



KATE BROWN  
Governor

February 8, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

It is with great pleasure that Oregon submits to the Centers for Medicare and Medicaid Services (CMS) the enclosed 1115(a) Demonstration Waiver renewal application. Oregon's application will continue foundational elements of the Oregon Health Plan (OHP) with a substantial refocus on addressing health inequities in our state, while maintaining our commitment to achieving universal coverage and delivery system reforms that promote high-quality care while containing costs.

Oregon has successfully used our 2017-2022 demonstration to innovate within our health care system, improve outcomes and contain costs. However, COVID-19 laid bare the deep and abiding inequities that permeate our health care system and our society. We believe that focusing on rectifying health inequities, along with a clear alignment with other health policy initiatives in our state, will allow us to meaningfully improve health outcomes in communities who face historic and contemporary injustices.<sup>1</sup>

Oregon's 1115(a) Demonstration began in 1994 and has been renewed and improved periodically over the ensuing years. In 2012, our renewal launched coordinated care organizations (CCOs), which deliver care to Medicaid members through a service delivery model designed to address problems stemming from a fragmented health system. CCOs are paid a fixed monthly budget for physical, behavioral, and oral health services with financial flexibilities to address members' needs outside traditional medical services. This budget includes financial incentives for improving outcomes and quality. In 2016, Oregon's renewal expanded this effort by focusing on upstream investment in social determinants of health through the use of Health Related Services (HRS) that allows CCOs flexibility to pay for non-medical services that improve health.

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<sup>1</sup> These communities include, but are not limited to Oregon's nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

Despite these considerable achievements, we can and must do better in serving the people most harmed by health inequities in Oregon. Oregon Health Plan members and community partners have consistently reported the need for OHA to address health inequities both in the health system and in the communities where members live and work. As mentioned, the COVID-19 pandemic brought this need into sharp relief as communities that face historic and contemporary injustices were—and continue to be—disproportionately impacted by the disease. People in these communities consistently report that lack of access to care and health resources is at the center of their struggle to stay safe.

We have learned from our experience with COVID-19, which is reflected in both our new goals and improvements to the Coordinated Care Model, building on prior successes. To do so, our renewal application seeks to:

**Maximize continuous and equitable access to coverage**

Oregon’s commitment to the expansion of coverage in the state has been unwavering. During my tenure, Oregon has secured stable revenue for funding for the Oregon Health Plan, protecting the expansion of Medicaid under the ACA and allowing for investments to further reduce the rate of uninsured in Oregon. In 2017, Oregon’s legislature passed the Cover All Kids program, extending state-financed coverage to children under the age of 19, regardless of immigration status. In 2021, the program was expanded to cover low-income adults regardless of immigration status. These programs are essential to bridging the gaps in the federal Medicaid program and a reflection of the state’s commitment to coverage and equity.

Our most recent statewide health survey showed that between 2019 and 2021 the state’s uninsured rate dropped from 6% to 4.6% and that the uninsured rate for Black Oregonians dropped from 8% to 5%. This change is in no small part a result of the continuous coverage provided to Medicaid beneficiaries during the COVID public health emergency—those provisions prove the importance of the Medicaid program in reducing churn and improving health equity. It is only with continuous and equitable access to coverage that people can access the care they need to stay healthy. We know that people of color and communities that face systemic barriers based on historical inequities have lower coverage rates. Our approach seeks to eliminate inequitable access with strategies to extend coverage and services to every eligible child and adult in Oregon.

**Improve health outcomes by streamlining life and coverage transitions**

Data show people often lose coverage and access to care during life transitions and in transitions between systems, like criminal justice or the state hospital. Individuals face interruptions in access to essential behavioral and physical health services during these transitions, which come at great cost to the individual and to the system. By providing specific benefit packages to members in transition, we can ensure they stay covered, have important social determinants of health needs met and maintain access to care and medicine, which ultimately improves health outcomes.

### **Move to a value-based population payment**

Compared to other states, Oregon has generated significant federal and state savings from our approach to Medicaid. Our model of care delivery through Coordinated Care Organizations is both innovative and cost-effective. To maintain and build on our successes, we must continue to build a payment system that rewards spending on health equity and improving the health of Medicaid and CHIP beneficiaries rather than spending on medical procedures and services alone.

### **Incentivize equitable care**

Our coordinated care model is built on incentivizing quality and access. We have learned over the last decade that paying for performance works. While quality payments have helped incentivize quality improvement, significant inequities in quality and outcomes remain. OHP members and community members tell us that equity must be the focus across the system going forward. By revising our metrics to focus not only on traditional quality and access for downstream health but also creating a new set of equity-driven performance metrics for upstream health factors, we can make significant progress in driving the system toward more equitable health outcomes.

### **Improve health through focused equity investments led by communities**

Our system can do more to invest in the community-based approaches to address social determinants of health that drive health inequity. We have learned that in order to address health inequities, we must shift decision-making, power and resources to communities that face inequities in the system. Oregon is requesting to make equity-focused investments that redistribute resources and decision-making power to the community itself. In order to support community-driven investments in health equity as well as development of essential financial and data infrastructure for community-based organizations providing these services, we are requesting that CMS authorize federal financial participation (FFP) for designated state health programs (DSHP).

Oregon is not proposing to use DSHP resources to fund the core Medicaid program or backfill a budget challenge. Instead, Oregon is proposing that new state-only health investments made by the Legislature in recent years are DSHP-eligible and that the new federal resources can be used by communities affected by historical injustices, specifically to address health inequities. We would like approval for DSHP funding as soon as possible in order to immediately lay the groundwork for closing Oregon's health equity gap. We anticipate that the programs would be authorized by Section 1115(a) cost not otherwise matchable (CNOM) authority and funded with a portion of the savings that Oregon has achieved under the waiver program.

With our focus on community-driven investments in health equity, we believe we can better address larger scale barriers to improved health, lower costs and health equity.

### **Alignment with Tribal partners' priorities**

We are committed to working with the nine federally recognized Tribes in Oregon and the Urban Indian Health Program (UIHP) to identify mechanisms to ensure we achieve Tribal health care

objectives while honoring traditional Tribal practices and upholding the government-to-government relationship between the sovereign nations and the state. Through partnership with the Tribes and the Tribal Consultation process, we have developed policies that improve health outcomes for Tribal members in the state.

If approved, all of these policies will deliver changes to OHP to address the same goals as our original 1994 1115(a) waiver and subsequent renewals, as well as ensure that we are responding to and addressing the lessons we've learned since we established our Medicaid coordinated care model 10 years ago – particularly those surfaced by community partners, Tribes and OHP members directly.

We have asked to keep in place many features of our current 1115(a) Demonstration including:

- Prioritized List of Health Services and Health Evidence Review Commission;
- The coordinated care model and physical, behavioral, and oral health integration;
- Coordinated Care Organizations serving members within their local communities;
- Value-based payment methodologies;
- Commitments to care quality and access;
- Community Advisory Councils; and
- Tribal engagement and collaboration protocol for CCOs and OHA.

Importantly, we have made the decision not to seek a renewal of our longstanding waiver around Early Preventive Screening, Diagnosis, and Treatment (EPSDT) for children. The decision comes in the wake of clear feedback from the community, advocates, children's service organizations, and other interested parties. We will continue to base OHP benefits on the Prioritized List of Health Services, however, the State will arrange for, and make available to children, all medically necessary services that are required for treatment of conditions identified as part of an EPSDT screening.

Similarly, in line with our current practice of allowing retroactive eligibility, Oregon will not be seeking to renew the waiver that would permit the denial of retroactive coverage.

We have appreciated our historically strong partnership with the federal government as the state has worked toward a goal of universal coverage and equitable access to care. We appreciate the clear goals that CMS and indeed the Biden Administration has broadly laid out for health care including its focus on

- Improving health for historically underserved communities;
- Expanding access to affordable coverage; and
- Making a system that is easier to navigate for patients.

As you will see, these goals are aligned with the approaches that we have outlined in our renewal application. We share the Administration's belief that a healthy population will only result from

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February 8, 2022  
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a clear focus on addressing the unique health care coverage, access issues and other barriers faced by individuals and communities.

We look forward to discussing these concepts with you and your team and arriving at a 1115(a) Demonstration Waiver renewal that makes meaningful improvements to the health outcomes of people across Oregon.

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Kate Brown". The signature is written in black ink and includes a horizontal flourish at the end.

Governor Kate Brown



Medicaid  
HEALTH SYSTEMS DIVISION

Kate Brown, Governor

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February 18, 2022

To: Dan Tsai, Deputy Administrator and Director, Center for Medicaid and CHIP Services  
Judith Cash, Director of Demonstration Group, Center for Medicaid and CHIP Services

From: Dana Hittle, Interim Medicaid Director

The Oregon Health Authority (OHA) is pleased to submit Oregon's application for renewal of the Oregon Health Plan (OHP) 1115(a) Demonstration Waiver for the 2022-2027 demonstration period. Oregon has successfully used our 1115(a) demonstration to innovate in our health care system, improve care and lower costs. As you will see in our application, this draft was revised based on public comment and responds to the community feedback we have received over the past five years and builds on the existing foundation of OHP to more intentionally address health equity. Focusing our waiver application on meaningful progress toward health equity, along with clear alignment with other health policy initiatives in our state, will allow us to improve health outcomes in communities most harmed by social injustices. To carry out this vision we are seeking to:

- Maximize continuous and equitable access to coverage;
- Streamline transitions between systems through defined benefit packages of social determinants of health services;
- Move to a value-based population payment;
- Improve health through focused equity investments led by communities;
- Ensure quality and access through equity-driven performance metrics; and
- Align with Tribal partners' priorities.

Oregon's 1115(a) Demonstration began in 1994 and has been renewed and improved periodically. In 2012, our renewal launched coordinated care organizations (CCOs), which deliver care to Medicaid members through a service delivery model designed to address problems stemming from a fragmented health system. CCOs are paid a fixed monthly budget for providing physical, behavioral, and oral health services with financial flexibilities to address members' needs outside traditional medical services. This budget includes financial incentives for improving outcomes and quality. In 2017, Oregon's renewal expanded this effort by focusing on upstream investment in social determinants of health using health-related services (HRS) that allowed CCOs further flexibility to pay for non-medical services that improve health outcomes. While we have made much progress, we need more flexibility for CCOs to pay for improving population health rather than on medical expenses for people who are sick.

Despite our considerable achievements, there's more work to do. Specifically, we must better address the health inequities that disproportionately impact communities of color. The facts and need are stark. In Oregon:

- American Indians and Alaska Natives and non-Latina(o) African Americans are more than twice as likely to die from diabetes as non-Latina(o) whites.<sup>2</sup>
- Latino/a/x Oregonians comprise only 12% of the population but represent more than 18% of COVID-19 cases, and Black Oregonians are 3.1 times more likely to have a COVID-19 associated hospitalization than their white counterparts.<sup>3</sup>
- Non-Latina(o) African Americans have nearly twice the rate of avoidable deaths from heart disease, stroke, and high blood pressure as non-Latina(o) whites.<sup>1</sup>
- American Indians and Alaska Natives have a much higher death rate from chronic liver disease than any other group.<sup>1</sup>

OHP members and community stakeholders have regularly voiced the need for OHA to address health inequities both in the health system and in the communities where members live and work. The COVID-19 pandemic brought this need into sharp relief as communities most harmed by social injustices were—and continue to be—disproportionately harmed by the disease. These communities consistently reported that lack of access to care and health resources was at the center of their struggle to stay safe.

OHA has established a 10-year strategic goal to eliminate health inequities. Given the facts cited above, along with myriad other examples of health inequities permeating our health care system, Oregon's 1115 demonstration waiver is focused on pushing our Medicaid system to address health equity directly and systematically.

In this application you will see that we plan to build on our successes and address the deficiencies we have identified. Specifically, our policy concepts propose to:

#### Oregon's health equity definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.

<sup>1</sup> Evaluation of Oregon's 2012-2017 Medicaid Waiver; OHSU Center for Health Systems Effectiveness, Dec. 29, 2017.

<https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>

<sup>2</sup> Oregon's State Health Assessment, 2018: <https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf>

<sup>3</sup> OHA COVID-19 Weekly Report, Sep. 29, 2021.

<https://www.oregon.gov/oha/covid19/Documents/DataReports/Weekly-Data-COVID-19-Report.pdf>

**Maximize continuous and equitable access to coverage**

It is only with continuous and equitable access to coverage that people can access the care they need to stay healthy. We know that people of color and communities most harmed by social injustices have lower coverage rates. Our approach will seek to eliminate inequitable access with strategies to extend and stabilize coverage to every eligible child and adult in Oregon.

**Streamline transitions between systems through defined benefit packages of social determinants of health services**

Data show members of high-risk populations often lose coverage and access to care during life transitions and in transitions between systems, like incarceration or the state hospital. These disruptions come at great cost to the individual and to the system. By providing defined benefit packages to members in transition, we can ensure they stay covered, have important social determinants of health met and maintain access to care and medicine, which ultimately improves health outcomes.

**Move to a value-based population payment**

Compared to other states, Oregon has generated large savings from our approach to Medicaid. Our CCO model is both innovative and cost-effective. To maintain and build on our successes, we must continue to build a rate-setting methodology that rewards spending on health equity and improving the health of communities rather than spending on medical procedures and services alone. This focus on value when setting capitation rates will further drive our system to spend on health, rather than health care.

**Improve health through focused equity investments led by communities**

Our system can do more to invest in community-based approaches to address social determinants of health that drive health inequity. With focused equity investments, we will redistribute both funds and decision-making power to local communities. With this focus on community-driven solutions, we believe we can use funding to better address larger scale barriers to health and health equity.

**Ensure quality and access through equity-driven performance metrics**

Our coordinated care model is built on incentivizing quality and access. OHP members and community stakeholders have continued to tell us that equity must be the focus across the system. By revising our metrics to focus on traditional quality and access for downstream health and creating a new set of equity-driven performance metrics for upstream health factors, we can make significant progress in driving the system toward more equitable health outcomes.

**Align with Tribal partners' priorities**

OHA is committed to working with the nine federally recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure Tribal health care objectives are achieved while honoring traditional Tribal practices and upholding the government-to-government relationship between the sovereign nations and the state.

These policy changes will deliver changes to OHP that address the same goals as the original 1994 waiver and subsequent renewals, as well as ensure that we are responding to and addressing the lessons we've learned over the past 10 years – particularly those raised directly by community partners, OHP members and Tribal partners – and those highlighted by the disparate impacts of COVID-19.



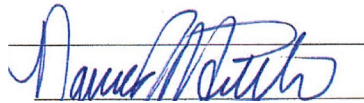
Finally, Oregon appreciates the clear goals that the Biden Administration has laid out for health care, including its focus on:

- Improving health for historically underserved communities;
- Expanding access to affordable coverage; and
- Making a system that is easier to navigate for patients.

These goals are aligned with the approaches that we have outlined in our attached policy conceptual framework, we share the Administration's belief that a healthy population will only result from a clear focus on addressing the unique health care coverage, access issues and other barriers faced by individuals and communities.

OHA is confident our policy concepts will lead to an 1115(a) Demonstration Waiver application that prioritizes health equity, provides incentives for spending more effectively, and makes meaningful improvements to Medicaid for the people of Oregon. Our waiver renewal is an integral part of a statewide strategy designed to center equity while increasing coverage, improving health care quality, and containing costs. Oregon has used Medicaid as a tool for driving delivery system innovation, leading to related improvements in other health care markets. We anticipate this renewal will be no different; it represents a critical step in moving to put equity at the center of health care in Oregon.

Sincerely,

A handwritten signature in blue ink, appearing to read "Dana Hittle", written over a horizontal line.

Dana Hittle  
Interim Medicaid Director  
Oregon Health Authority, HSD

# **Application for Renewal and Amendment**

*Oregon Health Plan*  
*1115 Demonstration Project*  
**Medicaid and Children's Health Insurance Program**

**Submitted: February 18, 2022**

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## Section I. Program Description

### 1. Introduction

#### 1.1 Background

The Oregon Health Authority (OHA) is pleased to submit its renewal application for the Oregon Health Plan (OHP) 1115(a) Demonstration Waiver for the July 1, 2022- June 30, 2027 demonstration period so Oregon can continue its health system transformation through specific modifications to Medicaid and CHIP programs under this current waiver. Oregon has successfully used our 1115(a) demonstration since 1994 to innovate in our health care system, improve care and lower costs. As currently implemented, the demonstration renewal will continue to operate statewide and will cover the 1.3 million people in Oregon currently receiving benefits through the OHP. This renewal application is responsive to the community feedback we have received over the past five years and builds on the existing foundation of OHP to more intentionally address health equity. Focusing our waiver application on meaningful progress toward health equity, along with clear alignment with other health policy initiatives in our state, will allow us to improve health outcomes in communities most harmed by social injustices. To carry out this vision we are seeking to:

- **Maximize continuous and equitable access to coverage.** It is only with continuous and equitable access to coverage that people can access the care they need to stay healthy. We know that people of color and communities most harmed by social injustices in Oregon have lower coverage rates. Our approach will seek to eliminate inequitable access with strategies to extend and stabilize coverage to every eligible child and adult in Oregon.
- **Streamline transitions between systems through defined benefit packages of social determinants of health services.** By providing defined benefit packages to members in times of transition, we can ensure they stay covered, have important social determinants of health met and maintain access to care and medicine, which ultimately improves health outcomes.
- **Move to paying for population health.** Compared to other states, Oregon has generated large savings from our approach to Medicaid. Our model, which uses Coordinated Care Organizations (CCOs) to coordinate the physical, behavioral, and oral health services and provides flexibility to use Medicaid funding for services designed to improve health, is both innovative and cost-effective. To maintain and build on our successes, we must continue to build a rate-setting methodology that rewards spending on health equity and improving the health of communities rather than spending on medical procedures and services alone. This focus on value within CCO's budgets will further drive our system to spend on health, rather than health care.

- **Improve health through focused equity investments led by communities.** Our system can do more to invest in community-based approaches to address social determinants of health that drive health inequity. With focused equity investments, we will redistribute funds and decision-making power from managed care and health systems toward local communities. With this focus on community-driven solutions, we believe we can use funding to better address large-scale barriers to health and health equity.
- **Ensure quality and access through equity-driven performance metrics.** Our coordinated care model is built on incentivizing quality and access. OHP members and community stakeholders have continued to tell us that equity must be the focus across the system. By revising our metrics to focus on traditional quality and access for downstream health and creating a new set of equity-driven performance metrics for upstream health factors, we can make significant progress in driving the system toward more equitable health outcomes.
- **Align with Oregon’s nine Tribal governments’ priorities.** OHA is committed to working with the nine federally recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure Tribal health care objectives are achieved while honoring traditional Tribal practices and upholding the government-to-government relationship between the sovereign nations and the state.

## 1.2 Advancing Health Equity

The overarching goal of Oregon’s 1115(a) Medicaid Waiver Demonstration renewal is to advance health equity in alignment with the Oregon Health Authority’s strategic goal to eliminate health inequities in the state by 2030. OHA’s definition of health equity is:

*Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

### What this means for the waiver

Often, the burden of implementing equity, diversity and inclusion strategies in health systems falls on the shoulders of those who belong to historically marginalized communities. Oregon is committed to ensuring that advancing racial and health equity in the system becomes a collaboration of all regions and sectors in the state, including



tribal governments. The state's waiver goals and strategies stem from this commitment to advancing health inequity.

### 1.3 Research Hypotheses

The Oregon Health Authority will test the following research hypotheses through the section 1115 demonstration:

- Earlier OHP enrollment with fewer gaps in coverage for vulnerable populations will result in more members with improved health outcomes including receiving care in the right settings, improved health status, and improved quality of life
- Enrolling more eligible, uninsured people will reduce existing inequities in insurance coverage by race and ethnicity.
- Social determinants of health services designed to support individuals experiencing life transitions will result in reduction in avoidable hospitalizations and unnecessary medical utilization (e.g., lower emergency department use, lower avoidable ED visits).
- Increased use of health-related services will result in improved care delivery and member health and community-level health care quality improvements.
- Offering a predictable budget, based on a streamlined method with predictable cost growth, allows for greater clarity around available funds for CCO reinvestment in local community and increases community investments.
- Offering a predictable budget, based on a streamlined method with predictable cost growth, allows community partners to more effectively partner with CCOs to meet members' needs for SDOH support services.
- Using the Health Equity Quality Metrics Committee's new decision-making structure to define, select, and operationalize CCO incentive metrics will result in greater improvements in health inequities than under the decision-making structure in place by the Health Plan Quality Metrics Committee during the 2012-2017 waiver.
- Redistributing power and resources to individuals and communities most harmed by historical and contemporary racism through funding tied to community decision-making will result in improvements in health inequities and self-reported measures of autonomy, health status and quality of life.
- A focus on health equity improvements for specific populations that have experienced disproportionately poor health outcomes will result in improved health outcomes, increased access to care, and a reduction in the gap between outcomes for populations of focus and those that have historically experienced favorable health outcomes.

These hypotheses collectively focus on extending the triple aim of better health, better care and lower costs to emphasize the elimination of health inequities. To better assess the proposed demonstration period, Oregon proposes to examine specific activities and the impact on health equity as outlined in the evaluation section.

## 1.4 Financing Support and Initiatives

Oregon requests federal investment for a set of programs intended to advance health equity. The programs proposed for investment are vital to achieving Oregon's goal of eliminating health inequities in the state by 2030, including investing in social determinants of health supports for members experiencing life transitions and new community-led collaboratives who will reinvest funding in large-scale health equity initiatives.

## 2. Historical Narrative and Key Accomplishments

### 2.1 Highlights of progress to date: Waiver Demonstrations

Oregon's 1115(a) Demonstration began in 1994 and has been renewed and improved every five years. Prior to 1994, eligibility for Oregon Medicaid was based on income and categorical eligibility, such as children, pregnant people, and people with disabilities. As part of the 1994 waiver, Oregon expanded the populations eligible for Medicaid to all adults with income less than 100% of the federal poverty level. Oregon's Prioritized List of Health Services, created at the same time, ranks condition and treatment pairs, from the most important to the least important, representing the comparative benefits of each treatment. Evidence on clinical effectiveness, cost of treatment, and public values obtained through community meetings are used in ordering the list. The Prioritized List is determined by the Health Evidence Review Commission (HERC), a 13-member, Governor-appointed body.

Oregon's health system transformation through the coordinated care model began when CMS approved Oregon's section 1115 demonstration in 2012. Supported by a series of Medicaid 1115 demonstration waivers, a 1332 waiver under the Affordable Care Act (ACA), and several federal grant opportunities, Oregon has made huge gains in expanding health care coverage and launched a community-governed model of coordinated care for Medicaid members, with aggressive targets for value-based care payments, statewide limits on the program's spending, and a highly effective quality metrics program.

In 2012, Oregon launched Coordinated Care Organizations (CCOs) through the state's 1115 Medicaid waiver and an accompanying state innovation model grant from the Center for Medicare and Medicaid Innovation (CMMI). CCOs are community-governed organizations that deliver care to Medicaid members through a coordinated care model of service delivery designed to address problems inherent in a fragmented health system. CCOs are responsible for physical, behavioral and oral health care services for Medicaid members. They receive a fixed monthly budget from the state to coordinate care with flexibility to address their members' needs outside traditional medical services and financial incentives for improving outcomes and quality.

Oregon will continue its successful CCO model in the proposed demonstration renewal. The CCO model relies on financial innovation to drive improvements. Payment via a per member per month rate integrates physical, behavioral and oral health care under one

funding stream and provides CCOs with flexibility in how dollars are spent while holding costs to a 3.4% annual growth rate. Further, the CCO model requires community involvement in decision-making. Community Advisory Councils (CACs) for each CCO engage CCO members and other community representatives in guiding some of the spending within the flexible funds. CACs utilize Community Health Assessments and Community Health Improvement Plans to provide direction and ensure alignment with local hospitals and public health authorities. In 2017, Oregon's renewal expanded this effort by focusing on upstream investment in social determinants of health through the use of health-related services (HRS) that allowed CCOs further flexibility to pay for non-medical services that improve health outcomes.

HRS are defined as non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One of the purposes of HRS is to give CCOs a specific funding mechanism within their budgets to address the social determinants of health (SDOH), including the health-related social needs of their members. For CCOs to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria. The goals of HRS are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Categories of HRS include:

1. **Flexible services**, which are cost-effective services offered to an individual member to supplement covered benefits; and,
2. **Community benefit initiatives**, which are community-level interventions that include members, but are not necessarily limited to only members, and are focused on improving population health and healthcare quality.

In 2018, an independent evaluation of CCOs under Oregon's 1115(a) demonstration found that under CCOs patient-reported health status improved, quality had improved where CCOs were paid for performance, cost growth was slowed, and access and patient satisfaction were maintained.<sup>1</sup>

## 2.2 Highlights of Health System Transformation in Oregon

### PCPCH

The Patient Centered Primary Care (PCPCH) Program was established in 2009 by the Oregon State legislature as part of the state's broader transformation efforts to achieve better health, better care, and lower costs within the health system. The intent was to

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<sup>1</sup> Evaluation of Oregon's 2012-2017 Medicaid Waiver; OHSU Center for Health Systems Effectiveness, Dec. 29, 2017.

<https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>

improve Oregon's primary care system by developing a set of standards for how primary care practices care for their patients. More than 600 primary care practices are recognized as a PCPCH in Oregon - about 2/3 of all primary care practices in the state. Approximately ¾ of all people living in Oregon get their care from a PCPCH. A 2016 evaluation<sup>2</sup> by researchers at Portland State University found the PCPCH program had saved the state of Oregon approximately \$240 million in its first three years. Further, the evaluation found the cumulative effect of all the PCPCH standards had more impact on cost and utilization measures than their independent effects.

High-quality primary care is foundational to a health system. Oregon's 1115(a) Demonstration Waiver renewal, which prioritizes health equity, directly aligns with the PCPCH Program's integral efforts to reduce health inequities for all Oregonians. The PCPCH program recently launched a health equity initiative to ensure the program supports a primary care system that addresses community-identified needs, especially the needs of those who experience systemic racism, barriers in accessing care, and health inequities.

## **CCO 2.0**

In October 2019, the Oregon Health Authority (OHA) completed a successful procurement and signed contracts with 15 organizations to serve as coordinated care organizations (CCOs) for the Oregon Health Plan's nearly 1 million members. On Jan. 1, 2020, these 15 CCOs began service to OHP members across the state. The health system transformation goals of CCO 2.0 build on Oregon's history of innovation to promote delivery of high quality, coordinated, value-based care, and centered on four priority areas detailed in the [2018 CCO 2.0 Recommendations of the Oregon Health Policy Board](#)<sup>3</sup>.

These priorities were to:

- Improve the behavioral health system
- Increase value and pay for performance
- Focus on social determinants of health and health equity, and
- Maintain sustainable cost growth and improve financial transparency.

CCO 2.0 made several changes designed to advance these priorities through policies that:

- Require CCOs be fully accountable for the behavioral health benefit
- Address prior authorization and network adequacy issues that limit member choice and timely access to providers

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<sup>2</sup> <https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf>

<sup>3</sup> <https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report.pdf>

- Require CCOs to support electronic health record adoption and access to electronic health information exchange
- Develop a diverse and culturally responsive workforce
- Increase CCO use of value-based payment (VBP) arrangements with providers every year and achieve a VBP goal of 70% by 2024
- Increase CCO support of Patient-Centered Primary Care Homes (PCPCHs) and require VBPs for PCPCH infrastructure and operations
- Increase strategic spending by CCOs on social determinants of health, health equity and reducing health disparities in communities, including encouraging effective community partnerships
- Align community health assessment and community health improvement plans to increase the impact on population health
- Strengthen meaningful engagement with Oregon’s Nine Federally Recognized Tribes, diverse OHP members, and community advisory councils (CACs)
- Build CCOs’ organizational capacity to advance health equity
- Increase the integration and use of traditional health workers (THWs)
- Set up new tools to evaluate and reward CCOs for improving health outcomes and containing costs
- Ensure program-wide financial stability and program integrity through improved reporting and strategies to manage any CCO in financial distress, if that should happen

Early data to assess the progress toward achieving the goals of CCO 2.0 show that:

- CCOs on average exceeded the 2020 VBP target and did so ahead of schedule; of all CCO payments to providers in 2019, 32% were paid within a VBP arrangement (versus a 20% target by 2020)
- In 2020, all CCOs met the minimum threshold requirement for risk-based capital, a new financial indicator under CCO 2.0 to assess financial stability
- CCOs have developed strong statewide consumer engagement to elevate consumer voice and promote equity; of the total membership across all 36 Community Advisory Councils (CACs), 53% of CAC members were consumers for the reporting period ending 6/30/21
- CCO spending on health-related services (HRS) in 2020 was \$34.15M, more than twice what the HRS spending was in 2019.

Many quality measures showed improvement during the first CCO 2.0 contract year, including:

- A decrease in cigarette smoking prevalence
- Immunizations for adolescents

Oregon has made great strides in our CCO model over the last 10 years. This experience has set us up to take our health system transformation to a new level as outlined in this 1115 waiver renewal application. This new work is innovative, and

Oregon is ready as it focuses on eliminating health inequities, increasing and maintaining consistent Medicaid coverage, and continuing to hold spending to a sustainable rate of growth.

## **Cost Growth Target**

Oregon has been working to contain health care costs in Medicaid and across other markets. Under its 2012 and 2017 1115 demonstration waivers, Oregon committed to reducing the per member per month (PMPM) Medicaid spending growth rate by two percentage points to 3.4% from a projected national average of 5.4%. These waivers held Oregon to a “two percent test”, putting the federal investment at risk for not meeting that target and adopting a payment methodology and contracting protocol for CCOs that promoted increased spending on health-related services and advanced the use of value-based payment. To date, Oregon has succeeded in meeting this commitment, and containing costs remains a top priority for the state. Oregon has historically met this spending target through its CCO contract, which incentivizes high-quality care delivery while slowing the rate of cost growth.

In 2021, Oregon expanded this model, and is in the process of applying a statewide Sustainable Health Care Cost Growth Target to all markets. If Oregon meets its target, annual per-capita health care cost growth across the state will be at or below 3.4% for 2021-2025 and 3.0% for 2026-2030. This legislative commitment to slowing cost growth will result in substantial savings to the federal government. The estimated five-year savings to the federal government resulting from tying Medicaid per-capita expenditure growth to Oregon’s Sustainable Health Care Cost Growth Target is between \$1.72 and \$1.77 billion, depending on the value of the target in later years (i.e., 3.4% over the waiver duration, then a change to 3% in 2026).<sup>4</sup> Second, Oregon has a relatively high proportion of Medicare enrollees in Medicare Advantage plans – 47% in Oregon as compared to 38% nationally.<sup>5</sup> Because the new spending target applies to all markets, the federal government will see additional savings among Medicare Advantage plans accruing to the federal government. Finally, by lowering spending for Qualified Health Plans, this program may result in lower premiums for commercial carriers, including those in the Marketplace, leading to additional federal savings on Advance Premium Tax Credits.

## **Cover All Kids and Cover All People**

In 2017, the Oregon Legislature passed SB 558, the “Cover All Kids” bill, which opened OHP to thousands more children younger than 19, regardless of immigration status. Because OHP was newly open to more immigrant youth, there was a need for targeted

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<sup>4</sup> Estimated savings calculated based on OHA analysis of National Health Expenditure data <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>

<sup>5</sup> Data source: CMS National Health Care Expenditures

community-based outreach to promote the program and assist families with successfully enrolling and navigating the health care system. OHA formed an external stakeholder workgroup to develop a culturally and linguistically responsive outreach campaign. The campaign focused on connecting the Cover All Kids population to local, trusted community partners who could help them enroll in the program.

Today, over 6,500 children and teens are enrolled in Cover All Kids, and local community partners continue to help children and families access OHP enrollment and with access to services. The program is a critical component of OHA's goal to ensure everyone has access to comprehensive health coverage and is able to successfully navigate the health care system to receive the care they need in a linguistically and culturally appropriate manner.

In 2021, the Oregon Legislature passed HB 3352, the "Cover All People" bill, which expands upon the success of Cover All Kids. This legislation extends comprehensive OHP benefits to adults who would be eligible for Medicaid except for their immigration status beginning July 1, 2022. For the 2021-2023 biennium, the Legislature appropriated \$100 million to run the program and, like Cover All Kids, to provide a statewide outreach, engagement, and education program with the goal of enrolling and assisting eligible people in the state. The bill also allows OHA to limit eligibility in the first year of the program to remain within the budget.

To ensure that equity and various community perspectives are at the forefront, an advisory workgroup of community members will be guiding the program's design and the outreach, engagement, and education strategy. Planning and implementation work is underway to prepare for coverage beginning in July 2022.

Cover All People is a key tool for improving the rates of health care coverage among immigrant and refugee populations, driving improvements in health and health outcomes, and addressing historic and contemporary inequities.

Oregon has made significant improvements in the health care system since beginning Health System Transformation in 2012. The state improved upon its initial waiver in 2017 and further refined its goals in CCO 2.0. Then, through the Cost Growth Target, Oregon worked to bring all markets together with a focus on sustainable costs. Cover All Kids and Cover All People brought more people into the healthcare system through expanded coverage. Now, Oregon seeks to elevate the system further to address the remaining issues that were highlighted during COVID-19, Oregon's extreme climate events that included wildfires and extreme heat, and all the state has learned since our last waiver renewal. began its health system transformation journey in 2012, made improvements in 2017

## **2.4 Future goals and approach to renewal**

Despite our considerable achievements, there's more work to do. Specifically, we must address the health inequities that continue to disproportionately impact communities of color. In Oregon:

- American Indians and Alaska Natives and non-Latino/a/x African Americans are more than twice as likely to die from diabetes as non-Latino/a/x whites.<sup>6</sup>
- Latino/a/x Oregonians comprise only 12% of the population but represent more than 18% of COVID-19 cases, and Black Oregonians are 3.1 times more likely to have a COVID-19 associated hospitalization than their white counterparts.<sup>7</sup>
- Non-Latino/a/x African Americans have nearly twice the rate of avoidable deaths from heart disease, stroke, and high blood pressure as non-Latino/a/x whites.<sup>1</sup>
- American Indians and Alaska Natives have a much higher death rate from chronic liver disease than any other group.<sup>1</sup>

OHP members and community stakeholders have regularly voiced the need for OHA to more explicitly address health inequities both within the health system and in the communities where members live and work. The COVID-19 pandemic brought this need into sharp relief as communities most harmed by social injustices were—and continue to be—disproportionately harmed by the disease. These communities consistently reported that lack of access to care and health resources was at the center of their struggle to stay safe.

OHA has established a 10-year strategic goal to eliminate health inequities. Given the facts cited above, along with myriad other examples of health inequities permeating our health care system, Oregon’s 1115(a) demonstration waiver renewal is focused on moving our Medicaid system to directly and systematically address health equity through the strategies proposed in this application.

The sustained effort to reshape the health delivery system in Oregon since 2012 has led to important gains and laid the groundwork for the next level of reform. We have learned a great deal following the implementation of the first waiver and two separate procurements and have identified several areas, through our current evaluation and community engagement, that require us to modify our approach in response to recent events to move health system transformation forward for all communities.

The changes proposed in this waiver application are aligned with the goals of our current demonstration but reflect our response to the lessons learned over the last 10 years. Oregon will continue our efforts in cost containment, community-driven governance, investment in the social determinants of health, and care coordination and integration. Each new focus area builds on work from the previous waivers with the recognition that improving overall population health does not do enough to eliminate the health inequities experienced by those facing historical and contemporary injustices. Further, by aligning with other health policy initiatives across the state, we increase our

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<sup>6</sup> Oregon’s State Health Assessment, 2018: <https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf>

<sup>7</sup> OHA COVID-19 Weekly Report, Sep. 29, 2021. <https://www.oregon.gov/oha/covid19/Documents/DataReports/Weekly-Data-COVID-19-Report.pdf>



likelihood of success by shaping the direction of the entire health system, including beyond Medicaid.

## **What we learned during COVID-19**

A key piece of Oregon's health system transformation vision has been to support health equity for all Oregonians. In late 2019, as part of long-term strategic planning, the Oregon Health Authority (OHA) established a 10-year goal of eliminating health inequities, articulating an urgency that has been heightened by the devastating impact of COVID-19 on communities of color and the inadequacies of governmental response.

The response to COVID-19 required the rapid coordination of the public and private sectors to collect and share information, provide services to individuals and communities, and identify the barriers between these systems in order to save lives. The response to COVID-19 also showed in real-time the flaws and continued gaps in the current system that disproportionately harm communities of color and resulted in a profound loss of life.

In a year of unprecedented disruption due to the pandemic and extreme climate events, Oregon simultaneously suffered one of the worst wildfire seasons on record. Over 1.1 million acres burned, more than 4,000 homes were destroyed, and thousands of people were evacuated and displaced for weeks and months at a time. As with COVID-19, the state's response involved the coordination of multiple agencies to provide emergency relief in the form of food and shelter, medical care, and temporary housing.

Although known issues were exacerbated by the pandemic and significantly harmed communities of color, the state saw evidence that policy changes enacted during the Public Health Emergency were effective, and that local communities and community-based organizations were ready and willing to support the effort.

For example, the state had significant success providing direct investment to community-based organizations partnering with the health care delivery system to provide comprehensive, wrap around services to communities experiencing health inequities. New relationships were formed across local public health, social service agencies and Oregon's health care entities to enable the holistic care that supports health equity – bridges that must be maintained and strengthened moving forward.

Many of the proposals in Oregon's 1115 waiver application were designed to continue the approaches to address the types of barriers that were highlighted during the COVID-19 pandemic, extreme climate events such as the record-breaking heat that resulted in the loss of over 100 lives and the 2020 wildfire season:

- Allowing individuals to self-attest to their income during OHP application process as well as the maintenance of effort requirements preserved continued access to health care for a large population of vulnerable people. *The state is planning to continue income self-attestation after the end of the Public Health Emergency*

*and proposes to extend the redetermination period from 12 to 24 months with this application.*

- Shifting more funding with decision-making authority to community-based organizations was more effective at meeting the needs of people than many centralized and state-driven efforts. *The state is seeking expenditure authority to shift a portion of CCO budgets to locally driven Community Investment Collaboratives and direct federal investment to build local capacity to administer these funds.*
- Disaster case management implemented during the wildfires enabled the state to connect individuals with multiple services based on the needs identified in one assessment. The ability to assess how these policies are working to eliminate health inequities is contingent upon the ability to collect detailed data about patients and members, and to evaluate the effectiveness not just at the population level, but by race and ethnicity. *The state is seeking changes to eligibility and enrollment to allow for easier connection to supportive services and proposes an evaluation plan that is directly tied to measurable reductions in health inequities by race and ethnicity.*

### **Continued commitment to REALD and SOGI data collection**

Oregon has been working diligently on improving data collection and associated measurements within the areas of race, ethnicity, language, disability, sexual orientation, and gender identity. Our REALD (Race, Ethnicity, Language, Disability) law passed in 2013 which requires collection of race, ethnicity, language and disability status. Despite ongoing complexity, Oregon will be prepared in 2024 to report on Medicaid Child and Adult Core Set measures by race and ethnicity as required. In addition, we plan to incorporate stratifications by race and ethnicity into Oregon's successful Quality Incentive Program in 2024 and collect the appropriate data from providers and partners to facilitate this measurement.

In June 2021, Oregon's legislature made key investments in improving the collection of REALD data and sexual orientation and gender identity (SOGI) data. Oregon House Bill 3159 (2021), known as the Data Justice Act, requires health care providers, insurers, and CCOs to submit REALD and SOGI data to a central registry to be developed by OHA. This expanded data collection coming from HB 3159 will help to improve the quality and consistent collection of race and ethnicity data for all people who reside in Oregon, including Medicaid members.

REALD data are vital to monitor progress towards our goal of eliminating health inequities in Oregon. OHA data systems, including the OregONEligibility (ONE) system through which people in Oregon enroll in Medicaid, and the Oregon MMIS (Medicaid Management Information System) system have been required to use the REALD data collection protocol for nearly five years. Like many states, Oregon has a high percentage of incomplete race and ethnicity data in MMIS, especially for children.

Recently, OHA successfully pilot-tested a process to link members' race/ethnicity information in the MMIS with other historically reported race/ethnicity records to reduce the amount of missing data. Improving the quality and consistency of our REALD data will help ensure all OHP members can access and receive quality care while prioritizing groups of people who face contemporary and historical inequities.

### 3. Proposed Changes

#### 3.1 Maximize OHP Coverage

It is clear that barriers to coverage and coverage continuity are avoidable, and that these barriers disproportionately harm people in communities of color and result in health inequities. People of color are more likely to be uninsured, and closing gaps in the system that cause people to lose coverage or prevent them from signing up in the first place is a priority for the state<sup>8</sup>. The Oregon Legislature has taken steps to expand equitable access to coverage and the strategies described below advance the goal to extend and stabilize coverage for every Medicaid eligible child and adult in Oregon.

#### **Strategy 1: Provide continuous enrollment for children until their 6th birthday**

Oregon requests federal match to provide continuous enrollment for children through the end of the month in which their 6th birthday falls, regardless of when they first enroll in the Oregon Health Plan, and regardless of changes in circumstances that would otherwise cause a loss of eligibility. Oregon currently exercises the federal option for 12-month continuous enrollment for all children ages 0-18, with provisions to disenroll children who turn 19 or move out of state, per federal requirements. Lengthening this time frame for younger children will stabilize their insurance coverage and thus increase access to early-childhood screenings and necessary treatment.

Consistent OHP coverage will reduce frequent enrollment and disenrollment in this vulnerable population and allow for more predictable access to care, which is an important driver of improved health. Because many of these children remain eligible for coverage, eliminating churn also reduces state administrative costs and burden for families in application reprocessing. Further, expanding the pool of children who are continuously covered may ultimately reduce per member costs of coverage, as children who stay on OHP longer will have better access to preventive and primary care services that can reduce the need for higher-cost treatments due to delayed care. Increasing the time between eligibility reviews for other family members will further ease the administrative burden on families and increase coverage stability for individuals and families on OHP.

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<sup>8</sup> Oregon Health Insurance Survey, 2019

## **Strategy 2: Establish two-year continuous OHP enrollment for people ages 6 and up**

Oregon also seeks to provide continuous two-year enrollment for children and adults ages 6 and older, regardless of changes in circumstances that would otherwise cause a loss of eligibility. This change will:

- stabilize coverage for older children and adults,
- increase access to primary and preventive services, and
- preserve patients' continuity in accessing ongoing care.

Establishing continuous enrollment and increasing the length of time between eligibility renewals will preserve the coverage continuity gains achieved in the wake of federally enacted COVID relief bills passed in 2020. In 2018 and 2019, nearly 25% of new OHP enrollees had been enrolled in OHP within the previous 6 months. Over the last 6 months of 2020, this rate fell to just 5% of new enrollees. The speed with which people re-enrolled in OHP suggests that they may have been losing OHP coverage despite being eligible. The drop in the new enrollee rate suggests that federal policies enacted around the pandemic to keep people covered successfully reduced Medicaid churn.

## **Strategy 3: Provide an expedited OHP enrollment path for people who apply for SNAP benefits**

After discussion with CMS, Oregon is no longer requesting an expedited OHP enrollment option for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits through the 1115 Waiver. However, Oregon and CMS are investigating options to pursue this through a State Plan Amendment or other mechanisms.

### **3.2 Improving Health Outcomes by Streamlining Life and Coverage Transitions**

Oregon is working to meet the physical, behavioral, oral and developmental needs of all OHP members using an integrated, patient-centered, whole person approach. To achieve this goal, Oregon is requesting permission to modify Medicaid rules to better reach people in certain life situations, and to provide health-related supports and services during transitions between settings or during wildfire, extreme heat, or other extreme climate events. If approved, Oregon will address gaps in Medicaid coverage by extending coverage – for limited periods of time – to eligible transition populations and provide SDOH services defined in *Section IV. Benefits and Cost Sharing*.

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

## **Strategy 1: Obtain expenditure authority to allow people in custody to access Medicaid benefits**

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

Failure to provide health insurance and health care services to individuals transitioning from custody has a major impact on recidivism, health outcomes, and cost.<sup>9,10</sup> Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses.<sup>11</sup> And, people of color are over-represented among those incarcerated in Oregon,<sup>12</sup> which means people of color are disproportionately harmed by gaps in OHP coverage often experienced transitioning from institutions.

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

- limited or full OHP coverage; and,
- CCO enrollment that covers care coordination and navigation services alongside the proposed transition SDOH services.

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

### **With this demonstration authority, Oregon will specifically:**

- a) Retain benefits and/or extend full OHP Plus Medicaid benefits to all youth otherwise eligible for Medicaid upon entering county or local juvenile detention facilities throughout the duration of their involvement

Youth who are involved in the juvenile justice system are inherently at high risk. Youth with a history of involvement in the child welfare or behavioral health systems are

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<sup>9</sup>[https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing\\_30\\_Day\\_Inpatient\\_Psychiatric\\_Recidivism.8.aspx](https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing_30_Day_Inpatient_Psychiatric_Recidivism.8.aspx)

<sup>10</sup> [https://cdr.lib.unc.edu/concern/honors\\_theses/j6731775s](https://cdr.lib.unc.edu/concern/honors_theses/j6731775s)

<sup>11</sup> Rich, J. D., Wakeman, S. E., & Dickman, S. L. (2011). Medicine and the Epidemic of Incarceration in the United States. *New England Journal of Medicine*, 364(22), 2081- 2083. doi:10.1056/nejmp1102385

<sup>12</sup> <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf>

disproportionately referred to the juvenile justice system. And again, youth of color are grossly over-represented, in the juvenile corrections system, with high rates of entry into secure correctional facilities.<sup>13</sup> These youth of color are more likely to have complicated and expensive medical and behavioral health needs because of the effects of structural racism and other factors, and less likely to have received consistent medical care and preventive services over their lifetime.<sup>14</sup> These individuals are often involved with multiple systems (medical, behavioral health, education, child welfare) and may need high-level specialty treatment resources that are difficult to access without clear payment sources and case management. By providing health care services and the strength of the coordinated care model during a serious life transition (county or local juvenile detention) and critical life stage (youth, and often youth of color being over-represented), this strategy could improve lifelong health for these high-risk youth and save long term costs across multiple systems.

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

OHP members leaving incarceration are particularly at risk for poor health outcomes. Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of violence, overdose, and suicide than people who have never been incarcerated. For example, overdose death rates for justice-involved individuals are over 100-fold the rates of the general population.<sup>15</sup> Incarcerated people who have a behavioral health disorder are more likely than those without a disorder to have been homeless in the year prior to their incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse.<sup>16</sup>

Oregon proposes that young adults over the age of 18 under the legal jurisdiction of the Department of Corrections but in the physical custody of an Oregon Youth Authority closed-custody correctional facility will receive the benefits outlined for adults incarcerated and in custody of the Department of Corrections.

Youth and young adults in the Oregon Youth Authority closed custody correctional facilities, including those under the legal jurisdiction of the Department of Corrections, will continue to be identified and reported to the Agency for OHP suspension of all

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<sup>13</sup> <https://pubmed.ncbi.nlm.nih.gov/23334336/>

<sup>14</sup> Sedlak AJ, McPherson KS. Youth's needs and services. OJJDP Juvenile Justice Bulletin. 2010; April:10–11. Available at: [www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf](http://www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf)

<sup>15</sup> Binswanger, Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release From Prison — A High Risk of Death for Former Inmates," *New England Journal of Medicine*, January 2007

<sup>16</sup> Gates, A., Artiga, S., Rudowitz, R., "Health Coverage and Care for the Adult Criminal Justice Involved Population," Kaiser Family Foundation, September 5, 2014. <https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/>.

Medicaid benefits until such time as they are eligible for the limited benefit package within 90 days of release.

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

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

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

This request for coverage takes into account the relatively short (less than 90 days) and uncertain length of stays in county jail and other local correction facilities. In order to maintain continuity of care and ensure physical and behavioral needs are met on release, OHP members in county jails and local correction facilities will benefit by having a limited OHP benefit throughout incarceration, regardless of duration. Oregon requests that those without current valid OHP coverage would be supported by the OHA Community Partner Outreach Program and local corrections staff in initiating, completing and submitting a new OHP application within 72 hours of arrest and booking. These populations are at risk for poor outcomes and would benefit in health improvements as described in paragraph b above. These populations would also be eligible for transition related SDOH services. This policy would also apply to Tribal jails.

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

For YSHCN, Oregon proposes extending OHP coverage to age 26 and retaining eligibility levels of 305% FPL to support smooth transitions from pediatric to adult health care. Many of these children and young adults are from communities of color, LGBTQAI+, members of Tribes in Oregon and have experienced homelessness, Intellectual and Developmental Disability (IDD)<sup>17</sup> or poverty. Addressing this transition is key to Oregon's health equity goals because few YSHCN are receiving adequate transition preparation, and some evidence indicates that this situation is worse for racial and ethnic minorities.<sup>18</sup> According the 2018-19 National Survey of Children's Health,

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<sup>17</sup> <https://link.springer.com/article/10.1007/s11920-019-1016-1>

<sup>18</sup> [https://pediatrics.aappublications.org/content/126/Supplement\\_3/S129.short](https://pediatrics.aappublications.org/content/126/Supplement_3/S129.short)

45% of Oregon youth aged 12-17 had a special health care need. Family members of youth with special health care needs reported that:

- 69% did not receive health care transition preparation services,
- 38% did not have time alone with their provider during their last check-up,
- 21% did not learn skills for managing their own care from their health care providers, and
- 44% did not receive help from their health care provider to understand the changes in care that happen at age 18.<sup>19</sup>

The transition to adulthood requires the youth to apply for Medicaid separately from their parents or guardians to avoid a lapse in coverage. The coverage itself also changes from a package of benefits designed for children and adolescents to benefits designed for adults. Removing the transition to a new adult benefit package, while including YSHCN as eligible for transitional SDOH services, will provide them time to better navigate these changes with the fewest possible disruptions, increasing the likelihood that they will transition into adulthood with the care and access necessary for good health and quality of life. This coverage change applies to adolescents and young adults with a behavioral, developmental, emotional, and/or long-term or chronic physical condition ages 17 up to 26 years.

For young adults with special health care needs, effective transition from pediatric to adult health care results in increased<sup>20</sup>:

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

and decreased:

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

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<sup>19</sup> Oregon Center for Children and Youth with Special Health Needs Fact Sheet, Rev. 4/26/2021  
<https://www.ohsu.edu/sites/default/files/2021-04/Transition%20FACT%20SHEET%20rev.4.26.2021.pdf>

<sup>20</sup> Oregon Center for Children and Youth with Special Health Needs Fact Sheet, Rev. 4/26/2021, Op. cit.



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

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

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

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

Oregon requests expenditure authority for costs otherwise not matchable to make payments to CCOs outside of the capitated payments to address SDOH for OHP members experiencing these specified life transitions or disruptions. Oregon views these funds as a catalyst for increasing HRS spending within the population health budgets at the end of the waiver period, because they will enable CCOs to build capabilities and identify the most effective services before they are fully at risk. Oregon proposes that the funding outside of the population health budget phase down beginning in year three of the demonstration period. Further, Oregon requests upfront federal investment to cover these SDOH transitions services.

## Proposed SDOH transition services

### Housing

Housing is a key social determinant of health, and being housed is associated with lower inpatient hospitalizations, fewer ED visits, and lower incarceration rates.<sup>21,22</sup> In a study in Oregon, Medicaid costs declined by 12% on average after people moved into affordable housing.<sup>23</sup> Institutional racism has impacted access to housing. According to 2018 data, people in Oregon who are Black, Native American or Pacific Islander, or two or more races represent a greater share of the unhoused population than their share of the total population.<sup>24</sup> Without interventions to support stable housing, homelessness can trigger destabilizing transitional events and, ultimately, create higher costs for the health care system and poorer health outcomes for individuals. Supports may include one or more of the following components:

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

### Health-related non-medical transportation

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

### Food assistance

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

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<sup>21</sup> Nakamura MM, Toomey SL, Zaslavsky AM, et al. Measuring pediatric hospital readmission rates to drive quality improvement. *Acad Pediatr.* 2014

<sup>22</sup> Oregon Medicaid Advisory Committee. May 2018. Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model

<sup>23</sup> [https://oregon.providence.org/~media/Files/Providence%20OR%20PDF/core\\_health\\_in\\_housing\\_full\\_report\\_feb\\_2016.pdf](https://oregon.providence.org/~media/Files/Providence%20OR%20PDF/core_health_in_housing_full_report_feb_2016.pdf)

<sup>24</sup> <http://oregonhousingconference.org/wp-content/uploads/2018/10/Oregon-Housing-Conference-10-15.pdf>

#### 4. Medically tailored meal delivery

##### Employment Supports

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

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

##### Exposure to climate events

Over the last several years Oregon has endured several extreme climate change-related events, including wildfires, ice storms, and extreme heat. During Oregon's most recent extreme heat event in late June 2021, 116 people in Oregon died of heat-related illness or hyperthermia. Vulnerable populations, including children, pregnant people, older adults, communities of color, immigrant groups (including those with limited English proficiency), American Indians and Alaska Natives, people with disabilities, vulnerable occupational groups, such as workers who are exposed to extreme weather, low-income communities, people with pre-existing or chronic medical conditions, and intersections among these groups, experience disproportionate adverse health impacts because they experience less climate-resiliency.<sup>25</sup> Extreme climate events are occurring with greater frequency and severity, can disrupt health care access and even coverage.<sup>26</sup> Benefits for people impacted by climate disasters and vulnerable to extreme weather can reduce health inequities and disruptions to health care services and coverage. Supports may include one or more of the following components:

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

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<sup>25</sup> <https://www.apha.org/topics-and-issues/climate-change/vulnerable-populations>

<sup>26</sup> [https://earthobservatory.nasa.gov/features/RisingCost/rising\\_cost5.php](https://earthobservatory.nasa.gov/features/RisingCost/rising_cost5.php)

6. Clothing and/or food for members affected by extreme (e.g., wildfire) weather events
7. Broadband or other internet supports to help adults and children to access important services, such as education

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

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

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

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

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

**Strategy 6. Obtain expenditure authority to allow Child Welfare to pay for reserved Psychiatric Residential Treatment Services (PRTS) and prioritize youth in Child Welfare custody for these services.**

Oregon’s Psychiatric Residential Treatment Services (PRTS) serves youth who require facility-based care to address their mental health needs. Currently, Oregon does not have the adequate capacity to meet the needs of children and youth in Oregon, which can cause very long waitlists. When youth involved with Child Welfare, including foster care, experience long waits for these services it increases the chance of placement disruption, including temporary lodging, and can lead to youth being supported in settings that do not meet their needs. Currently, there is no established methodology or ability to prioritize admission for youth in Oregon according to urgency or Child Welfare involvement.

The Oregon Health Authority is proposing as part of its 1115 waiver application to allow the Child Welfare Division (“Child Welfare”) to:

- Create the ability to pay for non-billable (evaluation and assessment) services and to reserve capacity for youth involved with Child Welfare that meet medical necessity; and
- Develop mechanisms between Child Welfare, CCOs and OHA with PRTS providers to prioritize youth in Child Welfare custody for these services.

**Strategy and Proposal:** Oregon proposes to pay for added care and capacity that prioritizes access for youth in Child Welfare.

- 1) Given current capacity:
  - Child Welfare will have the ability to develop a direct agreement with existing PRTS providers to prioritize youth in Child Welfare custody on a PRTS provider’s waitlist, and pay for assessment and evaluation services within these settings that are currently not paid for under Medicaid.
  - Child Welfare and providers will agree on the number of youth to be prioritized and will develop processes that balance access for prioritized youth with the total population, such as supporting up to 2 beds for children and youth in Child Welfare out of 12 available beds.
  - This proposal seeks priority for admission, not a bed held vacant for youth who are in the custody of child welfare. In some circumstances, a bed may be held for less than 48 hours while the youth in Child Welfare custody is transferred from another residential setting or traveling from out of area.
- 2) As new capacity is developed in the future:
  - Child Welfare will collaborate with the Children’s Behavioral Health team to identify providers or programs willing to expand PRTS capacity. As providers start up a new program or expand capacity, Child Welfare will seek an agreement as described above to establish a number of beds that are prioritized for youth involved in Child Welfare.

- As described with current agreements, Medicaid dollars will support added care (evaluation and assessment) and reserved capacity for youth in Child Welfare, balancing access for youth in Child Welfare with the total population.

In its current state, Oregon does not have adequate PRTS capacity and for that reason, Child Welfare does not intend to use this waiver concept to hold empty beds. Child Welfare will work with providers to create prioritized admissions based on PRTS waitlists. If in the future capacity exceeds demand, Child Welfare may enter into agreements that would ensure a bed is available at the time a crisis is identified.

### **3.3 Paying for Population Health**

When Oregon created CCOs and the Medicaid coordinated care model in 2012, a primary goal was to move from focusing on delivering health care services to a new model: one where community-governed organizations that operate under a different economic structure focus on improving health outcomes and managing population health. Oregon aspired to implement a rate-setting methodology with two goals:

1. blend physical, behavioral and oral health funding streams together so one organization is responsible for all of its members' health care needs; and
2. change the financial incentives in the health care system so that financial rewards come from populations served being healthier, rather than sick.

Under Oregon's original CCO rate setting methodology, the goal was to see the health system shift spending to focus on prevention that reduces avoidable acute care; for example, stronger investments in community behavioral health that could avoid hospital visits. Another goal was to increase funding spent on health-related services – such as those that address social needs, like housing and food – with the goal of improving health and avoiding medical costs.

Oregon has had success in blending funding streams for billable health care services; however, under the current federal requirements for capitation rates, we have yet to see significant change in financial incentives for the outcomes we seek. The vision of paying for improving community health and health equity has not yet been fully realized in Oregon. Specifically, CCOs' rates remain largely based on recent medical expenses, perpetuating the built-in disincentives to shift resources to prevention and health-related services, and to contain costs.

Oregon has innovated as much as possible within the current CMS requirements for managed care capitation rates to change the financial incentives that promote population health and has been insufficient to fundamentally change the economic model that drives CCO spending. While the amount of CCO spending on health-related services has increased over time, Oregon has not seen a marked shift in how much CCOs spend in this area. Health-related services spending on average constitutes 0.7% of CCOs' annual budgets as of 2020. Oregon's original concept was intended to drive

local, community conversations about how to shift spending within the system to better meet community needs and to spend wisely within limited resources to maximize health outcomes. However, the distribution of spending within Oregon’s health care system (e.g., the amounts split between physical, behavioral, and oral health) remains largely the same, indicating that spending is following historical habits and market power, rather than a true shift in focus to population health. Oregon cannot fully address health inequities or correct historical racism and power imbalances in the health system, unless the financial incentives in the system more fully focus on population health and drive community conversations about prioritizing resources to achieve better outcomes.

Oregon seeks expenditure authority for modifications to the capitated rate development methodology that is as simple as possible and easy for the community and CCO to understand, as well as more predictable for the state and community. It needs to be clear that in focusing spending on health equity, prevention, care coordination and quality, CCOs will improve health and realize savings. This streamlined methodology will be paired with robust accountability to member and community needs, as well as strategies to ensure health equity spending is driven by the community.

With Oregon’s proposed changes to the rate methodology, we would expect the following outcomes:

- A substantial increase in health-related services coupled with reduced administrative burden of detailed counting of health-related services in order to get “credit” in rate setting (as is currently required under the Performance-Based Reward). More spending on health-related services will lead to:
  - More investment in community health that promotes health equity
  - More investment in high-value, preventive services
- Increased care coordination and better management of members who incur high costs, including members transitioning between systems and life stages: corrections, Oregon State Hospital, Mental Health residential services, foster care youth – due to clearer financial incentives for improving outcomes
- A decrease in spending on lower value care and avoidable episodes as CCOs shift funds to prevention and care coordination
- More accountability for CCOs to the community they serve for how funding for population health is spent
- The rate of cost growth is limited to publicly determined targets and matches overall spending targets in Oregon’s health care system

Oregon is requesting additional flexibility in how CCO capitation rates are typically established, while maintaining reasonable and appropriate rates, in order to meet the goals described above. Specifically, we will implement the following strategies:

**Strategy 1: Calculate 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.**

To truly shift focus toward providing the highest value care, Oregon needs to pay CCOs for population health in a way that is simpler and more predictable over the long term, and that removes any real or perceived incentives for unnecessary health care spending in the short term. Moving to a value-based budget will incentivize CCOs to provide high-value care rather than increasing annual spending to improve the next year's rates.

Under Oregon's waiver proposal, the state would set an initial statewide, reasonable and appropriate CCO budget largely in line with how base budgets are set today, with two exceptions:

- Considering a longer period of time (up to five years) for historical trends to increase confidence that the base budget is sound, and
- Including health-related services spending, in addition to spending on state plan services, over a period of up to five years.

In addition, to maintain a focus on eliminating health inequities, Oregon plans to direct CCOs to invest at least 3% of their budgets for population health toward health equity investments (as required by Oregon House Bill 3353), of which at least 30% would be directed to community entities, called community investment collaboratives (CICs), for community health equity investments. Oregon proposes to establish a community-led accountability structure for all required health equity spending that includes a statewide oversight committee in addition to the regional CICs. As noted above, Oregon requests the ability to count spending under HB 3353 as part of the medical load when calculating rates, so that the requirement to make these health equity investments does not negatively impact CCOs' future rates.<sup>27</sup>

Going forward, Oregon would adjust CCO budgets annually by a predictable growth trend rate, in line with statewide goals for sustainable growth,<sup>28</sup> and would also carefully

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<sup>27</sup> HB 3353 requirements are contingent on CMS approval for directing 3% of CCO budgets for population health to spending that improves health inequities and reaching agreement that such expenditures count as utilization for the purposes of rate setting.

<sup>28</sup> Oregon's sustainable cost growth goals are part of a statewide effort that includes CCOs, commercial plans, and public health plans, and which aims to create statewide savings to address other state needs. Achieving sustainable growth in the health care system can free up critical resources needed to correct historical racism, power-imbalances, and health inequities. At the same time, a sustainable cost growth target, when combined with other steps in this process, will create incentives for CCOs to focus on health equity, prevention, and the high-quality services that we know reduce costs.

<https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>



monitor CCO spending to identify any additional, targeted adjustments that may be necessary to address unanticipated events.

**Strategy 2: Trend the base rate forward in a predictable way over five years, without resetting base budgets each year.**

Oregon proposes that, in line with reducing health care spending growth in all markets, CCO budgets be trended forward for five years at the statewide health care cost growth target, which will be 3.0 to 3.4 percent during the demonstration period. This trending forward would allow more predictability for CCOs to make longer-term investments in health equity, prevention, and community improvement—leading to an overall healthier population and lower health care costs over time. Targeted rate adjustments would be made for significant changes in risk profile by CCO, covered benefits, and statewide population, for example, in times of significant change such as coverage expansion during the COVID-19 pandemic.

When combined with an enhanced quality strategy and the ability to count health-related services in the medical load for the purposes of rate setting, this design would allow CCOs to keep savings stemming from appropriate declines in utilization. This design will create more flexibility for CCOs to invest in care improvements and health related services, including through investments in preventive care, addressing social needs, and eliminating health inequities.

**Strategy 3: Increase predictability of costs and ensure value for spending through closer management of pharmacy costs by excluding coverage of accelerated approval drugs with limited or inadequate evidence of clinical efficacy.**

Oregon seeks the ability to more closely manage pharmacy costs in its Medicaid program and authority to allow exclusion of accelerated approval drugs with limited or inadequate evidence of clinical efficacy.

Drugs coming to market through the FDA’s accelerated approval pathway have not yet demonstrated clinical benefit. FDA approval is instead based on intermediate “surrogate” endpoints as predictors of clinical outcomes. Approval is contingent on the sponsor’s agreement to complete a post-approval confirmatory trial to demonstrate clinical effectiveness. When such trials demonstrate effectiveness, FDA approval may be converted to a full approval. Unfortunately, confirmatory trials are often delayed or inadequate, or they conclude without a demonstration of effectiveness. Such products are not always pulled from the market. Oregon seeks the ability to use its own rigorous review process to determine coverage of drugs previously granted accelerated approval that have not had benefit confirmed with conversion to full FDA approval in the expected time interval. Through this process, the state could incentivize drug sponsors to complete their regulatory obligations to demonstrate clinical benefit as laid out by the FDA upon approval. This will allow Oregon to avoid spending on high-cost drugs marketed to treat conditions that have yet to demonstrate a clinical benefit despite

ample time to do so. Many national experts, including the Institute for Clinical and Economic Review (ICER)<sup>29</sup> urge national policy changes to ensure proper oversight after approval of accelerated pathway drugs. Current Medicaid regulations generally require States to cover all FDA-approved medications. This includes medications approved through the FDA's accelerated approval pathway, which have not been shown to be clinically effective. It even applies when the drug sponsor fails to show clinical efficacy within the timelines set forth as a condition of accelerated approval.

To that end, Oregon proposes to limit the coverage of drugs that have been approved through the accelerated pathway under narrow circumstances. Under this proposal, Oregon would utilize the timelines set out in the FDA approval letter and review confirmation of benefit data in peer reviewed literature or [clinicaltrials.gov](https://clinicaltrials.gov). Applying the FDA-developed guidance and timetables ensures a universal standard, with clinically feasibility and drug sponsor agreement.

New drugs approved under the FDA's accelerated approval pathway tend to be specialty medications that represent a significant portion of pharmacy expenditures. As such, it is our responsibility to ensure we are following through with the promise of expedited approval pathways. As part of our efforts, we will ensure continued pharmacy protections for members, so that Oregon's closer management of pharmacy costs does not negatively impact member access to the spectrum of safe and effective drugs to treat various conditions.

#### *Develop strong programmatic safeguards to protect members*

Oregon's proposed budget strategy is designed to create additional flexibility and allow CCOs to keep savings stemming from smart spending decisions. We also recognize that enhanced flexibility must be paired with member protections, specifically directed at addressing health inequities that exist. Without a strong accountability system there is the risk of negative impacts to health equity and members' access to high-quality care due to profit-seeking within the system. To mitigate such risk, Oregon proposes a comprehensive accountability structure to address the risk that these changes could exacerbate health inequities, ensure member and provider satisfaction, and protect member access and quality of care. On an annual basis, Oregon will conduct an overall assessment of each plan paired with specific rate and contract-based mechanisms to hold CCOs to minimum standards in each of these four areas: equity, member and provider satisfaction, access, and quality of care.

First, Oregon will assess health inequities by monitoring disparities in member satisfaction, member access, and quality of care for priority populations most harmed by health inequities. These include but are not limited to Tribal Nations and Tribal

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<sup>29</sup> Kaltenboek, Mehlman, and Pearson. "STRENGTHENING THE ACCELERATED APPROVAL PATHWAY: AN ANALYSIS OF POTENTIAL POLICY REFORMS AND THEIR IMPACT ON UNCERTAINTY, ACCESS, INNOVATION, AND COSTS" April 26, 2021 Institute for Clinical and Economic Review (ICER) viewable at; [https://icer.org/wp-content/uploads/2021/04/Strengthening-the-Accelerated-Approval-Pathway\\_-\\_ICER-White-Paper\\_-\\_April-2021.pdf](https://icer.org/wp-content/uploads/2021/04/Strengthening-the-Accelerated-Approval-Pathway_-_ICER-White-Paper_-_April-2021.pdf)

communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities covered under Oregon's Cover Kids and Cover All People programs. Oregon will use tools such as:

- Collecting data that allows the State to monitor quality of care by race and ethnicity, such as through REALD;
- Considering/reporting on as many of the core quality metrics by race, ethnicity and language as possible;<sup>30</sup>
- Monitoring performance on equity-focused metrics (such as access to interpreters);
- Considering CCO network adequacy with regard to equity factors such as cultural and linguistic responsive provider capacity; and
- Using tools such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and qualitative data from the OHA Ombuds program and Community Partner Outreach Program (Oregon's enroller and navigator network) to identify concerns for priority populations.

Next, Oregon will assess overall member and provider satisfaction, access, and quality of care in the following ways:

**Member and provider satisfaction:** OHA will assess by CCO using tools such as the CAHPS survey, review of Notices of Adverse Benefit Determination, appeals, and grievances, and enhanced feedback mechanisms to assess provider satisfaction.

**Access:** OHA will consider indicators in the areas of network adequacy, overutilization and underutilization, and timely and appropriateness of care. For network adequacy, OHA will use the Delivery System Network Reporting (DSN), which includes minimum standards for time and distance, to assess and monitor an individual CCOs provider capacity to serve projected and current member enrollment; have a network that meets the demographics of enrolled members including but not limited to preferred language or cultural representation; and a network sufficient across the continuum of care. For utilization of services, OHA will rely on an analysis and monitoring system that will focus on priority services prone to underspend, such as behavioral health; and member and provider-identified concerns. Timely and appropriateness of care assessment will use tools such as DSN and quality reporting to monitor member's access.

**Quality of care:** In alignment with the Quality Incentive Program, OHA will monitor quality of care through CMS Medicaid core set measures and potentially other measures as added in the metrics programs such as forthcoming CMS quality rating system measures. Measures will be benchmarked for a basic level of care (as opposed to more aspirational benchmarks used in the Quality Incentive Program).

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<sup>30</sup> Some metrics will have too small of a denominator to support analysis at a subpopulation level.

CCOs will be expected to further address health inequities by strengthening community voice and decision-making in the CCO model. OHA intends to incentivize metrics in the Quality Incentive Program by race, ethnicity and language as guided by the Metrics and Scoring and the planned Health Equity Quality Metrics Committees.

#### *Develop robust annual financial monitoring*

Oregon will develop robust annual financial monitoring, including monitoring utilization and spending, to assess CCO solvency and ensure the annual growth targets are reasonable for covering expected costs, as well as develop a mechanism for budget adjustments if unforeseen events, such as new high-cost treatments, result in the annual trend being inadequate to cover members' health needs. OHA will use focused rate and contract mechanisms to hold CCOs accountable. Instead of spending significant resources on building annual rates based on the CCOs prior year's spending, Oregon will devote resources to analyzing health equity and health-related services spending trends, analyzing access to care and medical loss ratio (MLR). Oregon plans to tighten financial metrics (for example, minimum MLR requirements). Additionally, Oregon may employ other financial mechanisms to hold CCOs accountable for meeting targets for certain services, such as behavioral health or chronic disease management. By creating a new, flexible payment methodology, Oregon anticipates that the amount of money subject to both quality metrics and accountability will grow over time as the CCO model improves care and reduces cost growth. OHA will continue to use tools developed for the most recent CCO procurement to monitor for high cost or low value health spending and push for redeployment of those resources to lower costs, higher value interventions.

### **3.4 Incentivizing Equitable Care**

To ensure all Oregon Health Plan members can access and receive high-quality care while prioritizing groups of people who face inequities and structural racism, both contemporary and historical, Oregon proposes restructuring the Quality Incentive Program so that equity is the primary organizing principle. Oregon proposes changing STC 38 to reflect modified decision-making power that incorporates greater community and member voice, as well as adjusting STCs 39 and 36e.iii to better align with proposed program changes.

Oregon intends to refine its Quality Incentive Program to prioritize health equity, using several complementary strategies:

#### **Strategy 1: Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity**

To ensure all Medicaid members have access to services and receive high-quality care while prioritizing people in communities that face contemporary and historical inequities,

Oregon proposes separating the Quality Incentive Program into two complementary and interrelated components, each of which will be incentivized to improve equity.

a) *A small set of “upstream” metrics focused on factors affecting health equity*

**Table 1. Upstream metrics focused on health equity**

Upstream Health Equity Metric	Year incentivized	Additional Information
Mental, Physical and Oral Health Assessment Within 60 Days for Children in DHS Custody <sup>31</sup>	2013	Incentivizes timely assessments for children in foster care, so their physical, oral and behavioral health needs are identified and can be addressed.
Meaningful Language Access to Culturally Responsive Health Care Services <sup>32</sup>	2021	Incentivizes the provision of high-quality interpreter services when needed and access to care and information (explanations of benefits, take-home resources, and more) in members’ preferred languages, enabling them to more effectively participate in their own care.
Health Aspects of Kindergarten Readiness (HAKR) <sup>33</sup>	2022 <sup>34</sup>	Incentivizes more culturally responsive services being offered to help children start kindergarten ready to learn.
Social Determinants of Health: Social Needs Screening and Referral <sup>35</sup>	2023 <sup>36</sup>	Incentivizes more CCO members having their social needs acknowledged and addressed

The first component of the new measurement structure will contain up to up to six metrics incentivized for the duration of the waiver. These metrics are expected to require long-term, sustained effort to achieve. For this waiver period, the upstream set is largely identified. For the next waiver period, OHA will work with the Health Equity Quality Metrics Committee (restructured from the existing Health Plan Quality Metrics Committee, see strategy #2 for more detail) and other interested parties to plan and potentially develop new measures.

<sup>31</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2014-Assessments-Children-DHS-Custody-Guidance-Document.pdf>

<sup>32</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx>

<sup>33</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx>

<sup>34</sup> For Social Emotional Health component of HAKR bundle

<sup>35</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx>

<sup>36</sup> Potential implementation

Given the extensive lead time required to develop new metrics, OHA has identified four existing metrics for the upstream measure set. Two more metrics could be added and, depending on timing considerations, the new Health Equity Quality Metrics Committee may guide measure development.

These metrics were developed during the current and previous waiver periods in response to analysis of harms to specific populations and community-identified needs. They are designed to incentivize systems-level changes that advance health equity, and they address domains for which no standardized metrics currently exist. The following table outlines the four existing metrics that will be included in the upstream metrics.

These domains were chosen because of their relation to OHP members who experience historical and contemporary injustices and structural racism. The measure development webpages referenced above provide more information from the public workgroups and other interested parties who worked through measure specification and pilot testing. This measure set will allow the state to monitor improvements in access to resources that directly address these injustices.

*b) A set of “downstream” metrics that focuses on traditional quality and access measures*

The second component of the new measurement structure will align with measures of health care processes, outcomes, and utilization that are used nationally (downstream metrics). These metrics will draw from traditional quality and access measure sets. Downstream metrics will be selected from the CMS Medicaid Adult and Child Core sets and other CMS-required measures (e.g., may include Medicaid MCO Quality Rating System measures in the future).<sup>37</sup> OHA will develop criteria to ensure that the selected metrics address the full breadth of health care quality considerations: cost, quality, access, and health equity, as well as address oral, behavioral, and physical health. As before, Oregon’s Metrics and Scoring Committee will select the metrics, but as described below, a newly redesigned and separate committee called the Health Equity Quality Metrics Committee will have oversight and approval.

This approach builds on work Oregon is required to undertake on the Medicaid Child Core Set and Behavioral Health measures in the Medicaid Adult Core Set when reporting becomes mandatory in 2024. Aligning with the CMS Core Sets will promote cost savings and enable comparison to other state Medicaid programs’ performance. The downstream metrics will be monitored and publicly reported at the subpopulation level to ensure quality and access for members within race, ethnicity, language, and disability groups whenever possible. Downstream metrics will continue to be incentivized for continuous quality improvement and, as addressed in Strategy 3 below, will use new benchmarking approaches where possible to address inequities among racial and ethnic groups.

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<sup>37</sup> Oregon recognizes that because of variations in benefit packages among states, the Medicaid Adult Core set does not include measures of adult oral health. To fill that gap, Oregon may include in the downstream set of measures one or two adult oral health measures from the Dental Quality Alliance or similar national measure steward.

## **Strategy 2: Redistribute decision-making power to communities**

To ensure that the Quality Incentive Program drives system-level improvements as well as improvements to patient care, those who are most affected by health inequities will have more decision-making power within the committee structure that selects downstream metrics.

OHA is committed to redistributing power in the Quality Incentive Program and plans to modify the structure of Committees that are responsible for selecting and incentivizing metrics. While maintaining a public committee process for metrics selection, OHA intends to work with the legislature to amend the statutes establishing the metrics committees so the current Health Plan Quality Metrics Committee can change its membership, focus and role to become the Health Equity Quality Metrics Committee (HEQMC). HEQMC members will represent the interests of those most affected by health inequities including Oregon Health Plan members, community members from diverse communities, individuals with lived experience of health inequities, health equity and measurement professionals and researchers, and a representative from the state's Behavioral Health committee.

This Committee will oversee and approve the downstream metrics selected by the Metrics and Scoring Committee and will advise OHA about how to design the program to best address member and community concerns and priorities. As OHA adopts broader community engagement strategies, input received in those forums will also inform measure selection and implementation. In addition, OHA will consider member and community voices in the presentation of measure performance. For example, OHA will continue to produce an annual CCO Incentive Metrics report and supplement the quantitative data typically included in this report with qualitative information, including priorities identified by members of the HEQMC.

## **Strategy 3: Rethink the incentive structure to better advance equity**

Oregon's current Quality Incentive Program consists of one set of metrics incentivized for the initial round of payments and a subset incentivized for the challenge pool. Using this approach, any incentive funds that are not earned in the initial round are distributed in the challenge pool round. In the initial and challenge pool rounds, CCOs can earn incentives by meeting either an overall benchmark or a CCO-specific "improvement target," which is calculated to close the gap between the CCO's baseline performance and the benchmark. Each year, the entire pool of available quality funds is paid out; if any funds are not paid out in the initial round, they are then paid out in the challenge pool round.

While this overall structure will remain the same for the 2022-2027 waiver, OHA proposes to work with the new Health Equity Quality Metrics Committee and the Metrics and Scoring Committee to select which upstream and downstream metrics are

incentivized to best improve health equity. OHA will present the committees with a range of approaches from which to select.

For instance, for the downstream metrics, one option is that the only metrics eligible for the challenge pool would be those that address significant inequities, and payment of challenge pool funds would be contingent on reducing inequities in the downstream metrics where performance can be compared to other state Medicaid programs.

Another option is to focus on closing inequitable performance gaps in all eligible metrics, not only in the challenge pool. This could be accomplished by making payment of incentives contingent on achieving CCO-specific improvement target for a metric (as opposed the aspirational benchmark for the metric) for all subpopulations with at least 50 members. In this option CCOs would not be able to rely on simply making progress toward a benchmark unless they make progress for all subpopulations.

For the upstream metrics focused on rectifying the systems and structures that create inequities, CCO incentives will be paid per metric as either individual CCO improvement targets or the benchmark is reached. Funds not earned after payout for the upstream metrics, as well as any funds not earned in the initial round of payout for the downstream metrics, will be paid out in the challenge pool round.

### **3.5 Focused Equity Investments**

For Oregon to begin to rectify historical and contemporary injustices that are the root cause of health inequities, we must make new and focused investments outside health care facility walls. These investments must also shift the decision-making power and resources to direct these investments to the communities most harmed by social injustices.

With CMS support, Oregon can increase investments to promote health equity and support strong models of community governance across the state. Oregon anticipates these investments will improve upstream social determinants of health—resulting in improved health outcomes for those most harmed by systemic racism and social injustice—as well as downstream cost savings for the state and federal government.

#### **Strategy 1: Invest federal funds toward infrastructure to support health equity interventions**

##### *Build capacity for community-led health equity investments*

Oregon requests federal investment to support capacity-building among community investment collaboratives (CICs) that will enhance the CICs' ability to direct and manage large-scale investments.

While Oregon expects CICs to leverage existing organizations and efforts in many communities, the reality is that community-based organizations (CBOs) are chronically under-resourced when compared with health care organizations. Consideration of this is key due to the role that CBOs play in meaningfully mending the gaps in health and



social determinants of health systems to address community-level inequities. Other states and communities have found it essential to provide capacity-building funding and resources to CBOs so they can effectively partner with health care organizations.<sup>38</sup> Funds could support, for example, building CICs' CBO networks and developing internal leadership to support community driven and effective investment decision-making.

*Provide resources for statewide infrastructure to support community-led health equity investments*

In addition to federal investment in CICs, Oregon requests federal funds for statewide infrastructure to support both the CIC program as well as cross-sector communication and partnerships. Federal investment for CICs could include, for example, technical assistance to support stronger health care (CCO and provider) and community collaboration, or support for collaboration across CICs with similar interventions. While CICs coordinate local interventions, there will also be a need for statewide systems—such as Community Information Exchange—that could support all CICs in addressing health inequities in their communities. Some community organizations will need access to capacity- building grants to support things like technical assistance to operate specialized software related to their community-level investments, development of more rigorous fiscal tracking practices, assistance to fund necessary administrative work, training to support leadership development so more community leaders are empowered to be engaged in health equity work so burnout and over engagement are mitigated, and other supports that work toward long-term sustainability, etc. Ultimately, needs related to capacity- building grants will need to be customized and informed by each organization and the community-level investments they are working to implement based on the unique challenges their communities are facing.

**Strategy 2. Invest federal funds in community-led health equity interventions and statewide initiatives**

*CCOs investment in community-managed funds to count as medical and quality improvement expenditures*

Once CICs have developed sufficient infrastructure to assume financial responsibility, they will manage community funds from CCOs to reduce health inequities, roughly equivalent to 1% of the CCO's budget (per Oregon House Bill [HB] 3353). The remaining amount required under HB 3353 would be a directed enhanced provider payments fund and individual member services as described in the Focused Equity Investments concept paper, see Appendix A. Oregon's CCOs currently have the

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<sup>38</sup> Recent 1115(a) demonstration waivers in several other states, such as North Carolina and Massachusetts, have included capacity-building/infrastructure funding for community-based and/or social service organizations partnering with health care. A case study of community-based organizations participating in New York's DSRIP program identified "building capacity" as a key need to "level the playing field" between CBOs and health care organizations. See *Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community-Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program*, [https://academyhealth.org/sites/default/files/achieving\\_health\\_equity\\_medicaid\\_cbos\\_april2019.pdf](https://academyhealth.org/sites/default/files/achieving_health_equity_medicaid_cbos_april2019.pdf)

flexibility in their budgets to spend on promoting health equity and social determinants of health, including through health-related services and the Supporting Health for All through Reinvestment (the SHARE Initiative).<sup>39</sup> However, spending on HRS remains low (0.7% on average), considering the potential impact investments in health-related social needs could have on health outcomes. Because spending in this area remains low, and inequities continue to persist in priority population<sup>40</sup> health, community-directed spending is a strategy to more effectively mitigate the harm and early death caused by inequities while promoting health equity. As mentioned in the background, HB 3353 requires OHA to seek approval from CMS that 3% of CCO budgets directed to improving health inequities are counted as medical and quality improvement expenditures in rate setting.

### **Strategy 3. Grant community-led collaboratives resources to invest in health equity**

*Oregon requests additional federal investment to support health equity investment (HEI) grants—funds made available directly to CICs through a process managed by the state.*

HEI grants will allow qualifying CICs to invest in addressing health inequities that impact local Medicaid members and their families. Ideally, the grant process would be designed to support as many community needs as possible; i.e., it would not be competitive, limited to a small number of awards, or prescriptive about which topics to address. HEI grants will allow qualifying CICs to invest in addressing health inequities that impact local Medicaid members and their families.

HEI grant proposals will identify the population served and planned investments, both of which must be informed by available community-based quantitative and qualitative evidence as well as local community health assessments and community health improvement plans.<sup>41</sup> Examples of HEIs could include expanding availability of housing supports and services; improving language access supports; wildfire relief/recovery; enhancing green space and making improvements in the built environment to promote health and well-being and climate resiliency; improvements to transportation-related

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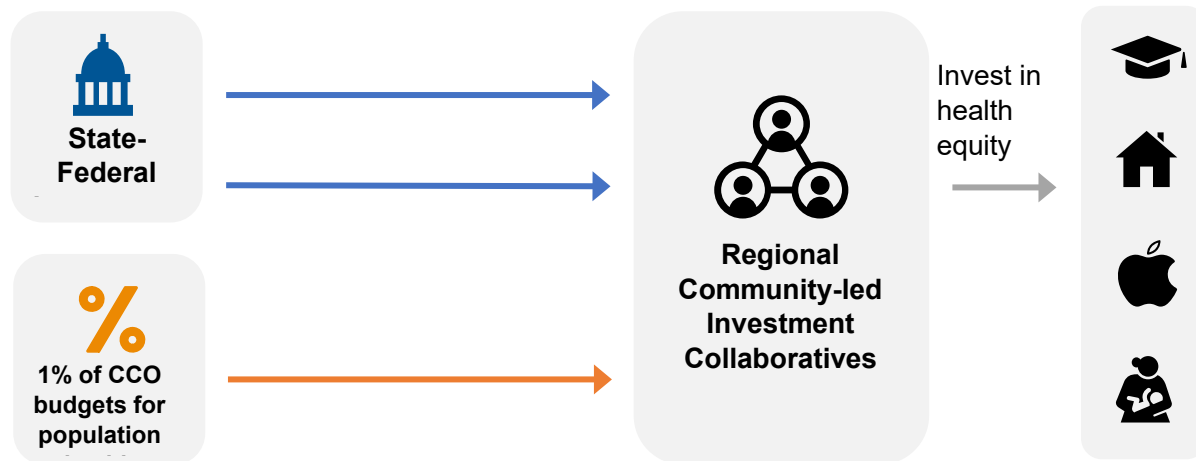
<sup>39</sup> The SHARE Initiative comes from a legislative requirement for coordinated care organizations to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity. For more information, visit <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx>

<sup>40</sup> Priority populations are defined as: Populations and communities who have been most harmed by historic and contemporary injustices and health inequities include but are not limited to Tribal Nations and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

<sup>41</sup> Including qualitative and quantitative data such as race, ethnicity, language, disability, sexual orientation, gender identity and other demographic data from the census; as well as data from community-initiated needs assessments explaining existing and emerging community needs.

barriers; increasing access to social and mental health supports; dismantling structural racism, such as efforts to expand and create future pathways for a more culturally and linguistically responsive work force; and affordable childcare. Further, depending on a community's needs, HEIs may focus interventions on a specific population, such as children and families, especially from priority populations. By allowing CICs to invest in the range of supports they know are of highest priority, HEI grants will facilitate community agency and resilience.

Figure 1. Oregon's proposed model forms Community Investment Collaboratives to leverage multiple sources of funding.\*



*\*In addition to investments from the state and CCOs, regional CICs could leverage other health system funds, such as hospital community benefit funding, and philanthropy for health equity investments in communities.*

#### *Invest in statewide health equity initiatives*

In addition to federal funds to invest in community-led interventions, Oregon requests investment in statewide, large-scale initiatives to address health equity. For example, Oregon seeks federal investment to modify the OHP to support members through disruptions in coverage and life transitions (described in section 3.2 above). The goal is to address gaps in Medicaid coverage; to extend coverage for a limited time; and to provide a defined set of supportive Social Determinant of Health services during transitional periods (e.g., aging out of foster care) or disruptive climate events (e.g., wildfire, heat). Given that Oregonians experiencing these transitions are disproportionately from populations and communities that have been most harmed by historic and contemporary injustices and health inequities, these initiatives will be critical to advancing health equity in the state.

### **3.6 Align with Tribal Partners' Priorities**

OHA is committed to working with the nine federally recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure Tribal health care objectives are achieved while honoring traditional Tribal practices and

upholding the government-to-government relationship between the sovereign nations and the state. OHA follows agreements and processes set forth in Oregon’s existing 1115 Medicaid Demonstration waiver, specifically Attachment I: Tribal Engagement and Collaboration Protocol, OHA’s Commitment Letter to Oregon Tribes, and the Tribal Consultation and Urban Indian Health Program Confer Policy. Please see *Section X. Align with Tribal Partners’ Priorities* that details Oregon’s requests in alignment with the federally recognized tribes. These priorities include:

- Removing prior authorization requirements for American Indian/Alaska Native patients
- Extending of the current Uncompensated Care Program
- Converting the Special Diabetes Program for Indians (SDPI) to a Medicaid Benefit
- Reimbursement for tribal-based practices
- Payment for currently unreimbursed social determinants of health services

## 4. Not Included in the State’s Request

### **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**

After careful consideration of community input and a comprehensive internal review, OHA has decided to not seek a renewal of its long-standing waiver regarding the EPSDT benefit for children and adolescents in its current structure.

OHA proposes to cover all treatments and services determined as medically necessary in accordance with the EPSDT benefit no later than January 1, 2024, after a phase out period, as described below.

The public and transparent process of Oregon’s Health Evidence Review Commission (HERC) and the Prioritized List of Health Services will retain important roles in determining OHP benefits for children, adolescents and adults. Oregon will specifically meet the EPSDT benefit requirements for children and adolescents in the following ways:

- Any treatment covered according to the Prioritized List of Health Services will, by default, be considered medically necessary for all people covered by OHP.
- For services not covered according to the Prioritized List, the medical necessity of services for individual children and adolescents will be considered on a case-by-case basis as required by EPSDT.

In preparation for this transition, OHA will take several steps to ensure that Medicaid-eligible children, adolescents and their families are aware of EPSDT and have access to

required screenings and medically necessary treatments. These steps include but are not limited to:

- The HERC will complete a comprehensive review of services not currently covered according to the Prioritized List of Health Services with attention to the unique needs of children and adolescents.
- The HERC will adjust the Prioritized List to ensure that all medically necessary EPSDT services for the population of children and adolescents are covered.
- For services not covered according to the Prioritized List, OHA will ensure there are accessible and effective pathways for individual case-by-case review of medical necessity as required by EPSDT. OHA is aware that these processes can be lengthy and burdensome to providers and families and aims to improve that experience. OHA understands that children, adolescents and families managing complex medical needs require processes that are accessible and responsive to their needs.
- OHA will develop clear guidance and communications for providers and families to ensure they are aware of the change in benefits, including the right to an individual determination of medical necessity.

In order to achieve OHA’s goal of eliminating health inequities by 2030, barriers to medically necessary care must be removed for children and adolescents in accordance with EPSDT.

## Section II. Waivers and Expenditure Authorities

As detailed in the table below, there are several changes requested in this renewal application, but the state believes that its existing authority already allows for many of the proposed changes. The state anticipates changes to its Special Terms and Conditions to reflect the proposed programmatic changes.

Oregon’s current waiver includes authority that the state wishes to maintain, including expenditure authority. These authorities allow the state to:

**Table 2. Current waiver includes authority that the Oregon wishes to maintain, including expenditure authority**

#	Request	Waiver/Expenditure Authority to continue
	Contract with managed care entities and insurers that operate locally	Section 1902(a)(1) 42 CFR 431.50
	Offer benefits consistent with a prioritized list of conditions and treatments, subject to certain exceptions for protected benefits	Section 1902(a)(10)(A) 1902(a)(10)(B) 42 CFR 440.230-250

Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans	Section 1902(a)(23)(A) 42 CFR 431.51
Not pay disproportionate share hospital payments for managed care enrollees	Section 1902(a)(13)(A)
In general, to permit coordinated care organizations to limit periods during which enrollees may disenroll, with an amendment the state is seeking with this renewal (see below)	Section 1902(a)(4) as implemented in 42 CFR 438.56(c) and 438.52
<ul style="list-style-type: none"> <li>• CCOs are expected to have comprehensive risk contracts.</li> <li>• State is considering potential options for risk- sharing arrangements.</li> <li>• Financial solvency requirements– State is considering brokering re-insurance or stop-loss insurance.</li> </ul>	<p>42 CFR § 434.20 and 21–basic HMO and PHP rules and contract requirements  SSA § 1902(a)(30): Payments must be consistent with efficiency, economy, and quality of care.  42 CFR § 438.6(b)– comprehensive risk contracts  42 C.F.R. § 434.50–protection against insolvency  42 CFR § 438.116–solvency standards</p>
<p>Oregon wishes to maintain its waiver to allow mandatory managed care enrollment, auto-enrollment without choice of plan, and lock-in for Medicaid-eligible populations, including for those dually eligible for Medicaid and Medicare.</p> <p>State will continue to provide choice among providers in plan</p>	42 CFR 431.51
Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed entities for care providers that do not comply with section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees’ right to disenroll in the initial 90 days of enrollment in an MCO.	
Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet	

the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.	
Receive federal financial participation for certain state-funded health care programs	
Expenditures for primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority that were restricted or eliminated from coverage effective January 1, 2010 for non-pregnant adults enrolled in OHP.	
Allowing passive enrollment of Medicare and Medicaid dually eligible individuals into CCOs with the option to opt out at any time.	
Permitting enrollees dually eligible through Medicare and Medicaid to disenroll from CCOs without cause at any time	42 CFR § 438.56
Extend the Tribal Uncompensated Care Program (UCCP) to extend payments to Tribal providers for certain services previously not funded under the OHP.	Section 1115 (a)
Implement Value-based payment methodologies to reimburse on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care and comprehensive care coordination, including requiring CCOs to make value-based payments for a minimum percentage of contracted services	42 CFR § 438.6
The inclusion flexible, health-related, services as reimbursable to CCOs at the medical services payment rate rather than as administrative costs	42 CFR § 434.20-21, SSA § 1902 42 CFR § 438.6

	Reinvestment of CCO savings into health-related services	42 CFR § 434.50 42 CFR § 438.116
	Doulas to provide services within the doula’s scope of practice without supervision of an existing licensed medical provider	SSA § 1905(a); 42 CFR § 440.60
	Facilitate Care Coordination and Care Coordination resources and access for American Indians and Alaska Natives (AI/AN), including primary care case management PCCM.	SSA § 1905(a) <b>§ 1902(a)(1) 42 CFR 431.50</b>
		Specifying the demonstration will not impact American Indian and Alaska Natives (AI/AN) rights to exemption from managed care, or the requirements to comply with the Medicaid Managed Care Regulations published April 26, 2016, including the AI/AN specific provisions at 42 CFR section 438.14.
		Establishing minimum requirements, such as inclusion of the Model Medicaid and CHIP Managed Care Addendum for Indian Health Care Providers, and a Model CCO Tribal Engagement and Collaboration Protocol for the CCOs to collaborate and communicate in a timely and equitable manner with tribes and Indian Health Care Providers.
In addition to Oregon’s existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow for:		
<b>#</b>	<b>Request</b>	<b>Waiver/Expenditure Authority</b>
1	Provide continuous Oregon Health Plan (OHP) enrollment for children until their sixth birthday (age 0 to 6);	To allow federal financial participation for the continuous enrollment of children without regard to whether a child’s income exceeds eligibility limits; and To enable the state to waive the requirements for individuals to report and the agency to act on changes with respect to income eligibility 42 C.F.R. 435.916



2	Establish two-year continuous OHP enrollment for people ages six and up; and	Expenditure authority to permit the State to implement continuous enrollment.
3	Count investments that meet the definitions in HB 3353 as medical expenses for the purposes of rate setting <sup>1</sup>	Expenditure authority to count investments described in Oregon House Bill 3353 as medical expenses for the purposes of rate setting
4	A new federal investment focused on improving health equity, including investments to build infrastructure to support health equity interventions; support community-led health equity interventions and statewide initiatives; grant community-led collaboratives resources to invest in health equity.	Expenditure authority for state-funded health-related initiatives.
5	Obtain spending authority to support implementation capacity at the community level, including payments for provider and community-based organizations (CBO) infrastructure and capacity building.	Expenditure authority to fund payments to provider and community-based organizations for infrastructure and capacity building.
6	Expenditure authority to receive federal match on Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions or disruptions as described in Section IV - Benefits.	Expenditure authority to fund health-related services for members experiencing certain life transitions.
7	Cover through Medicaid certain costs of medical services for a member in custody, including justice-involved populations and those in the Oregon State Hospital and psychiatric residential facilities	Expenditure authority for Medicaid services rendered to institutionalized individuals.
8	Retain child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) from age 17-26.	Waiver of comparability to permit the State to offer additional benefits to YSCHN up to age 26, specifically, sections 1902(a)(10) and 1902(a)(17). Expenditure authority to cover YSCHN from age 17-26 up to 300 % of the federal poverty level, who would not otherwise be eligible for Medicaid.
9	Expand and fund, with spending authority, the infrastructure needed to	Expenditure authority for services delivered by Traditional Health Workers,

	support access to services using providers outside of the medical model.	including community health workers, personal health navigators, peer wellness and support specialist and doulas.
10	Oregon proposes to pay for added Psychiatric Residential Treatment Services (PRTS) care and capacity that prioritizes access for youth in Child Welfare.	Expenditure authority to pay for reserved Psychiatric Residential Treatment Services (PRTS) and prioritize youth in Child Welfare custody for these services.
11	Authority to modify the managed care rate setting process to provide longer-term predictability and flexibility to CCOs and providers, in turn driving additional upstream investments in prevention and health-related services to improve health outcomes and reduce avoidable healthcare costs.	Expenditure authority to pay for capitation rates that are built with specified deviations from the rate development standards outlined in 42 C.F.R. 438.5.
12	Authority to allow exclusion of accelerated-approval drugs that have not been shown to be clinically effective	Waiver of the permissible coverage restriction requirements for outpatient drugs, specifically §1902(a)(54) insofar as it incorporates Section 1927(d)(1)(B; §1902(a)(14) insofar as it incorporates Section 1916 and 1916A; §1902(a)(23)(A)
13	Authority to count CCO investments in health equity required by HB 3353 and as described in <i>Section V. Delivery System and Payment Rates</i> as medical claims or quality improvement spending for purposes of CCO rate setting.	Expenditure authority to pay for capitation rates that are built with specified deviations from the rate development standards outlined in 42 C.F.R. 438.5.

## Section III. Demonstration Eligibility

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

### **Oregon aims to address these issues by:**

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

The populations impacted by the demonstration and the eligibility and benefit criteria applied to each are described below. Oregon wishes to retain all existing eligibility groups providing the full OHP Plus benefit package, with enhanced and/or protected benefits for children and pregnant individuals. The state intends to continue with the current managed care delivery system, utilizing Coordinated Care Organizations (CCO). Under this demonstration, Oregon proposes extending services and supports to members experiencing life transitions.

## Populations impacted by the demonstration

### **Youth transitioning to adulthood with Special Health Care Needs**

Youth with Special Health Care Needs have challenges transitioning from pediatric to adult services, health care coverage and social supports. Many of these children and young adults are from communities of color, LGBTQAI+, members of Tribes in Oregon and have experienced homelessness, Intellectual and Developmental Disability (IDD)<sup>42</sup> or poverty. Addressing this transition is key to Oregon's health equity goals because few YSHCN are receiving adequate transition preparation, and some evidence indicates that this situation is worse for racial and ethnic minorities.<sup>43</sup> According the 2018-19 National Survey of Children's Health, 45% of Oregon youth aged 12-17 had a special health care need. Family members of youth with special health care needs reported that:

- 69% did not receive health care transition preparation services,

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<sup>42</sup> <https://link.springer.com/article/10.1007/s11920-019-1016-1>

<sup>43</sup> [https://pediatrics.aappublications.org/content/126/Supplement\\_3/S129.short](https://pediatrics.aappublications.org/content/126/Supplement_3/S129.short)

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

The transition to adulthood requires the youth to apply for Medicaid separately from their parents or guardians to avoid a lapse in coverage. The coverage itself also changes from a package of benefits designed for children and adolescents to benefits designed for adults. Removing the transition to a new adult benefit package, while including YSHCN as eligible for transitional SDOH services, will provide them time to better navigate these changes with the fewest possible disruptions, increasing the likelihood that they will transition into adulthood with the care and access necessary for good health and quality of life. This coverage change applies to adolescents and young adults with a behavioral, developmental, emotional, and/or long-term or chronic physical condition ages 17 up to 26 years.

For young adults with special health care needs, effective transition from pediatric to adult health care results in increased<sup>45</sup>:

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

and decreased:

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

Providing additional supports (described in *Section IV. Benefits and Cost Sharing*) will provide these youth sufficient time to better navigate these changes with the fewest possible disruptions, increasing the likelihood that they will transition into adulthood with uninterrupted and coordinated access to care and services necessary for good health and an improved quality of life.

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<sup>44</sup> Oregon Center for Children and Youth with Special Health Needs Fact Sheet, Rev. 4/26/2021  
<https://www.ohsu.edu/sites/default/files/2021-04/Transition%20FACT%20SHEET%20rev.4.26.2021.pdf>

<sup>45</sup> Oregon Center for Children and Youth with Special Health Needs Fact Sheet, Rev. 4/26/2021, Op. cit.

*Strategy 1: Provide YSHCN with extended income eligibility for Medicaid (300% FPL) until the age of 26*

- Oregon proposes to extend OHP coverage until age 26 and retain eligibility levels of 300% FPL, maintaining child income eligibility and benefits for Medicaid for youth with special health care needs.
- In order to be eligible for extended coverage, youth must have met YSHCN qualifications before the age of 19.

*Strategy 2: Support YSCHN as they transition to adulthood with a package of services that provides health and social supports ages 17- 26.*

- Youth with special health care needs between age 17 until age 26 will be able to access a package of transition-specific social determinants of health services described in *Section IV. Benefits and Cost Sharing*.
- The package of transition services will:
  - Support the transfer of care between pediatric and adult clinical providers; and
  - Provide social support services such as food, housing, employment, education and transportation supports

**Table 3. Supporting youth with special health care needs transitioning to adulthood**

Youth transitioning to adulthood with Special Health Care Needs	
Description	Adolescents and young adults with a qualifying behavioral, developmental, emotional, and/or physical condition ages 17 up to 26 years.
Standards and Methodology	<p>This creates a new OHP eligibility category that will provide OHP coverage for youth with special health care needs that are transitioning into adulthood, up to age 26. To qualify for this eligibility category, the youth must meet the following criteria.</p> <ul style="list-style-type: none"> <li>• Be at least 17 years of age; and</li> <li>• Have active and continuous OHP eligibility at the time they turn 19 years of age; and</li> <li>• Countable income not to exceed 300% FPL; and</li> <li>• Have one of the following:               <ul style="list-style-type: none"> <li>○ Have service or Medicaid eligibility through Aged and Peoples with Disabilities (APD); or</li> <li>○ Have service or Medicaid eligibility through Oregon Developmental Disability Services (ODDS); or</li> <li>○ Have an intellectual or developmental disability; or</li> <li>○ Have a complex chronic condition or impairment that may be physical, developmental, behavioral, or emotional in nature.</li> </ul> </li> </ul>
Projected # of Individuals	<p>Oregon anticipates this population will grow throughout the duration of the demonstration. Estimates by state fiscal year are below.</p> <p>SFY 24 – 1,500            SFY 25 – 3,000            SFY 26 – 4,500            SFY 27 – 6,000</p>

## Justice-involved

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

Failure to provide health insurance and health care services to individuals transitioning from custody has a major impact on recidivism, health outcomes, and cost.<sup>46,47</sup> Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses.<sup>48</sup> And once again, people of color are over-represented among those incarcerated in Oregon,<sup>49</sup> which means people of color are disproportionately harmed by gaps in OHP coverage often experienced transitioning from institutions.

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

- limited OHP coverage and
- CCO enrollment that covered care coordination and navigation services alongside the proposed transition SDOH services (*described in Section IV. Benefits and Cost Sharing*).

Oregon requests expenditure authority for federal match to enroll a person in custody in OHP for the following populations. These individuals otherwise meet the Medicaid eligibility criteria except for their custody status.

Table 4. Youth in the custody of the Juvenile Justice System placed in secure facilities

Youth in custody of the Juvenile Justice System placed in secure facilities	
Description	Youth in custody (pre- and post- adjudication) of the Juvenile Justice System and reside in a juvenile corrections or detention facility, such as those managed by the Oregon Youth Authority and local or county juvenile department, who either enter with current OHP enrollment or become enrolled while in custody.
Standards and Methodology	<ul style="list-style-type: none"><li>• Youth must be residing in a close-custody correctional or detention facility under the jurisdiction of the Oregon Youth Authority or county/local juvenile departments.</li></ul>

<sup>46</sup>[https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing\\_30\\_Day\\_Inpatient\\_Psychiatric\\_Recidivism.8.aspx](https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing_30_Day_Inpatient_Psychiatric_Recidivism.8.aspx)

<sup>47</sup> [https://cdr.lib.unc.edu/concern/honors\\_theses/j6731775s](https://cdr.lib.unc.edu/concern/honors_theses/j6731775s)

<sup>48</sup> Rich, J. D., Wakeman, S. E., & Dickman, S. L. (2011). Medicine and the Epidemic of Incarceration in the United States. *New England Journal of Medicine*, 364(22), 2081- 2083. doi:10.1056/nejmp1102385

<sup>49</sup> <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf>

	<p>Eligibility is determined pursuant to 42 CFR as implemented through the Oregon Administrative Rules Section 410, Division 200. The child must be under the age of 19, meet the income standards for the eligibility determination group, and meet the non-financial eligibility criteria based on the program.</p> <p>Oregon Youth Authority Closed-Custody Correctional Facilities:</p> <ul style="list-style-type: none"> <li>• Young adults over the age of 18 under the legal jurisdiction of the Department of Corrections but in the physical custody of an Oregon Youth Authority closed-custody correctional facility will receive the benefits outlined for adults incarcerated and in custody of the Department of Corrections.</li> <li>• Youth and young adults in the Oregon Youth Authority closed custody correctional facilities, including those under the legal jurisdiction of the Department of Corrections, will continue to be identified and reported to the Agency for OHP suspension of all Medicaid benefits until such time as they are eligible for the limited benefit package within 90 days of release. The Oregon Youth Authority will continue existing processes that include release planning prior to their release to the community.</li> <li>• The application for OHP eligibility is determined within 90 days or less of the youth’s release to the community. A new benefit package with limited OHP eligibility will be authorized until release, if found eligible. Upon returning to the community the full OHP benefit package will be available.</li> <li>• Eligibility will be determined through the use of trained Oregon Youth Authority staff using the OregONEligibility(ONE) system. The exception will be for youth in the legal custody of Child Welfare. Child Welfare youth will continue to assign OHP eligibility using the ORKids system.</li> </ul> <p>Local Detention Facilities:</p> <ul style="list-style-type: none"> <li>• Youth encountering a county or local juvenile detention facility with active OHP benefits will continue to receive the full OHP benefit package for the duration of incarceration at the facility.</li> <li>• Youth encountering a county or local juvenile detention facility without OHP eligibility will be offered an opportunity to apply for OHP with the assistance of a community application assistor. If found eligible they will receive the full OHP benefit package for the duration of their incarceration at the juvenile detention facility.</li> <li>• Youth encountering a county or local juvenile detention facility that are identified as releasing to the community will be assessed for transitional services as defined in the benefit package.</li> <li>• Eligibility will be determined through the use of community-based application assistors or trained agency staff using the</li> </ul>
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	<p>OregONEligibility (ONE) system. The exception will be for youth in the legal custody of Child Welfare. Child Welfare youth will continue to assign OHP eligibility using the ORKids system.</p> <p>When applicable, notification of OHP eligibility and CCO enrollment will be communicated to the receiving CCO via the 834-enrollment file followed by subsequent community provider assignments.</p>
Projected # of Individuals	130 individuals, annually

**Table 5. Adults incarcerated and in custody of the Department of Corrections**

Adults incarcerated and in custody of the Department of Corrections	
Description	Individuals in custody of Department of Corrections planned for release within in 90 days or less and meet Medicaid income requirements and would otherwise meet Medicaid eligibility requirements.
Standards and Methodology	<p>An individual transitioning from a Department of Corrections facility to a county jail or local correctional facility for the purpose of responding to separate charges will be subject to the allowable benefit package associated with their place of incarceration.</p> <p>Young adults over the age of 18 under the legal jurisdiction of the Department of Corrections but in the physical custody of an Oregon Youth Authority closed-custody correctional facility will receive the benefits outlined for adults incarcerated and in custody of the Department of Corrections.</p> <p>Adults entering the Department of Corrections will continue to be identified and reported to the Agency for OHP suspension of all Medicaid benefits until such time as they are eligible for the limited benefit package within 90 days of release. The Department of Corrections will continue existing processes that include release planning with incarcerated individuals 90 days prior to their release to the community.</p> <p>The application for OHP eligibility is determined within 90 days or less of the adult’s release to the community. A new benefit package with limited OHP eligibility will be granted until release, if found eligible. Upon returning to the community the full OHP benefit package will be available.</p> <p>Eligibility is determined pursuant to 42 CFR as implemented through the Oregon Administrative Rules Section 410, Division 200. The adult must be age 19 or older, meet the income standards for the eligibility determination group, and meet the non-financial eligibility criteria based on the program.</p> <p>Eligibility will be determined through the use of trained Department of Corrections (DOC) staff using the Oregon Eligibility (ONE) system. Notification of the limited OHP benefits and CCO enrollment will be communicated to the receiving CCO via the 834-enrollment file</p>



	followed by subsequent community provider assignments. Upon release from incarceration the DOC will notify OHP of the release and address released to for access to the full OHP eligibility and benefit package with local CCO providers.
Projected # of Individuals	Oregon anticipates this population will grow between the first two years of implementation. Estimates by state fiscal year are below. SFY 24 – 842 SFY 25 – 918 SFY 26 – 918 SFY 27 – 918

**Table 6. Adults in custody of local correction facilities**

Adults in custody of local correction facilities	
Description	Individuals in custody (pre- and post- adjudication) of county jails or local correction facilities, including Tribal jails, who either enter with current OHP enrollment or become enrolled while in custody.
Standards and Methodology	<p>Additionally, an adult transitioning from one county jail, local correctional facility, or a Department of Corrections facility into a new occurrence at another county jail or local correctional facility for the purpose of responding to separate charges will be subject to the allowable benefit package associated with their place of incarceration. Adults encountering a county jail or local correctional facility with active OHP benefits will continue to receive the full OHP benefit package for the duration of incarceration at the facility.</p> <p>Adults encountering a county correctional facility without OHP eligibility will be offered an opportunity to apply for OHP with the assistance of a community application assistor. If found eligible they will receive the full OHP benefit package for the duration of their incarceration at the county jail or local correctional facility.</p> <p>Adults in the custody of county jails or local correctional facilities that are identified as releasing to the community will be assessed for transitional services as defined in the benefit package.</p> <p>Eligibility is determined pursuant to 42 CFR as implemented through the Oregon Administrative Rules Section 410, Division 200. The adult must be age 19 or older, meet the income standards for the eligibility determination group, and meet the non-financial eligibility criteria based on the program.</p> <p>Eligibility will be determined through the use of community application assistants and trained county jail or local correctional facility staff using the Oregon Eligibility (ONE) system.</p> <p>Notification of the OHP eligibility and CCO enrollment will be communicated to the receiving CCO via the 834-enrollment file followed by subsequent community provider assignments. Upon release from incarceration the county jail or local correctional facility</p>

	the OHP Member will notify OHP of their updated address to ensure timely access to their local CCO providers.
Projected # of Individuals	Oregon anticipates this population will grow between the first two years of implementation. Estimates by state fiscal year are below. SFY 24 – 10,562 SFY 25 – 11,522 SFY 26 – 11,522 SFY 27 – 11,522

**Institute for Mental Disease (IMD)**

Oregon was granted an IMD exclusion under its 1115 SUD waiver. Oregon seeks to extend this eligibility criteria to include individuals in non-SUD IMDs including the Oregon State Hospital (OSH).

**Table 7. Adults (over age of 21) in the Oregon State Hospital (OSH) or are in a Psychiatric Residential Treatment Facility (IMD)**

Adults (over age of 21) in the Oregon State Hospital (OSH) or are in a Psychiatric Residential Treatment Facility (IMD)	
Description	<ul style="list-style-type: none"> <li>Adults who are in the care of the Oregon State Hospital (OSH) or Psychiatric Residential Treatment Facility that is an Institute of Mental Disease (IMD) who meet Medicaid income eligibility who are planned for discharge within 90 days, <u>or less</u>.</li> <li>Oregon Medicaid does not currently have any enrolled Psychiatric Residential Facilities (IMD) outside of the Oregon State Hospital. The following assumes that in the waiver timeframe there will be greater access.</li> </ul>
Standards and Methodology	<p>The application for OHP eligibility is determined within 90 days or less of the Oregonians discharge from the Oregon State Hospital. A new benefit package with limited OHP eligibility will be granted until discharge, if found eligible. Upon discharge from the Oregon State Hospital the full OHP benefit package will be available.</p> <p>Adults entering the Oregon State Hospital who are already enrolled in OHP will continue to be identified and reported to the Agency for OHP suspension of all Medicaid benefits until such time as they are eligible for the limited benefit package within 90 days of discharge. The Oregon State Hospital will continue existing processes that include discharge planning with patients throughout their stay.</p> <p>For those who are not already enrolled, Eligibility is determined pursuant to 42 CFR as implemented through the Oregon Administrative Rules Section 410, Division 200. The adult must be age 19 or older, meet the income standards for the eligibility determination group, and meet the non-financial eligibility criteria based on the program.</p>

	<p>Eligibility will be determined through trained Oregon State Hospital staff using the Oregon Eligibility (ONE) system. Notification of the OHP eligibility and CCO enrollment will be communicated to the receiving CCO via the 834-enrollment file followed by subsequent community provider assignments. Upon discharge from the Oregon State Hospital the staff will notify OHP of the discharge and updated address to ensure timely access to their local CCO providers.</p>
<p>Projected # of Individuals</p>	<p>Approximately 360 individuals per year for each demonstration year</p>

**Changes to Eligibility Processes**

**SNAP**

After discussion with CMS, Oregon is no longer requesting an expedited OHP enrollment option for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits through the 1115 Waiver. OHA and CMS are investigating options to pursue this through a State Plan Option or other mechanisms.

**Changes to Redetermination Process**

Oregon is requesting changes to the redetermination process for already-eligible individuals to extend the duration of enrollment before undergoing income verification. Members will be subject to the same existing mandatory reporting regarding a change in physical or mailing address and a change in household membership including death. Additional existing safeguards will continue to remain in place, including taking action on cases when mail is returned, in response to reports of deaths from Vital Records, and in response to reports that alert us to a member applying for benefits in another state. We anticipate the new enrollment and redetermination processes included in this waiver application will begin no sooner than mid-2023 and therefore after 12 months following the end of the Public Health Emergency and the end of Maintenance of Effort requirements

**Provide continuous enrollment for children until their 6<sup>th</sup> birthday**

Oregon requests to provide continuous enrollment for children through the end of the month in which their 6th birthday falls, regardless of when they first enroll in the Oregon Health Plan, and regardless of changes in circumstances that would otherwise cause a loss of eligibility. This demonstration request will end churn among young Medicaid-enrolled children to better address their primary and preventive health care needs. It will ensure coverage disruptions do not prevent children from receiving any ongoing

treatment and services they require during the critical early years of development and growth.

**Table 8. Continuous enrollment for children until their 6<sup>th</sup> birthday**

Continuous enrollment for children until their 6 <sup>th</sup> birthday	
Projected # of Individuals	Oregon anticipates the number of members under this redetermination change will grow throughout the duration of the demonstration. Estimates by state fiscal year are below. SFY 24 – 4,850 SFY 25 – 14,007 SFY 26 – 22,522 SFY 27 – 29,256

**Establish two-year continuous OHP enrollment for people ages 6 and up**

Oregon also seeks to provide continuous two-year enrollment for people ages 6 and older, regardless of changes in circumstances that would otherwise cause a loss of eligibility. This change will stabilize coverage for older children and adults, increase access to primary and preventative services and preserve patients’ continuity in access ongoing care.

**Table 9. Two-year continuous OHP enrollment for people ages 6 and up**

Two-year continuous OHP enrollment for people ages 6 and up	
Projected # of Individuals	Oregon anticipates the number of members under this redetermination change will grow throughout the duration of the demonstration. Estimates by state fiscal year are below. SFY 24 – 5,438 SFY 25 – 15,605 SFY 26 – 22,253 SFY 27 – 27,763

**Long-term services and supports**

Long-term services and supports are not furnished under the demonstration.

**Table 10. Existing Populations**

Oregon wishes to maintain eligibility for the following populations. There are no enrollment limits on any population. Please note, Oregon intends to apply a 5% income disregard.

<b>Pop.</b>	<b>Description</b>	<b>Funding</b>	<b>Authority</b>	<b>Income Limits</b>	<b>Resource Limits</b>	<b>Benefit Package</b>	<b>EG Group</b>
1	Pregnant Women	Title XIX	Title XIX state plan and section 1115	0% up to 185% FPL	None	OHP Plus	Base 1
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL**  Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or  Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus	Base 1
4	Children 0 through 18	Title XXI	Title XXI state plan and section 1115	134% up to 300% FPL	None	OHP Plus	Base 1

5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	\$2,000	OHP Plus	Base 2
6	Medicaid mandatory section 1931 low income families. (parents /caretaker relatives and their children)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent amounts	\$2,500 for applicants, \$10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1
7	Aged, Blind, & Disabled	Title XIX  Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	SSI Level	\$2,000 for a single individual, \$3,000 for a couple	OHP Plus	Base 2

8	Aged, Blind, & Disabled	Title XIX  Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	\$2,000 single individual; \$3,000 for a couple	OHP Plus	Base 2
9	Former Foster Care Youth to age 26	Title XIX	Title XIX state plan and Section 1115	No FPL limit if in Oregon Foster Care at age 18	None	OHP Plus	Base 1
21	Uninsured or underinsured women under the age of 65 receiving treatment services under the Breast and Cervical	Title XIX	Title XIX state plan and Section 1115	0% up to 250% FPL	None	Limited – case-by-case basis	Base 1
23	Low-Income Expansion Adults	Title XIX	Title XIX state plan and Section 1115	0% up to 133% FPL	None	ABP  (OHP Plus)	Base 2

**Table 11. Proposed New Population**

Oregon proposes to add eligibility for the following population. There are no enrollment limits on any population. Please note, Oregon intends to apply a 5% income disregard.

Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
Youth transitioning to adulthood (aged 17-26) with Special Health Care Needs (YSHCN)	Title XXI	Title XXI state plan and section 1115	134% up to 300% FPL	None	OHP Plus	Base 1



## Section IV. Demonstration Benefits and Cost Sharing Requirements

Oregon is proposing changes to how services that are designed to stabilize disruptive transitions across different systems, across health care settings and across life stages, or due to point-in-time events, are paid for and provided to members. The proposed strategies aim to address the spectrum of factors that impact health, both medical and non-medical, by providing services to members aimed at addressing the social determinants of health (SDOH). This may also occur – through community-based services provided outside of the medical model - prior to transitions in Medicaid benefit and/or eligibility changes.

Transitions that frequently create gaps in coverage or access to services are triggered by movement across stages of life, changes in institutionalization, natural disasters, or combinations of these. Further, gap-causing transitions occur disproportionately for OHP members from communities of color, limiting their ability to have their health and social needs met. Periods of significant transition are challenging for OHP members to navigate given the complicated health care system, as members may lose Medicaid eligibility or be disenrolled from their CCO, resulting in disruptions in treatment and coordination between providers.

Services that would improve the ability of a member to maintain their health and quality of life, such as readily available access to housing supports once released from custody, are not traditionally Medicaid covered benefits. Disruptions in coverage and benefits caused by these events can cause instability in a person's life at a moment of increased vulnerability and often lead to gaps in access to providers or services, resulting in adverse health outcomes and more costly care further down the road.

Oregon intends to maintain all existing benefits and add two new benefits under this renewal:

- A limited OHP benefit covering coordination services for individuals in custody; and
- A suite of social determinants of health support services for populations experiencing transitions.

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

## Oregon Health Plan Coordination Benefit Package for individuals in custody

Oregon proposes adding a limited benefit package covering care coordination and continuum of care services to adults in custody, non-SUD IMD settings, and youth in the Oregon Youth Authority closed-custody correctional settings 90 days prior to release. Specific eligibility criteria are described in *Section III. Eligibility*. Routine medical care and other services provided by the facility would not be included in this benefit.

Table 12. Services for individuals in custody

Category	Types of services
<b>CARE COORDINATION NAVIGATION</b>	<p>For individuals experiencing transitions, a care coordination navigator will be available to provide:</p> <ul style="list-style-type: none"> <li>• Care coordination services for health-related assessments in preparation for returning to the community</li> <li>• Provider identification and scheduling health care appointments in preparation for returning to the community</li> <li>• Navigation services to support connections to SDOH and health services once they are released</li> </ul>
<b>CONTINUUM OF CARE</b>	<p>When an individual moves between health systems or settings, they can experience changes in what health plan coverage they have access to, and what services those plans cover. Sometimes this leaves them unable to schedule appointments with a new provider, which can create gaps in access to medical necessities like insulin or services designed to support recovery from substance use disorders.</p> <p>These services are designed to facilitate a continuum of care as an individual transitions between systems and to ensure a smoother connection to providers and services. For individuals who are incarcerated or in an IMD facility, eligibility for full OHP benefits begins upon release, but screenings and assessments are often needed to establish the need for specific providers, which can delay access to care. These services may include:</p> <ul style="list-style-type: none"> <li>• Drug and alcohol screenings and assessments</li> <li>• Behavioral health screenings and assessments</li> <li>• Telehealth appointments to establish as a new patient with a primary care or behavioral health provider</li> <li>• 60 days of prescription medication when returning to community to augment the 30 days provided by the releasing facility</li> </ul>

## Changes to Benefit Packages – Social Determinants of Health Support Services

Short-term, focused supports and services will be individualized to a member’s transition and circumstances based on a social needs assessment. They will reduce the impact of events that exacerbate health inequities, leading to better health outcomes and downstream cost savings for the state and federal government.

Oregon is requesting up front federal investment through Designated State Health Programs (DSHP) to fund these defined services outside of the per member per month (PMPM) capitation rate paid to CCOs to demonstrate that providing these services results in greater stability for the member and improved health. The DSHP funds will be directed to finance SDOH transitions support services for populations which disproportionately face historic and contemporary injustices, and to fund Community Investment Collaboratives to support Oregon’s goal of eliminating health inequities in the state by 2030. Over the course of the demonstration, Oregon expects DSHP funding to phase out and for those services to be paid for by CCOs and incorporated into the rate setting process.

By making these supports available, members experiencing qualifying transitions will have access to the tools necessary to successfully navigate the transition while maintaining the stability needed for good health and quality of life. By funding these services through CCOs outside of the capitation rate initially, the state will learn which services are most effective as CMS phases down its additional funding.

Table 13. Categories of Transition Support Services

Category	Types of services and anticipated impact on health:
<b>HOUSING SUPPORTS</b>	<p>Access to safe, quality, affordable housing and the supports necessary to maintain stable housing constitutes one of the most basic and powerful social determinants of health. Securing housing requires more than just locating a property with vacancy, it means providing a person with a package of supportive services to ensure stability, predictability, and health. These services are designed to work in conjunction with programs offered by state, local and community organizations that provide training and education to build the skills needed to find and maintain stable housing, and may include:</p> <ul style="list-style-type: none"> <li>• Rental assistance or temporary housing (rental payments, deposits, past rent, motels, etc. for up to 12 months)</li> <li>• Home and community-based services (ramps, handrails, environmental remediation, etc.)</li> </ul>

Category	Types of services and anticipated impact on health:
	<ul style="list-style-type: none"> <li>• Utility assistance (device and broadband support, utility set-up, resources for bill assistance)</li> <li>• Pre-tenancy and tenancy support services (employment services, eviction prevention, housing application, moving support, etc.)</li> <li>• Housing-focused navigation</li> <li>• Assisting with identifying housing preferences, completing housing application and selection process, developing housing support plan, completing reasonable accommodations requests, reducing risk of eviction (conflict resolution etc.)</li> <li>• Supports for budgeting and financial literacy and independent living skills</li> </ul>
<b>FOOD ASSISTANCE</b>	<p>Food assistance is intended to be provided alongside housing supports and furthers the goal of creating a stable and healthy environment for individuals experiencing disruptive life transitions. Access to nutritious food and a healthy diet is a primary driver of health. These services are designed to connect people with the framework and tools for healthy eating, and may include:</p> <ul style="list-style-type: none"> <li>• Links to community-based food resources (e.g., application support for Supplemental Nutrition Assistance Program (SNAP)/Special Supplemental Nutrition Program for Women, Infants and Children (WIC))</li> <li>• Nutrition and cooking education</li> <li>• Fruit and vegetable prescriptions and healthy food boxes/meals</li> <li>• Medically tailored meal delivery</li> <li>• Assistance accessing school-based food programs</li> </ul>
<b>EDUCATION SUPPORTS</b>	<p>Education is intrinsically tied to health and well-being. People with higher levels of education are more likely to be healthier and live longer. These services may include:</p> <ul style="list-style-type: none"> <li>• Person centered employment planning through education (e.g., skills and interest assessments etc.)</li> <li>• Assistance with FAFSA, grant, and scholarship applications for vocation schools or higher education</li> </ul>

Category	Types of services and anticipated impact on health:
	<ul style="list-style-type: none"> <li>• Assistance locating and applying for the vocation schools or higher education</li> </ul>
<b>EMPLOYMENT SUPPORTS</b>	<p>Once stable housing and access to healthy food have been established, creating connections to community and job opportunities further the goal of ensuring a stable and successful transition. These services are intended to provide individualized educational supports, skill development, job training and placement, and may include:</p> <ul style="list-style-type: none"> <li>• Person-centered employment planning support</li> <li>• Individualized job development and placement (e.g., job fairs, interviews)</li> <li>• Mentoring (e.g., on how to change behavior, re-entry from incarceration)</li> <li>• Linkage to appropriate interview attire</li> <li>• Transportation (provided either as a separate transportation service to employment services or to the member’s job)</li> </ul>
<b>HEALTH-RELATED NON-MEDICAL TRANSPORTATION</b>	<p>Outside of the environmental factors that impact health, direct access to social service and SDOH providers is also a challenge for many individuals because they do not have access to a vehicle, cannot drive because of a medical condition, do not live in an area where public transportation is available, or cannot afford the cost of transportation. These services are designed to bridge the gap between the individual and the service provider when a lack of reliable transportation is the barrier. This benefit expands beyond NEMT which is available to OHP members, and may include:</p> <ul style="list-style-type: none"> <li>• Linkages to existing transportation resources and programs</li> <li>• Payment for transportation to support access to SDOH services, (e.g., bus passes, taxi vouchers, ridesharing credits).</li> <li>• Payment for transportation to education, job search activities, and employment</li> <li>• Health-related transportation services in addition to Non-Emergency Medical Transportation (NEMT)</li> </ul>

Category	Types of services and anticipated impact on health:
	<ul style="list-style-type: none"> <li>• Transportation to warming, cooling, or evacuation shelters in extreme weather events</li> </ul>
<b>CLIMATE SUPPORTS</b>	<p>Weather emergencies and natural disasters can happen unexpectedly or with little warning forcing people to leave without warning and flee to a safer place. For those individuals who are already more vulnerable due to serious medical conditions or unstable living environments, emergencies can be even more difficult to recover from. These supports are designed to address a sudden or acute need that disrupts a person’s access to their belongings or healthy living environment as a result of an extreme climate event, and may include:</p> <ul style="list-style-type: none"> <li>• Payment for transportation to cooling / warming and/or evacuation shelters (e.g., taxi vouchers, ridesharing credits, use of NEMT or health-related transportation above)</li> <li>• Payment for devices that maintain healthy temperatures and clean air, including air conditioners, heaters, air filters and generators to operate devices when power outages occur</li> <li>• Payment or vouchers to address high electric bills due to extreme temperatures</li> <li>• Housing supports and services, housing repairs due to wildfires to make housing livable</li> <li>• Immediate access to durable medical equipment (DME) left behind without a prescription or prior authorization</li> <li>• Clothing and/or food for members affected by extreme (e.g., wildfire) weather events</li> <li>• Broadband or other internet supports to help adults and children to access important services, such as education</li> </ul>
<b>OTHER</b>	<ul style="list-style-type: none"> <li>• Additional services for specific populations are described below.</li> </ul>

**Changes to Benefits by Population**

Descriptions of these populations may be found in *Section III. Eligibility*. Services will be age appropriate and catered to an individual’s needs based on a social needs screening.

Table 14. Changes to Benefits by population

Population	Services
<p><b>Adults incarcerated and in the custody of the Department of Corrections</b></p>	<p>OHP Coordination Benefit Package</p> <ul style="list-style-type: none"> <li>• Adults incarcerated/in custody of Department of Corrections who would be eligible for Medicaid except for custody status will receive limited OHP benefits 90 days prior to release to facilitate a smooth transition once released</li> </ul> <p>Social determinants of health services available upon release and enrollment into full OHP may include:</p> <ul style="list-style-type: none"> <li>• Housing supports</li> <li>• Education supports</li> <li>• Employment supports</li> <li>• Health-related non-medical transportation</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>• Routine medical care provided while in custody</li> <li>• Full OHP benefit package while in custody</li> </ul>
<p><i>Projected # of Individuals</i></p>	<p>Oregon anticipates this population will grow between the first two years of implementation. Estimates by state fiscal year are below.</p> <p>SFY 24 – 842            SFY 25 – 918            SFY 26 – 918            SFY 27 – 918</p>
<p><b>Adults in custody of local correction facilities</b></p>	<p>Full OHP benefit package</p> <ul style="list-style-type: none"> <li>• Adults in custody of local corrections facilities, including Tribal jails, who are already OHP members or become enrolled while in custody will receive the full OHP benefit package for the duration of their stay in local corrections.</li> </ul> <p>Social determinants of health services upon release may include:</p> <ul style="list-style-type: none"> <li>• Housing supports</li> <li>• Education supports</li> <li>• Employment supports</li> <li>• Health-related non-medical transportation</li> </ul> <p><i>Benefit does not include:</i></p>

Population	Services
	<ul style="list-style-type: none"> <li><i>Routine medical care provided while in custody</i></li> </ul>
<i>Projected # of Individuals</i>	<p>Oregon anticipates this population will grow between the first two years of implementation. Estimates by state fiscal year are below.</p> <p>SFY 24 – 10,562  SFY 25 – 11,522  SFY 26 – 11,522  SFY 27 – 11,522</p>
<p><b>Adults (over the age of 21) who are in the care of the Oregon State Hospital (OSH) or are in a Psychiatric Residential Treatment Facility</b></p>	<p>Limited OHP benefit package</p> <ul style="list-style-type: none"> <li>Adults in the care of the Oregon State Hospital or other Psychiatric Residential Treatment Facility (IMD) would be eligible for Medicaid except for custody status will receive limited OHP benefits 90 days prior to release to facilitate a smooth transition once discharged.</li> </ul> <p>Social determinants of health services upon discharge may include:</p> <ul style="list-style-type: none"> <li>Housing supports</li> <li>Education supports</li> <li>Employment supports</li> <li>Health-related non-medical transportation</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li><i>Routine medical care provided by the facility</i></li> <li><i>Full OHP benefit package while in custody</i></li> </ul>
<i>Projected # of Individuals</i>	<p>Approximately 360 individuals per year for each demonstration year</p>
<p><b>Youth in custody of Local Juvenile Detention Facilities</b></p>	<p>Full OHP benefit package</p> <ul style="list-style-type: none"> <li>Youth in custody of local Juvenile Detention facilities who are already OHP members or become enrolled while in custody will receive the full OHP benefit package for the duration of their stay in the facility.</li> </ul> <p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>Health-related non-medical transportation</li> <li>Secure non-emergent transportation services to health-related appointments</li> <li>Navigation supports moving into the adult serving systems and transitioning into community or independent living</li> </ul>



Population	Services
	<ul style="list-style-type: none"> <li>Life skills training</li> <li>Peer navigator</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>Routine medical care provided while in custody</li> </ul>
<i>Projected # of Individuals</i>	130 individuals, annually
<p><b>Youth in custody of Oregon Youth Authority Juvenile Corrections placed in secured facilities</b></p>	<p>OHP Coordination Benefit Package</p> <ul style="list-style-type: none"> <li>Youth in custody of the Oregon Youth Authority in closed-custody correctional facilities who would be eligible for Medicaid except for custody status will receive limited OHP benefits (SDOH transitions package) 90 days prior to release to facilitate a smooth transition once released</li> </ul> <p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>Navigation supports moving into the adult serving systems and transitioning into community or independent living</li> <li>Life skills training</li> <li>Peer navigator</li> <li>Health-related non-medical transportation</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>Routine medical care provided while in custody</li> </ul>
<i>Projected # of Individuals</i>	130 individuals, annually
<p><b>Youth transitioning into adulthood (17-26) with Special Health Care Needs and with special health related conditions</b></p>	<p>Full OHP benefit package</p> <ul style="list-style-type: none"> <li>This is a new eligibility group proposed by the waiver. These individuals will receive full pediatric-level OHP benefit package up to age 26; and</li> <li>Extended access to pediatric providers as the young adult slowly transitions to adult providers</li> </ul> <p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>Navigation supports moving into the adult serving systems and transitioning into community or independent living</li> <li>Life skills training</li> <li>Peer navigator</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>Services provided by other Oregon Department of Human Services agencies (e.g., APD, ODDS)</li> </ul>

Population	Services
<i>Projected # of Individuals</i>	Oregon anticipates this population will grow throughout the duration of the demonstration. Estimates by state fiscal year are below. SFY 24 – 1,500 SFY 25 – 3,000 SFY 26 – 4,500 SFY 27 – 6,000

**POPULATIONS BELOW THIS LINE ASSUME THE INDIVIDUAL ALREADY HAS OHP ENROLLMENT**

Oregon has also identified and proposes to address transitional events that a currently enrolled member may experience in their lifetime that can result in inconsistent access to medical care, supportive services, or treatment. Depending on the nature of the transition and disruption experienced by the member, elements of the package may include enhanced care coordination, housing navigation assistance, employment support and connection to other social services by way of community partners and community-based organizations.

These are existing OHP members who:

- Must have OHP eligibility pursuant to 42 CFR as implemented through the Oregon Administrative Rules Section 410, Division 200. The individual must meet the income standards for the eligibility determination group and meet the non-financial eligibility criteria based on the program; and
- Fall in one of the population categories below:

Table 15. Services by population

<p><b>Youth involved or at risk of involvement with the Juvenile Justice System in the community</b></p> <p>Youth living in the community and identified by Oregon’s juvenile justice system as involved or at risk of involvement with the juvenile justice system. This will include the youth residing at the Oregon Youth Authority transition camp for youth transiting to adulthood that receive their health-related services in the community. Youth identified as involved or at risk of involvement in</p>	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>• Housing</li> <li>• Employment assistance</li> <li>• Transportation</li> <li>• Health-related non-medical transportation</li> <li>• Navigator</li> <li>• Life skills training</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>• <i>Services provided by the Oregon Youth Authority or local county corrections</i></li> </ul>
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Population	Services
<p>the juvenile justice system as referred through</p> <ul style="list-style-type: none"> <li>• Oregon Youth Authority</li> <li>• County Juvenile Departments</li> <li>• Local or State Law Enforcement</li> </ul>	
<p><i>Projected # of Individuals</i></p>	<p>5,000<sup>50</sup></p>
<p><b>Youth who are involved or at risk of involvement with the child welfare system, transitioning in and out of foster care homes, including those aging out of the system</b> Existing youth OHP members who meet at least one of the following criteria:</p> <ul style="list-style-type: none"> <li>• Identified by Child Protective Services (CPS)</li> <li>• Identified by Child Welfare (pre-custody referrals or post custody OHP eligibility category)</li> <li>• Identified by CCOs</li> <li>• Identified by OHA behavioral health system</li> </ul>	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>• Peer support or navigation to help families apply for OHP and other services (services to prevent entering the child system)</li> <li>• Single point of contact to help navigate through changing foster homes, returning to natural home, moving service areas</li> <li>• Housing</li> <li>• Life skills training</li> <li>• Employment assistance</li> <li>• Transportation</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>• <i>Services provided by the child welfare system</i></li> </ul>
<p><i>Projected # of Individuals</i></p>	<p>18,000, annually</p>
<p><b>Members transitioning to dual Medicare-Medicaid enrollment</b> Existing OHP members who are dually eligible for Medicare and Medicaid per OHP eligibility determinations.</p>	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>• Navigator to assist in transitioning onto Medicare and to support continuity of providers and managing provider networks</li> <li>• Navigation to educate/assist in accessing benefits such as oral health, specialized mental health services, NEMT etc.</li> <li>• Accessing LTSS services including community based LTSS supports</li> </ul>

<sup>50</sup> Estimate from the juvenile crime prevention program statewide evaluation summary

Population	Services
	<ul style="list-style-type: none"> <li>• Education esp. coordination of benefits, navigating provider networks, primary care</li> <li>• Housing</li> <li>• Transition of Care (continuation of provider and approved treatments)</li> <li>• Food assistance</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>• Services and supports provided by Medicare</li> </ul>
<i>Projected # of Individuals</i>	<i>3,000 per year<sup>51</sup></i>
<p><b>Individuals who are homeless or at risk of becoming homeless</b></p> <p>Existing OHP members who are identified as homeless or at-risk of becoming homeless per standard assessment tool</p>	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>• Housing</li> <li>• Food assistance</li> <li>• Health-related non-medical transportation</li> <li>• Employment assistance</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>• Services provided by other agencies</li> </ul>
<i>Projected # of Individuals</i>	<p><i>Point in time homeless population: 15,800</i></p> <p><i>At risk of becoming homeless after a crisis: 150,000<sup>52</sup></i></p>
<p><b>Individuals vulnerable to extreme climate events</b></p> <p>Available to all OHP members who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by either OHA or the Governor of Oregon.</p>	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> <li>• Climate supports</li> <li>• Health-related transportation</li> <li>• Food assistance</li> </ul> <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <li>• Services provided by other agencies during emergency event</li> </ul>
<i>Projected # of Individuals</i>	<i>129,549<sup>53</sup></i>

<sup>51</sup> Estimate is based on the number of newly dual-eligible OHP members per year

<sup>52</sup> The Oregon Community Foundation <https://oregoncf.org/assets/PDFs-and-Docs/PDFs/OregonHomelessness.pdf>

<sup>53</sup> Estimate based on population of OHP members in zip codes affected by wildfire and extreme heat disaster declarations 2020

## Changes to Service Providers

### Access to Peer-Delivered Services for Persons in Need of Social Determinants of Health services during transitions

Oregon also requests the ability to provide some of these transition services (such as screenings, assessments, navigation and coordination) to members using Traditional Health Workers (THWs), which include community health workers, personal health navigators, peer wellness and support specialist and doulas. THWs and peers are often trusted individuals from members' communities who may also share socioeconomic ties and lived life experiences, making them well positioned to help members successfully navigate a transition.

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

### Changes to Prescription Drug Benefits

Oregon seeks the ability to more closely manage pharmacy costs in its Medicaid program, through the strategy below,

*Allow exclusion of accelerated approval drugs with limited or inadequate evidence of clinical efficacy*

Drugs coming to market through the FDA's accelerated approval pathway have not yet demonstrated clinical benefit. FDA approval is instead based on intermediate "surrogate" endpoints as predictors of clinical outcomes. Approval is contingent on the sponsor's agreement to complete a post-approval confirmatory trial to demonstrate clinical effectiveness. When such trials demonstrate effectiveness, FDA approval may be converted to a full approval. Unfortunately, confirmatory trials are often delayed or inadequate, or they conclude without a demonstration of effectiveness. Such products are not always pulled from the market. Oregon seeks the ability to use its own rigorous review process to determine coverage of drugs previously granted accelerated approval that have not had benefit confirmed with conversion to full FDA approval in the expected

time interval. Through this process, the state could incentivize drug sponsors to complete their regulatory obligations to demonstrate clinical benefit as laid out by the FDA upon approval. This will allow Oregon to avoid spending on high-cost drugs marketed to treat conditions that have yet to demonstrate a clinical benefit despite ample time to do so. Many national experts, including the Institute for Clinical and Economic Review (ICER)<sup>54</sup> urge national policy changes to ensure proper oversight after approval of accelerated pathway drugs. Current Medicaid regulations generally require States to cover all FDA-approved medications. This includes medications approved through the FDA's accelerated approval pathway, which have not been shown to be clinically effective. It even applies when the drug sponsor fails to show clinical efficacy within the timelines set forth as a condition of accelerated approval.

To that end, Oregon proposes to limit the coverage of drugs approved through the accelerated pathway, under narrow circumstances. Under this proposal, Oregon would utilize the timelines set out in the FDA approval letter and review confirmation of benefit data in peer reviewed literature or clinicaltrials.gov. Applying the FDA-developed guidance and timetables ensures a universal standard, with clinically feasibility and drug sponsor agreement.

New drugs approved under the FDA's accelerated approval pathway tend to be specialty medications that represent a significant portion of pharmacy expenditures. As such, it is our responsibility to ensure we are following through with the promise of expedited approval pathways. As part of our efforts, we will ensure continued pharmacy protections for members, so that Oregon's closer management of pharmacy costs does not negatively impact member access to the spectrum of safe and effective drugs to treat various conditions.

### **Alignment with Tribal partner priorities**

Representatives of Oregon's Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) have identified a number of tribal priorities for inclusion in the Oregon Health Authority's latest 1115 Waiver. Below are OHA's current recommendations related to benefits and cost sharing for inclusion in the 1115 waiver based on ongoing conversations with tribal representatives. More detail about the state's commitment to working with the Tribes and with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) as well as details of the process of Tribal Consultation can be found elsewhere in the application.

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<sup>54</sup> Kaltenboeck, Mehlman, and Pearson. "STRENGTHENING THE ACCELERATED APPROVAL PATHWAY: AN ANALYSIS OF POTENTIAL POLICY REFORMS AND THEIR IMPACT ON UNCERTAINTY, ACCESS, INNOVATION, AND COSTS" April 26, 2021 Institute for Clinical and Economic Review (ICER) viewable at; [https://icer.org/wp-content/uploads/2021/04/Strengthening-the-Accelerated-Approval-Pathway\\_-\\_ICER-White-Paper\\_-\\_April-2021.pdf](https://icer.org/wp-content/uploads/2021/04/Strengthening-the-Accelerated-Approval-Pathway_-_ICER-White-Paper_-_April-2021.pdf)

## **Remove Prior Authorization Requirements for American Indian/Alaska Native patients**

Medicaid services to tribes are an obligation arising from the Federal Trust Responsibility to provide health care to American Indians and Alaska Natives, wherever they reside. OHA has received feedback from the tribes that prior authorization requirements all too often place administrative hurdles in the way of the delivery of this health care. This issue is most acute in the delivery of behavioral health services, including and particularly treatment for substance use disorders. The tribes have requested that all prior authorization requirements be waived for tribal members enrolled in the Oregon Health Plan.

## **Extension of current Uncompensated Care Program**

Oregon's current 1115 waiver includes language providing tribes with Medicaid reimbursement for adult dental and vision services via the Uncompensated Care Program (UCCP). The tribes have requested that UCCP and its coverage of adult dental and vision services be extended and included in the waiver renewal.

## **Convert Special Diabetes Program for Indians (SDPI) to Medicaid Benefit**

The Indian Health Service's SDPI program has been very successful in reducing rates of diabetes in tribal communities. The tribes requested of OHA leadership in 2018 that OHA make SDPI diabetes prevention services a covered Medicaid benefit. Coverage of SDPI services will likely lower costs over time due to the preventative nature of the services provided. SDPI also includes a tribal-developed curriculum for providers to follow, ensuring that these services are culturally-responsive.

## **Tribal-based Practices**

Tribal communities have a long-standing history of conducting and implementing cultural practices. These tribal-based practices have demonstrated efficacy in effecting positive health outcomes in tribal communities. Tribal-based practices employ non-Western, non-clinical modalities to address cultural trauma and are strength based to reduce the impact of persistent health disparities. The Tribes seek reimbursement for these tribal-based practices and coverage as a Medicaid-covered benefit, with reimbursement for tribal-based practices via claims-based Medicaid reimbursement using standard procedure codes.

The Oregon Health Authority and the Oregon tribes have implemented a process by which tribal-based practices are developed and approved by the Tribal-Based Practice Review Panel, which is comprised of tribal representatives. The list of approved tribal-based practices, and additional information about each, can be found at the following website: <https://www.oregon.gov/OHA/HSD/AMH/Pages/ebp-practices.aspx>

## **Social Determinant of Health Payment for currently unreimbursed services**

Tribal health programs provide a variety of currently unreimbursed services that address social determinants of health and root causes of poor health status. The tribes request Medicaid reimbursement for services not currently Medicaid-reimbursable that improve health outcomes, reduce costs, and address social determinants of health. CCO's currently have flexibility to provide and receive payment for these activities via Health Related Services funds. Similar flexibility in fee for service Medicaid reimbursement would address root causes of systemic health inequities and encourage the tracking and promotion of protective factors. We seek flexibility in reimbursement for these services as described in the concept paper "Improving Health Outcomes by Streamlining Life and Coverage Transitions", available below:

[https://apps.state.or.us/Forms/Served/he3786D\\_2.pdf](https://apps.state.or.us/Forms/Served/he3786D_2.pdf)

## **Continuing from the current demonstration**

Oregon wishes to continue using benchmark-equivalent coverage under the Secretary Approved Alternative Benefits for ACA adults standard. Premium assistance for employer sponsored coverage will not be available through the demonstration.

In addition, the Oregon Health Plan has no premiums or other cost-sharing requirements and members do not pay co-pays for any covered services.

Long Term Services and Supports are carved out from CCOs and delivered Fee-for-Service through the state's operating agency, Oregon Department of Human Services.



## Section V. Delivery System and Payment Rates for Services

### Delivery System Overview

Under the renewal, Oregon will continue to use Coordinated Care Organizations (CCOs) to deliver services to enrolled members. CCOs will be responsible for providing all physical, mental, and oral health covered services, unless otherwise noted in *Section IV. Benefits and Cost Sharing* for developing a culturally and linguistically appropriate provider network that ensures quality and access to services, for negotiating payment rates with providers, and for coordinating care for members across the continuum of care.

Delivery systems and payments will remain the same for the Medicaid population and the CHIP state plan.

Oregon will use the following delivery systems in the Demonstration:

- Managed Care
  - Managed Care Organizations (MCO) through Oregon's Coordinated Care Organizations (CCO)
- Fee-for-Service
  - Integrated Care Model
- Primary Care Case Management (PCCM)
  - Indian Managed Care Entity (IMCE)

Fee-for-service payments will be made by the agency for services provided to individuals not enrolled in a CCO or in situations where services are carved out, and those payments are all made according to state fee schedules and state plan methodologies.

### Managed Care Enrollment

Oregon utilizes managed care in the form of its Coordinated Care Organizations. Enrollment in a CCO will be mandatory unless the individual qualifies for an exemption – granted if the individual is an American Indian or Alaska Native (AI/AN), or on a case-by-case basis. Under the 2017-2022 demonstration waiver, Oregon successfully transitioned Dual eligible members to an opt-out-system wherein dual eligible members are automatically be enrolled in a CCO unless the individual actively chooses not to enroll and notifies the state of this choice. CMS guidelines will be followed to ensure individuals are able to exercise their rights if they choose not to be enrolled in managed care.

### Statewideness of Managed Care

CCOs are available statewide however there is not a single CCO that covers the entire state. Oregon has a waiver of statewideness through our current 1115 waiver and we are seeking renewal of this waiver authority in this application.

Oregon's CCOs have regional service areas and each county has at least one CCO. In service areas with multiple CCOs, members are given the opportunity to select or change their CCO.

### **Payments to Indian Health Services clinics**

In Oregon there are two Indian Health Services (IHS) clinics and eight Tribal health programs (in accordance with P.L. 93-638 Indian Self-Determination Act) enrolled in Oregon Medicaid. There is also an Urban Indian Health Program (UIHP) enrolled as a Federally Qualified Health Center in the Portland area. IHS clinics are reimbursed through an all-inclusive rate which is published in the Federal Register each year. Tribal 638 health centers may choose either the IHS all-inclusive rate or a cost-based Prospective Payment System (PPS) encounter rate developed for their clinic. Two-thirds of Tribal 638 health centers have elected the PPS reimbursement method. The UIHP, by virtue of being enrolled as an FQHC, is also reimbursed through a PPS encounter rate.

To further assist in efforts to expand coordination of care for tribal members, OHA has contracted with one organization to provide care coordination services for the roughly 17,000 AI/AN members not enrolled in a CCO (approximately 53% of OHP's AI/AN population). The contract was recently renewed for a second year.

### **Rollout of managed care**

Managed care entities are currently in operation in all parts of the state. Implementation of changes to benefits and eligibility will be based on the operational changes necessary and will coincide with the annual contract restatement schedule.

### **Assure choice of MCOs, access to care and provider network adequacy**

As required by CFR 438.202(d), Oregon assesses how well the Coordinated Care Organizations (CCO) and Managed Care Organizations are meeting network adequacy requirements through the performance measurement process and ongoing analysis of the quality, access, and appropriateness of care and services delivered to enrollees, and consumer satisfaction data. Additional details on the quality strategy can be found in *Section IX. Quality Strategy*.

### **Selection of managed care providers**

Oregon's CCOs are selected through an open procurement process. The current contracted CCOs were awarded in 2019 to serve contract years 2020-2024. The OHA will begin the procurement process for subsequent years in 2023.

## **Services not included under proposed delivery system**

For new eligibility categories, the benefit package will be limited and is described in *Section IV. Benefits and Cost Sharing*.

Oregon delineates services carved-out from CCO contracts by those which require care coordination by the CCO and those which do not.

### **Non-Covered Health Services with Care Coordination**

- Out-of-Hospital birth (OOHB) services including prenatal and postpartum care
- Long Term Services and Supports (LTSS)
- Home visiting services for families with newborns up to 6 months (Family Connects Oregon)
- Mental health drugs
- Therapeutic foster care
- Therapeutic group home coverage for persons under 21 years of age
- Behavioral rehabilitative services
- Investigation of Members for Civil Commitment
- Long Term Psychiatric Care (LTPC) for Members 18 years of age and older
- Preadmission screening and resident review for Members seeking admission to a LTPC
- LTPC for Members age 17 and under, including:
  - Secure Children's Inpatient program
  - Secure Adolescent Inpatient Program
  - Stabilization and transition services
- Personal care in adult foster homes for Members 18 years of age and older;
- Residential mental health services for Members 18 years of age and older provided in licensed Community treatment programs
- Abuse investigations and protective services
- Personal care services

### **Non-Covered Health Services without Care Coordination**

- Physician assisted suicide under the Oregon Death with Dignity Act
- Hospice services for Members who reside in a Skilled Nursing Facility
- School-Based Health Services that are Covered Services provided in accordance with Individuals with Disabilities Education Act ((IDEA) requirements
- Administrative examinations
- Services provided to Citizenship Waived Medical (CWM) and Citizen Waived Medical Plus (CWM Plus)
- Abortions

## Personal care and long-term services and supports

Opportunities to self-direct services are available to people receiving Long-Term Services and Supports through Oregon’s 1915(c) waivers, 1915(k) Community-First Choice State plan option, 1915(i) Home and Community-Based Services option, and 1915(j) Self-Directed Services option. Oregon offers Employer Authority under all of these authorities and Budget Authority under 1915(j). Self-direction opportunities and supports for self-direction are offered as part of the person-centered planning process to individuals eligible under any of these authorities. The opportunities, process and Medicaid authorities will continue to be available to eligible individuals throughout the Demonstration period.

## Fee-for-service deviations from state plan

No, Oregon does not have any instances where services outside the CCO contract are reimbursed differently than in the approved State Plan.

## Capitation rate setting methodology

Oregon is proposing to continue to categorize health-related services as “activities that improve health care quality” and include the costs of these services in the benefit component of the CCO capitation rate (i.e., treat them like medical expenses for rate setting purposes). OHA will continue to break this component out in the rate certification for CMS’ review.

Oregon proposes the following changes to the rate development process:

### **1. Calculate a base budget (capitation rate) using up to five years of historical utilization and spending, while also looking at recent trends to ensure the base is reasonable and adequate for covered services and the risk of the population, and that it accounts for spending on health-related services.**

The base budget would be built considering both historical medical expenses as well as spending on health-related services, thereby incentivizing spending on activities that are proven to prevent morbidity and mortality. Under Oregon’s waiver proposal, the state would set an initial statewide, reasonable and appropriate CCO value-based budget largely in line with how base budgets are set today, with two exceptions:

- Considering a longer period of time (up to five years) for historical trends to increase confidence that the base budget is sound, and
- Including health-related services spending, in addition to spending on state plan services, over a period of up to five years.

In addition, to maintain a focus on eliminating health inequities, Oregon plans to direct CCOs to invest at least 3% of their capitation rate toward health equity investments (as required by Oregon House Bill 3353), of which at least 30% would be directed to community entities, called regional community investment collaboratives (CICs), for community health equity investments. Oregon proposes to establish a community-led

accountability structure for all required health equity spending that includes a statewide oversight committee in addition to the regional CICs. As noted above, Oregon is requesting expenditure authority to count these investments as medical for the purposes of rate setting, so that the requirement to make these health equity investments does not negatively impact CCOs' future rates.

Going forward, Oregon would adjust CCO budgets annually by a predictable growth trend rate, in line with statewide goals for sustainable growth, and would also carefully monitor CCO spending to identify any additional, targeted adjustments that may be necessary to address unanticipated events.

**2. Trend the base rate forward in a predictable way over five years by adjusting the budget based on Oregon's new statewide health care cost growth target, as well other targeted adjustments needed to address unanticipated events, without resetting base budgets each year.**

Oregon proposes that, in line with reducing health care spending in all sectors, CCO budgets be trended forward for five years at the statewide health care cost growth target, which will be 3.0 to 3.4 percent during the demonstration period. This trending forward would allow more predictability for CCOs to make longer-term investments in health equity, prevention, and community improvement—leading to an overall healthier population and lower health care costs over time. Targeted rate adjustments would be made for significant changes in risk profile by CCO, covered benefits, and statewide population, for example, in times of significant change such as coverage expansion during the COVID-19 pandemic.

When combined with an enhanced quality strategy and the ability to count health-related services in the medical load for the purposes of rate setting, this design would allow CCOs to keep savings stemming from appropriate declines in utilization. It would also create more flexibility for CCOs to invest in care improvements, including through investments in preventive care, addressing social needs, and eliminating health inequities.

Oregon also recognizes that enhanced flexibility must be paired with robust member protections, specifically directed at addressing health inequities that exist. To that end, Oregon also proposes a robust accountability system with new mitigation strategies covering four priority areas: equity, member and provider satisfaction, access, and quality of care, described in more detail in the Quality Strategy.

### **Quality Incentive Payments**

Oregon will continue its incentive programs for coordinated care organizations, utilizing the pay for performance programs as levers to drive focus on improving health equity across Oregon. The CCO Quality Metrics Program will continue for the length of the waiver, which will be guided by the legislatively appointed public committees to review program performance, select measures and set benchmarks on an annual basis. In the

new waiver, Oregon plans to build on the Quality Metrics Program by adding a focus on metrics that address health equity. Oregon is proposing to split the current metrics program into two parts: upstream metrics that focus to correct historical and contemporary injustices and downstream metrics that line up with standard health metrics used by other Medicaid organizations across the county.

**Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity**

To ensure all Medicaid members have access to care and receive high-quality care while prioritizing people in communities that face contemporary and historical inequities, Oregon proposes separating the Quality Incentive Program into two complementary and interrelated components, each of which will be incentivized to improve equity.

*a) A small set of “upstream” metrics focused on factors affecting health equity*

The first component of the new measurement structure will contain up to six metrics incentivized for the duration of the waiver. These metrics are expected to require long-term, sustained effort to achieve. For this waiver period, the upstream set is largely identified. For the next waiver period, OHA would work with the Health Equity Quality Metrics Committee (restructured from the existing Health Plan Quality Metrics Committee, see strategy #2 on page 4 for more detail) and other interested parties to plan and potentially develop new measures.

Given the extensive lead time required to develop new metrics, OHA has identified four existing metrics for the upstream measure set. Two more metrics could be added and, depending on timing considerations, the new Health Equity Quality Metrics Committee may guide measure development.

These metrics were developed during the current and previous waiver periods in response to analysis of harms to specific populations and community-identified needs. They’re designed to incentivize systems-level changes that advance health equity, and they address domains for which no standardized metrics currently exist. The following table outlines the four existing metrics that will be included in the upstream metrics.

**Table 16. Existing metrics to be included in upstream metrics**

Upstream Health Equity Metric	Year incentivized	Additional Information
Mental, Physical and Oral Health Assessment Within 60 Days for Children in DHS Custody <sup>55</sup>	2013	Incentivizes timely assessments for children in foster care, so their physical, oral and behavioral health needs are identified and can be addressed.

<sup>55</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2014-Assessments-Children-DHS-Custody-Guidance-Documents.pdf>

Meaningful Language Access to Culturally Responsive Health Care Services <sup>56</sup>	2021	Incentivizes the provision of high-quality interpreter services when needed and access to care and information (explanations of benefits, take-home resources, and more) in members' preferred languages, enabling them to more effectively participate in their own care.
Health Aspects of Kindergarten Readiness (HAKR) <sup>57</sup>	2022 <sup>58</sup>	Incentivizes more culturally responsive services being offered to help children start kindergarten ready to learn.
Social Determinants of Health: Social Needs Screening and Referral <sup>59</sup>	2023 <sup>60</sup>	Incentivizes more CCO members having their social needs acknowledged and addressed.

These domains were chosen because of their focus on Oregon Health Plan members who experience historical and/or contemporary injustices and structural racism. The measure development webpages provide more information from the public workgroups and other interested parties who worked through measure specification and pilot testing. This measure set will allow the state to monitor improvements in access to resources that directly address these injustices.

*b) A set of “downstream” metrics that focuses on traditional quality and access measures*

The second component of the new measurement structure will align with measures of health care processes, outcomes, and utilization that are used nationally (downstream metrics). These metrics will draw from traditional quality and access measure sets. Downstream metrics will be selected from the CMS Medicaid Adult and Child Core sets and other CMS-required measures (e.g., may include Medicaid MCO Quality Rating System measures in the future).<sup>61</sup> OHA will develop criteria to ensure that the selected metrics address the full breadth of health care quality considerations: cost, quality, access, and health equity, as well as address oral, behavioral, and physical health. As before, Oregon’s Metrics and Scoring Committee will select the metrics, but as described below, a newly redesigned and separate committee called the Health Equity Quality Metrics Committee will have oversight and approval.

<sup>56</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx>

<sup>57</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx>

<sup>58</sup> For Social Emotional Health component of HAKR bundle

<sup>59</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx>

<sup>60</sup> Potential implementation

<sup>61</sup> Oregon recognizes that because of variations in benefit packages among states, the Medicaid Adult Core set does not include measures of adult oral health. To fill that gap, Oregon may include in the downstream set of measures one or two adult oral health measures from the Dental Quality Alliance or similar national measure steward.

This approach builds on work Oregon is required to undertake on the Medicaid Child Core Set and Behavioral Health measures in the Medicaid Adult Core Set when reporting becomes mandatory in 2024. Aligning with the CMS Core Sets will promote cost savings and enable comparison to other state Medicaid programs' performance. The downstream metrics will be monitored and publicly reported at the subpopulation level to ensure quality and access for members within race/ethnicity, language, and disability groups whenever possible. Downstream metrics will continue to be incentivized for continuous quality improvement and, as addressed in Strategy 3 below, will use new benchmarking approaches where possible to address inequities among racial and ethnic groups.

### **1. Redistribute decision-making power to communities**

To ensure that the Quality Incentive Program drives system-level improvements as well as improvements to patient care, those who are most affected by health inequities will have power within the committee structure that selects downstream metrics.

OHA is committed to redistributing power in the Quality Incentive Program and plans to modify the structure of Committees that are responsible for selecting and incentivizing metrics. While maintaining a public committee process for metrics selection, OHA intends to work with the legislature to amend the statutes establishing the metrics committees so the current Health Plan Quality Metrics Committee can change its membership, focus and role to become the Health Equity Quality Metrics Committee (HEQMC). HEQMC members will represent the interests of those most affected by health inequities including Oregon Health Plan members, community members from diverse communities, individuals with lived experience of health inequities, and health equity professionals and researchers, and a representative from the state's Behavioral Health committee.

This Committee will oversee and approve the downstream metrics selected by the Metrics and Scoring Committee and will advise OHA about how to design the program to best address member and community concerns and priorities. As OHA adopts broader community engagement strategies, input received in those forums will also inform measure selection and implementation. In addition, OHA will consider member and community voices in the presentation of measure performance. For example, OHA will continue to produce an annual CCO Incentive Metrics report and supplement the quantitative data typically included in this report with qualitative information, including priorities identified by members of the HEQMC.

### **2. Rethink the incentive structure to better advance equity**

Oregon's current Quality Incentive Program consists of one set of metrics incentivized for the initial round of payments and a subset incentivized for the challenge pool. Using this approach, any incentive funds that are not earned in the initial round are distributed in the challenge pool round. In the initial and challenge pool rounds, CCOs can earn incentives by meeting either an overall benchmark or a CCO-specific "improvement



target,” which is calculated to close the gap between the CCO’s baseline performance and the benchmark. Each year, the entire pool of available quality funds is paid out; if any funds are not paid out in the initial round, they are then paid out in the challenge pool round.

While this overall structure will remain the same for the 2022-2027 waiver, OHA proposes to work with the new Health Equity Quality Metrics Committee and the Metrics and Scoring Committee to select which upstream and downstream metrics are incentivized to best improve health equity. OHA will present the committees with a range of approaches from which to select.

For instance, for the downstream metrics, one option is that the only metrics eligible for the challenge pool would be those that address significant inequities, and payment of challenge pool funds would be contingent on reducing inequities in the downstream metrics where performance can be compared to other state Medicaid programs.

Another option is to focus on closing inequitable performance gaps in all eligible metrics, not only in the challenge pool. This could be accomplished by making payment of incentives contingent on achieving CCO-specific improvement target for a metric (as opposed the aspirational benchmark for the metric) for all subpopulations with at least 50 members. In this option CCOs would not be able to rely on simply making progress toward a benchmark unless they make progress for all subpopulations.

For the upstream metrics focused on rectifying the systems and structures that create inequities, CCO incentives will be paid per metric as either individual CCO improvement targets or the benchmark is reached. Funds not earned after payout for the upstream metrics, as well as any funds not earned in the initial round of payout for the downstream metrics, will be paid out in the challenge pool round. Oregon is exploring how best to fund the quality incentive payments: as a withhold, bonus, or some combination of the two.

### **What these policies would mean for OHP members**

With the revised incentive structure, all OHP members can expect to continue to see improvements in health equity outcomes and health care quality by CCOs. OHP members and communities also will have a greater voice in the quality incentive program. The pace of improving health inequities by CCOs will be measured, monitored and publicly reported. On measures of health care quality, CCOs will have accountability for improved performance not just for their overall members but also for racial and ethnic groups within their CCO membership.

The revised program includes locally developed measures of health equity. For example, the meaningful language access measure is intended to help members receive high-quality interpreter services when needed and access care and information (explanations of benefits, take-home resources, and more) in their preferred languages and easily understood formats, so they can more effectively participate in their own

care. The social-emotional health measure is intended to help families connect to needed services, including culturally responsive services, so children start kindergarten ready to learn. The assessments for children in DHS custody measure is intended to ensure that kids in foster care get timely assessments of their physical, oral and behavioral health, so their needs are identified and met. The social needs screening and referral measure will require CCOs will build partnerships with community-based organizations and improve processes so Oregon Health Plan members' unmet social needs (food insecurity, housing insecurity, and transportation needs) are addressed.

### **Obtain expenditure authority to allow Child Welfare to pay for reserved Psychiatric Residential Treatment Services (PRTS) and prioritize youth in Child Welfare custody for these services.**

Oregon's Psychiatric Residential Treatment Services (PRTS) serves youth who require facility-based care to address their mental health needs. Currently, Oregon does not have the adequate capacity to meet the needs of children and youth in Oregon, which can cause very long waitlists. When youth involved with Child Welfare, including foster care, experience long waits for these services it increases the chance of placement disruption, including temporary lodging, and can lead to youth being supported in settings that do not meet their needs. Currently, there is no established methodology or ability to prioritize admission for youth in Oregon according to urgency or Child Welfare involvement.

The Oregon Health Authority is proposing as part of its 1115 waiver application to allow the Child Welfare Division ("Child Welfare") to:

- Create the ability to pay for non-billable (evaluation and assessment) services and to reserve capacity for youth involved with Child Welfare that meet medical necessity; and
- Develop mechanisms between Child Welfare, CCO's and OHA with PRTS providers to prioritize youth in CHILD WELFARE custody for these services.

We acknowledge that currently, there is an overall crisis related to the lack of children's PRTS capacity in the state of Oregon due to a complex set of issues including workforce, screening, reporting and payment. It is a challenging decision to prioritize access for any children in need of these services given the lack of capacity, however there are compelling reasons to consider prioritizing children involved with Child Welfare:

- When Child Welfare identifies a child that would benefit from PRTS and there is no bed available, they are forced to employ temporary or insufficient options such as temporary lodging or supporting youth in less appropriate settings. Child Welfare is aiming to eliminate the need for those options which are costly and traumatizing for the youth and families affected.

- Currently, PRTS providers maintain control of their waitlists and admission order. This means that there is limited ability for Child Welfare to predict or influence when a youth will be admitted.
- Children and youth involved in child welfare experience an added stigma and cycle of re-traumatization when seeking access to these services that results in delays in their care and an escalation of needs.
- Children and youth of color are over-represented among this population, making this an equity issue. Black or African American youth make up about 6.5% of Oregon's Child Welfare Population. Of the total number of youth that require higher levels of care, 10% are Black or African American.
- The State of Oregon has a unique and compelling responsibility to assure access for children and youth in our custody.

**Strategy and Proposal:** Oregon proposes to pay for added care and capacity that prioritizes access for youth in Child Welfare.

3) Given current capacity:

- Child Welfare will have the ability to develop a direct agreement with existing PRTS providers to prioritize youth in Child Welfare custody on a PRTS provider's waitlist, and pay for assessment and evaluation services within these settings that are currently not paid for under Medicaid.
- Child Welfare and providers will agree on the number of youth to be prioritized and will develop processes that balance access for prioritized youth with the total population, such as supporting up to 2 beds for children and youth in Child Welfare out of 12 available beds.
- This proposal seeks priority for admission, not a bed held vacant for youth who are in the custody of child welfare. In some circumstances, a bed may be held for less than 48 hours while the youth in Child Welfare custody is transferred from another residential setting or traveling from out of area.

4) As new capacity is developed in the future:

- Child Welfare will collaborate with the Children's Behavioral Health team to identify providers or programs willing to expand PRTS capacity. As providers start up a new program or expand capacity, Child Welfare will seek an agreement as described above to establish a number of beds that are prioritized for youth involved in Child Welfare.
- As described with current agreements, Medicaid dollars will support added care (evaluation and assessment) and reserved capacity for youth in Child Welfare, balancing access for youth in Child Welfare with the total population.

In its current state, Oregon does not have adequate PRTS capacity and for that reason, Child Welfare does not intend to use this waiver concept to hold empty beds. Child Welfare will work with providers to create prioritized admissions based on PRTS

waitlists. If in the future capacity exceeds demand, Child Welfare may enter into agreements that would ensure a bed is available at the time a crisis is identified.

### **Costs:**

Currently, Child Welfare's contract with Looking Glass allocates \$972 per day for each bed for a total cost of \$4.4m (this is based on 2021 rates; it is anticipated that this will be higher in 2022 given Medicaid rate increases and programmatic upgrades).

Under the current contract that Child Welfare holds with Looking Glass, they can bill CCOs for about 60% of the total amount from Child Welfare, which they pay back quarterly. The gap in payment is for services that are not reimbursed, such as assessment and evaluation in the setting, and for short-term vacancies while youth are in transition to a bed. Currently, that gap is about \$1.7 million paid for by Child Welfare annually.

- \$1.7 million is the gap to pay for the current 12 bed existing prioritized capacity
- Estimated \$5.1 million needed if expanded to meet Child Welfare needs

### **Impact:**

- Child Welfare currently supports approximately 30 children/youth per year through an existing agreement with a PRTS provider. They conservatively estimate a need for up to 36 additional beds statewide, capacity which would be developed over time and would support close to 90 children annually, to prioritize youth in Child Welfare custody.
- Children and youth will have more immediate access to PRTS services when needed. This will minimize delayed care and prevent youth from repeated or extended Emergency Department visits, prevent higher intensity and more expensive services later, ultimately deescalating the trauma that children and youth experience when needed care is delayed or unavailable.
- This policy helps meet agency goals to prevent foster care placement, reduce the need for temporary lodging and out of state placement of children and youth in their custody.

## Section VI. Demonstration Financing and Budget Neutrality

Oregon understands that the state must demonstrate budget neutrality for the Oregon Health Plan (OHP) Demonstration. A budget neutral demonstration project does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration.

The state is requesting a five-year extension to its Oregon Health Plan Section 1115 Medicaid Demonstration waiver to maintain and further advance Oregon's health system transformation. The budget neutrality test performed for this extension application applies the methodology that was adopted for the OHP demonstration approvals originally granted in 1993, as amended in the 2017 demonstration extension which reduced our savings to 25% of the calculation each year and only allows carryover savings from the most recent demonstration period.

For the next waiver renewal period, the demonstration is not anticipated to have a negative impact on Medicaid enrollment and, upon approval of proposals outlined in this extension request, will have a positive impact overall. Appendix A includes Oregon's budget neutrality calculations including enrollment and expenditures for the current waiver period and projections for the renewal period. Also, attached is a spreadsheet showing Oregon's Title XXI CHIP allotment historical spending and projections for the requested five-year extension period.

Administrative costs will continue to be reimbursed based on the allowed federal matching rates of 50 percent, 75 percent or 90 percent of the administrative expense and are not subject to the budget neutrality test.

### Components of the Budget Neutrality Test

Oregon requests that the current Section 1115 demonstration methodology specified in the state's Special Terms and Conditions (ST&Cs) and modified in 2017 to reduce the available savings be used for the purpose of evaluating budget neutrality for the five-year extension period. This methodology uses a set of specified annual per capita costs multiplied by the actual or projected enrollment for each year of the five-year extension period. The result of this calculation is an aggregate allowable (i.e., without waiver) expenditure level, or ceiling. The aggregate allowable expenditure level is then compared to actual and projected expenditures for the extension period (i.e., with waiver) to calculate the variance or savings attributed to the demonstration. The calculations include the following assumptions.

#### Base Year Per Capita Costs

Oregon proposes to use the Demonstration Year (DY) 20 (State Fiscal Year 2022) per capita costs approved by CMS in the ST&Cs for the various eligibility groups under the current demonstration as the basis to determine the expenditure limit (ceiling) for five-year extension.

## Trending Factors

The expenditure limit for the current demonstration is calculated from the CMS-approved DY 2016 per capita rates trended by the CMS-approved allowable trend rates for each year through DY 20 (State Fiscal Year 2022), as found in the state's current ST&Cs. For the new demonstration period, the state is requesting President's Budget trends for the without waiver; 5.4% is used as a proxy for President's Budget trends until detailed trends are provided by CMS. Per capita with-waiver growth is projected to be 3.4% per year, reflecting the state's broader health care cost benchmark goals.

## Beneficiaries and Services Included

Overall projected enrollment is held at 2022 levels for the new demonstration for the purposes of these calculations given the uncertainty of coverage post-COVID. As outlined below, the proposals contained in this waiver renewal only extend new strategic and targeted services focused on SDOH, transitions, and health equity. No services will be removed from the underlying OHP benefit package.

As outlined in *Section III. Eligibility* and *Section IV. Benefits and Cost Sharing*, Oregon's waiver renewal includes a number of proposals that would increase the member months for certain Medicaid enrollees including:

- Establishing continuous enrollment for younger children from birth until their 6th birthday
- Establishing 2-year continuous OHP enrollment for people ages 6 and up
- Waiving the federal rule preventing Medicaid coverage for a person in custody, including justice-involved populations and those in the Oregon State Hospital and psychiatric residential facilities, to specifically:
  - Retaining benefits and/or extend Medicaid benefits to all youth otherwise eligible for Medicaid entering a local or county juvenile detention facility throughout the duration of incarceration at the facility.
  - Providing a limited OHP benefit (e.g., prescription drugs, navigation, access to transition services) and CCO enrollment for OHP adult members who will be discharged from Oregon State Hospital, psychiatric residential facilities or are justice-involved in state prison, 90 days pre-release and for OHP youth and young adults in the Oregon Youth Authority closed correctional facilities.
  - Providing OHP benefits and CCO enrollment for adult OHP members in jail or a local correction facility, including those awaiting adjudication and for youth in county or local juvenile detention facility.
- Retaining child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) age 17 to 26.

For the purposes of budget neutrality, Oregon proposes to treat the member month and subsequent budget impact of these proposals as hypothetical expenditures as the

extended eligibility would be permitted under the program were it not for current federal Medicaid enrollment restrictions. The calculations included in Table 17 below and Appendix A are adjusted by the anticipated additional member months. These pass-through adjustments have been made to both the expenditure ceiling (i.e., without waiver) and Oregon's projected expenditures (i.e., with waiver).

Additionally, the member months are adjusted to exclude Medicaid beneficiaries and their expenditures covered under the Oregon Health Plan Substance Use Disorder 1115 Demonstration (Project Number 11-W-00362/10) approved earlier in 2020. Please see Appendix A for detailed data on this separate Section 1115 demonstration.

### **Requested Investments**

Oregon's projected expenditures under the demonstration extension includes new federal investment (DSHP) focused on improving health equity by funding defined SDOH transition support services, through building infrastructure, supporting community-led interventions and statewide initiatives, and granting community-led collaboratives resources to invest in health equity and social determinants of health (outlined in *Appendix A. Budget Neutrality Worksheets and Projections* of this application). The requested investment ranges from \$207 million to \$237 million total funds per year between SFY 2023 and SFY 2027. This funding will allow for an investment of approximately \$483 million to \$518 million total funds per year in equity investments and expenditures for SDOH services over the same period. Additionally, with the passage of HB 3353, an additional \$200 million is assumed beginning in SY 2023 for focused equity investment through CCOs that would equate to 3% of CCO capitation rates.

### **Historical Savings**

Oregon is a demonstrated leader in delivering high quality care and containing spending growth in its Medicaid program. Oregon is requesting to continue use of the historical demonstration savings as defined in the 2017 extension approval (currently estimated at \$6.7 billion total funds through DY 20). The calculated savings are reduced to 25% of the total calculation and include only savings from the current demonstration period per the ST&Cs for the demonstration.

### **CMS Templates**

Oregon's five years of historical data is provided in the requested CMS template.

Table 17. Summary of Adjusted Caseload Included in Waiver Renewal Budget Neutrality Calculations

(Member Months)

DEMONSTRATION YEARS (DY) State Fiscal Years	Current Waiver					Proposed Waiver				
	16	17	18	19	20	21	22	23	24	25
	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
<b>Current Services Caseload</b>	10,281,000	10,290,200	10,409,000	12,064,000	13,819,100	13,819,100	13,819,100	13,819,100	13,819,100	13,819,100
<b>Estimated Waiver Renewal Adjustments</b>										
<i>Continuous enrollment and transition proposals</i>							378,300	637,300	837,600	1,004,700
<i>Exclusion of IMD 1115 member months</i>				(2,800)	(11,500)	(12,000)	(12,500)	(13,100)	(10,100)	(10,600)
<b>Total Adjustments</b>				(2,800)	(11,500)	(12,000)	365,800	624,200	827,500	994,100
<b>Total Adjusted Caseload</b>	10,281,000	10,290,200	10,409,000	12,061,200	13,807,600	13,807,100	14,184,900	14,443,300	14,646,600	14,813,200



## Section VII. Implementation of Demonstration

### Implementation Schedule

All of the changes proposed in the demonstration renewal application will be phased in based on operational and contractual factors and will continue through the five-year waiver period with the exception of the Equity Infrastructure supports and the transitions supports services.

- Year 1-3: Investments to build capacity for community investment collaboratives and social determinants of health transitions supports are funded outside of the CCO's primary budget through Designated State Health Program (DSHP) funds. CCOs build capabilities and identify the most effective services.
- Year 4: Funding outside of the CCO's primary budget for community investment collaborative capacity building and social determinants of health transitions supports phase down.
- Year 4-5: CCOs are fully at risk for transitions supports services. Both transitions support services and spending on investments to address health inequities are treated as medical claims or quality improvement spending for purposes of CCO rate setting.

### Notification and Enrollment

Oregon will continue to use the notification and enrollment processes in place under the current demonstration and will retain the policies to streamline the application and redetermination process available as part of the COVID Public Health Emergency.

### Contracting with managed care organizations

Oregon will continue to use the annual contracting process to ensure that Coordinated Care Organizations are responsible for delivering the required services and supports to Oregon Health Plan members.

## Section VIII. Evaluation

### Evaluation Design for Demonstration waiver renewal (2022-2027)

#### Evaluation Focus Areas

- Maximize OHP Coverage
- Encourage Smart, Flexible Spending
- The impact of innovative community-led interventions on health outcomes and eliminating health inequities

#### Evaluation Questions and Hypotheses

##### Summary

An evaluation plan will inform OHA if the interventions (policies and programs) in the waiver will reduce the health inequities and improve health outcomes for Oregon Health Plan (OHP) members. The plan will cover the “why it matters” (purpose), “what is being done” (evaluation activities), and “how we will know” (measures). As the waiver policy concepts are further detailed with CMS and OHA, the evaluation plan will be developed in more detail. Based upon the waiver goals and objectives, the waiver question and hypotheses will guide the evaluation plan details are included below. Additionally, evaluation parameters section will provide information on evaluation design, population, potential measures, and methods.

##### Current demonstration evaluation activities to date

In the 2017-2022 demonstration period, Oregon continued to support evaluations that assessed the state’s and CCOs’ activities to transform Medicaid using the six “levers” of transformation set forth in the 2012-2017 demonstration.

- Lever 1: Improving care coordination at all points in the system with an emphasis on patient- centered primary care homes (PCPCHs)
- Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes
- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care
- Lever 4: Increased efficiency through administrative simplification and a more effective model of care
- Lever 5: Use of flexible services (now known as health-related services) to improve care delivery or enrollee health
- Lever 6: Testing, accelerating and spreading effective innovations and best practices

Oregon's evaluation priorities for the 2017-2022 demonstration period shifted from assessing transformation activities as a whole to assessing activities in specific focus areas of the waiver:

- Continued integration of behavioral, oral, and physical health care
- Implementation and impact of health-related services, including the degree to which HRS are addressing social determinants of health
- The effects of transitioning to 'opt-out' CCO enrollment for dual eligible individuals, including the impact on total expenditures

The Oregon Health Authority selected Oregon Health & Science University's Center for Health Systems Effectiveness (CHSE) to carry out the evaluation of the 2017-2022 waiver. The evaluation focuses on four areas: behavioral health integration, oral health integration, health-related services (HRS), and the population dually eligible for Medicare and Medicaid. CHSE assessed data from 2011-2019, capturing the initiation of Oregon's Coordinated Care Organization (CCO) model under the 2012-2017 waiver and including three years of experience (2017-2019) under the renewal. The interim report assessment did not include performance under new CCO contracts (CCO 2.0) effective in 2020, nor did it assess impacts of the COVID-19 pandemic or the 2020 wildfires that severely affected Oregon.

Key findings under the interim evaluation:

- Progress in behavioral health integration, a key focus of the 2012-2017 and priority area in the waiver renewal, has been mixed. The state and CCOs engaged in several activities focused on integration which include investments in primary care, support from the transformation center, use of the Emergency Department Information Exchange (EDIE) and PreManage tools, continued support of Certified Community Behavioral Health Clinics (CCBHC) and contract changes in CCO 2.0 to disallow subdelegation of behavioral health. While some utilization and quality measures moved in the desired direction between 2016 and 2019, evaluators found it difficult to discern a roadmap of strategy for implementing integration and found that many activities do not appear to be coordinated across the state.
- Efforts to advance oral health integration appear to be having some positive effects. Activities included increases in payment rates, expansion of teledentistry, and the introduction of new CCO quality incentive metrics for oral health. Measures of access to dental services and utilization of dental procedures improved between 2016 and 2019 and Emergency Department use for non-traumatic dental conditions continued to decline.
- Spending on health-related services increased between 2016 and 2019; however, as of 2019, HRS remained a small share (0.36%) of total spending on member services. Furthermore, the administrative burden on CCOs to track and report HRS data resulted in variability in reporting by CCO.

- Care for dual-eligible members did not seem to change substantially from 2016 to 2018. Data from the interim analysis did not allow for the assessment of the 2019 shift from “opt-in” to “opt-out” of CCOs nor the impact of CCO 2.0.
- Evaluators also noted the need for more granular data, in particular Race, Ethnicity, Language and Disability (REALD) data to assess the impact of interventions on health inequities.

The interim report can be found in Appendix D and is posted publicly on OHA’s 1115 Waiver webpage here: <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2017-2022-Interim-Evaluation.pdf>. The summative evaluation of the 2017-2022 demonstration will be conducted by CHSE and will include additional years of data covering CCO 2.0, the impacts of COVID-19 and Oregon’s 2020 wildfires event. The evaluation will be completed in 2023.

## Changes to Current Waiver Evaluation

The state is proposing changes to what will be evaluated with this extension that are similar to what is being evaluated under the current demonstration. These changes continue to align with the original strategies and reflect Oregon’s priority of eliminating health inequities and are described below:

Table 18. Changes to current waiver evaluation

Current Demonstration - Evaluation		Changes Proposed
<b>1. Oregon is proposing policies designed to improve care coordination and integration through continuous coverage and the use of transition support packages (outside of traditional covered services) to improve how care is delivered to members.</b>		
Original 2012 Waiver Strategies	Evaluation (2017-2022)	Evaluation – 2022-2027
<p>Lever 1: Improving care coordination at all points in the system with an emphasis on patient- centered primary care homes (PCPCHs)</p> <p>Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care</p> <p>Lever 5: Use of flexible services (now known as health-related services) to improve care delivery or enrollee health</p>	<p>Evaluation area:</p> <ul style="list-style-type: none"> <li>Continued integration of behavioral, oral, and physical health care</li> </ul> <p>Waiver goal:</p> <ul style="list-style-type: none"> <li>Enhance Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance driven system</li> </ul>	<p><b>New Evaluation area:</b></p> <ul style="list-style-type: none"> <li><b>The impact of continuous coverage and defined transition support packages on coordination and integration of care and overall member health</b></li> </ul> <p><b>Waiver goal(s):</b></p> <ul style="list-style-type: none"> <li><b>Maximize continuous and equitable access to coverage</b></li> <li><b>Streamline transitions between systems through defined benefit packages of social determinants of health services</b></li> </ul>

2. Oregon is proposing to evaluate the impact of expanding community-driven decision making about the use of investment funds designed to address the social determinants of health.		
Original 2012 Waiver Strategies	Evaluation (2017-2022)	Evaluation – 2022-2027
Lever 6: Testing, accelerating and spreading effective innovations and best practices	<p>Evaluation area:</p> <ul style="list-style-type: none"> <li>Implementation and impact of health-related services, including the degree to which HRS are addressing social determinants of health</li> </ul> <p>Waiver goal:</p> <ul style="list-style-type: none"> <li>Encourage CCOs to address the social determinants of health and improve health equity</li> </ul>	<p><b>New Evaluation area:</b></p> <ul style="list-style-type: none"> <li><b>The impact of community-driven decision making for investment on reducing health inequities</b></li> </ul> <p><b>Waiver goal:</b></p> <ul style="list-style-type: none"> <li><b>Improve health through focused equity investments led by communities</b></li> </ul>
3. The implementation of opt-out CCO enrollment for dual eligibles has been completed. Oregon is proposing changes to the rate setting process that would create a flexible, predictable rate for CCOs and incentivize investments and to evaluate the impact of those changes on the availability and use of funds on community-driven investments. In addition, Oregon is proposing a new process for operationalizing incentive metrics to evaluate the impact of those changes on reducing health inequities.		
<p>Lever 4: Increased efficiency through administrative simplification and a more effective model of care</p> <p>Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes</p>	<p>Evaluation area:</p> <ul style="list-style-type: none"> <li>The effects of transitioning to ‘opt-out’ CCO enrollment for dual eligible individuals, including the impact on total expenditures</li> </ul> <p>Waiver goal(s):</p> <ul style="list-style-type: none"> <li>Commit to an ongoing sustainable rate of growth, advance the use of value-based payments, and promote increased investments in health-related services</li> <li>Continue to expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members</li> </ul>	<p><b>New Evaluation area(s):</b></p> <ul style="list-style-type: none"> <li><b>The impact of a flexible, predictable capitation rate on community investment to reduce health inequities and improve population health</b></li> <li><b>The impact of equity-driven processes for operationalizing incentive metrics on reducing health inequities</b></li> </ul> <p><b>Waiver goal(s):</b></p> <ul style="list-style-type: none"> <li><b>Move to paying for population health</b></li> <li><b>Ensure quality and access through equity-driven performance metrics.</b></li> </ul>

## **Evaluation Questions and Hypotheses – Proposed**

### **Q1. Will the 1115 waiver renewal proposed interventions decrease health inequities by race and ethnicity?**

#### Hypothesis #1:

Redistributing power and resources to individuals and communities most harmed by historical and contemporary racism will result in improvements in health inequities and self-reported measures of autonomy, health status and quality of life.

#### Hypothesis #2:

Using the new decision-making structure to select and operationalize CCO incentive metrics will result in greater improvements in health inequities by race/ethnicity than occurred under the decision-making structure in place during the 2012-2017 waiver.

### **Q2. Does continuous coverage improve health outcomes?**

#### Hypothesis #3

Earlier OHP enrollment with fewer gaps in coverage for vulnerable populations will result in more members receiving care in the right settings, and improved health status and quality of life.

#### Hypothesis #4:

Offering packages of SDOH support services to individuals experiencing transitions is more effective at improving integration for successful transition than offering individual services alone.

### **Q3. Does the new rate development methodology for a value-based population health budget increase CCO spending in community investments to reduce health inequities?**

#### Hypothesis #5

Offering a predictable budget, based on a streamlined method with predictable cost growth, allows for greater clarity around available funds for CCO reinvestment in local community and increases community investments.

#### Hypothesis #6

Offering a predictable budget, based on a streamlined method with predictable cost growth, allows community partners to more effectively partner with CCOs to meet members' needs for SDOH support services.

## Evaluation Parameters

### Design

Across the hypotheses there will be varying evaluation designs to suit the proposed evaluation measures. For example, for hypothesis #3 under continuous coverage, a pre/post comparison may be suitable. However, with hypothesis #5 a post assessment will determine how much investments have been made to the community.

### Population and Measures

Table 19. Population and measures

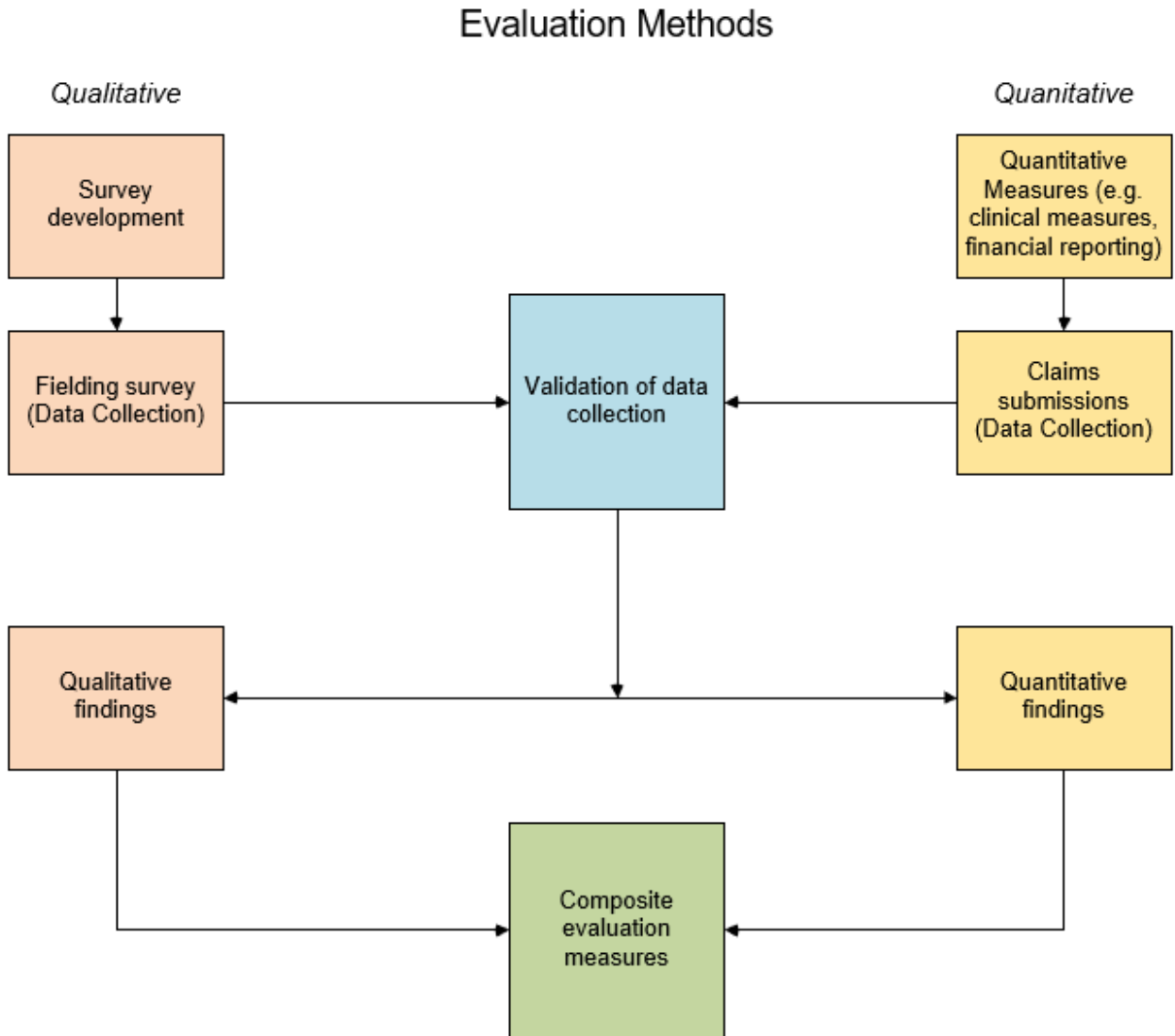
Evaluation Question	Hypothesis	Potential Population	Potential Methods / Measures
<b>Will the 1115 waiver extension proposed interventions decrease health inequities by race and ethnicity?</b>	Redistributing power and resources to individuals and communities most harmed by historical and contemporary racism will result in improvements in health inequities and self-reported measures of autonomy, health status and quality of life.	<ul style="list-style-type: none"> <li>Community organizations (regional health equity coalitions, community advisory councils, proposed regional community groups)</li> <li>Whole OHP population by race/ethnicity</li> </ul>	<ul style="list-style-type: none"> <li>Community survey</li> <li>Self-reported measures of stability and security</li> <li>CMS core measures by race/ethnicity</li> <li>HRS investments</li> </ul>
	Using the new decision-making structure to select and operationalize CCO incentive metrics will result in greater improvements in health inequities by race/ethnicity than occurred under the decision-making structure in place during the 2012-2017 waiver	<ul style="list-style-type: none"> <li>Medicaid members</li> <li>CCO incentive measures</li> <li>Metrics decision-making Committees</li> </ul>	<ul style="list-style-type: none"> <li>Committee members survey</li> <li>Community partner survey</li> <li>Equity impact assessment of metrics</li> <li>Measures of observed disparities by CCO incentive metrics</li> </ul>
<b>Does continuous coverage</b>	Earlier OHP enrollment with fewer gaps in coverage for vulnerable populations will result in	<ul style="list-style-type: none"> <li>Children ages 0-5 with race/ethnicity breakdowns</li> </ul>	<ul style="list-style-type: none"> <li>Kindergarten readiness measures</li> </ul>



<b>improve health outcomes?</b>	improved health outcomes, health status, and quality of life.	<ul style="list-style-type: none"> <li>• Children ages 6+ with race/ethnicity breakdowns</li> </ul>	<ul style="list-style-type: none"> <li>• Re-enrollment of OHP members</li> </ul>
	Offering packages of SDOH support services to individuals experiencing transitions is more effective at improving integration and stabilization for successful transition than offering health care services alone	<ul style="list-style-type: none"> <li>• Whole OHP population by race/ethnicity</li> <li>• Youth with special health care needs by race/ethnicity</li> <li>• Individuals at risk of becoming homeless</li> </ul>	<ul style="list-style-type: none"> <li>• Self-reported measures of stability and security</li> <li>• Reduced recidivism rates</li> <li>• Reduced ED visits for Behavioral Health and non-traumatic dental needs</li> <li>• Time to first appointment with patient centered primary care home (PCPCH)</li> <li>• Time to first appointment with behavioral health provider</li> </ul>
<b>Does the streamlined capitation rate development methodology for a new value-based global budget increase CCO spending in community investments for reducing health inequities?</b>	Offering a predictable budget, based on a streamlined method with predictable cost growth, allows for clarity around available funds for reinvestment.	<ul style="list-style-type: none"> <li>• Community organizations (regional health equity coalitions, community advisory councils, proposed regional community groups)</li> <li>• CCOs</li> <li>• Actuarial unit</li> </ul>	<ul style="list-style-type: none"> <li>• Community survey</li> <li>• CCO survey</li> </ul>
	Offering a predictable budget, based on streamlined method with predictable cost growth, increases community investments.	<ul style="list-style-type: none"> <li>• CCOs</li> </ul>	<ul style="list-style-type: none"> <li>• HRS investments</li> </ul>

## Methods

Figure 2. Evaluation methods



## Reasoning for Changes to Current Evaluation

The state is proposing changes to what will be evaluated with this extension that are similar to what is being evaluated under the current demonstration. The changes are described below:

Table 20. Changes to current evaluation

Current Demonstration Focus Areas	Changes Proposed to Evaluation Hypotheses	Reason for Change
Enhancing health equity	<p>Redistributing power and resources to individuals and communities most harmed by historical and contemporary racism will result in improvements in health inequities and self-reported measures of autonomy, health status and quality of life.</p>	<p>Health inequities are exacerbated when communities do not have the resources needed to address the root causes directly. The state will evaluate whether additional resources and decision making power results in measurable improvements in reducing health inequities.</p>
Improving population and social determinants of health	<p>Earlier OHP enrollment with fewer gaps in coverage for vulnerable populations will result in improved health outcomes and self-reported measures of health status and quality of life for the following groups:</p> <ul style="list-style-type: none"> <li>• children ages 0-5</li> <li>• individuals ages 6+</li> <li>• individuals in jail or local corrections</li> <li>• incarcerated individuals 90 days prior to release</li> </ul>	<p>People without insurance coverage have a harder time accessing health care services and often delay needed care and face significant medical debt when they do get care. The rates of uninsured by race and ethnicity show that communities of color are more likely to be uninsured, which exacerbates health inequities by making it more difficult to receive the services needed for good health. The state will evaluate whether policies aimed at closing gaps in coverage will result in reduced health inequities.</p>
Implementing health-related services to improve	Offering pre-defined packages of SDOH support services to	This hypothesis focuses on whether the state can better

care delivery and member health	individuals experiencing transitions is more effective at improving the integration of services needed for successful transition than offering individual services alone for the following populations:	support the integration of care for vulnerable populations (such as members with Medicaid and Medicare eligibility, members needing behavioral health services, and Youth with Special Health Care Needs) by defining a list of non-medical services designed to improve care delivery and member health. The proposed change combines hypotheses concerning health-related services to improve health; access to housing for members needing behavioral health services and other vulnerable populations; integrating physical, behavioral, and oral health care; and improving access, experience, and quality of care for dual-eligible members.
Improving access to sustainable housing for members needing behavioral health services and other vulnerable populations		
Integrating physical, behavioral, and oral health care		
Improving quality of care, access to care, experience of care, and health status, and reducing costs for members with Medicaid and Medicare eligibility (i.e., dual eligibility)		
Implementing value-based payments that reward quality and efficiency	Using the Health Equity Quality Metrics Committee to define incentive measures will result in metrics that result in greater improvements in health inequities by race/ethnicity than those recommended by the Health Plan Quality Metrics Committee	Value-based payments and incentive measures for quality and efficiency remain a proven strategy to drive health system transformation. The state will evaluate the impact of focusing the incentive structure on one domain.
<i>Improving hospital quality through the Hospital Transformation Performance Program</i>	<i>Not applicable</i>	<i>Program ended June 30, 2018 and shifted to Qualified Directed Payment (QDP) Programs</i>

## Section IX. Quality Strategy

### **Quality Strategy for 2022-2027 Demonstration Period**

The Medicaid Quality Strategy for the proposed 2022 waiver application includes several components. The current Medicaid Quality Strategy was updated and posted in May 2021 to bring current with Coordinated Care Organization (CCO) contracts and CCO 2.0 priorities. The more substantive changes coming to the OHA Medicaid Quality Strategy will include updates to align with 2022 1115 Waiver application goals and objectives, health equity, CMS Quality Strategy guidance released July 2021, and based upon assessment of current quality strategy. The next iteration will involve community engagement, CCOs, and tribes. The following components are included in OHA's draft quality strategy.

- Quality Strategy Overview
- 2017-2021 Quality Strategy Assessment
- 2022-2027 Draft Quality Strategy
- 2021 OHA Medicaid Quality Strategy

## Quality Strategy Overview

Oregon's Medicaid program, the Oregon Health Plan (OHP), has a quality strategy to reduce health inequities while ensuring quality and access to care for OHP members across all health care services and settings for physical, behavioral, and oral health. The OHP Quality Strategy applies for all plans, Coordinated Care Organization (CCO), Dental Care Organization (DCO), and open card fee-for-service OHP.

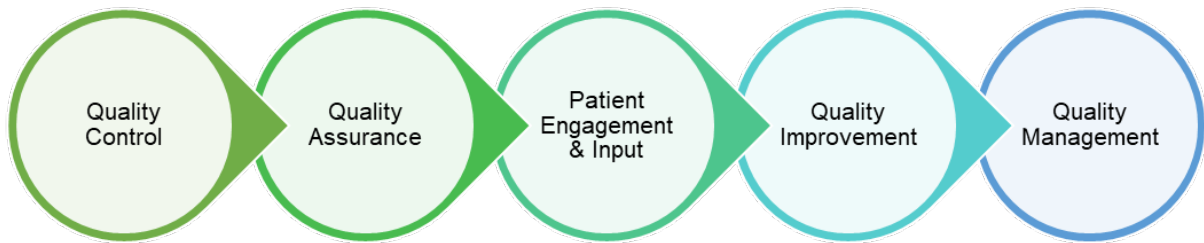
## Quality Definitions

**Connecting all the pieces of quality management.** Multiple systems, processes, inputs (data and patient/member input) assist in the quality program. Below are a few visuals which cover the key quality components.

Figure 3. Quality management



Figure 4. Quality Connections



### 2017-2021 Quality Assessment Summary

Under Oregon’s 2017–2022 Section 1115(a) Medicaid Demonstration Waiver approved by the Centers for Medicare & Medicaid Services (CMS) OHA contracts with five dental care organizations (DCOs) and 16 coordinated care organizations (CCOs) to deliver managed care to members enrolled in the Oregon Health Plan (OHP), Oregon’s Medicaid Program. CCOs are responsible for the physical, behavioral, and oral health benefits for their members. DCOs are responsible for the oral health benefits for those members in the OHP open card.

The Oregon Health Authority has utilized information across the community, agency, and federal input to assess the quality and access to care for OHP members. Figure 5 shows the key quality inputs which inform the quality assessment.

Figure 5. Quality Inputs



### OHA Health System Division, Medicaid Quality Assurance and Compliance Monitoring Activities

The Quality Assurance and Compliance Monitoring team is supporting quality in several areas: network adequacy, provider directory, Grievance and Appeals, CCO member material reviews, and workforce development (particularly traditional health workers).

Specifically, the team, along with an External Quality Review Organization (EQRO), conducted a comprehensive review of CCOs’ provider networks focusing on provider capacity, provider directory validation, and other issues affecting members’ access to

care to ensure transparency and to minimize the impact inadequate access can have on health equity. The delivery system network (DSN) report includes a narrative report and a provider capacity report. The full results of the DSN report will be made final with the OHP Section 1115 Annual Report for 7/2020 through 6/2021; which was recently submitted to CMS for approval.

#### *Performance Improvement*

The statewide performance improvement project (PIP) transitioned to a new topic to align with state priorities for behavioral health. The project design completed in CY2021 will target the CCOs work for mental health access to care for members two years and older. Aligning the statewide PIP to the access issue for behavioral health will further support and align partners, CCOs, and OHA in addressing the need.

#### *External Quality Review*

The External Quality Review (EQR) is conducted by an EQRO. For the demonstration period prior to July 2018, HealthInsight Assure was the EQRO. From July 2018 until present, Health Services Advisory Group (HSAG) is Oregon's EQRO. EQR is an annual review of the state, the CCOs, and DCOs. Over the course of the annual reviews the EQRO conducts compliance monitoring reviews, validation of performance improvement projects, performance measure validation, validation of network adequacy, and encounter data validation. Additional EQR work included mental health parity analysis and other performance improvement project reviews.

Below is a summary of the annual EQRs to inform the areas of success and improvement to ensure quality and access for OHP members. From year to year the improvement of CCOs and DCOs is further reflected in the individual annual review reports for each CCO and DCO and the annual technical report submitted to CMS. CCOs and DCOs worked on resolving EQR (2017-2020) findings in the subsequent review year with success and improvements noted across the waiver demonstration years. CY2020 compliance reviews identified several improvement areas and OHA and CCOs are currently working on improvement plans. Full EQR reports can be found on the OHA Quality Assurance and Contract Oversight website:  
<https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA.aspx>.



Table 21. EQR Activities

EQR Review Area	Areas of Success	Areas of Improvement *(CY2020)
<p><b>Compliance Reviews</b></p>	<p>Across CCOs and DCOs, Coverage and Authorization of Services has an average score of 94% out of 100% for CCOs and 91% for DCOs. 2019 CCO review of prior years' (2017/2018) findings resulted in resolution of a majority of CCO findings. CCOs have appropriate credentialing policies. DCOs scored 90% for availability of services and 98% for Grievance and Appeal systems. "A notable strength for all DCOs was their commitment to improving quality of care and access to care, and proactively addressing any grievances and appeals." (EQR 2019)</p>	<p>Member Rights and Protection policies with an average score of 83% out of 100% for CCOs; with the need for CCOs to improve offering members all options for reporting discrimination complaint. Policies developed for coordination of care, yet implementation of policies needs improvement for DCOs. 2019 improvement plans from CCOs for the outstanding documentation needed for findings resolution of prior years.</p>
<p><b>Performance Improvement Project</b></p>	<p>All CCOs met PIP validation criteria for the design state (CY 2019) for the acute opioid prescribing project. However, this project did not proceed past design due to the COVID-19 impacts to the delivery system. Statewide and CCO-specific data for the safe prescribing of opioids statewide PIP showed there was a statistically significant statewide improvement (decrease) in the rate of high-dose opioid prescriptions from baseline to the final remeasurement.</p>	
<p><b>Performance Measure Validation</b> <i>Review of performance</i></p>	<p>Annual select performance measures are selected and review. Annually the review findings show compliance with specifications.</p>	<p>Quality assurance check between the rate review summary and the detail file.</p>

EQR Review Area	Areas of Success	Areas of Improvement *(CY2020)
<i>measure calculations and results</i>		
<b>Network Adequacy</b> <i>Assessment of the provider network</i>	CCOs received an average score of 88.1%, with three CCOs meeting all delivery system network report categories. Two DCOs received a full score of 100%.	DCOs need technical assistance in how to complete reporting requirements.
<b>Encounter Data Validation</b>	The policy and procedure documents showed that the CCOs employed encounter file generation and review processes that had been tailored to meet OHA's encounter submission contractual requirements and specifications. All CCOs collected TPL data for their managed care members, although information was processed at different points in their adjudication processes. The CCOs considered TPL data before finalizing their claims adjudication. All CCOs appeared to have processes both to track encounters sent to OHA and then process the response files back such that CCOs could monitor the rejections/pends and handle necessary corrections and resubmissions.	Documentation of OHA and CCOs quality assurance activity monitoring activities. CCOs ability to oversee and validate data of subdelegates prior to submission to OHA.

### *CCO Performance Report*

The quality measures are reported annually in the CCO Performance Report. There are three types of measure categories 1) state quality measures 2) CMS Core measures 3) CCO incentive measures. A measure can be in more than one category. The incentive measures have payment tied to CCO performance on the measure. The payment, “quality pool”, is established to drive improvement through incentive payments to CCOs. Each CCO is paid for reaching benchmarks or improvements in the CCO incentive measures. The quality pool amount varies across years. Additional information on the quality pool and CCO incentive measures, including selection and adoption, can be found on the OHA Metrics website:

<https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx>.

Below is a summary of performance across key measures. Of note, calendar year (CY) 2020 impacted several measures due to the COVID-19 pandemic and the health delivery system impacts (e.g. in-person care severely disrupted). Many measures showed significant decline in 2020 due to in-person care disruptions. Additionally, the incentive measure program made changes as a result of the COVID-19 pandemic.

Table 22. CCO Performance Measures

Measure	Measure Performance Summary	Notes and next steps
Adolescent immunizations (combo 2: Tdap/TD, meningococcal, and HPV) before their 13 <sup>th</sup> birthday	CY2017, 31.3% to a measure high in CY2020 of 36.3%. Of note in CY2019, measure performance was 36%, just a bit under CY2020.	In-person care disruptions have impacted adolescents getting into providers for information and vaccination. Ongoing supports to the providers, quality improvement methods (root causes, plan-do-study-act (PDSA)), will be needed to assist families and members.
All-cause readmissions	Observed to Expected ratio for CY2019 was 0.72 with a slight increase to 0.75. Lower is better for the ratio.	Monitoring the return of adults to the hospital within 30 days after an inpatient stay. There are multiple measures that monitor this to ensure quality of care from inpatient stay through discharge.  Performance varies across CCOs and regions.
Assessments for children in DHS custody (timely visits for medical, behavioral, and dental)	CY2014 measured 27.9%, increased with a measured high of 87.8% in CY2019, with a decline to 79.9% in CY2020.	Statewide the performance in this measure has steadily increased and currently includes all three clinical assessments (dental, medical, and behavioral health). This measure requires the continued efforts of CCOs, communities, and providers to work

Measure	Measure Performance Summary	Notes and next steps
		together to support this critical population.
Childhood immunization status (combo 2) before child's second birthday	CY2015, 68.2% to CY2019 with a measure high of 75.5% with a decline to 70.7% in CY2020.	Continuing outreach efforts to members in need of vaccination; including targeted outreach via lessons learned from COVID-19 vaccination.
Cigarette smoking prevalence	CY2016, 29.3% to a measure low of 23% in CY2020. Of note: lower number is better.	Collaborative efforts between CCOs, local public health, state public health efforts include but not limited to, tobacco cessation coverage, member screening at clinics, Quit-line supports and technical assistance.
Colorectal cancer screening	CY2014, 46.2% to a measure high of 57.9% in CY2019 with a decrease to 49.3% in CY2020.	Recent, May 2021, guideline changes from the US Preventive Services Task Force (USPSTF) now recommends colorectal cancer screening for adults aged 45 and older.  Current measure is for 50 years and older. OHA is monitoring changes to the metric from CMS and other federal partners.
Dental services for ages 1-5 years old	CY2018, 49.2% to CY2019, 51.2% with a decrease to 37.5% in CY2020.	Part of OHA's kindergarten readiness suite of measures, this measure includes dental services provided in

Measure	Measure Performance Summary	Notes and next steps
		primary care and dental practices to support care integration across settings.
Developmental screenings in the first 36 months of life	CY2011, 20.9% to CY2019, 75.0% with a decrease to 70.3% in CY2020.	A new measure that will represent the referral for a positive screen will be implemented in the future years.
Diabetes care: HbA1c poor control	CY2014, 21.8% to CY2019 with a measure low of 21.5% with an increase to 29% in CY2020. Of note: lower number is better.	The measure has had years of increase with progress from 2018 to 2019. Engaging primary care practices and patients in chronic disease self-management will be key in the future years as the pandemic improves and health care delivery returns.
Emergency department utilization among members with mental illness	CY2017, 106.3 to a measure low in CY2019, 99.2.	In CY2020 performance showed a significant drop to 83.6 mainly due to the in-person care disruptions due to the COVID-19 pandemic.
Initiation and engagement of alcohol or other drug treatment	CY2019, 38.4%.	Has been a state quality measure however recently added as an incentive measure in CY2019.
Postpartum care visit	CY2014, 44.7% to CY2019, 68.2%. Performance in CY2020 is measure high of 73.7%.	There is a need for an assessment of performance improvement during COVID-19 pandemic. Improvement could be a result of access to care due to limited in-person services.

Measure	Measure Performance Summary	Notes and next steps
Screening, brief intervention and referral to treatment (SBIRT)	Screening received (rate 1) reported in CY2019 at 62.8%. Referral for treatment (rate 2) based upon a positive screen reported in CY2019 at 42.8%.	The SBIRT measure changed from a claims-based reporting measure to a EHR reported measure to improve quality of reporting and inclusion of referral for treatment.
Topical fluoride varnish	CY2018, 23.3% then a decrease in CY2019 to 21.3% and further reduction in CY2020 to 11.4%.	OHA has entered into CMS affinity group (learning experience) to improve topical fluoride varnish rates for children in Oregon. The learning experience will include CCOs, DCOs, local public health, tribes and quality improvement organizations.
Well-child visit for ages 3-6 years old	CY2018, 66.5% to CY2019, 68.6% with a decrease to 59.2% in CY2020.	This measure is part of OHA's kindergarten readiness suite of measures in addition to being a CCO incentive metric.

# 2022-2027 Draft Quality Strategy

## I. Introduction

To monitor how well Oregon’s coordinated care model is achieving its goals of access, equity, quality and outcome improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have robust performance monitoring strategies and mechanisms to monitor and assess all Medicaid delivery systems (including coordinated care organizations (CCOs), dental care organizations (DCOs) and fee-for-service (FFS)).

As required by CFR 438.340, Oregon assesses how well the CCOs and managed care organizations are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees, and member satisfaction.

Oregon has developed a comprehensive program to assess all aspects of the delivery system and the CCO and DCO activities to determine quality improvement and contract compliance. This Quality Strategy describes the components of that program.

## II. Background

Figure 6. Oregon’s 1115 Waiver Goals



Table 23. Oregon Medicaid Landscape

Plan	Plan Type	Managed care authority	Population Served
CCO A	MCO	1115	Medicaid children without disabilities, parents, and expansion adults ages 20-64
Care Oregon	DSNP		Beneficiaries dually eligible for Medicaid and Medicare



### III. Overview

#### Framework for quality

To monitor quality, the Oregon Health Authority will build upon the eight currently implemented focus areas across Oregon’s health care delivery system. Continuing the progress in the focus areas, the Oregon Health Authority will intensify key focus areas, such as adding oral health to the existing primary care and behavioral health integration. Working collaboratively across the system, CCOs, DCOs, and the Oregon Health Authority will support the framework through quality improvement in these focus areas. Focus areas are detailed in the following “Improvement Strategies” section.

Continuing on the pathway to achieve the Triple Aim, the Oregon Health Authority recognizes the need for alignment across all health care delivery systems for quality. Increased focus on alignment will include programs in Medicare, Medicaid (CCO and FFS systems) and federal improvement programs (for example, value-based payment). Working with a regional quality improvement organization (QIO), OHA’s External Quality Review Organization and health care delivery systems (CCOs, DCOs, FFS), the Oregon Health Authority will look for opportunities to align state efforts with federal direction in quality and transformation activities. While maintaining the state’s program integrity related to gains in health transformation, the Oregon Health Authority will develop strategic alignment for quality programs to increase organizations’ efficiency and decrease burden on the health systems for reporting and communicating common-thread goals that will continue Oregon’s work towards the triple aim of better health, better care and decreasing costs.

#### Accountability summary

To drive innovation, improve health outcomes, and maintain compliance with regulatory agencies, OHA is working with a variety of stakeholders, committees, and oversight bodies to ensure CCO accountability and improve delivery system quality of care. This work is equity centered and rooted in increasing access and quality of care for Oregon Health Plan/Medicaid and CHIP members. Key attributes of this work include the following:

- Oregon Health Policy Board – develops strategic direction of health system transformation and is equity centered.
- OHA Quality Council – monitors clinical quality performance, health system transformation and quality improvement.
- Medicaid Advisory Committee – advises the OHA on the policies, procedures, and operation of the Oregon Health Plan.

- Quality management/contract compliance – monitors CCOs and DCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud, waste, abuse).
- Quality Management Committee – provides overall structure for the Oregon Health Plan quality governance to monitor and improve quality initiatives.
- Health delivery system (partnership committees with delivery system and OHA):
  - Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation;
  - Health Evidence Review Committee – reviews and develops evidence-based practices for all managed care entities (including FFS); and
  - CCO Operations Collaborative and Contracts and Compliance Workgroup – monitors compliance with CCO contract requirements and provides guidance on operational implementation of requirements.

### **Methods and resources for monitoring**

Across the Oregon Health Authority’s quality programs, the agency utilizes multiple quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and LEAN principles are examples of proven methods of improvement. Ongoing use of these methods across the agency supports the transformation in the health care delivery system through train-the-trainer models with CCOs and contractual relationships with FFS. An additional resource for monitoring includes robust data systems to drive a data decision-making culture. Key agency data include, but are not limited to, the all payer all claims database, performance monitoring through measures reporting, delivery system network reports, appeal and grievance data, and CCO data dashboards from claims reporting and deliverable tracking.

### **Standards for managed care contracts**

As required by CFR 438.340, Oregon must establish standards for all managed care contracts regarding access to care, structure and operations, and quality measurement and improvement. Within the CCO and DCO contracts, the federal regulations are outlined with the applicable CCO and DCO deliverables to support quality through monitoring and contract compliance.

### **Compliance and expectations for CCOs and DCOs**

Achieving the policy objectives of CCO 2.0 requires a strong operational foundation with clearly defined performance expectations and a system to monitor compliance with all contract provisions. While some flexibility allows CCOs to meet the unique needs of

their communities, OHA also has a responsibility to conduct effective oversight of the program to ensure members across the state receive the care they deserve.

OHA is developing the internal structures necessary to set the standard for accountability throughout the health care delivery system and to consistently apply that standard to all providers. To improve oversight and provide guidance to CCOs and DCOs, OHA created a comprehensive and standardized process for all OHA divisions to proactively evaluate, monitor and manage individual CCO remediation to the new CCO 2.0 contract. The standardized process also applies to monitoring of DCO performance. Aligning contract deliverables with a streamlined, transparent compliance review process will:

- Create a sustainable process that is standardized and driven by deliverable requirements, not variable and people driven;
- Ensure MCEs have clear information and guidance about deliverables for which they are accountable, OHA's review process, and corresponding timelines;
- Strengthen partnership and coordination between CCOs, DCOs, and OHA; and
- Enable remediation of process gaps and focus on prevention of future findings.

The standard evaluation process will ensure OHA is able to monitor and track CCO and DCO performance across all federal and state requirements. The contract requirements (deliverables) will be updated annually to improve clarity of requirements, reporting and deliverables, due dates, and the accountability process. Through this effort, OHA is developing more prescriptive guidance in areas where stakeholders have expressed concern about barriers to access or inconsistency, providing technical assistance (if needed), and utilizing enforcement mechanisms when necessary to achieve those outcomes.

Through improvements to the monitoring and compliance infrastructure, increased enforcement of new and existing requirements, and clarification of the performance expectations for CCOs, OHA plays an important role in creating the conditions for CCO, DCO, and health transformation success.

## **Health priority alignment**

### *CCO 2.0 priorities*

The next phase of Oregon's health care transformation, called CCO 2.0, is focused on four key areas identified by the Governor:

1. Improve the behavioral health system and address barriers to access to and integration of care.

Integrate behavioral, physical, and oral health to allow patients to receive the right care at the right time and in the right place. Focus on behavioral health (mental health and

substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.

2. Increase value and pay for performance.

Reward providers' delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.

3. Focus on social determinants of health and health equity.

Build stronger relationships between CCOs and other sectors. In addition, align outcomes between health care and other social systems to improve health equity. Encourage a greater investment in prevention and the factors that affect our health outside the doctor's office

4. Maintain sustainable cost growth and ensure financial transparency.

Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

These focus areas and the associated policies are the foundation of the CCO contracts awarded for 2020–2024.

#### *State Health Improvement Plan*

OHA provides backbone support for implementation of the State Health Improvement Plan, Healthier Together Oregon (HTO). Oregon's 2020–2024 HTO identifies efforts needed to advance health equity for priority populations through collective action in five priority areas: (i) institutional bias, (ii) adversity, trauma and toxic stress, (iii) access to equitable preventive health care, (iv) behavioral health, and (v) economic drivers of health, such as housing, food security and living wage jobs. HTO is intended to be an alignment tool for anyone working to improve health, including other state agencies and partners that develop and implement community health improvement plans (CHPs). CCO CHPs are required to align with at least two HTO priorities and strategies. Finally, OHA convenes the PartnerSHIP, a community-based steering committee, to provide oversight and governance of the plan. The PartnerSHIP is made up of representatives of priority populations and implementers of the State Health Improvement Plan, including CCOs and their community advisory councils.

#### *Equity*

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential. However, there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain disadvantaged communities. Some communities are less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider.

OHA utilizes several levers to improve health equity. The coordination of these levers and the monitoring and accountability are essential actions to have the greatest impact. Levers include, but not limited to, measurement monitoring and reporting across racial and ethnic disparities, health equity pay for performance incentive metric, CCO health equity plans, equity components of the CCO Transformation and Quality Strategy, and connections to the community health improvement plans and regional health equity coalitions.

To reinforce Oregon Health Authority's commitment to improve health and equity, OHA adopted a definition of health equity and a 10-year goal for achieving health equity both of which serve as a foundation for the agency's work. The foregoing strategic goal was informed by an extensive statewide community engagement process to ensure the agency was especially responsive to the people in Oregon most impacted by health inequities, which stems from long-standing and contemporary racism and oppression. The process also allowed for understanding where work needs to be focused, will facilitate robust internal and external coordination, and impacted the agency's thinking about, and the work that needs to be done to, achieve health equity.

OHA 10-year goal: [To end health inequities in the state of Oregon by 2030.](#)

10-year goal key questions:

- How does the state address the equitable distribution and redistribution of resources and power?
- How does this impact the state's policy, practice, and decision making?
- What does the state need to do differently?

[Health equity definition](#)

In October 2019 the Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) adopted the health equity definition developed by the Health Equity Committee (a subcommittee of OHPB). The definition states that:

*Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*

*Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*

- *The equitable distribution or redistribution of resources and power; and*
- *Recognizing, reconciling, and rectifying historical and contemporary injustices.*

## IV. Quality Strategy Goals and Objectives

Forthcoming – 2022. An example is provided below.

Table 24. Example of Quality Strategy goals and objectives

Objective	Objective description	Quality measure	Statewide performance baseline (year)	Statewide performance target for objective (year)
Goal 1: Improve access to care				
CMS Core measure		CMS CAHPS		
Qualitative measure (Homegrown)		OHA DSN reporting time/distance		
Qualitative		Patient report, patient survey		
TBD (Consumer/Community)		C&G on access		
Goal 2:				

## V. Methods

### Accountability methods

Oregon has developed a comprehensive program to assess all aspects of the delivery system. This program involves routine analysis and monitoring of delivery system performance and consumer satisfaction data, comprehensive on-site operational reviews, and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews (described below).

#### *Ongoing focused reviews*

Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through routine monitoring processes and grievance and appeal reporting. These reviews will also provide more detailed information on areas of particular interest to the state such as emergency department

visits, availability and access of services, behavioral health, utilization management, and data collection problems. An example of a focused review is an ongoing review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

#### *Appointment and availability studies*

The purpose of these studies is to review managed care and FFS provider availability/ accessibility and to determine compliance with contractually defined performance standards. The Oregon Health Authority (OHA) and its external quality review organization (EQRO) conduct a secret shopper telephone survey among primary physical health care providers (PCPs) contracted with one or more CCOs. The primary purpose of this secret shopper survey is to collect appointment availability for Oregon Health Plan (OHP) members new to the provider location and requesting routine well-checks or non-urgent problem-focused ("symptomatic") visits. Specific survey objectives included the following:

- Determine whether PCP service locations accepted OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligned with the CCOs' delivery system network (DSN) provider capacity report data;
- Determine whether PCP service locations accepting OHP for the requested CCO accepted new patients and the degree to which new patient acceptance aligned with the CCOs' DSN provider capacity report data; and
- Determine appointment availability with the sampled PCP service locations for routine well-checks and non-urgent symptomatic visits.

#### *Marketing and member materials review*

Managed care contractors are contractually required to submit all marketing materials, advertising, and written member notices to the state for approval prior to use. This process ensures the information presented to members and potential members is compliant with state and federal requirements.

#### *Performance monitoring*

Through the standardized deliverable evaluation process, OHA will have the ability to compare and measure performance across all CCOs and DCOs for a variety of deliverables. OHA is improving the reporting and systems used to measure performance in key priority areas: (i) timely and appropriate denials, appeals, hearings and grievances, (ii) access to language translation services, (iii) quality of non-emergent medical transportation services, (iv) adequacy of provider network, (v) access to care coordination services and intensive care coordination services, and (vi) integration of behavioral health services.

#### *On-site operational reviews*

On-site reviews will be conducted periodically as a result of, for example, gaps in performance, when requested by CCO, or when requested by the EQRO. Reviews will

include, but not limited to, validating reports and data previously submitted by the CCO, an assessment of supporting documentation, and/or conducting a more in-depth review of the CCO's quality assurance activities. Reviews will also serve as an opportunity for in-person, one-on-one technical assistance in identified gap area. For example, a site visit relating to performance improvement projects will include a refresher in CCO deliverables, review of applicable state and federal requirements, and the provision of technical assistance in root cause, development, and a statement of objectives.

Further, on-site review(s) will supplement the state monitoring program of CCOs, by providing CCOs with direct and focused areas of improvement.

#### *Quality Management Committee reviews*

The OHA Quality Management Committee meets quarterly to review contract compliance issues across all delivery systems in aggregate and performance metrics.

As per STC 24b.ii, OHA will contractually require each CCO to address four of the quality improvement focus areas, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

## **Performance improvement**

#### *Advancing PIPs*

Moving forward, the PIP strategies are maturing into the use of technology around care coordination and expanding into integrated practices. Allowing for the CCOs that have developed data monitoring systems, case management programs, and measurement alignment to develop initiatives in the space of social determinants of health will be key to continuing to push health transformation. Additionally, lessons learned from the 2012–2017 demonstration for PIP implementation have led to the development of SMART (specific, measurable, attainable, relevant, timely) objectives with a corresponding measurement for monitoring progress. Future technical assistance and monitoring will continue to focus on these quality improvement foundations.

#### *PIP focus areas*

To move forward in testing and implementing improvement strategies, the CCOs will be required to conduct four performance improvement projects. Two of the four will be selected from the focus area list by the CCO, the third will be a statewide PIP under the “integration of health” focus area, and the fourth PIP will be a statewide substance use



disorder PIP. The quality improvement focus areas, as referenced in Oregon's 2017–2022 1115 Waiver Attachment E are:

- Reducing preventable re-hospitalizations;
- Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs;
- Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers;
- Integrating health: physical health, oral health and/or behavioral health;
- Ensuring appropriate care is delivered in appropriate settings;
- Improving perinatal and maternity care;
- Improving primary care for all populations through increased adoption of the Patient- Centered Primary Care Home (PCPCH) model of care; and
- Addressing social determinants of health.

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. PIP focus areas are subject to change as CCOs mature.

### **External Quality Review Organization (EQRO) activities**

States with Medicaid managed care delivery systems are required to provide an annual assessment of managed care entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services provided by each entity, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Oregon Health Authority contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to perform the assessment. The EQRO performs the following mandatory and optional external quality review (EQR) activities, as described in 42 CFR Part 438 and 42 CFR §438.358.

- Compliance monitoring reviews (CMR) to determine MCE compliance with federal (42 CFR §438) and State standards that address requirements related to access, structure and operations, and quality measurement and improvement. CMR activities also included follow-up on the status of past CMR findings and related improvement plans for the DCOs from calendar year 2019;
- Validation of performance improvement projects and focus studies;
- Performance measure validation of seven specific measures to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for the State's CCOs;

- Validation of network adequacy involving the comprehensive review of MCE delivery system network (DSN) provider capacity reports and DSN provider narrative reports regarding compliance in accordance with the State’s standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN;
- An encounter data validation study to evaluate CCO processes for collecting, maintaining, and submitting encounter data to OHA; and
- A mental health parity analysis to ensure that coverage and access to mental health/substance use disorder benefits were provided in parity with medical/surgical benefits.

## Surveys

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, which asks them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members’ expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

Seventeen CAHPS measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

## VI. Quality Components

### Quality management plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance.

#### *Transformation and quality strategy*

The transformation and quality strategy (TQS), developed in 2017, incorporates all components of the Quality Assessment and Performance Improvement (QAPI) program. The QAPI has been incorporated into the CCO’s TQS and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. The TQS specifically focuses on CCO documentation of key efforts across the following components, as well as documentation of the CCO’s overall quality program within the CCO’s larger strategic plan:

- Access: quality and adequacy of services,
- Access: cultural considerations,
- Access: timely,
- Behavioral health integration,
- CLAS standards,
- Grievance and appeal system,
- Health equity: data,
- Health equity: cultural responsiveness,
- Oral health integration,
- Patient-centered primary care home: member enrollment,
- Patient-centered primary care home: tier advancement,
- Serious and persistent mental illness,
- Social determinants of health & health equity,
- Special health care needs, and
- Utilization review.

CCO TQS documentation will be monitored to ensure a robust CCO quality and transformation program, in accordance with best practices and CFR. This includes a formal OHA assessment and scoring of each CCO TQS submission with actionable feedback to support continuous quality improvement. The TQS will also be used as a basis for peer sharing of evidence-based and emerging best practices to further health transformation across CCOs. See “Expectations of CCOs” section above for further details.

#### *Health equity plan*

As a CCO 2.0 contract deliverable, CCOs are required to develop and submit a yearly health equity plan. The health equity plan aims to provide the CCO and its stakeholders a clear framework to becoming an organization that values and prioritizes health equity. The framework includes an action plan detailing where the CCO is headed, what it plans to achieve, the methods it will use, and milestones to monitor progress. A successful health equity plan is built on a thorough analysis of the existing CCO structure, governance, staff, program or service mix, collaborations, and resources, including financial, human, technical and material. This analysis is vital because it allows an organization to understand which components it must change in order to achieve its health equity goals.

OHA requires all CCOs to develop a health equity plan that:

- Acts as a catalyst to initiate the deep organizational changes needed to build equity and diversity into service planning and delivery in the organization, community and provider network;
- Creates the foundation to build equity into ongoing accountability, resource allocation and performance management relationships between OHA, the CCO and the provider network;
- Provides a visible and concrete context for widespread discussion of health equity – within individual organizations, within sectors, across sectors, and in the wider community; and
- Incorporates and operationalizes the health equity definition.

## Performance improvement projects

### *Overview of CCO PIPs*

Under Oregon’s 1115 2012–2017 demonstration waiver, CCOs developed performance improvement projects (PIPs) in a few key areas: high utilizers, maternal care, increased patient assignment within Primary Centered Primary Care Homes (PCPCH), and diabetes care for individuals with serious and persistent mental illness. Development of effective coordination strategies across health systems, primary care, specialty care and hospital systems for high utilizers and reducing rehospitalizations is an ongoing effort. The PIPs initially focused on breaking down the silos of care and expanding care delivery to team-based approaches. A few key lessons learned from adolescent well-care visits and maternal health have been helpful in providing for patients’ social determinants of health (food insecurity, stable transitions, supportive services); therefore, an additional focus area has been added for CCOs to test new models in the area of social determinants of health.

## Access

### *Network adequacy*

Federal and State regulations require each Medicaid managed care entity to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. As of December 2020, CMS had not published the validation of network adequacy protocol referenced in federal regulations for managed care. Each MCE must submit documentation to the State Medicaid authority<sup>62</sup> demonstrating its capacity to serve enrolled members in its service area in accordance with the State’s standards for access to care.<sup>63</sup>

<sup>62</sup> 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5).

<sup>63</sup> See 42 Code of Federal Regulations (CFR) §438.206 and §438.207; Oregon Administrative Rules (OAR)410-141-3515.

The Oregon Health Authority (OHA) is currently performing an analysis to document the accessibility of CCO provider networks and to assess compliance with existing network standards and requirements. OHA is looking at three key dimensions to explore and understand member access to care (network capacity, geographic distribution, and availability of service). Network capacity addresses the underlying foundation of the provider network and refers to the supply of provider services available to beneficiaries. Using a variety of measures (for example, provider-to-beneficiary ratios and provider counts), an assessment of the underlying capacity of a provider network can be obtained. If services are available and an adequate supply of providers and services are present, the opportunity to obtain health care exists, suggesting that beneficiaries may have access to services.

Once capacity and infrastructure are established, it is important to understand the extent to which beneficiaries can gain access to reported services. However, access to and utilization of services are dependent upon physical accessibility and acceptability of services, not simply on adequacy of supply. Geographic distribution addresses whether or not the distribution of available services is adequate to facilitate access by all beneficiaries. Key measures for assessing the geographic distribution of providers include time/distance analyses and compliance with network adequacy requirements. When combined with beneficiary and provider characteristics, these analyses will determine the extent to which the supply of providers is distributed appropriately relative to the beneficiary population. However, even with adequate capacity and appropriate distribution of services, assessing the availability of relevant services is critical in making sure beneficiaries have access.

The third dimension of access, availability of services, is important for understanding the extent to which network services are relevant and effective in producing positive health outcomes. The availability of services will be assessed in terms of appointment availability, utilization and/or outcomes of services. Taken together, the three dimensions offer a broad understanding of the factors impacting beneficiaries' access to care. The framework addresses the intersection of a network's underlying infrastructure (making services available), distribution (getting the services to beneficiaries) and availability (having the right kind of services available when needed). The analysis will help OHA identify network adequacy gaps and improve the network adequacy requirements at the state level.

#### *Network adequacy monitoring*

Pursuant to 42 CFR §438.206 and 42 CFR §438.207, the MCEs are required to demonstrate to OHA, with supporting documentation, that all covered services are available and accessible to members and that they have adequate provider capacity. To support federal and state network adequacy requirements, the MCEs are contractually required to develop and submit DSN reports that consist of two components, an annual DSN provider narrative report and quarterly DSN provider capacity reports, that crosswalk to the network standards in the MCEs' contracts with the State.

### DSN provider narrative

The DSN provider narrative report requirement defines five categories based on OHA's MCE contract requirements. Each category includes corresponding elements that require the MCEs to describe and submit comprehensive narrative responses and analysis demonstrating how the MCEs ensure, monitor and evaluate adequate provider capacity, including geographic location of network providers and members, considering distance, travel time, member needs, coordination of care and performance metrics. MCEs must, at a minimum, incorporate the provided specifications into their comprehensive written responses and supplemental documentation (for example, policies, procedures, manuals, analytics) and demonstrate how the DSN is monitored to ensure adequate provider capacity and member access.

If any component of a MCE's DSN is subcontracted or delegated, the MCE must also include a narrative response and supplemental documentation (for example, policies, procedures, manuals, analytics), including three OHA-defined time and distance standards for each geographic classification in its service area, describing how delegated services are integrated with the MCE's overall DSN, and how the MCE monitors its delegated providers, ensuring compliance with federal and State provider network requirements.

The DSN provider narrative report additionally requires each MCE to document its compliance with OHA's travel time and distance standards pursuant to OAR 410-141-3515. MCEs demonstrate compliance by reporting the time and distance standards of minutes and miles of overall member access for each geographic classification in its service area.

### DSN provider capacity report

MCEs submit a DSN provider capacity report, which is an inventory of the MCEs' providers and facilities, using a template provided by OHA. All participating providers, either employed directly or through subcontract with an MCE and providing services to Medicaid members, were included. Required data elements of the report are outlined in the OHA 2020 Health MCE Contracts (Exhibit G(2)(a)). Each provider capacity report is evaluated on four domains:

- Quality of DSN provider capacity reporting
- Provider network count
- Provider accessibility
- Geographic distribution

Using member data, a time and distance analysis is performed looking at the following key measures:

- Percentage of members living within the time/distance standards.

- Average time (in minutes) and distance (in miles) to the nearest three providers for each provider type evaluated (for example, primary care providers and hospitals)

#### *Provider directory validation*

OHA is also carrying out a variety of supplemental activities to assess access to providers and provider information. For example, OHA contracted with its EQRO to perform a provider directory validation activity to ensure members have appropriate access to provider information. For the provider directory validation, key elements published in the online provider directories were compared with the data in the provider capacity reports and, when the validation is completed, will confirm whether each MCE’s website meets the federal requirements in 42 CFR §438.10(h), OAR 410-141-3585, and relevant State contractual requirements.

#### *Secret shopper survey*

OHA has contracted with its EQRO to conduct a secret shopper telephone survey among primary physical health care providers (PCPs) contracted with one or more CCOs. The primary purpose of this secret shopper survey is to collect appointment availability for Oregon Health Plan (OHP) members new to the provider location by requesting routine well-checks or non-urgent problem-focused (“symptomatic”) visits. Specific survey objectives include the following:

- Determine whether PCP service locations accept OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligns with the CCOs’ delivery system network (DSN) provider capacity report data;
- Determine whether PCP service locations accept OHP members for the requested CCO as new patients and the degree to which new patient acceptance aligned with the CCOs’ DSN provider capacity report data; and
- Determine appointment availability with the sampled PCP service locations for routine well-checks and non-urgent symptomatic visits.

## **Provider Oversight**

#### *Credentialing*

CCOs and MCO plans must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as: (i) valid licenses, (ii) professional misconduct or malpractice actions, (iii) confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies, and (iv) the provider’s National Practitioner Data Bank profile. FFS providers are also enrolled through the state’s Provider Enrollment Unit, which confirms that Medicaid, Medicare, or other state agencies have not sanctioned providers. Additionally, all credentialed providers must verify regularly through the Office of Inspector General and Substance

Abuse and Mental Health Services Administration (SAMHSA) for compliance with conflict of interest standards.

Policy requirements include standards on credentialing, privileging, conflict of interest compliance, including time and interval of credentialing functions. CCOs must also work with OHA to assure proper credentialing of mental health programs, associated providers and traditional health care workers.

#### *Licensing*

CCOs and MCOs must ensure all licensed or certified providers maintain active licenses or certifications. The CCOs and MCOs must monitor provider licenses and certifications for any adverse action from a licensing or certifying entity and develop a process for reviewing a provider's contractual status due to any adverse action. All actions against a provider's license, certification or contractual status with a CCO or MCO must be immediately reported to the Provider Enrollment Unit through the [OHA.Provider.Review@dhsosha.state.or.us](mailto:OHA.Provider.Review@dhsosha.state.or.us) email address. Adverse action reports must include the provider information, the action taken by the CCO or MCO and all supporting documents.

### **Member Satisfaction**

#### *Ombuds team*

Pursuant to Oregon Revised Statute (ORS) 414.712, OHA provides Ombuds services to individuals who receive medical assistance through Oregon's Medicaid program. The Ombudsperson serves as the advocate for Oregon Health Plan (Medicaid and Children's Health Insurance Program) recipients in these areas:

- Access to care;
- Quality of care; and
- Channeling member experience into recommendations for system improvement.

The OHA Ombuds position is a formal, internal voice for process and system improvements responsive to identified trends impacting services for the more than 1.2 million Oregonians served by the Oregon Health Plan. This work is essential for health care transformation that is grounded in the needs of Oregonians and informs the Ombuds Program recommendations for client-focused process and system improvements with OHA and ODHS. As required by ORS 182.500, the OHA Ombuds Program provides a quarterly report to both the Governor and the Oregon Health Policy Board. Each person who makes it to the Ombuds Program deserves nurturing and support. The stories they share often illustrate challenges many others experience. Each story brings lessons for ways to improve Oregon's Medicaid delivery system.

#### *Medicaid Advisory Committee*

The Medicaid Advisory Committee (MAC) is a federally mandated body that advises OHA and DHS leadership, the Oregon Health Policy Board, the Legislature and the



Governor's office about the operation and administration of the Oregon Health Plan from a consumer and community perspective. The MAC's role includes reviewing Oregon's Medicaid Quality Strategy, changes to OHA's quality rating strategy for managed care organizations, managed care marketing materials, and the access monitoring plan for OHP members enrolled in the Open Card plan (FFS Medicaid). Additionally, the MAC receives information about CAHPS survey findings, Ombuds Program updates, grievance and complaint data trends, and CCO deliverables that provide visibility into Oregon's health transformation from a consumer experience lens.

#### *Grievances and appeals*

The state's contracted EQRO evaluates MCE's compliance with Grievance and Appeal System requirements including: grievance and appeal processes, provision of information to members and contracted providers, and adherence to time frame and notification requirements, pursuant to 42 CFR §438.400-424, applicable Oregon Administrative Rules (OARs), and contractual requirements. The MCE's are evaluated against the following requirements:

- Implementing written procedures for accepting, processing, and responding to all grievances and appeals, consistent with requirements;
- Providing information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract;
- Providing members with information on their rights regarding grievances, appeals and contested case hearings and allowing for members to freely exercise their rights without discouragement or retaliation;
- Adhering to content requirements for notifications sent to members;
- Adhering to required time frames for notifications, resolution of grievances and appeals, expedited requests, extended time frames and contested case hearings;
- Advising members of the process for continuation of benefits and adhering to delivery of services and payment requirements; and
- Complying with record-keeping requirements for grievances and appeals.

In addition, OHA requires MCEs submit a quarterly report including a log of complaints, denials, appeals, and all NOABDs issued for Applied Behavioral Analysis and Hepatitis C issued to members during the previous quarter. OHA selects a random sample of denials from the log and each MCO must submit the selected sample of Notices of Adverse Benefit Determination (NOABDs) and associated Prior Authorization (PA) documentation. The NOABD sample submitted by each MCO is evaluated against criteria inclusive of state and federal requirements.

The summary of all complaints registered during that quarter, along with a more detailed record of all complaints that have been unresolved for more than 30 days. A uniform

report format has been developed to ensure that complaint data is consistent and comparable. OHA uses complaint data to identify developing trends that may indicate a problem in access, quality of care, and/or education. Grievance and appeals report also identify FFS provider trends.

Improving upon the uniformed report will be the next step with administrative simplification through technology updates to the report, which will lead to deeper analysis for trend reporting. Analysis through the updated automated report will provide greater detail for health system (oral health, behavioral health, physical health) delineation of complaints origin and tracking of topic issues (e.g. non-emergency medical transportation) across the CCOs sampler. Potential changes also include developing systems for details regarding dual eligible client complaint tracking to ensure a smooth transition from passive enrollment.

On an annual basis, the OHA reviews MCO Grievance and Appeal System Policies and Procedures (P&Ps) to ensure they meet the requirements of OARs, 42 CFR §438.406, and address how the MCE will accept, process, and respond to Grievances, Notices of Adverse Benefit Determinations, Appeals, and Hearings.

#### *Surveys*

Seventeen Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

## **Quality payment programs**

#### *Medicaid Efficiency and Performance Program*

Performance Based Reward (PBR) is a financial incentive program under CCO 2.0 designed to incentivize spending on health-related services, while controlling costs, maintaining quality, and improving efficiency. One component of PBR is the Medicaid Efficiency and Performance Program (MEPP); CCOs must participate in MEPP work to be eligible for PBR. MEPP is based on an efficiency and quality algorithm that reviews claims data and identifies adverse actionable events (AAE) — downstream medical complications that could potentially be avoided with better upstream care. CCOs are asked to design interventions for three different types of episodes (such as diabetes, SUD, and asthma) with the goal of improving outcomes as measured by AAE.

#### *Qualified directed payments*

CCOs are required by contract to administer qualified directed payments (QDPs) as directed by OHA, and as approved by CMS. OHA will continue to follow federal guidance on how to reference this quality strategy to support the quality improvement goals of each QDP.

## **Fiscal monitoring**

### *Fraud, waste and abuse*

The CCOs must submit complaints of or allegations of suspected fraud or abuse, within 7 days, that are made to or identified by the CCO and warrant preliminary investigation. The CCO must also submit the following information on an ongoing basis for each case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees or any other source:

- The name, NPI and tax ID (or member ID number) of the individual or entity that is suspected of committing the fraud or abuse;
- The source that identified the fraud or abuse;
- The type of provider, entity, or organization that is suspected of committing the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data or information as requested.

The CCOs also conduct audits of providers, subcontractors, and other third parties to identify overpayments and uncover suspected fraud and abuse. CCOs provide quarterly and annual audit reports to OHA and report any recouped overpayments from their audit activities on the quarterly and annual Exhibit L financial reports.

The OHA Office of Program Integrity conducts audits on an ongoing basis of FFS providers as well as managed care participating providers, CCO subcontractors, and other downstream entities or parties receiving Medicaid funds through a CCO.

## **Surveys**

### *CAHPS*

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

## MHSIP

The Mental Health Statistics Improvement Program (MHSIP) are a set of validated surveys to measure clients' perceptions of the quality and efficiency of the mental health services they receive. The program consists of four surveys fielded annually, which vary based on the client's age and the type of services they received. These surveys are: (i) adults who have received outpatient services; (ii) adults who have received residential treatment services; (iii) parents or guardians of youth 0-17 years of age who have received mental health services; and (iv) youth 14-17 years of age who have received mental health services. The four surveys assess perception of mental health services across several domains, such as access to services, quality of services, satisfaction with surveys, and treatment outcomes and participation.

## VII. Quality measurement

### Performance measures

Established in the 2012 waiver, and corresponding state legislation, the CCO quality incentive program is a mechanism for focusing CCO efforts and driving continuous quality improvement. Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. Oregon's strategy has been to annually increase the percentage of CCO payment at risk for performance, providing a meaningful incentive to achieve significant performance improvement and affect transformative change in care delivery. To date, the CCO incentive metrics program has been a success, and CCOs show improvements in a number of incentivized areas, as documented in the 2019 [CCO Metrics Performance Report](#)<sup>64</sup>.

Measures in the CCO quality incentive program are selected annually by the Metrics and Scoring Committee, from the menu of measures established by the Health Plan Quality Metrics Committee (HPQMC). The Metrics and Scoring Committee also sets the benchmark for each measure. Detailed measure specifications, technical documentation and additional guidance are all published online.

## VI. Quality Strategy governance

### Quality structure

The Oregon Health Authority (OHA) is comprised of subject matter experts in evidence-based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency-wide

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<sup>64</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf>

committees responsible for oversight and planning. Underpinned across the quality and health transformation elements are health equity and social determinants of health with key contributions at the leadership committee level.

Oregon Health Authority structure to support quality and access monitoring:

- Oregon Health Authority
  - Oregon Health Policy Board
  - OHA Quality Council
  - Medicaid Advisory Committee
  - Quality Management Program and contract compliance
  - Quality Management Committee
- Health delivery systems
  - Quality and Health Outcomes Committee
  - Health Evidence Review Committee
  - CCO Operations Collaborative and Contracts and Compliance Workgroup

### **Review of Quality Strategy**

The OHA Quality Strategy shall be reviewed annually by OHA. The OHA Quality Strategy review and update will be completed by December of each year and submitted to CMS, upon significant changes, in the subsequent quarterly report update.

The OHA Quality Council shall have overall responsibility to guide the annual review and update of the Quality Strategy. The review and update shall include an opportunity for both internal and external stakeholders to provide input and comment on the Quality Strategy. Key stakeholders shall include, but are not limited to:

- Addictions and Mental Health Planning and Advisory Council\*
- Medicaid Advisory Committee\*
- Health Systems Division Executive Team
- Health Policy and Analytics Management Team
- OHA Executive Team
- CCO medical directors
- FFS contractors
- CCO quality management coordinators
- Local Government Advisory Committee\*
- DHS internal stakeholders

- OHA internal stakeholders
- Health Equity Committee\*

\* Committees including consumer representatives.

Final versions will be posted on the OHA website.

## **Enforcement**

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance, and reports for monitoring. If a plan cannot meet a reporting deadline, a request for an extension must be submitted in writing to the division. The division then replies in writing within one week of receiving the request. Plans that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: (i) contact the division within one week with an acceptable extension plan; or (ii) submit the information within one week.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the non-compliant plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. If these efforts are not producing results, a corrective action plan may be jointly developed, and the plan monitored for improvement. More aggressive enforcement options that OHA may apply include restricting enrollment, financial penalties, and, ultimately, non-renewal of contracts.

Conditions that may result in sanctions:

- Fails to authorize or otherwise substantially provide Medically Appropriate services that Contractor is required to authorize and provide to a Member in accordance with applicable State or federal law or as required under this Contract;
- Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under this Contract or applicable State or federal law; Contractor shall not charge Members any Premiums for any services provided pursuant to this Contract.
- Acts to discriminate among Members on the basis of their protected class such as race, ethnicity, national origin, religion, sex, sexual orientation, marital status, age, disability, health status, or need for health care services. Acts that may be evidence of discrimination include, but are not limited to: (i) Disenrollment of, or refusal to reenroll, a Member, except as permitted under this Contract, (ii) any practice that would reasonably be expected to discourage Enrollment, or (iii) any practice that seeks or encourages the

- Disenrollment of individuals whose protected class, medical condition or history indicates probable need for substantial future Medical Services;
- Misrepresents or falsifies any information that is required to be submitted to CMS, the State, or their designees under this Contract, including but not limited to any such information submitted in: (i) or in connection with Contractor's Application, or enrollment with CMS, (ii) any certification made in connection with this Contract, (iii) any report required to be submitted under this Contract, or (iv) any other documentation or other communication provided to the State, CMS, or their designees relating to the care or services provided to a Member or as otherwise required to be made under this Contract;
  - Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;
  - Fails to comply with the requirements for Physician Incentive Plans, as the requirements are set forth in 42 CFR §422.208 and §422.210 and this Contract;
  - Fails to comply with the operational and financial accounting and reporting requirements required under Ex. L of this Contract
  - Fails to maintain a Participating Provider Network sufficient to ensure adequate capacity to provide Covered Services to its Members under this Contract;
  - Fails to implement and maintain an internal Quality Improvement program, a Fraud, Waste and Abuse prevention program, a Quality Assurance and Performance Improvement Program, or to provide timely reports and data in connection with the such programs as required under this Contract;
  - Fails to comply with Grievance and Appeal System requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, or record keeping and reporting requirements;
  - Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services as required under this Contract;
  - Fails to make timely claims payments to Providers or fails to provide timely approval of authorization requests;
  - Fails to disclose required ownership information or fails to supply requested information to OHA relating to Contractor's Subcontractors or suppliers of goods and services;
  - Fails to submit accurate, complete, and truthful Pharmacy or Non-Pharmacy Encounter Data in the time and manner required by Ex. B, Part 8;

- Distributes directly or indirectly through any Agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information;
- Violates any of the other applicable requirements of sections 1903(m), 1932 or 1905(t) of the Social Security Act and any implementing regulations; or
- Violates any of the other applicable requirements of 42 USC §1396b(m) or §1396u-2 and any implementing regulations.

## **Technical report**

The technical report provides a feedback loop for ongoing quality strategy direction and development of any technical assistance training plans. In addition to the statement of deficiencies and resulting plans of correction, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

### **Part A: CCO Contract**

The CCO managed care contract template can be found on the OHA website for CCO contract forms. <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>

### **Part B: Quality definitions**

#### **Disability in adults**

The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) that can be expected to result in death or that have lasted or can be expected to last for a continuous period of not less than 12 months.

#### **Disability in children**

Under title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Source: <https://www.ssa.gov/disability/professionals/bluebook/general-info.htm>



## **Special Health Care Needs (SCHN)**

Adolescents and young adults with a behavioral, developmental, emotional, and/or physical condition ages 12 until 26 years.

## **2021 OHA Medicaid Quality Strategy**

Oregon's current Medicaid Quality Strategy is attached and can be found online here:

[https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2021%20OHA%20Medicaid%20Quality%20Strategy\\_FINAL\\_05312021.pdf](https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2021%20OHA%20Medicaid%20Quality%20Strategy_FINAL_05312021.pdf)

## Section X. Align with Tribal Partners' Priorities

OHA is committed to working with the Nine Federally Recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure tribal health care objectives are achieved while respectfully honoring tribal based practices and upholding the government-to-government relationship between the sovereign nations and the state.

Representatives of Oregon's nine Federally-recognized tribes and Urban Indian Health Program have identified a number of tribal priorities for inclusion in the Oregon Health Authority's latest 1115 Waiver. OHA and tribal representatives have held meetings throughout 2021 to identify and develop these priorities. In accordance with CMS requirements and OHA's Tribal Consultation and Urban Confer Policy, a Dear Tribal Leader Letter including an invitation for consultation will be distributed no fewer than sixty days before submission of the final waiver language to CMS. Below are OHA's current recommendations for inclusion in the 1115 waiver based on ongoing conversations with tribal representatives.

### **Remove Prior Authorization Requirements for American Indian/Alaska Native patients**

Medicaid services to tribes are an obligation arising from the Federal Trust Responsibility to provide health care to American Indians and Alaska Natives, wherever they reside. OHA has received feedback from the tribes that prior authorization requirements all too often place administrative hurdles in the way of the delivery of this health care. This issue is most acute in the delivery of behavioral health services, including and particularly treatment for substance use disorders. The tribes have requested that all prior authorization requirements be waived for tribal members enrolled in the Oregon Health Plan.

### **Extension of current Uncompensated Care Program**

Oregon's current 1115 waiver includes language providing tribes with Medicaid reimbursement for adult dental and vision services via the Uncompensated Care Program (UCCP). The tribes have requested that UCCP and its coverage of adult dental and vision services be extended and included in the waiver renewal.

### **Convert Special Diabetes Program for Indians (SDPI) to Medicaid Benefit**

The Indian Health Service's SDPI program has been very successful in reducing rates of diabetes in tribal communities. The tribes requested of OHA leadership in 2018 that OHA make SDPI diabetes prevention services a covered Medicaid benefit. Coverage of SDPI services will likely lower costs over time due to the preventative nature of the services provided. SDPI also includes a tribal-developed curriculum for providers to follow, ensuring that these services are culturally-responsive.

OHA does not believe that creating this AI/AN-specific Medicaid benefit will run afoul of antidiscrimination concerns for the following reasons:

- AI/AN refers to individuals who meet the Centers for Medicare and Medicaid Services definition of “Indian” at 42 CFR § 447.51. This definition of “Indian” operates throughout the Medicaid system. Many AI/AN-specific protections in Medicaid rely on this definition and are only available to this population. Examples of these protections include exemption from mandatory managed care enrollment, exemption from cost-sharing, and exemption of certain tribal property from eligibility determinations.
- Many AI/AN-specific protections already exist in both federal and state law without triggering equal protection concerns (e.g, the federal Office of Urban Indian Programs).
- The Indian Health Service itself is an example of services available only to AI/AN, in recognition of the federal trust responsibility to provide health care to AI/AN individuals. Creating the SDPI program as a Medicaid-covered service would fulfill the same goal and is based upon the same framework as IHS.

### **Tribal-based Practices**

Tribal communities have a long-standing history of conducting and implementing cultural practices. These tribal-based practices have demonstrated efficacy in effecting positive health outcomes in tribal communities. Tribal-based practices employ non-Western, non-clinical modalities to address cultural trauma and are strength based to reduce the impact of persistent health disparities. The Tribes seek reimbursement for these tribal-based practices and coverage as a Medicaid-covered benefit, with reimbursement for tribal-based practices via claims-based Medicaid reimbursement using standard procedure codes.

The Oregon Health Authority and the Oregon tribes have implemented a process by which tribal-based practices are developed and approved by the Tribal-Based Practice Review Panel, which is comprised of tribal representatives. The list of approved tribal-based practices, and additional information about each, can be found at the following website:

<https://www.oregon.gov/OHA/HSD/AMH/Pages/ebp-practices.aspx>

### **Social Determinant of Health Payment for currently unreimbursed services**

Tribal health programs provide a variety of currently unreimbursed services that address social determinants of health and root causes of poor health status. The tribes request Medicaid reimbursement for services not currently Medicaid-reimbursable that improve health outcomes, reduce costs, and address social determinants of health. CCO’s currently have flexibility to provide and receive payment for these activities via Health Related Services funds. Similar flexibility in fee for service Medicaid reimbursement would address root causes of systemic health inequities and encourage the tracking and promotion of protective factors. We seek flexibility in reimbursement for these services as described in the concept paper “Improving Health Outcomes by Streamlining Life and Coverage Transitions”, available below:

## **Non-Waiver Strategy Commitments**

### **Prepaid Health Plan Supplemental Payment (CCO Wraparound)**

Federal law requires states to provide tribes with a supplemental payment that represents the difference, if any, between the amount a CCO will pay the tribe for a Medicaid-covered service and the amount that the tribe would have received if the state had paid the tribe at their encounter rate for a fee-for-service patient. The implementation of this policy results in tribes billing two different entities for the same service: first, the CCO, which pays some portion of the tribe's encounter rate, and secondly, the state, which makes up the difference. This process involves many steps, resulting in significant delays for the tribe to receive the full payment owed. The tribes have asked OHA to simplify this process, which will result in less administrative burden and fewer delays.

The simplest approach to this request would be to require CCOs to pay tribes the same (encounter) rate that tribes would receive if they had billed OHA fee-for-service. This approach has been implemented successfully by both Washington State and Idaho Medicaid. Because this solution would direct CCOs to pay tribes their PPS or IHS encounter rate, CCO rates would need to be adjusted accordingly.

## Section XI. Public Notice and Public Comment Process

*This section includes information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408.*

### Public Notice and Public Comment Process

#### Overview

Oregon's 1115 Waiver Renewal is the product of many decades of public and partner engagement. In order to refine the processes, Oregon's engagement efforts have been iterative and focused on the following key principles: prioritizing accessibility, elevating voices from priority populations, intentional incorporation of feedback, and sustained outreach to and communication with partners and the public. For more information on the state's approach to public and partner engagement in developing the 2022-2027 waiver, please see Appendix K.

As part of its overall public and partner engagement approach, OHA undertook a robust public notice process, guided by federal requirements under 42 CFR 431.408, to gather feedback and make edits to the draft 1115 Waiver Application to reflect the ideas and concerns of individuals and organizations engaged during this period. This section details the extent to which efforts were made to make information accessible and to solicit feedback and other public comments from a wide breadth of audiences. OHA has also taken great effort to evaluate the public comments received, incorporate the feedback deliberately into the Waiver Application, and then respond to commenters on actions taken. The summary of public comments and OHA's responses are detailed in subsection II of Appendix J.

#### Public Comment Process

The draft 1115 Waiver Application was made available publicly on December 1, 2021. The required 30-day public comment period ran from December 7, 2021, through January 7, 2022. The public was invited to give written and oral comments on the draft Waiver Application during this public comment period. These comments informed the final Application prior to submission to CMS in February 2022.

Printed copies or alternate formats of the Application and other Waiver-related information were made available on the Waiver webpage at [Oregon.gov/1115WaiverRenewal](https://Oregon.gov/1115WaiverRenewal) and by request: by phone at 503-947-1193, by email at [1115Waiver.Renewal@dhsosha.state.or.us](mailto:1115Waiver.Renewal@dhsosha.state.or.us), or by USPS mail at Oregon Health Authority, The Human Services Building, 500 Summer Street NE, Salem, OR, 97301. Upon request, OHA also provides free help to access materials or information. Some examples of the free help OHA offered to the public included:

- Sign language and spoken language interpreters,

- Written material in other languages,
- Braille,
- Large print, and
- Audio and other formats.

Comments and feedback received during the public comment period were logged and a summary of that feedback can be found in Table J.1 in Appendix J. While public comment closed as of January 7, 2022 for members of the public to provide feedback on the draft 1115 Waiver Application, OHA continues to accept comments focused on implementation and operations. All comments from the public comment period will be posted publicly with the final application.

## Public Notice

OHA officially notified the public about the State’s intent to submit a renewal 1115 Demonstration Waiver application on December 1, 2021. An abbreviated public notice was published in the Oregon Secretary of State Bulletin, the State’s administrative record. The abbreviated notice included a direct link to the draft waiver application and a link to the 1115 Waiver Renewal webpage where the full public notice, draft application, and other information were available. Additional descriptions about information on the website is in the Public Website subsection (next subsection). The abbreviated public notice is included in Appendix J and can be viewed on pages 4-7 of the Secretary of State Bulletin for December 2021:

<http://records.sos.state.or.us/ORSOSWebDrawer/Recordpdf/8427031>

The full public notice was made available on the website in the following languages (English and Spanish versions are included in Appendix J): [English](#) | [Spanish](#) | [Russian](#)<sup>65</sup> | [Vietnamese](#)<sup>66</sup> | [Traditional Chinese](#)<sup>67</sup> | [Simplified Chinese](#)<sup>68</sup> | [Somali](#)<sup>69</sup> | [Arabic](#)<sup>70</sup> | [Hmong](#)<sup>71</sup> | [Portuguese](#)<sup>72</sup> | [Chuukese](#)<sup>73</sup> | [Marshallese](#)<sup>74</sup> | [Korean](#)<sup>75</sup>

<sup>65</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hr3821.pdf>

<sup>66</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hv3821.pdf>

<sup>67</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/h43821.pdf>

<sup>68</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hn3821.pdf>

<sup>69</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hi3821.pdf>

<sup>70</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/ha3821.pdf>

<sup>71</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hh3821.pdf>

<sup>72</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hp3821.pdf>

<sup>73</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/h273821.pdf>

<sup>74</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/h333821.pdf>

<sup>75</sup> <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/hk3821.pdf>

OHA made extensive efforts to notify the public about Oregon’s intent to submit an application for CMS consideration, make the draft application widely available, communicate clearly about the content of the application, and solicit public comment through a clear and accessible process. OHA distributed this information through press releases, electronic mailing lists, and partner networks. An overview is detailed in Table 25 below, including information provided, release dates, and estimated circulation. Press releases and Spanish-language meeting notices are included in Appendix J.

**Table 25. Public Notice Distribution for 1115 Draft Waiver Application and Public Comment Period**

Distribution Channels	Summary of Distribution	Release Dates	Estimated Circulation / Reach
Press Release	Issued press release/meeting notice with links to draft application, all public comment opportunities with webinar registration details, instructions on commenting in writing. <a href="https://content.govdelivery.com/accounts/ORDHS/bulletins/2fe9f32">https://content.govdelivery.com/accounts/ORDHS/bulletins/2fe9f32</a>	12/1/21	46,885
Press release	Issued public meeting notice for Oregon Health Policy Board presentation about the draft 1115 Waiver Application and public comment opportunity. <a href="https://content.govdelivery.com/accounts/ORDHS/bulletins/2fed57b">https://content.govdelivery.com/accounts/ORDHS/bulletins/2fed57b</a>	12/1/21	46,885
Press release	Issued public meeting notice for public webinar about the draft 1115 Waiver Application and public comment opportunity. <a href="https://content.govdelivery.com/accounts/ORDHS/bulletins/2ffc49a">https://content.govdelivery.com/accounts/ORDHS/bulletins/2ffc49a</a>	12/8/21	46,885
Press release	Issued public meeting notice for Medicaid Advisory Board presentation about the draft 1115 Waiver Application and public comment opportunity. <a href="https://content.govdelivery.com/accounts/ORDHS/bulletins/3002446">https://content.govdelivery.com/accounts/ORDHS/bulletins/3002446</a>	12/9/21	46,885
Press release	Issued public meeting notice for Oregon Health Policy Board public comment opportunity. <a href="https://content.govdelivery.com/accounts/ORDHS/bulletins/3034973">https://content.govdelivery.com/accounts/ORDHS/bulletins/3034973</a>	12/30/21	46,885
Electronic Mailing List	Meeting notices to mailing lists of interested parties with links to draft application, all public comment opportunities with webinar registration	12/2/21	387



	<p>details, instructions on commenting in writing. Sent to:</p> <ul style="list-style-type: none"> <li>• Prior 1115 Waiver Workshop attendees and registrants</li> </ul>		
Electronic Mailing List	<p>Meeting notices to mailing lists of interested parties with links to draft application, all public comment opportunities with webinar registration details, instructions on commenting in writing. Sent to:</p> <ul style="list-style-type: none"> <li>• Subscribers of 1115 Demonstration Waiver electronic bulletin</li> </ul>	12/2/21	1655
Electronic Mailing List	<p>Meeting notices to mailing lists of interested parties with links to draft application, all public comment opportunities with webinar registration details, instructions on commenting in writing. Sent to:</p> <ul style="list-style-type: none"> <li>• Subscribers of Oregon Health Plan electronic bulletin</li> </ul>	12/2/21	8363
Distribution to Partners	<p>Meeting notices sent and telephone calls to:</p> <ul style="list-style-type: none"> <li>• Spanish-speaking Community Partner Outreach Program partner organizations and associated partners</li> </ul>	11/9/21 - 12/9/21	60
Distribution to Partners	<p>Meetings notice sent to:</p> <ul style="list-style-type: none"> <li>• Interested Legislators</li> </ul>	12/1/21 - 12/2/21	15
Distribution to Partners	<p>Meeting notice sent to:</p> <ul style="list-style-type: none"> <li>• CCO executives</li> <li>• CCO trade organization</li> </ul>	12/2/21	20
Distribution to Partners	<p>Meeting notice sent to:</p> <ul style="list-style-type: none"> <li>• Oregon Health Policy Board members</li> <li>• Health Equity Committee members</li> </ul>	12/2/21	20
Distribution to Partners	<p>Meeting notice sent to:</p> <ul style="list-style-type: none"> <li>• Regional Health Equity Coalition members</li> </ul>	12/2/21	1500
Distribution to Partners	<p>Meetings notice sent to:</p> <ul style="list-style-type: none"> <li>• CCO community advisory councils</li> </ul>	12/2/21	115
Distribution to Partners	<p>Meeting notice (English) sent to:</p> <ul style="list-style-type: none"> <li>• Community Partner Outreach Program partner organizations and associated partners</li> </ul>	12/2/21	2600+

## Public Website

To ensure information about proposed changes were available and accessible to the public, OHA maintains a public-facing 1115 Waiver Renewal webpage<sup>76</sup> in both [English](#) and in [Spanish](#); the Spanish website is updated simultaneously when any updates are made to the English website.

The draft 1115 Waiver Application was posted on the waiver webpage on December 1, 2021. As required by federal statute, 42 CFR 431.408(a)(2)(i), the public waiver webpage also included information on the public input process, information and ways to access the public hearings, and the full public notice.<sup>77</sup> The website also includes a link to the current 1115 Demonstration Waiver website and a way for the public to submit comments and questions about the draft application directly to an email inbox set up for the renewal development process.

The waiver webpage also included the following supporting materials for the public to review and better contextualize the draft 1115 Waiver Application:<sup>78</sup>

- **Waiver impact briefs** on Behavioral Health, Children’s Health, and Oral Health that describe potential impacts of the waiver, if approved, under those topic areas.
- **Final Policy Concept Papers** that detail the policy concepts that are the basis of the OHA’s 2022-2027 waiver; these Final Concept Papers were also submitted to CMS.
- **Policy Concept Summaries** that describe the final policy concepts in plain language.
- **Draft Policy Concept Papers** that describe a draft version of the policy concepts that were presented to the public and partners to solicit feedback.
  - o **Changes made to concept papers summary** describes the changes made between the Draft Concept Papers and Final Concept Papers as a result of sustained public and partner engagement and conversations with CMS.
- Information about **previous engagement efforts**, including the timeline of public engagement, previous public meetings, and summaries of previous feedback received.

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<sup>76</sup> Oregon.gov/1115waiverrenewal

<sup>77</sup> The full public notice was made available in 13 languages, including English, Spanish, Russian, Vietnamese, Somali, Arabic, Chuukese, Hmong, Korean, Marshallese, Simplified Chinese, Traditional Chinese, and Portuguese, and all translated versions were posted on the public website.

<sup>78</sup> The Final Concept Papers, Policy Concept Summaries, Draft Policy Concept Papers, Changes made to concept papers summary were made available in 13 languages, including English, Spanish, Russian, Vietnamese, Somali, Arabic, Chuukese, Hmong, Korean, Marshallese, Simplified Chinese, Traditional Chinese, and Portuguese, and all translated versions were posted on the public website.

## Public Hearings

As listed below, OHA held seven scheduled public hearings for members of the public to provide oral comments on the Waiver Application draft posted on December 1, 2021. Members could also pre-register to provide oral public comment for any of the seven public hearings through the public comment survey (for more details on the survey, see section below in subsection Written Input). Public hearings were held in English unless otherwise noted.

Table 26. Public Hearings Held during Public Comment Period

Date and Meeting Time	Meeting Name	Audience Description	Meeting Format	Summary of Discussion (major themes and topics)
December 7, 2021 8:30 AM-12:00 PM	Oregon Health Policy Board (OHPB) December Meeting	Public meeting of oversight board	Online webinar with teleconferencing ability	Overview of draft application Take public comment
December 9, 2021 12:00 AM-2:00 PM	Health Equity Committee (HEC) Meeting	Public meeting of oversight committee	Online webinar with teleconferencing ability	No presentation Take public comment
December 9, 2021 3:30 PM-5:30 PM	Community Partnership Outreach Program (CPOP) Session #3 (held in Spanish)	Community and Social Service Organizations, Member Advocacy Partners	Online webinar with teleconferencing ability	Overview of draft application Take public comment
December 15, 2021 9:00 AM-12:00 PM	Medicaid Advisory Committee (MAC) Meeting	Public meeting of oversight committee	Online webinar with teleconferencing ability	Overview of draft application Take public comment
December 16, 2021 5:30 PM-7:30 PM	Waiver Workshop #3: Designing the Future of OHP (Spanish interpretation available)	Public webinar (Consumers, Member Advocacy Partners, Community and Social Service Organizations, Providers, Industry Partners)	Online webinar with teleconferencing ability	Overview of draft application Take public comment
December 17, 2021	Community Partnership Outreach	Community and Social Service Organizations,	Online webinar with	Overview of draft application

10:30 AM-12:30 PM	Program (CPOP) Session #3 (Spanish interpretation available)	Member Advocacy Partners	teleconferencing ability	Take public comment
January 4, 2021 8:30 AM-12:00 PM	Oregon Health Policy Board (OHPB) January Meeting	Public meeting of oversight board	Online webinar with teleconferencing ability	Initial analysis of public comment (who we have heard from so far and themes) Take public comment

### Written Input

Public input was also taken by email ([1115Waiver.Renewal@dhsosha.state.or.us](mailto:1115Waiver.Renewal@dhsosha.state.or.us)) or received via physical mail at:

Health Policy and Analytics Medicaid Waiver Renewal Team  
500 Summer St. NE, 5th Floor, E65  
Salem, OR 97301

For those that preferred a survey format, public input was taken through a survey available at <https://tinyurl.com/OHPWaiverSurvey>. A Spanish version of the survey was also available at [https://mslc.qualtrics.com/jfe/form/SV\\_6FrBJG1k21PCbmS](https://mslc.qualtrics.com/jfe/form/SV_6FrBJG1k21PCbmS). The English and Spanish 1115 Waiver Renewal websites included links to the survey in respective languages. A link to the survey was also included in announcements about public forums and at the forums themselves through presentation slides and the online chat function to participants. The survey was open beginning on December 1, 2021, and remained available throughout the public comment period. Seventy-nine respondents completed either version of the survey.<sup>79</sup> Please see subsection III in Appendix J for a copy of the survey questions in both English and Spanish.

### Summary of Public Comment Received

#### Summary of Public Comment Submissions

In the period of December 7, 2021, through January 7, 2022, Oregon received 188 comments through a variety of sources, including oral comments during any of the seven public hearings, emails, and letters submitted through the waiver inbox, and

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<sup>79</sup> Since the survey was also used to collect registration information and demographic information, survey respondents could complete the survey but not leave public comment.

responses submitted through the online survey.<sup>80</sup> For a full breakdown of comments received through each of the sources, please see the below table.

**Table 27. Public Comments Received through Each Source**

<b>Group / Source</b>	<b>Meeting Name</b>	<b>Total Meetings</b>	<b>Total Comments Received</b>
<b>Public Hearings</b>	Oregon Health Policy Board Monthly Meeting	2	10
	Health Equity Committee Meeting	1	1
	CPOP Webinar, Spanish	1	11
	CPOP Webinar, English	1	3
	Waiver Workshop #3: Designing the Future of OHP	1	1
	Medicaid Advisory Committee Meeting	1	2
	<b>Subtotal</b>	<b>7</b>	<b>28</b>
<b>Written Comments through Letters or Email</b>	--	--	<b>120</b>
<b>Online Survey</b>	--	--	<b>62</b>
<b>Total</b>	--	<b>7</b>	<b>210<sup>81</sup></b>

The commenters reflected a wide variety of audiences, including, but not limited to: (i) OHP members and advocates, (ii) CCOs, hospital and health system representatives, (iii) health care providers, community organizations, and social service providers and organizations, and (iv) legislative/policy makers, political lobbyists, and special interest groups. Each group brought forward unique perspectives and provided comments of support or ideas on enhancements or modifications to the draft 1115 Waiver Application. Amongst the commenters, 181 unique organizations provided public comment, which reflects active interest in the waiver demonstration from organizations across the state and nationally. See the table below for a summary of the public comments received by each audience group, and the associated audience categories.

<sup>80</sup> In a small number of instances, an individual may have provided public through multiple sources. The counts in this summary reflect total comments submitted, and, therefore, they reflect some duplication.

<sup>81</sup> While there were 210 comments submitted, a commenter may have submitted their comment multiple times through multiple sources; therefore, after additional processing, the number of official public comment received on the draft 1115 waiver application is 188.

Table 28. Public Comments Received by Each Audience Group<sup>82</sup>

<b>Audience Group</b>	<b>Audience Category</b>
<b>Members and Advocates</b> Number of Comments: 104	Advocate/consumer or community representative or advocacy organization
	Consumer/community member
	Member advocate
	Oregon Health Plan Member
<b>CCO, Hospital, and Health System Representatives</b> Number of Comments: 20	Payer-Coordinated Care Organization
	Provider-hospital and/or health system
<b>Healthcare, Community Organizations, and Social Service Providers</b> Number of Comments: 30	Community based organizations (service provider)
	Provider - social services
	Provider or clinic-behavioral health
	Provider or clinic-oral health
	Provider or clinic-physical health
	Provider-Federally Qualified Health Center
	Social Services
<b>Legislative / Policy Makers, Political Lobbyists / Special Interest Groups</b> Number of Comments: 29	Committee/board member
	Elected official
	Lobbyist or political advocacy group
	State or local government
	CAC
<b>Declined to Answer or Other</b> Number of Comments: 5	Declined to Answer or Other
<b>Total Comments: 188</b>	

### Major Topics of Interest

In general, the vast preponderance of comments on the draft 1115 Waiver Renewal application have been supportive of Oregon’s waiver direction. Many commenters expressed support for continuing the health system transformation and moving forward the innovative solutions it presents, such as investing in equitable and culturally appropriate health care and were excited about the vision and plan proposed by OHA. For its submission of the final 1115 Waiver Application, Oregon acknowledged, reviewed, and considered all comments received during the public comment process.

<sup>82</sup> The nearly 200 public comments in this analysis includes all comments submitted to OHA during its official public comment period. Note, the numbers are not representative of all phases of engagement, and therefore not representative of all comments received / audiences engaged in development of the 1115 waiver. In other phases of waiver development, the representation of public and partner audiences may vary.

While the comments on the waiver have been, as a whole, overwhelmingly supportive, over half of comments received included multiple topics of interest and/or provided feedback on several policies or strategies within in the waiver.<sup>83</sup> For the comments related to 1115 waiver policies, the topics of greatest interest to commenters are ranked in frequency below:

**Table 29. Topics Discussed in Public Comments, Ranked in Order of Frequency**

#	Topic	Topic Summary
1.	Closed Formulary	Includes proposal to allow OHA and CCOs to operate closed formularies and proposal to allow OHA to exclude certain drugs that have inadequate evidence of efficacy
2.	EPSDT	Includes EPSDT waiver proposal, and ensuring coverage in its absence
3.	Coverage – Enrollment	Includes proposal regarding continuous enrollment for kids and adults
4.	Power sharing	Includes Community Investment Collaboratives proposal
5.	Covered services	Includes recommended policies for incarcerated individuals
6.	Transitions - Implementation	Includes SDOH Supports for members experiencing certain transitions proposal and the SNAP pathway for expedited enrollment proposal
7.	Finance and Rates	Includes comments related to rate development
8.	Providers - Availability/Workforce	Includes comments related to traditional health workers, concerns about workforce, and comments related to CCO provider networks
9.	Retroactive Eligibility	Includes 3-month retroactive eligibility proposal
10.	Quality Incentive Program	Includes changes to proposed incentive metrics
11.	Investment	Includes Community Investment Collaboratives proposal
12.	Inequities	Includes comments related to the waiver focus on eliminating health inequities
13.	CIE and HIT	Includes comments related to community information exchange and health information exchange
14.	Performance	Includes changes to incentive metrics

<sup>83</sup> Note, while the vast majority of submitted comments included support for the general direction of the waiver, these comment requests may vary as they address multiple issues, so those individual requests may be categorized differently.

15.	Data and REAL-D	Includes comments related to data collection and efforts to improve visibility to health inequities by race and ethnicity
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Additionally, Table 30. Top Five Topics by Audience Group below describes the areas most commented on by different audience groups. In many cases, commenters within certain audience groups provided feedback on many of the same policies or strategies, making up the majority of submitted comment requests for that group. For example, members and advocates, accounting for about half of all comment requests received, commented most frequently on topics related to closed formulary proposal, EPSDT proposal, and coverage and enrollment strategies – these three topics addressed the top 60% of concerns of this group. Several OHP members and advocates within this group submitted their personal stories along with their comments and provided insights across some of the same themes: ensuring coverage and care for all people in Oregon, addressing health disparities and barriers to access, and addressing the needs and concerns of certain populations.

While CCO and hospital representatives often reflected similar concerns as members and member advocates, some CCO and hospital commenters also provided comments that were more operational in nature. CCO and hospital representatives provided less than 20% of all comment requests received; the public comment requests of this audience group centered primarily around power sharing, transitions (as it relates to implementation), and coverage / enrollment strategies. These ranged from comments on spending on health equity, to social determinants of health investments, to asking for clarification on their participation in the proposed Community Investment Collaboratives.

Other times, an audience group’s interests were more widely distributed across topics. Healthcare, community organization, and social service providers submitted comments most frequently on coverage and enrollment strategies, community information exchange (CIE) and health information technology (HIT), and covered services; however, these three topics combined made up less than half of comment requests submitted by this group. Similar to CCO and hospital representatives, the commenters within this group also reflected themes that were more operational, including ensuring service delivery and details on coverage and access.

**Table 30. Top Five Topics by Audience Group**

Audience Group	Top Five Topics by Audience Group
Members and Advocates	Closed Formulary
	EPSDT
	Coverage-enrollment
	Covered services
	Retroactive eligibility
	Power sharing



CCO, Hospital, and Health System Representatives	Coverage-enrollment
	Transitions-implementation
	Finance and rates
	Closed Formulary
Healthcare, Community Organization, and Social Service Providers	Coverage-enrollment
	CIE and HIT
	Covered services
	EPSDT
	Closed Formulary
Legislative / Policy Makers, Political Lobbyists / Special Interest Groups	Closed Formulary
	Power sharing
	Transitions-implementation
	Coverage-enrollment
	Finance and rates

When considering a specific action requested by commenters (i.e., keep, remove, change, clarify, or no request), these also varied across commenters. About one fifth of comment requests specifically asked that OHA keep policies or strategies already present within the 1115 Waiver. These included support of the continuous eligibility proposal for children and adults and the focused equity framework proposed in the Waiver. Individuals also made requests for modifications or clarifications of current Waiver proposals; these made up of about 30% of comment requests collectively. For instance, regarding the Community Investment Collaborative (CIC) proposal, Oregon heard requests for clarification or additional information on the following: how CICs will function with existing infrastructure and how SDOH supports will work with other agencies and organizations.

Public commenters also provided recommendations or ideas for additions to the Waiver (less than 10% of comment requests). For example, several commenters provided suggestions, such as their recommended policies for incarcerated individuals, that could be accomplished outside the Waiver (such as through SPA, contract, or legislation). As with other public comment, OHA reviewed these comments prior to Application submission and evaluated whether the 1115 Waiver was the most appropriate mechanism for addressing those ideas or if another avenue was more appropriate. As detailed in subsection II of Appendix J, OHA’s responses to comments are summarized and the appropriate avenue is described when the resolution to the commenter’s concern was not applicable to this Waiver authority.

Continued engagement and outreach to different audiences are critical components of Oregon’s core value of health equity. Oregon also recognizes that many partners, members, advocates, etc., are similarly interested in the health and well-being of their communities. The rigor of comments reflects their consistent work toward identifying equitable opportunities; changing policies, processes, and investment strategies; and

pushing toward collaboration with the community and other stakeholders. While OHA's official public comment period on this waiver application has closed, the State continues to reach out, solicit feedback from, and collaborate with its partners and the public through negotiation of the STC's and implementation. For a summary of public comments received on the draft 1115 Waiver Application, broken up by topic, as well as a summary of OHA's responses to public comment received, please see section II of Appendix J. Note, all public comments will also be made available on the waiver website or upon request.

## **Tribal Consultation and Urban Indian Health Program Confer Process and Priorities**

### **Overview**

OHA is committed to working with the nine federally recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure Tribal health care objectives are achieved while honoring traditional Tribal practices and upholding the government-to-government relationship between the sovereign nations and the state. OHA follows agreements and processes set forth in Oregon's existing 1115 Medicaid Demonstration waiver, specifically Attachment I: Tribal Engagement and Collaboration Protocol, OHA's Commitment Letter to Oregon Tribes, and OHA's Tribal Consultation and Urban Indian Health Program Confer Policy. OHA also follows all federal requirements for Tribal Consultation as set forth in the American Recovery and Reinvestment Act (ARRA) Sec. 5006 (e) and all associated CMS rules and regulations.

### **Ongoing partnership with Tribal governments**

In addition to meeting the requirements for Tribal Consultation, OHA partnered with the Tribes so that they were involved in and informed of the ongoing development of the state's 2022-2027 1115 Waiver Application. This included regular updates at Tribal Monthly Meetings and SB 770 HHS Cluster Meetings, drafting a Tribal Concept Paper based on known concerns raised previously by Tribal governments, and working with the Tribes to develop this concept paper before inclusion in the application. A full list of these engagements and the topics of discussion can be found in Table 31 below.

### **Description of Tribal Consultation**

In accordance with CMS requirements and OHA's Tribal Consultation and Urban Indian Health Program Confer Policy, a Dear Tribal Leader Letter, which included an invitation for consultation, was distributed on November 29, 2021 to all of Oregon's Nine Federally Recognized Tribes and the UIHP. The 1115 Medicaid Waiver Tribal Consultation occurred via videoconference on December 14, 2021 from 1-3pm which was no fewer than sixty days before submission of the final Waiver language to CMS on February 15, 2022. Attendees included members of five of Oregon's Nine Federally

Recognized Tribes and the Northwest Portland Area Indian Health Board. The Tribes with members in attendance included:

- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warm Springs
- Confederated Tribes of Grand Ronde
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Siletz Indians

At Tribal Consultation, OHA provided an overview of waiver policy ideas, walked through the public notice, and discussed the Tribal Concept Paper that is included in the waiver application. OHA provided an opportunity for Tribes to ask any questions they had about any aspect of the waiver application, which had been sent out to the Tribes with the Dear Tribal Leader Letter in advance.

**Table 31. Summary of discussion and corresponding changes**

<b>Comment</b>	<b>Response</b>
The Tribes asked for clarification on whether the policy for those incarcerated in jails would include those in Tribal jails.	OHA determined that this would include Tribal jails and added language to the waiver application to clarify this.
The Tribes asked whether Tribes could claim 100% FMAP for Care Coordination Agreements (CCAs) with local county jails.	<p>OHA researched this question and provided the following answer back to the Tribes. No changes are needed in the waiver.</p> <p>CMS guidance in SHO Letter #16-002 provides enhanced FMAP for Medicaid services “received through” an IHS/Tribal Facility for AI/AN Medicaid members. Per SHO Letter #16-002, Tribes can enter into care coordination agreements with non-tribal providers to receive enhanced FMAP for services provided to AI/AN members by non-tribal Medicaid providers.</p> <p>As long as the county jail system is</p> <ul style="list-style-type: none"> <li>• An OHP enrolled Medicaid provider</li> <li>• Serving AI/AN OHP clients</li> <li>• Providing Medicaid covered services pursuant to a written care coordination agreement with a Tribe</li> <li>• Consistent with the requirements of SHO Letter #16-002</li> </ul>

	Then the Tribe can submit for enhanced FMAP. So short answer is yes, subject to the above. Nothing will be needed in the waiver to make this possible.
Tribes asked how the limited OHP benefits apply (or not) to OHP-eligible individuals in federal custody.	The policies proposed for incarcerated individuals, including limited OHP benefits, would not apply to those in federal custody. Addressing those in federal custody is out of scope of the waiver at this time.
The Tribes asked whether broadband supports and services to support distance learning could be added to the social determinants of health support package for extreme climate events.	OHA added broadband support services to the extreme climate events social determinants of health support packages per the request of the Tribes.
Tribes were interested in learning whether CCOs break Third Party Liability (TPL) data out for tribal members and whether this could be required.	OHA will work with our tribal partners and CCOs to implement this request in the near future.
The Tribes asked that OHA review Attachment I and ensure that it was up to date.	OHA reviewed Attachment I from the previous waiver; a redlined version was provided to the Tribes for review. Additional feedback was given to OHA by representatives from the Northwest Portland Area Indian Health Board. Once final agreement by tribes has been made it will be available for review by CMS as needed.
The Tribes asked whether supports for the effects of COVID and long COVID could be included in the waiver application.	OHA determined that the waiver was not the appropriate mechanism for this concern and will address it as part of the Tribal commitment letter. No changes are needed to the waiver application.

Table 32. List of all waiver engagements with the Tribes & UIHP

Date	Time	Event Name	What was discussed (major themes and questions)
02/12/21	11AM	OHA Tribal Monthly Meeting	Waiver 101, overview of waiver renewal process

04/14/21	10AM- 3PM	SB 770 HHS Quarterly Cluster Meeting	Overview of waiver & waiver renewal process, potential waiver priorities
05/07/21	12PM-4PM	Tribal Brainstorming Session	Overview of ideas for Tribal Concept Paper, discussion of Attachment I, Tribal Commitment Letter, discussion of potential priorities and considerations.
05/14/21	10AM-3PM	OHA Tribal Monthly Meeting	Update and discussion of Tribal priorities
06/11/21	10AM-3PM	OHA Tribal Monthly Meeting	Update and discussion on waiver concept papers
07/14/21	10AM-3PM	SB 770 HHS Quarterly Cluster Meeting	Comprehensive waiver updates and overview of proposed Tribal Priorities for concept paper
09/10/21	10AM-3PM	OHA Tribal Monthly Meeting (no waiver presentation)	Brief update on Tribal Concept paper and timeline
10/13/21	10AM-3PM	SB 770 HHS Quarterly Cluster Meeting	General waiver updates provided
11/12/21	10AM-3PM	OHA Tribal Monthly Meeting	Reviewed and discussed questions on Tribal Concept Paper. Update on timeline, discussed a time to review other concept papers, possible consultation dates.
11/15/21	3-4PM	Tribal Based Practices – 1115 Waiver Tribal Concept Paper (1/2)	Work session with the Tribes to refine and finalize the Tribal Based Practices concept in the Tribal Concept Paper.
11/16/21	2-3PM	Tribal Based Practices – 1115 Waiver Tribal Concept Paper (2/2)	Continued work session with the Tribes to refine and finalize the Tribal Based Practices concept in the Tribal Concept Paper.
11/19/21	10-11AM	1115 Waiver Concept Papers	Overview presentation for the tribes of all additional (non-

			Tribal) concept papers in the Waiver application.
12/10/21	10AM-3PM	OHA Tribal Monthly Meeting	No discussion- Reminder of upcoming consultation
12/14/21	1-3PM	Tribal & UIHP Consultation	Formal consultation on the draft 1115 Waiver Application
1/12/22	8:30AM-1:30PM	SB 770 HHS Quarterly Cluster Meeting	No discussion- Reminder of consultation timeline and follow-up

## Section XII. Demonstration Administration

*Please provide the contact information for the state's point of contact for the Demonstration application.*

Dana Hittle  
Interim Medicaid Director  
Oregon Health Authority  
503-945-6491  
[Dana.Hittle@dhsoha.state.or.us](mailto:Dana.Hittle@dhsoha.state.or.us)

# Appendix A: Budget Neutrality Worksheets and Projections

## Oregon Section 1115 Budget Neutrality Calculation Overview \$ in millions

DEMONSTRATION YEARS (DY) State Fiscal Years	Previous Waiver	Current Waiver					Proposed Waiver				
	15 SFY17	16 SFY18	17 SFY19	18 SFY20	19 SFY21	20 SFY22	21 SFY23	22 SFY24	23 SFY25	24 SFY26	25 SFY27
<b>Without Waiver (WOW)</b>	<b>10,945</b>	<b>\$ 10,817</b>	<b>\$ 11,195</b>	<b>\$ 11,720</b>	<b>\$ 13,702</b>	<b>\$ 16,013</b>	<b>\$ 16,877</b>	<b>\$ 18,179</b>	<b>\$ 19,458</b>	<b>\$ 20,763</b>	<b>\$ 22,105</b>
<b>With Waiver (WW)</b>											
Total PMPM payments	5,788	\$ 6,075	\$ 6,489	\$ 6,977	\$ 7,653	\$ 8,998	\$ 9,303	\$ 9,877	\$ 10,355	\$ 10,819	\$ 11,284
Other payments	176	\$ 184	\$ 109	\$ 44	\$ 31	\$ 47	\$ 50	\$ 52	\$ 54	\$ 55	\$ 57
Waiver Extension Requests											
CCO Targeted Equity Investments (HB 3353)							\$ 200	\$ 207	\$ 214	\$ 221	\$ 229
Designated State Health Programs							\$ 207	\$ 214	\$ 221	\$ 229	\$ 237
Targeted Equity and SDOH Investments							\$ 483	\$ 488	\$ 493	\$ 504	\$ 518
<b>Total WW</b>	<b>5,964</b>	<b>\$ 6,259</b>	<b>\$ 6,598</b>	<b>\$ 7,020</b>	<b>\$ 7,685</b>	<b>\$ 9,044</b>	<b>\$ 10,244</b>	<b>\$ 10,838</b>	<b>\$ 11,337</b>	<b>\$ 11,828</b>	<b>\$ 12,324</b>
<b>Base Variance WOW Less WW</b>	<b>4,981</b>	<b>\$ 4,558</b>	<b>\$ 4,597</b>	<b>\$ 4,700</b>	<b>\$ 6,018</b>	<b>\$ 6,968</b>	<b>\$ 6,633</b>	<b>\$ 7,342</b>	<b>\$ 8,121</b>	<b>\$ 8,935</b>	<b>\$ 9,781</b>
Savings reduction to 25% per Current ST&Cs	1,245	\$ 1,139	\$ 1,149	\$ 1,175	\$ 1,504	\$ 1,742	\$ 1,658	\$ 1,835	\$ 2,030	\$ 2,234	\$ 2,445
<b>Net Cumulative Variance Current &amp; Prior Waiver Periods</b>	<b>16,019</b>	<b>\$ 17,158</b>	<b>\$ 18,308</b>	<b>\$ 19,483</b>	<b>\$ 20,987</b>	<b>\$ 22,729</b>					
<b>Net Cumulative Variance Current &amp; Proposed Waiver Periods</b>		<b>\$ 1,139</b>	<b>\$ 2,289</b>	<b>\$ 3,464</b>	<b>\$ 4,968</b>	<b>\$ 6,710</b>	<b>\$ 8,369</b>	<b>\$ 10,204</b>	<b>\$ 12,234</b>	<b>\$ 14,468</b>	<b>\$ 16,913</b>





**Oregon Section 1115 Member Months**

Current Services Caseload DEMONSTRATION YEARS (DY) State Fiscal Years	Current Waiver					Proposed Waiver				
	16	17	18	19	20	21	22	23	24	25
	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
AFDC	1	871,300	941,900	1,023,000	1,110,900	1,087,800	1,087,800	1,087,800	1,087,800	1,087,800
PWO	2	130,800	115,500	110,700	103,700	113,500	113,500	113,500	113,500	113,500
CMO	3	3,204,000	3,119,300	3,077,300	3,339,100	3,855,800	3,855,800	3,855,800	3,855,800	3,855,800
BCCP	4	2,300	2,200	2,300	2,400	2,100	2,100	2,100	2,100	2,100
Old Age Assistance	5	533,900	554,800	571,600	635,300	750,400	750,400	750,400	750,400	750,400
Aid to Blind/Disabled	6	1,013,000	1,006,000	1,007,100	1,069,300	1,129,800	1,129,800	1,129,800	1,129,800	1,129,800
Foster Children	7	246,600	242,000	238,500	228,700	216,500	216,500	216,500	216,500	216,500
New ACA Adults	8	4,279,100	4,308,500	4,378,500	5,574,600	6,663,200	6,663,200	6,663,200	6,663,200	6,663,200
<b>Total MMths</b>		<b>10,281,000</b>	<b>10,290,200</b>	<b>10,409,000</b>	<b>12,064,000</b>	<b>13,819,100</b>	<b>13,819,100</b>	<b>13,819,100</b>	<b>13,819,100</b>	<b>13,819,100</b>

Waiver Renewal Estimated Adjustments DEMONSTRATION YEARS (DY) State Fiscal Years	Current Waiver					Proposed Waiver				
	16	17	18	19	20	21	22	23	24	25
	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
<i>Member month impacts of waiver proposals</i>										
AFDC	1						4,670	4,670	7,059	10,518
PWO	2						438	438	438	438
CMO	3						70,796	205,760	322,505	415,591
BCCP	4						9	9	9	9
Old Age Assistance	5						-	-	-	-
Aid to Blind/Disabled	6						10,300	14,463	18,525	22,586
Foster Children	7						3,071	8,477	13,718	18,609
New ACA Adults	8						288,990	403,480	475,339	536,981
<b>Total MMths</b>							<b>378,274</b>	<b>637,298</b>	<b>837,593</b>	<b>1,004,732</b>

Exclusion of member months under IMD 1115	Current Waiver					Proposed Waiver				
	16	17	18	19	20	21	22	23	24	25
	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
AFDC	1			(371)	(1,498)	(1,563)	(1,630)	(1,701)	(1,316)	(1,374)
PWO	2			(71)	(286)	(298)	(311)	(325)	(251)	(262)
CMO	3			(132)	(536)	(559)	(583)	(608)	(471)	(491)
BCCP	4									
Old Age Assistance	5									
Aid to Blind/Disabled	6			(143)	(576)	(601)	(627)	(654)	(506)	(529)
Foster Children	7			(41)	(167)	(174)	(182)	(190)	(147)	(153)
New ACA Adults	8			(2,089)	(8,445)	(8,809)	(9,189)	(9,585)	(7,419)	(7,745)
<b>Total MMths</b>				<b>(2,846)</b>	<b>(11,508)</b>	<b>(12,005)</b>	<b>(12,523)</b>	<b>(13,062)</b>	<b>(10,110)</b>	<b>(10,555)</b>
<b>Total Adjustments</b>				<b>(2,846)</b>	<b>(11,508)</b>	<b>(12,005)</b>	<b>365,752</b>	<b>624,235</b>	<b>827,483</b>	<b>994,177</b>

Adjusted Caseload DEMONSTRATION YEARS (DY) State Fiscal Years	Current Waiver					Proposed Waiver				
	16	17	18	19	20	21	22	23	24	25
	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
AFDC	1	871,300	941,900	1,023,000	1,110,500	1,086,200	1,090,800	1,090,800	1,093,500	1,096,900
PWO	2	130,800	115,500	110,700	103,600	113,200	113,600	113,600	113,700	113,700
CMO	3	3,204,000	3,119,300	3,077,300	3,339,000	3,855,200	3,926,000	4,061,000	4,177,800	4,270,900
BCCP	4	2,300	2,200	2,300	2,400	2,100	2,100	2,100	2,100	2,100
Old Age Assistance	5	533,900	554,800	571,600	635,300	750,400	750,400	750,400	750,400	750,400
Aid to Blind/Disabled	6	1,013,000	1,006,000	1,007,100	1,069,200	1,129,200	1,129,500	1,143,600	1,147,800	1,151,900
Foster Children	7	246,600	242,000	238,500	228,700	216,300	219,400	224,800	230,100	235,000
New ACA Adults	8	4,279,100	4,308,500	4,378,500	5,572,500	6,654,800	6,943,000	7,057,100	7,131,100	7,192,400
<b>Total Adjusted MMths</b>		<b>10,281,000</b>	<b>10,290,200</b>	<b>10,409,000</b>	<b>12,061,200</b>	<b>13,807,600</b>	<b>14,184,800</b>	<b>14,443,400</b>	<b>14,646,500</b>	<b>14,813,300</b>

**Oregon Section 1115 Per Member Per Month**

WOW DEMONSTRATION YEARS (DY) State Fiscal Years	Current Waiver					Proposed Waiver (5.4% as President's Budget Proxy for WOW & 3.4% for WW)				
	16 SFY18	17 SFY19	18 SFY20	19 SFY21	20 SFY22	21 SFY23	22 SFY24	23 SFY25	24 SFY26	25 SFY27
AFDC	632	661	691	722	754	795	838	883	931	981
PWO	2,443	2,560	2,683	2,812	2,947	3,106	3,273	3,450	3,636	3,833
CMO	894	927	963	999	1,037	1,093	1,152	1,215	1,280	1,349
BCCP	3,138	3,280	3,427	3,581	3,743	3,945	4,158	4,382	4,619	4,868
Old Age Assistance	962	997	1,032	1,070	1,108	1,168	1,231	1,297	1,367	1,441
Aid to Blind/Disabled	3,371	3,506	3,646	3,792	3,943	4,156	4,381	4,617	4,867	5,129
Foster Children	1,108	1,150	1,194	1,240	1,287	1,356	1,429	1,507	1,588	1,674
New ACA Adults	672	701	731	762	795	838	883	931	981	1,034

W/W DEMONSTRATION YEARS (DY) State Fiscal Years	Current Waiver					Proposed Waiver				
	16 SFY18	17 SFY19	18 SFY20	19 SFY21	20 SFY22	21 SFY23	22 SFY24	23 SFY25	24 SFY26	25 SFY27
AFDC	597	640	663	644	711	735	760	786	813	840
PWO	1,563	1,736	1,795	1,900	2,246	2,323	2,402	2,483	2,568	2,655
CMO	297	317	333	311	298	308	318	329	340	352
BCCP	2,156	2,030	2,212	1,954	1,862	1,926	1,991	2,059	2,129	2,201
Old Age Assistance	505	456	557	578	602	623	644	666	688	712
Aid to Blind/Disabled	1,338	1,296	1,373	1,381	1,442	1,491	1,542	1,594	1,648	1,704
Foster Children	661	689	770	773	734	759	785	811	839	867
New ACA Adults	609	689	727	660	688	712	736	761	787	814

**Oregon SUD Section 1115 Demonstration Budget Neutrality Projections**

IMD Cost Limit member month must be non-duplicative of SUD Hypothetical CNOM Services Limit member months, and must also be non-duplicative of general comprehensive demonstration budget neutrality limit member months. SUD Hypothetical CNOM Services Limit member months can be duplicative of general comprehensive demonstration budget neutrality limit member months.

ELIGIBILITY GROUP	DY 00	TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
4/8/21-3/31/22 4/1/22-3/31/23 4/1/23-3/31/24 4/1/24-3/31/25 4/1/25-3/31/26								
<b>SUD IMD Services</b>								
Eligible Member Months			11,644	12,156	12,691	13,249	13,832	
PMPM Cost	\$1,784	4.5%	\$1,864.00	\$1,948.00	\$2,036.00	\$2,127.00	\$2,223.00	
Total Expenditure			\$21,704,018	\$23,680,108	\$25,838,839	\$28,181,442	\$30,749,332	\$130,153,738

Member Months								
			DY 01	DY 02	DY 03	DY 04	DY 05	Total
Non-CHIP Member Months			11,386	11,877	12,389	12,923	13,480	62,055
PCR	13%		1,482	1,546	1,613	1,682	1,755	8,079
PWO	2%		283	295	308	321	335	1,542
CMO	5%		530	553	577	602	627	2,889
ABAD	5%		570	595	621	647	675	3,108
FC	1%		165	173	180	188	196	902
ACA	73%		8,355	8,715	9,091	9,483	9,891	45,536
CHIP/CAWEM Prenatal MM			258	279	302	326	353	1,518
Combined Total MM			11,644	12,156	12,691	13,249	13,832	63,573
Conversion to 1115 Waiver		SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	Total
<b>MMs to REMOVE</b>		2,846	11,508	12,005	12,523	13,062	10,110	62,055
PCR	13%	371	1,498	1,563	1,630	1,701	1,316	8,079
PWO	2%	71	286	298	311	325	251	1,542
CMO	5%	132	536	559	583	608	471	2,889
ABAD	5%	143	576	601	627	654	506	3,108
FC	1%	41	167	174	182	190	147	902
ACA	73%	2,089	8,445	8,809	9,189	9,585	7,419	45,536

PMPM								
			DY 01	DY 02	DY 03	DY 04	DY 05	Total
Non-CHIP PMPM			1,249	1,305	1,364	1,425	1,489	6,831
PCR	13%		163	170	178	185	194	889
PWO	2%		31	32	34	35	37	170
CMO	5%		58	61	63	66	69	318
ABAD	5%		63	65	68	71	75	342
FC	1%		18	19	20	21	22	99
ACA	73%		916	958	1,001	1,045	1,093	5,013
CHIP/CAWEM Prenatal PMPM			615	643	672	702	734	3,367
Combined Total PMPM			1,864	1,948	2,036	2,127	2,223	10,198
Conversion to 1115 Waiver		SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	Total
<b>PMPMs to REMOVE</b>		312	1,263	1,320	1,379	1,441	1,117	6,831
PCR	13%	41	164	172	180	188	145	889
PWO	2%	8	31	33	34	36	28	170
CMO	5%	15	59	61	64	67	52	318
ABAD	5%	16	63	66	69	72	56	342
FC	1%	5	18	19	20	21	16	99
ACA	73%	229	927	968	1,012	1,057	820	5,013

Cost Estimates								
			DY 01	DY 02	DY 03	DY 04	DY 05	Total
Non-CHIP PMPM			21,545,087	23,500,573	25,636,029	27,952,339	30,490,528	129,124,555
PCR	13%		2,804,856	3,059,432	3,337,437	3,638,987	3,969,423	16,810,136
PWO	2%		535,435	584,033	637,103	694,667	757,746	3,208,983
CMO	5%		1,002,911	1,093,938	1,193,342	1,301,165	1,419,316	6,010,673
ABAD	5%		1,079,108	1,177,050	1,284,007	1,400,022	1,527,149	6,467,336
FC	1%		313,024	341,434	372,460	406,113	442,990	1,876,021
ACA	73%		15,809,753	17,244,686	18,811,680	20,511,385	22,373,904	94,751,406
CHIP/CAWEM Prenatal Estimate			158,931	179,534	202,810	229,103	258,804	1,029,183
Combined Total Estimate			21,704,018	23,680,108	25,838,839	28,181,442	30,749,332	130,153,738
Conversion to 1115 Waiver		SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	Total
<b>Cost to REMOVE</b>		5,386,272	22,033,958	24,034,437	26,215,106	28,586,886	22,867,896	129,124,555
PCR	13%	701,214	2,868,500	3,128,934	3,412,825	3,721,596	2,977,067	16,810,136
PWO	2%	133,859	547,585	597,300	651,494	710,437	568,309	3,208,983
CMO	5%	250,728	1,025,668	1,118,789	1,220,298	1,330,703	1,064,487	6,010,673
ABAD	5%	269,777	1,103,593	1,203,789	1,313,010	1,431,804	1,145,362	6,467,336
FC	1%	78,256	320,126	349,191	380,873	415,332	332,242	1,876,021
ACA	73%	3,952,438	16,168,486	17,636,434	19,236,606	20,977,014	16,780,428	94,751,406

**Oregon CHIP Allotment Historical Spending & Allotment Projections**

	CHIP Allotment Per CMS 21-B Report					Actuals/ Projections	Projections	Projections (inflated 3.4%) annually			
	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2022	SFY2023	SFY2024	SFY2025	SFY2026	SFY2027
<b>Federal Share</b>	\$ 268,903,101	\$ 342,556,364	\$ 416,231,780	\$ 401,882,537	\$ 377,337,334	\$ 416,534,005	\$ 398,832,867	\$ 412,393,184	\$ 426,414,552	\$ 440,912,647	\$ 455,903,677
State Share	\$ 4,041,813	\$ 8,225,428	\$ 12,953,263	\$ 37,656,992	\$ 66,647,345	\$ 159,829,753	\$ 156,489,977	\$ 161,810,637	\$ 167,312,198	\$ 173,000,813	\$ 178,882,841
Total Funds	\$ 272,944,914	\$ 350,781,792	\$ 429,185,043	\$ 439,539,529	\$ 443,984,679	\$ 576,363,758	\$ 555,322,844	\$ 574,203,821	\$ 593,726,751	\$ 613,913,460	\$ 634,786,518

**CHIP TF Impact of Waiver Proposals**

<b>Federal Share</b>								\$ 11,935,278	\$ 32,372,460	\$ 48,308,112	\$ 61,899,970
State Share								\$ 4,591,000	\$ 12,452,325	\$ 18,582,101	\$ 23,810,318
Total Funds								\$ 16,526,277	\$ 44,824,786	\$ 66,890,214	\$ 85,710,288

<b>Federal Share</b>	\$ 268,903,101	\$ 342,556,364	\$ 416,231,780	\$ 401,882,537	\$ 377,337,334	\$ 416,534,005	\$ 398,832,867	\$ 424,328,462	\$ 458,787,013	\$ 489,220,759	\$ 517,803,647
State Share	\$ 4,041,813	\$ 8,225,428	\$ 12,953,263	\$ 37,656,992	\$ 66,647,345	\$ 159,829,753	\$ 156,489,977	\$ 166,401,637	\$ 179,764,524	\$ 191,582,914	\$ 202,693,159
Total Funds	\$ 272,944,914	\$ 350,781,792	\$ 429,185,043	\$ 439,539,529	\$ 443,984,679	\$ 576,363,758	\$ 555,322,844	\$ 590,730,098	\$ 638,551,536	\$ 680,803,674	\$ 720,496,805

	A	B	C	D	E	F	G	H
1	<b>5 YEARS OF HISTORIC DATA</b>							
2								
3	<b>SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:</b>							
4								
5	<b>Population 1: Parent, Caretaker, Relative</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>2018-22</b>
6	<b>TOTAL EXPENDITURES</b>	\$ 519,815,124	\$ 602,643,351	\$ 678,096,919	\$ 715,011,401	\$ 772,336,974		\$ 3,287,903,768
7	<b>ELIGIBLE MEMBER MONTHS</b>	871,300	941,900	1,023,000	1,110,500	1,086,300		
8	<b>PMPM COST</b>	\$ 596.60	\$ 639.82	\$ 662.85	\$ 643.86	\$ 710.98		
9	<b>TREND RATES</b>							<b>5-YEAR</b>
10				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
11	TOTAL EXPENDITURE		15.93%	12.52%	5.44%	8.02%		10.41%
12	ELIGIBLE MEMBER MONTHS		8.10%	8.61%	8.55%	-2.18%		5.67%
13	PMPM COST		7.24%	3.60%	-2.86%	10.42%		4.48%
14								
15	<b>Population 2: Pregnant Women</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>5-YEARS</b>
16	<b>TOTAL EXPENDITURES</b>	\$ 204,485,158	\$ 200,490,603	\$ 198,706,530	\$ 196,848,590	\$ 254,291,572		\$ 1,054,822,453
17	<b>ELIGIBLE MEMBER MONTHS</b>	130,800	115,500	110,700	103,600	113,200		
18	<b>PMPM COST</b>	\$ 1,563.34	\$ 1,735.85	\$ 1,795.00	\$ 1,900.08	\$ 2,246.39		
19	<b>TREND RATES</b>							<b>5-YEAR</b>
20				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
21	TOTAL EXPENDITURE		-1.95%	-0.89%	-0.94%	29.18%		5.60%
22	ELIGIBLE MEMBER MONTHS		-11.70%	-4.16%	-6.41%	9.27%		-3.55%
23	PMPM COST		11.03%	3.41%	5.85%	18.23%		9.49%
24								
25	<b>Population 3: Children's Medicaid</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>5-YEARS</b>
26	<b>TOTAL EXPENDITURES</b>	\$ 951,522,114	\$ 987,609,136	\$ 1,025,526,087	\$ 1,039,621,582	\$ 1,146,984,193		\$ 5,151,263,112
27	<b>ELIGIBLE MEMBER MONTHS</b>	3,204,000	3,119,300	3,077,300	3,339,000	3,855,300		
28	<b>PMPM COST</b>	\$ 296.98	\$ 316.61	\$ 333.26	\$ 311.36	\$ 297.51		
29	<b>TREND RATES</b>							<b>5-YEAR</b>
30				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
31	TOTAL EXPENDITURE		3.79%	3.84%	1.37%	10.33%		4.78%
32	ELIGIBLE MEMBER MONTHS		-2.64%	-1.35%	8.50%	15.46%		4.73%
33	PMPM COST		6.61%	5.26%	-6.57%	-4.45%		0.04%
34								
35	<b>Population 4: BCCP</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>5-YEARS</b>
36	<b>TOTAL EXPENDITURES</b>	\$ 4,959,235	\$ 4,465,134	\$ 5,088,701	\$ 4,690,234	\$ 3,910,767		\$ 23,114,071
37	<b>ELIGIBLE MEMBER MONTHS</b>	2,300	2,200	2,300	2,400	2,100		
38	<b>PMPM COST</b>	\$ 2,156.19	\$ 2,029.61	\$ 2,212.48	\$ 1,954.26	\$ 1,862.27		
39	<b>TREND RATES</b>							<b>5-YEAR</b>
40				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
41	TOTAL EXPENDITURE		-9.96%	13.97%	-7.83%	-16.62%		-5.77%
42	ELIGIBLE MEMBER MONTHS		-4.35%	4.55%	4.35%	-12.50%		-2.25%
43	PMPM COST		-5.87%	9.01%	-11.67%	-4.71%		-3.60%
44								
45	<b>Population 5: Old Age Assistance</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>5-YEARS</b>
46	<b>TOTAL EXPENDITURES</b>	\$ 269,608,429	\$ 253,207,300	\$ 318,394,991	\$ 366,998,997	\$ 451,777,412		\$ 1,659,987,129
47	<b>ELIGIBLE MEMBER MONTHS</b>	533,900	554,800	571,600	635,300	750,400		
48	<b>PMPM COST</b>	\$ 504.98	\$ 456.39	\$ 557.02	\$ 577.68	\$ 602.05		
49	<b>TREND RATES</b>							<b>5-YEAR</b>
50				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
51	TOTAL EXPENDITURE		-6.08%	25.74%	15.27%	23.10%		13.78%
52	ELIGIBLE MEMBER MONTHS		3.91%	3.03%	11.14%	18.12%		8.88%
53	PMPM COST		-9.62%	22.05%	3.71%	4.22%		4.49%
54								
55	<b>Population 6: Aid to Blind/Disabled</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>5-YEARS</b>
56	<b>TOTAL EXPENDITURES</b>	\$ 1,355,849,512	\$ 1,303,451,722	\$ 1,382,829,006	\$ 1,476,052,850	\$ 1,628,182,195		\$ 7,146,365,285
57	<b>ELIGIBLE MEMBER MONTHS</b>	1,013,000	1,006,000	1,007,100	1,069,200	1,129,200		
58	<b>PMPM COST</b>	\$ 1,338.45	\$ 1,295.68	\$ 1,373.08	\$ 1,380.52	\$ 1,441.89		
59	<b>TREND RATES</b>							<b>5-YEAR</b>
60				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
61	TOTAL EXPENDITURE		-3.86%	6.09%	6.74%	10.31%		4.68%
62	ELIGIBLE MEMBER MONTHS		-0.69%	0.11%	6.17%	5.61%		2.75%
63	PMPM COST		-3.20%	5.97%	0.54%	4.45%		1.88%
64								
65	<b>Population 7: Foster Children</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>5-YEARS</b>
66	<b>TOTAL EXPENDITURES</b>	\$ 162,980,290	\$ 166,815,798	\$ 183,595,782	\$ 176,781,217	\$ 158,729,148		\$ 848,902,235
67	<b>ELIGIBLE MEMBER MONTHS</b>	246,600	242,000	238,500	228,700	216,300		
68	<b>PMPM COST</b>	\$ 660.91	\$ 689.32	\$ 769.79	\$ 772.98	\$ 733.84		
69	<b>TREND RATES</b>							<b>5-YEAR</b>
70				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
71	TOTAL EXPENDITURE		2.35%	10.06%	-3.71%	-10.21%		-0.66%
72	ELIGIBLE MEMBER MONTHS		-1.87%	-1.45%	-4.11%	-5.42%		-3.22%
73	PMPM COST		4.30%	11.67%	0.41%	-5.06%		2.65%
74								
75	<b>Population 8: ACA Adults</b>	<b>SFY18</b>	<b>SFY19</b>	<b>SFY20</b>	<b>SFY21</b>	<b>SFY22</b>		<b>5-YEARS</b>
76	<b>TOTAL EXPENDITURES</b>	\$ 2,605,887,990	\$ 2,970,088,966	\$ 3,184,359,130	\$ 3,677,444,919	\$ 4,581,477,154		\$ 17,019,258,159
77	<b>ELIGIBLE MEMBER MONTHS</b>	4,279,100	4,308,500	4,378,500	5,572,500	6,654,800		
78	<b>PMPM COST</b>	\$ 608.98	\$ 689.36	\$ 727.27	\$ 659.93	\$ 688.45		
79	<b>TREND RATES</b>							<b>5-YEAR</b>
80				<b>ANNUAL CHANGE</b>				<b>AVERAGE</b>
81	TOTAL EXPENDITURE		13.98%	7.21%	15.48%	24.58%		15.15%
82	ELIGIBLE MEMBER MONTHS		0.69%	1.62%	27.27%	19.42%		11.67%
83	PMPM COST		13.20%	5.50%	-9.26%	4.32%		3.11%

# Appendix B: Public Comment Logs

*This appendix includes supplemental information to Section XI of the application, which details how OHA solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. This appendix also includes summaries of public comments received and OHA's response to public comments.*

## Included in Appendix B:

### **I. Public Notice**

- a. *Attachment 1. Full Public Notice (English)*
- b. *Attachment 2. Full Public Notice (Spanish)*
- c. *Attachment 3. Abbreviated Public Notice (English)*
- d. Press release and meeting notifications for public hearings
  - i. *Attachment 4. Public Notice Press Release*
  - ii. *Attachment 5. Oregon Health Policy Board December Meeting Notice*
  - iii. *Attachment 6. Designing the Future of OHP Meeting Notice*
  - iv. *Attachment 7. Medicaid Advisory Committee Meeting Notice*
  - v. *Attachment 8. Oregon Health Policy Board January Meeting Notice*
  - vi. *Attachment 9. Community Outreach Partnership Program's Spanish Webinar Notifications*
  - vii. *Attachment 10. Community Outreach Partnership Program's English Webinar Announcement*

### **II. Summary of Public Comments and OHA Responses**

- a. Table B.1. Incentivizing equitable care
- b. Table B.2. Continuous enrollment for adults and children
- c. Table B.3. Retroactive eligibility
- d. Table B.4. SNAP pathway for expedited enrollment
- e. Table B.5. Social determinants of health (SDOH) supports for members experiencing transitions
- f. Table B.6. Covered services
- g. Table B.7. Juvenile justice system
- h. Table B.8. Community Investment Collaboratives
- i. Table B.9. Federally Recognized Tribes and Tribal Services
- j. Table B.10. Finance and rates
- k. Table B.11. Evaluation plan
- l. Table B.12. Immigration and citizenship
- m. Table B.13. Race, Ethnicity, Language, and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) data
- n. Table B.14. Pharmacy
- o. Table B.15. Prioritized List and use of Quality Adjusted Life Years (QALYs)

- p. Table B.16. Community information exchange (CIE) and health information technology (HIT)
  - q. Table B.17. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
  - r. Table B.18. Workforce
- III. Public Comment Survey of Stakeholders on Oregon’s Waiver Renewal**
- a. *Attachment 11.* Public Comment Survey (Spanish version)
  - b. *Attachment 12.* Public Comment Survey (English version)





# Public Notice

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## Public comment process

OHA will open a public comment period on the draft 1115 Medicaid Demonstration Renewal application beginning December 7, 2021 through January 7, 2022. During this time, written and verbal comments on the proposed application will be accepted. These comments will be used to inform the final application prior to submission to the Centers for Medicare and Medicaid Services (CMS) in February 2022.

**The draft application is available here:** <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Renewal-Application.pdf>.

Everyone has a right to know about and use OHA programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written material in other languages
- Braille
- Large print
- Audio and other formats

To receive documents in alternate formats, please contact Michelle Hatfield at 503-551-3881 or [1115Waiver.Renewal@dhsaha.state.or.us](mailto:1115Waiver.Renewal@dhsaha.state.or.us)

## How to submit comments

The public is invited to give written and verbal comments on the draft waiver application from December 7, 2021 through January 7, 2022. **The deadline for comment is January 7, 2022, 11:59 PM, Pacific Time.** The public may provide verbal or written comments. All public comments received by OHA will be posted at [Oregon.gov/1115WaiverRenewal](https://Oregon.gov/1115WaiverRenewal).

Beginning December 7, 2021, written comments can be emailed to [1115Waiver.Renewal@dhsosha.state.or.us](mailto:1115Waiver.Renewal@dhsosha.state.or.us), submitted through [Oregon.gov/1115WaiverRenewal](https://Oregon.gov/1115WaiverRenewal), or sent via physical mail to:

Health Policy and Analytics Medicaid Waiver Renewal Team  
Attn: Michelle Hatfield  
500 Summer St. NE, 5th Floor, E65  
Salem, OR 97301

Members of the public may provide verbal comment at any of the following public hearings:

### Oregon Health Policy Board

Dec. 7, 2021 | 8:30 a.m. – 12 p.m.

Join Meeting:

<https://www.zoomgov.com/j/1602657497?pwd=emhzUnJsK1EzWk5rV0VpYTdjU3VrQT09>

One tap mobile: [+16692545252](tel:+16692545252), 1602657497#,,,,,0#,,306554#

If you need help or accommodations, please contact Tara Chetock at 971-304-9917 or [tara.a.chetock@dhsosha.state.or.us](mailto:tara.a.chetock@dhsosha.state.or.us) at least 48 hours before the meeting.

### Community Partner meeting (en español)

Dec. 9, 2021 | 3:30 p.m. – 5:30 p.m.

Join meeting: <https://us02web.zoom.us/meeting/register/tZwkde6uqTsuGtE7CbrxDUI4WL0f70I18wg5>

### Health Equity Committee

Dec. 9, 2021 | 12 p.m. – 2 p.m.

Microsoft Teams meeting [Click here to join the meeting](#)

Or call in (audio only)

One tap mobile: [+1 971-277-2343](tel:+19712772343), 928637902#

Phone Conference ID: 928 637 902#

If you need help or accommodations, please contact Maria Castro at 503-884-4448 or [maria.castro@dhsosha.state.or.us](mailto:maria.castro@dhsosha.state.or.us) at least 48 hours before the meeting.

### Medicaid Advisory Committee

Dec. 15, 2021 | 9 a.m. – 12 p.m.

Microsoft Teams meeting [Click here to join the meeting](#)

Or call in (audio only)

One tap mobile: [+1 971-277-2343](tel:+19712772343), [243372877#](tel:+1243372877) Phone Conference ID: 243 372 877#

If you need help or accommodations, please contact Jackie Wetzel at 503-580-5603 or [Jackie.Wetzel@dhsosha.state.or.us](mailto:Jackie.Wetzel@dhsosha.state.or.us) at least 48 hours before the meeting.

### **Designing the future of OHP – Workshop 3**

Dec. 16, 2021 | 5:30 p.m. – 7:30 p.m.

Register in advance for this meeting: [https://www.zoomgov.com/meeting/register/vJlsc--spjoqHteaw5dXCTUmWwDVE\\_7NgDU](https://www.zoomgov.com/meeting/register/vJlsc--spjoqHteaw5dXCTUmWwDVE_7NgDU)

If you need help or accommodations, please contact Michelle Hatfield at 503-551-3881 or [michelle.m.hatfield@dhsosha.state.or.us](mailto:michelle.m.hatfield@dhsosha.state.or.us) at least 48 hours before the meeting.

### **Community Partner meeting**

Dec. 17, 2021 | 10:30 a.m. – 12:30 p.m.

Join meeting: <https://us02web.zoom.us/meeting/register/tZcod-6trD8sEtHdQadl0abTNYkZVpihdfFJ>

### **Oregon Health Policy Board**

Jan. 4, 2022 | 8:30 a.m. – 12 p.m.

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1609166382?pwd=Ulp0eis5bUZPeUNQdWM3VU9aMnZwQT09>

Meeting ID: 160 916 6382 Passcode: 912812

One tap mobile [+16692545252](tel:+16692545252),,1609166382# ,, 0#,,912812# US (San Jose)

If you need help or accommodations, please contact Tara Chetock at 971-304-9917 or [tara.a.chetock@dhsosha.state.or.us](mailto:tara.a.chetock@dhsosha.state.or.us) at least 48 hours before the meeting.

## **Background**

In 2012, Oregon launched Coordinated Care Organizations (CCOs) through the state's 1115 Medicaid waiver and an accompanying state innovation model grant from the Center for Medicare and Medicaid Innovation (CMMI). CCOs are community-based organizations that deliver care to Medicaid members through a coordinated care model of service delivery designed to address problems inherent in a fragmented health system. CCOs are responsible for physical, behavioral and oral health care services for Medicaid members. They receive a fixed monthly budget from the state to coordinate care with flexibility to address their members' needs outside traditional medical services and financial incentives for improving outcomes and quality.

Oregon will continue the CCO model in the proposed demonstration renewal. As currently implemented, the demonstration renewal will continue to operate statewide and will cover the 1.3 million Oregonians currently receiving benefits through the OHP and proposes changes to the benefits available to existing members. The application also proposes changes to eligibility that would extend coverage to individuals who are not currently eligible to enroll in a CCO. The state seeks to renew this demonstration for the period from July 1, 2022 through June 30, 2027 so Oregon can continue its health system transformation through specific modifications to Medicaid and CHIP programs under the current waiver. These modifications will allow the state to meet its overall goals that are aligned with the triple aim to improve patient experience, improve health, and reduce costs.

Payment via a per member per month rate integrates physical, behavioral and oral health care under one funding stream and provides CCOs with flexibility in how dollars are spent while holding costs to a 3.4% annual growth cap. Further, the CCO model requires community involvement in decision-making. Community Advisory Councils (CACs) for each CCO engage CCO members and other community representatives in guiding some of the spending within the

flexible funds. CACs utilize Community Health Assessments and Community Health Improvement Plans to provide direction and ensure alignment with local hospitals and public health authorities. In 2017, Oregon's renewal expanded this effort by focusing on upstream investment in social determinants of health through the use of health-related services (HRS) that allowed CCOs further flexibility to pay for non-medical services that improve health outcomes.

HRS are defined as non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One of the purposes of HRS is to give CCOs a specific funding mechanism within their budgets to address the social determinants of health (SDOH), including the health-related social needs of their members. For CCOs to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria. The goals of HRS are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being.

Following are the elements of the current Section 1115 demonstration that are proposed to continue:

- Contracting with Coordinated Care Organizations (CCOs) to provide physical, behavioral, and oral health services to Medicaid Oregon Health Plan members
- The use of the prioritized list of conditions and treatments, subject to certain exceptions for protected benefits
- The use of Health Related Services
- Restrict coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one
- Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans
- Care Coordination for individuals residing in institutions for mental diseases (IMDs)

Continue Uncompensated Care payments for Tribal Health Facility Program

## Purpose, goals, and objectives

The Oregon Health Authority (OHA) will submit an application for renewal of the Oregon Health Plan (OHP) 1115(a) Demonstration Waiver for the July 1, 2022- June 30, 2027 demonstration period. The renewal requests changes to the current demonstration that will:

- Increase access to continuous OHP coverage for some populations by proposing changes to the current enrollment processes and eligibility criteria;
- Define a series of benefit packages of supportive services for individuals experiencing transitions across different systems, across health care settings, and across life stages or due to point-in-time events with the goal of minimizing the disruptions in care that often occur during these transitions;
- Propose changes to the methodology used to set capitation rates that are used to pay CCOs;

- Allow CCOs to spend 3% of their per-member per-month capitation rate on investments to improve health equity and for those investments to be counted as medical expenses during rate development as required by House Bill 3353 from the 2021 Oregon Legislative Session;
- Request federal funding for spending on improving health equity, including investments to build infrastructure to support health equity interventions, to support community-led health equity interventions and statewide initiatives, and grant community-led collaboratives resources to invest in health equity.
- Provide the state with the ability to define preferred drugs for OHP members in an effort to better control the financial impact of rising drug costs;
- Change the process for selecting and operationalizing CCO incentive metrics to focus on reducing health inequities; and
- Expand benefits for American Indian/Alaska Native OHP members to include Tribal-based practices as a covered service, and waive prior authorization criteria for tribal members

The proposed program changes would meet the following goals and objectives:

- Maximize continuous and equitable access to coverage
- Streamline transitions between systems through defined benefit packages of social determinants of health services
- Increase flexibility for Coordinated Care Organizations (CCOs) to invest in community health and health equity
- Improve health through focused equity investments led by communities
- Ensure quality and access through equity-driven performance metrics
- Align with Oregon's nine Tribal governments' priorities

## Beneficiaries who will be affected by the demonstration

Oregon proposes the following changes for beneficiaries under the demonstration:

Population	Criteria	Changes proposed
Youth with Special Health Care Needs	<i>Adolescents and young adults with a behavioral, developmental, emotional, and/or physical condition ages 17 up to 26 years and have service or Medicaid eligibility through Aged and Peoples with Disabilities (APD), Oregon Developmental Disability Services (ODDS); or, be identified through the Pediatric Medical Complexity Algorithm (PMCA); or be identified through the following indicators: Intellectual or Developmental Disability (IDD), or Medically Fragile or Medically Involved indicators</i>	The changes requested would extend this coverage through age 26 and would qualify them for services designed to support employment, life skills development, and other benefits designed to aid in the transition to adult benefits.
American Indian / Alaska Native OHP Members	<i>OHP members who are enrolled as American Indian or Alaska Native</i>	Services provided to these members would have prior authorization criteria waived for all services offered to tribal members under OHP. Additionally, the proposal requests that defined Tribal-based Practices be included as covered services for tribal members.
Youth in custody of Juvenile Corrections (Oregon Youth Authority)	<i>Youth in custody (pre- and post-adjudication) of Juvenile Corrections who either enter with current OHP enrollment or become enrolled while in custody</i>	Youth in custody would maintain continuous OHP enrollment for the entire duration of their time in custody, allowing them to access a defined package of support services to aid in the transition at time of release. This differs from the current demonstration which does not allow the enrollment of individuals in custody until they have been released.

Population	Criteria	Changes proposed
Adults who are incarcerated or in the custody of the Department of Corrections	<i>Individuals in custody of Department of Corrections planned for release within in 90 days or less and meet Medicaid income requirements</i>	Individuals would be eligible to enroll in OHP beginning 90 days prior to their date of release, allowing them to access a defined package of support services to aid in the transition. This differs from the current demonstration, which does not allow the enrollment of individuals in custody until they have been released.
Adults in the custody of local correction facilities	<i>Individuals in custody (pre- and post- adjudication) of county jails or local correction facilities who either enter with current OHP enrollment or become enrolled while in custody.</i>	Individuals who are enrolled in OHP at the time they are held in the custody of county jails or local correction facilities would not be disenrolled from OHP. This differs from the current demonstration, which suspends enrollment at the time of arrest even if the charges are not sustained.
Individuals residing in the Oregon State Hospital	<i>Individuals who are in the care of the Oregon State Hospital (OSH) who meet Medicaid income eligibility who are planned for discharge within 90 days or less.</i>	Individuals in the care or custody of the Oregon State Hospital would be eligible to enroll in OHP beginning 90 days prior to the date of discharge. This differs from the current demonstration, which suspends enrollment at the time of intake.
Individuals residing in Psychiatric Residential Facilities (IMD)	<i>Individuals who are in the care of an Institute of Mental Disease (IMD) who meet Medicaid income eligibility who are planned for discharge within 90 days or less.</i>	Individuals who are in the care of a Psychiatric Residential Treatment Facility would be eligible to enroll in OHP beginning 90 days prior to their date of discharge. This differs from the current demonstration, which suspends enrollment when an individual enters this type of facility.

Population	Criteria	Changes proposed
Youth transitioning out of Foster Care	<i>Currently enrolled OHP youth who are involved or at risk of involvement with the child welfare system, transitioning in and out of foster care homes, including those aging out of the system</i>	Individuals would be qualified for supportive services such as housing, life skills training, employment assistance, or transportation, including peer supports or navigation when changing foster homes aging out of foster care, or returning to the natural home. These services are not currently provided under the demonstration.
Members transitioning from Medicaid-only coverage to Medicare-Medicaid Coverage	<i>Existing OHP members who are dually eligible for Medicare and Medicaid per OHP eligibility determinations</i>	Individuals who are dually eligible may be qualified to receive additional support to assist in transitioning onto Medicare, accessing benefits they are newly eligible for and to support continuity of providers. These services are not currently provided under the demonstration.
Individuals vulnerable to extreme climate events	<i>Individuals who are enrolled in OHP located in an area affected by a declared state of emergency due to climate change.</i>	Individuals who are enrolled in OHP and who are located in an area affected by a declared state of emergency such as wildfires, extreme heat events, flooding, or other climate events would qualify to receive additional services designed to mitigate the negative impact to a person's health and well-being. These services are not currently provided under the demonstration.
Children under the age of 6	<i>Individuals who meet Medicaid income eligibility and are between the ages of 0 and 6 years</i>	Children under the age of 6 would not be required to undergo the annual eligibility redetermination process until age 6 and would experience continuous enrollment in OHP. This differs from the current demonstration, which requires eligibility redetermination once a year.



Population	Criteria	Changes proposed
People age 6 and up	<i>Currently enrolled OHP members who meet Medicaid income eligibility and are age 6 and older</i>	Individuals enrolled in OHP would undergo eligibility redetermination every 24 months instead of every 12 months under the current demonstration.
All other OHP members	<i>Any individual currently receiving OHP benefits</i>	Individuals who receive prescription drugs under the Oregon Health Plan may see changes to what medications are preferred by their plan
SNAP-eligible individuals who are not currently enrolled in OHP	<i>Individuals who meet Medicaid income eligibility and who are currently enrolled in SNAP benefits</i>	Individuals who are eligible for the Supplemental Nutrition Assistance Program would be screened for OHP eligibility and offered streamlined enrollment using income criteria already established during SNAP enrollment. This differs from the current demonstration which reviews an individual's eligibility for OHP and for SNAP separately.

No other changes to eligibility criteria are being requested.

## Delivery system and eligibility requirements

Oregon proposes to keep the Coordinated Care Organization (CCO) model of service delivery. CCOs will still be contracted to provide physical, behavioral, and oral health services for eligible members. Eligibility requirements will remain the same outside of those changes described above.

## Changes to benefits and coverage

The benefits for OHP members that are defined in the State Plan will not change. Additional benefits will be available to individuals who qualify under the eligibility changes described above, and include:

Changes proposed	Current program
Coverage of a defined set of services to support members experiencing transitions in care between systems, between settings, and during live events	Some services in this proposal are available from CCOs as health-related services, but are not considered a covered service
Availability of some peer-delivered services expanded to include coverage of services before a treatment plan is developed and after a treatment plan has been completed	Peer-delivered services are considered covered services when they are performed under the supervision of a certified provider and are included in a member's treatment plan
Flexibility to exclude drugs with limited or inadequate clinical efficacy, with a pathway for coverage for non-preferred drugs	The state does not have the ability to exclude coverage of approved drugs

No other changes to benefits are being requested.

## Cost sharing requirements

No changes to cost sharing requirements are being requested. OHP does not require cost sharing.

## Estimate of expected change in annual enrollment and annual expenditures

Historical data (current waiver period)					
	SFY18	SFY19	SFY20	SFY21	SFY22
Total enrollment	856,262	857,297	879,157	1,005,122	1,131,501
Total expenditure	\$6,258,934,391	\$6,597,659,631	\$7,073,711,147	\$7,784,273,070	\$9,555,087,914

Demonstration renewal period					
	SFY23	SFY24	SFY25	SFY26	SFY27
Total projected enrollment	1,019,073	1,123,740	1,132,032	1,134,884	1,115,832
Total projected expenditure	\$10,007,172,653	\$11,620,080,436	\$12,088,770,684	\$12,537,125,292	\$12,556,399,420

## Hypotheses and evaluation parameters

The state is proposing changes to what will be evaluated with this extension that are similar to what is being evaluated under the current demonstration. The changes are described below:

### Q1. Will the 1115 waiver renewal proposed interventions decrease health inequities by race and ethnicity?

#### Hypothesis #1:

Redistributing power and resources to individuals and communities most harmed by historical and contemporary racism will result in improvements in health inequities and self-reported measures of autonomy, health status and quality of life.

#### Hypothesis #2:

Using the new decision-making structure to select and operationalize CCO incentive metrics will result in greater improvements in health inequities by race/ethnicity than occurred under the decision-making structure in place during the 2012-2017 waiver.

### Q2. Will continuous coverage improve health outcomes?

#### Hypothesis #3:

Earlier OHP enrollment with fewer gaps in coverage for vulnerable populations will result in more members receiving care in the right settings, and improved health status and quality of life.

#### Hypothesis #4:

Offering packages of SDOH support services to individuals experiencing transitions is more effective at improving integration for successful transition than offering individual services alone.

### Q3. Does the new rate development methodology for a value-based budget increase CCO spending in community investments to reduce health inequities?

#### Hypothesis #5:

Offering a predictable budget, based on a streamlined method with predictable cost growth, allows for greater clarity around available funds for CCO reinvestment in local community and increases community investments.

#### Hypothesis #6:

Offering a predictable budget, based on a streamlined method with predictable cost growth, allows community partners to more effectively partner with CCOs to meet members' needs for SDOH support services.

## Waiver and expenditure authorities requested for the demonstration

Oregon is requesting to continue the following waiver and expenditure authorities used under the current demonstration:

Waiver authority	Use for waiver
Section 1115 (a)	Continuation of the state's Tribal Uncompensated Care Program (UCCP)
42 CFR § 438.56	<ul style="list-style-type: none"> <li>• Permitting enrollees dually eligible through Medicare and Medicaid to disenroll from CCOs without cause at any time</li> <li>• Contract with managed care entities and insurers that operate locally</li> <li>• Offer benefits consistent with a prioritized list of conditions and treatments, subject to certain exceptions for protected benefits</li> <li>• Restrict coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one</li> <li>• Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans</li> <li>• Not pay disproportionate share hospitals payments for managed care enrollees</li> <li>• In general, to permit coordinated care organizations to limit periods during which enrollees may disenroll</li> <li>• Provide coverage for certain chemical dependency services for targeted beneficiaries</li> <li>• Receive federal financial participation for certain state-funded health care programs</li> </ul>

In addition to Oregon's existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow for:

Waiver authority	Use for waiver	Reason for waiver request
42 C.F.R. 435.916	Expenditure authority to permit the State to implement continuous enrollment.	This allows the state to request federal financial participation for the continuous enrollment of children without regard to whether a child's income exceeds eligibility limits and provide continuous OHP enrollment for children until their sixth birthday (age 0-5)
42 C.F.R. 435.916	Expenditure authority to permit the State to implement continuous enrollment.	This allows the state to waive the annual redetermination requirements with respect to income eligibility and establish two-year continuous OHP enrollment for people ages six and up
42 CFR 438.8 and 42 CFR 438.74  45 CFR 158.150 or 45 CFR 158.151	Allow Health Related Services to be counted in the numerator of the MLR.	This allows the state to count health-related services that meet the requirements in the numerator of the Medical Loss Ratio when evaluating CCO financial reporting
	Expenditure authority to permit the State use SNAP eligibility information as the basis for determining Medicaid enrollment.	This allows the state to provide an expedited enrollment path for people who apply and are eligible for Supplemental Nutrition Assistance Program (SNAP) benefits.

Waiver authority	Use for waiver	Reason for waiver request
	Expenditure authority for state-funded health-related initiatives.	This allows the state to request a new federal investment focused on improving health equity, including investments to build infrastructure to support health equity interventions; support community-led health equity interventions and statewide initiatives; grant community-led collaboratives resources to invest in health equity.
	Expenditure authority to fund payments to provider and community-based organizations for infrastructure and capacity building	This allows the state to request federal investment for Community Investment Collaboratives to support implementation capacity at the community level, including payments for provider and community-based organizations (CBO) infrastructure and capacity building.
	Expenditure authority to fund health-related services for individuals during certain life transitions.	This allows the state to request additional funding for a defined set of SDOH transition services to support members in need during transition in coverage periods and life transitions.
	Expenditure authority for Medicaid services rendered to institutionalized individuals	This would waive the federal rule preventing Medicaid coverage for a person in custody, including justice-involved populations and those in the Oregon State Hospital and psychiatric residential facilities, and allows the state to request federal fund participation for the enrollment of individuals in custody.
	Expenditure authority for Medicaid services rendered to institutionalized individuals.	This allows the state to cover through Medicaid certain costs of medical services for a member in custody, including justice-involved populations and those in the Oregon State Hospital and psychiatric residential facilities

Waiver authority	Use for waiver	Reason for waiver request
sections 1902(a)(10) and 1902(a)(17).	Waiver of comparability to permit the State to offer additional benefits to YSCHN up to age 26.	This allows the state to retain child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) up to age 26.
sections 1902(a)(10) and 1902(a)(17)	Expenditure authority to cover YSCHN up to age 26 up to <b>305</b> % of the federal poverty level, who would not otherwise be eligible for Medicaid.	This allows the state to request federal fund participation for Youth with Special Health Care Needs (YSHCN) up to age 26.
	Expenditure authority for services delivered by Traditional Health Workers, including community health workers, personal health navigators, peer wellness and support specialist and doulas.	This allows the state to expand and fund the services provided by Traditional Health Workers outside of the currently approved settings
42 C.F.R. 438.5	Expenditure authority to pay for capitation rates that are built with specified deviations from the rate development standards outlined in 42 C.F.R. 438.5	This allows the state to request changes to the methodology used to develop per-member per-month capitation rates paid to CCOs for providing care to members.
§1902(a)(54); Section 1927(d)(1)(B); §1902(a)(14); Section 1916 and 1916A; §1902(a)(23)(A)	Waiver of the permissible coverage restriction requirements for outpatient drugs, specifically §1902(a)(54) insofar as it incorporates Section 1927(d)(1)(B); §1902(a)(14) insofar as it incorporates Section 1916 and 1916A; §1902(a)(23)(A)	This allows the state to define a list of preferred drugs and exclude unproven or low-value drugs based on clinical efficacy.

Waiver authority	Use for waiver	Reason for waiver request
	Expenditure authority to fund health-related services for members experiencing certain life transitions.	This allows the state to obtain federal match for Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions
42 C.F.R. 438.5.	Expenditure authority to pay for capitation rates that are built with specified deviations from the rate development standards outlined in 42 C.F.R. 438.5.	This allows the state the authority to count CCO investments in health equity required by HB 3353 as medical claims or quality improvement spending for purposes of CCO rate setting.

**Document accessibility:** For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Community Partner Outreach Program at [community.outreach@dhsosha.state.or.us](mailto:community.outreach@dhsosha.state.or.us) or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.



# Aviso público



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## Proceso de comentarios públicos

El Oregon Health Authority, OHA abrirá un período de comentarios públicos sobre la versión preliminar de la solicitud de Renovación de Demostración de Medicaid 1115 a partir del 7 de diciembre de 2021 y hasta el 7 de enero de 2022. Durante este período, se aceptarán comentarios verbales y por escrito sobre la solicitud propuesta. Estos comentarios se usarán para informar la solicitud final antes de su presentación a los Centros de Servicios de Medicare y Medicaid (Centers for Medicare and Medicaid Services, CMS) en febrero de 2022.

### La versión preliminar de la solicitud se encuentra disponible aquí:

<https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Renewal-Application.pdf>.

Todo el mundo tiene derecho a conocer y utilizar los programas y servicios del OHA. El OHA provee ayuda gratuita. Algunos ejemplos de la ayuda gratuita que puede proporcionar el OHA son los siguientes:

- Intérpretes de lenguaje de señas e idiomas
- Material escrito en otros idiomas
- Braille
- Letra grande
- A audio y otros formatos

Para recibir los documentos en otros formatos, comuníquese con **NOMBRE** al **NÚMERO DE TELÉFONO** o **CORREO ELECTRÓNICO**.

## Cómo enviar los comentarios

Se invita al público a compartir sus comentarios verbales y por escrito sobre la versión preliminar de la solicitud de exención desde el 7 de diciembre de 2021 hasta el 7 de enero de 2022. **La fecha límite para enviar los comentarios es el 7 de enero de 2022 a las 11:59 p. m., hora del Pacífico.** El público puede enviar sus comentarios verbales o por escrito. El OHA publicará todos los comentarios públicos recibidos en [Oregon.gov/1115WaiverRenewal](https://Oregon.gov/1115WaiverRenewal).

A partir del 7 de diciembre de 2021, puede enviar sus comentarios por escrito por correo electrónico a [1115Waiver.Renewal@dhsosha.state.or.us](mailto:1115Waiver.Renewal@dhsosha.state.or.us) o bien puede enviarlos a través de [Oregon.gov/1115WaiverRenewal](https://Oregon.gov/1115WaiverRenewal), o por correo postal a la siguiente dirección:

Health Policy and Analytics Medicaid Waiver Renewal Team  
A la atención de: Michelle Hatfield  
500 Summer St. NE, 5th Floor, E65  
Salem, OR 97301

Los miembros del público pueden proporcionar sus comentarios verbales en cualquiera de las siguientes audiencias públicas:

### Consejo de Políticas de Salud de Oregon

7 de diciembre de 2021 | de 8:30 a. m. a 12 p. m.

Unirse a la reunión:

<https://www.zoomgov.com/j/1602657497?pwd=emhzUnJsK1EzWk5rV0VpYTdjU3VrQT09>

Enlace móvil: [+16692545252](tel:+16692545252),,1602657497#,,,,,0#,,306554#

Si necesita ayuda o alguna adaptación, comuníquese con Tara Chetock al 971-304-9917 o al correo electrónico [tara.a.chetock@dhsosha.state.or.us](mailto:tara.a.chetock@dhsosha.state.or.us) al menos 48 horas antes de la reunión.

### Reunión de socios comunitarios (en español)

9 de diciembre de 2021 | de 3:30 p. m. a 5:30 p. m.

Unirse a la reunión: <https://us02web.zoom.us/meeting/register/tZwkde6uqTsuGtE7CbrxDUI4WL0f70I18wg5>

### Comité de Equidad Sanitaria

9 de diciembre de 2021 | de 12 p. m. a 2 p. m.

Reunión de Microsoft Teams [Haga clic aquí para unirse a la reunión](#)

O bien únase a la llamada (solo audio)

Enlace móvil: [+1 971-277-2343](tel:+19712772343),,928637902#

ID de conferencia telefónica: 928 637 902#

Si necesita ayuda o alguna adaptación, comuníquese con Maria Castro al 503-884-4448 o al correo electrónico [maria.castro@dhsosha.state.or.us](mailto:maria.castro@dhsosha.state.or.us) al menos 48 horas antes de la reunión.

### Comité Asesor de Medicaid

15 de diciembre de 2021 | de 9 a. m. a 12 p. m.

Reunión de Microsoft Teams [Haga clic aquí para unirse a la reunión](#)

O bien únase a la llamada (solo audio)

Enlace móvil: [+1 971-277-2343,243372877#](tel:+19712772343,243372877#) ID de conferencia telefónica: 243 372 877#

Si necesita ayuda o alguna adaptación, comuníquese con Jackie Wetzel al 503-580-5603 o al correo electrónico [Jackie.Wetzel@dhs.ohha.state.or.us](mailto:Jackie.Wetzel@dhs.ohha.state.or.us) al menos 48 horas antes de la reunión.

### **Diseñando el futuro del OHP – Taller 3**

16 de diciembre de 2021 | de 5:30 p. m. a 7:30 p. m.

Registrarse con anticipación para esta reunión:

[https://www.zoomgov.com/meeting/register/vJlsc--spjoqHteaw5dXCTUmWwDVE\\_7NgDU](https://www.zoomgov.com/meeting/register/vJlsc--spjoqHteaw5dXCTUmWwDVE_7NgDU)

Si necesita ayuda o alguna adaptación, comuníquese con Michelle Hatfield al 503-551-3881 o al correo electrónico [michelle.m.hatfield@dhs.ohha.state.or.us](mailto:michelle.m.hatfield@dhs.ohha.state.or.us) al menos 48 horas antes de la reunión.

### **Reunión de socios comunitarios**

17 de diciembre de 2021 | de 10:30 a. m. a 12:30 p. m.

Unirse a la reunión: <https://us02web.zoom.us/j/6trD8sEtHdQadI0abTNykZVpihdfFJ>

### **Consejo de Políticas de Salud de Oregon**

4 de enero de 2022 | de 8:30 a. m. a 12 p. m.

Unirse a la reunión ZoomGov

<https://www.zoomgov.com/j/1609166382?pwd=Ulp0eis5bUZPeUNQdWM3VU9aMnZwQT09>

ID de reunión: 160 916 6382 Código de acceso: 912812

Enlace móvil [+16692545252,1609166382#](tel:+16692545252,1609166382#) , 0#,,912812# US (San Jose)

Si necesita ayuda o alguna adaptación, comuníquese con Tara Chetock al 971-304-9917 o al correo electrónico [tara.a.chetock@dhs.ohha.state.or.us](mailto:tara.a.chetock@dhs.ohha.state.or.us) al menos 48 horas antes de la reunión.

## **Antecedentes**

En 2012, Oregon lanzó las Organizaciones de Atención Coordinada (Coordinated Care Organization, CCO) a través de la exención estatal de Medicaid 1115 y una subvención modelo estatal de innovación por parte del Centro de Innovación de Medicare y Medicaid (Center for Medicare and Medicaid Innovation, CMMI). Las CCO son organizaciones basadas en la comunidad que brindan atención a los miembros de Medicaid mediante un modelo de atención coordinada de prestación de servicios que está diseñado para tratar los problemas propios de un sistema de salud fragmentado. Las organizaciones son responsables de los servicios de atención médica física, conductual y odontológica para los miembros de Medicaid. Reciben un presupuesto mensual fijo por parte del estado para coordinar la atención con la flexibilidad necesaria para abordar las necesidades de los miembros que están fuera de los servicios médicos tradicionales; además, reciben incentivos financieros por mejorar los resultados y la calidad.

Oregon continuará con el modelo de CCO en la renovación de demostración propuesta. De acuerdo con su implementación actual, la renovación de demostración seguirá funcionando a nivel estatal y abarcará a los 1.3 millones de residentes de Oregon que actualmente reciben beneficios a través del Plan de Salud de Oregon (Oregon Health Plan, OHP) y propone cambios en los beneficios disponibles para los miembros actuales. Además, la solicitud propone cambios en la elegibilidad que extenderían la cobertura a las personas que,

actualmente, no son elegibles para inscribirse en una CCO. El estado busca renovar esta demostración para el período entre el 1.º de julio de 2022 y el 30 de junio de 2027 de manera que Oregón pueda continuar con su transformación del sistema de salud mediante modificaciones específicas a Medicaid y a los Programas de Seguro Médico para Niños (Children's Health Insurance Program, CHIP) que están en la exención actual. Estas modificaciones permitirán que el estado cumpla sus objetivos generales en línea con la meta triple de mejorar la experiencia del paciente, mejorar la salud y reducir los costos.

El pago mediante una tasa mensual por miembro integra la atención médica física, conductual y odontológica en un canal de financiación, y les brinda a las CCO la flexibilidad en el uso del dinero; al mismo tiempo, mantiene los costos con un límite de crecimiento actual del 3.4%. Por otra parte, el modelo de CCO exige la participación de la comunidad en la toma de decisiones. Los consejeros asesores comunitarios (Community Advisory Council, CAC) de cada CCO involucran a los miembros de las CCO y a otros representantes comunitarios para acordar parte del gasto que pertenece a los fondos flexibles. Los CAC usan las Evaluaciones de salud comunitaria y los Planes de mejora de salud comunitaria para proporcionar una orientación y garantizar la alineación con los hospitales locales y las autoridades de salud pública. En 2017, la renovación de Oregón extendió sus esfuerzos concentrando la inversión ascendente en los determinantes sociales de la salud mediante el uso de servicios relacionados con la salud (Health-Related Services, HRS) que permitieron que las CCO tengan más flexibilidad para pagar servicios no médicos que mejoran los resultados de salud.

Los HRS son servicios no cubiertos por el Plan estatal de Medicaid de Oregón que no son requisitos administrativos y cuyo objetivo es mejorar la provisión de atención y la salud y el bienestar general de los miembros y de la comunidad. Uno de los objetivos de los HRS es proporcionarles a las CCO un mecanismo de financiación específico dentro de sus presupuestos para abordar los determinantes sociales de la salud (Social Determinant of Health, SDOH), incluidas las necesidades sociales relacionadas con la salud de sus miembros. Para que las CCO usen los fondos federales de Medicaid para pagar los servicios, deben cumplir criterios estatales y federales. Los objetivos de los HRS son promover el uso eficiente de los recursos y abordar los determinantes sociales de la salud de los miembros a fin de mejorar los resultados de salud, reducir las inequidades de la salud y mejorar el bienestar general de la comunidad.

A continuación, presentamos los elementos de la demostración actual de la Sección 1115 que proponemos que continúen:

- Contratar a Organizaciones de Atención Coordinada (CCO) para proporcionar servicios de atención médica física, conductual y odontológica a los miembros del Plan de Salud de Oregon de Medicaid
- El uso de una lista de afecciones y tratamientos prioritarios, sujeto a determinadas excepciones para los beneficios protegidos
- El uso de servicios relacionados con la salud
- Limitar la cobertura de los servicios de tratamiento identificados durante la etapa de detección, diagnóstico y tratamiento temprano y periódico (Early and Periodic Screening, Diagnosis and Treatment, EPSDT) a los servicios que coincidan con la lista prioritaria de servicios de salud para las personas mayores de un año

- Definir los tipos de aseguradoras e inscribir de forma obligatoria y automática a las personas en los planes de atención administrada
- Coordinación de la atención para las personas que viven en instituciones para enfermedades mentales (Institutions for Mental Diseases, IMD)

Continuar con los pagos de atención no compensados para el Programa de Centros de Salud Tribales

## Propósito, metas y objetivos

El Oregon Health Authority (OHA) presentará una solicitud de renovación de la versión de demostración 1115(a) del Plan de Salud de Oregon para el período de demostración del 1.º de julio de 2022 al 30 de junio de 2027. Los cambios en las solicitudes de renovación de la demostración actual harán lo siguiente:

- Aumentar el acceso a la cobertura continua del OHP para algunas poblaciones mediante cambios en los procesos actuales de inscripción y los criterios de elegibilidad;
- Definir una serie de paquetes de beneficios de servicios de apoyo para las personas que hacen la transición entre distintos sistemas, entornos de atención médica y etapas de la vida, o debido a eventos puntuales con el objetivo de minimizar las interrupciones en la atención que suelen darse durante estas transiciones;
- Proponer cambios en la metodología utilizada para establecer los índices de capitación que se utilizan para pagarles a las CCO;
- Permitir que las organizaciones gasten el 3% de su índice de capitación mensual por miembro en inversiones para mejorar la equidad en la salud y que estas inversiones se contabilicen como gastos médicos durante el desarrollo de los índices, según lo exigido por el Proyecto de Ley 3353 de la Cámara Legislativa de Oregón 2021;
- Solicitar financiamiento federal para gastos centrados en la mejora de la equidad de la salud, que incluya inversiones para crear una infraestructura que apoye las intervenciones en materia de equidad de la salud, que apoye las intervenciones en materia de equidad de la salud dirigidas por la comunidad y las iniciativas estatales, y que conceda a los colaboradores dirigidos por la comunidad recursos para invertir en equidad de la salud.
- Proporcionarle al estado la capacidad de definir los medicamentos preferidos para los miembros del programa en un esfuerzo por controlar mejor el impacto financiero del aumento en el costo de los medicamentos;
- Cambiar el proceso de selección y funcionamiento de las métricas de incentivo para las CCO a fin de hacer hincapié en la reducción de las inequidades de la salud; y
- Extender los beneficios a los miembros indios americanos o nativos de Alaska del OHP para incluir prácticas tribales como un servicio cubierto, y eximir los criterios de autorización previa para los miembros tribales

Los cambios propuestos en el programa cumplirían las siguientes metas y objetivos:

- Maximizar el acceso continuo y equitativo a la cobertura
- Agilizar las transiciones entre los sistemas mediante paquetes de beneficios definidos de servicios de los determinantes sociales de la salud

- Aumentar la flexibilidad para que las organizaciones de atención coordinada (CCO) inviertan en salud comunitaria y equidad de la salud
- Mejorar la salud mediante inversiones de equidad dirigidas por las comunidades
- Garantizar la calidad y el acceso mediante métricas de desempeño centradas en la equidad
- Estar en línea con las prioridades de los nueve gobiernos tribales de Oregón

## Beneficiarios alcanzados por la demostración

Oregón propone los siguientes cambios para los beneficiarios en función de la demostración:

Población	Criterios	Cambios propuestos
<p>Jóvenes con necesidades especiales de atención médica</p>	<p><i>Adolescentes y jóvenes adultos con una afección conductual, del desarrollo, emocional o física de 17 a 26 años que tengan elegibilidad para el servicio o para Medicaid a través de la Agencia para Personas con Discapacidades (Agency for Persons with Disabilities, APD), los Servicios para Discapacidades del Desarrollo de Oregón (Oregon Developmental Disability Services, ODDS); o bien que se hayan identificado mediante el algoritmo de complejidad médica pediátrica (Pediatric Medical Complexity Algorithm, PMCA); o que se hayan identificado mediante los siguientes indicadores: discapacidades intelectuales o del desarrollo (Intellectual or Developmental Disability, IDD), o indicadores de debilidad o implicancia médica.</i></p>	<p>Los cambios solicitados extenderían esta cobertura hasta los 26 años y harían que estos jóvenes sean elegibles para los servicios diseñados para respaldar el empleo, el desarrollo de las habilidades para la vida y otros beneficios que pretenden ayudar en la transición hacia los beneficios para adultos.</p>
<p>Miembros indios americanos o nativos de Alaska del OHP</p>	<p><i>Miembros del OHP que estén inscritos como indios americanos o nativos de Alaska.</i></p>	<p>Los servicios proporcionados a estos miembros no necesitarían cumplir criterios de autorización previa para los servicios ofrecidos a los miembros tribales en virtud del OHP. Además, la propuesta solicita que algunas prácticas tribales específicas se incluyan como servicios cubiertos para los miembros tribales.</p>

Población	Criterios	Cambios propuestos
Jóvenes bajo custodia que residan en correccionales juveniles (Autoridad Juvenil de Oregón)	<i>Jóvenes bajo custodia que estén en correccionales juveniles (antes y después de la adjudicación) que ingresan con la inscripción actual al OHP o que se inscriben mientras están bajo custodia.</i>	Los jóvenes bajo custodia mantendrían la inscripción continua en el OHP durante el plazo de su custodia, lo que les permitiría acceder a un paquete de servicios de apoyo definidos que los ayudarán en la transición al momento de su liberación. Esto difiere de la demostración actual, que no permite inscribir personas que están bajo custodia hasta que recuperen su libertad.
Adultos encarcelados o bajo custodia del Departamento de Correccionales	<i>Personas que están bajo custodia del Departamento de Correccionales cuya liberación está planificada en el plazo de 90 días o menos, y que cumplen los requisitos de ingresos para Medicaid.</i>	Las personas serían elegibles para inscribirse en el OHP a partir de 90 días antes de su fecha de liberación, lo que les permite acceder a un paquete de servicios de apoyo definidos que los ayudarán en la transición. Esto difiere de la demostración actual, que no permite inscribir personas que están bajo custodia hasta que recuperen su libertad.
Adultos bajo custodia de los centros correccionales locales	<i>Personas bajo custodia que estén en cárceles del condado o centros correccionales locales (antes y después de la adjudicación) que ingresan con la inscripción actual al OHP o que se inscriben mientras están bajo custodia.</i>	No se cancelaría la inscripción en el OHP de las personas que están inscritas en el momento en que quedan bajo custodia de cárceles del condado o centros correccionales locales. Esto difiere de la demostración actual, que suspende la inscripción en el momento del arresto, incluso si no se mantienen los cargos.



Población	Criterios	Cambios propuestos
Personas que residen en el Oregon State Hospital	<i>Personas que están al cuidado del Oregon State Hospital (OSH) que cumplen los criterios de ingresos de Medicaid y cuya fecha de alta planificada es en 90 días o menos.</i>	Las personas que están al cuidado del Oregon State Hospital (OSH) serían elegibles para inscribirse en el OHP a partir de 90 días antes de la fecha del alta. Esto difiere de la demostración actual, que suspende la inscripción en el momento de la admisión.
Personas que residen en Centros Residenciales Psiquiátricos (IMD)	<i>Personas que están al cuidado de un Instituto de Salud Mental (Institute of Mental Disease, IMD) que cumplen los criterios de ingresos de Medicaid y cuya fecha de alta planificada es en 90 días o menos.</i>	Las personas que están al cuidado de un Centro Residencial de Tratamiento Psiquiátrico serían elegibles para inscribirse en el OHP a partir de 90 días antes de la fecha del alta. Esto difiere de la demostración actual, que suspende la inscripción en el momento en que la persona ingresa a este tipo de centro.
Su transición del hogar temporal	<i>Jóvenes que actualmente están inscritos en el OHP y que forman parte del sistema de protección infantil o están en riesgo de formar parte de este sistema, que entran y salen de hogares temporales, incluidos los que son demasiado grandes para estar en el sistema.</i>	Las personas estarían calificadas para recibir servicios de apoyo como vivienda, capacitación en habilidades para la vida, ayuda para el empleo o transporte, incluido el apoyo de pares o la orientación al cambiar de hogar temporal, al cumplir el límite de edad para estar en un hogar temporal o al regresar al hogar natural. Estos servicios no se proporcionan en función de la demostración actual.

Población	Criterios	Cambios propuestos
Miembros que pasan de una cobertura exclusiva de Medicaid a una cobertura de Medicare-Medicaid.	<i>Miembros del OHP actual que tienen elegibilidad doble para Medicare y Medicaid según las determinaciones de elegibilidad del OHP.</i>	Las personas que tienen elegibilidad doble pueden estar calificadas para recibir asistencia adicional en la transición a Medicare, en el acceso a beneficios cuando comienzan a ser elegibles y en la continuidad de los proveedores. Estos servicios no se proporcionan en función de la demostración actual.
Personas vulnerables a acontecimientos climáticos extremos	<i>Personas que están inscritas en un OHP ubicado en una zona afectada por un estado de emergencia declarado debido al cambio climático.</i>	Las personas que están inscritas en un OHP que está ubicado en una zona afectada por un estado de emergencia declarado (p. ej., incendios forestales, calor extremo, inundaciones u otros acontecimientos climáticos) calificarían para recibir servicios adicionales que fueron diseñados para aliviar el impacto negativo para la salud y el bienestar de la persona. Estos servicios no se proporcionan en función de la demostración actual.
Niños menores de 6 años	<i>Personas que cumplen los requisitos de ingresos de Medicaid y tienen entre 0 y 6 años.</i>	Los niños menores de 6 años no estarían obligados a someterse al proceso anual de redeterminación de elegibilidad hasta cumplir los 6 años, por lo que tendrían una inscripción continua en el OHP. Esto difiere de la demostración actual, que exige una redeterminación anual de la elegibilidad.

Población	Criterios	Cambios propuestos
Personas mayores de 6 años	<i>Miembros del OHP inscritos actualmente que cumplen los criterios de ingresos de Medicaid y son mayores de 6 años.</i>	Las personas inscritas en el OHP deberían someterse a una redeterminación de la elegibilidad cada 24 meses en lugar de cada 12 meses, como ocurre con la demostración actual.
Todos los demás miembros del OHP	<i>Cualquier persona que actualmente reciba beneficios del OHP.</i>	Las personas que reciben medicamentos recetados en función del Plan de Salud de Oregon pueden ver algunos cambios en los medicamentos preferidos del plan.
Personas elegibles para el Programa Suplementario de Asistencia Nutricional (Supplemental Nutrition Assistance Program, SNAP) que no están inscritas en el OHP actualmente	<i>Personas que cumplen los criterios de ingresos de Medicaid y que actualmente están inscritas en los beneficios del SNAP.</i>	Las personas que son elegibles para el Programa Suplementario de Asistencia Nutricional serían evaluadas para la elegibilidad del OHP y se les ofrecería una inscripción agilizada usando los criterios de ingresos ya establecidos durante la inscripción en el SNAP. Esto difiere de la demostración actual, que revisa la elegibilidad de una persona para el OHP y para el SNAP por separado.

No se solicita ningún otro cambio en los criterios de elegibilidad.

## Sistema de provisión y requisitos de elegibilidad

Oregón propone mantener el modelo de Organizaciones de Atención Administrada (CCO) para la provisión de los servicios. Se seguirá contratando a las CCO para que presten servicios de salud física, conductual y odontológica para los miembros elegibles. Los requisitos de elegibilidad seguirán siendo los mismos, a excepción de los cambios descritos anteriormente.

## Cambios en los beneficios y la cobertura

Los beneficios para los miembros del OHP que están definidos en el Plan Estatal no cambiarán. Habrá beneficios adicionales disponibles para las personas que califiquen en función de los cambios en la elegibilidad descritos anteriormente, que incluyen los siguientes:

Cambios propuestos	Programa actual
Cobertura de un conjunto de servicios específicos para respaldar a los miembros que están atravesando una transición de la atención entre sistemas, entre entornos y durante acontecimientos de la vida	Algunos servicios de esta propuesta se encuentran disponibles en las CCO como servicios relacionados con la salud, pero no se consideran un servicio cubierto
La disponibilidad de algunos servicios prestados por pares se extendió para incluir la cobertura de servicios antes de desarrollar un plan de tratamiento y después de haberlo completado	Los servicios prestados por pares se consideran servicios cubiertos cuando se realizan bajo la supervisión de un proveedor certificado y se incluyen en el plan de tratamiento del miembro
Flexibilidad para excluir los medicamentos cuya eficacia clínica sea limitada o inadecuada, con la posibilidad de incluir la cobertura de medicamentos no preferidos	El estado no tiene la capacidad de excluir la cobertura de los medicamentos aprobados

No se solicita ningún otro cambio en los beneficios.

## Requisitos de costo compartido

No se solicita ningún cambio en los requisitos de costo compartido. El OHP no exige costos compartidos.

## Cálculo del cambio esperado en la inscripción anual y los gastos anuales

Datos históricos (período de la exención actual)					
	Año fiscal estatal 2018	Año fiscal estatal 2019	Año fiscal estatal 2020	Año fiscal estatal 2021	Año fiscal estatal 2022
Inscripción total	856,262	857,297	879,157	1,005,122	1,131,501
Gastos totales	\$6,258,934,391	\$6,597,659,631	\$7,073,711,147	\$7,784,273,070	\$9,555,087,914

Período de renovación de la demostración					
	Año fiscal estatal 2023	Año fiscal estatal 2024	Año fiscal estatal 2025	Año fiscal estatal 2026	Año fiscal estatal 2027
Inscripción total proyectada	1,019,073	1,123,740	1,132,032	1,134,884	1,115,832
Gasto total proyectado	\$10,007,172,653	\$11,620,080,436	\$12,088,770,684	\$12,537,125,292	\$12,556,399,420

## Hipótesis y parámetros de evaluación

El estado propone cambios en lo que se evaluará con esta exención, que son similares a lo que se está evaluando en virtud de la demostración actual. A continuación, se describen los cambios:

### P1. ¿Reducirán las intervenciones propuestas en la renovación de la exención 1115 las inequidades de la salud en función de la raza y etnia?

#### Hipótesis n.º 1:

La redistribución del poder y los recursos a las personas y comunidades que se han visto más afectadas por el racismo histórico y contemporáneo dará como resultado mejoras en las inequidades de la salud y las medidas de autonomía, estado de salud y calidad de vida informadas por las personas.

#### Hipótesis n.º 2:

El uso de la nueva estructura de toma de decisiones para seleccionar y hacer funcionar las métricas de incentivo para las CCO dará como resultado mayores mejoras en las inequidades de la salud en función de la raza o etnia que lo que ocurría con la estructura de toma de decisiones vigente durante la exención de 2012 a 2017.

### P2. ¿Mejorará la cobertura continua los resultados de salud?

#### Hipótesis n.º 3:

Una inscripción más temprana en el OHP con menos interrupciones en la cobertura para las poblaciones vulnerables significará que más personas recibirán atención en los entornos adecuados, lo que mejorará su estado de salud y calidad de vida.

#### Hipótesis n.º 4:

Ofrecer paquetes de servicios de apoyo de SDOH a las personas que están atravesando una transición es más eficaz para mejorar la integración y lograr así una transición exitosa que solo ofrecer servicios individuales.

**P3. ¿Aumenta la nueva metodología de desarrollo de índices para un presupuesto basado en el valor el gasto de las CCO en inversiones comunitarias a fin de reducir las inequidades de la salud?**

**Hipótesis n.º 5:**

Ofrecer un presupuesto predecible, sobre la base de un método agilizado con un crecimiento de costos predecible, permite tener mayor claridad en torno a los fondos disponibles para la reinversión de las CCO en la comunidad local y aumenta las inversiones comunitarias.

**Hipótesis n.º 6:**

Ofrecer un presupuesto predecible, sobre la base de un método agilizado con un crecimiento de costos predecible, permite que los socios de la comunidad trabajen de forma más eficaz con las CCO a fin de cumplir las necesidades de servicios de apoyo de SDOH que tienen los miembros.

## Autoridades de exención y gastos solicitadas para la demostración

Oregón solicita continuar con las siguientes autoridades de exención y gastos que se usaron durante la demostración actual:

Autoridad de exención	Uso de la exención
Sección 1115(a)	Continuación del Programa de Atención Tribal no Compensada (Tribal Uncompensated Care Program, UCCP)
Título 42, Secc. 438.56 del Código de Regulaciones Federales (Code of Federal Regulations, CFR)	<ul style="list-style-type: none"> <li>• Permitir que los inscritos que tienen elegibilidad doble a través de Medicare y Medicaid cancelen su inscripción en las CCO sin causa en cualquier momento</li> <li>• Contratar a entidades de atención administrada y aseguradoras que operen a nivel local</li> <li>• Ofrecer beneficios que coincidan con una lista de afecciones y tratamientos prioritarios, sujeto a determinadas excepciones para los beneficios protegidos</li> <li>• Limitar la cobertura de los servicios de tratamiento identificados durante la etapa de detección, diagnóstico y tratamiento temprano y periódico (Early and Periodic Screening, Diagnosis and Treatment, EPSDT) a los servicios que coincidan con la lista prioritaria de servicios de salud para las personas mayores de un año</li> <li>• Definir los tipos de aseguradoras e inscribir de forma obligatoria y automática a las personas en los planes de atención administrada</li> <li>• No hacer pagos de hospitales compartidos desproporcionados por los inscritos en atención administrada</li> <li>• En general, permitir que las organizaciones de atención coordinada limiten los períodos en los que los inscritos pueden cancelar su inscripción</li> <li>• Proporcionar cobertura para determinados servicios relacionados con la dependencia de sustancias químicas para beneficiarios específicos</li> <li>• Recibir una participación financiera federal para determinados programas de atención médica financiados por el estado</li> </ul>

Además de la autoridad de exención existente de Oregón, el estado trabajará con los CMS para determinar si necesita una mayor autoridad de exención que le permita hacer lo siguiente:

<b>Autoridad de exención</b>	<b>Uso de la exención</b>	<b>Motivo de la solicitud de exención</b>
Título 42, Secc. 435.916 del CFR	Autoridad de gastos que permita que el estado implemente una inscripción continua.	Esto permite que el estado solicite la participación financiera federal para la inscripción constante de niños sin tener en cuenta si sus ingresos superan los límites de elegibilidad y proporcionar la inscripción continua en el OHP hasta su sexto cumpleaños (de 0 a 5 años)
Título 42, Secc. 435.916 del CFR	Autoridad de gastos que permita que el estado implemente una inscripción continua.	Esto permite que el estado exima los requisitos de redeterminación anual con respecto a la elegibilidad de los ingresos y que establezca una inscripción continua en el OHP durante dos años para las personas mayores de seis años
Título 42, Secc. 438.8, y Título 42, Secc. 438.74 del CFR  Título 45, Secc. 158.150, o Título 45, Secc. 158.151 del CFR	Permitir que los servicios con la salud se contabilicen en el numerador del Índice de Pérdidas Médicas (Medical Loss Ratio, MLR).	Esto permite que el estado contabilice los servicios relacionados con la salud que cumplan los requisitos en el numerador del Índice de Pérdidas Médicas al evaluar los informes financieros de las CCO
	Autoridad de gastos que permita que el estado utilice la información de elegibilidad del SNAP como base para determinar la inscripción en Medicaid	Esto permite que el estado proporcione una vía de inscripción acelerada para las personas que solicitan los beneficios del SNAP y son elegibles para este programa.



<b>Autoridad de exención</b>	<b>Uso de la exención</b>	<b>Motivo de la solicitud de exención</b>
	Autoridad de gastos para las iniciativas relacionadas con la salud financiadas por el estado.	Esto permite que el estado solicite una nueva inversión federal centrada en la mejora de la equidad de la salud, que incluya inversiones para crear una infraestructura que apoye las intervenciones en materia de equidad de la salud; apoye las intervenciones en materia de equidad de la salud dirigidas por la comunidad y las iniciativas estatales; conceda a los colaboradores dirigidos por la comunidad recursos para invertir en equidad de la salud.
	Autoridad de gastos para financiar los pagos a proveedores y organizaciones comunitarias para el desarrollo de infraestructura y capacidades.	Esto permite que el estado solicite inversiones generales para colaboraciones de inversión comunitaria a fin de respaldar las capacidades de implementación a nivel comunitario, incluidos los pagos para la infraestructura y el desarrollo de capacidades de proveedores y organizaciones comunitarias (Community-Based Organizations, CBO).
	Autoridad de gastos para financiar los servicios relacionados con la salud para personas durante determinadas transiciones de su vida.	Esto permite que el estado solicite financiamiento adicional para un conjunto de servicios de transición de SDOH específicos que permitan respaldar a los miembros que lo necesiten durante la transición en períodos de cobertura y transiciones de la vida.
	Autoridad de gastos para los servicios de Medicaid prestados a personas que residen en una institución.	Esto eximiría de la norma federal que impide la cobertura de Medicaid para una persona detenida, incluidas las poblaciones implicadas en la justicia y las que se encuentran en el Oregon State Hospital y en centros residenciales psiquiátricos y permite que el estado solicite la participación con fondos federales para la inscripción de personas bajo custodia.

Autoridad de exención	Uso de la exención	Motivo de la solicitud de exención
	Autoridad de gastos para los servicios de Medicaid prestados a personas que residen en una institución.	Esto permite que el estado cubra algunos costos de servicios médicos para un miembro que está bajo custodia a través de Medicaid, incluidas las poblaciones implicadas en la justicia y las que se encuentran en el Oregon State Hospital y en centros residenciales psiquiátricos.
Secciones 1902(a)(10) y 1902(a)(17)	Exención de comparabilidad para permitir que el estado ofrezca beneficios adicionales a los YSHCN hasta los 26 años.	Esto permite que el estado mantenga los niveles de elegibilidad de los niños y el paquete de beneficios para los jóvenes con necesidades especiales de atención médica (Youth with Special Health Care Needs, YSHCN) hasta los 26 años.
Secciones 1902(a)(10) y 1902(a)(17)	Autoridad de gastos para cubrir a los YSHCN hasta los 26 años hasta el <b>305%</b> del nivel federal de pobreza, que de otro modo no serían elegibles para Medicaid.	Esto permitiría que el estado solicite la participación con fondos federales para los jóvenes con necesidades especiales de atención médica (YSHCN) hasta los 26 años.
	Autoridad de gastos para los servicios prestados por trabajadores de salud tradicionales, incluidos los trabajadores de la salud comunitarios, los guías de salud personales, los especialistas de apoyo entre pares y las doulas.	Esto permite que el estado extienda y financie los servicios prestados por trabajadores de salud tradicionales fuera de los entornos aprobados actualmente.
Título 42, Secc. 438.5 del CFR	Autoridad de gastos para pagar los índices de capitación creados con desviaciones específicas de los estándares de desarrollo de índices descritos en el Título 42, Sección 438.5, del CFR.	Esto permite que el estado solicite cambios en la metodología utilizada para crear los índices de capitación mensuales por miembro que se pagan a las CCO para la prestación de atención a sus miembros.

Autoridad de exención	Uso de la exención	Motivo de la solicitud de exención
Sección 1902(a)(54); Sección 1927(d)(1)(B); Sección 1902(a)(14); Sección 1916 y 1916A; Sección 1902(a)(23)(A)	Exención de los requisitos de restricción de cobertura permitidos para los medicamentos para pacientes ambulatorios, específicamente los de la Sección 1902(a)(54) en tanto que incorpore la Sección 1927(d)(1)(B); Sección 1902(a)(14) en tanto que incorpore la Sección 1916 y 1916A; Sección 1902(a)(23)(A).	Esto permite que el estado defina una lista de medicamentos preferidos y que excluya los medicamentos no comprobados o de poco valor, en función de su eficacia clínica.
	Autoridad de gastos para financiar los servicios relacionados con la salud para miembros que están atravesando determinadas transiciones de su vida.	Esto permite que el estado obtenga un aporte compensatorio federal para fondos de Medicaid gastados para atender los determinantes sociales de la salud (SDOH) de miembros del OHP que atraviesen transiciones específicas en su vida.
Título 42, Secc. 438.5 del CFR	Autoridad de gastos para pagar los índices de capitación creados con desviaciones específicas de los estándares de desarrollo de índices descritos en el Título 42, Sección 438.5, del CFR.	Esto permite que el estado tenga autoridad para contabilizar las inversiones de las CCO en equidad de la salud que exige el Proyecto de Ley 3353 como reclamaciones médicos o gastos de mejora de calidad a los fines de establecer los índices de las CCO.

**Accesibilidad a los documentos:** para las personas con discapacidades o personas que hablan un idioma que no es inglés, el OHA puede proporcionar información en formatos alternativos, como traducciones, letra grande o braille. Comuníquese con el Programa de socio comunitario de extensión en [community.outreach@dhsosha.state.or.us](mailto:community.outreach@dhsosha.state.or.us) o bien llame al 1-833-647-3678. Aceptamos todas las llamadas por servicio de retransmisión o puede marcar el 711.

**Abbreviated Notice for Section 1115 Amendment and Renewal****OREGON HEALTH AUTHORITY****ABBREVIATED PUBLIC NOTICE REQUEST FOR  
COMMENTS AND NOTICE OF PUBLIC HEARINGS ON  
PROPOSED SECTION 1115 DEMONSTRATION AMENDMENT AND  
RENEWAL APPLICATION**

This abbreviated public notice provides information of public interest regarding a proposed amendment and renewal request to the federal Centers for Medicare & Medicaid Services (CMS) for the Oregon Health Plan (OHP) Section 1115 demonstration by the Oregon Health Authority (OHA). OHA is seeking this demonstration approval to implement key provisions.

The Section 1115 demonstration will amend and renew the Oregon Health Plan demonstration, currently in effect through June 30, 2022. The effective term of the proposed amendment and renewal for the OHP Section 1115 demonstration is July 1, 2022, to June 30, 2027. All proposed requests are subject to approval by CMS.

A copy of the proposed OHP Section 1115 demonstration and initial notice of public interest, both posted on Dec 1, 2021, is available on the OHA website at <https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx>

The proposal is posted on the OHA website at: <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Renewal-Application.pdf>

Following are the elements of the current Section 1115 demonstration that are proposed to continue:

- Contracting with Coordinated Care Organizations (CCOs) to provide physical, behavioral, and oral health services to Medicaid Oregon Health Plan members
- The use of the prioritized list of conditions and treatments, subject to certain exceptions for protected benefits
- The use of Health Related Services
- Restrict coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one
- Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans
- Care Coordination for individuals residing in institutions for mental diseases (IMDs)
- Continue Uncompensated Care payments for Tribal Health Facility Program

Following are the elements that are proposed for inclusion under the OHP Section 1115 demonstration:

- Increase access to continuous OHP coverage for some populations by proposing changes to the current enrollment processes and eligibility criteria;

## Abbreviated Notice for Section 1115 Amendment and Renewal

- Define a series of benefit packages of supportive services for individuals experiencing transitions across different systems, across health care settings, and across life stages or due to point-in-time events with the goal of minimizing the disruptions in care that often occur during these transitions;
- Propose changes to the methodology used to set capitation rates that are used to pay CCOs;
- Allow CCOs to spend 3% of their per-member per-month capitation rate on investments to improve health equity and for those investments to be counted as medical expenses during rate development as required by House Bill 3353 from the 2021 Oregon Legislative Session;
- Provide the state with the ability to define preferred drugs for OHP members in an effort to better control the financial impact of rising drug costs;
- Change the process for selecting and operationalizing CCO incentive metrics to focus on reducing health inequities;
- Expand benefits for American Indian/Alaska Native OHP members to include Tribal-based practices as a covered service, and waive prior authorization criteria for tribal members;

Following are the elements of the current Section 1115 demonstration that will or have sunset and are not included for renewal under the Section 1115 demonstration.

- Hospital Transformation Performance Program (HTPP)

### PUBLIC REVIEW AND COMMENTS

The public is invited to give written and verbal comments on the draft waiver application from December 7, 2021 through January 7, 2022. The deadline for commenting is January 7, 2022, 11:59 PM, Pacific Time. The public may provide verbal or written comments. All public comments received by OHA will be posted at [Oregon.gov/1115WaiverRenewal](https://www.oregon.gov/1115WaiverRenewal).

OHA will host the following public hearings to solicit stakeholder comments. The public hearings will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

#### **Oregon Health Policy Board**

Dec. 7, 2021 | 8:30 a.m.- 12 p.m.

Join Meeting:

<https://www.zoomgov.com/j/1602657497?pwd=emhzUnJsK1EzWk5rV0VpYTdjU3VrQT09>

One tap mobile: [+16692545252](tel:+16692545252), [1602657497](tel:+1602657497)#,.....,0#,.,306554#

If you need help or accommodations, please contact Tara Chetock at 971-304-9917 or [tara.a.chetock@dhs.oha.state.or.us](mailto:tara.a.chetock@dhs.oha.state.or.us) at least 48 hours before the meeting.

#### **Community Partner meeting (en español)**

Dec. 9, 2021 | 3:30 p.m. – 5:30 p.m.

Join meeting: <https://us02web.zoom.us/join/1602657497>

**Abbreviated Notice for Section 1115 Amendment and Renewal****Health Equity Committee**

Dec. 9, 2021 | 12 p.m. – 2 p.m.

Microsoft Teams meeting [Click here to join the meeting](#)

Or call in (audio only)

One tap mobile: [+1 971-277-2343,,928637902#](#)

Phone Conference ID: 928 637 902#

If you need help or accommodations, please contact Maria Castro at 503-884-4448 or [maria.castro@dhsola.state.or.us](mailto:maria.castro@dhsola.state.or.us) at least 48 hours before the meeting.**Medicaid Advisory Committee**

Dec. 15, 2021 | 9 a.m. – 12 p.m.

Microsoft Teams meeting [Click here to join the meeting](#)

Or call in (audio only)

One tap mobile: [+1 971-277-2343,,243372877#](#) Phone Conference ID: 243 372 877#If you need help or accommodations, please contact Jackie Wetzel at 503-580-5603 or [Jackie.Wetzel@dhsola.state.or.us](mailto:Jackie.Wetzel@dhsola.state.or.us) at least 48 hours before the meeting.**Designing the future of OHP - Workshop 3**

Dec. 16, 2021 | 5:30 PM-7:30 PM

Register in advance for this meeting:

[https://www.zoomgov.com/meeting/register/vJlsc--spjogHteaw5dXCTUmWwDVE\\_7NgDU](https://www.zoomgov.com/meeting/register/vJlsc--spjogHteaw5dXCTUmWwDVE_7NgDU)If you need help or accommodations, please contact Michelle Hatfield at 503-551-3881 or [michelle.m.hatfield@dhsola.state.or.us](mailto:michelle.m.hatfield@dhsola.state.or.us) at least 48 hours before the meeting.**Community Partner meeting**

Dec. 17, 2021 | 10:30 a.m. – 12:30 p.m.

Join meeting: <https://us02web.zoom.us/j/6trD8sEtHdQadI0abTNYkZVpihdfJ>**Oregon Health Policy Board**

Jan. 4, 2022 | 8:30 a.m. – 12 p.m.

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1609166382?pwd=Ulp0eis5bUZPeUNQdWM3VU9aMnZwQT09>

Meeting ID: 160 916 6382 Passcode: 912812

One tap mobile +16692545252,,1609166382# ,, 0#,,912812# US (San Jose)

If you need help or accommodations, please contact Tara Chetock at 971-304-9917 or [tara.a.chetock@dhsola.state.or.us](mailto:tara.a.chetock@dhsola.state.or.us) at least 48 hours before the meeting.

Beginning December 7, 2021, written comments can be emailed to [1115Waiver.Renewal@dhsola.state.or.us](mailto:1115Waiver.Renewal@dhsola.state.or.us), submitted through [Oregon.gov/1115WaiverRenewal](https://oregon.gov/1115WaiverRenewal), or sent via mail to:

Health Policy and Analytics Medicaid Waiver Renewal Team  
Attn: Michelle Hatfield

**Abbreviated Notice for Section 1115 Amendment and Renewal**

500 Summer St. NE, 5th Floor, E65  
Salem, OR 97301

To be assured consideration prior to submission of the Section 1115 demonstration application to CMS, comments must be received no later than 11:59 PM (Pacific Time) on January 7, 2022.

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

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@dhsosha.state.or.us](mailto:community.outreach@dhsosha.state.or.us) or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.

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## Public comment period on Medicaid waiver renewal to start Dec. 7

The Oregon Health Authority and Department of Human Services sent this bulletin at 12/01/2021 04:48 PM PST

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**Dec. 1, 2021**

**Contact:** Philip Schmidt (503) 383-6079 (media), meeting info and accommodations contacts listed below.

## Public comment period on Medicaid waiver renewal to start Dec. 7

**What:** OHA is seeking the public's input on 1115 Medicaid Demonstration waiver renewal application. The public is invited to give input on the draft waiver application Dec. 7, 2021 through Jan. 7, 2022. Details on meetings and how to comment are below.

[The draft application is available here.](#)

For people unable to attend a meeting, or who prefer to submit comments in writing, they can be sent to [1115Waiver.Renewal@dhs.oha.state.or.us](mailto:1115Waiver.Renewal@dhs.oha.state.or.us), via this form <https://tinyurl.com/OHPWaiverSurvey> or send them via mail to:

Health Policy and Analytics Medicaid Waiver Renewal Team

Attn: Michelle Hatfield

500 Summer St. NE, 5th Floor, E65



Salem, OR 97301

**Agenda:** At each meeting, OHA staff will give an overview of the waiver application followed by an opportunity for community members to give public comment.

## Meeting details:

- **Dec. 7, 2021, 8:30 a.m.- 12 p.m Oregon Health Policy Board**
  - [Click here to join the meeting](#) one tap mobile:+16692545252,,1602657497#,,,,,0#,,306554#.
  - Meeting info, accommodations: Tara Chetock, [tara.a.chetock@dhsoha.state.or.us](mailto:tara.a.chetock@dhsoha.state.or.us), 971-304-9917
- **Dec. 9, 2021, 3:30 p.m. – 5:30 p.m. Community Partner meeting (en español)**
  - [Click here to join the meeting](#).
  - Meeting info, accommodations: Ruby Graven, [community.outreach@dhsoha.state.or.us](mailto:community.outreach@dhsoha.state.or.us), 503-884-1175
- **Dec. 9, 2021, 12 p.m. – 2 p.m. Health Equity Committee meeting (Public forum only – no presentation)**
  - [Click here to join the meeting](#) Or call in (audio only) +1 971-277-2343,,928637902# Phone Conference ID: 928 637 902
  - Meeting info, accommodations: Maria Castro, [maria.castro@dhsoha.state.or.us](mailto:maria.castro@dhsoha.state.or.us), 503-884-4448
- **Dec. 15, 2021, 9 a.m. – 12 p.m. Medicaid Advisory Committee meeting**
  - [Click here to join the meeting](#) Or call in (audio only) +1 971-277-2343,243372877# Phone Conference ID: 243 372 877#.
  - Meeting info, accommodations: Jackie Wetzel, [Jackie.wetzel@dhsoha.state.or.us](mailto:Jackie.wetzel@dhsoha.state.or.us), 503-580-5603
- **Dec. 16, 2021, 5:30 p.m. -7:30 p.m. Designing the future of OHP - Workshop 3**
  - Register in advance for this meeting: [Click here to register](#).
  - Meeting info, accommodations: Michelle Hatfield, [michelle.m.hatfield@dhsoha.state.or.us](mailto:michelle.m.hatfield@dhsoha.state.or.us), 503-551-3881.
- **Dec. 17, 2021, 10:30 a.m. – 12:30 p.m. Community Partner meeting**
  - [Click here to join the meeting](#).
  - Meeting info, accommodations: Ruby Graven, [community.outreach@dhsoha.state.or.us](mailto:community.outreach@dhsoha.state.or.us), 503-884-1175
- **Jan. 4, 2022, 8:30 a.m. – 12 p.m. Oregon Health Policy Board Meeting**
  - [Click here to join the meeting](#) Meeting ID: 160 916 6382 Passcode: 912812 One tap mobile +16692545252,,1609166382# ,, 0#,,912812.
  - Meeting info, accommodations: Tara Chetock, [tara.a.chetock@dhsoha.state.or.us](mailto:tara.a.chetock@dhsoha.state.or.us), 971-304-9917.

**Background:** Over the past year, OHA has been developing a shared vision from a diverse range of health care and community voices for changes to the Medicaid system – often referred to as the Oregon Health Plan (OHP). The vision for those proposals are outlined in a series of five policy concept papers, linked below. Based on the concept papers, OHA has developed a draft waiver application which formally proposes the concepts to the federal government. OHA is seeking public comment on the draft application during the Dec. 7, 2021 to Jan. 7, 2022 period.

**[Draft Medicaid waiver application](#)**

Final concept papers:

[Maximizing continuous and equitable access to coverage](#)

[Improving health outcomes by streamlining life and coverage transitions](#)

[Moving to a value-based global budget](#)

[Incentivizing Equitable Care](#)

[Improving health through focused equity investments led by communities](#)

###

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- Sign language and spoken language interpreters.
- Written materials in other languages.
- Braille.
- Large print.
- Audio and other formats.

If you need help or have questions, please contact the meeting information/accommodations contact listed below each meeting by phone or their email at least 48 hours before the meeting. OHA accepts all relay calls.



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Oregon Health Plan 1115 Demonstration Waiver – Application for Renewal 2022-2027  
Project Numbers 11-W-00160/10 & 21-W-00013/10

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## **CORRECTED: Oregon Health Policy Board meets December 7 via Zoom**

The Oregon Health Authority and Department of Human Services sent this bulletin at 12/01/2021 05:08 PM PST

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**December 1, 2021**

**Contacts:** Philip Schmidt, [503-383-6079](tel:503-383-6079), [philip.schmidt@dhsaha.state.or.us](mailto:philip.schmidt@dhsaha.state.or.us)  
(media inquiries)

Tara Chetock, 971-304-9917, [tara.a.chetock@dhsaha.state.or.us](mailto:tara.a.chetock@dhsaha.state.or.us) (meeting information or accommodation)

## **Oregon Health Policy Board meets December 7 via Zoom**

**What:** A public meeting of the Oregon Health Policy Board.

**When:** December 7, 8:30 a.m. to noon.

**Where:** Virtual meeting only. The public can join remotely via Zoom or a conference line. To join via Zoom: <https://www.zoomgov.com/j/1602657497?pwd=emhzUnJsK1EzWk5rV0VpYTdjU3VrQT09>

To call in to the meeting on a mobile device, use the following number:

+16692545252,,1602657497#,,,,,,0#,,306554# US (San Jose)

**Proposed Agenda Topics:**

1. Welcome, Roll Call, and Minutes Approval
2. Oregon Health Authority Director’s Update
3. Oregon Health Policy Board Committee Liaison Updates
4. Committee Membership Workgroup Request
5. Health Equity Committee: Proposed Membership Slate
6. OHA 1115 Medicaid Waiver: [Draft Application](#) and Public Comment Process
7. Public Comment\*

\*To provide public comment, please submit your [request for public comment](#) at least 48 hours prior to the meeting at: <https://www.surveymonkey.com/r/OHPB-Public-Comment>

For more information and meeting materials, please visit the OHPB [meeting webpage](#) at <https://www.oregon.gov/oha/OHPB/Pages/OHPB-Meetings.aspx>

###

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If you need help or have questions, please contact Tara Chetock at 971-304-9917, 711 TTY, [tara.a.chetock@dhs.oha.state.or.us](mailto:tara.a.chetock@dhs.oha.state.or.us), at least 48 hours before the meeting.



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## Workshop 3: Designing the future of OHP – Oregon’s next 1115 Medicaid Waiver

The Oregon Health Authority and Department of Human Services sent this bulletin at 12/08/2021 04:03 PM PST

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## Workshop 3: Designing the future of OHP – Oregon’s next 1115 Medicaid Waiver

Please join the Oregon Health Authority (OHA) for the final workshop on Oregon’s upcoming Medicaid waiver application to continue to transform the Oregon Health Plan (OHP) in coming years. Workshop three is intended to introduce the draft waiver application, and provide time for more detailed feedback and input.

**Date and time:** Thursday, December 16, 5:30 to 7:30 p.m.

[View the full agenda](#)

[Click here to register for OHA's December 16 workshop](#)

OHA released the draft waiver application and a summary public notice on December 1. They are linked here.

- [Draft application](#)
- [Public notice](#)

You can also read about the policy concepts that are the basis of the application in plain language. These summaries are in "Policy Concepts" section on the waiver webpage [Oregon.gov/1115WaiverRenewal](http://Oregon.gov/1115WaiverRenewal).

**If you are unable to attend this workshop, you are welcome to submit written**

**comment** via email to [1115Waiver.Renewal@dhsoha.state.or.us](mailto:1115Waiver.Renewal@dhsoha.state.or.us), or using this form at <https://tinyurl.com/OHPWaiverSurvey>. You can also mail a comment to:

OHA Health Policy and Analytics  
Medicaid Waiver Renewal Team  
Attn: Michelle Hatfield 500 Summer St. NE, E65  
Salem, OR 97301

**To learn more:**

More information about the waiver application process can be found at [Oregon.gov/1115WaiverRenewal](http://Oregon.gov/1115WaiverRenewal). You can also read [OHA's 1115 Waiver fact sheet](#).

**Questions?**

If you have questions about this event, please reach out to [1115Waiver.Renewal@dhsoha.state.or.us](mailto:1115Waiver.Renewal@dhsoha.state.or.us).

**Meeting accommodation**

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help or have questions, please email [1115Waiver.Renewal@dhsoha.state.or.us](mailto:1115Waiver.Renewal@dhsoha.state.or.us).

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## Medicaid Advisory Committee - Wednesday Dec 15, 2021

The Oregon Health Authority and Department of Human Services sent this bulletin at 12/09/2021 01:58 PM PST

### Medicaid Advisory Committee Meeting Wednesday, December 15, 2021 9am-Noon

**What:** The monthly public meeting of the Medicaid Advisory Committee (MAC) will take place via Microsoft Teams.

**Agenda:**

1. Welcome and approval of October MAC meeting minutes
2. 1115 Waiver Renewal – Draft Application Summary
3. Public Comment – 1115 Waiver Application
4. REALD Implementation
5. Health Information Technology Oversight Council (HITOC): Strategic Plan Update and Community Information Exchange
6. Committee REALD Data Request

**When:** Wednesday December 15, 2021 from 9:00am – 12:00pm.

Public comment will take place immediately after each agenda item; this is in addition to the dedicated time on the agenda for public comment on the 1115 waiver.

**Public Comment on the 1115 Waiver Application:** If you would like to provide public comment on the 1115 Waiver during the MAC meeting on 12/15/21, please sign up here: <https://tinyurl.com/OHPWaiverSurvey>.

The sign-up process includes a brief survey with optional questions, and this information will be kept confidential. OHA will use the survey to plan focused outreach to groups we have not received input from. If you'd like to review the draft waiver application or learn more about the Waiver process and opportunities for input, you can explore our webpage: [Oregon.gov/1115WaiverRenewal](https://Oregon.gov/1115WaiverRenewal)

### Microsoft Teams meeting

**Join on your computer or mobile app**

[Click here to join the meeting](#)

**Or call in (audio only)**

+1 971-277-2343,,243372877# United States, Portland

Phone Conference ID: 243 372 877#

Oregon's [Medicaid Advisory Committee](#) is a federally mandated body which advises the State Medicaid Director, the Oregon Health Authority (OHA), the Oregon Health Policy Board (OHPB) and the Department of Human Services (DHS) on the policies, procedures, and operation of Oregon's Medicaid program through a consumer and community lens. The MAC develops policy recommendations at the request of the governor, the legislature and OHA.

# # #

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help or have questions, please contact Jackie Wetzel at 503-580-5603 711 TTY or [jackie.wetzel@state.or.us](mailto:jackie.wetzel@state.or.us) at least 48 hours before the meeting.



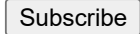
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## Oregon Health Policy Board meets January 4 via Zoom

The Oregon Health Authority and Department of Human Services sent this bulletin at 12/30/2021 11:45 AM PST

Having trouble viewing this email? [View it as a Web page.](#)



**December 30, 2021**

**Contacts:** Philip Schmidt, [503-383-6079](tel:503-383-6079), [philip.schmidt@dhsoha.state.or.us](mailto:philip.schmidt@dhsoha.state.or.us)  
(media inquiries)

Tara Chetock, 971-304-9917, [tara.a.chetock@dhsoha.state.or.us](mailto:tara.a.chetock@dhsoha.state.or.us) (meeting information or accommodation)

## Oregon Health Policy Board meets January 4 via Zoom

**What:** A public meeting of the Oregon Health Policy Board.

**When:** January 4, 8:30 a.m. to noon.

**Where:** Virtual meeting only. The public can join remotely via Zoom or a conference line. To join via Zoom: <https://www.zoomgov.com/j/1609166382?pwd=Ulp0eis5bUZPeUNQdWM3VU9aMnZwQT09>

To call in to the meeting on a mobile device, use the following number:

+16692545252,,1609166382# ,, 0#,,912812# US (San Jose)

### Proposed Agenda Topics:

Oregon Health Plan 1115 Demonstration Waiver – Application for Renewal 2022-2027  
Project Numbers 11-W-00160/10 & 21-W-00013/10

1. Welcome, Roll Call, and Minutes Approval
2. Oregon Health Authority (OHA) Director's Update
3. OHA Behavioral Health Updates
4. Public Comment\*
5. Oregon's Health Care Reform Roadmap
6. Cost Growth Target Program Updates
7. OHA 1115 Medicaid Waiver Updates
8. OHA 1115 Medicaid Waiver Public Comments\*\*

\*To provide public comment, please submit your [request for public comment](#) at least 48 hours prior to the meeting at: <https://www.surveymonkey.com/r/OHPB-Public-Comment>

\*\*To provide public comments for the 1115 Medicaid Wavier, please complete the general public comment registration above(\*) AND the 1115 Medicaid Waiver public comment registration at: <https://tinyurl.com/OHPWaiverSurvey>

For more information and meeting materials, please visit the OHPB [meeting webpage](#) at <https://www.oregon.gov/oha/OHPB/Pages/OHPB-Meetings.aspx>

###

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- CART (live captions)
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help or have questions, please contact Tara Chetock at 971-304-9917, 711 TTY, [tara.a.chetock@dhs.oha.state.or.us](mailto:tara.a.chetock@dhs.oha.state.or.us), at least 48 hours before the meeting.



You are subscribed to Oregon Health Authority News Releases. [View all OHA news releases.](#)

**From:** [Graven Ruby](#)  
**Subject:** Envíe sus comentarios  
**Date:** Tuesday, November 9, 2021 6:47:00 PM  
**Attachments:** [Spanish Nov Medicaid Waiver update for collabs.pdf](#)  
**Importance:** High

---

La Oregon Health Authority (OHA, por sus siglas en inglés) publica los conceptos finales de la política de exención 1115!

Socios de la comunidad,

- Nos ha pedido que le enviemos un correo electrónico actualizado sobre la exención de Medicaid. Consulte la actualización urgente adjunta.
- Esperamos reunirnos con usted nuevamente en diciembre. Reserve la fecha para el **9 de diciembre de 3:30 a 5:30 p.m.** y esté atento a la página de registro de Zoom.

Gracias!

**Ruby Graven** – OHA Regional Outreach Coordinator

Pronouns: She/Hers

Washington & Columbia County

Cell: 503.884.1175

[Ruby.Graven@dhsosha.state.or.us](mailto:Ruby.Graven@dhsosha.state.or.us)



**From:** [Graven Ruby](#)  
**Subject:** Marque su calendario para el 9 de diciembre a las 3:30 pm  
**Date:** Thursday, December 2, 2021 4:17:00 PM  
**Importance:** High

---

Buenas tardes, socios de la comunidad:

Marquen su calendario y guarden la fecha para la tercera reunión de exención de Medicaid para socios de la comunidad en español!

### ¿Cuándo?

La semana que viene **jueves 9 de diciembre 3:30 - 5:30 pm**

### ¿Cómo me registro?

Seguiré con más información el viernes 2 de diciembre.

### ¿Me recordará dónde está el sitio web de exención de Medicaid en español?

[haga clic aquí](#)

### ¿Hay algo que deba hacer mientras tanto?

Sí, comience a leer los **documentos conceptuales finales** en nuestro sitio web de exenciones de Medicaid [haga clic aquí](#). Los artículos finales y los resúmenes de conceptos están disponibles en español.

**Ruby Graven** – OHA Regional Outreach Coordinator

Pronouns: She/Hers

Washington & Columbia County

Cell: 503.884.1175

[Ruby.Graven@dhsosha.state.or.us](mailto:Ruby.Graven@dhsosha.state.or.us)



**Asunto:** La Oregon Health Authority (OHA, por sus siglas en inglés) publica los conceptos finales de la política de exención 1115

Colegas:

El equipo de renovación de la Exención de demostración de la Oregon Health Authority (OHA, por sus siglas en inglés) 1115 le complace en anunciar la publicación de los documentos conceptuales finales de la política. Estos documentos describen los diversos cambios que la OHA propone realizar en el Plan de Salud de Oregon (OHP, por sus siglas en inglés) como parte de nuestro esfuerzo para promover la equidad en la salud. Estos conceptos son la base de la próxima solicitud que OHA le entregara al gobierno federal, cuyo permiso se necesita para implementar las políticas.

También hemos hecho resúmenes en lenguaje sencillo de los conceptos de política, que se encuentran adjuntos con los documentos de política. Todos los documentos están disponibles en 12 idiomas en la página [web de renovación de la exención de demostración 1115 de la OHA](#).

- [Resumen ejecutivo](#)
- [Como utilizar completamente la cobertura de OHP](#) | [Resumen](#)
- [Estabilizar las transiciones para minimizar las interrupciones en la atención](#) | [Resumen](#)
- [Presupuesto global flexible y basado en valor](#) |
- [Incentivar la atención equitativa](#) | [Resumen](#)
- [Inversiones centradas en la equidad](#) | [Resume](#)

### Envío de comentarios:

Agradecemos que provean sus comentarios sobre estos documentos de políticas que se enfoquen en cómo estos cambios propuestos podrían afectarlo a usted o a las comunidades a las que sirve. Tendremos un período de comentarios del público a partir del 7 de diciembre. Usted puede proveer sus comentarios de dos maneras:

1. Por correo electrónico a [1115.WaiverRenewal@dhsaha.state.or.us](mailto:1115.WaiverRenewal@dhsaha.state.or.us)
  - Los socios de la comunidad también pueden enviar correos electrónicos en nombre de los miembros de la comunidad.

Puede obtener este documento en otros idiomas, en letra grande, en braille o en el formato que usted prefiera. Comuníquese con el Programa de socio comunitario de extensión en [community.outreach@dhsaha.state.or.us](mailto:community.outreach@dhsaha.state.or.us) o bien llame al 1-833-647-3678. Aceptamos todas las llamadas por servicio de retransmisión o puede marcar el 711



2. En una de las juntas públicas en diciembre y enero donde se aceptarán comentarios. Publicaremos un calendario completo de juntas en las próximas semanas.
- 7 de diciembre - [Junta de Políticas de Salud de Oregon](#)
  - 9 de diciembre - [Comité de Equidad sobre la Salud](#)
  - 15 de diciembre - [Comité Asesor de Medicaid](#)
  
  - 16 de diciembre - [Diseñando el futuro de OHP - Taller 3](#)
  - 4 de enero - [Junta de Políticas de Salud de Oregon](#)

Gracias por su interés en nuestros esfuerzos para promover la equidad a través del OHP. Si tiene preguntas o comentarios, envíe un correo electrónico a [1115.WaiverRenewal@dhsosha.state.or.us](mailto:1115.WaiverRenewal@dhsosha.state.or.us).

Puede obtener este documento en otros idiomas, en letra grande, en braille o en el formato que usted prefiera. Comuníquese con el Programa de socio comunitario de extensión en [community.outreach@dhsosha.state.or.us](mailto:community.outreach@dhsosha.state.or.us) o bien llame al 1-833-647-3678. Aceptamos todas las llamadas por servicio de retransmisión o puede marcar el 711

**From:** [Graven Ruby](#)  
**Subject:** Regístrese ahora! Junta jueves 9 de diciembre.  
**Date:** Tuesday, December 7, 2021 12:14:00 PM  
**Importance:** High

---

Atención socios comunitarios,

Si recibe este correo electrónico, nos pidió que le enviemos actualizaciones sobre el diseño del Plan de Salud de Oregon o la exención de Medicaid de Oregon.

Me di cuenta de que la mayoría de ustedes no obtuvieron el enlace de registro para nuestra reunión de **esta semana el jueves**. Regístrese aquí [haga clic aquí](#) y **recuerde revisar el correo electrónico a continuación**. También puede [hacer clic en el video aquí](#) para escuchar y prepararse para nuestra junta el **jueves 9 de diciembre**.

---

**From:** Graven Ruby  
**Sent:** Thursday, December 02, 2021 4:20 PM  
**Subject:** Marque su calendario para el 9 de diciembre a las 3:30 pm  
**Importance:** High

Buenas tardes, socios de la comunidad:

Marquen su calendario y guarden la fecha para la tercera reunión de exención de Medicaid para socios de la comunidad en español!

### ¿Cuándo?

La semana que viene **jueves 9 de diciembre 3:30 - 5:30 pm**

### ¿Cómo me registro?

Seguiré con más información el viernes 3 de diciembre.

### ¿Me recordará dónde está el sitio web de exención de Medicaid en español?

[haga clic aquí](#)

### ¿Hay algo que deba hacer mientras tanto?



Sí, comience a leer los **documentos conceptuales finales** en nuestro sitio web de exenciones de Medicaid [haga clic aquí](#). Los artículos finales y los resúmenes de conceptos están disponibles en español.

**Ruby Graven** – OHA Regional Outreach Coordinator

Pronouns: She/Hers

Washington & Columbia County

Cell: 503.884.1175

[Ruby.Graven@dhsosha.state.or.us](mailto:Ruby.Graven@dhsosha.state.or.us)





**From:** [Graven Ruby](#)  
**To:** [delfina@orlhc.org](mailto:delfina@orlhc.org)  
**Subject:** Regístrese ahora! Junta jueves 9 de diciembre 3:30 - 5:30 PM  
**Date:** Thursday, December 9, 2021 10:58:00 AM  
**Importance:** High

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Si recibe este correo electrónico, nos pidió que le enviemos actualizaciones sobre el diseño del Plan de Salud de Oregon o la exención de Medicaid de Oregon.

Me di cuenta de que la mayoría de ustedes no obtuvieron el enlace de registro para nuestra reunión de **esta semana el jueves**. Regístrese aquí [haga clic aquí](#) y **recuerde revisar el correo electrónico a continuación**. También puede [hacer clic en el video aquí](#) para escuchar y prepararse para nuestra junta el **jueves 9 de diciembre**.

### ¿Cuándo?

Hoy **jueves 9 de diciembre 3:30 - 5:30 pm**

### ¿Me recordará dónde está el sitio web de exención de Medicaid en español?

[haga clic aquí](#)

### ¿Hay algo que deba hacer mientras tanto?

Sí, comience a leer los **documentos conceptuales finales** en nuestro sitio web de exenciones de Medicaid [haga clic aquí](#). Los artículos finales y los resúmenes de conceptos están disponibles en español.

**Ruby Graven** – OHA Regional Outreach Coordinator

Pronouns: She/Hers

Washington & Columbia County

Cell: 503.884.1175

[Ruby.Graven@dhsosha.state.or.us](mailto:Ruby.Graven@dhsosha.state.or.us)





December 14, 2021

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## Designing the future of Oregon Health Plan



### Agenda

[Click here to register](#)

Dear Community Partners,

Join us at the next Community Partner Medicaid waiver meeting in English on **Friday, December 17, 2021 10:30 a.m. - 12:30 p.m. Pacific Time**. Interpretation in Spanish will be available for those who prefer Spanish and missed our meeting in Spanish last week. Find a recording of this meeting last week by [clicking HERE](#)

### Agenda

Presentation

- Medicaid waiver 101
- What's changing, and what's staying the same?

Public comment

-Public comments will be an opportunity to provide public comment on the [draft application](#)

### Meeting accommodation

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help or have questions, please email Ruby Graven at [community.outreach@state.or.us](mailto:community.outreach@state.or.us)

## Listen in and learn more



Click on the video/image to the left to learn about Oregon's Medicaid waiver and prepare for our meeting on December 17th.

## How do I provide public comment?

Public comments (exactly as written or stated) on the Medicaid waiver draft application will be documented and reported to Centers for Medicare & Medicaid Services (CMS).

**We will need:**

- Your full name
- Your statement
- Your organization (if relevant)

The public is invited to submit verbal comments at the Community Partner Medicaid waiver meeting or written comments can be submitted from Dec. 7, 2021 through Jan. 7, 2022. The deadline for comment is Jan. 7, 2022, 11:59 p.m. Pacific Time.

The Oregon Health Authority (OHA) has developed a draft application with proposals for changes to the Oregon Health Plan as part of our effort to advance health equity. The application will be submitted in February 2022 to CMS, whose approval is needed to implement policies reflected in the application. If approved, Oregon would make changes to OHP during the 2022 – 2027 demonstration period.

[Click here](#) to find the draft waiver application, final policy concepts and learn more.

**Please complete public comment survey below**

[Click here to complete survey](#)

As part of our efforts to improve the public engagement process, we would like to know more about who we are hearing from, and have included several questions about your demographics, whether you are a provider or from an organization, and if so, who you serve. These questions are optional, and this information will be kept confidential and will be used to plan focused outreach to groups we have not received input from.

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@dhsosha.state.or.us](mailto:community.outreach@dhsosha.state.or.us) or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.

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***Thank you for your time!***

## II. Summary of Public Comments and OHA Responses

OHA solicited public comments on the draft 1115(a) waiver renewal application from Dec. 7, 2021 through Jan. 7, 2022. Interested parties were invited to comment at a series of public meetings, via email or letter, or through a survey posted on OHA’s website. Many people around the state provided a wide range of comments. Text of written comments and transcripts of verbal comments will be posted at [Oregon.gov/1115WaiverRenewal](https://Oregon.gov/1115WaiverRenewal) shortly after submission of the final application to CMS. In the following tables, OHA summarized comments thematically and noted the agency’s response.

Table B.1. Incentivizing equitable care

#	Summary of Comments Received	OHA Response
	<p><b>Summary:</b> OHP member advocates, a CBO, and a CCO lobby group expressed support for changes to the metrics committee structure while a separate CCO expressed concern about the change. A member advocate expressed concern about inadequate focus on the children and youth with special health care needs (CYSHCN) population. A CCO lobby group expressed concerned that too many metrics would lead to provider burnout.</p>	
1.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b> Support:</p> <ul style="list-style-type: none"> <li>• General support for the focus on social determinants of health and addressing structural racism</li> </ul> <p>Concerns and recommendations:</p> <ul style="list-style-type: none"> <li>• Concern about inadequate focus on Children and Youth with Special Health Care Needs (CYSCHN)</li> </ul>	<p><b>Response:</b></p> <p>OHA appreciates the feedback about the incentive metrics program and the support for the focus on health equity. OHA is increasing the size of the upstream metric set from 3-5 to six to ensure adequate space to focus on multiple areas of health equity. The number of metrics has been carefully considered to ensure that equity can be adequately focused on without overburdening providers.</p>
2.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b> Support:</p> <ul style="list-style-type: none"> <li>• Some CCO and provider support for change in committee structure</li> </ul> <p>Concerns and recommendations:</p> <ul style="list-style-type: none"> <li>• Health system desire to maintain current committee structure and consider adding new members to address health equity needs</li> <li>• Request for quality incentive funds to be made available for CBOs</li> <li>• Concern about keeping upstream metrics to a number/scope that does not lead to provider burnout</li> <li>• Request for a guaranteed role for Local Public Health Authority (LPHA) representatives</li> </ul>	<p>The ability to distribute quality incentive funds directly to CBOs is prohibited by federal law and therefore is not a change that can be pursued.</p>

Table B.2. Continuous enrollment for adults and children

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> Advocacy organizations and non-CCO providers expressed support for Oregon’s proposals related to continuous eligibility for children and adults. No parties expressed concerns or suggested changes.</p>		
3.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Continuous eligibility increases equitable access to care</li> <li>• Could prevent negative health outcomes</li> </ul>	<p><b>Response:</b></p> <p>OHA appreciates the support for this policy and has maintained the policy as-is.</p>
4.	<p><b>Audience Group:</b> Healthcare, Community Organizations, and Social Service Providers</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Helps keep people covered and mitigate churn</li> </ul>	

Table B.3. Retroactive eligibility

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> Commenters, all advocacy organizations or member advocates, oppose Oregon’s request for a waiver of the requirement to provide retroactive eligibility and ask it be removed from the waiver.</p>		
5.	<p><b>Summary:</b> Commenters, all advocacy organizations or member advocates, oppose Oregon’s request for a waiver of the requirement to provide retroactive eligibility and ask that it be removed from the waiver.</p>	<p><b>Response:</b></p> <p>Although OHA has had a waiver to permit the state to <i>not</i> provide retroactive coverage, OHA has never made use of the waiver. As a result of this and the extensive feedback, OHA has decided not to pursue renewal of this long-standing waiver and has removed it from the current waiver renewal application.</p>

Table B.4. SNAP pathway for expedited enrollment

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> Comments from members and advocates and non-CCO providers were supportive of the SNAP pathway proposed in the waiver. Some comments touched on issues related to SNAP that were outside the scope of the waiver and/or OHA.</p>		
6.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Decreases burden on family and children and could reduce administrative costs for state</li> </ul>	<p><b>Response:</b></p> <p>OHA appreciates the support for this policy. Through discussions with CMS, OHA</p>

	<ul style="list-style-type: none"> <li>A member advocate requested processes related to eligibility for SNAP benefits that were outside the scope of the waiver</li> </ul>	has determined that the waiver is not the appropriate pathway for this policy at this time and is removing it from the waiver application. OHA is exploring options with CMS to pursue this through policy State Plan Amendment (SPA).
7.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>General support for SNAP pathway to get more people covered</li> </ul>	

Table B.5. Social determinants of health (SDOH) supports for members experiencing transitions

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> Comments were supportive of proposed waiver solutions. Commenters from CCOs and other providers requested that OHA be aware of the operational concerns associated with these changes and that extensive partner engagement inform planning efforts. A request for internet supports for climate SDOH transitions package is already being incorporated based on Tribal request so no further changes are needed.</p>		
8.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Expression of support for the inclusion of access to SDOH supports for vulnerable populations that are transitioning through multi-system involvement and crisis.</li> <li>Member advocates request internet supports for climate SDOH transitions package</li> <li>Support for the ease and continuity being requested for Medicaid eligibility.</li> </ul>	<p><b>Response:</b></p> <p>These comments will be used to inform implementation planning for these support packages. The waiver renewal application is being updated to incorporate internet supports for the climate support package as a result of this feedback and per request of the Tribes in the Tribal Consultation and Urban Indian Confer. Federal funding is being requested to support this work and many issues relating to workforce are being considered in Oregon's legislative session.</p>
9.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>There was support from CCOs for the intent of the policy but concern about workforce capacity for this work and sustainable funding.</li> <li>Recommendation that OHA partner with relevant partner agencies</li> <li>Request for more information about what assessment tool will be used to determine whether an individual is at risk of homelessness</li> </ul>	
10.	<p><b>Audience Group:</b> Non-CCO providers and political advocacy organizations</p> <p><b>Summary of Comments:</b></p>	



	<ul style="list-style-type: none"> <li>• Expression of support for the inclusion of access to SDOH supports for vulnerable populations that are transitioning through multi-system involvement and crisis.</li> <li>• Support for the ease and continuity being requested for Medicaid eligibility.</li> <li>• Support expressed for community health related to addressing the community and individual needs climate crisis.</li> <li>• Support for Medicaid access for youth in juvenile detention facilities and for incarcerated individuals</li> <li>• Support for community driven decision making.</li> <li>• Request from a service-providing CBO that outreach and engagement activities be included as an allowable SDOH transition support service.</li> <li>• Request to add qualified mental health associates (QMHA's) as a provider type to assist during transitions.</li> </ul>	
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Table B.6. Covered services

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> Concerns raised relating to implementation planning and considerations of what should be accomplished outside the waiver through SPA, contract, or legislation.</p>		
11.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Request to include a provision affirming protections for persons with disabilities for those who express a desire to harm or kill themselves in a medical setting, even when they qualify for lethal drugs under Oregon’s “Death with Dignity Act”.</li> <li>• Request change to payment models regarding children’s behavioral health, specifically: <ul style="list-style-type: none"> <li>○ Fund community-based care connecting families with services in their home, community, or school</li> <li>○ Pay for trauma-informed care</li> </ul> </li> <li>• Include increased funding and policies to address workforce challenges</li> </ul>	<p><b>Response:</b></p> <p>We appreciate this feedback and will consider it for implementation planning.</p> <p>No changes are needed to the waiver application as a result of this feedback.</p> <p>The comments around children’s behavioral health will be considered to inform implementation planning for the CYSHCN and foster youth populations. Infrastructure support funding for community based organizations (CBOs) could be used to assist organizations in billing Medicaid for its services.</p>
12.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Continue OHP coverage for incarcerated individuals who are accessing Medication-Assisted Therapy (MAT).</li> <li>• Cover drop in behavioral health services as a Medicaid covered service for psychiatric rehabilitation services.</li> </ul>	<p>The comments around children’s behavioral health will be considered to inform implementation planning for the CYSHCN and foster youth populations. Infrastructure support funding for community based organizations (CBOs) could be used to assist organizations in billing Medicaid for its services.</p>

Table B.7. Juvenile justice system

#	Summary of Comments Received	OHA Response
13.	<p><b>Audience Group:</b> Government Partners</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Recommendation to include the term “local juvenile detention facility” in the sections describing eligibility and benefits</li> <li>• The Oregon Youth Authority (OYA) provided written comment and engaged in substantive conversation with the Oregon Health Authority and noted the following concerns:               <ul style="list-style-type: none"> <li>○ Administrative burden: OYA does not have an infrastructure to bill Medicaid for services provided by OYA staff health care providers. OYA does not have adequate capacity to negotiate and maintain agreements with CCOs for OYA staff healthcare providers.</li> <li>○ Restrictions on Health Care services: OYA provides a more robust scope of services than Medicaid coverage allows based on the HERC Prioritized List.</li> <li>○ Access to services: OYA notes several examples where providers they use that are external to their facility either do not take Medicaid at all or will not provide services at Medicaid rates. This seems to be specific regionally and by specialty provider, though not an isolated issue (multiple examples).</li> <li>○ Coordination with CCOs: OYA cited concerns about CCO enrollment delays, lack of predictability of youth geographic placement in preparation for release resulting in limited/no pre-planning with receiving CCOs and subsequent access to care issues after they leave custody (i.e., obtaining or coordinating appointments, pharmacy, etc.).</li> <li>○ Transition services (SDOH benefit package): OYA staff are very supportive of the package of transition services, and the extended timeline that young people in their custody could be supported with in their transition back to the community.</li> </ul> </li> </ul>	<p><b>Response:</b></p> <p>Based on feedback from our local and state agency government partners, especially extensive conversations with the Oregon Youth Authority, OHA will be modifying the waiver proposal for youth in OYA closed-custody correctional settings to request limited Medicaid eligibility for CCO enrollment limited to the transition services benefit package. The benefit package request for youth in local juvenile detention facilities will remain unchanged.</p>

Table B.8. Community Investment Collaboratives

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> Community members expressed strong support for the proposal. CCOs expressed concerns about the proposed governance structure, their role in it, and the relationship to Oregon House Bill 3353 (2021) as intended.</p>		
14.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Prioritize community-based organizations and avoid duplication</li> <li>• Support for the CIC proposal, principles of HB 3353</li> <li>• Strong support for expanding community-led investments</li> <li>• Value of partnerships between community development and healthcare</li> <li>• Addresses health disparities in the state</li> <li>• Shifts power and resources</li> </ul>	<p><b>Response:</b></p> <p>The Oregon Health Authority appreciates the strong support of the proposal from members and advocates and appreciates the concerns from CCOs and others regarding operationalizing this proposal. OHA will clarify the application to highlight the intent of the regional Community Investment Collaboratives (CICs) is to leverage existing, community-led entities and shift more power and resources to these entities. OHA will also clarify the request for the 3% of CCO spending as directed by HB 3353 to be counted as a medical expense. The other recommendations will be considered while developing the proposal further for implementation planning.</p>
15.	<p><b>Audience Group:</b> Non-CCO Providers</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• General support with emphasis on potential for use in environmental improvement from a service-delivering CBO</li> </ul>	
16.	<p><b>Audience Group:</b> CCO and Health System</p> <p><b>Summary of Comments:</b></p> <p>Support for:</p> <ul style="list-style-type: none"> <li>• Including 3% upstream investments as part of medical expenditures</li> <li>• Flexibility to make upstream investments; support intention and show desire to do this work</li> </ul> <p>Concerns:</p> <ul style="list-style-type: none"> <li>• The proposal silos funding structures</li> <li>• Lack of clarity around connection to CHPs, Health Equity Plans, Comprehensive BH plans, and CCO financial arrangements</li> <li>• Belief that as proposed, it contradicts intent of HB 3353</li> <li>• Geography and funding structure of CICs and the roles of people included in the Oversight Committees and CICs.</li> <li>• Concerns and questions regarding clarity of the state's role with the Oversight Committee and CICs</li> <li>• Concern upstream investments don't currently "count" and are instead counted as administrative expenditures</li> </ul>	

17.	<p><b>Audience Group:</b> Lobbyists or political advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• One request made to guarantee a role for local public health officials in CICs within each service area.</li> </ul>	
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Table B.9. Federally Recognized Tribes and Tribal Services

#	Summary of Comments Received	OHA Response
18.	<p><b>Audience Group:</b> Members and advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Question about whether there is an effort to include those who identify as tribal but are not a member of a federally-recognized tribe</li> </ul>	<p><b>Response:</b></p> <p>For Medicaid services, the Oregon Health Authority follows the federal Centers for Medicare and Medicaid Services' definition of American Indian/Alaska Native at 42 CFR § 447.51. This definition is inclusive of individuals who identify as tribal, based on descendency and/or eligibility for IHS services, but who are not enrolled members of a federally-recognized tribe. Oregon maintains a government-to-government relationship with the state's nine federally-recognized tribes, the tribal priorities section was developed in partnership with Oregon tribal representatives.</p> <p>Note: The Tribal Consultation and Urban Indian Health Program Confer process is documented separately from public comment received.</p>

Table B.10. Finance and rates

#	Summary of Comments Received	OHA Response
19.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Expressed concern about the lack of annual rate rebasing and wanted to ensure that any changes to rate development were still actuarially sound</li> </ul>	<p><b>Response:</b></p> <p>OHA appreciates the concern about actuarially sound rates and will work with federal partners to ensure any rate changes adequately reflect financial risk.</p>

Table B.11. Evaluation plan

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> A CCO expressed comments around the use of surveys in the evaluation plan and a concern about using Health Related Services (HRS) investment to test proposed hypotheses.</p>		
20.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Expressed concern about community surveys to evaluate demonstration, in particular the funding mechanism for this endeavor</li> <li>Requested that Health Related Services (HRS) investment not be a method of testing hypothesis around redistributing power and resources</li> </ul>	<p><b>Response:</b></p> <p>OHA appreciates this feedback and the full details of the evaluation plan will be developed with federal partners after the approval of the demonstration.</p>

Table B.12. Immigration and citizenship

#	Summary of Comments Received	OHA Response
<p><b>Summary:</b> OHA received strong support for the Healthier Oregon Program and several suggestions on how to improve member experience regardless of immigration or citizenship status.</p>		
21.	<p><b>Audience Group:</b> Members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Expressed strong support for Healthier Oregon Program (formerly known as Cover All People and Cover All Kids) to cover individuals regardless of immigration status</li> <li>A request to cover the immigration legal services costs borne by OHP members, including green card holders, refugees, asylees and humanitarian visa holders because the cost of immigration legal services can be prohibitive for many new Oregonians living at or below the poverty level</li> <li>Request support for undocumented individuals on OHP over age 65</li> </ul>	<p><b>Response:</b></p> <p>OHA appreciates the support for the Healthier Oregon Program. At this time, strategies related to covering individuals regardless of immigration status is outside of the scope of our current waiver policy efforts. We have passed on these comments to the Healthier Oregon Program team for consideration in implementation and will</p>

	<ul style="list-style-type: none"> <li>Request to consider families with mixed immigration statuses when making eligibility determinations</li> <li>Need for easier access to medical and dental coverage for those who are undocumented, especially for children with disabilities</li> <li>Navigating the fee-for-service or “open card” system is particularly difficult for immigrants</li> </ul>	consider how to use these comments to make operational improvements to OHP for all members regardless of immigration or citizenship status.
22.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives and Healthcare, Community Organization, and Social Service Providers</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Expressed strong support of Healthier Oregon Program (formerly known as Cover All People and Cover All Kids) to cover individuals regardless of immigration status</li> </ul>	

Table B.13. Race, Ethnicity, Language, and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) data

#	Summary of Comments Received	OHA Response
23.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Encouraged OHA to ensure accurate and consistent collection of REALD data when planning the operationalization of health equity metrics</li> <li>Cautioned that REALD data collection can place burdens on providers and community partners, especially with multiple entities across the health system collecting information</li> </ul>	<p><b>Response:</b></p> <p>OHA agrees that it is imperative to collect consistent and accurate data on member race, ethnicity, age, language and disability (REALD), as well as sexual orientation and gender identity (SOGI) from front line providers and CCOs in order to assess the impact of policy changes on reducing health inequities. This will be especially critical for operationalizing health equity incentive metrics and for evaluating the outcome of the demonstration.</p> <p>OHA appreciates that collecting data can pose challenges for smaller organizations such as community-based organizations and can be particularly difficult and will be a consideration in planning for any future requirements.</p>
24.	<p><b>Audience Group:</b> Legislative / Policy Makers, Political Lobbyists / Special Interest Groups</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Expanding the infrastructure to allow CBOs to submit data when providing services will create challenges for smaller organizations with limited administrative funding</li> <li>Recommendation that any requirements should ensure that billing for social services is as simple and efficient as possible</li> <li>Suggestion to look to FQHCs for insights as they have often been at the forefront of piloting how to collect and utilize data that demonstrates a patients’ non-medical needs</li> </ul>	

Table B.14. Pharmacy

#	Summary of Comments Received	OHA Response
	<p><b>Summary:</b>            Concern that a <b>closed formulary</b> will limit providers ability to make medical decisions for the care of their patients and negatively impact access to prescription drugs for persons with behavioral and mental health needs, disabilities, and other chronic conditions.</p> <p>Concern that <b>limiting access to drugs approved under the FDA’s Accelerated Approval process</b> is based on an inaccurate understanding of the FDA’s accelerated approval pathway and if implemented would cause significant harm to persons with rare diseases.</p>	
25.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b>            Closed Formulary (Concerns)</p> <ul style="list-style-type: none"> <li>• Appeal processes would be necessary for access to non-formulary medications</li> <li>• Potential adverse impact on persons with rare diseases, HIV, and cancer</li> <li>• Limits the ability of providers to make medical decisions</li> <li>• Potential for inequitable adverse outcomes for people of color or those in historically disadvantaged populations</li> <li>• Potential conflict with federal regulations governing the Medicaid Drug Rebate (MDR) program</li> </ul> <p>Limited Access for Accelerated Approval Drugs (Concerns)</p> <ul style="list-style-type: none"> <li>• Harm to patients by restricting access to novel and lifesaving therapies               <ul style="list-style-type: none"> <li>○ Assertion the proposal undermines the FDA’s scientific approach to determine drug safety and efficacy and discourages innovation for the treatment of rare diseases.</li> </ul> </li> </ul>	<p><b>Response:</b>            The draft application included two proposals related to pharmacy. One was to allow OHA and CCOs to operate a closed formulary. The second was to allow OHA to exclude certain drugs that have inadequate evidence of efficacy. Based on the feedback received, OHA is removing its request for a closed formulary from the final application. OHA is requesting approval from CMS to allow the exclusion of accelerated approval drugs with limited or inadequate evidence of clinical efficacy.</p>
26.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b>            Closed Formulary (Concerns)</p> <ul style="list-style-type: none"> <li>• Diminishment of the FDA’s statutory role</li> <li>• Conflicts with the federal Medicaid Drug Rebate (MDR) program</li> <li>• Required use of a closed formulary would dramatically increase costs by disrupting efficiencies inherent in integrated health systems</li> </ul> <p>Limited Access for Accelerated Approval Drugs (Concerns)</p>	

	<ul style="list-style-type: none"> <li>OHA has demonstrated skepticism of the clinical merits of drugs approved via the accelerated pathway, which reflects a strong bias and concern OHA would not conduct a review with the same rigor as the FDA in its approval process.</li> </ul>	
27.	<p><b>Audience Group:</b> Healthcare, Community Organization, and Social Service Providers</p> <p><b>Summary of Comments:</b> Closed Formulary (Concerns)</p> <ul style="list-style-type: none"> <li>Potential for problems with psychiatry, including the SPMI population, concern about burdens on providers with paperwork and bureaucracy of prior authorizations taking time away from patient care and delaying access that could lead to negative outcomes and increased system costs including hospitalizations.</li> </ul>	
28.	<p><b>Audience Group:</b> Legislative / Policy Makers, Political Lobbyists / Special Interest Groups</p> <p><b>Summary of Comments:</b> Closed Formulary (Concerns)</p> <ul style="list-style-type: none"> <li>In direct conflict with the Medicaid Drug Rebate (MDR) program and federal law</li> <li>The model could harm Medicaid beneficiaries and restrict access to life saving medications leading to negative outcomes</li> <li>Interchangeability of epilepsy drugs</li> <li>Model runs counter to OHA’s mission of health equity and will exacerbate health inequities</li> <li>Reported literature that shows limiting formularies correlates to poor medication adherence outcomes.</li> </ul> <p>Limited Access for Accelerated Approval Drugs (Concerns)</p> <ul style="list-style-type: none"> <li>OHA lacks an accurate understanding of the FDA’s drug approval process and evidentiary standards</li> <li>Patients with serious and unmet medical needs will likely be harmed by this initiative <ul style="list-style-type: none"> <li>If new drugs for rare diseases are not covered by Medicaid, this will curtail innovation and the development of new treatments</li> </ul> </li> </ul>	



Table B.15. Prioritized List and use of Quality Adjusted Life Years (QALYs)

#	Summary of Comments Received	OHA Response
	<p><b>Summary:</b> Advocates and members and some health care providers expressed concern about the use of QALYs in the Prioritized List as discriminatory against people with disabilities. Advocates also raised concerns about the Prioritized List leading to denials of care.</p>	
29.	<p><b>Audience Group:</b> OHP members and Advocates</p> <p><b>Summary of Comments:</b> Concerns about QALYs:</p> <ul style="list-style-type: none"> <li>• Oppose the use of QALYs in deciding what conditions will be covered or not covered in Oregon’s Medicaid Program</li> <li>• Concern that QALY scores are inherently discriminatory, placing an arbitrary value on the lives of people with disabilities, patients, older adults and people of color because of existing disparities in healthcare</li> <li>• Concern that the Health Evidence Review Commission (HERC) uses cost effectiveness reports that use and draw attention to QALY scores and other concepts closely resembling QALYs</li> <li>• Concern that the use of QALYs is in violation of the Americans with Disabilities Act (ADA) and contrary to the mission of OHA to promote health equity. <ul style="list-style-type: none"> <li>○ Cites changes made to 1992 waiver application in 1993 to be in compliance with ADA</li> </ul> </li> <li>• Request OHA negotiate of allocation of resources alongside disability rights advocates to promote equity</li> <li>• Request inclusion of the following provision in the waiver application <ul style="list-style-type: none"> <li>○ “Prohibition on Reliance on Discriminatory Measures. The state shall not develop or utilize, directly or indirectly, in whole or in part, through a contracted entity or other third-party, a dollars-per-quality-adjusted life year or any similar measures or research in determining whether a particular health care treatment is cost-effective, recommended, the value of a treatment, or in determining coverage, reimbursement, appropriate payment amounts, cost-sharing, or incentive policies or programs.”</li> </ul> </li> </ul> <p><b>Concerns about Prioritized List:</b></p> <ul style="list-style-type: none"> <li>• Statement that the Prioritized List functions to ration health care services to Medicaid recipients in Oregon</li> <li>• Concern that Prioritized List is inflexible around medical necessity and medical appropriateness such that medically appropriate and necessary services are routinely denied</li> </ul>	<p><b>Response:</b> OHA understands that advocates have concerns that some uses of Quality-adjusted life years (QALY’s) may create or exacerbate disparities in coverage for people with disabilities. OHA and the Health Evidence Review Commission (HERC) take these concerns very seriously and work to ensure equitable treatment and services for OHP members.</p> <p>QALYs currently play only a minor role in decisions by the Health Evidence Review Commission, usually in comparing two treatments for the same condition. OHA does not believe they are 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. Regardless, any estimate of QALY’s would only be one consideration among many in terms of evaluating cost-effectiveness.</p> <p>The Prioritized List is developed by the Health Evidence Review Commission using a</p>

	<ul style="list-style-type: none"> <li>Concern that those who have a condition above the line of coverage on the list are still left without adequate treatment because their treatment isn't paired with their condition</li> <li>Request that the 1115 waiver be amended "to include specific instructions requiring approval of medically necessary, medically appropriate care for OHP enrollees if their particular combination of conditions requires treatment that does not perfectly match the Prioritized List condition/treatment pairings"</li> </ul>	<p>transparent public process, applying medical evidence and taking into account the values and preferences of providers and members.</p> <p>If there are concerns about lack of coverage for particular services, the Commission will consider reprioritization, addition to the funded region, or changes in guideline notes. Alternately, members of the public can suggest a topic for review during the public comment period which is a part of HERC meetings.</p>
30.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Request that the waiver include a provision explicitly renouncing the use of discriminatory measures such as QALYs</li> </ul>	

Table B.16. Community information exchange (CIE) and health information technology (HIT)

#	Summary of Comments Received	OHA Response
31	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>OHA should plan for robust data sharing and coordination processes, building on the successes of data sharing in other contexts, to support people in the custody of an institutional system who retain Oregon Health Plan benefits</li> </ul>	
32	<p><b>Audience Group:</b> Healthcare, Community Organization, and Social Service Providers</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>Quality care coordination, including referrals across both the health care system and social services agencies, require an improved and expanded IT infrastructure. OHA should support and prioritize the work of the Health Information Technology Oversight Committee which can improve member experience and support health and social services workforces.</li> </ul>	<p><b>Response:</b> OHA understands and agrees with the importance of data sharing to support transitions of care including infrastructure needed to support providers and CBOs.</p>
33	<p><b>Audience Group:</b> Legislative / Policy Makers, Political Lobbyists / Special Interest Groups</p> <p><b>Summary of Comments:</b></p>	

	<ul style="list-style-type: none"> <li>• OHA should recognize and incorporate the important work to build and support Community Information Exchanges (CIE) which are tools to support social care navigation by making it easier for connecting individuals to available community resources</li> <li>• To address health-related social needs and advance health equity, it is critical that CBOs are adequately and sustainably funded</li> <li>• OHA’s waiver application should recognize the importance of the HITOC/CIE Workgroup to set direction as state builds capacity to support SDOH benefits for transition populations and progress toward meeting upstream metrics related to SDOH screening and referral</li> <li>• OHA should consider the overlaps of ongoing CIE work in Oregon with those proposed in this waiver, including existing CIE governance structures and the Community Investment Collaboratives;</li> <li>• OHA pursue federal Medicaid matching funding to support CIE infrastructure investments, and should use this Waiver opportunity, coupled with administrative claiming opportunities, to communicate intent to build long-term sustainable financing of the CIE.</li> <li>• OHA’s CIE work should include: <ul style="list-style-type: none"> <li>○ Establish a single set of standards to allow for standardized data collection and streamlined care coordination efforts across the state, including CIE alignment with REALD regulations</li> <li>○ Establishing privacy and security requirements and protecting individual data privacy, with individuals maintaining control over their personal information.</li> <li>○ Billing systems adopted and/or procured by and/or for CBOs participating in reimbursement arrangements with CCOs should be seen as shared infrastructure</li> <li>○ Supporting a truly interoperable approach - OHP can play a role in this process by requiring integration and advancing interoperability standards,</li> <li>○ Fostering an open and focused network and giving members the opportunity to seek services through self-navigation, without being required to have someone else do it for them;</li> </ul> </li> </ul>	
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Table B.17. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Please note, due to a longer response, this comment is formatted differently with the response below the summary of comments.

#	Summary of Comments Received
	<p><b>Summary:</b> From all audiences who commented, OHA received strong feedback requesting removal of the waiver of EPSDT. Members and advocates, CCOs and health system representatives, and healthcare, community organizations cited concerns around children’s health.</p>
34.	<p><b>Audience Group:</b> Members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• The waiver authority would be discriminatory against children with disabilities and their families</li> <li>• Oregon is the only state in the country to have a limit in place on these benefits for children under 19</li> <li>• Limiting this benefit undermines the very core of what Oregon purports to do with its demonstration—advance health equity and maximize equitable access to coverage</li> <li>• OHA did not explain the services that would not be covered nor what protections the state has in place to ensure that restrictions on EPSDT services do not have a disparate impact on children of color</li> <li>• The proposal excludes treatment for disorders common in children with developmental disabilities, including selective mutism, conduct and impulse disorders, deformities of the upper body and limbs, sleep disorders, and pica</li> <li>• Many of the condition / treatment pairs that are “below the line” are debilitating but treatable, and denying coverage can lead to significant harm</li> </ul>
35.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Waiver of EPSDT would deprive children with epilepsy of needed services</li> <li>• Request removal of EPSDT waiver</li> <li>• EPSDT ensures access to medical care for children in alignment with Congressional intent</li> <li>• EPSDT is particularly important for children and youth with special health care needs</li> </ul>
36.	<p><b>Audience Group:</b> Healthcare, Community Organization, and Social Service Providers</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Request to end the waiver of EPSDT coverage</li> <li>• Concern that EPSDT is not needed for OHA to meet its stated goals for children’s health</li> <li>• Request to provide medically necessary orthodontia services to advance health equity</li> <li>• Need for meaningful reporting and accountability structure once EPSDT waiver is removed</li> <li>• A request for data reporting stratified by subpopulation to ensure children are being served equitably under new orthodontia benefit</li> </ul>
<p><b>OHA Response</b></p>	
<p>The Oregon Health Authority (OHA) appreciates the clear feedback from the community, including advocates, children’s service organizations and other interested parties, regarding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to children and adolescents enrolled in the Oregon Health Plan (OHP). OHA has taken this feedback seriously.</p>	

After careful consideration of community input and a comprehensive internal review, the Oregon Health Authority (OHA) has made the decision *not* to seek a renewal of its longstanding waiver regarding the EPSDT benefit for children and adolescents in its upcoming 1115(a) Medicaid waiver renewal application in its current structure. In its waiver application, OHA will propose to the Centers for Medicare and Medicaid Services (CMS) to cover all treatments and services determined as medically necessary in accordance with the EPSDT benefit, after a phase out period, in the following manner.

The public and transparent process of Oregon’s Health Evidence Review Commission (HERC) and of the Prioritized List of Health Services will retain important roles in determining OHP benefits for children, adolescents and adults. Oregon will specifically meet the ESPDT benefit requirements for children and adolescents in the following ways:

- Any covered treatment according to the Prioritized List of Health Services will, by default, be considered medically necessary for all people covered by OHP.
- For services not covered according to the Prioritized List, the medical necessity of services for individual children and adolescents will be considered on a case-by-case basis as required by EPSDT.

In preparation for this transition, OHA will take several steps to ensure that Medicaid-eligible children, adolescents and their families are aware of EPSDT and have access to required screenings and medically necessary treatments. These steps include but are not limited to:

- The HERC will complete a comprehensive review of services not currently covered according to the Prioritized List of Health Services with attention to the unique needs of children and adolescents. The HERC will adjust the Prioritized List to ensure that all medically necessary EPSDT services for the population of children and adolescents are covered.
- For services not covered according to the Prioritized List, OHA will ensure there are accessible and effective pathways for individual case-by-case review of medical necessity as required by EPSDT. OHA is aware that these processes can be lengthy and burdensome to providers and families and aims to improve that experience. OHA understands that children, adolescents and families managing complex medical needs require processes that are accessible and responsive to their needs.
- OHA will develop clear guidance and communications for providers and families to ensure they are aware of the change in benefits, including the right to an individual determination of medical necessity.

In order to achieve OHA’s goal of ending health inequities by 2030, barriers to medically necessary care must be removed for children and adolescents in accordance with EPSDT. OHA appreciates the feedback from all interested parties regarding this important topic and looks forward to ongoing collaboration to optimize child and adolescent health as part of the state’s next Medicaid waiver renewal.

Table B.18. Workforce

#	Summary of Comments Received	OHA Response
	<p><b>Summary:</b> Consensus recognition of the impact workforce issues have had on the healthcare delivery system. Opportunities identified for Traditional Health Workers (THWs) to play an increased role in providing OHP services and increasing access to healthcare for people to receive services from providers they trust in their communities. Opportunities exist for payment reform and to address provider</p>	

shortages in rural areas including dental providers, substance abuse treatment, and preventative services.	
37.	<p><b>Audience Group:</b> Members and Advocates</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Support for using peer-based and community health workers, especially needed in rural areas</li> <li>• Expressed a need to further invest in workforce, in particular community health workers, doulas, home visitors, and peer navigators in order to support families’ health</li> <li>• Request that Oregon work to create incentives and increase opportunities for people of color to be hired in medical settings or clinics to address generational trauma and mistrust in communities so that all can receive equal and appropriate care.</li> <li>• Request change to payment models regarding children’s behavioral health, specifically: <ul style="list-style-type: none"> <li>○ Fund community-based care connecting families with services in their home, community, or school</li> </ul> </li> </ul>
38.	<p><b>Audience Group:</b> CCO, Hospital, and Health System Representatives</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Broaden the ability of OHP to use federal match for Traditional Health Worker (THW) services</li> <li>• There is a shortage of dental providers, especially in rural areas.</li> <li>• Concern about cost-effective provision of transportation benefit in rural areas.</li> <li>• Request that OHA clarify or address certificate of approval requirements and supervision requirements for Traditional Health Workers (THWs)</li> <li>• Request confirmation that the term “recovery peer” would encompass those peer specialists whose scope of work includes assisting individuals in their recovery from behavioral health and substance use disorders</li> <li>• Concern that the state’s Traditional Health Worker Commission recommended enhancements to the waiver which were not reflected in the draft application</li> </ul>
39.	<p><b>Audience Group:</b> Healthcare, Community Organization, and Social Service Providers</p> <p><b>Summary of Comments:</b></p>
	<p><b>Response:</b></p> <p>OHA appreciates the extensive comments on issues related to the healthcare workforce. We recognize a need for investment in the healthcare workforce, especially for behavioral health. OHA also appreciates the support for the proposal to expand the use of Traditional Health Workers (THWs) in the waiver application.</p> <p>OHA evaluated the recommendations provided by the Traditional Health Worker Commission and incorporated several of the recommendations into the application. This includes proposing that peer-delivered services not be limited to a treatment plan, the enrollment of justice-involved individuals 90-days prior to release, requesting coverage of non-medical transportation to access SDOH support services, housing supports including rent assistance, and the proposed changes to metrics to incentivize improvements in health equity. Those recommendations that fell outside the scope of the waiver or that were more appropriate to pursue through contract or State Plan Amendment will be considered in the future.</p>

	<ul style="list-style-type: none"> <li>• Request that OHA address access to care issues for trauma-informed crisis services when providers are available but not contracted with the CCO in a rural area</li> <li>• Ensure that Traditional Health Workers, Community Health Workers, navigators – are covered at a livable wage rate to promote the quality and quantity of these positions in our state.</li> </ul>	
40.	<p><b>Audience Group:</b> Legislative / Policy Makers, Political Lobbyists / Special Interest Groups</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Open access to safety net providers and other community providers would create meaningful change for patient access and provider burden</li> <li>• Reinforced the need for increasing access to quality preventive and sexual and reproductive care when setting requirements for CCO provider network</li> <li>• Concerns about the ability of OHP members to receive care from providers within their own communities regardless of location or whether they are “in-network” for their CCO</li> <li>• When establishing CCO provider network requirements, commenters highlighted the importance of receiving care from community health workers, personal health navigators, peer wellness and support specialists and doulas to ensure trust between providers and patients, and allow for culturally responsive services for OHP members</li> <li>• OHA should explore other types of non-traditional community care/healing work that federal requirements may not allow to receive payment or that are not considered to be Traditional Health Workers (THW)</li> </ul>	
41.	<p><b>Audience Group:</b> Government Partners</p> <p><b>Summary of Comments:</b></p> <ul style="list-style-type: none"> <li>• Support to use person and community-centered approaches such as Personal Health Navigators, Traditional Health Workers, Peer Support Specialists and Peer Wellness Specialists</li> </ul>	

### III. Public Comment Survey of Stakeholders on Oregon's Waiver Renewal

OHA created a survey to assist with registration for public hearings as well as provide an additional avenue through which individuals and organizations could provide public comment. The survey was open in English beginning on December 1, 2021 and remained available throughout the public comment period. A Spanish version of the survey was provided to Community Partnership Outreach Program (CPOP) partners who prefer communications in Spanish and to attendees of the CPOP public hearing, held in Spanish, on December 7, 2021. The Spanish and English surveys are included as Attachment 11 and Attachment 12, respectively.



# Exención 1115 de Oregon: encuesta de comentarios públicos

## Q1.1 Bienvenido a la encuesta de comentarios públicos sobre la exención 1115 de Oregon

Los comentarios públicos se recibirán a partir del 7 de diciembre de 2021 hasta el 7 de enero de 2022. Si planea asistir a una reunión o hacer un comentario público sobre la versión preliminar de la solicitud de renovación de la exención 1115, se lo agradecemos.

En el siguiente enlace, se puede encontrar una copia de la solicitud de exención: <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Renewal-Application.pdf>.

Como parte de los esfuerzos para mejorar el proceso de participación pública, nos gustaría conocer más acerca de los participantes de la encuesta y por eso hemos incluido varias preguntas para saber sobre sus datos demográficos, si es un proveedor o representa a una organización, y en caso de ser así, a quiénes brinda servicios. Estas preguntas son opcionales; la información será confidencial y se utilizará para planificar una estrategia de alcance dirigida a grupos de los que no hayamos obtenido respuesta.

La encuesta también le permitirá ingresar su comentario público sobre la versión preliminar de la solicitud de exención 1115. **Dicha información, junto con su nombre, se hará pública cuando se envíe la solicitud final a los Centros de Servicios de Medicare y Medicaid (Centers for Medicare and Medicaid Services, CMS).** En ella no se incluirá ningún dato demográfico. Agradecemos que se tome el tiempo para dar su opinión sobre la versión preliminar de la solicitud.

¿De parte de quién está respondiendo usted a esta encuesta?

- De si mismo(a)
- Respondo como miembro de familia, representante autorizado de otra persona que no puede hacer comentarios por su cuenta
- Represento a una organización, tal como un proveedor, un grupo de abogacía o un grupo de cabildeo

## Inscripción en evento de comentarios públicos

A través de esta encuesta, puede inscribirse en cualquiera de los eventos programados para

hacer comentarios públicos. Indique a qué junta o juntas asistirá (o ya ha asistido). (Seleccione todas las opciones que correspondan).

- Junta de diciembre del Consejo de Políticas de Salud de Oregon (Oregon Health Policy Board, OHPB), el 12/7/21
- Junta de diciembre del Comité de Equidad en la Salud (Health Equity Committee, HEC), el 12/9/21
- Sesión n.º 3 del Programa de Alcance de Socios Comunitarios (Community Partner Outreach Program, CPOP) (en español), el 12/9/21
- Junta de diciembre del Comité Asesor de Medicaid (Medicaid Advisory Committee, MAC), el 12/15/21
- Días de exención n.º 3: diseñar el futuro del Plan de Salud de Oregon (Oregon Health Plan, OHP), el 12/16/21
- Sesión n.º 3 del CPOP (en inglés), el 12/17/21
- Junta de enero del Consejo de Políticas de Salud de Oregon (OHPB), el 1/4/22

¿Necesitará usted o la persona, los servicios de alguno de los siguientes intérpretes para asistir a los eventos? Los servicios de interpretación no tendrán ningún costo para usted.

- Un intérprete del lenguaje hablado. Indique el idioma de preferencia \_\_\_\_\_
- Un intérprete de lenguaje de señas estadounidense
- Un intérprete de sordos para ciegos sordos, con dificultades adicionales o ambos
- Un intérprete de lenguaje de señas Pidgin Signed English (PSE)
- Otro. Indique, por favor \_\_\_\_\_

### **Solicitud de comentarios públicos**

¿Hará comentarios verbales en alguno de los siguientes eventos programados para hacer comentarios públicos? (Seleccione todas las opciones que correspondan).

NOTA: También tendrá la oportunidad de hacer o entregar comentarios por escrito al final de esta encuesta.

- Junta de diciembre del Consejo de Políticas de Salud de Oregon (OHPB), el 12/7/21
- Junta de diciembre del Comité de Equidad en la Salud (HEC), el 12/9/21
- Sesión n.º 3 del CPOP (en español), el 12/9/21
- Junta de diciembre del Comité Asesor de Medicaid (MAC), el 12/15/21
- Días de exención n.º 3: diseñar el futuro del OHP, el 12/16/21
- Sesión n.º 3 del CPOP (en inglés), el 12/17/21
- Junta de enero del Consejo de Políticas de Salud de Oregon (OHPB), el 1/4/22

Questions for those completing a survey on behalf of themselves

Indique su nombre, correo electrónico y código postal. (Los nombres de las personas que hagan comentarios públicos se darán a conocer cuando se envíe la solicitud final a los CMS).\*

- Nombre\* \_\_\_\_\_
- Apellido\* \_\_\_\_\_
- Dirección de correo electrónico (es obligatorio si asistes a un evento) \_\_\_\_\_
- Código postal\* \_\_\_\_\_

¿Es usted miembro del Plan de Salud de Oregon?\*

- Sí
- No
- No sé la respuesta

Si responde esta encuesta para si mismo, indique si es miembro de alguno de los siguientes grupos:\*

- Consumidor o miembro de la comunidad
- Abogo por los miembros
- Miembro de una tribu
- No sé la respuesta/me niego a responder

Questions for those completing a survey on behalf of someone else

Provea su nombre y código postal. (Los nombres de las personas que hagan comentarios públicos se darán a conocer cuando se envíe la solicitud definitiva a los CMS).

- Nombre\* \_\_\_\_\_
- Apellido\* \_\_\_\_\_
- Dirección de correo electrónico (es obligatorio si asistes a un evento) \_\_\_\_\_
- Código postal\* \_\_\_\_\_

¿La persona es miembro del Plan de Salud de Oregon?\*

- Sí
- No
- No sé la respuesta

Si responde esta encuesta en nombre de otra persona, indique a qué grupo representa esa persona:\*

- Consumidor o miembro de la comunidad
- Abogo por los miembros
- Miembro de una tribu
- Prefiero no responder/me niego a responder

*REALD and SOGI questions only available for those completing a survey on behalf of themselves or someone else*

## **REALD and SOGI**

Para identificar mejor las disparidades en la salud originadas por diferencias de raza, etnia, idioma, discapacidad, orientación sexual e identidad de género, el Oregon Health Authority (OHA) ha promovido el uso de estándares para la recopilación de datos sobre raza, etnia, idioma y discapacidad (Race, Ethnicity, Language, and Disability, REALD) y sobre orientación sexual e identidad de género (Sexual Orientation and Gender Identity, SOGI) en todo el OHA y el Departamento de Servicios Humanos de Oregon. Una recopilación minuciosa de datos sobre REALD y SOGI permitirá al OHA descubrir las inequidades y las estructuras institucionales que las fomentan. Los datos de REALD y SOGI son pilares fundamentales para eliminar las inequidades en la salud, lograr la equidad en la salud total y corregir los factores causales relacionados con el racismo, la discriminación y la opresión.

Si bien le recomendamos altamente que las responda, las preguntas sobre REALD y SOGI son totalmente opcionales y **no es obligatorio responderlas**. Puede negarse a responder algunas o la totalidad de estas preguntas. El OHA mantendrá bajo reserva las respuestas a las

preguntas de REALD y SOGI, y solo dará a conocer la información de manera tal que no se identifique a ninguna persona. Si tiene alguna inquietud en particular con respecto a la confidencialidad de las respuestas, indíquelo abajo.

Gracias por tomarse el tiempo para responder estas preguntas, las cuales nos permitirán saber cómo atender mejor las necesidades de los residentes del estado.

- Acepto
- Prefiero ir directamente a los comentarios públicos

**Edad (El OHA mantendrá bajo reserva las respuestas individuales a estas preguntas).**

Indique su edad. \_\_\_\_\_

**Identidad de género (El OHA mantendrá bajo reserva las respuestas individuales a estas preguntas).**

La orientación sexual e identidad de género son aspectos importantes de la diversidad en Oregon, donde los prejuicios en el sistema de atención médica pueden generar resultados no equitativos en la salud. Recientemente, la Legislatura de Oregon sumó un requisito para el OHA (y el Departamento de Servicios Humanos de Oregon) mediante el cual se exige recopilar e informar datos sobre la orientación sexual e identidad de género de los residentes de Oregon a los que estas organizaciones asisten, incluidos los miembros del Plan de Salud de Oregon (proyecto de ley 3159 [2021] de la Cámara de Representantes). Aunque el OHA no ha determinado la manera en que se recopilarán esos datos, estas son las preguntas que recomienda hacer el grupo de partes interesadas convocado por la División de Igualdad e Inclusión del OHA en 2018.

Describa su género de la manera que prefiera: \_\_\_\_\_

¿Cuál es su género? (Marque todas las opciones que correspondan):

- Mujer/niña
- Hombre/niño
- Agénero/ningún género
- No binario
- En duda
- No mencionado.  
Especifique: \_\_\_\_\_
- No sé
- No sé a qué se refiere esta pregunta

- Prefiero no responder

¿Es usted transgénero?

- Sí
- No
- No mencionado.  
Especifique: \_\_\_\_\_
- No sé
- No sé a qué se refiere esta pregunta
- Prefiero no responder

**Orientación e identidad sexual (El OHA mantendrá bajo reserva las respuestas individuales a estas preguntas).**

¿Cómo describiría su orientación o identidad sexual? (Marque todas las opciones que correspondan).

- Le gustan las personas del mismo género
- Le gustan las personas del mismo sexo
- Lesbiana
- Homosexual
- Bisexual
- Heterosexual (le atraen principalmente o únicamente las personas de otro género)
- Pansexual
- Asexual
- Queer
- Cuestionando
- No mencionado.  
Especifique: \_\_\_\_\_
- No sé
- No sé a qué se refiere esta pregunta
- Prefiero no responder

Describa su orientación o identidad sexual de la manera que desee: \_\_\_\_\_

**Raza y etnia (El OHA mantendrá bajo reserva las respuestas individuales a estas preguntas).**

¿Cómo identifica su raza, etnia, afiliación tribal, país de origen o ascendencia? \_\_\_\_\_

¿Cuál de las siguientes opciones describe su identidad racial o étnica? Marque TODAS las opciones que correspondan.

<b>Hispana y latino/a/x</b>	<b>De Oriente Medio o Del Norte de África</b>
• Centroamericano	• De Oriente Medio
• Mexicano	• Del Norte de África
• Sudamericano	<b>Asian</b>
• Otro hispano o latino	• Asiático indio
<b>Native Hawaiian and Pacific Islander</b>	• Camboyano
• CHamoru (Chamorro)	• Chino
• Marshalés	• Comunidades de Myanmar
• Comunidades de la región de Micronesia	• Filipino
• Nativo hawaiano	• Hmong
• Samoano	• Japonés
• Otro isleño del Pacífico	• Coreano
<b>White</b>	• Laosiano
• De Europa del Este	• Sudasiático
• Eslavo	• Vietnamita
• De Europa Occidental	• Otro asiático
• Otro blanco	<b>Otras categorías</b>
<b>Aborígen de América del Norte y Nativo de Alaska</b>	• Otro (indique)
• Aborígen de América del Norte	• No sé
• Nativo de Alaska	• Prefiero no responder
• Canadian Inuit, Metis, or First Nation	
• Indígena de México, América Central o América del Sur	
<b>Black and African American</b>	
• Afroamericano	
• Afrocaribeño	
• Etíope	
• Somalí	
• Otro africano (negro)	
• Otro negro	

Si marcó más de una categoría arriba, ¿hay alguna que considere como su identidad racial o étnica principal?

Sí. Indique su identidad racial o étnica principal  
abajo: \_\_\_\_\_

No tengo una identidad racial o étnica principal.

No. Me identifico como birracial o multirracial.

N/A. Marque una sola categoría arriba.

No sé

Prefiero no responder

**Idioma (El OHA mantendrá bajo reserva las respuestas individuales a estas preguntas).**

El OHA también hace preguntas sobre las necesidades de acceso al idioma a todos los miembros del OHP. A todos los participantes de comentarios públicos les haremos las mismas preguntas de acceso al idioma que a los miembros del OHP.

¿Qué idioma o idiomas habla en el hogar? \_\_\_\_\_

¿En qué idioma desea que nos comuniquemos en persona, por teléfono o virtualmente con usted? \_\_\_\_\_

¿En qué idioma quiere que le escribamos? \_\_\_\_\_

¿Necesita o desea un intérprete para que nos comuniquemos con usted?

- Sí
- No
- No sé
- Prefiero no responder

Si necesita o desea un intérprete, ¿qué tipo de intérprete prefiere? (Seleccione todas las opciones que correspondan).

- Un intérprete del lenguaje oral
- Un intérprete de sordos para ciegos sordos, con dificultades adicionales o ambos
- Un intérprete de lenguaje de señas estadounidense
- Un intérprete de lenguaje de señas Pidgin Signed English (PSE)
- Otro (indique): \_\_\_\_\_



¿Qué tan bien habla inglés?

- Muy bien
- Bien
- No muy bien
- Nada bien
- No sé
- Prefiero no responder

**Diferencias en la salud y los servicios (El OHA mantendrá bajo reserva las respuestas individuales a estas preguntas).**

Las respuestas a las siguientes preguntas nos permitirán saber de qué manera pueden afectar los cambios en el Plan de Salud de Oregon a las personas que tienen o no dificultades funcionales. Las respuestas son confidenciales. (\*Indique “no sé” si no sabe cuándo contrajo esta afección, o “prefiero no responder” si no desea contestar la pregunta).

¿Es usted sordo o tiene alguna dificultad auditiva grave?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

¿Es usted ciego o tiene dificultades visuales graves, incluso cuando usa anteojos?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

¿Tiene serias dificultades para caminar o subir escaleras?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

Debido a una afección física, mental o emocional, ¿tiene serias dificultades para concentrarse, recordar o tomar decisiones?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

¿Tiene dificultad para vestirse o bañarse?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

¿Tiene serias dificultades para aprender a hacer las tareas que la mayoría de las personas de su edad pueden aprender?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

Al usar su idioma habitual (tradicional), ¿tiene serias dificultades para comunicarse (por ejemplo, para entender a los demás o que le entiendan)?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder
- No sé a qué se refiere esta pregunta

Debido a una afección física, mental o emocional, ¿tiene dificultades para realizar diligencias solo, como visitar el consultorio del médico o ir de compras?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

¿Tiene serias dificultades con lo siguiente: estado anímico, sentimientos intensos, control de su comportamiento, o tiene delirios o alucinaciones?

- Sí. Si la respuesta es “Sí”, ¿a qué edad comenzó esta afección? \_\_\_\_\_
- No
- No sé
- Prefiero no responder

**Questions for those completing a survey as a representative of an organization**

Indique su nombre, correo electrónico, código postal, nombre de la organización que representa y cargo o puesto que ocupa. **(Los nombres se darán a conocer cuando se envíe la solicitud final a los CMS).**

- Nombre\* \_\_\_\_\_
- Apellido\* \_\_\_\_\_
- Dirección de correo electrónico (es obligatorio si asistes a un evento) \_\_\_\_\_
- Código postal\* \_\_\_\_\_
- Cargo o puesto que ocupa \_\_\_\_\_
- Nombre de la organización que representa \_\_\_\_\_

Además de representar a una organización, ¿es usted miembro del Plan de Salud de Oregon?\*

- Sí
- No
- No sé la respuesta

Seleccione el tipo de organización:\*

- Organización que defiende los intereses de miembros o comunidades
- Representantes tribales (podrían incluirse miembros del personal de clínicas tribales pero no proveedores, o identificarse como aborigen de América del Norte o nativo de Alaska en lo personal)
- Organizaciones basada en la comunidad que prestan servicios
- Sindicato
- Grupo de influencia o apoyo político
- Pagador: compañía de seguros de salud comerciales
- Pagador: organización de atención coordinada
- Proveedor: hospital o sistema de salud
- Proveedor o clínica: salud conductual
- Proveedor o clínica: salud bucal
- Proveedor o clínica: salud física
- Proveedor: centro de salud habilitado a nivel federal
- Proveedor: clínica o centro de salud tribal
- Departamento de salud pública
- Servicios sociales
- Agencia estatal
- Prefiero no responder/me niego a responder

¿Dónde ofrece servicios su organización? (Marque todas las opciones que correspondan).

- Centro (Crook, Deschutes, Hood River, Jefferson, Sherman, Wasco)
- Costa (Clatsop, Columbia, Coos, Lincoln, Tillamook)
- Este (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler)
- Área Metropolitana de Portland (Clackamas, Multnomah, Washington)
- Sur (Curry, Douglas, Jackson, Josephine, Klamath)
- Valle de Willamette (Benton, Lane, Linn, Marion, Polk, Yamhill)
- En todo el estado
- Mi organización no opera en Oregon

¿Su organización representa **principalmente** alguno de los siguientes grupos? (Seleccione todas las opciones que correspondan).

- Aborígenes de América del Norte o nativos de Alaska
- Miembros de las nueve tribus de Oregon reconocidas a nivel federal
- Nativos hawaianos e isleños del Pacífico
- Personas con discapacidad (por ejemplo, sordos, sordomudos o con problemas de audición, personas con discapacidad física, visual, intelectual/del desarrollo o de aprendizaje, o con enfermedades mentales, adicciones, trastornos por abuso de sustancias, etc.)
- Niños
- Adolescentes
- Adultos mayores (de más de 65 años)
- Negros y afroamericanos
- De Oriente Medio/Norte de África
- Hispanos y latinos
- Asiáticos
- Poblaciones que no hablan inglés o con dominio limitado del inglés
- Personas sin hogar
- LGBTQ+
- Comunidades religiosas
- Poblaciones económicamente desfavorecidas
- Comunidades rurales
- Comunidades de inmigrantes
- Comunidades de refugiados y solicitantes de asilo
- Comunidades indocumentadas
- Otro (describa):

*Questions available to all survey participants – to record their public comment*

### Envío de comentarios públicos

En el campo de texto de abajo, ingrese los comentarios públicos que desea enviar. **Esta información se hará pública.**

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También puede entregar los comentarios públicos en forma de documento. Carguelos aquí.

Solo podrá agregar un archivo con un tamaño máximo de 100 MB. Puede entregar varios archivos si los comprime primero en un archivo ZIP. Los comentarios se pueden hacer en un archivo PDF, de documento (DOC, DOCX, TXT, ODT), de hoja de cálculo (CSV, XLS, XLSX, ODS) o de gráfico (JPG, PNG, GIF). Por razones de seguridad, no se permite cargar archivos que se comparten para editar (como los que terminan en .exe).

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El OHA recibirá los comentarios públicos a partir del 7 de diciembre de 2021 hasta el 7 de enero de 2022, y publicará una lista con todos los comentarios recibidos, a más tardar, el 15 de

febrero de 2022. La lista de comentarios públicos y las respuestas del OHA se publicarán en el sitio web del OHA.

Para recibir información actualizada sobre la renovación de la exención 1115, incluyendo una notificación de cuando se publiquen en línea los comentarios y las respuestas, suscríbase a la lista de distribución de correo electrónico. Puede cancelar la suscripción en cualquier momento. \_\_\_\_\_

# Oregon 1115 Waiver - Public Comment Survey

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## Welcome to the Oregon 1115 Waiver Public Comment Survey

We will be accepting public comment from December 7, 2021 through January 7, 2022. If you are providing public comment on the 1115 Waiver Renewal Application draft and/or attending a meeting, thank you.

A copy of the waiver application can be found at this address:

<https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Renewal-Application.pdf>

As part of our efforts to improve the public engagement process, we would like to know more about who we are hearing from, and have included several questions about your demographics, whether you are a provider or from an organization, and if so, who you serve. These questions are optional, and this information will be kept confidential and will be used to plan focused outreach to groups we have not received input from.

This survey also allows you to type or upload your public comment about the draft 1115 waiver application. **This information, including your name, will be posted publicly when the final application is sent to CMS.** No demographic information will be included. We appreciate you taking the time to provide input on the draft application.

Who are you representing?\*

- I am representing myself
- I am providing comment as a family member, advocate, or authorized representative of another person who is unable to provide comment for themselves.
- I am representing an organization such as a provider, advocacy group, or lobbyist

### Public Comment Event Registration

You can register for any of the scheduled public comment events through this survey. Please indicate which meeting(s) you will be attending (or have already attended.) (Select all that apply)

- Oregon Health Policy Board (OHPB) December Meeting on 12/7/21
- Health Equity Committee (HEC) December Meeting on 12/9/21
- CPOP Session #3 (Spanish) on 12/9/21
- Medicaid Advisory Committee (MAC) December Meeting on 12/15/21
- Waiver Days #3: Designing the Future of OHP on 12/16/21
- CPOP Session #3 (English) on 12/17/21
- Oregon Health Policy Board (OHPB) January Meeting on 1/4/22

Will you or the individual need any of the following interpreter services to attend the event(s)?  
 Interpreters will be available to you for no charge.

- I do not need interpreter services
- Spoken language interpreter. Please indicate language of preference:  
 \_\_\_\_\_
- American Sign Language interpreter
- Deaf interpreter for DeafBlind, additional barriers, or both
- Contact sign language (PSE) interpreter
- Other. Please list \_\_\_\_\_

### Public Comment Request

Will you be providing verbal comments at any of the following scheduled public comment events? (Select all that apply)

NOTE: You will also have an opportunity to write or upload written comments at the end of this survey.

- Oregon Health Policy Board (OHPB) December Meeting on 12/7/21
- Health Equity Committee (HEC) December Meeting on 12/9/21
- CPOP Session #3 (Spanish) on 12/9/21
- Medicaid Advisory Committee (MAC) December Meeting on 12/15/21
- Waiver Days #3: Designing the Future of OHP on 12/16/21
- CPOP Session #3 (English) on 12/17/21
- Oregon Health Policy Board (OHPB) January Meeting on 1/4/22

### Questions for those completing a survey on behalf of themselves

Please provide your name, email, and zip code. (The names of individuals who provide public comment will be made public when the final application is submitted to CMS) \*

- First Name\* \_\_\_\_\_
- Last Name\* \_\_\_\_\_
- Email address (required if you are attending an event) \_\_\_\_\_
- Zip code\* \_\_\_\_\_

Are you an Oregon Health Plan member?\*

- Yes
- No
- I don't know



If you are filling out this survey yourself, please indicate if you are a member of any of the following groups:\*

- I am a consumer or community member
- I am a member advocate
- I am a Tribal member
- I don't know to answer/decline

Questions for those completing a survey on behalf of someone else

Please tell us your name and zip code. (The names of individuals who provide public comment will be made public when the final application is submitted to CMS.)

- First Name\* \_\_\_\_\_
- Last Name\* \_\_\_\_\_
- Email address (required if you are attending an event) \_\_\_\_\_
- Zip code\* \_\_\_\_\_

Is the individual an Oregon Health Plan member?\*

- Yes
- No
- I don't know

If you are filling out this survey on behalf of someone, please indicate what group the individual represents:\*

- I am a consumer or community member
- I am a member advocate
- I am a Tribal member
- I don't want to answer/Decline

## REAL-D

To better identify health disparities due to differences in race, ethnicity, language, and disability, sexual orientation and gender identity, the Oregon Health Authority (OHA) has promoted Race, Ethnicity, Language, and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) data collection standards across the OHA and the Oregon Department of Human Services. Comprehensive collection of REALD and SOGI data will allow OHA to unmask inequities and institutional structures that propel inequities. REALD and SOGI data are critical building blocks to eliminate health inequities in order to achieve full health equity and rectify the root causes related to racism, discrimination and oppression.

**You are not required** to answer the REALD and SOGI questions, and responding to these questions is completely optional, though we strongly encourage you to answer them. You can decline to answer some or all of the questions. OHA will keep your responses to the REALD and SOGI questions confidential and will only release information in a manner that does not identify any individual. If you have any particular concerns about the confidentiality of the

answers to these questions, please include that information below.

Thank you for taking the time to answer these questions so we can understand how to better serve the people of our state.

- Ok
- I would like to skip straight to inputting my public comment

**Age (OHA will keep your individual responses to these questions confidential.)**

Please indicate your age. \_\_\_\_\_

**Gender Identity (OHA will keep your individual responses to these questions confidential.)**

Sexual orientation and gender identity are important aspects of the diversity of Oregon where bias in the health care system can lead to inequitable health outcomes. The Oregon Legislature recently added a requirement for OHA (and the Oregon Department of Human Services) to collect and report data about the sexual orientation and gender identity of Oregonians served, including Oregon Health Plan members (House Bill 3159 (2021)). While OHA has not finalized how such data would be collected, these are the questions that were recommended by a stakeholder group convened by the OHA Division of Equity & Inclusion in 2018.

Please describe your gender in any way you prefer:

\_\_\_\_\_

What is your gender (check all that apply):

- Woman/ Girl
- Man/ Boy
- Agender/No gender
- Non-binary
- Questioning
- Not listed. Please specify: \_\_\_\_\_
- Don't know
- I don't know what this question is asking
- I don't want to answer

Are you transgender?

- Yes
- No
- Not listed. Please specify: \_\_\_\_\_
- Don't know
- I don't know what this question is asking
- I don't want to answer

**Sexual Orientation / Identity (OHA will keep your individual responses to these questions confidential.)**

How do you describe your sexual orientation or sexual identity? (Check all that apply)

- Same-gender loving
- Same-sex loving
- Lesbian
- Gay
- Bisexual
- Straight (attracted mainly to or only to other gender[s])
- Pansexual
- Asexual
- Queer
- Questioning
- Not listed. Please specify: \_\_\_\_\_
- Don't know
- I don't know what this question is asking
- I don't want to answer

Please describe your sexual orientation or sexual identity in any way you want:

\_\_\_\_\_

**Race and Ethnicity (OHA will keep your individual responses to these questions confidential.)**

How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

\_\_\_\_\_

Which of the following describes your racial or ethnic identity? Please check ALL that apply

<b>Hispanic and Latino/a/x</b>	<b>Middle Eastern/North African</b>
• Central American	• Middle Eastern
• South American	• North African
• Mexican	<b>Asian</b>
• Other Hispanic or Latino/a/x	• Asian Indian
<b>Native Hawaiian and Pacific Islander</b>	• Cambodian
• CHamoru (Chamorro)	• Chinese
• Marshallese	• Communities of Myanmar
• Communities of the Micronesian Region	• Filipino/a
• Native Hawaiian	• Hmong
• Samoan	• Japanese
• Other Pacific Islander	• Korean
<b>White</b>	• Laotian

• Eastern European	• South Asian
• Slavic	• Vietnamese
• Western European	• Other Asian
• Other White	<b>Other categories</b>
<b>American Indian and Alaska Native</b>	• Other (please list) _____
• Alaska Native	• Don't know
• American Indian	• Don't want to answer
• Canadian Inuit, Metis, or First Nation	
• Indigenous Mexican, Central American, or South American	
<b>Black and African American</b>	
• African American	
• Afro-Caribbean	
• Ethiopian	
• Somali	
• Other African (Black)	
• Other Black	

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- Yes. Please indicate your primary racial or ethnic identity below: \_\_\_\_\_
- I do not have just one primary racial or ethnic identity.
- No. I identify as Biracial or Multiracial.
- N/A. I only checked one category above.
- Don't know
- Don't want to answer

**Language (OHA will keep your individual responses to these questions confidential.)**

OHA also asks all OHP members questions about language access needs. We are asking anyone participating in public comment to answer the same language access questions that we ask OHP members.

What language or languages do you use at home? \_\_\_\_\_

In what language do you want us to communicate in person, on the phone, or virtually with you? \_\_\_\_\_

In what language do you want us to write to you? \_\_\_\_\_

Do you need or want an interpreter for us to communicate with you?

- Yes
- No
- Don't know
- Don't want to answer

If you need or want an interpreter, what type of interpreter is preferred? (select all that apply)

- Spoken language interpreter
- Deaf Interpreter for DeafBlind, additional barriers, or both
- American Sign Language interpreter
- Contact sign language (PSE) interpreter
- Other (please list): \_\_\_\_\_

How well do you speak English?

- Very well
- Well
- Not well
- Not at all
- Don't know
- Don't want to answer

**Health and Service Differences (OHA will keep your individual responses to these questions confidential.)**

Your answers to the following questions will help us understand how changes to the Oregon Health Plan may impact people with and without functional difficulties. Your answers are confidential. (\*Please indicate “don’t know” if you don’t know when you acquired this condition, or “don’t want to answer” if you don’t want to answer the question.)

Are you deaf or do you have serious difficulty hearing?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

Do you have serious difficulty walking or climbing stairs?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

Do you have difficulty dressing or bathing?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

Do you have serious difficulty learning how to do things most people your age can learn?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking

Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?

- Yes. If yes, at what age did this condition begin? \_\_\_\_\_
- No
- Don't know
- Don't want to answer

**Questions for those completing a survey as a representative of an organization**

Please provide your name, email, zip code, name of the organization you represent, and your role/title. **(Names will be made public when the final application is submitted to CMS)**

- First name\* \_\_\_\_\_
- Last name\* \_\_\_\_\_
- Email address (required if you are attending an event) \_\_\_\_\_
- Zip code\* \_\_\_\_\_
- Your role or title \_\_\_\_\_
- Name of the organization you represent \_\_\_\_\_

In addition to representing an organization, are you yourself an Oregon Health Plan member?\*

- Yes
- No
- I don't know

Please select the type of organization:\*

- Organization that advocates on behalf of members or communities
- Tribal representatives (might include tribal clinic staff but not providers, or identify as Native American or Alaskan Native individually)
- Community based organization that provides services
- Labor union
- Lobbyist or political advocacy group
- Payer - Commercial health insurer
- Payer - Coordinated Care Organization
- Provider - Hospital and/or health system
- Provider or clinic - Behavioral health
- Provider or clinic - Oral health
- Provider or clinic - Physical health
- Provider - Federally Qualified Health Center
- Provider - Tribal health clinic or center
- Public health department
- Social services
- State Agency
- Don't want to answer/Decline

Where does your organization provide services? (Check all that apply)

- Central (Crook, Deschutes, Hood River, Jefferson, Sherman, Wasco)
- Coast (Clatsop, Columbia, Coos, Lincoln, Tillamook)
- Eastern (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler)
- Portland Metro (Clackamas, Multnomah, Washington)
- Southern (Curry, Douglas, Jackson, Josephine, Klamath)
- Willamette Valley (Benton, Lane, Linn, Marion, Polk, Yamhill)
- Statewide
- My organization does not operate in Oregon

Does your organization **primarily** represent any of the following groups? (Please select all that apply)

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• American Indians and Alaska Natives</li> <li>• Native Hawaiian and Pacific Islanders</li> </ul>  | <ul style="list-style-type: none"> <li>• Members of Oregon’s nine federally recognized tribes</li> <li>• People with Disabilities (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/ substance use, etc.)</li> </ul> |
| <ul style="list-style-type: none"> <li>• Children</li> <li>• Older Adults (65+)</li> <li>• Middle Eastern/North Africans</li> <li>• Asians</li> </ul>   | <ul style="list-style-type: none"> <li>• Adolescents</li> <li>• Blacks and African Americans</li> <li>• Hispanic and Latino/Latina/Latinx</li> </ul>  |
| <ul style="list-style-type: none"> <li>• Houseless</li> <li>• Religious/faith</li> <li>• Rural communities</li> <li>• Refugee and asylum-seeking communities</li> <li>• Other (please describe):<br/>_____</li> </ul> | <ul style="list-style-type: none"> <li>• Limited English proficient and non-English proficient populations</li> <li>• LGBTQ+</li> <li>• Economically disadvantaged populations</li> <li>• Immigrant communities</li> <li>• Undocumented communities</li> </ul>                                    |

*Questions available to all survey participants – to record their public comment*

### Public Comment Submission

In the text field below, please include any public comments you would like to submit. **This information will be made public.**

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You may also upload your public comments as a document. Please upload them here. You may upload only one file that is up to 100MB. You may upload multiple files through one file upload question if the files are compressed into a ZIP file before uploading. Content options are PDF, Document (DOC, DOCX, TXT, ODT), Spreadsheet (CSV, XLS, XLSX, ODS), or Graphic



(JPG, PNG, GIF). For security reasons, executable files (such as those ending in .exe) are not permitted. \_\_\_\_\_

OHA will be collecting public comments December 7, 2021 – January 7, 2022. OHA will release a list of all comments received no later than February 15, 2022. The list of public comments and OHA's responses will be posted on the OHA website.

Sign up to the email list to receive updates about the 1115 Waiver Renewal, including a notification when comments and responses are posted online. You can unsubscribe at any time. \_\_\_\_\_

# Appendix C: Oregon’s Medicaid Quality Strategy

## I. Introduction

To monitor how well Oregon’s coordinated care model is achieving its goals of access, equity, quality and outcome improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have robust performance monitoring strategies and mechanisms to monitor and assess all Medicaid delivery systems (including coordinated care organizations [CCOs], dental care organizations (DCOs) and fee-for-service [FFS]).

As required by CFR 438.340, Oregon assesses how well the CCOs and managed care organizations are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees, and member satisfaction.

Oregon has developed a comprehensive program to assess all aspects of the delivery system and the CCO and DCO activities to determine quality improvement and contract compliance. This Quality Strategy describes the components of that program.

## II. Overview

### Framework for quality

To monitor quality, the Oregon Health Authority will build upon the eight currently implemented focus areas across Oregon’s health care delivery system. Continuing the progress in the focus areas, the Oregon Health Authority will intensify key focus areas, such as adding oral health to the existing primary care and behavioral health integration. Working collaboratively across the system, CCOs, DCOs and the Oregon Health Authority will support the framework through quality improvement in these focus areas. Focus areas are detailed in the following “Improvement Strategies” section.

Continuing on the pathway to achieve the Triple Aim, the Oregon Health Authority recognizes the need for alignment across all health care delivery systems for quality. Increased focus on alignment will include programs in Medicare, Medicaid (CCO and FFS systems) and federal improvement programs (for example, value-based payment). Working with a regional quality improvement organization (QIO), OHA’s External Quality Review Organization and health care delivery systems (CCOs, DCOs, FFS), the Oregon Health Authority will look for opportunities to align state efforts with federal direction in quality and transformation activities. While maintaining the state’s program integrity related to gains in health transformation, the Oregon Health Authority will develop strategic alignment for quality programs to increase organizations’ efficiency and decrease burden on the health systems for reporting and communicating common-thread goals that will continue Oregon’s work towards the triple aim of better health, better care and decreasing costs.

## Accountability summary

To drive innovation, improve health outcomes and maintain compliance with regulatory agencies, OHA is working across a variety of stakeholders, committees and oversight bodies to ensure CCO accountability and improve delivery system quality of care. This work is equity centered and rooted in increasing access and quality of care for Oregon Health Plan/Medicaid and CHIP members. Key attributes of this work include the following:

- Oregon Health Policy Board – develops strategic direction of health system transformation and is equity centered
- OHA Quality Council – monitors clinical quality performance, health system transformation and quality improvement
- Medicaid Advisory Committee – advises the OHA on the policies, procedures, and operation of the Oregon Health Plan.
- Quality management/contract compliance – monitors CCOs and DCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud, waste, abuse)
- Quality Management Committee – provides overall structure for the Oregon Health Plan quality governance to monitor and improve quality initiatives
- Health delivery system (partnership committees with delivery system and OHA)
  - Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation
  - Health Evidence Review Committee – reviews and develops evidence-based practices for all managed care entities (including FFS)
  - CCO Operations Collaborative and Contracts and Compliance Workgroup – monitors compliance with CCO contract requirements and provides guidance on operational implementation of requirements

## Methods and resources for monitoring

Across the Oregon Health Authority's quality programs, the agency utilizes multiple quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and LEAN principles are examples of proven methods of improvement. Ongoing use of these methods across the agency supports the transformation in the health care delivery system through train-the-trainer models with CCOs and contractual relationships with FFS. An additional resource for monitoring includes robust data systems to drive a data-decision culture. Key agency data include, but are not limited to, the all payer all claims database, performance monitoring through measures reporting, delivery system network reports, appeal and grievance data, and CCO data dashboards from claims reporting and deliverable tracking.

## Standards for managed care contracts

As required by CFR 438.340, Oregon must establish standards for all managed care contracts regarding access to care, structure and operations, and quality measurement

and improvement. Within the CCO and DCO contracts, the federal regulations are outlined with the applicable CCO and DCO deliverables to support quality through monitoring and contract compliance.

### **Compliance and expectations for CCOs and DCOs**

Achieving the policy objectives of CCO 2.0 requires a strong operational foundation with clearly defined performance expectations and a system to monitor compliance with all contract provisions. While some flexibility allows CCOs to meet the unique needs of their communities, OHA also has a responsibility to conduct effective oversight of the program to ensure members across the state receive the care they deserve.

OHA is developing the internal structures necessary to set the standard for accountability throughout the health care delivery system and to consistently apply that standard to all providers. To improve oversight and provide guidance to CCOs and DCOs, OHA created a comprehensive and standardized process for all OHA divisions to proactively evaluate, monitor and manage individual CCO remediation to the new CCO 2.0 contract. The standardized process also applies to monitoring of DCO performance. Aligning contract deliverables with a streamlined, transparent compliance review process will:

- Create a sustainable process that is standardized and driven by deliverable requirements, not variable and people driven.
- Ensure MCEs have clear information and guidance about deliverables for which they are accountable, OHA's review process, and corresponding timelines.
- Strengthen partnership and coordination between CCOs, DCOs and OHA.
- Enable remediation of process gaps and focus on prevention of future findings.

The standard evaluation process will ensure OHA is able to monitor and track CCO and DCO performance across all federal and state requirements. The contract requirements (deliverables) will be updated annually to improve clarity of requirements, reporting and deliverables, due dates, and the accountability process. Through this effort, OHA is developing more prescriptive guidance in areas where stakeholders have expressed concern about barriers to access or inconsistency; providing technical assistance, if needed; and utilizing enforcement mechanisms when necessary to achieve those outcomes.

Through improvements to the monitoring and compliance infrastructure, increased enforcement of new and existing requirements, and clarification of the performance expectations for CCOs, OHA plays an important role in creating the conditions for CCO, DCO and health transformation success.

### **Health priority alignment**

#### **CCO 2.0 priorities**

The next phase of Oregon's health care transformation, called CCO 2.0, is focused on four key areas identified by the Governor:

1. Improve the behavioral health system and address barriers to access to and integration of care.  
Integrate behavioral, physical and oral health to allow patients to receive the right care at the right time and in the right place. Focus on behavioral health (mental health and substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.
2. Increase value and pay for performance.  
Reward providers' delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.
3. Focus on social determinants of health and health equity.  
Build stronger relationships between CCOs and other sectors. In addition, align outcomes between health care and other social systems to improve health equity. Encourage a greater investment in prevention and the factors that affect our health outside the doctor's office
4. Maintain sustainable cost growth and ensure financial transparency.  
Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

These focus areas and the associated policies are the foundation of the CCO contracts awarded for 2020–2024.

### State Health Improvement Plan

OHA provides backbone support for implementation of the State Health Improvement Plan, Healthier Together Oregon (HTO). Oregon's 2020–2024 HTO identifies efforts needed to advance health equity for priority populations through collective action in five priority areas: institutional bias; adversity, trauma and toxic stress; access to equitable preventive health care; behavioral health; and economic drivers of health, such as housing, food security and living wage jobs. HTO is intended to be an alignment tool for anyone working to improve health, including other state agencies and partners who develop and implement community health improvement plans (CHPs). CCO CHPs are required to align with at least two HTO priorities and strategies. Finally, OHA convenes the PartnerSHIP, a community-based steering committee, to provide oversight and governance of the plan. The PartnerSHIP is made up of representatives of priority populations and implementers of the plan, including CCOs and their community advisory councils.

### Equity

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain

disadvantaged communities. Some communities are less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider.

OHA utilizes several levers to improve health equity. The coordination of these levers and the monitoring and accountability are essential actions to have the greatest impact. Levers include, but not limited to, measurement monitoring and reporting across racial and ethnic disparities, health equity pay for performance incentive metric, CCO health equity plans, equity components of the CCO Transformation and Quality Strategy, and connections to the community health improvement plans and regional health equity coalitions.

To reinforce Oregon Health Authority's commitment to improve health and equity, OHA adopted a 10-year goal and an equity definition as a foundation for the agency's work. The strategic goal was informed by an extensive community engagement process throughout the state to ensure the agency was especially responsive to people in Oregon most impacted by health inequities stemming from long-standing and contemporary racism and oppression. The process also allowed for understanding where work needs to focus, robust internal and external coordination, and impacts around how to think about and work towards achieving health equity.

*OHA 10-year goal: To end health inequities in the state of Oregon by 2030.*

10-year goal key questions:

- How do we address the equitable distribution and redistribution of resources and power?
- How does this impact our policy, practice and decision making?
- What do we need to do differently?

### *Health equity definition*

In October 2019 the Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) adopted the health equity definition developed by the Health Equity Committee (a subcommittee of OHPB). The definition states that:

*Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*

*Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*

- *The equitable distribution or redistribution of resources and power; and*
- *Recognizing, reconciling and rectifying historical and contemporary injustices.*

### III. Methods

#### Accountability methods

Oregon has developed a comprehensive program to assess all aspects of the delivery system. This program involves routine analysis and monitoring of delivery system performance and consumer satisfaction data, comprehensive on-site operational reviews, and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews (described below).

#### Ongoing focused reviews

Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through routine monitoring processes and grievance and appeal reporting. These reviews will also provide more detailed information on areas of particular interest to the state such as emergency department visits, availability and access of services, behavioral health, utilization management, and data collection problems. An example of a focused review is an ongoing review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

#### Appointment and availability studies

The purpose of these studies is to review managed care and FFS provider availability/ accessibility and to determine compliance with contractually defined performance standards. The Oregon Health Authority (OHA) and its external quality review organization (EQRO) conduct a secret shopper telephone survey among primary physical health care providers (PCPs) contracted with one or more CCOs. The primary purpose of this secret shopper survey is to collect appointment availability for Oregon Health Plan (OHP) members new to the provider location and requesting routine well-checks or non-urgent problem-focused ("symptomatic") visits. Specific survey objectives included the following:

- Determine whether PCP service locations accepted OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligned with the CCOs' delivery system network (DSN) provider capacity report data
- Determine whether PCP service locations accepting OHP for the requested CCO accepted new patients and the degree to which new patient acceptance aligned with the CCOs' DSN provider capacity report data
- Determine appointment availability with the sampled PCP service locations for routine well-checks and non-urgent symptomatic visits

#### Marketing and member materials review

Managed care contractors are contractually required to submit all marketing materials or advertising, and written member notices to the state for approval prior to use. This

process ensures the information presented to members and potential members is compliant with state and federal requirements.

### Performance monitoring

Through the standardized deliverable evaluation process, OHA will have the ability to compare and measure performance across all CCOs and DCOs for a variety of deliverables. OHA is improving the reporting and systems used to measure performance in key priority areas: timely and appropriate denials, appeals, hearings and grievances; access to language translation services; quality of non-emergent medical transportation services; adequacy of provider network; access to care coordination services and intensive care coordination services; and integration of behavioral health services.

### On-site operational reviews

On-site reviews will be conducted periodically as a result of, gaps in performance, requested by CCO, or requested by the EQRO for example. Reviews will include, but not limited to, validating reports and data previously submitted by the CCO, an assessment of supporting documentation, and/or conducting a more in-depth review of the CCO's quality assurance activities. Reviews will also serve as an opportunity for in-person, one-on-one technical assistance in identified gap area. For example, a site visit relating to performance improvement projects will include a refresher in CCO deliverable, applicable state and federal requirements and provide technical assistance in root cause development and aim statement objectives.

Furthermore, on-site review(s) supplement the state monitoring program of CCOs with direct and focused areas of improvement.

### Quality Management Committee reviews

The OHA Quality Management Committee meets quarterly to review contract compliance issues across all delivery systems in aggregate and performance metrics.

As per STC 24b.ii, OHA will contractually require each CCO to address four of the quality improvement focus areas, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

## Performance improvement

### Advancing PIPs

Moving forward, the PIP strategies are maturing into use of technology around care coordination and expanding into integrated practices. Allowing for the CCOs who have developed data monitoring systems, case management programs, and measurement



alignment to develop initiatives in the space of social determinants of health will be key continuing to push health transformation. Additionally, lessons learned from the 2012–2017 demonstration for PIP implementation have led to the development of SMART (specific, measurable, attainable, relevant, timely) objectives with a corresponding measurement for monitoring progress. Future technical assistance and monitoring will continue to focus on these quality improvement foundations.

### PIP focus areas

To move forward in testing and implementing improvement strategies, the CCOs will be required to conduct four performance improvement projects. Two of the four will be selected from the focus area list by the CCO, the third will be a statewide PIP under the “integration of health” focus area, and the fourth PIP will be a statewide substance use disorder PIP. The quality improvement focus areas, as referenced in Oregon’s 2017–2022 1115 Waiver Attachment E are:

1. Reducing preventable re-hospitalizations;
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs;
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers;
4. Integration of health: physical health, oral health and/or behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care;
7. Improving primary care for all populations through increased adoption of the Patient- Centered Primary Care Home (PCPCH) model of care, and
8. Social determinants of health

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. PIP focus areas are subject to change as CCOs mature.

### External Quality Review Organization (EQRO) activities

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities’ (MCEs’) performance related to the quality of, timeliness of, and access to care and services provided by each entity, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Oregon Health Authority (OHA) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to perform the assessment. The EQRO performs the following mandatory and optional external quality review (EQR) activities, as described in 42 CFR Part 438 and 42 CFR §438.358.

- Compliance monitoring reviews to determine MCE compliance with federal (42 CFR §438) and State standards that address requirements related to access, structure and operations, and quality measurement and improvement. CMR activities also included follow-up on the status of past CMR findings and related improvement plans for the DCOs from calendar year 2019.
- Validation of performance improvement projects and focus studies.
- Performance measure validation of seven specific measures to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for the State's CCOs.
- Validation of network adequacy involving the comprehensive review of MCE delivery system network (DSN) provider capacity reports and DSN provider narrative reports regarding compliance in accordance with the State's standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.
- An encounter data validation study to evaluate CCO processes for collecting, maintaining, and submitting encounter data to OHA.
- A mental health parity analysis to ensure that coverage and access to mental health/substance use disorder benefits were provided in parity with medical/surgical benefits.

### Surveys

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

Seventeen CAHPS measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

## IV. Quality components

### Quality management plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance.

### Transformation and quality strategy

The transformation and quality strategy (TQS), developed in 2017, incorporates all components of the Quality Assessment and Performance Improvement (QAPI) program. The QAPI has been incorporated into the CCO's TQS and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. The TQS specifically focuses on CCO documentation of key efforts across the following components, as well as documentation of the CCO's overall quality program within the CCO's larger strategic plan:

- Access: quality and adequacy of services
- Access: cultural considerations
- Access: timely
- Behavioral health integration
- CLAS standards
- Grievance and appeal system
- Health equity: data
- Health equity: cultural responsiveness
- Oral health integration
- Patient-centered primary care home: member enrollment
- Patient-centered primary care home: tier advancement
- Serious and persistent mental illness
- Social determinants of health & health equity
- Special health care needs
- Utilization review

CCO TQS documentation will be monitored to ensure a robust CCO quality and transformation program, in accordance with best practices and CFR. This includes a formal OHA assessment and scoring of each CCO TQS submission with actionable feedback to support continuous quality improvement. The TQS will also be used as a basis for peer sharing of evidence-based and emerging best practices to further health transformation across CCOs. See "Expectations of CCOs" section above for further details.

### Health equity plan

As a CCO 2.0 contract deliverable, CCOs are required to develop and submit a yearly health equity plan. The health equity plan aims to provide the CCO and its stakeholders a clear framework to becoming an organization that values and prioritizes health equity. The framework includes an action plan detailing where the CCO is headed, what it plans to achieve, the methods it will use, and milestones to monitor progress. A successful health equity plan is built on a thorough analysis of the existing CCO structure, governance, staff, program or service mix, collaborations and resources, including financial, human, technical and material. This analysis is vital because it

allows an organization to understand which components it must change to achieve its goals related to health equity.

OHA requires all CCOs to develop a health equity plan that:

- Acts as a catalyst to initiate the deep organizational changes needed to build equity and diversity into service planning and delivery in the organization, community and provider network;
- Creates the foundation to build equity into ongoing accountability, resource allocation and performance management relationships between OHA, the CCO and the provider network;
- Provides a visible and concrete context for widespread discussion of health equity – within individual organizations, within sectors, across sectors, and in the wider community; and
- Incorporates and operationalizes the health equity definition.

### Performance improvement projects

#### Overview of CCO PIPs

Under Oregon's 1115 2012–2017 demonstration waiver, CCOs developed performance improvement projects (PIPs) in a few key areas: high utilizers, maternal care, increased patient assignment within PCPCH medical homes, and diabetes care for individuals with serious and persistent mental illness. Development of effective coordination strategies across health systems, primary care, specialty care and hospital systems for high utilizers and reducing rehospitalizations is an ongoing effort. The PIPs initially focused on breaking down the silos of care and expanding care delivery to team-based approaches. A few key lessons learned from adolescent well-care visits and maternal health have been helpful in providing for patients' social determinants of health (food insecurity, stable transitions, supportive services); therefore, an additional focus area has been added for CCOs to test new models in the area of social determinants of health.

### Access

#### Network adequacy

Federal and State regulations require each Medicaid managed care contractor to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. As of December 2020, CMS has not published the validation of network adequacy protocol referenced in federal regulations for managed care. Each contractor must submit documentation to the State Medicaid

authority<sup>1</sup> demonstrating the contractor's capacity to serve enrolled members in its service area in accordance with the State's standards for access to care.<sup>2</sup>

The Oregon Health Authority (OHA) is currently performing an analysis to document the accessibility of CCO provider networks and to assess compliance with existing network standards and requirements. OHA is looking at three key dimensions to explore and understand beneficiary access to care (network capacity, geographic distribution, and availability of service). Network capacity addresses the underlying foundation of the provider network and refers to the supply of provider services available to beneficiaries. Using a variety of measures (for example, provider-to-beneficiary ratios and provider counts), an assessment of the underlying capacity of a provider network can be obtained. If services are available and an adequate supply of providers and services are present, the opportunity to obtain health care exists, suggesting that beneficiaries may have access to services.

Once capacity and infrastructure are established, it is important to understand the extent to which beneficiaries can gain access to reported services. However, gaining access to and utilization of services are dependent upon physical accessibility and acceptability of services, not simply on adequacy of supply. Geographic distribution addresses whether or not the distribution of available services is adequate to facilitate access to all beneficiaries. Key measures for assessing the geographic distribution of providers include time/distance analyses and compliance with network adequacy requirements. When combined with beneficiary and provider characteristics, these analyses will determine the extent to which the supply of providers is distributed appropriately relative to the beneficiary population. However, even with adequate capacity and appropriate distribution of services, assessing the availability of relevant services is critical in making sure beneficiaries have access.

The third dimension of access, availability of services, is important for understanding the extent to which network services are relevant and effective in producing positive health outcomes. The availability of services will be assessed in terms of appointment availability, utilization and/or outcomes of services. Taken together, the three dimensions offer a broad understanding of the factors impacting beneficiaries' access to care. The framework addresses the intersection of a network's underlying infrastructure (making services available), distribution (getting the services to beneficiaries) and availability (having the right kind of services available when needed). The analysis will help OHA identify network adequacy gaps and improve the network adequacy requirements at the state level.

### Network adequacy monitoring

Pursuant to 42 CFR §438.206 and 42 CFR §438.207, the MCEs are required to demonstrate to OHA, with supporting documentation, that all covered services are

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<sup>1</sup> 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5).

<sup>2</sup> See 42 Code of Federal Regulations (CFR) §438.206 and §438.207; Oregon Administrative Rules (OAR)410-141-3515.

available and accessible to members and that they have adequate provider capacity. To support federal and state network adequacy requirements, the MCEs are contractually required to develop and submit DSN reports that consist of two components, an annual DSN provider narrative report and quarterly DSN provider capacity reports, that crosswalk to the network standards in the MCEs' contracts with the State.

### *DSN provider narrative*

The DSN provider narrative report requirement defines five categories based on OHA's MCE contract requirements. Each category includes corresponding elements that require the MCEs to describe and submit comprehensive narrative responses and analysis demonstrating how the MCEs ensure, monitor and evaluate adequate provider capacity, including geographic location of network providers and members, considering distance, travel time, member needs, coordination of care and performance metrics. MCEs must, at a minimum, incorporate the provided specifications into their comprehensive written responses and supplemental documentation (for example, policies, procedures, manuals, analytics) and demonstrate how the DSN is monitored to ensure adequate provider capacity and member access.

If any component of a MCE's DSN is subcontracted or delegated, the MCE must also include a narrative response and supplemental documentation (for example, policies, procedures, manuals, analytics), including three OHA-defined time and distance standards for each geographic classification in its service area, describing how delegated services are integrated with the MCE's overall DSN, and how the MCE monitors its delegated providers, ensuring compliance with federal and State provider network requirements.

The DSN provider narrative report additionally requires each MCE to document its compliance with OHA's travel time and distance standards pursuant to OAR 410-141-3515. MCEs demonstrate compliance by reporting the time and distance standards of minutes and miles of overall member access for each geographic classification in its service area.

### *DSN provider capacity report*

MCEs submit a DSN provider capacity report, which is an inventory of the MCEs' providers and facilities, using a template provided by OHA. All participating providers, either employed directly or through subcontract with an MCE and providing services to Medicaid members, were included. Required data elements of the report are outlined in the OHA 2020 Health MCE Contracts (Exhibit G(2)(a)). Each provider capacity report is evaluated on four domains:

- Quality of DSN provider capacity reporting
- Provider network count
- Provider accessibility
- Geographic distribution

Using member data, a time and distance analysis is performed looking at the following key measures:

- Percentage of members living within the time/distance standards.
- Average time (in minutes) and distance (in miles) to the nearest three providers for each provider type evaluated (for example, primary care providers and hospitals)

### *Provider directory validation*

OHA is also carrying out a variety of supplemental activities to assess access to providers and provider information. For example, OHA contracted with its EQRO to perform a provider directory validation activity to ensure members have appropriate access to provider information. For the provider directory validation, key elements published in the online provider directories were compared with the data in the provider capacity reports and will confirm each MCE's website meets the federal requirements in 42 CFR §438.10(h), OAR 410-141-3585, and relevant State contractual requirements.

### *Secret shopper survey*

OHA contracted its EQRO to conduct a secret shopper telephone survey among primary physical health care providers (PCPs) contracted with one or more CCOs. The primary purpose of this secret shopper survey is to collect appointment availability for Oregon Health Plan (OHP) members new to the provider location and requesting routine well-checks or non-urgent problem-focused ("symptomatic") visits. Specific survey objectives include the following:

- Determine whether PCP service locations accept OHP members enrolled with the requested CCO and the degree to which CCO and OHP acceptance aligns with the CCOs' delivery system network (DSN) provider capacity report data.
- Determine whether PCP service locations accept OHP for the requested CCO accepted new patients and the degree to which new patient acceptance aligned with the CCOs' DSN provider capacity report data.
- Determine appointment availability with the sampled PCP service locations for routine well-checks and non-urgent symptomatic visits.

## **Provider Oversight**

### **Credentialing**

CCOs and MCO plans must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider's National Practitioner Data Bank profile. FFS providers are also enrolled through the state's Provider Enrollment Unit, which confirms that Medicaid, Medicare or other state agencies have not sanctioned providers. Additionally, all credentialed providers must

verify regularly through the Office of Inspector General and SAMHSA for compliance with conflict of interest standards.

Policy requirements include standards on credentialing, privileging, conflict of interest compliance including time and interval of credentialing functions. CCOs must also work with OHA to assure proper credentialing of mental health programs, associated providers and traditional health care workers.

### Licensing

CCOs and MCOs must ensure all licensed or certified providers maintain active licenses or certifications. The CCOs and MCOs must monitor provider licenses and certifications for any adverse action from a licensing or certifying entity and develop a process for reviewing a provider's contractual status due to any adverse action. All actions against a provider's license, certification or contractual status with a CCO or MCO must be immediately reported to the Provider Enrollment Unit through the [OHA.Provider.Review@dhsoha.state.or.us](mailto:OHA.Provider.Review@dhsoha.state.or.us) email address. Adverse action reports must include the provider information, the action taken by the CCO or MCO and all supporting documents.

### Member Satisfaction

#### Ombuds team

Pursuant to Oregon Revised Statute (ORS) 414.712, OHA provides Ombuds services to individuals who receive medical assistance through Oregon's Medicaid program. The Ombudsperson serves as the advocate for Oregon Health Plan (Medicaid and Children's Health Insurance Program) recipients in these areas:

- Access to care;
- Quality of care; and
- Channeling member experience into recommendations for system improvement.

The OHA Ombuds position is a formal, internal voice for process and system improvements responsive to identified trends impacting services for the more than 1.2 million Oregonians served by the Oregon Health Plan. This work is essential for health care transformation that is grounded in the needs of Oregonians and informs the Ombuds Program recommendations for client-focused process and system improvements with OHA and ODHS. As required by ORS 182.500, the OHA Ombuds Program provides a quarterly report to both the Governor and the Oregon Health Policy Board. Each person who makes it to the Ombuds Program deserves nurturing and support. The stories they share often illustrate challenges many others experience. Each story brings lessons for ways to improve Oregon's Medicaid delivery system.

### Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) is a federally mandated body that advises OHA and DHS leadership, the Oregon Health Policy Board, the Legislature and the Governor's office about the operation and administration of the Oregon Health Plan



from a consumer and community perspective. The MAC's role includes reviewing Oregon's Medicaid Quality Strategy, changes to OHA's quality rating strategy for managed care organizations, managed care marketing materials, and the access monitoring plan for OHP members enrolled in the Open Card plan (FFS Medicaid). Additionally, the MAC receives information about CAHPS survey findings, Ombuds Program updates, grievance and complaint data trends, and CCO deliverables that provide visibility into Oregon's health transformation from a consumer experience lens.

### Grievances and appeals

The state's contracted EQRO evaluates MCE's compliance with Grievance and Appeal System requirements including: grievance and appeal processes, provision of information to members and contracted providers, and adherence to time frame and notification requirements, pursuant to 42 CFR §438.400-424, applicable Oregon Administrative Rules (OARs), and contractual requirements. The MCE's are evaluated against the following requirements:

- Implementing written procedures for accepting, processing and responding to all grievances and appeals, consistent with requirements.
- Providing information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.
- Providing members with information on their rights regarding grievances, appeals and contested case hearings and allowing for members to freely exercise their rights without discouragement or retaliation.
- Adhering to content requirements for notifications sent to members.
- Adhering to required time frames for notifications, resolution of grievances and appeals, expedited requests, extended time frames and contested case hearings.
- Advising members of the process for continuation of benefits and adhering to delivery of services and payment requirements.
- Complying with record-keeping requirements for grievances and appeals.

In addition, OHA requires MCEs submit a quarterly report including a log of complaints, denials, appeals, and all NOABDs issued for Applied Behavioral Analysis and Hepatitis C issued to members during the previous quarter. OHA selects a random sample of denials from the log and each MCO must submit the selected sample of Notices of Adverse Benefit Determination (NOABDs) and associated Prior Authorization (PA) documentation. The NOABD sample submitted by each MCO is evaluated against criteria inclusive of state and federal requirements.

The summary of all complaints registered during that quarter, along with a more detailed record of all complaints that have been unresolved for more than 30 days. A uniform report format has been developed to ensure that complaint data is consistent and comparable. OHA uses complaint data to identify developing trends that may indicate a

problem in access, quality of care, and/or education. Grievance and appeals report also identify FFS provider trends.

Improving upon the uniformed report will be the next step with administrative simplification through technology updates to the report, which will lead to deeper analysis for trend reporting. Analysis through the updated automated report will provide greater detail for health system (oral health, behavioral health, physical health) delineation of complaints origin and tracking of topic issues (e.g. non-emergency medical transportation) across the CCOs simpler. Potential changes also include developing systems for details regarding dual eligible client complaint tracking to ensure a smooth transition from passive enrollment.

On an annual basis, the OHA reviews MCO Grievance and Appeal System Policies and Procedures (P&Ps) to ensure they meet the requirements of OARs, 42 CFR §438.406, and address how the MCE will accept, process, and respond to Grievances, Notices of Adverse Benefit Determinations, Appeals, and Hearings.

### Surveys

Seventeen CAHPS measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

### Quality payment programs

#### Medicaid Efficiency and Performance Program

Performance Based Reward (PBR) is a financial incentive program under CCO 2.0 designed to incentivize spending on health-related services, while controlling costs, maintaining quality and improving efficiency. One component of PBR is the Medicaid Efficiency and Performance Program (MEPP); CCOs must participate in MEPP work to be eligible for PBR. MEPP is based on an efficiency and quality algorithm that reviews claims data and identifies adverse actionable events (AAE) — downstream medical complications that could potentially be avoided with better upstream care. CCOs are asked to design interventions for three different types of episodes (such as diabetes, SUD, and asthma) with the goal of improving outcomes as measured by AAE.

#### Qualified directed payments

CCOs are required by contract to administer qualified directed payments (QDPs) as directed by OHA, and as approved by CMS. OHA will continue to follow federal guidance on how to reference this quality strategy to support the quality improvement goals of each QDP.

## Fiscal monitoring

### Fraud, waste and abuse

The CCOs must submit complaints of or allegations of suspected fraud or abuse, within 7 days, that are made to or identified by the CCO and warrant preliminary investigation. The CCO must also submit the following information on an ongoing basis for each case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees or any other source:

- The name, NPI and tax ID (or member ID number) of the individual or entity that is suspected of committing the fraud or abuse;
- The source that identified the fraud or abuse;
- The type of provider, entity, or organization that is suspected of committing the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data or information as requested.

The CCOs also conduct audits of providers, subcontractors and other third parties to identify overpayments and uncover suspected fraud and abuse. CCOs provide quarterly and annual audit reports to OHA and report any recouped overpayments from their audit activities on the quarterly and annual Exhibit L financial reports.

OHA Office of Program Integrity conducts audits on an ongoing basis of FFS providers as well as managed care participating providers, CCO subcontractors and third parties or downstream entities receiving Medicaid funds through a CCO.

## Surveys

### CAHPS

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

### MHSIP

The Mental Health Statistics Improvement Program (MHSIP) are a set of validated surveys to measure clients' perceptions of the quality and efficiency of the mental health services they receive. The program consists of four surveys fielded annually, which vary

based on the client's age and the type of services they received. These surveys are: 1) adults who have received outpatient services; 2) adults who have received residential treatment services; 3) parents or guardians of youth 0-17 years of age who have received mental health services; and 4) youth 14-17 years of age who have received mental health services. The four surveys assess perception of mental health services across several domains, such as access to services, quality of services, satisfaction with surveys, and treatment outcomes and participation.

## V. Quality measurement

### Performance measures

Established in the 2012 waiver, and corresponding state legislation, the CCO quality incentive program is a mechanism for focusing CCO efforts and driving continuous quality improvement. Financial incentives are a key strategy for stimulating quality of services and for moving from a capitated payment structure to value-based purchasing. Oregon's strategy has been to annually increase the percentage of CCO payment at risk for performance, providing a meaningful incentive to achieve significant performance improvement and affect transformative change in care delivery. To date, the CCO incentive metrics program has been a success, and CCOs show improvements in a number of incentivized areas, as documented in the 2019 [CCO Metrics Performance Report](#).

Measures in the CCO quality incentive program are selected annually by the Metrics and Scoring Committee, from the menu of measures established by the Health Plan Quality Metrics Committee (HPQMC). The Metrics and Scoring Committee also sets the benchmark for each measure. Detailed measure specifications, technical documentation and additional guidance are all published online.

## VI. Quality Strategy governance

### Quality structure

The Oregon Health Authority (OHA) is comprised of subject matter experts in evidence-based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency-wide committees responsible for oversight and planning. Underpinned across the quality and health transformation elements are health equity and social determinants of health with key contributions at the leadership committee level.

Oregon Health Authority structure to support quality and access monitoring:

- Oregon Health Authority
  - Oregon Health Policy Board
  - OHA Quality Council
  - Medicaid Advisory Committee

## Oregon’s Medicaid Quality Strategy

- Quality Management Program and contract compliance
- Quality Management Committee
- Health delivery systems
  - Quality and Health Outcomes Committee
  - Health Evidence Review Committee
  - CCO Operations Collaborative and Contracts and Compliance Workgroup

### Review of Quality Strategy

The OHA Quality Strategy shall be reviewed annually by OHA. The OHA Quality Strategy review and update will be completed by December of each year and submitted to CMS, upon significant changes, in the subsequent quarterly report update.

The OHA Quality Council shall have overall responsibility to guide the annual review and update of the Quality Strategy. The review and update shall include an opportunity for both internal and external stakeholders to provide input and comment on the Quality Strategy. Key stakeholders shall include, but are not limited to:

- Addictions and Mental Health Planning and Advisory Council\*
- Medicaid Advisory Committee\*
- Health Systems Division Executive Team
- Health Policy and Analytics Management Team
- OHA Executive Team
- CCO medical directors
- FFS contractors
- CCO quality management coordinators
- Local Government Advisory Committee\*
- DHS internal stakeholders
- OHA internal stakeholders
- Health Equity Committee\*

\* Committees including consumer representatives.

Final versions will be posted on the OHA website.

### Enforcement

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance and reports for monitoring. If a plan cannot meet a reporting deadline, a request for an extension must be submitted in writing to the division. The division will reply in writing as well, within one week of receiving the request. Plans that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: (1) contact the division within one week with an acceptable extension plan; or (2) submit the information within one week.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. If these efforts are not producing results, a corrective action plan may be jointly developed, and the plan monitored for improvement. More aggressive enforcement options that OHA may apply include restricting enrollment, financial penalties and ultimately, non-renewal of contracts.

Conditions that may result in sanctions:

1. Fails to authorize or otherwise substantially provide Medically Appropriate services that Contractor is required to authorize and provide to a Member in accordance with applicable State or federal law or as required under this Contract;
2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under this Contract or applicable State or federal law; Contractor shall not charge Members any Premiums for any services provided pursuant to this Contract.
3. Acts to discriminate among Members on the basis of their protected class such as race, ethnicity, national origin, religion, sex, sexual orientation, marital status, age, disability, health status, or need for health care services. Acts that may be evidence of discrimination include, but are not limited to: (i) Disenrollment of, or refusal to reenroll, a Member, except as permitted under this Contract, (ii) any practice that would reasonably be expected to discourage Enrollment, or (iii) any practice that seeks or encourages the Disenrollment of individuals whose protected class, medical condition or history indicates probable need for substantial future Medical Services;
4. Misrepresents or falsifies any information that is required to be submitted to CMS, the State, or their designees under this Contract, including but not limited to any such information submitted in: (i) or in connection with Contractor's Application, or enrollment with CMS, (ii) any certification made in connection with this Contract, (iii) any report required to be submitted under this Contract, or (iv) any other documentation or other communication provided to the State, CMS, or their designees relating to the care or services provided to a Member or as otherwise required to be made under this Contract;
5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;
6. Fails to comply with the requirements for Physician Incentive Plans, as the requirements are set forth in 42 CFR §422.208 and §422.210 and this Contract;
7. Fails to comply with the operational and financial accounting and reporting requirements required under Ex. L of this Contract
8. Fails to maintain a Participating Provider Network sufficient to ensure adequate capacity to provide Covered Services to its Members under this Contract;

9. Fails to implement and maintain an internal Quality Improvement program, a Fraud, Waste and Abuse prevention program, a Quality Assurance and Performance Improvement Program, or to provide timely reports and data in connection with the such programs as required under this Contract;
10. Fails to comply with Grievance and Appeal System requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, or record keeping and reporting requirements;
11. Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services as required under this Contract;
12. Fails to make timely claims payments to Providers or fails to provide timely approval of authorization requests;
13. Fails to disclose required ownership information or fails to supply requested information to OHA relating to Contractor's Subcontractors or suppliers of goods and services;
14. Fails to submit accurate, complete, and truthful Pharmacy or Non-Pharmacy Encounter Data in the time and manner required by Ex. B, Part 8;
15. Distributes directly or indirectly through any Agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information;
16. Violates of any of the other applicable requirements of sections 1903(m), 1932 or 1905(t) of the Social Security Act and any implementing regulations; or
17. Violates any of the other applicable requirements of 42 USC §1396b(m) or §1396u-2 and any implementing regulations.

### Technical report

The technical report provides a feedback loop for ongoing quality strategy direction and development of any technical assistance training plans. In addition to the statement of deficiencies and resulting plans of correction, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

### Appendix A: CCO Contract

The CCO managed care contract template can be found on the OHA website for CCO contract forms. <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>

### Appendix B: Quality definitions

#### Disability in adults

The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) that

can be expected to result in death or that have lasted or can be expected to last for a continuous period of not less than 12 months.

### **Disability in children**

Under title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Source: <https://www.ssa.gov/disability/professionals/bluebook/general-info.htm>



# Appendix D: Interim Evaluation

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-25-26  
Baltimore, Maryland 21244-1850



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## State Demonstrations Group

January 26, 2022

Dana Hittle  
Interim Medicaid Director  
State of Oregon, Oregon Health Authority  
500 Summer Street, NE E49  
Salem, OR 97301

Dear Ms. Hittle:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Oregon Health Plan Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs) of Oregon's section 1115 demonstration, "Oregon Health Plan" (Project Nos: 21-W-000 13/10 and 11-W-00160/10). The demonstration is authorized from January 12, 2017 through June 30, 2022. CMS determined that the Interim Evaluation Report, which was submitted on June 28, 2021 and revised on October 15, 2021, is in alignment with the approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Interim Evaluation Report. In accordance with the STCs, the approved Interim Evaluation Report may now be posted to the state's Medicaid website within thirty days. CMS will also post the Evaluation Report on Medicaid.gov.

The report is organized around four thematic goals of the demonstration: behavioral health integration, oral health integration, expanding CCO use of health-related services (HRS), and improving health outcomes for dually-eligible individuals. The report shows that considerable progress has been made toward achieving these goals over the course of the demonstration time period, although caution in interpretation of these results is warranted as these findings may have been impacted by policies and programs outside of this demonstration. Overall and potentially-avoidable emergency department (ED) utilization for behavioral healthcare declined by 10.6% between 2016 and 2019. ED use for non-traumatic dental conditions also decreased by 17%, while ED spending for dental conditions declined 6% from 2016 to 2019. Access to dental care also appears to have improved over this time period. Integration of care particularly improved for children, as the share of children who received physical, mental, and dental assessments increased by 13.3% between 2016 and 2019. CCOs have also increased spending on HRS, from \$7.2 million in 2016 to \$16.2 million in 2019. Community benefit initiatives such as housing, food security and care coordination programs represented the largest share of HRS spending, though spending patterns and amounts varied between CCOs. Finally, behavioral health

outpatient visits for dual-eligible members increased. However, the state was unable to estimate the impact of passive enrollment (a policy which was implemented in 2019) because data on dual-eligible members was only available up to 2018. The Final Evaluation Report may provide greater insight into demonstration effects in these areas.

We look forward to our continued partnership on the Oregon Health Plan section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly Digitally signed by  
Danielle Daly -S  
Date: 2022.01.26  
13:33:34 -05'00'  
-S

Danielle Daly  
Director  
Division of Demonstration  
Monitoring and Evaluation

cc: Nikki Lemmon, Oregon State Lead, CMS Medicaid and CHIP Operations Group

# Evaluation of Oregon's 2017-2022 Medicaid Waiver

## INTERIM REPORT

October 15, 2021

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS



**Prepared for:**

Oregon Health Authority



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Thomas Meath and Vijet Muley provided data validation and processing support. Kyle Tracy and Matt Goerg provided database management and analytic assistance. Stephanie Renfro and Christina Charlesworth consulted on quantitative methods. Erika Simeon worked on editing and layout. Bonnie Lind, Stephan Lindner Shauna Petchel, and Angela Senders provided helpful comments on an earlier draft.

We thank representatives from Oregon's Coordinated Care Organizations for their generous participation in interviews. We also thank staff at the Oregon Health Authority for information on Oregon's Medicaid transformation efforts, assistance with obtaining data for the evaluation, and feedback on this report.

## About Us

The Center for Health Systems Effectiveness at Oregon Health & Science University is a research organization that uses economic approaches and big data to answer pressing questions about health care delivery. Our mission is to provide the analyses, evidence, and economic expertise to build a more sustainable health care system.

CHSE's publications do not necessarily reflect the opinions of its clients and funders.

[www.ohsu.edu/chse](http://www.ohsu.edu/chse)

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# Acronyms

<b>AOD</b> – Alcohol or Other Drug	<b>HIT</b> – Health Information Technology
<b>APAC</b> – All Payer All Claims	<b>HRS</b> – Health-Related Services
<b>APM</b> – Alternative Payment Model	<b>HSD</b> – Health Systems Division
<b>A.R.C.</b> – Addiction Recovery Center	<b>MA</b> – Medicare Advantage
<b>CAC</b> – Community Advisory Council	<b>MAC</b> – Medicaid Advisory Council
<b>CAHPS</b> – Consumer Assessment of Healthcare Providers and Systems	<b>MCO</b> – Managed Care Organization
<b>CARES</b> – Coronavirus Aid, Relief and Economic Security	<b>MLR</b> – Medical Loss Ratio
<b>CBO</b> – Community-Based Organization	<b>MM</b> – Member Months
<b>CCO</b> – Coordinated Care Organization	<b>MMIS</b> – Medicaid Management Information System
<b>CCBHC</b> – Certified Community Behavioral Health Clinic	<b>OAR</b> – Oregon Administrative Rules
<b>CDPS</b> – Chronic Illness and Disability Payment System	<b>ODHS</b> – Oregon Department of Human Services
<b>CHSE</b> – Center for Health Systems Effectiveness	<b>OHA</b> – Oregon Health Authority
<b>CIE</b> – Community Information Exchange	<b>OHP</b> – Oregon Health Plan
<b>CMS</b> – Centers for Medicare & Medicaid Services	<b>OHPB</b> – Oregon Health Policy Board
<b>CPC+</b> – Comprehensive Primary Care Plus	<b>PCPCH</b> – Patient Centered Primary Care Home
<b>DCO</b> – Dental Care Organization	<b>PHE</b> – Public Health Emergency
<b>DID</b> – Difference-in-Differences	<b>PMPM</b> – Per Member per Month
<b>D-SNP</b> – Dual-eligible Special Needs Plan	<b>REALD</b> – Race, Ethnicity, Language and Disability
<b>ED</b> – Emergency Department	<b>ROI</b> – Return on Investment
<b>EDIE</b> – Emergency Department Information Exchange	<b>SDOH</b> – Social Determinants of Health
<b>FBDE</b> – Full-Benefit Dual-Eligible	<b>SHARE</b> – Supporting Health for All through Reinvestment
<b>FFS</b> – Fee-For-Service	<b>SPA</b> – State Plan Amendment
<b>FQHC</b> – Federally Qualified Health Center	<b>SPMI</b> – Severe and Persistent Mental Illness
<b>HCBS</b> – Home and Community-Based Services	<b>SMI</b> – Severe Mental Illness
<b>HCP-LAN</b> – Health Care Payment Learning and Action Network	<b>SUD</b> – Substance Use Disorder
<b>HEDIS</b> – Healthcare Effectiveness Data and Information Set	<b>THW</b> – Traditional Health Worker

# Executive Summary

In 2017, Oregon executed a five-year renewal of its 1115 Medicaid waiver with the Centers for Medicare & Medicaid Services (CMS). The Oregon Health Authority (OHA) selected Oregon Health & Science University's Center for Health Systems Effectiveness (CHSE) to carry out an evaluation of the 2017-2022 waiver renewal, and this report presents results from the interim evaluation. The evaluation focused on four areas: behavioral health integration, oral health integration, health-related services (HRS), and the population dually eligible for Medicare and Medicaid. CHSE assessed data from 2011-2019, capturing the initiation of Oregon's Coordinated Care Organization (CCO) model under the 2012-2017 waiver and including three years of experience (2017-2019) under the renewal. Our assessment did not include performance under new CCO contracts (CCO 2.0) effective in 2020, nor did it assess impacts of the COVID-19 pandemic.

## Summary of Findings

Under Oregon's 2017-2022 Medicaid waiver renewal, the state continued with the goals of the CCO model, including a commitment to limit increases in per capita spending and improve health care access and quality. The waiver renewal included a strengthened focus on integrating physical, behavioral, and oral health care. The renewal encouraged more significant investments in HRS, previously known as "flexible services," to address social determinants of health (SDOH). Additionally, the waiver renewal established that Medicare and Medicaid dually eligible individuals could be passively enrolled by the state into a CCO, moving from an "opt-in" to an "opt-out" model.

### *Behavioral Health Integration: Progress on behavioral health integration has been mixed.*

Behavioral health integration was a focus of the 2012-2017 waiver and an area identified as a priority in the waiver renewal. However, progress has been mixed. Overall, the evaluation team found it difficult to identify a well-articulated definition, set of goals, or milestones for behavioral health integration.

- During the 2017-2019 period, the state and CCOs engaged in several activities focused on behavioral health integration. Oregon participated in the Substance Abuse and Mental Health Services Administration's Certified Community Behavioral Health Clinics (CCBHC) Demonstration project, which currently includes 21 sites throughout Oregon, serving approximately 50,000 individuals per year. The state supported a Behavioral Health Collaborative and created a Behavioral Health Information Technology Workgroup. As part of "CCO 2.0" contracting effective in 2020, the state made substantial changes to the contracting mechanism in an effort to reduce the separation of behavioral health and physical health financing. (As mentioned, this report uses data through 2019 and therefore could not assess any changes associated with CCO 2.0.) Despite these initiatives, it is difficult to discern a roadmap or strategy for implementing behavioral health integration. Many of the activities focused on behavioral health integration do not appear to be coordinated across the state. In contrast to the work on HRS, the documentation of models, efforts, or milestones around behavioral health integration is unavailable or outdated.
- Some utilization and quality measures moved in the desired direction between 2016 and 2019, including decreasing ED visits and avoidable ED visits for members with behavioral health

conditions and increasing outpatient visits. Expenditures for individuals with behavioral health conditions began to increase in 2016, rising by approximately 3% annually between 2016 and 2019. The percentage of enrollees diagnosed with a substance use disorder (SUD) increased substantially during the period covered by this evaluation, moving from 3.4% in 2011 to 8.3% in 2019.

- Between 2016 and 2019, care coordination and access for non-English speaking individuals with behavioral health conditions worsened relative to English speaking individuals with behavioral health conditions.

***Oral Health Integration: Efforts to advance oral health integration appear to be having some positive effects.***

Like behavioral health, integration of oral health services with physical health services has been a goal of Oregon's Medicaid transformation since 2012. The 2017-2022 waiver called on CCOs to implement recommendations from the state's 2016 Oral Health Roadmap, including integrating oral health into Patient Centered Primary Care Home (PCPCH) standards and practices and improving internal coordination on oral health within OHA.

- During the first three years of the renewal, OHA worked to address access barriers associated with oral health provider shortages and member awareness of dental benefits. In 2019, OHA worked with staff at PCPCHs to develop standards for oral health integration, and OHA's Transformation Center assisted CCOs in implementing oral health integration pilot projects. Other efforts included increases in payment rates, expansion of teledentistry, and the introduction of new CCO incentive metrics for oral health.
- Measures of access to dental services and utilization of dental procedures improved between 2016 and 2019. Additional measures of oral health integration also moved in the desired direction. These improvements may reflect progress on oral health integration and increases in dental payment rates implemented in 2018.
- Spending on dental services outside the ED increased between 2016 and 2019. These changes likely reflect increases in payment rates for dental services implemented in 2018 as well as increased access to needed services.
- Between 2016 and 2019, improvements in oral health access measures were somewhat greater for non-English speaking individuals compared to English speaking individuals. Access increases were also slightly more pronounced among children compared to adults.

***Health Related Services: The state has expanded its mechanisms to support HRS, with early signs that CCOs are responding positively.***

One finding of the 2012-2017 waiver evaluation was that spending on flexible services was lower than anticipated, with less than 0.1% of all spending attributable to flexible services in 2015. The lack of spending on flexible services was tied to a variety of factors, including confusion about what might qualify as flexible services, how spending on flexible services would factor into the Medical Loss Ratio (MLR), and whether spending on flexible services might adversely affect rate setting. The waiver renewal included a variety of responses to these challenges. HRS were defined to include flexible services and community benefit initiatives, with the state providing examples of what would qualify as HRS. The waiver also clarified that spending on HRS would be included in the numerator of the MLR.

- During the first three years of the waiver renewal, the state issued additional guidance on the types of spending that could qualify as HRS and how CCOs could use HRS to address SDOH.



The state also began developing adjustments to capitation rate setting to mitigate “premium slide” (a scenario in which increased spending on HRS might lead to lower capitation rates). In addition, the state is in the process of implementing a program that complements HRS, the Supporting Health for All through Reinvestment (SHARE) Initiative, which requires a portion of CCOs’ profits to be spent on SDOH domains. Across all of these activities, the OHA’s Transformation Center has provided a substantial amount of technical assistance to facilitate the understanding and use of HRS.

- Although it is still early, available data suggest that CCOs increased their HRS expenditures substantially, from \$7.2 million in 2016 (\$0.66 per member per month) to more than \$16.2 million in 2019 (\$1.51 per member per month). In interviews, CCOs indicated that much of this growth reflected their efforts to report existing SDOH programs as HRS spending. CCOs appear to have established new connections with community-based organizations and have expanded their toolkits for gathering information, conducting outreach, and deploying HRS funds to address SDOH. However, as of 2019, HRS remained a small share (0.36%) of spending on member services.
- Despite these encouraging trends, there are a variety of issues that OHA should monitor. These include the costs and benefits of standardized definitions and reporting of HRS spending across CCOs and tracking the administrative and financial burden associated with HRS data collection and reporting. Furthermore, OHA has an opportunity to contribute to the evidence base for HRS as well as using existing and emerging evidence to guide HRS investments.

***Impacts of a CCO Closure: The departure of FamilyCare in 2017 did not appear to result in adverse behavioral health or oral health outcomes for members in the Portland tri-county area.***

During the evaluation period, the FamilyCare CCO exited the market, with most of its 113,000 members transitioning to coverage by Health Share of Oregon. We found that most behavioral and oral health measures were unchanged or showed modest improvements for enrollees in the tri-county area relative to other areas following the exit of FamilyCare. However, total expenditures for individuals with behavioral health conditions increased more in the tri-county area than in other parts of the state. OHA should consider assessing whether these increased expenditures were associated with improvements in access and quality or simply greater utilization of services.

***Dual-Eligible Members: Care for dual-eligible members did not seem to change substantially from 2016 to 2018. Data available for the interim analysis did not allow for an assessment of the effects of passive enrollment in CCOs.***

The waiver renewal aims to simplify coverage and choices for beneficiaries who are dually eligible for Medicare and Medicaid through passive enrollment in CCOs, with the option to opt-out and return to the state’s FFS program at any point in time.

- Oregon implemented passive enrollment in CCOs for dual-eligible members in 2019. Prior to 2019, dual-eligible members were enrolled in FFS coverage by default but could choose to enroll in a CCO (an “opt-in” model).
- Results for measures of health care access, quality, and spending suggest that care for dual-eligible members did not change substantially from 2016 to 2018. Outpatient visits increased, particularly for behavioral health, whereas access to primary and preventive care were relatively flat. Declines in ED utilization and avoidable ED visits were limited to dual-eligible members residing in urban areas. Total spending increased from 2016 to 2018 for dual-eligible members in isolated and rural areas.

- Our analyses used data through 2018 and therefore did not capture any impact of the 2019 change to passive enrollment in CCOs. Likewise, the evaluation did not assess the impact of new requirements for Medicare Advantage plan alignment implemented through CCO 2.0 contracts.

## Recommendations

Based on findings from this evaluation, and factoring in OHA's strategic goal of eliminating health inequities by 2030, we present 13 recommendations, categorized into five areas.

### Behavioral Health Integration

**Recommendation 1.** Provide a strategic plan and vision for behavioral health integration (at the financial and delivery system levels), including what milestones should serve as indicators of progress, especially for communities most impacted by health inequities. It is currently difficult to discern what activities or populations CCOs are expected to prioritize, how integration will be measured, or what the future state should look like.

**Recommendation 2.** Reconsider the way accountability for behavioral health is shared or assigned within and outside of OHA. The state should investigate where roles may be unclear and consider options for providing clarity. Oregon is undertaking a range of ambitious activities that address mental health and SUD. Coordination and accountability will be necessary to ensure these funds are deployed efficiently and the initiatives achieve their aims. The 2019 appointment of Steve Allen as the state's new Behavioral Health Director offers an opportunity to reduce ambiguity about who is responsible or empowered to facilitate change.

**Recommendation 3.** Consider the needs of multiple populations and systems of care, particularly for communities most impacted by health inequities. Adults with serious mental illness and children with serious emotional disorders may require different models of care beyond behavioral health services that are integrated at the primary care site. Because racial and ethnic disparities may be particularly acute in behavioral health services, OHA should consider efforts that specifically target the intersection of equity and behavioral health.

### Oral Health Integration

**Recommendation 4.** The state should continue to build on its apparent successes in the area of oral health integration. Overall, claims- and survey-based measures suggested that access to services and the quality of oral health care have improved.

**Recommendation 5.** OHA's incoming Dental Director should be tasked with strengthening communication and coordination across OHA on oral health, building a shared definition of oral health integration that aligns with the goal to end health inequities, defining milestones for delivery system and financial integration, and organizing the agency's activities strategically to achieve these milestones.

### Health-Related Services

**Recommendation 6.** Continue refining guidance on reporting of HRS expenditures to promote consistency across CCOs. Some of the differences in reported spending on HRS appear to be related to definitions instead of real differences in investments in HRS or SDOH.

**Recommendation 7.** Monitor the administrative and financial burden on CCOs that is associated with collecting and reporting HRS data. This will require OHA to consider the balance between the administrative burden, which may be disproportionately felt by communities most impacted by health inequities, and the need for data to understand the impact on outcomes for the Medicaid population.

**Recommendation 8.** Continue to develop the evidence base for HRS and investments in SDOH. Oregon can play an important role in providing robust, credible evidence on the impacts of these investments, which will help shape programs within the state and beyond.

**Recommendation 9.** Identify areas where capacity or resources restrict CCOs' ability to affect SDOH. In some regions, housing shortages and the lack of affordable options may create significant challenges in helping enrollees obtain stable housing. OHA should assess opportunities to address houselessness broadly – including opportunities to weave or braid funding from multiple sources to create more extensive systems-based solutions.

## Health Equity

**Recommendation 10.** In addition to “health equity,” state rules and guidance documents use equity-related terms such as “social determinants of equity” (SDOE) and “social determinants of health and equity” (SDOH-E). Each of these has a slightly different application and definition, but the nuances may be lost to a larger audience. Further separation and articulation of the meaning of these terms would reduce the risk of confusion and conflation of priorities.

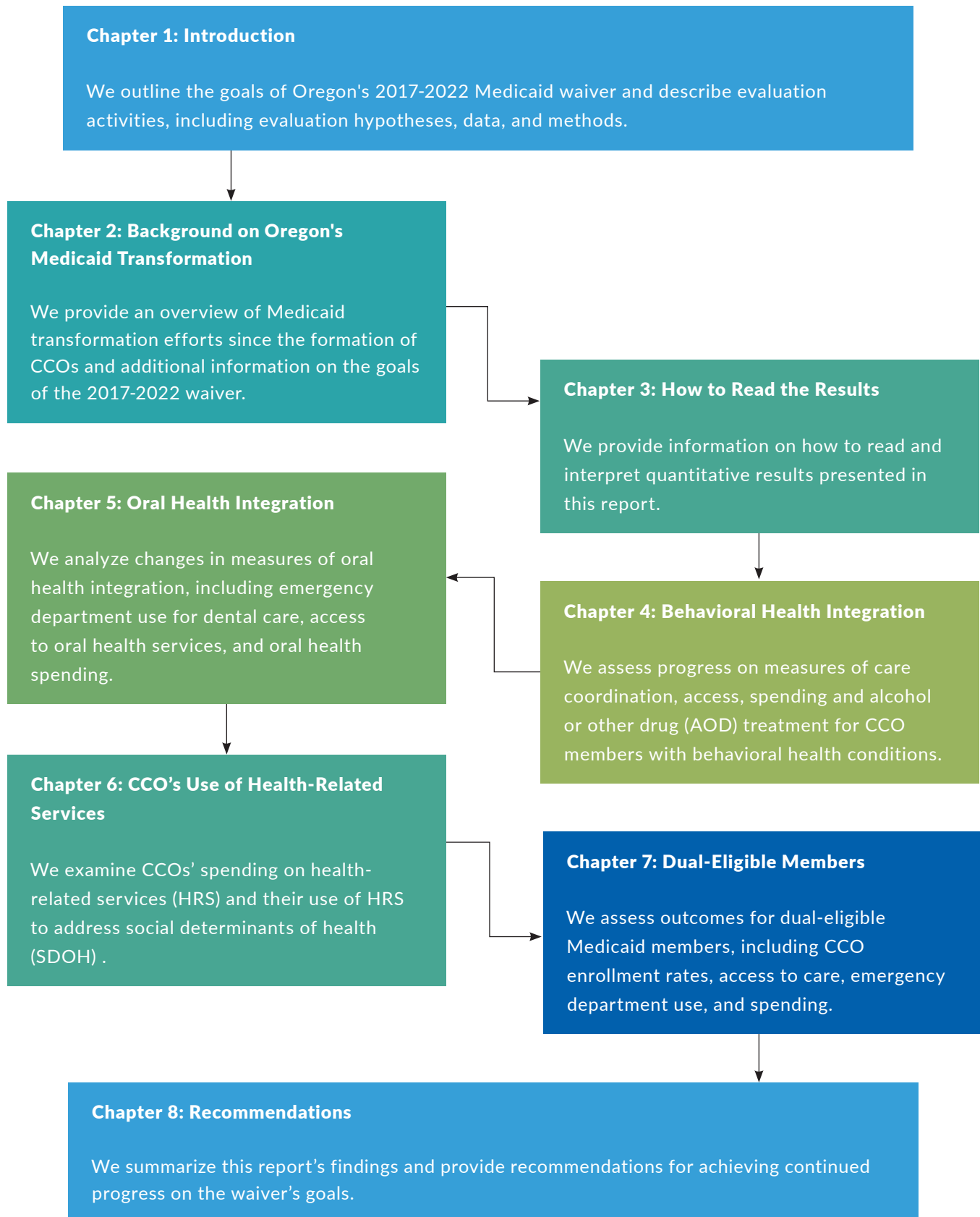
**Recommendation 11.** Health equity has been identified by OHA leadership as a clear priority, adopting a 10-year goal to eliminate health inequities by 2030. This requires engagement with communities most impacted by health inequities to prioritize initiatives and interventions. Current data systems limit the state's ability to achieve this, due to a lack of information on race and ethnicity. OHA should continue to support CCOs in collecting Race, Ethnicity, Language, and Disability (REALD) data and ensure that resources are available to manage and maintain these data. To track progress, OHA should monitor and report on the percentage of members for whom REALD data are collected.

## Dual-Eligible Members

**Recommendation 12.** Oregon implemented passive enrollment in CCOs for dual-eligible members starting in 2019. The waiver evaluation is intended to assess the impacts of passive enrollment on health care access, quality, and spending for this population. However, the most recent data available for interim analyses covered 2018 and therefore did not capture any such effects. Future evaluation work should assess changes occurring with the introduction of this policy.

**Recommendation 13.** CCO 2.0 introduced new requirements intended to increase enrollment of dual-eligible members in Medicare Advantage plans provided by (or affiliated with) their CCO. Research suggests that alignment of Medicare and Medicaid plans may contribute to improved outcomes. To assess whether this occurs and inform future policy development, OHA should consider monitoring rates of enrollment of dual-eligible members in aligned plans over time and tracking outcomes for dual-eligible members enrolled in aligned versus non-aligned plans.

# Roadmap to the Report



# Introduction

## Overview

In January 2017, Oregon obtained approval from the Centers for Medicare & Medicaid Services (CMS) to extend its Section 1115 Medicaid waiver, the “Oregon Health Plan” (OHP), effective from January 12, 2017 through June 30, 2022. The Oregon Health Authority (OHA), the agency that oversees Oregon’s Medicaid program, selected Oregon Health & Science University’s Center for Health Systems Effectiveness (CHSE) as the independent evaluator of the 2017-2022 waiver.

This report presents results from CHSE’s interim evaluation of performance during the first three years of the waiver (2017-2019). We assess progress in four key areas: behavioral health integration, oral health integration, the use of health-related services (HRS) – a mechanism for addressing social determinants of health (SDOH) – and program enhancements for individuals who are dually enrolled in Medicaid and Medicare.

## Oregon’s 2017-2022 Medicaid Waiver

Medicaid demonstration waivers give states flexibility to test innovative approaches to health care delivery and payment. In 2012, Oregon used a Section 1115 Medicaid demonstration waiver with CMS to transform its Medicaid program, establishing sixteen “Coordinated Care Organizations,” or CCOs, to provide comprehensive care for its Medicaid population. As part of its waiver and transition to the CCO model, the state committed to reducing spending growth, and improving access and quality for its Medicaid members. The 2017-2022 waiver renewal allows Oregon to continue enhancing the CCO model to achieve four key goals:<sup>1</sup>

1. Enhance Oregon’s Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve.
2. Increase the state’s focus on encouraging CCOs to address SDOH and improve health equity for communities of color and across all low-income or vulnerable Oregonians to improve population health outcomes.
3. Commit to an ongoing sustainable rate of growth, and adopt a payment methodology and contracting protocol for CCOs that promotes increased investments in HRS and advances the use of value-based payments.
4. Expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual-eligible members.

Oregon’s waiver renewal includes a variety of other changes, including:

- Extension of the state’s Hospital Transformation Performance Program, which provides incentive payments to participating hospitals for adopting initiatives for quality improvement, through June 30, 2018. After that date, hospital pay-for-performance payments would transition to CCO contracts.
- Conversion of the tribal uncompensated care payments to a Medicaid benefit.

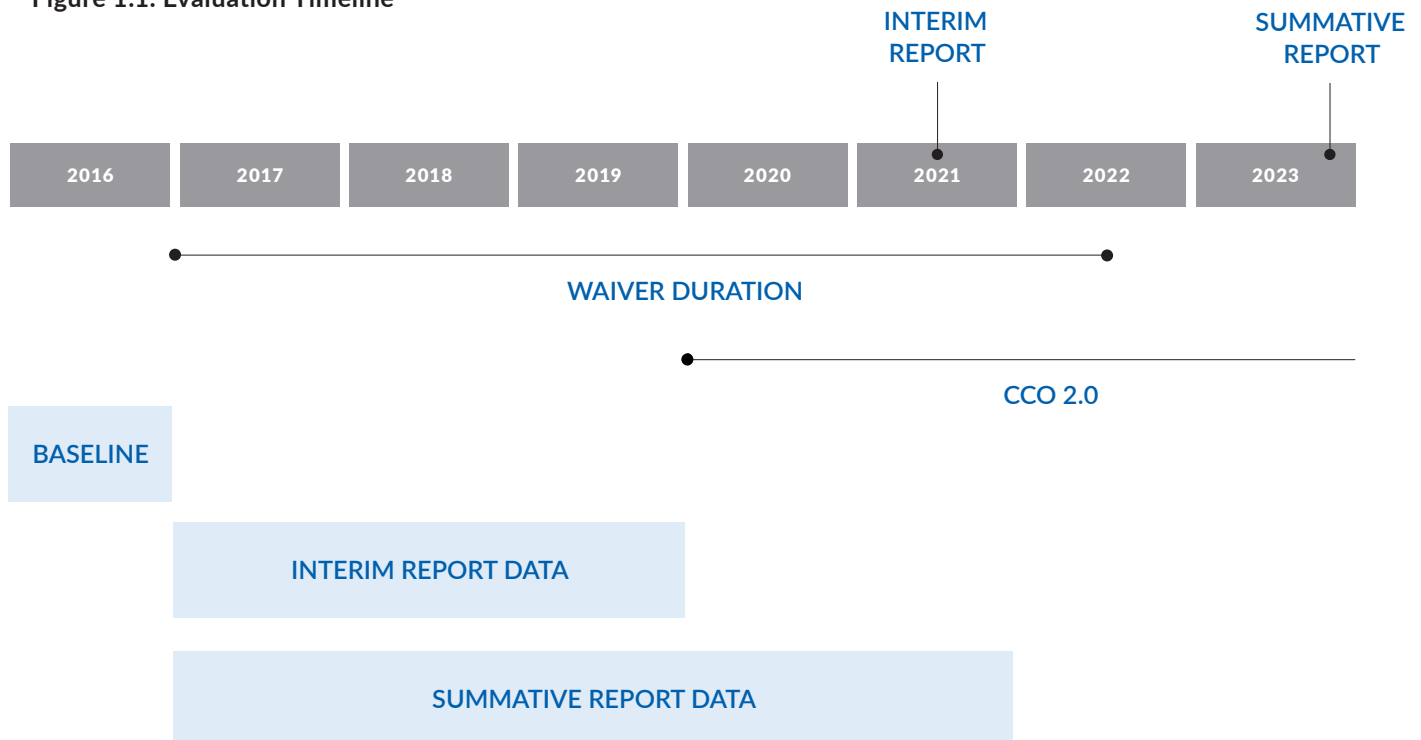
- Specifying that the waiver will not impact American Indian and Alaska Native (AI/AN) rights to exemption from managed care.
- Support for incentive payments for Comprehensive Primary Care Plus (CPC+) providers tied to outcomes for Medicaid members served by the state’s fee-for-service (FFS) delivery system.
- Establishing minimum requirements — such as inclusion of the Model Medicaid and CHIP Managed Care Addendum for Indian Health Care Providers, and a Model CCO Tribal Engagement and Collaboration Protocol — to ensure CCOs’ timely and equitable collaboration and communication with tribes and Indian Health Care Providers.

OHA used the introduction of new CCO contracts, “CCO 2.0”, effective from January 1, 2020, as a key mechanism for implementing program changes needed to achieve these goals. We describe these changes further in Chapter 2 and Appendix D.

## Evaluation Activities

Section 1115 Medicaid waivers require states to contract with an independent evaluator to test hypotheses for delivery system outcomes such as quality, access, and cost. Oregon selected CHSE as the independent evaluator to carry out the waiver evaluation according to the CMS-approved evaluation design.<sup>2</sup> The evaluation includes two key products: this interim report, to be delivered to CMS by June 30, 2021, and a summative evaluation report due to CMS by December 31, 2023. Figure 1.1 summarizes timelines and deliverables for the evaluation per CHSE’s contract with OHA. This report covers data through 2019 and therefore does not capture changes associated with the implementation of CCO 2.0. Additionally, the study period ends before the COVID-19 pandemic hit the U.S. in early 2020. The summative evaluation, including data through 2021, will assess performance during the pandemic and the first two years of CCO 2.0. Box 1.1 clarifies how to read this report in view of these events.

Figure 1.1: Evaluation Timeline



**Box 1.1: How to Read this Report**

Readers of this report are encouraged to interpret results within the context of Oregon's implementation efforts through December 2019. The interim evaluation relies on quantitative data through 2019, and therefore does not assess performance under CCO 2.0 or during the COVID-19 pandemic, which both began in early 2020. Data collection for 2020 was limited to qualitative information from CCO interviews relating to the use of HRS. As such, the findings in this report reflect early successes and challenges in implementing the provisions of the waiver renewal. The summative evaluation (featuring data through 2021) will address the ways in which CCO 2.0 implementation and COVID-19 may have affected Oregon's progress and goals set out in the renewal. To set the stage for these analyses, Appendices D and F provide relevant information on CCO 2.0 and actions taken to support the Medicaid delivery system during COVID-19, respectively.

**Questions and Hypotheses**

The CMS-approved evaluation design features four evaluation questions focusing on behavioral health integration, oral health integration, HRS, and the dual-eligible population. Each question is associated with several hypotheses, as shown in Exhibit 1.1 below.

**Exhibit 1.1: Evaluation Questions and Hypotheses**

Evaluation Question	Hypothesis
1 What progress has been made in integrating behavioral and physical health care for Oregon's Medicaid population? What effects has increased integration had on access, quality, and costs?	1.1 Coordination of care for CCO members with behavioral health diagnoses will improve.
	1.2 The ability to identify and refer members to substance abuse interventions will improve over time.
	1.3 Integration of behavioral health services will improve access for CCO members with severe mental illness.
	1.4 Integration of behavioral health services with physical health services will be associated with reduced growth of total spending and spending on high-cost settings (e.g. ED and inpatient), and with sustained or increased spending on primary or preventive care, for CCO members with behavioral health diagnoses.

**Exhibit 1.1: Evaluation Questions and Hypotheses (continued)**

2	What progress has been made in integrating oral and physical health care for Oregon's Medicaid population? What effects has increased integration had on access, quality, and costs?	2.1	Emergency dental visits for non-traumatic dental reasons will reduce over time for CCO enrollees.
		2.2	Access to oral health services and dental care will improve for CCO enrollees.
		2.3	Integration & coordination of oral health with other health services will improve for CCO enrollees.
		2.4	Integration of oral health services with physical health services will be associated with reduced growth of spending on oral health services in high-cost settings (e.g., ED) and sustained or increased spending on preventive oral health services
3	What degree of adoption of HRS has occurred? How do patients experience HRS, and what impact does receipt of HRS have on quality and costs?	3.1	Provision and utilization of HRS (previously known as flexible services) will increase over time.
		3.2	Enrollees receiving HRS will report satisfaction with those services and better patient experience overall.
		3.3	Use of HRS will be associated with reduced utilization of more intensive or higher-cost care.
		3.4	Use of HRS will help address social determinants of health to improve individual and population health outcomes.
		3.5	Use of HRS will be associated with reduced growth of total spending and spending in high-cost settings (e.g., ED and inpatient) and with sustained or increased spending on primary or preventive care.
4	What is the rate of uptake of CCO enrollment among dual-eligible members (those who are newly eligible and those previously in FFS)? What impact has CCO enrollment had on quality and costs for dual-eligible members?	4.1	The proportion of dual-eligible members enrolled in a CCO will increase compared with past demonstration levels without loss of member satisfaction.
		4.2	CCO enrollment will encourage appropriate use of clinical resources and ancillary care for dual-eligible members.

Source: Centers for Medicare & Medicaid Services. (2017). *Special Terms and Conditions—Oregon Health Plan 21-W-00013/10 and 11-W-00160/10*. Attachment B – Evaluation Design.



## Evaluation Data and Analyses

CHSE's interim evaluation addresses these questions and hypotheses mainly through quantitative analyses of outcome measures related to quality, access and spending, with a qualitative component for assessing CCOs' adoption of HRS. Outcome measures associated with each hypothesis, identified in collaboration with OHA, are listed in Appendix A. Below we provide an overview of evaluation data, study populations, and quantitative methods. Further details on quantitative and qualitative methods can be found in Appendices B and C, respectively.

### Data

We rely on the following data sources to calculate outcome measures for the evaluation:

- Medicaid claims/encounters and enrollment records from OHA's Health Systems Division (HSD).
- Medicare claims/encounters and enrollment records from OHA's All Payer All Claims Database (APAC).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses from the Medicaid CAHPS survey administered by OHA.
- Specialized data extracts from OHA, required to calculate two evaluation measures (Screening, Brief Intervention, and Referral to Treatment and Assessments within 60 Days for Children in Oregon Department of Human Services Custody).

We use data spanning the years 2011-2019, allowing us to assess performance over the full course of the 2012-2017 waiver and the first three years of the 2017-2022 waiver.

In addition, to address hypotheses related to HRS, we use spending data from CCOs' "Exhibit L" financial reports for the years 2014 through 2019. We also incorporate qualitative data from interviews with CCO representatives. Interviews addressed CCOs' approaches to providing HRS and their use of HRS to address SDOH. We conducted a total of 12 interviews in the second half of 2020, with two to five informants in each interview. Interviewees held diverse CCO roles, including CEO, CFO, medical officer, and positions in community engagement, health equity, and government affairs.

### Study Populations

The study population for evaluation questions 1 (behavioral health integration), 2 (oral health integration) and 3 (HRS) consists of members enrolled in a CCO who are not dually eligible for Medicare and Medicaid. For evaluation question 4, the study population is limited to dual-eligible members, including members enrolled in FFS Medicaid. For behavioral health integration measures, we define subpopulations as members with Severe and Persistent Mental Illness (SPMI) and Substance Use Disorder (SUD). Technical definitions for these subpopulations can be found in Appendix B.

For measures related to evaluation questions 1-3, we further stratify analyses by subgroups based on age, gender (binary definition), geography of residence (urban, rural, isolated), disability (disabled, not disabled), and the presence of chronic physical health conditions. For measures associated with evaluation question 4 (dual-eligible members), we stratify by geography of residence only. Due to data quality concerns, the current report does not show results stratified by race/ethnicity. We anticipate incorporating race/ethnicity data in the summative report; see Box 1.2 below for details.

Additionally, for measures assessing oral and behavioral health integration, we examine outcomes for populations of focus, defined in the evaluation design as “groups that have historically experienced disproportionately poor health outcomes, or that have been identified by Oregon’s leadership as appropriate populations on which to focus the state’s health improvement efforts.”<sup>3</sup> In consultation with OHA, we selected two focus populations:

- Children, defined as individuals under the age of 18.
- Individuals with limited English language proficiency, defined as persons from a household where the main language spoken is not English, based on HSD enrollment data. (For brevity, we refer to these individuals as “non-English speaking members.”)

We compare outcomes for each focus population to a “reference” population, representing a “group that has historically experienced favorable health outcomes relative to other groups with respect to the particular outcome or issue under examination.”<sup>4</sup> We use adults and members from households where the main language spoken is English (“English speaking members), respectively, as reference groups for the selected focus populations.

### **Box 1.2: Use of Race and Ethnicity Data in the Evaluation**

*This report does not present outcomes by race/ethnicity due to concerns about the validity of this information in the Medicaid enrollment files obtained from HSD. Beginning in 2017, the enrollment data showed a significant increase in both the number and percentage of adult Medicaid recipients for whom race was reported as unknown/missing/other, with the percentage reaching 40% by 2019. This appears to have been driven largely by a decline in the percentage of enrollees identifying as white or Hispanic.*

*For the summative report, which will cover data through 2021, we anticipate using race/ethnicity and other demographic information collected according to Race, Ethnicity, Language and Disability (REALD) standards to assess health disparities among Medicaid members. Appendix E provides background on the development of REALD standards and OHA’s activities in 2020 to enhance REALD data collection. The summative report will stratify results and adjust outcomes for race, ethnicity and other demographic characteristics.*

*Chapters 4 and 5 of this report evaluate outcomes for two populations of focus; individuals with limited English language proficiency and persons under the age of 18. We assess how outcomes changed for these populations and whether disparities between focus and reference populations were reduced during the initial three years of the waiver renewal.*

#### *Reference:*

*Centers for Medicare & Medicaid Services. (2017). Special Terms and Conditions—Oregon Health Plan 21-W-00013/10 and 11-W-00160/10. Attachment B – Evaluation Design.*

## **Quantitative Analyses**

The evaluation plan includes two types of quantitative analyses. First, we use claims data to evaluate changes in outcome measures among Oregon’s Medicaid members. We conduct the following analyses for each measure:

1. Determine whether the study population met the target or benchmark for the measure.

2. Analyze the change in the measure across the study population as a whole and within subgroups.
3. Analyze the change in the measure for populations of focus compared to reference populations.

Second, to address hypothesis 3.1, we conduct descriptive analyses of CCO spending on HRS using data from CCOs' Exhibit L reports.

We define the “target” for each measure as an improvement over the mean performance in 2015-2016. We use mean performance in 2015-16 as a historical benchmark to capture Oregon’s performance prior to the waiver renewal in the two years following Medicaid expansion. This benchmark was defined in consultation with OHA. To analyze changes in measures, we use regression modeling to adjust for demographic factors and risk. We use 2016 as the primary baseline for measuring change across the study population. In addition to being the last full calendar year of the 2012-2017 waiver, 2016 occurs after the 2014 Medicaid expansion and after the 2015 transition to ICD-10 codes, allowing for more consistent comparison over time. We perform additional regression analyses using 2011 data (where available) as the baseline, measuring changes since before the inception of CCOs. For behavioral and oral health integration measures, we also analyze outcome changes for populations of focus, using difference-in-differences modeling to determine whether gaps between focus and reference populations decreased or increased. Appendix B provides further details on quantitative methods.

## Structure of this Report

Chapter 2 of this report provides an overview of Oregon’s Medicaid transformation efforts since the formation of CCOs. We provide additional information on the goals of the 2017-2022 waiver and describe the development of new CCO contracts effective in 2020.

Chapter 3 provides information on how to read and interpret quantitative results presented in this report.

Chapter 4 assesses the state’s progress on integration of behavioral and physical health care and explores the effects of integration on access, quality and costs. First, we provide an overview of behavioral health integration activities under the 2017-2022 waiver. We then assess outcomes for coordination of care for CCO members with behavioral health diagnoses, referral to SUD treatment, access for CCO members with behavioral health conditions, and spending. We report regression-adjusted changes in measures for the CCO-enrolled non-dual-eligible population, stratify results by subgroup, and compare changes for non-English speaking members versus English speaking members.

Chapter 5 describes oral health integration activities under the 2017-2022 waiver and assesses progress on measures relating to ED use for dental visits, access to oral health services, integration of oral health and other health services, and oral health spending. We report regression-adjusted changes in measures for the CCO-enrolled non-dual eligible population, stratifying by subgroup and comparing changes for focus populations versus reference populations.

Chapter 6 examines CCOs’ spending on HRS. We explore annual trends in per member per month HRS spending, variation in spending among CCOs, and the distribution of spending across HRS types (flexible services, community benefit initiatives, and health IT) and categories (housing,

care coordination, transportation, etc.). We use information from CCO interviews to interpret and contextualize spending data. In addition, we present interview findings on CCOs' approaches to using HRS for addressing SDOH.

Chapter 7 analyzes outcomes for dual-eligible Medicaid members, including CCO enrollment rates, utilization of clinical and ancillary care, and per member per month spending. We report regression-adjusted changes in measures for the dual-eligible population overall and stratified by residence in urban, rural and isolated geographies.

Chapter 8 summarizes this report's findings and provides recommendations for achieving continued progress on the waiver's goals.

Appendices A through C provide details on quantitative and qualitative evaluation methods.

Appendix D summarizes changes to Oregon's Medicaid program implemented through CCO 2.0 contracts, including efforts to enhance capacity to address SDOH and promote health equity.

Appendix E provides information on the REALD protocol used in Oregon since 2014 for collecting demographic data.

Appendix F describes changes to Oregon's Medicaid program introduced in 2020 in response to the COVID-19 pandemic.

Appendix G provides supplemental results, including sensitivity analyses exploring differences in behavioral and oral health outcomes associated with the closure of a CCO in the tri-county region.

# Background on Oregon's Medicaid Transformation

## Overview

This chapter provides a summary of Oregon's Medicaid transformation efforts since the creation of CCOs in 2012 through to 2019. We first briefly describe Oregon's 2012-2017 Medicaid waiver and how it laid the foundation for initiatives under the 2017-2022 waiver renewal. Next, we provide additional information on the goals of the waiver renewal. Finally, we describe Oregon's process for developing new five-year CCO contracts effective in 2020.

## Oregon's 2012-2017 Waiver

Oregon's 2012-2017 waiver marked the creation of the CCO model and the beginning of a major change in the state's Medicaid program. Some CCOs formed from a single managed care organization (MCO), maintaining their contractual relationships with health care providers. Other CCOs formed from partnerships among MCOs, health systems, mental health organizations, dental care organizations, and county health departments. Ultimately, sixteen CCOs were approved to provide coverage for Oregon Medicaid members across the state. Most regions were served by a single CCO, although a few, including the Portland metropolitan area, were served by two CCOs.

The CCO model has similarities to both MCOs and accountable care organizations. However, the model is unique among Medicaid delivery systems. It includes a number of distinguishing characteristics:

**Local governance with representation from health care providers, Medicaid members, and other community members.** CCOs' governance structures are required to include health care providers, members of a community advisory council (CAC), and community members at large to ensure decision making is consistent with community values and priorities. The CACs were established to ensure that the health needs of CCOs' communities were being met. CACs are required to include representatives of the community and county government, with Medicaid members making up the majority. The 2012-2017 waiver included other provisions to ensure that CCOs responded to community needs: CCOs were required to establish agreements with local governments, carry out community health assessments, and develop community health improvement plans based on these assessments.

**Global budgets covering physical, behavioral, and oral health care.** CCOs receive global budgets: per capita payments to cover the cost of members' physical, behavioral, and oral health care. Adult non-SUD behavioral health residential services and certain mental health drugs are "carved out" of the global budget. CCOs are accountable for managing all services covered by the global budget. However, they have flexibility to allocate their global budgets to meet the needs of their members and communities. Global budgets placed CCOs "at risk" for all types of health care, creating a financial incentive to coordinate and integrate different types of care.

**Flexibility to use funds to address SDOH.** CCO budgets allow for local flexibility, including spending on services and supports that may not meet the definition of what has traditionally been thought of as “medically necessary.” CCOs have been encouraged to address their members’ social needs. The CCO model allows for spending outside the traditional medical system if such expenses can improve outcomes and reduce spending growth.

**Payment for performance.** CCOs are eligible to receive incentive payments from a state Quality Incentive Program (“quality pool”) for improving specific member outcomes, called CCO incentive measures. The Metrics and Scoring Committee, established by Oregon’s legislature in 2012, selects incentive measures and determines the performance benchmarks and improvement targets for awarding incentive payments. Incentive measures and performance goals are adjusted annually.

**Accountability for health care access and quality.** CCOs serve as a single point of accountability for members’ health care access and quality. The Oregon-CMS agreement required that the quality of care, as defined by 33 measures, would not diminish over time. In addition, OHA publicly reports CCOs’ performance on a variety of outcome measures on its website, reinforcing accountability.

**Accountability for the growth in health care spending.** Under its 2012-2017 waiver, Oregon committed to reducing the per capita Medicaid spending growth rate from a historical average of 5.4% to 3.4% within three years.

Most Medicaid members were required to enroll in a CCO. Members of Oregon’s Federally Recognized Tribes and Medicare and Medicaid dual-eligible members were allowed to choose CCO enrollment or FFS coverage. Medicaid members with special health needs were required to transition from FFS coverage to a CCO after receiving an individualized transition plan to meet their care needs. By 2014, almost 90% of the state’s one million Medicaid enrollees received care through CCOs, which included a mix of for-profit and not-for-profit organizations with varied enrollment size (from fewer than 15,000 enrollees to more than 200,000 enrollees).

The 2012-2017 waiver articulated six levers that served as a roadmap for health system transformation:

- **Lever 1:** Improving care coordination at all points in the system with an emphasis on Patient-Centered Primary Care Homes (PCPCHs).
- **Lever 2:** Implementing value-based payment methodologies to focus on value and pay for improved outcomes.
- **Lever 3:** Integrating physical, behavioral, and oral health care structurally and in the model of care.
- **Lever 4:** Increased efficiency through administrative simplification and a more effective model of care.
- **Lever 5:** Use of flexible services to improve care delivery or enrollee health.
- **Lever 6:** Testing, accelerating, and spreading effective innovations and best practices.

The summative evaluation of Oregon’s 2012-2017 waiver, conducted by CHSE, found that the CCO model was associated with reductions in spending growth and improvements in some quality domains.<sup>5</sup> Measures of care experience and self-reported health status for CCO members also

improved. Measures of access to care decreased slightly among CCO members, potentially due to the large increase in enrollment in the state as part of the 2014 Medicaid expansion. The evaluation also pointed to areas where change had not been as transformative as planned, including the integration of behavioral and oral health services and the use of flexible services to address social determinants of health.

## Goals of the 2017-2022 Waiver

The waiver renewal, spanning January 12, 2017 through June 30, 2022, uses some of the original levers to drive health system transformation, building on the strengths of the CCO model while addressing some of its shortcomings. Figure 2.1 below summarizes the waiver's key goals and their relationship to the levers. The renewal emphasizes the following efforts:

**An expanded focus on the integration of physical, behavioral, and oral health care through a performance-driven system (Goal 1).** The financial and delivery system integration of physical, behavioral, and oral health have been core elements of the CCO model. The 2012-2017 experience, while promising, demonstrated that additional time, effort, and coordination among different sectors (e.g., health care, corrections systems, counties, other agencies) would be necessary to achieve full integration. During the demonstration renewal period, OHA and CCOs have committed to taking the following actions:

- Implementing and supporting models of care that promote integration, such as the Certified Community Behavioral Health Clinic (CCBHC) Demonstration project.
- Supporting Oregon's Behavioral Health Collaborative workgroups in developing and implementing a behavioral health framework that addresses the systemic and operational barriers to the integration of mental health and substance abuse services.
- Implementing recommendations from the December 2016 Oral Health Roadmap, including integrating oral health into PCPCH standards and practices, and enhancing internal coordination on oral health within OHA.

**An enhanced focus on SDOH (Goal 2).** With the waiver renewal, Oregon defined HRS to include flexible services (cost-effective services offered to an individual member to supplement covered benefits) and community benefit initiatives (interventions focused on improving population health and health care quality). HRS are not covered under Oregon's State Plan but are intended to improve overall beneficiary health and can be used to address SDOH. The evaluation of Oregon's 2012-2017 waiver found that spending on flexible services was relatively modest. Expenditures on flexible services were inhibited by several factors, including confusion over what was allowable, whether they would be counted as "administrative" vs. "medical" expenses, and concerns that expenditures on flexible services could lead to lower capitation rates for CCOs. The waiver renewal addresses several of these issues. CMS clarified that HRS are included in the Medical Loss Ratio (MLR) numerator and count toward rate development in the non-benefit load. The waiver also allows CCOs to earn financial incentives if they improve quality and control per capita cost growth through HRS.

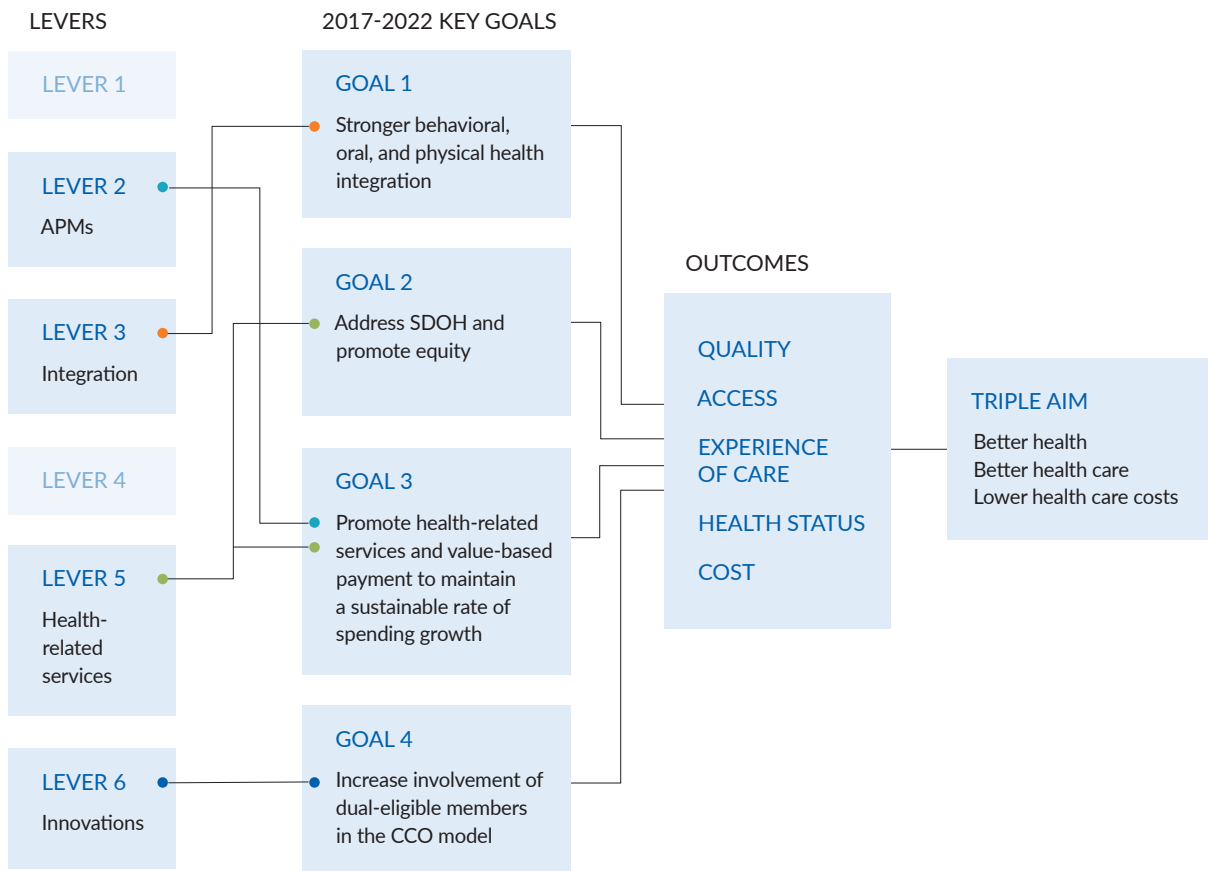
**A commitment to an ongoing sustainable rate of growth of 3.4% (Goal 3).** Continuing with the goal set out in the 2012-2017 waiver, the state must demonstrate that per capita spending growth remains below 3.4%. Oregon must report spending growth for each eligibility group

and in the aggregate, although the savings reduction requirement will be applied only to the aggregate.

**Increased use of value-based payments (Goal 3).** Oregon committed to developing a value-based payment (VBP) roadmap for CCOs with targets for VBP payments by the end of the demonstration period. The plan would provide a broad definition of VBP and include a schedule to ensure phased-in implementation throughout the demonstration. (See Appendix D for details on the CCO VBP Roadmap published in September 2019.) The state will also introduce contracting protocols and technical assistance for CCOs that promote the use of VBPs. The VBP roadmap and adoption are not part of the formal 2017-2022 waiver evaluation. However, OHA will monitor progress in meeting VBP targets and report to CMS in regular quarterly and annual reports.

**Continued expansion of the CCO model, including innovative strategies for ensuring better outcomes for dual-eligible members (Goal 4).** During 2012-2017, more than half of beneficiaries who were dually eligible for Medicare and Medicaid voluntarily enrolled in a CCO. However, the choices and opportunities for this population were not always clear. The renewal aims to simplify coverage and choices for dual-eligible individuals through passive enrollment into CCOs, which began in 2019, with the option to opt-out of the CCO model and return to the state’s FFS program at any point in time.

**Figure 2.1: Goals of the 2017-2022 Waiver**



Source: Centers for Medicare & Medicaid Services. (2017). *Special Terms and Conditions—Oregon Health Plan 21-W-00013/10 and 11-W-00160/10*. Appendix A – Medicaid Theory of Change.



## Designing New CCO Contracts

Oregon's CCO model was initiated in 2012 and continued with the 2017-2022 waiver renewal. In 2017, Governor Brown directed the Oregon Health Policy Board (OHPB) to provide specific recommendations in four key areas to inform OHA's design and implementation of new five-year CCO contracts:<sup>6</sup>

1. Focus on social determinants and equity.
2. Increase value and pay for performance.
3. Improve the behavioral health system.
4. Maintain a sustainable cost growth.

Guided by these recommendations, in January 2018, OHA and the OHPB initiated a process to identify a new CCO contracting framework that would advance the state's goals. OHPB board members reviewed recommendations from the 2012-2017 waiver evaluation, "maturity assessments" in key policy areas for CCOs, and OHA's 2017-2019 Action Plan for Health. From February through August 2018, representatives from OHA and OHPB traveled the state, attended meetings, conducted presentations, and issued surveys, hearing from more than 2,500 experts, partners, and stakeholders. The state used this input to develop the next phase of health care transformation, CCO 2.0. Appendix D provides information on the key features of CCO 2.0 relating to SDOH, health equity, VBP, and behavioral health. Results for outcome measures presented in this report are based on data through 2019 (i.e., pre-CCO 2.0). The summative evaluation will assess how the implementation of CCO 2.0 impacted outcomes under the waiver renewal.

# How to Read the Results

## Overview

This chapter describes how to interpret the charts and tables in this report. We use results for measures relating to Hypothesis 1.1, *Coordination of care for CCO members with behavioral health diagnoses will improve*, as an example. Evaluation measures for this hypothesis are defined as follows:

- **Emergency Department (ED) Utilization per 1,000 Member Months (MM) for Members with Behavioral Health Conditions:** Number of ED visits per 1,000 member months among members with SPMI and/or SUD diagnoses.
- **Potentially Avoidable ED Visits per 1,000 MM for Members with Behavioral Health Conditions:** ED visits that were preventable or treatable with appropriate primary care per 1,000 member months among members with SPMI and/or SUD diagnoses.
- **Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications:** Percentage of members taking a 2nd generation antipsychotic medication who had a HbA1c test.
- **Lipid Testing for Members Using 2nd Gen. Antipsychotic Medications:** Percentage of members taking a 2nd generation antipsychotic medication who had a cholesterol test.
- **30-Day Follow-Up after Hospitalization for Mental Illness:** Percentage of discharges after hospitalization for mental illness where the patient received follow-up within 30 days.

Appendix A provides detailed specifications for all measures included in this report.

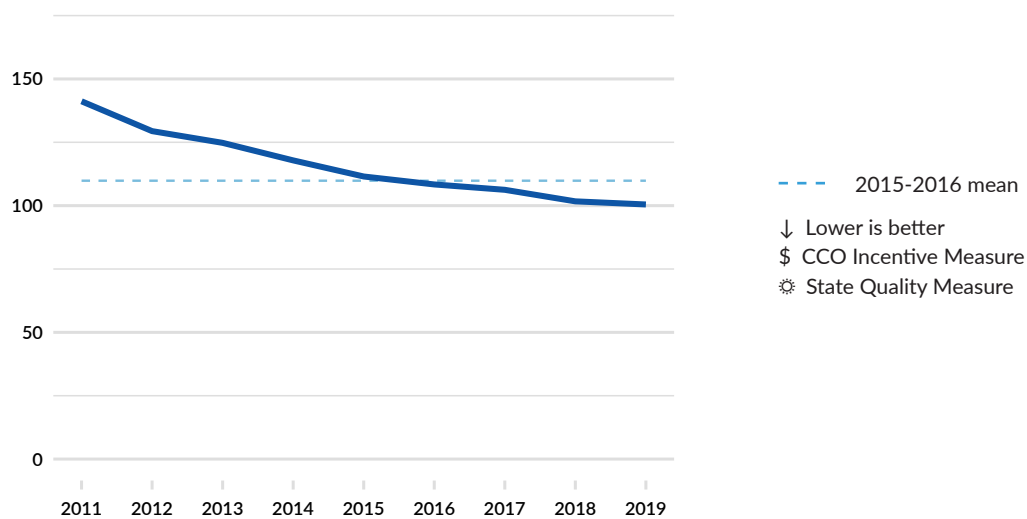
## Line Graphs

We first display annual 2011-2019 unadjusted outcomes for each measure as a line graph. Symbols in the title provide additional information about the measure:

- “↓” indicates that a decrease in the measure represents an improvement.
- “\$” indicates that the measure was a CCO incentive measure at any time during the study period.
- “⚙️” indicates that the measure was a state quality measure at any time during the study period.

Graphs feature a light blue dashed line showing the mean value for the measure in 2015-2016. We use mean performance in 2015-16 as a historical benchmark to capture Oregon’s performance prior to the waiver renewal in the two years following Medicaid expansion. This benchmark was defined in consultation with OHA. In the example below showing ED visits for members with behavioral health diagnoses, the dark blue line fell below the dashed line in 2016 and subsequent years, indicating that the state achieved its target for the measure in those years, as defined for purposes of this evaluation.

**Figure 4.1: Utilization per 1,000 Member Months for Members with Behavioral Health Diagnoses (↓ \$ ⚙️)**



## Adjusted Changes from Baseline

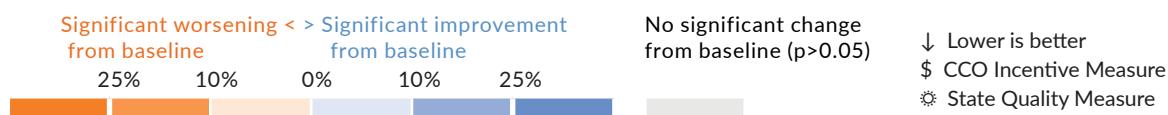
The “2016” and “2019” columns in the table below display unadjusted values for each measure in 2016 and 2019. The two righthand columns display the “adjusted” change in each measure from 2016 to 2019 and from 2011 to 2019, respectively. Adjusted changes show how much each measure changed from the baseline year (2016 or 2011) to 2019, controlling for the effect of members’ demographic characteristics and risk. Appendix B provides details on the pre-post statistical model used to obtain adjusted changes.

Shades of **blue** indicate that performance on a measure improved relative to the baseline year and that the change was statistically significant. Shades of **orange** indicate that a measure worsened significantly from baseline. For measures where “lower is better” (e.g., ED visits), statistically significant decreases are shown as improvements, and vice versa. Shading shows the magnitude of the change; for example, a dark blue shaded result indicates a statistically significant improvement of 25% or greater from baseline, whereas a light orange shaded result indicates the measure worsened by less than 10%. Gray indicates the change was not statistically significant at the 0.05 level of significance ( $p > 0.05$ ).

Symbols (defined above) next to some measures provide additional information about those measures.

**Table 4.1: Adjusted Change in Measures of Care Coordination for Members with Behavioral Health Conditions, 2011-2019 and 2016-2019**

Measure		2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
ED Utilization per 1,000 MM Members with Behavioral Health Conditions	↓ \$ ☼	108.4	100.5	-10.6	-22.4
Potentially Avoidable ED Visits per 1,000 MM for members with Behavioral Health Conditions	↓ ☼	15.2	12.2	-3.8	-13.5
Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications		86.8%	88.5%	1.5	0.8
Lipid Testing for Members 2nd Gen. Antipsychotic Medications		59.8%	59.4%	-0.1	-0.2
30-Day Follow-Up after Hospitalization for Mental Illness	\$ ☼	81.0%	82.3%	1.3	7.3



For example, potentially avoidable ED visits for members with behavioral health diagnoses decreased by 3.8 visits per 1,000 members between 2016 and 2019 (adjusted for members’ demographic characteristics and risk), representing an improvement of between 10% and 25%.

## Subgroup Results

Subgroup tables show the direction of the change in each measure from 2016 to 2019 for specific subgroups of members. As in the first table, changes are adjusted for members' demographic characteristics and risk. These results are obtained by applying the pre-post statistical model (see Appendix B) separately for each subgroup. Symbols "+" and "-" denote an increase or decrease in the measure from 2016 to 2019. As in the first table, color coding shows whether the increase or decrease represented a statistically significant improvement or worsening, and the percentage magnitude of the change. Gray boxes indicate the change was not statistically significant. Boxes with "NA" (not shown in the example below) indicate no subgroup results were available due to lack of data or because the measure was already defined as being limited to that subpopulation.

**Table 4.4: Adjusted Change from 2016 to 2019 in Measures of Care Coordination for Members with Behavioral Health Conditions, by Disability and Chronic Condition Status**

Measure		Disability		Chronic Condition	
		Yes	No	Yes	No
ED Utilization per 1,000 MM Members with Behavioral Health Conditions	↓ \$ ☀	-	-	-	-
Potentially Avoidable ED Visits per 1,000 MM Members with Behavioral Health Conditions	↓ ☀	-	-	-	-
Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications		+	+	+	+
Lipid Testing for Members Using 2nd Gen. Antipsychotic Medications		-	+	-	+
30-Day Follow-Up After Hospitalization for Mental Illness	\$ ☀	+	+	+	+

Significant worsening < - Significant improvement  
from baseline from baseline

25% 10% 0% 10% 25%

No significant change from baseline (p>0.05)

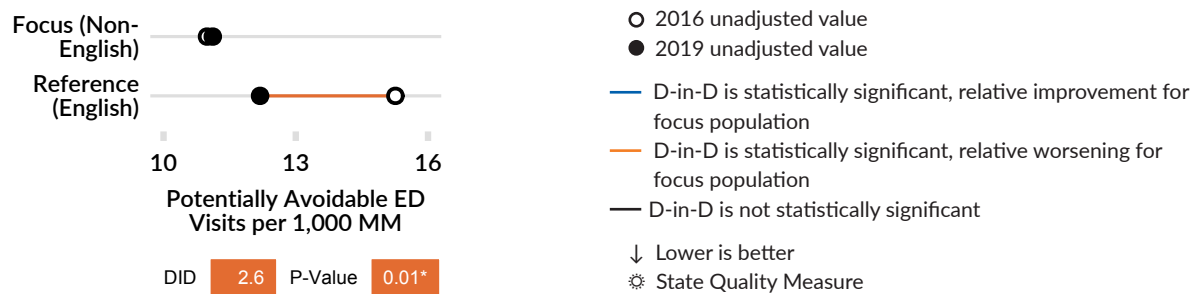
+ Increase  
- Decrease  
↓ Lower is better  
\$ CCO Incentive Measure  
☀ State Quality Measure

For example, ED utilization for members with behavioral health conditions decreased (improved) significantly regardless of members' disability status, although the decrease (improvement) was largest (between 10% and 25%) for members without a disability.

## Focus Population Results

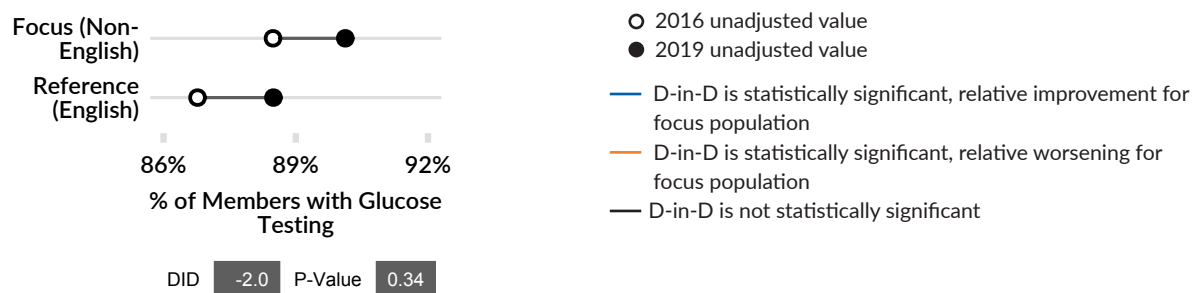
Results for focus population analyses are displayed as barbell plots. Each plot shows the (unadjusted) change in a given measure from 2016 to 2019 for the focus and reference populations. 2016 outcomes are shown as black circles, and 2019 outcomes as black dots. The color of the line connecting the 2016 and 2019 outcomes indicates whether the 2016-2019 change was significantly different for the focus population compared to the reference population, after adjusting for demographics and risk. Blue indicates that a measure *improved* in the focus population relative to the reference population, whereas orange indicates that the measure *worsened* in the focus population relative to the reference population. Gray indicates that the 2016-2019 change was not significantly different for the focus population compared to the reference population. Labels beneath each plot show the difference-in-differences (“DID”) coefficient estimate and its p-value. Appendix B provides details on the statistical model used to obtain these results.

**Figure 4.7: Avoidable ED visits for members with behavioral health conditions increased for non-English speaking members relative to English speaking members (↓ ⚙)**



In the above plot, the focus population saw a slight increase in avoidable ED visits from 2016 to 2019, whereas the reference population experienced a decrease. Lower is better for this measure. Therefore, focus population outcomes worsened relative to reference population outcomes.

**Figure 4.8: The change in glucose testing for members using 2nd generation antipsychotic medications was not significantly different for non-English speaking members compared to English speaking members**



Here, both the focus and reference populations saw an increase in glucose testing from 2016 to 2019. The change from 2016 to 2019 was not significantly different (i.e. it was roughly the same) for focus and reference populations after adjusting for demographics and risk. In other words, the performance of the focus population relative to the reference population did not change significantly over time.

# Behavioral Health Integration

## Overview

This chapter assesses Oregon's progress on integrating behavioral health as part of the CCO model during the first three years of the waiver renewal. We first describe the context for behavioral health integration and the history of Oregon's efforts in this area since the 2012 waiver. We then present results for evaluation measures related to quality, access, and spending on behavioral health based on data through 2019. Results include statistically adjusted changes over time, outcomes for subgroups of Medicaid members, and assessment of the focus population of non-English speaking members. Measures address the following evaluation hypotheses:

- 1.1 Coordination of care for CCO members with behavioral health diagnoses will improve.
- 1.2 Ability to identify and refer members to substance abuse interventions will improve over time.
- 1.3 Integration of behavioral health services will improve access for CCO members with serious mental illness (SMI).
- 1.4 Integration of behavioral health services with physical health services will be associated with reduced growth of total spending and spending in high-cost settings (e.g., ED and inpatient), and with sustained or increased spending on primary or preventive care, for CCO members with behavioral health diagnoses.

## KEY FINDINGS

- Since 2012, the state and CCOs have been active in a variety of areas designed to advance behavioral health integration. However, there does not appear to be a clearly communicated set of priorities or milestones for gauging progress.
- A variety of measures moved in the desired direction between 2013 and 2016, including decreasing ED visits and avoidable ED visits, improvements in Glucose Testing for People Using Second Generation Antipsychotic Medications and Engagement in the Treatment of Alcohol and Drug Disorders, and increases in outpatient visits for individuals with behavioral health conditions.
- Some quality measures were essentially unchanged between 2013 and 2016, including Lipid Testing for People Using Second Generation Antipsychotic Medications, 30-Day Follow-Up after Hospitalization for Mental Illness, and Initiation in the Treatment of Alcohol and Drug Disorders, and measures of access to primary care.
- Expenditures per enrollee increased sharply between 2016 and 2019.
- The percentage of enrollees diagnosed with SUD increased from 3.4% in 2011 and to 8.3% 2019 – an increase of almost 150% in 8 years.

## Behavioral Health Integration Efforts under the Waiver Renewal

Oregon made progress on behavioral health integration under the 2012-2017 waiver, as CCOs' global budgets and structure enabled them to act as a single point of accountability for members' health. (See Box 4.1 for details.) The 2012-2017 waiver evaluation noted this progress as well as the need for additional effort and time. The 2017-2022 waiver renewal called on Oregon to reinforce its commitment to integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and restraining costs.

### Box 4.1: Behavioral Health Integration and the 2012-2017 Waiver

*States need ways to provide high quality, accessible, and cost-effective behavioral health services for their Medicaid members. The prevalence of behavioral health conditions is almost twice as high for individuals in Medicaid relative to the general population, and the prevalence of SMI is almost three times that of the general population (MACPAC, 2015). Nearly 12% of Medicaid enrollees over the age of 18 have an SUD (SAMHSA, 2013). Medicaid is a major source of financing for behavioral health services, paying for at least 25% of those services in the country in 2014 (Mark et al, 2016).*

*Behavioral health integration has become a focus for many states, including Oregon. Numerous research studies have demonstrated that integrating primary care and behavioral health care can improve patient outcomes (see for example, Miller et al, 2013). Models that focus on the integration of physical health care into the behavioral health care setting have demonstrated similar benefits (see for example, Druss et al, 2016).*

*During the 2012-2017 waiver, the CCO model was associated with an increased use of screening and brief intervention for alcohol and other drug (AOD) disorders. However, this did not translate to increased initiation of treatment, suggesting that providers may not have been prepared for the expanded clinical responsibilities of integrating SUD treatment or referral into their practice. It is also possible that increases seen in screening rates may have been due to changes in documentation rather than actual changes in care (Rieckmann et al, 2018). Efforts by CCOs and OHA also spurred increased co-location of behavioral health and primary care. Nonetheless, practices reported ongoing challenges in identifying funding mechanisms to support integration and a variety of examples of fragmented financing and delivery systems have persisted across the state (Kroening-Roche et al, 2017).*

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## Actions Specified in the Waiver Renewal

The 2017-2022 waiver specifically called on OHA and CCOs to undertake the following actions:

- Implement models of care that promote integration, including the Substance Abuse and Mental Health Services Administration’s (SAMSHA) 2017-2019 CCBHC Demonstration project.
- Support Oregon’s Behavioral Health Collaborative workgroups. The workgroups will concentrate in five areas: governance and financing; peer-delivered services; standards & competencies; workforce; and information technology.

CCBHCs were designed to provide a comprehensive range of behavioral health and SUD services, utilize a cost-based rate, collect standardized metrics and provide care coordination, particularly to individuals with serious behavioral health needs. In Oregon, CCBHCs were also responsible for providing 20 hours per week of on-site primary care, designed to support physical-behavioral health integration. Since 2019, this program continues to include 12 clinics at 21 sites throughout Oregon, serving approximately 50,000 individuals per year.

The Behavioral Health Collaborative recommended the state create a single point of shared accountability within each geographic service area. These Regional Behavioral Health Collaboratives were to be formed by CCOs, community mental health programs, local mental health authorities, local public health authorities, tribes, individuals with lived experience, and other key system partners in each geographic region of the state to improve individual health outcomes.

## Progress leading up to 2020

In many ways, Oregon is well positioned to push forward on integration efforts. Oregon has made significant investments in its primary care system, which serves as a necessary point of coordination for most integration efforts. The PCPCH model – Oregon’s version of the “primary care medical home” – was established in 2009 and has been a centerpiece of the CCO model. The state also participates in CMS’s CPC+ model, a multi-payer approach that offers additional infrastructure support for integration efforts.

Integration is also supported by OHA’s Transformation Center, launched in 2013 as part of the CCO initiative. The Transformation Center is the state’s hub for innovation, quality improvement and learning for Oregon’s health system. Its activities include, for example, technical assistance to connect CCOs with resources for advancing work on behavioral health integration.

The state has made advances in sharing information related to opioid use. Oregon has had widespread adoption of two web-based communications tools, the Emergency Department (ED) Information Exchange (EDIE) and PreManage. EDIE collects emergency department and inpatient Admit Discharge Transfer data from hospitals and pushes notifications back to the ED in real time. PreManage is a companion tool that offers the same notifications to those outside of the hospital system. Hospitals that have integrated EDIE into their electronic health record (EHR) may now include prescription drug monitoring program data in their EDIE alerts.

Oregon created a Behavioral Health Information Technology (HIT) Workgroup in 2018 to provide recommendations to OHA. The workgroup’s recommendations have included the development of training and toolkits to address privacy and security rules governing health information exchange, guidance on adoption of EHRs, and the creation of behavioral health peer learning collaboratives.

In July 2018, OHA reorganized its behavioral health program, creating a position for state behavioral health director. This position was filled in April 2019 by Steve Allen, a national expert on behavioral health policy and state government reform, and experienced behavioral health administrator,

In 2019, the Governor created a Behavioral Health Advisory Council, which provided recommendations for the State's behavioral health system in 2020. The Council recommended multiple investments in behavioral health programs and services, including program changes that would be directly responsive to and driven by communities of color, tribal communities and people with lived experience, funding for continued operations and study of existing CCBHC demonstration sites, increased support for community restoration and an additional secure residential treatment facility, and the design of a statewide crisis system. The Council also recommended investments in the behavioral health workforce, including the creation of a behavioral health incentive fund, implementation and sustainability of culturally based practices, additional support for training of the behavioral health workforce, and a 309 rule revision to reduce provider administrative burden. Finally, the Council noted the importance of investments in housing and housing supports and provided a number of recommendations designed to increase the opportunities for safe and supportive places to live.

In 2020, Oregon voters passed Measure 110, the Drug Addiction Treatment and Recovery Act. The measure's goal was to shift the response to drug possession from criminalization to treatment and recovery. OHA was required to establish a treatment and recovery services fund to support new Addiction Recovery Centers (A.R.C.s), with fifteen A.R.C.s to be established throughout the state by October 1, 2021.

### Areas of Concern

Despite the stated focus on behavioral health integration included in the waiver renewal, it was difficult to discern a clear strategy for this work based on publicly available policy documents and guidance. In contrast to communications and documentation around health-related services (see Chapter 5), OHA's messaging on behavioral health integration lacks clarity about how these efforts are being managed and coordinated with CCOs. As of this writing (March 2021), OHA's website on behavioral health integration does not appear to have been updated since 2017. The state and CCOs are active in a variety of areas, but there does not seem to be an articulated set of priorities or milestones for measuring progress.

Furthermore, although CCO 2.0 contracts in 2020 were designed to eliminate the subdelegation of behavioral health services and required CCOs to seamlessly integrate care so that members would be "unaware of any differences in how the benefits are managed," it is not clear if this level of full integration has occurred across all CCOs. For example, beneficiaries visiting the website of Portland's largest CCO (Health Share of Oregon) are directed to CareOregon for their behavioral health needs but are given the option of a variety of other "medical health plans" for their physical health needs.

A 2020 audit of the state's behavioral health system identified a variety of problems with the current behavioral health treatment system, including shortcomings in data and performance measurement, workforce shortages, fragmented care, and a lack of consistent governance.<sup>7</sup> The audit singled out the state's behavioral health system for children as a system in crisis, failing to serve children, youth, and families who are involved with multiple systems with complex needs. The findings of this audit, coupled with the lack of clear information from the state on its strategy for behavioral health integration, suggests that considerable work is needed in this area.

## Behavioral Health Outcomes

This section presents the results of our analyses of measures related to behavioral health integration. We present outcomes for CCO-enrolled, non-dual eligible Medicaid members for the period 2011 through 2019, including changes from 2011 and 2016 baselines adjusted for demographic characteristics and risk. We define “members with behavioral health conditions” based on diagnoses of SPMI or SUD; see Appendix B for details. We report results for subgroups based on age group, gender (binary classification), geography of residence (rural, urban, isolated), disability status (disabled, non-disabled), and the presence of chronic physical health conditions. We also assess outcomes for non-English speaking members, comparing changes in this focus population to English speaking members. We show results separately for each of the evaluation hypotheses relating to behavioral health integration. Appendix B provides details on statistical methods used for these analyses.

### Coordination of Care for CCO Members with Behavioral Health Diagnoses (Hypothesis 1.1)

We assessed progress on care coordination for CCO members with behavioral health conditions based on the following five measures:

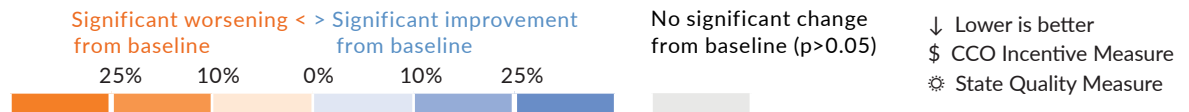
- **ED Utilization per 1,000 Member Months (MM) for Members with Behavioral Health Conditions:** Number of ED visits per 1,000 member months among members with SPMI and/or SUD diagnoses.
- **Potentially Avoidable ED Visits per 1,000 MM for Members with Behavioral Health Conditions:** ED visits that were preventable or treatable with appropriate primary care per 1,000 member months among members with SPMI and/or SUD diagnoses.
- **Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications:** Percentage of members taking a 2nd generation antipsychotic medication who had a HbA1c test.
- **Lipid Testing for Members Using 2nd Gen. Antipsychotic Medications:** Percentage of members taking a 2nd generation antipsychotic medication who had a cholesterol test.
- **30-Day Follow-Up after Hospitalization for Mental Illness:** Percentage of discharges after hospitalization for mental illness where the patient received follow-up within 30 days

### Overall Trends

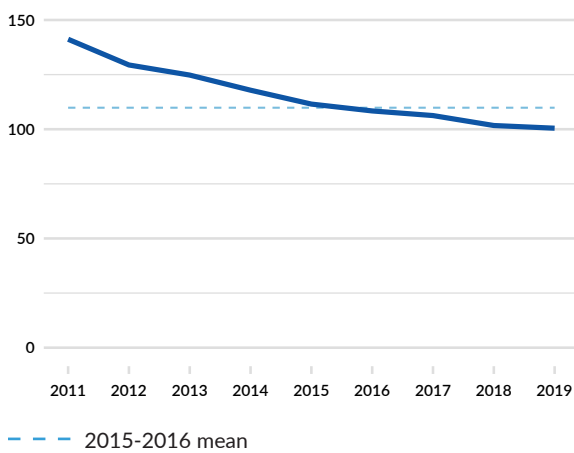
Figures 4.1-4.5 show outcomes for key measures of coordination for CCO members with behavioral health conditions from 2011 through 2019. Table 4.1 displays changes from 2011-2019 and from 2016-2019 after adjustment for demographics and risk. Several measures moved in the desired direction. For example, ED visits and potentially avoidable ED visits decreased over time, and 30-Day Follow-Up after Hospitalization for Mental Illness improved, although there were no statistically significant improvements between 2016 and 2019. Glucose Testing for People Using Second Generation Antipsychotic Medications demonstrated a modest improvement (1.5% between 2016 and 2019). The measure Lipid Testing for People Using Second Generation Antipsychotic Medications was relatively stable.

**Table 4.1: Adjusted Change in Measures of Care Coordination for Members with Behavioral Health Conditions, 2011-2019 and 2016-2019**

Measure		2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
ED Utilization per 1,000 MM Members with Behavioral Health Conditions	↓ \$ ☼	108.4	100.5	-10.6	-22.4
Potentially Avoidable ED Visits per 1,000 MM for members with Behavioral Health Conditions	↓ ☼	15.2	12.2	-3.8	-13.5
Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications		86.8%	88.5%	1.5	0.8
Lipid Testing for Members 2nd Gen. Antipsychotic Medications		59.8%	59.4%	-0.1	-0.2
30-Day Follow-Up after Hospitalization for Mental Illness	\$ ☼	81.0%	82.3%	1.3	7.3

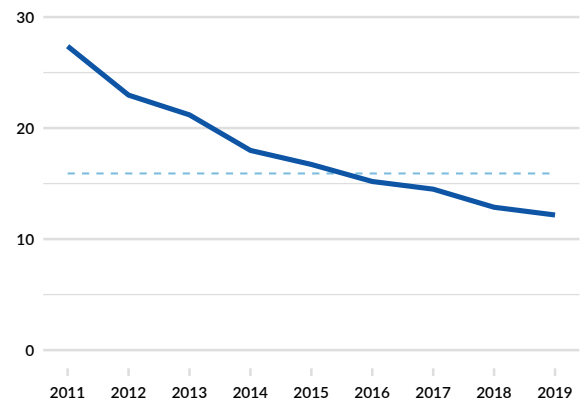


**Figure 4.1: ED Utilization per 1,000 MM for Members with Behavioral Health Conditions (↓ \$ ☼)**

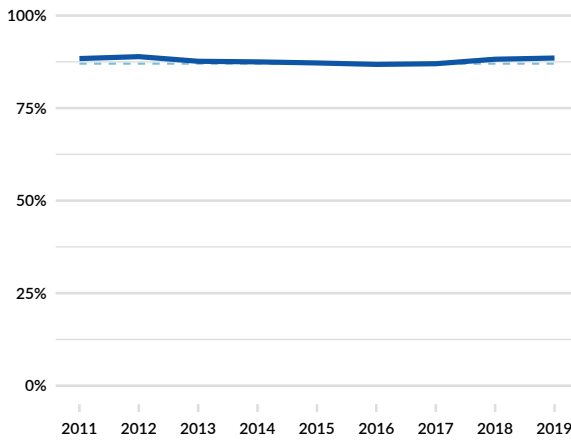


↓ Lower is better  
\$ CCO Incentive Measure  
☼ State Quality Measure

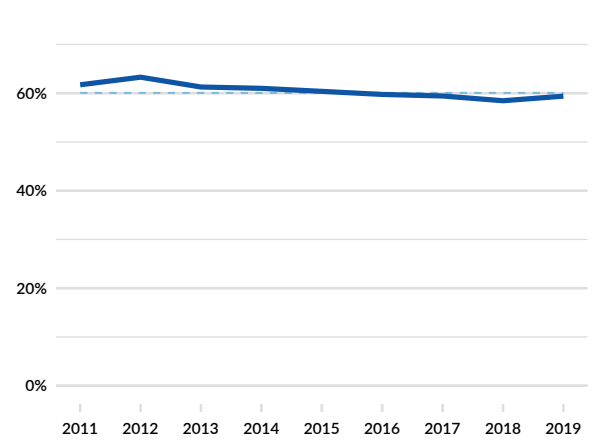
**Figure 4.2: Potentially Avoidable ED Visits per 1,000 Members for Members with Behavioral Health Conditions (↓ ☼)**



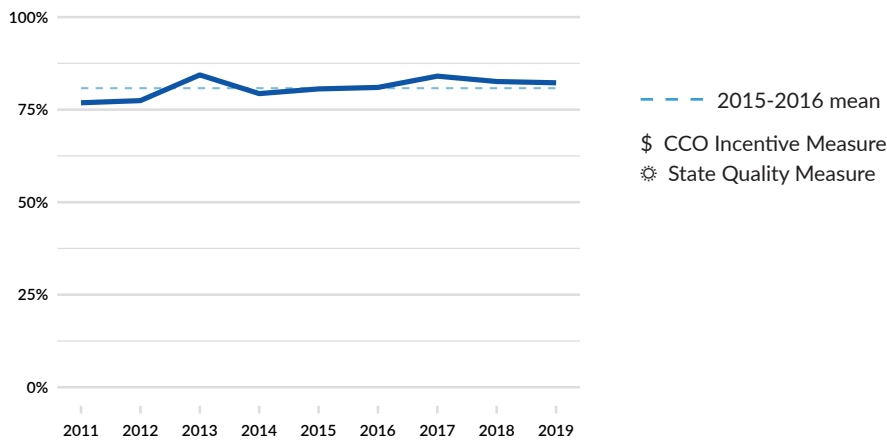
**Figure 4.3: Glucose Testing for People Using Second Generation Antipsychotic Medications**



**Figure 4.4: Lipid Testing for People Using Second Generation Antipsychotic Medications**



**Figure 4.5: 30-Day Follow-Up after Hospitalization for Mental Illness (\$ ⚙)**



     2015-2016 mean  
\$ CCO Incentive Measure  
⚙ State Quality Measure

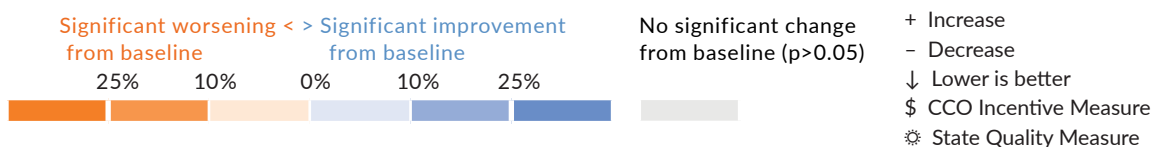
### Subgroup Analyses

Tables 4.2, 4.3 and 4.4 display changes among subgroups for key measures of care coordination between 2016 and 2019 (after adjustment for demographic characteristics and risk). ED visits declined, on average, for members with behavioral health conditions, but the largest decreases were among individuals aged 18-34 and among women – a pattern that also held in potentially avoidable ED visits. Glucose testing for individuals on second-generation antipsychotic medications improved slightly for all groups. We did not observe significant improvements for Lipid Testing in most groups, although the measure worsened slightly among rural enrollees and improved among those in isolated areas (defined as population centers of less than 2,500 without commuting flow to urban areas). Follow-Up after Hospitalization for Mental Illness was unchanged among most subgroups, but worsened for individuals ages 18 and under. Changes in these measures were relatively similar for individuals with and without a disability and for individuals with and without a physical health chronic condition. (Three of the measures below – avoidable ED visits, glucose testing, and lipid testing – are not defined for individuals under the age of 18. We do not report these measures for this subgroup).

**Table 4.2: Adjusted Change from 2016 to 2019 in Measures of Care Coordination for Members with Behavioral Health Conditions, by Age & Gender**

Measure		Age			Gender	
		<18	18-34	35-64	Male	Female
ED Utilization per 1,000 MM Members with Behavioral Health Conditions	↓ \$ ☼	-	-	-	-	-
Potentially Avoidable ED Visits per 1,000 MM for Members with Behavioral Health Conditions	↓ ☼	NA	-	-	-	-
Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications		NA	+	+	+	+
Lipid Testing for Members Using 2nd Gen. Antipsychotic Medications		NA	+	-	-	+
30-Day Follow-Up after Hospitalization for Mental Illness	\$ ☼	-	+	+	+	+

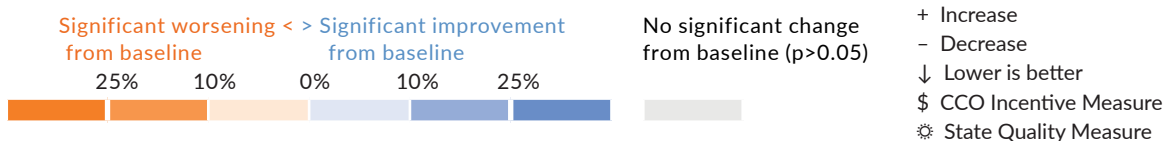
Note: Enrollment data for gender was based on a binary classification.



**Table 4.3: Adjusted Change from 2016 to 2019 in Measures of Care Coordination for Members with Behavioral Health Conditions, by Geography of Residence.**

Measure		Geography of Residence		
		Rural	Urban	Isolated
ED Utilization per 1,000 MM Members with Behavioral Health Conditions	↓ \$ ☼	-	-	-
Potentially Avoidable ED Visits per 1,000 MM Members with Behavioral Health Conditions	↓ ☼	-	-	-
Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications		-	+	+
Lipid Testing for Members Using 2nd Gen. Antipsychotic Medications		-	+	+
30-Day Follow-Up After Hospitalization for Mental Illness	\$ ☼	+	+	-

Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas



**Table 4.4: Adjusted Change from 2016 to 2019 in Measures of Care Coordination for Members with Behavioral Health Conditions, by Disability and Chronic Condition Status**

Measure		Disability		Chronic Condition	
		Yes	No	Yes	No
ED Utilization per 1,000 MM Members with Behavioral Health Conditions	↓ \$ ☀	-	-	-	-
Potentially Avoidable ED Visits per 1,000 MM Members with Behavioral Health Conditions	↓ ☀	-	-	-	-
Glucose Testing for Members Using 2nd Gen. Antipsychotic Medications		+	+	+	+
Lipid Testing for Members Using 2nd Gen. Antipsychotic Medications		-	+	-	+
30-Day Follow-Up After Hospitalization for Mental Illness	\$ ☀	+	+	+	+

Significant worsening < > Significant improvement from baseline  
 25% 10% 0% 10% 25%

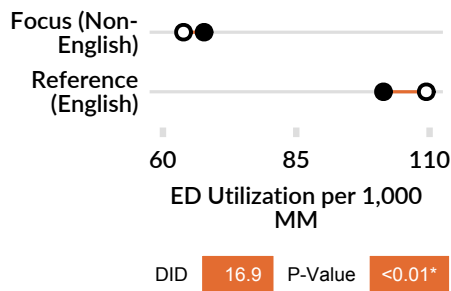
No significant change from baseline ( $p > 0.05$ )

+ Increase  
 - Decrease  
 ↓ Lower is better  
 \$ CCO Incentive Measure  
 ☀ State Quality Measure

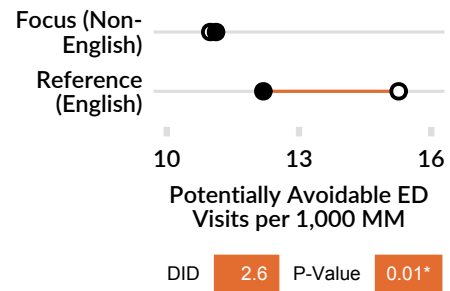
### Focus Population — Non-English Speaking Members

Figures 4.6 through 4.10 compare changes in outcomes for non-English speaking individuals versus English speaking members. Non-English speaking members were identified in Medicaid enrollment data as members who indicated that the main language spoken in their household was not English. We used a difference-in-differences (“DID”) framework (described in detail in Appendix B) to determine whether and how the 2016-2019 change for the focus population was different from the change seen in the reference population, after adjusting for demographic characteristics and risk. Compared to English speaking members, ED visits increased among the non-English speaking members. Avoidable ED visits were relatively flat among the group of non-English speaking members, even as these visits declined among English speaking members. Although Lipid Testing was relatively unchanged among English speakers, this quality measure decreased among non-English speaking members. There were no significant differential trends among the other two quality measures (Glucose Testing and Follow-Up after Hospitalization for Mental Illness).

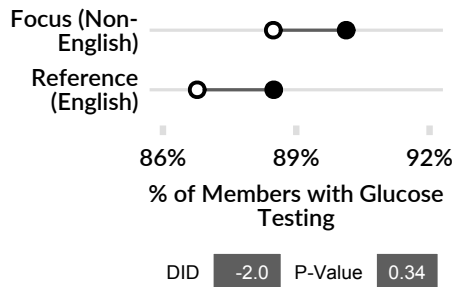
**Figure 4.6: ED utilization for members with behavioral health conditions increased for non-English speaking members compared to English speaking members (↓ \$ ☼)**



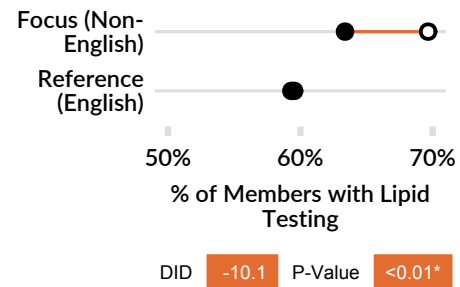
**Figure 4.7: Avoidable ED visits for members with behavioral health conditions increased for Non-English speaking members relative to English speaking members (↓ ☼)**



**Figure 4.8: The change in glucose testing for members using 2nd generation antipsychotic medications was not significantly different for non-English speaking members compared to English speaking members**



**Figure 4.9: Lipid testing for members using 2nd generation antipsychotic medications decreased for non-English speaking members relative to English speaking members**

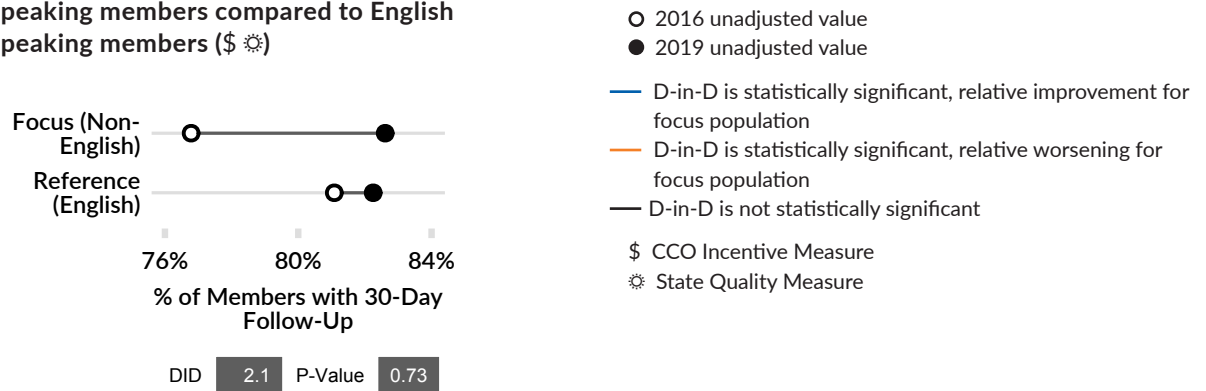


Note: "Non-English" includes members who indicated that English was not the main language spoken in their household.

- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant
- ↓ Lower is better
- \$ CCO Incentive Measure
- ☼ State Quality Measure



**Figure 4.10: The change in 30-day follow-up after hospitalization for mental illness was not significantly different for non-English speaking members compared to English speaking members (\$ ☼)**



Note: "Non-English" includes members who indicated that English was not the main language spoken in their household.

## Referral to SUD Treatment (Hypothesis 1.2)

To assess whether the ability to identify and refer members with substance use disorders improved in the first three years of the waiver renewal, we analyzed four measures:

- **Initiation of Alcohol and Other Drug (AOD) Dependence Treatment:** Percentage of members aged 13-64 diagnosed with alcohol or other drug dependence who started treatment within 14 days.
- **Engagement of AOD Dependence Treatment:** Percentage of members aged 13-64 diagnosed with alcohol or other drug dependence who received at least two services for alcohol or other drug abuse within 30 days of starting treatment.
- **Percentage of Members with SUD:** Percentage of members with two or more substance use disorder claims in a 2-year period.
- **Screening, Brief Intervention, and Referral to Treatment (SBIRT):** Measured as two rates; (1) percentage of members aged 12 and over who received an age-appropriate screening for alcohol or other substance abuse, (2) percentage of members who screened positive for alcohol or other substance abuse and received a brief intervention or referral to treatment.

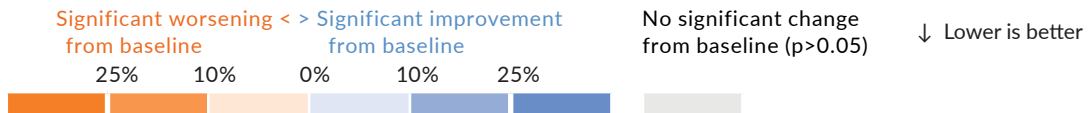
We present results for the first of these three measures below. The collection of data SBIRT has changed over time, and we were therefore unable to analyze changes over time. Appendix G includes SBIRT outcomes for 2019.

## Overall Trends

Figures 4.11-4.13 show outcomes for measures related to SUD diagnosis and treatment from 2011 through 2019. Table 4.5 displays changes from 2011 to 2019 and from 2016 to 2019 after adjustment for demographics and risk. Initiation of AOD Dependence Treatment decreased between 2011 and 2016 and was relatively flat between 2016 and 2019; Engagement of AOD Dependence Treatment followed a similar pattern.

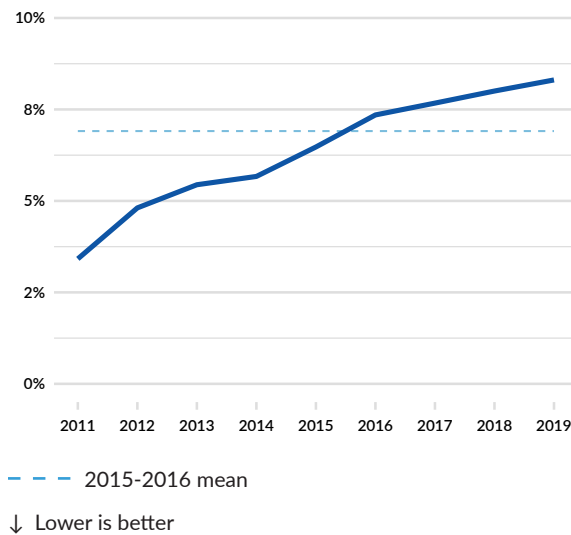
**Table 4.5: Adjusted Change in Measures of SUD Diagnosis and Treatment, 2011-2019 and 2016-2019**

Measure	2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
Initiation of AOD Dependence Treatment, 13-64 years	33.1%	33.3%	0.6	-2.5
Engagement of AOD Dependence Treatment, 13-64 years	20.6%	20.6%	0.7	-3.0
Percentage of Members with SUD ↓	7.3%	8.3%	0.7	5.1

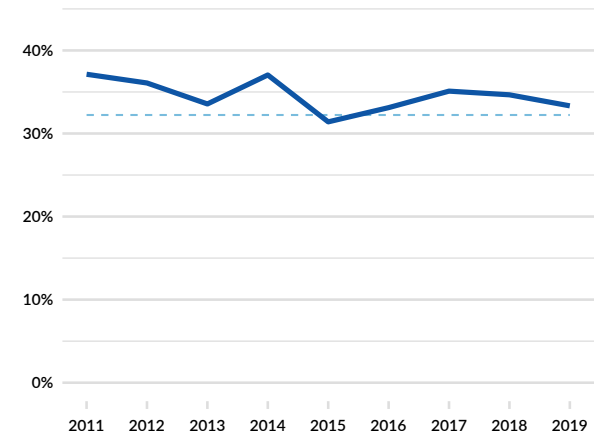


As shown in Figure 4.11, Oregon has experienced a large and steady increase in the percentage of CCO members with SUDs, increasing from 3.4% in 2011 to 8.3% in 2019 (an increase of almost 150% in 8 years). These changes are in line with national and regional trends in opioid use and methamphetamine use. However, it is unclear how much of the change in this measure was driven by changes in the underlying prevalence of SUD versus increased screening and detection of SUD.

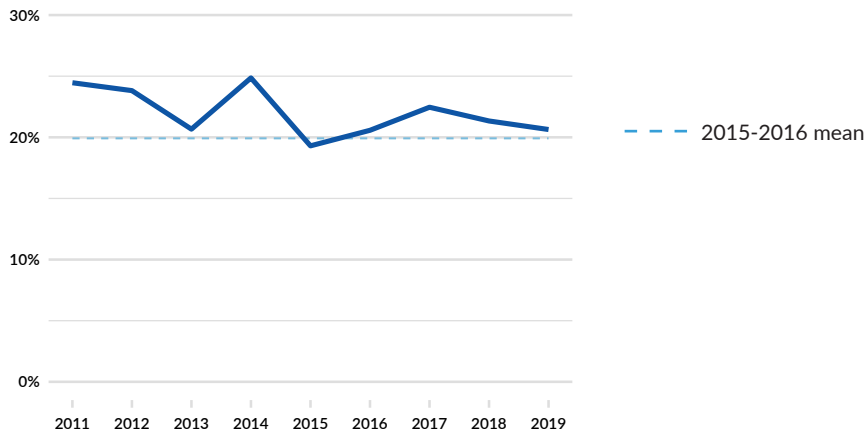
**Figure 4.11: Percentage of Members with SUD (↓)**



**Figure 4.12: Initiation of Alcohol or Other Drug Dependence Treatment, 13-64 years**



**Figure 4.13: Engagement of Alcohol or Other Drug Dependence Treatment, 13-64 years**



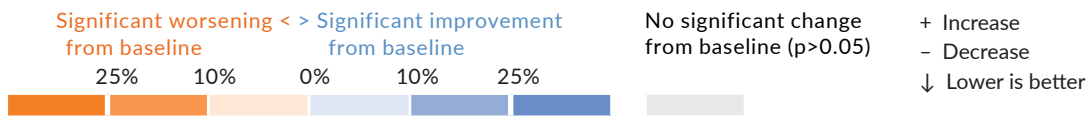
**Subgroup Analyses**

Tables 4.6, 4.7 and 4.8 display changes among subgroups for SUD measures between 2016 and 2019 after adjusting for changes in demographics and risk. Improvements in engagement and initiation of treatment were only significant among male members. The 2016-2019 change in the percentage of CCO members with SUDs was largest among males and individuals aged 35-64, larger in rural and isolated areas than in urban areas, and larger among individuals without a physical chronic condition or disability.

**Table 4.6: Adjusted Change from 2016 to 2019 in Measures of SUD Diagnosis and Treatment, by Age & Gender**

Measure	Age			Gender	
	<18	18-34	35-64	Male	Female
Initiation of AOD Dependence Treatment, 13-64 years	-	+	+	+	-
Engagement of AOD Dependence Treatment, 13-64 years	-	+	+	+	+
Percentage of Members with SUD ↓	-	-	+	+	+

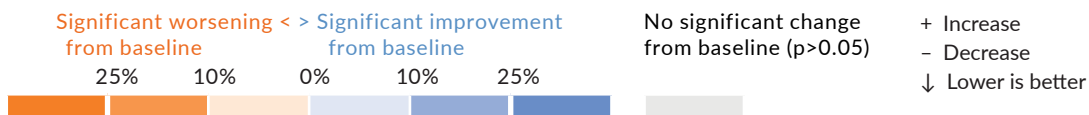
Note: Enrollment data for gender was based on a binary classification.



**Table 4.7: Adjusted Change from 2016 to 2019 in Measures of SUD Diagnosis and Treatment, by Geography of Residence**

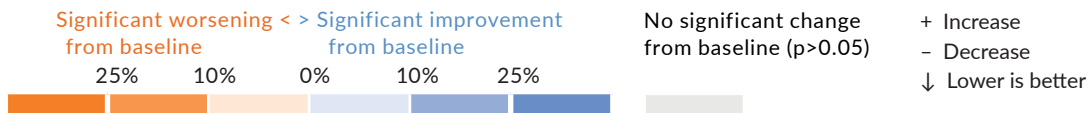
Measure	Geography of Residence		
	Rural	Urban	Isolated
Initiation of AOD Dependence Treatment, 13-64 years	+	+	-
Engagement of AOD Dependence Treatment, 13-64 years	+	+	-
Percentage of Members with SUD	+	+	+

Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas.



**Table 4.8: Adjusted Change from 2016 to 2019 in Measures of SUD Diagnosis and Treatment, by Disability and Chronic Condition Status**

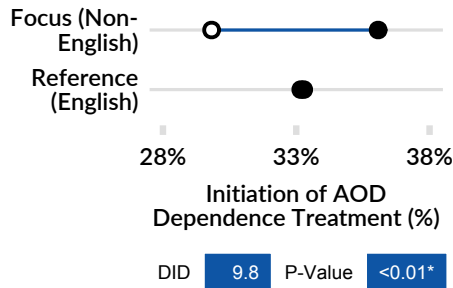
Measure	Disability		Chronic Condition	
	Yes	No	Yes	No
Initiation of AOD Dependence Treatment, 13-64 years	-	+	+	-
Engagement of AOD Dependence Treatment, 13-64 years	-	+	+	-
Percentage of Members with SUD	-	+	+	+



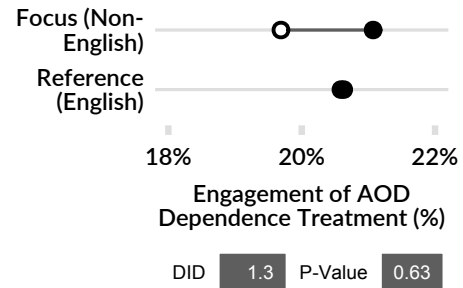
**Focus Population — Non-English Speaking Members**

Figures 4.14 through 4.16 compare changes in outcomes for non-English speaking versus English speaking individuals. Relative to English speaking enrollees, there was a significant increase in Initiation of AOD Dependence Treatment, but relatively little difference in Engagement of AOD Dependence Treatment. There was almost no change in the percentage of CCO members with SUDs among non-English speaking members, even as this percentage grew substantially among English speakers.

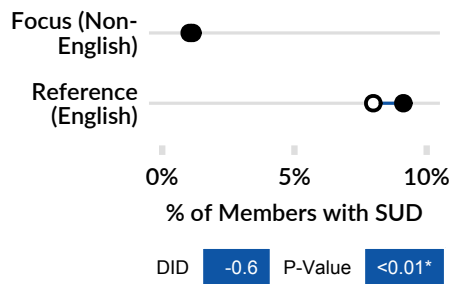
**Figure 4.14: Initiation of AOD dependence treatment increased among non-English speaking members compared to English speaking members**



**Figure 4.15: The change in engagement of AOD dependence treatment was not significantly different for non-English speaking members compared to English speaking members after adjusting for demographics and risk**



**Figure 4.16: The percentage of members with SUD increased significantly more among English-speaking members compared to non-English speaking members (↓)**



○ 2016 unadjusted value  
 ● 2019 unadjusted value  
 — D-in-D is statistically significant, relative improvement for focus population  
 — D-in-D is statistically significant, relative worsening for focus population  
 — D-in-D is not statistically significant  
 ↓ Lower is better

Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

### Access for CCO Members with Behavioral Health Conditions (Hypothesis 1.3)

The following evaluation measures were included in the analysis of access for CCO members with behavioral health conditions:

- **Outpatient Visits for Behavioral Health Care per 1,000 MM:** Number of outpatient visits for behavioral health care per 1,000 member months among members with SPMI and/or SUD diagnoses.
- **Outpatient Visits for Non-Behavioral Health Care per 1,000 MM:** Number of outpatient visits for non-behavioral health care per 1,000 member months among members with SPMI and/or SUD diagnoses.
- **Members with Any Primary Care for Members with Behavioral Health Conditions:** Percentage of members who had at least one visit to a primary care provider among members with SPMI and/or SUD diagnoses.

- **Adults' Access to Preventive-Ambulatory Services for Members with Behavioral Health**

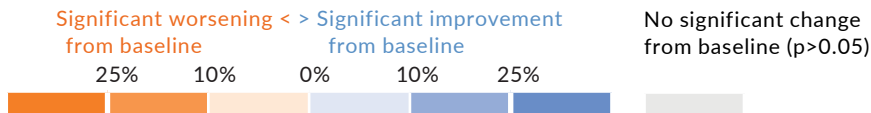
**Conditions:** Percentage of adults (age 20 and over) who had an outpatient our preventive care visit among members with SPMI and/or SUD.

**Overall Trends**

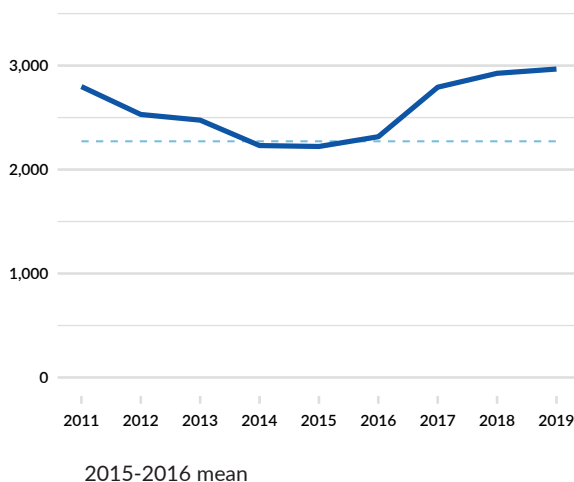
Figures 4.17-4.20 show outcomes for key measures of access for CCO members with behavioral health conditions from 2011 through 2019. Table 4.9 displays adjusted changes for 2011-2019 and 2016-2019. Outpatient Visits for Behavioral Health Care increased steadily and substantially over the 2011-2019 time period, as did Outpatient Visits for Non-Behavioral Health Care. Two measures - Any Primary Care and Adults' Access to Preventive-Ambulatory Services - were relatively stable during this time period for members with behavioral health conditions..

**Table 4.9: Adjusted Change in Measures of Access for CCO Members with Behavioral Health Conditions, 2011-2019 and 2016-2019**

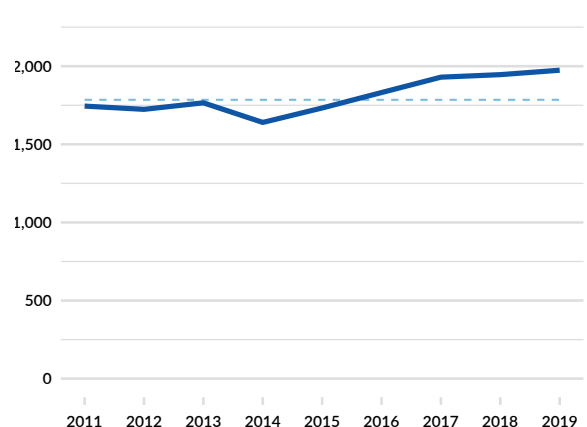
Measure	2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
Outpatient Visits for Behavioral Health Care per 1,000MM	2315.8	2966.7	659.1	320.6
Outpatient Visits for Non-Behavioral Health Care per 1,000MM	1831.5	1974.4	208.5	798.1
Members with Any Primary Care for Members with Behavioral Health Conditions	90.8%	91.2%	0.1	0.5
Adults' Access to Preventative-Ambulatory Services for Members with Behavioral Health Conditions	91.4%	91.4%	-0.1	-0.2



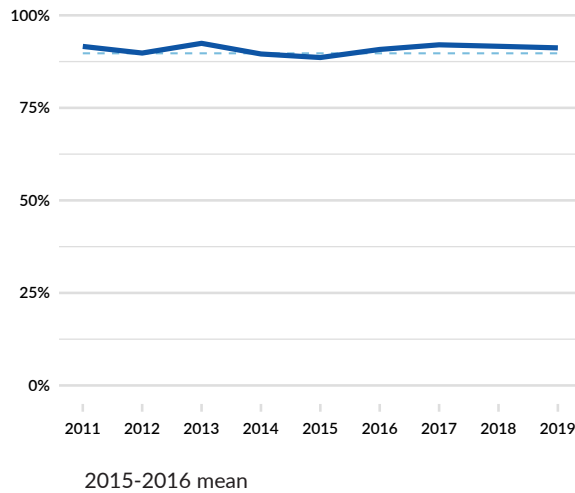
**Figure 4.17: Outpatient Visits for Behavioral Health Care per 1,000 MM**



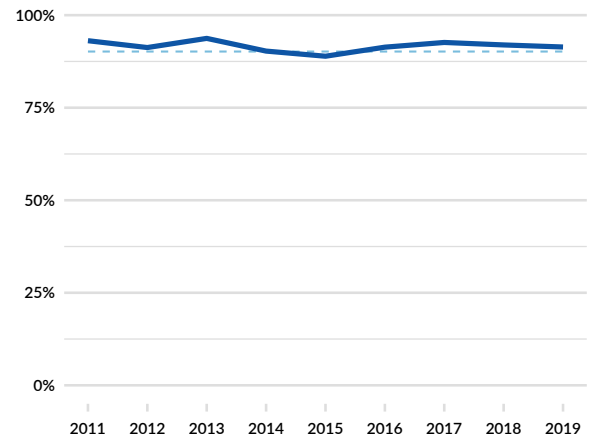
**Figure 4.18: Outpatient Visits for Non-Behavioral Health Care for Members with Behavioral Health Conditions per 1,000 MM**



**Figure 4.19: Members with Any Primary Care for Members with Behavioral Health Conditions**



**Figure 4.20: Adults' Access to Preventive-Ambulatory Services for Members with Behavioral Health Conditions**



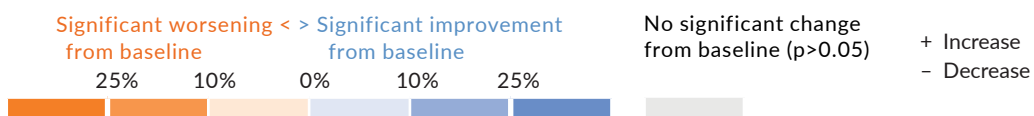
**Subgroup Analyses**

Tables 4.10, 4.11 and 4.12 display adjusted changes for access measures among subgroups of CCO members with behavioral health conditions between 2016 and 2019. There were significant increases in Outpatient Visits (Behavioral and Non-Behavioral) among all subgroups, with the largest changes occurring among individuals ages 35-64, enrollees with an urban residence, and disabled individuals. For the measure Any Primary Care, there was relatively little change among most subgroups, although individuals ages 35-64 exhibited a small but statistically significant decrease in this measure. A similar pattern occurred in Adults' Access to Preventive-Ambulatory Service.

**Table 4.10: Adjusted Change from 2016 to 2019 in Measures of Access for CCO Members with Behavioral Health Conditions, by Age & Gender**

Measure	Age			Gender	
	<18	18-34	35-64	Male	Female
Outpatient Visits for Behavioral Health Care per 1,000 MM	-	+	+	+	+
Outpatient Visits for Non-Behavioral Health Care per 1,000 MM	+	+	+	+	+
Members with Any Primary Care for Members Behavioral Health Conditions	+	+	-	+	+
Adults' Access to Preventative-Ambulatory Services for Members with Behavioral Health Conditions	NA	+	-	-	-

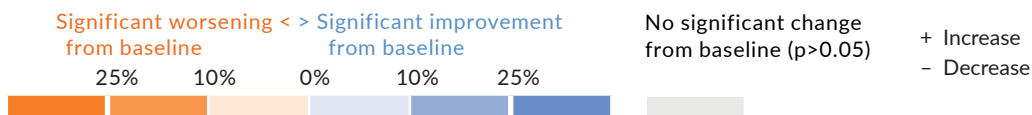
Note: Enrollment data for gender was based on a binary classification.



**Table 4.11: Adjusted Change from 2016 to 2019 in Measures of Access for CCO Members with Behavioral Health Conditions, by Geography of Residence**

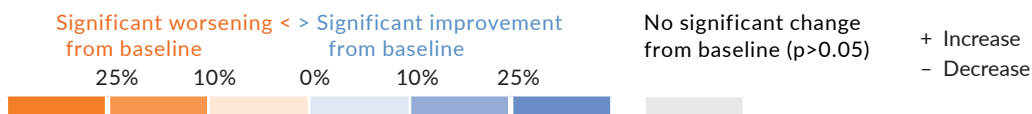
Measure	Geography of Residence		
	Rural	Urban	Isolated
Outpatient Visits for Behavioral Health Care per 1,000 MM	+	+	+
Outpatient Visits for Non-Behavioral Health Care per 1,000 MM	+	+	+
Members with Any Primary Care for Members Behavioral Health Conditions	-	+	+
Adults' Access to Preventative-Ambulatory Services for Members with Behavioral Health Conditions	-	+	+

*Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas.*



**Table 4.12: Adjusted Change from 2016 to 2019 in Measures of Access for CCO Members with Behavioral Health Conditions, by Disability and Chronic Condition Status**

Measure	Disability		Chronic Condition	
	Yes	No	Yes	No
Outpatient Visits for Behavioral Health Care per 1,000 MM	+	+	+	+
Outpatient Visits for Non-Behavioral Health Care per 1,000 MM	+	+	+	+
Members with Any Primary Care for Members Behavioral Health Conditions	+	+	+	+
Adults' Access to Preventative-Ambulatory Services for Members with Behavioral Health Conditions	+	-	-	+

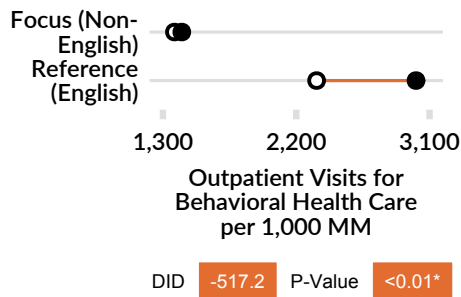


**Focus Population — Non-English Speaking Members**

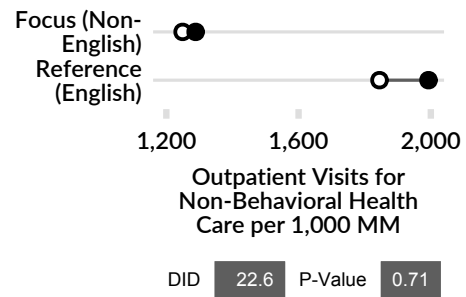
Figures 4.21-4.24 compare changes in outcomes for individuals who are non-English speaking versus English speaking members. Relative to their English-speaking counterparts, non-English speaking members had significantly fewer outpatient visits and exhibited smaller increases over time (Behavioral and Non-Behavioral). There was relatively little difference in the measures of Any Primary Care and Adults' Access to Preventive-Ambulatory Services.



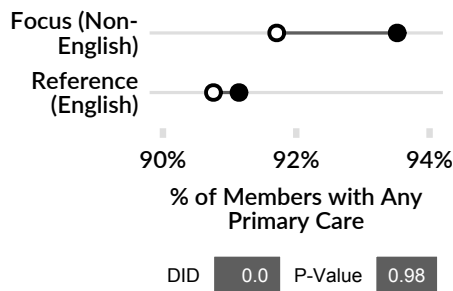
**Figure 4.21: Outpatient visits for behavioral health care increased more for English speaking members compared to non-English speaking members between 2016 and 2019**



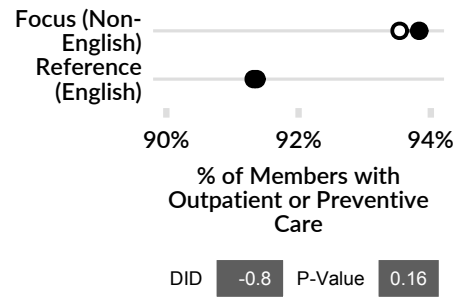
**Figure 4.22: Outpatient visits for non-behavioral health care increased more for English speaking members compared to non-English speaking members between 2016 and 2019**



**Figure 4.23: The change in primary care access for members with behavioral health conditions was not significantly different for non-English speaking versus English speaking members after adjusting for demographics and risk**



**Figure 4.24: The change in access to preventive-ambulatory services for members with behavioral health conditions was not significantly different for non-English speaking members versus English speaking members after adjusting for demographics and risk**



Note: "Non-English" includes members who indicated that English was not the main language spoken in their household.

- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant

## Spending (Hypothesis 1.4)

To assess spending changes for members with behavioral health conditions, we used the following measures:

- **Primary Care Spending PMPM for Members with Behavioral Health Conditions:** Total spending on primary care services (excluding behavioral health services), divided by months of enrollment among members with SPMI and/or SUD diagnoses.
- **ED Spending PMPM for Members with Behavioral Health Conditions:** Total spending on ED services (excluding behavioral health services), divided by months of enrollment among members with SPMI and/or SUD diagnoses.
- **Inpatient Facility Spending PMPM for Members with Behavioral Health Conditions:** Total inpatient professional spending (excluding behavioral health services), divided by months of enrollment among members with SPMI and/or SUD diagnoses.
- **Inpatient Professional Spending PMPM for Members with Behavioral Health Conditions:** Total inpatient professional spending (excluding behavioral health services), divided by months of enrollment among members with SPMI and/or SUD diagnoses.
- **Total Spending PMPM for Members with Behavioral Health Conditions:** Total spending on emergency department, primary care, prescription drug, inpatient, behavioral health, and other outpatient spending divided by months of enrollment among members with SPMI and/or SUD diagnoses.

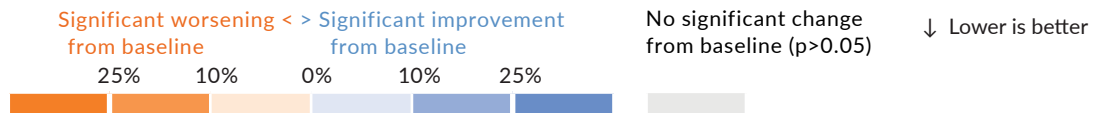
## Overall Trends

Figures 4.25-4.29 show per member per month (PMPM) expenditure measures for CCO members with behavioral health conditions from 2011 through 2019. Table 4.13 displays changes from 2016 to 2019 and from 2011 to 2019 after adjusting for demographics and risk. Spending on primary care decreased between 2011 and 2016 and was relatively flat between 2016 and 2019. Spending on ED services also decreased substantially between 2011 and 2016 and then began to increase after 2016. Inpatient facility spending declined marginally from 2016 to 2019, although the change was not statistically significant. Inpatient professional spending continued a downward trend from 2016 to 2019. Total spending decreased from 2011 to 2014 and but then began an upward trajectory, increasing substantially since 2016.

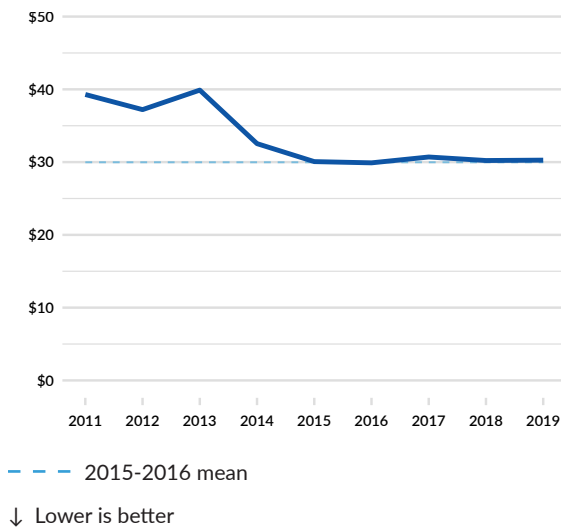
In the tables below, blue shading denotes better performance and orange shading denotes worse performance. In the categories of spending, increases in primary care spending have been coded as improved performance (blue), whereas increases in spending in other categories have been coded as worse performance (orange). We note that these categorizations are subjective and there may be reasons to view increased spending on patients with behavioral health conditions as a positive improvement.

**Table 4.13: Adjusted Change in Measures of PMPM Spending for Members with Behavioral Health Conditions, 2011-2019 and 2016-2019**

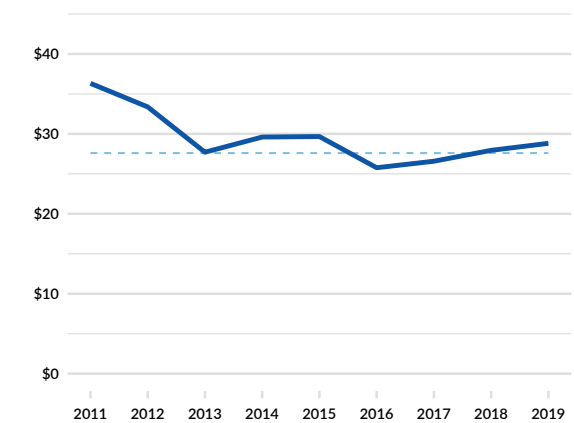
Measure		2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
Primary Care Spending PMPM for Members with Behavioral Health Conditions		\$29.90	\$30.27	0.07	-11.19
ED Spending PMPM for Members with Behavioral Health Conditions	↓	\$25.76	\$28.82	3.52	-8.88
Inpatient Facility Spending PMPM for Members with Behavioral Health Conditions	↓	\$125.32	\$122.09	-1.81	2.44
Inpatient Professional Spending PMPM for Members with Behavioral Health Conditions	↓	\$14.79	\$13.44	-1.26	-4.28
Total Spending PMPM for Members with Behavioral Health Conditions	↓	\$747.76	\$814.82	75.75	45.30



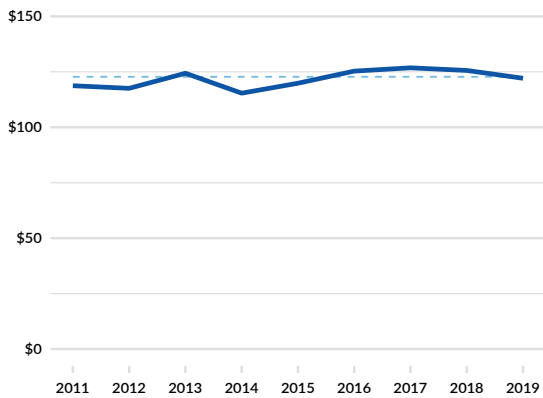
**Figure 4.25: Primary Care Spending (\$) PMPM for Members with Behavioral Health Conditions**



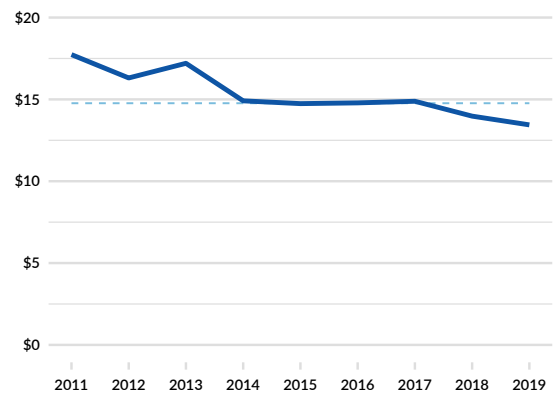
**Figure 4.26: ED Spending (\$) PMPM for Members with Behavioral Health Conditions (↓)**



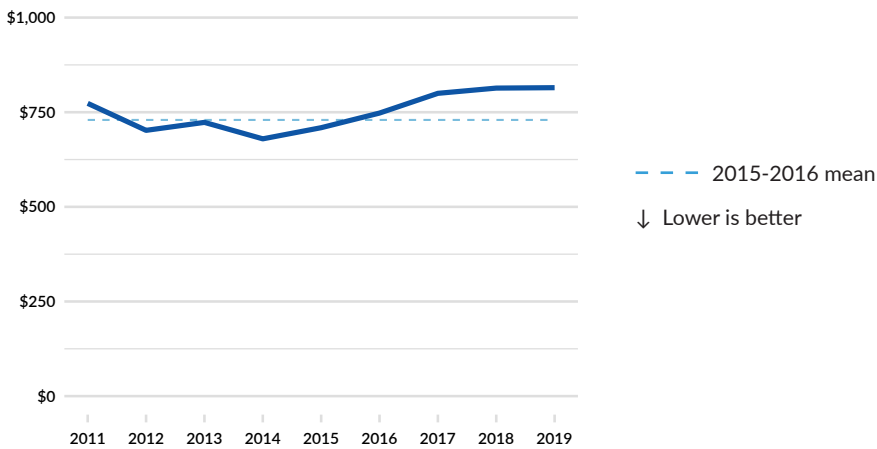
**Figure 4.27: Inpatient Facility Spending (\$) PMPM for Members with Behavioral Health Conditions (↓)**



**Figure 4.28: Inpatient Professional Spending (\$) PMPM for Members with Behavioral Health Conditions (↓)**



**Figure 4.29: Total Spending (\$) PMPM for Members with Behavioral Health Conditions (↓)**



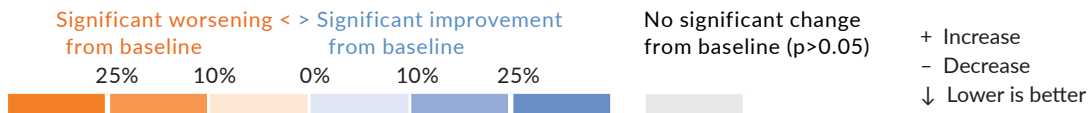
**Subgroup Analyses**

Tables 4.14, 4.15 and 4.16 display spending changes among subgroups of CCO members with behavioral health conditions between 2016 and 2019, after adjustment for demographics and risk. In the area of primary care spending, the biggest increases were among individuals ages 18 and less, those living in rural areas, and the disabled population. Spending on ED services exhibited the largest increases among males, individuals aged 35-64, disabled individuals, and individuals living in urban areas. Inpatient spending (facility and professional) decreased most significantly among individuals ages 18-34 and among females. There were substantial differences among men and women in changes in total spending, with males responsible for larger increases. Spending increases were also concentrated among individuals aged 35-64.

**Table 4.14: Adjusted Change from 2016 to 2019 in Measures of PMPM Spending for Members with Behavioral Health Conditions, by Age & Gender**

Measure	Age			Gender	
	<18	18-34	35-64	Male	Female
Primary Care Spending PMPM for Members with Behavioral Health Conditions	+	+	-	-	+
ED Spending PMPM for Members with Behavioral Health Conditions	+	+	+	+	+
Inpatient Facility Spending PMPM for Members with Behavioral Health Conditions	-	-	+	+	-
Inpatient Professional Spending PMPM for Members with Behavioral Health Conditions	-	-	-	-	-
Total Spending PMPM for Members with Behavioral Health Conditions	+	+	+	+	+

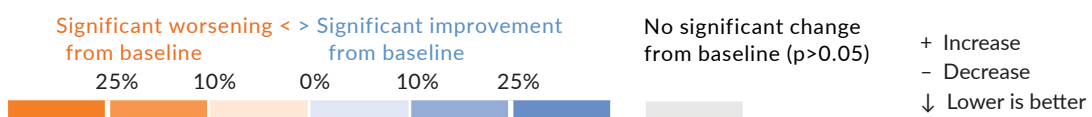
Note: Enrollment data for gender was based on a binary classification.



**Table 4.15: Adjusted Change from 2016 to 2019 in Measures of PMPM Spending for Members with Behavioral Health Conditions, by Geography of Residence**

Measure	Geography of Residence		
	Rural	Urban	Isolated
Primary Care Spending PMPM for Members with Behavioral Health Conditions	+	-	+
ED Spending PMPM for Members with Behavioral Health Conditions	+	+	+
Inpatient Facility Spending PMPM for Members with Behavioral Health Conditions	+	-	+
Inpatient Professional Spending PMPM for Members with Behavioral Health Conditions	-	-	-
Total Spending PMPM for Members with Behavioral Health Conditions	+	+	+

Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas.



**Table 4.16: Adjusted Change from 2016 to 2019 in Measures of PMPM Spending for Members with Behavioral Health Conditions, by Disability and Chronic Condition Status**

Measure		Disability		Chronic Condition	
		Yes	No	Yes	No
Primary Care Spending PMPM for Members with Behavioral Health Conditions		+	-	+	+
ED Spending PMPM for Members with Behavioral Health Conditions	↓	+	+	+	+
Inpatient Facility Spending PMPM for Members with Behavioral Health Conditions	↓	-	-	-	-
Inpatient Professional Spending PMPM for Members with Behavioral Health Conditions	↓	-	-	-	-
Total Spending PMPM for Members with Behavioral Health Conditions	↓	+	+	+	+

Significant worsening < Significant improvement from baseline

25% 10% 0% 10% 25%

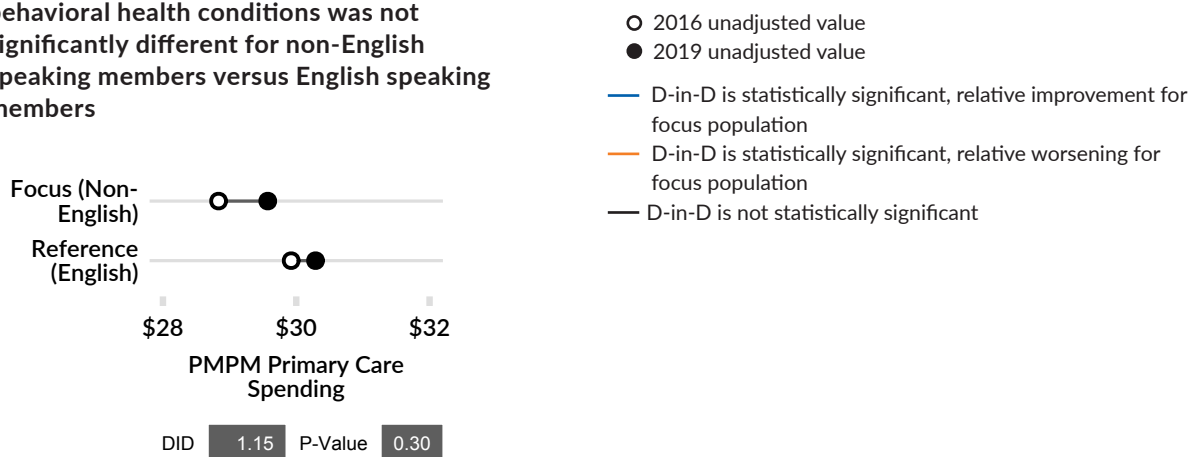
No significant change from baseline (p>0.05)

+ Increase  
- Decrease  
↓ Lower is better

**Focus Population — Non-English Speaking Members**

Figures 4.30-4.34 compare changes in outcomes for non-English speaking versus English speaking members. Non-English speaking members exhibited trends similar to their English speaking counterparts in all categories.

**Figure 4.30: The 2016-2019 change in primary care spending for members with behavioral health conditions was not significantly different for non-English speaking members versus English speaking members**



Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

Figure 4.31: The 2016-2019 change in ED spending for members with behavioral health conditions was not significantly different for non-English speaking members versus English speaking members

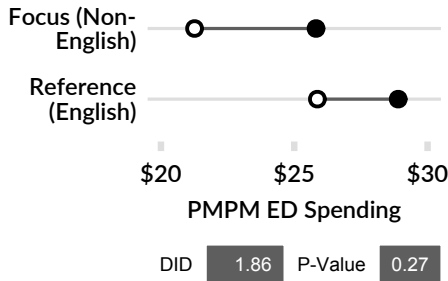


Figure 4.32: The 2016-2019 change in inpatient facility spending for members with behavioral health conditions was not significantly different for non-English speaking members versus English speaking members

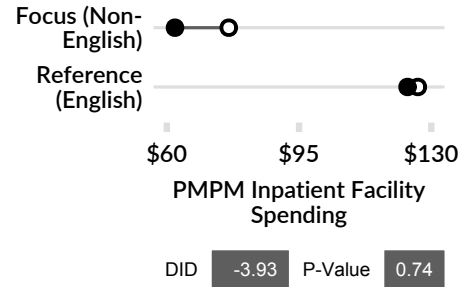


Figure 4.33: The 2016-2019 change in inpatient professional spending for members with behavioral health conditions was not significantly different for non-English speaking members versus English speaking members

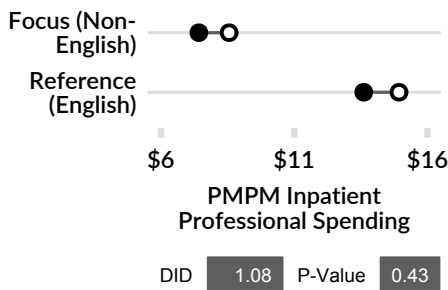
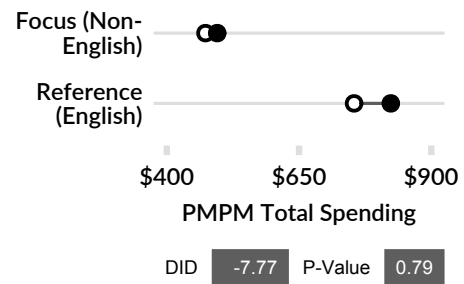


Figure 4.34: The 2016-2019 change in total spending for members with behavioral health conditions was not significantly different for non-English speaking members versus English speaking members



Note: "Non-English" includes members who indicated that English was not the main language spoken in their household.

- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant

## Assessing the Impacts of CCO Closure

During the evaluation period, there was one significant change in the CCOs that affected coverage for the Oregon Medicaid population. FamilyCare, Inc., Oregon's second largest CCO serving members in Washington, Multnomah, Clackamas, and Marion counties, shut its doors on January 31, 2018. With FamilyCare's closure, the majority of its 113,000 enrollees transitioned into Health Share of Oregon. (A smaller number of FamilyCare members in Marion County transitioned into Willamette Valley Community Health, while those in the Gaston area of Washington County moved into Yamhill Community Care. FamilyCare members who were also members of a tribe were not transitioned into a new CCO. They remained in the FFS program but could choose to enroll in a CCO in their area.) OHA worked with CCOs in FamilyCare's service area to transition members while protecting access to and continuity of care.<sup>8</sup>

To assess the potential for this transition to create a disruption and affect our results, we conducted sensitivity analyses on the 2016-2019 adjusted change, testing for differences for people in the tri-county region (Clackamas, Multnomah and Washington counties). We found that for most measures, the 2016-2019 change was no different or modestly greater (indicating greater improvement) for enrollees in the tri-county area. One area to monitor is total spending, which increased slightly more for individuals in the tri-county area. This difference could reflect increased service use - possibly beneficial for these enrollees - or challenges in managing the costs associated with the transition. With this exception, we did not find evidence in the claims-based measures that outcomes had worsened for enrollees in the tri-county area following the departure of FamilyCare. Detailed results are provided in Appendix G.

## Conclusions and Limitations

Oregon has been pursuing the integration of behavioral and physical health since the CCO model began in 2012. During the 2017-2020 time period, these efforts continued, and CCO 2.0 contracts included provisions designed to advance the goals of integration. However, areas of concern remain. In particular, in our review of publicly available policy documents and guidance, it was difficult to discern a clear strategy, vision, or milestones for achieving behavioral health integration.

Beginning in 2012, several performance measures began to move in the desired direction, with ED visits and avoidable ED visits decreasing among individuals with behavioral health conditions, while other outpatient visits increased, measures of primary care access remained relatively stable, and some measures of quality (e.g., 30-Day Follow-Up after Hospitalization for Mental Illness) improved. Expenditures per member also decreased between 2011 and 2016. However, beginning in 2016, some of this progress slowed or was reversed. We saw relatively little improvement in most measures, and expenditures per member increased substantially between 2016 and 2019. There was a steady increase in the percentage of members diagnosed with an SUD throughout the entire period.

The results presented here should be considered in the context of several limitations. First, the analysis is based on a "pre-post" design, comparing changes before and after the waiver renewal. With this approach, we cannot separate changes that could be attributed to Oregon's policies from secular changes - i.e., improvements occurring across the health system because of technology, provider supply and training, or other factors. Furthermore, analyses that rely on a short pre- or post-period could be biased if those years are outlier years and not representative of general trends. Second, our analyses are intended to provide a broad assessment of the effect of behavioral health integration. We did not evaluate the merits of specific evidence-based practices or approaches that



CCOs may have undertaken. Rather than measuring the success of specific tools or practices CCOs employed, these analyses should be seen as an assessment of the overall effects of integration efforts. Third, we did not conduct analyses that stratified by race or ethnicity, because we did not have reliable data. However, significant disparities exist in Oregon. Fourth, our results are based on data through 2019 and therefore do not capture any changes associated with CCO 2.0 contracts effective in 2020. The summative evaluation will assess the impact of CCO 2.0 on behavioral health integration. Finally, to calculate spending measures, we used imputed values for services subject to capitation arrangements (see Appendix B for details). Our results for these measures therefore are closer to a summary measure of utilization rather than actual CCO expenditures. Furthermore, changes in spending may reflect changes in benefits and covered services in addition to overall changes in utilization.

# Oral Health Integration

## Overview

This chapter assesses Oregon's progress on integrating oral health care services as part of the CCO model during the first three years of the waiver renewal. We first describe OHA and CCO activities in 2017-2019 to improve oral health integration and access to oral health services for Medicaid members. We then present results for evaluation measures related to quality, access, and spending on oral health, including regression-adjusted changes over time, results for subgroups of CCO-enrolled members, and comparison of focus and reference population outcomes. Measures address the following evaluation hypotheses:

- 2.1 Emergency dental visits for non-traumatic dental reasons will reduce over time for CCO enrollees.
- 2.2 Access to oral health services and dental care will improve for CCO enrollees.
- 2.3 Integration & coordination of oral health with other health services will improve for CCO enrollees.
- 2.4 Integration of oral health services with physical health services will be associated with reduced growth of spending on oral health services in high-cost settings (e.g., ED) and sustained or increased spending on preventive oral health services.

## KEY FINDINGS

- Oregon has made broad progress on oral health quality and access measures since the waiver renewal.
- ED use for non-traumatic dental conditions continued a downward trajectory between 2016 and 2019.
- Access to dental services and utilization of dental procedures increased between 2016 and 2019 after declining through 2015, although the percentage of members with a regular dentist stayed relatively flat. Both focus populations (non-English speaking individuals and children) saw improvements in access and utilization of dental care compared to reference populations.
- Measures intended to capture progress on oral health integration also moved in the desired direction. Spending on dental services outside the ED increased, reflecting increases in payment rates implemented in 2018.

## Oral Health Efforts under the Waiver Renewal

Integration of oral health services with physical health services is a key goal of Oregon's Medicaid delivery system transformation. Box 5.1 provides background on the state's progress on oral health integration under the 2012-2017 waiver. The 2017-2022 waiver specifically called on OHA and CCOs to implement recommendations from the December 2016 Oral Health Roadmap, including integrating oral health into PCPCH standards and practices and improving internal coordination on oral health within OHA.<sup>8,9</sup> This section provides a brief overview of activities undertaken by OHA and CCOs in 2017-2019 to promote progress on oral health integration and access to oral health services. We describe initiatives for delivery system integration, addressing access barriers, and using outcomes metrics to gauge progress.

### Box 5.1: Background on Oral Health Integration

*“Oral health services” includes services provided under the supervision of a dentist as well as services by non-dentists, such as expanded practice dental hygienists, primary care providers and pediatricians. OHP offers comprehensive dental benefits for both CCO-enrolled and FFS members. Prior to Oregon’s health system transformation, the majority of Medicaid members received dental services through OHA contracts with Dental Care Organizations (DCOs), which functioned as managed care organizations and dental provider organizations. In July 2014, funding for dental services was integrated into CCOs’ global budgets. CCOs took over the management of dental benefits for their members, contracting directly with DCOs. OHA still contracts with DCOs to provide dental services to FFS members.*

*Following budget integration, CCOs began work on improving and integrating oral health services delivery at the local level. An evaluation using data through December 2015 found that access, utilization, and spending for dental services decreased moderately from July 2014, suggesting that delivery system integration of dental care required more time and resources, particularly in light of increased enrollment due to Medicaid expansion. As of mid-2016, OHA reported that eight CCOs had included specific oral health strategies in their transformation plans. CCOs also initiated a variety of pilot projects. These included initiatives to reduce ED use through early intervention dental care, integrate dental hygienists into primary care settings, and provide enhanced dental services to members with diabetes. A 2016 “environmental scan” of oral health integration concluded that Oregon’s integration efforts were progressing but were still in their early stages. Ongoing challenges included the limited number of dentists accepting Medicaid patients, a lack of clear consensus on the definition of oral health integration, and differences in administrative requirements and processes between CCOs and DCOs.*

#### References:

- Oregon Health Authority. (2017). *Oral Health in Oregon’s CCOs: A Metrics Report*. <https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/oral-health-ccos.pdf>
- Young, J., Kushner, J., & McConnell, K. (2016). *The Impact of Dental Integration in Oregon’s Medicaid Program*. OHSU Center for Health Systems Effectiveness.
- Health Management Associates. (2016). *Oral Health Integration in Oregon: Environmental Scan & Recommendations*. <https://www.oregon.gov/oha/HPA/dsi-tc/Resources/Oral%20Health%20Integration%20in%20Oregon%20-%20Environmental%20Scan%20and%20Recommendations.pdf>

## Oral Health Integration

OHA recognizes that numerous barriers exist to achieving oral health integration at the delivery system level. These include the need for agreements between different providers, interprofessional medical-dental training, and electronic health system interoperability to enable bi-directional referrals.<sup>10</sup> In 2018, two CCOs initiated oral health integration projects with assistance from OHA's Transformation Center. One project involved working with stakeholders to develop a work plan for oral health integration. The second project reviewed a pilot program integrating oral health care in the primary care setting.

In 2018, OHA also collaborated with the American Cancer Society to offer a dental track at the Oregon HPV Statewide Summit in May 2018. Areas of focus included ways for medical and dental professionals to work together to decrease oropharyngeal cancer rates by ensuring that clients received the human papillomavirus vaccine.<sup>11</sup>

In 2019, OHA worked with staff at PCPCHs to develop standards for oral health integration.<sup>12</sup> PCPCH standard 3.F, released in February 2021, featured three levels of integration of oral health services: provision of screening/assessment for oral health needs (3.F.1), facilitating access to oral health services via relationships and agreements with dental providers (3.F.2), and offering dental care at the practice site (3.F.3).<sup>13</sup>

## Addressing Barriers to Access

In 2016, Oregon's Medicaid Advisory Committee convened a workgroup tasked with developing a framework for improving oral health access in Medicaid.<sup>14</sup> The workgroup highlighted a lack of member awareness of dental benefits as a barrier to accessing oral health services. Another major barrier was the shortage of OHP-enrolled oral health providers, particularly for FFS members and members residing in rural areas.

In response to the workgroup's recommendations, OHA developed a series of member and provider education materials to help raise awareness of dental benefits. OHA also disseminated an Oral Health Toolkit with resources for supporting oral health integration intended for CCOs, oral health providers, primary care providers, and health care transformation leaders.<sup>15</sup>

To encourage dental providers to enroll in OHP, OHA increased FFS rates by 10% for certain diagnostic and preventive services and 30% for specified surgical oral services as of January 2018. Effective January 2019, OHA launched a FFS dental incentive program to increase provider participation in treating FFS dental patients.<sup>16</sup> The program, codified under OAR 410-123-1245, allowed oral health providers to earn incentive payments for providing preventive services to new Medicaid patients.<sup>17</sup>

Teledentistry services offers another opportunity to improve access to dental services in rural and isolated areas of the state. In 2019, OHA adopted new administrative rules (OAR 410-123-1265) which expanded Medicaid telehealth to include teledentistry services, allowing dental providers to reach underserved areas of the state.<sup>18</sup>

## Oral Health Quality Metrics

OHA tracked dental sealants on permanent molars for children as part of the CCO incentive program from 2015 through 2019. As part of the 2019 measure set, OHA's Metrics & Scoring Committee introduced a new CCO incentive metric, "oral evaluation for adults with diabetes." Effective 2020, the committee adopted a measure of preventive dental care for children: preventive dental visits, ages 1-5 (kindergarten readiness) and 6-14.<sup>19</sup>

## Oral Health Outcomes

This section presents performance relevant to assessing progress on oral health integration (evaluation question 2). Results include all CCO-enrolled, non-dual eligible Medicaid members, regardless of whether they were enrolled in dental benefits prior to the integration of dental services into CCO budgets in 2014. We present outcomes for the period 2011 through 2019, including changes from 2011 and 2016 baselines adjusted for demographic characteristics and risk. We report results for subgroups based on age group, gender, geography of residence (rural, urban, isolated), the presence of chronic physical health conditions, and disability status (disabled, non-disabled). Additionally, we compare changes from 2016 to 2019 for focus populations (children and non-English speaking members) to changes for reference populations (adults and English speaking members, respectively). We show results separately for each of the evaluation hypotheses. Appendices A and B provide measure specifications and details on statistical methods.

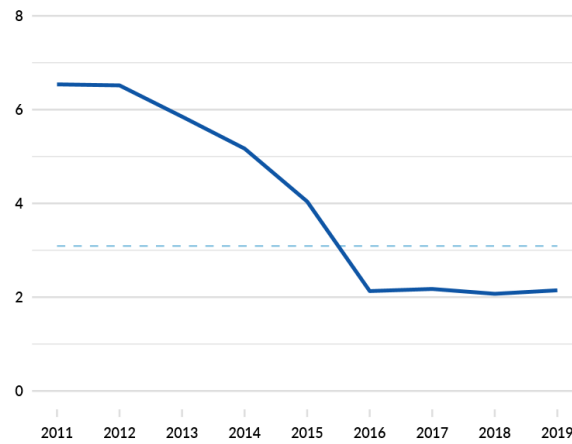
### ED Use for Non-Traumatic Dental Visits (Hypothesis 2.1)

We assessed two measures of ED use for dental conditions; ED Visits for Traumatic Dental Conditions per 1,000 Members and ED Visits for Non-Traumatic Dental Conditions per 1,000 Members. These are calculated as counts (per 1,000 members) of the number of ED visits in a calendar year with specific discharge diagnosis codes (see Appendix A for the full list).

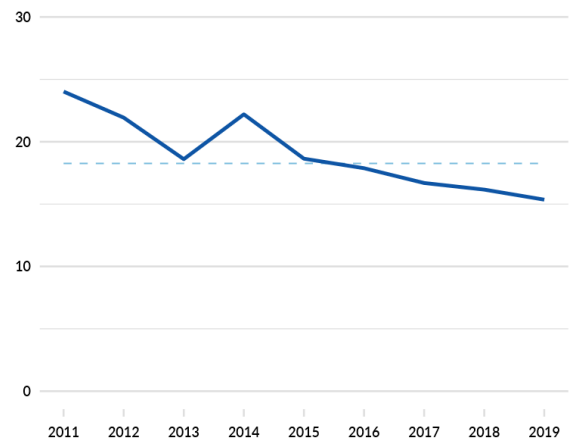
### Overall Trends

Figures 5.1 and 5.2 show annual ED visits for traumatic and non-traumatic dental conditions for 2011 through 2019. Each figure includes a dotted blue line representing the mean value of the measure for 2015 and 2016. The "target" (for purposes of this evaluation) was met in years where ED utilization was at or below this line. Both ED visit types decreased considerably between 2011 and 2019, although the number of traumatic dental visits was mostly flat after the waiver renewal. For both measures, ED utilization during the first three years of the waiver renewal (2017-2019) remained below the 2015-2016 mean. The inclusion of overall ED utilization as a CCO incentive metric from 2013 to 2019 is likely to have contributed to these trends.

**Figure 5.1: ED Visits for Traumatic Dental Conditions per 1,000 Members (↓)**



**Figure 5.2 ED Visits for Non-Traumatic Dental Conditions per 1,000 Members (↓)**



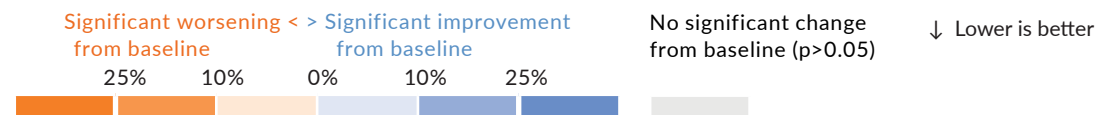
--- 2015-2016 mean

↓ Lower is better

Table 5.1 displays adjusted changes in each measure, comparing 2019 to the baseline years of 2011 and 2016, respectively. Changes were adjusted to account for differences in members’ demographics and risk over time using a pre-post statistical model (described in further detail in Appendix B). ED visits for traumatic dental conditions were unchanged from 2016 to 2019, with an overall decline of 4.5 visits per 1,000 members between 2011 and 2019. (Generally, this measure is likely to be an undercount, as patients with traumatic dental conditions typically suffer multiple injuries, and dental conditions are less frequently captured in ED claims than physical injuries.) ED visits for non-traumatic dental conditions declined significantly from 2016 to 2019.

**Table 5.1. Adjusted Change in ED Use for Dental Conditions, 2011-2019 and 2016-2019**

Measure		2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
ED Visits for Traumatic Dental Conditions per 1,000 Members	↓	2.1	2.1	-0.2	-4.5
ED Visits for Non-Traumatic Dental Conditions per 1,000 Members	↓	17.9	15.3	-6.5	-21.4



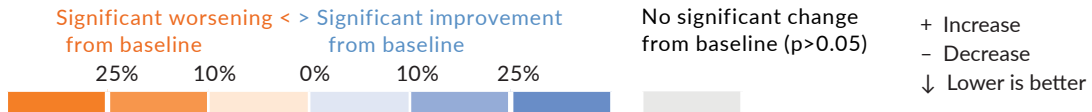
**Subgroup Analyses**

Tables 5.2, 5.3, and 5.4 show changes between 2016 and 2019 by subgroup, adjusted for changes in members’ demographic characteristics and risk. ED visits for traumatic dental conditions decreased significantly for children. Declines in non-traumatic ED visits were seen across all subgroups, except for members residing in isolated areas (defined as population centers of less than 2,500 without commuting flow to urban areas).

**Table 5.2: Adjusted Change from 2016 to 2019 in ED Use for Dental Conditions, by Age and Gender**

Measure		Age			Gender	
		<18	18-34	35-64	Male	Female
ED Visits for Traumatic Dental Conditions per 1,000 Members	↓	-	-	+	-	-
ED Visits for Non-Traumatic Dental Conditions per 1,000 Members	↓	-	-	-	-	-

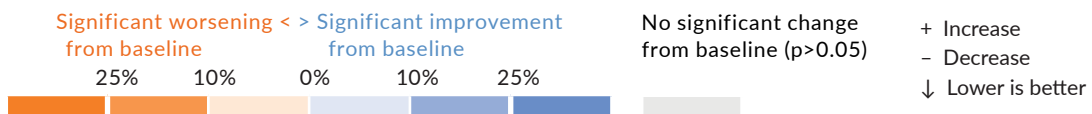
Note: Enrollment data for gender was based on a binary classification.



**Table 5.3: Adjusted Change from 2016 to 2019 in ED Use for Dental Conditions, by Geography of Residence**

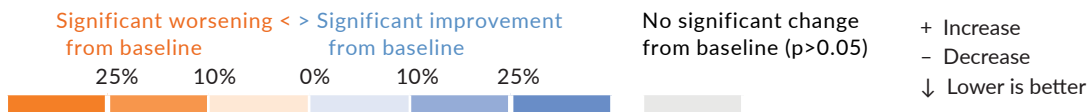
Measure		Geography of Residence		
		Rural	Urban	Isolated
ED Visits for Traumatic Dental Conditions per 1,000 Members	↓	-	-	-
ED Visits for Non-Traumatic Dental Conditions per 1,000 Members	↓	-	-	-

Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas.



**Table 5.4: Adjusted Change from 2016 to 2019 in ED Use for Dental Conditions, by Disability and Chronic Condition Status**

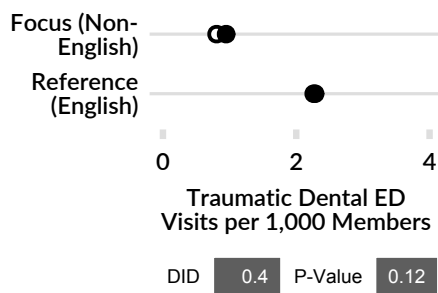
Measure		Disability		Chronic Condition	
		Yes	No	Yes	No
ED Visits for Traumatic Dental Conditions per 1,000 Members	↓	-	-	-	-
ED Visits for Non-Traumatic Dental Conditions per 1,000 Members	↓	-	-	-	-



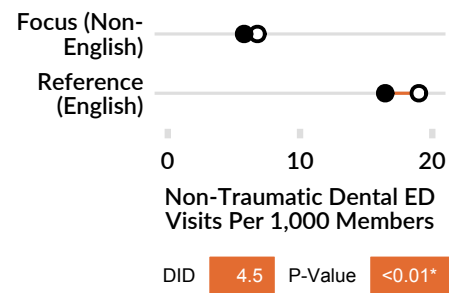
### Focus Population — Non-English Speaking Members

We examined how changes in outcomes from 2016 to 2019 differed for non-English speaking members compared to English speaking members using a difference-in-differences model (described in further detail in Appendix B). Non-English speaking members were identified in Medicaid enrollment data as members who indicated that the main language spoken in their household was not English. As shown in Figures 5.3 and 5.4, non-English speaking members had consistently lower rates of ED utilization for dental conditions than English speakers. However, the change in traumatic ED visits from 2016 to 2019 was not significantly different for non-English speaking members compared to English speakers. In contrast, the decline in ED visits for non-traumatic dental conditions was significantly larger among English speakers than non-English speaking members.

**Figure 5.3: The change in traumatic dental ED visits from 2016 to 2019 was not significantly different for non-English speaking members compared to English speaking members (↓)**



**Figure 5.4: The decline in non-traumatic dental ED visits from 2016 to 2019 was significantly smaller for non-English speaking members compared to English speaking members (↓)**



Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

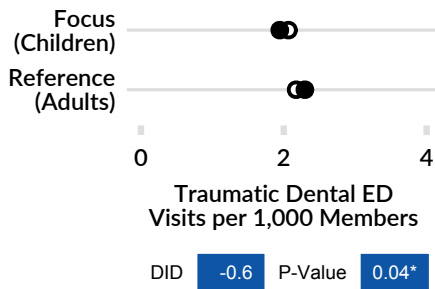
- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant
- ↓ Lower is better

### Focus Population — Children

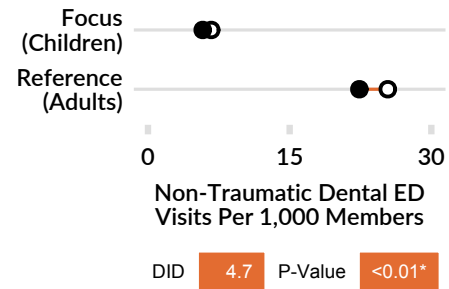
Results from comparing changes among children versus adults are presented in Figures 5.5 and 5.6. Adjusted for demographics and risk, the difference-in-differences model indicated that ED visits for traumatic dental conditions decreased among children relative to adults. While children had substantially lower rates of non-traumatic ED visits compared to adults, this gap narrowed between 2016 and 2019, with adult utilization declining more than the decline in child utilization.



**Figure 5.5: ED visits for traumatic dental conditions declined for children relative to adults (↓)**



**Figure 5.6: ED visits for non-traumatic dental conditions declined more for adults than children (↓)**



- 2016 unadjusted value
- 2019 unadjusted value

- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant
- ↓ Lower is better

## Access to Oral Health Services (Hypothesis 2.2)

We evaluated access to oral health services based on the following measures:

- **Percentage of Members with at Least One Visit for Any Dental Procedure:** Percentage of members who had a visit for any dental procedure (including an ED visit for a traumatic or non-traumatic dental procedure) during the calendar year.
- **Percentage of Members with at Least One Visit for Core Dental Procedures:** Percentage of members who had a visit for any of 14 common dental procedures, including preventive and restorative dental services such as oral exams, x-rays, fillings, crowns and root canals, during the calendar year. (Appendix A lists procedure codes used to identify core dental procedures.)
- **Number of Visits for Any Dental Procedure per 1,000 Members:** Number of visits in a calendar year for any dental procedure, reported per 1,000 members.
- **Number of Visits for Core Dental Procedures per 1,000 Members:** Number of visits in a calendar year for core dental procedures, reported per 1,000 members.
- **Dental Sealants on Permanent Molars for Children:** Percentage of children aged 6-14 who received a sealant on a permanent molar during the calendar year.
- **Percentage of Members with a Regular Dentist:** Percentage of members who said they had a regular dentist they would go to for checkups, cleanings, or when they had a cavity or tooth pain.

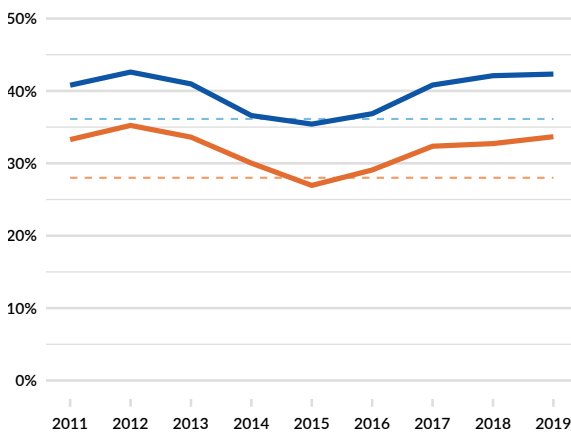
Appendix A provides detailed specifications for these measures. The narrower definition of “core” dental services for some measures allows for an assessment of utilization and access changes disregarding the effect of any new services introduced over time, for example as a result of innovation or practice changes. Using a defined set of procedure codes thus provides an “apples-to-apples” comparison over time.

### Overall Trends

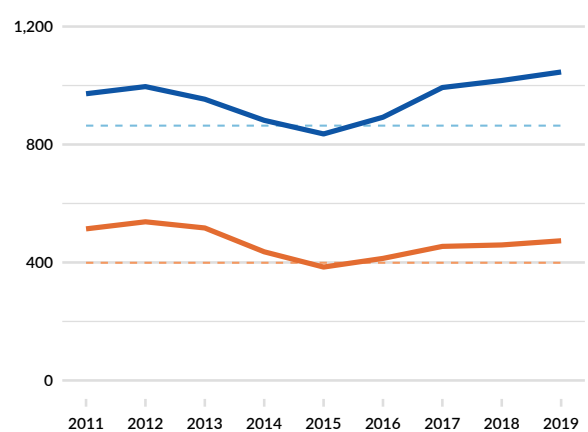
Figures 5.7 through 5.10 show annual performance on oral health access measures in the years 2011 through 2019. The percentage of members with at least one visit for any dental procedure and core dental procedures declined between 2012 and 2015, climbing back up in 2016-2019. Visit counts for dental procedures showed the same general pattern. The percentage of children aged 6-14 receiving dental sealants on permanent molars declined in 2012-14 but began an upward trajectory in 2015 when the measure became a CCO incentive metric. The percentage of members with a regular dentist increased from 2015 to 2016 but declined thereafter, falling below the historical benchmark in 2019. (We did not have data on the percentage of members with a regular dentist prior to 2015.)

Table 5.5 displays adjusted changes for each measure from 2016 to 2019 and 2011 to 2019. Changes were adjusted to account for differences in members’ demographics and risk over time using a pre-post statistical model (described in further detail in Appendix B). The percentage of members with at least one visit for any dental procedure increased in both periods, with an adjusted increase of 2.2 percentage points between 2016 and 2019. The percentage of members accessing core dental services increased by a similar magnitude. The number of visits for dental procedures (and core dental procedures) also increased in both periods. The percentage of children aged 6-14 receiving dental sealants on permanent molars increased from 16.5% in 2016 to 20.4% in 2019, for an adjusted change of 3.2 percentage points in the first three years of the waiver renewal. The percentage of members with a regular dentist declined slightly from 2016 to 2019, although the change was not statistically significant.

**Figure 5.7: Percentage of Members with at Least One Visit for Any Dental Procedure and Core Dental Procedures**

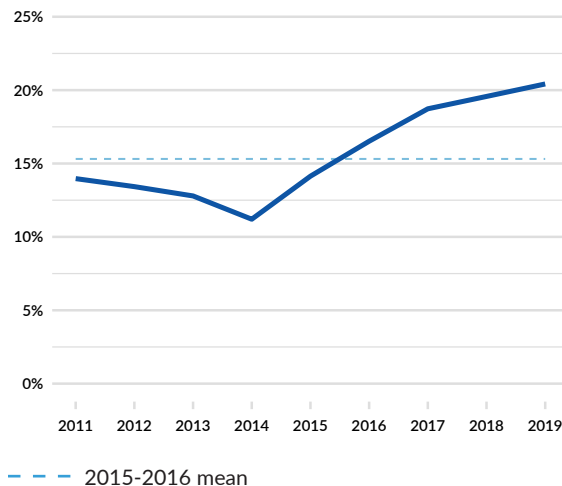


**Figure 5.8: Number of Visits for Any Dental Procedure and Core Dental Procedures per 1,000 Members**

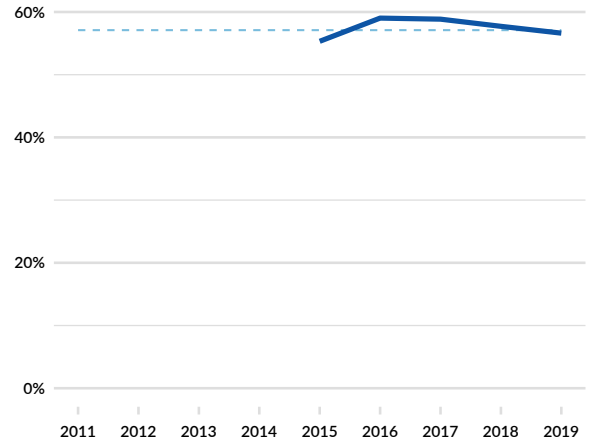


— Any dental procedure      - - - 2015-2016 mean  
 — Core dental procedure      - - - 2015-2016 mean (core procedures)

**Figure 5.9: Dental Sealants on Permanent Molars for Children (\$ ☼)**



**Figure 5.10: Percentage of Members with a Regular Dentist**



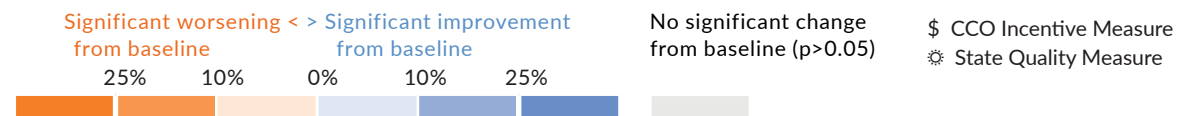
--- 2015-2016 mean

\$ CCO Incentive Measure

☼ State Quality Measure

**Table 5.5: Adjusted Change in Measures of Access to Oral Health Services, 2011-2019 and 2016-2019**

Measure	2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
Percentage of Members with at Least One Visit for Any Dental Procedure	36.9%	42.3%	2.2	6.8
Percentage of Members with at Least One Visit for Core Dental Procedures	29.1%	33.7%	2.4	7.8
Number of Visits for Any Dental Procedure per 1,000 Members	892.5	1045.9	75.8	199.1
Number of Visits for Core Dental Procedures per 1,000 Members	413.8	473.6	24.1	72.9
Dental Sealants on Permanent Molars for Children	\$ ☼ 16.5%	20.4%	3.2	6.6
Percentage of Members with a Regular Dentist	59.0%	56.6%	-1.8	NA



**Subgroup Analyses**

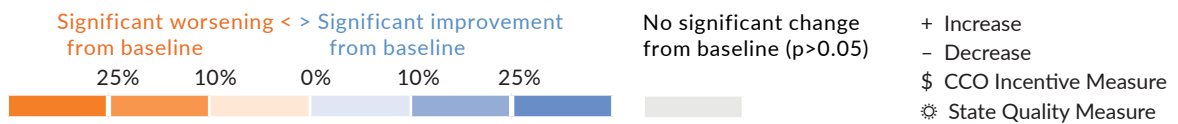
Tables 5.6, 5.7, and 5.8 show changes in oral health access measures between 2016 and 2019 by subgroup, adjusted for demographics and risk. Access to dental services, number of visits per 1,000 members, and access to dental sealants increased across all subgroups, although improvements were less consistent for members with a disability. Declines in the percentage of members with a regular dentist were not statistically significant for any age- or gender-based subgroup. (We

did not have data to calculate adjusted changes in this measure for subgroups based on zip code designation, disability or chronic condition status.)

**Table 5.6: Adjusted Change from 2016 to 2019 in Measures of Access to Oral Health Services, by Age and Gender**

Measure	Age			Gender	
	<18	18-34	35-64	Male	Female
Percentage of Members with at Least One Visit for Any Dental Procedure	+	+	+	+	+
Percentage of Members with at Least One Visit for Core Dental Procedures	+	+	+	+	+
Number of Visits for Any Dental Procedure per 1,000 Members	+	+	+	+	+
Number of Visits for Core Dental Procedures per 1,000 Members	+	+	+	+	+
Dental Sealants on Permanent Molars for Children \$ ⚙	NA	NA	NA	+	+
Percentage of Members with a Regular Dentist	NA	-	-	-	-

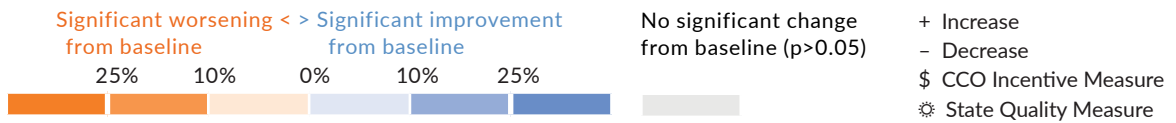
*Note: Enrollment data for gender was based on a binary classification.*



**Table 5.7: Adjusted Change from 2016 to 2019 in Measures of Access to Oral Health Services, by Geography of Residence**

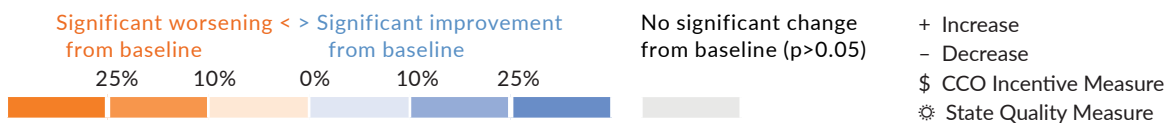
Measure	Geography of Residence		
	Rural	Urban	Isolated
Percentage of Members with at Least One Visit for Any Dental Procedure	+	+	+
Percentage of Members with at Least One Visit for Core Dental Procedures	+	+	+
Number of Visits for Any Dental Procedure per 1,000 Members	+	+	+
Number of Visits for Core Dental Procedures per 1,000 Members	+	+	+
Dental Sealants on Permanent Molars for Children \$ ☼	+	+	+

Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas.



**Table 5.8: Adjusted Change from 2016 to 2019 in Measures of Access to Oral Health Services, by Disability and Chronic Condition Status**

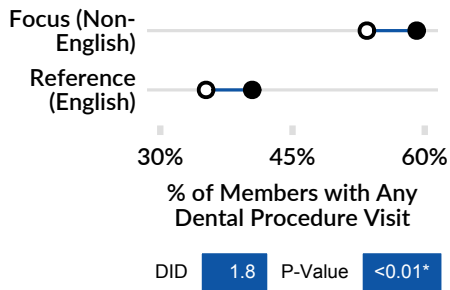
Measure	Disability		Chronic Condition	
	Yes	No	Yes	No
Percentage of Members with at Least One Visit for Any Dental Procedure	+	+	+	+
Percentage of Members with at Least One Visit for Core Dental Procedures	+	+	+	+
Number of Visits for Any Dental Procedure per 1,000 Members	+	+	+	+
Number of Visits for Core Dental Procedures per 1,000 Members	+	+	+	+
Dental Sealants on Permanent Molars for Children \$ ☼	+	+	+	+



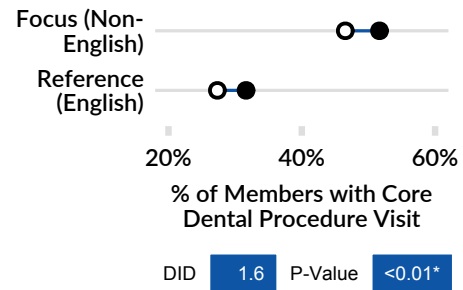
### Focus Population — Non-English Speaking Members

Access to dental visits was higher among non-English speaking members than English speaking members, and this gap increased between 2016 and 2019 (see Figures 5.11 through 5.15). A similar pattern emerged for utilization (number of visits per 1,000) of any and core dental procedures and children’s access to dental sealants. We did not have data to calculate outcomes for regular dentist access for the non-English speaking focus population.

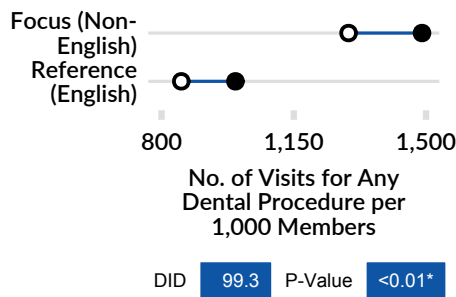
**Figure 5.11: The percentage of members accessing dental services increased more for Non-English speaking members than English speaking members**



**Figure 5.12: The percentage of members accessing core dental services increased more for Non-English speaking members than English speaking members**



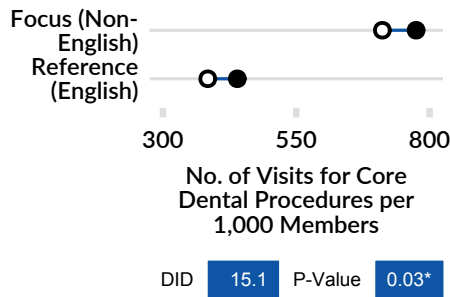
**Figure 5.13: The number of visits for dental procedures increased more for Non-English speaking members than for English speaking members**



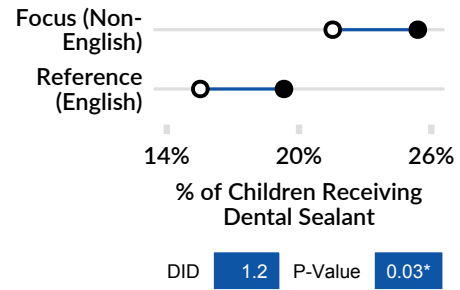
- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant

Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

**Figure 5.14: The number of visits for core dental procedures increased more for Non-English speaking members than English speaking members**



**Figure 5.15: The percentage of children aged 6-14 who received a sealant on a permanent molar increased more for Non-English speaking members than English speaking members (\$ ☼)**



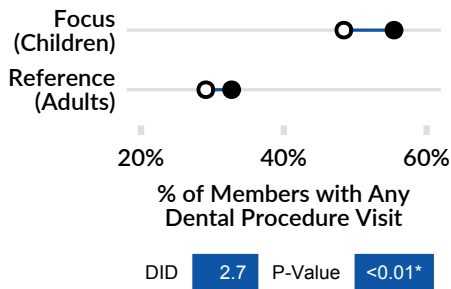
Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant
- \$ CCO Incentive Measure
- ☼ State Quality Measure

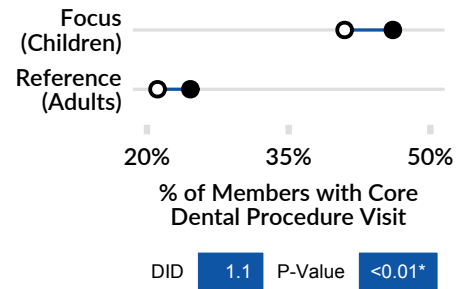
### Focus Population — Children

Access to dental visits was greater among children than adults throughout the study period. For example, 55.4% of children had a least one dental procedure in 2019, compared to 32.7% of adults (see Figure 5.16). This gap widened between 2016 and 2019, with access rates increasing more for children compared to adults, adjusted for demographics and risk. Utilization of dental procedures followed a similar pattern. (We did not have data to calculate regular dentist access among persons under age 18.)

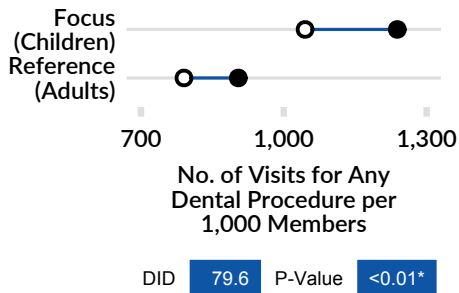
**Figure 5.16: The percentage of members accessing dental services increased more for children than adults**



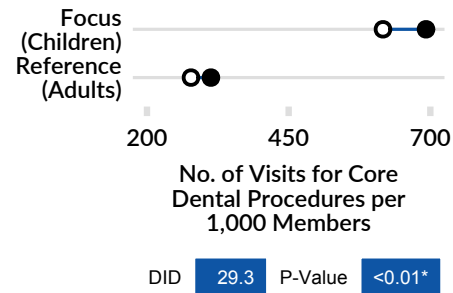
**Figure 5.17: The percentage of members accessing core dental services increased more for children than adults**



**Figure 5.18: The number of visits for dental procedures increased more among children than adults**



**Figure 5.19: The number of visits for core dental procedures increased more among children than adults**



- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant

### Integration of Oral Health with Other Health Services (Hypothesis 2.3 and 2.4)

We assessed progress on integration of oral health with other health services using the following metrics:

- **Assessments within 60 Days for Children in ODHS Custody:** Percentage of members aged 0-17 in custody of the Oregon Department of Human Services (ODHS) who received required physical, mental, and dental assessments.
- **Percentage of Members with at Least One Visit for Any Dental Procedure for Members with a Chronic Condition:** Percentage of members with a chronic physical health condition who had a visit for any dental procedure (including an ED visit for a traumatic or non-traumatic dental procedure).



- **Percentage of Members with at Least One Visit for Core Dental Procedures for Members with a Chronic Condition:** Percentage of members with a chronic physical health condition who had a visit for any of 14 common dental procedures. (See Appendix A for procedure codes used to identify core dental procedures).
- **Spending on ED Visits for Dental Conditions PMPM:** Total spending on ED visits for either traumatic or non-traumatic dental conditions, divided by months of enrollment.
- **Spending on Dental Services Excluding ED Visits for Dental Conditions PMPM:** Total spending on dental services (excluding ED visits for traumatic or non-traumatic dental conditions), divided by months of enrollment.

Appendix A provides detailed specifications for these measures.

### Overall Trends

Assessments for children in ODHS custody increased between 2016 and 2019, as shown in Figure 5.20. The percentage of members with a chronic physical health condition accessing dental services decreased from 2012 to 2015 but improved gradually from 2016 onwards (see Figure 5.21), similar to trends across the CCO-enrolled population as a whole. PMPM spending on ED visits for dental conditions (Figure 5.22) dropped between 2011 and 2016, increasing slightly in 2017-2019. Spending on dental services excluding ED visits declined between 2016 and 2018, increasing sharply in 2019 (Figure 5.23).

Table 5.9 displays adjusted changes in oral health integration measures from 2016 to 2019 and 2011 to 2019. Changes were adjusted to account for differences in members' demographics and risk over time using a pre-post statistical model (described in further detail in Appendix B). The percentage of children in ODHS custody receiving a mental, physical, and oral health assessment within 60 days increased by 13.3 percentage points between 2016 and 2019, adjusted for demographics and risk. Access to oral health services for members with chronic physical health conditions increased from 2016 to 2019. The percentage of members with at least one dental visit increased from 41.8% to 44.8%, an adjusted change of 2.2 percentage points. Between 2011 and 2019, the measure increased by 6.8 percentage points, adjusting for demographics and risk. Core dental services access for members with a chronic condition showed similar trends. ED spending for dental conditions declined slightly from 2016 to 2019, whereas spending declined by \$1.28 PMPM from 2011 to 2019. Spending on dental services excluding ED visits increased by \$2.89 PMPM between 2016 and 2019. (Blue shading in the Table characterizes both the decline in ED spending and the increase in other spending as an "improvement.")

**Table 5.9: Adjusted Change in Measures of Integration of Oral Health with Other Health Services, 2011-2019 and 2016-2019**

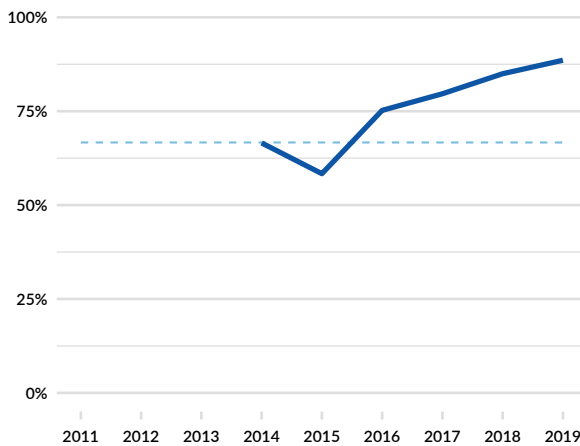
Measure		2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
Assessments within 60 Days for Children in ODHS Custody	\$ ☼	75.2%	88.6%	13.3	NA
Percentage of Members with at Least one Visit for Any Dental Procedure for Members with a Chronic Condition		41.8%	44.8%	2.2	6.8
Percentage of Members with at Least one Visit for Core Dental Procedures for Members with a Chronic Condition		32.1%	35.1%	2.4	7.8
Spending on ED Visits for Dental Conditions PMPM	↓	\$0.66	\$0.70	-0.04	-1.28
Spending on Dental Services Excluding ED Visits for Dental Conditions PMPM		\$7.37	\$10.63	2.89	3.28

Significant worsening < > Significant improvement from baseline  
from baseline  
 25% 10% 0% 10% 25%

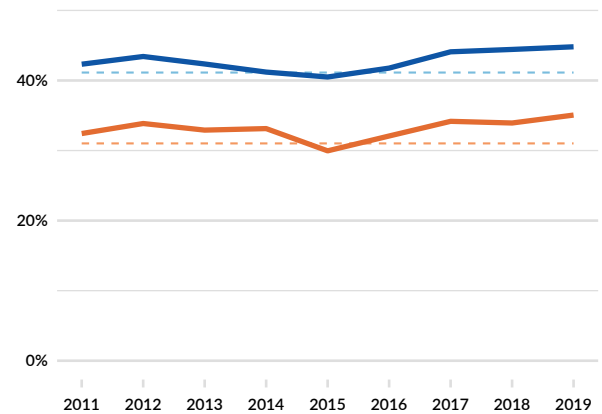
No significant change from baseline (p>0.05)

↓ Lower is better  
 \$ CCO Incentive Measure  
 ☼ State Quality Measure

**Figure 5.20: Assessments within 60 Days for Children in ODHS Custody (\$ ☼)**



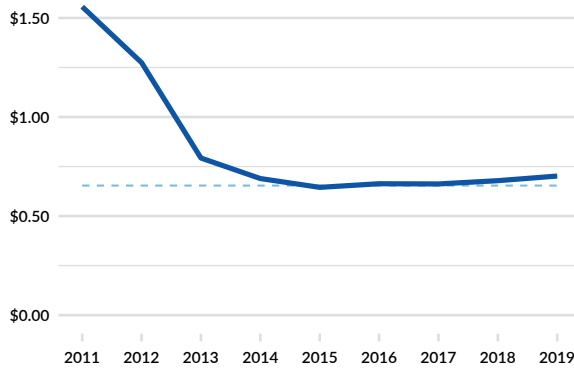
**Figure 5.21: Percentage of Members with at Least One Visit for Any Dental Procedure and Core Dental Procedures for Members with a Chronic Condition**



— Any dental procedure      - - - 2015-2016 mean  
— Core dental procedure      - - - 2015-2016 mean (core procedures)

\$ CCO Incentive Measure  
 ☼ State Quality Measure

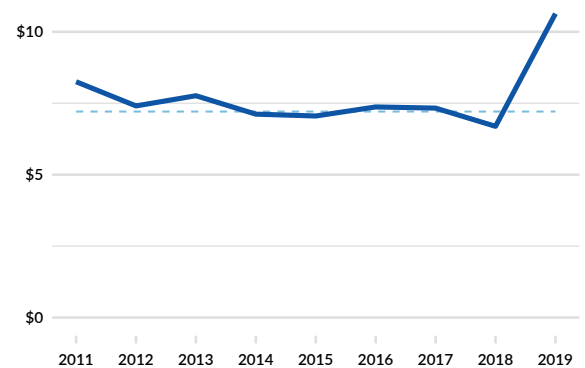
**Figure 5.22: Spending (\$) PMPM on ED Visits for Dental Conditions (\$)**



--- 2015-2016 mean

\$ CCO Incentive Measure

**Figure 5.23: Spending (\$) PMPM on Dental Services Excluding ED Visits for Dental Conditions**



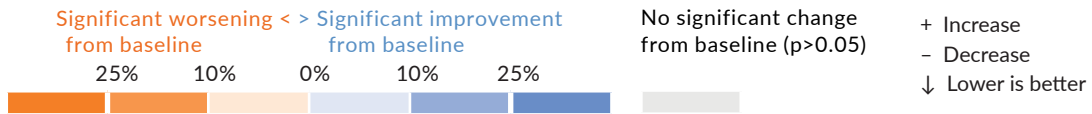
### Subgroup Analyses

Tables 5.10, 5.11 and 5.12 present subgroup-level changes from 2016-2019 for oral health integration measures, adjusted for demographics and risk. The percentage of members with chronic conditions accessing dental procedures increased across all subgroups, except for members with a disability, for whom the change in access to any dental procedure was not statistically significant. Spending on ED visits for dental conditions decreased significantly among young adults, urban residents, non-disabled members, and persons with a chronic condition, while increasing for persons with no chronic physical health conditions. Spending on dental services excluding ED visits increased across all subgroups. We did not have data to calculate subgroup outcomes for the ODHS assessment measure.

**Table 5.10: Adjusted Change from 2016 to 2019 in Measures of Integration of Oral Health with Other Health Services, by Age and Gender**

Measure	Age			Gender	
	<18	18-34	35-64	Male	Female
Percentage of Members with at Least One Visit for Any Dental Procedure for Members with a Chronic Condition	+	+	+	+	+
Percentage of Members with at Least One Visit for Core Dental Procedures for Members with a Chronic Condition	+	+	+	+	+
Spending on ED Visits for Dental Conditions PMPM	-	-	-	-	-
Spending on Dental Services Excluding ED Visits for Dental Conditions PMPM	+	+	+	+	+

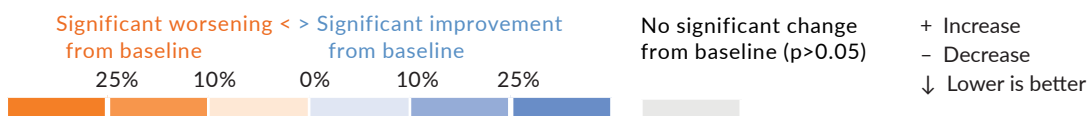
Note: Enrollment data for gender was based on a binary classification.



**Table 5.11: Adjusted Change from 2016 to 2019 in Measures of Integration of Oral Health with Other Health Services, by Geography of Residence**

Measure	Geography of Residence		
	Rural	Urban	Isolated
Percentage of Members with at Least One Visit for Any Dental Procedure for Members with a Chronic Condition	+	+	+
Percentage of Members with at Least One Visit for Core Dental Procedures for Members with a Chronic Condition	+	+	+
Spending on ED Visits for Dental Conditions PMPM	+	-	+
Spending on Dental Services Excluding ED Visits for Dental Conditions PMPM	+	+	+

Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas.



**Table 5.12: Adjusted Change from 2016 to 2019 in Measures of Integration of Oral Health with Other Health Services, by Disability and Chronic Condition Status**

Measure	Disability		Chronic Condition	
	Yes	No	Yes	No
Percentage of Members with at Least One Visit for Any Dental Procedure for Members with a Chronic Condition	+	+	NA	NA
Percentage of Members with at Least One Visit for Core Dental Procedures for Members with a Chronic Condition	+	+	NA	NA
Spending on ED Visits for Dental Conditions PMPM	-	-	-	+
Spending on Dental Services Excluding ED Visits for Dental Conditions PMPM	+	+	+	+

↓

Significant worsening < from baseline

25% 10% 0%

Significant improvement > from baseline

0% 10% 25%

+ Increase

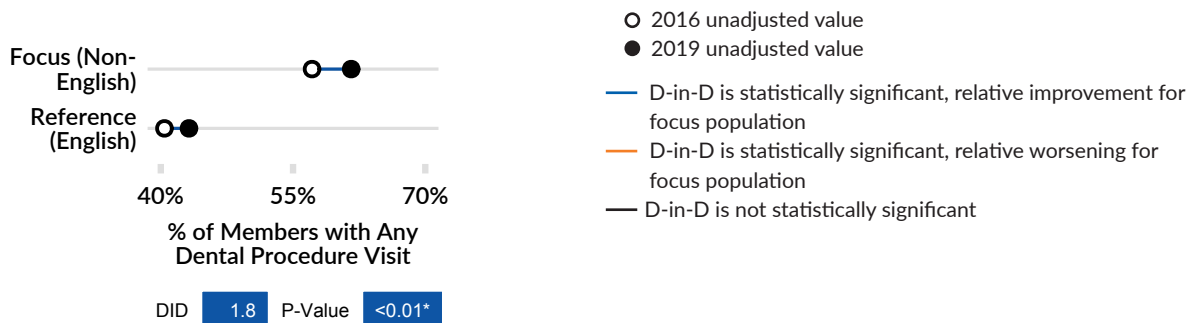
- Decrease

↓ Lower is better

### Focus Population — Non-English Speaking Members

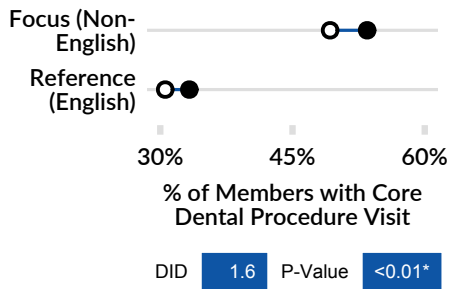
Figures 5.24 through 5.27 display oral health integration outcomes for non-English speaking members and compares changes within this focus population to changes among English speaking members. Access to dental services among persons with a chronic condition was higher for non-English speaking members than English speakers. This gap increased slightly between 2016 and 2019. For both ED and non-ED spending on dental conditions, 2016-2019 changes were not significantly different for non-English speaking members compared to English speakers.

**Figure 5.24: The increase in access to dental procedures among members with a chronic condition was greater for Non-English speaking members compared to English speaking members**

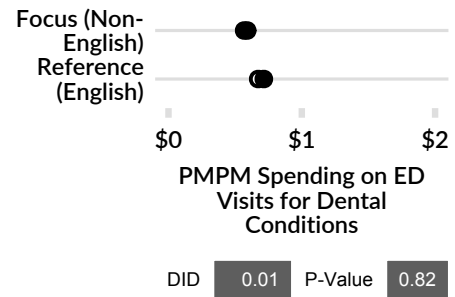


Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

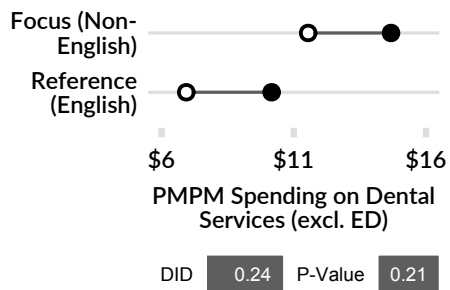
**Figure 5.25: The increase in access to core dental procedures among members with a chronic condition was greater for Non-English speaking members compared to English speaking members**



**Figure 5.26: Changes in spending on ED visits for dental conditions did not differ significantly between Non-English speaking and English speaking members (↓)**



**Figure 5.27: Changes in spending on dental services excluding ED visits for dental conditions did not differ significantly between Non-English speaking and English speaking members**



- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant
- ↓ Lower is better

Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

### Focus Population — Children

Figures 5.28 through 5.31 compare changes in oral health integration measures for children versus adults. Access to dental services among members with a chronic condition was higher for children compared to adults, and the differential increased from 2016 to 2019. PMPM spending on dental services excluding ED visits increased more for children than adults. ED spending also increased slightly more among children.

Figure 5.28: The increase in access to dental procedures was significantly greater for children than adults

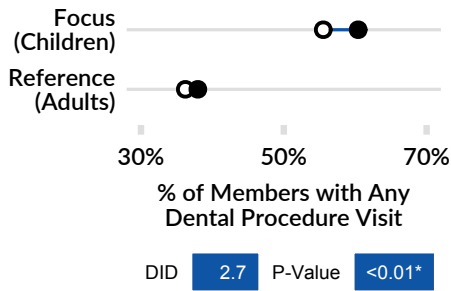


Figure 5.29: The increase in access to core dental procedures was significantly greater for children than adults

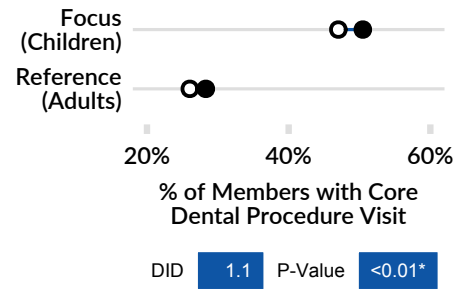


Figure 5.30: The increase in spending on ED visits for dental conditions was greater for children than adults (↓)

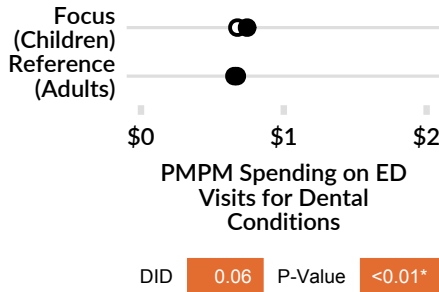
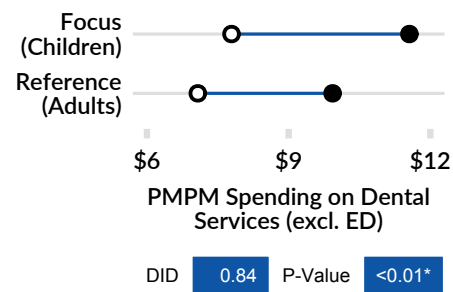


Figure 5.31: The increase in spending on dental services excluding ED visits was greater for children than adults



Note: “Non-English” includes members who indicated that English was not the main language spoken in their household.

- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant
- ↓ Lower is better

## Assessing the Impacts of CCO Closure

FamilyCare, Inc., a CCO serving members in Washington, Multnomah, Clackamas, and Marion counties since 2012, ceased operations in January 2018. The majority of FamilyCare’s members transitioned to Health Share of Oregon, while some moved to two other CCOs serving Marion and Washington counties. To assess whether the transition may have affected outcomes for these members, we conducted sensitivity analyses on the 2016-2019 adjusted change. We used a difference-in-differences framework to test whether the adjusted change was different for people in the tri-county region (Clackamas, Multnomah, and Washington counties).

We found that changes from 2016 to 2019 were no different or slightly greater (indicating greater improvement) in the tri-county area relative to other areas. For example, ED visits for non-traumatic dental conditions declined more markedly in the tri-county area. An exception was Dental Sealants on Permanent Molars for Children, which improved less in the tri-counties, although from a higher 2016 baseline. The increase in spending on dental services outside the ED was slightly smaller for CCO enrollees in the tri-county area, although baseline spending was higher. Overall, these results suggest that for most CCO enrollees in the tri-county area, the departure of FamilyCare did not adversely affect oral health services. Appendix G provides additional information on methods and results for these analyses.

## Conclusions and Limitations

Results for oral health integration measures suggest that Oregon has made broad progress on oral health quality and access since the waiver renewal. ED use for dental conditions continued a downward trajectory between 2016 and 2019. Access to dental services and utilization of dental procedures increased between 2016 and 2019 after declining through 2015, although the percentage of members with access to a regular dentist stayed relatively flat. Both focus populations (non-English speaking members and children) saw improvements in access and utilization of dental care relative to reference populations. Several measures intended to capture progress on oral health integration also moved in the desired direction. Spending on dental conditions excluding ED visits increased from 2018 to 2019, reflecting the increase in payment rates implemented in 2018.

The results presented here should be considered in the context of several limitations. First, the analysis is based on a “pre-post” design, comparing changes before and after the waiver renewal. With this approach, we cannot separate changes that could be attributed to Oregon’s policies from secular changes occurring across the health care system. Furthermore, analyses that rely on a short pre- or post-period could be biased if those years are outlier years and not representative of general trends. Second, our analyses are intended to provide a broad assessment of progress on oral health integration. We did not evaluate the merits of specific evidence-based practices or approaches that CCOs or DCOs may have undertaken. Rather, these analyses should be seen as an assessment of the overall effects of integration efforts. Third, our analyses did not include FFS enrollees, and we did not attempt to distinguish between CCO members receiving services under a DCO contract and members who did not. Fourth, we were unable to conduct analyses stratifying by race or ethnicity, because we did not have reliable data. However, significant disparities exist in Oregon. Finally, to calculate spending measures, we used imputed values for services subject to capitation arrangements (see Appendix B for details). Our results for these measures are therefore closer to a summary measure of utilization rather than actual CCO expenditures.



# CCOs' Use of Health-Related Services

## Overview

Medical care is not the only way to influence health. Oregon's CCOs have the option to use HRS to reach beyond the health care system to address the social and environmental factors that affect their members' lives. HRS are broadly defined as "non-covered" services that improve care delivery and overall member and community health. This chapter examines CCOs' spending on HRS, assessing trends in HRS adoption and the use of HRS to address SDOH. We begin by providing background on the development of Oregon's Medicaid policies for HRS. We then describe our mixed methods approach and present findings.

### KEY FINDINGS

- **Since the waiver renewal, the state has implemented several changes designed to expand the use of HRS and reduce barriers to addressing SDOH.** The state's efforts include guidance on the treatment of HRS in the Medical Loss Ratio (MLR) calculation, clarifying that HRS could count toward rate development, and technical assistance to support CCOs' use of HRS.
- **In response, CCOs have increasingly prioritized HRS spending during the first three years of the waiver renewal.** Total spending on HRS increased by more than 120% between 2016 and 2019, from \$7.2 million (\$0.66 PMPM) to \$16.2 million (\$1.51 PMPM). In interviews, CCOs indicated that much of this growth reflected their efforts to categorize existing SDOH programs as HRS spending. CCOs also made new and deeper connections with community-based organizations (CBOs) and expanded their toolkits for gathering information about the best ways to deploy HRS funding. However, as of 2019, HRS remained a small share (0.36%) of total spending on member services.
- **Despite the growth in HRS spending, there was considerable variability in reported spending across CCOs.** One CCO spent more than \$10 PMPM in 2019, while a small number of CCOs reported HRS spending levels that were close to zero. Within HRS classified as flexible services, the top three categories based on 2018 and 2019 spending were housing, transportation, and training and education, although their share of spending varied by CCO.
- **Despite advancements in the use of HRS, CCOs identified a variety of challenges, primarily related to a high administrative burden in tracking and reporting data.** Although HRS created opportunities for CCOs to address their members' needs, their comments indicated that use of HRS under the waiver renewal required new relationships, data, and tools.

## HRS Provisions in the 2017-2022 Waiver

During the 2012-2017 waiver, CCOs were encouraged to use flexible services broadly to seek out and pay for cost-effective alternatives to medical services. Flexible services were defined as low-cost services not covered by Oregon's Medicaid program that would promote health and could replace or reduce the need for medical care. Box 6.1 provides additional background on flexible services spending prior to 2017.

### **Box 6.1: Oregon's History with Flexible Services Prior to 2017**

*A noteworthy feature of the CCO model, as envisioned in 2012, was the allowance for spending on flexible services. An early example of flexible services' potential was illustrated through a hypothetical purchase of an air conditioner for a beneficiary with congestive heart failure experiencing increased pain and difficulty breathing during a heatwave. The traditional Medicaid program paid for repeated ED visits but was limited in addressing the cause of the symptoms. However, CCOs could use the flexible services mechanism to purchase a \$200 air conditioner, addressing the symptoms and reducing utilization.*

*During the early years of the 2012-2017 waiver, spending on flexible services was relatively modest, with less than 0.1% of all spending attributable to flexible services in 2014 and 2015. Expenditures on flexible services were inhibited by several factors, including confusion over what was allowable, what was counted as "administrative" vs. "medical" expenses, and concerns that expenditures on flexible services could lower capitation rates for CCOs.*

*A 2016 update to Oregon's administrative rules clarified that flexible services were services that lacked traditional billing or encounter codes and were likely to be cost-effective alternatives to covered benefits. These services could be provided at the individual or community level. The rules required CCOs to work with Medicaid members and their care teams to determine the flexible services members should receive, and required CCOs to create formal policies on how they would work with health care providers to deliver flexible services (55.2 Or. Bull. 537).*

*Reference:*

*Kushner, J., & McConnell, K. J. (2019). Addressing Social Determinants of Health through Medicaid: Lessons from Oregon. Journal of Health Politics, Policy and Law, 44(6), 919-935. <https://doi.org/10.1215/03616878-7785823>*

With the 2017-2022 waiver, the state renamed this category of spending to "health-related services" (HRS) and created two types of HRS: flexible services and community benefit initiatives. Flexible services were defined as cost-effective member-level services offered as an adjunct to medical services and focused on improving members' health. Community benefit initiatives were defined as community-level interventions focused on improving population health and could include expenditures related to health information technology.

The waiver also featured several provisions designed to expand the use of HRS and, in particular, created opportunities to use HRS spending to address SDOH. These included provisions to:

1. Clarify services which could qualify as HRS under federal rule.
2. Clarify and refine the treatment of HRS spending in the MLR calculation.
3. Introduce a Performance-Based Reward (PBR) consisting of a variable profit margin for CCOs that use HRS to contain cost growth while maintaining quality.

We describe the first two changes in further detail below. (The PBR provision had yet to be implemented at the time of writing.)

### HRS Criteria

First, the waiver referenced federal rules requiring that HRS meet the following criteria (45 CFR 158.150):

1. Designed to improve health care quality.
2. Increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements.
3. Directed toward either individuals or segments of enrollees, or provide health improvements to the population beyond those enrolled without additional costs for the non-members.
4. Grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

Furthermore, activities that improve health care quality (per criterion 1) must meet *one* of four requirements:

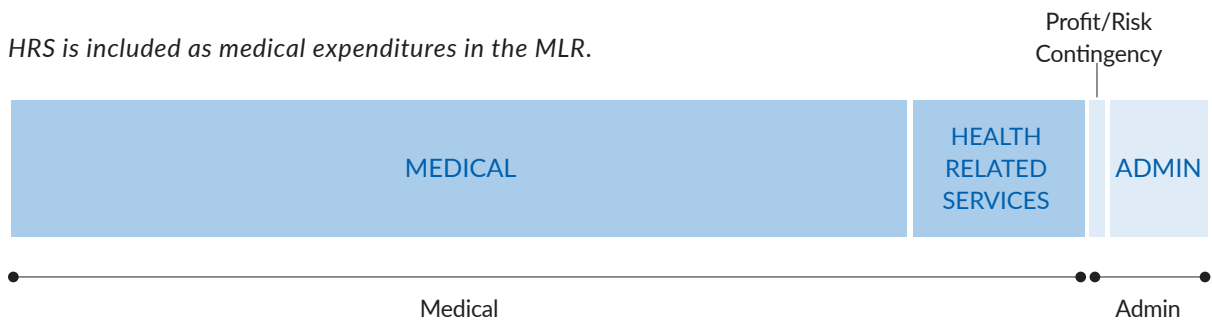
1. Improve health outcomes and reduce health disparities.
2. Prevent hospital readmissions.
3. Improve patient safety, reduce medical errors, and lower infection and mortality rates.
4. Increase focus on wellness and health promotion activities.

HRS may also include expenditures related to HIT and meaningful use requirements to improve health care quality (45 CFR 158.151).

### MLR Calculation

Second, the waiver clarified that HRS-related spending meeting the above criteria would be included in the MLR numerator as required under 42 CFR 438.8 and 42 CFR 438.74, as illustrated in Figure 6.1.

**Figure 6.1: Inclusion of HRS in the MLR Calculation**



Additionally, the waiver allowed CCOs to calculate the MLR for a given year on a three-year rolling basis (that is, using data from the previous three years). This change allows a CCO with an MLR below the 85% threshold in a given year to “catch up” by spending more on HRS in the next year, increasing its averaged MLR, and avoiding any penalties.

### Technical Assistance from OHA's Transformation Center

OHA's Transformation Center provided significant technical assistance to support HRS. The Transformation Center has hosted numerous events to disseminate information and has produced guidance documents that define HRS, provide concrete examples of HRS, and, for example, describe how housing-related services and supports can qualify as health-related services.

### HRS and SDOH

In 2017, Oregon's Medicaid Advisory Council (MAC) identified CCO investment in HRS as a key mechanism to address SDOH. OHA's guidance encourages CCOs to use HRS as the “primary strategy” for addressing SDOH at the member and community levels.<sup>20</sup> The MAC further identified housing-related services and supports as a key priority, collaborating with OHA to develop guidance for how CCOs could use HRS to provide these services.<sup>21</sup>

While there is significant overlap between SDOH and the definition of HRS, not all HRS investments are targeted to address SDOH at the individual or community levels. For example, patient incentives for preventive care or spending to address HIT meaningful use for clinical functions could be considered HRS but would not fall under the category of SDOH. Conversely, not all SDOH investments qualify as HRS under the criteria described above.<sup>22</sup> For example, funding for new housing development meets the definition of SDOH but is not an allowable use of Medicaid funds, per CMS. Appendix D summarizes the state's key initiatives introduced in 2020 to promote CCO investments in SDOH.

## Methods

We used a convergent mixed methods approach to assess CCOs' implementation of HRS and other SDOH efforts. Quantitative analyses of expenditure data from CCOs' Exhibit L documents provided evidence of qualifying expenditures, while interviews with each CCO provided a high-level understanding of strategies adopted for HRS use. Interview data collected in mid-2020 offered a more recent picture of HRS activities than Exhibit L spending data, which spanned 2014-2019. Although the year 2020 (including CCO 2.0 implementation and the COVID-19 pandemic) was outside the formal study period for the interim evaluation, the timing of interviews provided a valuable opportunity to collect qualitative data to inform work on the summative evaluation. We have incorporated these data below. Quantitative and qualitative teams met to assess and integrate findings and themes after both had completed preliminary analyses.

### Quantitative Methods

We collected HRS spending data from CCOs' Exhibit L financial reports for the years 2014 through 2019. These reports, submitted to OHA annually, contain member services expenses broken out by type, including HRS expenditures, member months, and expenses by type per member per month. Exhibit L data may not provide a complete picture of a CCO's spending on HRS in a given year, as not all CCOs reported HRS spending prior to 2019. In addition, the data may not be directly comparable across years, for two main reasons. First, OHA's requirements for reporting HRS spending in Exhibit

L have evolved to become more specific and granular over time. Second, for the years 2014-2017, HRS reporting was not subject to OHA approval, whereas for 2018 and 2019, we include only spending that was approved by OHA as qualifying HRS expenditures. We describe these limitations further in Appendix B.

We made a number of adjustments to the data, also described in Appendix B. For analyses of the 2014-2019 time period, we focus on overall HRS spending. For 2018 and 2019, CCOs provided more detailed data, allowing us to assess spending within HRS types and categories. We do not present detailed analyses of community benefit initiative spending, because CCOs assigned the majority of this spending to broad categories (“community benefit initiative” or “programs to improve community or public health”). Seventy-one percent of community benefit initiative spending in 2018 and 55% in 2019 fell into one of these two categories.

Exhibit 6.1 presents the HRS categories we report in our findings and how they correspond to category names as presented in the Exhibit L template or as entered by CCOs.

### Exhibit 6.1: HRS Categories

Category	Category in Exhibit L Template
Case Management	Care coordination, navigation, or case management activities not otherwise covered under State Plan benefits
Food/Social	Assistance with food or other social resources
Home	Home and living environment items or improvements not otherwise covered by 1915 Home and Community Based Services
Housing	Housing supports related to social determinants of health
Other	Other non-covered service <sup>1</sup>
Training/Education	Training and education for health improvement or management
Transportation	Transportation not covered under State Plan benefits

<sup>1</sup>Also reported as “Other” or “Other non-covered social and community health services and supports.”

### Qualitative Methods

To assess CCOs’ use of HRS, we conducted semi-structured interviews with CCO informants. We carried out 12 interviews (representing 13 CCOs continuing from the first waiver, plus two new CCOs). Interviews included two to five informants each for a total of 34 interviewees. Four CCOs overseen by the same parent organization were covered in one interview. CCOs were provided with a list of topics to be covered in the interviews (related to HRS and SDOH) and were asked to select staff best suited to respond. Roles of the resulting informants were diverse, including CEOs, COOs, CFOs, medical officers, and staff members in areas such as community engagement, finance, health equity, quality, population health, transformation, and public relations. See Exhibit 6.2 below for a breakdown of interviewees by organizational roles. The interview guide is reproduced as Appendix C. We conducted interviews before completing Exhibit L data analyses, and thus interviews did not include detailed questions about reported expenditures.

Interviews were professionally transcribed and then coded and reviewed by a project team that met 1-2 times per week to analyze data for themes related to HRS and SDOH. We also performed a

qualitative review of HRS spending reported by CCOs in Exhibit L to assess the alignment of financial reporting with interview data. In addition, we reviewed publicly available documents and held informal discussions with OHA staff.

### Exhibit 6.2: Key Informant Interview Roles and Counts

Key Informant Category	Number of Interviewees
Community Engagement & Public Relations	5
Social Determinants of Health and Health Equity	8
Executive Leadership	16
Government Affairs	2
Strategic Initiatives, Contracting & Finance	3
<b>Total</b>	<b>34</b>

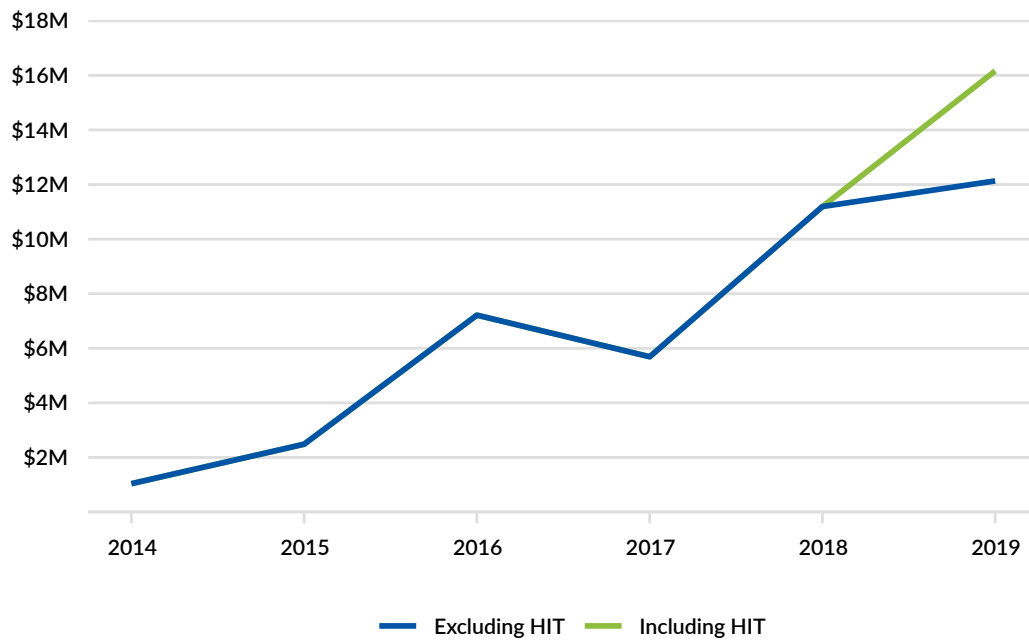
## CCOs' Use of Health-Related Services

Findings reported here reflect a mix of quantitative results from analysis of Exhibit L spending and qualitative data from CCO interviews. Where possible, we use qualitative data to interpret, contextualize, and elaborate on quantitative results. First, we assess overall adoption of HRS and variation in HRS spending across CCOs. We then discuss CCOs' approaches to prioritizing HRS investments for addressing SDOH and describe how CCOs allocated spending across HRS types (flexible services, community benefit initiatives, and HIT) and categories (housing, transportation, food, etc.). Finally, we present qualitative findings on CCOs' partnerships with external organizations to deliver community benefit initiatives and describe challenges with Exhibit L reporting. Appendix G provides detailed data tables summarizing annual HRS spending at the CCO level.

### Adoption of HRS

CCOs indicated in interviews that the waiver renewal had prompted an increased focus on addressing SDOH, further sharpened through the CCO 2.0 contracts. Most CCOs were aware of the state's guidance about using HRS as their primary vehicle for addressing SDOH and were working to implement this approach, although some continued to support these efforts through other mechanisms, including previous-year revenues and quality incentive metric bonuses. These statements aligned with data from CCOs' Exhibit L reports, which showed HRS expenditures increasing overall during the study period. Figure 6.2 displays the growth in HRS spending between 2014 and 2019.

Figure 6.2: Total Health-Related Services Spending (\$ Million), 2014-2019



Note: Trillium did not submit Exhibit Ls in 2014 and 2015, so their HRS spending is unknown and not included in this figure. See Appendix B (Exhibit B.4) for further detail on missing HRS data.

Total HRS spending rose from \$1 million in 2014 to \$16 million in 2019. In 2014, HRS spending PMPM was \$0.11 or 0.03% of total member services spending. By 2019, HRS spending had increased to \$1.51 PMPM or 0.36% of member services spending. Beginning in 2019, CCOs were required to report spending on HIT separately from community benefit initiative spending. CCOs reported spending \$4 million on HIT in 2019, with HIT accounting for two-thirds of the growth in HRS spending between 2018 and 2019.

### **Waiver, CCO 2.0 initiatives led to greater uptake of HRS**

Prior to the waiver renewal, numerous CCOs had already made significant investments in addressing SDOH in their communities. With the waiver renewal, most CCOs studied OHA's guidance on HRS for SDOH efforts and aimed to fit the majority of their SDOH expenditures into HRS requirements. Thus, much of the growth in HRS spending reflected CCOs' efforts to report existing SDOH spending as HRS.

Most CCOs indicated that, under the waiver renewal, both leaders and staff found it easier to prioritize HRS spending. One CCO respondent observed that the new contract and state guidance had created greater awareness of SDOH among CCO staff and helped justify to CCO leadership the use of funds to meet members' social needs.

*Some mentality of our staff I've noticed has changed where they're saying, "Okay, so, CCO 2.0, this new contract, this new leadership mentality that I see, makes it okay." I don't need to decline and say, "This seems out of the ordinary. This doesn't have anything to do with health."*

Other features of CCO 2.0, such as the promotion of traditional health worker (THW) engagement, also helped increase the use of flexible services by increasing CCOs' interactions with members experiencing social needs. As an example, one CCO hired more THWs into its corps of care

coordinators in anticipation of CCO 2.0, resulting in increased identification of social needs and expanded funding for flexible services.

*[By] putting more staff out there and more proactively trying to engage with our membership, we're finding additional needs that didn't come up to us before. So, we anticipated that, and we allocated additional funds for 2020.*

### **HRS spending varied by CCO**

Within the overall growth trend for HRS, however, there was significant variation in spending across CCOs. Figure 6.3 displays HRS spending by CCO in 2018 and 2019. On a PMPM basis, HRS spending increased for most CCOs between these years, ranging from \$0 to \$4.40 PMPM in 2018, and from \$0.04 to \$10.29 in 2019.

Interview data suggested several reasons for this wide variation. First, interviews indicated that, in 2020, CCOs were in varying states of implementing SDOH planning. Some CCOs were continuing priorities or programs implemented in CCO 1.0, while others had shifted to new strategies and investments or were still in the planning stages of some efforts. Thus, some variation among CCOs in HRS spending appeared to reflect differing levels of program maturity.

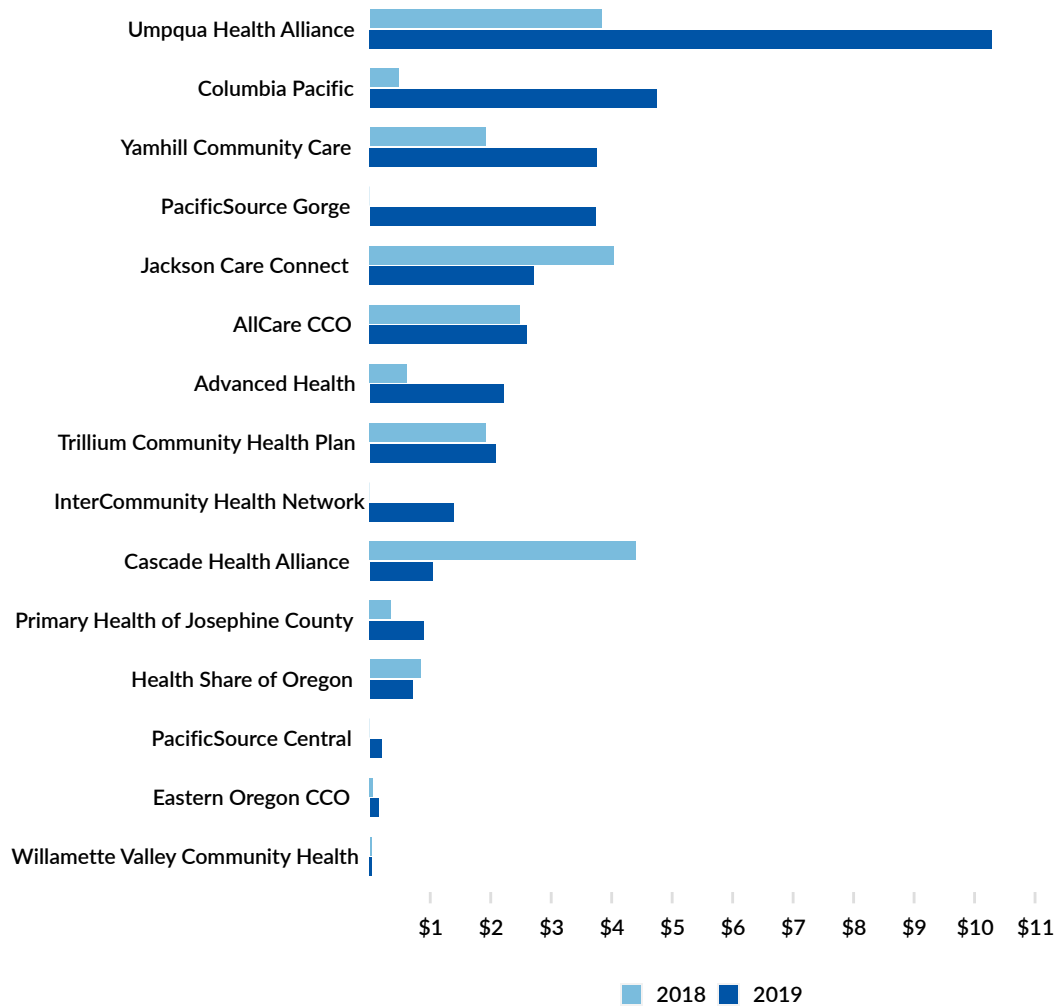
Second, a small group of CCOs reported still funding their SDOH work primarily through non-HRS spending mechanisms. For example, one CCO that reported minimal HRS expenditures stated that it typically invested between \$1 million and \$1.5 million annually on SDOH-related projects from its quality incentive metric earnings. Two CCOs reported investing several million dollars in SDOH and community projects that were not reflected on their Exhibit L reports.

Some CCOs with established SDOH programs described continued challenges in reconciling SDOH needs with HRS requirements. For example, several CCOs were confronting urgent community housing shortages that might have motivated contributions to new housing construction. However, that kind of capital investment did not qualify as HRS (a prohibition not specific to Oregon's waiver, but part of the national Medicaid policy).

*[HRS] works really well if you have a service to invest in. One of the places that we're getting a little stymied is when we have a clear need --it's articulated by our board. It shows up in care coordination when we're working with numbers and doing assessments. We're hearing it over and over from the community. We're hearing it from our members. In order to deliver that service, we would need to develop it, and it's not clear where our role is in developing new services, and I'm talking specifically about housing services here. Building an apartment building isn't something the CCO can do. How do we come in and support our partners doing that?*



Figure 6.3: PMPM Health-Related Services Spending (\$) by CCO, 2018 and 2019



### Prioritizing HRS Investments to Address SDOH

To select priorities for their HRS and SDOH spending, CCOs relied on input from various advisory and assessment structures, including their Community Advisory Councils, Community Health Assessments, Community Health Improvement Plans, and CCO boards. They made use of available data to orient their HRS and SDOH programs.

#### ***Obtaining data needed for effective SDOH planning remained a challenge***

CCOs indicated that they did not have access to data needed to effectively prioritize and plan for HRS and other SDOH work. CCOs' capacities to access, store, and synthesize SDOH-related data varied significantly. CCOs owned by or affiliated with larger organizations often had access to larger data platforms and warehouses. Other CCOs struggled to set up these systems or needed to make large HIT investments to enable them.

CCOs have engaged in efforts to collect data on social needs. They have begun to ask providers to submit "Z codes" (codes indicating specific social needs) with claims data or purchased access to the PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) assessment tool. CCOs have also participated in wider SDOH screening programs, such as CMS's Accountable Health Communities. Some CCOs relied on community surveys or community health

assessments. As with REALD data, some CCOs struggled to manage social needs and screening data on a unified, accessible platform.

*We have a very large service area with a lot of different types of providers and community partners. And trying to figure out how we're going to gather all of this data in one place -- it's something that's a unique challenge that I know everyone is experiencing right now.*

There was some tension about whether the collection of social needs data should be a CCO or community partner responsibility. Not all partners were equipped or willing to collect data.

*If you ask provider in a very small town like us, that is an additional set of work. It's not the work that they... they empathize with it, but that's not the work that they went to school to do.*

CCOs have increased their participation in community information exchange (CIE) platforms as another way to “know where the needs are.” As of February 2021, nine CCOs were listed as partners on the website of ConnectOregon, run by the CIE vendor Unite Us. Another CCO had adopted the “Aunt Bertha” platform.

Some respondents mentioned using medical risk models (including the Prometheus tool, provided by OHA, and the Milliman Advanced Risk Adjuster, which some CCOs had acquired), to merge SDOH efforts with broader population-health efforts, combining SDOH goals with the aim of reducing utilization of ED and inpatient care.

CCOs noted the utility and challenges of REALD data. Enrollment files from OHA served as the primary source of REALD data. However, these data were often missing. Data on primary language was typically more complete than race and ethnicity, so some CCOs relied on these data to look for inequities in services.

CCOs were using multiple strategies to fill in missing population data. One CCO had a “concierge” program that reached out to welcome new members and ask initial questions, including race and ethnicity. However, the program experienced some hesitancy from members:

*I think one of the challenges around there, when you ask somebody, “What’s your race,” they have a tendency to feel like if they provide that information, they would be profiled, when, in fact, the intention is completely benign. I think stigmas and fears around providing the information, knowing that it’s going to be used for good and not to limit their services, has been a real challenge.*

A small number of CCOs appeared to have made significant inroads into analyzing subgroups experiencing disparities. These changes led to more informed and targeted approaches to addressing social needs. For example, one CCO identified disparities by specific member subgroups with particular needs, such as members facing housing challenges:

*You're much more likely to experience a higher population of homeless youth who are LGBTQ+. Then, if you looked at the adult population, you're more likely to run into people who are indigenous and people of color who have language barriers. The health equity piece becomes really, really practical.*

### **CCOs relied on a variety of inputs to guide HRS and SDOH investments**

CCOs used input from multiple sources to identify SDOH target groups and prioritize investments. Most mentioned using Community Health Improvement Plans or Regional Health Improvement Plans

to guide HRS decisions. Many CCOs had provided their CACs with dedicated budgets to disburse to community partners for SDOH related projects using grant-type application processes.

*I really appreciate our CAC from the perspective of, they will really labor over spending \$5,000 in the community. And it's a long conversation. They have developed, with help from our administrative team, a lot of policies and procedures that allow them to take in applications with some standardized criteria to basically proliferate the reporting and outcomes data that they're looking for from these programs.*

In addition, CCOs used input from their boards (which include representatives from community organizations, local agencies, and providers), other committees, and from staff working on SDOH projects to make decisions on community benefit initiatives and SDOH investments.

Most CCOs found the housing priority designated by OHA for 2020 compatible with internal priorities. CCOs supported case-management services so that community housing partners could devote more dollars to capital improvements. Several CCOs lamented that they were unable to address shortages of housing directly through construction.

### Spending on Community Benefit Initiatives and Flexible Services

Figure 6.4 displays types of HRS spending in 2018 and 2019. In 2018, just over 75% of HRS spending (\$8.8 million or \$0.84 PMPM) went toward community benefit initiatives, with the remainder on flexible services (\$2.4 million or \$0.23 PMPM). (In 2018, CCOs were not required to separate HIT spending in their reporting. Thus, community benefit initiative spending in 2018 is likely to include some HIT spending). In 2019, spending on community benefit initiatives and flexible services grew to \$0.86 and \$0.28 PMPM, respectively. CCOs spent \$0.38 PMPM on HIT in 2019.

**Figure 6.4: Health-Related Services Spending (\$ PMPM) by Type, 2018-2019**

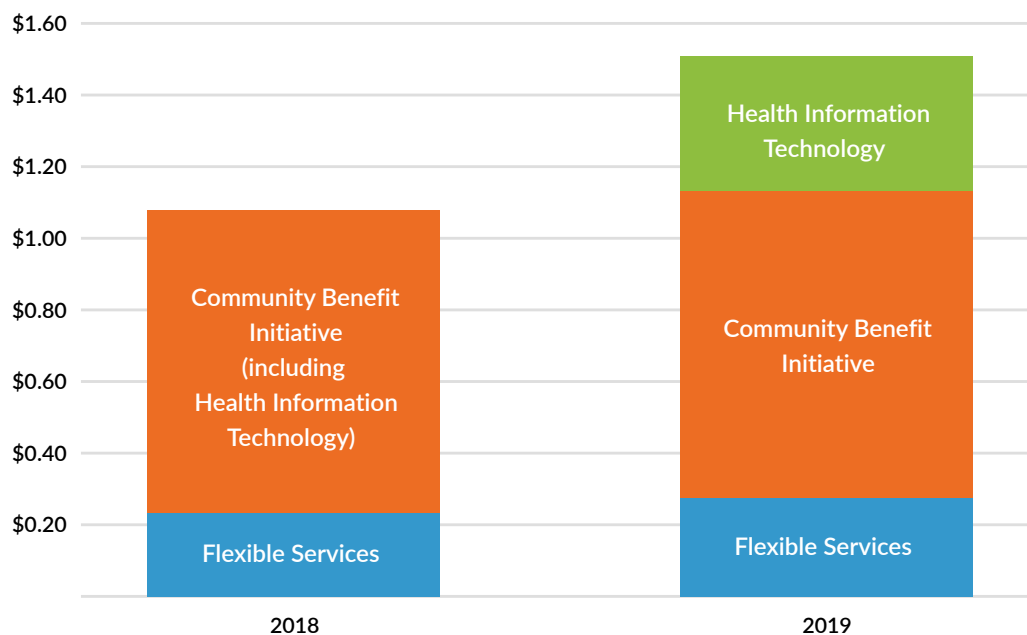
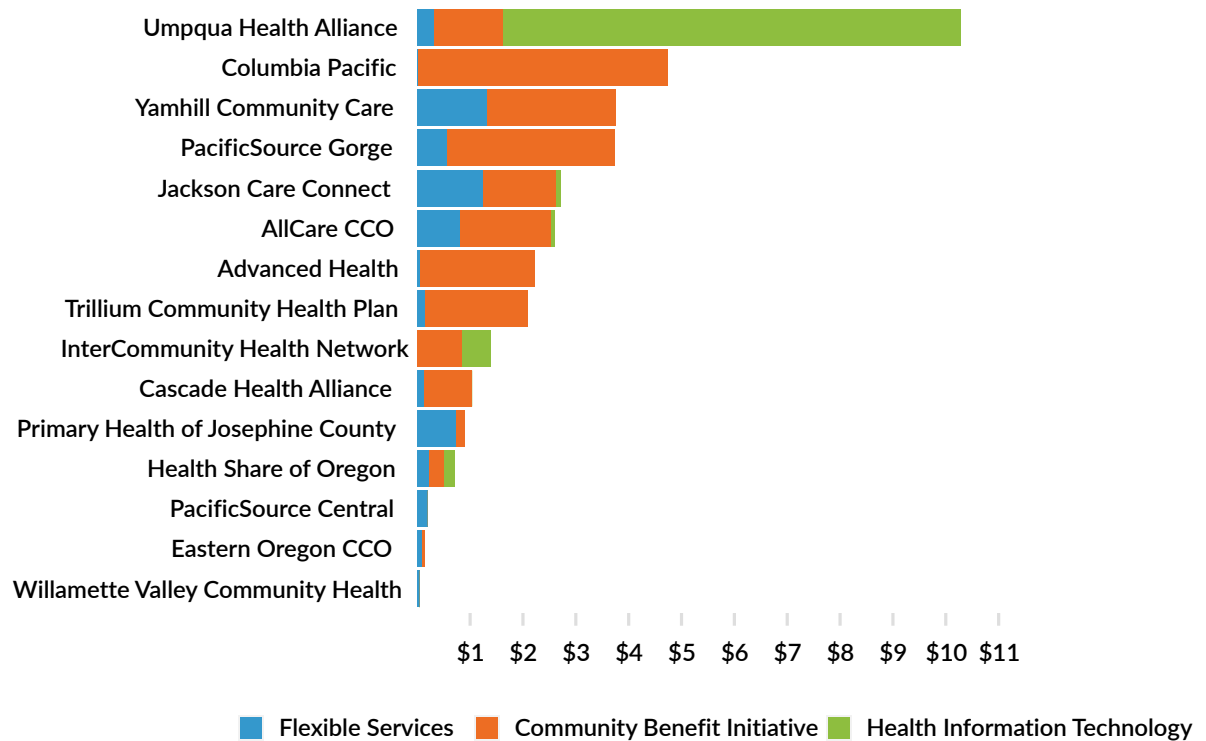


Figure 6.5 displays HRS spending by CCO in 2019, categorized as community benefit initiatives, flexible services, and HIT. Community benefit initiatives were the predominant form of HRS spending across most CCOs. One exception was Umpqua Health Alliance, which spent the bulk of its 2019 HRS dollars (\$2.8 million or \$8.68 PMPM) on HIT. Three CCOs—Umpqua Health Alliance, Health Share and Intercommunity Health Network—accounted for the vast majority (98%) of CCO-wide HIT spending. This included expenditures to integrate electronic medical record systems and incorporate social risk screening for community partners.

Figure 6.5: Types of Health-related Services Spending (\$ PMPM) by CCO, 2019



### Community Benefit Initiative Investments

Community benefit initiatives are community-level interventions focused on improving population health. They are available to CCO members but may include other community members if additional costs are not incurred. Spending on community benefit initiatives frequently involved funding community nonprofit organizations to address CCOs' SDOH priorities.

Community benefit initiatives applied to multiple SDOH areas. Exhibit 6.3 provides examples (cited by CCO interviewees) of community benefit initiative projects within the various SDOH areas. Exhibit L data did not provide sufficient information to determine the allocation of community benefit spending across categories. Although CCOs were required in Exhibit L to designate a category for community benefit spending, they categorized the majority of these expenditures into two nondescript categories: "community benefit initiative" or "programs to improve community health."

**Exhibit 6.3: Examples of Community Benefit Initiative Projects, by SDOH Area**

SDOH Area	Examples of Community Benefit Initiative Projects
Housing	<ul style="list-style-type: none"> <li>• “We have a medical recuperation program for individuals discharging from the hospital who are homeless and need a place to recuperate. We provide a place for those individuals to live to receive homecare and to get better.”</li> </ul>
Food security	<ul style="list-style-type: none"> <li>• “We also started with [CCO name] Veggie Rx, and it was a pilot in partnership with our diabetes prevention program to get folks access to fresh fruits and vegetables.”</li> </ul>
Access to communications or technology	<ul style="list-style-type: none"> <li>• “Access to broadband and infrastructure, and then also ensuring that our members have access to information. So one of the projects that we’ve implemented in partnership with another organization is bringing information directly through SMS services to a member phone. So we push, we’re able to get members information almost on an instant basis. Cell phone, SMS, text messaging.”</li> </ul>
Care coordination in the community	<ul style="list-style-type: none"> <li>• “[Program] is part of our HRS and kind of internal infrastructure program and a way that we work with our provider network to support our maternal child population that’s also struggling with SUD issues.”</li> </ul>
Community partner capacity-building	<ul style="list-style-type: none"> <li>• “We’ve worked a lot regarding adversity, trauma, and toxic stress, and we supported the development of [local initiative], which is a community collaborative where we have trained master trainers by ACE Interface that have brought the awareness of the effects of toxic stress to our community.”</li> <li>• “An important area of investment, especially in our region, is supporting organizations to actually apply for funds. We call it “universal tools,” but grant writers and supports that help organizations that might have limited services or a capacity, I mean, to apply for funds other than CCO funds.”</li> </ul>

**Flexible Services Spending**

Flexible services are cost-effective services provided to individual CCO members that are outside covered Medicaid health benefits, promote health, and may replace or reduce the need for medical care. Exhibit 6.4 displays examples of flexible services CCOs provided to their members based on Exhibit L reporting in 2019 and interview data.

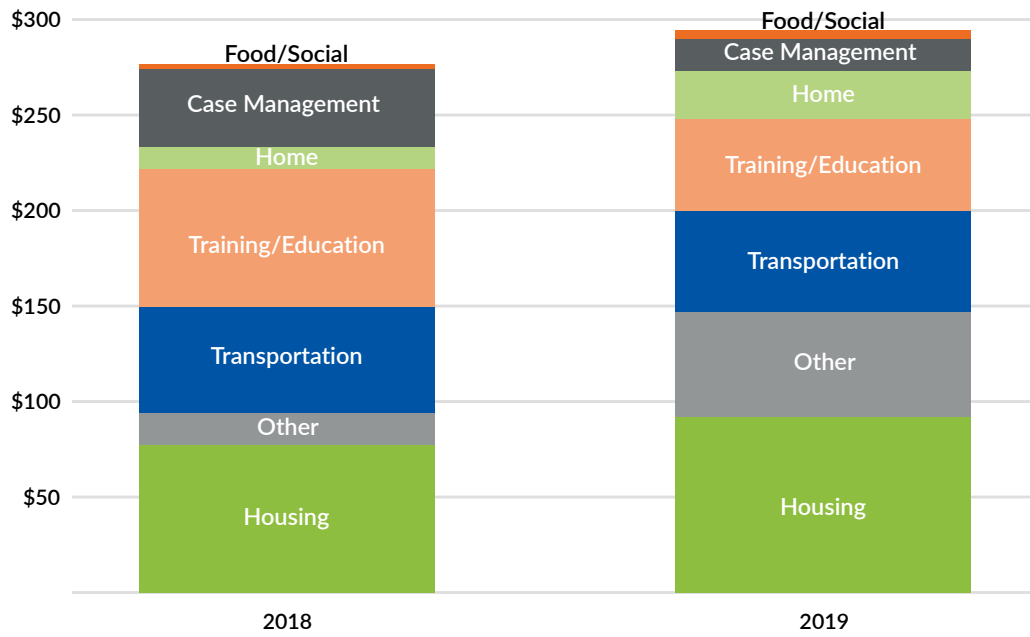
**Exhibit 6.4: Examples of Flexible Services Expenditures, by Category**

HRS Category	Examples of Flexible Services
Case Management	Birth certificate, driver's license and other IDs, background check, cell phone minutes, gas card, miscellaneous items
Housing	Short-term rental assistance, motel rooms, transitional housing, storage, moving costs, mortgage payment, utilities
Home	Air conditioner, air filter, air purifier, bathroom scale, refrigerator, mattress, furniture, heater, items for baby, washer/dryer, bath chair, ADA ramp, camping equipment
Transportation	Bus passes, van rides, gas, car insurance, taxis, bike or car repair, purchase of bike, tires
Food/Social	Meals, crockpot, hot plate, adoption fee
Training/Education	Recreation center passes, cooking classes, gardening program, summer camp, foster youth program, pain management training, youth soccer league, SUD diversion class, self-help course, workforce development, CPR training, child birth class, yoga class, guitar lessons, parent education
Other	Computer tablets, cell phones, incentive gifts for well care visits, art supplies, hair care, court fees, orthodontia, therapy pet supports, iPad, medical legal partnership, non-covered medical costs

Figure 6.6 displays categories of spending on flexible services in 2018 and 2019. Housing was the single largest expenditure in 2018 and 2019, growing from \$77 to \$92 per 1,000 members per month. Training and education and transportation expenses were also common in both years. In 2019, expenses categorized as "other" grew substantially.

Figure 6.7 displays the percentage of flexible services spending in each category by CCO. There was wide variation in CCOs' allocation of spending across categories. For example, PMPM expenditures by AllCare CCO and Umpqua Health Alliance were focused largely on transportation. Their investments in this area comprised most of the statewide spending in this category. In contrast, Yamhill Community Care, Primary Health of Josephine County, Cascade Health Alliance, and PacificSource Gorge allocated the bulk of flexible services spending to training and education. Health Share of Oregon, Columbia Pacific, and Willamette Valley Community Health had the highest PMPM spending on housing-related services. Interview data suggested that some CCOs made additional community benefit investments in these areas that were not reported as HRS.

Figure 6.6: Monthly Flexible Services Spending (\$ per 1,000 Members) by Category, 2018-2019



Year	Housing	Other	Transportation	Training/Education	Home	Case Management	Food/Social
2018	\$77	\$17	\$55	\$72	\$11	\$41	\$3
2019	\$92	\$55	\$53	\$48	\$25	\$16	\$5

Figure 6.7: Percentage of CCOs' 2019 Flexible Services Spending by Category

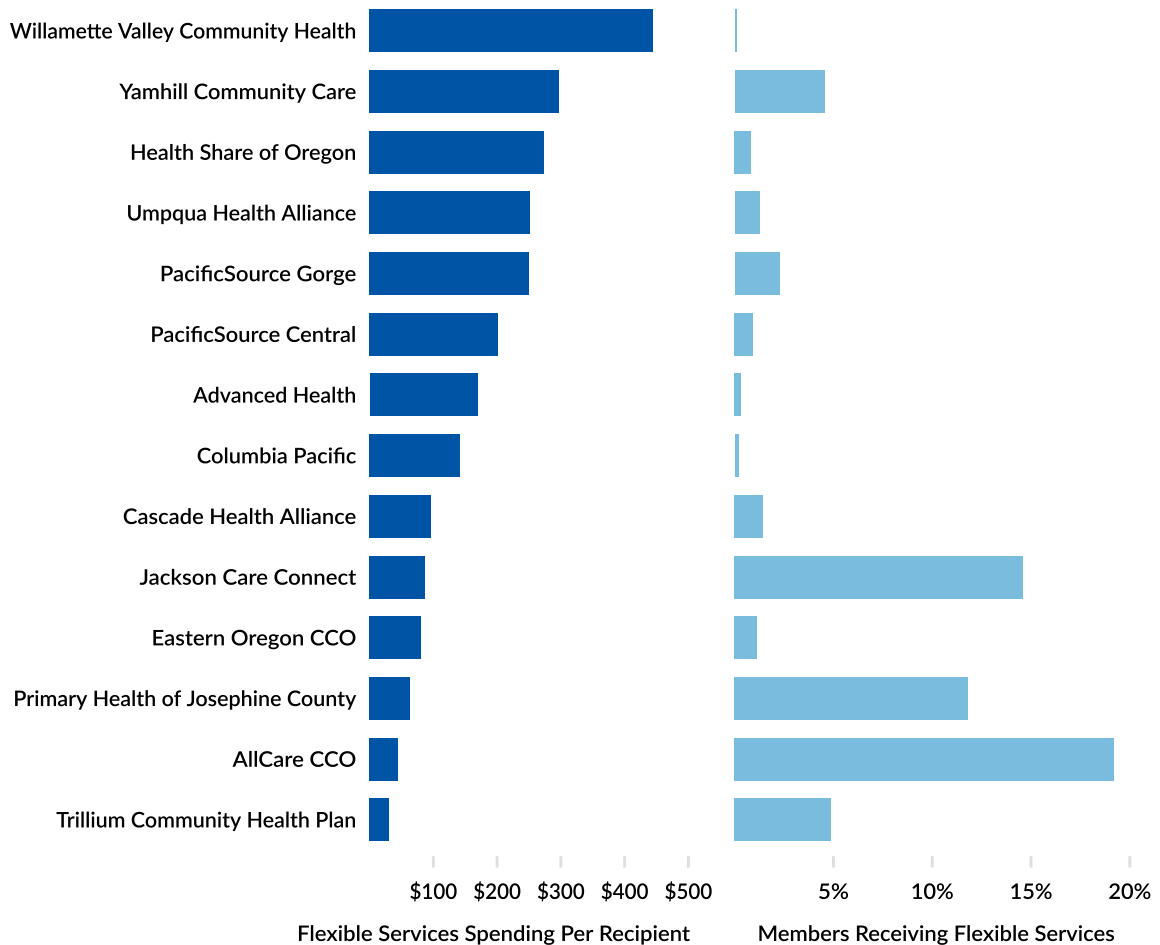


Figure 6.8 displays 2019 flexible services expenditures per recipient and the percentage of members receiving flexible services, by CCO. In general, CCOs with high spending per recipient (Willamette Valley Community Health, Yamhill Community Care) served lower percentages of their member populations. CCOs with particularly high percentages of members receiving flexible services (e.g., AllCare CCO, Jackson Care Connect) had lower spending per recipient.



**Figure 6.8: Scale and Reach of Flexible Services Spending, by CCO, 2019**

CCOs with higher spending per recipient generally reached a smaller percentage of members.



CCOs expanded their use of flexible services in 2020. Interviewees described how these expansions catalyzed new infrastructure for processing flexible services requests and working with new community partners. Many CCOs created online request forms to facilitate access for members and other providers and partners. CCOs also increased outreach to promote new requests, including seeking help in reaching traditionally underserved communities (e.g., Spanish speakers) through new partnerships.

*There's trust issues and language issues there. So we gave directly to our community partners, hopefully to get to the members that we don't reach. Or that maybe wouldn't go online. Yes, we translate our documents into Spanish, but maybe they don't know about going online, and using this form, and don't have access to the resources in the same way.*

### HRS Partnerships

While some flexible services were delivered to members directly by CCO staff, most community benefit initiatives and larger projects involved CCOs partnering with external organizations. HRS partners included public health agencies, CBOs and, in some cases, larger foundations. These partnerships were characterized by differences in longevity and depth. Some had begun early during the first CCO contract period and continued since, while others represented new relationships to address specific SDOH areas. Some CCOs used the term “anchor partner” to identify a CBO or

foundation with which they had a longstanding or key relationship. One respondent described the heterogeneous partnerships of a rural CCO:

*Our anchor partners have been the YMCAs, and there are several, [housing CBO], which is the housing organization that I referenced. I think those are our main anchors. That being said, we support probably close to 30 other organizations in various ways. It's not that those are the most important. It's just that those have been probably the longest relationships of the ones I just mentioned. Those two were selected because they really were the only ones filling a gap that was childcare provision and, at the Y, and housing for [housing CBO].*

### **Partnership structures and funding arrangements varied in complexity**

CCOs used a spectrum of contractual arrangements, ranging from grant-like gifts with few reporting obligations to provider-like contracts that allowed detailed follow-up. The structure of these arrangements and the levels of reporting they required affected the extent to which CCOs could report on project outcomes and return on investment (ROI).

Two CCOs stood out for articulating a progression in funding structures, beginning with a short-term grant or pilot engagement, and moving into an increasingly performance-based contract. One CCO shared this example with a housing partner:

*(A current project) is a good example. It used to be called [CBO name], and then it was [new CBO name]... They were building ramps in the community, and doing handrails, and things like that. We're giving them grants, giving them grants, year after year after year. Then, [CCO program manager], realizing this was an ongoing system that's happening [asks], "How can we just pay them?" The contract folks step in the picture, and the network folks. [CBO name] now actually has an NPI number...they've got a Medicaid ID number...It's in the physical health bucket. There's an ROI for it that I can analyze to then justify if we're going to give them more money or less money.*

Some CCOs used foundations or similar organizations to act as intermediaries between the CCO and local organizations. A rural CCO in the planning stages of its current SDOH program spoke of contracting with an intermediary partner to augment the CCO's capacity at managing other partners.

Maintaining stable funding levels for community partners was an additional priority for CCOs, especially as partnerships became more interdependent. Uncertainty about future CCO budgets and availability of funds for SDOH work was presented challenges to stable, long-term partnerships. The need to "braid" funds from multiple sources while maintaining compliance with funder policies was also a concern.

### **Community capacity for addressing SDOH was limited**

Even when funding was available, there was limited capacity in some communities to carry out SDOH projects. Some local partners had limited staff, lacked information technology infrastructure, and did not have the capacity to pursue external funding. These capacity issues were particularly acute in rural and frontier areas.

One CCO described taking an "active investor" model with partners:

*We're usually pretty involved and deeply invested in the development of new programs and partnerships just to make sure that we're getting what we're hoping out of it, that the partner is getting they're needing out of it. It's a lot of collaboration in that space.*

Several CCOs voiced the desire to support community capacity that would continue to live on and grow, even if the CCO ceased to exist.

*That's really a focus of ours, is building capabilities that are local. Building infrastructure that's local. Building the resource base that is local. So that, at some point, we've stood up organizations and capabilities that don't require ongoing investment by the CCO because we've scaled the wall, if you will, and organizations are able to get over to the other side.*

### Use of HRS to respond to COVID-19 and Wildfires

COVID-19 and the large wildfires affecting Oregon in 2020 created unprecedented challenges and health risks. In response to the pandemic, OHA released its pool of quality funds early to CCOs. These were immediately put into use in communities across Oregon, often capitalizing on the flexibility of HRS infrastructure. Some CCOs took steps to create new programs to deal specifically with the impacts of COVID-19. One CCO set up a “COVID -19 Community Support Program” via Unite Us to help individual members apply for flexible spending funds.

*We went ahead and created this program called the COVID-19 community support program...Using Unite Us, our members were able to just go online and fill out this form. We made it easier than we've ever had it before for members to access their flexible services funds. I think we multiplied this project—the amount of funds spent-- by about 20 from previous years' spending on flexible services. Our leadership buy-in was really fantastic there, though, to say, “Yes, let's allocate these funds to this COVID response, emergency response.”*

Telehealth and easy access to technology became important topics and investments for CCOs.

*We were able to provide Samsung smartphones with three months pre-paid service and video capability all over the state basically to promote connectivity and telehealth. One of the clinics that we provided it to..., [its] population was very badly hit by the wildfires...That was something that we were able to, from the health-related services side, provide as well.*

### Tracking HRS Outcomes and ROI

CCOs exhibited varying levels of ability to track HRS outcomes and estimate ROI from HRS spending. They pursued different strategies for evaluating outcomes of their HRS and other SDOH investments. These ranged from discussions of precise ROI estimations to remarks about “community goodwill.” Some CCOs spoke of ROI measurement as a long-term goal that was currently out of reach. Others challenged whether the returns on longer-term, population-based investments were measurable in the time frame addressed by Exhibit L. Most CCOs acknowledged ongoing challenges with tracking outcomes and assessing the value of different interventions to target investments more successfully in the future.

A few CCOs indicated they were tracking member-level outcomes of particular programs, often collaborating with community partners on evaluations. One CCO took new programs through a pilot and evaluation phase before committing to a longer-term partnership, using member-level outcomes of different types of utilization (primary care, behavioral care, emergency department, inpatient, non-emergent medical transportation) to measure program outcomes. A second CCO exhibited a sophisticated understanding in evaluating ROI patterns across SDOH interventions:

*It's really interesting because if you look at two years of data, you'd stop a program. Year one, they're at whatever their baseline is. Year two, they're better engaged in care, if things are working right, so their [health risk] score actually goes up. They are a riskier proposition because they're suddenly using their health care. Then, if you look at subsequent years in a successful program arc, like we've seen, it starts going back down... It's kind of a nice predictable arc for a program that's being effective in helping to offset those member costs.*

In contrast, another CCO used a low-burden grant process for SDOH projects with fewer reporting requirements. However, they described greater difficulty estimating efficacy of spending, settling for “a little bit” of accountability for funding and some reporting.

*So, yes, the ROI is important, and we can't always measure it from a dollar standpoint, that there's not always something there. But when you hear the stories, the goodwill that it builds in the community, the impact you can make on certain individuals, when you hear those stories coming back as these projects wrap up each year, that means a lot to the board and to the community.*

Although the state asked CCOs only to “describe intended measurable outcomes” in its reports, multiple CCO teams appeared to interpret this as an imminent requirement for outcomes data. This perception in some cases introduced new pressures on community partners that did not have experience reporting detailed outcomes, potentially stressing partner relationships.

*There's this push—this sort of friction with, “Okay, we need to trace this to health outcomes. We have to for our return on investment, for our reporting to the Oregon Health Authority, and for showing that these projects are evidence-based, and do reduce things—health outcomes like emergency department visits, or incidence and prevalence of diabetes, right?”... Since we're so new to this, and we don't collect the data on this—we haven't historically, we do now, and we're working on that -- there is sort of this friction of, “What can we depend on our community partners for?”*

One CCO, recognizing challenges with tracking outcomes, had instead gone the route of choosing an intervention with an established evidence base as the focal point of its SDOH efforts. This strategy, sanctioned by OHA, helped the CCO support a childhood intervention with a long window of ROI and reduced concerns about demonstrating short-term ROI. No other CCOs, however, were explicitly using that approach.

One CCO pointed out that much SDOH work took place through internal work of CCO staff, such as care management or health equity teams, which would not be captured as HRS spending. ROI for adding staff to address SDOH, which several CCOs pointed out was necessary for building out programs, was typically not captured and difficult to assess. One CCO management team member explained:

*When there are direct payments to third parties, those are relatively easy to track. Because health equity and social determinants is so interwoven with all our other endeavors and population, we don't track costs that way. We might have to go back and do some serious homework.*

## **Exhibit L Reporting**

OHA has improved the utility of information reported by CCOs on their HRS spending with CCO 2.0, allowing for much more detailed analysis. As the volume of HRS spending reported increased in 2018 and 2019, the level of detail reported for each expense or investment has increased as well. The reports, however, still exhibit areas of variation between how CCOs are recording expenses,

and seeking further consistency in reporting practices across CCOs could help with analyzing expenditures across CCOs and across years.

For example, CCOs showed variation in the number of individual flexible services they were reporting. One CCO included more than 100 lines of individual services in its report, while another, of comparable size, reported seven. Another CCO reported many thousands of dollars in transportation flexible services with only a handful of individual member IDs as recipients. These variations and anomalies may reflect differing capacities to collect data or different understanding of reporting instructions.

In addition, CCOs included some individual-level expenditures (such as case management) as community benefit initiatives, presumably because they benefited both members and non-members. Reporting these services as community benefit initiatives, however, reduced the potential for tracking provision of HRS to individual members.

### **Reporting requirements brought considerable administrative burdens**

CCOs indicated that there was a significant time and personnel burden associated with collecting and maintaining the data required for Exhibit L. Some CCOs required two staff members to manage flexible services administration and reporting. At least one CCO mentioned avoiding the HRS mechanism even for expenses that probably qualified because of the complexity of reporting involved.

*It just hasn't made a lot of sense for us all the time to go through every single investment we're making in every single region to figure out if it fits into a health-related services rubric, because I don't think the benefit of doing that is aligned with the urgency of the work.*

Several CCOs described lengthy HRS “reconciliation” communications with OHA to explain and justify line items reported on Exhibit L. One CCO questioned whether the focus on detailed reporting might be overshadowing the assessment of outcomes, which it saw as ultimately more important.

## **Broad Trends in Quality and Costs**

The CMS-approved evaluation of Oregon’s waiver renewal is intended to assess how enrollees experience HRS as well as the impact of HRS on quality and costs by addressing the following four hypotheses:

- 3.2** Enrollees receiving HRS will report satisfaction with those services and better patient experience overall.
- 3.3** Use of HRS will be associated with reduced utilization of more intensive or higher-cost care.
- 3.4** Use of HRS will help address social determinants of health to improve individual and population health outcomes.
- 3.5** Use of HRS will be associated with reduced growth of total spending and spending in high-cost settings (e.g. ED and inpatient) and with sustained or increased spending on primary or preventive care.

Although we cannot assess these hypotheses rigorously with data available at the time of the writing of this report, this section provides information on ten relevant measures of quality and cost derived from claims and survey data:

- **Members with Any Primary Care:** Percentage of members who had at least one visit to a primary care provider during the measurement year.
- **Getting Care Quickly:** Average of two percentages based on CAHPS survey data; percentage of members who said they usually or always got care for illness or injury as soon as needed, and percentage of members who said they usually or always got non-urgent/routine care appointments as soon as needed within the last six months.
- **Getting Needed Care:** Average of two percentages based on CAHPS survey data; percentage of members who said it was usually or always easy to get needed care, tests, or treatments, and percentage of members who said it was usually or always easy to get appointments with specialists as soon as needed within the last six months.
- **Rating of All Health Care:** Percentage of members (based on CAHPS survey data) who rated all their health care in the last six months an 8, 9, or 10 on a scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible.
- **ED Utilization per 1,000 MM:** Number of ED visits per 1,000 member months of enrollment.
- **Member Rating of Health Status:** Percentage of members (based on CAHPS survey data) who rated their overall health as good, very good, or excellent.
- **Total Spending PMPM:** Total spending on ED, primary care, prescription drugs, inpatient, behavioral health, and other outpatient care, divided by months of enrollment.
- **ED Spending PMPM:** Total spending on ED services (excluding behavioral health services), divided by months of enrollment.
- **Inpatient Spending PMPM:** Total inpatient spending (facility and professional, excluding behavioral health services), divided by months of enrollment.
- **Primary Care Spending PMPM:** Total spending on primary care services (excluding behavioral health services), divided by months of enrollment.

**Table 6.1: Adjusted Change in Measures of Quality and Costs, 2011-2019 and 2016-2019**

Measure		2016	2019	Adj. Change 2016-2019	Adj. Change 2011-2019
Members with Any Primary Care		75.7%	79.4%	0.1	0.0
Getting Care Quickly	\$ ☼	80.9%	83.3%	2.4	NA
Getting Needed Care	☼	77.8%	80.0%	2.3	NA
Rating All Health Care	☼	67.2%	70.9%	3.5	NA
ED Utilization per 1,000 MM	↓ \$ ☼	46.4	46.0	-6.2	-9.9
Member Rating of Health Status	☼	70.2%	68.1%	-1.7	NA
Total Spending PMPM	↓	\$239.10	\$279.81	46.07	13.92
ED Spending PMPM	↓	\$13.14	\$15.55	2.52	-4.98
Inpatient Spending PMPM	↓	\$55.95	\$58.49	1.09	-19.41
Primary Care Spending PMPM		\$20.50	\$22.80	0.79	-8.62

Significant worsening < from baseline < Significant improvement from baseline > No significant change from baseline (p>0.05)

25% 10% 0% 10% 25%

↓ Lower is better  
 \$ CCO Incentive Measure  
 ☼ State Quality Measure

As shown in Table 6.1, among claims-based measures, there was relatively little change in primary care access, whereas ED utilization decreased. Changes in survey-based, self-reported measures were mixed. The percentage of people who rated their health care at least 8 out of 10 increased slightly, whereas increases in enrollees who said they could get care when they needed it or get the care they needed were not statistically significant. On the other hand, the percentage of members who rated their overall health as good, very good, or excellent decreased slightly, although this change was also not statistically significant.

Between 2016 and 2019, spending on primary care services increased slightly. Total spending and ED spending increased considerably between 2016 and 2019. As described in Appendix B, spending measures were calculated using imputed values for services subject to capitation arrangements. Our results for these measures therefore are closer to a summary measure of utilization rather than actual CCO expenditures. Furthermore, results for primary care spending may not match the values in OHA's Primary Care Spending in Oregon report, because we used different methodologies and definitions.

## Limitations

Qualitative interviews were limited to a single hour with each CCO, which restricted the team's ability to probe in detail into specific aspects of HRS provision, as well as the ability of individual CCO respondents to speak privately and at greater length. We conducted interviews prior to completing Exhibit L quantitative analyses and therefore were not able to ask detailed questions about reported expenditures. Interviews did not capture perspectives of CCO members seeking or receiving services, or of community partners helping CCOs deliver them. The second round of HRS interviews for the summative evaluation will include this additional content. Interviews were carried out before OHA held webinars on HRS and Supporting Health for All through Reinvestment (SHARE) requirements in late 2020/early 2021; CCOs' strategies for using HRS and addressing SDOH may have changed due to that guidance.

The HRS spending analyses presented here are preliminary and should be cautiously interpreted. Exhibit L data were missing for Trillium in 2014-2015. Some CCOs continue to fund the majority of SDOH work through non-HRS mechanisms. The years 2014-17 reflect all reported spending, whereas 2018-19 data show approved spending only. Additionally, reporting requirements and practices have evolved considerably over time and were subject to different interpretations, limiting comparability across years and CCOs.

Furthermore, we were not able to link HRS spending to individual outcomes to assess the impact of HRS on quality and cost. More granular data from Exhibit L should facilitate more detailed analyses for the summative evaluation. Finally, Table 6.1 displayed broad trends in quality and costs. We were unable to provide information about how these changes may have improved or worsened across different racial and ethnic groups.

## Conclusions

Three conclusions emerged from evaluation of HRS:

1. **CCOs have prioritized SDOH and increased their spending on HRS.** Changes by the state with the waiver renewal and as part of the CCO 2.0 contracting have focused CCOs' efforts to address SDOH and expanded spending on HRS. However, at 0.36% of member services spending in 2019, HRS remains a small fraction of CCOs' total spending.
2. **CCOs are still learning how to use HRS.** The use of HRS is still new to CCOs, even as many have established "anchor partners" and identified paths for outreach and coordination. As of yet, CCOs have relatively little ability to robustly assess the effectiveness of their expenditures.
3. **The use of HRS creates opportunities for CCOs but also carries a significant administrative burden.** HRS entails new data, relationships, and reporting requirements, all of which create a notable administrative burden on CCOs. In some cases, the burden may be large enough to deter accurate reporting or impede more expansive spending.

Chapter 8 includes recommendations for HRS and SDOH activities.



# Dual-Eligible Members

## Overview

In 2019, approximately 13% of OHP members were simultaneously enrolled in both Medicare and Medicaid benefits (“dual-eligible members”). That year, Oregon introduced passive enrollment in CCOs for dual-eligible members as part of the state’s commitment under the waiver renewal to expand access to coordinated care for these individuals. Prior to 2019, dual-eligible members were enrolled in FFS coverage by default but could choose to enroll in a CCO (an “opt-in” model). Under passive enrollment, dual-eligible members were enrolled in a CCO by default but given the option to “opt-out” and return to FFS at any time. This chapter examines the state’s progress on providing high-quality, cost-effective, and person-centered care for dual-eligible members. We first provide background on the characteristics of this population and their coverage under Medicare and Medicaid. We then review the passive enrollment provisions of the 2017-2022 waiver and describe Oregon’s implementation of these provisions. Finally, we present evaluation measures related to quality, access and spending for dual-eligible members using data through 2018, showing changes over time and stratifying by geography. Measures address the following evaluation hypotheses:

- 4.1 The proportion of dual-eligible members enrolled in a CCO will increase compared with past demonstration levels without loss of member satisfaction.
- 4.2 CCO enrollment will encourage appropriate use of clinical resources and ancillary care for dual-eligible members.

## KEY FINDINGS

- Results for measures of health care access, quality, and spending for dual-eligible members were mixed in the first two years of the waiver renewal. Our analyses used data through 2018 and therefore did not capture any impact of dual-eligible members’ passive enrollment in CCOs, which was implemented starting in 2019.
- Outpatient visits increased among dual-eligible members, particularly for behavioral health, whereas access to primary and preventive care were relatively flat. Declines in ED utilization and avoidable ED visits were limited to dual-eligible members residing in urban areas.
- Total spending increased somewhat between 2016 and 2018 for dual-eligible members in isolated and rural areas.
- Overall, results for evaluation measures indicate that care for dual-eligible members did not change substantially from 2016 to 2018. Future analyses will assess the impacts of passive CCO enrollment occurring in 2019.

## Background

Dual-eligible members represent a unique segment of the Medicaid population. They are among the most economically and socially vulnerable Medicaid members. Compared to other members,

they have a higher prevalence of chronic physical health conditions and co-occurring behavioral health conditions. Many have long-term care needs and social risk factors. Spending on dual-eligible members represents a disproportionate share of total Medicaid spending. Nationally, they account for 15% of Medicaid enrollees but 32% of Medicaid expenditures; in the Medicare program, they account for 20% of enrollees and 34% of Medicare expenditures.<sup>23</sup>

Dual-eligible individuals may qualify for Medicare based on age (65 years or older) or because they have a disability or end-stage renal disease. In Oregon, about 57% of dual-eligible members are aged 65 or older, whereas 43% qualify through disability (based on data from the fourth quarter of 2018). The latter group includes individuals who qualify for Social Security disability benefits due to SPMI. Medicare pays for all Medicare-covered services (including most preventive, primary, and acute health care services and prescription drugs). Medicaid pays for any services that Medicare does not cover, including Medicare premiums and cost sharing (deductibles, coinsurance and copayments), long-term services and supports, and certain behavioral health services, including behavioral health services obtained from provider types not eligible for Medicare enrollment. Some dual-eligible members qualify only for partial Medicaid benefits; coverage for these members is limited to expenses related to payment of Medicare premiums and cost sharing.<sup>24</sup> Full-benefit dual eligible (FBDE) members receive Medicare benefits outside of Part D prescriptions in addition to payment of Medicare premiums and cost-sharing. Only FBDE members may be enrolled in a CCO. Box 7.1 describes the potential for greater alignment between Medicaid and Medicare programs to improve care for dual-eligible members.

### **Box 7.1: Medicare & Medicaid Plan Alignment**

*Given the high prevalence of chronic physical and behavioral health conditions among dual-eligible members, care integration and coordination under the CCO model has strong potential to improve outcomes for this population. However, CCOs may have weaker incentives to address the specific needs of dual-eligible individuals compared to other member populations. Since Medicare acts as the primary payer, any cost savings from care coordination and integration for dual-eligible members (for example, resulting from reduced ED visits) are likely to benefit Medicare. As secondary payers, CCOs may also lack information about dual-eligible members' health care utilization, further limiting their ability to coordinate and manage care.*

*A 2018 study of dual-eligible members enrolled in Oregon CCOs analyzed outcomes among CCOs that also offered Medicare Advantage (MA) plans. In these cases, the CCO bears financial risk for both Medicaid and Medicare programs. Dual-eligible individuals served by these "aligned" plans experienced more improvement in health and quality of care outcomes compared to members whose plans were not aligned. Dual-eligible members with aligned plans also had lower emergency department visit and hospitalization rates, higher primary care visit rates, and were more likely to receive diabetes and cholesterol screening.*

*Under CCO 2.0, OHA is requiring that all CCOs offer aligned MA plans, through affiliation agreements, and provide integrated care and processes for FBDE members. CCOs are also required to contact their FBDE members annually to inform them of the opportunity to align their Medicaid and Medicare benefits. The interim evaluation uses data through 2018 and therefore does not assess how these changes may have affected outcomes for dual-eligible members.*

#### *References:*

*Kim, H., Charlesworth, C. J., McConnell, K. J., Valentine, J. B., & Grabowski, D. C. (2019). Comparing Care for Dual-Eligibles Across Coverage Models: Empirical Evidence From Oregon. Medical Care Research and Review, 76(5), 661-677. <https://doi.org/10.1177/1077558717740206>*

Under Oregon's 2012-2017 waiver, dual-eligible members were enrolled in FFS Medicaid by default but could choose to "opt-in" to CCO enrollment. When the CCO model was first implemented in 2012, most dual-eligible members previously enrolled in managed care became enrolled in a CCO. CCOs were encouraged to pursue alignment or affiliation agreements with MA plans to better coordinate care for dual-eligible members. However, not all CCOs held MA contracts, and the amount of alignment between MA plans and Medicaid CCOs varied regionally.

A 2016 study used Medicare and Medicaid claims data to examine the effects of CCO implementation on health care utilization and quality among Oregon's dually eligible population. The study found that the introduction of CCOs led to some improvements in quality of care for dual-eligible members with diabetes, although there were no meaningful improvements in utilization.<sup>25</sup> The study did not explore differences in outcomes for dual-eligible members served by aligned MA plans (e.g., whose CCO also managed their MA benefits) and those who were not. A later study (referenced in Box 7.1) indicated that Oregon should consider opportunities to build alignment as a means of improving outcomes for dual-eligible members.

### Auto-Enrollment Under the Waiver Renewal

Oregon's waiver renewal called out a "lack of clarity about local care delivery opportunities and choices" for dual-eligible members.<sup>26</sup> To simplify coverage and choices for dual-eligible members, individuals were to be provided an option to opt-out of being automatically enrolled in a CCO via passive enrollment. Enrollment changes were subject to the following requirements:<sup>27</sup>

1. Dual-eligible members must receive a 90-day notice regarding passive enrollment in a CCO.
2. Dual-eligible members residing in an area with two CCOs would be enrolled using the same process as other OHP members (e.g., based on previous enrollment, enrollment of other family members, and CCO area capacity limits).
3. Dual-eligible individuals enrolled in a dual-eligible special needs plan (D-SNP) would be assigned to the affiliated CCO. Additionally, dual-eligible members enrolled in a MA plan would be assigned to the affiliated CCO.
4. Dual-eligible members who did not opt-out initially would have the continued option to opt-out and return to FFS at any time.

Passive enrollment provisions were codified in OAR 410-141-3060, effective January 1, 2019.<sup>28</sup> In 2019, partnering with ODHS, OHA began a phased regional implementation of passive enrollment for dual-eligible individuals. The phased approach was designed to ensure that member questions and concerns could be adequately addressed and that systems could be adapted in response to unforeseen challenges. In accordance with federal requirements, OHA sent letters to dual-eligible members prior to passive enrollment offering an opportunity to opt-out. Individuals could respond by phone or letter if they wanted to opt-out, and OHA sent a second notice to members who had not responded affirmatively. Partnering with ODHS, OHA trained customer service representatives to answer questions and assist dual-eligible members through the automated enrollment process.<sup>29</sup> In describing the implementation, OHA noted that (as of 2018) the majority of dual-eligible members enrolled in CCOs had remained enrolled and that these members were generally satisfied with their care. OHA emphasized the benefits of CCO enrollment for dual-eligible individuals, including access to wrap-around services, trauma-informed care, integrated behavioral and oral health care services, and preventive services.<sup>30</sup>

## Outcomes for Dual-Eligible Members

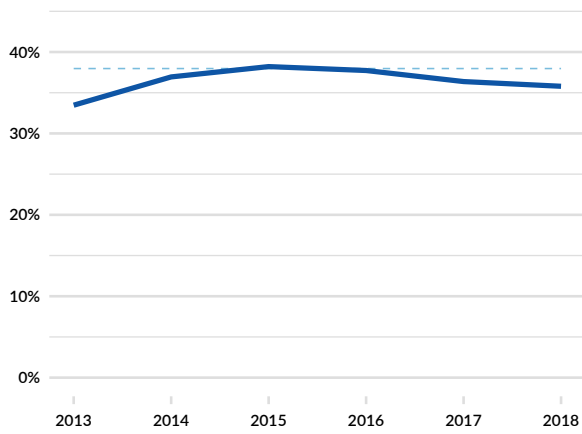
This section analyzes performance on the following outcome measures for dual-eligible members:

- **Percentage of Oregon Dual-Eligible Members Enrolled in CCOs:** Percentage of members who were dually eligible for Medicare and Medicaid services who were enrolled in a CCO at any time during the measurement year.
- **Members with Any Primary Care:** Percentage of members who were dually eligible for Medicare and Medicaid services who had at least one visit to a primary care provider.
- **Adults' Access to Preventive-Ambulatory Services:** Percentage of members who were dually eligible for Medicare and Medicaid services who had an outpatient or preventive care visit.
- **Outpatient Visits for Behavioral Health Care per 1,000 MM:** Number of outpatient visits for behavioral health care per 1,000 months of enrollment among members who were dually eligible for Medicare and Medicaid services.
- **Outpatient Visits for Non-Behavioral Health Care per 1,000 MM:** Number of outpatient visits for non-behavioral health care per 1,000 months of enrollment among members who were dually eligible for Medicare and Medicaid services.
- **ED Utilization per 1,000 MM:** Number of ED visits per 1,000 months of enrollment among members who were dually eligible for Medicare and Medicaid services.
- **Potentially Avoidable ED Visits:** Number of ED visits that were preventable or treatable with appropriate primary care per 1,000 months of enrollment among members who were dually eligible for Medicare and Medicaid services.
- **30-Day Plan All-Cause Readmissions:** Percentage of hospital stays with unplanned readmissions to the hospital within 30 days among members who were dually eligible for Medicare and Medicaid services.
- **Total Spending PMPM:** Total spending for members who were dually eligible for Medicare and Medicaid services divided by months of enrollment.

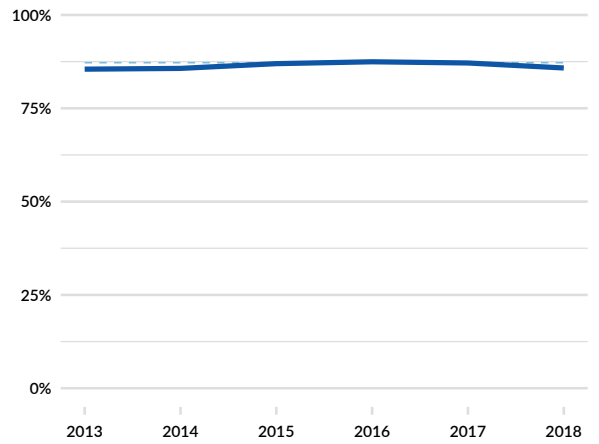
The study population includes dual-eligible members enrolled in CCOs or in FFS Medicaid. We present results for the period 2013 through 2018, including changes from two baseline periods – 2013 and 2016 – adjusted for demographic characteristics and risk. We report results for subgroups based on geography of residence (rural, urban, and isolated). Isolated geographies are defined as population centers of less than 2,500 without commuting flow to urban areas.

Figure 7.1 displays the rate of CCO enrollment among dual-eligible members from 2013 through 2018. Enrollment in CCOs increased in 2013-2015, leveling out at 38% and declining slightly to 36% by 2018. These numbers are not directly comparable to OHA's reporting of CCO enrollment rates for dual-eligible members, because we did not have data to exclude non-FBDE members (who are not eligible for CCO enrollment). Figures 7.2 through 7.9 display unadjusted trends in measures of access, quality, and spending among dual-eligible members. The percentage of dual-eligible members accessing primary care and preventive-ambulatory services was relatively flat. Outpatient visits for behavioral health increased steadily from 2014, and outpatient visits for non-behavioral health care trended upwards in 2018 after remaining relatively unchanged since 2014. Avoidable ED visits decreased from 2016 to 2018, although readmissions increased slightly from 2017 to 2018. Total PMPM spending for dual-eligible members increased considerably from 2013 to 2015, followed by a smaller increase in 2017.

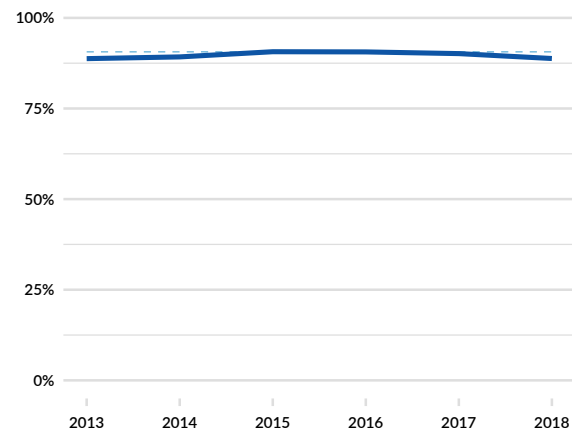
**Figure 7.1: Percentage of Oregon Dual-Eligible Members Enrolled in CCOs**



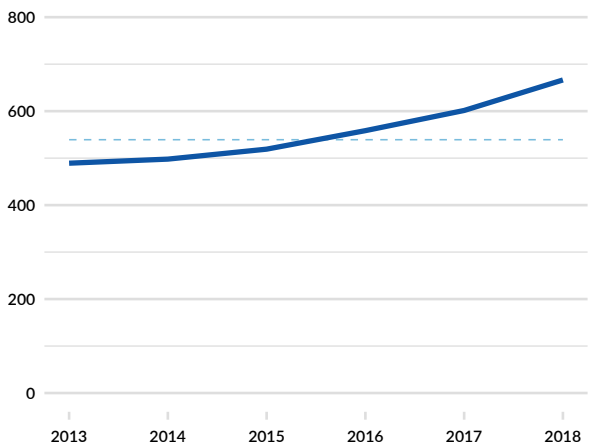
**Figure 7.2: Percentage of Dual-Eligible Members with Any Primary Care**



**Figure 7.3: Adult Dual-Eligible Members' Access to Preventive-Ambulatory Services**

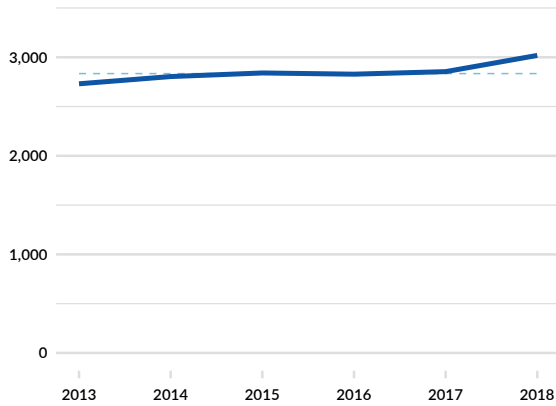


**Figure 7.4: Dual-Eligible Members' Outpatient Visits for Behavioral Health Care per 1,000 MM**

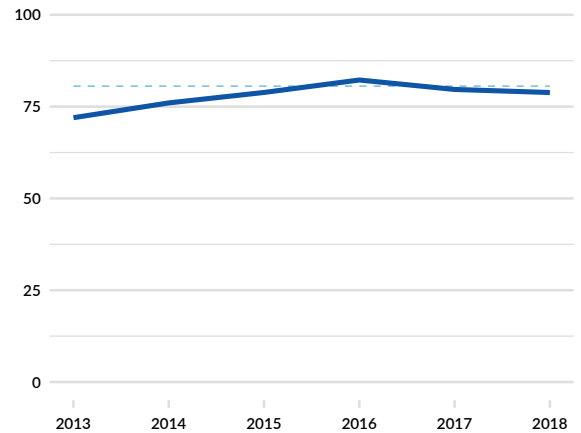


--- 2015-2016 mean

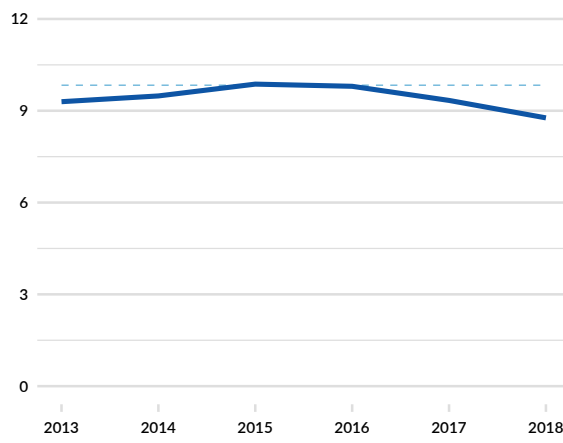
**Figure 7.5: Dual-Eligible Members' Outpatient Visits for Non-Behavioral Health Care per 1,000 MM**



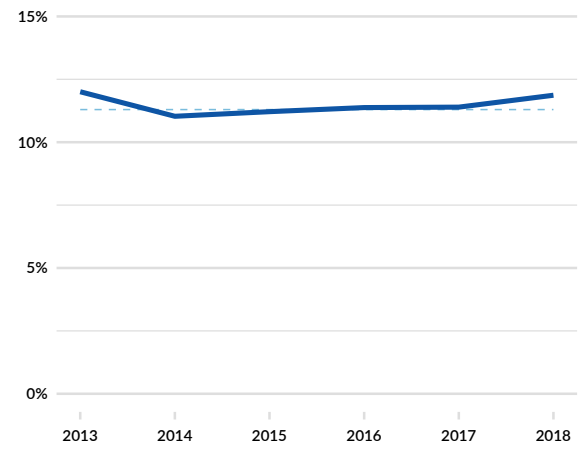
**Figure 7.6: Dual-Eligible Members' ED Utilization per 1,000 MM (↓ \$ ☼)**



**Figure 7.7: Dual-Eligible Members' Potentially Avoidable ED Visits per 1,000 MM (↓ ☼)**



**Figure 7.8: Dual-Eligible Members' 30-day Plan All-Cause Readmissions (↓ ☼)**



--- 2015-2016 mean  
 ↓ Lower is better  
 \$ CCO Incentive Measure  
 ☼ State Quality Measure

**Figure 7.9: Total Spending PMPM for Dual-Eligible Members (↓)**

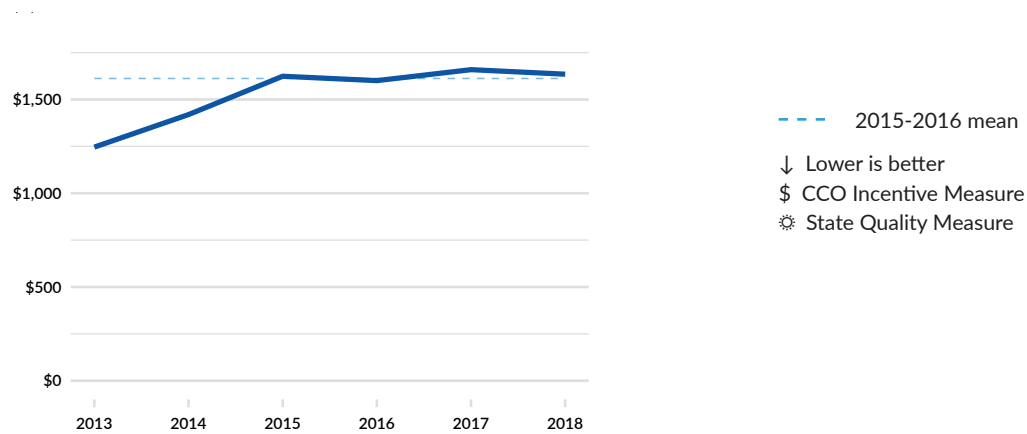


Table 7.1 summarizes changes from 2013 and 2016 baselines to 2018, adjusting for demographics and risk. The percentage of dual-eligible members accessing primary care and preventive-ambulatory services did not change meaningfully between 2016 and 2018. Outpatient visits for behavioral health care increased by 117 visits per 1,000 member months from 2016 to 2018. Avoidable ED visits declined slightly from 2016 to 2018, whereas the decline in overall ED utilization was not statistically significant. After adjusting for demographics and risk, the change in all-cause readmissions was not statistically significant. Total spending for dual-eligible members increased by \$37 PMPM between 2016 and 2018, representing an annualized growth rate of 1.2%.

**Table 7.1 Adjusted Change in Outcome Measures for Dual-Eligible Members, 2013-2018 and 2016-2018**

Measure		2016	2018	Adj. Change 2016-2018	Adj. Change 2013-2018
Adults' Access to Preventative-Ambulatory Services		0.9%	0.9%	-0.01	0.01
Potentially Avoidable ED Visits per 1,000 MM	↓ ☼	9.8	8.8	-0.8	0.4
ED Utilization per 1,000 MM	↓ \$ ☼	82.2	78.8	-1.2	15.6
Outpatient Visits for Behavioral Health Care per 1,000 MM		558.5	666.4	116.8	187.4
Outpatient Visits for Non-Behavioral Health Care per 1,000 MM		2828.4	3018.8	238.0	571.2
Members with Any Primary Care		0.9%	0.9%	-0.01	0.01
30-Day Plan All-Cause Readmissions	↓ ☼	0.1%	0.1%	0.004	-0.0003
Total Spending PMPM	↓	\$1,600.46	\$1,634.79	37.28	396.48

Significant worsening < from baseline 25% 10% 0% Significant improvement > from baseline 10% 25%

No significant change from baseline (p>0.05)

↓ Lower is better  
 \$ CCO Incentive Measure  
 ☼ State Quality Measure

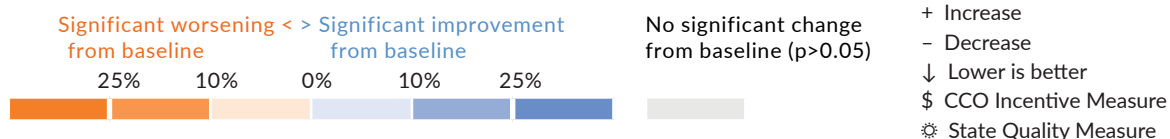
Table 7.2 displays changes from 2016 to 2018 separately for residents of urban, rural, and isolated areas. Outpatient visits increased for all subgroups, with outpatient behavioral health visits increasing more in urban and isolated areas. Access to primary care and preventive services declined slightly for dual-eligible members in rural and urban areas. Avoidable ED visits and ED utilization declined significantly for dual-eligible members in urban areas but were statistically unchanged in rural and isolated areas. Increases in PMPM spending were statistically significant only in isolated and rural areas, with relatively greater spending increases for dual-eligible members in isolated areas



**Table 7.2: Adjusted Change from 2016 to 2018 in Outcome Measures for Dual-Eligible Members, by Geography of Residence**

Measure	Geography of Residence		
	Rural	Urban	Isolated
Adults' Access to Preventative-Ambulatory Services	-	-	-
Potentially Avoidable ED Visits per 1,000 MM	↓ ☀	-	-
ED Utilization per 1,000 MM	↓ \$ ☀	-	+
Outpatient Visits for Behavioral Health Care per 1,000 MM	+	+	+
Outpatient Visits for Non-Behavioral Health Care per 1,000 MM	+	+	+
Members with Any Primary Care	-	-	-
30-Day Plan All-Cause Readmissions	↓ ☀	+	+
Total Spending PMPM	↓	+	+

*Note: Isolated areas were defined as population centers of less than 2,500 without commuting flow to urban areas.*



## Limitations

The results presented here should be considered in the context of several limitations. First, the analysis is based on a “pre-post” design, comparing changes before and after the waiver renewal. With this approach, we cannot separate changes that could be attributed to Oregon’s policies from secular changes occurring across the health care system. Furthermore, analyses that rely on a short pre- or post-period could be biased if those years are outlier years and not representative of general trends. Second, our analyses should be seen as an assessment of overall progress on providing high-quality, cost-effective, and person-centered care for dual-eligible members. We did not evaluate the merits of specific evidence-based practices or approaches that CCOs may have undertaken to improve care for dual-eligible members. Third, these results reflect data through 2018 and therefore do not capture the impact of dual-eligible members’ passive enrollment in CCOs, implemented in 2019, or new requirements for MA plan alignment under CCO 2.0. Fourth, we did not assess differences in outcomes between CCO-enrolled and FFS dual-eligible members, nor did we examine differences for CCO members enrolled in aligned versus non-aligned plans. Fifth, to calculate spending measures, we used imputed values for services subject to capitation arrangements (see

Appendix B for details). Our spending measure results can be considered a proxy measure of utilization rather than actual Medicare and Medicaid expenditures. Finally, in calculating the rate of enrollment of dual-eligible members in CCOs, we were unable to exclude members for whom Medicaid covers only Medicare premiums (“partial” dual-eligible members) or individuals participating in Oregon’s Program of All-Inclusive Care for the Elderly, who are not eligible for enrollment in a CCO.

## Conclusions

Changes in health care access, quality, and spending for dual-eligible members were mixed in the first two years of the waiver renewal. Outpatient visits increased, particularly for behavioral health, whereas access to primary and preventive care were relatively flat. Significant decreases in ED utilization and avoidable ED visits were limited to dual-eligible members residing in urban areas. Total spending increased somewhat between 2016 and 2018 for residents of isolated and rural areas. Overall, care for dual-eligible members did not seem to change substantially from 2016 to 2018. Future analyses should assess the impacts of passive enrollment in CCOs and new requirements for MA plan alignment under CCO 2.0.

# Recommendations

## Overview

This chapter presents recommendations and considerations for the duration of the 2017-2022 waiver and beyond. The recommendations are based on our assessment of performance and activities described in the preceding chapters, factoring in OHA's strategic goal of eliminating health inequities by 2030. Overall, there are signs of progress in the areas of oral health integration and health-related services. However, behavioral health integration is an area of concern. There is opportunity in all areas to better integrate health equity.

## Behavioral Health Integration

Our evaluation of Oregon's efforts in behavioral health integration – a cornerstone of the CCO model since 2012 – suggests considerable work may still be necessary to achieve the promise of integrated physical and behavioral health.

**Recommendation 1.** Provide a strategic plan for how behavioral health integration will be achieved and what milestones should serve as indicators for progress, especially for communities most impacted by health inequities. The evaluation team found it difficult to discern what activities or populations CCOs are expected to prioritize, how integration will be measured, or what the future state should look like.

**Recommendation 2.** Reconsider the way accountability for behavioral health is shared or assigned within and outside of OHA. The state should investigate where roles may be unclear and consider options for providing clarity. Oregon is undertaking a range of activities and laws that touch on behavioral health, including new legislation that could potentially transform substance use treatment, efforts to address the intersection of homelessness and mental health, a new 1115 SUD Waiver, and the need to address a growing number of civil commitments and "Aid and Assist" patients. It will be important to coordinate these activities to ensure that funds are deployed effectively and efficiently, that OHA staff and stakeholders outside of OHA have a clear understanding of these disparate activities, and that the efforts have the greatest potential for improving public health. The 2019 appointment of Steve Allen as the state's new Behavioral Health Director offers an opportunity to reduce ambiguity about who is responsible or empowered to facilitate change. The state should also consider the value of a behavioral health ombuds to collect input about where integration efforts are falling short.

**Recommendation 3.** Consider the needs of multiple populations and systems of care, particularly for communities most impacted by health inequities. The state's approach to behavioral health integration is broad and comprehensive. While this approach has merit, there may be benefits to more consideration of specific populations' needs. The needs of adults with behavioral health conditions may be substantially different than the needs of children with serious emotional disorders. Additionally, adults with serious mental illness may require specialty care. In contrast, adults with mild to moderate behavioral health issues may stand to gain the most from behavioral health integration at the primary care site. Optimal models of care might look considerably different in urban and rural areas. Furthermore, given the well documented impact of racism on health and the

existing racial and ethnic disparities in behavioral health services, OHA should consider efforts that specifically target the intersection of equity and behavioral health.<sup>31, 32, 33, 34, 35, 36, 37</sup>

## Oral Health Integration

**Recommendation 4.** Continue progress in oral health integration. The evaluation focused on changes in claims-based measures; it did not assess potential challenges in oral health care delivery which would not be captured by these measures. Overall, claims- and survey-based measures suggested that access to services and the quality of oral health care has improved. The state should continue to build on these apparent successes.

**Recommendation 5.** OHA is currently hiring for a new Dental Director. This transition to new leadership provides an opportunity to redouble efforts initiated through the 2016 Oral Health Roadmap process to strengthen communication and coordination across OHA on oral health, build a shared definition of oral health integration that aligns with the goal to end health inequities, define milestones for delivery system and financial integration, and organize the agency's activities strategically to achieve these milestones.

## Health-Related Services

**Recommendation 6.** Continue refining guidance on reporting of HRS expenditures to promote consistency across CCOs. Some of the differences in reported spending on HRS appear to be related to definitions instead of real differences in investments in HRS or SDOH.

**Recommendation 7.** Assess the balance between data needs and the administrative and financial burden associated with collecting and reporting HRS data. OHA will need data to evaluate impacts of HRS activities and verify that spending meets requirements under the waiver. However, these needs should be balanced against the increased administrative demands on CCOs and their contracted community partners, which may be disproportionately felt by communities most impacted by health inequities. Refining the guidance on HRS expenditures and promoting consistency across CCOs may be helpful here. Additional technical assistance may be another avenue for identifying opportunities to collect high quality data while limiting the reporting burden on CCOs.

**Recommendation 8.** Continue to develop the evidence base for HRS and investments in SDOH. The evidence for effective programs and investments in SDOH is still nascent and largely conceptual, particularly as it applies to the Medicaid population. An evidence summary by the Commonwealth Fund assessed 56 studies and rated only 14 of them as providing "strong" evidence,<sup>38</sup> with some positive and promising results in housing and nutrition. In contrast, a recent meta-analysis of 38 randomized trials of social policy interventions found that early life and income-based interventions held potential.<sup>39</sup> However, the study did not find positive effects associated with housing and neighborhood interventions. These studies suggest that evidence about which programs work – and when – is still at a formative stage. The effectiveness of interventions may be highly dependent on the population and the design of the intervention. Oregon can play an important role in providing robust, credible evidence, which will help shape programs within the state and beyond.

**Recommendation 9.** Identify areas where housing capacity or community resources restrict CCOs' ability to affect SDOH. Oregon's MAC identified housing-related services and supports as a top priority for CCOs and HRS spending. However, in some areas, housing shortages and the lack of affordable options may create significant challenges in helping enrollees obtain stable housing. OHA should assess opportunities to address houselessness broadly – including opportunities to weave or

braided funding from multiple sources to create larger systems-based approaches. Finally, the goals of improved health and reductions in homelessness may be incompatible with regulations and norms that restrict the supply of housing. OHA should assess whether HRS spending is the most effective way to address these issues, or whether, for example, it may be more effective to address policies outside of health care (e.g., zoning) or cultural norms (e.g., preferences for historical neighborhood attributes and concerns for property values).

## Health Equity

**Recommendation 10.** In addition to “health equity,” state rules and guidance documents use equity-related terms such as “social determinants of equity” (SDOE), and “social determinants of health and equity” (SDOH-E). Each of these has a different application and definition, but the nuances may be lost to a larger audience. Further separation and articulation of the meaning of these terms would reduce the risk of confusion and conflation of priorities.

**Recommendation 11.** Health equity has been identified by OHA leadership as a clear priority, adopting a 10-year goal to eliminate health inequities by 2030. This requires engagement with communities most impacted by health inequities to prioritize initiatives and interventions. Current data systems limit the state’s ability to achieve this, due to a lack of information on race and ethnicity. OHA should continue to support CCOs in collecting REALD data and ensure that resources are available to manage and maintain these data. In addition, to track progress, OHA should monitor and report on the percentage of members for whom REALD data are collected.

## Dual-Eligible Members

**Recommendation 12.** The waiver renewal aims to simplify coverage and choices for beneficiaries who are dually eligible for Medicare and Medicaid through passive enrollment in CCOs, with the option to opt-out and return to the state’s FFS program at any point in time. The waiver evaluation is intended to assess the impacts of these changes on the dually eligible population. However, the most recent data available for this interim evaluation covered 2018, and we were therefore unable to assess effects of the transition to passive enrollment, which occurred in 2019. Future evaluation work should assess changes associated with the introduction of this policy.

**Recommendation 13.** CCO 2.0 introduced new requirements intended to increase enrollment of dual-eligible members in MA plans provided by (or affiliated with) their CCO. Research suggests that such “alignment” of Medicare and Medicaid plans may contribute to improved outcomes. To assess whether this occurs and inform future policy development, OHA should consider monitoring rates of enrollment of dual-eligible members in aligned plans over time and tracking outcomes for dual-eligible members enrolled in aligned versus non-aligned plans.

# Measure Definitions

## Behavioral Health Integration

### H1.1: Coordination of care for CCO members with behavioral health diagnoses will improve

#### **ED Utilization per 1,000 MM for Members with Behavioral Health Conditions**

Formal Name: Ambulatory Care: ED Utilization per 1,000 MM for Members with SPMI and SUD  
 Description: Number of emergency department visits by members with severe and persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions), reported per 1,000 member months  
 Source: Medicaid Claims  
 Steward: NCQA (HEDIS 2016)

#### **Potentially Avoidable ED Visits per 1,000 MM for Members with Behavioral Health Conditions**

Description: Number of emergency department visits with a diagnosis indicating they were preventable or treatable with appropriate primary care, for members with severe persistent mental illness and/or substance use disorder diagnoses, reported per 1,000 member months; reported separately for members age 1 to 17 and 18 and over  
 Source: Medicaid Claims  
 Steward: Medi-Cal

#### **Glucose Testing for People Using 2nd Gen. Antipsychotic Medications**

Formal Name: Glucose Testing for People Using Second Generation Antipsychotic Medications  
 Description: Percentage of members age 18 to 64 with a filled prescription for second-generation antipsychotic medication in the prior year who had at least one HbA1c test performed within 180 days of last prescription fill  
 Source: Medicaid Claims  
 Steward: CHSE (based on a measure developed by RAND Corporation for the Veterans Administration)

#### **Lipid Testing for People Using 2nd Gen. Antipsychotic Medications**

Formal Name: Lipid Testing for People Using Second Generation Antipsychotic Medications  
 Description: Percentage of members age 18 to 64 with a filled prescription for second-generation antipsychotic medication in the prior year who had at least one LDL-C screening performed within 180 days of last prescription fill  
 Source: Medicaid Claims  
 Steward: CHSE (based on a measure developed by RAND Corporation for the Veterans Administration)

#### **30-Day Follow-Up after Hospitalization for Mental Illness**

Description: Percentage of discharges from a hospital after a member was hospitalized for mental illness in which the member received follow-up from a health care provider within 30 days of discharge  
 Source: Medicaid Claims  
 Steward: NCQA (HEDIS 2016)

## **H1.2: Ability to identify and refer members to substance abuse interventions will improve over time**

### **Engagement of AOD Dependence Treatment, 13-64 years**

Formal Name: Engagement of Alcohol or Other Drug Dependence Treatment, 13-64 years

Description: Percentage of members age 13 and over diagnosed with alcohol or drug dependence who started treatment, and who received at least two services for alcohol or other drug abuse within 30 days of starting treatment

Source: Medicaid Claims

Steward: NCQA (HEDIS 2016)

### **Initiation of AOD Dependence Treatment, 13-64 years**

Formal Name: Initiation of Alcohol or Other Drug Dependence Treatment, 13-64 years

Description: Percentage of members age 13 and over diagnosed with alcohol or drug dependence who started treatment within 14 days of the diagnosis

Source: Medicaid Claims

Steward: NCQA (HEDIS 2016)

### **Screening, Brief Intervention, and Referral to Treatment**

Description:

Rate 1: Percentage of members 12 years and older who received an age-appropriate screening for alcohol or other substance abuse

Rate 2: Percentage of members who screened positive for alcohol or other substance abuse and received a brief intervention or referral to treatment.

Source: CHSE used a summarized data extract from OHA to calculate this measure

Steward: OHA (2014)

### **Percentage of Members with SUD**

Description: Percentage of members with 2 or more substance use disorder claims in a 2 year period, based on the NCQA HEDIS definition of AOD dependence. AOD includes abuse of alcohol, opioids, cannabis, cocaine, amphetamines, hallucinogens, anti-depressant drugs, or a sedative-, hypnotic- or anxiolytic-related disorder, or the onset of delirium tremens.

Source: Medicaid Claims

Steward: CHSE

## **H1.3: Integration of behavioral health services will improve access for CCO members with severe mental illness**

### **Outpatient Visits for Behavioral Health Care per 1,000 MM**

Description: Number of outpatient visits for behavioral health care, reported per 1,000 member months among members with severe and persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions)

Source: Medicaid Claims

Steward: CHSE

### **Outpatient Visits for Non-Behavioral Health Care per 1,000 MM**

Description: Number of outpatient visits for non-behavioral health care, reported per 1,000 member months among members with severe and persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions)

Source: Medicaid Claims

Steward: CHSE

**Members with Any Primary Care for Members with Behavioral Health Conditions**

Formal Name: Members with Any Primary Care for Members with SPMI and SUD

Description: Percentage of members with severe persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions), who received any primary care during the measurement year

Source: Medicaid Claims

Steward: CHSE

**Adults' Access to Preventive-Ambulatory Services for Members with Behavioral Health Conditions**

Formal Name: Adults' Access to Preventive-Ambulatory Services for Members with SPMI and SUD

Description: Percentage of adults with severe persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions) who had an outpatient or preventive care visit in the measurement year; reported separately for adults age 20-44 and 45-64, and 65 and over

Source: Medicaid Claims

Steward: NCQA (HEDIS 2016)

**H1.4: Integration of behavioral health services with physical health services will be associated with reduced growth of total spending and spending in high-cost settings (e.g., ED and inpatient), and with sustained or increased spending on primary or preventive care, for CCO members with behavioral health diagnoses**

**Primary Care Spending PMPM for Members with Behavioral Health Conditions**

Formal Name: Primary Care Spending Per Member, Per Month for Members with SPMI and SUD

Description: Total spending on primary care services (excluding behavioral health services) for members with severe persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions), divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

**ED Spending PMPM for Members with Behavioral Health Conditions**

Formal Name: Emergency Department Spending Per Member, Per Month for Members with SPMI and SUD

Description: Total spending on emergency department services (excluding behavioral health services) for members with severe persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions), divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

**Inpatient Facility Spending PMPM for Members with Behavioral Health Conditions**

Formal Name: Inpatient Facility Spending Per Member, Per Month for Members with SPMI and SUD

Description: Total inpatient facility spending (excluding behavioral health services) for members with severe persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions), divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE



**Inpatient Professional Spending PMPM for Members with Behavioral Health Conditions**

Formal Name: Inpatient Professional Spending Per Member, Per Month for Members with SPMI and SUD

Description: Total inpatient professional spending (excluding behavioral health services) for members with severe persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions), divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

**Total Spending PMPM for Members with Behavioral Health Conditions**

Formal Name: Total Spending Per Member, Per Month (CHSE) for Members with SPMI and SUD

Definition: Total spending on emergency department, primary care, prescription drug, inpatient, behavioral health, and other outpatient spending for members with severe persistent mental illness and/or substance use disorder diagnoses (see Appendix B for definitions), divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

**Oral Health Integration****H2.1: Emergency dental visits for non-traumatic dental reasons will reduce over time for CCO enrollees****ED Visits for Traumatic Dental Conditions per 1,000 Members**

Description: Number of ED visits in a calendar year, reported per 1,000 members, with the following discharge diagnosis codes: 52511, 8300-1, 8481, 87343-4, 87349-54, 87359-65, 87369-75, 87379, K062, K08419, S030XXA, S01409A, S034XXA, S01501A, S01409A, S0180XA, S0993XA, S01429A, S0182XA, AS01521A, S01422A, S0182XA, S01502A, S01512A, S025XXA, S025XXB, S01512A, S01522A. These codes were drawn from the Association of State & Territorial Dental Directors Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments

Source: Medicaid Claims

Steward: CHSE

**ED Visits for Non-Traumatic Dental Conditions per 1,000 Members**

Description: Number of ED visits in a calendar year, reported per 1,000 members, with the following discharge diagnosis codes: 5200-9, 52100-25, 52130-5, 52140-2, 52149, 5215-29, 52300-1, 52310-1, 52320-5, 52330-3, 52340-2, 5235-6, 5238-9, 52400-12, 52419-39, 5244, 52450-76, 52479, 52481-2, 52489, 5249-50, 52510, 52512-13, 52519-26, 5253, 52540-44, 52550-54, 52560-67, 52569, 52571-73, 52579, 5258-65, 52661-3, 52669, 52681, 52689, 5269-79, 52800-2, 52809, 5281-6, 52871-2, 52879, 5288-96, 5298-99 78492, 7924, V523, V534, V585, V722-3, A690, K000-11, K023, K0251, K0261-3, K027, K029-37, K0381, K0389, K039-48, K0490, K0499-501, K0510-11, K0520-22, K0530-2, K0540, K055-6, K060-1, K080, K08101-4, K08109, K0820-26, K083, K08401-4, K08409, K08429, K08439, K08499, K0850-2, K08530-1, K0854-5, K0856, K0859, K088-91, K098, K110-1, K1120, K113-22, K1230-2, K1233, K1239, K130, K1321-2, K1323, K1329, K135, K1370, K1379, K140-6, K148-9, M2600-12, M2619-20, M26211-13, M26220-25, M2629-37, M2639, M264, M2650-7, M2659-63, M2669-74, M2679, M2681-2, M2689, M269, M271-3, M2749, M2751-3, M2759, M2761-3, M2769, M278-9, R682, R6884, R859, Z0120-1, Z463, Z464. These codes were drawn from the Association of State & Territorial Dental

Directors Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments

Source: Medicaid Claims

Steward: CHSE

Note: Results for this measure are not directly comparable to those reported in CHSE's 2016 report on Oregon's dental integration. We used different criteria for continuous enrollment to determine members' inclusion in the measure and a different, less restrictive approach for identifying eligible ED visits.

## **H2.2: Access to oral health services and dental care will improve for CCO enrollees**

### **Percentage of Members with at Least One Visit for Any Dental Procedure**

Definition: Percentage of members who had a visit for any procedure with a procedure code from D0100 to D0999 or an ED visit for a traumatic or non-traumatic dental procedure identified using codes drawn from the Association of State & Territorial Dental Directors Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments

Source: Medicaid Claims

Steward: CHSE

### **Percentage of Members with at Least One Visit for Core Dental Procedures**

Definition: Percentage of members who had a visit for any of the following common dental procedures - "D0120" Periodic oral exam, "D0150" Comprehensive oral exam, "D0210" Complete X-rays, "D0272" Bitewing X-rays, "D0330" Panoramic X-rays, "D1120" Child prophylaxis, "D1203" Application of topical fluoride, "D2331" Anterior tooth resin, "D2150" Permanent tooth amalgam, "D2751" Porcelain crown, "D2930" Prefabricated steel crown, "D3220" Therapeutic pulpotomy, "D3310" Root canal, "D7110" Extraction

Source: Medicaid Claims

Steward: CHSE

### **Number of Visits for Any Dental Procedure per 1,000 Members**

Definition: Number of visits in a calendar year, reported per 1,000 members, with a procedure code from D0100 to D0999 or an ED visit for a traumatic or non-traumatic dental procedure identified using codes drawn from the Association of State & Territorial Dental Directors Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments

Source: Medicaid Claims

Steward: CHSE

### **Number of Visits for Core Dental Procedures per 1,000 Members**

Definition: Number of visits in a calendar year, reported per 1,000 members, for any of the following common dental procedures - "D0120" Periodic oral exam, "D0150" Comprehensive oral exam, "D0210" Complete X-rays, "D0272" Bitewing X-rays, "D0330" Panoramic X-rays, "D1120" Child prophylaxis, "D1203" Application of topical fluoride, "D2331" Anterior tooth resin, "D2150" Permanent tooth amalgam, "D2751" Porcelain crown, "D2930" Prefabricated steel crown, "D3220" Therapeutic pulpotomy, "D3310" Root canal, "D7110" Extraction

Source: Medicaid Claims

Steward: CHSE

### **Dental Sealants on Permanent Molars for Children**

Definition: Percentage of children age 6-14 who received a sealant on a permanent molar in the measurement year

Source: Medicaid Claims

Steward: OHA, 2016

**Percentage of Members with a Regular Dentist**

Definition: Percentage of members who said they had a regular dentist they would go to for checkups and cleanings or when they have cavity or tooth pain

Source: CHSE used a summarized CAHPS Survey data extract from OHA to calculate this measure

Steward: CAHPS Health Plan

**H2.3: Integration and coordination of oral health with other health services will improve for CCO enrollees****Assessments within 60 Days for Children in DHS Custody**

Definition: Percentage of members aged zero to 17 years in custody of the Oregon Department of Human Services who received required physical, mental, and dental assessments

Source: Medicaid Claims

Steward: OHA, 2019

**Percentage of Members with at Least One Visit for Any Dental Procedure for Members with a Chronic Condition**

Definition: Percentage of members with a chronic condition diagnosis (see Appendix B for definition) who had a visit for any procedure with a procedure code from D0100 to D0999 or an ED visit for a traumatic or non-traumatic dental procedure identified using codes drawn from the Association of State & Territorial Dental Directors Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments

Source: Medicaid Claims

Steward: CHSE

**Percentage of Members with at Least One Visit for Core Dental Procedures for Members with a Chronic Condition**

Definition: Percentage of members with a chronic condition diagnosis (see Appendix B for definition) who had a visit for any of the following common dental procedures - "D0120" Periodic oral exam, "D0150" Comprehensive oral exam, "D0210" Complete X-rays, "D0272" Bitewing X-rays, "D0330" Panoramic X-rays, "D1120" Child prophylaxis, "D1203" Application of topical fluoride, "D2331" Anterior tooth resin, "D2150" Permanent tooth amalgam, "D2751" Porcelain crown, "D2930" Prefabricated steel crown, D3220" Therapeutic pulpotomy, "D3310" Root canal, "D7110" Extraction

Source: Medicaid Claims

Steward: CHSE

**H2.4: Integration of oral health services with physical health services will be associated with reduced growth of spending on oral health services in high-cost settings (e.g., ED) and sustained or increased spending on preventive oral health services****Spending on ED Visits for Dental Conditions PMPM**

Formal Name: Spending on ED Visits for Dental Conditions Per Member, Per Month

Definition: Sum of spending, divided by months of enrollment, for ED visits for either traumatic or non-traumatic dental conditions identified using codes drawn from the Association of State & Territorial Dental Directors Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments

Source: Medicaid Claims

Steward: CHSE

**Spending on Dental Services Excluding ED Visits for Dental Conditions PMPM**

Formal Name: Spending on Dental Services Excluding ED Visits for Dental Conditions Per Member, Per Month

Definition: Sum of spending, divided by months of enrollment, for dental services in a calendar year (identified using procedure codes from D0100 to D0999) excluding ED visits for traumatic or non-traumatic dental conditions identified using codes drawn from the Association of State & Territorial Dental Directors Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments

Source: Medicaid Claims

Steward: CHSE

**Health-Related Services****H3.2 Enrollees receiving HRS will report satisfaction with those services and better patient experience overall****Members with Any Primary Care**

Description: Percentage of members who received any primary care during the measurement year. CPT codes are used to identify primary care provider visits, based on an algorithm from Chang et al (see <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3108147/>).

Source: Medicaid Claims

Steward: CHSE

Note: Results for this measure are not directly comparable to data presented in OHA's Primary Care in Oregon report, due to different definitions and methodologies used.

**Getting Care Quickly**

Description: Average of two percentages: Percentage of members who said they usually or always got care for illness or injury as soon as needed; and percentage of members who said they usually or always got non-urgent/routine care appointments as soon as needed within the last six months

Source: CHSE used a summarized CAHPS Survey data extract from OHA to calculate this measure

Steward: CAHPS Health Plan

**Getting Needed Care**

Description: Average of two percentages: Percentage of members who said it was usually or always easy to get needed care, tests, or treatments; and percentage of members who said it was usually or always easy to get appointments with specialists as soon as needed within the last six months

Source: CHSE used a summarized CAHPS Survey data extract from OHA to calculate this measure

Steward: CAHPS Health Plan

**Rating of All Health Care**

Description: Percentage of members who rated all their health care in the last six months an 8, 9, or 10 on a scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible

Source: CHSE used a summarized CAHPS Survey data extract from OHA to calculate this measure

Steward: CAHPS Health Plan

### **H3.3 Use of HRS will be associated with reduced utilization of more intensive or higher-cost care**

#### **ED Utilization per 1,000 MM**

Formal Name: Ambulatory Care: ED Utilization per 1,000 MM

Description: Number of emergency department visits by members, reported per 1,000 member months

Source: Medicaid Claims

Steward: NCQA (HEDIS 2016)

### **H3.4 Use of HRS will help address social determinants of health to improve individual and population health outcomes**

#### **Member Rating of Health Status**

Description: Percentage of members who rated their overall health as good, very good, or excellent

Source: CHSE used a summarized CAHPS Survey data extract from OHA to calculate this measure

Steward: CAHPS Health Plan

### **H3.5 Use of HRS will be associated with reduced growth of total spending and spending in high cost settings (e.g., ED and inpatient) and with sustained or increased spending on primary or preventive care**

#### **Total Spending PMPM**

Formal Name: Total Spending Per Member, Per Month

Definition: Total spending on emergency department, primary care, prescription drug, inpatient, behavioral health, and other outpatient spending, divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

#### **ED Spending PMPM**

Formal Name: ED Spending Per Member, Per Month

Description: Total spending on emergency department services (excluding behavioral health services), divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

#### **Inpatient Spending PMPM**

Formal Name: Inpatient Spending Per Member, Per Month

Description: Total inpatient spending (facility and professional, excluding behavioral health services), divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

#### **Primary Care Spending PMPM**

Formal Name: Primary Care Spending Per Member, Per Month

Description: Total spending on primary care services (excluding behavioral health services) for members, divided by months of enrollment

Source: Medicaid Claims

Steward: CHSE

Note: Results for this measure may not match the values in OHA's Primary Care Spending in Oregon report, due to differences in definitions and methodologies used.

## Dual-Eligible Members

### H4.1: The proportion of dual-eligible members enrolled in a CCO will increase compared with past demonstration levels without loss of member satisfaction

#### **Percentage of Oregon Dual-Eligible Members Enrolled in CCOs**

Description: Percentage of members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition) who were enrolled in a CCO at any time during the measurement year

Source: APAC and Medicaid Claims

Steward: CHSE

Note: These numbers are not directly comparable to OHA's reporting of CCO enrollment rates for dual-eligible members, because our data did not allow us to exclude non-FBDE members (who are not eligible for CCO enrollment).

### H4.2: CCO enrollment will encourage appropriate use of clinical resources and ancillary care for dual-eligible members

#### **Members with Any Primary Care (Dual-Eligible Population)**

Description: Percentage of members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition), who received any primary care during the measurement year

Source: APAC and Medicaid Claims

Steward: CHSE

#### **Adults' Access to Preventive-Ambulatory Services (Dual-Eligible Population)**

Description: Percentage of adults who were dually eligible for Medicare and Medicaid services (see Appendix B for definition), who had an outpatient or preventive care visit in the measurement year

Source: APAC and Medicaid Claims

Steward: NCQA (HEDIS 2016)

#### **Outpatient Visits for Behavioral Health Care per 1,000 MM (Dual-Eligible Population)**

Description: Number of outpatient visits for behavioral health care by members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition), reported per 1,000 member months

Source: APAC and Medicaid Claims

Steward: CHSE

#### **Outpatient Visits for Non-Behavioral Health Care per 1,000 MM (Dual-Eligible Population)**

Description: Number of outpatient visits for non-behavioral health care by members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition), reported per 1,000 member months

Source: Medicaid Claims

Source: APAC and Medicaid Claims

Steward: CHSE

**ED Utilization per 1,000 MM**

Formal Name: Ambulatory Care: ED Utilization per 1,000 MM (Dual-Eligible Population)

Description: Number of emergency department visits by members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition), reported per 1,000 member months

Source: APAC and Medicaid Claims

Steward: NCQA (HEDIS 2016)

**Potentially Avoidable ED Visits (Dual-Eligible Population)**

Description: Number of emergency department visits with a diagnosis indicating they were preventable or treatable with appropriate primary care, for members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition), reported per 1,000 member months

Source: APAC and Medicaid Claims

Steward: Medi-Cal

**30-day Plan All-Cause Readmissions (Dual-Eligible Population)**

Description: Number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition)

Source: APAC and Medicaid Claims

Steward: NCQA (HEDIS 2016)

**Total Spending PMPM**

Formal Name: Total Spending Per Member, Per Month (Dual-Eligible Population)

Description: Total spending for members for members who were dually eligible for Medicare and Medicaid services (see Appendix B for definition), divided by months of enrollment

Source: APAC and Medicaid Claims

Steward: CHSE

# Quantitative Methods

## Overview

This appendix provides details on quantitative methods used throughout this report. The first section describes methods used to analyze claims- and survey-based outcome measures, including data sources, definition of study populations, specification of statistical models, and calculation of spending measures. The second section provides additional information on the analysis of HRS spending data presented in Chapter 6.

## Analysis of Outcome Measures

### Data

We relied on the following data sources to calculate outcome measures for the evaluation:

- Medicaid claims/encounters and enrollment records from OHA's HSD.
- Medicare claims/encounters and enrollment records from OHA's APAC database.
- CAHPS survey responses from the Medicaid CAHPS survey administered by OHA.
- Specialized data extracts from OHA.

We used data spanning the years 2011-2019 for most claims-based measures. In addition to Medicaid data, we used Medicare claims and enrollment records from the APAC database to calculate measures for dual-eligible members. We obtained APAC data for the years 2011 through 2018. However, data validation suggested that Medicare Advantage enrollment records prior to 2013 were incomplete, and we therefore did not include 2011-2012 in our analyses. Two evaluation measures (Screening, Brief Intervention, and Referral to Treatment and Assessments within 60 Days for Children in ODHS Custody) required data not available in Oregon's Medicaid Management Information System (MMIS). We therefore obtained separate data extracts from OHA to calculate these measures. For CAHPS-based measures and Assessments within 60 days for Children in ODHS Custody, we used data spanning the years 2014-2019 due to lack of data for prior years. Screening, Brief Intervention, and Referral to Treatment was only analyzed for 2019, because this was the first year of EHR-based (as opposed to claims-based) data collection. As such, prior years were not directly comparable.

### Study Populations

We used the following definitions to identify CCO-enrolled non-dual-eligible members and dual-eligible members, respectively, for inclusion in the analyses:

**CCO-enrolled non dual-eligible members.** Analyses of measures for evaluation questions 1 (behavioral health integration), 2 (oral health integration), and 3 (health-related services) included all members enrolled in a CCO at least three months in the year who were not dual-eligible members. (See below for the definition of dual-eligible members.) For 2011, we included members enrolled in an MCO. For analysis of measures based on CAHPS survey responses, we attempted to exclude data for dual-eligible members by excluding all responses from members age 65 and older. (CAHPS responses did not include information needed to directly identify dual-



eligible members.) Additionally, we excluded CAHPS responses for which the CCO name was “Fee-for-Service.”

**Dual-eligible members.** Analyses of measures for evaluation question 4 included all dual-eligible members enrolled in OHP (including FFS enrollees) and in Medicare FFS or Medicare Advantage for at least three months in the year.

### Measure-specific subpopulations

For behavioral health integration measures, we defined a subpopulation of the non-dual-eligible, CCO-enrolled population as members with SPMI or SUD. We refer to this subpopulation as “members with behavioral health conditions.”

Members were identified as having SPMI if they met one of the following criteria in a calendar year:

1. Any health care claim during the year for inpatient hospitalization, partial hospitalization in a psychiatric facility, or psychiatric residential care with a diagnosis listed in Exhibit B.1.
2. Two or more health care claims, on separate dates within the year, with a diagnosis listed in Exhibit B.1.

#### Exhibit B.1: Diagnosis Codes Used to Identify People with SPMI

Diagnosis	ICD-9 Codes	ICD-10 Codes
Schizophrenia and other psychotic disorders	295.XX, 297.3, 298.8, 298.9	F20, F23, F24, F25, F28, F29
Major depression and bipolar disorders	296.XX	F30, F31, F32, F33, F34.8, F34.9, F39
Schizotypal and borderline personality disorders	301.22, 301.83	F21, F60.3
Post-traumatic stress disorder	309.81	F43.10, F43.11, F43.12
Obsessive compulsive disorder	300.3	F42

This definition of SPMI was developed internally at CHSE in collaboration with a physician researcher at OHSU. Codes were selected for clinical relevance using definitions from the Washington State Medicaid Transformation Project and the Kansas Department of Aging and Disability.

Members were identified as having SUD if they had two or more claims in the preceding two years with a SUD diagnosis (see Exhibit B.2). Diagnosis codes for identifying alcohol/opioid/other drug use disorders were taken from the Healthcare Effectiveness Data and Information Set (HEDIS) AOD Dependence Value Set. This definition includes alcohol, opioid, cannabis, sedative, hypnotic, anxiolytic, cocaine, stimulant, hallucinogen, inhalant, and psychoactive substance abuse and dependence.

**Exhibit B.2: Diagnosis Codes Used to Identify People with SUD**

Diagnosis	ICD-9 Codes	ICD-10 Codes
Alcohol Abuse and Dependence	291, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.89, 291.9, 303.00–303.03, 303.90–303.93, 305.00–305.03, 535.30, 535.31, 571.1	F10
Opioid Abuse and Dependence	304.00–304.03, 304.70–304.73, 305.50–305.53	F11
Cannabis Abuse and Dependence	304.30–304.33, 305.20–305.23	F12
Sedative, Hypnotic, or Anxiolytic Abuse or Dependence	304.10–304.13, 305.40–305.43	F13
Cocaine Abuse and Dependence	304.20–304.23, 305.60–305.63	F14
Other Stimulant Abuse and Dependence	304.40–304.43, 305.70–305.73	F15
Hallucinogen Abuse and Dependence	304.50–304.53, 305.30–305.33	F16
Other Drug Abuse and Dependence	304.60–304.63, 304.80–304.83, 304.90–304.93, 305.80–305.83, 305.90–305.92	F18, F19

For evaluation question 2 (oral health integration), we also defined persons with a chronic physical health condition. We defined chronic physical health conditions broadly, using Chronic Illness and Disability Payment System (CDPS) risk adjusters as well as markers from the CMS Chronic Conditions Data Warehouse.<sup>40</sup> Chronic conditions included acquired hypothyroidism; acute myocardial infarction; Alzheimer’s disease; anemia; asthma; atrial fibrillation; benign prostatic hyperplasia; cataracts; chronic kidney disease; chronic obstructive pulmonary disease; cystic fibrosis; diabetes; epilepsy; glaucoma; heart failure; HIV/AIDS; hip or pelvic fracture; hyperlipidemia; hypertension; hypothyroidism; ischemic heart disease; kidney disease; liver disease; multiple sclerosis; muscular dystrophy; osteoporosis; rheumatoid arthritis; stroke; and a variety of cancers (breast, colorectal, lung, prostate, leukemia, and endometrial). Behavioral health conditions including psychiatric and substance use indicators were excluded from our definition of chronic physical health conditions.

### Subgroups

We further stratified analyses for subgroups based on age group, gender (using the binary classification available in Medicaid enrollment data), geography of residence (urban, rural, isolated), disability (disabled, not disabled), and the presence of chronic health conditions. Exhibit B.3 provides definitions for each subgroup. For measures associated with evaluation question 4 (dual-eligible members), we stratified by geography of residence only. Due to limited demographic information in the CAHPS data, we did not report subgroup results by geography of residence, disability status, or chronic condition status for CAHPS-based outcomes.

**Exhibit B.3: Subgroup Definitions**

Criteria	Subgroups	Definition
Age group	<18	Age as indicated in Medicaid enrollment records (for claims-based measures) or self-reported age (for CAHPS-based measures)
	18-34	
	35-64	
Gender	Female	Gender (binary classification) as indicated in Medicaid enrollment records
	Male	
Geography of residence	Isolated	Resided in an area without a population center of 2,500 or more, with no commuting flows to an urban area
	Rural	Resided in an area with a population center of 2,500 to 49,000, or connected to such an area through commuting patterns
	Urban	Resided in an area with a population center of 50,000 or more, or connected to such an area through commuting patterns
Other characteristics	Disabled	Eligible for Medicaid based on blindness or another disability
	Chronic condition	Presence of chronic physical health condition based on markers from CDPS and the Chronic Conditions Data Warehouse.

**Focus populations**

Additionally, for measures assessing behavioral and oral health integration, we examined outcomes for populations of focus, defined in the evaluation design as “groups that have historically experienced disproportionately poor health outcomes, or that have been identified by Oregon’s leadership as appropriate populations on which to focus the state’s health improvement efforts.”<sup>41</sup> In consultation with OHA (and considering the lack of data on race and ethnicity), we selected two focus populations:

- Children, defined as individuals under the age of 18.
- Individuals with limited English language proficiency, defined as persons from a household where the main language spoken is not English, based on HSD enrollment data.

We compared outcomes for each focus population to a “reference” population, representing a “group that has historically experienced favorable health outcomes relative to other groups with respect to the particular outcome or issue under examination.”<sup>42</sup> We used adults and members of English-speaking households, respectively, as reference groups for the selected focus populations. For behavioral health measures, we did not analyze outcomes for children versus adults, as many of these measures apply mostly, or entirely, to the adult population.

## Statistical Models

We used two analytic approaches to reflect different aspects of progress.

### Pre-post

Our main analysis assessed changes from two baseline points, 2011 (prior to the CCO transition) and 2016 (prior to the waiver renewal), comparing changes from those years to 2019. In these analyses, we estimated the following equation:

$$Y_{it} = m(b_0 + b_1 * \text{Year2019}_t + a * X_{it} + e_{it}) \quad (1)$$

where  $Y_{it}$  is the outcome of interest for individual  $i$  in year  $t$ ,  $\text{Year2019} = 1$  if the observation occurred in the Year 2019 and 0 otherwise,  $X_{it}$  is a vector of demographic covariates and risk adjusters, and  $e_{it}$  is a random error term associated with the unmeasured variation in the outcome of interest. We ran this regression twice: once using data from 2011 and 2019, and once using data from 2016 and 2019.

We use the following individual level covariates: age-range (<18, 18-34, 35-64, and 65+); gender (female, male); urban residence based on zip code; CDPS risk indicators; and an indicator for individuals newly enrolled as part of the 2014 Medicaid expansion. We clustered standard errors at the level of the Primary Care Service Area.<sup>43</sup>

To obtain results for subgroups, we estimated model (1) separately for each subgroup.

### Difference-in-differences

For selected populations, we compared changes in a focus population to a reference population, as defined above. These analyses were intended to provide insights as to whether focus population outcomes improved more or less relative to the reference population. We estimated the following equation:

$$Y_{it} = m(b_0 + b_1 * \text{Year2019}_t + b_2 * \text{Focus}_i + b_3 * \text{Year2019}_t * \text{Focus}_i + a * X_{it} + e_{it}) \quad (2)$$

where  $\text{Focus}_i$  takes a value of 1 if the individual is part of the relevant focus population. The coefficient  $b_3$  measures the “difference-in-differences,” or the difference between the 2016-2019 change in the focus population and the 2016-2019 change in the reference population. For measures where higher values represent an improvement, a positive, statistically significant value for this coefficient indicates that improvement from 2016 to 2019 was greater in the focus population compared to the reference population. (For measures where lower values represent an improvement, a negative, statistically significant value indicates an improvement over time for the focus population relative to the reference population.)

### Spending Measures

Our spending measures used imputed prices for claims where the “amount allowed” was zero due to capitation or other payment arrangements. For these claims, we did not have detailed information on actual amounts paid to providers. Through imputation, we attached the same “price” to similar services, disregarding any differences in actual amounts paid across CCOs. The spending measures, which sum across these repriced claims, can thus be considered “price-weighted volume-of-care” measures. Expenditures are higher with greater utilization of services, or with services that, on average, cost more. However, these measures do not capture differences in reimbursement rates that may exist among CCOs.

To address medical encounter claims where the “amount allowed” was listed as zero, we imputed spending by taking the annual mean value for non-zero payments across six categories of spending: inpatient, emergency department, outpatient, professional, pharmacy, and other. We further calculated mean values separately for each Current Procedural Terminology (CPT) code or Diagnosis Related Group (DRG). Dental encounter claim spending where the “amount allowed” was entered as zero was imputed using the annual mean value by CPT. Pharmacy claim spending was imputed using the annual mean value by National Drug Code (NDC). We used the same methodology to impute Medicare Advantage claims to calculate spending for dual-eligible members. Following imputation, we checked for duplication between Medicare and Medicaid medical claims based on Member ID, visit dates, diagnosis codes, and DRG/CPT codes. Where duplicates were identified, the Medicaid claim was dropped.

Spending data were further adjusted for inflation using the Consumer Price Index (CPI) to represent 2019 dollars.<sup>44</sup> To reduce the sensitivity of health expenditure data to rare conditions, we limited the covariates in these analyses to age, gender, urban versus rural residence, language, and presence of any chronic condition. We also top-coded outlier individuals at the 99th percentile (e.g., spending for individuals above the 99th percentile for a given measure and year was censored at the 99th percentile).

## Analysis of HRS Spending from Exhibit L

We collected HRS spending data from CCOs' Exhibit L financial reports for the years 2014 through 2019. These reports, submitted to OHA annually, contain member services expenses broken out by type—including HRS—as well as member months (except for 2014 and 2015, for which member months were gathered from OHA enrollment reports).<sup>45</sup> Exhibit L data may not provide a complete picture of a CCO's spending on HRS in a given year and may not be directly comparable across years. We describe these limitations below and outline the adjustments we made to account for missing and inconsistent entries.

### Limitations of the HRS Data

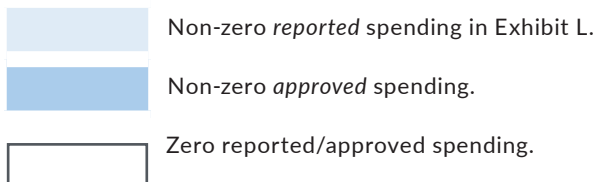
Not all CCOs reported HRS spending prior to 2019. CCO stakeholders confirmed that there were years where they did make HRS expenditures but did not report them to the state. Exhibit B.4 summarizes the years of HRS data available in Exhibit L for each CCO. PacificSource Central Oregon, PacificSource Columbia Gorge, Cascade Health Alliance, Eastern Oregon CCO, and Yamhill CCO reported no HRS in 2014. Eastern Oregon CCO, PacificSource Central Oregon, and PacificSource Columbia Gorge also did not report any HRS in 2015. Trillium Community Health Plan was not required to submit an Exhibit L in 2014 or 2015. The absence of data for 2014 and 2015 may cause us to underestimate HRS spending in these years.

For 2018 and 2019, we limited our data to expenditures approved by OHA as meeting the requirements for HRS. In 2019, 61.6% of HRS spending was approved, with approval highest for flexible services and HIT spending. Three CCOs (InterCommunity Health Network, PacificSource Central Oregon, and PacificSource Columbia Gorge) had no approved HRS spending in 2018, because they did not provide sufficient detail on the spending for OHA to qualify it as HRS. Prior to 2018, reporting of HRS spending on Exhibit L was not subject to OHA review and approval. For the years 2014-17, we therefore report on all HRS spending submitted by CCOs (including expenditures that may not have satisfied OHA's requirements). By including expenses that were not reviewed and approved by OHA, we may overestimate spending in 2014-2017.

In addition to under- and over-reporting concerns, HRS data from Exhibit L are not directly comparable across years. Beginning in 2018, CCOs were required to report HRS spending line items separately (rather than simply reporting total HRS spending). Exhibit B.5 presents HRS reporting requirements and the years they were implemented. Some of these requirements were “soft” requirements prior to 2019. For instance, OHA HRS guidelines issued in 2019 noted that “many CCOs’ 2018 annual Exhibit L templates did not include rationales for their HRS expenditures, but were accepted as HRS based on the details in the HRS investment name.” Going forward, the state indicated that only HRS expenditures “with a clear rationale would be considered for qualification as HRS.”<sup>46</sup>

**Exhibit B.4: CCOs’ Reporting of HRS Expenditures in Exhibit L, by Year**

	2014	2015	2016	2017	2018	2019
Advanced Health						
AllCare CCO						
Cascade Health Alliance						
Columbia Pacific						
Eastern Oregon CCO						
FamilyCare					N/A	N/A
Health Share of Oregon						
InterCommunity Health Network						
Jackson Care Connect						
PacificSource Central						
PacificSource Gorge						
Primary Health of Josephine County						
Trillium Community Health Plan	N/A	N/A				
Umpqua Health Alliance						
Willamette Valley Community Health						
Yamhill Community Care						



FamilyCare ceased operations in January 2018. Trillium was not required to submit an Exhibit L in 2014 or 2015.

## Exhibit B.5: Exhibit L HRS Reporting Requirements, by Year

Year	New Exhibit L Reporting Requirements	New Optional Items
2014	Include HRS as a medical spending line item in Exhibit L	
2018	Report each HRS line item. For each item, provide: <ul style="list-style-type: none"> <li>• Service name</li> <li>• Category</li> <li>• Amount (\$) flexible services</li> <li>• Amount (\$) community benefit initiatives</li> <li>• Rationale</li> <li>• Length of investment</li> <li>• Number of members served for flexible services line items</li> </ul>	<ul style="list-style-type: none"> <li>• Intended outcomes, projected ROI</li> <li>• Number of members served for community benefit initiatives and HIT</li> </ul>
2019	<ul style="list-style-type: none"> <li>• Amount (\$) for HIT (separately from community benefit initiative amount)</li> <li>• Description of services</li> <li>• Type of organization receiving funds</li> <li>• Investment goal</li> <li>• Medicaid member IDs of those receiving flexible services unless the item “is relatively inexpensive and the vast majority of members routinely receive the item.”</li> </ul>	<ul style="list-style-type: none"> <li>• Start and end date of investment</li> <li>• Time period in which outcomes will be achieved</li> <li>• Medicaid member IDs for community benefit initiatives and HIT</li> </ul>
2020	<ul style="list-style-type: none"> <li>• Medicaid member IDs for persons receiving at least \$200 in HRS</li> <li>• HRS category and \$ amount (by member ID) for persons receiving at least \$200 in HRS</li> </ul>	

## Sources:

Oregon Health Authority. (2018 and 2019). *Exhibit L financial reporting templates*.

Oregon Health Authority. (2019). *CCO Guidance for Exhibit L Financial Reporting Template: Health-Related Services Expenditures*. <https://www.oregon.gov/oha/HSD/OHP/CCO/Exhibit%20L%20-%20General%20Guidelines%20for%20CCO%20HRS%20Spending.pdf>

Oregon Health Authority. (2020). *CCO Guidance for Exhibit L Financial Reporting Template: Health-Related Services Expenditures*. <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Exhibit-L-Reporting-Guide.pdf>

Oregon Health Authority. (2020). *HRS Frequently Asked Questions*.

## Adjustments

We made the following adjustments to the HRS spending data from Exhibit L reports:

**Imputation of missing data on members served:** When data on “members served” were missing, but the name, description, and/or rationale fields indicated that one member was served, we replaced the missing value with a value of one. When “members served” was entered as one, but these fields indicated more members were served, we changed the value to missing.

**Imputation of HRS categories:** When the category was missing, we imputed it where possible using the name and description or rationale fields. In some cases, the name, description, rationale, and spending type (flexible services/community benefit initiative/HIT) variables conflicted with the category. We retained the category except in these situations:

- If the spending type was reported as HIT or if the name or description indicated spending was for HIT, but the category was not HIT, we categorized these services as HIT.
- If the spending type was reported as flexible services, but the category was “Programs to improve community or public health,” we categorized these services as Other.

**Imputation of spending type:** In some cases, the name or description conflicted with the spending type. We imputed spending type to HIT when the name or description indicated HIT, as HIT investments were most easily identifiable.

**Inflation adjustment:** We converted spending amounts for 2014-2018 to 2019 dollars using CPI data from the Bureau of Labor Statistics.<sup>47</sup>



# CCO Interview Guide

The questions below are the general topic areas we will explore with interview participants. The questions will be modified in light of what we learn during the study, to fit the timing of the interview, and to fit the expertise of the interviewee.

## Introduction to the Study

*Hello and thank you for participating in today's interview. We are speaking with you because we value your perspective, and we would like to hear about efforts by your CCO to address health-related social and economic needs in the community. We're especially interested in learning how new CCO contracts with the Oregon Health Authority, sometimes called "CCO 2.0," have affected these efforts. This study will help policymakers and other stakeholders understand how health care organizations can address health-related social and economic needs.*

## Introduction to the Interviewee

*I'd like to start by telling you a little bit about myself. I am [name]. I work at [name] as a [role].*

[Invite the respondent to introduce themselves.]

### **1. Please tell me about yourself.**

- What is your role at [CCO name]?
- How long have you worked for [CCO name]?

### **2. Please tell me about your role as it relates to addressing health-related social and economic needs in the community.**

- What are your specific responsibilities in this area?
- How long have you been involved in this work?

*Thank you for the introduction! Now that I have a better understanding of your role, I'd like to talk about your CCO's approach to addressing health-related social and economic needs.*

## Approach to Social Determinants of Health

*We understand that CCOs' new contracts with the Oregon Health Authority require CCOs to spend a portion of their net income or reserves on services to address "social determinants of health" and "health equity." We also understand that different CCOs may be thinking about these terms in different ways.*

### **3. How does your CCO define "social determinants of health" and "health equity"?**

- To what extent do you see a connection between social determinants of health and health equity?
- To what extent is your CCO addressing social determinants of health together or separately?

[If the respondent needs more information to help answer the question, read the following definition and ask Question 3 again. Otherwise, proceed to Question 4.]

*The Oregon Health Authority uses the following definitions of “social determinants of health” and “health equity”:*

- *“Social determinants of health” means the social, economic, and environmental conditions in which people are born, grow, work, live, and age.*
- *“Health equity” means that all people can reach their full potential and well-being, and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address the equitable distribution or redistributing of resources and power; and recognizing, reconciling and rectifying historical and contemporary injustices.*

[If the respondent says the CCO is addressing these concepts together, say:] *Next, I’m going to ask you questions about social determinants of health, but for your CCO we would take that to include health equity, since you’re addressing social determinants of health and equity together.*

[If the respondent says the CCO is addressing these concepts separately, say:] *For the rest of this interview, I’m going to focus on social determinants of health, but I’ll ask you later in the interview about health equity.*

4. **Please tell me about your CCO’s approach to addressing social determinants of health.** [If the respondent said the CCO is addressing these concepts together, add:] **We understand this includes health equity for your CCO.**
  - What are the most important goals of this approach?
  - Which populations does your CCO serve with this approach?
  - What are your CCO’s highest-priority projects in this area?
  - Which projects address health disparities?
5. **Please tell me about the partner organizations your CCO is working with to address social determinants.** [If the respondent said the CCO is addressing these concepts together, add:] **We understand this includes health equity for your CCO.**
  - Which partner organizations is your CCO working with most closely?
  - How did your CCO choose to work with them?
  - How long has your CCO been working with them?
6. **To what extent do community-based organizations, such as social service providers, work with health care providers in your CCO’s network on project to address social determinants of health?** [If the respondent said the CCO is addressing these concepts together, add:] **We understand this includes health equity for your CCO.**
  - What mechanisms are in place to sustain these efforts?
  - How does your CCO’s approach to addressing social determinants of health help your CCO achieve its goals as a health care organization?

7. How is this approach different from what your CCO was doing before the new contracts with Oregon Health Authority, sometimes called “CCO 2.0”? [If needed, remind the respondent that the contracts extend from 2020 through 2024.]
8. What kinds of challenges does your CCO face with addressing social determinants of health? [If the respondent said the CCO is addressing these concepts together, add:] We understand this includes health equity for your CCO.

### Resources Allocated to Social Determinants of Health

*Next, we'd like to ask about the resources allocated by your CCO to addressing social determinants of health.*

9. Please tell me about the resources allocated by your CCO to addressing social determinants of health right now. [If the respondent said the CCO is addressing these concepts together, add:] We understand this includes health equity for your CCO.
  - Has your CCO targeted a specific dollar amount or percentage of total spending for social determinants of health?
  - What proportion of your CCO's overall spending does spending on social determinants of health represent?
  - How does your CCO track spending on social determinants of health?
  - Has your CCO allocated specific staff to work on social determinants of health?
  - How adequate are these resources for meeting your CCO's goals?
10. Please tell me about the resources allocated by your CCO to addressing social determinants of health before CCO 2.0. [If the respondent said the CCO is addressing these concepts together, add:] We understand this includes health equity for your CCO.
  - Did your CCO target a specific dollar amount or percentage of total spending for social determinants of health?
  - What proportion of your CCO's overall spending did spending on social determinants of health represent?
  - How did your CCO track spending on social determinants of health?
  - Did your CCO allocate specific staff to work on social determinants of health?
  - How adequate were these resources for meeting your CCO's goals?

### Health-Related Services

*Next, we'd like to ask about your CCO's use of “health related services.” The Oregon Health Authority defines health-related services as services not covered by Medicaid that are intended to improve care delivery and overall member and community well-being. They include services delivered to individuals to supplement covered benefits and improve well-being, sometimes called “flexible services,” and community-level interventions focused on improving population health and health care quality, sometimes called “community benefit initiatives.”*

*The Oregon Health Authority has said that CCOs can use health-related services to address social determinants of health.*

**11. Please tell me about your CCO's approach to providing health-related services.**

- What are your CCO's most important goals for health-related services?
- Which populations does your CCO target with health-related services?
- What kinds of health-related services does your CCO provide to individuals?
- What kinds of health-related services does your CCO provide to communities?
- What kinds of health-related services does your CCO provide that are related to health information technology?
- How do health-related services your CCO provides address health disparities?

**12. To what extent are your CCO's health-related services related to your other work to address social determinants of health?**

- What kinds of health-related services provided by your CCO address social determinants of health?
- What kinds of health-related services provided by your CCO do not address social determinants of health, but serve other goals?
- How much overlap exists between staff who work on health-related services and staff who work on social determinants of health at your CCO?

**13. What kinds of challenges does your CCO face with providing health-related services?****Health Equity**

[If the respondent said the CCO is addressing social determinants of health and health equity together in response to Question 3, proceed to Question 13; if the respondent said the CCO is addressing social determinants of health and health equity separately in response to Question 3, skip to Question 14.]

*Earlier in this interview, you mentioned that your CCO is addressing social determinants of health and health equity together. We want to make sure we have a complete picture of your CCO's efforts to promote health equity.*

**14. Please tell me about any efforts by your CCO to promote health equity that we haven't already discussed.**

- What kinds of health disparities exist in your community?
- What kinds of health disparities is your CCO working to reduce?
- What kinds of training is your CCO using to promote health equity?
- Please tell us about your CCO's health equity plan.
- How is your CCO's approach to health equity different from what your CCO was doing before the new contracts with Oregon Health Authority?

[Skip to Question 15.]

*Earlier in this interview, you mentioned that your CCO is addressing social determinants of health and health equity separately.*

**15. Please tell me about your CCO's efforts to promote health equity.**

- What kinds of health disparities exist in your community?
- What kinds of health disparities is your CCO working to reduce?
- What kinds of training is your CCO using to promote health equity?
- Please tell us about your CCO's health equity plan.
- How is your CCO's approach to health equity different from what your CCO was doing before the new contracts with Oregon Health Authority?

**Plans for the Future and Wrap-Up**

*Now, we'd like to transition back to asking about your CCO's overall efforts to address social determinants of health.*

**16. Please tell me about your CCO's plans to address social determinants of health in the future.**

[If the respondent said the CCO is addressing these concepts together, add:] **We understand this includes health equity for your CCO.**

- What will your CCO be doing in this area a year from now?
- What will your CCO be doing in this area four years from now, when the new contracts with the Oregon Health Authority end?
- How will the resources allocated by your CCO to address social determinants of health change in the future?

**17. Before we close, what else should we know about your CCO's efforts to address social determinants of health?**

- What have we missed about your CCO's efforts in this interview?

*Thank you very much for taking time to meet with us. We learned a great deal about your CCO's efforts to address health-related social and economic needs, and your insights were invaluable. We are conducting interviews with all CCOs to understand the "big picture" of their efforts in this area. We may follow up with your CCO to learn more about specific topics we discussed today.*

[Turn off the recording device.]

# Overview of CCO 2.0

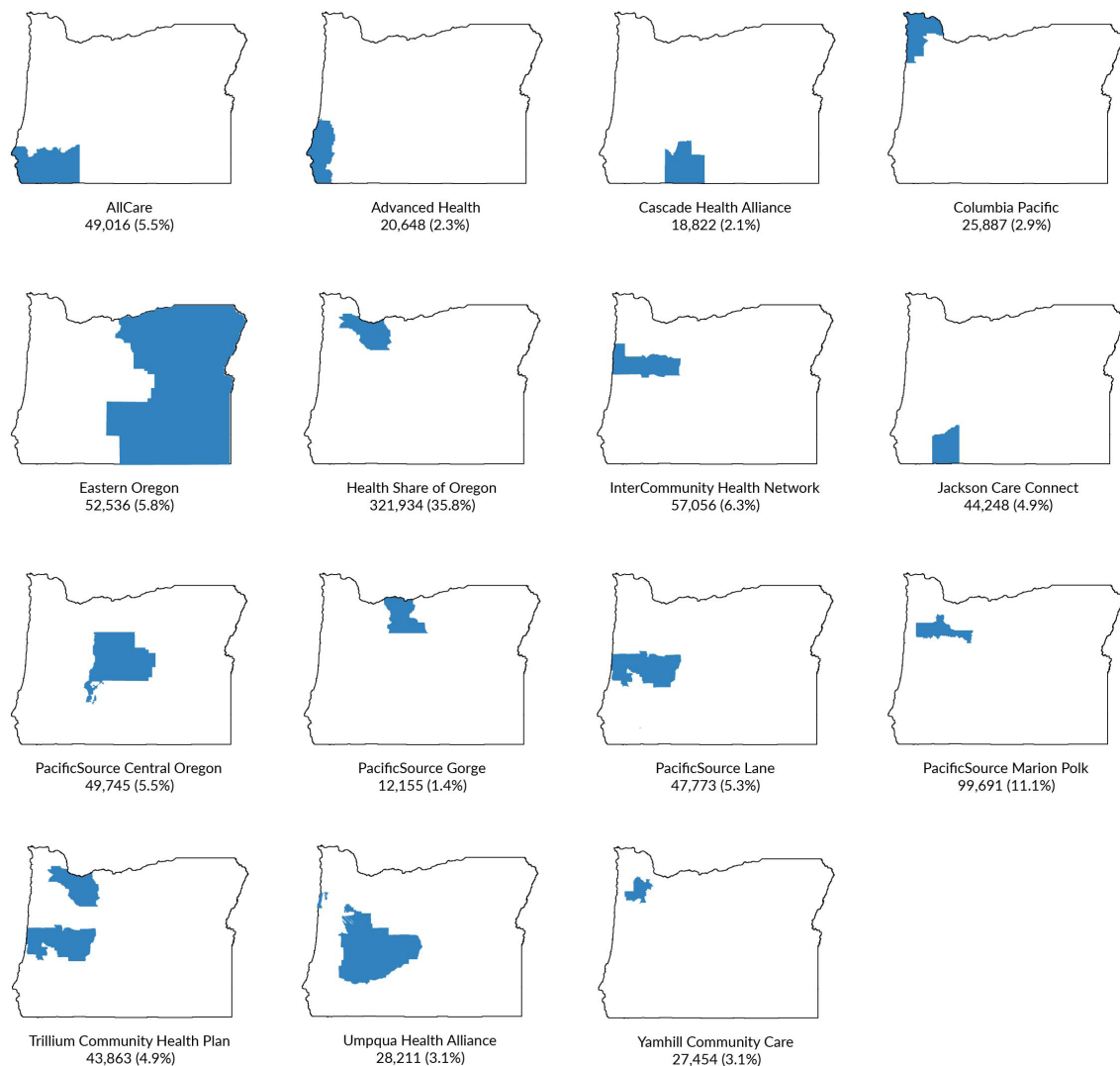
## Overview

In 2019, OHA awarded new five-year contracts to 15 CCOs, which were required to implement CCO 2.0 models beginning January 1, 2020. This appendix summarizes the key features of the CCO 2.0 model relating to SDOH, health equity, VBP, and behavioral health. The summative evaluation (featuring data through 2021) will assess the ways in which CCO 2.0 implementation affected Oregon's progress and goals set out in the 2017-2022 waiver renewal.

## Service Areas and Enrollment

Figure D.1 shows CCO 2.0 service areas, members enrolled with each CCO, and percentage of total CCO enrollment in January 2020.

Figure D.1: CCO 2.0 Service Areas



Figures represent number of members enrolled on January 15, 2020. Trillium Community Health Plan's tri-county service area did not go live until September 1, 2020. The number of members in the Trillium figure are all members enrolled in the Lane County service area.

Source: Oregon Health Authority, Office of Health Analytics. (2020). *Monthly Medicaid Population Report—CCO by Eligibility Group for Physical Plan Type* (January 2020).

### Contractual Requirements to Address SDOH and Health Equity

The CCO 2.0 model included contractual requirements to address SDOH and health equity. (See Box D.1 for OHA's definition of health equity.) These requirements, detailed below, were designed to enhance spending on SDOH and health equity, ensure that the work addresses community and member priorities, and increase the effective use of traditional health workers (THWs), including community health workers. CCOs were required to give CACs a role in decisions on HRS community benefit spending and ensure that these projects aligned with priorities in their community health improvement plan. CCOs were also required to develop a Health Equity Plan, making equity an institutional foundation and creating more standardization of health equity infrastructure across communities. Additionally, CCOs had to hire a Health Equity Administrator and incorporate cultural responsiveness and implicit bias components in their training of staff.

### **Box D.1: OHA's Definition of Health Equity**

In October 2019, OHA's Health Equity Committee finalized a new framework-oriented definition of health equity:

*Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*

*Achieving health equity requires ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*

- *The equitable distribution or redistribution of resources and power, and;*
- *Recognizing, reconciling and rectifying historical and contemporary injustices.*

*The new framework drew attention to the inequitable distribution of power and resources as a root cause of health inequities and recognized the role of historical and current forms of discrimination and structural barriers facing racial and ethnic minority communities. OHA has adopted the goal of eliminating health inequities in Oregon by 2030.*

Reference:

Oregon Health Authority. Health Equity Committee. <https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx>

In 2021, CMS released State Health Official Letter 21-001 (Opportunities in Medicaid and CHIP to Address Social Determinants of Health), describing principles states should adhere to when offering services and supports to address SDOH within their Medicaid and CHIP programs, and outlining federal authorities states could use for this purpose. CMS identified a non-exclusive list of areas states could cover, including housing-related services and supports, non-medical transportation, home-delivered meals, educational services, employment, community integration and social supports, and case management. Oregon's wide-ranging SDOH efforts align with these directives.

### **The SHARE Initiative**

The Supporting Health for All through Reinvestment (SHARE) Initiative emerged in response to a legislative requirement in Oregon's House Bill 4018 (2018), which aimed to address SDOH. The SHARE Initiative requires that a portion of CCOs' profits or net revenues are reinvested in their communities. These reinvestments must be directed to upstream factors that affect health.<sup>48</sup> The SHARE Initiative requirements include the following:

1. Spending must fall within SDOH domains (economic stability, neighborhood and built environment, education, and social and community health) and include spending toward a statewide housing priority.
2. Spending priorities must align with community priorities from CCOs' Community Health Improvement Plans (CHPs).
3. A portion of funds must go to SDOH Partners.
4. CCOs must designate a role for the CAC(s) related to its SHARE Initiative funds.



The SHARE Initiative began in 2020. In April 2021, CCOs reported 2020 SHARE designations (the portion of their net income to be contributed to the SHARE Initiative) based on 2020 financials. They will then submit spending plans for the 2020 designation in June 2021 and spend-down updates in April 2022. This cycle repeats annually. (For 2020 and 2021 expenditure years, CCOs have flexibility to decide how much of their profits they will contribute to the SHARE Initiative. OHA expects to set a formula to prescribe each CCO's annual SHARE Initiative requirement. This formula may be prescribed in CY 2022, although a firm date has not been established.)

### **Health Equity Plans**

CCOs are required to develop and begin implementing a health equity plan. Initially scheduled for March 2020, the due date for these plans was postponed to December 2020.<sup>49</sup> CCOs are required to develop the plan with input from their CACs, other community members, and other stakeholders. CCOs are also required to submit annual progress assessments that describe efforts to increase capacity and leadership for health equity and cultural responsiveness, strategies to recruit, retain and promote a diverse workforce, how they have used REALD data, provision of linguistically appropriate services to members, and delivery of culturally and linguistically appropriate services in the organization and the provider network.<sup>50</sup>

### **Traditional Health Workers (THWs)**

As part of their 2020-2024 contracts, CCOs must implement the THW Integration and Utilization Plans developed as part of their applications. CCOs must inform members about the availability and benefits of THWs. CCOs must also increase their use of THWs and integrate them into the delivery of care, and are required to collect data on the use of, and payment for, THW services. Reporting on these efforts began in December 2020.<sup>51</sup>

### **Value-Based Payment**

CCO 2.0 also expanded VBP requirements in accordance with Oregon's CCO VBP Roadmap (see Box D.2). Like many other states, Oregon adopted the Health Care Payment Learning and Action Network's (HCP-LAN) Alternative Payment Models Framework to categorize VBP arrangements and set specific targets. For example, the state will require at least 25% of CCOs' payments to include downside risk, categorized as HCP-LAN Category 3B, by 2024.

### Box D.2: Oregon's CCO VBP Roadmap

OHA published its Value-Based Payment Roadmap for Coordinated Care Organizations (“the CCO VBP Roadmap”) in September 2019. (OHA intentionally shifted from using the term “alternative payment model” (APM) to reflect the importance of linking payment with outcomes.) The CCO VBP Roadmap established a common definition of VBPs for Oregon’s CCOs - “payments to a provider that explicitly reward the value that can be produced through the provision of health care services to CCO members” - and aligned Oregon’s payment reform efforts with a national framework for categorizing VBPs, the HCP-LAN framework. This framework established four standardized payment categories, including:

1. Traditional FFS.
2. FFS with a quality component.
  - A. Foundational payments for infrastructure & operations.
  - B. Pay-for-reporting.
  - C. Pay-for-performance.
3. FFS with shared financial risk.
  - D. Alternative payment models (APMs) with shared savings.
  - E. APMs with shared savings and downside risk.
4. Population-based payments with a quality component.
  - E. Condition-specific population-based payment.
  - F. Comprehensive population-based payment.
  - G. Integrated finance and delivery system.

Oregon’s CCO VBP Roadmap outlined specific requirements for CCOs during the CCO 2.0 contract cycle (2020-2024), including:

- Meeting increasing annual targets for the overall percentage of a CCO’s payments that qualify as pay-for-performance (i.e., Category 2C in the LAN framework). By 2024, all CCOs are required to make at least 70% of payments as Category 2C payments.
- Beginning in 2023, meeting annual targets for the overall percentage of a CCO’s payments that qualify as shared savings with downside risk (i.e., Category 3B in the LAN framework). By 2024, all CCOs are required to make at least 25% of payments as Category 3B payments.
- Establishing a new per-member per-month “Foundational Payment for Infrastructure and Operations” for PCPCHs. This payment model is required to include tiers that reward organizations for achieving higher levels of PCPCH recognition, with payment amounts increasing during each year of the CCO 2.0 contract.
- Developing targeted 2C or higher payment models in five care delivery areas: hospital care, maternity care, behavioral health care, children’s health care and oral health care.

To evaluate progress toward these goals, OHA is monitoring CCOs’ efforts to design, implement and expand VBP models. In 2020, these efforts were affected by the COVID-19 pandemic and the resulting temporary changes to the CCO incentive program (some of which are outlined below). While the impact of these events on Oregon’s progress toward its VBP goals is not yet known, it is clear that the pandemic substantially changed the context in which future VBP work will occur.

#### References:

Oregon Health Authority. (2019). Value-Based Payment Roadmap for Coordinated Care Organizations. <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf>

Health Care Payment Learning & Action Network. (2017). Alternative Payment Model (APM) Framework White Paper: Refreshed 2017. <https://hcp-lan.org/apm-refresh-white-paper/>

## Behavioral Health Provisions

Additionally, CCO 2.0 contracts provided more direction for CCOs in terms of how integration of physical and behavioral health care was to be executed. In particular, Exhibit M indicated that CCOs could not subcontract with a third party for the provision of behavioral health services, effectively ruling out the subdelegation of the behavioral health benefit. In addition, the contract specified that CCOs should reimburse for behavioral health services rendered in primary care settings and cover physical health services rendered in behavioral health settings. The contract language also specified that multiple services provided on the same day and in the same clinic should be reimbursed.

# Background on REALD

## Overview

Devising policies and interventions to reduce health inequities necessitates data disaggregated by race, ethnicity, and other demographic characteristics. This Appendix outlines Oregon's efforts to improve collection of these data through implementation of the REALD program.

## About REALD

In 2013, Oregon House Bill 2134 directed OHA, in collaboration with Oregon's DHS, to standardize and improve data collection for race, ethnicity, spoken and written language, and disability demographic information. By enhancing the accuracy and granularity of demographic data, the REALD initiative would improve measurement of disparities in health, social needs, and service utilization. This would inform equitable resource allocation to address disparities and improve quality, including the development of accessible, culturally specific and linguistic services. In 2014, standards for REALD data collection were codified in OARs 943-070-0000 through 943-070-007.

REALD data collection is based on the following core principles:<sup>52</sup>

- **Self-report.** Individuals self-identify as being from a certain population or subgroup.
- **Active responses.** Respondents must actively choose 'decline' or 'unknown' rather than leaving blanks (passive non-responses).
- **Combine race & ethnicity.** This reduces "missing" and "other" responses, as persons identifying as Latino/a/x may not distinguish between race and ethnicity.
- **Fluidity.** Identities are not fixed; they may change over time. People can acquire new limitations or experience temporary limitations. Responses may vary based on the respondent's relationship with the requestor. In most settings, REALD questions should be asked annually.

Collection of race/ethnicity information relies on three questions<sup>53</sup>

1. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?
2. Which of the following describes your racial and ethnic identity? (Respondents may choose from 39 categories.)
3. If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

Sexual Orientation and Gender Identity data is not currently included in REALD.

OHA's initial efforts on REALD focused on redesigning Oregon's new online benefits eligibility system (OregONEligibility, or ONE), to be fully compliant with REALD standards. The upgraded ONE system launched in June 2017, with REALD data flowing from ONE into the Oregon MMIS. CHSE's analyses showed that the launch of REALD coincided with an increase in both the number and percentage of adult Medicaid recipients for whom race was recorded as unknown/missing/other, with the percentage reaching 40% by 2019. This appears to have been driven largely by a decline in the percentage of enrollees identifying as white or Hispanic. OHA is currently working to improve the quality of REALD data.

## REALD and COVID-19

In June 2020, as part of Oregon's COVID-19 response, the Legislature passed House Bill 4212 requiring OHA to establish rules for phased REALD data collection and reporting by providers for COVID-19 encounters. Providers would report these data to OHA as part of COVID-19 disease reporting (including test results, cases, and hospitalizations).<sup>54</sup> Requirements were effective October 1, 2020 for hospitals, health systems and FQHCs, with health care facilities and providers working with individuals in a congregate setting required to start reporting March 1, 2021.

To support the new requirements, OHA held a series of learning sessions in late 2020 addressing the purpose of REALD, its role in identifying and reducing health inequities, implementation of REALD data collection, and strategies for asking REALD questions, among other topics. OHA also introduced a monthly provider webinar series and is conducting outreach to impacted communities to provide education on REALD data collection and reporting.

In October 2020, OHA also released revised REALD data collection templates. Revisions included the addition of six race/ethnicity categories, allowing individuals to indicate if they do not have a single primary racial or ethnic identity, refinement of language questions to include people who use sign language, additional disabilities questions, and changes to interpreter questions.<sup>55</sup>

# Responding to COVID-19

## Overview

In 2020 the State of Oregon, OHA, and CCOs undertook a wide range of measures to respond to the needs of patients and providers during the COVID-19 pandemic. This appendix outlines some of these changes. We describe the major changes to Medicaid policies and regulations enacted at the federal and state levels, OHA's actions to support CCOs and providers, as well as the state's intensified focus on health equity. The summative evaluation (featuring data through 2021) will assess some of the ways in which COVID-19 and the state's pandemic response affected Oregon's progress and goals set out in the 2017-2022 waiver renewal.

## COVID-19 in Oregon

The first confirmed case of COVID-19 in Oregon was reported on February 28, 2020. On March 8, 2020, Governor Brown issued Executive Order 20-03, declaring COVID-19 a public health emergency under ORS 401.025(1) and calling for immediate action by OHA and other state agencies to respond to the virus' spread in Oregon. Oregon's daily reported cases stayed relatively low (below 100) through the Spring of 2020, aided by various infection control measures, including business and school closures, limitations on social gatherings, workplace restrictions, and a statewide "stay at home" order effective March 23, 2020. Governor Brown gradually lifted the "Stay Home, Save Lives" executive order beginning in May 2020, introducing a phased system whereby counties had to meet benchmarks for COVID-19 prevalence and hospitalization to further loosen restrictions. The state also introduced requirements for face coverings in indoor public spaces. These rules gradually expanded from a few counties to statewide and included outdoor spaces, workplaces, and educational institutions. Despite these measures, daily incident cases climbed in June 2020 to an initial peak of 409 in July, with a second wave beginning to build in September 2020 and peaking at over 1,600 daily cases by late December 2020. (Case rates began declining again in January 2021.) By late February 2021, Oregon had reached more than 150,000 reported cases, 8,500 hospitalizations, and 2,100 deaths from COVID-19. Mirroring trends nationwide, the disease disproportionately affected communities of color and tribes, leading to substantially higher rates of cases, severity, and deaths in these populations. For example, by February 2021, Latino/a/x individuals (roughly 13% of Oregon's population) accounted for 26% of total cases and 9.3% of deaths. Adjusted for age, case and death rates were more than three times higher for Latino/a/x individuals compared with others, and more than double for the Black community compared with the white community.<sup>56</sup>

In addition to its tremendous human toll, the pandemic caused widespread disruption to the state's health care delivery system, including substantial adverse financial impacts for providers. With looming shortages in personal protective equipment, Governor Brown ordered the cancellation of elective and non-urgent procedures (effective March 23, 2020) across all care settings until June 15, 2020.<sup>57</sup> Patient concern about infection risk further reduced preventive and other routine care visits. Capacity limitations due to social distancing requirements led to sharp revenue declines for residential behavioral health providers.

## Federal Legislation

The U.S. Congress enacted several pieces of legislation to respond to the COVID-19 emergency, including the Families First Coronavirus Response Act (HR6201) and the Coronavirus Aid, Relief and Economic Security (CARES) Act (HR748), which impacted Medicaid programs nationwide in a number of ways outlined below. CMS also issued revisions to Medicare and Medicaid regulations to offer additional assistance to health care providers and ensure enrollees' access to needed services.

The Families First Coronavirus Response Act, effective March 18, 2020 and amended by the CARES Act, contained a number of provisions impacting Medicaid, including:

- A temporary increase in the federal matching rate (FMAP) of 6.2 percentage points (not applicable to Medicaid expansion populations).
- Coverage for COVID-19 testing without cost sharing.
- An option for states to use Medicaid to pay for COVID-19 testing for uninsured individuals.

To qualify for the FMAP increase, state Medicaid programs could not terminate enrollment for any reason unless the person moved out of state or requested voluntary disenrollment.

The CARES Act, signed into law on March 27, 2020, contained provisions for increased unemployment benefits, stimulus payments to individuals and families, support for small businesses and assistance to sectors of the U.S. economy severely impacted by the pandemic. Health-related provisions of the Act included:<sup>58</sup>

- Expanded coverage of telehealth services and grants to fund greater use of these services.
- Reauthorization of multiple programs such as Temporary Assistance for Needy Families, the Healthy Start Program, and rural community health programs.
- More than \$242 billion in appropriations for health-related programs and entities, such as food assistance programs, the Federal Emergency Management Agency, the Centers for Disease Control and Prevention, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, CMS, and the Department of Health and Human Services (including \$100 billion for reimbursing hospitals and other health care entities for extraneous expenses and lost revenues attributable to the coronavirus).

## 1135 Waivers

During a public health emergency (PHE), states are allowed to seek additional flexibilities in Medicaid delivery under Section 1135 of the Social Securities Act. During the course of 2020, Oregon obtained a series of Section 1135 flexibilities intended broadly to ensure adequate availability of services for Medicaid enrollees and support providers' financial viability.<sup>59</sup> Effective retroactively from March 1, 2020 and through the duration of the PHE, these waivers authorized the following changes to OHP:<sup>60</sup>

- Temporary suspension of Medicaid FFS prior authorization requirements.
- Extension of pre-existing authorizations for procedures which were delayed due to COVID-19 restrictions.
- Suspension of nursing facility pre-admission screening and annual review assessments for nursing home residents.
- Extension of timeframe for enrollees to request a fair hearing for eligibility or FFS appeals.

- Temporary enrollment of out-of-state providers who are enrolled with another State Medicaid Agency.
- Full reimbursement for services provided in alternative settings (unlicensed facilities).

CMS also approved multiple Section 1135 flexibilities relating to home- and community-based services (HCBS) provided under the 1915(k) state plan benefit, the 1915(i) HCBS state plan benefit, and the 1915(c) HCBS waiver program. These included extended timeframes for eligibility determinations, care needs assessments and re-assessments, and allowing for provision of services in alternative settings.<sup>61</sup>

Some of these changes may be continued beyond the expiration of the PHE.

### State Plan Amendments

To further assist the state's response to COVID-19, Oregon applied for State Plan Amendments (SPAs) to implement temporary changes to Medicaid provider requirements and reimbursement rates. Changes approved by CMS via SPAs included:

- Higher FFS rates (equivalent to face-to-face encounters) for telehealth visits with established patients.<sup>62</sup>
- Temporary changes to the 1915(k) Community First Choice<sup>63</sup>, 1915(j) Independent Choices<sup>64</sup> and 1915(i) Home and Community-Based Services programs.<sup>65</sup>
- Telehealth (point-of-service code 2) reimbursed at non-facility RVU rate regardless of the provider's entity type.<sup>66</sup>
- Payments for telehealth services not otherwise paid under the Medicaid state plan.<sup>67</sup>
- Waiver of day supply limits for outpatient drugs when appropriate to reduce risk, with early refills allowed for a 2-week reserve supply.<sup>68</sup>
- Automatic renewal of prior authorization for medications.<sup>69</sup>
- Authorization for contracted Community Partner organizations to perform presumptive eligibility determinations.<sup>70</sup>
- Reserve Service Capacity payments to mental health and substance use disorder residential treatment providers.<sup>71</sup>
- Enhanced and supplemental payments to Tribal 638, Urban Indian Health, and Indian Health Service programs.<sup>72</sup>
- 10% increase in rates for nursing facilities, assisted living facilities and residential care facilities.<sup>73</sup>
- Contracted FFS providers may apply for interim stability payments to help them stay in business; payment equal to average monthly FFS billing to OHA in 2019.<sup>74</sup>
- Provider reimbursement for use of qualified interpreters for non-English speaking members and/or deaf/hard of hearing members.<sup>75</sup>

SPA changes went into effect in March 2020 and will expire on the last day of the PHE unless the state obtains CMS approval for their extension. OHA and ODHS are currently planning to request a continuation of some of these changes, including the updated reimbursement policies for telehealth and interpretation services.



## OHA's Actions to Support CCOs and Providers

OHA and CCOs were an essential point of response to the COVID-19 pandemic. This section outlines some of the actions taken by OHA and CCOs to respond to the needs of Medicaid members and providers.

### Telehealth Guidance

To accompany the expanded coverage for telehealth services, OHA issued new guidance to CCOs and OHP providers on increasing access to physical, behavioral, and oral telehealth services. While reimbursement rates could vary, OHA directed CCOs to reimburse telehealth services “on par” with in-person services.<sup>76</sup> Consistent with new guidelines from the Health Evidence Review Commission, OHA encouraged the use of telehealth services for new and existing patients for all services that can “reasonably approximate” an in-person visit, not just COVID-related services, and introduced additional billing code options.<sup>77</sup> Providers could use various delivery models (e.g., two-way video, telephone, email, text) and platforms, including non-HIPAA compliant platforms if needed. (HHS waived HIPAA requirements for telehealth during the pandemic.<sup>78</sup>) CCOs were asked to develop communications materials on telehealth services for beneficiaries in multiple languages and submit these for OHA approval.<sup>79</sup>

### Changes to the CCO Quality Incentive Program

As part of its efforts to financially support providers through the crisis, OHA in March 2020 released early payments to CCOs from the 2019 quality pool. CCOs typically use quality pool awards to pay providers based on quality performance, VBP strategies, and other contractual arrangements. Each CCO received an advance payment equal to 60% of its allowable quality pool funds, for a total of \$98 million. The remaining 40% was paid out in June 2020 based on CCOs' individual performance in 2019.<sup>80</sup>

Beginning in April 2020, OHA suspended the 2020 quality withhold for the duration of the public health emergency. Under 2020 CCO contracts, this withhold was 4.25% of each CCO's monthly capitation revenue. OHA estimated a resulting cash infusion to CCOs of around \$17 million per month.<sup>81</sup> Funds withheld in January through March 2020 will be available for the 2020 quality pool to be distributed in June 2021.

CCOs were required to report details of their spending of the 2019 quality pool and withhold dollars to OHA, including amounts distributed by recipient. All CCOs reported paying these funds to their provider networks, although the types of providers targeted and conditions for payment varied. CCOs generally sought to compensate providers for decreased FFS revenues. These payments could include, for example, payments based on historical FFS spending, pre-payment of incentive funds, or new capitation arrangements. CCOs also reported engaging in discussions with FFS providers about the benefits of capitation and other VBP arrangements in reducing utilization-related revenue volatility.<sup>82</sup> Additionally, CCOs used the flexibility of HRS to help their members adapt to the challenges of COVID-19. We describe these initiatives further in Chapter 6.

In July 2020, OHA's Metrics & Scoring Committee voted to make all 2020 CCO incentive measures “reporting only” because data from 2020 could not be meaningfully used to assess quality improvement. Thus, the 2020 quality pool payments will not be subject to CCOs' achievement of benchmarks or improvement targets. Early evidence suggests many CCOs used this emergency flexibility to support providers, converting performance-based contracts to “reporting only” in 2020. In October 2020, the Committee decided to use 2019 as the baseline for assessing quality improvement in 2021, rolling forward initial 2020 benchmarks to 2021. Benchmarks for 2021 could

be reassessed in the presence of extenuating external factors, as defined by a set of predetermined criteria related to school/county reopening, the Governor's state of emergency, closure of medical/dental facilities, suspension of elective procedures, and preventive visits, COVID cases, and OHP telemedicine coverage.<sup>83</sup>

## Renewed Focus on Health Equity

With communities of color and tribal communities disproportionately affected by the pandemic, COVID-19 laid bare the health system's inequities.<sup>84</sup> Health equity, which was already a focus in CCO 2.0, emerged as a central priority for the state and the CCO model. Calls for racial justice in the Black Lives Matter movement further highlighted systemic racism and oppression as key drivers of health inequities, both indirectly via social determinants (e.g., housing, income, neighborhood environment, educational outcomes), and directly through chronic stress/trauma, lack of access to culturally responsive services, and general distrust in the health care system. The events of 2020 prompted a reinforced commitment to health equity among Oregon's health care system leaders and stakeholders.

Oregon has a long history of racial discrimination, including discriminatory laws and ordinances, housing, labor and school segregation, and racial violence.<sup>85</sup> In 1850, the federally enacted Oregon Donation Land Act prevented non-whites from claiming land in Oregon even if they had already settled there. Oregon's constitution (effective in 1859) explicitly barred Black people from residing in the state until 1926. Throughout the 20th century, the City of Portland implemented racist land use planning practices which excluded Black people and other unjustly treated racial and ethnic groups from homeownership. These policies were associated with housing segregation, displacement, and exclusion from educational and economic opportunities.<sup>86</sup> A 2010 report on communities of color in Multnomah County found large racial and ethnic disparities in measures of poverty, educational attainment, health, preschool access, labor market outcomes, child welfare, and juvenile detention rates. The report attributed these disparities to "institutional, ideological, behavioral and historic racism."<sup>87</sup>

Accurate demographic data are necessary to identify and assess inequities and resulting health disparities. In 2013, the Oregon legislature passed House Bill 2134 directing OHA and ODHS to standardize and improve the way race, ethnicity, spoken and written language, and disability (REALD) demographics are collected in agency datasets. Implementing this protocol is an important step to reduce health inequities. Appendix E provides additional information on REALD. In June 2020, as part of Oregon's COVID-19 response, the Legislature passed House Bill 4212, requiring OHA to establish rules for phased REALD data collection and reporting by providers for COVID-19 encounters. Providers would report these data to OHA as part of COVID-19 disease reporting (including test results, cases, and hospitalizations).<sup>88</sup> Requirements were effective October 1, 2020 for hospitals, health systems and Federally Qualified Health Centers (FQHCs), with health care facilities and providers working with individuals in a congregate setting required to start reporting March 1, 2021.

In the fall of 2020, as part of its renewed commitment to addressing health inequity and the passage of House Bill 4212, OHA significantly increased technical assistance and outreach to providers on REALD implementation. OHA also released revised REALD data collection templates intended to facilitate accurate data collection.

# Supplemental Results

## Screening, Brief Intervention, and Referral to Treatment

Table G.1 provides outcomes for Screening, Brief Intervention, and Referral to Treatment (SBIRT) for 2019 based on EHR data received from OHA. The collection of data for this measure has changed over time, so we were unable to assess changes during the waiver renewal. We calculated two rates describing screening and brief intervention/referral, respectively:

- **Rate 1:** Percentage of members 12 years and older who received an age-appropriate screening for alcohol or other substance abuse.
- **Rate 2:** Percentage of members who screened positive for alcohol or other substance abuse and received a brief intervention or referral to treatment.

**Table G.1: SBIRT Results for 2019**

CCO	Rate 1	Rate 2
Advanced Health	67.1%	1.3%
AllCare CCO	23.9%	57.3%
Cascade Health Alliance	35.6%	93.2%
Columbia Pacific	78.2%	13.1%
Eastern Oregon CCO	69.3%	58.2%
Health Share of Oregon	65.7%	25.7%
InterCommunity Health Network	50.2%	85.4%
Jackson Care Connect	46.7%	26.1%
PacificSource Central	56.6%	11.0%
PacificSource Gorge	54.3%	10.4%
Primary Health of Josephine County	47.0%	24.2%
Trillium Community Health Plan	68.7%	31.0%
Umpqua Health Alliance	44.9%	49.6%
Willamette Valley Community Health	73.9%	28.0%
Yamhill Community Care	80.5%	12.6%
Statewide	62.8%	42.8%

## Assessing the Impacts of a CCO Closure

In 2018, Oregon transitioned from 16 CCOs to 15 CCOs. FamilyCare became a CCO in 2012 serving approximately 115,000 enrollees in Washington, Multnomah, Clackamas, and Marion counties. It shut its doors on January 31, 2018. With its closure, the majority of members were expected to transition into Health Share of Oregon. FamilyCare members in Marion County were to transition into Willamette Valley Community Health, while those in the Gaston area of Washington County

were to transition into Yamhill Community Care. FamilyCare members who were also members of a tribe were not transitioned into a new CCO. They would remain in the FFS program but could choose to enroll in a CCO in their area.

One concern is that the disruption at the FamilyCare level could confound overall changes otherwise attributable to the CCO model. In order to disentangle the effects of the CCO model from changes in the market, we conducted sub-analyses of the markets where CCO representation remained stable through 2019. Specifically, we compared differences in outcomes across the state and in the tri-county area (Washington, Multnomah, and Clackamas) area, using the following equation:

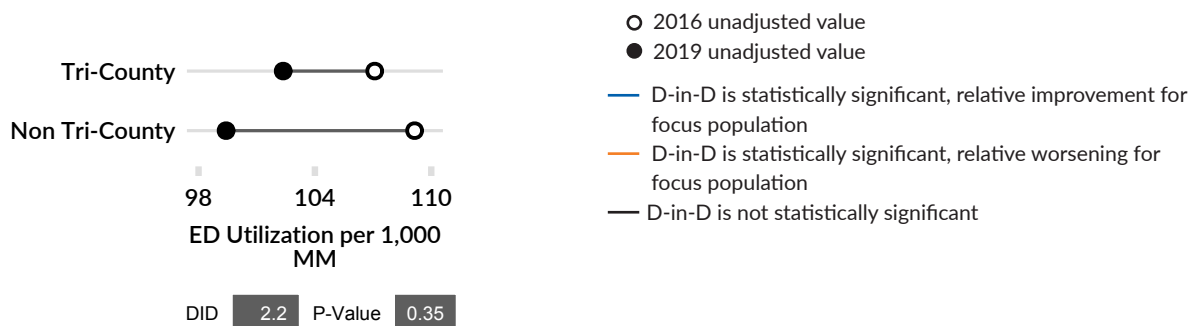
$$Y_{it} = m(b_0 + b_1*d2019_t + b_2*TriCounty_i + b_3* TriCounty_i *d2019_t + a*X_{it} + e_{it}) \quad (1)$$

Where TriCounty<sub>i</sub> takes a value of 1 if the individual resides in the tri-county area. The coefficient b<sub>3</sub> captures the difference between the 2016-2019 change in the tri-county region compared to other regions of the state (difference-in-differences; “DID”). For example, a negative, statistically significant coefficient would indicate that any improvement in the outcome Y<sub>it</sub> between 2016 and 2019 was smaller in the tri-county area.

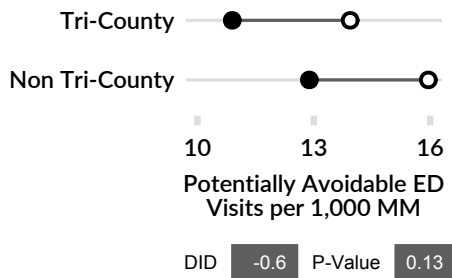
We report results for behavioral health measures in Figures G.1 through G.17 below. We found that for most behavioral health measures, the 2016-2019 change was no different or modestly greater (indicating greater improvement) for enrollees in the tri-county area. One area to monitor is total spending, which increased slightly more for individuals in the tri-county area. This difference could reflect increased service use - possibly beneficial for these enrollees - or challenges in managing the costs associated with the transition. With this exception, we did not find evidence in the claims-based measures that outcomes had worsened for enrollees in the tri-county area following the departure of FamilyCare.

For oral health, changes from 2016 to 2019 were no different or slightly greater (indicating greater improvement) in the tri-county area relative to other areas (see Figures G.18 through G.28). For example, ED visits for non-traumatic dental conditions declined more markedly in the tri-county area. An exception was Dental Sealants on Permanent Molars for Children, which improved less in the tri-counties, although from a higher 2016 baseline. The increase in spending on dental services outside the ED was slightly smaller for CCO enrollees in the tri-county area, although baseline spending was higher. Overall, these results suggest that for most members, the departure of FamilyCare did not adversely affect oral health services.

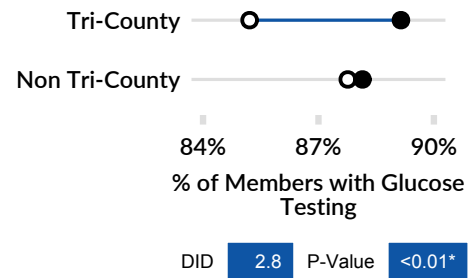
**Figure G.1: The 2016-2019 change in ED utilization for members with behavioral health conditions did not differ significantly for tri-county versus non tri-county residents**



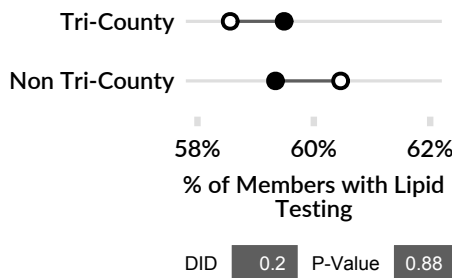
**Figure G.2: The 2016-2019 change in potentially avoidable ED visits for members with behavioral health conditions did not differ significantly for tri-county versus non tri-county residents**



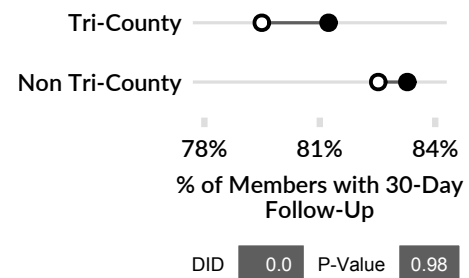
**Figure G.3: Rates of glucose for testing for members using 2nd gen. antipsychotic medications increased slightly more for tri-county residents than for non-tri-county residents from 2016 to 2019**



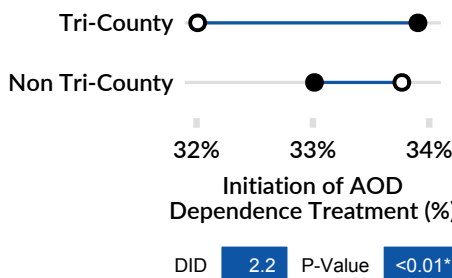
**Figure G.4: The 2016-2019 change in lipid testing for members using 2nd gen. antipsychotic medications did not differ significantly for tri-county versus non tri-county residents**



**Figure G.5: Changes from 2016 to 2019 in the rate of follow-up within 30 days after hospitalization for mental illness did not differ significantly for tri-county residents compared to non tri-county residents**

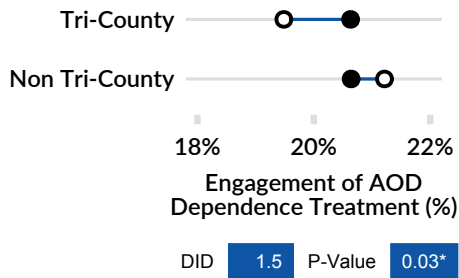


**Figure G.6: The rate of initiation of AOD dependence treatment increased slightly more for tri-county residents than for non tri-county residents from 2016 to 2019**

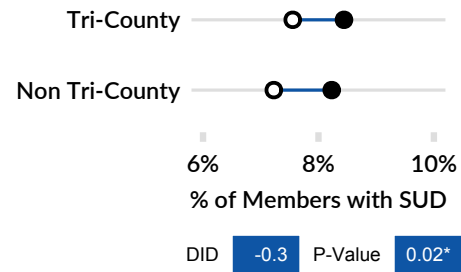


- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant

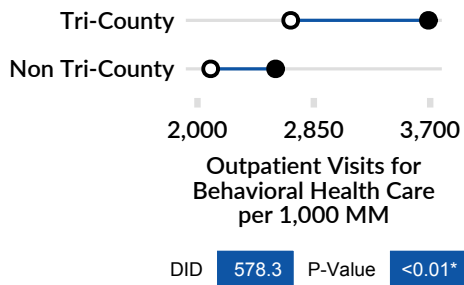
**Figure G.7: The rate of engagement in AOD dependence treatment increased slightly more for tri-county residents than for non tri-county residents from 2016 to 2019**



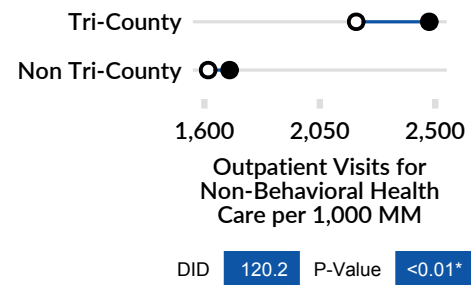
**Figure G.8: The increase from 2016 to 2019 in the percentage of members with SUD was slightly smaller for tri-county residents compared to non tri-county residents**



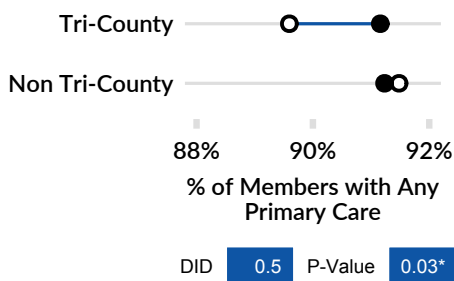
**Figure G.9: The 2016-2019 increase in outpatient visits for behavioral health care was greater for tri-county residents compared to non tri-county residents**



**Figure G.10: The 2016-2019 increase in outpatient visits for non-behavioral health care was greater for tri-county residents compared to non tri-county residents**



**Figure G.11: The 2016-2019 increase in primary care access for members with behavioral health conditions was slightly greater for tri-county residents compared to non tri-county residents**



○ 2016 unadjusted value  
 ● 2019 unadjusted value  
 — D-in-D is statistically significant, relative improvement for focus population  
 — D-in-D is statistically significant, relative worsening for focus population  
 — D-in-D is not statistically significant

Figure G.12: The 2016-2019 increase in preventive-ambulatory services access for members with behavioral health conditions was slightly greater for tri-county residents compared to non tri-county residents

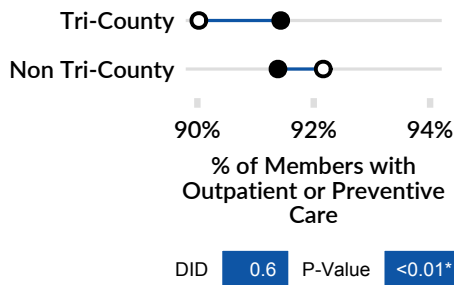


Figure G.13: The 2016-2019 increase in primary care spending was slightly greater for tri-county residents compared to non tri-county residents

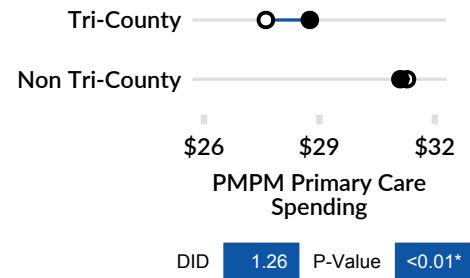


Figure G.14: The 2016-2019 increase in ED spending was greater for tri-county residents compared to non tri-county residents

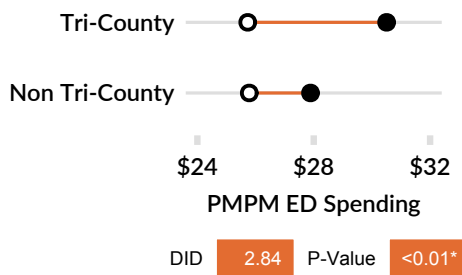


Figure G.15: The 2016-2019 change in inpatient facility spending was not significantly different for tri-county residents compared to non tri-county residents

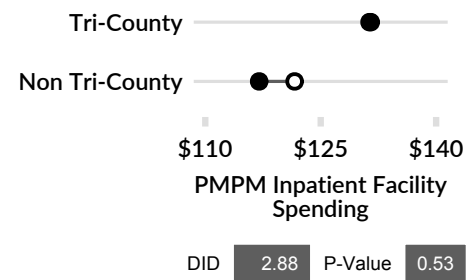
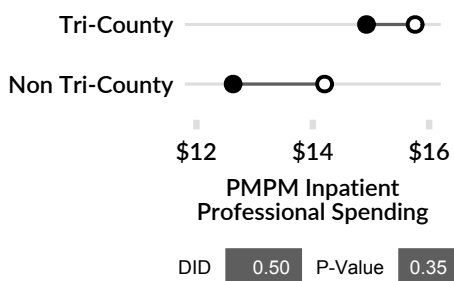


Figure G.16: The 2016-2019 change in inpatient professional spending was not significantly different for tri-county residents compared to non tri-county residents



- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant

Figure G.17: The 2016-2019 increase in total spending was slightly greater for tri-county residents compared to non tri-county residents

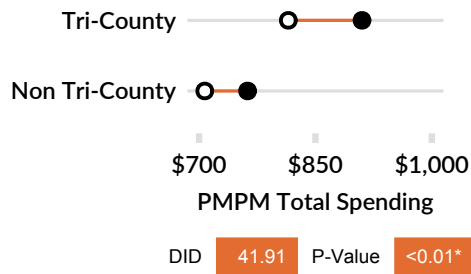


Figure G.18: The 2016-2019 change in ED visits for traumatic dental conditions was not significantly different for tri-county residents compared to non tri-county residents

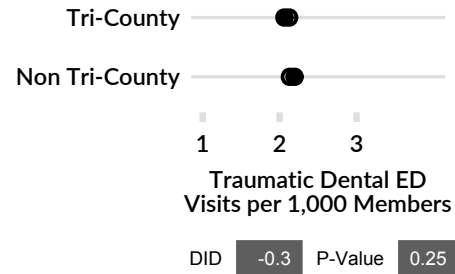


Figure G.19: The 2016-2019 decrease in ED visits for non-traumatic dental conditions was greater for tri-county residents compared to non tri-county residents

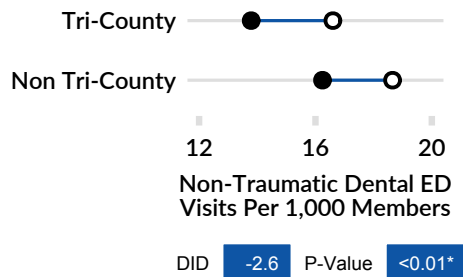


Figure G.20: The 2016-2019 increase in access to dental procedures was slightly greater for tri-county residents compared to non tri-county residents

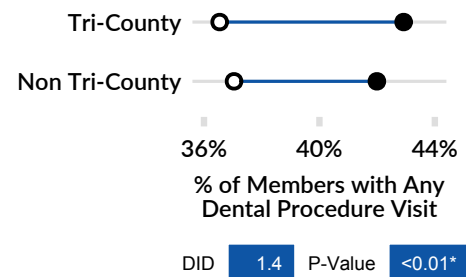
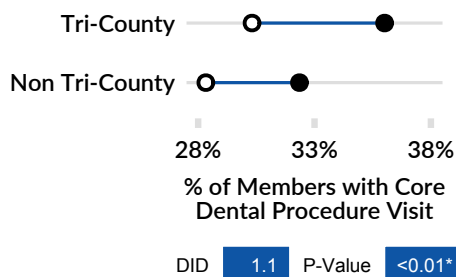


Figure G.21: The 2016-2019 increase in access to core dental procedures was slightly greater for tri-county residents compared to non tri-county residents



- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant



Figure G.22: The 2016-2019 increase in dental procedure visits was slightly greater for tri-county residents compared to non tri-county residents

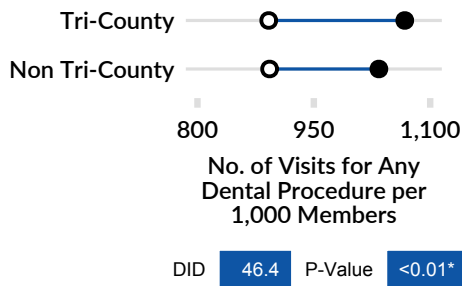


Figure G.23: The 2016-2019 increase in core dental procedure visits was slightly greater for tri-county residents compared to non tri-county residents

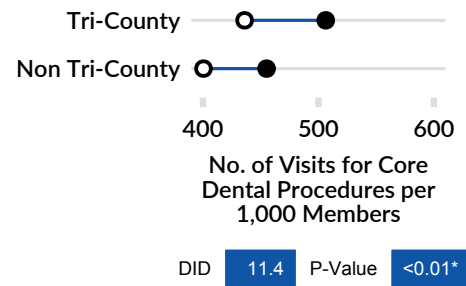


Figure G.24: The 2016-2019 increase in rates of dental sealants for permanent molars for children was smaller for tri-county residents compared to non tri-county residents

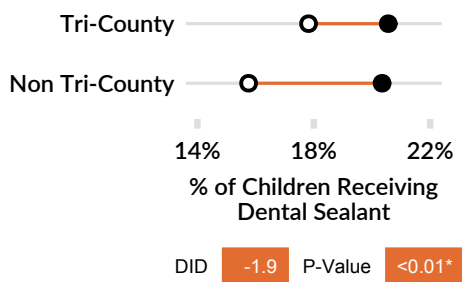


Figure G.25: The 2016-2019 increase in access to dental procedures for members with a chronic condition was slightly greater for tri-county residents compared to non tri-county residents

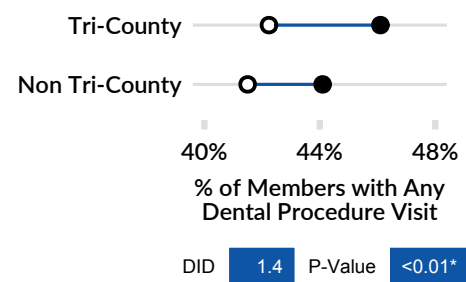
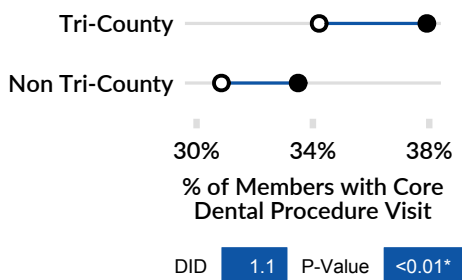
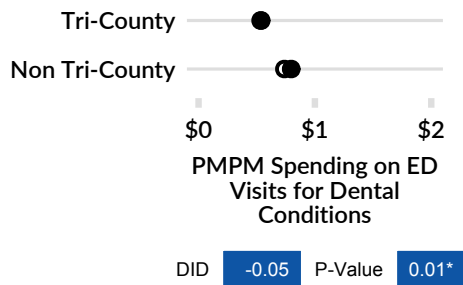


Figure G.26: The 2016-2019 increase in access to core dental procedures for members with a chronic condition was slightly greater for tri-county residents compared to non tri-county residents



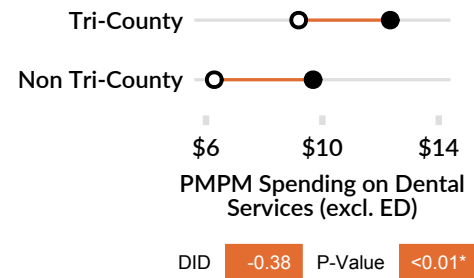
○ 2016 unadjusted value  
 ● 2019 unadjusted value  
 — D-in-D is statistically significant, relative improvement for focus population  
 — D-in-D is statistically significant, relative worsening for focus population  
 — D-in-D is not statistically significant

**Figure G.27: Spending on ED visits for dental conditions decreased slightly for tri-county residents relative to non tri-county residents between 2016 and 2019**



- 2016 unadjusted value
- 2019 unadjusted value
- D-in-D is statistically significant, relative improvement for focus population
- D-in-D is statistically significant, relative worsening for focus population
- D-in-D is not statistically significant

**Figure G.28: The 2016-2019 increase in spending on dental services excluding ED visits was slightly smaller among tri-county residents compared to non tri-county residents**



### HRS Expenditures

Tables G.2-G.6 display annual spending on HRS, as reported by CCOs in Exhibit L submissions. Table G.2 contains aggregate CCO spending by year for 2014-2019. Tables G.3 and G.4 show total and PMPM spending by CCO and HRS type (flexible services, community benefit initiative, health IT), for 2018 and 2019. Monthly flexible services spending per 1,000 members by category can be found in Table G.5. Finally, we present in Table G.6 and Figure G.29 annual flexible services spending per recipient, percentage of annual members who were flexible services recipients, and distribution of per-recipient flexible services spending by category.

**Table G.2: Health-Related Services Spending by Year, 2014-2019**

Year	HRS Total (\$)	HRS PMPM (\$)	HRS % of Member Services Spending
2014	1,038,590	0.11	0.03
2015	2,484,966	0.24	0.07
2016	7,213,874	0.66	0.17
2017	5,689,636	0.55	0.14
2018	11,193,764	1.08	0.27
2019	16,163,747	1.51	0.36

Note: 2018 and 2019 spending data was reviewed and approved by OHA. 2014-2017 spending data was not subject to review.

Table G.3: Total Health-Related Services Spending (\$) by Type and CCO, 2018-2019

Year	CCO	Health-Related Services Total	Type of Spending		
			Flexible Services	Community Benefit Initiative	Health Information Technology
2018	Advanced Health	136,730	-	136,730	-
	AllCare CCO	1,459,262	335,178	1,124,084	-
	Cascade Health Alliance	882,275	122,094	760,181	-
	Columbia Pacific	143,121	925	142,196	-
	Eastern Oregon CCO	29,210	28,202	1,008	-
	Health Share of Oregon	3,103,269	258,322	2,844,947	-
	InterCommunity Health Network	-	-	-	-
	Jackson Care Connect	1,511,175	1,133,678	377,497	-
	PacificSource Central	-	-	-	-
	PacificSource Gorge	-	-	-	-
	Primary Health of Josephine County	40,278	35,974	4,304	-
	Trillium Community Health Plan	2,099,762	110,845	1,988,917	-
	Umpqua Health Alliance	1,192,115	50,186	1,141,930	-
	Willamette Valley Community Health	30,082	30,082	-	-
	Yamhill Community Care	566,484	318,191	248,294	-
	<b>All</b>	<b>11,193,764</b>	<b>2,423,677</b>	<b>8,770,087</b>	<b>-</b>
2019	Advanced Health	526,357	12,854	513,503	-
	AllCare CCO	1,570,634	496,038	1,034,596	40,000
	Cascade Health Alliance	224,683	29,722	194,961	-
	Columbia Pacific	1,461,059	8,631	1,452,428	-
	Eastern Oregon CCO	89,284	55,229	34,055	-
	Health Share of Oregon	2,716,625	874,810	1,074,842	766,973
	InterCommunity Health Network	956,546	-	580,785	375,761
	Jackson Care Connect	1,044,211	482,030	523,904	38,276
	PacificSource Central	113,254	113,254	-	-
	PacificSource Gorge	540,260	81,365	458,895	-
	Primary Health of Josephine County	108,979	89,802	19,177	-
	Trillium Community Health Plan	2,308,466	163,762	2,144,704	-
	Umpqua Health Alliance	3,330,102	102,535	417,784	2,809,783
	Willamette Valley Community Health	47,570	47,570	-	-
	Yamhill Community Care	1,125,717	395,482	730,235	-
	<b>All</b>	<b>16,163,747</b>	<b>2,953,084</b>	<b>9,179,869</b>	<b>4,030,794</b>

Table G.4: PMPM Health-Related Services Spending (\$) by Type and CCO, 2018-2019

Year	CCO	Health-Related Services Total	Type of Spending		
			Flexible Services	Community Benefit Initiative	Health Information Technology
2018	Advanced Health	0.61	-	0.61	-
	AllCare CCO	2.48	0.57	1.91	-
	Cascade Health Alliance	4.40	0.61	3.79	-
	Columbia Pacific	0.48	-	0.47	-
	Eastern Oregon CCO	0.05	0.05	-	-
	Health Share of Oregon	0.84	0.07	0.77	-
	InterCommunity Health Network	-	-	-	-
	Jackson Care Connect	4.04	3.03	1.01	-
	PacificSource Central	-	-	-	-
	PacificSource Gorge	-	-	-	-
	Primary Health of Josephine County	0.35	0.31	0.04	-
	Trillium Community Health Plan	1.92	0.10	1.82	-
	Umpqua Health Alliance	3.83	0.16	3.67	-
	Willamette Valley Community Health	0.02	0.02	-	-
	Yamhill Community Care	1.91	1.07	0.84	-
<b>All</b>	<b>1.08</b>	<b>0.23</b>	<b>0.84</b>	<b>-</b>	
2019	Advanced Health	2.21	0.05	2.16	-
	AllCare CCO	2.60	0.82	1.71	0.07
	Cascade Health Alliance	1.04	0.14	0.90	-
	Columbia Pacific	4.74	0.03	4.71	-
	Eastern Oregon CCO	0.15	0.09	0.06	-
	Health Share of Oregon	0.71	0.23	0.28	0.20
	InterCommunity Health Network	1.39	-	0.85	0.55
	Jackson Care Connect	2.72	1.25	1.36	0.10
	PacificSource Central	0.19	0.19	-	-
	PacificSource Gorge	3.73	0.56	3.17	-
	Primary Health of Josephine County	0.89	0.74	0.16	-
	Trillium Community Health Plan	2.08	0.15	1.93	-
	Umpqua Health Alliance	10.29	0.32	1.29	8.68
	Willamette Valley Community Health	0.04	0.04	-	-
	Yamhill Community Care	3.75	1.32	2.44	-
<b>All</b>	<b>1.51</b>	<b>0.28</b>	<b>0.86</b>	<b>0.38</b>	

Table G.5: Monthly Flexible Services Spending (\$) per 1,000 Members, by Category and CCO, 2018-2019

Year	CCO	Flexible Services Total	Category of Spending						
			Housing	Other	Transportation	Training/Education	Home	Case Management	Food/Social
2018	Advanced Health	-	-	-	-	-	-	-	-
	AllCare CCO	570	33	0.1	481	47	4	5	-
	Cascade Health Alliance	609	-	-	-	570	25	-	14
	Columbia Pacific	3	-	-	-	2	-	1	0.3
	Eastern Oregon CCO	50	-	-	-	-	50	-	-
	Health Share of Oregon	70	14	10	1	7	3	31	3
	InterCommunity Health Network	-	-	-	-	-	-	-	-
	Jackson Care Connect	3,031	1,533	-	396	748	118	217	18
	PacificSource Central	-	-	-	-	-	-	-	-
	PacificSource Gorge	-	-	-	-	-	-	-	-
	Primary Health of Josephine County	313	-	-	1	307	-	1	4
	Trillium Community Health Plan	102	-	100	-	-	2	-	-
	Umpqua Health Alliance	161	-	-	156	5	-	-	-
	Willamette Valley Community Health	25	14	-	-	4	5	2	0.4
Yamhill Community Care	1,072	46	4	2	489	-	532	-	
<b>All</b>	<b>233</b>	<b>77</b>	<b>17</b>	<b>55</b>	<b>72</b>	<b>11</b>	<b>41</b>	<b>3</b>	
2019	Advanced Health	54	10	39	5	-	-	-	-
	AllCare CCO	821	53	0.3	709	-	7	16	37
	Cascade Health Alliance	137	-	26	-	81	25	-	5
	Columbia Pacific	28	17	-	-	2	5	2	2
	Eastern Oregon CCO	91	7	13	0.2	-	68	2	-
	Health Share of Oregon	227	165	9	5	14	26	2	7
	InterCommunity Health Network	-	-	-	-	-	-	-	-
	Jackson Care Connect	1,255	361	769	-	2	122	0.2	-
	PacificSource Central	194	64	-	8	87	35	-	-
	PacificSource Gorge	561	15	5	24	455	63	-	-
	Primary Health of Josephine County	736	1	1	2	699	-	29	5
	Trillium Community Health Plan	148	0	147	-	0.1	0.3	0.0	-
	Umpqua Health Alliance	317	62	9	225	-	20	-	1
	Willamette Valley Community Health	39	22	5	1	2	5	4	-
Yamhill Community Care	1,319	49	88	3	682	38	458	-	
<b>All</b>	<b>276</b>	<b>92</b>	<b>55</b>	<b>53</b>	<b>48</b>	<b>25</b>	<b>16</b>	<b>5</b>	

**Table G.6: Annual Flexible Services Spending per Recipient (\$) and Percentage of Members Receiving Flexible Services, by CCO, 2018-2019**

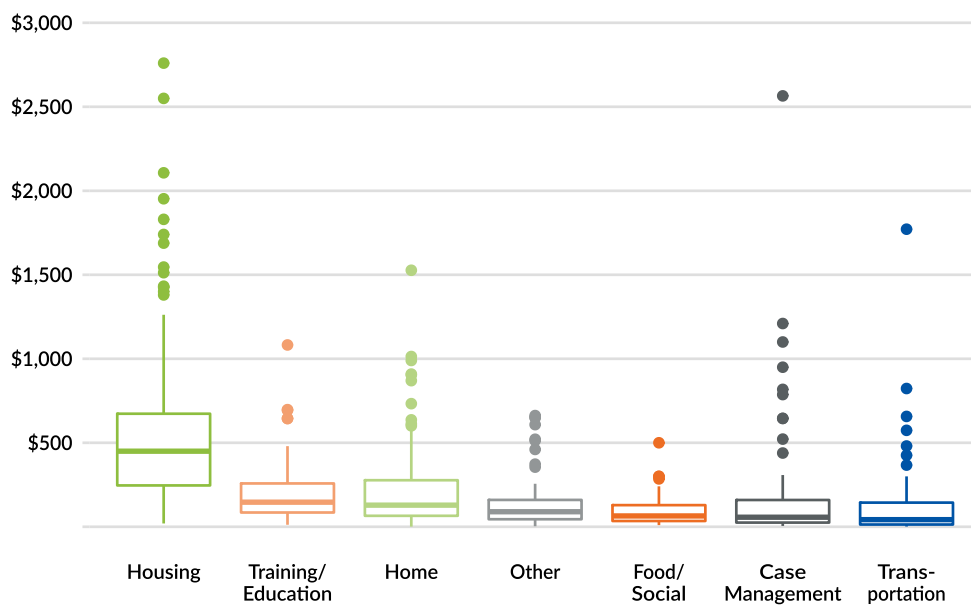
Year	CCO	Amount (\$) per FS Recipient	% of Members Receiving FS
2018	Advanced Health	-	-
	AllCare CCO	48	12.3
	Cascade Health Alliance	224	2.7
	Columbia Pacific	18	0.2
	Eastern Oregon CCO	128	0.4
	Health Share of Oregon	19	3.6
	InterCommunity Health Network	-	-
	Jackson Care Connect	56	57.0
	PacificSource Central	-	-
	PacificSource Gorge	-	-
	Primary Health of Josephine County	24	13.1
	Trillium Community Health Plan	26	4.2
	Umpqua Health Alliance	177	0.9
	Willamette Valley Community Health	241	0.1
	Yamhill Community Care	573	2.0
	<b>All</b>	<b>50</b>	<b>5.6</b>
2019	Advanced Health	169	0.3
	AllCare CCO	44	19.2
	Cascade Health Alliance	97	1.4
	Columbia Pacific	141	0.2
	Eastern Oregon CCO	80	1.1
	Health Share of Oregon	273	0.8
	InterCommunity Health Network	-	-
	Jackson Care Connect	87	14.6
	PacificSource Central	201	0.9
	PacificSource Gorge	250	2.3
	Primary Health of Josephine County	63	11.8
	Trillium Community Health Plan	31	4.9
	Umpqua Health Alliance	251	1.3
	Willamette Valley Community Health	445	0.1
	Yamhill Community Care	297	4.5
	<b>All</b>	<b>97</b>	<b>3.1</b>

Note: "All" rows contain the overall amounts and percentages among CCOs with Flexible Services spending.

Figure G.29 presents the distribution of 2019 flexible services spending per recipient for each category. In this plot, the boxes represent the interquartile ranges, the dots are outliers (expenditures greater than the 75th percentile plus 1.5 times the interquartile range), and the vertical lines extend to the minimum and maximum excluding the outliers. Horizontal lines show the median spending per recipient in each category. (Eight expenditures that exceeded \$3,000 were excluded from this display: \$16,668 for other; \$9,276, \$5,131, and \$3,125 for housing; \$3,976 and \$3,150 for home; \$3,465 for training/education, and \$3,122 for case management.)

This distribution of flexible services spending per recipient varied by category. Housing had the highest spending per recipient with a median value of \$454, reaching a maximum (outlier value) of \$9,276. Transportation had the lowest median value (\$43), but food and social had the smallest range, never exceeding more than \$500 per recipient.

**Figure G.29: Distribution of Flexible Services Spending Per Recipient (\$) by Category, 2019**



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# Appendix E: Final Oregon 1115 Waiver Renewal Concept Papers

*This appendix includes the final concept papers provided to CMS on October 13, 2021, and to the public prior to the release of the draft 1115 Waiver Application.*

## Dual Focus on Engagement and Health Equity

Oregon's final application responds to the community feedback we received on these final concept papers as well as the draft application. The final application builds on the existing foundation of OHP to more intentionally address health equity, while aligning with the priorities of Oregon's nine Federally Recognized Tribes and the Urban Indian Health Program. Focusing our waiver application on meaningful progress toward health equity, along with clear alignment with other health policy initiatives in our state, will allow us to improve health outcomes in communities most harmed by social injustices. To carry out this vision we are seeking to:

- Maximize continuous and equitable access to coverage;
- Streamline transitions between systems through defined benefit packages of social determinants of health services;
- Move to a value-based global budget;
- Improve health through focused equity investments led by communities; and
- Ensure quality and access through equity-driven performance metrics.

Final concept papers on each of these topic areas are included this appendix.

# Maximizing coverage through the Oregon Health Plan

Oregon aims to:

1. Reduce the state's current uninsured rate of six percent to below two percent, and
2. Eliminate the racial and ethnic inequities in uninsured rates that currently exist.

To accomplish these goals, Oregon will work to remove systemic barriers that cause people to lose coverage or prevent them from accessing coverage in the first place. The strategies outlined in this concept paper will move the state closer to universal coverage, as well as reduce inequities by enrolling more already-eligible people in Medicaid and establishing longer continuous coverage periods to keep people enrolled.

Given that two percent of uninsured people in Oregon say they are not interested in coverage,<sup>1</sup> Oregon aims to enroll 98 percent of the state in affordable, comprehensive coverage, with no meaningful inequities in coverage among racial or ethnic groups. To achieve this goal, non-waiver strategies outlined in Appendix B will be implemented alongside the following proposed 1115(a) demonstration waiver policies:

1. Provide continuous Oregon Health Plan (OHP) enrollment for children until their sixth birthday (age 0-5);
2. Establish two-year continuous OHP enrollment for people ages six and up; and
3. Provide an expedited OHP enrollment path for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits.

## Problem and background

People need insurance coverage to access health care and maintain good health for themselves and their families. People without insurance coverage have a harder time accessing health care services,<sup>2</sup> they may face significant medical debt when they do get care,<sup>3</sup> and their children are less likely to access pediatric preventive care than their Medicaid-covered peers.<sup>4</sup> They are also more likely to delay needed care, which

<sup>1</sup> Oregon Health Insurance Survey (2019)

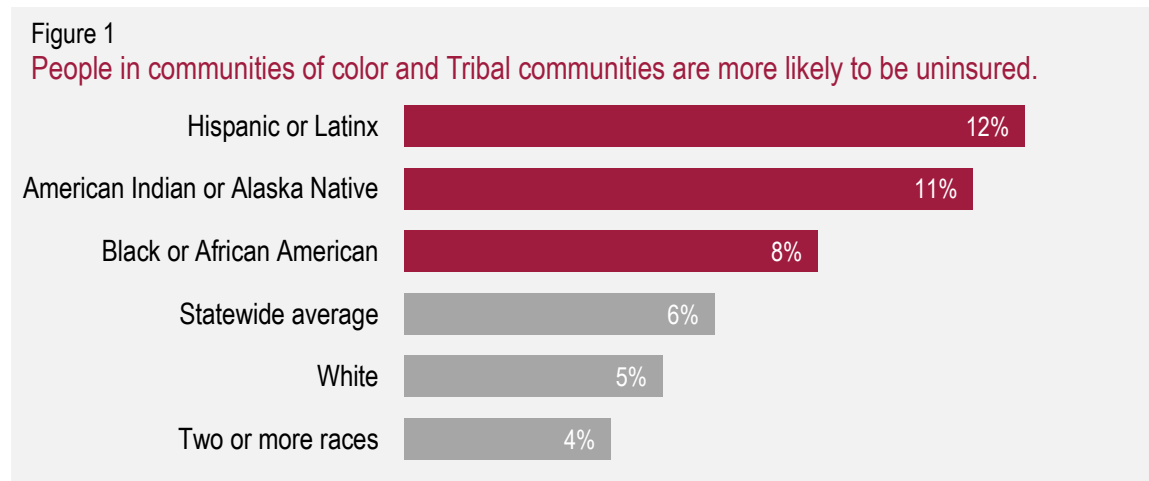
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can lead to worse health outcomes and increase their need for higher intensity care, resulting in higher overall costs for the health care system.<sup>5, 6</sup>

Despite significant coverage expansion since the Affordable Care Act (ACA) and Oregon’s existing 1115(a) demonstration were implemented, too many people in Oregon still lack insurance coverage. The statewide uninsured rate has remained near 6 percent since the ACA expansion in 2014. Importantly, uninsured rates among some communities of color and Tribal communities are twice as high (see Figure 1).<sup>7</sup> Such inequities reflect that our systems are structured to benefit dominant racial groups. To reach our goal of eliminating health inequities by 2030, Oregon must remove the structural barriers that are causing unequal access to coverage.



Source: Oregon Health Insurance Survey, 2019

Immigration status continues to prevent people from obtaining health insurance, accounting for some of these inequities. With the passage of Cover All Kids (2017) and Cover All People (2021), the Oregon Legislature has demonstrated a firm commitment to investing state funds in extending comprehensive coverage to people in Oregon currently ineligible for Medicaid due to immigration status.<sup>8,9</sup> However, without more sustainable and inclusive programs, people who are undocumented and uninsured face language, cultural, fear-based and other barriers to accessing coverage and care.<sup>10</sup> Oregon seeks to address these barriers by expanding upon current culturally appropriate outreach and education efforts to connect people to state-based or Medicaid coverage depending on their circumstances, and to ensure they can access health care services when needed.

<sup>5</sup> KFF analysis of the 2019 National Health Interview Survey. <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/view/footnotes/#footnote-494622-13>

<sup>6</sup> Cesar I. Fernandez-Lazaro, et al., “Medication Adherence and Barriers Among Low-Income, Uninsured Patients with Multiple Chronic Conditions,” *Research in Social and Administrative Pharmacy* 15, no. 6 (June 2019): 744-753.

<sup>7</sup> Oregon Health Insurance Survey, 2019

<sup>8</sup> <https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB3352>

<sup>9</sup> <https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB558/Enrolled>

<sup>10</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4634824/>



Most uninsured people in Oregon are eligible for Medicaid or Marketplace coverage. Analysis of the Oregon Health Insurance Survey (OHIS) reveals the following:

**More than one-third of uninsured people in Oregon reported that “lost OHP coverage” was a reason for being uninsured.**<sup>11</sup> Oregon Health Insurance Survey data suggests that many uninsured people in Oregon may still be eligible for OHP even when they lose OHP coverage, and as a result may re-enroll within a year or two.

Job loss (23%), not being able to afford employer-based coverage (20%), reduced work hours making them ineligible for job-based coverage (12%), and that an employer stopped offering coverage (7%) are other leading reasons for being uninsured.

**Approximately 78% of uninsured people in Oregon are likely eligible for OHP or for subsidized coverage on the Oregon Health Insurance Marketplace.** About 26% of uninsured people in Oregon are likely eligible for OHP. The share of uninsured children eligible for Medicaid is even higher: about 60% of uninsured children in Oregon are eligible for CHIP. Approximately 52% of uninsured people in Oregon are likely eligible for subsidized coverage through the Oregon Health Insurance Marketplace

**People of color are overrepresented among uninsured people who are likely eligible for OHP.** This means that focused efforts to better cover eligible people for OHP are a central strategy to reduce coverage inequities. Among Hispanic or Latinx communities, 1 in 3 are potentially eligible for OHP but not enrolled; and among non-Hispanic people who identify as a race other than White, about 42% have income that should qualify them for OHP.

Coverage disruptions highlighted by the OHIS data can be life-altering because disruption causes people lose access to care or established relationships with providers they trust. One 2015 study examined the impact of churn (switching coverage types or losing and then re-enrolling in coverage) and found that people experienced a coverage gap as part of their churn were more likely to have to switch doctors and more likely to skip doses or stop taking medications, compared to those who churned without a coverage gap. People who experienced a coverage gap were also more likely to have reported delaying care due to cost, trouble paying bills, or receiving only fair or poor quality care. In the end, half of those who experienced a coverage gap reported it having a negative impact on their overall health and quality of care (compared to 20 percent for those without a coverage gap).<sup>12</sup> Furthermore, a 2015 analysis of national data from 2005-2010 estimated that the administrative cost of a person leaving/regaining coverage just one time, including disenrolling and reenrolling, costs between \$400 and \$600 in 2015, an amount which would likely be higher now.<sup>13</sup>

Oregon aims to extend continuous eligibility for children from birth up to their sixth birthday in alignment with the vision to ensure all children enter school ready to learn. As is documented in Oregon’s roadmap for Raise Up Oregon program,<sup>14</sup> increasing early childhood physical and social-emotional health promotion and prevention, and identifying young children with social-emotional, developmental and health care needs

<sup>11</sup> Oregon Health Insurance Survey, 2019

<sup>12</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455>

<sup>13</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204>

<sup>14</sup> <https://oregonearlylearning.com/wp-content/uploads/2019/01/Raise-Up-Oregon-Web-corrected.pdf>

early is critical to this vision. Continuous coverage for young children is an important tool to promote consistent access to health care and the preventive services needed to identify and address physical, behavioral, and developmental concerns before they impede a child's performance in school.<sup>15</sup> Studies demonstrate inconsistent coverage leads to a higher likelihood of unmet medical, prescription and dental needs, a delay in accessing urgent care (14) and a lower likelihood of having a usual source of care and well child care<sup>16,17</sup>. These gaps in access are particularly consequential for the pre-school aged children that Oregon has prioritized, as experts recommend 16 well-child checks before age 6.<sup>18</sup>

Oregon is also implementing a range of policy solutions to enroll uninsured people in OHP or in subsidized coverage through the Oregon Health Insurance Marketplace. In an effort to streamline and simplify enrollment in assistance programs and improve user experience, Oregon implemented the Oregon Eligibility (ONE) system for MAGI Medicaid/CHIP programs in 2015, and upgraded the system in 2020 to incorporate SNAP, TANF, and Employment Related Daycare (ERDC) programs.<sup>19</sup>

In 2013, Oregon implemented an expedited enrollment process in accordance with CMS guidance received, in which the state conducted targeted outreach to SNAP recipients who were likely eligible but not enrolled in OHP.<sup>20</sup> Analysis of 2021 SNAP membership indicates an estimated 17% of adult (ages 19 and older) SNAP case members with income below 138% FPL (per SNAP household and income calculations) are not enrolled in OHP, and 7% of child (ages 18 or younger) SNAP case members with income below 305% FPL are not enrolled in OHP. This suggests an opportunity to use cross-program data sources to maximize OHP coverage.

## Proposed strategies

Given the issues outlined above, it is clear that there are avoidable barriers to coverage and coverage continuity; and that these barriers disproportionately harm people in communities of color and result in health inequities. People of color are more likely be uninsured, and so Oregon is prioritizing closing gaps in the system that cause people to lose coverage or prevent them from signing up in the first place. While the Oregon Legislature has taken steps to expand equitable access to coverage, the strategies described below are designed to address remaining structural barriers to coverage that result in health inequities.

### Establish continuous enrollment for children during early years

#### **1. Provide continuous enrollment for children until their 6<sup>th</sup> birthday**

Oregon requests to provide continuous enrollment for children through the end of the month in which their 6th birthday falls, regardless of when they first enroll in the Oregon Health Plan, and regardless of changes in circumstances that would otherwise cause a loss of eligibility. Oregon currently exercises the federal option for 12-month continuous enrollment for all children ages 0-18, with provisions to disenroll children

<sup>15</sup> <https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf>

<sup>16</sup> Jennifer E. DeVoe, Alan Graham, Lisa Krois, Jeanene Smith, Gerry L. Fairbrother, "Mind the Gap" in Children's Health Insurance Coverage: Does the Length of a Child's Coverage Gap Matter?, *Ambulatory Pediatrics*, Volume 8, Issue 2, 2008.

<sup>17</sup> Cassidy A, Fairbrother G, Newacheck PW. The impact of insurance instability on children's access, utilization, and satisfaction with health care. *Ambul Pediatr*. 2008 Sep-Oct;8(5):321-8. doi: 10.1016/j.ambp.2008.04.007. Epub 2008 Jun 16. PMID: 18922506.

<sup>18</sup> <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf>

<sup>19</sup> ONE.oregon.gov is Oregon's single system to apply for health and human services benefits

<sup>20</sup> SHO letter dated May 17, 2013, titled "RE: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014"

who turn 19 or move out of state, per federal requirements. Lengthening this time frame for younger children will stabilize their insurance coverage and thus increase access to early-childhood screenings and necessary treatment.

Consistent OHP coverage will reduce churn in this vulnerable population and allow for more predictable access to care, which is an important driver of improved health. Because many of these children remain eligible for coverage, eliminating churn also reduces state administrative costs and burden for families in application reprocessing. Further, expanding the pool of children who are continuously covered may ultimately reduce per member costs of coverage, as children who stay on OHP longer will have better access to preventive and primary care services that can reduce the need for higher-cost treatments due to delayed care. Increasing the time between eligibility reviews for other family members will further ease the administrative burden on families and increase coverage stability for individuals and families on OHP.

## **Preserve policies that reduce churn for Medicaid members**

### ***2. Establish two-year continuous OHP enrollment for people ages 6 and up***

Oregon also seeks to provide continuous two-year enrollment for children and adults ages 6 and older, regardless of changes in circumstances that would otherwise cause a loss of eligibility. This change will:

- stabilize coverage for older children and adults,
- increase access to primary and preventive services, and
- preserve patients' continuity in accessing ongoing care.

Establishing continuous enrollment and increasing the length of time between eligibility renewals will preserve the coverage continuity gains achieved in the wake of federally enacted COVID relief bills passed in 2020. In 2018 and 2019, nearly 25% of new OHP enrollees had been enrolled in OHP within the previous 6 months. Over the last 6 months of 2020, this rate fell to just 5% of new enrollees. The speed with which people re-enrolled in OHP suggests that they may have been losing OHP coverage despite being eligible. The drop in the new enrollee rate suggests that federal policies enacted around the pandemic to keep people covered successfully reduces Medicaid churn.

## **Streamline enrollment and eligibility procedures for people seeking other benefits**

### ***3. Provide an expedited OHP enrollment path for people who apply for SNAP benefits***

Oregon requests an expedited OHP enrollment option for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits. The Oregon Health Authority will identify people who: 1) are part of a SNAP case 2) have income within applicable OHP standards and 3) are not requesting or enrolled in OHP. People will be notified they are eligible to enroll in OHP based on their SNAP information. Those who respond affirmatively and answer minimal questions (to confirm OHP enrollment would not cause disruption to Medicare, Marketplace coverage, or age- and disability-related services) will be enrolled in OHP using the household size and income calculation established by SNAP program policy.

Using SNAP case information for the purpose of Medicaid/CHIP enrollment is supported by CMS in the 2015 SHO # 15-001 letter titled, "RE: Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies." The allowance in this SHO letter is limited to case scenarios

where treatment of eligibility criteria between SNAP and Medicaid/CHIP align and excludes SNAP households where it differs. Most notably, SNAP households containing “ineligible non-citizens” would be excluded from consideration for expedited Medicaid/CHIP enrollment; many people whose immigration status meets Medicaid/CHIP requirements for full coverage; and all people who would be eligible for CAWEM, Cover All Kids, or eventual Cover All People coverage would be excluded with that allowance. For this reason, Oregon requests waiver provisions to enable OHA to assume applicants’ eligibility for OHP based on their SNAP case information even when some data typically used to determine Medicaid eligibility is not available. People who gain OHP coverage through the expedited SNAP pathway will become continuously eligible for two years upon their initial OHP enrollment. After two years, they will go through the regular OHP redetermination process.

Enrolling SNAP applicants will further ease the burden on families to apply for services from multiple programs. This change should increase enrollment in the Oregon Health Plan and increase the effectiveness of both programs as they collectively meet individuals’ and families’ needs.

## What these policies would mean for OHP members

For people who are eligible but not enrolled in OHP, there will be more outreach and engagement to support enrollment in OHP, ideally in the member’s preferred language or by trusted partners and community- based organizations who can assist the member. If the person or family receives other benefits, such as food assistance the Supplemental Nutrition Assistance Program, sometimes called Oregon Trail Card or EBT benefits, but don’t have health coverage, they may receive information about enrolling in OHP with minimal requirements for new information.

For children on OHP, continuous enrollment from birth until their sixth birthday means that health insurance coverage and access to familiar providers will remain consistent minimizing disruptions in coverage during critical pre-school years when regular checkups are most important.

For parents and caregivers of children on OHP ages six and up, a two-year continuous enrollment policy means that there will be less worry about whether a small shift in employment or income will cause disruptions in care for children and adults. Parents and other adults on OHP will also benefit from longer periods between renewals, easing stress, reducing the stress of paying for health care and access to familiar providers will remain consistent.

# Appendix A

## Additional (non-1115(a) waiver) strategies

Below are additional complementary strategies Oregon is pursuing to support this work. If necessary, Oregon may pursue 1332 waivers and other mechanisms to implement these strategies.

1. Develop commercial insurance market reforms designed to improve coverage continuity and access to care for people who obtain health insurance coverage through the Oregon Health Insurance Marketplace, with an emphasis on policies and strategies that help people and families when they move from Medicaid to commercial coverage, potentially through a 1332 waiver request.
2. 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.
3. Ensure CCOs continue to provide ongoing outreach and navigation services that support and retain existing members who remain eligible in advance of redetermination dates and that outreach and engagement efforts are coordinated across programs.
4. With the passage of Senate Bill 65<sup>21</sup> during the 2021 Oregon Legislative session, the responsibility for operating the Oregon Health Insurance Marketplace will move to OHA. This transition will allow OHA to more easily identify opportunities to stabilize coverage for people who shift between OHP and the Marketplace coverage.
5. Align with other existing state and federal efforts to expand or stabilize health care coverage, including the Oregon Task Force on Universal Healthcare and legislative efforts to explore a state-based public option.<sup>22</sup>
6. Continue implementing Cover All Kids (2017) and Cover All People (2021), complementary initiatives based on the Oregon legislature's commitment to covering people in Oregon currently ineligible for Medicaid due to immigration status.
7. Continue implementing the Citizen Alien Waived Emergent Medical (CAWEM) program benefit to include more services that are included in the definition of the emergency benefit and supplement coverage for Cover All people, applying CAWEM funding to emergency services accessed by Cover All People enrollees.
8. Allow applicants to self-attest their income, a policy which was successful at nearly eliminating churn in coverage during the COVID-19 pandemic.<sup>23</sup> Oregon would like to retain the policy that was available as part of the Public Health Emergency to streamline the application and redetermination process. This change has increased the speed at which applicants obtain proof of coverage and are able to access care by allowing coverage prior to verification of income.

<sup>21</sup> <https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB65>

<sup>22</sup> <https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx>

<sup>23</sup> OHA analysis of Medicaid enrollment data

9. Align the timing of members' eligibility renewal so that members' SNAP, TANF and OHP eligibility redeterminations happen concurrently. This change will ease the process for families to retain services and reduce administrative costs to the state.

# Improving Health Outcomes by Streamlining Life and Coverage Transitions

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

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

Oregon aims to address these issues by:

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

## *Ensuring OHP coverage across life transitions*

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

## *Addressing the full set of factors that impact health*

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

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

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

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

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



## Problem and background

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

- With the exception of the Asian population, people of color experience homelessness at a disproportionate rate compared to the general population.
- Almost all racial and ethnic groups in Oregon – particularly African Americans – experience higher levels of poverty than in the United States as a whole.
- One-third of all African American households spend more than 50% of their income on housing costs, compared to 17% of all households in the state.
- African Americans in Oregon are 4.6 times more likely than their white counterparts to be incarcerated, and Native Americans and Latino/a/x populations experience rates of incarceration 1.8 and 1.4 times greater than whites, respectively.

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

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

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

Short-term, focused supports and services that are specifically tied to screening for disruptive events, social needs and improved outcomes will aid in achieving more successful transitions and reduce the impact of

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

<sup>4</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/>

<sup>5</sup> <https://pubmed.ncbi.nlm.nih.gov/28728555/>

<sup>3</sup> Health inequities happen when unfair social policies and practices deny groups of individuals the opportunity for optimal health, either through a lack of resources that promote health or through increased exposure to risk factors for disease. [https://www.bphc.org/healthdata/health-of-boston-report/Documents/3A\\_Health%20Equity\\_16-17\\_HOB\\_final-3.pdf#search=difference%20between%20inequities%20and%20disparities](https://www.bphc.org/healthdata/health-of-boston-report/Documents/3A_Health%20Equity_16-17_HOB_final-3.pdf#search=difference%20between%20inequities%20and%20disparities)

<sup>6</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/>

<sup>7</sup> <https://pubmed.ncbi.nlm.nih.gov/28728555/>

events that exacerbate health inequities, providing better health outcomes and downstream cost savings for the state and federal government.

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

Under Oregon's 2017-2022 1115(a) demonstration waiver renewal, OHA introduced health-related services (HRS) to increase CCOs' ability to use non-medical services to address members' health-related social factors and inequities that contribute to poor health. However, to date, spending on HRS remains low (0.7% on average) and has not fully addressed the needs of populations moving through transitions in coverage. This low spending is concerning considering the potential to improve member and community health outcomes.

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

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

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

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

## Proposed strategies

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

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

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

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

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

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

#### **With this waiver authority, Oregon will specifically:**

- Retain benefits and/or extend Medicaid benefits to all youth otherwise eligible for Medicaid upon entering the juvenile correction system throughout the duration of their involvement in juvenile corrections.**

Youth who are involved in the juvenile justice system are inherently at high risk. Youth with a history of involvement in the child welfare or behavioral health systems are disproportionately referred to the juvenile justice system. And again, youth of color are grossly over-represented, in the juvenile corrections system, with high rates of entry into secure correctional facilities.<sup>12</sup>

These youth of color are more likely to have complicated and expensive medical and behavioral health needs because of the effects of structural racism and other factors, and less likely to have received consistent medical care and preventive services over their lifetime.<sup>13</sup>

<sup>8</sup>[https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing\\_30\\_Day\\_Inpatient\\_Psychiatric\\_Recidivism.8.aspx](https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing_30_Day_Inpatient_Psychiatric_Recidivism.8.aspx)

<sup>9</sup> [https://cdr.lib.unc.edu/concern/honors\\_theses/j6731775s](https://cdr.lib.unc.edu/concern/honors_theses/j6731775s)

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

<sup>11</sup> <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf>

<sup>12</sup> <https://pubmed.ncbi.nlm.nih.gov/23334336/>

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

These individuals are often involved with multiple systems (medical, behavioral health, education, child welfare) and may need high-level specialty treatment resources that are difficult to access without clear payment sources and case management. By providing health care services and the strength of the coordinated care model during a serious life transition (justice involvement) and critical life stage (youth, and often youth of color being over-represented), this strategy could improve lifelong health for these high-risk youth and save long term costs across multiple systems.

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

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

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

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

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

This request for coverage takes into account the relatively short (less than 90 days) and uncertain length of stays in county jail and other local correction facilities. In order to maintain continuity of care and ensure physical and behavioral needs are met on release, OHP members in county jails and local correction facilities will benefit by having a limited OHP benefit throughout incarceration. Oregon requests that those without current valid OHP coverage would be supported by the OHA Community Partner Outreach Program and local corrections staff in initiating, completing and submitting a new OHP application within 72 hours of arrest and booking. These populations are at

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

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

risk for poor outcomes and would benefit in health improvements as described in paragraph b above. These populations would also be eligible for transition related SDOH services.

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

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

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

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

For young adults with special health care needs, effective transition from pediatric to adult health care results in increased<sup>19</sup>:

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

and decreased:

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

<sup>16</sup> <https://link.springer.com/article/10.1007/s11920-019-1016-1>

<sup>17</sup> [https://pediatrics.aappublications.org/content/126/Supplement\\_3/S129.short](https://pediatrics.aappublications.org/content/126/Supplement_3/S129.short)

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

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

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

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

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

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

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

## **Proposed SDOH transition services**

### **Housing**

Housing is a key social determinant of health, and being housed is associated with lower inpatient hospitalizations, fewer ED visits, and lower incarceration rates.<sup>20,21</sup> In a study in Oregon, Medicaid costs declined by 12% on average after people moved into affordable housing.<sup>22</sup> Institutional racism has impacted access to housing. According to 2018 data, people in Oregon who are Black, Native American or

<sup>20</sup> Nakamura MM, Toomey SL, Zaslavsky AM, et al. Measuring pediatric hospital readmission rates to drive quality improvement. *Acad Pediatr*. 2014

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

<sup>22</sup> [https://oregon.providence.org/~media/Files/Providence%20OR%20PDF/core\\_health\\_in\\_housing\\_full\\_report\\_feb\\_2016.pdf](https://oregon.providence.org/~media/Files/Providence%20OR%20PDF/core_health_in_housing_full_report_feb_2016.pdf)

Pacific Islander, or two or more races represent a greater share of the unhoused population than their share of the total population.<sup>23</sup> Without interventions to support stable housing, homelessness can trigger destabilizing transitional events and, ultimately, create higher costs for the health care system and poorer health outcomes for individuals. Supports may include one or more of the following components:

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

### **Health-related transportation**

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

### **Food assistance**

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

### **Employment Supports**

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

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

### **Exposure to climate events**

Over the last several years Oregon has endured several extreme climate change-related events, including wildfires, ice storms, and extreme heat. During Oregon's most recent extreme heat event in late June 2021, 116 people in Oregon died of heat-related illness or hyperthermia. Vulnerable populations, including

<sup>23</sup> <http://oregonhousingconference.org/wp-content/uploads/2018/10/Oregon-Housing-Conference-10-15.pdf>

children, pregnant people, older adults, communities of color, immigrant groups (including those with limited English proficiency), American Indians and Alaska Natives, people with disabilities, vulnerable occupational groups, such as workers who are exposed to extreme weather, low-income communities, people with pre-existing or chronic medical conditions, and intersections among these groups, experience disproportionate adverse health impacts because they experience less climate-resiliency.<sup>24</sup> Extreme climate events are occurring with greater frequency and severity, can disrupt health care access and even coverage.<sup>25</sup> Benefits for people impacted by climate disasters and vulnerable to extreme weather can reduce health inequities and disruptions to health care services and coverage. Supports may include one or more of the following components:

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

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

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

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

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

<sup>24</sup> <https://www.apha.org/topics-and-issues/climate-change/vulnerable-populations>

<sup>25</sup> [https://earthobservatory.nasa.gov/features/RisingCost/rising\\_cost5.php](https://earthobservatory.nasa.gov/features/RisingCost/rising_cost5.php)



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

## What these policies would mean for OHP members

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

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

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

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

# Appendix A

## Additional (non-waiver) strategies

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

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

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<sup>26</sup> <https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2417>

# Value-Based Global Budget

Oregon is requesting authority to create coordinated care organization (CCO) value-based global budgets that will better drive investments in health equity, incentivize spending on health-related services, and be developed to cover all reasonable, appropriate costs of running the CCO program while increasing at a predictable growth rate in line with the state's cost growth target.<sup>1</sup> The new value-based global budgets would provide longer-term predictability and flexibility to CCOs and providers, in turn driving additional upstream investments in prevention and health-related services to improve health outcomes and reduce avoidable health care costs.

This value-based global budget would further flip financial incentives in the delivery system: instead of being financially rewarded when Medicaid members are sick and access more care, CCOs would be accountable for Members' health and have more resources to invest when members' health improves, inequities are eliminated, and avoidable health events are prevented through better, more coordinated care for members.

In this 1115(a) demonstration waiver renewal, Oregon is requesting waiver flexibility in how Medicaid managed care (CCO) capitation rates are typically established, while maintaining reasonable and appropriate rates, in order to meet the goals described above. Specifically, Oregon requests the authority to:

1. Calculate 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.
2. Trend the base rate forward in a predictable way over five years, without resetting base budgets each year.
3. Increase predictability of costs through closer management of pharmacy costs, by allowing a commercial-style closed formulary approach that may exclude drugs with limited or inadequate evidence of clinical efficacy.

## Problem and background

Most of peoples' health is determined not by the medical care they receive but by social determinants, such as neighborhood and built environment, access to healthy food, and job opportunities and income.<sup>2</sup> Oregon increasingly recognizes that we need to address these social determinants of health to reduce medical costs and improve health equity.<sup>3</sup>

Further, Oregon's Nine Federally-Recognized Tribes and Tribal communities, Latino/Latina/Latinx, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, communities of color, people with disabilities, people with limited English proficiency, and immigrant and refugee communities have worse social and environmental conditions and worse health outcomes,

<sup>1</sup> Annual per capita spending target that will apply across all health care markets beginning in 2021

<sup>2</sup> Magnan, S. (2017). Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine. Available at: <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>

<sup>3</sup> <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>; <https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-1-19.pdf>

resulting in part from chronic underinvestment by the state and federal government. The COVID-19 pandemic has underscored this point, with communities of color experiencing harm at a disproportionate rate when compared to their white counterparts.<sup>4</sup>

The current system for managed care organizations does not do enough to incentivize investments in health, prevention, improved outcomes, or health equity. Traditionally, managed care organizations and health care providers are paid based on how sick a member is and how many health care services they receive. Generally, managed care organizations see increases in their capitation rates year-over-year when members are sick and access more services and/or incur more costs and decreases in their rates if patients are healthier and need fewer services. This payment model is an inherent disincentive to focus on prevention, care management, and other lower-cost interventions that could avoid a health event and resulting services for a member.

When Oregon created CCOs and the Medicaid coordinated care model in 2012, a primary goal was to move from a model primarily focused on delivering health care services to a new model: community-governed organizations that operate under a different economic model and focus on improving health outcomes and managing population health. Oregon aspired to implement a rate-setting methodology with two goals:

- (1) blend physical, behavioral and oral health funding streams together so one organization is responsible for all of its members' health care needs; and
- (2) change the financial incentives in the health care system so that financial rewards come from populations served being healthier, rather than sick.

Under Oregon's original CCO rate setting methodology, the goal was to see the health system shift spending to focus on prevention that reduces avoidable acute care; for example, stronger investments in community behavioral health that could avoid hospital visits. Another goal was to see increasing amounts of funds spent on health-related services – such as those to address social needs, like housing and food – with the goal of improving health and avoiding medical costs.

Oregon has had success in blending funding streams for billable health care services; however, under the current federal requirements for capitation rates, we have yet to see a true change in financial incentives for the outcomes we seek. The vision of a value-based, global budget has not yet been fully realized in Oregon. Specifically, CCOs' rates remain largely based on recent medical expenses, perpetuating the built-in disincentives to shift resources to prevention and health-related services, and to contain costs.

Oregon has innovated as much as possible within the current CMS requirements for managed care capitation rates to change the financial incentive to promote population health. Despite Oregon's efforts to refine the rate setting process over time (see box on next page), these strategies have been insufficient to fundamentally change the economic model driving CCO spending. While increasing, Oregon has not seen a marked shift in how much CCOs spend on health-related services. Health-related services spending averages 0.7% of CCOs' annual budgets. Oregon's original global budget concept was intended to drive local, community conversations about how to shift spending within the system to better meet community needs and to spend wisely within limited resources to maximize health outcomes. However, the distribution of spending within Oregon's health care system (e.g. the amounts split between physical, behavioral, and oral health) remains largely the same, indicating spending is following historical habits and market power,

<sup>4</sup> <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>

rather than a true shift in focus to population health. Oregon cannot fully address health inequities or correct historical racism and power imbalances in the health system, unless the financial incentives in the system more fully focus on population health and drive community conversations about prioritizing resources to achieve better outcomes.

### ***Rate methodology changes to date***

CCO rates are built using a methodology that has evolved over time in an effort to incentivize the use of high-value, low-cost services and reduce the opportunities for gamesmanship and excessive profit at the expense of member access and quality, while staying within the bounds of established actuarial principles. For example:

- **Statewide base data.** During the most recent 5-year CCO contract procurement in 2019, OHA introduced the use of statewide base data when developing initial capitation rates. This was done to smooth the impact of high utilization by any single CCO and prevent it from driving rates up indefinitely, while applying regional factors to ensure rates were reflective of appropriate variations in utilization and pricing.
- **Performance-Based Reward Program.** In 2022, OHA will implement Performance-Based Reward (PBR), a program approved through our last waiver renewal which is designed to reward achievements in health-related services and cost containment, subject to quality safeguards. The PBR functions by varying the profit margin of a CCO relative to how much it spent on HRS, to encourage wider adoption of high-value non-medical services. This partially guards against so-called “premium slide” where savings come at a disincentive to the CCO, i.e. when rates are built using historical cost and utilization data, CCOs that reduce costs see reductions in rates each year.

Oregon seeks authority to rely on a capitated rate development methodology for a new, value-based global budget that is as simple as possible and easy for the community and CCO to understand, as well as more predictable for the state and community. It needs to be clear that in focusing spending on health equity, prevention, care coordination and quality, CCOs will improve health and realize savings. This streamlined methodology will be paired with robust accountability to member and community needs, as well as strategies to ensure health equity spending is driven by the community.

With Oregon’s proposed changes to create a value-based global budget, we would expect the following outcomes:

- A substantial increase in health-related services coupled with reduced administrative burden of detailed counting of health-related services in order to get “credit” in rate setting (as is currently required under the Performance-Based Reward). More spending on health-related services will lead to:
  - More investment in community health that promotes health equity
  - More investment in high-value, preventive services

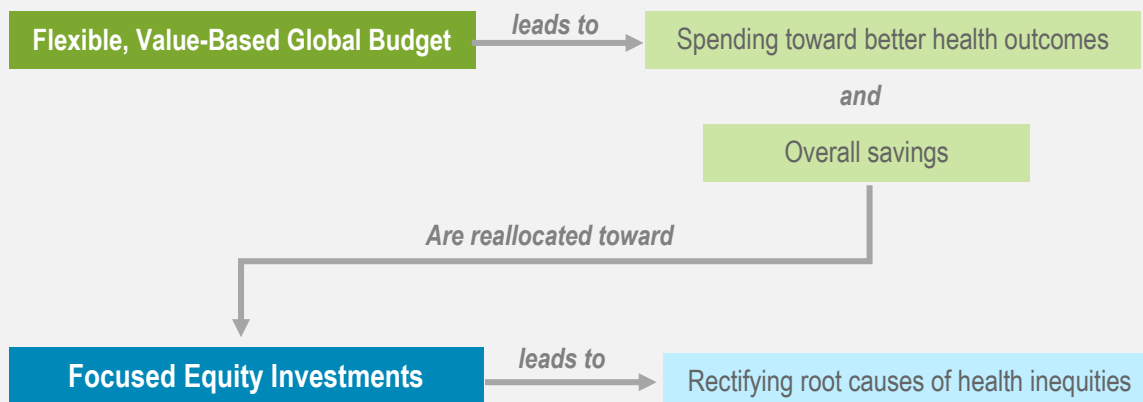
- Increased care coordination and better management of members who incur high costs, including members transitioning between systems and life stages: corrections, Oregon State Hospital, Mental Health residential services, foster care youth – due to clearer financial incentives for improving outcomes.
- A decrease in spending on lower value care and avoidable episodes as CCOs shift funds to prevention and care coordination.
- More accountability of the CCOs to the community they serve for how their value-based global budget is spent.
- The rate of cost growth is limited to publicly determined targets (see box below) and matches overall spending targets in Oregon’s health care system.

Central to Oregon’s value-based global budget strategy is a commitment to sustainable growth. The strategy has always been to save money through more efficient and effective spending that leads to better health outcomes rather than by reducing services or tightening eligibility.

Oregon’s CCO model is innovative and cost-effective. But, keeping cost growth within the target continues to be a challenge. People in Oregon face a statewide housing crisis, regular climate emergencies brought on by climate change, and widespread inequities caused by structural racism – which, in sum, lead to higher health care costs.

The value-based global budget methodology proposed in this concept paper will reward spending on equitable, high-quality health outcomes **while helping Oregon continue to curb per capita cost growth.**

In the *Focused Equity Investments* concept paper, we propose that the federal and state savings achieved through our commitment to sustainable growth at 3.0-3.4% (across all markets, not just Medicaid) will be shared at the statewide and local levels to invest in long-range initiatives that will show measurable improvements toward health equity. By comparison, national Medicaid trend is projected at 4.9% for 2022 through 2028.<sup>5</sup>



<sup>5</sup> NHE Projections (national), Table 17 - NHE Projections 2019-2028

## Proposed strategies

While the factors that most impact length and quality of life are the social and community conditions in which people live, work and play, the US health care system wastes billions of dollars every year on unnecessary services, inefficient delivery, and inflated costs. By changing and simplifying the underlying incentives, Oregon seeks to shift funding toward the expanded use of services designed to address social determinants of health and to health equity investments that are often outside the health care provider walls, thereby reducing health inequities and improving overall health.

Oregon is requesting waiver flexibility in how CCO capitation rates are typically established, while maintaining reasonable and appropriate rates, in order to meet the goals described above. Specifically, we request the ability to:

1. Calculate a base budget (capitation rate) using up to five years of historical utilization and spending, while also looking at recent trends to ensure the base is reasonable and adequate for covered services and the risk of the population, and that it accounts for spending on health-related services. The base budget would be built considering both historical medical expenses as well as spending on health-related services, thereby incentivizing spending on activities that are proven to prevent morbidity and mortality.
2. Trend the base rate forward in a predictable way over five years by adjusting the budget based on Oregon's new statewide health care cost growth target, as well other targeted adjustments needed to address unanticipated events, without resetting base budgets each year.
3. Increase predictability of costs through closer management of pharmacy costs, by allowing adoption of a commercial-style closed formulary approach that may exclude drugs with limited or inadequate evidence of clinical efficacy. This strategy may also help contain pharmacy costs for emergent drugs in ways that could mitigate future rate adjustments.

**To protect OHP members' right to the full array of medically necessary Medicaid benefits and mitigate any unintended impacts of the above waiver requests, Oregon will incorporate the following:**

**Mitigation strategy #1:** Develop strong programmatic safeguards to protect members through ongoing measurement and reporting by CCOs of access, quality, and outcomes to assure against inappropriate underutilization or denials of necessary care.

**Mitigation strategy #2:** Develop robust annual financial monitoring, including monitoring utilization and spending, to monitor CCO solvency and ensure the annual targets are reasonable for covering expected costs, as well as develop a mechanism for budget adjustments if unforeseen events, such as new high-cost treatments, result in the annual trend being inadequate to cover members' health needs.

- 1. Calculate 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.**

To truly shift focus toward providing the highest value care, Oregon needs a value-based global budget for CCOs that is simpler and more predictable over the long term, and that removes any real or

perceived incentives for unnecessary health care spending in the short term. Moving to a value-based budget will focus CCOs on providing high-value care rather than increasing annual spending to improve the next year's rates.

Under Oregon's waiver proposal, the state would set an initial statewide, reasonable and appropriate CCO value-based budget largely in line with how base budgets are set today, with two exceptions:

1. Considering a longer period of time (up to five years) for historical trends to increase confidence that the base budget is sound, and
2. Including health-related services spending, in addition to spending on state plan services, over a period of up to five years.

In addition, to maintain a focus on eliminating health inequities, Oregon plans to direct CCOs to invest at least 3% of their value-based global budgets toward health equity investments (as required by Oregon House Bill 3353), of which at least 30% would be directed to community entities, called regional community investment collaboratives (CICs), for community health equity investments. (See *Focused Equity Investments* concept paper). Oregon proposes to establish a community-led accountability structure for all required health equity spending that includes a statewide oversight committee in addition to the regional CICs. As noted above, Oregon requests the ability to count health-related spending under HB 3353 as part of the medical load when calculating rates, so that the requirement to make these health equity investments does not negatively impact CCOs' future rates.<sup>6</sup>

Going forward, Oregon would adjust CCO budgets annually by a predictable growth trend rate, in line with statewide goals for sustainable growth,<sup>7</sup> and would also carefully monitor CCO spending to identify any additional, targeted adjustments that may be necessary to address unanticipated events.

## **2. Trend the base rate forward in a predictable way over five years, without resetting base budgets each year.**

Oregon proposes that, in line with reducing health care spending in all sectors, CCO budgets be trended forward for five years at the statewide health care cost growth target, which will be 3.0 to 3.4 percent during the demonstration period. This trending forward would allow more predictability for CCOs to make longer-term investments in health equity, prevention, and community improvement—leading to an overall healthier population and lower health care costs over time. Targeted rate adjustments would be made for significant changes in risk profile by CCO, covered benefits, and statewide population, for example, in times of significant change such as coverage expansion during the COVID-19 pandemic.

When combined with an enhanced quality strategy and the ability to count health-related services in the medical load for the purposes of rate setting, this design would allow CCOs to keep savings stemming from appropriate declines in utilization. It would also create more flexibility for CCOs to invest in care

<sup>6</sup> HB 3353 requirements are contingent on CMS approval for directing 3% of CCO value-based global budgets to spending that improves health inequities and reaching agreement that such expenditures count as utilization for the purposes of rate setting.

<sup>7</sup> Oregon's sustainable cost growth goals are part of a statewide effort that includes CCOs, commercial plans, and public health plans, and which aims to create statewide savings to address other state needs. Achieving sustainable growth in the health care system can free up critical resources needed to correct historical racism, power-imbalances, and health inequities. At the same time, a sustainable cost growth target, when combined with other steps in this process, will create incentives for CCOs to focus on health equity, prevention, and the high-quality services that we know reduce costs.

<https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>



improvements, including through investments in preventive care, addressing social needs, and eliminating health inequities.

Oregon also recognizes that enhanced flexibility must be paired with robust member protections, specifically directed at addressing health inequities that exist. To that end, Oregon also proposes a robust accountability system with new mitigation strategies covering four priority areas: equity, member and provider satisfaction, access, and quality of care, described in more detail on pg. 8.

### **3. Increase predictability of costs through closer management of pharmacy costs by adopting commercial-style closed formularies and by excluding drugs with limited or inadequate evidence of clinical efficacy.**

Oregon seeks the ability to more closely manage pharmacy costs in its Medicaid program, through a two-part strategy:

#### *A. Adopt a commercial-style closed formulary approach*

Taking a closed formulary approach for adult members, including at least a single drug per therapeutic class, would enable OHA and CCOs to negotiate more favorable rebate agreements with manufacturers. Oregon would keep an open formulary for children. For each therapeutic class, manufacturers could be offered an essentially guaranteed volume in exchange for a larger rebate. Currently, OHA and CCOs have limited ability to offer such volume deals to manufacturers, given the requirement to cover all drugs in the Medicaid rebate program. OHA would create a collaborative process that includes CCOs to select drugs for the closed formulary.

In recent years the majority of commercial pharmacy benefit managers (PBMs) have adopted such closed formularies, which allow them to customize their drug offerings based on clinical efficacy and cost considerations. As an example, for 2021 CVS Health excluded from its formulary 57 additional products—some because a less expensive, medically equivalent drug had become available and some because the drugs were hyperinflationary, having dramatically increased in price without clear justification. Medicare Part D commercial plan are also permitted to employ such closed formularies (as authorized under 42 CFR 423.120) with at least two drugs per therapeutic class. Medicare Part D plans may also include just a single drug per class if only one drug is available, or if only two drugs are available but one drug is clinically superior. Given that Medicare and other commercial plans are permitted to adopt closed formularies, we believe Oregon should have the same flexibility for Medicaid.

#### *B. Allow exclusion of drugs with limited or inadequate evidence of clinical efficacy*

Many drugs coming to market through the FDA's accelerated approval pathway have not yet demonstrated clinical benefit and have been studied in clinical trials using only surrogate endpoints.<sup>8</sup> Oregon seeks the ability to use its own rigorous review process to determine coverage of new drugs and to prioritize patient access to clinically proven, effective drugs. Through this process, the state could avoid exorbitant spending on high-cost drugs that are not medically necessary. The 21st Century Cures Act was intended to expedite the drug approval process by reducing the level of evidence required for drugs to reach the market and allowing doctors, patients, and payers to decide whether to

<sup>8</sup> A surrogate endpoint is a marker, such as a laboratory measurement, radiographic image, physical sign or other measure that is thought to predict clinical benefit, but is not itself a measure of clinical benefit. <https://www.fda.gov/drugs/information-health-care-professionals-drugs/accelerated-approval-program>

purchase them. Unfortunately, current rules do not allow Medicaid programs to exercise discretion about whether these drugs should be covered without being fully clinically proven.

Oregon proposes to utilize new flexibility granted under this waiver to exclude drugs with limited or inadequate clinical efficacy under its closed formulary approach. Limited or inadequate clinical efficacy may be defined as when one or more of the following conditions exist:

- Primary endpoints in clinical trials have not been achieved.
- Only surrogate endpoints have been reported.
- Clinical benefits have not been assessed.
- The drug provides no incremental clinical benefit within its therapeutic class, compared to existing alternatives.

New drugs approved under the FDA's accelerated approval pathway can be particularly costly and would be ideal for more rigorous evaluation of coverage and potential labeling as non-formulary where appropriate. In addition, re-formulations of older, existing drugs that provide no incremental clinical benefit might be labeled non-formulary as well. While commercial payers can exercise discretion to exclude drugs from their formularies in such situations, OHA and CCOs currently do not have this latitude.

As part of our efforts, we will ensure pharmacy protections for members, so that Oregon's closer management of pharmacy costs does not negatively impact member access to the spectrum of safe and effective drugs to treat various conditions.

## **Protect member access, quality, and health equity**

All of these strategies and tools will promote predictability and flexibility for the CCOs, so that Oregon can achieve a fundamentally different economic model in its Medicaid program – one that rewards health equity, preventive services, and improved population health. However, it is critical that these rate setting changes be paired with appropriate safeguards to ensure that access and quality are maintained and to guard against any incentive to provide inadequate or low-quality care. In addition, careful monitoring of financial reporting will assure CCOs are not inappropriately awarding shareholders or business owners at the expense of OHP members and communities.

### *Mitigation strategy #1: Develop strong programmatic safeguards to protect members.*

Oregon's value-based budget strategy is designed to create additional flexibility and allow CCOs to keep savings stemming from smart spending decisions. However, without a strong accountability system, there is the risk of negative impacts to health equity and members' access to high-quality care due to profit-seeking within the system. To mitigate such risk, Oregon proposes a comprehensive accountability structure to address health inequities, ensure member and provider satisfaction, and protect member access and quality of care. On an annual basis, Oregon will conduct an overall assessment of each plan paired with specific rate and contract-based mechanisms to hold CCOs to minimum standards in each of these four areas: equity, member and provider satisfaction, access, and quality of care.

First, Oregon will assess health inequities by monitoring disparities in member satisfaction, member access, and quality of care for priority populations most harmed by health inequities. These include but are not limited to Tribal Nations and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color;

people with disabilities; people with limited English proficiency; and immigrants and refugee communities. Oregon will use tools such as:

- Collecting data that allows the State to monitor quality of care by race and ethnicity, such as through REALD;<sup>9</sup>
- Considering/reporting on as many of the core quality metrics by race, ethnicity and language as possible;<sup>10</sup>
- Monitoring performance on equity-focused metrics (such as access to interpreters);
- Considering CCO network adequacy with regard to equity factors such as cultural and linguistic responsive provider capacity; and
- Using tools such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and qualitative data from the OHA Ombuds program and Community Partner Outreach Program (Oregon's enroller and navigator network) to identify concerns for priority populations.

Next, Oregon will assess overall member and provider satisfaction, access, and quality of care in the following ways:

- **Member and provider satisfaction:** OHA will assess by plan using tools such as the CAHPs survey, review of Notices of Adverse Benefit Determination, appeals, and grievances, and enhanced feedback mechanisms to assess provider satisfaction.
- **Access:** OHA will consider indicators in the areas of network adequacy, overutilization and underutilization, and timely and appropriateness of care. For network adequacy, OHA will use the Delivery System Network Reporting (DSN), which includes minimum standards for time and distance, to assess and monitor an individual CCOs provider capacity to serve projected and current member enrollment; have a network that meets the demographics of enrolled members including but not limited to preferred language or cultural representation; and a network sufficient across the continuum of care. For utilization of services, OHA will rely on an analysis and monitoring system that will focus on priority services prone to underspend, such as behavioral health; and member and provider-identified concerns. Timely and appropriateness of care assessment will use tools such as DSN and quality reporting to monitor member's access.
- **Quality of care:** In alignment with the Quality Incentive Program (see *Incentivizing Equitable Care* concept paper), OHA monitor quality of care through CMS Medicaid core set measures and potentially other measures as added in the metrics programs such as forthcoming CMS quality rating system measures. Measures will be benchmarked for a basic level of care (as opposed to more aspirational benchmarks used in the Quality Incentive Program).

OHA will push CCOs to further address health inequities by strengthening community voice and decision-making in the CCO model (see *Focused Equity Investments* concept paper) and restructuring the Quality Incentive Program so that equity is the primary organizing principle (see *Incentivizing*

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<sup>9</sup> REALD is a type of demographic information, like age, marital status, employment and more. REALD stands for the types of information it includes: Race, Ethnicity, Language, and Disability. Oregon will also consider using SOGI (Sexual Orientation and Gender Identity) data for analyses when accessible and appropriate.

<sup>10</sup> Some metrics will have too small of a denominator to support analysis at a subpopulation level.

*Equitable Care* concept paper). OHA also intends to incentivize some of the metrics by race, ethnicity and language as guided by the Metrics and Scoring and the planned Health Equity Quality Metrics Committees.

### **Mitigation strategy #2: Develop robust annual financial monitoring**

Oregon will develop robust annual financial monitoring, including monitoring utilization and spending, to monitor CCO solvency and ensure the annual targets are reasonable for covering expected costs, as well as develop a mechanism for budget adjustments if unforeseen events, such as new high-cost treatments, result in the annual trend being inadequate to cover members' health needs. OHA will use focused rate and contract mechanisms to hold CCOs accountable. Instead of spending significant resources on building annual rates based on the CCOs prior year's spending, Oregon will devote resources to analyzing health equity and health-related services spending trends, analyzing access to care and medical loss ratio (MLR). Oregon plans to tighten financial metrics (for example, minimum MLR requirements). Additionally, Oregon may employ other financial mechanisms to hold CCOs accountable for meeting targets for certain services, such as behavioral health or chronic disease management. By creating a new, flexible payment methodology, Oregon anticipates that the amount of money subject to both quality metrics and accountability will grow over time as the CCO model improves care and reduces cost growth. OHA will continue to use tools developed for the most recent CCO procurement to monitor for high cost or low value health spending and push for redeployment of those resources to lower costs, higher value interventions.

## **What these policies would mean for OHP members**

Establishing a value-based global budget will align financial incentives for CCOs so that OHP members with higher health care needs experience better care coordination, access to health-related services, including access to additional benefits when transitioning to and from institutions, such as jails and prisons.

OHP members will maintain access to the range of clinically effective drugs. At least one drug per drug class will be covered and OHP members will be able to ask to get a different one through their health care provider.

OHP members, families, and communities will see increased community investment by CCOs due to more sustainable cost growth and required community investments.

## **Conclusion**

Over the past decade, Oregon has made strong progress in changing financial incentives from a near exclusive focus in traditional health care financing on health care spending and downstream treatment, to increasing attention to prevention, health-related services, and coordinated care to treat the whole person. However, despite these efforts, a fundamental shift in the economic model for Oregon's Medicaid plans has proven elusive, in large part due to limitations in the rate setting process. Oregon seeks waiver flexibility to create this fundamental shift, so that payment, incentives (see *Incentivizing Equitable Care* concept paper), and accountability all drive collectively to a healthier population. We request approval to better manage the rising cost of drugs that curtails the shift in resources necessary to achieve population health and health equity in our state. We further seek the ability to ensure a minimum amount of investment in health equity

and social needs, under community leadership, as required by recently passed HB 3353 (see *Focused Equity Investments* concept paper).

# Focused Equity Investments

Oregon is requesting a federal investment to support closing health equity gaps for Oregon Health Plan (OHP) members across the state. While Oregon's commitment to slowing statewide health care cost growth has saved significant federal funds across markets and improved quality, the health outcomes have varied based on race and ethnicity. Moreover, improvements have not adequately addressed health inequities resulting from long-standing systemic racism and oppression. Accordingly, as part of our federal-state partnership, Oregon requests CMS provide an upfront federal investment in community-driven initiatives focused on eliminating health inequities among OHP members. Oregon anticipates that community-driven investments will improve the health of those most harmed by health inequities,<sup>1</sup> as well as address upstream social determinants of health. Both of these improvements will result in downstream cost savings for the state and federal government.

Oregon further requests that coordinated care organization (CCO) spending to address health inequities be counted as medical claims or quality improvement expenses within the value-based global budget for purposes of rate setting, budgeting, and the medical loss ratio (MLR). This request was directed by the Oregon State Legislature (HB 3353)<sup>2</sup> in July 2021. (See *Value-based Global Budget* concept paper for further information on this request.)

## Oregon requests:

1. A new federal investment focused on improving health equity, including investments to build infrastructure to support health equity interventions; support community-led health equity interventions and statewide initiatives; grant community-led collaboratives resources to invest in health equity.

In order to implement this federal investment, **Oregon requests the following spending authorities:**

2. Expenditure authority to draw down federal match on Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions or disruptions as described in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper.
3. Authority to count CCO investments in health equity required by HB 3353 and as described in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper as medical claims or quality improvement spending for purposes of CCO rate setting.

For full proposed strategies, please see page 8.

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<sup>1</sup> Populations and communities who have been most harmed by historic and contemporary injustices and health inequities include but are not limited to Tribal Nations and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

<sup>2</sup> <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3353/Enrolled>

# Problem and background

## Health inequity

It is widely accepted that health is largely determined not by the medical care people receive but by social determinants of health, including factors such as built environment and housing, access to healthy food and green spaces, job opportunities and income.<sup>3</sup> People of color and those living with fewer financial resources are more likely to be exposed to unsafe neighborhoods, substandard housing, lack of transportation, the criminal justice system, and low-quality schools, which means they are more likely to experience worse health outcomes, and shorter lifespans.

Despite increased access to health coverage and care throughout Oregon, health inequities persist because systems and institutions have been created to benefit a select group of people over time. Health inequities are traceable to inequitable access to power, resources, opportunities and decision-making resulting from long-standing, generations-old racism and oppression, social injustice, bigotry, bias, discrimination and colonization. Communities of color and Tribal communities have experienced chronic underinvestment, resulting in increasingly damaging social determinants of health and worse health outcomes than their white counterparts. These inequities also result in financial burden. An estimated 31% of medical care expenditures result from health inequities caused by systemic racism and oppression.<sup>4</sup> The 2018 Oregon State Health Assessment<sup>5</sup> found the following inequities regarding social determinants of health:

### *Poverty and food insecurity*

- Almost all racial and ethnic groups in Oregon experience higher levels of poverty than in the United States as a whole, particularly people who identify as African American.
- Oregon ranks 44th in the country in food insecurity. Food insecurity is highest in rural communities, communities of color, households with children, and among renters.

### *Housing and homelessness*

- One-third of all African American households spend more than 50% of their income on housing costs, compared to 17% of all households in the state.

## Oregon's health equity definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

<sup>3</sup> Magnan, S. (2017). Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine.

Available at: <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>

<sup>4</sup> <https://journals.sagepub.com/doi/pdf/10.2190/HS.41.2.c>

<sup>5</sup> <https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf>

- Just 32% of African American people in Oregon’s most populous county owned homes in 2010, compared to 60% of white people in the county.
- With the exception of people who identify as Asian, people of color experience homelessness at a disproportionate rate compared to their white counterparts.

### *Incarceration*

- In Oregon, people of color are more likely to be incarcerated than white people:
  - African Americans are 4.6 times more likely
  - Native Americans are 1.8 times more likely
  - Latino/a/x people are 1.4 times more likely

### *COVID-19*

The COVID-19 pandemic underscores the persistence of health inequity in Oregon and serves as a wake-up call to the severity of the gaps.

- Hispanic Oregonians comprise only 12% of the population but represent more than 18% of COVID-19 cases.<sup>6</sup>
- Black Oregonians are 3.1 times more likely to have a COVID-19 associated hospitalization than their white counterparts.<sup>6</sup>

### **Legislatively required health equity investments**

In July 2021, the Oregon Legislature passed HB 3353 (see Appendix A), which requires CCOs to:

- spend at least 3% of their global budget on programs and services that improve health equity, *and*
- be more accountable to community.

To support the intent of this directive, under this 1115(a) demonstration waiver renewal OHA will propose that CCOs allocate at least 1/3 of these funds (at least 33% of the 3%) to be directly administered by new community investment collaboratives. Importantly, this proposal was co-created with Oregon Regional Health Equity Coalitions (RHECs) through a unique community-driven process, as described below. Further, the legislation requires OHA to seek CMS approval that 3% of the CCO value-based global budgets be directed to improving health inequities, and that such spending be counted as medical and quality improvement expenditures for the purposes of rate setting (for more, please see *Value-based Global Budget* concept paper).

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<sup>6</sup> OHA Weekly COVID-19 Report, September 29, 2021. <https://www.oregon.gov/oha/covid19/Documents/DataReports/Weekly-Data-COVID-19-Report.pdf>



*Community voice in CCO decision-making*

A core element of Oregon’s CCO model has been to build community voice into CCO decision-making, which Oregon hopes to expand through community-led partnerships that will focus on populations and communities who have been most harmed by historic and contemporary injustices and health inequities.

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*“And who better to say what’s needed in the community than the community?”*

*-OHA Strategic Plan community input*

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*Regional health equity coalitions*

In 2011, RHECs came to OHA with a proposal for the 1115(a) demonstration waiver renewal, and subsequently worked closely with the Oregon legislature to inform the design of HB 3353. Subsequently, OHA and RHEC leadership worked closely together to build out the intent of HB 3353 and increase accountability to community by emphasizing community role in identifying inequities and making investment decisions to address inequities.

RHECs, which reach anywhere from 300-500 organizations, are leaders in empowering diverse groups to become involved in developing unique, culturally responsive and sustainable solutions to pervasive issues of inequity that impact the health and wellbeing of people in Oregon. A key part of their work includes helping diverse communities build their capacity to work with decision-makers, CCOs, and other health systems to address systemic inequities at the policy, system and environment change level that are barriers to communities achieving their full health potential.

The OHA/RHEC workgroup met 12 times between May and July 2021 to develop strategies to develop a model for shifting power and resources to community. Recognizing that the process can be as important as the outcome, the work involved relationship and trust building, particularly to build increased trust between community organizations and government, naming some of the values we hold in conducting work together through developing group agreements, sharing needs to successfully accomplish the work together, clarifying roles and scope of work, and agreeing on guiding principles to ensure the model was designed to achieve health equity goals, including investment in racial, cultural, and underserved communities.

*Community advisory councils*

Since 2012, statute has required each CCO to convene and operate a community advisory council (CAC) to oversee the CCO’s community health assessment (CHA) and community health improvement plan (CHP) and to ensure that the health care needs of consumers and community are addressed. At least half of each CAC’s membership must be CCO members.

CCOs are also financially encouraged to partner with local, culturally specific organizations and community entities, such as Oregon’s Regional Health Equity Coalition (RHECs) (see Appendix A). Under its most recent CCO procurement, Oregon took steps to strengthen CACs’ advisory roles and increase community representation and diversity on CACs. However, CACs remain advisory committees to the CCOs, with varying influence on decision-making.

*Community investment collaboratives*

Now, Oregon will request federal investment in community-led collaboratives that direct health equity investments. Oregon has already laid groundwork to support this strategy: HB 3353 intends to enable

communities to direct a portion of Medicaid funds to address health care and social factors that most contribute to health inequities.

In accordance with this legislation, Oregon, in close partnership with the community RHECs, designed a pilot program to create and resource new community investment collaboratives (CICs). These community-led partnerships will focus on populations and communities who have been most harmed by historic and contemporary injustices and health inequities, including but not limited to Oregon’s nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

While addressing root causes of health inequity caused by white supremacy is a relatively new venture for the health care system, RHECs and community-based organizations (CBOs), including social service organizations and culturally specific organizations, have long been mitigating inequities and addressing social determinants of health. As CCOs continue to expand their work to address OHP members’ social needs, health equity and community social determinants of health, it is critical that Oregon supports historically underserved CBOs as strong partners and leaders in that effort.

### **Federal savings**

Oregon has been working to contain health care costs in Medicaid and across other markets. Under its 2012 and 2017 demonstration renewals, Oregon committed to reducing the per member per month (PMPM) Medicaid spending growth rate by two percentage points from a projected national average of 5.4% to 3.4%. To date, Oregon has succeeded in meeting this commitment, and containing costs remains a top priority for the state. Oregon has met this target through its innovative health system reform model, CCOs, which are incentivized to maintain high-quality care delivery while slowing the rate of cost growth.

In 2021, Oregon expanded this model, applying a statewide sustainable health care cost growth target to all markets. This target caps annual per-capita health care cost growth across the state to 3.4% for 2021-2025 and 3.0% for 2026-2030. Oregon projects significant savings across markets. Oregon could save \$19 billion in Medicaid, Medicare, and commercial health care costs over the next 7 years, as shown in Figure 1.

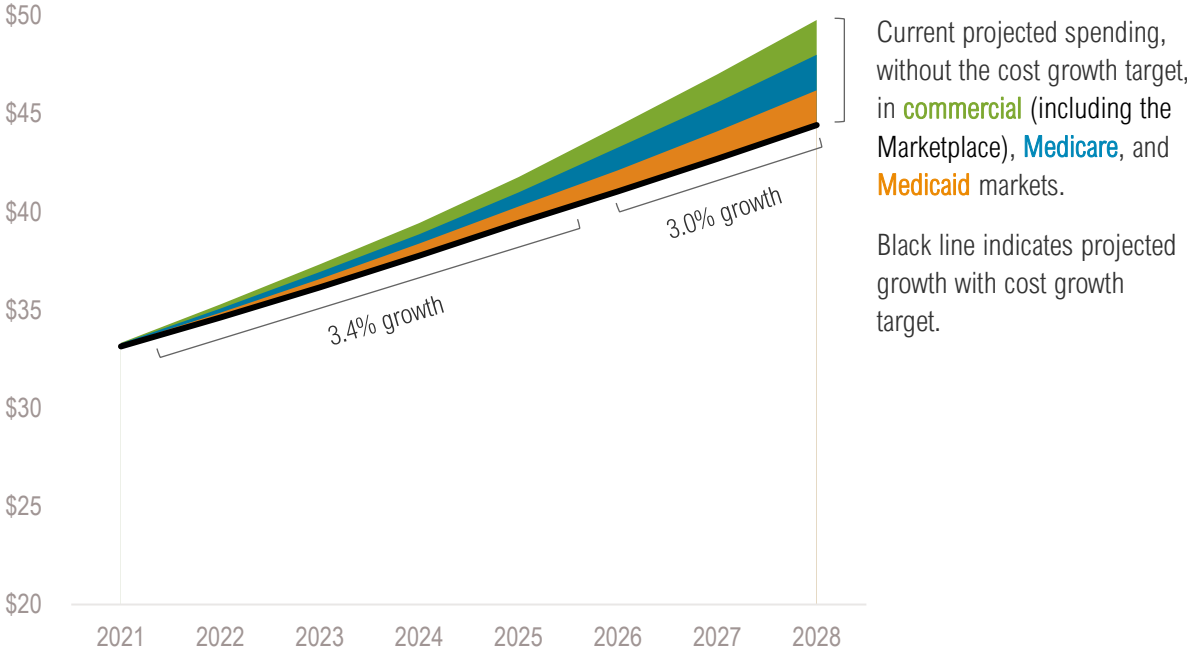
By lowering spending for qualified health plans, this sustainable health care cost growth program may result in lower premiums for commercial carriers, including those in the Marketplace, leading to additional federal savings on Advance Premium Tax Credits.

Finally, Oregon has a relatively high proportion of Medicare enrollees in Medicare Advantage plans – 47% in Oregon as compared to 38% nationally. Because the new spending cap applies to all markets, the federal government can expect to see additional savings among Medicare Advantage plans accruing to the federal government.

Figure 1

**Oregon’s Cost Growth Target could save \$19 billion in Medicaid, Medicare, and commercial health care costs over the next 7 years.<sup>7</sup>**

Dollar figures are in billions



<sup>7</sup> Data source: CMS National Health Care Expenditures

# Proposed strategies

For Oregon to begin to rectify historical and contemporary injustices that are the root cause of health inequities, we must make new and focused investments outside health care facility walls. These investments must also shift the decision-making power and resources to direct these investments to the communities most harmed by social injustices.

With CMS support, Oregon can increase investments in health equity and support strong models of community governance across the state. Oregon anticipates these investments will improve upstream social determinants of health, resulting in improved health outcomes for those most harmed by systemic racism and social injustice, as well as downstream cost savings for the state and federal government.

**Oregon requests new federal investment focused on improving health equity, including funding to:**

- 1. build infrastructure to support health equity interventions
- 2. support community-led health equity interventions and statewide initiatives
- 3. grant community-led collaboratives resources to invest in health equity.

In order to implement this federal investment, Oregon requests the following spending authorities:

- a. Expenditure authority to draw down federal match on Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions or disruptions as described in the in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper.
- b. Authority to count CCO investments in health equity required by HB 3353 and as described in the in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper as medical claims or quality improvement spending for purposes of CCO rate setting.

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*“The people who are already doing the work and have been doing the work for so long... **There doesn’t need to be a new strategic plan.** I think it needs to bring everybody to the table who already has plans going on and be like, “Okay, how can we uplift y’all who are already doing the work?” **I think the work that OHA can do as an institution is advocate for the organizations who are already doing the work.**”*

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-OHA Strategic Plan community input

## 1. Invest federal funds toward infrastructure to support health equity interventions

**a. Build capacity for community-led health equity investments**

Oregon requests federal investment to support capacity-building among community investment collaboratives (CICs) and enhance their ability to direct and manage large-scale investments.

While Oregon expects CICs to leverage existing organizations and efforts in many communities, the reality is that CBOs are chronically under-resourced when compared with health care

organizations. Other states and communities have found it essential to provide capacity building funding and resources to CBOs to partner with health care organizations.<sup>9</sup>

**b. Resource statewide infrastructure to support community-led health equity investments**

In addition to directing federal investment toward CICs, Oregon requests federal funds for statewide infrastructure to support the CIC program and for cross-sector communication more broadly. Federal investment for CICs could include, for example, technical assistance to support the CIC grant process or support for collaboration across CICs with similar interventions. While CICs coordinate local interventions, there will also be a need for statewide systems that support communities in addressing health inequities outside of the CIC program.

**2. Invest federal funds in community-led health equity interventions and statewide initiatives**

**a. CCOs investment in community-managed funds to count as medical and quality improvement expenditures**

Once CICs have developed sufficient infrastructure to assume financial responsibility, they will manage CCOs’ community funds (per HB 3353). As discussed in the *Value-based Global Budgets* concept paper, Oregon’s CCOs currently have the flexibility in their budgets to spend on health equity and social determinants of health, including through health-related services (HRS) and the Supporting Health for All through REinvestment: the SHARE Initiative.<sup>10</sup> However, spending on HRS remains low (0.7% on average), considering the potential impact investments in health-related social needs could have on health outcomes. As mentioned in the background, HB 3353 requires OHA to seek approval from CMS that 3% of the CCO value-based global budgets directed to improving health inequities and counted as medical and quality improvement expenditures.

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<sup>9</sup> Recent 1115(a) demonstration waivers in several other states, such as North Carolina and Massachusetts, have included capacity-building/infrastructure funding for community-based and/or social service organizations partnering with health care. A case study of community-based organizations participating in New York’s DSRIP program identified “building capacity” as a key need to “level the playing field” between CBOs and health care organizations. See *Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community-Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program*, [https://academyhealth.org/sites/default/files/achieving\\_health\\_equity\\_medicaid\\_cbos\\_april2019.pdf](https://academyhealth.org/sites/default/files/achieving_health_equity_medicaid_cbos_april2019.pdf)

<sup>10</sup> The SHARE Initiative comes from a legislative requirement for coordinated care organizations to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity. For more information, visit <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx>

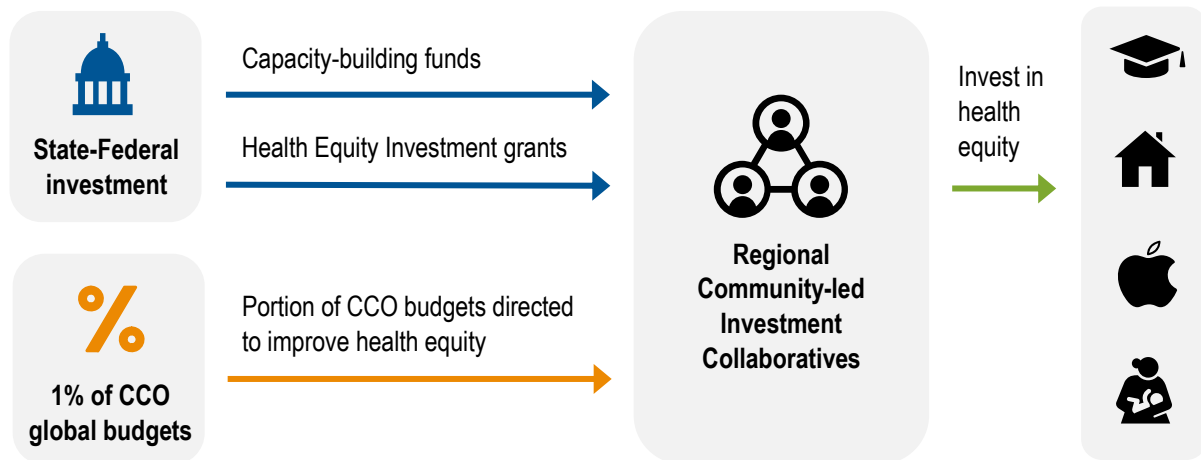
### 3. Grant community-led collaboratives resources to invest in health equity

**a. Oregon requests additional federal investment to support health equity investment (HEI) grants—funds made available directly to CICs through a process managed by the state.**

Ideally, the grant process would not be competitive, limited to a small number of awards, or prescriptive about which topics to address. HEI grants would allow qualifying CICs to further invest in addressing health inequities that impact local Medicaid members and their families.

HEI grant proposals will identify the population served and planned investments, both of which must be informed first by available community-based and empirical evidence as well as local community health assessments/community health improvement plans.<sup>11</sup> Examples of proposed HEIs could include expanding availability of housing supports and services; enhancing green space and making improvements in the built environment; increasing access to social and mental health supports; dismantling structural racism, such as efforts to expand a culturally and linguistically responsive work force; and/or affordable childcare. Further, depending on a community's needs, HEIs may focus interventions on a specific population, such as children and families, especially from priority populations. By allowing CICs to invest in the range of supports they know are of highest priority, HEI grants will facilitate community agency and resilience. (See Appendix A for details about HB 3353, CICs and HEI grants.)

Oregon’s proposed model forms Community Investment Collaboratives to leverage multiple sources of funding.\*



<sup>11</sup> Including qualitative and quantitative data such as race, ethnicity, language, disability, sexual orientation, gender identity and other demographic data from the census; as well as data from community-initiated needs assessments explaining existing and emerging community needs.

\*In addition to investments from the state and CCOs, regional Community-led Investment Collaboratives could leverage other health system funds, such as hospital community benefit funding, and philanthropy for health equity investments in communities.

**c. Invest in statewide health equity initiatives**

In addition to investing in community-led interventions, Oregon requests investment in statewide, large-scale initiatives to address health equity. For example, as discussed in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper, Oregon seeks federal investment to modify the OHP to support members through disruptions in coverage and life transitions. The goal is address gaps in Medicaid coverage; to extend coverage for a limited time; and to provide a defined set of supportive services during transitional periods (e.g., aging out of foster care) or disruptive climate events (e.g., wildfire, heat). Given that Oregonians experiencing the transitions of focus are disproportionately from populations and communities who have been most harmed by historic and contemporary injustices and health inequities, these initiatives will be critical to advancing health equity in the state.

## What these policies would mean for OHP members

OHP members who experience historical and contemporary injustices will participate in designing—or delegate other community-based organizations and advocates to design—a process for establishing Community Investment Collaboratives in the state.

The goal of this concept is that OHP members and other members of the public who come from groups that have been most harmed by historic and contemporary injustices will experience improved health as a result of community-led health equity interventions. This concept moves beyond the idea of community participation and toward community engagement in decision-making about the investment of resources. The goal is community empowerment, improved health for community members and ultimately the elimination of health inequities.

# Appendix A

## Oregon House Bill 3353 (2021)

To make meaningful change requires more than enhancing community decision-making and direction in the CCO model – it also requires building on ideas that have come directly *from* communities and collaborating directly *with* historically underserved communities to build a new model. To that end, the strategies behind Oregon’s 1115(a) demonstration waiver renewal were co-created through a unique community-driven process.

### **Background**

In July 2011, OHA established the Regional Health Equity Coalition (RHEC) initiative. RHECs are leaders in empowering diverse groups to become involved in developing unique, culturally appropriate and sustainable solutions to pervasive issues of inequity that impact the health and wellbeing of people in Oregon. RHECs work to identify the most pressing health equity issues in the state and find creative solutions to address root causes of barriers to health and wellness through changes to policies, systems and environments. A key part of their work includes helping racially and ethnically diverse communities build their capacity to work with decision-makers, CCOs, and other health systems to address systemic inequities at the policy, systems and environmental levels and reduce barriers to individuals and families achieving their full health potential.

*Currently six RHECs reach 11 of Oregon’s 36 counties and the Confederated Tribes of Warm Springs. In 2021, Oregon’s legislature passed Senate Bill 70 which will resource four additional RHECs, with a goal of statewide coverage in the coming years.*

RHECs approached OHA with a proposal for the 1115(a) demonstration waiver renewal and worked closely with the legislature to inform the design of HB 3353. Subsequently, OHA and RHEC leadership formed the Community Managed Funds workgroup to build out the intent of HB 3353, inform relevant content in the 1115(a) demonstration waiver renewal and increase accountability to historically oppressed communities by emphasizing a community role in identifying inequities and making investment decisions to address inequities.<sup>12</sup>

### **HB 3353**

As discussed in the *Value-Based Global Budgets* concept paper, Oregon’s CCOs have the flexibility in their budgets to spend on health equity and social determinants of health, including through health-related

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<sup>12</sup> The OHA/RHEC Community Managed Funds workgroup met 12 times between May and July to develop strategies to develop a model for shifting power and resources to community. Recognizing that the process can be as important as the outcome, the work involved relationship and trust building, particularly to build increased trust between community organizations and government, naming some of the values we hold in conducting work together through developing group agreements, sharing needs to successfully accomplish the work together, clarifying roles and scope of work, and agreeing on guiding principles to ensure the model was designed to achieve health equity goals, including investment in racial, cultural, and underserved communities.



services (HRS) and the SHARE Initiative.<sup>13</sup> However, spending on HRS remains low (0.7% on average), considering the potential impact investments in health-related social needs could have on health outcomes. The bill requires OHA to seek approval from CMS that 3% of the CCO value-based global budgets directed to improving health inequities are counted as medical expenditures.

Beginning in 2020, Oregon RHECs collaborated with CCOs and the legislature to develop HB 3353, legislation which subsequently passed in 2021 with nearly 90% support. Key elements of the bill include:

- At least 3% of CCOs’ global budgets will be directed toward investments in health equity, social determinants of health, and a culturally responsive workforce with a focus on priority populations including, but not limited to, Oregon’s nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.
- Increasing accountability to communities and community-led oversight of spending.
- Adopting evaluation methods that use strengths-based approaches and qualitative data.

**Implementation: Governance**

Building from requirements in HB 3353, Oregon proposes to develop a two-level oversight structure for CCO health equity investments:

A **state-level oversight committee**, as required by HB 3353, will be comprised of “members who represent the regional and demographic diversity of this state based on statistical evidence compiled by the authority about medical assistance recipients and at least one representative from the nine federally recognized tribes in this state or urban Indian health programs.”<sup>14</sup> The state-level oversight committee will be charged with developing criteria for required spending and advising on a Request for Proposals (RFP) for Community Investment Collaboratives, resolution of disputes,<sup>15</sup> and evaluation.

**Regional Community Investment Collaboratives (CICs)** will form as collaborative entities comprising representatives of diverse groups from local communities, including partners such as RHECs, culturally specific CBOs that do not replicate the damaging processes of the dominant culture in the region, CCO health councils, or other community bodies; CCOs and Community Advisory Councils; local hospitals; and local public health authorities. Each CIC will identify a lead entity, community council, and fund/reporting manager. (One entity could play multiple roles.)

CICs will be community-led and ideally leverage existing community efforts, such as RHECs and CCO health councils if these entities met criteria set by the oversight committee and OHA. To meaningfully shift power and decision-making authority, Oregon expects to establish criteria for

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<sup>13</sup> Ibid. Footnote 10.

<sup>14</sup> Ibid. Footnote 2.

<sup>15</sup> Per HB 3353, the oversight committee is charged with resolving disputes between OHA and CCOs as to what qualifies as an appropriate expenditure.

lead entities to be representative of and serve priority populations<sup>16</sup> who experience the greatest health inequities. Because dominant culture agencies and organizations can perpetuate inequities due to historic and current day structural barriers, they will be considered as potential partners who can assist in supporting and championing community entity goals, but should not be considered as a lead entity for decision making. Therefore, CCOs will be expected to be partners in CICs, but CCOs and health system partners will not be eligible to be a lead entity. In the RHEC model, a similar approach has enabled RHECs to establish more equitable approaches to governance that give more voice and power to racially and ethnically diverse communities.

CICs will set sub-criteria for regional spending on health equity; ensure community-led plans are considered in criteria and investment decisions, including Community Health Improvement Plans approved by the CACs; and be responsible for investing a portion of the CCOs' 3% spending requirement in health equity initiatives in their local communities.

CICs will ideally be comprised of existing CBOs and social service organizations that are chronically underfunded compared to health care organizations. CICs will need support for administrative expenses, such as hiring and training staff, building or enhancing a community council, establishing initial agreements among lead entity and funding/reporting managers, establishing agreements with CCOs, and building the infrastructure and information technology systems needed to support community investments on an ongoing basis. As described earlier in this concept paper, CICs will have opportunities to apply for capacity-building funding. As CICs become established, they will also qualify for funding for ongoing administrative and operational expenses, focused technical assistance from OHA, and competitive "Health Equity Investments" funding to further improve health equity in their communities.

### ***Implementation: Spending***

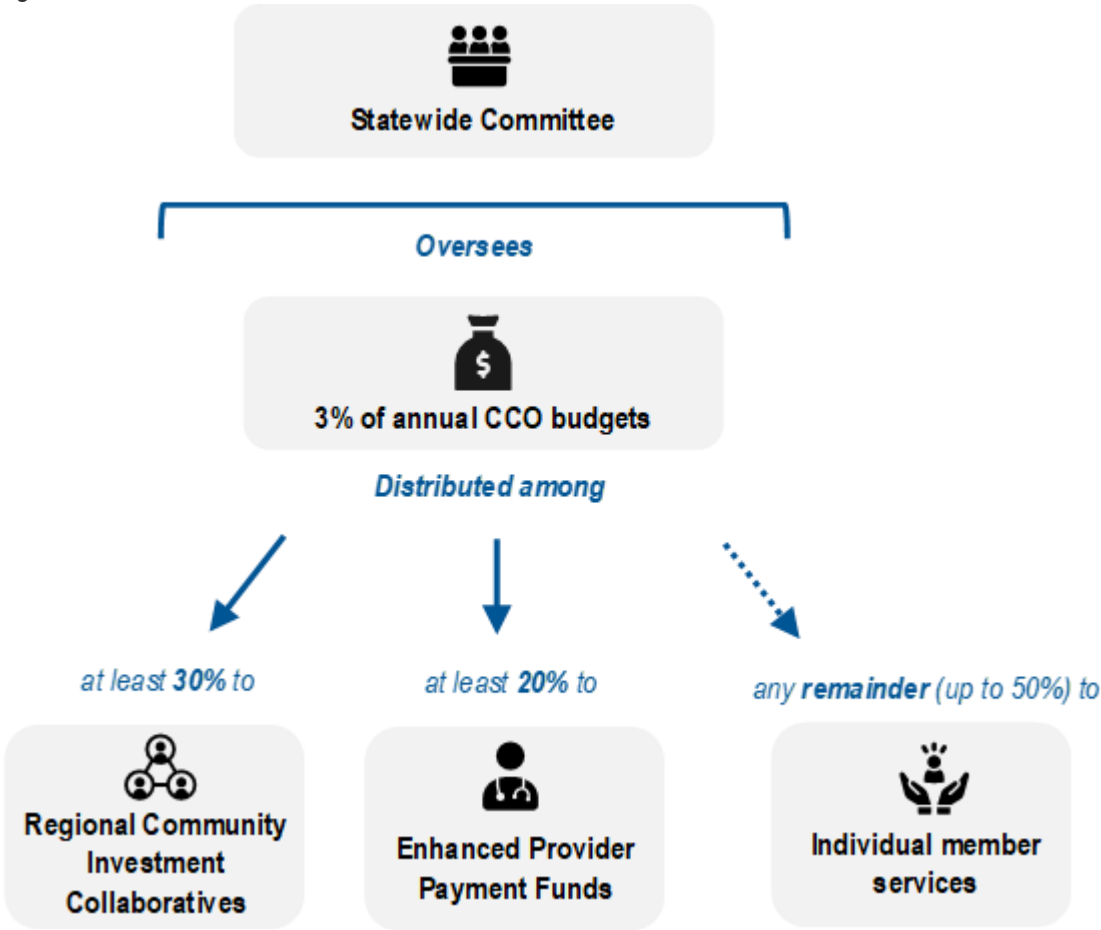
Oregon plans to establish three broader types of spending to encompass the types of expenditures outlined in HB 3353:

1. **30% of the 3%** (~1% of CCO global budgets) would be directed to programs and services to improve health equity in racial, cultural and underserved populations. These community-level investments would be directed to CICs.
2. CCOs would be required to dedicate at least **20% of the 3%** (~0.6% of global budgets) to an **enhanced provider payments fund** designated for behavioral health, culturally and linguistically responsive services, and providers offering peer-based services (such as Traditional Health Workers).
3. **Remaining funds** under the 3% would be **flexible and responsive to community needs** and could be directed to any of the three general types of health equity funding: individual services for OHP members, additional community-level investments, or additional enhanced provider payments.

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<sup>16</sup> Priority populations include but not limited to Oregon's nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

Figure 2:



**Implementation: Operations**

**Stage 1:** The Statewide Oversight Committee prescribed by HB 3353 will develop CIC criteria and advise OHA on a request for information (RFI) process to obtain information about which community entities intend to partner in forming CICs.

The criteria will specify:

- The requirements for organizations comprising CICs, which will likely include but not be limited to: comprising representatives of diverse groups from local communities, including partners such as RHECs, culturally specific CBOs that do not replicate the damaging processes of the dominant culture in the region, CCO health councils, or other community bodies; CCOs and Community Advisory Councils; local hospitals; and local public health authorities;
- CIC lead organizations must represent, serve and be comprised of priority populations including, but not limited to, Oregon’s nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations

and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities;

- CICs must be able to assume fiscal responsibility (which will be supported by capacity-building grants; see below); and
- The minimum dollar amount that can be requested for both capacity-building grants and HEI grants (see below).

The RFI will provide information on:

- Which community entities wish to form CICs, their geographic boundaries and demographic scope;
- Which parts of the state are represented by CICs, including whether there is at least one in each CCO area and whether any of the proposed CICs overlap; and
- Whether OHA needs to conduct focused outreach to support CIC design and development. For example, if the RFI shows there are overlapping CICs, OHA may suggest CICs combine efforts, or may determine overlapping CICs is appropriate. Conversely, if the RFI indicates some CCO regions lack a CIC, OHA, in collaboration with the HB 3353 Statewide Oversight Committee, could engage in local conversations to support development of a CIC.

**Stage 2:** CICs may apply for a capacity-building grant, which will:

- Fund administrative work, capacity building, and technical assistance for CICs to build their CBO networks and develop internal leadership;
- Fund Community Information Exchange or other technological needs to facilitate cross-sector communication; and/or
- Provide technical assistance and resources to build CIC infrastructure to be able to accept and administer CCO funding, Health Equity Investment grants (see below), and possible funding from other sources (e.g., hospital community benefit, other government funding, or philanthropy).

**Stage 3:** CICs may apply for a Health Equity Investment (HEI) grant, which the CIC will use to fund community-identified strategies to address inequities.

HEI grant proposals will identify the population served and planned investments, both of which must be informed first by available community-based and empirical evidence as well as local community health assessments/community health improvement plans.<sup>17</sup> Examples of proposed HEIs could include enhancing green space and making improvements in the built environment; increasing access to social and mental health supports; dismantling structural racism, such as efforts to expand a culturally and linguistically responsive work force; and expanding availability of housing and/or affordable childcare. Further, depending on a community's needs, HEIs may focus interventions on a specific population, such as children and families, especially from priority populations. By allowing CICs to invest in the range of supports they know are of highest priority, HEI grants will facilitate community agency and resilience.

For example, addressing factors related to climate change may be a priority for some Oregon communities. Climate change—a major factor in Oregon's unprecedented 2020 wildfire season and the 2021 extreme

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<sup>17</sup> Including qualitative and quantitative data such as REALD, SOGI and other demographic data from the census; as well as data from community-initiated needs assessments explaining existing and emerging community needs.

heat dome event—often disproportionately affects communities of color due to neighborhood conditions and residential segregation,<sup>18</sup> a disproportionate share of chronic conditions,<sup>19</sup> and other factors. The Oregon wildfires of 2020 decimated communities across the state, including Talent and Phoenix, which were 90% Latino/a/x. Increasing green space and other improvements to the built environment, such as climate resilient housing, can ameliorate the impact of climate change. Further, the evidence linking time outdoors with better mental health and social cohesion is substantial.<sup>20</sup>

Note there will be no predetermined number of HEI grants; this will depend on the number of CICs that apply and the amount of funds available. Investments will be evaluated using methods that may include practice-based or community-based evidence, with a focus on community-engaged and community-led evaluation efforts, such as community-based participatory research (CBPR), wherever possible. CBPR involves researchers and community engaging as equal partners in all steps of the research process and can be a strategy to improve data collection and interpretation while also promoting community health and addressing health inequities.<sup>21</sup>

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<sup>18</sup> See e.g. Jesdale BM, Morello-Frosch R, Cushing L. 2013. The racial/ethnic distribution of heat risk-related land cover in relation to residential segregation. *Environ Health Perspect* 121(7):811–817, PMID: 23694846, 10.1289/ehp.1205919. [Link](#), [Google Scholar](#); Davies IP, Haugo RD, Robertson JC, Levin PS (2018) The unequal vulnerability of communities of color to wildfire. *PLoS ONE* 13(11): e0205825. <https://doi.org/10.1371/journal.pone.0205825>

<sup>19</sup> Daw, J. 2017. Contribution of four comorbid conditions to racial/ethnic disparities in mortality risk. *American Journal of Preventive Medicine*. 52(1) supplement 1: S95-S102. [https://www.ajpmonline.org/article/S0749-3797\(16\)30322-1/fulltext](https://www.ajpmonline.org/article/S0749-3797(16)30322-1/fulltext)

<sup>20</sup> <https://willamettepartnership.org/wp-content/uploads/2014/06/HealthFramework-Final-Reduced.pdf>

<sup>21</sup> See e.g. Salimi Y., Shahandeh K., Malekafzali H., Looi N., Kheiltash A., Jamshidi E., Majdzadeh R. Is Community-based Participatory Research (CBPR) Useful? A Systematic Review on Papers in a Decade. *Int. J. Prev. Med.* 2012;3:386–393. <https://www.ahrq.gov/research/findings/factsheets/minority/cbprbrief/index.html>

# Incentivizing Equitable Care

## Problem and background

Since 2013, Oregon has been a national leader in implementing robust quality measurement for its Medicaid system, delivered through Coordinated Care Organizations (CCOs). This robust quality measurement has included:

- Regular quality and access measures reporting, and
- A successful Quality Incentive Program that focuses CCO attention and drives notable improvements in care delivery, patient experience and outcomes.

The final evaluation of Oregon’s 2012-2017 Section 1115(a) Demonstration Waiver renewal concluded that Oregon’s “financial incentives were strongly associated with improvements in performance.”<sup>1</sup> This shows that the Quality Incentive Program offers a powerful opportunity to address structural barriers that prevent equitable access to high-quality care.

Although statewide and CCO-level incentive metrics demonstrate that care quality for Oregon Health Plan members has improved in aggregate since 2013, many measures reveal inequities when analyzed by race/ethnicity, language and disability.<sup>2,3</sup> Structural racism makes it more likely that people in communities of color and Tribal communities are subjected to inequitable employment, housing —placing them at higher risk of poor health outcomes.<sup>4</sup> This structural racism has also created barriers to accessing quality health care, resulting in worse health outcomes. To rectify this and provide all Oregon Health Plan members equitable access to high-quality care, Oregon must prioritize strategies that:

- Improve cultural responsiveness,
- Mitigate social stigmas and the harm of racism, and
- Create equitable access.<sup>1,2,5</sup>

Given the demonstrated impacts of structural racism on health outcomes for people in communities of color and Tribal communities, Oregon plans to use every available tool to eliminate health inequities. As discussed in the *Value-Based Global Budget* concept paper, the proposed changes in the CCO Quality Incentive Program are part of a comprehensive strategy to ensure equity and improve the quality of care. By harnessing the power of the Quality Incentive Program so that equity is the primary organizing principle and aligning this proposal with other levers outlined in the waiver, OHA will create a multifaceted approach

<sup>1</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>

<sup>2</sup> Metrics & Scoring Committee Equity Impact Assessment, May 2021

<https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MS-C-Equity-Impact-Assessment-Report.pdf>

<sup>3</sup> Oregon Health System Transformation: CCO Metrics 2017 Final Report, June 2018

<https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2017-CCO-Performance-Report-Quality-Access-Data.pdf>

<sup>4</sup> COVID-19 Vaccine Advisory Committee recommendations 2021

<https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3580.pdf>

<sup>5</sup> CCO OHPB Listening Session Final Recommendation. <https://www.oregon.gov/oha/OHPB/Documents/OHPB-CCO-Listening-Session-Recommendations-Final.pdf>

that encourages the system to eliminate health inequities that disproportionately harm Oregon's Nine Federally-Recognized Tribes and Tribal communities, Latino/Latina/Latinx, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, communities of color, people with disabilities, people with limited English proficiency, and immigrant and refugee communities.

## Proposed strategies

To ensure all Oregon Health Plan members can access and receive high-quality care while prioritizing groups of people who face inequities and structural racism, both contemporary and historical, Oregon proposes restructuring the Quality Incentive Program so that equity is the primary organizing principle. Oregon proposes changing STC 38 to reflect modified decision-making power that incorporates greater community and member voice, as well as adjusting STCs 39 and 36e.iii to better align with proposed program changes.

Oregon intends to refine its Quality Incentive Program to prioritize health equity, using several complementary strategies:

1. Ensure space for focused equity work by restructuring the Quality Incentive Program into two complementary components:
  - a. A small set of upstream metrics focused on supporting health equity and requiring sustained effort over the period of this waiver;
  - b. A set of downstream metrics chosen from CMS's Medicaid Adult and Child Core Sets (and potentially the future Medicaid MCO Quality Rating System measure set) focused on factors such as quality, access, and outcomes with a particular emphasis on reducing inequities;
2. Redistribute decision-making power among communities; and
3. Rethink the incentive structure to better advance equity.

### 1. Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity

To ensure all Medicaid members have access to care and receive high-quality care while prioritizing people in communities that face contemporary and historical inequities, Oregon proposes separating the Quality Incentive Program into two complementary and interrelated components, each of which will be incentivized to improve equity.

#### **a) A small set of "upstream" metrics focused on factors affecting health equity**

The first component of the new measurement structure will contain up to five metrics incentivized for the duration of the waiver. These metrics are expected to require long-term, sustained effort to achieve. For this waiver period, the upstream set is largely identified. For the next waiver period, OHA would work with the Health Equity Quality Metrics Committee (restructured from the existing Health Plan Quality Metrics Committee, see strategy #2 on page 4 for more detail) and other interested parties to plan and potentially develop new measures.

Given the extensive lead time required to develop new metrics, OHA has identified four existing metrics for the upstream measure set. A fifth metric could be added and, depending on timing considerations, the new Health Equity Quality Metrics Committee may guide measure development.

These metrics were developed during the current and previous waiver periods in response to analysis of harms to specific populations and community-identified needs. They're designed to incentivize systems-level changes that advance health equity, and they address domains for which no standardized metrics currently exist. The following table outlines the four existing metrics that will be included in the upstream metrics.

Upstream Health Equity Metric	Year incentivized	Additional Information
Mental, Physical and Oral Health Assessment Within 60 Days for Children in DHS Custody <sup>6</sup>	2013	Incentivizes timely assessments for children in foster care, so their physical, oral and behavioral health needs are identified and can be addressed.
Meaningful Language Access to Culturally Responsive Health Care Services <sup>7</sup>	2021	Incentivizes the provision of high-quality interpreter services when needed and access to care and information (explanations of benefits, take-home resources, and more) in members' preferred languages, enabling them to more effectively participate in their own care.
Health Aspects of Kindergarten Readiness (HAKR) <sup>8</sup>	2022 <sup>9</sup>	Incentivizes more culturally responsive services being offered to help children start kindergarten ready to learn.
Social Determinants of Health: Social Needs Screening and Referral <sup>10</sup>	2023 <sup>11</sup>	Incentivizes more CCO members having their social needs acknowledged and addressed.

These domains were chosen because of their focus on Oregon Health Plan members who experience historical and/or contemporary injustices and structural racism. The measure development webpages provide more information from the public workgroups and other interested parties who worked through measure specification and pilot testing. This measure set will allow the state to monitor improvements in access to resources that directly address these injustices.

***b) A set of “downstream” metrics that focuses on traditional quality and access measures***

The second component of the new measurement structure will align with measures of health care processes, outcomes, and utilization that are used nationally (downstream metrics). These metrics will draw from traditional quality and access measure sets. Downstream metrics will be selected from the CMS Medicaid Adult and Child Core sets and other CMS-required measures (e.g., may include Medicaid MCO

<sup>6</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2014-Assessments-Children-DHS-Custody-Guidance-Document.pdf>

<sup>7</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx>

<sup>8</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx>

<sup>9</sup> For Social Emotional Health component of HAKR bundle

<sup>10</sup> <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx>

<sup>11</sup> Potential implementation



Quality Rating System measures in the future).<sup>12</sup> OHA will develop criteria to ensure that the selected metrics address the full breadth of health care quality considerations: cost, quality, access, and health equity, as well as address oral, behavioral, and physical health. As before, Oregon's Metrics and Scoring Committee will select the metrics, but as described below, a newly redesigned and separate committee called the Health Equity Quality Metrics Committee will have oversight and approval.

This approach builds on work Oregon is required to undertake on the Medicaid Child Core Set and Behavioral Health measures in the Medicaid Adult Core Set when reporting becomes mandatory in 2024. Aligning with the CMS Core Sets will promote cost savings and enable comparison to other state Medicaid programs' performance. The downstream metrics will be monitored and publicly reported at the subpopulation level to ensure quality and access for members within race/ethnicity, language, and disability groups whenever possible. Downstream metrics will continue to be incentivized for continuous quality improvement and, as addressed in Strategy 3 below, will use new benchmarking approaches where possible to address inequities among racial and ethnic groups.

## 2. Redistribute decision-making power to communities

To ensure that the Quality Incentive Program drives system-level improvements as well as improvements to patient care, those who are most affected by health inequities will have power within the committee structure that selects downstream metrics.

OHA is committed to redistributing power in the Quality Incentive Program and plans to modify the structure of Committees that are responsible for selecting and incentivizing metrics. While maintaining a public committee process for metrics selection, OHA intends to work with the legislature to amend the statutes establishing the metrics committees so the current Health Plan Quality Metrics Committee can change its membership, focus and role to become the Health Equity Quality Metrics Committee (HEQMC). HEQMC members will represent the interests of those most affected by health inequities including Oregon Health Plan members, community members from diverse communities, individuals with lived experience of health inequities, and health equity professionals and researchers.

This Committee will oversee and approve the downstream metrics selected by the Metrics and Scoring Committee and will advise OHA about how to design the program to best address member and community concerns and priorities. As OHA adopts broader community engagement strategies, input received in those forums will also inform measure selection and implementation. In addition, OHA will consider member and community voices in the presentation of measure performance. For example, OHA will continue to produce an annual CCO Incentive Metrics report and supplement the quantitative data typically included in this report with qualitative information, including priorities identified by members of the HEQMC.

## 3. Rethink the incentive structure to better advance equity

Oregon's current Quality Incentive Program consists of one set of metrics incentivized for the initial round of payments and a subset incentivized for the challenge pool. Using this approach, any incentive funds that are not earned in the initial round are distributed in the challenge pool round. In the initial and challenge

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<sup>12</sup> Oregon recognizes that because of variations in benefit packages among states, the Medicaid Adult Core set does not include measures of adult oral health. To fill that gap, Oregon may include in the downstream set of measures one or two adult oral health measures from the Dental Quality Alliance or similar national measure steward.

pool rounds, CCOs can earn incentives by meeting either an overall benchmark or a CCO-specific “improvement target,” which is calculated to close the gap between the CCO’s baseline performance and the benchmark. Each year, the entire pool of available quality funds is paid out; if any funds are not paid out in the initial round, they are then paid out in the challenge pool round.

While this overall structure will remain the same for the 2022-2027 waiver, OHA proposes to work with the new Health Equity Quality Metrics Committee and the Metrics and Scoring Committee to select which upstream and downstream metrics are incentivized to best improve health equity. OHA will present the committees with a range of approaches from which to select.

For instance, for the downstream metrics, one option is that the only metrics eligible for the challenge pool would be those that address significant inequities, and payment of challenge pool funds would be contingent on reducing inequities in the downstream metrics where performance can be compared to other state Medicaid programs.

Another option is to focus on closing inequitable performance gaps in all eligible metrics, not only in the challenge pool. This could be accomplished by making payment of incentives contingent on achieving CCO-specific improvement target for a metric (as opposed the aspirational benchmark for the metric) for all subpopulations with at least 50 members. In this option CCOs would not be able to rely on simply making progress toward a benchmark unless they make progress for all subpopulations.

For the upstream metrics focused on rectifying the systems and structures that create inequities, CCO incentives will be paid per metric as either individual CCO improvement targets or the benchmark is reached. Funds not earned after payout for the upstream metrics, as well as any funds not earned in the initial round of payout for the downstream metrics, will be paid out in the challenge pool round. Oregon is exploring how best to fund the quality incentive payments: as a withhold, bonus, or some combination of the two.

## Current waiver authority

The CCO Quality Incentive Program was originally outlined in Oregon’s 2012 demonstration extension and amendment, and as such any modifications to the program need to be negotiated with each subsequent waiver renewal. In this waiver application, Oregon proposes to restructure the CCO Quality Incentive Program to prioritize advancing health equity in support of the Oregon Health Authority’s goal to eliminate health inequities by 2030. Listed below are the primary strategies to prioritize advancing health equity and the associated special term and condition (STC) which may require modification:

### 1. Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity

**STC 39:** Additional Quality Measures and Reporting at the CCO Level. The CCOs will be required to collect and validate data and report to the state on the metrics listed in this section, which may be revised or added to over time as the demonstration matures. CMS also encourages the CCOs to report on the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP.

## 2. Redistribute decision-making power among communities

**STC 38:** Metrics and Scoring Committee. The state's strategy for a robust measurement includes the Metrics and Scoring Committee. The Committee reviews data and the relevant literature determines which measures will be included in the CCO incentive program and establishes the performance benchmarks and targets to be used in this incentive program. The Committee will endorse specifications for each measure. In future years, the Committee will review earlier decisions and adjust as needed. The Metrics and Scoring Committee recommends metrics that will be used to determine financial incentives for CCOs.

## 3. Rethink the incentive structure to better advance equity

**STC 36e.iii:** The state will establish an incentive pool. Incentives must be designed to reduce costs and improve health care outcomes. When developing the incentive pool, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases to reduce the incentive for volume-based billing. The incentive pool will comply with the relevant portions of 438.6. The state will alert the CCOs that the incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole incentive pool amount will be at risk. The state will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance.

## What these policies would mean for OHP members

With the revised incentive structure, all OHP members can expect to continue to see improvements in health equity outcomes and health care quality by CCOs. OHP members and communities also will have a greater voice in the quality incentive program. The pace of improving health inequities by CCOs will be measured, monitored and publicly reported. On measures of health care quality, CCOs will have accountability for improved performance not just for their overall members but also for racial and ethnic groups within their CCO membership.

The revised program includes locally developed measures of health equity. For example, the meaningful language access measure is intended to help members receive high-quality interpreter services when needed and access care and information (explanations of benefits, take-home resources, and more) in their preferred languages and easily understood formats, so they can more effectively participate in their own care. The social-emotional health measure is intended to help families connect to needed services, including culturally responsive services, so children start kindergarten ready to learn. The assessments for children in DHS custody measure is intended to ensure that kids in foster care get timely assessments of their physical, oral and behavioral health, so their needs are identified and met. The social needs screening and referral measure will require CCOs will build partnerships with community-based organizations and improve processes so Oregon Health Plan members' unmet social needs (food insecurity, housing insecurity, and transportation needs) are addressed.

# Appendix F: Public and Partner Engagement

*This appendix includes supplemental information to Section VIII of the application and further describes how OHA engaged the public and partners in the development of the proposals in this application.*

## Included in Appendix F:

### **I. Public and Partner Engagement Approach**

- Description of public and partner engagement

### **II. Public and Partner Engagement Meetings and Events Log**

- *Table K.1.* Public and Partner Engagement Meetings and Events Log

### **III. Changes Made to Oregon’s 1115(a) Waiver Renewal Concept Papers**

- Attachment 1. Changes Made to Oregon’s 1115(a) Waiver Renewal Concept Papers

### **IV. Engagement Feedback Summary Report**

- Attachment 2. Engagement Feedback Summary Report (February 10 – September 30, 2021)

## I. Summary of Public and Partner Engagement

### Waiver Development Approach

As a state, Oregon has been a leader nationally on health care transformation efforts, much of which centered on the Oregon Health Plan (OHP), the State’s Medicaid program. As the Oregon Health Authority (OHA) was constructing a new 1115 Demonstration Waiver submittal to the federal government, Oregon aimed to build on successes and seize the opportunity to address problems like health inequities and cost growth. The below figure depicts the waiver development approach Oregon has taken.

**Figure F.1. Oregon 1115 Waiver Development Approach**

## Waiver development approach



### History

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

### Key Goals

For Oregon’s 2022-2027 waiver, OHA has identified four key goals with corresponding strategies to achieve the overall aim of “Progress towards elimination of health inequities.” This

waiver will seek to build on Oregon’s strong history of innovation in health care, and make progress toward:

- Creating a more equitable, culturally and linguistically responsive health care system;
- Helping contain costs by providing quality health care;
- Investing in equitable and culturally appropriate health care; and
- Ensuring everyone can get the coverage they need.

### **Designing the Future of OHP**

To develop the waiver components and goals for the waiver submission, OHA reviewed existing statewide strategic plans and initiatives:

- State Health Improvement Plan (2020-2024)
- Community listening sessions feedback from COVID-19 response (2020)
- CCO 2.0 policies adopted by the OHPB (2018)
- CCO 2.0 community engagement feedback (2018-2019)
- Oregon Alcohol and Drug Policy Commission Statewide Strategic Plan (2020-2025)
- Statewide Housing Strategic Plan (2019-2023)

Partners and the public requested that OHA take this approach, given their focus on COVID-19 response and the existence of these initiatives and plans that they had previously informed. To refine the concepts during this initial development phase, OHA obtained feedback from partners and the public through meetings with partners and public presentations.

OHA described the resulting components, or strategies, in draft “Concept Papers” released on July 1, 2021. These Concept Papers describe the policy strategies that OHA proposed including in the 1115 Medicaid Waiver Renewal and builds on and refines the policy frameworks already established within OHP. OHA incorporated many of the key themes in existing statewide plans and initiatives into the draft Concept Papers and made further revisions based on feedback received. Upon further consideration and engagement with the public and partners, OHA released its final Concept Papers on October 16, 2021.

Throughout the development of the concept papers, OHA engaged community partners who work with populations that historically have been systemically excluded from policymaking. OHA created opportunities for communities to learn about and become involved in the 1115 Waiver process by releasing important documents in 13 languages, such as the concept papers, plain language summaries, and public notice. The OHA Community Partnership Outreach Program held a series of interactive webinars in Spanish with organizations with Medicaid application assister programs, and translation and other accommodations were available at all public meetings upon request.

Significantly, OHA also worked with Oregon Regional Health Equity Coalitions (RHECs) to co-development the Focused Equity Investment concept paper through a unique community-driven process. OHA and RHECs met 12 times between May and July 2021 to develop a model for shifting power and resources to communities. Recognizing that the process can be as important as the outcome, the work involved relationship and trust building to build increased trust between community organizations and government.

On December 1, 2021, following extensive community engagement, Oregon released its draft Application with proposals for changes to the Oregon Health Plan as part of an effort to advance health equity. The public comment period began on December 7, 2021 to allow the public time to consider the draft before opening the 30-day comment period. The draft Application reflects changes resulting from conversations with and review from CMS, formal Tribal Consultation, and continuous partner engagement. If approved, Oregon will make changes to OHP during the 2022 – 2027 demonstration period.

Please see the below timeline for a breakdown of the engagement phases and communication topics at each phase of waiver development and engagement. The communication materials listed below are also available publicly on the waiver webpage, <https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx>.

**Figure F.2. Public and Partner Engagement Phases and Communications Topics**

Waiver Development and Engagement Phases	Timeframe/Duration
<b>Phase 0: Planning Period</b>	<b>Through February 2021</b>
<b>Phase I: Introduction to Waiver/Waiver Education</b>	<b>March-April 2021</b>
<p><b>Communication Topics</b></p> <ul style="list-style-type: none"> <li>• Review of existing statewide plans and initiatives</li> <li>• Discussion of the basics of a “waiver” <b>and</b> foundational waiver information</li> </ul> <p><b>Communication Materials Released</b></p> <ul style="list-style-type: none"> <li>• Release Waiver Basics fact sheet in 12 languages (English, Spanish, Arabic, Vietnamese, Korean, Russian, Hmong, Marshallese, Chuukese, Traditional Chinese, Simplified Chinese, Somali)</li> <li>• Release OHA calendar of meetings</li> </ul>	
<b>Phase II: Draft Policy Concepts Development</b>	<b>May - July 2021</b>
<p><b>Communication Topics:</b></p> <ul style="list-style-type: none"> <li>• Discussion of all four topic areas and associated high level strategies: <ul style="list-style-type: none"> <li>○ Ensuring Access to Coverage</li> <li>○ Future of CCO Global Budgets</li> <li>○ Equity-Centered Systems of Health</li> <li>○ Reinvesting Savings across System</li> </ul> </li> <li>• Co-development of Focused Equity Investments concept with RHECs</li> <li>• Discussion of feedback received to date</li> </ul> <p><b>Communication Materials Released</b></p>	

<ul style="list-style-type: none"> <li>• Release draft concept papers in 13 languages (English, Spanish, Russian, Vietnamese, Somali, Arabic, Chuukese, Hmong, Korean, Marshallese, Simplified Chinese, Traditional Chinese, Portuguese)</li> <li>• Release first version of OHA Communications Engagement Feedback Analysis and Summary Report</li> </ul>	
<b>Phase III: Final Concepts Development</b>	<b>August – October 2021</b>
<p><b>Communication Topics:</b></p> <ul style="list-style-type: none"> <li>• Discussion of all six (modified) topic areas and associated high level strategies: <ul style="list-style-type: none"> <li>○ Maximize continuous and equitable access to coverage</li> <li>○ Improve health outcomes by streamlining life and coverage transitions</li> <li>○ Move to a value-based global budget</li> <li>○ Incentivize equitable care</li> <li>○ Improve health through focused equity investments led by communities</li> <li>○ Align with Tribal partners’ priorities</li> </ul> </li> <li>• Discussion of feedback received to date and changes made to concept papers in response to feedback</li> </ul> <p><b>Communication Materials Released</b></p> <ul style="list-style-type: none"> <li>• Release final concept papers in 13 languages (English, Spanish, Russian, Vietnamese, Somali, Arabic, Chuukese, Hmong, Korean, Marshallese, Simplified Chinese, Traditional Chinese, Portuguese)</li> <li>• Release summaries of policy concepts in 13 languages (English, Spanish, Russian, Vietnamese, Somali, Arabic, Chuukese, Hmong, Korean, Marshallese, Simplified Chinese, Traditional Chinese, Portuguese)</li> <li>• Release summary of changes made to concept papers prior to their final submission in 13 languages (English, Spanish, Russian, Vietnamese, Somali, Arabic, Chuukese, Hmong, Korean, Marshallese, Simplified Chinese, Traditional Chinese, Portuguese)</li> <li>• Release second and third version of OHA Communications Engagement Feedback Analysis and Summary Report in both English and Spanish</li> </ul>	
<b>Phase IV: Public Comment Period</b>	<b>November - January 2022</b>
<p><b>Communication Topics:</b></p> <ul style="list-style-type: none"> <li>• Discussion of the overall components of the submitted waiver application</li> <li>• Discussion of the feedback received and how that feedback was incorporated</li> <li>• Decision summary to be developed and shared</li> </ul> <p><b>Communication Materials Released</b></p> <ul style="list-style-type: none"> <li>• Release draft application in English</li> <li>• Release full public notice in 13 languages (English, Spanish, Russian, Vietnamese, Traditional Chinese, Simplified Chinese, Somali, Arabic, Hmong, Portuguese, Chuukese, Marshallese, and Korean)</li> <li>• Release waiver impact issue briefs related to Behavioral Health, Children's Health and Oral Health. These describe the impacts to each domain, if the draft waiver were approved as written.</li> </ul>	



## Continuous Public and Partner Engagement Process

At each stage of the waiver development process, OHA has solicited and received input from the public asking OHA to use this waiver renewal to push for a more equitable health care system. As shown in Figure F.3 below, the public process has allowed OHP members, the public, members of Oregon’s Nine Federally recognized tribes, consumers, health systems, CCOs, providers, and other key partners the opportunity to provide feedback on the proposed renewal of the 1115 demonstration. This process has continued to shape and evolve the waiver strategies and concepts. The result reflects a spirit of collaboration that informed this process and that will ensure the acceptance of the upcoming changes. OHA will continue seeking input throughout the development and implementation of Medicaid reforms.

**Figure F.3. Public and Partner Feedback Informs Waiver Development**



### Public and Partner Audiences

Oregon’s 1115 Waiver Renewal was developed in consultation and collaboration with the Governor’s office, other state agencies partners, such as the Housing and Community Services Division and Legislative committee partners, and federally recognized Tribes and Tribal-serving organizations. OHA and the Governor’s Office staff have continuously engaged leaders and partners across the state, including:

- **Consumer and member advocacy groups**, including the Human Services Coalition of Oregon; Oregon Latino Health Coalition; Oregon Primary Care Association; Oregon Community Health Workers Association; COFA Alliance National Network; tribal-affiliated organizations, such as the Native American Rehabilitation Association of the

Northwest; organizations advocating for individuals with specific conditions or circumstances such as epilepsy, incarceration or previously incarcerated, homelessness or risk of homelessness; children’s advocates and foster youth advocates; organizations with Medicaid application assister programs, such as Unidos Bridging Communities, Mano a Mano, and Northwest Family Services; senior advocates and advocates for individuals with disabilities.

- **Hospitals and Health Systems leaders**, including the Oregon Health & Science University (OHSU); Kaiser Permanente; Doernbecher Children’s Hospital; Providence Health and Services; Indian Health Care Programs (IHCPs).
- **Coordinated care organization leaders**, including CCO Chief Executive Officers; CCO Medical Directors; CCO Behavioral Health Directors and other representatives of CCOs, CCO Oregon and the Coalition for a Healthy Oregon (COHO).
- **Policy makers and local government organizations**, including state legislators and governments, including Oregon’s nine federally recognized Tribes; the Association of Oregon Counties; Polk County Health Services; Multnomah County Health Department; and the Coalition of Local Health Officials (CLHO).
- **Health and health care committees, advisory groups and work groups, and boards**, including the Oregon Health Policy Board (public meetings); Medicaid Advisory Committee (public meetings); the Health Equity Committee (HEC) of the Oregon Health Policy Board; the OHA Consumer Advisory Council; and the OHA Ombuds Advisory Council, the Governor’s Racial Justice Council.
- **Other community leaders and Medicaid consumer-involved agencies and organizations**, such as Oregon Health & Science University Oregon Office on Disability and Health; Oregon Latino Health Coalition, and the Regional Health Equity Coalitions (RHEC).
- Health care contractors and special interest groups, such as PhRMA and Sarepta Therapeutics.

Note, engagement with Tribal partners and tribal consultation is detailed in Section XI of the application and, therefore, was not included in this summary.

### **Outreach and Opportunities for Engagement**

Engagement with the public and OHA’s partners include various methods and avenues to ensure a wide scope of audiences are being reached and their feedback is being captured. OHA decided to take a more active role in outreach and communication, and meeting audiences where they already are. Relationship-building was also crucial, both in the early stages but also continued through the waiver development process. In some instances, OHA would reach out to community partners to understand where engagement already existed and try to participate in those avenues.

OHA augmented its outreach and engagement through its online presence, including frequently updating its public waiver webpage, engaging on social media, surveys, webinars, etc. A dedicated email inbox was also available for individuals to submit their questions or feedback,

and a timely response was provided. OHA and local / state media outlets also collaborated to share updates to waiver progress and address any trends or ideas. Employing a mix of communication vehicles helped Oregon target specific groups and reach as large audiences as possible. Furthermore, as part of its communication strategy, Oregon was proactive in releasing timely, well-researched, and easy-to-understand materials. This included providing the appropriate resources for the targeted audience or avenue of engagement. For example, OHA's engagement approach included having informed internal staff to present information and to answer questions in real-time. Furthermore, for OHA-hosted meetings, OHA would summarize any feedback received and provide responses; by posting these summaries online or distributing them to partners, OHA attempted to close the loop on any questions and feedback raised, for members of the public to digest at a later time.

In other instances, OHA took conscious effort in making existing opportunities for engagement more accessible. Oregon also maintains a fully functioning website in two languages, English and Spanish, which are updated in tandem. For many written materials posted, Oregon staff went through a process of plain language review and subsequent translations. For example, the final concept papers that were submitted to CMS were translated into 13 languages (including English, Spanish, Russian, Vietnamese, Somali, Arabic, Chuukese, Hmong, Korean, Marshallese, Simplified Chinese, Traditional Chinese, Portuguese); these final concept papers were also released with supplemental summaries (also translated into 13 languages) that was more easily digestible. OHA encouraged its partners to distribute these materials in the various formats to better inform the public. Similarly, for any public and partner meetings, an individual can request translation services or other meeting accommodations (for example sign language and spoken language interpreters; written materials in other languages; Braille; large print; audio and other formats, etc.).

### **Public and Partner Engagement Meetings**

Prior to the beginning of the public comment period, Oregon engaged the public and its partners through meetings to develop the Concept Papers and draft Waiver Application (posted online on December 1). As shown in Table F.1 below, OHA staff logged over 80 formal meetings and opportunities to provide input and feedback.

## II. Public and Partner Engagement Meetings and Events Log

**Table F.1. Public and Partner Engagement Meetings and Events Log (January 2021 – December 2021)**

Date/Time	Meeting Name	Audience	Summary of Discussion (Major Themes and Topics)
January 28, 2021	CAK Steering Committee	Legislative	Background and update on Oregon's 1115 Medicaid Demonstration Waiver
January 28, 2021	House Committee on Health Care	Legislative	History and update on Health Systems Transformation in Oregon
February 9, 2021 8:00 AM	Oregon Health Policy Board (OHPB) Educational Webinar	Policy	Background and update on Oregon's 1115 Medicaid Demonstration Waiver
February 10, 2021 11:00 AM	Legislative Work Group	Legislative	Background and update on Oregon's 1115 Medicaid Demonstration Waiver
February 23, 2021 5:00 PM	Legislative Work Group	Legislative	Timelines; Broad policy goals for health care transformation; Where to from here (waiver)
March 1, 2021 8:00 AM	Legislative Work Group	Legislative	Building on Oregon's progress: Where to from here; Waiver proposals from other states; discussion of barriers and strategies
March 4, 2021 10:00 AM	Oregon Health Forum	Policy	Renewing Oregon's 1115 Medicaid Waiver; policy and budget implications
March 11, 2021 12:00PM-2:00 PM	Health Equity Committee (HEC) Meeting	Policy	Background and update on Oregon's 1115 Medicaid Demonstration Waiver
March 15, 2021 8:00 AM-9:00 AM	Legislative Work Group	Legislative	Evolving the waiver priorities document; Shared vision and goals; Engagement development plan
March 22, 2021	OHA/Governor's Office Check-In	Governor's Office	Vision document and timing; CCO Workgroup; Role of RJC in policy development
March 22, 2021	OHA/Oregon Department of Transportation (ODOT) MOU Meeting	Policy	Update on 1115 Waiver
April 5, 2021 2:00 PM-3:00 PM	Oregon Association of Hospitals and Health Systems (OAHHS) Meeting	Industry	1115 Waiver Renewal process and engagement plan

April 6, 2021 8:30 AM- 12:00 PM	Oregon Health Policy Board (OHPB) Monthly Meeting	Policy	Community engagement approach, proposed waiver strategies
April 8, 2021 12:00 PM-2:00 PM	Health Equity Committee (HEC) Meeting	Policy	Status of 1115 Waiver Renewal; developing policy proposals; oversight role of HEC
April 12, 2021 3:00 PM-4:00 PM	Legislative Work Group	Policy	HB 3353-1 discussion; Engagement update
April 19, 2021	Coordinated Care Organizations (CCO) Behavioral Health Directors	Industry	
April 22, 2021 8:00 AM- 9:00 AM	Coordinated Care Organizations (CCO) Waiver Renewal Work Group	Industry	Waiver timeline; future waiver work sessions; 2021 policy engagement calendar; Overarching Waiver Goal: Health Equity
April 23, 2021 9:30 AM-12:30 PM	Coordinated Care Organizations (CCO) GR Workgroup	Industry	Waiver timeline; future waiver work sessions; 2021 policy engagement calendar; Overarching Waiver Goal: Health Equity
April 23, 2021 9:30 AM-12:30 PM	Children's System Advisory Council – Behavioral Health	Policy	Intro to 1115 Waiver Renewal project
April 26, 2021 3:00 PM-4:00 PM	Legislative Work Group	Policy	Waiver strategy presentation and discussion; engagement update
April 27, 2021 10:00 AM-12:00 PM	Community Partnership Outreach Program Meeting (Spanish)	Medicaid Assistants, Community Partners	Intro to 1115 Waiver Renewal project
April 28, 2021 9:00 AM-12:00 PM	Medicaid Advisory Committee (MAC) Meeting	Policy	Status of 1115 Waiver Renewal; developing policy proposals; oversight role of MAC in application development; Engagement plan
May 4, 2021 8:30 AM- 12:00 PM	Oregon Health Policy Board (OHPB) Monthly Meeting	Policy	Community Engagement update; deep dive on budget policy concepts
May 5, 2021	Community Managed Funds Workgroup	Community, Policy	Intro to 1115 Waiver Renewal project
May 6, 2021	Racial Justice Council	Policy	1115 Waiver process and timeline; HB 3353
May 10, 2021 3:00 PM-4:00 PM	Legislative Work Group	Legislative	Waiver and budget policy concept discussion; Engagement update

May 10, 2021 1:00 PM-3:00 PM	Community Partnership Outreach Program Series Meeting 1	Medicaid Assistants, Community Partners	1115 Waiver intro; approach and timeline; community input
May 12, 2021 8:00 AM-8:20 AM	House Behavioral Health (BH) Committee	Legislative	Overview of 1115 waiver renewal; BH specific items that were in the last waiver request and where they landed and BH items that may be included in this draft
May 12, 2021 11:00 AM-12:00 PM	Coordinated Care Organizations (CCO) Waiver Renewal Work Group	Industry	Flexible Spending concept
May 13, 2021 1:00 PM-3:00 PM	Community Partnership Outreach Program Series Meeting 1	Medicaid Assistants, Community Partners	Waiver 101; approach and timeline; community input
May 13, 2021 12:00 PM-2:00 PM	Health Equity Committee (HEC) Meeting	Policy	Timeline; current and future state
May 13, 2021 3:00 PM-4:00 PM	Legislative Work Group	Legislative	Overview of current waiver proposals
May 18, 2021	CCO GR Workgroup	Industry	Potential 1115 waiver strategies and policy proposals; how to engage in proposal development process
May 18, 2021 4:00 PM-5:00 PM	Legislative Work Group	Legislative	Overview of current waiver proposals
May 26, 2021 9:00 AM-12:00 PM	Medicaid Advisory Committee (MAC) Meeting	Policy	Address MAC questions; Recap of policy areas; Policy deep dive on Coverage; Engagement Update
May 26, 2021 12:30 PM-5:00 PM	Designing the Future of OHP (Waiver Workshop #1)	Consumers, Community Partners, Industry	Waiver 101; policy deep dives; Q&A session
June 1, 2021 8:30 AM-12:00 PM	Oregon Health Policy Board (OHPB) Monthly Meeting	Policy	Equity-centered system of health; Policy concept papers; Reinvesting savings deep dive
June 3, 2021 2:00 PM-3:00 PM	Coordinated Care Organizations (CCO) CEO Workgroup	Industry	Concept Papers
June 4, 2021	Coordinated Care Organizations (CCO) GR Workgroup	Industry	Concept Papers

June 10, 2021 1:00 PM-2:00 PM	Health Equity Committee (HEC) Meeting	Policy	Concept papers; Waiver development timeline
June 14, 2021 1:30 PM-2:30 PM	Senate Health Informational Hearing	Legislative	State of Health Equity and 1115 waiver
June 14, 2021 4:00 PM-5:00 PM	Legislative Work Group	Legislative	Equity Centered System of Health and Reinvesting Government Savings discussion with a focus on behavioral health
June 16, 2021 4:00 PM-5:00 PM	Coordinated Care Organizations (CCO) CEO Workgroup	Industry	Coverage and Budget concepts
June 17, 2021	Coordinated Care Organizations (CCO) GR Workgroup	Industry	Equity Centered System of Health and Reinvesting Government Savings discussion with a focus on behavioral health; Waiver concepts; Waiver development process
June 17, 2021	Association of Oregon Counties – County College	Policy, Community Partners	Waiver renewal update, cost growth target implementation, and coverage
June 17, 2021 2:30 PM-3:15 PM	Public Health Policy Board (PHPB) Meeting	Policy	Overview + PH interest areas/questions
June 21, 2021 1:00 PM-2:30 PM	Waiver Check-in Meeting with OHPB Members	Policy	Concept Papers
June 22, 2021 8:00 AM-9:00 AM	Waiver Check-in Meeting with OHPB Members	Policy	Concept Papers
June 22, 2021 9:00 AM-9:30 AM	Waiver Check-in Meeting with OHPB Members	Policy	Concept Papers
June 22, 2021 5:30 PM-7:30 PM	Designing the Future of OHP (Waiver Workshop #2)	Consumers, Community Partners, Industry	Concept papers
June 22, 2021	Oregon Pediatric Improvement Partnership (OPIP) Partners	Industry	Overview of waiver concepts

June 30, 2021 9:00 AM-12:00 PM	Coordinated Care Organizations (CCO) CEO Workgroup	Industry	Discussion on two concept papers: Equity-centered system of health and Reinvesting savings
June 30, 2021 9:00 AM-12:00 PM	Medicaid Advisory Committee (MAC) Meeting	Policy	Concept papers; Waiver development timeline
July 6, 2021 3:00 PM-5:00 PM	Community Partnership Outreach Program Series #2 - English	Medicaid Assistants, Community Partners	Waiver 101; health equity; timeline
July 6, 2021 8:30 AM- 12:00 PM	Oregon Health Policy Board (OHPB) Monthly Meeting	Policy	Discussion on the waiver policy areas, how proposals move us towards equity
July 7, 2021 2:30 PM-4:30 PM	Community Partnership Outreach Program Meeting 2 (Spanish)	Medicaid Assistants, Community Partners	Waiver 101; health equity; timeline
July 12, 2021 3:00 PM- 4:00 PM	Legislative Work Group	Legislative	Updates on timeline and public comment; Feedback Legislators have been receiving; Shared savings
August 3, 2021 4:30 PM-6:00 PM	Latino Emotional Health Collaborative (LEHC) Meeting	Community Partners	Waiver update
August 3, 2021 8:30 AM- 12:00 PM	Oregon Health Policy Board (OHPB) Monthly Meeting	Policy	Health Equity Zones and Preview of changes to policy concept based on public input
August 5, 2021 12:30 PM-3:30 PM	Health Information Technology Oversight Council Meeting	Policy	General update on the Waiver with a focus on Transitions concepts
August 9, 2021 10:00 AM-12:30 PM	Quality and Health Outcomes Committee Meeting	Policy	Brief update on Quality Strategy to provide feedback
September 2, 2021 10:00 AM- 11:30 AM	Health Cabinet Meeting	Legislative	Waiver renewal update
September 7, 2021 8:30 AM- 12:00 PM	Oregon Health Policy Board (OHPB) Monthly Meeting	Policy	Overview of stakeholder engagement and Metrics concept paper
September 9, 2021 12:00 PM-2:00 PM	Health Equity Committee (HEC) Meeting	Policy	Overview of stakeholder engagement and Metrics concept paper
September 9, 2021 3:00 PM-5:00 PM	Association of Oregon Counties	Legislative	Waiver renewal update



	(AOC) Health and Human Services Steering Committee		
September 22, 2021 9:00 AM-12:00 PM	Medicaid Advisory Committee (MAC) Meeting	Policy	Overview of stakeholder engagement and update on timeline
October 4, 2021	2021 Coordinated Care Organizations (CCO) Oregon Annual Conference	Industry	Value-based global budget
October 7, 2021 10:00 AM-11:00 AM	Medicaid/CHIP Operations Coordination Steering Committee Meeting	Policy	Overview of waiver, process, and potential impact on programs
October 11, 2021 3:00 PM-4:00 PM	Legislative Work Group	Legislative	To update Legislative Days presentation; EPSDT update; timeline
October 19, 2021	OHPB Special Session	Policy	Preview of final concept papers
October 26, 2021	2021 Oregon State of Reform Health Policy Conference	Industry	Overview of waiver focus areas and timeline
October 26, 2021	OHPB Special Session	Policy	Preview of final concept papers
October 27, 2021 9:00 AM-12:00 PM	Medicaid Advisory Committee (MAC) Meeting	Policy	Timeline; Policy Concepts; Impact on Members
October 29, 2021	Oregon Health Policy Board (OHPB) Special Session	Policy	Preview of final concept papers
November 2, 2021 8:30 AM- 12:00 PM	Oregon Health Policy Board (OHPB) Monthly Meeting	Policy	Overview of recently released final concept papers, what has changed; overview of public comment
November 9, 2021 1:00 PM-3:30 PM	Allies for a Healthier Oregon	Policy, Community Advocates	Overview of priority policy areas, OHPB members presenting
November 8, 2021 3:00 PM-4:00 PM	Legislative Work Group	Legislative	EPSDT, concept papers, public comment
November 16, 2021 12:00 PM-1:30 PM	Jail Health Care Standards Advisory Council	Policy	Update as to where you're at with the 1115 waiver development or go over the "Streamlining Life and Coverage Transitions" concept paper
November 17, 2021 3:00 PM-4:00 PM	Community Advisory Council Meeting	Industry, Community	Focused Equity Investment concept paper presentation

November 17, 2021 2:00 PM-3:30 PM	Racial Justice Council (RJC)	Policy	Waiver update and timeline, community engagement approach, policy concepts, continuing engagement with RJC
November 18, 2021 12:00 PM-2:00 PM	Health Equity Committee (HEC) Meeting	Policy	Overview of public comment
December 1, 2021 2:00 PM-3:00 PM	Coordinated Care Organizations (CCO) Oregon	Industry	Discussion of waiver draft proposals
December 2, 2021	Coordinated Care Organizations (CCO) Pharmacy Directors' meeting	Industry	Waiver update, next steps, and timeline

# Changes Made to Oregon's 1115(a) Waiver Renewal Concept Papers

This document describes changes made to Oregon's 1115(a) Waiver renewal concept papers between the first drafts (published in June 2021) and final drafts (October 2021). Changes are presented in the following categories:

- [Strategies that are NEW to the October drafts](#)
- [Strategies that were REVISED between June to October drafts](#)
- [Strategies that existed in the June drafts, but were DROPPED in October drafts](#)
- [Strategies that remained the same between June and October, but moved between concept papers](#)

In each section, tables are further organized by individual concept papers. Please note that concept paper titles have also shifted since the first draft released in June:

New or revised concept title (October 2021)	Original concept title (June 2021)
■ <i>Maximizing Coverage through the Oregon Health Plan</i>	■ <i>Coverage and Eligibility</i>
■ <i>Improving Health Outcomes by Streamlining Life and Coverage Transitions</i>	■ <i>Equity-Centered System of Health</i>
■ <i>Value-Based Global Budget</i>	■ <i>Future of CCO Global Budgets</i>
■ <i>Incentivizing Equitable Care</i>	n/a (concept paper is new)
■ <i>Focused Equity Investments</i>	■ <i>Reinvesting Savings in Communities</i>

## NEW waiver strategies (Oct. 2021)

The strategies described below are **new** to the waiver concept papers in October 2021. These strategies were not part of the first drafts released in June 2021.

Maximizing Coverage through the Oregon Health Plan	
New waiver strategy (October 2021)	Why was it added?
Provide an expedited OHP enrollment path for individuals who apply for Supplemental Nutrition Assistance Program (SNAP) benefits.	Aligns with Oregon's goal to maximize coverage, remove barriers, and reduce administrative burdens for those seeking health insurance.
Improving Health Outcomes by Streamlining Life and Coverage Transitions	
New waiver strategy (October 2021)	Why was it added?
Expenditure authority to draw down federal match on Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions or disruptions.	Further development of this strategy refined the proposal to the federal government and allowed for additional detail.

Value-Based Global Budget	
New waiver strategy (October 2021)	Why was it added?
Increase predictability of costs through closer management of pharmacy costs, by allowing a commercial-style closed formulary approach that may exclude drugs with limited or inadequate evidence of clinical efficacy.	Addresses concerns about rising pharmacy costs based on further research and development while protecting OHP members' access to needed pharmaceuticals.
Incentivizing Equitable Care	
New waiver strategy (October 2021)	Why was it added?
Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity	This is a new concept paper in October 2021 that expands upon the strategy "Revamp Oregon's metrics program so that equity is the primary organizing principle" mentioned in the June <b>Value-Based Global Budget</b> paper
Redistribute decision-making power among communities.	
Rethink the incentive structure to better advance equity.	
Focused Equity Investments	
New waiver strategy (October 2021)	Why was it added?
N/A – no changes	

## REVISED waiver strategies

The table below describes waiver strategies that have **changed** since the first draft concept papers were released in June 2021.

Maximizing Coverage through the Oregon Health Plan		
Revised strategy <i>October 2021</i>	Previous strategy <i>June 2021</i>	Reason for change
Provide continuous Oregon Health Plan (OHP) enrollment for children until their sixth birthday (ages 0-5)	Provide 5-year continuous eligibility for children.	Narrowed age range to cover children at key developmental stage and to align with other initiatives on child health, including Raise Up Oregon and measurement of Health Aspects of Kindergarten Readiness.
Improving Health Outcomes by Streamlining Life and Coverage Transitions		
Revised strategy <i>October 2021</i>	Previous strategy <i>June 2021</i>	Reason for change
Expand and fund, with expenditure authority, the infrastructure needed to support access to services using providers outside of the medical model.	Allow recovery peers to be paid for providing services outside of a traditional treatment plan (i.e., pre- and post-treatment) or alternatively utilize in lieu of services to again allow for services outside of typical medical model that address social needs of individuals, as described in crisis strategy and further describe later around housing supports.	This strategy has been reworded to align with the level of detail appropriate for CMS audience.  The request for peers to be paid for providing services outside of a traditional treatment plan <b>remains the same.</b>
Value-Based Global Budget		
Revised strategy <i>October 2021</i>	Previous strategy <i>June 2021</i>	Reason for change
Mitigation Strategies #1-2 1. Develop strong programmatic safeguards to protect members 2. Develop robust annual financial monitoring	Increase CCO accountability to delivering care and supports that members need	Further development allowed for additional detail. These strategies address concerns about CCO accountability.
Incentivizing Equitable Care		
<b>Note: This is a new concept paper in October 2021; all strategies are new</b>		

## Focused Equity Investments

<b>Revised strategy</b> <i>October 2021</i>	<b>Previous strategy</b> <i>June 2021</i>	<b>Reason for change</b>
A new federal investment focused on improving health equity, including investments to (a) build local capacity for community-led health equity interventions ; (b) resource statewide infrastructure to support community-led health equity investments; (c) grant community-led collaboratives resources to invest in health equity.	Establish a methodology for projected savings to Medicaid and Medicare Advantage Programs in Oregon and retain those savings within the state.	The state is broadening the ask for more flexibility in this strategy.
	Reinvest savings by piloting new "health equity zones"	Conversations with community partners led to further policy and strategy development and changes in how this work is being described.

## DROPPED waiver strategies

The table below describes waiver strategies that were in the drafts released June 2021 and Oregon is no longer pursuing.

Maximizing Coverage through the Oregon Health Plan	
Strategy (June 2021)	Reason(s) removed
Adopt policies that keep families covered together as income changes	This strategy does not require a waiver. New policy proposals to cover OHP members age 6 and up for 2 years address this concern.
Seek more flexibility to leverage federal Affordable Care Act funding to enroll eligible people	Oregon is pursuing a constellation of other strategies related to enrollment.
Transitions...	
Strategy (June 2021)	Reason(s) removed
Reserved capacity for children in Child Welfare	OHA is pursuing further research on this topic before deciding whether to go forward with this strategy.
Extend OHP eligibility to every child at the point of diagnosis of behavioral health needs	Needed substantial further development to move forward as a viable strategy for the state at this time.
Value-Based Global Budget	
Strategy (June 2021)	Reason(s) removed
N/A – no changes	
Incentivizing Equitable Care	
Strategy (June 2021)	Reason(s) removed
<b>Note: This is a new concept paper in October 2021; all strategies are new</b>	
Focused Equity Investments	
Strategy (June 2021)	Reason(s) removed
N/A – no changes	

## Strategies that have MOVED (but did not change)

The table below describes strategies that have moved between concept papers. Intent of strategy did not change but some strategies have been reworded for clarity.

Old Strategy	Old location (June 2021)		New location (October 2021)		Reason moved
Hold CCO program to sustainable cost growth target	■	Value-Based Global Budget	■	Focused Equity Investments (background)	Does not require waiver authority
Shift power to community to direct community investments: working directly with Oregon RHECs on implementation of HB 3353	■	Value-Based Global Budget	■	Focused Equity Investments	To ensure all information about 3353 and RHEC collaboration is in one location.
Revamp Oregon's metrics program so that equity is the primary organizing principle	■	Value-Based Global Budget	■	Incentivizing Equitable Care	Further development of this strategy led to new concept paper.
Ensure Oregon's approach to evidence-based benefits enhances access to innovative and high-value care	■	Value-Based Global Budget	■	Transitions	Further development of this strategy led to our proposed set of SDOH transition services.
Tribal-specific strategies	■	Transitions		N/A- currently in development	Developing in partnership with Oregon's nine federally recognized tribes through tribal consultation process.

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# Communications Engagement Feedback Analysis and Summary Report v4.0

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## 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.<sup>1</sup> 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

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<sup>1</sup> 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.



<b>Improve health outcomes by streamlining life and coverage transitions Create an equity-centered system of health<sup>2</sup></b>			
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
		<b>Total</b>	<b>222</b>
<b>Ensure access to coverage for all people in Oregon</b>			
Access to coverage	74	Governance	7
Expanded eligibility	13	Shared power	11
		<b>Total</b>	<b>105</b>
<b>Encourage smart, flexible spending that supports health equity</b>			
Capitation	30	Payer alignment	4
Data/measurement	10	Program Integrity	7
Incentives/metrics	8	Provider payment	20
		Value-based payment	3
		<b>Total</b>	<b>85</b>
<b>Reinvest government savings across systems to achieve health equity</b>			
Investment	36		
		<b>Total</b>	<b>36</b>
<b>TOTAL</b>			
		Total tagged comments	514
		Count of duplicates	20
		<b>GRAND TOTAL</b>	<b>536</b>

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.

<sup>2</sup> 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.<sup>3</sup>

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
<i>Count of tagged comments</i>	514
<i>Count of duplicates</i>	20
<b>GRAND TOTAL</b>	<b>536</b>

<sup>3</sup> 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<sup>4</sup>**

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

<sup>4</sup> 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<sup>5</sup>

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

<sup>5</sup> 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<sup>6</sup> 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.

<sup>6</sup> 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 oversight 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](https://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@dhsosha.state.or.us](mailto:community.outreach@dhsosha.state.or.us) or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.

# Appendix G: Letters of Support

*This appendix documents letters of support from oversight bodies and a key agency partner. Table G.1 is followed by copies of the letters.*

**Table G.1. List of Letters of Support**

#	Letter of Support
1	<b>2-7-22 – Medicaid Advisory Committee; Lavinia Goto, MAC co-chair; Leslee Huggins, MAC Co-chair</b> General Letter of Support
2	<b>2-8-22 – Oregon Health Policy Board; David Bangsberg, OHPB chair; Oscar Arana, OHPB Co-chair</b> General Letter of Support
3	<b>2-9-22 – Oregon Department of Human Services; Fariborz Pakseresht, Director</b> General Letter of Support
4	<b>2-14-22 – Health Equity Committee; Jorge Ramirez Garcia, HEC Co-chair; Stick Crosby, HEC Co-chair</b> General Letter of Support



Office of Delivery System Innovations  
Health Policy and Analytics Division

Kate Brown, Governor

Oregon Health Authority

500 Summer Street  
Salem, OR 97306

February 4, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Ms. Brooks-LaSure,

On behalf of the Medicaid Advisory Committee (MAC), we are writing in support of Oregon's 1115 waiver application. Members of the MAC are grateful for the opportunity to advise the Oregon Health Authority, the Oregon Health Policy Board, and the legislature on the operations and policies pertaining to Oregon's Medicaid program from a consumer and community perspective.

MAC members are particularly supportive of the waiver policies that are designed to:

- advance equity,
- increase coverage and access to health care,
- support OHP members with transitions across systems,
- address upstream social determinants of health,
- establish equity-focused metrics,
- support investment in communities, and
- maintain existing waiver components such as the HERC, prioritized list, and the CCO model.

The waiver helps address foundational values centered on assuring access for Oregonians. We encourage OHA to continuously address how specific investments in value-based care and drug plan coverage may also limit or change coverage for some patients, and encourage a highly transparent, collaborative, and patient-centered approach to implementation.

We are excited about the overall waiver design and potential for achieving the goals of improved care access, health outcomes, and equity for all people in Oregon.

Sincerely,

Lavinia Goto, RN, CDE, MPH, MBA, DHA  
Medicaid Advisory Committee Co-chair

Leslee Huggins, DDS, MS  
Medicaid Advisory Committee Co-chair

**Medicaid Advisory Committee Members**

**Daniel Alrick, Chair, Oregon Council on Developmental Disabilities**

**Brandy Charlan, Caregiver and OHP Member**

**Adrienne Daniels, Deputy Director, Integrated Clinical Services, Multnomah County**

**Lavinia Goto, Project Manager of LTC Innovation & SDOH, NorthWest Senior & Disability Services,  
and Operations Manager, Oregon Wellness Network**

**Miguel Angel Herrada, Health Equity and Diversity Strategist for PacificSource, Central Oregon**

**Leslee Huggins, Pediatric Dentist and Orthodontist, Capitol Dental Care/InterDent**

**Jeremiah Rigsby, Chief of Staff, CareOregon**

**Divya Sharma, Chief Medical Officer, Central Oregon Independent Practice Association**

**Kārun Virtue, Chair, Lincoln Country Community Advisory Council**

**Rachel Currans-Henry, Strategic Initiatives Administrator, Aging and People with Disabilities, DHS**

**David Inbody, CCO Operations Manager, Oregon Health Authority**

**John Santa, OHPB Member and MAC Liaison (non-voting)**



Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

February 4, 2022

Dear Chiquita Brooks-LaSure,

On behalf of the Oregon Health Policy Board (OHPB), we are writing to support the 1115 Waiver Renewal application submitted in February by the Oregon Health Authority (OHA).

As the policy oversight body to OHA, OHPB is dedicated to developing and guiding implementation of health care policy and we are committed to providing access to quality, affordable health care for all Oregonians and improving population health. For many years Oregon has been a leader in Medicaid reform with our coordinated care model, which integrates all aspects of health care including a focus on factors outside the traditional health care system that affect health. Now our state is asking to further deepen that model and begin the very necessary transition to a focus on health equity. We are supportive of this approach, which builds on the strong points of our current system.

In particular we support the waiver renewal application's focus on

- **Maximizing continuous and equitable access to coverage.** Oregon's approach will seek to eliminate inequitable access with strategies to extend coverage and services to every eligible child and adult in Oregon.
- **Improving health outcomes by streamlining life and coverage transitions**  
If Oregon is able to provide specific benefit packages to members in transition, we can ensure they stay covered, have important social determinants of health needs met and maintain access to care and medicine.
- **Moving to a value-based population payment.** To maintain and build on our successes, our state must continue to build a system that rewards spending on health equity and improving the health of communities rather than spending on medical procedures and services alone.
- **Incentivizing equitable care.** By revising metrics to focus on traditional quality and access for downstream health while creating a new set of equity-driven performance metrics for upstream health factors, Oregon can make significant progress in driving the system toward more equitable health outcomes.



- **Improving health through focused equity investments led by communities**  
With equity-focused investments Oregon will create expectations of redistributing funds and decision-making power around community investments to the community itself to better address larger scale barriers to health and health equity.
- **Alignment with Tribal partners’ priorities.** We appreciate Oregon’s continued commitment to work with the nine federally recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to help ensure we achieve Tribal health care objectives. Not only is addressing Tribal health an important element of health equity but honoring traditional Tribal practices and upholding the government-to-government relationship between the sovereign nations and the state are important processes that we support.

We support all of the policy proposals outlined above individually but we believe that the entire package, if approved fully, will make a significant impact on health equity in Oregon along with better health for individuals.

OHPB applauds OHA’s application and commitment to further adjusting Oregon’s Medicaid system to focus on the deep inequities experienced by communities of color and other oppressed communities in our state.

We believe that the proposed 1115 waiver is a significant step for people in Oregon and ask for approval.

Sincerely,



David Bangsberg, MD, MPH  
Chair, Oregon Health Policy Board

Oscar Arana, MBA  
Vice-Chair, Oregon Health Policy Board



# Oregon

Kate Brown, Governor

## Department of Human Services

Office of the Director  
500 Summer St. NE, E-15  
Salem, OR 97301  
Voice: 503-945-5600  
Fax: 503-581-6198  
TTY: 503-945-5896

February 9, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Ms. Brooks-LaSure,

I am writing to express my support and the support of the Oregon Department of Human Services (ODHS) for the 1115(a) Waiver Renewal application submitted in February by the Oregon Health Authority.

As a human services organization we are committed to our vision that all who live in Oregon, regardless of race, identity, age, disability or place, have the needed supports to achieve whole well-being. Health care is a critical component of this vision. We dedicate ourselves to work with community and partners to support the whole well-being of individuals, families and communities. We know that upstream policy interventions have a ripple effect and the Oregon Health Authority's waiver renewal application focuses on critical upstream strategies and innovations. Now our state is asking to further deepen our coordinated care model and begin the very necessary transition to a focus on health equity. We are supportive of this approach, which builds on the strong points of our current system.

We support the waiver renewal application's focus on:

- **Maximizing continuous and equitable access to coverage.** Oregon's approach will seek to eliminate inequitable access with strategies to extend coverage and services to every eligible child and adult in Oregon.
- **Improving health outcomes by streamlining life and coverage transitions**  
If Oregon is able to provide specific benefit packages to members in transition, we can ensure they stay covered, have important social determinants of health needs met and maintain access to care and medicine. ODHS supports this effort in alignment with our wellbeing initiative and effort to use the social determinants of health as a lens for the programs and benefits we offer. These

services and benefits can work in tandem with Medicaid benefit packages to help Oregonians rebound from challenging transitions and work toward stability.

- **Moving to a value-based population payment.** To maintain and build on our successes, our state must continue to build a system that rewards spending on health equity and improving the health of communities rather than spending on medical procedures and services alone.
- **Incentivizing equitable care.** By revising metrics to focus on traditional quality and access for downstream health while creating a new set of equity-driven performance metrics for upstream health factors, Oregon can make significant progress in driving the system toward more equitable health outcomes. ODHS endorses this effort as we endeavor to refocus our work, holding ourselves accountable to lead with equity. ODHS plays an important role in addressing upstream factors that impact health outcomes, and we look forward to partnering with Oregon Health Authority in this work.
- **Improving health through focused equity investments led by communities**  
With equity-focused investments Oregon will create expectations of redistributing funds and decision-making power around community investments to the community itself to better address larger scale barriers to health and health equity. ODHS supports this work as we engage in complementary efforts to lead with community voice, engage communities as thought partners and decision makers, and transfer power to those most impacted by our work.
- **Alignment with Tribal partners' priorities.** We appreciate Oregon's continued commitment to work with the nine federally recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to help ensure we achieve Tribal health care objectives. Not only is addressing Tribal health an important element of health equity but honoring traditional Tribal practices and upholding the government-to-government relationship between the sovereign nations and the state are important processes that we support. ODHS shares this priority and fully endorses a commitment to Tribal partnerships as foundational to health equity.

We support all policy proposals outlined above individually and we believe that the entire package, if approved fully, will make a significant impact on health equity in Oregon along with better health for individuals which will help lead us to an equitable Oregon and well-being for everyone.

As an equity focused and driven state agency, we applaud the commitment to further adjusting Oregon’s Medicaid system to focus on the deep inequities experienced by communities of color and other oppressed communities in our state.

We believe that the proposed 1115 waiver is a significant step for people in Oregon and request approval.

Sincerely,

A handwritten signature in blue ink that reads "Fariborz Pakseresht". The signature is fluid and cursive, with the first name being more prominent.

Fariborz Pakseresht  
Director



HEALTH EQUITY COMMITTEE

Kate Brown, Governor

Equity and Inclusion Division  
421 SW Oak St., Suite 750  
Portland, OR 97204

<https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee>

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

February 14, 2022

Dear Chiquita Brooks-LaSure,

On behalf of the Health Equity Committee (HEC) we are writing to support the 1115 Waiver Renewal application submitted in February by the Oregon Health Authority (OHA).

The legacy of racism is that people of color, including the tribes, due to historical and current unequal distribution of resources, experience overall worse health outcomes. There is no doubt that everyone—no matter their race, economic, or immigration status, gender, age, or ability—would like to achieve their highest level of health they can achieve, and they want a healthcare delivery system that is person centered, equitable, and culturally and linguistically responsive. Medicaid is no exception.

Our committee strongly believes that approaches to bring health equity to the forefront should be informed by Oregon's diverse communities' health concerns and perspectives. Often, these individuals' concerns and needs are overlooked or dismissed. Historically rooted structures, processes, and practices often get in the way of equitable security and opportunity for all.

Members of the Health Equity Committee are proud to have contributed in part to overcome those barriers in the development of Oregon's 1115 waiver application by:

- Advising OHA in some of the aspects of this waiver such as ensuring meaningful community engagement.
- Advising and supporting the development of a health equity impact assessment tool to evaluate waiver policies from an equity perspective and develop recommendations for adjusting initiatives in ways to mitigate negative impacts and optimize positive impacts on the health of populations that have experienced inequities.

The Health Equity Committee was formed in 2017 by the Oregon Health Policy Board (OHPB) and its purpose has been to coordinate and develop policy that proactively promotes the elimination of health disparities and the achievement of health equity for all people in Oregon

Our experience and knowledge of how social injustices produce health inequities has been recognized and, at the request of OHPB, our committee developed a definition of health equity that was adopted by the Oregon Health Policy Board and the Oregon Health Authority in 2019. This definition has been a guiding force behind the development of the Oregon’s 1115 waiver policies that have informed this application:

*Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*

*Achieving health equity requires the ongoing collaboration of all regions and sectors of the State, including tribal governments, to address:*

- *The equitable distribution or redistribution of resources and power; and*
- *Recognizing, reconciling, and rectifying historical and contemporary injustices.*

The Health Equity Committee supports all the policy proposals that have been brought forward as part of the waiver application, but we are particularly supportive of policy proposals that:

- **Maximize continuous and equitable access to coverage**
- **Incentivize equitable care**
- **Improve health through focused equity investments led by communities**
- **Align with Tribal partners’ priorities**

We believe that the entire package of policy proposals has the potential to make a significant impact on health equity in Oregon along with better health for individuals.

As a Health Equity Committee, we applaud the commitment to further adjusting Oregon’s Medicaid system to focus on the deep inequities experienced by communities of color and other oppressed communities in our state.

We believe that the proposed 1115 waiver is a significant step for people in Oregon and ask for approval.

*Signed by Health Equity Committee Co-Chairs on behalf of members of the Health Equity Committee.*



Jorge Ramirez García, Ph.D.  
Co-Chair



Stick Crosby  
Co-Chair

Cc: Oregon Health Policy Board

