CCO 2.0 Policies Impacting CCO Community Advisory Councils (CACs)

Pulled from Appendix A:

CCO 2.0 recommended policies and implementation expectations

CCO 2.0 Policies Impacting CCO Community Advisory Councils (CACs)

Policies are outlined below, with full policy details available in the Appendix A excerpt at the end of this document. Click on each policy number below to navigate to the full policy details in the appendix. The full Appendix A, with all recommended CCO 2.0 policies, is available on the CCO 2.0 website at www.oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx.

Policy #1

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).

Policy #2

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.

Policy #4

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.

Policy #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 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.

Policy #6

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.

Policy #7

Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the community advisory council (CAC) and tribes, and/or tribal advisory committee if applicable (see Policy 4, Part D), connect to the CCO board.

Policy #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 CHAs and shared CHP priorities and strategies.

A) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need.

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.

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.

Policy #9

Require CCOs to submit their community health assessment (CHA) to OHA .

Recommended Policies: Begin implementation in year 1

Policy #1

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).

Dashboard

★	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

How heavy is lift?	●●○
How large is impact?	●●●

✓	**2019 POP planned**
	Requires legislation
	Recommendation for OHA
	Exists in contract; needs strengthening or improved monitoring
✓	**Health equity impact assessment**
✓	**Potential to impact children**
✓	**May require OHA TA support**
✓	**Increases transparency**

Intended impact

Increased strategic spending by CCOs on social determinants of health and health equity/disparities. Decision-making is inclusive and consumer-informed.

Policy implementation considerations

- CCOs will be expected to engage tribes in this work and in decision-making processes about SDOH and health equity spending.
- Mandated by HB 4018; Part C is not required but strongly recommended by OHA staff.
- HPA and actuarial staff to develop investing guidelines, additional requirements, and reporting and monitoring strategy.
- TA and compliance needed.
- NOTE: Policy option package (POP) is for a SDOH transformation analyst who would support a variety of SDOH work; could be applied to this policy option.
- Year 1 and 2 spending amounts contingent on OHA's 2020 budget and 3.4% growth cap.
- Builds toward 2012–2017 waiver evaluation recommendation #7: Require CCOs to commit one percent of their global budget to spending on social determinants of health.
- Spending must align with CCO CHP priorities, transformation and quality strategy (TQS), and waiver.
- Pros: May encourage spending on health-related services as key mechanism to track investments in SDOH; may encourage additional spending on SDOH within the global budget.
- Cons: Could reduce funds flowing to clinical providers.

- Feedback:
- Oregon Health Policy Board (OHPB) 7/10/18: Support for statewide priority of housing-related supports and services.
- CCO 2.0 Survey and Medicaid Advisory Committee survey ranked housing as a top priority for SDOH work.
- Agency partnerships: OHA is partnering with Oregon Housing and Community Services to expand supportive housing in the state, and there are opportunities to leverage this partnership to increase housing infrastructure in communities while expanding the housing-related services and supports that CCOs provide to complement this infrastructure.

Policy implementation expectations

Initial baseline expectations

- CCO clearly articulates criteria for selecting the SDOH/HE partners it intends to direct SDOH/HE funding to through contract, memorandum of understanding (MOU), grant or other formal agreement (including housing partners to meet the statewide priority requirement).
- CCO demonstrates it has mechanisms in place to track and report SDOH/HE expenses and outcomes of spending, including for funds directed to SDOH/HE partners.
- CCO provides a policy demonstrating the CAC's role in tracking, reviewing and making decisions regarding SDOH/HE spending.
- CCO may choose to select 1-2 community priorities for spending in addition to the statewide housing priority.
- CCO demonstrates that its expenditures (both to partners and other SDOH/HE spending) address the SDOH, health equity, health disparities, or population health policy and systems change as defined by OHA.

Transformational expectations

- CCO dedicates a percentage of its global budget to SDOH and health equity spending.
- CCO focuses its SDOH/HE spending on families with children under age 5.
- CCO demonstrates impacts on racial/ethnic disparities as a result of SDOH/HE spending.

Examples of accountability

- Part C: CCO submits to OHA its spending priorities and how it has chosen to implement the housing spending priority; CCO demonstrates how selected priorities and spending plans align with CHP.
- CCO reports SDOH/HE expenditures and outcomes to OHA (financial reporting, Transformation and Quality Strategy [TQS], CHP progress reports), including number of members served by SDOH/HE investments.
- OHA publishes annual data on CCOs' SDOH/HE spending.

Policy #2

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.

Dashboard

	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

How heavy is lift?	●●○
How large is impact?	●●○

	2019 POP planned
	Requires legislation
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	Exists in contract; needs strengthening or improved monitoring
✓	**Health equity impact assessment**
✓	**Potential to impact children**
✓	**May require OHA TA support**
✓	**Increases transparency**

Intended impact

SDOH spending is aligned in communities and across various SDOH spending strategies. Community resources are used more efficiently. Decision-making is inclusive and consumer-informed.

Policy implementation considerations

- No substantive contract changes for Part A ("encourage").
- Contract language change for Part B.
- OHA to develop guidance, FAQs to ensure clarity on HRS requirements.
- Builds toward 2012–2017 waiver evaluation recommendation #5: Create a "one-stop shop" where CCOs and other stakeholders can find information about health-related services.
- Pros: Leverages existing work and other SDOH spending requirements.
- Cons: Competing priorities for investment.

Policy implementation expectations

Initial baseline expectations

- CCO submits policies describing how community benefit investment decisions will be made, including but not limited to the types of entities that will be eligible for funding, how entities may apply for funding, and the process for how funding will be awarded.
- CCO clearly articulates the CAC's role regarding HRS community-benefit initiatives in this policy.

Transformational expectations

- CCO demonstrates that their HRS spending aligns with the CHA and CHP.
- CCO annually reports all HRS spending itemized with any evidence of return on investment.

Examples of accountability

- OHA publishes quarterly data on each CCO's HRS spending by category and as a percent of total member expenditures.
- OHA/CCO publishes CCO policies relating to HRS and CAC's role in HRS decisions.
- CCO includes community-based initiatives and explains CAC's role in deciding community-based initiatives.

Policy #4

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.

Dashboard

	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

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✓	**May require OHA TA support**
✓	**Increases transparency**

Intended impact

CCOs have a representative CAC. This builds trust and relationship with members. Systems are designed with the OHP member in mind.

Policy implementation considerations

- Part B to be implemented in Year 2 or later.
- Due to need for legislative change, other components of this policy may need to be implemented in Year 2 of contract (TBD; pending confirmation with procurement team).
- CCOs will not be required to use enrollment data to identify demographics; census data or other sources may be used.
- Health Systems Division (HSD) work needed to ensure better demographic data of CCO enrollment.
- Transformation Center capacity for TA and receiving and reviewing reports.
- Need to define OHP consumer.
- Pros: Supports better representation and meaningful engagement of consumers; potential benefit to recruitment/retention (elevate CAC due to role on board – Part C).

- Cons: Potential recruitment and retention challenges (including possible resistance to CAC members reporting their own demographic information to their CAC/CCO); enrollment data issues/complexity (can use demographic data from American Community Survey or other sources as needed); possible concern with information privacy and how much of that info is shared with the federal government.
- Requiring alignment with communities came from interest from numerous stakeholders in supporting more diversity and better representation, but this specific policy option as worded did not come directly from CACs.
- Requiring CCOs to have more than one CAC representative (Part C) on the board was included after interviews with key informants (primarily CAC coordinators).

Policy implementation expectations

Initial baseline expectations

- CCO identifies data sources it will use to analyze member demographics (could include enrollment data, American Community Survey data, or other sources).
- CCO demonstrates it has mechanisms, resources and community partnerships in place to support recruitment and engagement of diverse CAC members aligned with member demographics.
- CCO clearly articulates its criteria and process for engaging CAC representatives that align with CHP priorities.
- CCO shares plan for how it will meaningfully engage an OHP consumer(s) on CCO board.
- CCO describes its plan for how it will meaningfully engage tribes and/or a tribal advisory committee, if applicable.
- CCO meets reporting requirements and identifies barriers and challenges to CAC demographic alignment, which will inform tailored supports from OHA to assist CCO's progress toward a fully aligned CAC.
- Part B may be phased in after Year 1.

Transformational expectations

- CAC composition is reflective of Medicaid member demographics in the CCO service area.
- CCO decision-making is meaningfully informed by CAC members, and tribal advisory committee members if applicable, and CCO demonstrates this in its reporting.
- CAC members report feeling meaningfully engaged and empowered in their roles on the CAC and CCO board.
- CCO has systems in place that ensure constant representation and filled CAC seats and no lapses in 51% OHP consumer makeup of CAC.

Examples of accountability

- Reports include detailed information about CAC member composition and all components outlined in this policy option; reports posted publicly.
- CAC member satisfaction report/surveys. Surveys include inquiry about whether processes are trauma informed and meet the needs of members who have experienced trauma.

Policy #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 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.

Dashboard

	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

How heavy is lift?	● ○ ○
How large is impact?	● ● ○

	2019 POP planned
	Requires legislation
	Recommendation for OHA
	Exists in contract; needs strengthening or improved monitoring
✓	**Health equity impact assessment**
✓	**Potential to impact children**
✓	**May require OHA TA support**
✓	**Increases transparency**

Intended impact

Standardization of health equity infrastructure present in all CCOs.

CCO health equity expertise, capacity and infrastructure to facilitate adoption of measures to reduce health disparities.

Policy implementation considerations

RFA applicants:

- Need to provide current organizational health equity infrastructure capacity (based on guidelines provided by OHA).
- Need to commit to the designation of a "single point of accountability" for health equity and demonstrate allocation of resources for health equity activities.

In Year 1 all CCOs will:

- Develop a health equity plan following OHA guidelines.
- Designate a "single point of accountability" role.
- Develop an organizational and provider network training and education plan based on "Cultural Responsiveness and Implicit Bias Fundamentals" guidance document provided by OHA.

In Year 2-5, all CCOs will:

- Report increased capacity and leadership for health equity and cultural responsiveness, and the use of race, ethnicity, language and disability (REAL+D) and culturally and linguistically appropriate services (CLAS) in the organization and the provider network using TQS as a reporting mechanism.
- Provide an outline of the general activities it will undertake to accomplish the goals and objectives outlined in the health equity plan over the course of three years for monitoring and TA.

General Timeline:

- All strategies in this policy will be in contract and are set to begin **Year 1**. However, full implementation and completion of activities will vary and could be aligned with TQS to reduce administrative burden.

OHA role:

- Provide a framework for the development of CCO health equity Infrastructure:
    a) OHA/Office of Equity and Inclusion (OEI)/Transformation Center (TC) to staff/lead a work group that will develop health equity plan guidelines for CCOs.
    b) OHA/OEI/TC to develop "single point of accountability" role expectations that relate to prioritization of health equity; engagement with the community; health disparities work;

use of REAL+D data; workforce diversity; patient engagement using HIT tools; and organizational learning.

c) OHA/OEI/TC to develop a guidance document on cultural responsiveness and implicit bias training fundamentals plan.

- CCO 1.0 maturity assessment showed that lack of detailed tracking mechanisms and data related to health equity contributed to the challenge of understanding how CCOs have impacted these areas over the last five years. The infrastructure proposed through CCO 2.0 will facilitate standardization and will improve OHA's ability to provide quality TA.
- Some CCOs have developed a strong organizational infrastructure for health equity, others have not; this represents an inequity that will be remedied in CCO 2.0.
- The development of CCO internal infrastructure and investment to coordinate and support CCO equity is necessary to ensure (a) CCOs around the state are moving in the same direction; (b) OHA, and OHPB and its Health Equity Committee have a conduit to connect with CCOs on health equity activities, build learning collaboratives, and provide guidance and technical assistance; and (c) health equity infrastructure will facilitate the deployment of health equity metrics once they are developed.
- The term "health equity infrastructure" refers to the organizational adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to community and member engagement; provision of quality and culturally responsive language access; organizational and provider network workforce diversity; Americans with Disabilities Act compliance and accessibility of CCO and provider network; Affordable Care Act 1557 compliance; CCO and provider network organizational training and development implementation of the CLAS Standards and non-discrimination policies; and other models, policies and practices that aim to advance health equity and eliminate inequities in health and health services that are avoidable, unnecessary and also unjust and unfair.
- In the development of CCOs' health equity infrastructure, OHA expects CCOs will:
    a) Meaningfully engage CACs and community partners in the development of CCO health equity infrastructure strategies, plans, policies and programs;
    b) Transform CCO organizational culture to make health equity a priority; and
    c) Institutionalize the health equity culture in all facets of the organizational structure.

Policy implementation expectations

Initial baseline expectations

- CCO provides information to OHA on its current organizational infrastructure to demonstrate its ability to implement health equity activities, including its capacity to collect and analyze REAL+D data.
- CCO develops a health equity plan, allocates necessary resources for health equity activities, and provides a timeline for implementing the plan's components.
- Potential components of the health equity plan include language access; workforce diversity; implementation of CLAS standards; collection and analysis of REAL+D; provider network accessibility; and meaningful community engagement.
- CCO designates a single point of accountability for health equity work. CCO develops an organizational and provider network training and education plan based on the Cultural Responsiveness and Implicit Bias Fundamentals guidance document provided by OHA.

Transformational expectations

- CCO ensures that its diverse member population receives the highest quality, culturally and linguistically appropriate health care from their provider network.

Recommended Policies: Begin implementation in year 1

- All CCO and provider network programs, community partnerships, priorities, policies and activities have solid and consistent health equity components that go beyond the use of an equity lens by, for example, incorporating health equity into their organizational structure, and being informed by the collection and use of REAL+D data.
- CCOs meaningfully engages CACs, providers and community partners in the development of CCO health equity infrastructure strategies, plans, policies and programs.

Examples of accountability

Year 1:

- CCO develops health equity plan following OHA guidelines.
- CCO designates a "single point of accountability" role.
- CCO develops an organizational and provider network training and education plan based on the Cultural Responsiveness and Implicit Bias Fundamentals guidance document provided by OHA.
- OHA develops appropriate monitoring, reporting and compliance process needed for all three strategies. This process could be aligned to current TQS process to reduce CCO administrate burden.

Year 2:

- CCOs potentially use TQS to report increased capacity and leadership for health equity and cultural responsiveness and the use of REAL+D and CLAS in the organization and the provider network.
- CCO provides an outline of the activities it will undertake to accomplish the goals and objectives outlined in the health equity plan over the course of three years for monitoring and technical assistance.

Recommended Policies: Begin implementation in year 1

Policy #6

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.

Dashboard

★	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

How heavy is lift?	●●○
How large is impact?	●●●

	2019 POP planned
	Requires legislation
	Recommendation for OHA
	Exists in contract; needs strengthening or improved monitoring
✓	**Health equity impact assessment**
✓	**Potential to impact children**
✓	**May require OHA TA support**
✓	**Increases transparency**

Intended impact

Increases THW workforce by setting up a livable and equitable payment system.

Increases access to preventive, high-quality care beyond clinical setting and improves outcomes.

Increases access to culturally and linguistically diverse providers beyond clinical setting.

Policy implementation considerations

- All activities will be in contract beginning in Year 1; expectation for implementation/completion varies by activity.
- CCOs will work with THW Commission, OEI and HSD to:
    a) Designate CCO liaison;
    b) Develop integration and utilization plan with metrics to track integration milestones with scores for progress; and
    c) Determine centralized standard reimbursement rates using the payment models grid created by the THW Commission Payment Model Committee.
- Builds upon THW services requirements already in contract.
- Recommended by the Department of Consumer and Business Services in its Report on Existing Barriers to Effective Treatment for and Recovery from Substance Use Disorders, Including Additions to Opioids and Opiates.
- Strong support came from health systems; health insurance carriers such as Providence, CareOregon and Kaiser; the Oregon Primary Care Association; and other community-based organizations and federally qualified health centers (FQHCs).
- Need to dedicate necessary resources to ensure policies are adequately and appropriately staffed, monitored and enforced.
    a) The integration and utilization plan fulfills the mandates established by the following legislation: House Bill 3650 (2011), House Bill 3311 (2011), Senate Bill 1580 (2012), House Bill 3407 (2013) and House Bill 2304 (2017).
    b) Literature shows improved health outcomes for consumers, which saves money for OHA

through Medicaid program savings. Positive return on investment will increase with increased number and utilization of THWs.

- Payment model grid contains a variety of pathways for THW payment including alternative payment methods; value-based payments such as bundling and per-member-per-month payments; fee-for-service; grants and contracts; Medicaid administrative; targeted case; and direct employment.

Policy implementation expectations

Initial baseline expectations

- CCO describes the components of its comprehensive integration and utilization plan for THWs, including benchmarks, milestones and timelines. The plan should ensure that each CCO member is an active partner in their own health care and services and not a passive recipient of care.
- CCO describes how it will integrate best practices for THW service delivery to ensure 1) recruitment and retention of diversified workforce that is culturally and linguistically responsive to the population served by the CCOs, and 2) measurable best practice standards and metrics are created to promote THW program fidelity and effectiveness.
- CCO clearly articulates how it will create a dedicated liaison position for coordinating workforce, payments, utilization, supervision, service delivery, and member accessibility to THW services.
- CCO clearly describes its plans for establishing sustainable payment rates for THWs.
- CCO identifies a THW to participate in the CHA and CHP development process.
- CCO develops a payment rate and reimbursement plan across the board for all THWs.

Transformational expectations

- CCO's plan ensures that THWs are part of the member's care team to provide and assist in services navigation, access to culturally and linguistically responsive care/providers, community connection and social support that impacts the member's health care and service needs.
- CCO consistently utilizes THW best practices to be proactive in educating health care providers, consumers and administrators about the members' health care needs and the culturally responsive interventions and supports available through a culturally responsive workforce.
- CCO THW liaison position effectively acts as the "hub" for THWs, consumers and the community within the CCO health care system, and this is demonstrated in CCO reporting.
- CCO meaningfully engages THWs during the CHA and CHP development process.
- CCO implements centralized reimbursement/ payment rates for all THWs to be efficiently utilized in all health care settings and ensures that payments are not contingent upon health outcomes.

Examples of accountability

- Reporting to OHA includes benchmarks, milestones and targets that measure impacts such as: increases in recruitment and retention of THW workforce, improvements in access to THW services, increases in engagement of THWs in member care teams and increases in members assigned to THWs as appropriate for the members' health needs.
- CCO recruits THW liaison and begins measuring: encounters between consumers and THWs; THW-related improvements in health outcomes by race, ethnicity, primary language; THW-related reductions in the rate of non-emergent ED visits; increases in patient engagement with THWs; and utilization by THW type with a plan to address transitions in care within the delivery system.

Recommended Policies: Begin implementation in year 1

- CCO develops and publishes payment guidelines (which include value-based payments such as bundling and per-member-per-month payment, as well as fee-for-service payments), and fully implements in-house payment structure and processes for all THWs. OHA provides system-level support to reduce billing barriers.
- Reporting includes number of THWs involved in CHA and CHP and how they are actively participating.

Recommended Policies: Begin implementation in year 1

Policy #7

Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the community advisory council (CAC) and tribes, and/or tribal advisory committee if applicable (see Policy 4, Part D), connect to the CCO board

Intended impact

Transparency on fulfillment of statutory requirement.

Policy implementation considerations

- Transformation Center staff will monitor in a to be determined reporting method.

Policy implementation expectations

Initial baseline expectations

- CCO clearly articulates relationship between CAC and CCO board, including CAC participation on the CCO board and other CCO committees, and CCO staff participation on the CAC.
- CCO clearly articulates relationship between CAC, CCO board and tribal advisory council, if applicable.
- CCO provides a visual organizational chart demonstrating these connections.

Transformational expectations

- CCO demonstrates the engagement of its CAC by illustrating multiple feedback loops of CAC input that are integrated into a wide variety of areas of CCO decision-making.

Examples of accountability

- OHA publishes organizational structure information from CCOs.
- Reporting includes supplemental information about CAC role in decision-making (recommended policy #4).

Dashboard

	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

How heavy is lift?	● ○ ○
How large is impact?	● ○ ○

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	Potential to impact children
	May require OHA TA support
✓	**Increases transparency**

Recommended Policies: Begin implementation in year 1

Policy #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 CHAs and shared CHP priorities and strategies.**

A) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need.

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.

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.

Dashboard

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Priority area:	**SDOH / Health Equity**

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	Increases transparency

Intended impact

Improved population health outcomes through CHA and CHP collaboration and investment.

CHAs and CHPs that reflect the needs and priorities of the entire community.

Reduced burden for community members due to streamlined community assessment and planning processes.

Policy implementation considerations

- Contract changes and rule changes needed.
- Needs to be in contract for Year 1; work would phase in. CCOs would be required to meet these policy requirements with new CHAs and CHPs developed during the 2020–24 contract period (in the next CHA/CHP cycle; may differ by CCO).
- OHA could convene a work group in Year 1 of the contract to develop recommendations for addressing barriers to shared CHAs and shared CHP priorities and strategies. This would build upon the work of the 2014 OHA CHA/CHP alignment work group.
- Technical assistance provided by HPA and PHD.
- Staffing needs identified for monitoring and compliance within HSD.
- Shared CHAs and shared CHP priorities and strategies: Recommended by the Public Health Advisory Board. Supported by OHPB at June meeting. Supported during road show forums.
    a) Likely to reduce burden on community members who are asked to participate in multiple health assessments. Will reflect the needs of entire community, beyond Medicaid. Challenges with shared CHP development can be addressed through implementation and contractual requirements.
- SHIP priority alignment: Recommended by OHA staff. Support from OHPB at 7/10 meeting.
    a) High level of alignment currently between CHPs and 2015–19 SHIP. All CCOs could meet requirement with 2015–19 SHIP priorites (note there will be a new SHIP for 2020–24). This policy option would require CCOs to implement statewide strategies for shared priorities. Ohio

and New York have implemented similar requirements. May result in statewide gains on health conditions.

- Including organizations that address SDOH and health equity: Recommended by the THW Commission (see Policy 2, Part D).
- Will ensure the voice of OHP consumers experiencing health disparities is included in the CHP/CHP process. May create a small limitation on local flexibility by prescribing the organizations to be involved.

Policy implementation expectations

Initial baseline expectations

- If CCO has an existing CHA/CHP in place, CCO clearly describes:
    a) Existing partnerships with local public health authorities (LPHAs), nonprofit hospitals and other CCOs that share the service area for the current CHA;
    b) Gaps in these partnerships;
    c) Steps the CCO will take to address these gaps prior to developing the next CHA;
    d) The tribes, THWs and organizations addressing social determinants of health and health equity that were involved in the development of the CHA and CHP; and
    e) Gaps in involvement of SDOH/HE organizations and how the CCO will meaningfully engage these organizations in developing the next CHA and CHP.
- A CCO that does not have a current CHA/CHP describes existing partnerships with LPHAs, nonprofit hospitals, other CCOs that share the service area, organizations that address social determinants of health, tribes and THWs; gaps in existing partnerships; and the steps the CCO will take to meaningfully engage these organizations when it develops its first CHA and CHP.
- CCO identifies the CHP priorities and strategies currently being implemented by the CCO and LPHAs, nonprofit hospitals, and any CCO that shares the service area.
- For any new CHP developed during the contract period, the CCO identifies and describes areas of alignment with at least two SHIP priorities, including which statewide strategies are being implemented.
- CCO makes progress toward CHP goals and demonstrates accountability through annual progress reports that include a description of the actions the CCO will take if goals are not being met.

Transformational expectations

- CHP is a single community document describing community health improvement priorities (note that CCOs, hospitals and LPHAs may document their strategies toward those goals in separate documents).
- In regions with aligned service areas, the CHP is fully shared by CCOs, LPHAs and nonprofit hospitals.
- The CHA/CHP partnership of CCOs, LPHAs and nonprofit hospitals has a governance structure that is responsible for allocating resources to CHP priorities, overseeing shared metrics, and is the accountable body for meeting targets and goals.
- Inclusion of tribes, organizations that address social determinants of health, and THWs in developing the CHA and CHP shifts focus in CHA/CHP to the root causes of poor health and health disparities, which includes social determinants of health and trauma. Consumer voice is demonstrated in development of community priorities and improvement strategies.
- CCO demonstrates investment of a percentage of its global budget in implementing CHP priorities to meet CHP goals.

Recommended Policies: Begin implementation in year 1

Examples of accountability

- Year 1, and annually: CHA/CHP submissions and annual progress reports demonstrate meeting baseline expectations based on OHA review.
- Upon submission of new CHA and CHP (timeline will vary for CCOs):
    a) CCO demonstrates local partnership of LPHAs, nonprofit hospitals, tribes and other CCOs in the service area.
    b) CCO demonstrates accountability for making progress toward meeting CHP goals.
    c) CCO demonstrates alignment with SHIP priorities, including implementation of statewide strategies.
    d) CCO and partners demonstrate achievement of targets and goals in CHPs.
- SHIP annual progress reports also demonstrate improvements on priorities and strategies that are being implemented at the local level.

Policy #9

Require CCOs to submit their community health assessment (CHA) to OHA

Intended impact

Transparency and support of community partner efforts.

Policy implementation considerations

- Should be included in contract from Year 1. Would go into effect at first CHA cycle in 2020–2024 contract period (may differ by CCO).
- Monitoring is very straightforward (existing Transformation Center capacity).
- Origin of recommendation: OHA Transformation Center.
- Pros: Promotes transparency and can allow for improved technical assistance to CCOs.
- Cons: Would add a deliverable to CCO contract, but by rule CHA development is already required, so it should be easy for a CCO to submit their CHA to OHA to fulfill this requirement.

Dashboard

	Fulfills state or federal mandate

Priority area:	**SDOH / Health Equity**

How heavy is lift?	●●○
How large is impact?	●●●

	2019 POP planned
	Requires legislation
	Recommendation for OHA
	Exists in contract; needs strengthening or improved monitoring
✓	**Health equity impact assessment**
	Potential to impact children
	May require OHA TA support
✓	**Increases transparency**

Policy implementation expectations

Initial baseline expectations

- CCO submits CHA by June 30 of the first year of the contract.

Transformational expectations

- Increased transparency about the health of communities and about how health priorities for the CHP are selected.
- CHA becomes a readily accessible data source for community partners or other organizations seeking to understand the health of the community.

Examples of accountability

- Year 1: CHA submissions demonstrate meeting baseline expectations based on OHA review.
- CHAs are posted online.

For future exploration or not recommended at this time

Policies for future exploration

A. **Clinic-level health equity plans**. OHA should explore a model wherein providers identify disparities, and the health equity workplan is generated at the clinic level (with CCO/OHA guidance). This is a multi-year approach to addressing health disparities at the clinic level (model from Minnesota). Providers are engaged at the clinic level to identify what they see as the greatest health disparities within their practice (Year 1), to create a plan for measuring those health disparities (Year 2), and to measure and report on those disparities and create plans for reducing the disparities (Year 3). This type of model could potentially be tied to or inform CCO health equity plans in the future.

B. **Dental care organizations.** CCOs should explore how their contracts with various dental care organizations or other providers of dental care inhibit their ability to provide integrated oral health care to members. Several CCOs work with clinics with co-located oral health care that cannot provide dental care to all the CCO's members because not all the CCO's dental contractors contract with the clinics. This creates a significant barrier to coordinated, patient-centered care.

C. **Health care interpretation incentives.** OHA should explore requiring CCOs to develop a system to incentivize or reimburse providers that use qualified or certified health care interpreters. As health care providers try to remain competitive and manage cost, offering them financial incentives for providing adequate language access services is necessary. It is unrealistic to expect health care organizations alone to shoulder the burden of providing the services, and it is a disincentive to the provision of language access services. Models for providing payment for language services include providing additional payments to health care organizations that take care of a disproportionate share of patients with limited English proficiency such as FQHCs, CHCs, MHCs, CAHs, CMHs and others

D. **Oral health policy.** OHA should explore developing an oral health policy recommendation parallel to the one that requires CCOs to 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, including ensuring an adequate provider network, timely access to services, and effective treatment.

E. **Quality and appropriateness of language services.** OHA has encouraged CCOs to use certified and qualified interpreters. CCOs and provider networks have adopted different approaches to the provision of language services. To be able to meet the immediate language support needs, CCOs have contracted with telephonic or video-based interpreter services. These services may or may not use certified or qualified health care interpreters. In addition, members are not able to choose what modality of language services meets their needs. Some may prefer telephone or in-person interpretation for different types of encounters but may not be aware they can voice this preference when they present for care. Because video and telephone interpretation limits the ability to recognize and respond to emotional and physical cues, providers and members may find in-person interpretation more appropriate than remote interpreting, especially in complex, sensitive situations. Some aspects of enhancing this work are included in the health equity infrastructure policies (see Policy #5), but additional ongoing work will create a more robust system of culturally responsive language access.

For future exploration or not recommended at this time

Policies not recommended at this time

A. **COST:** Expand/revise existing risk corridor programs.
This option is not being recommended because of the recommendation to examine in greater detail the idea of establishing a program-wide reinsurance program.

B. **COST:** Incentivize health care services with highest clinical value by rewarding their use in rate setting.
This option has been incorporated as an aspect of variable profit implementation strategy.

C. **BH:** Develop a train-the-trainer investment in BH models of care.
This option is not being recommended.

Dashboard Legend

Feasibility – In general, how heavy is the "lift" for this policy across systems?	
●○○	**Generally easy/straightforward to implement**; little to no additional work or resources required; is already part of the plan/expectation.
●●○	**Requires moderate increase in staff time**, resources, development or funding; could face some challenges.
●●●	**Will be a challenge to implement** and will require new resources (funding, staff time, significant development, work groups, etc.)
Impact – In general, how much does this policy move the needle in achieving the goals of the coordinated care model?	
●○○	**Plays a supporting role, offers some clarity or direction**; will have a small impact on business practices.
●●○	**Medium impact**; policy will strengthen Oregon's direction and we'll see some type of effect across the state.
●●●	**Fundamental to moving the needle in this area of the model;** significant impact or transformational.
The health equity impact assessment check mark indicates the policy was assessed for a health equity impact. Further details on the result of that assessment are available in Appendix B, the health equity impact assessment.	
✓	**Health equity impact assessment**