Appendix C:

CCO 2.0 and children's health

CCO 2.0 and Children's Health

Health in the earliest years of life – starting with a mother's health before pregnancy – has lifelong impacts on well-being. Early childhood is a unique and critical window of opportunity to set a positive trajectory for a child's long-term health. In the first few years after birth, a child's brain forms more than one million new neural connections every second. Early childhood brain development is impacted by numerous factors, including the social determinants of health. Research on adverse childhood experiences (ACEs) also demonstrates that early life exposure to negative events, trauma, and family instability increases the likelihood of poor health later in life and creates barriers to educational success.

Additionally, large disparities in health outcomes exist across Oregon's child population, with state and national data demonstrating that children of color and children in poverty fare worse, overall, than white children and those of higher socioeconomic status. Early childhood disparities exist across numerous areas of health and well-being, from infant and maternal mortality to oral health status to ACEs, trauma and toxic stress. Prominent disparities exist in other domains with strong implications for early childhood health, including access to basic needs like food, diapers, and safe and stable housing. Children and youth with special health care needs and their families also face significant barriers in accessing health care and other supportive services.

Investment in early childhood services and maternal and child health is a proven strategy to improve health outcomes and contain health care costs, as well as creating notable returns on investment in education costs, workforce productivity, crime reduction, and reduced burden on safety net services. Evidence also shows the most effective interventions to support healthy early childhood development are those that support parent-child connections and family stability, impacting two generations – for it is difficult to sustain positive impacts on children without addressing the needs of their caregivers.

As stated in Healthy People 2020, improving the well-being of mothers, infants, children and families is a critical public health goal. The health and well-being of these populations determine the health and well-being of today's citizens as well as the next generation. It can also predict future opportunities and challenges for communities and health care systems. CCO 2.0 offers a unique opportunity for the Oregon Health Authority and the coordinated care model to positively impact the trajectories of our youngest Oregonians' lives through health system transformation strategies and policies.

CCO 2.0 policies impacting children's health

Staff have strategically considered how each CCO 2.0 policy will impact children and families, including implementation options at the CCO level for maximum impact on child outcomes. Included in the CCO 2.0 policies are strategies to prevent and address the behavioral health issues that destabilize families and impede children's readiness for kindergarten; payment strategies to improve delivery of maternity and pediatric care; and policies that drive CCOs' work to improve the social and environmental context in which the most vulnerable Oregonians live.

Overall, 26 out of 43 CCO 2.0 policies were determined to have a potential to positively impact children. These are noted in the "Dashboard" section in Appendix A: CCO 2.0 Recommended Policies and Implementation Expectations and listed in Table 1 below. In addition, some key examples of how these policies are intended to impact children and families are provided here:

Policy 1 includes a proposed strategy to build into the CCOs' global budget rate methodology a specific amount of spending to advance members' social determinants of health and health equity. This includes a statewide priority of CCO spending on housing-related supports and services, including opportunities and encouragement to partner with community housing entities and capitalize on state efforts toward permanent housing for low-income families. CCOs can further leverage this opportunity by focusing their spending on families with young children and can complement these investments with strategic use of health-related services (**policy 2**) to provide parenting supports, as well as meet childcare and transportation needs to enhance families' access to health care services.

Policy 10 requires that in years three through five of the CCO 2.0 contracts, each CCO will implement new value-based payments (VBPs) in five care delivery focus areas, two of which are maternity care and children's health care. Maternity care VBPs offer promise in delivering higher-quality, cost-effective care through promoting care coordination and flexibility in types of services, providers and care settings. This is especially important for at-risk populations that have lower utilization of prenatal care and higher rates of adverse birth outcomes. In addition, through their children's health care VBPs, CCOs will begin to develop payment models that address social determinants of health (including trauma related to adverse childhood experiences), thus supporting long-term positive health outcomes.

Policy 21 prioritizes access to behavioral health services and early intervention for pregnant women, parents, families and young children to prevent poor long-term outcomes and reduce costs. CCOs can ensure children and families have access to evidence-based treatment approaches for families that help children with symptoms of emotional disorders. Additionally, CCOs will be expected to prioritize access to substance use disorder services for pregnant women, parents, families and their children to provide the best outcomes for young children and their caregivers. CCOs can improve outcomes for new families by ensuring mothers continue to have access to behavioral health services, including traditional health workers. CCO 2.0 will require that behavioral health services are accessible and available to all members throughout their lifespan (**policy 25**) and CCOs will ensure care coordinators are identified for families of children and youth with special health care needs (**policy 24**).

Integrating oral health care in the primary care setting offers an excellent way to set up children for a lifetime of improved oral health, which has significant impacts on academic success and overall well-being. This integration is supported through a variety of CCO 2.0 policies including **policy 10,** which encourages oral health integration through value-based payment, and **policy 18,** which drives measurement of integration of behavioral and oral health into physical health care.

Teledentistry is a key strategy for expanding access to oral health care in frontier/rural areas and reducing geographic disparities in access and outcomes. **Policy 42** standardizes coverage for telehealth services, including teledentistry. This can be especially important for children

receiving care in school settings from expanded practice dental hygienists who may rely on electronic consultation with dentists.

Policy 33 requires CCOs to ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology. Electronic HIE for care coordination offers significant benefits to families and caregivers of children, especially those with complex medical needs. It can eliminate the need to fax, mail or hand-carry medical records when seeing a new specialist, ensure all members of the child's care team can access the child's up-to-date health information at appointments, and provide real-time notifications to care team members that the child is being seen at the emergency department (ED) to facilitate follow-up – or even allow care team members to reach out to the family before they leave the ED.

OHA will also implement a policy from the 2017 Medicaid waiver renewal (**policy 11**) that will reward CCOs for delivering efficient care and encourage care delivery with the highest clinical value. This policy should provide CCOs additional incentive to increase the availability of health-related services for children and their families and should build on other policy options that more directly encourage CCOs to improve delivery of behavioral health services and address social determinants of health. Embedded in this policy are new data and analytical tools that should help CCOs and OHA better identify CCO success and areas for improvement, which should in turn improve the system's ability to serve children and their families covered by OHP.

Table 1: CCO 2.0 policies identified as having a potential to positively impact children

#	Focus area	Policy
1	Social Determinants of Health and Health Equity	**Implement House Bill 4018: Require CCOs to spend portion of net income or reserves on social determinants of health (SDOH; including supportive population health policy and systems change) and health equity/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 and health equity spending to, SDOH partners through a transparent process. B. Require CCOs to designate role for community advisory council (CAC), and tribes and/or tribal advisory committee if applicable (see Policy 4, Part D), in directing and tracking/reviewing spending. C. **Years 1 and 2:** Concurrent with implementation of HB 4018 spending requirements, OHA will evaluate the global budget rate methodology and seek to build in a specific amount of SDOH and health equity investment. This is 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. **i.** **Require one statewide priority** – housing-related supports and services – in addition to community priority(ies).
2	Social Determinants of Health and Health Equity	**Increase strategic spending by CCOs on health-related services** (HRS) by: A. Encouraging HRS community benefit initiatives to align with community priorities, such as those from the community health assessments (CHAs) and community health improvement plans (CHPs); and

		B. Requiring CCOs' HRS policies to include a role for the community advisory councils (CACs) and tribes and/or tribal advisory committee if applicable (see Policy 4, Part D) in making decisions about how community benefit HRS investments are made.
3	Social Determinants of Health and Health Equity	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** by the Health Plan Quality Metrics Committee (HPQMC) and Metrics & Scoring (M&S) Committee for inclusion in the CCO quality pool
4	Social Determinants of Health and Health Equity	**Strengthen community advisory council (CAC)/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 Oregon Health Plan (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 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 (for example, public health, housing, education, etc.); and C. Require CCOs to have two CAC representatives, at least one being an OHP consumer, on the 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.
5	Social Determinants of Health and Health Equity	**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 organizational commitment to health equity; B. Require a single point of accountability with budgetary decision-making authority and health equity expertise; and C. Require an organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation.

6	Social Determinants of Health and Health Equity	**Implement recommendations of the Traditional Health Worker (THW) Commission:** A. Require CCOs to create a plan for integrating and utilizing 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 THWs affiliated with organizations listed under ORS 414.629 (note that Part D is also included under Policy 8 for CHAs/CHPs). E. Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for THW services.
8	Social Determinants of Health and Health Equity	Require CCOs to partner with local public health authorities, nonprofit hospitals, and any CCO that shares a portion of its service area to **develop shared CHAs and shared CHP priorities and strategies.** If a federally recognized tribe in the CCO's 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. 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/CHP,** including THWs affiliated with organizations listed under ORS 414.629.
10	Value-based Payment	**Increase CCOs' use of value-based payments (VBP) with their contracted providers**
11	Cost	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.**
17	Behavioral Health	**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.
18	Behavioral Health	**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 CCO's 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, implementing culturally responsive principles including trauma-informed practices, and meeting metrics

19	Behavioral Health	**CCOs identify actions for developing 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 ensure parity with their membership. • Develop the health care 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 that can provide culturally and linguistically appropriate care, and trauma-informed practices, with attention to marginalized populations. Ensure current workforce completes a cultural responsiveness training in accordance with House Bill 2611**.**
20	Behavioral Health	Require CCOs **utilize best practices to outreach to culturally specific populations**, including development of a diverse behavioral and oral health workforce that can provide culturally and linguistically appropriate care (including utilization of THWs)
21	Behavioral Health	**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 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.
22	Behavioral Health	Implement risk-sharing with the Oregon State Hospital (OSH)
24	Behavioral Health	**Require CCOs to ensure a care coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disturbances (SED), and individuals in medication-assisted treatment for SUD** and incorporate the following: • Develop standards for care coordination 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) • Establish outcome measure tool for care coordination.

25	Behavioral Health	**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
26	Behavioral Health	**System of Care (SOC) to be fully implemented for the children's system**
27	Behavioral Health	Require **wraparound is available to all children and young adults who meet criteria**
28	Behavioral Health	**MOU between community mental health program (CMHP) and CCOs enforced and honored**
29	Behavioral Health	**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, Parent-Child Interaction Therapy, Early Assessment and Support Alliance); and • Examine equality in behavioral health and physical health reimbursement.
33	Behavioral Health/Health Information Technology	**Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology** that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications
35	All	Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources
39	Behavioral Health	Identify, promote and expand programs that integrate primary care in behavioral health settings (**Behavioral Health Homes**)
40	Behavioral Health	CCOs, with the support of OHA, to **require providers to implement trauma-informed care practices**
42	Behavioral Health/Health Information Technology	**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 or urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (it does not require CCOs to add new providers to ensure telehealth is broadly available) but focuses on coverage.

Linkages to other system work to support children and families

In 2018, Governor Brown's Children's Agenda includes a set of priorities that impact the health and well-being of young children and their families; CCO 2.0 aligns with many of these priorities. The Governor's Agenda priorities includes supporting pregnant and postpartum women who experience substance use disorder so they can effectively parent, parent-child centered behavioral treatments, and community-based family and parent support programs such as parenting education and Relief Nursery services. In addition, multi-prong strategies are being considered around housing and sheltering specifically for families with young children,

affordable high-quality early care and education services for children 0–3 and quality preschool for children ages 3 to kindergarten entry.

One of the key strategies prioritized in the Governor's Children's Agenda is supporting home visiting programs for new parents and their children, intervening early to put families on a pathway to success. Home visiting is an upstream prevention strategy used to support parents in providing safe, nurturing and supportive environments for their children. Home visiting programs include voluntary, structured visits by trained professionals to provide parenting education on a wide variety of topics including feeding and sleeping; building a strong attachment; guidance with navigating other community services; screenings for child development milestones, maternal depression and intimate partner violence; and referrals to community supports such as early intervention, counseling, food and clothing, and rental assistance. Evidence shows that the top five benefits of home visiting are: mothers and babies are healthier, children are better prepared for school, children are safer, families are more self-sufficient, and for every $1 spent on home visiting programs, $5 of savings from reduced health care and welfare services spending.

CCOs can leverage this priority by investing in, supporting and partnering closely with home visiting programs in their regions to ensure families with young children have the supports they need to be healthy, connect with other services, and ensure family stability and on-track child development. Local public health agencies, tribal health agencies, early learning entities and community-based organizations implement evidence-based and evidence-informed programs such as Nurse-Family Partnership, Healthy Families Oregon, Babies First! and Early Head Start. Across the state, these programs stand ready to work with CCOs on coordinating and implementing this effective community-based service for families of young children.

Community partnership opportunities

In addition to opportunities to support home visiting programs, CCOs' work to impact early childhood should include partnerships with a wide variety of entities, including but not limited to parenting support programs, childcare and preschool programs, Relief Nurseries and early learning hubs. By engaging and supporting these community-based experts within the early learning system, CCOs can help build strong community systems to ensure Oregon's youngest children and their families are fully supported for good health outcomes and readiness for school.

Senate Bill 902 (2015) requires that CCOs and their community advisory councils partner with early learning and youth development programs for developing their community health improvement plans (CHPs) to the extent practicable. Community health assessments (CHAs) and CHP development are key areas for collaboration and partnership with early childhood partners, and to date many CCOs' CHPs include priorities and strategies related to maternal and child health. Following the increasing focus and urgency around child health throughout the state, CCO 2.0 policies driving alignment of CHA and CHP development across multiple entities in a region can emphasize and direct resources to this work in new and efficient ways.

Child health measure development

Concurrently with CCO 2.0, a variety of work is underway at the Oregon Health Authority in support of children's health measurement. The Children's Institute, in collaboration with OHA and with technical expertise from the Oregon Pediatric Improvement Partnership (OPIP), continues to convene the Health Aspects of Kindergarten Readiness Technical Workgroup. The purpose of this group is to explore development of potential CCO incentive metrics to impact school readiness for children on the Oregon Health Plan.

OHA also continues its partnership with OPIP to develop new system-level approaches for identifying children with "health complexity," including children with a combination of both medical and social complexity factors. OPIP, through its partnership with OHA, Kaiser Permanente NW, and CCOs, will support the distillation, development and dissemination of leanings from this work, including case management approaches for children with health complexity that can meaningfully applied by CCOs.

The Metrics and Scoring Committee, which is responsible for identifying outcome and quality measures for the CCOs, continues to highlight early childhood health in its selected measures, including a focus on postpartum care, developmental screening, childhood immunizations, dental sealants for children, and adolescent well-visits.