

APPLICATION FOR RENEWAL AND AMENDMENT

Oregon Health Plan **1115 Demonstration Waiver**

Draft Application for Public Comment
12/1/2021

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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 of 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 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 are focused 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 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 focused programs identified 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.¹

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 improve Oregon's primary care system by developing a set of standards for how primary care practices care for

¹ 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>

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 evaluation² 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](#)³.

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
- 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

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

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

- 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).⁴ Second, Oregon has a relatively high proportion of Medicare enrollees in Medicare Advantage plans – 47% in Oregon as compared to 38% nationally.⁵ 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 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.

⁴ 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>

⁵ Data source: CMS National Health Care Expenditures

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.⁶

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

- 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.⁷
- 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.¹
- American Indians and Alaska Natives have a much higher death rate from chronic liver disease than any other group.¹

OHP members and community stakeholders have regularly voiced the need for OHA to more explicitly 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(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 likelihood of success by shaping the direction of the entire health system, including beyond Medicaid.

⁷ OHA COVID-19 Weekly Report, Sep. 29, 2021.

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

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 continues to result 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 as well as extend the redetermination period from 12 to 24 months with this waiver request.*

- 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.*
- 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 state is seeking to use SNAP eligibility criteria to assess eligibility for OHP and perform outreach to individuals who are likely eligible for other safety net programs.*

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.

Continued commitment to REALD 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.

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 race/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’s MMIS (Maintenance Management Information System) system have been required to use the REALD data collection protocol for about 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 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 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 to be uninsured, and Oregon is prioritizing closing gaps in the system that cause people to lose coverage or prevent them from signing up in the first place⁸. The Oregon Legislature has taken steps to expand equitable access to coverage and the strategies described below further this concept to extend and stabilize coverage to 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.

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

⁸ Oregon Health Insurance Survey, 2019

- 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

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 aligns 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 Citizenship Waived Medical (CWM), 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.

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 for reenrollment 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.^{9,10} Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses.¹¹ And, people of color are over-represented among those incarcerated in Oregon,¹² 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

⁹https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing_30_Day_Inpatient_Psychiatric_Recidivism.8.aspx

¹⁰ https://cdr.lib.unc.edu/concern/honors_theses/j6731775s

¹¹ 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

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

- 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 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.¹³ 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.¹⁴ 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 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.¹⁵ 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

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

¹⁴ 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

¹⁵ 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

incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse.¹⁶

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 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.

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)¹⁷ 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

¹⁶ 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/>.

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

worse for racial and ethnic minorities.¹⁸ According the 2018-19 National Survey of Children’s Health, 45% of Oregon youth aged 12-17 had a special health care need. Family members of youth with special health care needs reported that:

- 69% did not receive health care transition preparation services,
- 38% did not have time alone with their provider during their last check-up,
- 21% did not learn skills for managing their own care from their health care providers, and
- 44% did not receive help from their health care provider to understand the changes in care that happen at age 18.¹⁹

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 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 increased²⁰:

- 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

¹⁸ https://pediatrics.aappublications.org/content/126/Supplement_3/S129.short

¹⁹ 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>

²⁰ 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.^{21,22} In a study in Oregon, Medicaid costs declined by 12% on average after people moved into affordable housing.²³ 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.²⁴ 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

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

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

²² 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

²³ https://oregon.providence.org/~media/Files/Providence%20OR%20PDF/core_health_in_housing_full_report_feb_2016.pdf

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

Employment Supports

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

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

Exposure to climate events

Over the last several years Oregon has endured several extreme climate change-related events, including wildfires, ice storms, and extreme heat. During Oregon's most recent extreme heat event in late June 2021, 116 people in Oregon died of heat-related illness or hyperthermia. Vulnerable populations, including children, pregnant 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.²⁵ Extreme climate events are occurring with greater frequency and severity, can disrupt health care access and even coverage.²⁶ 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

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

²⁶ https://earthobservatory.nasa.gov/features/RisingCost/rising_cost5.php

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 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 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) 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, CCO’s and OHA with PRTS providers to prioritize youth in CW 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.

1. Given current capacity:
 - Child Welfare will have the ability to develop a direct agreement with existing PRTS providers to prioritize youth in CW 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 CW 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, CW 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, CW’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.

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 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 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 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 that drives 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 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 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 authority to rely on a capitated rate development methodology for a new value-based budget for population health 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 pay for population health 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 budgets 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 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 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 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 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 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 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.²⁷

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

²⁷ 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.

²⁸ 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,

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

Strategy 3: Increase predictability of costs and ensure value for spending 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

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>

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.²⁹ 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 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.

²⁹ 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>

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.

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. 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 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;³⁰
- 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).

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.

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

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 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 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.

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 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:

Upstream Health Equity Metric	Year incentivized	Additional Information
Mental, Physical and Oral Health Assessment Within 60 Days for Children in DHS Custody ³¹	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 ³²	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) ³³	2022 ³⁴	Incentivizes more culturally responsive services being offered to help children start kindergarten ready to learn.
Social Determinants of Health: Social Needs Screening and Referral ³⁵	2023 ³⁶	Incentivizes more CCO members having their social needs acknowledged and addressed

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

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

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

³⁴ For Social Emotional Health component of HAKR bundle

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

³⁶ Potential implementation

These domains were chosen because of their relation to OHP members who experience historical and/or 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).³⁷ 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.

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

³⁷ 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.

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 and measurement 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.

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 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.

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) 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 effectively partner with health care organizations.³⁸

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

³⁸ 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

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.

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 CCOs' community funds (per HB 3353). 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.³⁹ 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 CCO budgets for population health 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.

Ideally, the grant process 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.

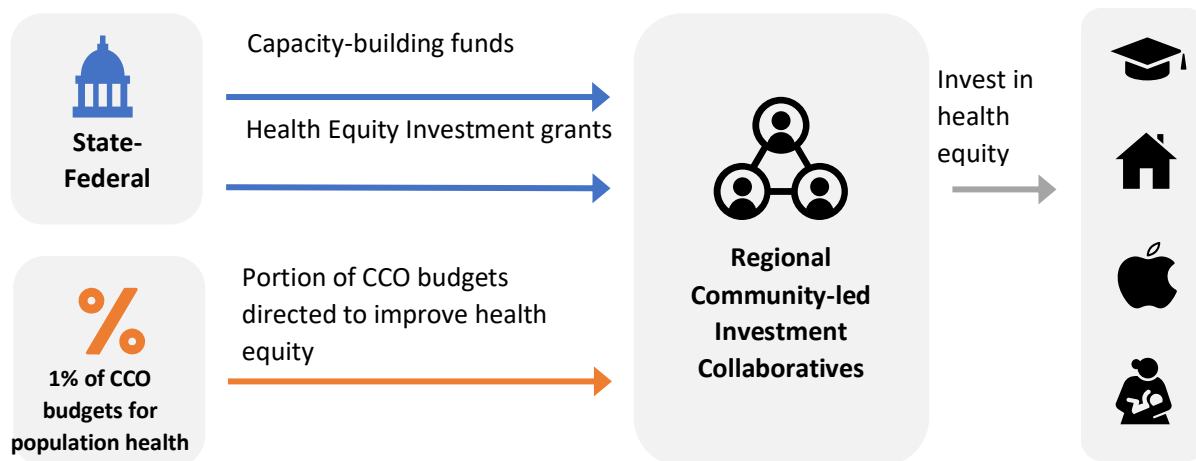
HEI grant proposals will identify the population served and planned investments, both of which must be informed first by available community-based and empirical evidence as well as local community health assessments and community health improvement plans.⁴⁰ Examples of proposed HEIs could include expanding 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

³⁹ 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>

⁴⁰ 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.

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.

Oregon’s proposed model forms Community Investment Collaboratives to leverage multiple sources of funding.*



**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.*

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, 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 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 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.

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 'Tribal Strategies' Section 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

Section II. Waiver and Expenditure Authorities

Waiver Authority

As detailed in the table below, there are several changes that will occur to the OHP based on 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:

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
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	Section 1902(a)(10)(A) and 1902(a)(43)(C)
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	Section 1902(a)(4) as implemented in 42 CFR 438.56(c) and 438.52

Request	Waiver/Expenditure Authority to continue
amendment the state is seeking with this renewal (see below)	
<ul style="list-style-type: none"> • CCOs are expected to have comprehensive risk contracts. • State is considering potential options for risk-sharing arrangements. • Financial solvency requirements—State is considering brokering re-insurance or stop-loss insurance. 	<p>42 CFR § 434.20 and 21—basic HMO and PHP rules and contract requirements</p> <p>SSA § 1902(a)(30): Payments must be consistent with efficiency, economy, and quality of care.</p> <p>42 CFR § 438.6(b)— comprehensive risk contracts</p> <p>42 C.F.R. § 434.50—protection against insolvency</p> <p>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
Oregon will maintain authority to continue retroactive eligibility which is a waiver to enable the state to not provide three months of retroactive coverage (applies to all Medicaid state populations, except 7 and 8, listed in Section III. Eligibility).	Section 1902(a)(34)
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)	

Request	Waiver/Expenditure Authority to continue
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	42 CFR § 438.56

Request	Waiver/Expenditure Authority to continue
disenroll from CCOs without cause at any time	
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
Doula's 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) § 1902(a)(1) 42 CFR 431.50

Request	Waiver/Expenditure Authority to continue
	<p>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.</p>
	<p>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.</p>

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:

#	Request	Waiver/Expenditure Authority
1	<p>Provide continuous Oregon Health Plan (OHP) enrollment for children until their sixth birthday (age 0-5);</p>	<p>To allow federal financial participation for the continuous enrollment of children without regard to whether a child’s income exceeds eligibility limits; and</p> <p>To enable the state to waive the requirements for individuals to report and the agency to act on changes with respect to income eligibility</p> <p>42 C.F.R. 435.916</p>

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	Provide an expedited OHP enrollment path for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits.	Expenditure authority to permit the State use SNAP eligibility information as the basis for determining Medicaid enrollment.
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 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 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	Expenditure authority for Medicaid services rendered to institutionalized individuals.

	State Hospital and psychiatric residential facilities	
8	Retain child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) up to age 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 up to age 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 support access to services using providers outside of the medical model.	Expenditure authority for services delivered by Traditional Health Workers, 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 limit formulary to exclude unproven or low-value drugs	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 Section V – Delivery System and Payment Rates 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.
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Section III. 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.

Oregon proposes adding a new eligibility group targeted at supporting Youth with Special Health Care Needs (YSHCN). For YSHCN, Oregon proposes to extend OHP coverage to age 26 and retain CHIP eligibility levels to support smooth transitions from pediatric to adult health care. Providing additional supports (described in *Section IV – Benefits and Cost Sharing*) will provide these youth 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.

OHA proposes two key strategies to address this problem:

1. Provide YSHCN with extended income eligibility for Medicaid, (300% FPL) until the age of 26 (aligned with the ACA), and
2. Support YSCHN as they transition to adulthood with a package of services that provides health and social supports.

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 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 through age 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

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"> • Be at least 17 years of age; and, • Have active and continuous OHP eligibility at the time they turn 19 years of age; and, • Countable income not to exceed 300% FPL; and, • Have one of the following: <ul style="list-style-type: none"> ○ Have service or Medicaid eligibility through Aged and Peoples with Disabilities (APD); or, ○ Have service or Medicaid eligibility through Oregon Developmental Disability Services (ODDS); and, <ul style="list-style-type: none"> • Be identified through the Intellectual or Developmental Disability (IDD) indicator in MMIS; or • Be identified through the Medically Fragile or Medically Involved indicator in MMIS

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</p> <p>SFY 25 – 3,000</p> <p>SFY 26 – 4,500</p> <p>SFY 27 – 6,000</p>
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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.^{41,42} Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses.⁴³ And once again, people of color are over-represented among those incarcerated in Oregon,⁴⁴ 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*).

⁴¹https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing_30_Day_Inpatient_Psychiatric_Recidivism.8.aspx

⁴²https://cdr.lib.unc.edu/concern/honors_theses/j6731775s

⁴³ 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

⁴⁴ <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf>

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.

Youth in custody of Juvenile Corrections placed in secure facilities	
Description	Youth in custody (pre- and post- adjudication) of Juvenile Corrections 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"> Youth must be residing in a close-custody facility under the jurisdiction of the Oregon Youth Authority or county/local juvenile departments. <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>Eligibility will be determined through the use of community- based application assistors or trained agency staff using the Oregon Eligibility (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

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.
Standards and Methodology	This may or may not include individuals transitioning from a county jail or local correctional facility into a Department of Correction facility. Additionally, an individual transitioning from a Department of Corrections facility to a county jail or local correctional facility for the purpose of

	<p>responding to separate charges will be subject to the allowable benefit package associated with their place of incarceration.</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.</p> <p>Notification of the limited 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 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.</p>
<p>Projected # of Individuals</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</p> <p>SFY 25 – 918</p> <p>SFY 26 – 918</p> <p>SFY 27 – 918</p>

Adults in custody of local correction facilities	
Description	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.
Standards and Methodology	<p>This may or may not include individuals transitioning from a county jail or local correctional facility into a Department of Correction facility. 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.</p> <p>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 assistors 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 the OHP Member will notify OHP of their updated address to ensure timely access to their local CCO providers.</p>
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 to include non-SUD IMDs including the Oregon State Hospital (OSH). At this time, the OSH is the only non-SUD IMD in the state.

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"> • 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>. • 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.
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 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>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.</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 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.
Projected # of Individuals	Approximately 360 individuals per year for each demonstration year

Changes to Eligibility Processes

SNAP

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. 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.

Members enrolled via SNAP pathway	
Projected # of Individuals	<p>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.</p> <p>SFY 24 – 85,783</p> <p>SFY 25 – 85,783</p> <p>SFY 26 – 85,783</p> <p>SFY 27 – 85,783</p>

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 6th 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.

Continuous enrollment for children until their 6th 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.

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: 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.

Pop.	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group
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	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

	the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)						
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 Cancer	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: 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. Benefits and Cost Sharing

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 is proposing changes to how services 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 SDOH services to members. This may also occur – through community-based services provided outside of the medical model - prior to transitions in Medicaid benefit and/or eligibility changes.

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 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.

Category	Types of services
CARE COORDINATION NAVIGATION	<p>For individuals experiencing transitions, a care coordination navigator will be available to provide:</p> <ul style="list-style-type: none"> • Care coordination services for health-related assessments in preparation for returning to the community • Provider identification and scheduling health care appointments in preparation for returning to the community • Navigation services to support connections to SDOH and health services once they are released
CONTINUUM OF CARE	<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"> • Drug and alcohol screenings and assessments • Behavioral health screenings and assessments • Telehealth appointments to establish as a new patient with a primary care provider • Telehealth appointments to establish as a new patient with a behavioral health provider • 60 days of prescription at return to community to augment the 30 days provided by the releasing facility

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. 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 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 capitation rate initially, the state will learn which services are most effective as CMS phases down its additional funding.

Categories of Transition Support Services

Category	Types of services and anticipated impact on health:
HOUSING SUPPORTS	<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">• Rental assistance or temporary housing (rental payments, deposits, past rent, motels, etc. for up to 12 months)• Home and community-based services (ramps, handrails, environmental remediation, etc.)• Utility assistance (device and broadband support, utility set-up, resources for bill assistance)• Pre-tenancy and tenancy support services (employment services, eviction prevention, housing application, moving support, etc.)

Category	Types of services and anticipated impact on health:
	<ul style="list-style-type: none"> • Housing-focused navigation • 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.) • Supports for budgeting and financial literacy and independent living skills
FOOD ASSISTANCE	<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"> • 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)) • Nutrition and cooking education • Fruit and vegetable prescriptions and healthy food boxes/meals • Medically tailored meal delivery • Assistance accessing school-based food programs
EDUCATION SUPPORTS	<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"> • Person centered employment planning through education (e.g., skills and interest assessments etc.) • Assistance with FAFSA, grant, and scholarship applications for vocation schools or higher education • Assistance locating and applying for the vocation schools or higher education
EMPLOYMENT SUPPORTS	<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</p>

Category	Types of services and anticipated impact on health:
	<p>intended to provide individualized educational supports, skill development, job training and placement, and may include:</p> <ul style="list-style-type: none"> • Person-centered employment planning support • Individualized job development and placement (e.g., job fairs, interviews) • Mentoring (e.g., on how to change behavior, re-entry from incarceration) • Linkage to appropriate interview attire • Transportation (provided either as a separate transportation service to employment services or to the member’s job)
HEALTH-RELATED TRANSPORTATION	<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"> • Linkages to existing transportation resources and programs • Payment for transportation to support access to SDOH services, (e.g., bus passes, taxi vouchers, ridesharing credits). • Payment for transportation to education, job search activities, and employment • Health-related transportation services in addition to Non-Emergency Medical Transportation (NEMT) • Transportation to warming, cooling, or evacuation shelters in extreme weather events
CLIMATE SUPPORTS	<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</p>

Category	Types of services and anticipated impact on health:
	<p>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"> • Payment for transportation to cooling / warming and/or evacuation shelters (e.g., taxi vouchers, ridesharing credits, use of NEMT or health-related transportation above) • 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 • Payment or vouchers to address high electric bills due to extreme temperatures • Housing supports and services, housing repairs due to wildfires to make housing livable • Immediate access to durable medical equipment (DME) left behind without a prescription or prior authorization • Clothing and/or food for members affected by extreme (e.g., wildfire) weather events
OTHER	<ul style="list-style-type: none"> • Additional services for specific populations are described below

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.

Population	Services
<p>Adults incarcerated and in the custody of the Department of Corrections</p>	<p>OHP Coordination Benefit Package</p> <ul style="list-style-type: none"> • 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 <p>Social determinants of health services available upon release and enrollment into full OHP may include:</p> <ul style="list-style-type: none"> • Housing supports • Education supports

Population	Services
	<ul style="list-style-type: none"> • Employment supports • Health-related transportation <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • <i>Routine medical care provided while in custody</i> • <i>Full OHP benefit package while in custody</i>
<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 – 842</p> <p>SFY 25 – 918</p> <p>SFY 26 – 918</p> <p>SFY 27 – 918</p>
Adults in custody of local correction facilities	<p>Full OHP benefit package</p> <ul style="list-style-type: none"> • Adults in custody of local corrections 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 local corrections. <p>Social determinants of health services upon release may include:</p> <ul style="list-style-type: none"> • Housing supports • Education supports • Employment supports • Health-related transportation <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • <i>Routine medical care provided while in custody</i>

Population	Services
<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</p> <p>SFY 25 – 11,522</p> <p>SFY 26 – 11,522</p> <p>SFY 27 – 11,522</p>
<p>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</p>	<p>Limited OHP benefit package</p> <ul style="list-style-type: none"> • 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. <p>Social determinants of health services upon discharge may include:</p> <ul style="list-style-type: none"> • Housing supports • Education supports • Employment supports • Health-related transportation <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • <i>Routine medical care provided by the facility</i> • <i>Full OHP benefit package while in custody</i>
<i>Projected # of Individuals</i>	<p>Approximately 360 individuals per year for each demonstration year</p>
<p>Youth in custody of Juvenile Corrections placed in secured facilities</p>	<p>Full OHP benefit package</p> <ul style="list-style-type: none"> • Youth in custody of Juvenile Corrections placed in secured 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.

Population	Services
	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> • Health-related transportation • Secure non-emergent transportation services to health-related appointments <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • <i>Routine medical care provided while in custody</i>
<i>Projected # of Individuals</i>	130 individuals, annually
<p>Youth transitioning into adulthood (17-26) with Special Health Care Needs and with special health related conditions</p>	<p>Full OHP benefit package</p> <ul style="list-style-type: none"> • This is a new eligibility group proposed by the waiver. These individuals will receive full pediatric-level OHP benefit package through age 26; and • Extended access to pediatric providers as the young adult slowly transitions to adult providers <p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> • Navigation supports moving into the adult serving systems and transitioning into community or independent living • Life skills training • Peer navigator or mentor <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • <i>Services provided by other Oregon Department of Human Services agencies (e.g., APD, ODDS)</i>
<i>Projected # of Individuals</i>	<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</p> <p>SFY 25 – 3,000</p> <p>SFY 26 – 4,500</p> <p>SFY 27 – 6,000</p>

POPULATIONS BELOW THIS LINE ASSUME THE INDIVIDUAL ALREADY HAS OHP ENROLLMENT

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.

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:

Population	Services
<p>Youth involved or at risk of involvement with the Juvenile Justice System in the community</p> <p>Youth living in the community and identified by Oregon’s juvenile justice system as involved or at risk of involvement with the 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.</p> <p>Youth identified as involved or at risk of involvement in the juvenile justice system as referred through:</p> <ul style="list-style-type: none"> • Oregon Youth Authority • County Juvenile Departments 	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> • Housing • Employment assistance • Transportation • Health-related transportation • Navigator or mentor • Life skills training <p><i>Benefit does not include:</i></p> <p><i>Services provided by the Oregon Youth Authority or local county corrections</i></p>

<ul style="list-style-type: none"> Local or State Law Enforcement 	
<i>Projected # of Individuals</i>	5,000 ⁴⁵
<p>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</p> <p>Existing youth OHP members who meet at least one of the following criteria:</p> <ul style="list-style-type: none"> Identified by Child Protective Services (CPS) Identified by Child Welfare (pre-custody referrals or post custody OHP eligibility category) Identified by CCOs Identified by OHA behavioral health system 	<p>Social determinants of health services may include:</p> <ul style="list-style-type: none"> Peer support or navigation to help families apply for OHP and other services (services to prevent entering the child system) Single point of contact to help navigate through changing foster homes, returning to natural home, moving service areas Housing Life skills training Employment assistance Transportation <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> <i>Services provided by the child welfare system</i>
<i>Projected # of Individuals</i>	48,000, annually
<p>Members transitioning to dual Medicare-Medicaid enrollment</p> <p>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"> Navigator to assist in transitioning onto Medicare and to support continuity of providers and managing provider networks Navigation to educate/assist in accessing benefits such as oral health, specialized mental health services, NEMT etc. Accessing LTSS services including community based LTSS supports Education esp. coordination of benefits, navigating provider networks, primary care Housing

⁴⁵ Estimate from the juvenile crime prevention program statewide evaluation summary

	<ul style="list-style-type: none"> • Transition of Care (continuation of provider and approved treatments) • Food assistance <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • Services and supports provided by Medicare
<i>Projected # of Individuals</i>	199,220 ⁴⁶
<p>Individuals who are homeless or at risk of becoming homeless</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"> • Housing • Food assistance • Health-related transportation • Employment assistance <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • Services provided by other agencies
<i>Projected # of Individuals</i>	374,800 ⁴⁷
<p>Individuals vulnerable to extreme climate events</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"> • Climate supports • Health-related transportation • Food assistance <p><i>Benefit does not include:</i></p> <ul style="list-style-type: none"> • Services provided by other agencies during emergency event
<i>Projected # of Individuals</i>	129,549 ⁴⁸

⁴⁶ Estimate is based on current population of dual eligible OHP members

⁴⁷ Oregon Community Foundation, <https://oregoncf.org/assets/PDFs-and-Docs/PDFs/OregonHomelessness.pdf>

⁴⁸ 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 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

Ability to define a preferred drug list for pharmacy benefits

Oregon seeks the ability to more closely manage pharmacy costs in its Medicaid program, through a two-part strategy:

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.

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. 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 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 ability.

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

Delivery System Overview

Under this waiver, 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)
 - Prepaid Ambulatory Health Plans (PAHP) through Oregon’s five Dental Care Organizations (DCOs)
- 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 Coordination Care Organizations (CCO). 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, 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 not 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 – 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 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 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.

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 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 ⁴⁹	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 ⁵⁰	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.

⁴⁹ <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2014-Assessments-Children-DHS-Custody-Guidance-Document.pdf>

⁵⁰ <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx>

Health Aspects of Kindergarten Readiness (HAKR) ⁵¹	2022 ⁵²	Incentivizes more culturally responsive services being offered to help children start kindergarten ready to learn.
Social Determinants of Health: Social Needs Screening and Referral ⁵³	2023 ⁵⁴	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).⁵⁵ 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.

⁵¹ <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx>

⁵² For Social Emotional Health component of HAKR bundle

⁵³ <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx>

⁵⁴ Potential implementation

⁵⁵ 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.

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.

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.

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.

Section VI. Finance and Budget Neutrality

Updated 12/7/2021

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. This section discusses the budget neutrality test for the extension application. The budget neutrality test performed for this extension application applies the methodology that was adopted for the OHP Demonstration approvals that were originally granted in 1993, as amended in the 2017 demonstration extension.

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 C 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) 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. To calculate the expenditure limit, the CMS-approved DY 2016 per capita rates are trended by the CMS-approved allowable trend rates for each year through DY 20 (State Fiscal Year 2022). For the new demonstration period, the state is requesting the continuation of the trend rates approved for the current demonstration. 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. All populations are reported as the average number of persons covered for the entire period. The Office of Forecasting, Research and Analysis, Oregon Department of Human Services, prepared the caseload estimates through state fiscal year 2027 and are reflected in the attached spreadsheets (Appendix C). 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
- Providing an expedited OHP enrollment path for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits. Note that this provision may not require waiver approval and may be removed from the final demonstration proposal pending CMS advisement.
- 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 the juvenile correction system throughout the duration of their involvement in juvenile corrections regardless of setting.
 - Providing 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.
 - Providing OHP benefits and CCO enrollment for OHP members in jail or a local correction facility, including those awaiting adjudication.
- Retaining child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) up to age 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 A below and Appendix C are adjusted to reflect the most recent estimate of 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).

Important note: The estimates of member month and associated impact in per capita costs are preliminary. OHA is working to refine the anticipated enrollment and per capita cost impact of the proposals more fully prior to waiver submission.

As noted above, the expedited OHP enrollment path for people who apply for Supplemental Nutrition Assistance Program (SNAP) benefits may not require waiver authority and may be removed from the final demonstration application. This policy is intended to increase OHP enrollment of Oregonians who are already Medicaid eligible but have not applied. Unlike the other policies included in the budget neutrality calculations, the increase in member months from this policy is not due to new coverage provisions, but rather streamlines the enrollment process to add OHP members. The current member month estimates assume that 50% of the people who are enrolled in SNAP but not in Medicaid will enroll in Medicaid as a result of this proposal. OHA continues to gather lessons learned from similar previous efforts to refine these estimates.

Additionally, the member months are adjusted to exclude Medicaid eligibles 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 C 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 through building infrastructure, supporting community-led interventions and statewide initiatives, and granting community-led collaboratives resources to invest in health equity (outlined in *Section I – Program Description* of this application). The requested investment ranges from \$240 million to \$274 million total funds per year between SFY 2023 and SFY 2027. This funding will allow for an investment of approximately \$560 million to \$619 million total funds per year in equity investments over the same period.

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 \$5.2 billion total funds through DY 20). The calculated savings are reduced to 20%

of the total calculation and include only savings from the current demonstration period per the ST&Cs for the demonstration.

Table A. Summary of Adjusted Caseload Included in Waiver Renewal Budget Neutrality Calculations
(Member Months)

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
Current Services Caseload	10,275,141	10,287,563	10,549,878	12,064,304	13,589,518	12,240,883	12,191,016	12,025,503	11,856,825	11,463,720
Estimated Member Month Adjustments										
<i>Proposed continuous enrollment and transition proposals</i>							271,983	528,186	721,465	911,736
<i>Expedited OHP enrollment provision for SNAP applicants*</i>						-	514,698	514,698	514,698	514,698
<i>Exclusion of member months under IMD 1115</i>				(2,846)	(11,508)	(12,005)	(12,523)	(13,062)	(10,110)	(10,555)
Total Adjustments				(2,846)	(11,508)	(12,005)	774,159	1,029,822	1,226,053	1,415,880
Total Adjusted Caseload	10,275,141	10,287,563	10,549,878	12,061,458	13,578,009	12,228,878	12,965,175	13,055,325	13,082,879	12,879,600

**This is an estimated projection of member months attributed to OHP enrollees who are likely to receive expedited enrollment for OHP when applying for Supplemental Nutrition Assistance Program (SNAP) benefits. This provision may not require waiver approval and may be removed from the final demonstration proposal pending CMS discussions*

Section VII. Implementation Plan

Implementation Schedule

All of the changes proposed in the demonstration renewal application will be implemented in year 1 and will continue through the five-year waiver period with the exception of the Equity Infrastructure supports and the transitions supports services.

- Year 1-5: CCOs are responsible for providing physical, behavioral, and oral health services, as well transitions support services and Equity Infrastructure investments funded through a combination of a primary budget and additional SDOH-T budgets.
- Year 1-3: Equity Infrastructure supports, and SDOH-T supports are funded outside of the CCO's primary budget through Disproportionate Share Hospital funds. CCOs build capabilities and identify the most effective services.
- Year 3: Funding outside of the CCO's primary budget for Equity Infrastructure supports and SDOH-T supports phase down.
- Year 4-5: CCOs are fully at risk for transitions supports services. Both transitions support services and Equity infrastructure spending 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. Under the new demonstration, Oregon will align the timing of members' eligibility renewal so that members' SNAP, TANF and OHP eligibility redeterminations happen concurrently.

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 Plan

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 build out with 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.

Evaluation Focus Areas

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

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:

Current Demonstration - Evaluation		Changes Proposed
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.		
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"> Continued integration of behavioral, oral, and physical health care <p>Waiver goal:</p> <ul style="list-style-type: none"> Enhance Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance driven system 	<p>New Evaluation area:</p> <ul style="list-style-type: none"> The impact of continuous coverage and defined transition support packages on coordination and integration of care and overall member health <p>Waiver goal(s):</p> <ul style="list-style-type: none"> Maximize continuous and equitable access to coverage <p>Streamline transitions between systems through defined benefit packages of social determinants of health services</p>

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"> Implementation and impact of health-related services, including the degree to which HRS are addressing social determinants of health <p>Waiver goal:</p> <ul style="list-style-type: none"> Encourage CCOs to address the social determinants of health and improve health equity 	<p>New Evaluation area:</p> <ul style="list-style-type: none"> The impact of community-driven decision making for investment on reducing health inequities <p>Waiver goal:</p> <p>Improve health through focused equity investments led by communities</p>
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"> The effects of transitioning to ‘opt-out’ CCO enrollment for dual eligible individuals, including the impact on total expenditures <p>Waiver goal(s):</p> <ul style="list-style-type: none"> Commit to an ongoing sustainable rate of growth, advance the use of value-based payments, and promote increased investments in health-related services 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 	<p>New Evaluation area(s):</p> <ul style="list-style-type: none"> The impact of a flexible, predictable capitation rate on community investment to reduce health inequities and improve population health The impact of equity-driven processes for operationalizing incentive metrics on reducing health inequities <p>Waiver goal(s):</p> <ul style="list-style-type: none"> Move to paying for population health Ensure quality and access through equity-driven performance metrics.

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 is being reviewed by the OHA and CMS. The summative evaluation of the 2012-2017 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.

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 global 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 investment has been made in the community.

Population and Measures

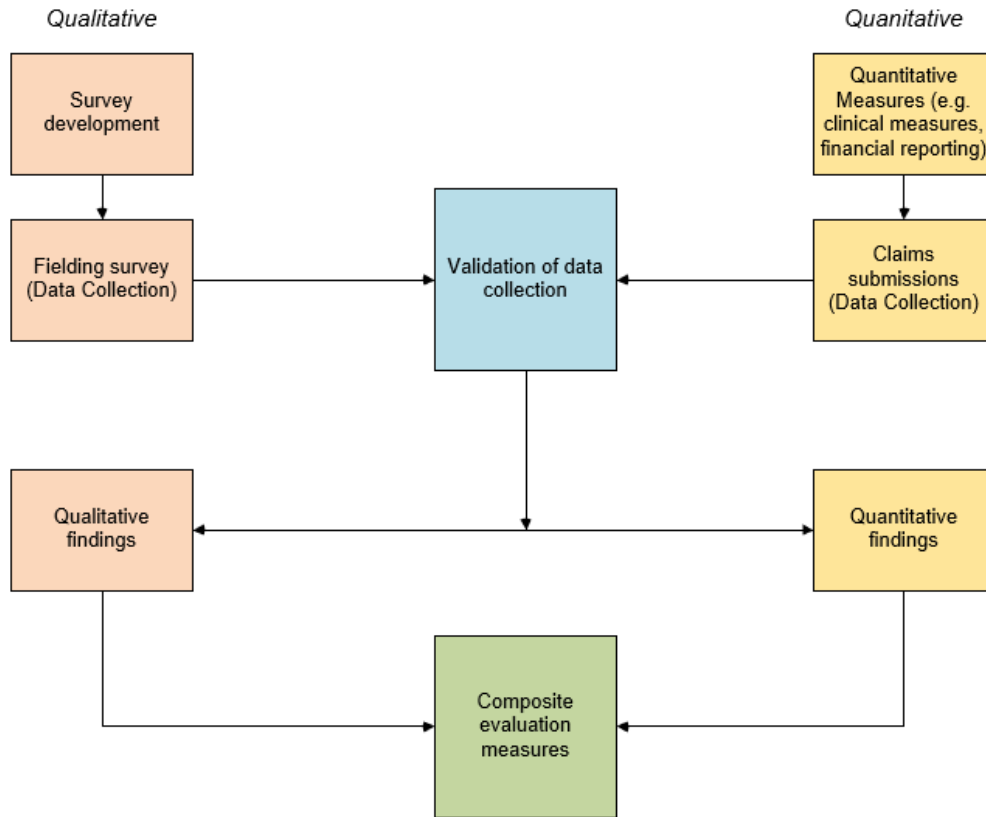
Evaluation Question	Hypothesis	Potential Population	Potential Methods / Measures
<p>Will the 1115 waiver extension proposed interventions decrease health inequities by race and ethnicity?</p>	<p>Redistributing power and resources to individuals and communities most harmed by historical and contemporary racism will result in improvements in health inequities and self-reported measures of autonomy, health status and quality of life.</p>	<ul style="list-style-type: none"> • Community organizations (regional health equity coalitions, community advisory councils, proposed regional community groups) • Whole OHP population by race/ethnicity 	<ul style="list-style-type: none"> • Community survey • Self-reported measures of stability and security • CMS core measures by race/ethnicity • HRS investments
	<p>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</p>	<ul style="list-style-type: none"> • Medicaid members • CCO incentive measures • Metrics decision-making Committees 	<ul style="list-style-type: none"> • Committee members survey • Community partner survey • Equity impact assessment of metrics • Measures of observed disparities by CCO incentive metrics

Evaluation Question	Hypothesis	Potential Population	Potential Methods / Measures
<p>Does continuous coverage improve health outcomes?</p>	<p>Earlier OHP enrollment with fewer gaps in coverage for vulnerable populations will result in improved health outcomes, health status, and quality of life.</p>	<ul style="list-style-type: none"> • Children ages 0-5 with race/ethnicity breakdowns • Children ages 6+ with race/ethnicity breakdowns 	<ul style="list-style-type: none"> • Kindergarten readiness measures • Re-enrollment of OHP members
	<p>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</p>	<ul style="list-style-type: none"> • Whole OHP population by race/ethnicity • Youth with special health care needs by race/ethnicity • Individuals at risk of becoming homeless 	<ul style="list-style-type: none"> • Self-reported measures of stability and security • Reduced recidivism rates • Reduced ED visits for Behavioral Health and non-traumatic dental needs • Time to first appointment with patient centered primary care home (PCPCH) • Time to first appointment with behavioral health provider

Evaluation Question	Hypothesis	Potential Population	Potential Methods / Measures
Does the streamlined capitation rate development methodology for a new value-based global budget increase CCO spending in community investments for reducing health inequities?	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"> • Community organizations (regional health equity coalitions, community advisory councils, proposed regional community groups) • CCOs • Actuarial unit 	<ul style="list-style-type: none"> • Community survey • CCO survey
	Offering a predictable budget, based on streamlined method with predictable cost growth, increases community investments.	<ul style="list-style-type: none"> • CCOs 	<ul style="list-style-type: none"> • HRS investments

Methods

Evaluation Methods



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

Oregon's current Medicaid Quality Strategy can be found in Appendix B and online here:

https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2021%20OHA%20Medicaid%20Quality%20Strategy_FINAL_05312021.pdf

Quality Strategy Overview

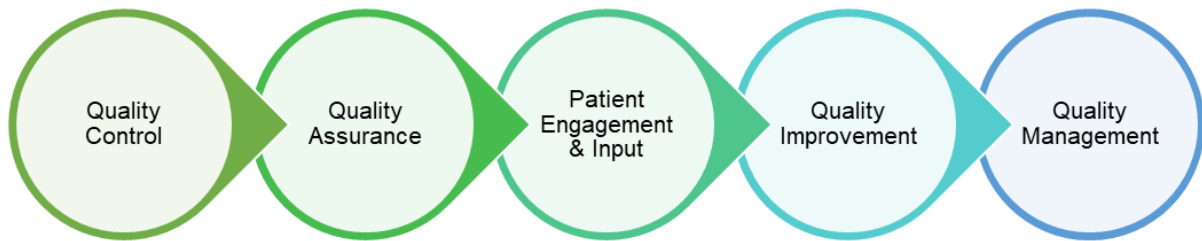
Oregon's Medicaid program, the Oregon Health Plan (OHP), has a quality strategy to reduce health inequities while ensuring quality and access to care for OHP members across all health care services and settings for physical, behavioral and oral health. The OHP Quality Strategy applies for all plans, 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.



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 1 shows the key quality inputs which inform the quality assessment.

Figure 1 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 the 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 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 External Quality Review Organization (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 and 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 scope of work includes 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 the Centers for Medicare and Medicaid Services. CCOs and DCOs work on resolving EQR (2017-2020) findings in the subsequent review year with success and improvements noted across the waiver demonstration years. CY2020 compliance reviews have 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>.

EQR Activities

EQR Review Area	Areas of Success	Areas of Improvement *(CY2020)
<p>Compliance Reviews</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.</p> <p>2019 CCO review of prior years’ (2017/2018) findings resulted in resolution of a majority of CCO findings.</p> <p>CCOs have appropriate credentialing policies.</p> <p>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.</p> <p>Policies developed for coordination of care, yet implementation of policies needs improvement for DCOs.</p> <p>2019 improvement plans from CCOs for the outstanding documentation needed for findings resolution of prior years.</p>
<p>Performance Improvement Project</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.</p> <p>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>Performance Measure Validation</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>Review of performance measure calculations and results</i>		
Network Adequacy <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.	DCOs need technical assistance in how to complete reporting requirements.
Encounter Data Validation	<p>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.</p> <p>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.</p> <p>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.</p>	<p>Documentation of OHA and CCOs quality assurance activity monitoring activities.</p> <p>CCOs ability to oversee and validation data of subdelegates prior to submission to OHA.</p>

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 measure 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.

CCO Performance Summary

Measure	Measure Performance Summary	Notes and next steps
Adolescents immunizations (combo 2: Tdap/TD, meningococcal, and HPV) before their 13 th 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 the youth 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, 27.9% to CY2019 with a measure high of 87.8% 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 together to support this critical population.

Measure	Measure Performance Summary	Notes and next steps
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 primary care and dental practices to support care integration across settings.

Measure	Measure Performance Summary	Notes and next steps
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 a 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.
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.

Measure	Measure Performance Summary	Notes and next steps
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

Oregon’s 1115 Waiver Goals



**Maximizing
OHP
coverage**



**Stabilizing
transitions to
minimize
disruptions in care**



**Encouraging
smart, flexible
spending for
health equity**



**Focused
health equity
investments**

Oregon’s 1115 Waiver Driver Diagram

Forthcoming – 2022.

Plan Demographics

Forthcoming – 2022.

Waiver Goals – Quality Strategy Crosswalk Visual

Forthcoming – 2022.

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 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.*

IV. Quality Strategy Goals and Objectives

Forthcoming – 2022.

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
- 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.

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
- 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 authority⁵⁶ demonstrating the contractor's capacity to serve enrolled members in its service area in accordance with the State's standards for access to care.⁵⁷

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.

⁵⁶ 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5).

⁵⁷ See 42 Code of Federal Regulations (CFR) §438.206 and §438.207; Oregon Administrative Rules (OAR)410-141-3515.

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 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@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.

- 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.

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 Report⁵⁸.

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

⁵⁸ <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf>

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
 - 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>

Special Health Care Needs (SCHN)

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

Section X. Strategies to 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 visions 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 in will run afoul of antidiscrimination concerns for the following reasons:

- AI/AN status is a political designation, therefore it does not trigger strict scrutiny analysis under the equal protection clause of the U.S. Constitution.
- Many AI/AN-specific protections already exist in both federal and state law without triggering equal protection concerns (e.g, AI/AN preference in hiring).
- 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 and in Appendix A:

https://apps.state.or.us/Forms/Served/he3786D_2.pdf

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

Oregon's public notice is attached and posted online here:

<https://www.oregon.gov/OHA/HSD/OHP/Announcements/1115-Waiver-Public-Notice-120121.pdf>



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](mailto:Michelle.Hatfield@dhsosha.state.or.us) at **503-551-3881** or 1115Waiver.Renewal@dhsosha.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.

Beginning December 7, 2021, written comments can be emailed to 1115Waiver.Renewal@dhsosha.state.or.us, submitted through 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 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/tZwkde6uqTsuGtE7CbrxDUI4WL0f70l18wg5>

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 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#](tel:+19712772343243372877#) 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 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

If you need help or accommodations, please contact Michelle Hatfield at 503-551-3881 or 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/j/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 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

Population	Criteria	Changes proposed
		requires eligibility redetermination once a year.
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 *(data is preliminary and will be revised)*

	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	1,080,431	1,087,944	1,090,240	1,073,300
Total projected expenditure	\$9,990,572,653	\$10,752,997,279	\$11,186,228,492	\$11,604,370,869	\$11,605,648,635

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	<p>Permitting enrollees dually eligible through Medicare and Medicaid to disenroll from CCOs without cause at any time</p> <p>Contract with managed care entities and insurers that operate locally</p> <p>Offer benefits consistent with a prioritized list of conditions and treatments, subject to certain exceptions for protected benefits</p> <p>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</p> <p>Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans</p> <p>Not pay disproportionate share hospitals payments for managed care enrollees</p> <p>In general, to permit coordinated care organizations to limit periods during which enrollees may disenroll</p> <p>Provide coverage for certain chemical dependency services for targeted beneficiaries</p> <p>Receive federal financial participation for certain state-funded health care programs</p>

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 305 % 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.

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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@dhs.oh.state.or.us or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.

Section XII. Demonstration Administration

Dana Hittle

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Appendix A. Concept Papers

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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,⁵⁹ 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,⁶⁰ they may face significant medical debt when they do get care,⁶¹ and their children are less likely to access pediatric preventive care than their Medicaid-covered peers.⁶² They are also more likely to delay needed care, which

⁵⁹ Oregon Health Insurance Survey (2019)

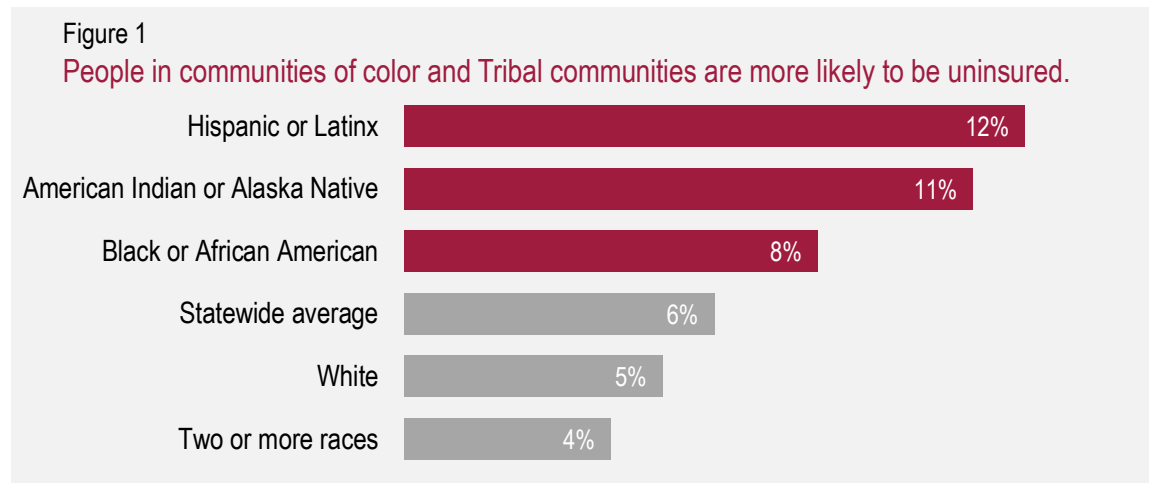
⁶⁰ Hailun Liang, May A. Beydoun, and Shaker M. Eid, Health Needs, Utilization of Services and Access to Care Among Medicaid and Uninsured Patients with Chronic Disease in Health Centres, *Journal of Health Services Research & Policy* 24, no. 3 (Jul 2019): 172-181.

⁶¹ Sherry Glied and Richard Kronick, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills* (Washington, DC: Office of Assistant Secretary for Planning and Evaluation, HHS, May 2011), <http://aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.pdf>

⁶² Maya Venkataramani et al., “Spillover Effects of Adult Medicaid Expansions on Children’s Use of Preventive Services,” *Pediatrics*, December 2017, <https://pediatrics.aappublications.org/content/140/6/e20170953>

can lead to worse health outcomes and increase their need for higher intensity care, resulting in higher overall costs for the health care system.^{63, 64}

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).⁶⁵ 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.^{66,67} 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.⁶⁸ 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.

⁶³ 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>

⁶⁴ 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.

⁶⁵ Oregon Health Insurance Survey, 2019

⁶⁶ <https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB3352>

⁶⁷ <https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB558/Enrolled>

⁶⁸ <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.⁶⁹ 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).⁷⁰ 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.⁷¹

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

⁶⁹ Oregon Health Insurance Survey, 2019

⁷⁰ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455>

⁷¹ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204>

Raise Up Oregon program,⁷² increasing early childhood physical and social-emotional health promotion and prevention, and identifying young children with social-emotional, developmental and health care needs 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. ⁷³ 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^{74,75}. 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 6.⁷⁶

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.⁷⁷

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.⁷⁸ 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.

⁷² <https://oregonearlylearning.com/wp-content/uploads/2019/01/Raise-Up-Oregon-Web-corrected.pdf>

⁷³ <https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf>

⁷⁴ 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.

⁷⁵ 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.

⁷⁶ <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf>

⁷⁷ ONE.oregon.gov is Oregon’s single system to apply for health and human services benefits

⁷⁸ SHO letter dated May 17, 2013, titled “RE: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014”

Establish continuous enrollment for children during early years

1. Provide continuous enrollment for children until their 6th 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 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 65⁷⁹ 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.⁸⁰
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.⁸¹ 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

⁷⁹ <https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB65>

⁸⁰ <https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx>

⁸¹ OHA analysis of Medicaid enrollment data

proof of coverage and are able to access care by allowing coverage prior to verification of income.

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.^{82, 83} These SDOH, including structural racism, are root causes of health inequities and shorter lifespans.³

Oregon aims to address these issues by:

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

Ensuring OHP coverage across life transitions

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

Addressing the full set of factors that impact health

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

⁸² 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/>

⁸³ 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.⁸⁴ 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.^{85,86}

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.^{87,88}

⁸⁴ <https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf>

⁸⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/>

⁸⁶ <https://pubmed.ncbi.nlm.nih.gov/28728555/>

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

⁸⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/>

⁸⁸ <https://pubmed.ncbi.nlm.nih.gov/28728555/>

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

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

Under Oregon's 2017-2022 1115(a) demonstration waiver renewal, OHA introduced health-related services (HRS) to increase CCOs' ability to use non-medical services to address members' health-related social factors and inequities that contribute to poor health. However, to date, spending on HRS 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.^{89,90} Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses.⁹¹ And once again, people of color are over-represented among those incarcerated in Oregon,⁹² which means people of color are disproportionately harmed by gaps in OHP coverage often experienced transitioning from institutions.

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

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

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

With this waiver authority, Oregon will specifically:

- a. **Retain benefits and/or extend Medicaid benefits to all youth otherwise eligible for Medicaid upon entering the juvenile correction system throughout the duration of their involvement in juvenile corrections.**

Youth who are involved in the juvenile justice system are inherently at high risk. Youth with a history of involvement in the child welfare or behavioral health systems are disproportionately referred to the juvenile justice system. And again, youth of color are grossly over-represented, in the juvenile corrections system, with high rates of entry into secure correctional facilities.⁹³ 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

⁸⁹https://journals.lww.com/professionalcasemanagementjournal/Abstract/2009/03000/Reducing_30_Day_Inpatient_Psychiatric_Recidivism.8.aspx

⁹⁰ https://cdr.lib.unc.edu/concern/honors_theses/j6731775s

⁹¹ 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

⁹² <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf>

⁹³ <https://pubmed.ncbi.nlm.nih.gov/23334336/>

preventive services over their lifetime.⁹⁴ 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.⁹⁵ 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.⁹⁶

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.

⁹⁴ 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

⁹⁵ 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

⁹⁶ 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/>.

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.

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)⁹⁷ 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.⁹⁸ According the 2018-19 National Survey of Children’s Health, 45% of Oregon youth aged 12-17 had a special health care need. Family members of youth with special health care needs reported that:

- 69% did not receive health care transition preparation services,
- 38% did not have time alone with their provider during their last check-up,
- 21% did not learn skills for managing their own care from their health care providers, and
- 44% did not receive help from their health care provider to understand the changes in care that happen at age 18.⁹⁹

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 increased¹⁰⁰:

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

⁹⁷ <https://link.springer.com/article/10.1007/s11920-019-1016-1>

⁹⁸ https://pediatrics.aappublications.org/content/126/Supplement_3/S129.short

⁹⁹ 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>

¹⁰⁰ Oregon Center for Children and Youth with Special Health Needs Fact Sheet, Rev. 4/26/2021, Op. cit.

and decreased:

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

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

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

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

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

- h. Homeless members, or at risk of becoming homeless
- i. Members transitioning from Medicaid-only coverage to Medicare-Medicaid Coverage
- j. Members vulnerable to extreme weather events
- k. Members (adults and youth) transitioning out of the criminal justice system
- l. Adults transitioning out of Institutions for Mental Diseases (IMD)
- m. Youth with Special Health Care Needs up to age 26
- n. 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.^{101,102} In a study in Oregon, Medicaid costs declined by 12% on average after people moved into affordable housing.¹⁰³ 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.¹⁰⁴ 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:

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

Health-related transportation

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

Food assistance

5. 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))
6. Nutrition and cooking education
7. Fruit and vegetable prescriptions and healthy food boxes/meals
8. 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:

5. Person-centered employment planning support

¹⁰¹ Nakamura MM, Toomey SL, Zaslavsky AM, et al. Measuring pediatric hospital readmission rates to drive quality improvement. *Acad Pediatr*. 2014

¹⁰² 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

¹⁰³ https://oregon.providence.org/~media/Files/Providence%20OR%20PDF/core_health_in_housing_full_report_feb_2016.pdf

¹⁰⁴ <http://oregonhousingconference.org/wp-content/uploads/2018/10/Oregon-Housing-Conference-10-15.pdf>

6. Individualized job development and placement (e.g., job fairs, interviews)
7. Mentoring (e.g., on how to change behavior, re-entry from incarceration)
8. 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.¹⁰⁵ Extreme climate events are occurring with greater frequency and severity, can disrupt health care access and even coverage.¹⁰⁶ 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:

7. Payment for transportation to cooling / warming and/or evacuation shelters (e.g., taxi vouchers, ridesharing credits, use of NEMT or health-related transportation above)
8. 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
9. Payment or vouchers to address high electric bills due to extreme temperatures
10. Housing supports and services, housing repairs due to wildfires to make housing livable
11. Immediate access to durable medical equipment (DME) left behind without a prescription or prior authorization
12. 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.

¹⁰⁵ <https://www.apha.org/topics-and-issues/climate-change/vulnerable-populations>

¹⁰⁶ https://earthobservatory.nasa.gov/features/RisingCost/rising_cost5.php

Allowing access to peer-delivered services without a treatment plan will remove barriers to treatment and ensure individuals have access to recovery supports throughout the course of their recovery, including before and after active treatment and during transitions of care. Members will continue to receive PDS during treatment through the Medicaid State Plan. While these improvements will benefit all members, they are critical to support members undergoing a transitional period in their coverage. This concept has garnered much support from the public, community-based organizations, and the recovery community.

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

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

What these policies would mean for OHP members

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

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

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

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

Appendix A

Additional (non-waiver) strategies

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

1. In the 2021 session, the Oregon Legislature invested over \$500 million in state funds to improve Oregon’s behavioral health community system to work toward shorter lengths of stays in the Oregon State Hospital and other IMD facilities.
2. In the 2021 legislative session, Oregon established and funded a 9-8-8 suicide prevention and behavioral health crisis hotline to support individuals experiencing acute mental health crises (Oregon House Bill 2417(2021)).¹⁰⁷
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.

¹⁰⁷ <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.¹⁰⁸ 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.¹⁰⁹ Oregon increasingly recognizes that we need to address these social determinants of health to reduce medical costs and improve health equity.¹¹⁰

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,

¹⁰⁸ Annual per capita spending target that will apply across all health care markets beginning in 2021

¹⁰⁹ 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/>

¹¹⁰ <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>

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, 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.¹¹¹

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

¹¹¹ <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>

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, 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

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:

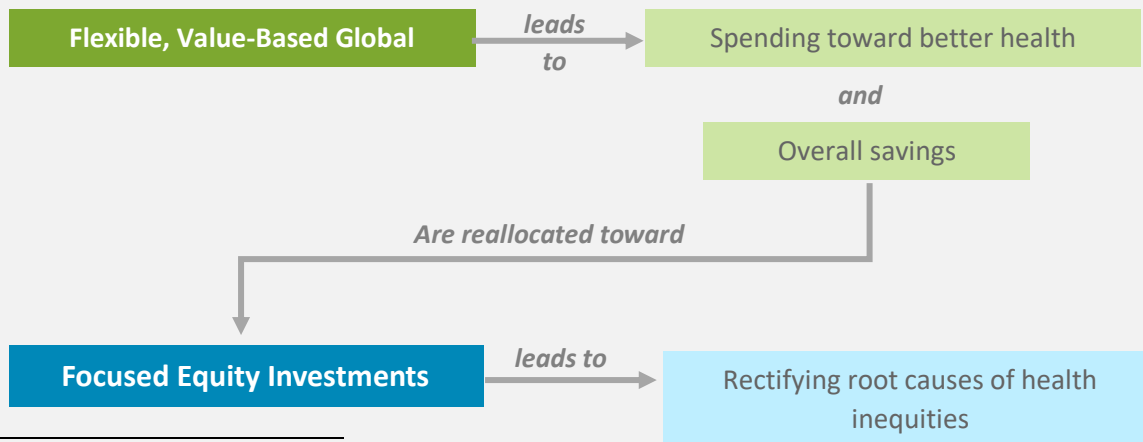
- More investment in community health that promotes health equity
- More investment in high-value, preventive services
- Increased care coordination and better management of members who incur high costs, including members transitioning between systems and life stages: corrections, Oregon State Hospital, 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 2028.¹¹²



¹¹² 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.¹¹³

Going forward, Oregon would adjust CCO budgets annually by a predictable growth trend rate, in line with statewide goals for sustainable growth,¹¹⁴ 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.

¹¹³ 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.

¹¹⁴ 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>

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 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.¹¹⁵

¹¹⁵ 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>

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 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;¹¹⁶
- Considering/reporting on as many of the core quality metrics by race, ethnicity and language as possible;¹¹⁷
- 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.

¹¹⁶ 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.

¹¹⁷ Some metrics will have too small of a denominator to support analysis at a subpopulation level.

- **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 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).

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.”¹¹⁸ 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.^{119,120} 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.¹²¹ 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.^{1,2,122}

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.

¹¹⁸ <https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>

¹¹⁹ Metrics & Scoring Committee Equity Impact Assessment, May 2021

<https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MS-Committee-Equity-Impact-Assessment-Report.pdf>

¹²⁰ 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>

¹²¹ COVID-19 Vaccine Advisory Committee recommendations 2021

<https://shredsystems.dhsoha.state.or.us/DHSForms/Served/le3580.pdf>

¹²² CCO OHPB Listening Session Final Recommendation. <https://www.oregon.gov/oha/OHPB/Documents/OHPB-CCO-Listening-Session-Recommendations-Final.pdf>

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 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.

4. 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 ¹²³	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 ¹²⁴	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) ¹²⁵	2022 ¹²⁶	Incentivizes more culturally responsive services being offered to help children start kindergarten ready to learn.
Social Determinants of Health: Social Needs Screening and Referral ¹²⁷	2023 ¹²⁸	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

¹²³ <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2014-Assessments-Children-DHS-Custody-Guidance-Document.pdf>

¹²⁴ <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx>

¹²⁵ <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx>

¹²⁶ For Social Emotional Health component of HAKR bundle

¹²⁷ <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx>

¹²⁸ Potential implementation

measure specification and pilot testing. This measure set will allow the state to monitor improvements in access to resources that directly address these injustices.

5. 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).¹²⁹ 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

¹²⁹ 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.

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 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

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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.

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,¹³⁰ 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)¹³¹ 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.

¹³⁰ 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.

¹³¹ <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3353/Enrolled>

For full proposed strategies, please see page 8.

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.¹³²

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.¹³³ The 2018 Oregon State Health Assessment¹³⁴ 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.

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.

¹³² 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/>

¹³³ <https://journals.sagepub.com/doi/pdf/10.2190/HS.41.2.c>

¹³⁴ <https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf>

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.
- 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.¹³⁵
- Black Oregonians are 3.1 times more likely to have a COVID-19 associated hospitalization than their white counterparts.⁶

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).

¹³⁵ 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.

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

*“And who better to say
what’s needed in the
community
than the community?”*

*-OHA Strategic Plan community
input*

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.

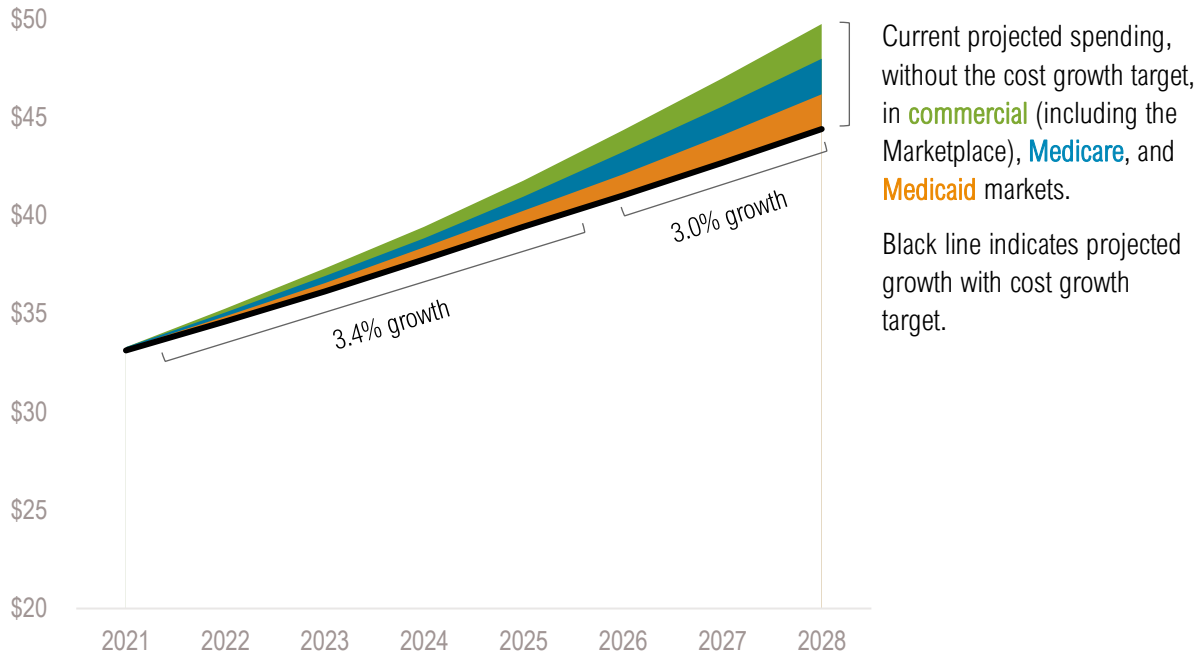
By lowering spending for qualified health plans, this sustainable health care cost growth program may result in lower premiums for commercial carriers, including those in the Marketplace, leading to additional federal savings on Advance Premium Tax Credits.

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.¹³⁶

Dollar figures are in billions



¹³⁶ 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.

*“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.**”*

-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.¹³⁸

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.¹³⁹ 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.

¹³⁸ 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

¹³⁹ 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>

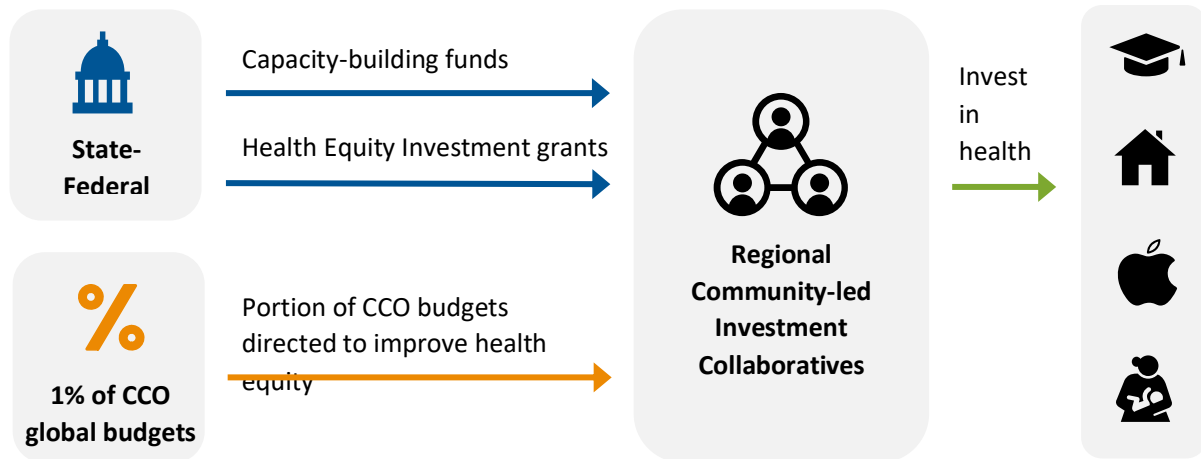
3. Grant community-led collaboratives resources to invest in health equity

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.¹⁴⁰ 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.*



¹⁴⁰ 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.¹⁴¹

¹⁴¹ 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.

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 services (HRS) and the SHARE Initiative.¹⁴² 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.”¹⁴³ 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,¹⁴⁴ 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

¹⁴² Ibid. Footnote 10.

¹⁴³ Ibid. Footnote 2.

¹⁴⁴ 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 populations¹⁴⁵ 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

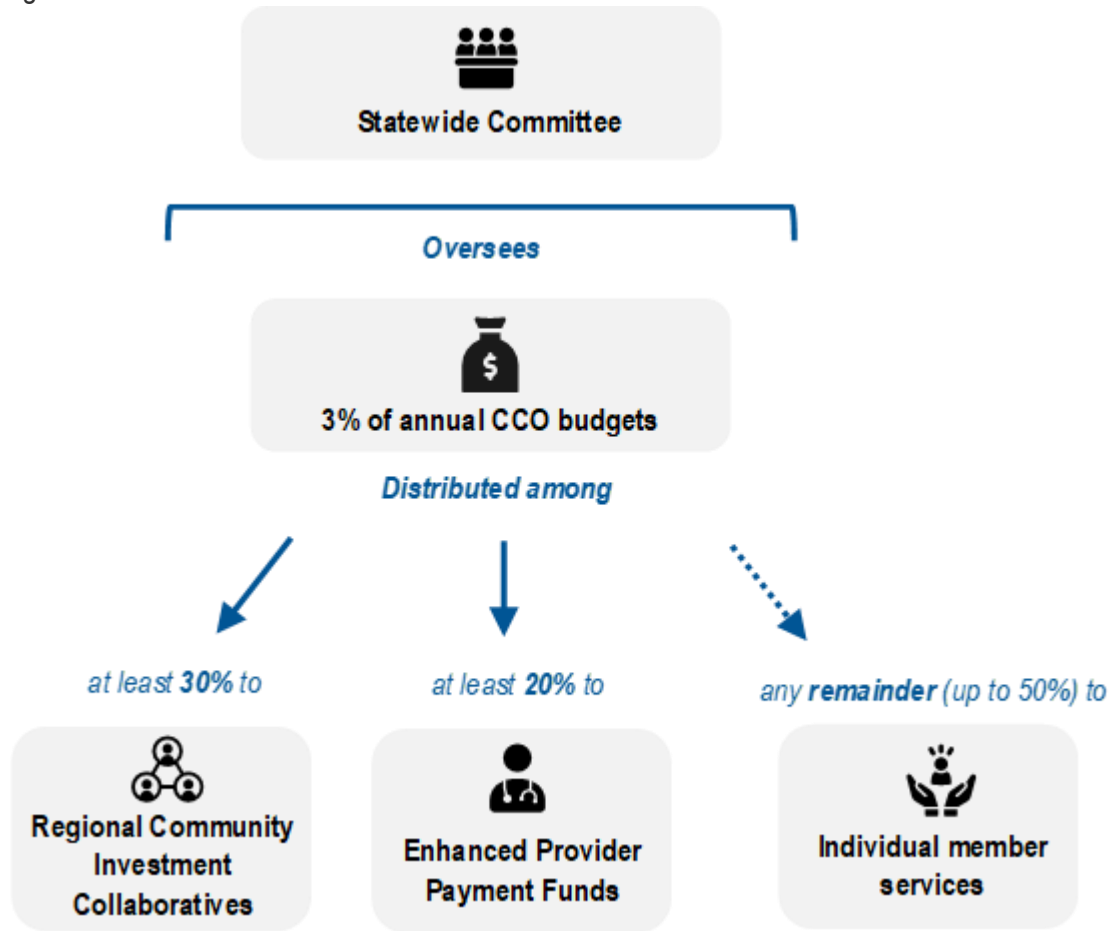
Oregon plans to establish three broader types of spending to encompass the types of expenditures outlined in HB 3353:

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

¹⁴⁵ 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.

OHP members, additional community-level investments, or additional enhanced provider payments.

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.¹⁴⁶ 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

¹⁴⁶ 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.

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 heat dome event—often disproportionately affects communities of color due to neighborhood conditions and residential segregation,¹⁴⁷ a disproportionate share of chronic conditions,¹⁴⁸ 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.¹⁴⁹

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.¹⁵⁰

¹⁴⁷ 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>

¹⁴⁸ 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)

¹⁴⁹ <https://willamettepartnership.org/wp-content/uploads/2014/06/HealthFramework-Final-Reduced.pdf>

¹⁵⁰ See e.g. Salimi Y., Shahandeh K., Malekafzali H., Loori 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>

Appendix B. Oregon's 2021 Quality Strategy

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

https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2021%20OHA%20Medicaid%20Quality%20Strategy_FINAL_05312021.pdf

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

OregonHealth 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 authority¹ demonstrating the contractor's capacity to serve enrolled members in its service area in accordance with the State's standards for access to care.²

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

¹ 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5).

² 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

be 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@dhs.oha.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 Ombuds person 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 action 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
- 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,

- aFraud, Waste and Abuse prevention program, a Quality Assurance and Performance Improvement Program, or to provide timely reports and data inconnection 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 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 C. Budget Neutrality Summary

Attached are the budget neutrality summary documents.

BUDGET NEUTRALITY SUMMARY

Budget Neutrality Summary Table 1

Total Computable

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
Without Waiver (WOW)										
AFDC	\$ 550,645,755	\$ 622,256,512	\$ 705,697,635	\$ 801,589,151	\$ 961,560,391	\$ 945,884,303	\$ 1,014,721,178	\$ 1,032,733,883	\$ 1,058,345,078	\$ 1,083,752,476
PWO	\$ 319,494,696	\$ 295,406,890	\$ 292,610,925	\$ 291,829,914	\$ 307,269,924	\$ 346,656,491	\$ 363,252,856	\$ 377,924,193	\$ 392,118,563	\$ 403,461,640
CMO	\$ 2,853,389,620	\$ 2,892,426,204	\$ 3,004,286,944	\$ 3,336,790,362	\$ 3,667,382,487	\$ 3,422,250,110	\$ 4,098,515,216	\$ 4,304,122,692	\$ 4,489,426,025	\$ 4,706,739,510
BCCP	\$ 7,095,787	\$ 7,234,718	\$ 8,115,473	\$ 8,423,364	\$ 9,375,016	\$ 8,783,956	\$ 9,526,257	\$ 10,467,727	\$ 11,344,904	\$ 12,342,971
Old Age Assistance	\$ 513,599,242	\$ 552,871,876	\$ 591,280,351	\$ 679,704,198	\$ 750,614,898	\$ 814,366,933	\$ 889,251,065	\$ 959,804,010	\$ 1,028,775,057	\$ 1,098,500,501
Aid to Blind/Disabled	\$ 3,414,620,311	\$ 3,526,656,820	\$ 3,691,582,523	\$ 4,053,331,746	\$ 4,453,892,419	\$ 4,811,551,957	\$ 5,206,573,473	\$ 5,555,575,605	\$ 5,926,104,527	\$ 5,192,284,635
Foster Children	\$ 273,279,209	\$ 278,412,197	\$ 284,828,000	\$ 283,354,790	\$ 285,569,971	\$ 291,710,787	\$ 305,408,716	\$ 324,119,919	\$ 342,749,229	\$ 362,707,429
New ACA Adults	\$ 2,878,179,755	\$ 3,017,716,755	\$ 3,268,181,098	\$ 4,247,253,195	\$ 5,272,066,565	\$ 4,671,910,312	\$ 4,983,359,430	\$ 5,208,462,698	\$ 5,404,508,280	\$ 5,595,706,286
Without Waiver (WOW) Total Neutrality Ceiling	\$ 10,810,304,375	\$ 11,192,981,971	\$ 11,846,582,949	\$ 13,702,276,720	\$ 15,707,731,672	\$ 15,313,114,848	\$ 16,870,608,192	\$ 17,773,210,727	\$ 18,653,371,665	\$ 18,455,495,449
With Waiver (WW)										
AFDC	\$ 519,815,124	\$ 602,643,351	\$ 683,329,660	\$ 724,852,819	\$ 934,818,515	\$ 920,956,855	\$ 977,579,439	\$ 984,459,440	\$ 998,253,322	\$ 1,011,457,502
PWO	\$ 204,485,158	\$ 200,490,603	\$ 200,560,967	\$ 200,455,636	\$ 232,062,759	\$ 249,604,182	\$ 258,059,250	\$ 264,894,511	\$ 271,171,186	\$ 275,287,353
CMO	\$ 951,522,114	\$ 987,609,136	\$ 1,032,822,268	\$ 1,053,882,841	\$ 1,278,964,997	\$ 1,239,401,423	\$ 1,478,602,519	\$ 1,546,800,052	\$ 1,607,181,781	\$ 1,678,490,895
BCCP	\$ 4,959,235	\$ 4,465,134	\$ 5,119,911	\$ 4,750,320	\$ 5,339,201	\$ 5,062,249	\$ 5,432,255	\$ 5,906,289	\$ 6,333,847	\$ 6,818,533
Old Age Assistance	\$ 269,608,429	\$ 253,207,300	\$ 320,865,762	\$ 372,002,741	\$ 437,836,330	\$ 452,082,715	\$ 492,703,387	\$ 530,770,890	\$ 567,816,939	\$ 605,134,006
Aid to Blind/Disabled	\$ 1,355,849,512	\$ 1,303,451,722	\$ 1,392,121,823	\$ 1,493,843,326	\$ 1,799,387,454	\$ 1,880,273,051	\$ 2,022,903,741	\$ 2,146,049,587	\$ 2,275,974,922	\$ 1,982,641,220
Foster Children	\$ 162,980,290	\$ 166,815,798	\$ 184,618,397	\$ 178,603,366	\$ 185,928,994	\$ 187,861,785	\$ 195,925,138	\$ 207,127,247	\$ 218,187,958	\$ 230,003,011
New ACA Adults	\$ 2,605,887,990	\$ 2,970,088,966	\$ 3,210,184,685	\$ 3,724,494,598	\$ 4,627,073,618	\$ 4,201,454,347	\$ 4,442,890,519	\$ 4,603,532,409	\$ 4,735,611,654	\$ 4,860,859,320
Subtotal PMPM Payments	\$ 6,075,107,852	\$ 6,488,772,010	\$ 7,029,623,473	\$ 7,752,885,648	\$ 9,501,411,869	\$ 9,136,696,607	\$ 9,874,096,248	\$ 10,289,540,426	\$ 10,680,531,609	\$ 10,650,691,840
Additional payments:										
Hospital Performance transformation	\$ 89,758,991	\$ (94,526)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Tribal Uncompensated Care	\$ 149,875	\$ -	\$ 998,534	\$ 703,442	\$ 4,203,105	\$ 4,203,105	\$ 4,346,011	\$ 4,493,775	\$ 4,646,564	\$ 4,804,547
Tribal Air Settlements	\$ -	\$ -	\$ 32,770,042	\$ 23,632,270	\$ 31,509,693	\$ 31,509,693	\$ 32,581,023	\$ 33,688,777	\$ 34,834,196	\$ 36,018,558
Tribal Coordinated Care	\$ -	\$ -	\$ 284,095	\$ 201,692	\$ 359,759	\$ 359,759	\$ 371,991	\$ 384,638	\$ 397,716	\$ 411,238
Leverages	\$ 93,917,673	\$ 108,982,147	\$ 10,035,002	\$ 6,850,018	\$ 17,603,488	\$ 17,603,488	\$ 18,202,007	\$ 18,820,875	\$ 19,460,785	\$ 20,122,452
Waiver Extension Requests										
Designated State Health Programs						\$ 240,000,000	\$ 248,200,000	\$ 256,600,000	\$ 265,300,000	\$ 274,300,000
Targeted Equity Investments						\$ 560,200,000	\$ 575,200,000	\$ 582,700,000	\$ 599,200,000	\$ 619,300,000
With Waiver (WW) Total Actuals	\$ 6,258,934,391	\$ 6,597,659,631	\$ 7,073,711,147	\$ 7,784,273,070	\$ 9,555,087,914	\$ 9,990,572,653	\$ 10,752,997,279	\$ 11,186,228,492	\$ 11,604,370,869	\$ 11,605,648,635
Base Variance WOW Less WW	\$ 4,551,369,984	\$ 4,595,322,340	\$ 4,772,871,802	\$ 5,918,003,650	\$ 6,152,643,758	\$ 5,322,542,196	\$ 6,117,610,913	\$ 6,586,982,234	\$ 7,049,000,795	\$ 6,849,846,813
Reduction of savings (Retain 20% per ST&Cs)	\$ 910,273,997	\$ 919,064,468	\$ 954,574,360	\$ 1,183,600,730	\$ 1,230,528,752	\$ 1,064,508,439	\$ 1,223,522,183	\$ 1,317,396,447	\$ 1,409,800,159	\$ 1,369,969,363
Net Cumulative Variance	\$ 910,273,997	\$ 1,829,338,465	\$ 2,783,912,825	\$ 3,967,513,555	\$ 5,198,042,307	\$ 6,262,550,746	\$ 7,486,072,929	\$ 8,803,469,375	\$ 10,213,269,535	\$ 11,583,238,897

Note on Expenditure Reporting for Budget Neutrality: Per STC 72.f in Oregon's current ST&Cs, the state has always reported demonstration expenditures on the forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. In 2017, CMS began to request states use total actual expenditures reported on CMS Schedule C for the purposes of budget neutrality reporting. At CMS' request, OHA conducted extensive analysis on the reporting in 2015 and later to accurately reflect expenditures subject to budget neutrality on the CMS Schedule C going forward. However, early years of reporting on the CMS Schedule C during the current waiver period are not accurately reflected. Actual PMPMs and eligible totals should be used when examining Oregon's trends and savings estimates.

BUDGET NEUTRALITY SUMMARY

Member Months *Table 2*

Current Services Caseload	Current Waiver					Proposed Waiver				
DEMONSTRATION YEARS (DY)	16	17	18	19	20	21	22	23	24	25
State Fiscal Years	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
AFDC	870,655	941,514	1,021,785	1,111,018	1,276,423	1,201,696	1,138,731	1,104,611	1,076,942	1,050,074
PWO	130,800	115,399	109,071	103,868	104,569	112,560	112,018	111,539	109,571	107,332
CMO	3,193,426	3,118,618	3,120,652	3,339,290	3,536,178	3,179,101	3,514,087	3,428,972	3,335,999	3,255,020
BCCP	2,261	2,206	2,368	2,352	2,505	2,246	2,286	2,402	2,493	2,598
Old Age Assistance	533,948	554,807	572,735	635,511	677,428	709,429	748,269	780,577	808,343	833,740
Aid to Blind/Disabled	1,013,015	1,006,013	1,012,558	1,069,164	1,130,063	1,173,859	1,217,927	1,246,299	1,273,950	1,067,115
Foster Children	246,564	241,999	238,512	228,633	222,112	218,592	217,746	217,525	216,692	215,857
New ACA Adults	4,284,472	4,307,007	4,472,197	5,574,468	6,640,240	5,643,401	5,239,953	5,133,577	5,032,835	4,931,985
Total MMths	10,275,141	10,287,563	10,549,878	12,064,304	13,589,518	12,240,883	12,191,016	12,025,503	11,856,825	11,463,720
Waiver Renewal Estimated Adjustments	Current Waiver					Proposed Waiver				
DEMONSTRATION YEARS (DY)	16	17	18	19	20	21	22	23	24	25
State Fiscal Years	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
<i>Member month impacts of waiver proposals</i>										
AFDC							94,931	96,994	101,084	104,370
PWO							541	217	1,002	1,243
CMO							153,800	281,937	392,845	511,234
BCCP							45	49	49	49
Old Age Assistance							(520)	(1,542)	(2,338)	(3,009)
Aid to Blind/Disabled							3,451	6,836	11,187	15,681
Foster Children							2,738	7,904	12,920	18,234
New ACA Adults							531,695	650,489	719,414	778,632
Total MMths							786,681	1,042,884	1,236,163	1,426,434
<i>Exclusion of member months under IMD 1115</i>										
AFDC				(371)	(1,498)	(1,563)	(1,630)	(1,701)	(1,316)	(1,374)
PWO				(71)	(286)	(298)	(311)	(325)	(251)	(262)
CMO				(132)	(536)	(559)	(583)	(608)	(471)	(491)
BCCP										
Old Age Assistance										
Aid to Blind/Disabled				(143)	(576)	(601)	(627)	(654)	(506)	(529)
Foster Children				(41)	(167)	(174)	(182)	(190)	(147)	(153)
New ACA Adults				(2,089)	(8,445)	(8,809)	(9,189)	(9,585)	(7,419)	(7,745)
Total MMths				(2,846)	(11,508)	(12,005)	(12,523)	(13,062)	(10,110)	(10,555)
Total Adjustments				(2,846)	(11,508)	(12,005)	774,159	1,029,822	1,226,053	1,415,880
Adjusted Caseload	Current Waiver					Proposed Waiver				
DEMONSTRATION YEARS (DY)	16	17	18	19	20	21	22	23	24	25
State Fiscal Years	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
AFDC	870,655	941,514	1,021,785	1,110,647	1,274,925	1,200,133	1,232,031	1,199,905	1,176,710	1,153,070
PWO	130,800	115,399	109,071	103,797	104,283	112,261	112,248	111,432	110,322	108,313
CMO	3,193,426	3,118,618	3,120,652	3,339,158	3,535,643	3,178,542	3,667,304	3,710,301	3,728,373	3,765,762
BCCP	2,261	2,206	2,368	2,352	2,505	2,246	2,331	2,451	2,542	2,647
Old Age Assistance	533,948	554,807	572,735	635,511	677,428	709,429	747,749	779,035	806,005	830,731
Aid to Blind/Disabled	1,013,015	1,006,013	1,012,558	1,069,021	1,129,486	1,173,257	1,220,751	1,252,481	1,284,631	1,082,267
Foster Children	246,564	241,999	238,512	228,592	221,945	218,417	220,302	225,239	229,466	233,937
New ACA Adults	4,284,472	4,307,007	4,472,197	5,572,379	6,631,795	5,634,591	5,762,459	5,774,480	5,744,831	5,702,873
Total Adjusted MMths	10,275,141	10,287,563	10,549,878	12,061,458	13,578,009	12,228,878	12,965,175	13,055,325	13,082,879	12,879,600
	856,262	857,297	879,157	1,005,122	1,131,501	1,019,073	1,080,431	1,087,944	1,090,240	1,073,300

Notes:

- Caseload Actuals through Jun21
- Caseload Spring21 Caseload Forecast
- Caseload Preliminary estimates provided by ODHS Office of Forecasting, Research and Analysis (OFRA)
- Official demonstration submission will be updated with the Fall 21 Forecast

BUDGET NEUTRALITY SUMMARY

Per Member Per Month *Table 3*

WOW	Without Waiver (WOW)									
	PMPM Rates per 1115 Waiver STCs					PMPM Rates Trended with Current ST&C Trend Rates				
DEMONSTRATION YEARS (DY)	16	17	18	19	20	21	22	23	24	25
State Fiscal Years	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
AFDC	632	661	691	722	754	788	824	861	899	940
PWO	2,443	2,560	2,683	2,812	2,947	3,088	3,236	3,392	3,554	3,725
CMO	894	927	963	999	1,037	1,077	1,118	1,160	1,204	1,250
BCCP	3,138	3,280	3,427	3,581	3,743	3,911	4,087	4,271	4,463	4,664
Old Age Assistance	962	997	1,032	1,070	1,108	1,148	1,189	1,232	1,276	1,322
Aid to Blind/Disabled	3,371	3,506	3,646	3,792	3,943	4,101	4,265	4,436	4,613	4,798
Foster Children	1,108	1,150	1,194	1,240	1,287	1,336	1,386	1,439	1,494	1,550
New ACA Adults	672	701	731	762	795	829	865	902	941	981

W/W	With Waiver (WW)									
	Current Waiver					Proposed Waiver				
DEMONSTRATION YEARS (DY)	16	17	18	19	20	21	22	23	24	25
State Fiscal Years	SFY18	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25	SFY26	SFY27
AFDC	597	640	669	653	733	767	793	820	848	877
PWO	1,563	1,737	1,839	1,931	2,225	2,223	2,299	2,377	2,458	2,542
CMO	298	317	331	316	362	390	403	417	431	446
BCCP	2,193	2,024	2,162	2,020	2,131	2,254	2,331	2,410	2,492	2,576
Old Age Assistance	505	456	560	585	646	637	659	681	704	728
Aid to Blind/Disabled	1,338	1,296	1,375	1,397	1,593	1,603	1,657	1,713	1,772	1,832
Foster Children	661	689	774	781	838	860	889	920	951	983
New ACA Adults	608	690	718	668	698	746	771	797	824	852

BUDGET NEUTRALITY SUMMARY

SUD Waiver Budget Neutrality Projections

Table 4

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		
SUD IMD Services									
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	
MMs to REMOVE			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	
PMPMs to REMOVE			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	
Cost to REMOVE			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