Communications Engagement Feedback Analysis and Summary Report v4.0

Contents

Introduction

This summary analysis was prepared by Myers and Stauffer for the Oregon Health Authority (OHA) to synthesize comments and questions received during various standing meetings and events to inform waiver policy development related to the next generation of Oregon's 1115 waiver. This analysis is based on feedback collected from February 10, 2021 through September 30, 2021. Meetings included such examples as the Oregon Health Plan (OHP) Waiver Renewal Legislative Workgroup, Coordinated Care Organization (CCO) workgroups, Community Partner Outreach Program (CPOP) webinars, Medicaid Advisory Committee (MAC) meetings, and Regional Health Equity Committee (RHEC) meetings.

For the development of this waiver, OHA has identified four key goals with corresponding strategies to achieve the overall aim of "Progress towards elimination of health inequities." OHA described the strategies in "concept papers" released on July 1, 2021. These concept papers describe the policy strategies that OHA proposed including in the 1115 Medicaid Waiver Renewal. OHA incorporated many of the key themes raised by partners into the original concept papers and made further revisions based on feedback received over the time period covered by this report.

Oregon's 1115 Waiver: History

- CMS initially approved the Oregon Health Plan section 1115 demonstration for a 5-year period beginning in 1994, which allowed Oregon to expand Medicaid eligibility criteria and control costs by using managed care and a Prioritized List of Health Services.
- Oregon's waiver has been renewed and expanded many times since 1994, most recently in 2017.
- The 2012 renewal established Coordinated Care Organizations (CCOs) and initiated Health System Transformation.
- The 2017 renewal built upon that model and included goals that were reflected in CCO 2.0, which was the state's procurement for the next five-year Medicaid managed care contract.
- The current waiver will expire in June 2022.

Revisions to this report

This report is a cumulative summary of feedback recorded to-date and has been updated since its initial release.[1] In the latest version of the report, we have provided summaries of key themes and revisions to the processes and policies included in the 1115 Medicaid Waiver in response to stakeholder feedback through September 30, 2021. These summaries

[1] The initial public release on July 2, 2021 captured information from February 10, 2021 through June 3, 2021. The second public release of this report on July 29, 2021 captured information from February 10, 2021 through July 16, 2021. This third revision captured information from February 10, 2021 through September 30, 2021.

highlight specific areas in the proposals for the 1115 Medicaid Waiver Renewal that address the feedback received; if there were areas of feedback not addressed through the 1115 waiver authority, these are also summarized.

Many of the key themes are addressed in the concept papers that form proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. The concept papers are available in multiple languages beginning November 1, 2021, and the draft application is available in English for public review beginning December 1, 2021, with other formats available upon request. Formal public comment will be accepted December 7, 2021 – January 7, 2022.

Approach

Using the comments and questions collected during engagement sessions, a qualitative analysis was then used to develop codes, or tags, to label text for analysis. Meeting participant quotes and perspectives were categorized using twenty-five (25) distinct tags for all comments in the feedback tracker. This allows the ability to count the frequency of similar comments and concerns. The coded text can now more readily be evaluated and prioritized for potential action. The list of primary tags was developed in combination through OHA pre-defined tags and those added by Myers and Stauffer during the review process.

Each tag was then cross-walked to either one of the four waiver goals, or placed into a general category. To support additional analysis, Myers and Stauffer also identified in the feedback tracker the following, as applicable:

- Audience descriptors most relevant to the engagement session
- Whether the feedback was a comment or question
- Whether the feedback aligned with one of the four goals, or offered more specific, action-oriented detail. Based on this, a comment was marked either “strategic”, or “operational.”
- Additional key words, or secondary tags

This analysis highlights common themes and patterns seen throughout the stakeholder comments, grouped by major topics, and are bolstered by comments identified to support our analysis. The comments in this report were chosen to capture illustrative examples that either support or add nuance to the analysis provided by the Myers and Stauffer team, and is not meant to reflect an exhaustive list.

Some slight edits were made to comments to improve readability, such as correcting typos or the addition of contextual information. The original comments and questions were preserved in the primary source document. The source document does not always capture direct quotes from stakeholders, and may instead be a mixture of summaries and paraphrasing of what was said during the stakeholder engagement. As part of every update process, Myers and Stauffer has incorporated changes including the addition of comments or questions that provide additional nuance, and removal of comments in favor of feedback that was more detailed or clearer. In some instances, comments have been regrouped and/or broken out to illuminate topics of further discussion during engagements.

Improve health outcomes by streamlining life and coverage transitions Create an equity-centered system of health2			
Behavioral health	17	HIT and interoperability	3
Coordination	27	SDOH	34
Community voice	10	Transportation	13
Covered services	56	Workforce	9
Health disparities	27	Access to care	26
		Total	**222**
Ensure access to coverage for all people in Oregon			
Access to coverage	74	Governance	7
Expanded eligibility	13	Shared power	11
		Total	**105**
Encourage smart, flexible spending that supports health equity			
Capitation	30	Payer alignment	4
Data/measurement	10	Program Integrity	7
Incentives/metrics	8	Provider payment	20
		Value-based payment	3
		Total	**85**
Reinvest government savings across systems to achieve health equity			
Investment	36		
		Total	**36**
TOTAL			
		Total tagged comments	514
		Count of duplicates	20
		GRAND TOTAL	**536**

For the purpose of this report, the comments were provided a primary tag. While this table is to be suggestive of frequency, the actual count of comments relating to each tag may be larger - many comments and questions covered several overlapping topics. The frequencies in this table are to support decision-making and prioritization of topics (for example, for future engagement sessions) – and not meant to be definitive counts.

[2] The description of this focus area was formerly "Create an equity-centered system of health." The description changed based on feedback from partners. Since the purpose of all proposals in the waiver is to improve health equity, the new description better describes how this goal area contributes to that aim.

Participant analysis

The following table provides summary statistics regarding the counts of participant categories engaged.[3]

Stakeholder group	Count
Advocacy group	21
CAC	19
CCO	69
Community partner	39
County health	45
Elected official (or representative)	5
General public	3
Industry; hospital provider	7
Insurance agent-member advocate	3
Justice-involved	4
Legislative	47
Lobby groups	7
OHP member/guardian/representative/care giver	2
OHPB member	71
Patient member advocate	6
Patient/member advocacy groups	39
Provider - behavioral health	3
Provider - dental	1
Provider - health system	1
Provider - oral	3
Provider - physical	3
Provider - clinic	3
Provider - community health center	12
Provider - county health	1
Provider - Health System	8
Provider - tribal health	10
RHEC	9
Social service organization	2
State agency	24
Unknown	49
Count of tagged comments	514
Count of duplicates	20
GRAND TOTAL	**536**

[3] As part of the revisions to this report, the stakeholder groups (and therefore counts) were adjusted based on guidance from Oregon's Office of Equity and Inclusion.

Reflecting tribal partner voice

Listed below are some of the comments reported from **Tribes**, which is an important government-to-government relationship that differs from stakeholder engagement. Some of the themes included: **ensuring coverage** and accessibility, **barriers to care** for tribes, additional **coordination** needed with tribal members and partners, better designating tribal status in electronic health records, etc. While some of these sentiments may be similarly reflected in other areas (as in, other sections of this report), we decided to uniquely call these comments out for consideration:

- *Vision and easier access to dental care*
- *Tiered eligibility for the churn populations*
- *Is there any talk surrounding opening up eligibility or expanding it into a tiered pay system for those who are in the churn percentages?*
- *Do you think it would be a worthy endeavor to collaborate with health care providers like clinics, dentists, etc. and to develop a program that would encourage them to hire or create a position for an in-house OHP Community Partner?*
- *Another reason for this question is the weird stigma that people seem to have with utilizing self sufficiency programs - there seems to be a psychological component that makes them feel better about it when it's a service that they are paying for. if it's affordable to them.*
- *I'm sure this subject has been brought up but I would like to reinforce the idea that having a designated tribal liaison for each of the CCO's that we can deal directly with to coordinate referrals and transitions with would really relieve some of the issues that we are currently seeing.*
- *You should consider financially incentivizing clinics to have a community partner on site to assist with CCO navigation. That's something that I do, I help navigate dental switches, the whole 9 yards. It's a successful situation. My position is grant funded. The tribes bend over backwards for their clients, and it's been successful having someone dedicated who can handle these situations.*
- *[The Confederated Tribes of Grand Ronde at the Health & Wellness center] offer[s] in clinic to do a cursory eligibility check for patients and get them signed up for Oregon Health Plan. So many patients are NOT aware of the eligibility guidelines or that it even might be a possible option when they are reaching out for care before turning to emergency care. So many people don't even bother to apply just because they think they either won't qualify or that the process itself is far too long and arduous, which really isn't true especially when dealing directly with a good CP.*
- *Talk more about this budget neutral mandate and what it means and how things will be funded and how to maintain transparency.*
- *After much research we have concluded that the CCO's are unable to view a patients AI/AN [American Indian and Alaskan Native] or HNA [Health Needs Assessment] status in MMIS [Medicaid Management Information System]. This has resulted in*

native patients being placed on capitation plans which result in continuity of care issues and delays while trying to remove them from that. In most cases, native patients will be receiving their care from an IHS [Indian Health Services] clinic first, who will then be coordinating their referral to another provider. It then gums up the process if they then have to go see a provider in network to their capitation plan to be assessed for the same issue and then be referred out for specialized care.

Reflecting the member / community voice

Members and the community are an integral voice, and soliciting their feedback is a critical part of building health equity into the waiver development process. The insight provided by these groups will help shape the future strategic direction of the Medicaid program, and ensure that new policies reflect the needs and priorities of the member and community.

Illustrative feedback and sentiments expressed by members, advocates, and other community partners or representatives across themes are summarized below:

- How are we ensuring coverage and care across all people in Oregon, including coverage for rural areas, coverage for those between CCO areas, coverage in identified gaps, etc.? How do we simplify enrollment processes and better communicate to ensure access to coverage?
- How are we addressing health disparities and barriers to access? How are we taking into account ease and accessibility for members? How do we ensure more culturally competent care as part of more accessible health care delivery?
- How will certain services be addressed within the waiver? How are we making sure resources are continuously available toward prevention and social needs? Can investments be longer term and focused on sustainability?
- Are we considering the needs and concerns of certain populations? How can we continuously involve input from members and the community and equitably distribute decision-making power and resources? How can we appropriately place more power into the hands of community members?
- What are other promising practices from other states or programs we can look to?

Reflecting CCO concerns or input[4]

CCOs are responsible for coordinating all the mental, physical, and dental care for OHP members. Under OHP, CCOs are paid through a per-member-per -month (PMPM) rate for each patient, with flexibility to manage the dollars to invest in community health and to pay for health-related services.

CCOs have a stake in improving health care for members under OHP and offer important input around reducing waste, improving efficiencies and eliminating avoidable differences in quality

[4] CCO representatives were asked to submit additional details and comments in notices to OHA. Since that process has not closed, and comments are being compiled, a future iteration of this report will reflect those sentiments and feedback.

and outcomes. While CCO representatives expressed many similar sentiments as the general public / community members about addressing health equity through the waiver renewal, they expressed **additional** concerns, as summarized below:

- How will we implement expanded coverage and can we implement it sustainably?
  - For example, *"We think about the populations that are really hard to manage - those that transition a lot in and out of different types of eligibility. Creating a pre-adjudication enrollment process would be helpful. Creating a care coordination only plan ("CCO-Z") that would allow a CCO to be a part of coordination even when they aren't paying for care would help sustain enrollment and reduce delays in care under FFS."*
  - For example, *"Fortunately, we have opportunity to utilize these still topical commissioned resources in effort to renew recognition of and refocus commitment to oral health's compelling, cost effective, value proposition that is intimately aligned to OHA's stated overarching goal for this 2022-2027 waiver renewal: a pathway to advancing health equity."*
- How can we build in additional accountability and tools for program integrity?
  - For example, *"We need to increase culturally appropriate care and then change OARs to audit to assure respect for, and offering of, culturally specific care."*
  - For example, *"We concur that traditional health workers need stable funding, but there are considerable barriers to traditional health workers operating in the community and receiving Medicaid funding for their services (outside of grants or employment or affiliation relationships with county mental health programs, primary care providers, and other partners in the care team). The Authority could clarify or address certificate of approval requirements and supervision requirements."*
- How does the model currently include opportunity for community investments?
  - For example, *"Each CCO has a different process for investing in community. We don't do it the same way across all CCOs, but we all do it. How can we take advantage of that?"*
- How will specific services be considered, as it relates to the global budget?
  - For example, *"CCOs are concerned about expensive drugs coming on market. Can we protect their global budgets? Delaying utilization is a concern."*

General — Summary and analysis

Waiver process

While many participants provided comments and feedback regarding the policy and strategies in development, some individuals also had questions and/or concerns regarding the **waiver development process** (as well as other related **administrative functions**). As expressed by individuals in the engagement sessions, some were interested in seeing a **comprehensive and intentional approach** for waiver development – this may include

further stakeholder engagement and a built-in feedback loop to keep up-to-date with progress. Below are some examples of the comments received:

- *How are communities of color and community members involved in this problem-solving and waiver development process?*
- *Want to have an intentional connection to the work on the waiver, be a link as discussing the agency and member priorities, engagement, support the agency and ensure interests are included in the development process*
- *When RHECs [Regional Health Equity Coalitions] reached out in November with a very specific waiver proposal idea, heard nothing back, then were outreached to work on this under very tight deadlines, it feels tokenizing. Especially during a uniquely challenging time with the pandemic, vaccine rollout, and wildfire response. In the future, when community partners come to OHA to engage the agency, there should be an actionable response. In other words: What actions did OHA take to work with the community partners on this proposal that was brought forward? How did OHA integrate these recommendations or proposals into their work?*
- *Be willing to do this work using new processes. For example, OHA has always used a "top-down" approach to the waiver proposal. Make space for community groups, like RHECs, to lead and provide sufficient time for that to happen in meaningful ways.*
- *Will OHA be assisting counties that currently do not have health equity coalitions in forming them?*
- *[Is there] a way that, when we move onto implementation, the HEC can look at the gaps and support this? Look at new investments of health equity and think broader to over those gaps*
- *Community partners are not a monolith, and have unique experiences, expertise, and perspectives. Do not lump all community partners into one group to engage. Similarly, be willing to hold the complexities of perspectives and take care not to pit community groups against each other in an effort to "align perspectives."*

Figure 1: Summary of adjustments to the waiver development process in response to stakeholder feedback

Upon review of the feedback on the internal waiver development process, here are the steps that OHA has taken to adjust for a **more equitable process**:

- OHA acknowledges the need for improved public engagement processes that elevate the voices of BIPOC and Tribal communities. Partners have made valuable suggestions and critiques of the agency's processes, and the team working on the 1115 Waiver Renewal is working within the agency, including with the Office of Equity and Inclusion, to identify opportunities to correct shortcomings in the long term, so communities are not continually frustrated by engagement that just doesn't work for them.

- In the meantime, for the 1115 Waiver renewal, OHA has committed to improving engagement, including:
  - **Translating documents** into multiple languages and releasing them together (i.e., not releasing the English language version first, giving English language speakers more time to review and respond).
  - **Holding Community Partner Outreach Program (CPOP) meetings** about the waiver in Spanish and English and offering translation for all other events about the waiver.
  - Supporting a **Health Equity Impact Assessment (HEIA)**, including a partner engagement gaps analysis, to understand what went well and what needs to be improved. The HEIA will be monitored by the Health Equity Committee of the Oregon Health Policy Board. OHA will use the results to improve engagement in the next phases of the project, including implementation of the waiver.
  - **Incorporating feedback** from previous public engagements about the waiver, such as Waiver Days and CPOP meetings, into the plan for the public comment period (December 7, 2021 through January 7, 2022). This will include an emphasis on dialogue over presentation and meetings scheduled in the evenings when availability is higher.
  - **Documenting public comments and showing where these are incorporated into the waiver application** or explaining why OHA is not incorporating the feedback. For comments that are related to OHP and health policy but cannot be addressed through the waiver, OHA will identify where these comments can be addressed in the agency and will communicate with the public how they can engage in those areas.

Goal 1 — Improving health outcomes by streamlining life and coverage transitions[5]

Goal 1 covered the largest group of comments expressed by participants and focused on **equity and better addressing health disparities** across populations – in fact, this was the largest area of discussion. We also included a discussion around covered services, and the unique considerations for some services covered under OHP.

Health disparities and access to care

A focus on **patient-centered care** and **utilizing existing community resources** and networks was a common theme presented by stakeholders. Several participants also noted

[5] The description of this goal area was formerly "Equity-centered System of Health." The description changed based on feedback from partners. Since the purpose of all proposals in the waiver is to improve health equity, the new description better describes how this goal area contributes to that aim.

that rural areas were a particular concern, as the access to services in **certain geographic areas** may be more limited. The following concerns surround individual experiences attempting to access care and the potential barriers that exist:

- *Patient centered, community centered, clinician centered is a key goal. What are barriers to that goal that the Waiver could address, e.g. insulin access (cost/refrigeration/housing)?*
- *I greatly appreciate the equity focus, [in] the next coming iteration of the waiver, but also coming from the behavioral health sector I'm extremely concerned about loss of programming and access, and the opportunity of improving CCOs ability to have a global budget that invests in access for that sector, particularly for equitable access and linguistically appropriate access, and more importantly for co-occurring care of complex individuals. We're seeing as I mentioned, really a degradation of access in the system due to COVID, workforce and many other factors.*
- *Yes, like [one participant] says, creating programs that work and bring in the community, then having them abruptly taken away breeds mistrust in the systems we want to create.*
- *Unfortunately the folks who really need the help do not know where to start finding it or have problems trusting entities in place. Having diverse workforce may help to provide more trusting and relatable connections between service and people.*
- *[Commenter] brought up access issues among aged facilities with workforce shortages. She asked the waiver consider it and noted pandemic impacts on the population.*
- *Some of the equity problems that we are trying to solve are created by the system itself, but we are relying on the same system for solutions; it is difficult to create new solutions for the problems that we don't even see with clarity; We don't have clear definition of health equity output; it is complicated.*

In the above comments, participants addressed barriers to the system as a whole. However, participants also commonly expressed considerations for more **specific populations or cases**; individuals relayed their own experiences and provided examples when addressing particular barriers:

- Addressing rural areas or other geographically inaccessible locations:
  - *As I've heard over and over, access to services is issue. Rural residents need transportation access but there are gaps. Not sure how this need will be met.*
  - *I'm from Harney county, which is very frontier/rural. Speaking of equity, getting services is quite challenging. Recently, community organizations are increasingly required as lead entity or partner to apply for funds, but we don't have non-profits or other CBOs in our area. Often the county is the only organization with the ability to offer services.*
- Addressing minorities and BIPOC populations:
  - *Many evidence-based benefits don't serve BIPOC populations well.*

- Addressing disability populations
  - *Would waiver enforce providers to provide services to people with disability when they go into doctors' offices?*
- Addressing incarcerated or previously incarcerated populations:
  - *I have experience working with the incarcerated population and this work is taking on a very complex cultural challenge - be prepared to explain that Oregon is asking for better care for [the] incarceration population; remember advocates had to sue for prisoners to get the COVID vaccination sooner in the priority list. We need to educate the public, partners and colleagues about the historic injustices that is in play with this population.*
  - *Someone in the system needs to be responsible for a person moving through the corrections system. Currently this is a gap. Perhaps CCOs could fill that role.*
  - *Propose Medicaid pay for and expand pathways for services for individuals with dual diagnosis and complex behavioral health issues in the criminal justice system.*
  - *Changing the process for those who have been incarcerated as the first few days after release are crucial to be able to access MH/BH/SUD treatment.*
- Addressing homeless populations:
  - *Many barriers for homeless population [exist]*
  - *Email and mail for houseless is a barrier*
- Addressing undocumented populations:
  - *When we have undocumented clients that are older than 65 they are having to wait for a call back from ODHS [Oregon Department of Human Services] to see if they qualify for other services. Their application is pended until they have had such appointment, these specific clients do not qualify for other services because of their status.*

One participant did express some **very specific policy recommendations** regarding removing barriers to care in the upcoming waiver:

- *Oregon is currently the only state in the country that reserves the right to withhold medically necessary care from children on Medicaid for the sole purpose of saving money, through the EPSDT [Early and Periodic Screening, Diagnosis, and Treatment] waiver clause… The State of Oregon has used this EPSDT clause to save money by withholding medically necessary care from needy children. Specifically, Oregon uses the prioritized list of health care services to determine which services are to be provided. Services that are "below the line" – or simply not recorded on the list at all – are withheld, regardless of individual determinations of medical necessity. Recommendation: The EPSDT clause in Oregon's section 1115 waiver should be removed. Oregon should comply fully with EPSDT, to ensure that all EPSDT-eligible children receive the medically necessary care that Congress intended, without rationing.*

- *Oregon has consistently used discriminatory "Quality Adjusted Life Year" (QALY) metrics as a factor in ranking services on the prioritized list. QALY is a tool that estimates the value of a treatment according to years of additional life – discounted by the level of disability. This approach places a lower value on years of life for those with disabilities – such as my children – than on years of life for people without disabilities – and is inherently discriminatory. When the Oregon Health Plan ranks services on the prioritized list, using QALYs in any way, it engages in discrimination against individuals in violation of the Americans with Disabilities Act and contrary to the mission of the Oregon Health Policy Board to promote health equity. Recommendation: The Waiver should include a provision explicitly renouncing use of discriminatory measures such as QALYs…*

Figure 2: Summary of key themes related to health disparities and access to care incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. Other key themes can be addressed in ways that do not need waiver authority.

- The overarching goal of the waiver is to advance health equity. This aligns with the Oregon Health Authority's strategic goal to eliminate health inequities in the state by 2030.
- The intent of health system transformation in Oregon is to create a health care system that improves health, improves care and lowers costs. Patient-centered care is an underlying value of these efforts, including for the waiver.
- In the waiver application, OHA is proposing ways to address unique challenges individuals and groups experience in accessing care. For example, OHA is:
  - Asking the federal government to waive the rule preventing a person in custody from accessing health benefits.
  - Proposing packages of services that are tailored to support people through destabilizing life transitions, such as becoming homeless, being released from incarceration, or being displaced by extreme weather events.
- OHA is committed to providing equitable and comprehensive treatments and services to children and adolescents on the Oregon Health Plan. Oregon's approach to ensuring we provide federally mandated Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) services is different than in other states. Oregon relies on a Prioritized List for covered services for all Medicaid patients, both children and adults. Treatments on the list are vetted by the Health Evidence Review Commission, which regularly considers new services/treatments for inclusion.

  Several interested parties have flagged for OHA that there may be services for children that may be limited by our approach. We take such concerns very

seriously and have researched these issues at the staff and Health Evidence Review Commission levels. OHA is addressing several of the concerns using our HERC process, which is public and accountable.

It is important to note that individual circumstances that may not have been considered by HERC can be addressed through a prior authorization request or an appeal process. In these processes, the provider asks for a review of the medical details of the case and for OHA to determine that the non-covered services are medically necessary. OHA diligently reviews any requests and often covers the services.

OHA also works closely with CCOs to make sure that they are offering their members all the EPSDT services that OHA has contracted with them to provide. Well child checks, preventative services, and age-appropriate screenings are all covered as listed in the prioritized list. The list details the treatments CCOs must cover for children's health conditions including those identified through screening. Additionally, under their contract CCOs must cover all diagnostic work needed to identify covered children's health conditions. We are in regular communication with CCOs around any barriers they, or their members are experiencing, and work collaboratively to resolve them.

OHA appreciates input from communities, individuals or advocacy groups when they experience gaps in coverage of any sort. We work hard to provide processes and resolutions which people can use to approach OHA with concerns. Again, OHA is committed to providing equitable and comprehensive services to everyone on the Oregon Health Plan.

- Quality-adjusted life years (QALY's) currently play only in a minor role in any decisions by the Health Evidence Review Commission, usually in comparing two treatments for the same condition. They are not used to discriminate against people with disabilities. Most often, a more cost-effective treatment may be preferred over a less cost-effective one. At other times, a trial of a lower-cost treatment must be tried before a more costly service can be used.

Coordination of care

Being able to access services in a timely and efficient manner requires an attention to **care coordination**. Several commenters stressed the importance of care coordination and provided some suggestions on improving it within the current system. For example, several discussed the importance of a **good referral network and communication amongst providers**. Some also further elaborated on the **incentives** (or disincentives) for proper care coordination:

- *Feedback from our Care Coordination team and community partners suggests inadequate collaboration among systems, which might be corrected through waiver*

and non-waiver activities. There may be a need for support for the Federal Government to mandate such systems communication.

- *Access to services for patients who are Open card[6] when they first get on OHP... It's very hard for them to access services and find providers as Open card.*
- *CCO wait times can be up to one month out for members to see an out-of-network clinician of their choice. Client choice should be honored quicker.*
- *Care coordination is a key component of Oregon's current waiver. Consider how barriers may be the cost to do coordination as the system is currently designed.*

Several individuals pointed out ways to support better access to quality care – with **proper communication and consistent / clear messaging** being at the center of these suggestions. This may also include the appropriate **feedback channels** (across groups) for continued sustainability and program progress.

- *Language, transportation, etc. What would help the most is community literacy classes.*
- *Providing grants and contracts and trainings to culturally specific community-based organizations.*
- *When there are no changes in systems following feedback, and they continue to operate in the same way, it further creates distrust in the system from community-based organizations (CBOs) and community members.*

Figure 3: Summary of key themes related to coordination of care incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. Other key themes can be addressed in ways that do not need waiver authority. For instance,

- Through the waiver, Oregon is requesting federal investment to support community-led investments and infrastructure for CBOs. These funds will increase resources and local collaboration to address health equity and improve coordination between health systems and CBOs.
- Many of the concerns raised about coordination of care can be addressed in ways that do not need waiver authority and can be addressed through operational and program changes rather than waiving federal regulations. However, the state is proposing to provide a suite of social determinant of health services to certain populations of focus experiencing life transitions with the goal of improving care coordination across systems.

[6] Health services for OHP members not in a CCO are paid by OHA, called Open Card, or Fee-for-Service (FFS) OHP. American Indians, Alaska natives, tribal members and Medicare members on OHP can choose to receive managed care or have an open card.

Covered services – medical services and other benefits

When discussing the services under OHP, individuals attending stakeholder events provided comments on a **wide range of services and programs**. In general, the individuals who commented wanted to make sure services that were provided were more **accessible**, including ways to **extend those services** (for particular populations, etc.). Other participants had general questions about how these services were currently provided or the costs that were associated.

Care for mothers and children also was a reoccurring theme; individuals expressed wanting better care options for **maternal and child care**, particularly for extending **post-partum services**.

- *Consider expansion of post-partum coverage to 12 months post-delivery. OHP coverage ends 60 days after birth; Georgia, Illinois and Missouri have received this extended coverage in their waivers.*
- *Our dream package for perinatal depression and anxiety supports includes… [ensuring] the supply of providers that are specifically trained in perinatal mental health, [ensuring] range of accessible methods (peer, group, individual, medical management, etc.), and [providing] reimbursement for support services like Baby Blues Connection – warm line, peer support, etc.*
- *[Consider] home visiting for everyone for the full year as needed, tied to payment for the parent not the baby*
- *The wait time for folks transitioning from Open card to a CCO is a huge challenge for our pregnant clients needing to get into prenatal care ASAP.*

There were a few comments related to **vision, dental, and pharmacy** services, related to costs and extending these services:

- *Most people need a referral if they have OHP to see an eye doctor*
- *Vision and easier access to dental care*
- *Oral health has been contractually integrated into CCOs since 2014-15; however, the CCO 2.0 policy recommendations were almost literally devoid of oral health inclusion despite availability of OHA-commissioned reports, recommendations, and research from Health Management Associates (HMA) and OHSU Center for Health System Effectiveness.*
- *What changes have you made to concept papers to include more on oral health?*

There were a couple comments and/or questions related to **interpreter** services, particularly around billing:

- *Can we treat interpreters as providers for billing purposes?*
- *Couldn't the interpreter bill if they became a community health worker (CHW) and then they would be considered a provider and would have an NPI # [National Provider Identifier number] through their CCO?*

- *CCOs cover interpreter services, but Open card does not. It would be nice if OHA covered interpreter services*

As for other types of services, several participants provided comments on receiving services through certain targeted programs, as well as comments about **services for specific populations** (including **telehealth, Citizen Alien Waived Emergent Medical (CAWEM), and Long-term Services and Supports (LTSS**):

- *I agree that we need to extend telehealth; perhaps indefinitely.*
- *Changing the name for Emergency Medical Care for Non-Citizens (CAWEM) as when people ask what it means; it's offensive, confusing.*
- *CAWEM coverage to cover outpatient dialysis if possible and immuno-suppressants.*
- *[A commenter] put LTSS on the table and noted how benefits for that population have evolved, he noted CBO considerations that relate to LTSS services. He said this may be a great place to gain learning since it's been done in a different space but may have some similar cross-over experiences. He said the preventing institutionalization population sub-set in this population is probably a better place to look.*

Figure 4: Summary of key themes related to covered medical services incorporated into policy proposals in response to stakeholder feedback

Many of the key themes are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. Other key themes can be addressed in ways that do not need waiver authority.

Some of these themes from stakeholder comments that do not require changes to 1115 waiver authority are highlighted below:

- Oral health: Opportunities to address some of the remaining challenges related to oral health are not best suited for the waiver, as they do not require additional federal authorities, and will be addressed in the coming months and years as we look towards the next Coordinated Care Organization (CCO) contracting cycle.
- Postpartum coverage: Oregon intends to extend Medicaid postpartum coverage for people who give birth to 12 months in April 2022 via a state plan amendment (SPA) per the provisions of the American Rescue Plan Act of 2021.
- Language access: While interpreter services are not being addressed in the waiver concept papers, ensuring access to interpreter services is one measure being considered for revisions to the Quality Incentive Program.
- Telehealth: Expansion of telehealth services is being researched and considered through means other than the waiver.

- CAWEM: OHA is currently in the process of changing the name from CAWEM to Citizenship Waived Medical (CWM) to better reflect our commitment to equity.
- CAWEM: Since July 1, 2021, emergency dialysis services have been covered for CWM beneficiaries, and starting January 1, 2022, outpatient dialysis will also be covered. Outpatient dialysis coverage for CWM beneficiaries will cover immunosuppressants.
- Transitioning from fee for service (Open Card): The Oregon Health Authority is working to address the wait time for those transitioning from Open Card to enrollment in a CCO through internal operational changes.

Covered services – behavioral health services

Behavioral health was a highly discussed topic during stakeholder engagements. The conversations centered around providing more focus on behavioral health issues, as well as finding ways to better increase access of these services.

- *What waiver funding and investment opportunities/concepts are being formulated to increase equitable and improved access to SUD [substance use disorder] and mental health across the lifespan both within fee for service and CCO's?*
- *In Rural areas there are not enough licensed Social Workers. Need to be able to reimburse other qualified counselors for mental health services, Challenge in community investments and continuity is that community investments are considered administrative expenses rather than Medical Care expensed and thus are artificially capped. Can we get CMS to consider them Medical even if not attributable to a specific member?*
- *Pointed out barriers to BH services from utilization management controls used by CCOs.*
- *Will the waiver proposal consider the expected surge in BH needs due to COVID impacts for community-based services crisis through prevention?*
- *I've heard from CPS [Child Protective Services]: more MH/BH providers in the area that take OHP are needed…*
- *A possible strategy to address health inequities consists of automatically enrolling children, regardless of income, with behavioral health diagnoses into the Oregon Health Plan… We would ask how this idea works with the proposal to maintain enrollment for children uninterrupted for five years.*

Other commenters provided suggestions and other potential best practices regarding **behavioral health services**:

- *Can Oregon get a waiver to reimburse certified mental health counselors beyond certified Social workers to provide mental health services in rural areas where there is shortage of MSWs [Master of Social Work]? In addition to Peer Counselors I was also*

thinking about Marriage and Family Counselors and other professionally trained counselors?

- *Is there an opportunity to create a behavioral health home? Switching providers creates chaos.*
- *Clackamas County BH provides a peer-centered BH program funded by Medicaid and invites OHA to visit/learn more about their model to inform the ECSH concepts in the Waiver.*
- *Nurture OR may provide a good model of wrap-around services – merges medical, peer, [behavioral] health (substance-use specific now but may be able to be more broadly applied)*

Figure 5: Summary of key themes related to covered behavioral health services incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. Other key themes can be addressed in ways that do not need waiver authority.

- Providers: Oregon is requesting to cover more providers outside the medical model to support behavioral health. Providers outside the medical model include traditional and community health workers, personal health navigators, peer wellness and support specialists, and doulas. Specifically, Oregon requests that 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. Recovery peers support members with Substance Use Disorders (SUD), which is a significant behavioral health need.
- Stabilizing services: Oregon also proposes coverage of additional services designed to support key social determinants of health for eligible populations; including those with high behavioral health needs and/or those at risk of behavioral health problems. These services, which include intensive care coordination, housing supports, transportation support, and more, can connect people to behavioral health supports and provide stabilization to address social determinants of behavioral health problems.
- 2021 Legislative session: OHA plans to address many of the challenges in the behavioral health system through the investments made by the legislature in the last legislative session, the provisions in the approved 1115 SUD waiver and in the next round of CCO contracting.

Covered services – services centered around social determinants of health

Many commenters also expressed wanting to focus more resources on **social determinants of health**, in addition to more traditional medical services. Several individuals gave suggestions and rationale behind why certain investments into prevention and social resources could better support better health outcomes across the system:

- *A key goal should be expanding what federal $ help pay for through waiver/flexibility and how systems of health and how health is defined to be more expansive. How can prevention be prioritized and expanded, e.g. housing? Consider how wrap-around services can be more comprehensive and intentional. Expansion in health-related services is part of the evolving story as is global budget flexibility so investments can be made and CCOs can benefit from up-stream investments.*
- *In some communities, non-medical service organizations are not readily available, and the Medicaid program alone cannot sustain them. The need for resources currently exceeds available capacity. It is important to ensure culturally and linguistically appropriate services are in place before offering them as a benefit. While lower-intensity care is valuable, we do not want to sacrifice quality for a wider variety of services.*
- *Consider access to palliative care and reimbursement*
- *The problem is not just housing the houseless, 99% of the work starts once housed. That is when the flexibility comes in handy. I love to just get people housed and wish them well. But that is not the case, some of these folks required more assistance, support, and more resources. This is where CCO support becomes critical.*
- *[One participant] identified the need to work with community health centers and for flexibility to meet SDOH/up-stream interventions is a good goal. She agreed with [another participant] regarding BH/oral health sub-cap rates and how that discourages better integrated care.*

Housing was a specific type of covered benefit that commenters wanted to explore more as an option. Below captures some of the sentiments and questions related to housing supports and how it may be covered under the new plan:

- *Asked if there was an opportunity to move housing and other support services costs under behavioral health integration and substance use treatment and mental health treatment*
- *How "real" are housing flexibility options as waiver components? CMS probably won't allow for building but things like short-term vouchers could be an option. Temporary housing after hospitalization may be another option for negotiation.*
- *Opportunity zones and housing shortages are not a result of a lack of financiers and developers. There is a barrier to development because they are not designated as opportunity zone (OZ) areas. How we designate opportunity zones will determine equity.*

- *Why are there not more efforts to consider tiny homes that could easily be placed on empty lots and maybe work with community organizations (like Salvation Army, TPI, etc.) to provide an onsite manager?*
- *[Ideas for inclusion:] (1) Homelessness or houselessness prevention, including paying [for] housing for those who are houseless and [paying] for housing to avoid evictions for those who are housed; (2) Ensuring that housing is safe for mother/baby*

Transportation was also another issue that participants continuously addressed. Several saw transportation as an integral benefit in supporting individuals to receive the care they need; in cases where transportation services were not as strong, individuals may have noted this being a barrier to care. Many pointed out that transportation across counties and **across different geographic areas** (particularly in rural areas) was sometimes difficult to access or coordinate.

- *Transportation for people trying to get OHP coverage, like those coming to see assisters in person would be appreciated. And, even when public transportation is available, it's not always the easiest*
- *For the rural clientele, transportation is a huge barrier. The local transportation programs are expected to transport everyone to their medical appointments. But in more and more cases, there is no transportation mileage reimbursement for transportation programs to access to offset the costs.*
- *What if a patient has an appointment in an out of county and the appointment is early the next day but since they have OHP in one county and the transportation doesn't cover the other county and they don't know any transportations in the other county?*
- *This problem is the gap in transportation funding when a person turns 65 and moves from the Medicaid program to Medicare… In a highly rural area, these rides can cover hundreds of miles and take a vehicle and driver an entire day to complete. This issue is called "dumping" in the public transportation world. A larger agency is able to push the cost burden over onto another agency, in this case a very small rural public transportation department with extremely limited resources.*

In addition to housing and transportation, participants listed **other benefits and resources** that would support a healthier population:

- *One issue no matter what your social economic status, but especially for those who are on food stamps and those who have limited food budgets, is the amount of processed food. The amount of carbs, salt and sugar in the processed foods is very harmful. It seems to me some education around understanding portions, and labeling should be a part of support… Maybe expanding farm coupons for those on food stamps could provide more access to fresh fruits and veggies.*
- *Why isn't there any type of a food stamp/ WIC (woman, infant, child) program for individuals who have diabetes? This type of program would assist individuals in being able to buy healthy foods so they can manage their diabetes better…*
- *Access to parks and recs - many people live in apartments, or don't have places to get exercise.*

- *What about linkages to education? Promote health strategies that improve education outcomes.*
- *Can community-based childcare centers be considered? Keeping childcare local makes it walkable, or at least reduces the need for travel, and provides work and builds trust in the local community.*
- *Childcare – CBO childcare makes it local, reduces need for travel, builds trust in community*

Figure 6: Summary of key themes related to services centered on social determinants of health incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment.

- Community-Based Organizations: Oregon is requesting federal investment to support Community Investment Collaboratives that will be community-led and invest in health equity. Additionally, Oregon is requesting federal investment to support infrastructure for community-based organizations. If accepted, these waiver requests are intended to make it easier for local organizations to address social determinants of health and other needs for services in their communities.
- In the waiver application, OHA is proposing ways to address social determinants of health for people experiencing significant life transitions. Specifically, OHP would offer packages of services that are tailored to support people through destabilizing life transitions, such as becoming houseless or transitioning into housing.
- Oregon also proposes to provide transportation supports for certain populations of focus experiencing life transitions.

A robust workforce

Several individuals expressed that the workforce is a key area, particularly surrounding the ability to provide **culturally appropriate care**. For example, some of the following excerpts were identified in conversations with stakeholders:

- *We need to increase culturally appropriate care and then change OARs to audit to assure respect for, and offer culturally specific care.*
- *Providers should not be providing care in other languages unless competent to do so – it is "not like ordering coffee in another language".*
- *As we increase and encourage culturally specific providers to join the network, how do we change the OAR's or auditing etc. to make sure we are enforcing rules in a way that respects the request we have for culturally specific care (as our OAR's [Oregon Administrative Rules] and other rules uphold white-centered care).*

- *OHP needs to contract with more individual therapists, who also could be better fit for clients with special needs (i.e., transgender clients, clients who don't speak English, etc.); reimbursement rate is low*

There were several instances where individuals suggested **more workforce resources** to support more accessible care, such as adding flexibilities to participate or increasing the number of providers.

- *I just want to see what the investment is or is there a specific policy called out in the waiver process where we are ensuring that our community worker workforce is included in the waiver as part of this sustainability process.*
- *Workforce expansion could be a key goal, consider flexibility regarding what can be paid for and reimbursed as it relates to integration and the workforce. 2012 waiver contained ability to reimburse community health workers and there may be an opportunity to build on that kind of flexibility. There is likely more flexibility that can be realized around workforce.*
- *As mentioned above, Oregon needs a concerted effort to invest in workforce recruitment, retention and development. The Secretary of State audit of the children's behavioral health system identified challenges associated with retaining direct care workers. Certainly while legislation potentially enacted this session could help lay the foundation for a stronger workforce, this effort will take time.*
- *Stakeholders voiced concern about workforce ability to deliver these services at Medicaid rates.*
- *[In relation to expanding OHP eligibility to every child], community consensus is that Oregon may not be able meet these requirements and maintain reasonable caseloads for providers without sacrificing quality.*
- *Direct funds to support training of clinical care teams on services and promising practices of CHW workforce to increase retention rates. I think more flexibility for folks with seasonal work, temp jobs, etc., maybe expediting re-certifications.*

Across multiple engagements and different stakeholder categories, the use of **community partners** was emphasized. Several participants expressed that community partners were an integral part of the system and should be further empowered and given the appropriate resources to better serve the local community.

- *Oregon's 1115 waiver can expand the role and function of non-medical/clinical model peer support that focuses on outreach and engagement in order to address access issues, support individual choice regarding avenues of care, and impact social determinants of health and equity (SDOH-E).*
- *How would the model take into account community governance already taking place in certain areas?*
- *A reliable funding source [for peer services] would sustain and support the development of equitable access to peer services across the state, and provide the opportunity to support equitable living wages for this critical and diverse workforce.*

Figure 7: Summary of key themes related to workforce incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. For instance,

- Oregon is requesting to cover more providers outside the medical model to support behavioral health. Providers outside the medical model include traditional and community health workers, personal health navigators, peer wellness and support specialists, and doulas.
- Oregon is requesting federal funds to invest in Community-Based Organizations (CBOs) to better support OHP members. Community-based organizations often best understand the needs of the community members they serve. They are therefore able to provide culturally-responsive services in people's preferred languages and connect them to resources.

Other themes from stakeholder comments are not addressed through the 1115 waiver authority, but are highlighted below:

- The majority of concerns related to workforce do not require additional authorities to address, but instead can be addressed through other mechanisms including investments by the legislature, operational changes to programs, and through CCO contracts and the next CCO procurement.

Goal 2 — Ensure access to coverage – summary and analysis

Generally, comments that mapped to this goal were related to ways to ensure coverage of beneficiaries, including access to coverage, enrollment processes, and the governance structures (and accountability) related to OHP

Ensuring access to coverage and enrollment

Several participants expressed interest in ways to **expand eligibility for certain populations**. Some believe that more individuals (not currently covered) could benefit from OHP coverage, in one or more of its programs – though, there may be some confusion on how those individuals will be able to access those services. There are also several cases where commenters discussed **churn populations** and trying to **ensure coverage** for those individuals who no longer have OHP coverage (or are transitioning in between programs):

- *I love the direction and "north star" of the papers. I was excited about the coverage and eligibility for increments of 5 years; this is great continuity.*
- *How do we expand coverage to people and get people enrolled in insurance, but also not lose sight of the problem of under insured people that just can't afford to use the insurance that they have?*

- *Regarding new, expanded Medicaid rolls adding between 100,000 and 300,000 new members to the Oregon Health Plan: What is Oregon's plan to create the additional $150- $400 million a year required to pay for the increased enrollment (assuming a 90-10 Federal match rate)?*
- *Absent the federal match currently available from the COVID-19 emergency, how will the state pay its share of the cost for these additional members?*
- *I always thought retroactive eligibility is wonderful but really the system means taking the insurance risk and really not getting resources to prevent that from happening… Is there an opportunity to do something with 60-to-64-year-olds who are headed for a huge transition from nothing to Medicare or Medicaid to Medicare? ...As you think about approaching CMS in terms of would you work with us to really fill the gaps, especially for this high-risk group, and if we succeed at it, will you share the savings as they go into Medicare?*
- *I think [President] Biden has expressed interest in the 60-64 year old population. They are the most risky commercial population. One risky feature is as they approach Medicare some of them may delay elective care hoping that Medicare will be better coverage than their high deductible coverage. Many sad stories about this costing people their lives.*
- *If your employer is offering you a plan then you are not eligible for exemptions/ coverage/ benefits. How do we help ease the churn and ensure the employer coverage is going to help the client, and not create gaps?*
- *Does OHA have any kind of program in place that identifies those who are 'chronically' cycling in-and-out of care, then strives to actively reconnect with those individuals (attempting to find and meet with in-person at last known address/phone #) to re-establish care?*
- *We think about the populations that are really hard to manage, those that transition a lot in and out of different types of eligibility. Creating a pre-adjudication enrollment process would be helpful. Creating a care coordination only plan ("CCO-Z") that would allow a CCO to be a part of coordination even when they aren't paying for care would help sustain enrollment and reduce delays in care under FFS.*
- *Is there discussion in the waiver about possibility of open card for clients who are mobile, houseless or 'transient' moving around a lot so they don't have to keep changing their CCO and navigating new systems?*
- *Suggesting is if there is a person who lives in California and is planning to move to Oregon. It would be helpful for them to have an opportunity to start their application process before they get here so that they don't have any sort of gaps in coverage.*
- *One of the areas that we've been talking about in our subcommittee has been the issue of when folks become eligible for Medicare. And they transition into a dual situation, and many of these people will obviously have complex care needs. And so it's, it's very disruptive… I was wondering whether or not there's been any discussions about ways to make those transitions smoother or to address some of those concerns.*

- *Our biggest problem in our office is when a child term's off of a coverage because they didn't fill out the renewal the go on a different coverage that they were before and it isn't one that we take in our office... Is there a way that they can see what program they were in before and keep them on it? Also, when adding a newborn to the family it also has the same issue.*
- *In line with the Authority's initiative to cover children uninterrupted for five years, [the commenter] believes that a complimentary policy of prioritizing care coordination for those interfacing with the Oregon Youth Authority. While providing care for all members of the Oregon Health Plan is paramount, we believe that earlier interventions and care coordination for our youth could serve as a central strategy for meeting the administration's goal of eliminating health inequities.*
- *Is there a path to allowing recently separated spouses to remain on OHP until custody is determined? We have had some spouses lose coverage due to the other spouse removing them from the family plan.*
- *How many of the added enrollees have been on OHP in the last two years? How many are eligible for subsidies on the Exchange? Has this enrollment been stratified by REALD data? What is the potential impact of Oregon's BIPOC populations in losing this coverage?*

Some participants also brought up some considerations for ensuring a more **fluid and accessible enrollment process** – to better support an equitable approach to coverage.

- *Also not everyone gets their mail because they are mobile or houseless, and email isn't always accessible due to broadband, so maybe some outreach via Traditional Health Workers partnering to contact people who are about to fall off or don't have coverage.*
- *Assisters are a great resource to support the community for OHP enrollment. However, their job is challenging because when they call the OHP line, they sometimes have to wait up to 3 hours and sometimes their issue is not resolved. Many families do not have the time to wait 4 hours with an assister to get their OHP.*
- *A lot of folks who could benefit from OHP but may not know how to access it have children in schools. Having liaisons from OHP in schools can help. School Health Navigators have been successfully connecting students, and their families, to OHP and health and SDOH services for several years in Benton County.*
- *[Commenter] suggests that the waiver could utilize the Community Partner Outreach Program for [bridging the gap for insurance coverage]. Via regional outreach coordinators, this team trains and certifies community-based Oregon Health Plan enrollment/application assisters/community partners. Many of these partners are culturally specific. Leveraging the waiver (and thus federal funds) to increase funding for the Community Partner Outreach Program biannual grant program could bolster outreach.*
- *Service is very difficult on OHP. Many times we call but the customer service person doesn't know the answer. Or, many smaller clinics refuse to take OHP because its*

bureaucracy is too overwhelming. Improve the customer experience to improve enrollment.

Figure 8: Summary of key themes related to coverage and enrollment incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment.

- In the new waiver, Oregon plans to make it easier for eligible people to get OHP coverage, and easier for OHP members to stay covered. Specifically, the waiver proposes:
  - A fast, easy way to get enrolled in OHP for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits since many people who are eligible for SNAP are also eligible for OHP health insurance;
  - Continuous OHP enrollment for children until their sixth birthday; and
  - Two-year continuous OHP enrollment for people age six and up, even if their income changes.
- The waiver proposes offering packages of services tailored to specific populations in need of additional support during transitions. This includes a package of services for members transitioning from Medicaid-only coverage to Medicare-Medicaid coverage.
- Oregon is asking permission to waive the federal rule preventing a person in custody from accessing Medicaid benefits. This will allow Oregon to provide coverage to eligible young people, even if they're in the juvenile correction system. For many young people, this will mean staying on OHP.

Governance and shared power

There were some suggestions related to the **governance** of the program and how OHA should consider **shared power** with communities and individuals.

- *I'm very happy about shifting power to community engagement, however, we should be more aggressive with language: For example, redistributing resources to communities most impacted by health inequities. Focusing on deeper, sustained long-term investments in communities that need it the most.*
- *Finally investing in "Statewide" goals with OHA as a "middle man" diminishes local control, local buy in, and community voices. CCO 2.0 already created a statewide PIP so putting this in the waiver is both repetitive and counterproductive.*
- *Can we talk about how a real power shift to empowering communities will look? OHA has tons of input from communities over the years and know well who speaks well for their communities, but these people/groups/orgs are not now truly empowered.*

- *Many opportunities giving power to individuals and may also need to consider issues re: privacy and confidentiality. Community is a good proxy but also need to consider individuals and empower to get their own information.*
- *The question is our health equity definition about the redistribution of resources and power? That's a very big structural shift to go from a bonus system to a withhold system and how CCS may be using that shift to be thinking about how it plays out in communities specific around health inequities that are already in existence and how we incentivize improvement in that territory.*
- *We need investment directed at root causes of inequities and we need rectification and accountability. This accountability should focus on CCOs, OHA, and include collaboration with local priority populations with the ultimate point of accountability being with local communities. Strategies in the proposal could include things like: An oversight committee, funded and reflective of the diversity of community, etc.*
- *I would like to focus on how the waiver might drive community spending decisions… [and] how the waiver proposal can help push spending decisions to the community… Community decision making is at the heart of our approach as a CCO… [Our CCO] carries out its responsibilities under the coordinated care organization contract by standing up health councils in the local community. Each region is going to be different, but in general terms the councils improve health in the region overall, not just for Oregon Health Plan members or the coordinated care organization.*

Figure 9: Summary of key themes related to governance and shared power incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment.

- OHA acknowledges that, to help solve health inequities, Oregon needs to give power and resources to communities. The waiver supports this through its processes and proposals. Specifically,
  - The Health Equity Committee (HEC) is supporting OHA in assessing the impact of the proposed waiver policies on health equity, the public engagement process, and the overall policy development process. As part of this work, the HEC is monitoring and advising OHA in piloting a Health Equity Impact Assessment. OHA will use the results to improve engagement in the next phases of the waiver.
  - Regional health equity coalitions worked closely with OHA to develop the "Focused Equity Investments" policy concept. This concept supports House Bill 3353, which was passed in 2021 and led by community partners. "Focused Equity Investments" describes how Oregon will use federal dollars, requested through the waiver, to fund new Community Investment Collaboratives (CICs). CICs will decide which problems are a priority to address and how funding will be spent to reduce health inequities.

Goal 3 — Smart, flexible spending – summary and analysis

Comments under this goal mentioned OHA's ability to support health equity-centered care through standardization and accountability measures. One comment regarding current CCO investment may offer some confirmation that investment in primary prevention programs can be successful.

Capitation

Capitation, or more specifically, **global budget payment models** for CCOs were mentioned several times. Often the topic was general in nature or questioned how CCOs could invest in community needs based on flexible dollars received through a global budget. Reinvestment comments were also regularly mapped to Goal 4.

- *It is gratifying that our community has united on expanding health* coverage, creating health equity in our communities, creating a true global budget, and maintaining local control of how to reinvest funding and supports into the community.
- *Can a global budget be actuarially sound?*
- *I had a question about the 3% [of the CCO global budgets invested into community managed funds]. That would be invested in communities. It seems pretty fixed. Is there an opportunity for that to expand when their communities that are quite diverse within one particular community? It seems like the pie gets, you know, slice, much smaller for those communities. How do you adjust for community need community size and diversity of community?*
- *If you have multiple CCOs, are they expected to work with the same community organization to do that? Or do they CCO do have a different community organization that they're working with their 3%?*
- *Ensure investment (global budget) is adequate to support and sustain statewide accessibility to high value, equitable, person-centered care.*
- *We understand the need to use rate structures to ensure medical benefits accrue to members going through key transitions… The rate structures will likely need to be informed by key metrics, which we believe could be difficult since those tracked are experiencing instability in their circumstances.*
- *How will we approach CMS differently to provide flexibility for the funds? Concerns about talking about specific populations, could carve into budgets or rates to create set-asides.*
- *I was surprised that one of the concerns was fragmentation of the social determinants of health… We are creating more integration with flexible spending with housing, with the criminal justice system. I see it as intentional integration rather than fragmentation. The problem is the systems have been managed by different funding streams and now we're trying to think of this one interrelated problem rather than several different problems…*

- *Excluding high-cost drugs for two years after initial approval from the cost calculation for CCOs will better reflect our collective work to manage utilization and costs that are within our control. Revisiting the exclusion every two years provides opportunity to include those drugs in program cost calculations as prices come down and generics or comparable therapeutics enter the market.*
- *Developing risk corridors for high-cost accelerated pathway drugs is another option to manage these costs outside of the CCO rate of growth. In this instance, the overall Medicaid program would still feel the impact of those costs, but the state may be able to further leverage rebates to lessen the financial burden.*

One commenter offered an example of how **CCOs were already supporting community investment**.

- *In Lane County our CCOs invest monthly (per member, per month) into primary prevention programs. CCOs contract Public Health to work with community members (the CAC) on deciding where/how funds are spent each year and managing those strategies. We target communities/regions that need more support, rural, BIPOC, etc. So for example, the earlier question about sustainable funding models for parenting programs, SDOH - this is a model that works great for CCOs, public health, and the community, and is aligned with our Community Health Improvement Plan*

A couple comments offered **operational-level feedback for OHA consideration**, such as:

- *Actuarial soundness needs to continue to be part of the conversation. Risk factors, historical experience, etc. could impact different CCOs differently.*
- *Reduce administrative costs associated with medical expenses*

Related to the global budget, several commenters were interested in how the waiver will tackle **managing drug costs**:

- *How will pharmaceutical costs be addressed in the waiver?*
- *Excluding high-cost drugs for two years after initial approval from the cost calculation for CCOs will better reflect our collective work to manage utilization and costs that are within our control. Revisiting the exclusion every two years provides opportunity to include those drugs in program cost calculations as prices come down and generics or comparable therapeutics enter the market.*
- *Developing risk corridors for high-cost accelerated pathway drugs is another option to manage these costs outside of the CCO rate of growth. In this instance, the overall Medicaid program would still feel the impact of those costs, but the state may be able to further leverage rebates to lessen the financial burden.*
- *[The stakeholder asks] that even if the State gets a rebate for newly approved high cost drugs for which the efficacy and/or safety evidence is poor, the Health Evidence Review Commission be allowed to restrict these drugs only to people who are at risk of immediate permanent harm, until the body of evidence is deemed sufficient to include them on the prescription drug list.*

Figure 10: Summary of key themes related to capitation incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. For instance,

- House Bill 3353, passed in 2021, requires CCOs to spend at least 3% of their value-based global budgets on health equity investments and for those investments to be counted differently for financial reporting and rate setting. The waiver proposals support this effort.
- The waiver proposes calculating a base budget (capitation rate) that is reasonable and adequate for covered services and the risk of the population, and is based on multiple years of historical utilization and spending, recent trends, and spending on health-related services. The intent is to give CCOs a simpler, more predictable global budget while encouraging CCOs to invest more in health-related care that improves health-outcomes and the lives of members.
- The waiver proposes closer management of pharmacy costs by adopting commercial-style closed formularies and by excluding drugs with limited or inadequate evidence of clinical efficacy.

Provider payment and program integrity

There were suggestions for payment at the **provider level** and interest in **program integrity**.

- *Emphasize and assimilate primary care medical home-oriented payment-care delivery models.*
- *Is it possible to insert reporting requirements into the waiver for OHA on these equity centered system changes? If some of these requirements were built into the waiver, it could trigger more oversight and enforcement for OHA to deliver on.*
- *If the intent of the ILOS (in lieu of services) initiative is to reimburse non-clinical service providers, the Authority will need to address who and in what manner this program will be overseen. This concept may need to include provisions for performing conflict and background checks, determining standards and mechanisms for reporting and auditing, and the like.*
- *[ILOS] does not allow for the creation or the maintaining of those services. In much of the state, necessary expanded services either don't exist or the Medicaid population alone can't maintain the services.*
- *Currently, a number of barriers exist around training and certification within the power of the Authority to resolve... For example, even though the Authority is in the process of evaluating how it certifies traditional health workers, the program stands as an*

example of an idea ostensibly established to improve equity but is complicated by contradictory program requirements and highly prescribed funding sources.

- *Create alternative methods for paying for peer delivered services (not having to bill Medicaid).*
- *What will be the Fraud Waste and Abuse oversite for self-attestations for enrollment?*

Figure 11: Summary of key themes related to services centered on social determinants of health incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. For instance,

- Concerns about program integrity, fraud, and abuse will be addressed in the Quality Strategy.

Payer alignment

There were specific comments that **recommended alignment between public programs, as well as between Medicaid and private payers**.

- *Asked about aligning public employee health benefit to leverage purchasing power with Medicaid through a waiver component.*
- *Do you envision a transition pathway for Medicaid members into another payer, such as a public option?*
- *[Wanted] to see more alignment with CCOs and private payers in BH*
- *Clarify intent and application related to Sustainable Health Care Cost Growth Target Program.*

Figure 12: Summary of key themes related to aligning payment models incorporated into policy proposals in response to stakeholder feedback

Many key themes from stakeholder comments can be addressed in ways that do not need waiver authority. Some of these themes are highlighted below:

- The Oregon Health Authority is working to align policies across Medicaid, PEBB and OEBB, and the commercial market wherever possible.
- In accordance with HB 2010 (2021), OHA and DCBS are currently developing a proposed public option implementation plan intended to facilitate a smooth transition for Medicaid members into the individual market. The state does not require a Medicaid waiver to accomplish this work.

Data/measurement and Incentives/metrics

Some inquiries related to **CCO reporting** and suggested that some **standardization** may help develop a better picture of what's happening and how it affects health care spend. In particular, investigating the kinds of information that CCOs have that would be helpful to OHA. Comments in the category also focused on the connection to health equity, such as:

- *Coordinated care organizations already operate with some "upstream" metrics. Metrics must be designed in a way that avoid unintended adverse consequences… We urge the Authority to first examine how current metrics may address health inequities; the Authority may wish to consider working with stakeholders to establish targets within the existing metrics…*
- *[As it relates to upstream and downstream structures], we would note that metrics must be chosen very carefully and will need to remain in place for a substantial amount of time in order to develop useful data – likely exceeding the current three-year requirement for quality improvement metrics.*
- *Change the economics so that providers make money off truly improving population health... [H]ave you fundamentally changed the economic model so that providers make money off the population they serve being healthier instead of sick?... If you haven't, then you're not going to truly incent better health and lower costs and the system won't change...*
- *Quality metrics must be aggregated by race and ethnicity in order to move health equity.*
- *[B]ecause health-related services (including community-based health-related services) require a high degree of compliance, coordinated care organizations devote considerable administrative supports to assisting communities in navigating these requirements. For [our] coordinated care organizations, we have seen our community shared savings model operate in a manner that achieves the objectives of community-based health-related services with less administrative cost.*
- *We also believe that a consistent application of quality standards and oversight is necessary for the success of peer delivered services, as well as for achieving positive health outcomes for the populations we serve*

Figure 13: Summary of key themes related to incentive measures and metrics incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. Other key themes can be addressed in ways that do not need waiver authority.

- Since 2013, Oregon's Quality Incentive Program has based part of CCOs' payments on performing well on certain health metrics or measurements of how well they are providing access to care for OHP members. In the new

waiver, Oregon plans to build on the program's success by adding a focus on metrics that address upstream factors affecting health equity.

- Development of metrics that measure the success of the waiver will be developed through established oversight bodies, such as the Metrics and Scoring Committee.

Goal 4 — Focused reinvestment of government savings – summary and analysis

The single tag "investment" was cross-walked to Goal 4. However, many clarifying questions, as well as strong recommendations, were put forward.

Investment

General questions included:

- *What research has been done regarding investments which drive down costs, e.g. primary care home model ROI [return on investment]?*
- *How do we drive economic opportunities towards BIPOC communities?*
- *How does the Provider Tax Mechanism factor into the waiver discussion, if at all?*
- *How do we realize savings in SDOH; we talked about minimal investments, is there a mechanism to invest in SDOH before savings are realized?*
- *Concerned we should move from a one-time investment to sustained investment*
- *If we don't get approval for extra funds from CMS, will this be off the table?*

There were more specific comments requesting information on the **CCO role and vision for community investment.** Support for long-term investment was mentioned more than once, however, there was also a concern over the potential for **unintended consequences** by carving out SDOH.

- *Prioritize investment to protect infrastructure (i.e. workforce) to ensure all populations covered under this waiver renewal have proportional access to quality, equitable care.*
- *Assure meaningful inclusion in equity-based regional reinvestment.*
- *[We ask that some provisions would be]: any new community investments must "demonstrate, through practice-based or community-based evidence, improved health outcomes for individual members of the coordinated care organization or the overall community served by the coordinated care organization."*
- *Could there be a presentation on OHP flex funds and how that works for different CCOs?*
- *Are we stepping away from CCOs current role and moving toward a model wherein OHA sends resources to community organizations?*

- *CCOs are already required to collaborate and distribute money based on CHIP goals, including equity. How does the new program work with that process? Does it replace that process?*
- *Raised interesting point around investing in community – require structure in place, technology improvement, access. What about standing up the infrastructure to facilitate the sharing of information, such as x-rays?*
- *I work for early childhood organization and partner with a lot of early childhood programs. One thing we've heard a lot is organizations get short term grant but then funding ends. There might not be long term continuity of investment. Could this be an indicator to track in terms of holding CCOs accountable in their communities – what is the longevity of the grant?*
- *CCO budgets are still based from year to year on their medical spend…Investment in community are not included in base budgets…Paying behavioral health providers above what is "usual and customary" is not included in CCOs base budgets. As a result, CCOs are negatively incentivized to make those upstream SDOH investments. CCOs still make these investments anyway but they are forced to make short term investments or one-time grants.*
- *The current funding structure doesn't allow for the sustained changes originally envisioned in the first CCO waiver from 2012. This idea of siloing out Social Determinants of Health funding from the CCOs is both foolish and unsustainable. You will just be creating the same system CCOs are stuck in, but now those Medicaid funds will be siloed even further from the health care system. It would also massively undercut the critical work of the CCOs CACs.*

Several individuals discussed the **health equity zones** and reinvestment strategy proposed by OHA, and some commented on the possibility of creating parallel tracks:

- *Concerns about equity zones concept: feels like we are creating a more fragmented system.*
- *[The stakeholder asks to include a provision that requires] that funds to quality for full federal reimbursement must "be part of a plan developed in collaboration with or directed by members of organizations or organizations that serve local priority populations that are underserved in communities served by the coordinated care organization, these include, but are not limited to, regional health equity coalitions, and be approved by the coordinated care organization's community advisory council."*
- *…We are concerned that, as currently drafted, the reinvestment strategy and "health equity zones" proposed by the OHA will essentially develop a second system that works in parallel to coordinated care… We feel that the unintended consequences of separate decision-making processes within the communities we serve will only lead to a disconnect between our work and OHP members. Our goal is to better integrate our work with local communities, as opposed to work apart from it.*
- *We understand communities want greater input in health equity investments. This can be done successfully within the CCO model without creating parallel structures. A*

parallel track could lead to a divergence of spending priorities, whereas community investments should be aligned in pursuing health equity.

Figure 14: Summary of key themes related to investments incorporated into policy proposals in response to stakeholder feedback

Many of the key themes above are addressed in OHA's proposals for the 1115 Medicaid Waiver Renewal, pending further public comment. For instance,

- Conversations with community partners about federal investment and health equity led to further policy and strategy development and changes in how this work is being described.
- The "Focused Equity Investments" policy concept describes how Oregon will use federal dollars, requested through the waiver, to fund new Community Investment Collaboratives (CICs). CICs will include CBOs and decide which problems are a priority to address and how funding will be spent to reduce health inequities.

Next steps

Myers and Stauffer has reviewed the process and materials related to the collection of We have concluded this phase of analysis for feedback received through September 30, 2021, on the first version of the concept papers and their further development. Myers and Stauffer has reviewed the process and materials related to the collection of stakeholder engagement, including collection, recording, and analyses of future feedback. We will continue to collaborate and support OHA as requested, particularly with next steps related to feedback collection and analysis on the final version of the concept papers and the draft application, which are available November 1 and December 1, 2021, respectively.

Feedback will be collected on the final version of the concept papers and draft version of the waiver application through the public comment period from December 7, 2021 to January 7, 2022. OHA will incorporate feedback on the concept papers and official public comment into the final application. Partners will have additional opportunities to further participate in implementation planning and application negotiations prior to the final, accepted waiver application.

More information about the waiver and opportunities to provide input can be found at **Oregon.gov/1115WaiverRenewal**.

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.