing TA to CCOs on implementation plans for HRS community benefits and inviting community organizations that CCOs have included as part of their community engagement plans to participate.
3	a) **Encourage CCOs to share financial resources with non-clinical and public health providers** for their contributions to incentive measures, through clarifying the intent that CCOs offer aligned incentives to both clinical **and** non-clinical providers with quality pool measure areas b) **Encourage adoption of SDOH, health equity and population health incentive measures** to the Health Plan Quality Metrics Committee (HPQMC) and Metrics & Scoring (M&S)	Sharing CCO financial resources with non-clinical and public health providers would support the sustainability of many programs that depend on grant funding to survive. "Clarifying the meaning of health equity can bring actors a step closer to identifying and promoting policies and practices that are likely to reduce inequities."[7] Performance measurement is an essential yet underused tool for advancing health equity. Measurement allows the monitoring of health disparities and assessment of the level to which	Social Determinants of Health, Health Equity, and other key terms will be defined in the CCO contract. This policy option "encourages" rather than "requires." This is due to concerns around federal waiver restrictions regarding requiring incentive payments to specific providers. In addition, there are concerns about requiring quality pool payments to a single provider type, which may have unintended consequences by setting a precedent for similar requirements for other provider groups.

[7] What Is Health Equity? And What Difference Does a Definition Make?
Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. (Robert Wood Johnson Foundation) | May 2017 http://nccdh.ca/resources/entry/what-is-health-equity-and-what-difference-does-a-definition-make

	Committee for inclusion in the CCO quality pool	interventions known to reduce disparities should be employed. Performance measures can also enable stakeholders to assess the impact of interventions known to reduce disparities. Moreover, measures can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality.	Operational definitions will support the development of objectives and specific targets, determine priorities for the use of limited resources and support measurement of progress. OHA should consider that SDOH, population health and health equity incentive measures must include provider motivation in their design.
4	Strengthen community advisory council (CAC) and CCO partnerships and ensure meaningful engagement of diverse consumers through the following: a) Require CCOs to report on CAC member composition and alignment with demographics of Medicaid members in their communities, including: 1. The percentage of CAC comprised of OHP consumers 2. How the CCO defines their member demographics and diversity 3. The data sources they use to inform CAC alignment with these demographics 4. Their intent and justification for their CAC makeup, and	Meaningful community engagement and representation of consumers, public health, community-based organizations and local and tribal government in the CCO governance is critical to health systems transformation in Oregon. From an equity perspective, many of the communities and members have not historically had a voice in the planning and implementing of the programs and services they use. Decision-making structures must be able to create opportunities for community leaders to participate. In addition, community leaders must receive support, so they can represent their communities appropriately. OHA must ensure expectations for progress in meaningful community engagement are	At implementation, OHA will provide CCOs with an operational definition of meaningful community engagement. In addition, OHA will consider developing a framework for community engagement to be used in the process of policy development and implementation. A framework can help guide CCO community engagement activities and ensure that critical considerations about health equity and the SDOH are consistently and meaningfully being used. CCOs will be expected to demonstrate that it has mechanisms, resources and community partnerships in place to support recruitment and engagement of diverse CAC members. CCOs will also be expected to describe their plans for how they will meaningfully engage

	5. An explanation of barriers to and efforts to increase alignment, and how they will demonstrate progress b) Require CCOs to report CAC member representation alignment with CHP priorities (e.g., public health, housing, education, etc.) and, c) Require CCOs have two CAC representatives, at least one being an OHP consumer, on CCO board. d) OHA is exploring adding a recommendation that CCOs use a Tribal Advisory Committee rather than simply ensuring tribal representation on the CAC. Development of this policy option is occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes. e) OHA is exploring implementation options for a requirement that CCOs have a designated Tribal Liaison per 1115 Waiver Attachment I, "Tribal Engagement and Collaboration Protocol." This is also occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes. OHA is exploring implementation	clear, and that reporting and tracking mechanisms to track the fulfillment of those expectations provide the information necessary for targeted TA to support improvements in demographic alignment and meaningful engagement.	tribes or a Tribal Advisory Committee, if applicable. CCOs will be provided with guidance and clarity that inclusive decision-making structures require: • Transparency • Power balance • Diversity • Intersectionality • Equal decision-making authority • Inclusion early in the process • Attention to power or hierarchy dynamics • Acknowledgment of historical or ongoing abuse and discrimination • Honoring tribal consultation, and • Recognition that community-based organizations have limited bandwidth and resources to dedicate to committee participation if they are not provided additional resources. OHA will consider ways to encourage that CCOs' support for robust representation requires commitment to long-term financial support, ongoing training, TA, and support; and a platform for collaboration.

	options for a requirement that CCOs have a designated Tribal Liaison per 1115 Waiver Attachment I, "Tribal Engagement and Collaboration Protocol." This is also occurring through ongoing collaboration with Oregon's nine Federally Recognized Tribes.		
5	**Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities** by implementing the following: a) Require CCOs to develop a health equity plan, including culturally and linguistically responsive practice, to institutionalize an organizational commitment to health equity, b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and c) Require organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation.	OHA has clarified that the intent of this policy option is not to silo the equity work being done by CCOs. Health Equity Plans must include an organizational approach to health equity. Embedding equity as an organizational goal means equity is present in every policy and every decision. This policy should build on existing equity infrastructure at a CCO and community level. It intends to develop and standardize coordination and accountability in all CCOs. The work on equity at a CCO level should be driven by CCO leadership in close collaboration with the community being served. CACs are a critical partner in this work. Based on community feedback the following must be addressed intentionally: Public input provided areas that would benefit from a more coordinated approach to health equity and culturally responsive	The health equity infrastructure policy option will establish a clear vision for CCOs to follow, with deliverables, timelines, and clearly defined objectives and outcomes. OHA will allow CCOs flexibility to meet organizational, service area, community, and member needs. OHA will provide guidance on areas of focus for health equity plans. The intent is to encourage CCOs to include elements around the advancement of health equity through service delivery; use of Race Ethnicity Language and Disability data standards (REAL-D); criteria for organizational and provider network cultural responsiveness; workforce diversity; community and member engagement, etc. In developing the plans, CCO should include realistic and achievable evaluation measures, benchmarks and milestones.

		care. For instance, CCOs should focus on the quality, and appropriateness of language services that are being provided. Also, there is great need for the inclusion of accessibility assessments [8] of provider network facilities to identify structural barriers that may impede or prevent individuals with disabilities from gaining access to a facility and receiving services, visiting patients, or participating in programs or services that are offered to the public.	To reduce CCO administrative burden, this policy option will be tied to elements of equity work already required for CCOs (via their Transformation Quality Strategies) to ensure accountability. The requirements for organization-wide cultural responsiveness and implicit bias training will include CCO Boards since they are key decision makers at CCOs.
6	**Implement recommendations of the Traditional Health Worker (THW) Commission:** a) Require CCOs to create a plan for integration and utilization of THWs. b) Require CCOs to integrate best practices for THW services in consultation with THW commission c) Require CCOs to designate a CCO liaison as a central contact for THWs d) Identify and include THW affiliated with organizations listed under ORS 414.629 (Note that d. is also covered	Health Equity Committee (HEC) and Medicaid Advisory Committee (MAC) recommendations call for strengthening requirements for THW contracting and utilization to maximize positive equity impact. Public input showed ample support for this policy option. Clear contract language and informed compliance and monitoring are a critical part of these recommendations.	OHA will include explicit language to support the integration of THWs in clinical *and* community settings. OHA will ensure that implementation of these policy options is done in consultation with the THW Commission. At implementation of other policy options that seek to implement delivery and payment changes to CCOs, OHA will consider opportunities to create greater integration of THWs into the health care system and provide more sustainable financing for THWs.[9]

[8] Increasing the Physical Accessibility of Healthcare Facilitates. Report. May 2017. Center for Medicaid and Medicare Services (CMS)

[9] Community Health Workers in Delivery and Payment Transformation: How New Delivery and Payment Models Can Incentivize and Support the Use of CHWs. (2018). Families USA.

	under Policy Option 8 for CHAs and CHPs) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for traditional health workers (THW) services.	CCOs have a role in increasing the THW workforce by setting up a livable and equitable payment system and that ensures sustainability. The incorporation of the THW must be done with fidelity, and it must not be left to interpretation. The development of relationships between CCOs and the THW Commission is critical for effective implementation of the model in the CCO service delivery.	
7	Require CCOs share with OHA (to be shared publicly) a **clear organizational structure that shows how the Community Advisory Council, and tribes or Tribal Advisory Committee if applicable (see policy #4d) connects to the CCO board.**	This policy should go beyond the demonstration of an organizational structure. It should require that CCOs share with OHA and the public strategies in place to ensure CAC full participation on the CCO board, including their process for inclusive CAC decision making.	For implementation consideration see Policy Option #4.
8	Require CCOs to partner with local public health authorities, non-profit hospitals, and any CCO that shares a portion of its service area to **develop shared Community Health Assessments (CHAs) and shared CHP priorities and strategies.** If a federally recognized tribe in a service area is developing a CHA or CHP, the CCO must partner with the tribe in developing the shared CHA and shared CHP priorities and strategies described above.	OHA should establish clear expectations in the development of shared CHA and CHP priorities and strategies. CCOs should demonstrate the ability to develop the connections and relationships in the community necessary to advance community-driven work in SDOH (e.g., community-based organizations, tribes, social service organizations, public health, etc.).	OHA will ensure the voice of consumers experiencing health disparities are included in the CHA and CHP planning process.

	a) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need. Ensure CCOs **include tribes and organizations that address the social determinants of health and health equity in the development of the CHA and CHP,** including THWs affiliated with organizations listed under ORS 414.629.	May create a small limitation on local flexibility by prescribing the type of organizations to be involved	
9	**Require CCOs to submit their community health assessment (CHA) to OHA**	Public reporting, transparency, and accountability are essential tools for advancing health equity. This supports a process which is open and inclusive, allowing for a traceable path to data and results. Promotes transparency and can allow for improved technical assistance to CCOs	CCOs will have the opportunity to share their CHA with a wide variety of community partners.
10	**Increase CCOs' use of value-based payments (VBP) with their contracted providers**	OHA should take into consideration underserved patient populations to help improve value-based care for everyone (Families USA report)[10] OHA should require CCOs to consider racial inequality, ethnicity, sex, sexual orientation, English language proficiency, immigration status, patient income, and	Support VBPs developed as another tool to improve and provide flexibility in the way care is delivered to better serve the diverse needs of OHP members. OEI and the Transformation Center will collaborate on developing and providing CCOs VBP technical assistance.

[10] A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Healthcare Delivery and Payment Systems. Families USA. https://familiesusa.org/product/health-equity-and-value-framework-action-delivery-and-payment-transformation-policy-options

		geographic disparities when designing and implementing VBPs. Proposed VBP policies should allow flexibility to CCOs to implement most appropriate VBP models within the most appropriate settings. Safety-net and small community providers face different challenges than large, urban providers. This approach will allow for transitions in payment models at the right level and pace within each community.	OHA will require CCOs applicants to: • Respond to specific questions in their RFA application that address how their VBP models will not negatively impact "priority populations," including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and members with complex health care needs, as well as populations at the intersections of these groups. OHA will require CCOs to: • Respond to a standardized set of questions within their annual interviews on steps they have taken to ensure their VBPs have not had unintended, negative consequences for "priority populations" and members with complex health care needs. This question set, as well as the questions within the RFA will be developed in partnership with OEI. • Report lessons learned, and strategies used to prevent unintended, negative consequences for these populations in their VBP arrangements, potentially as part of their TQS VBP submission (need CMS approval for this change).

			ethnicity data will provide valuable information to inform VBP policies in future years. OHA has reviewed all proposed VBP policy options with a trauma-informed lens.
11	Evaluate CCO performance with tools to **evaluate CCO efficiency, effective use of health-related services (HRS), and the relative clinical value of services** delivered through the CCO. **Use evaluation to set a performance-based reward at the individual CCO level.**	While these tools may not be able to identify health disparities, it is safe to say that within the healthcare system, every area is responsible to adopt approaches that will make achieving health equity a high priority and tailor solutions for that purpose.	At implementation, the methodology to evaluate CCO performance should consider CCO success in reducing health disparities to the extent possible. OHA will ensure that data collection for evaluation measurement identifies and accurately captures representation of diverse population groups and emerging subpopulations. In addition, care should be taken to ensure that the measures do not create incentives that effectively penalize CCOs with larger populations of people affected by disparities or that undermine CCO efforts to improve health equity. As this policy option is implemented over time, it is important to monitor its impact on health equity and health disparities and to continue to refine the methodology as needed to improve health equity
12	**Incorporate measures of quality & value in any OHA-directed payments to providers** (e.g., hospital payments) or OHA	Cost TAT has identified that there is a potential equity impact depending on metrics used to measure quality and value.	At implementation, OHA should consider the repercussions of the use of metrics of quality and value that could penalize institutions that

	reimbursement policies and **align measures** with CCO metrics Example: qualified directed payments made directly to hospitals are based in part on quality and value	Metrics measuring quality and value related to OHA-directed payments should consider ways to ensure that hospitals (or other provider types) are making equitable improvements in quality and value and could consider financial incentives for reductions in health disparities or other measurable improvements in health equity.	are most likely to care for populations affected by disparities and affected by social determinants of health. Would the use of measures of quality and value impact organizations such as safety-net providers or critical access hospitals? Evaluations will also need to be conducted over sufficiently long-time periods to identify any unintended consequences, such as long-term effects on vulnerable populations.[11]
13	**Adjust the operation of the CCO Quality Pool** to allow consideration of expenditures in CCO rate development to: • Align incentives for CCOs, providers, and communities to achieve quality metrics **Create consistent reporting of all CCO expenses** related to medical costs, incentive arrangements, and other payments regardless of funding source (quality pool or global budget)	Spending patterns should be monitored to ensure no negative unintended consequences takes place.	It is important to make clear that this policy recommendation does not affect the set of metrics chosen by the Metrics & Scoring Committee to determine CCO quality pool earnings. It is unclear whether this policy will change how CCOs spend their quality pool earnings, though spending patterns should be monitored to identify any populations that are positively or negatively affected this is important to ensure that interventions do not increase population health inequities.
14	**Address increasing pharmacy costs** and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers	Pharmacy is an integral component of patient care. Also, management of this benefit has significant downstream effects on health outcomes and cost of care. Bringing transparency to the benefit is important to support all patient populations.	**No equity considerations for implementation identified.**

[11] Pay for Performance Policy Brief. Health Affairs (2012) https://www.healthaffairs.org/do/10.1377/hpb20121011.90233/full/

15	**Address increasing pharmacy costs** and the impact of high-cost and new medications by increasing alignment of FFS and CCO PDLs	Increasing the alignment of pharmacy benefits across the state will minimize variability and will make the benefit easier to navigate for patients, especially for members who transition between CCOs. Increasing clarity and consistency within CCO prior authorization and coverage criteria will make the pharmacy benefit easier for patients and providers to navigate.	As CCO preferred drug lists are increasingly aligned over time, OHA and its partners should include a comprehensive equity analysis to identify any populations that are positively or negatively affected by CCO PDL policies. This is important to ensure that interventions do not increase population health inequities.
16	**Enhance financial reporting and solvency evaluation tools** by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk-Based Capital (RBC) tool to evaluate carrier solvency	**No equity considerations for development identified.**	**No equity considerations for implementation identified.**
17	**Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity.** This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.	Current CCOs may not have the expertise or infrastructure for the behavioral health benefit. Current CCOs may not have the expertise or infrastructure for the behavioral health benefit. Public input and OEI suggest that barriers like benefit limits or requirements for preauthorization should be addressed. The BH TAT has addressed this by clarifying that ownership of the benefit must include responsibility for pre-authorizations. The	Equity considerations for implementation of this recommendation will be directly impacted by other policy options. The BH TAT is aware of these considerations and will address in the workforce, continuum of care and outreach to culturally specific populations recommendations. CCOs in collaboration with OHA should identify gaps between community need and existing mental health services, including services that are not available at all or not accessible to specific populations because of geography, language, financing, or other barriers.

		use of pre-authorizations will be monitored through policy option 18 and through compliance. Other equity considerations are included in BH policy options but have direct impact on the success of this recommendation. The BH TAT is aware of these considerations and is addressing them in the workforce recommendation. They include: the BH provider network is deficient, especially in rural and frontier Oregon. The situation is critical if we account for a diverse provider network. OHA, CCOs and other stakeholders, including communities will address provider network deficiencies to maximize positive impact of this policy. Member provider choices are minimal with specific populations. Tribes, LGBTQ and LEP, are of concern. OEI suggests elevating this issue and addressing it throughout alignment with CCO 2.0 workforce policy development and implementation. Public input and OEI suggest that barriers like benefit limits or requirements for preauthorization should be addressed.	In the workforce and network adequacy the following elements are also addressed. CCOs in collaboration with OHA should identify gaps between community need and existing mental health services, including services that are not available at all or not accessible to specific populations because of geography, language, financing, or other barriers. CCOs should assess if there are existing services sufficient in quantity and quality to meet community need. If there are existing services not accessible to specific populations because of geography, language, financing, or other barriers. If there are services that are currently unavailable or unavailable in sufficient quantity that would better meet the needs of the community CCOs should take inventory of culturally specific services provided by culturally specific agencies. For this work, CCOs should engage with CACs, Regional Health Equity Coalitions, culture specific community-based organizations, etc.

		Another barrier that should be addressed is language and culturally responsive behavioral health services.	
18	**Identify metrics to track milestones of behavioral health (BH) and oral health (OH) integration** with physical health care by completing an active review of each CCOs plan to integrate services that incorporates a score for progress • OHA to refine definitions of BH and OH integration and add to the CCO contract • Increase technical assistance resources for CCOs to assist them in integrating care, culturally responsive principles including trauma informed practices, and meeting metrics	CCOs should have the ability to organize oral, behavioral, and physical health services in ways that better support integration. CCOs should streamline documentation requirements to truly support integrated care. CCOs should plan to enhance culturally specific integrated services, including culturally specific mental health services in physical health care settings. The CCOs have not consistently integrated behavioral health. This will be a lever to ensure CCOs integrate services, for OHA to measure progress and to target technical assistance	CCO plans to integrate BH and OH should consider the following first: There are barriers for timely access to services, language access and accessibility, appropriateness of services, and follow-through in each system. Disparities exist. Service delivery should aim to be culturally and linguistically appropriate; responsive to the community; committed to addressing social determinants of health; focused on language access services and be fully accessible for all members, patients, and clients.
19	**CCOs identify actions for the development of the medical, behavioral and oral health workforce**. CCOs will: • Report on the capacity and diversity of the medical, behavioral and oral health workforce within their geographical area and provider network. CCOs must monitor their provider network to	CCOs reporting on capacity and diversity of the medical, behavioral and oral health workforce and provider network must include language access (bilingual providers, or bilingual staff); provider use of certified and qualified healthcare interpreters; provider use of phone language services and provider accessibility	Language in this policy option should move CCOs further than "reporting" alone on capacity and diversity of the medical, behavioral and oral health workforce within their geographical area and provider network. Language should include enforcement to ensure CCOs are required to look at parity

	ensure parity with their membership. • Develop the healthcare workforce pipeline in their area by participating in and facilitating the current and future training for the health professional workforce. This includes encouraging local talent to return to their home areas to practice and supporting health professionals following their initial training; • Develop and support a diverse workforce who can provide culturally and linguistically appropriate care, trauma informed practices, with attention to marginalized populations; and Ensure current workforce completes a cultural responsiveness training in accordance with HB 2611.	*(ADA compliance- This is a federally mandated requirement*) CCOs should monitor the items mentioned above and develop technical assistance as part of their quality improvement processes. Important to note that the health care system should consider the distribution of providers within an area and between urban and rural areas as a matter of equitable access to care. The overall health care workforce needs to grow to meet demand, must be more ethnically and racially diverse, better distributed geographically, and inclusive of a broader array of jobs—from primary care providers to mid-level providers, to community health workers and peers. OHA should require CCOs to develop a plan on how to diversify their workforce to reflect the demographic composition of the community at all levels and incentivize network providers to do the same. A more diverse health care workforce can also help improve outreach and engagement with communities of color and other communities that experience health inequities.	and develop action plans for addressing any gaps identified. OHA should develop a process to assess the meaning of diversity in provider composition continually. As health outcomes by emerging populations (e.g., LGBTQ) evolve, it's critical the provider mix reflect those served. CCOs should maintain accurate and up-to-date network provider directories that are easily accessible to patients. CCO employment recruitment and retention plans and strategies are intentionally designed to attract a workforce to the organization that is reflective of the populations served. At implementation, CCOs can support the development of the healthcare workforce by: Advocating for more robust integration of health equity and social determinants of health in clinical training to develop a better understanding of how these issues factor into the direct clinical care of patients. Increasing the diversity of traditional health care providers and health system leaders by supporting the expansion of pipeline

		CCOs can support the development and expansion of partnerships and resources to address workforce diversity.	programs and other supports and incentives for students and providers from underrepresented groups and expanding opportunities for training in underserved areas. Working with local school districts, universities and community colleges, healthcare professional boards and community leaders and organizations, CCOs can develop a blueprint for: 1. Increasing diversity of the workforce, and 2. Making the existing workforce culturally responsive. Promoting the sustainable use and integration of THWs and similar community care team members. **Promoting the use and integration of mid-level providers into care teams.**
20	Require CCOs **utilize best practices to outreach to culturally specific populations**, including the development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs)	BH OHA is currently working on a project, in collaboration with OEI and other stakeholders that will identify best practices in culturally and linguistically appropriate care or service provision of behavioral health services. As CCOs integrate, BH special attention should be provided to prioritize addressing the need for cultural responsive and implicit bias training in the BH workforce.	On the implementation of this policy option, consultation with policy team leading this work, THW Commission or OHA Equity and Inclusion Division are strongly advised. Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.

		BH system is behind on addressing language access needs of the population already. Hiring practices must have language and culture as critical recruitment considerations even for front office staff. A more comprehensive approach should take place that encompasses BH organizations in addition to addressing BH care delivery. Adoption of CLAS as a framework to guide BH work on health equity is recommended.	
21	**Prioritize access for pregnant women and children ages birth through five years to health services, developmental services, early intervention, targeted supportive services, and behavioral health treatment.** • CCOs will ensure access to evidenced-based dyadic treatment and treatment that allows children to remain placed with their primary parent. • CCOs will support providers in assessing for adverse childhood experiences (ACEs) and trauma, to develop individual services and support plans. • For pregnant women, CCOs will support providers in screening for	CCOs have experience working with early learning and intervention and should capitalize on that existing relationship to ensure health services are equitable, family-centered and culturally and linguistically responsive. CCOs should recognize that primary care behavioral health delivery looks different in pediatric care settings. CCO collaboration with schools and early learning is fundamental. The focus should include addressing the BH needs of children and youth with specialized health needs.	At implementation, the following should be taken into consideration: Need for parental awareness about services available, types of support offered and their benefits. Information needs to be provided in a timely manner, and in a culturally and linguistically appropriate way. Parental understanding of the critical importance of the early years, and of the home environment for learning and development, with targeted support and tailored strategies for families. OHA and CCOs should ensure that services and interventions are available in a range of different languages.

	behavioral health needs and substance use prenatally and post-partum. CCOs will provide appropriate referrals and follow-up to referral. • CCOs will prioritize access to substance use disorder (SUD) services for pregnant women, parents, families, and children, including access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services for parents and behavioral health screening and treatment for children.	Focus on BH workforce with pediatric expertise. Concern over behavioral health scarcity of services. In many Oregon communities, children must leave their homes and receive care someplace else. Many factors influence the underutilization of behavioral health services by parents and children, including stigma, cost, cultural barriers, access to and regional distribution of providers, and a shortage of child and adolescent psychiatrists.	Mixed eligibility for health insurance within families is likely to be common due to differences in parental or spousal employment and documentation status. Regardless, those parents should be included in the interventions and treatment plans. Based on public input provided in culture-specific events, interventions that address children must have a parent education component and support. Literacy, language, and cultural needs must be addressed
22	Implement risk-sharing with the Oregon State Hospital (Behavioral Health Collaborative recommendation)	Implement risk-sharing with the state hospital (Behavioral Health Collaborative recommendation), in a way that is consumer driven and where equity considerations are met. As CCOs assume risk OHA anticipates an increase in community care and a decrease in hospitalizations.	Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.
23	Shift financial role for statewide HIT public and private partnership from OHA to CCOs to cover their fair share	Increasing CCO investment and participation in the HIT Commons will promote health equity by creating more opportunities for the HIT Commons to hear	**No equity considerations for implementation identified.**

		from a variety of communities across the state.	
24	**Require CCOs to ensure a care coordinator is identified for individuals. with severe and persistent mental illness (SPMI) and for children with serious emotional disturbances (SED), and those in medication assisted treatment for SUD** and incorporate the following: • Develop standards for care coordination that reflect principles that are trauma informed and culturally responsive. • Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (intellectual and developmental disabilities) Establish outcome measure tool for care coordination	Individuals with severe and persistent mental illness (SPMI) require more intensive support to effectively address the complexity of their needs. OHA should require CCOs to address the importance of cultural and linguistic competencies in the design and implementation of care coordination approaches. Focus care coordination efforts that consider the impact of race, ethnicity, language access, and other community factors, support engagement and effective transitions.	Any initiatives developed with the intent of fulfilling objectives of this policy option at implementation should include a comprehensive equity analysis to identify any populations that are positively or negatively affected; this is important to ensure that interventions do not increase population health inequities.
25	Develop mechanism to assess adequate capacity of services across the continuum of care. Ensure members have access to behavioral health services across the continuum of care.	Communities provide different types of treatment programs and services for children and adolescents with mental illnesses. The complete range of programs and services is referred to as the continuum of care. Not every community has every type of service or program on the continuum. This is a concern.	Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.

		From an equity perspective, the development of assessments on network capacity and continuum of care must include language and accessibility capabilities. Cultural and linguistic competence in the delivery of mental health services for racial and ethnic minority populations	
26	System of Care to be fully implemented for the children's system	Systems of care are broad, flexible array of evidence-informed services and support for defined populations, in this case, children. Implementation of SOC in children must include culturally and linguistically appropriate services, screenings, care coordination to be "fully implemented."	Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities.
27	Require **Wraparound is available to all children and young adults who meet criteria**	Wraparound is unique from typical service delivery strategies, in that it provides a comprehensive, holistic, and youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center.	Use of equity lens at the implementation of policies these population should be required. CCOs and OHA should ensure diverse community representation in all collaborative efforts to plan, implement and oversee Wraparound as a community process. Community partnerships should be in place to ensure access to needed support and services and that those services are culturally and linguistically appropriate.
28	**MOU between CMHP and CCOs enforced and honored**	**No equity considerations for development identified.**	**No equity considerations for implementation identified.**

29	Identify and address billing system and policy barriers to integration: • Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting • Develop payment methodologies to reimburse for warm handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, Wraparound, PCIT, EASA) • Examine equality in behavioral health and physical health reimbursement	Without a dedicated funding stream for coordination, it is difficult to bridge [separate] systems, including billing. Among the barriers to accessing care that. Implementing new billing and claims systems for non-traditional providers. Consider changes in legislation and regulations regarding scope of practice, licensing, prescribing, and supervision to allow more mid-level providers to practice at their highest level and facilitate integration. Exchange of physical and behavioral health diagnosis and treatment information among providers is a pillar of integrated care. Two issues make this especially dif-ficult concerning behavioral health services: lack of information technology and constraints on sharing behavioral health data across practices and agencies Special considerations to children's physical and behavioral health needs at integration.	Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected this is important to ensure that interventions do not increase population health inequities.
30	**Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts** Connect contractual requirements to ongoing evaluation of Oregon's	Oregon CCOs will be addressing social determinants of health and continuing to the path of adopting value-based payments. Risk adjustment is the standard solution for leveling the payment playing field so that providers are fairly compared to each other by adjusting for patient	Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected this is important to ensure that interventions do not increase population health inequities.

	sustainable spending target based on national trends and emerging data to inform more aggressive targets in future while providing CCOs with additional financial incentives to achieve spending targets in the form of shared savings arrangements	factors that are out of their control and research indicates that adjusting for social risk is a path that needs to be explored. When social risk factors are not accounted for in performance measurement and payment in the health care system, achieving performance benchmarks may be more difficult for providers disproportionately serving socially at-risk populations owing to the influence of social risk factors.	
31	Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy with financial implications	**No equity considerations for development identified.**	**No equity considerations for implementation identified.**

32	**Require CCOs support EHR adoption across behavioral, oral and physical health contracted providers**	"EHR adoption is not a goal in and of itself, but a pathway towards reducing historical health disparities."[12] EHRs and other HIT tools that are successfully integrated into clinical workflow have the potential to improve patient safety and quality of care while helping to eliminate health disparities. EHRs are also foundational to participation in many kinds of electronic health information exchange (HIE), which can help to support care coordination for patients with complex medical and social needs. OHA should be intentional supporting the adoption of EHRs and other innovative HIT tools for providers who treat underserved populations	OHA should ensure that targets for EHR adoption and the methods that CCOs use to support EHR adoption are driven by CCO's knowledge of community needs by allowing CCOs to choose targets and methods. CCOs should give careful attention to issues of EHR certification requirements to avoid the potential for unintended consequences for behavioral health providers, as there are few certified products that meet their needs. However, it is important to prioritize adoption of EHRs that can track language, sexual orientation, gender identity and social risk factors. CCOs should plan for technical assistance to support the collection and documentation of comprehensive patient demographic data.

[12] EHRs, health IT can be leveraged to cut health disparities. (2014) Jennifer Bresnick. Health IT Analytics. https://healthitanalytics.com/news/ehrs-health-it-can-be-leveraged-to-cut-health-disparities

33	**Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange technology** that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications	Electronic health information exchange (HIE) has the potential to improve patient safety and quality of care while helping to eliminate health disparities. It can also help to support care coordination for patients with complex medical and social needs. For example, providers are currently using PreManage, Oregon's statewide hospital event notifications tool to support Assertive Community Treatment teams, which provide care to people experiencing Serious and Persistent Mental Illness (SPMI). Other HIE tools, like regional HIE organizations, are working to bring together information from medical providers and social determinants of health providers to provide whole-person care to vulnerable populations.	OHA should ensure that targets for HIE adoption and the methods that CCOs use to support HIE adoption are driven by CCO's knowledge of community needs by allowing CCOs to choose targets and methods.
34	**Require CCOs to demonstrate necessary information technology (IT) infrastructure for supporting VBP arrangements,** including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and support contracted providers so they can effectively participate in VBP arrangements.	HIT is critical for participation in value-based care. Delivering high-quality, comprehensive health care is necessary but not sufficient for success under value-based payment. CCOs must be able to prove that their care results in better outcomes.	Any initiatives developed with the intent of fulfilling objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected this is important to ensure that interventions do not increase population health inequities. OHA should provide guidance to CCOs on health IT infrastructure needed for VBP reporting.

35	Establish a more robust team in OHA responsible for monitoring, compliance, and enforcement of CCO contracts, building on existing resources.	This policy option would require assessment of current resources and possible reallocation of existing capacity or new capacity. From a health equity perspective, the oversight required to address issues related to health equity: cultural responsiveness, health literacy, CLAS, language access, ADA and others, require capacities that differ from those needed to oversee standard contract requirements.	A number of factors drive the need for OHA to establish a team with the capacity to perform monitoring, compliance, and enforcement of areas related to health equity included in the CCO contract: (1) many oversight processes in this area will require specialized knowledge and skills; (2) effective oversight often requires close coordination among staff and other partners, including other OHA decisions such as OEI.

RECOMMENDED POLICIES: BEGIN IMPLEMENTATION YEARS 2-5			
#	**Policy**	**Equity Considerations for Policy Development**	**Equity Considerations for Policy Implementation**
36	**Shift mental health residential benefit to CCOs**	Setting aside benefit ownership the core issue is whether services can be delivered to populations throughout the state. Oregon must address fundamental, structural barriers present in the behavioral health care delivery system including workforce deficiencies, culturally and linguistically appropriate mental health residential services and billing procedures. The issue of residential treatment needs in rural areas continues to be a point to be considered.	Any initiatives developed with the intent of fulfilling the objectives of this policy option should include a comprehensive equity analysis to identify any populations that are positively or negatively affected. This is important to ensure that interventions do not increase population health inequities. OHA must provide technical assistance to Coordinated Care Organizations in integrating residential and outpatient behavioral health services.
37	**Establish a statewide reinsurance pool** for CCOs administered by OHA to spread the impact of low frequency, high-cost conditions and treatments across an entire program	**No equity considerations for development identified.**	When implementing a statewide reinsurance pool, there must be careful consideration of how the consumers will be affected to ensure that high-cost patients are not negatively impacted.
38	**Ensure continued CCO solvency** by establishing solvency thresholds at a level that adequately considers the financial risks CCOs face and strengthening OHA's solvency regulation tools	In the event, a CCO suffers an insolvency crisis, patients with the most complex social and medical needs would likely suffer the most. Ensuring that CCOs remain financially stable, or that OHA has the necessary tools to manage an impaired CCO protects patients and their access to	**No equity considerations for implementation identified.**

		the health care services they need and the providers they trust.	
39	Identify, promote and expand programs that integrate primary care into behavioral health settings (**Behavioral Health Homes)**	This policy option should consider applying an equity lens to further policy development and implementation. While research suggests that integrated models of behavioral health services (that is, models that involve colocation of physical and behavioral health services and collaborative care models in physical health care settings) are most effective in improving mental health outcomes for racial and ethnic minorities and reducing disparities Receiving mental health services in physical health care settings is thought to reduce barriers to access through practical convenience and privacy, which is particularly important for individuals who may refrain from seeking services because of culturally-based stigma about mental health problems and services. However, continuity of care is important for all patients, but it is especially critical for those with complex chronic conditions	At implementation, the following needs to be taken into consideration: Language barriers decrease the odds of using behavioral health services, therefore for behavioral health homes, the integration of primary care in behavioral health setting must include teams that are culturally and linguistically responsive, to the needs of the individuals seeking care and to the needs of the community. Current workforce shortages and the need for a culturally and linguistically responsive workforce in behavioral health prove that this intervention may be appropriate for certain groups but not for all. OHA when developing guidelines to identify, promote and expand programs that integrate primary care in behavioral health settings should consider the following: 1) the acceptability and use of behavioral health services are impacted by cultural attitudes, beliefs, and practices; 2) the current science base around psychiatric diagnosis and

		who need ongoing care. People with SPMI or substance use disorder frequently have limited access to primary care, due to stigma and environmental factors, and are often underdiagnosed and undertreated.	treatment is derived from research primarily involving European-origin populations; and 3) ethnic and minority communities face many increasing challenges around mental illness and substance use, such as lower access to services and evidence-based treatments, higher burdens of morbidity, and a multitude of social determinant stressors.[13]
40	CCOs, with the support of OHA, to **require providers to implement trauma-informed care practices**	Trauma-informed care practices involve both organizational and clinical changes that have the potential to improve patient engagement and health outcomes. CCOs and OHA should not focus only on health care providers but in the implementation of broad changes across their organizations to address trauma. Another consideration is that traditional payment systems present significant barriers to implementing a trauma-informed approach. The integration of behavioral health and primary care services, which provide coordinated care and a whole-person	Creating a Trauma-Informed Approach to Care[14] means engaging patients in organizational planning for the implementation of trauma-informed practices. OHA and CCOs should ensure that training and education components are developed to create a safe environment and to prevent secondary traumatic stress in staff. OHA and CCO should support providers by engaging referral sources and partnering with organizations. The timing of screenings should be carefully considered to reduce the risk of racial and ethnic bias.

[13] Eliminating Mental and Physical Health Disparities Through Culturally and Linguistically Centered Integrated Healthcare (2017) Octavio N. Martinez Jr. Journal of Family Strengths. Vol (17) Issue (1)
[14] ISSUE BRIEF Key Ingredients for Successful Trauma-Informed Care Implementation (2016) Christopher Menschner and Alexandra Maul, Center for Health Care Strategies.

		approach, increase the opportunity for successful trauma-informed treatment.	CCOs and OHA should ensure that health care professionals participating in the CCO provider network are proficient in trauma screening and know how to conduct appropriate follow-up discussions with patients that are sensitive to their cultural and ethnic characteristics (e.g., language, cultural concepts of traumatic events).
41	Develop an incentive program to support behavioral health providers' investments in electronic health records and other, related HIT. (Feasibility depends on 2019 legislative session)	Given the underutilization of electronic health records (EHRs) among behavioral health specialists, priority should be placed on designing a comprehensive incentive program that promotes use of EHRs in behavioral health practice settings and addresses the barriers for EHR implementation in a behavioral health setting and integration. Although EHRs can demonstrate long-term cost savings for providers, the initial financial investment and staffing requirements may be too great for a solo or a small group practice to bear. According to the literature, healthcare providers would invest more of their resources to integrating behavioral and physical health information to improve their population health initiatives were the resources available.	Without proper investment and support to BH providers investments in technology, integration is hard to imagine. Stakeholders, like OHA and CCOs and community-based organizations must work together and use health IT tools to create connections between social and behavioral healthcare organizations and the primary care system to develop a better understanding of patient's challenges and needs.

42	Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in-person, regardless of a patient's geographic setting (rural, urban). Coverage would include asynchronous communications if there is limited ability to use video conferencing. This proposal does not address the availability of telehealth services (i.e., does not require CCOs to add new providers to ensure telehealth is broadly available), but focuses on coverage.	This is a limited technical fix intended to bring CCOs into alignment with telehealth coverage rules for private payers. Currently, private payers are required to cover telehealth services provided by a contracted provider if they would have covered the service if the contracted provider had provided the service in person. CCOs, in contrast, can choose to cover telehealth services in that situation, but may also deny coverage. Many CCOs have already aligned with private payer rules; this policy option would provide uniformity by requiring CCOs to cover telehealth services in the situation described above, just as private payers are currently required to do.	Due to widespread lack of clarity about this policy option, OHA will delay implementation to allow for further stakeholder engagement and policy development. OHA may also engage in a broader discussion about building telehealth capacity, which is outside the scope of this policy option. Broadband capabilities that would enable telehealth in some areas in Oregon and its impact on quality and reimbursement should be addressed at implementation.
43	Continue CCO role in using HIT for patient engagement and link to health equity	CCOs should consider that HIT has a role in patient engagement and such initiatives could be part of the health equity plan. CCO should ask vendors for cultural and linguistic accessibility when discussing bringing on new tools for patient engagement (OHA is aware that accessible tools may not currently exist in the market; the requirement is simply to ask to demonstrate interest in such tools)	OHA should ensure health equity plan guidelines include a HIT component for patient engagement. OHA and CCOs should work together on addressing the need for better IT tools that are culturally and linguistically responsive.