Hello, I am the Director of the Oregon Pediatric Improvement Partnership.

Our organization has worked with and learned from nearly every CCO, we have heard from parent & youth advisors and family advocacy organizations across the state, and provide front-line implementation support to primary care & behavioral heath providers that contract with all 16 CCOs.

CCOs are a critical part of the health system for children in our state, with nearly two in five children receiving care supported by CCOs. Medicaid provides insurance for the majority of children of color in our state. **Eighty percent of children enrolled in CCOs** have some level of health complexity, comprised of medical and/or social complexity, which impacts their health and can have lifelong consequences.

In order to stay on time, I will share our three priority learnings since the adoption of CCOs.

#1: There are unintended negative impacts of a global budget for children.

- A global budget requires even well-meaning CCOs to focus on populations that cost more money and will impact their global budget. This creates a focus on expensive adults.
- A solution is to create separate global budgets for children and adults, and then an enhanced rate for family units. Secondly, there should be more transparent public reporting of how those global budget funds are spent specific to those populations.
- Considerations are also needed related to the harm of anchoring rate setting to previous health care use, as that creates **a disincentive** for CCOs to ensure access, screening and utilization of services for children and youth who had not previously accessed care.

#2: There is not network adequacy within CCOs for children's behavioral and dental health needs, which is the backbone of contractual agreement and global budget.

- Through the System-Level Social-Emotional Health metric, we have CCO reported data that starkly illuminates the lack of adequate behavioral health services available for CCO-insured young children.
- Through the preventive oral health incentive metric, we have seen a significant gap in dentist network adequacy for CCO insured children, particularly in rural regions of the sate.
- Reconsideration is needed if and how the global budget provides for fidelity behavioral and dental services.

#3: What is Measured is What is Focused on, Population Metrics are Needed to Ensure a Focus on the Most Vulnerable Children

- Data shows that quality healthcare for children and youth with special health care needs has not been achieved in the CCO model, even though health care is the last safety net for them.
- The "D" (or disability designation) in the state's priority focus on REAL-D only captures a very small proportion of children with special health care needs, as the criteria for disability in REAL-D focuses on adult conditions and limitations.
- CCOs need evidence-based, clinical recommendation-aligned indicators of **medical and social complexity, such as the Children's Health Complexity data, t**hat can guide their population health needs in addition to using REAL-D data to identify health disparities.
- OHA needs to provide CCOs with this actionable population health data, and quality metrics stratified by the available medical and priority social complexity indicators to guide efforts that will aim to eliminate health inequities for these most vulnerable populations of children.