Improving Health Outcomes by Streamlining Life and Coverage Transitions

Currently, the health care system is not well designed to support people who experience a gap in health insurance, especially those who rely on Oregon's Medicaid coverage, Oregon Health Plan (OHP). Interruptions in OHP coverage often result in members being unable to access medical treatment, not being able to see their established providers, and losing other critical stabilizing support services needed to address SDOH and maintain good health. Further, people who have greater clinical complexity, deeper social needs, and/or decreased capacity to coordinate their own care need robust care coordination from their providers.

Additionally, it is widely accepted that social determinants of health (SDOH), such as built environment and housing, access to healthy food and green spaces, job opportunities and income, account for 80-90% of a person's health outcomes.[1, 2] These SDOH, including structural racism, are root causes of health inequities and sorter lifespans.[3]

Oregon aims to address these issues by:

- Ensuring Oregon Health Plan (OHP) coverage across life transitions and changes in coverage, and
- Addressing the full set of factors that impact health, both medical and non-medical during life transitions.

Ensuring OHP coverage across life transitions

A defined set of non-medical, evidence-based interventions that address unmet needs in housing, health-related transportation, food insecurity, employment support and vulnerability to extreme weather events will be available to OHP members identified to be in defined life transitions. OHA will align funding and infrastructure to mobilize, incentivize, and support care delivery toward improving the long-term health of OHP members in life transitions.

Addressing the full set of factors that impact health

Oregon is working to meet the physical, behavioral, and developmental needs of all OHP members using an integrated, patient-centered, whole person approach. To achieve this goal, Oregon will request permission to modify Medicaid rules to better reach people in certain life situations, and to provide health-related supports and services during transitions between settings or during wildfire, extreme heat, or other extreme climate events. If approved, Oregon will address gaps in Medicaid

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[1] Magnan, S. (2017). Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine. Available at: https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

[2] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.

coverage by extending coverage – for limited periods of time – to eligible transition populations and provide SDOH services defined below.

To ensure OHP coverage across life transitions and to address the full set of factors that impact health, both medical and non-medical, Oregon will request to:

1. Waive the federal rule preventing Medicaid coverage for a person in custody, including justice-involved populations and those in the Oregon State Hospital and psychiatric residential facilities, to specifically:
    a. Retain benefits and/or extend Medicaid benefits to all youth otherwise eligible for Medicaid entering the juvenile correction system throughout the duration of their involvement in juvenile corrections regardless of setting.
    b. Provide a limited OHP benefit (e.g., prescription drugs, navigation, access to transition services) and CCO enrollment for OHP members who will be discharged from Oregon State Hospital, psychiatric residential facilities or are justice-involved in state prison, 90 days pre-release.
    c. Provide a limited OHP benefit and CCO enrollment for OHP members in jail or a local correction facility, including those awaiting adjudication.
2. Retain child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) up to age 26.
3. Develop and fund, with spending authority, a defined set of SDOH transition services to support members in need during transition in coverage periods and life transitions.
4. Expand and fund, with spending authority, the infrastructure needed to support access to services using providers outside of the medical model.
5. Obtain spending authority to support implementation capacity at the community level, including payments for provider and community-based organizations (CBO) infrastructure and capacity building.

Problem and Background

The 2018 Oregon State Health Assessment found the following inequities among others, rooted in social determinants of health.[3] Each of these inequities makes members more vulnerable to negative impacts from these transitions and extreme climate events.

- With the exception of the Asian population, people of color experience homelessness at a disproportionate rate compared to the general population.
- Almost all racial and ethnic groups in Oregon – particularly African Americans – experience higher levels of poverty than in the United States as a whole.
- One-third of all African American households spend more than 50% of their income on housing costs, compared to 17% of all households in the state.

[3] https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf

- African Americans in Oregon are 4.6 times more likely than their white counterparts to be incarcerated, and Native Americans and Latino/a/x populations experience rates of incarceration 1.8 and 1.4 times greater than whites, respectively.

One factor that contributes to these inequitable negative health impacts is gaps in OHP coverage, caused by life transitions. Disruptions of coverage and benefits can cause instability in a person's life, especially at a moment of increased vulnerability. Coverage gaps often cause members to lose access to providers or services, resulting in worse health outcomes and more costly care further down the road.[4,5]

Transitions that frequently create gaps in coverage are triggered by movement across stages of life, changes in institutionalization, natural disasters, or combinations of these. Further, gap-causing transitions occur disproportionately for OHP members from communities of color, limiting their ability to have their health and social needs met.

Periods of significant transition are challenging for OHP members to navigate given the complicated health care system. Members may lose Medicaid eligibility or be disenrolled from their coordinated care organization (CCO) resulting in disruptions in treatment and coordination between providers. Services that would improve the ability of a member to maintain their health and quality of life, such as predictable access to housing supports once released from custody, are not traditionally Medicaid covered benefits. Disruptions of coverage and benefits caused by these events can cause instability in a person's life at a moment of increased vulnerability and often lead to gaps in access to providers or services, resulting in worse health outcomes and more costly care further down the road.[6,7]

Short-term, focused supports and services that are specifically tied to screening for disruptive events, social needs and improved outcomes will aid in achieving more successful transitions and reduce the impact of events that exacerbate health inequities, providing better health outcomes and downstream cost savings for the state and federal government.

Addressing SDOH through the 2017-2022 1115(a) demonstration waiver renewal

Under Oregon's 2017-2022 1115(a) demonstration waiver renewal, OHA introduced health-related services (HRS) to increase CCOs' ability to use non-medical services to address members' health-related social factors and inequities that contribute to poor health. However, to date, spending on HRS

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[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/

[5] https://pubmed.ncbi.nlm.nih.gov/28728555/

[3] Health inequities happen when unfair social policies and practices deny groups of individuals the opportunity for optimal health, either through a lack of resources that promote health or through increased exposure to risk factors for disease. https://www.bphc.org/healthdata/health-of-boston-report/Documents/3A_Health%20Equity_16-17_HOB_final-3.pdf#search=difference%20between%20inequities%20and%20disparities

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/

[7] https://pubmed.ncbi.nlm.nih.gov/28728555/

remains low (0.7% on average) and has not fully addressed the needs of populations moving through transitions in coverage. This low spending is concerning considering the potential to improve member and community health outcomes.

For the next demonstration period, OHA will propose to set rates as a value-based global budget to provide greater predictability and flexibility for CCOs, thereby enabling them to increase investments in HRS without concern of premiums falling as health outcomes improve and medical expenses decrease.

To jumpstart that increased investment in HRS, OHA will seek spending authority to create a fixed pool of funds for investments in specific HRS for members experiencing life transitions that put them at high risk of losing coverage. This way, CCOs can evaluate which HRS meaningfully improve health and reduce medical expenses.

The menu of approved SDOH transition services will be designed to minimize the risk of disruptive coverage gaps and address SDOH. This may include housing services, health-related transportation services, nutrition assistance, employment assistance and/or assistance to members experiencing extreme weather events. By making these supports available, members going through qualifying transitions will have access to the tools necessary to successfully navigate the transition while maintaining the stability needed for good health and quality of life. By funding these services through CCOs outside of the global budget initially, the CCOs will learn which services are most effective and then invest their global budget funds in those services as OHA (and CMS) phases down its additional funding.

The strategies described below will provide coverage where there are currently gaps (e.g., entering/exiting institutional settings, age-related eligibility). Further, the proposed strategies aim to address the full set of factors that impact health, both medical and non-medical, by providing SDOH services to members – and, at times, through community-based service providers outside of the medical model - prior to transitions in Medicaid benefit and/or eligibility changes.

Proposed strategies

Strategy 1. Waive the federal rule preventing a person in custody from accessing Medicaid benefits.

Despite Oregon's success in enrolling hundreds of thousands of adults in OHP under state Medicaid expansion, justice-involved individuals, and those in Institutions for Mental Diseases (IMD) facilities face complex barriers to coverage. Currently, if these individuals are enrolled in OHP when institutionalized, Oregon suspends their coverage. Enrollment is reinstated upon release but often takes 10-14 days, leaving individuals without services. Members needing residential treatment or substance use disorder (SUD) services cannot be served until enrollment resumes, leaving them without those critical services for weeks.

Failure to provide health insurance and health care services to individuals transitioning from custody has a major impact on recidivism, health outcomes, and cost.[8,9] Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses.[10] And once again, people of color are over-represented among those incarcerated in Oregon,[11] which means people of color are disproportionately harmed by gaps in OHP coverage often experienced transitioning from institutions.

Members transitioning back into the community from institutions would experience fewer barriers accessing care and services if provided:

- limited OHP coverage and
- CCO enrollment that covered care coordination and navigation services alongside the proposed transition SDOH services.

Oregon requests to waive the federal rule preventing a person in custody from accessing Medicaid benefits and requests federal match to support coverage for these individuals.

With this waiver authority, Oregon will specifically:

a. **Retain benefits and/or extend Medicaid benefits to all youth otherwise eligible for Medicaid upon entering the juvenile correction system throughout the duration of their involvement in juvenile corrections.**
   Youth who are involved in the juvenile justice system are inherently at high risk. Youth with a history of involvement in the child welfare or behavioral health systems are disproportionately referred to the juvenile justice system. And again, youth of color are grossly over-represented, in the juvenile corrections system, with high rates of entry into secure correctional facilities.[12] These youth of color are more likely to have complicated and expensive medical and behavioral health needs because of the effects of structural racism and other factors, and less likely to have received consistent medical care and preventive services over their lifetime.[13]

   These individuals are often involved with multiple systems (medical, behavioral health, education, child welfare) and may need high-level specialty treatment resources that are difficult to access without clear payment sources and case management. By providing health care services and the strength of the coordinated care model during a serious life transition

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[8] https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing_30_Day_Inpatient_Psychiatric_Recidivism.8.aspx

[9] https://cdr.lib.unc.edu/concern/honors_theses/j6731775s

[10] Rich, J. D., Wakeman, S. E., & Dickman, S. L. (2011). Medicine and the Epidemic of Incarceration in the United States. New England Journal of Medicine,364(22), 2081- 2083. doi:10.1056/nejmp1102385

[11] https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf

[12] https://pubmed.ncbi.nlm.nih.gov/23334336/

[13] Sedlak AJ, McPherson KS. Youth's needs and services. OJJDP Juvenile Justice Bulletin. 2010;April:10–11. Available at: www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf

(justice involvement) and critical life stage (youth, and often youth of color being over-represented), this strategy could improve lifelong health for these high-risk youth and save long term costs across multiple systems.

b. Provide limited OHP benefits and CCO enrollment and transition services upon release for OHP members in (i) the Oregon State Hospital, (ii) psychiatric residential facilities, and (iii) prison (90 days pre-release).

OHP members leaving incarceration are particularly at risk for poor health outcomes. Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of violence, overdose, and suicide than people who have never been incarcerated. For example, overdose death rates for justice-involved individuals are over 100-fold the rates of the general population.[14] Incarcerated people who have a behavioral health disorder are more likely than those without a disorder to have been homeless in the year prior to their incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse.[15]

By working to ensure justice-involved populations have access to benefits 90 days pre-release and a ready network of health care services and supports upon release, alongside the proposed transition SDOH services, Oregon aims to:

- Improve physical and behavioral health outcomes of incarcerated members post-release
- Reduce emergency department visits, hospitalizations, and other avoidable services by connecting justice-involved OHP members to ongoing, community-based physical and behavioral health services
- Promote continuity of medication treatment
- Reduce health care costs by ensuring continuity of care and services upon release into the community

c. Provide limited OHP benefits and CCO enrollment for OHP members in jail or a local correction facility, including those awaiting adjudication

This request for coverage takes into account the relatively short (less than 90 days) and uncertain length of stays in county jail and other local correction facilities. In order to maintain continuity of care and ensure physical and behavioral needs are met on release, OHP members in county jails and local correction facilities will benefit by having a limited OHP benefit throughout incarceration. Oregon requests that those without current valid OHP

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[14] Binswanger, Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release From Prison — A High Risk of Death for Former Inmates," New England Journal of Medicine, January 2007

[15] Gates, A., Artiga, S., Rudowitz, R., "Health Coverage and Care for the Adult Criminal Justice Involved Population," Kaiser Family Foundation, September 5, 2014. https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justiceinvolved-population/.

coverage would be supported by the OHA Community Partner Outreach Program and local corrections staff in initiating, completing and submitting a new OHP application within 72 hours of arrest and booking. These populations are at risk for poor outcomes and would benefit in health improvements as described in paragraph b above. These populations would also be eligible for transition related SDOH services.

Strategy 2. Retain child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) up to age 26.

For YSHCN, Oregon proposes extending OHP coverage to age 26 and retaining eligibility levels of 305% FPL to support smooth transitions from pediatric to adult health care. Many of these children and young adults are from communities of color, LGBTQAI+, members of Tribes in Oregon and have experienced homelessness, Intellectual and Developmental Disability (IDD)[16] or poverty. Addressing this transition is key to Oregon's health equity goals because few YSHCN are receiving adequate transition preparation, and some evidence indicates that this situation is worse for racial and ethnic minorities.[17] According the 2018-19 National Survey of Children's Health, 45% of Oregon youth aged 12-17 had a special health care need. Family members of youth with special health care needs reported that:

- 69% did not receive health care transition preparation services,
- 38% did not have time alone with their provider during their last check-up,
- 21% did not learn skills for managing their own care from their health care providers, and
- 44% did not receive help from their health care provider to understand the changes in care that happen at age 18.[18]

The transition to adulthood requires the youth to apply for Medicaid separately from their parents or guardians to avoid a lapse in coverage. The coverage itself also changes from a package of benefits designed for children and adolescents to benefits designed for adults. Removing the transition to a new adult benefit package, while including YSHCN as eligible for transitional SDOH services, will provide them time to better navigate these changes with the fewest possible disruptions, increasing the likelihood that they will transition into adulthood with the care and access necessary for good health and quality of life. For young adults with special heath care needs, effective transition from pediatric to adult health care results in increased[19]:

- Adherence to care
- Adult clinic attendance
- Patient satisfaction
- Quality of life
- Self-care skills

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[16] https://link.springer.com/article/10.1007/s11920-019-1016-1

[17] https://pediatrics.aappublications.org/content/126/Supplement_3/S129.short

[18] Oregon Center for Children and Youth with Special Health Needs Fact Sheet, Rev. 4/26/2021 https://www.ohsu.edu/sites/default/files/2021-04/Transition%20FACT%20SHEET%20rev.4.26.2021.pdf

[19] Oregon Center for Children and Youth with Special Health Needs Fact Sheet, Rev. 4/26/2021, Op. cit.

and decreased:

- Lapses in care
- Perceived barriers to care
- Hospital admission rates
- Hospital lengths of stay
- Morbidity and mortality

Strategy 3. Provide a defined set of SDOH services based on transition-related criteria to support vulnerable populations in need during transitions

Oregon has identified and proposes to address transitional events that a member may experience in their lifetime that result in inconsistent access to medical care, supportive services, or treatment. Depending on the nature of the transition and disruption experienced by the member, elements of the package may include enhanced care coordination, housing navigation assistance, employment support and connection to other social services by way of community partners and community-based organizations. In addition, Oregon has identified transition-specific interventions to further support these populations, as described below. Specific transitions across different systems, across health care settings, and across life stages or due to point-in-time events would trigger eligibility for one or more benefits packages. Once a member is deemed eligible based on their specific transition, a social needs screening assessment will be used to identify which benefits are relevant.

Oregon requests spending authority to draw down federal match on Medicaid funds to make payments to CCOs outside of the global budget to address SDOH for OHP members experiencing specified life transitions or disruptions (further information on this request can be found in the *Focused Equity Investments* concept paper). Oregon views these funds as a catalyst for increasing HRS spending within the global budgets in future years, because they will enable CCOs to build capabilities and identify the most effective services before they are fully at risk. Oregon proposes that the funding outside of the global budget phase down beginning in year three of the demonstration period. Further, Oregon requests upfront federal investment to cover these SDOH transitions services.

Eligible populations for a defined set of SDOH transitional services include:

a. Homeless members, or at risk of becoming homeless
b. Members transitioning from Medicaid-only coverage to Medicare-Medicaid Coverage
c. Members vulnerable to extreme weather events
d. Members (adults and youth) transitioning out of the criminal justice system
e. Adults transitioning out of Institutions for Mental Diseases (IMD)
f. Youth with Special Health Care Needs up to age 26
g. Youth who are child welfare-involved and transitioning in and out of foster care homes, including those aging out

Proposed SDOH transition services

Housing

Housing is a key social determinant of health, and being housed is associated with lower inpatient hospitalizations, fewer ED visits, and lower incarceration rates.[20,21] In a study in Oregon, Medicaid costs declined by 12% on average after people moved into affordable housing.[22] Institutional racism has impacted access to housing. According to 2018 data, people in Oregon who are Black, Native American or Pacific Islander, or two or more races represent a greater share of the unhoused population than their share of the total population.[23] Without interventions to support stable housing, homelessness can trigger destabilizing transitional events and, ultimately, create higher costs for the health care system and poorer health outcomes for individuals. Supports may include one or more of the following components:

1. Rental assistance or temporary housing (rental payments, deposits, past rent, motels, etc. for up to 12 months)
2. Home and community-based services (ramps, handrails, utility assistance, environmental remediation, etc.)
3. Pre-tenancy and tenancy support services (employment services, eviction prevention, housing application, moving support, etc.)
4. Housing-focused navigation and/or case manager (1:30 ration; exploring traditional health worker integration)

Health-related transportation

1. Linkages to existing transportation resources
2. Payment for transportation to support access to SDOH services, (e.g., bus passes, taxi vouchers, ridesharing credits).
3. Health-related transportation services in addition to Non-Emergency Medical Transportation (NEMT)

Food assistance

1. Links to community-based food resources (e.g., application support for Supplemental Nutrition Assistance Program (SNAP)/Special Supplemental Nutrition Program for Women, Infants and Children (WIC))
2. Nutrition and cooking education
3. Fruit and vegetable prescriptions and healthy food boxes/meals
4. Medically tailored meal delivery

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[20] Nakamura MM, Toomey SL, Zaslavsky AM, et al. Measuring pediatric hospital readmission rates to drive quality improvement. Acad Pediatr. 2014

[21] Oregon Medicaid Advisory Committee. May 2018. Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model

[22] https://oregon.providence.org/~/media/Files/Providence%20OR%20PDF/core_health_in_housing_full_report_feb_2016.pdf

[23] http://oregonhousingconference.org/wp-content/uploads/2018/10/Oregon-Housing-Conference-10-15.pdf

Employment Supports

Employment supports services are determined to be necessary for an individual to obtain and maintain employment in the community. Employment supports services will be individualized and may include one or more of the following components:

1. Person-centered employment planning support
2. Individualized job development and placement (e.g., job fairs, interviews)
3. Mentoring (e.g., on how to change behavior, re-entry from incarceration)
4. Transportation (provided either as a separate transportation service to employment services or to the member's job)

Exposure to climate events

Over the last several years Oregon has endured several extreme climate change-related events, including wildfires, ice storms, and extreme heat. During Oregon's most recent extreme heat event in late June 2021, 116 people in Oregon died of heat-related illness or hyperthermia. Vulnerable populations, including children, pregnant women, older adults, communities of color, immigrant groups (including those with limited English proficiency), American Indians and Alaska Natives, people with disabilities, vulnerable occupational groups, such as workers who are exposed to extreme weather, low-income communities, people with pre-existing or chronic medical conditions, and intersections among these groups, experience disproportionate adverse health impacts because they experience less climate-resiliency.[24] Extreme climate events are occurring with greater frequency and severity, can disrupt health care access and even coverage.[25] Benefits for people impacted by climate disasters and vulnerable to extreme weather can reduce health inequities and disruptions to health care services and coverage. Supports may include one or more of the following components:

1. Payment for transportation to cooling / warming and/or evacuation shelters (e.g., taxi vouchers, ridesharing credits, use of NEMT or health-related transportation above)
2. Payment for devices that maintain healthy temperatures and clean air, including air conditioners, heaters, air filters and generators to operate devices when power outages occur
3. Payment or vouchers to address high electric bills due to extreme temperatures
4. Housing supports and services, housing repairs due to wildfires to make housing livable
5. Immediate access to durable medical equipment (DME) left behind without a prescription or prior authorization
6. Clothing and/or food for members affected by extreme (e.g., wildfire) weather events

Strategy 4. Expand the infrastructure needed to support access to services using providers outside of the medical model

Oregon proposes streamlining member access to services that promote health equity, including culturally responsive care through the use of Traditional Health Workers (THW) - which include community health workers, personal health navigators, peer wellness and support specialist and

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[24] https://www.apha.org/topics-and-issues/climate-change/vulnerable-populations

[25] https://earthobservatory.nasa.gov/features/RisingCost/rising_cost5.php

doulas. THWs and peers are often trusted individuals from members' communities who may also share socioeconomic ties and lived life experiences, making them well positioned to help members successfully navigate a transition.

Under Oregon's current Medicaid State Plan authority, peer delivered services (PDS) are provided as part of a treatment plan developed and implemented by a licensed treatment provider. Through this waiver, Oregon will expand access to PDS. Recovery peers would be allowed to be paid outside of a traditional treatment plan (i.e., pre- and post-treatment) or, alternatively, to utilize proposed SDOH services that address social needs of individuals outside of typical medical services and the associated payment model. Allowing access to peer-delivered services without a treatment plan will remove barriers to treatment and ensure individuals have access to recovery supports throughout the course of their recovery, including before and after active treatment and during transitions of care. Members will continue to receive PDS during treatment through the Medicaid State Plan. While these improvements will benefit all members, they are critical to support members undergoing a transitional period in their coverage. This concept has garnered much support from the public, community-based organizations, and the recovery community.

Strategy 5. Obtain expenditure authority to support implementation capacity at the community level, including payments for provider and community-based organizations (CBO) infrastructure and capacity building.

Oregon will seek to obtain expenditure authority to support implementation capacity at the community level, including payments for provider Community Based Organizations (CBO) infrastructure and capacity building. Community investment collaboratives (CICs), as described in the *focused equity investment* concept paper, will play a vital capacity building role to develop necessary infrastructure/systems to prepare providers to deliver authorized services, receive payment, and reporting of information for managing patient care, monitoring outcomes, and ensuring program integrity or for technical assistance and collaboration with stakeholders.

What these policies would mean for OHP members

OHP members will be eligible for certain benefits based on specific life transitions rather than diagnosis. For example, OHP members in custody, such as those in the Oregon State Hospital, other psychiatric residential facilities or justice involved- will receive limited benefits and CCO enrollment allowing them to connect to services like substance abuse treatment, housing supports, and transportation, during transitions out of custody.

Youth with Special Health Care Needs (YSHCN) will retain their child OHP benefits up to age 26. This ensures access to treatment and familiar providers even if their family's income would otherwise make them ineligible for OHP.

All OHP members in transition described above as well as homeless members, or at risk of becoming homeless; members transitioning from Medicaid-only coverage to Medicare-Medicaid Coverage, members vulnerable to extreme weather events; and youth who are child welfare-involved and transitioning in and out of foster care homes will receive enhanced supports and coordination during these times of transition. These supports include things that substantially support a person's health outcomes but aren't typically considered medical care (for example, removing barriers to obtaining or maintaining housing).

Members will have more access to services that promote health equity, including culturally responsive care through the use of Traditional Health Workers (THW) - which include community health workers, personal health navigators, peer wellness and support specialist and doulas. THWs and peers are often trusted individuals from members' communities who may also share socioeconomic ties and lived life experiences, making them well-positioned to help members successfully navigate a transition.

Appendix A

Additional (non-waiver) strategies

Below are additional strategies Oregon is pursuing to support this work but do not require waiver authority:

1. In the 2021 session, the Oregon Legislature invested over $500 million in state funds to improve Oregon's behavioral health community system to work toward shorter lengths of stays in the Oregon State Hospital and other IMD facilities.
2. In the 2021 legislative session, Oregon established and funded a 9-8-8 suicide prevention and behavioral health crisis hotline to support individuals experiencing acute mental health crises (Oregon House Bill 2417(2021)).[26]
3. Oregon is interested in pursuing strategies through changes to rules and contracting to better support people moving across CCO service areas (moving from one CCO to another). For example, children in child welfare may have a foster family living in a different CCO service area than their home CCO.
4. For those without current valid OHP coverage, OHA will partner with the OHA Community Partner Outreach Program and local corrections staff in initiating, completing and submitting a new OHP application within 72 hours of arrest and booking within county jails and local corrections facilities (the effective date of coverage would be the date of booking and coverage would be retroactively reinstated to that date); and that CCO enrollment in the area of the individual's residence (or choice of CCO where if there are multiple CCOs serving the area) would occur immediately upon OHP eligibility determination.

You can get this document in other languages, large print, braille or a format you prefer. Contact the Community Partner Outreach Program at community.outreach@dhsoha.state.or.us or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.

[26] https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2417