Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health

By Neva Kaye **February 2021**

Since 2012, Oregon has fostered partnerships between its Medicaid accountable care organizations (called coordinated care organizations or CCOs) and community-based organizations (CBOs). These CCO/CBO partnerships have helped reduce health inequities by addressing both individual CCO members' social needs and community social determinants of health (SDOH). Last year, Oregon launched a second phase of its CCO program, called CCO 2.0. This report explores how Oregon built on the achievements and lessons learned from the first phase to more effectively foster partnerships that focus on state and local population health priorities.

Background

Oregon launched CCO 1.0 in 2012 when it began contracting with regionally based CCOs to deliver Medicaid-covered services to program participants. CCOs are community-governed organizations that bring together physical, behavioral, and oral health providers to deliver coordinated care for their members. CCOs receive per member per month (PMPM) payments and are also eligible to receive annual incentive payments based on their performance in delivering access to high quality care.

Key Takeaways from Oregon's Experience

- Oregon's efforts to foster partnerships between CCOs and CBOs that address the social determinants of health have succeeded.
- Over time, Oregon strengthened and refined its CCO policies to more effectively foster CCO/CBO partnerships. Policy decisions were informed by assessments of the effectiveness of existing policies, stakeholder input, and relevant research.
- The most effective CCO/CBO partnerships had clear expectations and roles for both partners, which in turn created actions linked to measurable outcomes.
- Supporting both partners was critical to success. Oregon's Transformation Center helped CCOs, and to an extent CBOs, to implement the new policies. The Transformation Center developed written guidance and provided group and individual technical assistance.
- The state's public health agency is a critical partner in Oregon Medicaid's efforts to foster CCO/CBO partnerships. The state health department also provided support by convening partners and providing data that informed planning.

During CCO's first phase (CCO 1.0), Oregon sought to foster partnerships between the regionally based CCOs and local CBOs dedicated to addressing the SDOH. State officials and other stakeholders believed their efforts could be improved, and one of CCO 2.0's objectives was to strengthen the CCO/CBO partnership efforts. Oregon launched CCO 2.0 in January 2020 when new contracts with 15 CCOs went into effect.

Oregon's ultimate goal for the CCO/CBO partnerships is to help eliminate health inequities by addressing both individual social needs and community SDOH. Examples of CCO/CBO partnership activities that Oregon anticipates will reduce inequities include the following:

- One CCO supported development of affordable housing and established a "medical respite" program with a local shelter that allows individuals who are unstably housed or homeless CCO members to stay in a safe environment following a hospitalization or surgery.[1]
- One CCO contracted with a CBO to provide housing supports and case management to those at risk of homelessness.[2]
- Three CCOs provided financial support to the Self-Healing Community Initiative, which provides trauma-informed training sessions and events to schools, agencies, businesses, and community groups.[3]

> "We do this [work to create CCO/CBO partnerships] to support Medicaid members where they are at and drive the system upstream to address the root causes of health inequities."
> *-OHA official*

Policy Development Process

Oregon first began working on its CCO 2.0 in 2016, when at the direction of both the governor and the state legislature, the Oregon Health Policy Board (OHPB), which is the policy and oversight board for the Oregon Health Authority (OHA), was commissioned to provide policy guidance on the future of CCOs to both the legislature and the OHA. The OHPB based its initial recommendations on a review of quantitative data and stakeholder input gathered via in-person community listening sessions and an online survey. One of five themes to emerge from stakeholder input was, "CCO community coordination to address the social determinants of health has begun, but must be accelerated and strengthened..."[4] Oregon, therefore, made this task a major focus of its CCO 2.0 policy development process.

In 2017, development of CCO 2.0 began in earnest when Oregon's Governor and legislature asked the OHPB to build on its initial work by identifying specific policy changes that would, as part of a broader request, increase CCO focus (and spending) on addressing health equity and the SDOH in their communities. This work was based on both qualitative and quantitative information, including a maturity assessment of CCO 1.0's performance in this area. Policy changes that emerged from this process included embedding requirements that fostered CCO/CBO partnerships in the CCO selection process and 2020 CCO contract, as well as modifying CCO planning and state oversight activities to ensure that CCOs address health equity and the SDOH. In CCO 2.0, Oregon also strengthened the distinction between two types of SDOH-related activities:

- Those designed to address an individual CCO member's health-related social needs, and
- Community benefit initiatives designed to promote improvement in community-level SDOH and health

> "We often use the health impact pyramid with health care at top but an easier way to see it is that if you have an individual with HRSN (health-related social needs) you also need to address policy issues that lead that person to have HRSN."
> -OHA official

equity. (Note that CCO community benefit initiatives are distinct from hospital community benefit requirements.)

CCO 2.0 Performance Requirements that Foster CCO/CBO Partnerships

The OHA implemented the new policies through legislation, administrative rules, the contractor selection process, and contracts. Together, these documents define the state's expectations of its CCOs and enable the OHA to assess each CCO's planned approach to implementing the new policies.

The CCO 2.0 requirements built on several policies that were already in place. In the 1.0 phase, CCOs were required to conduct a community health assessment, develop and implement a community health improvement plan, and establish a community advisory council (CAC). In CCO 2.0, the OHA strengthened these requirements. For example, the new contract specifies that SDOH and equity (SDOH-E) partners and organizations must be included in the development of both the assessment and improvement plan. (An SDOH-E partner is an entity, including a CBO, that, "delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area.")[5] Also, the contract now indicates that the CAC must play a role in directing the CCO's investments in SDOH-E and in the CCO's community benefit initiatives. Compliance with these policies is monitored through two reporting mechanisms which are detailed below — each CCO's health-related services policy and each CCO's Supporting Health for All through REinvestment (SHARE) Initiative spending plan.

In CCO 1.0, CCOs were given the flexibility to pay for *health-related services*. These are services that are not covered by Oregon Medicaid but that would "improve care delivery and overall member and community health and well-being."[6] CCOs could choose to invest in providing services to individual members or in community benefit initiatives. However, during the policy development process for CCO 2.0, the OHA conducted a review that found that the agency was not collecting the information needed to fully understand and oversee these investments —
and, it found that what information it did have indicated that the investments, especially those in community benefit initiatives, were minimal. As a result, the CCO 2.0 contract encourages greater investments in health-related social services and strengthens both reporting and oversight of SDOH-E. For example, all health-related services investments must consider the CCO's health improvement plan, which must be developed with the input of CBOs and other stakeholders.

During the policy development process for CCO 2.0, the legislature also passed HB 4018, which, starting this year, will require the CCOs to spend a portion of their previous year's net income or reserves on services to address health disparities and the social determinants of health in line with the CCO's community health improvement plan. The OHPB recommended specific policies to guide the implementation of HB 4018, including requiring the CAC to have a role in spending, as described above, requiring alignment with a statewide housing priority, and requiring that a portion of the funding go directly to SDOH-E partners through a formal agreement (e.g., contract or memorandum of understanding - MOU). Through these agreements, the CCO can commission

CBOs or other SDOH-E partners to deliver a service or program, and/or foster policy or systems changes that address the SDOH and equity.

Oregon renamed this legislative requirement the Supporting Health for All through REinvestment (SHARE) Initiative. The SHARE Initiative was implemented on January 1, 2021 with the income/reserves produced by the CCOs in 2020. Under SHARE, the CCO must spend some of its profits/reserves on housing supports and may choose to spend the remainder of its funds in four priority areas: economic stability (e.g., access to quality childcare), neighborhood and built environment (e.g., quality, availability, and affordability of housing), education (e.g., high school graduation), and social and community health (e.g., trauma, such as adverse childhood experiences). The OHA reserves the authority to approve the CCO's spending priorities and plans for the SHARE funding. These requirements align with the public health agency's state health improvement plan for 2020-2024 which established economic drivers of health, such as housing, transportation and living wage jobs, as one of five priorities.

Oregon Health Authority Oversight

OHA oversight of both health-related services and SHARE began during the CCO 2.0 contractor selection process. Each organization seeking to be selected as a CCO had to report on its existing partnerships with potential SDOH-E partners, its approach to setting spending priorities, how the CAC would weigh in on spending decisions, and other information that enabled the OHA to assess how well the organization would meet the new requirements.

Also, new oversight structures went into place in January 2019 to track CCOs' efforts to address the SDOH-E, including their existing partnerships with CBOs. Specifically, the OHA created a financial reporting template for health-related services. This template collects detailed data about each CCO's health-related services expenditures, including those that address the SDOH and equity. The data collected includes the purpose of the expenditure (e.g., housing supports), whether the expenditure was made to provide services to individuals or as a community benefit initiative, intended outcomes, and whether the expenditure was made to improve SDOH-E. Other new reporting requirements strengthen the OHA's oversight ability. For example, each CCO's *Transformation and Quality Strategy* must describe its community-level SDOH and equity initiatives, including collaborations with community and SDOH-E partners. Finally, starting in 2021, CCOs must submit their SHARE Initiative spending plans and subsequently begin reporting SHARE Initiative expenses.

> "[We are] looking for the thing that moves the needle...You don't wait a long time to give someone insulin when they have diabetes, why wait to provide housing for people who need it."
>
> -OHA official

The OHA publicly reports the information it collects from the CCOs. As a result, the reports both enable the OHA to assess whether the CCOs are in compliance with the contract and also provide other stakeholders with information about CCO investments in partnerships to improve the SDOH-E.

How CCO Payment Policies Foster CCO/CBO Partnerships

Four elements of CCO payments foster the development of CCO/CBO partnerships to address the SDOH. Two of these were in place in CCO 1.0 and relate to the cost of providing health-related services, including those delivered through partnerships with CBOs.

- The cost of health-related services is considered in the administrative component of PMPM rate development. To the extent that these services are cost effective, providing these services should lower total CCO expenditures and, thus, help the CCOs keep cost increases under the 3.4 percent growth cap set for PMPM payments.
- The cost of health-related services is included in the medical, not the administrative, component of the medical loss ratio (MLR). CCOs are required to maintain a medical loss ratio of 85 percent — meaning that at least 85 percent of their revenue from premiums (e.g., capitation payments) must be for clinical services and quality improvements, not administration and profit. Thus, expenditures on qualified partnerships help the CCO meet MLR requirements.

Effective 2022, the OHA will implement a new performance-based payment model that rewards the efficient provision of health-related services, including those delivered through partnerships with CBOs. Specifically, the OHA will allow CCOs to earn variable profit margins through their health-related expenditures. Earning a variable profit margin would, in effect, result in payment of a financial incentive to the CCO. Funding for the performance-based payment model is dependent on projected 2022 program cost growth remaining at or below the 3.4 percent annual growth cap. CCOs will be eligible for the incentive depending on:

- Their performance on quality and efficiency metrics;
- Their individual rate of cost growth; and
- Their level of investment in health-related services.

To further strengthen incentives to address the SDOH, the OHA is developing a social needs screening measure. The agency's intent is to test the measure in 2021 and, if the test is successful, to propose the measure be considered for a performance incentive payment through the CCO incentive metric program. Two committees – the Oregon Health Plan Quality Metrics Committee and the Metrics and Scoring Committee – will ultimately decide whether the measure will be added to the program. CCOs that receive incentive payments through performance on these measures are expected to offer correlative incentive arrangements with providers that helped the CCO achieve these performance goals. Such providers could include SDOH-E Partners, such as CBOs. Although the need to address the COVID-19 pandemic has changed the planned approach for developing the measure, the OHA still intends to recommend the measure on the stated timeline.

Oregon's work to increase, measure and reward social needs screening sparked the creation of Oregon Community Information Exchange (CIE) Advisory Group, which was a public/private sector workgroup tasked with developing recommendations for a statewide CIE. This group defined a CIE as a technology platform that "…connects health care [and] human and social services partners to improve the health and well-being of communities and address health disparities and health equity." Although the work of this group was suspended in March 2020

due to COVID-19, it had already made substantial progress in assessing the current extent of CIE use in Oregon and creating a vision for a statewide CIE. Through its work, the group identified that CIEs were in place or in development in more than half of Oregon's counties, that most efforts were funded as CCO investments, that CIE use would continue to increase — and that the pandemic highlighted the need for CIEs.

Technical Assistance to CCOs and CBOs

> "Don't underestimate how much both sides of the partnership need support."
> -OHA official

The changes to performance requirements and payment have been extensive and far-reaching. Oregon knew that it would need to provide technical assistance to both CCOs and CBOs if they were to achieve these ambitious goals. Therefore, the OHA turned the technical assistance structure it had developed to support CCO 1.0 toward this new priority. This structure, which is administered by the OHA's Transformation Center, includes the development of written guidance, as well as group and individual technical assistance. Its primary task is to support the CCOs, but it also supports the work of the CACs that oversee each CCO's investments in partnerships to address the SDOH. Examples of the assistance offered to CCOs include:

- A webinar providing guidance on how to complete the SDOH section of the *Transformation and Quality Strategy*;
- A one-day conference to help CCOs and other stakeholders better understand the vision for health-related services; and
- Written guidance on new requirements, such as reporting health-related services expenditures as well as addressing SDOH and equity, and housing, through health-related services.

The OHA also took steps to connect the CCOs and CBOs. For example, in June 2019, the Transformation Center convened an innovation café on the SDOH. Both CBOs and CCOs participated in this event, which focused on small group discussions of existing projects. This format enabled CCO and CBO representatives to begin to develop relationships and provided them with examples of programs they could develop together. For example, one project that sought to address nutritional needs was based in a partnership between a CCO, a federally qualified health center (FQHC), a CBO, and the local farmer's market. The CCO offered funding, while the FQHC conducted SDOH screening, implemented an onsite Veggie Prescription program, and provided tokens that could be redeemed at the farmers' market.

Technical assistance directed solely to the CBOs has been more difficult to support. The OHA was hoping to build technical assistance resources and offer funding for CBOs, but due to budget limitations, a planned capacity-building program for CCOs and community partners was not implemented. The OHA still plans to produce some webinars and as previously described, is making a conscious effort to build resources that help both CCOs and CBOs. The CBOs, however, have technical support needs that sometimes go beyond CCO needs. Officials Interviewed for this report often mentioned that many CBOs need support to build a better case for how their services can help the CCOs achieve their goals to improve health outcomes and

reduce costs. As one interviewee stated, "They [CBO leaders] often have a good humanitarian angle, but it is essential to show how their programs are effective at doing what they do. We see this the most in CBOs that focus on groups of people who are normally under-represented." Others stated that CBOs sometimes needed assistance to understand what CCOs can and cannot fund. For example, although CCOs are required to address housing needs, they are prohibited from paying for a building or rent.

Summary and Lessons Learned

Interviewees advise other states seeking to foster Medicaid ACO/CBO partnerships to address the SDOH to expect:

- Forming effective partnerships will take time;
- Both partners will need support and guidance; and
- It's important to have both strategies meet individual patients' immediate health-related needs and strategies to produce policy changes that address the root causes of health inequities.

Interviewees suggested that states just starting these efforts could consider focusing their initial work on a small number (maybe just one) critical topic, such as housing, in order to make it easier for stakeholders to understand, take action, and build an evidence base for what works. Key lessons that emerged from Oregon's experience include:

Fostering partnerships to address the SDOH takes time and is an iterative process. State officials reported that it takes time for CCOs and CBOs to learn about each other and how to successfully partner. Also, not every intervention will work well in every situation and for every population. Oregon deliberately chose to start this effort by encouraging rather than requiring partnerships. This allowed the CCOs, CBOs, and state staff to learn what worked and what didn't. As their joint knowledge base and experience grew, the OHA strengthened and refined its partnership requirements.

Strong oversight authority allowed Oregon to leave decisions about which services to buy from CBOs to the CCOs. The OHA expects CCOs to directly provide care management and case management services. However, they are free to decide which SDOH-E services and programs they should purchase from CBOs and which they can themselves supply. State officials noted that some large CCOs have significant in-house capability, while smaller CCOs might have a greater need to develop new partnerships. It was important that the various partnerships developed by both types of CCOs could flourish. To allow that, the state sets minimum expectations (e.g., all programs must be evidence-based and spending must be for a limited number of priority areas) and then relies on its reporting requirements and oversight authority to make sure that the individual partnerships developed by each CCO are right for that CCO and its community — and work toward the state's policy goals.

The most effective partnerships are those with clear expectations and roles for both partners. State officials have observed the development of effective partnerships addressing a range of topics and scope. They have observed that both bi-directional partnerships between a single – sometimes very small CBO and CCO and multi-sector partnerships that include organizations other than CCOs and CBOs (e.g., local public health agencies or housing authorities) can be successful. The ones that are most effective have clear expectations and roles, which create clear pathways for action that are linked to measurable outcomes. Officials reported that it was also important to lay out the parameters of the partnership in an agreement, but that the form of the agreement (e.g., MOU or contract) was less important than its clarity.

The state public health agency has been a critical partner in the Medicaid agency's efforts to foster CCO/CBO partnerships. The state health department has helped convene potential partners and provided data that informed community health assessments and health improvement plans. CCOs are required to develop community health assessments and health improvement plans through a community-driven process. Local public health authorities (LPHAs) need to develop similar plans to qualify for accreditation and hospitals are also required to develop similar documents to meet community benefit requirements. The public health agency has emerged as a good neutral convener to bring together multiple CCOs and hospitals to work together to conduct a single planning process for their communities. Conducting a single process is less frustrating for community members and CBOs, which might otherwise be asked to engage in multiple processes. But more importantly, the plans that emerge from these processes will be aligned — and because these plans drive CCO and hospital investments, these organizations' work to address the SDOH-E will also be aligned.

Oregon has also worked to foster partnerships between CCOs and LPHAs. This work has taken a similar arc, starting with the requirement in CCO 1.0 that CCOs have an MOU or contract with local public health agencies for safety net services (e.g., family planning). Those agreements for billing and payment for services consistently expanded as partnerships grew. Today, most of these partnerships are still focused on services and programs that address individual needs. But some partnerships are starting to move beyond that. For example, a few CCO/LPHA partnerships jointly produce (and share the costs of producing) the community health assessment and health improvement plans.

Summary

Oregon's commitment to fostering CCO/CBO partnerships has set the stage for strong CCO-community coordination that can help eliminate health inequities by addressing the SDOH at both the individual patient and community levels. The iterative approach also enabled the agency to build capacity and accelerate its agenda as knowledge and experience grew, and to focus its efforts on state and local population health priorities. The COVID-19 pandemic has affected this effort – key staff have been assigned to new pandemic-related duties and the anticipation of large state budget cuts has limited the funding available for technical assistance. All those interviewed, however, reported that the pandemic, with its heavy impact on people of color and those with low-incomes has reinforced the importance of addressing health-related social needs and eliminating health inequities. As one interviewee summed up her experiences, "We are in a better place than two years ago and will be excited with what CCO 3.0 brings in the future."

Notes

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