



ADDRESSING SOCIAL NEEDS THROUGH MEDICAID:

*What Consumer Advocates Can Learn from
North Carolina and Oregon*

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Introduction

Health systems and policy makers are increasingly looking for ways to use health system levers, such as Medicaid, to address the social and economic factors that lead to poor health outcomes. While Medicaid alone cannot be expected to address the full range of factors that impact people's health outcomes, it can play a vital role in helping connect people to social services and meeting some of their immediate social needs.

An earlier [issue brief](#) examined some best practices for utilizing Medicaid to identify patients social needs, such as healthy food or stable housing, and refer patients to social service providers who can help them address those needs. While screening for social needs is an important first step, some states are experimenting with innovative ways to more directly address Medicaid beneficiaries' needs by paying for and providing services outside of what we normally think of as medical care, for example, healthy cooking classes, public transportation passes, or a deposit to secure housing. Specifically, this issue brief will look at North Carolina and Oregon, two very different states that are at the forefront of finding innovative approaches to address Medicaid beneficiaries' social needs.

While these two states provide a promising example for how Medicaid programs can improve health outcomes and better meet the needs of the most vulnerable patients, there are still a lot of unanswered questions. These innovations are in their infancy and their effectiveness and any possible unintended consequences are yet to be seen. In the case of North Carolina, these interventions are still at the proposal stage and have yet to actually be implemented.¹ Nevertheless, many other states are eager to replicate these policies, hoping to be on the cutting edge of these trends in Medicaid innovation. With that in mind, this issue brief is meant to help provide state advocates with questions to consider and advocacy strategies to pursue as their states look to follow Oregon and North Carolina's lead.

It is worth noting up front that interventions like those implemented or proposed in Oregon and North Carolina rely on a strong foundation of Medicaid coverage, adequate Medicaid funding, and well-resourced social service providers. As state advocates work to influence proposals to address Medicaid beneficiaries' social needs, they should continue to advocate for and emphasize the importance of these foundational pieces to the success of any proposal.

¹ The implementation of North Carolina's 1115 waiver has been delayed as a result of state budget battles. The exact timeline for implementation remains uncertain at the time of publication of this issue brief.

Covering Non-Medical Services

Examples:

Oregon Non-Medical Services	In Oregon’s Medicaid program, regional entities known as Coordinated Care Organizations (CCOs) are allowed to use their capitated payment ² to provide flexible “health-related services.” The state defines health-related services as “noncovered services that are offered as a supplement to covered benefits under Oregon’s Medicaid State Plan to improve care delivery and overall member and community health and well-being.” ³ This includes both services that meet individual health and social needs as well as community-level interventions. Examples include things like classes on healthy meal preparation, air conditioners, or a farmer’s market in a food desert. There is significant flexibility in how CCOs can choose to provide these services and they are not necessarily targeted at specific populations. Some flexible services, such as a gym membership, might be available to all enrollees, while others, such as transitional housing supports, might only be applicable for or recommended to specific enrollees in need of those services.
North Carolina Pilot Projects	North Carolina’s 1115 Medicaid waiver includes a new program called the Healthy Opportunities Pilot Project. ⁴ The state will select two to four regions where certain high-needs Medicaid managed care beneficiaries will receive enhanced services designed to address the social determinants of housing, food, transportation, and interpersonal violence. <ul style="list-style-type: none">• Participants must have at least one behavioral or physical health risk factor and at least one social risk factor.• Approved services are laid out in guidance from the state and include things like one-time payments to secure housing (first month’s rent), payment for public transportation, and healthy meal deliveries.

Questions Consumer Advocates Should Ask:

- **What services are covered?:** One of the first questions that must be addressed is what services would be covered under a proposal to expand the parameters of Medicaid coverage. While this is somewhat limited by statutory and waiver authority, there is a great deal of flexibility and state advocates should be mindful of what the definition of “non-medical services” might mean for consumers. For example, a definition that stipulates services must have a reasonable expectation of “*improving patient’s health*” might exclude services that would help improve quality of life for patients with chronic or terminal illnesses that aren’t expected to “improve.” There also might be a tendency among the states or Medicaid plans to only cover services that show a quick return on

² In Oregon, CCO’s receive a set per-member per-month amount to provide care for their enrolled members. This payment is based on a variety of factors including past claims data and the health status of enrollees.

³ Oregon Health Authority, Health Policy and Analytics Division. Health-Related Services Brief. July 2018. Available at: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf>

⁴ Elizabeth Hinton, Samantha Artiga, MaryBeth Musumeci and Robin Rudowitz. A First Look at North Carolina’s Section 1115 Medicaid Waiver’s Healthy Opportunities Pilots. May 2019. Available at: <https://www.kff.org/medicaid/issue-brief/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots/>

investment, even if these services aren't what communities most need. State advocates should ensure:

- The definition or list of covered services is grounded in patient needs and community priorities.
 - The definition or list of covered services reflects the needs of the populations served, including people with disabilities or chronic illnesses.
 - The definition or list of covered services does not exacerbate disparities or health inequities.
- **Who is eligible for the services?:** In some cases, like the North Carolina pilot projects, non-medical services might only be covered for particular populations considered most at need. While this is not necessarily a bad use of limited Medicaid dollars, it is important that the criteria be clear and understandable to patients and that the provision of non-medical services does not exacerbate existing health inequities. State advocates should ensure:
 - There is clear and patient-friendly information about who is eligible for these services and why, along with an opportunity to appeal an eligibility decision.
 - If the provision of non-medical services is targeted, it done in a way that does not exacerbate existing disparities or disadvantage high-need and traditionally underserved patients.
 - **Are there adequate Medicaid resources?:** One fear as more states look to cover social needs with Medicaid dollars is that these additional services will stretch Medicaid funding too thin and will potentially take the place of important medical services covered as part of Medicaid's primary mission. State advocates should ensure:
 - Medicaid rates are sufficient to cover non-medical services without impacting access to other medical services.
 - There is not a disproportionate emphasis on cost savings (as opposed to improvements in health outcomes) in the stated goals and objectives of the program.
 - **Does the state provide guidance and incentives to ensure plans are covering these services?:** Just providing flexibility to cover non-medical services does not guarantee that plans will do so. One concern is that without sufficient guidance, plans who don't have experience working with community-based organizations and social service providers will decide covering these services is too confusing and not worth the trouble. Requiring plans to partner with community-based organizations is one way of addressing this problem. State advocates should ensure:
 - There is enough guidance for both plans and social service providers to ensure they feel prepared to offer flexible services.
 - The state incentivizes the uptake of these services through payments, requirements or quality measure strategies.

In the first iteration of their CCO program, Oregon found that spending on flexible services made up a very small percentage of total spending – only about 0.14%. In response, the state made sure their new waiver included additional incentives for covering health-related services, including a bonus fund to reward CCOs that meet certain social determinant of health-related goals and requirements that CCO spending align with community health assessments and improvement plans.⁵ Although it is too early to tell whether or not these specific incentives have led to an increase in spending on flexible services, other states can learn from Oregon's experience and build in incentives earlier on in the process.

⁵ Diana Crumley and Rob Houston. Refining Oregon's Medicaid Transformation Strategy through CCO 2.0: A Q&A with the Oregon Health Authority. April 2019. Available at: <https://www.chcs.org/refining-oregons-medicaid-transformation-strategy-through-cco-2-0-a-qa-with-the-oregon-health-authority/>

Providing Non-Medical Services

Providing flexibility for Medicaid to cover non-medical services is one thing, but ensuring those services are delivered to patients in an effective and culturally-appropriate way requires additional thought. Many plans and providers might not be used to working with community-based social services providers. Furthermore, many Medicaid patients might be distrustful of their plan or provider offering such services. Requiring Medicaid plans to partner with community-based organizations or utilize trusted community providers such as community health workers or promotores can help address this concern.

	CBO Partnership Requirements	Community Provider Requirements
Oregon	Oregon requires CCOs to have contracts or formal agreements with Social Determinant of Health/Health Equity partners and direct a portion of their required spending on SDOH/health equity directly to these partners. ⁶ These partners are defined as “Community-based entities delivering services and policy and systems change to address the social determinants of health and health equity, including non-profit, non-Medicaid billing community based social and human service organizations (e.g. housing, social services, and food banks), culturally specific organizations; local public health authorities; local government and government associated entities; Tribes; Early Learning Hubs; local housing authorities; and Regional Health Equity Coalitions.” ⁷	In Oregon, CCOs are required to develop a plan for integrating and utilizing Traditional Health Workers in their care delivery. They also have to designate a tTraditional Health Worker ⁸ Liaison that serves as a central point of contact for all THWs within the organization. These requirements originated as recommendations from Oregon’s Traditional Health Workforce Commission, tasked with improving the integration of THWs into care delivery. ⁹
North Carolina	The North Carolina pilot projects will be coordinated by a Lead Pilot Entity (LPE) that will be chosen in a competitive procurement process. ¹⁰ LPEs are expected to be community-rooted health or social service organizations, not health systems. Examples include community-based organizations, local public agencies or health departments, social service agencies, and community health centers. These LPEs will manage a network of CBOs and social service organizations that will provide pilot services.	Although the use of Traditional Health Workers/ community-based providers is not an explicit part of the Health Opportunities Pilots, the program does open up the possibility of partnering with (and paying) community-based organizations and service providers who utilize community health workers as part of their care delivery. The pilot programs do explicitly carve out a role for case managers, who are required to be either Registered Nurses or Licensed Clinical Social Workers.

⁶ Oregon Health Policy Board. CCO 2.0 Request for Applications. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/04-CCO-RFA-4690-0-Appendix-C-Administrative-Rule-Concepts-Final.pdf>

⁷ Oregon Health Policy Board. CCO 2.0 Request for Applications. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/Reference-Documents/SDOH-and-Health-Equity-Glossary.pdf>

⁸ Oregon defines traditional health worker as “an umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider,” and lists 5 types of THWs including birth doula, personal health navigators, peer support specialists, peer wellness specialists, and community health workers. For more information, see: <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/Pages/Traditional-Health-Worker.aspx>

⁹ Oregon Health Authority. CCO 2.0 Recommendations of the Oregon Health Policy Board. October 2018. Available at: <https://apps.state.or.us/Forms/Served/1e9830.pdf>

¹⁰ North Carolina Department of Health and Human Services. North Carolina’s Healthy Opportunities Pilots: Lead Pilot Entity Statement of Interest and Supplementary Guidance. July 2019. Available at: <https://files.nc.gov/ncdhhs/LPE-Supplementary-Guidance-and-SOI-FINAL.pdf>

Questions Consumer Advocates Should Ask:

- **How does the State define “Community-Based Organizations?”:** From a consumer perspective, the goal of partnering with CBOs on this work is to ensure services are provided by people with appropriate knowledge and expertise, who have close ties to the community, and who are able to serve as trusted providers of culturally competent services. One concern is that hospitals and health systems might undermine the goals of these partnership requirements by partnering with or referring to clinics and service providers they own or are affiliated with. State advocates should ensure:
 - There are requirements to partner with community-based-providers who are unaffiliated with hospitals or health systems.
 - There are patient and community centered guidelines in place to prevent conflicts of interest.
- **Are there resources available for supporting CBOs in this work?:** Community-based social service providers are often under resourced, understaffed, and have limited experience with billing Medicaid or contracting with health care providers. Questions such as how CBOs will be paid, what, if any, risk they are asked to take on for a population, and how their effectiveness is measured will have a huge impact on whether or not the partnership is successful. Advocates should ensure:
 - CBO representatives are at the table for conversations around design and implementation.
 - CBOs will have flexibility to negotiate the terms of contracts with providers and are provided with legal resources to do this effectively.
 - There are financial resources and training tools available to help CBOs prepare to contract with health systems.
 - The payment system is set up in a way that makes it easy to reimburse CBOs who have limited experience with or infrastructure for medical billing.
- **Are the partnerships rooted in the community?:** One common concern advocates and cross-sector partners raise when discussing the health systems’ role in addressing social needs is that the provision of services will become “over-medicalized.” It is important that services are delivered by providers and entities who understand the community’s needs and have experience delivering those services effectively. Advocates should ensure:
 - The state requires a wide variety of partnerships outside of the health sector.
 - There are incentives to partner with organizations that have deep roots in the local community.
- **Are there measures in place ensuring the services are delivered in culturally sensitive ways?:** Providing non-medical services effectively requires awareness of and attention to the particular concerns and norms of each community. For example, in areas with large immigrant populations, beneficiaries might be hesitant to answer questions about their home and family situation out of concern for their

North Carolina recognized that hospitals and health systems are likely not best positioned to coordinate the provision of services within the pilot regions, so they implemented strict requirements regarding what kinds of organizations can serve as Lead Pilot Entities. If a hospital or health system wants to be considered as an LPE, they must provide a description of how the hospital or health system is exclusively positioned to serve as the LPE within the proposed region, as well as letters of attestation validating the applicant’s contention that no other entity could serve as the LPE from county leadership, 10 non-medical service provider organizations in the Pilot region and 10 healthcare provider organizations not affiliated with the applicant health system or hospital in the Pilot region.

immigration status. Language barriers might prevent effective communication about a patient’s needs. Advocates should ensure:

- There are requirements around implicit bias training or other kinds of trainings or education to address disparities.
- There are standards around language access or incentives to partner with organizations who can provide care in the primary language of beneficiaries.
- There are requirements about the accessibility of services for people with disabilities.
- There are incentives or requirements about working with trusted community partners who already have an established presence and relationship with a particular community.
- There are consumer education mechanisms in place to ensure beneficiaries understand why a provider is asking them about their social and economic needs and how that information will be used.

Sustainably Financing Non-Medical Services

A major barrier to effectively addressing social needs through Medicaid is finding sustainable financing for the interventions. There are a number of reasons for this. The Medicaid statute places limits on the types of services that can be covered using Medicaid dollars. Requirements around budget neutrality make it difficult to invest in interventions that might not show a cost savings for many years down the line. Additionally, despite the fact that Medicaid is already a relatively lean and efficient program, the program continues to face the threat of cuts at the state and federal level. Asking the Medicaid program to meet people’s medical and social needs on already tight budgets, without an influx of new investment dollars, is an unreasonable expectation.

	Reimbursement/Payment Model	Reserve Investment Requirements
Oregon	In Oregon, CCOs may cover health-related services as part of the services offered within their per-member-per-month capitation rates. There is no separate capitation rate for these services as there is in the North Carolina pilot model. Health-related services are included in the numerator of the Medical Loss Ratio (meaning spending on these services counts towards the minimum percentage of CCO spending that must go directly towards health care).	In 2018, the Oregon legislature passed a bill requiring CCOs to spend a portion of their reserves on services or activities that address the social determinants of health and health equity. This spending should align with priorities and needs identified in the CCO’s community health assessment and improvement plan.

	Reimbursement/Payment Model	Reserve Investment Requirements
North Carolina	<p>North Carolina plans to invest \$650 million of state and federal Medicaid funding into the pilot projects over a five year period, with \$100 million devoted to capacity building. The money is distributed to managed care plans as a capped amount in addition to their regular population-based payment for covering medical services. There are three types of reimbursement, depending on the type of service: fee-for-service, cost-based, or bundled payment.</p> <p>Over the five year period of the demonstration, the pilots will gradually move to a value-based payment system, where the capitation amount will eventually be tied to health outcomes.</p>	<p>Under most circumstances, North Carolina encourages but does not require their managed care plans to reinvest savings into community services and supports.¹¹ They do this by allowing such investments to count in the medical loss ratio (MLR) numerator. North Carolina also requires plans to provide evidence of their experience supporting and working with community-based organizations during the procurement process. If a plan falls below the required MLR threshold, they will be required to reinvest premium dollars into community services and supports.</p>

Questions Consumer Advocates Should Ask:

- **Is the funding for social needs sufficient?:** One major concern is that in the rush to try and meet patients’ social needs, Medicaid dollars will be stretched even thinner and coverage for the more traditional health care services Medicaid covers will be neglected. This is particularly concerning in situations where flexibility for covering non-medical services is expanded without an accompanying investment of resources necessary to provide those services. Consumer advocates should ensure:

 - The provision of non-medical services is sufficiently taken into account when developing the capitation rate.
 - There are quality measures in place to ensure beneficiaries are receiving high-quality care.
 - The grievance and appeals process is robust enough to ensure beneficiaries have an avenue for recourse if their health needs are not being met.
 - There is an attempt to address the issue of premium slide, where plans that save money by investing in effective interventions receive subsequently lower capitation rates and are no longer able to continue that investment.
- **Does the financing system exacerbate disparities or discourage plans or providers from serving high cost patients?:** We know that patients with unmet social needs often have poorer health outcomes and higher health care costs. Particularly in a capitated payment system, plans and providers have a disincentive to serve these patients. This is of increasing concern as it becomes more common to screen for social needs and collect data on patients’ social needs. Medicaid payment systems should take into account the costs associated with treating patients who have complex health and social needs. Consumer advocates should ensure:

 - Medicaid payments are risk adjusted for members’ social needs.
 - Programs are monitored to ensure that plans or providers are not excluding beneficiaries with the most complex needs.

¹¹ North Carolina Department of Health and Human Services. Prepaid Health Plans in North Carolina Medicaid Managed Care. May 2018. Available at: https://files.nc.gov/ncdhhs/documents/PHPs-in-Medicaid-Managed-Care-PolicyPaper_revFINAL_20180516.pdf

- **Does health system investment align with community needs and priorities?:** Requiring managed care plans/regional Medicaid entities to reinvest savings back into the community can be an effective way to ensure long-term investments in the upstream factors that impact health. These investments will be most effective if they are deeply rooted in the priorities and resident-identified needs of the community. Consumer advocates should ensure:
 - There are requirements that the Medicaid plan conduct a community needs assessment and that investments align with this assessment.
 - There is community representation on the bodies that set investment priorities.
 - Investments are monitored to ensure alignment with identified community needs.

Measurement, Evaluation and Accountability

Using Medicaid levers to directly address a wide variety of social needs is a relatively new concept, meaning that mechanisms for measuring and evaluating effectiveness are particularly important as policy makers figure out what works and think about scaling and replicating models. This is especially critical from a consumer perspective, as strong measurement, evaluation, and accountability mechanisms are necessary for ensuring that interventions don't exacerbate disparities or have negative impacts on people's access, experience and health outcomes.

	Measurement	Evaluation
Oregon	In addition to the much larger measurement strategy in place for the broader Medicaid program, Oregon is planning on developing a measurement strategy specifically around social determinants of health, with the purpose of setting milestones for the Social Determinants of Health- Health Equity Capacity-Building Bonus Fund. Oregon is establishing a public advisory group to recommend both process and outcome measures.	Both state and federal requirements governing the state's 1115 waiver require that the flexible services provided by CCOs be cost-effective and increase the likelihood of improved health outcomes, but CCOs have expressed challenges with trying to track and measure these things, making effective evaluation difficult. ¹² Oregon also received grant funding that allowed a team of researchers to conduct a comprehensive evaluation of the CCO transformation efforts, including the CCO's effectiveness in providing assistance with social determinants of health. ¹³

¹² Jonah Kushner and K. John McConnell. Addressing Social Determinants of Health through Medicaid: Lessons from Oregon. December 2019. Available at: <https://read.dukeupress.edu/jhpl/article/44/6/919/139736/Addressing-Social-Determinants-of-Health-through>

¹³ Office for Oregon Health Policy and Research. SHARE Research Summary Report. March 2015. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/SHARE%20-%20Evaluating%20the%20Access%20Quality%20Health%20and%20Cost%20Impacts%20of%20CCOs%20in%20Oregon.pdf>

	Measurement	Evaluation
North Carolina	Over the course of the five year pilot, the state will move from process measures to outcome measures in determining the effectiveness of the pilot programs. This means that in year one, the Lead Pilot Entities will be evaluated based on the adequacy of their network of service providers and infrastructure. By year five, the LPEs will be evaluated based on reduction in per-enrollee Medicaid spending and measures of enrollee health, for example, “improvements in reductions of HbA1c scores for adult enrollees with diabetes who are food insecure and received medically tailored meals through the Pilot.” Over time, these measurements will be increasingly linked to the payments plans receive. ¹⁴	There are three major components to the evaluation of North Carolina’s Healthy Opportunities Pilots. North Carolina will conduct rapid cycle assessments and modify or discontinue interventions and implementation strategies mid-stream if deemed necessary. Additionally, North Carolina is contracting with the University of North Carolina to conduct a more intensive and broader scope summative evaluation at the end of the pilot. The state is also incorporating randomized trials into the pilot project by providing some beneficiaries with a more intensive level of services to test the effectiveness and determine which populations might benefit most from more intensive interventions.

Questions Consumer Advocates Should Ask:

- **Are the measures consumer driven and patient centered?:** Because this is a new space for many Medicaid programs and plans, there are still a number of open questions about how to provide health-related services effectively. It will be critical that consumers are involved in defining and measuring what is considered “effective.” Evaluation and measurement strategies should be centered on the needs and experiences of consumers and reflect their experiences. When evaluating measurement strategies, consumer advocates should ensure:
 - The state places an emphasis on outcome measures rather than process measures.
 - There is an emphasis on using measures that are patient reported and look at patient experience.
 - There is a process for involving consumers in measure design and selection.
 - Consumer experience and feedback is incorporated into the evaluation process.
- **Is there a focus on equity and disparities in evaluation efforts?** Although addressing non-medical needs is only a small part of ensuring a more equitable health system, it is important to ensure these efforts center equity and do not exacerbate existing health disparities. Concerns about the availability of social services in already under-resourced areas or the difficulty in moving the needle on cost and quality for complex, high-needs populations speak to the need to closely measure the impacts of these policies on equity and disparities. Consumer advocates should ensure:
 - Plans are required to report data on uptake of non-medical services broken down by various demographic characteristics.
 - There is an explicit strategy for measuring and determining the impact offering non-medical services has on disparities in health outcomes.

¹⁴ North Carolina Department of Health and Human Services. North Carolina’s Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders. February 2019. Available at: https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf

- The measures do not disadvantage providers who care for more complex patients.
 - The measurement strategy emphasizes improvement over time as opposed to static benchmarks.
 - There is a risk adjustment strategy for performance measures that takes into account social and economic factors.
- **Does the evaluation process look at the broader impacts on Medicaid beneficiaries' access to and quality of care?:** Evaluation strategies should ensure that offering non-medical services does not in some way replace or impede access to and coverage of other crucial medical services. Advocates should ensure:
 - The broader evaluation strategy includes measures of access to care or unmet care needs.
 - The state is tracking changes in plan benefits, including which services are dropped as new ones are added.

Conclusion

This issue brief is meant to serve as a starting place for advocates who are engaging in conversations in their states about how to best address the unmet social needs of Medicaid beneficiaries. While it provides an overview of important consumer priorities to advocate for and red flags to be wary of as states move forward with new, innovative approaches, there is still much to learn in this arena. These interventions are still in their infancy and we will undoubtedly learn more about how they can best meet consumers needs over time. Additionally, other states such as New York, Massachusetts, and California, to name just a few, are advancing policies in this area and will provide us with more opportunities to learn about best practices and unintended consequences. It will be crucial that consumer voices are involved at every step in this process, from design to implementation and evaluation. We will continue monitoring these policies closely and share important lessons learned and advocacy tools to ensure policies to address social needs through Medicaid are patient-centered and effective.

FOR FURTHER READING:

- [Policy Principles to Guide Health Care's Role in Social Interventions](#), Community Catalyst
- [Community Solutions for Addressing the Social Determinants of Health: Choosing the Right Policy Levers](#)
- [Screening for Social Needs](#), Center for Consumer Engagement in Health Innovation
- [A First Look at North Carolina's Section 1115 Medicaid Waiver's Healthy Opportunities Pilots](#), Kaiser Family Foundation
- [Refining Oregon's Medicaid Transformation Strategy through CCO 2.0: A Q&A with the Oregon Health Authority](#), Center for Health Care Strategies
- [CCO 2.0 Recommendations](#), Oregon Health Policy Board
- [North Carolina's Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders](#), North Carolina Department of Health and Human Services



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