The Oregon Pediatric Improvement Partnership has worked with and learned from nearly every CCO in Oregon, heard from parent & youth advisors and family advocacy organizations across the state, and provided front-line implementation support to primary care & behavioral heath providers that contract with all 16 CCOs. With these experiences, we are providing this public testimony with some feedback about CCO 3.0.

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. Over 93% of children insured through Medicaid are insured in a CCO. Medicaid provides insurance for the majority of children of color in our state, and **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.

We have greatly appreciated the commitment that the Oregon Health Authority has had to children by ensuring broad and expansive coverage of children, with the Oregon Health Policy Board prioritizing a focus on children for a number of years, and support of innovative efforts such quality metrics that can drive Health Aspects of Kindergarten Readiness.

That said, in reviewing how Oregon's Medicaid/CHIP-insured children achieve access to quality care in comparison to other states nationally (see Appendix A), it appears that there needs to be opportunities to ensure that the global budget provided for physical, behavioral and oral services actually results in a network that can provide these services and to EPSDT-recommended care being provided.

In reviewing the draft Oregon Health Policy Board document and procurement recommendations, we would like to elevate an important **unintended negative impact of a global budget to CCOs that is not earmarked to the populations that the funds are meant to go towards**.

- 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.

We appreciate your draft recommendations related to **enhancing how network adequacy** is assessed, that then triggers if global budget funds are provided.

- As was heard in the input session and that we have quantitative data to confirm, 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.
  - Appendix A and CCO reported data 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 state.
  - We strongly recommend that the network adequacy documentation that needs to be provided ensure specificity for the populations that are meant to be served. Allowing a site to say "they see all patients", in our experience, almost always means they don't see a subset of children.

Thank you for consideration of these issue as you finalize your recommendations for CCO 3.0 procurement.