CCOs and Coordinated Care

House Behavioral Health and Health Care Committee
Oregon State Legislature
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CCO Oregon is a statewide, nonprofit 501(c)(3) member association that convenes payers, providers, and other care delivery partners to identify and advance evidence-based, stakeholder-driven strategies that support coordinated care and health transformation.

Our vision is a future with lower costs, increased access to quality care and health-related social needs, improved outcomes, and a sustainable workforce across the delivery system through the widespread implementation of the coordinated care model.

CCO Oregon engages our membership through our annual conference and monthly workgroups focused on Behavioral Health, Oral Health, Pharmacy, Government Relations, CCO Contracting & Operations, and Social Determinants of Health.

CCO Oregon celebrated the 10th anniversary of Oregon's coordinated care model in 2022. Watch the celebration video.

CCO Oregon Membership

Advantage Dental
Advanced Health CCO
AllCare Health
All Smiles Community Oral Health
Capitol Dental
CareOregon
Cascade Health Alliance CCO
Cascadia Health
Central City Concern
Central Oregon Health Council
Columbia Pacific CCO
Curandi
Eastern Oregon CCO
GOBHI
Health Share of Oregon
Hospital Association of Oregon
InterCommunity Health Network
Jackson Care Connect
Kaiser Permanente
Moda Health
ODS Community Dental
Oregon Dental Association
Oregon Primary Care Association
PacificSource Community Solutions
Permanente Dental Associates
Planned Parenthood of the Columbia Willamette
Providence Medical Group
Trillium Community Health Plans
Umpqua Health Alliance CCO
Willamette Dental
Willamette Health Council
Yamhill Community Care CCO

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OHP enrollment and CCOs

- Coordinated care organizations (CCOs) contract with OHA to deliver Medicaid, aka Oregon Health Plan (OHP) benefits.
- 1,438,080 Oregonians (33% of the state's population) are on OHP.
  - 92.4% (1,328,786) are enrolled in an CCO
  - 7.4% (106,418 OHP) members are on Open Card, aka Fee for Service
  - More data is available at the OHA dashboard, updated 12/31/24
- CCO enrollment increased over the past five years, with the implementation of the Healthier Oregon and OHP Bridge programs, as well as the COVID-19 pandemic.
- 97% of Oregonians have insurance coverage.
- There are currently 16 CCOs across Oregon.

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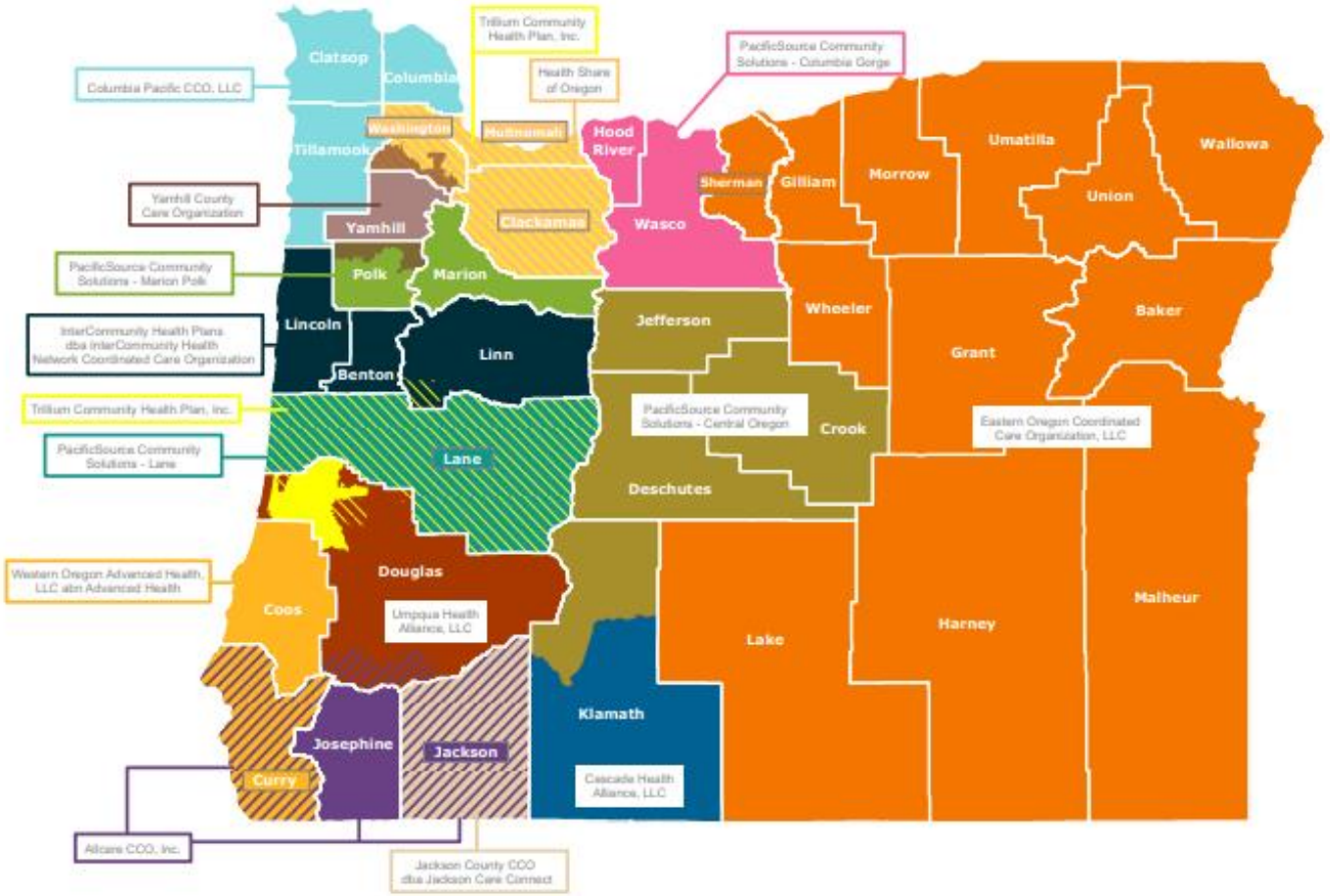
Coordinated Care Organization 2.0 Service Areas



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CCO 101

- A CCO establishes and maintains a network of local providers to deliver the care that Oregonians on OHP need. The CCO and its network is sometimes referred to as the “hub and spokes” model.
- In 2012, the Oregon Legislature passed SB 1580, authorizing CCOs to achieve the Triple Aim:
  - Better health and outcomes
  - Higher quality patience experience
  - Lower sustained costs
- Prior to CCOs, OHP members may have had three separate plans for physical, mental health, and dental care. The different providers types were also not coordinated. This structure made care more difficult for patients and providers and more expensive for the state.

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CCO 101 (cont'd)

- Every CCO is a local organization with a per-member budget that grows at a fixed annual rate of no more than 3.4% for all health care services.
- Each CCO is accountable for health outcomes in its community population.
- CCOs have more flexibility than other care delivery models to support innovative approaches to care, community-specific efficiencies, and more rapid adaptations to changing community needs.

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CCO provider networks and community partners

CCOs are subject to network adequacy standards and contract with:

- Hospitals
- Counties
- Peer support
- Housing and social service providers
- Community based organizations
- Primary care providers
- Wraparound services
- Schools and school-based health centers
- Mental health and substance use disorder (SUD) providers
- Community mental health programs (CMHPs)
- Certified community behavioral health clinics (CCBHCs)
- Federally qualified health centers (FQHCs)
- Dental care organizations (DCOs)
- Non-emergent medical transportation (NEMT)

CCOs are driven by and accountable to community

- CCOs' per-member/per-month global budget payments provide some flexibility for CCOs to coordinate care for improved health population outcomes and make investments in their local communities.
- CCOs are governed by local Medicaid stakeholders that include health care providers, community members, and health system partners.
- CCO Governing Board meetings are open to the public and include time for public comment; minutes are posted on the CCO website.
- Community Advisory Councils (CACs) are groups of volunteers including OHP members that help the CCO to develop and sustain programs, improve services, and engage the greater community for input, feedback and prioritization
- CCOs convene community providers and partners to develop Community Health Improvement Plans (CHPs). Community Health Assessments (CHAs), and Comprehensive Behavioral Health Plans.
- CCO Quality Incentive Metrics assess CCO impact on various population health factors, along with other federally and state required measures.
- The CCO model emphasizes comprehensive, integrated care that is coordinated and member-centered

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CCO contracting with the OHA

- Current statute requires that CCO Contracts have a term of at least 5 years, but have been repeatedly extended:
  - First contract: Began in 2012. OHA postponed the renewal until 2020
  - Second contract (CCO 2.0): Began on Jan. 1, 2020. Was also expected to last 5 years, but in 2023 was postponed by the Legislature to 2027
- The benefits of the model were clear by 2019: The overall cost of the CCO program grew at a rate of 3.4% per member per year. Prior to CCOs, the growth rate was at 5.4%, which means about $2.2 billion in costs were avoided over the first five years.
- Priority areas for CCO 2.0 were identified by Gov Brown:
  - Focus on social determinants and equity
  - Increase value and pay for performance
  - Improve the behavioral health system
  - Maintain a sustainable cost growth
- The third multi-year contract is slated to begin on Jan. 1, 2027 and is expected to sustain the overall the success of the model.

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And between multi-year contracts…

- CCOs and their provider networks are responsible for hundreds of planning documents, reports, and audits each year.
- Between the multi-year procurement contracts, OHA issues contract amendments each year with new requirements. For the 2025 amendment, 23 changes were made.
- Along with the amendment, OHA publishes new rate schedules and per-member/per-month capitation rates each year.
- CCOs and their provider network have implemented new §1115 Medicaid Demonstration Waiver programs, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage and Health Related Social Need (HRSN) climate, housing, and nutrition benefits.

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Current challenges across CCOs

- Provider reimbursement and fully funding Oregon's Medicaid model:
  - Providers rates are often higher under commercial plans; while acuity and administrative burden are often higher in Medicaid
  - Program expectations frequently exceed reimbursement (i.e., HRSN, IIBHT, dental, and more)
  - Lack of transparency into rate development; difficulty accepting trends and partner input
  - Medicaid and the Oregon Health Plan are not structured in a way that allows CCOs to just "pay more"
  - Difficulty with provider recruitment and retainment, especially in rural and geo-isolated communities
- Complicated regulatory system and at times delayed guidance from OHA or federal government
- Care continuity barriers and department silos across multiples agencies (i.e. corrections)
- Balancing access, accountability, program expectations, provider reporting burden, and quality
- Specific provider gaps (i.e. interpreters) and a lack of diversity in the workforce
- System capacity shortages such as acute care and the State Hospital for behavioral health
- Lack of and high cost of housing exacerbates core system problems for patients and providers
- Social and environmental factors outside of CCO or provider control, i.e. wildfire, public transportation, schools, pandemics, broadband access, fentanyl, etc.

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(Some) 2025 CCO-related legislation

- **Prioritized List task force:** Task force bill to advise and oversee moving OHP's "prioritized list" from the Medicaid Waiver to the State Plan Amendment (HB 2212)
- **CCO contract length:** Extend the multiyear CCO contract period to 10 years (HB 2205)
- **Rate review:** Establish a more formal and transparent process to set CCO capitation rates (HB 2215)
- **Minimum Medical Loss Ratio (MMLR):** Set MMLR in statute consistent with the federal standard (HB 2213)
- **Annual CCO contract changes:** Establish a clear process and criteria for proposing and adopting changes to the CCO contract that occur between the multi-year procurement process (HB 2209)
- **Streamline regional planning:** Align the community planning processes across CCOs, CMHPs, hospitals, and counties to better use payer and provider capacity (HB 2208)
- **Adult Mental Health residential task force:** Direct OHA to study and develop recommendations for CCOs to potentially administer the benefit for Adult Mental Health Residential Care (HB 2206)
- **SHARE Initiative:** Clarify and simplify CCO reserve requirements for community-led investments (HB 2214)
- **Funding:** Fully fund the OHP and coordinated care model, including the provider assessment (HB 2010)

*These bills will be individually endorsed by CCO Oregon members

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Questions?

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