In response to the Oregon Health Authority's proposed concepts for the next §1115 Medicaid Demonstration Waiver

Representing the Coordinated Care Organizations (CCOs) and provider partners responsible for delivering the Oregon Health Plan (OHP) benefit to Oregonians across the state, we offer the following recommendations in response to the waiver concepts proposed by the Oregon Health Authority (OHA) on June 1, 2021. Our recommendations are narrow in scope and follow the previous ideas CCOs submitted to the OHA and Oregon Health Policy Board (OHPB) at the end of May 2021 for the §1115 Medicaid Demonstration Waiver. It is expected that organizations represented here may also submit individual comment presenting additional ideas, concerns, or questions. Further, in recent conversations with lead OHA waiver team members, we were motivated to offer potential alternatives and solutions as we do here to system challenges not yet addressed by the OHA's proposed waiver concepts.

HIGH-COST PHARMACEUTICALS AND THERAPEUTICS

CCOs included the need to address high-cost drugs – generally those approved through FDA accelerated pathways that do not have comparable generic or lower cost options at market – in our initial ideas presented to the OHA. We remain concerned that the proposed waiver concepts do not include mitigation for these extreme costs.

Achieving approval for a true global budget at 3.4% rate of growth is a goal for the OHA, CCOs, and our provider partners. High-cost pharmaceuticals and therapeutics can skew the overall cost and rate of growth for the OHP and CCOs. Engaging the statewide Pharmacy and Therapeutics Committee and/or the Health Evidence Review Commission in processes to manage costs would bring in additional community perspectives and may offer opportunity to innovate further. Our goal is to ensure that we can deliver and coordinate quality care within a sustainable rate of growth without being penalized for the high-cost of certain drugs that our members may need.

CCOs and provider partners have reviewed multiple ideas and offer the following.

1. Excluding high-cost drugs for two years after initial approval from the cost calculation for CCOs will better reflect our collective work to manage utilization and costs that are within our control. Revisiting the exclusion every two years provides opportunity to include those drugs in program cost calculations as prices come down and generics or comparable therapeutics enter the market.

2. Developing risk corridors for high-cost accelerated pathway drugs is another option to manage these costs outside of the CCO rate of growth. In this instance, the overall Medicaid program would still feel the impact of those costs, but the state may be able to further leverage rebates to lessen the financial burden.

COMMUNITY REINVESTMENT STRATEGIES THAT FURTHER HEALTH SYSTEM TRANSFORMATION

CCOs are committed to working with historically underserved populations to better identify systemic health disparities and leverage the coordinated care model to amplify the community role in financial decision-making. We appreciate and support the goal and focus of OHA's fourth concept paper, "Reinvesting Savings in Communities (OHP 3786E)", to invest savings generated within the coordinated care model in health equity community-driven projects. We acknowledge that the voices of those with lived experience are essential to guiding our work. We understand that we must center the perspectives of those impacted by institutionalized racism, colonialism, sexism, ableism, and heteronormativity to ensure we eradicate all remnants of such perspectives in our health delivery system from frontline workers to system partners and from the state agency to our federal partners.

At the same time, it is important to reiterate the crucial role that CCOs have played in convening discussions around health equity and social determinants. Regional networks and partnerships developed across the coordinated care model leverage the role of the CCO as the hub or convener with a focus on local control and accountability. Since

launching CCOs a decade ago, CCOs and providers have fostered existing relationships and extended new partnerships to better meet the needs of those we serve and further overall health system transformation.

The CCO 2.0 contract expands this role for CCOs with heightened expectations and engagement processes for Community Advisory Councils (CACs), Community Health Improvement Plans (CHPs), aligning with parallel work in the State Health Improvement Plan (SHIP), and new programs, planning deliverables, and evaluations to ensure workforce diversity, language access, CAC representation, managing behavioral health risk in-house, Health Equity and Traditional Health Worker focused staff, value based payment in partnership with providers, and more. Additionally, providers have received greater direction and increased expectation to screen, refer, and provide whole person care through contract and legislation. And, coordinated care partners across the state have been developing Community Information Exchanges in partnership with community-based partners for years to better inform our work and ensure "warm handoffs" and needed connections to resources for our members. The goals of CCO 2.0 and eventual contract expectations and deliverables were driven by community input and disparities research to move us all further into health equity and social determinant work. The CCO 2.0 contracts went into effect 18 months ago and many of those deliverables, such as the Health Equity Plan and SHARE fund which call for a multitude of community voices to be engaged in planning and decision-making, are just coming due for the first time over the next couple months.

While we support the underlying goal of OHA's fourth concept paper, we are concerned that, as currently drafted, the reinvestment strategy and "health equity zones" proposed by the OHA will essentially develop a second system that works in parallel to coordinated care. Alternatively, we aspire to build upon the progress and investments made by CCOs and providers over the past decade by continuing to foster inclusive atmospheres for collaboration with the communities we serve for local control and local accountability. We feel that the unintended consequences of separate decision-making processes within the communities we serve will only lead to a disconnect between our work and OHP members. Our goal is to better integrate our work with local communities, as opposed to work apart from it.

With CCOs as the hub, provider, community, and OHP member voices are already engaged in identifying and choosing regionally developed strategies to improve overall health and address disparities. We are open to mechanisms that amplify community-based decision-making within the coordinated care model. We believe that acknowledging and strengthening the existing structures to support the reinvestment strategy will better optimize community member and health system resources, align versus bifurcate community conversations about health inequities, and further health system transformation.

We propose the following two scenarios (as we are unsure at this time how much one-time funding may be available for reinvestment) to leverage Oregon's existing coordinated care model center in community-led financial decision making that is regionally specific and accountable.

1. If there is a greater sum of reinvestment funding (more than a couple hundred million dollars):

    a. Use some portion of funds in the first 1-2 years to lead statewide workforce and infrastructure development efforts, fund the proposed expanded coverage populations and HB 3353, and offer technical assistance for CACs and targeted health system staff to continue transformation and move towards greater community-led decision-making, including the potential to further engage with non-Medicaid populations.

    b. In year two and after, utilize the CHP and perhaps the Comprehensive Behavioral Health Plan (CBHP) to identify problems, challenges, and opportunities at the regional level. Then, leverage the now re-centered regional networks/CACs to identify and make preferably sustainable community investments in response to the CHP and CBHP findings. We recommend the CHP and CBHP in this process because broad stakeholder and system partner engagement is already called out for each of these deliverables

and those processes could be amended at the state level and implemented by each CCO based on community input.

2. If there are less funds for reinvestment (up to a $100 million or so):

    a. Identify strategies at the state and regional level to broaden CAC scope and process to center equity. Develop a timeline for implementation of these strategies over the first year in partnership with CCOs, providers, and community and identify multiyear goals thereafter to continue progress.

    b. Utilize the CHP and perhaps the CBHP to identify problems, challenges, and opportunities at the regional level. Then, leverage existing structures to address the findings of the CHP and the CBHP. Identify if these investments are intentionally one-time, will need state general fund or other resources for sustainability, or steps to transition the work post-funding.

In closing, we appreciate the overall direction of the proposed waiver concepts. We agree that maintaining and/or expanding coverage or care coordination for targeted populations and specifically those facing transitions where they may currently lose their continuity of care or coverage should be a priority.

We recommend adding oral health as a potential equity-centered investment focus as there is significant data that oral health can impact physical and behavioral health and is often linked to social determinants. Further, we call upon the state to develop a statewide effort with stakeholder input to address the workforce crisis across all provider types and settings as well as infrastructure needs like statewide resources for Health and Community Information Exchanges. We believe this work is critical to guarantee that the proposed coverage expansions lead to the delivery of successful and sustainable whole person quality care.

Lastly, thank you for incorporating our earlier suggestions to develop care coordination or targeted coverage for those OHP members in pre adjudication, the Oregon State Hospital, and Oregon Youth Authority as well as improved access to peer support with less barriers like the federal treatment plan requirements.

The recommendations included here align with our previously submitted ideas and principles to ensure that Oregon's next 1115 Medicaid Demonstration Waiver strengthens the coordinated care model based on local control and accountability, maximizes funding flexibility to better deliver whole person care, furthers the goals of health transformation and CCO 2.0 including the elimination of health disparities, and sets a stage for growth towards CCO 3.0. We appreciate the work of the OHA waiver team and look forward to partnering on next steps.