## ANALYSIS

**Oregon Health Authority**
**CCO Contract Procurement Plan**

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**Analyst**: Steve Robbins

**Request**: Acknowledge receipt of the report on the upcoming coordinated care organization contract procurement plan by the Oregon Health Authority.

**Analysis**: The Oregon Health Authority (OHA) has submitted a report on the agency's coordinated care organization (CCO) contract procurement plan pursuant to a budget note approved in HB 5024 (2021):

> *The Oregon Health Authority shall report to the Legislature on its plans for the next round of coordinated care organization contracting. The report shall include: 1) anticipated milestones and deadline dates; 2) an outline of how the process will provide public transparency and communication; and 3) the anticipated resources the agency will need to perform the next round of CCO contracting. The report shall be delivered to the Joint Committee on Ways and Means by January 1, 2023.*

OHA provides an initial overview of the various influences and considerations the agency will consider as preparation begins for the third round of CCO contracting in 2025 (CCO 2025). This includes lessons learned from the prior two CCO procurements, OHA's strategic goal to eliminate health inequities by 2030, impacts and lessons learned from the public health emergency, building on the existing priorities in the Oregon Health Policy Board's (OHPB) CCO 2.0 policy recommendations, leveraging current CCO performance of deliverables, the influence of OHA's other primary initiatives, and any new priorities from the governor and state legislature.

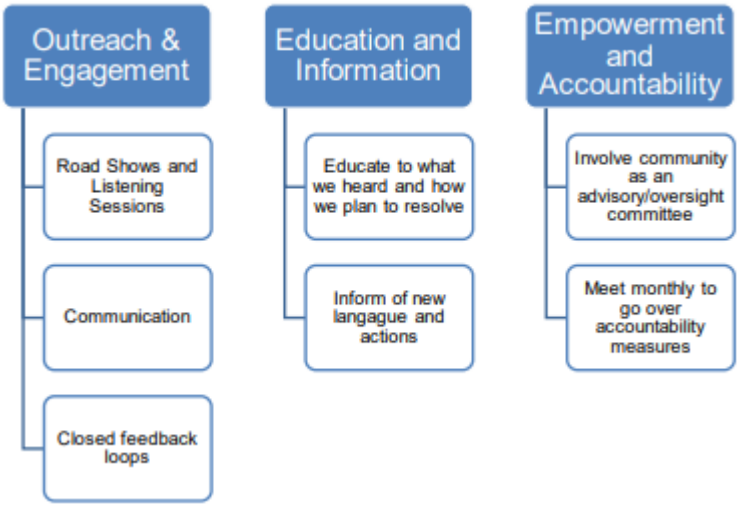
The report then speaks to the specific requirements of the budget note in the following areas.

<u>Anticipated milestones and deadline dates:</u>
OHA separates the procurement process into four phases with multiple sub-phases, some of which have already begun. The following table is a summary of the key procurement actions and milestones.

| Phase | Timeframe | Project Actions or Milestone |
|---|---|---|
| Initiation Phase | July-December 2022 | Develop Procurement Project Plan |
| | January 1, 2023 | Legislative report due |
| Planning Phase | January-June 2023 | OHPB, CCO and Community Engagement |
| | TBD (April 2023 or later) | Public Health Emergency Ends |
| Execution Phase | July-December 2023 | Draft and release procurement documents |
| | January 1, 2024 | Elements of new 1115 waiver implemented |
| | January-March 2024 | Evaluate and select CCOs for 2025-2029 |
| Implementation Phase | January-June 2024 | New contract development & readiness review |
| | July-December 2024 | Communication, education and technical assistance |
| | October 1, 2024 | New contract signed |
| | January 1, 2025 | Coverage period begins |
| Closeout Phase | January-March 2025 | Closeout assessment report prepared |

Outline of how the process will provide public transparency and communication:
The report indicates OHA's two plans intended to address public transparency and communication throughout the process: the community engagement plan and the communication plan.

*Community Engagement Plan:* The community engagement plan utilizes three tactics to work collaboratively with and through groups of people affiliated by geographic proximity, special interests or similar situations to address issues affecting the well-being of those people and communities, and ensuring that the community is actively engaged in the decision-making process:




*Communication Plan:* The communication plan will focus on utilizing targeted, salient information to key audiences on the topics of timeline, the goals of accelerating health transformation in Oregon and eliminating health inequities through the support of investments in social determinants of health. The plan topics will include the maintenance of sustainable cost growth in the Oregon Health Plan, increasing value-based payment focused on quality and outcomes, social determinants of health to impact the factors of poverty and housing access, and improving the behavioral health system.

Anticipated resources needed:
The report concludes by addressing resource needs in the context of other major OHA initiatives in the 2023-25 biennium, to include the implementation of the new 1115 Oregon Health Plan (OHP) demonstration waiver, the public health emergency (PHE) unwinding Medicaid eligibility redetermination, the establishment of the Basic Health Plan (BHP), and the expansion of the Healthier Oregon Program (HOP). OHA states that these initiatives will not only influence the next contract, but also impact OHA resources available for CCO 2025 process.

To mitigate the need for substantial investment in OHA staffing resources in previous procurement efforts, the agency will focus its efforts on collaboration through a consolidated meeting structure in which timelines, planning decision, and resource allocations can be determined across all projects wholistically. OHA will also focus on building on the work done to date and not recreating elements from scratch. Finally, included for consideration is narrowing the scope of the project by limiting applicant eligibility to possibly restricting procurement to existing CCOs or more narrowing defining organization requirements to qualify as a CCO.

The report concludes that resources are required for dedicated project management, community engagement and communications. Robust project management is desired based on coordination challenges in past procurements, to include a project manager and administrative support. Dedicated staff leading outreach and communication in the community is included involving to cross-collaborating with existing initiatives. OHA also includes the importance of offering stipends to community members who dedicate time to engaging with OHA during the outreach effort.

**Legislative Fiscal Office Recommendation**: The Legislative Fiscal Office recommends that the Joint Committee on Ways and Means acknowledge receipt of the report.

**Request:** Report on the upcoming contracting process for Coordinated Care Organizations (CCO) as directed by a budget note to House Bill 5024 (2021).

**Recommendation:** Acknowledge receipt of the report.

**Discussion:** House Bill 5024, the Oregon Health Authority's (OHA) main budget bill for the 2021-23 biennium, included the following budget note:

> The Oregon Health Authority shall report to the Legislature on its plans for the next round of coordinated care organization contracting. The report shall include: 1) anticipated milestones and deadline dates; 2) an outline of how the process will provide public transparency and communication; and 3) the anticipated resources the agency will need to perform the next round of CCO contracting. The report shall be delivered to the Joint Committee on Ways and Means by January 1, 2023.

OHA submitted its report on January 24, 2023, addressing the subjects requested in the budget note. In addition to the requested information, OHA provided the history of the policy development and significant events underlying the CCO model in Oregon. In brief, CCOs vary in enrollment, geographic coverage, and financial organization. CCOs cover approximately 90 percent of OHA's Medicaid caseload, with Tribal members and those dually eligible for Medicaid and Medicare able to choose between CCO coverage and traditional fee for service Medicaid. Adult residential behavioral health services are also carved out of the CCO model and are paid for via fee for service.

Since its inception in 2012, changes have been made to the CCO program to expand coverage, add services, change program financing and accountability measures, and incentivize investments in social determinants of health and health equity, among other changes. The COVID-19 pandemic delayed the implementation of or unwound some of these changes: only 25 of the 43 policies adopted as part of CCO 2.0 have been fully implemented to date, with the behavioral health recommendations lagging furthest. Another example of the impact of the pandemic on the CCO model was the unwinding of the quality incentive pool withhold model in early 2020, to provide a cash infusion to CCOs to help providers with cashflow issues.

Further significant changes to the program are planned in 2023-25 and beyond including implementation of the state's new Section 1115 Medicaid Waiver, federal funding for social determinants of health and continuous eligibility, rolling out the Healthier Oregon Program, unwinding the public health emergency and redetermining eligibility for OHA's entire caseload.

**Milestones and Deadlines**

OHA outlined the following high-level schedule for the development of the new CCO contracts:

| Phase | Timeframe | Project Actions or Milestone |
|---|---|---|
| Initiation Phase | July-December 2022 | Develop procurement project plan |
| | January 1, 2023 | Legislative report due |
| Planning Phase | January-June 2023 | OHPB, CCO and community engagement |
| | TBD (April 2023 or later) | Public health emergency ends |
| Execution Phase | July-December 2023 | Draft and release procurement documents |
| | January 1, 2024 | Elements of new 1115 waiver implemented |
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| Implementation Phase | January-June 2024 | New contract development & readiness review |
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| Closeout Phase | January-March 2025 | Closeout assessment report prepared |

The two-year timeline for policy development, community engagement and procurement leading up to the new CCO contracts in January 2025 is in alignment with the length of time it took to develop the current round of CCO contracts (January 2018 to January 2020).

**Public Transparency and Communication**

OHA identifies community engagement and communication as two key elements of the process for the success of the upcoming CCO contract procurement. The community engagement plan will focus on CCO members' experiences to ensure the services provided are coordinated, equitable, and culturally appropriate. OHA will work to integrate and coordinate its CCO contracting community engagement efforts with other community engagement work it is undertaking around the Section 1115 Medicaid Waiver, and member redeterminations due to the end of the public health emergency.

In addition to the community engagement plan, OHA's communication plan will ensure that all parties are informed about the contracting process as appropriate. OHA will use its communication plan to ensure its equity goals are integrated into the 2025 contracting process and that the new CCO contract is coordinated to the extent possible with other significant efforts. Audiences for the communication plan are both internal and external and include legislators, CCOs, CCO Community Advisory Councils, members, Regional Health Equity Coalitions, community-based organizations, and federal, state and local government partners.

**Resources Needs**

OHA did not submit a budget request in its 2023-25 Agency Request Budget for staff to work on the new CCO contracts. OHA plans to use existing resources to perform the work needed to complete the contracting process, including staff working on contracting and procurement, finance and data analysts, staff working on member transitions, organizational change

management, metrics, tribal policy, equity, administrative rules, IT systems. For context, OHA has received the following packages related to CCO administration in recent biennia:

| Purpose | Bill | General Fund | Total Funds | Positions / FTE |
|---|---|---|---|---|
| CCO 2.0 Staffing and Reinsurance Program | SB 5525 (2019) | $585,286 | $549,705 | 9 / 6.10 |
| CCO 2.0 Quality Assurance | HB 5024 (2021) | $870,172 | $2,022,756 | 4 / 4.00 |
| CCO Deliverable Automation | Package 201, 2023-25 ARB | $374,041 | $748,142 | 4 / 3.00 |

OHA has also received or requested the following investments in its overall contracting resources and capacity in recent biennia:

| Purpose | Bill | General Fund | Total Funds | Positions / FTE |
|---|---|---|---|---|
| Contracting Capacity | HB 5024 (2021) | $237,898 | $496,756 | 2 / 1.50 |

OFFICE OF THE DIRECTOR
Tina Kotek, Governor

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January 23, 2023

The Honorable Elizabeth Steiner, Co-Chair
The Honorable Tawna Sanchez, Co-Chair
Joint Ways and Means
900 Court St. NE
Salem, Oregon 97301

SUBJECT: Report on OHA's planning for CCO contracting

Dear Co-Chairs and Members of the Committee:

In response to a budget note in HB 5024 (2021), please find attached a report on OHA's planning for the next round of coordinated care organization contracting. The full report can be found at https://www.oregon.gov/OHA/HSD/OHP/DataReportsDocs/CCO-2025-Procurement-Plan.pdf

Sincerely,

James M. Schroeder
Interim Director

EC: The Honorable WInsvey Campos
The Honorable Andrea Valderrama

# CCO 2025 Report

## CCO Contract Procurement Plan

December 2022

Oregon Health Authority

# Contents



# Acknowledgments

This publication was prepared through collaboration across many Oregon Health Authority divisions, including Health Systems Division, Health Policy and Analytics Division and Equity and Inclusion Division,

For questions about this report, please contact: Dave Inbody, CCO Operations Director
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# Executive Summary

This report has been prepared at the request of the Oregon State Legislature in response to a budget note included in House Bill 5024 (2021). The full report can be found on the Oregon Health Plan (OHP) website.

This report is intended to provide an understanding of the proposed CCO 2025 contract procurement process. This is achieved by highlighting key influences and considerations, which will provide the foundational basis for the next CCO procurement. Informed by these influences and considerations, the structure for the procurement process will directly address the three components identified in the budget note: milestones and deadline dates, public transparency and communication, and needed resources.

Born of a financial shortfall, Oregon sought to transform the delivery of healthcare services with the establishment of coordinated care organizations (CCOs). Guided by a commitment to the triple aim - improving care, increasing value and cost containment, CCOs were established in 2012. The first contract with CCOs resulted in annual spending below projected rates.

The success of the CCO model led to a second CCO contract in 2020, with focus placed on four key areas: behavioral health, value and pay for performance, social determinants of health and health equity and sustainable cost growth. Informed by these priorities, the Oregon Health Policy Board (OHPB) developed policy recommendations as the foundation of the new CCO contract. Concurrent with the new contract, OHA emphasized its commitment to health equity by setting a goal of eliminating health inequity by 2030, which will be a central focus in the next contract.

However, 2020 also brought COVID-19 with a federal Public Health Emergency (PHE) declared three months into the new CCO contract. The PHE response included federal limitations on the termination of Medicaid coverage during the PHE resulting in an expansion of OHP membership of more than 35% in approximately two and a half years. Many CCO contractual requirements were altered, delayed or waived by OHA allowing CCOs to prioritize resources and activities for meeting COVID-related needs.

Although the PHE initially impacted the ability of OHA and CCOs to fully implement the new contract, a commitment to fully meet contractual requirements endured. Most of the CCO requirements have now been restored. Based on a review in mid-2022, 58% of OHPB's 43 recommendations have been fully implemented or are on track to be met, with an additional 25% partially met. While recommendations are being met, slightly less have achieved their intended results (42% achieved and 16% partially achieved). With most of the contract requirements restored, and the development of a dedicated quality assurance and compliance team to evaluate the associated deliverables, progress has been made. While progress continues, the next contract allows for a renewed focus on priorities not yet achieved and an examination of current deliverables.

Looking ahead, OHA will be undertaking four critical initiatives during 2023 including the implementation of the new 1115 OHP demonstration waiver, PHE unwinding Medicaid eligibility redetermination, the establishment of the Basic Health Plan (BHP), and the expansion of the Healthier Oregon Program (HOP). These initiatives will not only influence the next contract but also impact OHA resources available for the CCO procurement process.

At the same time, CCOs have been challenged to address the growing complexity of offering new programs and expanded benefits to a broader base of eligible individuals while maintaining local flexibility and collaborative engagement in meeting community-specific needs.

**CCO 2025 Procurement Process**

Acknowledging the significant staffing resources needed to successfully implement other key OHA projects in 2023, every effort will be made to maximize allocated resources through a reduction in the size and scope of the CCO procurement process. This will be achieved by utilizing a project management approach, leveraging resources and actions undertaken through other OHA projects, and committing existing resources to this work for the duration of the process.

The critical resources necessary to ensure this procurement process is successful are project management, community engagement and communications. Additionally, there are existing OHA resources that will need to be committed to this work throughout the process to address contracting, member transition, organizational change management, metrics, tribal policy, procurement, equity, finance, health policy, systems, data analysis, rules and legal review.

The contract procurement process will rely on a clear project management plan, as well as community engagement and communication plans. The following table is a summary of the key procurement actions and milestones.

| Phase | Timeframe | Project Actions or Milestone |
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The Community Engagement Plan will serve as the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interests, or similar situations to address issues affecting the well-being of those people and communities, identify needed changes that can be addressed through contractual modifications, and ensuring that the community is actively engaged in the decision-making process.

The communication plan will ensure that all parties are informed about the process. It will focus on the provision of targeted, salient information to key audiences on contract timeline, process and content. It will also seek to engage internal and external audiences to connect the CCO 2025 contract to OHA's goal of eliminating health inequities by 2030. The plan will also allow coordination between

the procurement process and OHA's other key projects to avoid misunderstandings, align messages and identify areas of efficiency between projects.

# Purpose of Report

This report has been prepared at the request of the Oregon State Legislature in response to the following budget note included in House Bill 5024 (2021):

*The Oregon Health Authority shall report to the Legislature on its plans for the next round of coordinated care organization contracting. The report shall include: 1) anticipated milestones and deadline dates; 2) an outline of how the process will provide public transparency and communication; and 3) the anticipated resources the agency will need to perform the next round of CCO contracting. The report shall be delivered to the Joint Committee on Ways and Means by January 1, 2023.*

This report is intended to provide an understanding of the proposed CCO 2025 contract procurement process. This is achieved by highlighting key influences and considerations, which will provide the foundational basis for the next CCO procurement. Informed by these influences and considerations, the structure for the procurement process will directly address the three components identified in the budget note: milestones and deadline dates, public transparency and communication, and needed resources.

# CCO 2025 Influences and Considerations

As preparation begins for the CCO 2025 contract procurement, knowledge gained from the current contract will be critical. Additionally, it is necessary to acknowledge and address new and developing influences. A comprehensive examination of these influences and considerations will inform the process, structure and content by providing new resources, priorities or impacts that are unique to the new procurement. Some of the primary influences and considerations include the following:

- Past CCO procurement and contracting
- OHA's strategic goal to eliminate health inequities by 2030
- Impacts and lessons learned from the public health emergency
- Building on the existing priorities in OHPB's CCO 2.0 policy recommendations
- Leveraging current CCO performance of CCO deliverables as part of evaluation
- Influence of OHA's other primary initiatives
- Maturing CCO Model
- New priorities from the governor and state legislature

## Past CCO procurement and contracting

**CCOs established**

For the 2011-2013 biennium, Oregon faced a shortfall of approximately $850 million for health care services provided by the state. Spending on human services and Medicaid represented nearly 26 percent of the state's budget and was projected to expand as a proportion of the budget. HB 3650 directed the Oregon Health Authority (OHA) to develop a system for Medicaid recipients in which services would be provided by coordinated care organizations (CCOs). CCOs would operate within a

global budget and be responsible for coordinating the delivery of physical, behavioral and oral health care services.

Using the triple aim as a guide, the vision for a future of coordinated care and the Oregon Health Plan (OHP) was developed with these guiding values:

- CCOs should remain locally governed, transparent, community-based organizations
- The state and CCOs should work together to expand upon the flexibility and use of the global budget concept
- Local flexibility is key to statewide transformation
- Integration of physical, behavioral, and oral health care must remain a priority
- Focusing on children requires distinct approaches from how care is delivered for adults, but is crucially important to any long-term health and well-being improvements in the state; and
- Everyone should have a fair and just opportunity to be as healthy as possible. Culturally and linguistically appropriate services are key elements in the work of eliminating health disparities and advancing health equity.

The first CCO began serving OHP members on August 1, 2012. By November 1, 2012, there were 15 CCOs serving OHP members.

A key feature of the Coordinated Care Model is the requirement that Oregon reduce federal Medicaid spending in Oregon by 2 percentage points (3.4%) relative to Medicaid spending levels projected without the model (5.4%). The requirement to limit annual growth informed state budgetary restrictions for OHA, which in turn informed the state's CCO rate-setting process. Spending on a per member per month (PMPM) basis came in at or below this target from 2013 to 2017. While the overall spending growth targets were achieved, it was unclear which specific CCO activities were most successful at controlling spending.

**CCO 2.0**

In September 2017, Governor Kate Brown outlined her vision to build upon the success achieved through the first contract by renewing a commitment to improve care, increase value and contain costs in CCO 2.0. She directed the Oregon Health Policy Board (OHPB) to provide recommendations to advance Oregon's transformation efforts in four key areas:

1. **Improve the behavioral health system and address barriers to the integration of care** – Integrate physical, behavioral and oral health to allow patients to receive the right care at the right time in the right place. Focus on behavioral health (mental health and substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.
2. **Increase value and pay for performance** – Reward providers' delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.

3. **Focus on social determinants of health and health equity** – Build stronger relationships between CCOs and other sectors. In addition, align outcomes between health care and other social systems to improve health equity. Encourage greater investment in prevention and the factors that affect our health outside the doctor's office.
4. **Maintain sustainable cost growth and ensure financial transparency** – Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

In January 2018, the OHPB began the CCO 2.0 policy development process by reviewing each of the four key policy areas. From February to August 2018, OHA and OHPB traveled the state, attending meetings, making presentations and issuing surveys to gather input on how to improve CCOs to meet member needs. In response to direction gathered during this engagement, OHA updated policy option considerations to also include the following:

- **Tribal consultation and meeting the health needs of tribal members –** Ensure clear and prioritized inclusion of the tribes in all community engagement processes.
- **Incorporating children's health needs into CCO 2.0 policies –** Focus on strategies to prevent and address the behavioral health issues that destabilize families and impede children's readiness for kindergarten, strategies that enhance care coordination for families of children and youth with special health care needs; payment strategies to improve delivery of maternity and pediatric care; and policies that drive CCOs' work to improve the social and environment context in which our most vulnerable Oregonians live.
- **Accountability, contract monitoring and enforcement -** Develop internal structures necessary to set the standard for accountability throughout the health care delivery system and to consistently apply that standard to all providers. Through improvements to the monitoring and compliance infrastructure inside the agency, increased enforcement of new and existing requirements, and clarifying the performance expectations for CCOs, OHA plays an important role in creating the conditions for CCO and health transformation success.

As a result of these activities, the OHPB developed 43 policy recommendations that would form the foundation of the CCO 2.0 contract requirements beginning January 1, 2020.

## OHA's strategic goal to eliminate health inequities by 2030

In 2020, OHA established a ten-year goal of eliminating health inequity by 2030 through the creation of a more equitable, culturally and linguistically responsive health care system. This goal requires change across all areas of work and intentional system-wide integration of equity, inclusion, anti-racism and accessibility. Social determinants of health (SDOH) and social determinants of health equity (SDOHE) are critical components in achieving this goal.

SDOH include the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities.

SDOHE are the systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies, and political systems, both historical and current.

The CCO 2.0 contract included several new CCO requirements to initiate progress toward this goal.

- Building organizational capacity to advance health equity through the development of CCO health equity plans
- Increasing the integration and utilization of traditional health workers (THWs)
- Increasing meaningful language access through use of certified and qualified healthcare interpreters
- Promoting CCO investment in health-related services and implementation of the Supporting Health for All through Reinvestment (SHARE) initiative
- Amplifying the influence of 32 community advisory councils (CACs) as the community engagement component of the CCO model.
- Leveraging the impact of community health improvement plans (CHPs) through greater collaboration with local public health authorities (LPHAs), local hospitals, and the Nine Federally Recognized Tribes of Oregon

Progress was also made when the Health Equity Committee developed a definition for health equity. Consensus around a definition of health equity helps foster dialogue and bridge divides. In order to develop an equity framework, it is necessary to begin with a common understanding of health equity. Here is the health equity definition.

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and wellbeing and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*
>
> *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
>
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling and rectifying historical and contemporary injustices*

In order to achieve the goal of eliminating health inequality, CCO 2025 will need to retain SDOH and health equity as key areas of focus.

## Impacts and lessons learned from the COVID-19 Public Health Emergency

The COVID-19 pandemic disrupted Oregon's healthcare system, including its Medicaid population, OHA operations and priorities, as well as CCO service delivery. Many CCO activities and reporting requirements were altered, delayed or waived by OHA in alignment with federal guidelines and state leadership directives. This allowed CCOs to prioritize resources and activities to address COVID-related issues and needs.

Oregon declared a state of emergency for COVID-19 on March 8, 2020, three months into the CCO 2.0 contract period, with multiple organizational and administrative changes enacted statewide. The national public health emergency was declared march 13, 202. In response to the declared emergencies, OHA rapidly implemented multiple temporary policy changes intended to help existing OHP members retain coverage during the pandemic and to simplify the application process for Oregonians who were newly eligible for OHP. These temporary policy actions included:

- Preventing OHP benefit terminations except for voluntary closure, death, incarceration or out-of-state residency;
- Accepting self-attestation of eligibility criteria without additional verification beyond citizenship or immigration status; and
- Discounting federal stimulus payments and unemployment benefits when making income-based eligibility determinations.

During this time, several other state emergency declarations were made for climate,-related events, such as the 2020 wildfires and the 2021 extreme heat event. COVID-19 flexibilities afforded by the federal government were leveraged, with approval, to respond to those emergencies as well. As a result, CCOs made several administrative and operational adjustments to serve Medicaid members and support state efforts to respond to these emergencies, including:

- Waiving most preauthorization requirements during the early stages of the pandemic;
- Investing in critical infrastructure, staffing and communities;
- Expediting reviews of grievances or appeals on member or provider request;
- Using health-related services funding to leverage non-emergency medical transportation for wellness checks, SDOH needs, and natural disaster evacuation and relief efforts;
- Improving and expanding the availability of telehealth services;
- Automatically refilling necessary durable medical equipment and pharmacy prescriptions; and
- Pooling electronic, staffing, economic, communication, data and physical resources for COVID-19 prevention, relief and vaccination efforts.

OHA made multiple adjustments to CCO activities to accommodate public health priorities and work schedules, including holding onsite audit evaluations via webinar, adjusting review and reporting schedules, and modifying review methodologies while still complying with federal and state requirements and guidelines.

Some measures were delayed such as the inclusion of oral health integration performance indicators that were planned for 2021. In some cases, changes were made, but long term objectives were maintained. For example, modifications to value-based payment (VBP) requirements were made, but the CCO VBP roadmap for achievement by 2024 remained on track. Some CCOs made widespread temporary changes to existing and planned VBP arrangements, often waiving performance targets or reducing reporting requirements for 2020.

**Behavioral health**

The pandemic exacerbated existing inequities and deficiencies in provider capacity in the children's behavioral health system. The need for behavioral health services increased during the pandemic while the resources to address the need declined. Many intensive day treatment and residential services for young people have closed over the past two years, with others operating at reduced

capacity due to workforce concerns and social distancing requirements. Intensive in-home behavioral health treatment, designed to support young people in their homes and avoid out-of-home placements, was launched by CCOs beginning in 2021. CCOs have reported struggles getting the program established due to workforce concerns and competing priorities.

The pandemic also had a significant impact on the adult behavioral health system. Access to all levels of care was restricted. As mental health services moved to telehealth options, adults with limited access to technology were further impacted and marginalized. Assertive Community Treatment (ACT) services, designed to treat individuals most severely affected by mental illness, had limited availability due to workforce issues and social distancing requirements. This made discharge from higher levels of care more challenging as providers struggled to wrap sufficient outpatient mental health services around vulnerable clients. Weathering decades of underfunding exacerbated by the COVID-19 pandemic, the behavioral health system is in the early stages of recovery as a result of historic investments by the Oregon Legislature.

**Social determinants of health and health equity**

In response to the pandemic, the CCO submission of health equity plans in 2020 was delayed from March to December. The pandemic created barriers to community engagement needed to develop health equity plan strategies and goals. CCOs did not see a feasible way to connect with their community while gatherings were restricted due to the pandemic. These challenges and concerns were considered in the evaluation of each 2020 CCO health equity plan.

THWs played a meaningful role in the state's COVID response. Many were trained and deployed to assist with COVID-related work, including contact tracing, assisting with COVID vaccine campaigns, and working at COVID vaccination sites. While critical to support the COVID-related needs, this limited access to THWs for non-COVID health care needs decreased. THW foundational training and continuing education moved to an online format, and the targeted growth of the THW workforce and implementation and utilization of THWs slowed.

The pandemic appears to have accelerated the decline in utilization of in-person interpretation services, which is the preferred modality for most members needing interpretation services. Data show significant differences in CCOs' utilization of telephonic compared to in-person interpretation services.

COVID-19 may have contributed to health-related services (HRS) spending more than doubling in 2020 as compared to 2019. due to CCO members' health-related social needs increasing. Of $34.5 million spent on HRS in 2020, more than $7.5 million were for pandemic-related needs. About 60% of pandemic spending went to basic needs like food, housing, utilities, transportation and supplies. The remainder went to prevention and wellness campaigns, remote learning supports, childcare, health information technology (HIT), and personal protective equipment supplies.

The pandemic made it much more difficult for CCOs to retain and fill open CAC seats. Some consumer CAC members left due to work or life changes brought on by the pandemic. Further, CCOs found it challenging to fill open seats while not being able to recruit potential CAC members in person. Use of a virtual meeting environment during the pandemic increased CAC members participation. The pandemic affected the extent to which the Nine Federally Recognized Tribes of Oregon were available to discuss Tribal CAC member recruitment. It also limited the availability of Tribal CAC members to participate on CACs.

CCOs that were completing Community Health Assessment/Community Health Improvement Plan (CHA/CHP) development in 2020 and 2021 were affected significantly by the pandemic. Best practices for CHA/CHP development require significant partner, stakeholder and community engagement, which has generally been done in person. Some engagement work can be shifted to online venues, but an online approach is less effective – particularly with broader community engagement. This is likely to reduce community buy-in to CHP priorities and jeopardize implementation success.

**Sustainable cost growth and financial transparency**

In response to the pandemic, OHA suspended the 4.19% quality withhold and released the full monthly capitation revenue to CCOs, who then moved to share the revenue downstream with providers. Additionally, the 2020–2022 capitation rates included considerations about the impact of COVID.

OHA presented CCOs with a voluntary contract amendment that contained additional COVID-related provisions, including a one-year medical loss rebate (MLR) measurement for 2020 (on account of provider closures during the pandemic), and flexibility to issue provider stabilization payments to ensure members' ongoing access to care.

Metrics that rely on 2020 utilization data are difficult to interpret due to COVID related restrictions on elective procedures, temporary clinic closures, and other measures that reduced capacity of healthcare services.

**Impact on CCO 2025**

Although the PHE initially impacted the ability of OHA and CCOs to fully implement the CCCO 2.0 contract, a commitment to fully meet the objectives of the contract has endured. In 2020, many of the contract requirements were waived, delayed or modified as OHA and CCOs focused on addressing the immediate needs associated with the pandemic. Since that time most have been restored. Many new partnerships and modifications to communication and engagement resulting from the PHE will benefit the CCO 2025 procurement.

## OHPB 2.0 recommendations: Building on existing priorities

Guided by the governor's vision and community engagement efforts, the OHPB developed 43 policy recommendations for CCO 2.0. This was a foundation on which CCO contractual requirements were developed. Thus far, 25 of the 43 recommendations (58%) have been fully met or are on track. An additional 11 recommendations (25%) have been partially met.

These policy recommendations were evaluated at the midway point of the CCO 2.0 contract (July 2022). The results from this evaluation are summarized in Table 1 and Table 2.

**Table 1: Status of OHPB Policy Recommendations by Policy Category**

| Policy Category | Met or On Track | Partially Met | Not Met |
|---|---|---|---|
| Social determinants of health | 8 | 1 | 0 |
| Value-based payments | 1 | 0 | 0 |

| | | | |
|---|---|---|---|
| Sustainable cost growth | 6 | 2 | 2 |
| Behavioral health | 3 | 8 | 4 |
| Health Information Technology | 6 | 0 | 1 |
| Compliance monitoring | 1 | 0 | 0 |
| **TOTAL** | **25** | **11** | **7** |

While most recommendations are being met, not all have resulted in achieving the intended impacts. Among the 43 recommendations, 18 have achieved the intended impacts and seven have partially achieved their intended impacts.

**Table 2: Status of OHPB Policy Recommendations in Achieving Intended Impacts**

| Policy Category | Achieved | Partially Achieved | Not Achieved | Unknown |
|---|---|---|---|---|
| Social determinants of health | 6 | 1 | 2 | 0 |
| Value-based payments | 1 | 0 | 0 | 0 |
| Sustainable cost growth | 6 | 2 | 2 | 0 |
| Behavioral health | 0 | 3 | 10 | 2 |
| Health Information Technology | 4 | 1 | 2 | 0 |
| Compliance monitoring | 1 | 0 | 0 | 0 |
| **TOTAL** | **18** | **7** | **16** | **2** |

Progress toward these recommendations can be one element in assessing the performance of both the CCOs and OHA in the implementation of CCO 2.0. This assessment can be a key component in the development of policy priorities for CCO 2025. More details regarding the 43 recommendations and the current performance toward them is contained in Appendix A: OHPB Policy Recommendations

## CCO deliverables: Leverage current performance for evaluation

In the current CCO contract, there are 205 identified deliverables. These deliverables represent requirements identified in the contract that require specific actions by the CCOs. More than half (111) of the deliverables are conditional actions only required under certain circumstances such as a change in CCO ownership or the termination of a provider in the CCO's network. This also includes deliverables that are only submitted upon a request from OHA, such as justification for the extension of time to send out a member notification letter. The remaining deliverables consist of reporting requirements (49) to reflect service provision or financial data, verification of compliance standards (35) through policies and procedures, as well as narrative plans (10) reflecting the CCOs approach to specific categories of work such as behavioral health or health equity.

The quality of these deliverables and an evaluation of CCO performance can be used to highlight where progress has been made or additional improvement is needed. Many of the deliverables correlate to priority areas included in the OHPB policy recommendations. Additional priority areas where accountability through deliverables appear in the current contract may warrant further

consideration or modification in the next procurement process. Here are a few critical areas and the current contract deliverables:

- Care coordination/intensive care coordination (ICC) – CCO annually submit related policies & procedures for OHA review and approval.
- Fraud, waste and abuse (FWA) – Annually CCOs submit a prevention plan, assessment report, and policies & procedures for review and approval. Additionally, CCOs submit quarterly audit reports, referrals & investigation reports.
- Grievances and appeals – Annually CCOs submit policies & procedures, as well as templates for member notices, for review and approval. On a quarterly basis, CCOs submit system reports and grievance and appeals logs.
- Language access – CCOs submit annual self-assessments and quarterly utilization reports for evaluation.
- Network adequacy – Annual narrative reports and quarterly capacity reports are submitted for evaluation.
- Non-emergency medical transportation (NEMT) – Annually policies & procedures, member rider guides and call center scripts are reviewed and approved. Quarterly utilization reports are also submitted for evaluation.

## Influence of OHA's other primary initiatives

In 2023, OHA may be undertaking four critical initiatives, depending on funding requests being made in the 2023 legislative session. These include the implementation of new authorities in the 1115 OHP demonstration waiver renewal, Medicaid eligiblity redetermination as part fo the PHE unwinding, the establishment of the Basic Health Plan (BHP), and the expansion of the Healthier Oregon Program (HOP). These efforts will not only influence changes to the contract but also impact OHA resources available for the CCO procurement process.

### New 1115 OHP demonstration waiver renewal (2022-2027)

As a result of the federally-approved waiver renewal, OHA seeks to make several changes to the Oregon Health Plan (OHP) in an ongoing effort to transform the healthcare system in Oregon over the course of the demonstration (October 1, 2022 – September 30, 2027).

Focusing on eliminating health inequities, as well as clearly aligning with other health policy initiatives will allow for significant improvements for individuals who face historic and contemporary injustices, increase individual, family and community resilience; and reduce health disparities for groups disproportionately affected.

Oregon's 2022-2027 waiver focuses on four main goals:

- Creating a more equitable, culturally and linguistically responsive health care system
- Ensuring people can maintain their health coverage
- Improving health outcomes by addressing social needs that impact health
- Ensuring smart, flexible spending for health equity

These goals were reflected in the approval of the following elements:

**Enrollment**

Enrollment was improved in two ways:

***Continuous OHP enrollment for kids***, from birth until their sixth birthday. This means children on OHP will have health care coverage until they turn six and can keep seeing the same health care providers for longer, which results in better health outcomes. Young children in Oregon will maintain their health care coverage until they are ready for kindergarten. Extending continuous coverage for young children promotes consistent access to health care to address concerns that may affect school readiness and will improve health inequities across the system.

***Two-year continuous OHP enrollment*** for people age six and older even if their eligibility status changes. Many people who lose OHP coverage are only ineligible for a short time and then rejoin OHP. This cycling "on and off" of OHP results in poorer health outcomes and costs taxpayers resources in administrative work. By providing two-year continuous enrollment, people will have better health over the long-term. With the implementation of these changes, OHP members will be able to stay covered for a longer time. Currently, members need to re-enroll every year. Members can also lose coverage if their circumstances change, like an increase in income. In the waiver renewal, members won't have to re-enroll as often, and temporary changes in eligibility won't result in a loss of coverage.

**Health-Related Social Needs (HRSN)**

Social supports to help improve health outcomes will be provided in a package of specific services known as health-related social needs (HRSN). Services will be provided for individuals and families who are experiencing transitions in their lives. When people go through major life transitions, like losing housing or becoming incarcerated, they often lose access to their health care providers, leading to worse health outcomes. To help members keep their coverage, stay in touch with their health care providers, and stay healthy, Oregon wants to provide social supports to members as they experience these types of events. HRSN services are expected to begin in 2024. Depending on the nature of the individual's transition, parts of the HRSN package may include services related to:

***Housing***

- Rental assistance or temporary housing (e.g., rental payments, deposits, utility assistance) for up to 6 months
- Home modifications (e.g., ramps, handrails, environmental remediation)
- Pre-tenancy and tenancy support services (e.g., housing application, moving support, eviction prevention)
- Housing-focused navigation and/or case manager

***Food assistance***

- Links to community-based food resources (e.g., application support for Supplemental Nutrition Assistance Program (SNAP)/Special Supplemental Nutrition Program for Women, Infants and Children (WIC))
- Nutrition and cooking education
- Fruit and vegetable prescriptions (for up to 6 months, also known as VeggieRX) and healthy food boxes/meals
- Medically tailored meal delivery

The populations who may be eligible for housing and food assistance under the waiver include:

- Youth with Special Health Care Needs up to age 26
- Youth who are child welfare involved
- People who are experiencing homelessness or at risk of homelessness
- Older adults who have both Medicaid and Medicare health insurance
- People being released from carceral settings or the Oregon State Hospital

***Protection from climate events for people at risk of extreme weather***

- Payment for devices that maintain healthy temperatures and clean air, including air conditioners, heaters, air filters
- Generators to operate devices when power outages occur.

## Measuring Outcomes

Since 2013, Oregon's Quality Incentive Program has paid bonuses to CCOs for performing well on certain health metrics or measurements. The program looks at things like the quality of health care services and access to care. In the waiver renewal, Oregon plans to change the Quality Incentive Program in a few ways:

- ***Change committee structure*** so those most affected by health inequities lead the CCO Quality Incentive Program. More seats for OHP members, community members from diverse communities, individuals with lived experience of health inequities, health equity professionals and researchers.
- ***Upstream and downstream metrics***
    - Upstream metrics focus on the causes of poor health and can be used to address health equity concerns. Example: a metric that looks at providing culturally responsive health care services in an OHP member's preferred language.
    - Downstream metrics relate to health outcomes aligning with standard health metrics used by other Medicaid organizations across the country. Example: metrics focus that on more traditional medical care, such as diabetes care and well child visits.

OHP members and communities will have a greater voice in the quality incentive program. The result will be that the program will be measuring and rewarding improvements that matter the most to the community and have the greatest chance of improving the long-term health of OHP members.

## Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Oregon did not seek a renewal of its waiver around Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for children. EPSDT's purpose is to discover and treat childhood health conditions before they become serious or disabling. The decision comes, in part, from clear feedback from the community, advocates, children's service organizations, and other interested parties. The decision also is consistent with the waiver's focus on eliminating health inequities across Oregon. OHP coverage of services and treatments rely on the Prioritized List of Health Services (prioritized list), however, the state will arrange for, and make available to children, all medically necessary and medically appropriate services that are required for treatment of conditions identified as part of an EPSDT screening, regardless of position or diagnosis/treatment pairing on the prioritized list.

Beginning January 1, 2023, all Medicaid-covered medically necessary and medically appropriate services will be made available to children and youth under age 21 on OHP. Any services that are denied will be accompanied by a notice of action or adverse benefit determination to the member and Medicaid fair hearing rights.

**Prioritized List of Health Services**

The intention of the Prioritized List over its 30-year history has been to provide evidence-based decisions regarding benefits through a transparent, public process. In accordance with the waiver renewal, Oregon will transition its prioritized list that determines the OHP benefit package to the Medicaid State Plan by January 1, 2027, while still maintaining a public process to guide decisions on efficacy and medical necessity criteria.

The state will need to complete a detailed regulatory and operational review with the potential for meaningful changes in law, rules, or processes to make this change. Oregon will work with CMS and stakeholders to effect all necessary changes to Medicaid benefits and operations.

## OHP member redetermination, Bridge Program and Basic Health Plan

During the PHE, temporary measures were put in place to prevent OHP members from losing coverage. Currently, there are more than 1.4 million Oregonians covered by OHP. When the PHE ends and the temporary measures to retain coverage are rescinded, it is estimated approximately 300,000 individuals may lose OHP coverage. House Bill 4035 (2022) directed OHA, in collaboration with Oregon Department of Human Services (ODHS), to develop and implement a plan for conducting OHP member redeterminations when notified by the federal government. This plan is intended to minimize the risk of disrupting coverage for high-risk populations. It stipulates the need to develop outreach and enrollment assistance, as well as a communications strategy in collaboration with a community and partner work group. Upon notification by the federal government, states will have 14 months to complete redeterminations for every person currently enrolled in Medicaid. In preparation, during October and November 2022, letters were sent to all OHP members notifying them of the redetermination process that will occur and verify their contact information with OHP. Information will be requested to confirm what coverage options will be available to the member.

The legislation also established a task force to develop a proposal for a bridge program to provide affordable health insurance coverage and improve continuity of coverage for those going through redeterminations. Work has begun in the development of a proposed bridge program to provide coverage for many of those at risk of losing coverage when redeterminations begin. A phased approach is proposed beginning with those at risk of losing Medicaid coverage. Individuals with income under138% of the federal poverty level (FPL) will remain eligible for OHP. Individuals with incomes from 138% to 200% FPL will temporarily remain eligible for OHP through an 1115 demonstration waiver but will eventually transition to the Basic Health Plan (BHP) when established. The BHP will enable these individuals to maintain healthcare coverage. Designed to mirror many of the benefits included in the OHP and potentially offered through the CCOs, alignment between this initiative and the new CCO contract will be critical. If the BHP is not established, these individuals will transition to the Oregon Health Insurance Marketplace (marketplace). Individuals with income above 200% FPL will be directed to the marketplace. Those not responding to requests for information during the redetermination period will have their coverage terminated.

### Healthier Oregon Program and CCO Non-Medicaid Contract

Through the passage of HB 3352 (2021), the Health Care for All Oregon Children program (also referred to as Cover All Kids) was renamed the Health Care for All Oregon program (now referred to as the Healthier Oregon Program) with eligibility expanded to allow adults who but for their immigration status would qualify for OHP to also qualify for state healthcare.

As a condition of the CCOs' Medicaid contract, CCOs agree to enter into a contract to provide Medicaid-equivalent services to individuals not eligible for OHP due to immigration status. Until the passage of HB 3352, this contract only included the Cover All Kids program. With the establishment of the Healthier Oregon Program effective on July 1, 2022, eligibility was expanded. A budget of $100 million, from the Oregon General Fund, was set for the 2021-2023 biennium for this program. Although the bill intended to cover all individuals who would qualify for state healthcare coverage but for immigration status, based on financial projections $100 million would not be enough to cover all individuals. OHA established a community advisory group to consider this funding challenge resulting in a recommendation that the program cover individuals up to age 25 and those 55 years and older.

Two additional bills, HB 4095 (2022) and SB 1538 (2022), also expanded coverage provided by this non-Medicaid contract with CCOs. HB 4095 established the Veterans Dental Program to provide oral health care to low-income veterans. SB 1538 established the Compact of Free Association (COFA) Dental Program to provide oral health care to COFA citizens.

As part of the next CCO contract procurement process, it will be necessary to consider not just the Medicaid contract but also the non-Medicaid contract.

## Maturing CCO model

Oregon has been administering healthcare services through the CCO model for more than a decade. As preparations are made for a third CCO contract, it is important to evaluate how the model has developed and evolved over that time. Consideration should also be made as to whether the current model continues to reflect the expectations as originally established or whether structural modifications are necessary.

CCOs have been challenged to address the growing complexity of offering new programs and expanded benefits to a broader base of eligible individuals while maintaining local flexibility and collaborative engagement in meeting community-specific needs. Individual CCOs differ in a variety of ways.

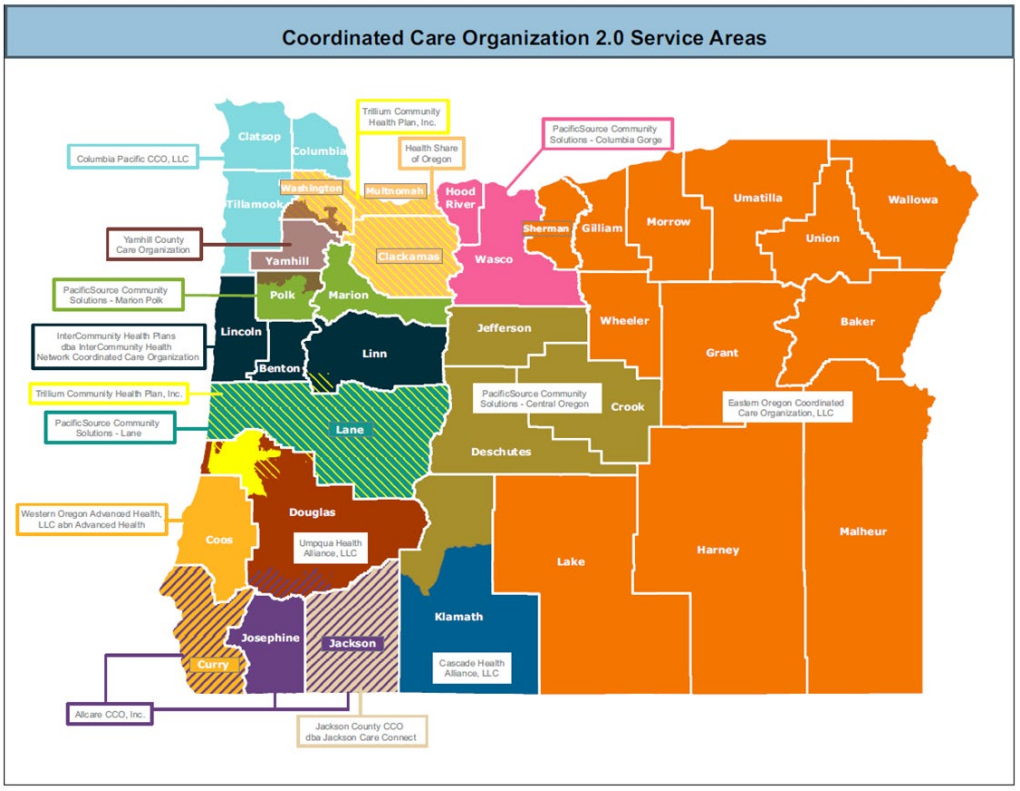
The service areas covered by CCOs vary widely, with individual CCOs covering as little as one county to as many as 12 counties. Service areas vary from primarily urban to exclusively rural. These variances result in CCO memberships ranging from just over 15,000 members for the smallest to more than 420,000 members for the largest. About half of all members are offered the choice of two CCOs, while the other half have one CCO covering their area. All of these variances highlight the benefit of local flexibility in meeting the needs of communities but create challenges in implementing contractual requirements that are standardized for all CCOs.

**Table 3: CCO Service Area & Membership (as of December 2022)**

| CCO | Service Area (Counties) | Members |
|---|---|---|

| | | |
|---|---|---|
| Advanced Health | Coos & Curry | 27,537 |
| AllCare | Curry, Jackson, Josephine & Douglas (part) | 62,222 |
| Cascade Health Alliance | Klamath (part) | 25,764 |
| Columbia Pacific | Clatsop, Columbia & Tillamook | 35,628 |
| Eastern Oregon | Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa & Wheeler | 71,830 |
| Health Share | Clackamas, Multnomah & Washington | 429,364 |
| InterCommunity Health Network | Benton, Lincoln & Linn | 80,826 |
| Jackson Care Connect | Jackson | 62,816 |
| PacificSource – Central Oregon | Crook, Deschutes, Jefferson & Klamath (part) | 73,492 |
| PacificSource-Columbia Gorge | Hood River & Wasco | 16,919 |
| PacificSource-Lane | Lane | 89,395 |
| PacificSource-Marion/Polk | Marion & Polk | 141,133 |
| Trillium Community Health Plan-South | Lane, Douglas (part) & Linn (part) | 36,519 |
| Trillium Community Health Plan-North | Clackamas, Multnomah & Washington | 37,731 |
| Umpqua Health Alliance | Douglas | 37,034 |
| Yamhill | Yamhill, Polk (part) & Washington (part) | 35,277 |

There are also variances in CCOs organizational structures. Several CCOs are owned by larger profit or non-profit organizations offering a portfolio of services broader than OHP or Medicaid. In contrast, there are smaller CCOs governed by members of the local health care community created primarily or exclusively to support Oregon Medicaid. There are also a few that have shared ownership between larger organizations and the local health care community. While designed to support Oregon Medicaid, they are partially owned by organizations offering a broader portfolio of service. Three organizations operate multiple CCOs and one CCO subcontracts with multiple healthcare plans. These differences can impact a CCO's ability to provide services or meet contractual requirements as a result of differences in resources and internal staff expertise. It can also be reflected in the level of community engagement and collaboration for a CCO. CCOs



governed locally can rely on existing relationships or understanding of local practices whereas some CCOs governed by larger organizations sometimes are faced with developing new relationships.

Acknowledgement of these differences and their impact on member access to services and quality of service delivery will be an important consideration for the next contract procurement process.

# CCO 2025 Procurement Process

The CCO 2025 procurement process will be guided by four inter-related plans: project plan, engagement & outreach plan, communication plan, and implementation plan. Additionally, coordination and collaboration with the OHA's other key projects will be maintained to ensure alignment of priorities, efficient use of staff resources and clear communication to members, CCOs and the impacted communities.

## Milestones and Deadline Dates

The procurement process can be separated into four phases: initiation phase, planning phase, execution phase and implementation phase. Actions associated with the initiation phase have already begun. This process will continue until the new contract period begins on January 1, 2025. A closeout phase is also planned to review the process and identify lessons learned that may be used to inform processes in the future. The following table is a summary of the key procurement actions and milestones.

**Table 4: CCO Contract Procurement Actions and Milestones**

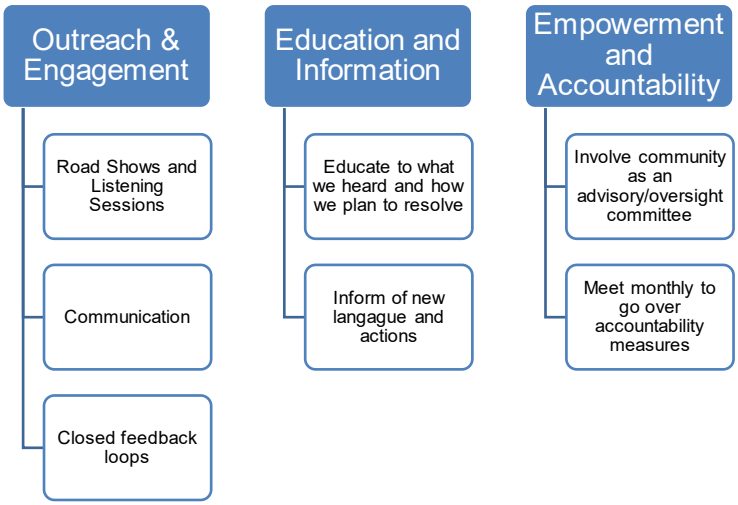
| Phase | Timeframe | Project Actions or Milestone |
|---|---|---|
| Initiation Phase | July-December 2022 | Develop Procurement Project Plan |
| | January 1, 2023 | Legislative report due |
| Planning Phase | January-June 2023 | OHPB, CCO and Community Engagement |
| | TBD (April 2023 or later) | Public Health Emergency Ends |
| Execution Phase | July-December 2023 | Draft and release procurement documents |
| | January 1, 2024 | Elements of new 1115 waiver implemented |
| | January-March 2024 | Evaluate and select CCOs for 2025-2029 |
| Implementation Phase | January-June 2024 | New contract development & readiness review |
| | July-December 2024 | Communication, education and technical assistance |
| | October 1, 2024 | New contract signed |
| | January 1, 2025 | Coverage period begins |
| Closeout Phase | January-March 2025 | Closeout assessment report prepared |

## Public Transparency and Communication

There are two plans intended to address public transparency and communication throughout the process: the community engagement plan and the communication plan.

**Community Engagement Plan**

The Community Engagement Plan will serve as the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interests, or similar situations to address issues affecting the well-being of those people and communities, identify needed changes that can be addressed through contractual modifications, and ensuring that the community is actively engaged in the decision-making process. Three tactics will be pursued to achieve those ends: outreach and engagement, education and information, and empowerment and accountability




Visibility into member experience and unfiltered member voice will be essential to ensure the health system is coordinated, equitable, and culturally appropriate for all. While OHA conducts many community engagement activities, often they are fragmented with limited opportunity to engage on terms the consumer defines. This process will seek to prioritize member experience using a framework that ensures visibility by race, ethnicity, preferred language, and disability status. Visibility into member experience and unfiltered member voice are essential to developing a system of care that is person-centered and equitable.

Efforts will be made to avoid past community engagement errors and limitations through promotion of the integration and coordination of information with other community engagement efforts will be critical. This can include work planned for the 1115 OHP demonstration waiver implementation, member Medicaid eligibility redeterminations during PHE unwinding and the development of the Basic Health Plan. This process will also rely on current OHA community member-centric committees such as, the Medicaid Advisory Committee's Consumer Experience Subcommittee, the Health Equity Committee, and the Ombuds Advisory Council to identify and develop an extensive community engagement plan for the procurement process.

While public meetings are a great way to reach a large number of people, there is also a need for less public settings. It is critical for this work to enable members to share the barriers faced in accessing care. This will require not just large public meetings, but also smaller engagement efforts in settings that promote and enable an unfiltered consumer voice to be heard. Often the communication of these experiences carry anxiety and personal trauma. Assurance of a supportive and empathetic environment will promote a more valuable engagement. A member-centered approach requires OHA to meet members where they are and eliminating barriers to participation.

Episodic community engagement limits the quality of input from members and the community. Yet, this is often the approach to community engagement. Acknowledging this limitation, OHA will focus on an ongoing, evolving and collaborative engagement throughout the procurement process. In addition to working closely with existing OHA committees, this process will identify and recruit members and communities to take part in an advisory and oversight committee that will hold OHA accountable for community engagement efforts.

**Communication Plan**

The communication plan will ensure that all parties are informed about the process. It will focus on the provision of targeted, salient information to key audiences on contract timeline, process and content. It will also seek to engage internal and external audiences to connect the CCO 2025 contract to OHA's goal to eliminate health inequities and other agency priorities. The plan will allow collaboration between the procurement process and OHA's other key projects to avoid misunderstandings, align messages and identify areas of efficiency between projects.

**Communications Goals**

- Demonstrate how CCO 2025 contracts will accelerate health transformation in Oregon and serve as a national model
- Demonstrate how CCO 2025 contracts will advance OHA's goal to eliminate health inequities and support investments in social determinants of health.

**Communications Topics**

Content will support information on areas of focus identified in the planning phase as well as the four key identified areas of continued improvement in CCO 2.0:

- Maintain sustainable cost growth in the Oregon Health Plan
- Increase value-based payments that pay providers for quality and outcomes rather than quantity or volume
- Focus on social determinants of health and health equity: factors like poverty and housing access that affect health outside of the doctor's office and can result in health disparities
- Improve the behavioral health system, which addresses mental health and addictive disorders

**Audiences:** Audiences include legislators; Coordinated Care Organizations (CCOs) including Community Advisory Councils; partners (may include but are not limited to: local, state, national, public, faith- and community-based, private, and academic organizations); agency leadership; internal staff; OHP members; Regional Health Equity Coalitions; and OHA, Oregon Department of Human Services, and Oregon Housing and Community Services advisory committees.

## Resource Needs

Acknowledging the significant staffing resources needed to successfully support other key OHA projects in 2023, every effort will be made to maximize allocated resources necessary through a reduction in the size and scope of the procurement process. This will be achieved by utilizing a project management approach to the process, leveraging resources and actions undertaken through other OHA projects and initiatives, and committing existing resources and committees to this work for the duration of the process.

Past initiatives have demonstrated that coordination, resourcing and collaboration are critical to success, and that without early and thorough project planning and ongoing project management, challenges in these areas can be significant. These experiences highlight the need for the next procurement process to have clear and robust project management from the outset.

Some preliminary steps have already been taken through the commitment of project management resources and establishment of a project management workgroup. A series of meetings were conducted with OHA leadership to outline the proposed process. This process has also been shared with OHPB. Initial objectives undertaken have included an examination of the CCO 2.0 process, a progress assessment of OHPB's CCO 2.0 policy recommendations, and review of federal audit feedback. A proposed business plan has been developed highlighting a general scope of work, timeline and resource needs. The workgroup was also integral in the preparation of this report.

Once the proposal has been approved, a charter can be developed for the project. The charter will provide the structure for the project through final implementation. Once a charter has been approved, a formal startup of the project can occur, effective assignment of resources and validation of authority can be confirmed. At this point, a detailed project plan will be developed. Expanding on the content of the charter, the project plan will lay out exactly how the project will be completed utilizing detailed timelines and clear actions through each phase of the process.

Previous procurement efforts relied on substantial OHA staffing resources. For this procurement process, an inventory of existing resources will be conducted. Starting with a member-centered approach consistent with OHA's goal to eliminate health inequities will align the process with departmental efforts already underway. This can also be achieved by leveraging work underway or planned in relation to the 1115 OHP demonstration waiver implementation, OHP member redeterminations, establishment of the Basic Health Plan and evolution of the Healthy Oregon Program. Although each project has unique needs and resources, there are significant areas of overlap, most notably in operational and administrative resources. The establishment of a shared organizational structure among projects will promote collaboration, reduce misaligned and overlapping activities and reduce staffing demands. This can be achieved through a consolidated meeting structure in which project timelines, project planning decisions and resource allocations can be determined taking all projects into account. Efficiencies can be realized in designing share project activities such as system enhancements, rule changes, communication strategies and community engagement efforts.

Relying on staff, committees and community partners, policy and contract requirement development can build upon existing efforts. For example, revisiting OHPB's policy recommendations will provide an indication of progress that has been made by CCOs and OHA, as well as areas where challenges remain. This can also provide a foundation to work with OHPB in developing recommended policy priorities for this procurement process. Relying on subject matter experts in both policy and operations, modifications can be made to existing contract requirements based on CCO performance and community engagement efforts.

Another consideration for narrowing the scope is to limit applicant eligibility. This could be by limiting the procurement to existing CCOs or more narrowly defining organizational requirements to qualify as a CCO. With a limited pool of applicants, more focus can be placed on establishing expectations for CCOs in the new contract.

Accounting for these efforts, there are a few critical resources committed to this work necessary to enable this procurement process to be successful.

- Project Management - As previously highlighted, dedicated project management throughout the entire process is critical. This should include a project manager and administrative support

to ensure the development of a complete project plan and adherence to it throughout the process.

- Community Engagement – It will be important to have dedicated staff leading outreach and engagement efforts in the community in collaboration with existing initiatives and similar efforts conducted for other OHA projects. It will also be important to offer stipends to community members who dedicate time to engaging with OHA during the outreach effort.
- Communications – Dedicated communications resources will ensure information is provided both internally and externally throughout the process. This is also an area where collaboration with existing initiatives and similar efforts conducted for other OHA projects will be beneficial.

Additionally, there are existing resources that will need to be committed to this work:

- Executive Steering Committee – Consisting of key members of leadership, this committee would be responsible to convene regularly for consideration of financial, staffing and other resources-related decisions.
- Oregon Health Policy Board – The OHPB was a key contributor in establishing policy recommendations for CCO 2.0. It is recommended that OHA engage with OHPB to receive similar input and guidance for the CCO 2025 contract as well.
- Medicaid Advisory Committee Consumer Experience Subcommittee, Health Equity Committee & Ombuds Advisory Council – Collaboration with these groups in support of community engagement.
- Contract Lead
- Member Transition Lead
- Organizational Change Management Lead
- Metrics Lead
- Tribal Policy & Program Analyst
- Procurement Analyst
- Equity Advisor
- Finance Analyst
- Health Policy Analyst
- Systems Data Analyst – MMIS & ONE system
- Rules Coordinator
- Department of Justice Contact

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