

## **EOCCO Comments on OHA 1115 Demonstration Waiver, Draft Application**

The Eastern Oregon Coordinated Care Organization (EOCCO) appreciates the overall direction of the proposed waiver concepts and draft application and we appreciate the opportunity to provide comment prior to the final submission. EOCCO has already adopted many elements of the key foundations of the 1115 waiver renewal and looks forward to the advancements of the coordinated care model in Oregon.

While EOCCO supports the overall intent of the proposed waiver concepts and draft application, further discussion is needed to ensure successful implementation of these concepts statewide. One area is maximizing OHP coverage. EOCCO applauds OHA for the innovative thought around continuous enrollment for kids however, a more robust process for CCOs and OHA to regularly validate members eligibility based on residency or other circumstances are needed. In addition, see comments below that outline additional areas that need further discussion prior to implementation.

### **Maximizing Continuous and Stabilizing Transitions Comments:**

1. One of our observations and an unintended consequence of keeping people enrolled without redetermination throughout the Public Health Emergency is that there are a growing number of individuals who appear to have moved out of State but that remain enrolled in the Oregon Health Plan. This information is determined via claims and prior authorization requests received from Out of State providers where members are seeking non-emergency services. This has resulted in expenses to the State and CCO's that may ultimately be the responsibility of another State agency. As mentioned above, EOCCO fully supports the concept of longer continuous enrollment periods, but processes to routinely validate that members remain a resident of Oregon, and as a result remain eligible for OHP coverage, are needed to avoid unnecessary costs to Oregon's Medicaid program. CCOs are willing to assist the State in validating member residency in situations like this, but today CCOs are not currently allowed to assist.
2. Currently, when people are in custody, they are treated by jail staff and providers under a restrictive and outdated medication formulary. Many of these members will be new to the behavioral health system and to Medicaid, and the bulk of the provision of care would fall to the Community Mental Health Programs. Behavioral health in general is severely understaffed at the moment and having to provide care for people in custody will overtax an already stressed system. If this provision goes through, it would be helpful if jail providers become enrolled in the Medicaid system and have the ability to bill for the services provided.
3. OHA is highly encouraged to have a robust and flexible process to assign members to a CCO to avoid delays in care and proper transition of care and care coordination. For

example, Baker City has a minimum-security prison that holds very few eastern Oregon residents. Upon release, these individuals leave the eastern Oregon region.

4. Consideration for exclusion in the Incentive Metrics should also be considered for the timeframe in which the member is still in the facility, as many services may be difficult to perform prior to release.
5. To ensure success in the housing strategy, the housing shortage, outside of the CCO work, needs to be addressed. In many of the counties across Oregon there is a severe housing shortage. Rental subsidies, while an incredible benefit, do not help when housing units are not available and are not in development. EOCCO intends to support efforts related to housing through the SHARE initiative, but additional support from the State is needed.
6. Peer support trainings, especially for youth and families, need to be expanded outside of the metro area to be successful in the future. Currently, there are only trainings located in the Salem and Portland area and only by a few organizations. OHA has disallowed many of the rural peer support trainings that were available. Centralizing these trainings to only the metro areas makes them inaccessible to rural areas due to cost, distance and time. The costs of training and supporting peers starts to become unmanageable when they are only allowed to bill to the lowest paying services codes, for example, peer support and skills training.
7. Statewide, there is a lack of adequate PRTS beds within the Child Welfare system and we look to OHA to have specific discharge plans prior to being able to "hold" a bed. While the need for children involved in child welfare is clearly articulated, these children are hard to place, and child welfare lacks foster parents and/or discharge plans. There are children that have been in PRTS beds for over 2 years that child welfare has no ability to transition. We look to further advance this conversation before overtaxing an already severely strained system.

EOCCO fully supports the continued concept of making financial investment to address health inequities and social determinants of health and equity (SHOH-E). EOCCO has a long history in investing in the communities we serve. While EOCCO supports investments in SDOH-E spending, available funding that reaches in the millions of dollars needs to have clear regulations around calculation and fund allocation.

**Flexible, value-based global budget and Focused Equity investment Comments:**

1. Further clarity from OHA is needed around the requirements and calculation of the spending required under HB 3353. This encompasses the methodology that will be used to calculate the total of 3% of the CCOs budget.
2. Collaboration with key stakeholders, including CCO representatives, is needed to ensure transparent requirements on how funds will be passed to the Community Investment Collaboratives (CICs). Additionally, careful consideration is needed as it relates to

reporting requirements, as many of the partners within the CICs even with funding of staff through the HEI grants, will still struggle to find qualified staff to maintain the agencies supporting the CICs.

3. Clarification is needed if the 3% of the annual CCO budget will include or exclude the SHARE Initiative and Health-Related Services. Having funds shift from Health-Related Services to the CICs can have financial impact through the Performance Based Rewards program.
4. Additionally, the SHARE Initiative, under the new rule, may allocate up to 20% of CCOs profits to the Initiative. If this amount is excluded from the 3% of the annual CCO budgets, it may lead to excess funds needing to be spent in communities where there is not enough infrastructure to support the funding. While providing additional funding at the local level is important, investments at this level need careful planning and need to be a sound investment with sustainability and staff to implement the projects.
5. This is important to understand how these funds will be reported on the exhibit L, prior to the implementation of these programs to ensure accurate reporting.
6. We propose an update to the wording of the first strategy for managing pharmacy costs. Currently, the strategy is titled “adopt a commercial-style closed formulary approach”. We recommend updating the wording to “adopt a commercial-style narrow formulary approach”. Many of the CCOs already have closed formularies. Additionally, other options such as “limited formulary” can imply we are restricting benefits from members.

The CCO quality incentive program has been a successful vehicle to show improvements in a number of incentivized metrics statewide. EOCCO is supportive of the program and the direction to further address health inequities by strengthening community voice and decision making in the CCO model.

#### **Incentivizing Equitable Care Comments:**

1. EOCCO strives to close inequitable performance gaps within the metrics space. However, if 50 members within a subpopulation would be implemented as a requirement to meet individual metrics, that is approximately .08% of EOCCO's December 2021 membership. The end result of having these members sought out to meet metrics is a potential unintended consequence. This could be viewed as targeting members and is exactly the opposite of health equity. The 50 members should be moved to a certain percentage of the total CCO membership, such as the language translation requirements of the CCO's membership, to ensure a proper denominator for each metric subpopulation. The concept papers note this as an "option" however, it should be reassessed prior to translation into formal policy.
2. Consideration for metric evaluation should occur with assessing rural and frontier counties separately than urban areas, as challenges faced in rural and frontier areas are

not consistent with urban populations. In addressing social determinates of health, geographic location is a key component in making strides to equitable outcomes.

To ensure CCOs are properly assessing issues of inequity, adequate and complete race/ethnicity data is needed. We encourage OHA to ensure accurate and complete REALD and SOGI data collection efforts prior to requiring CCOs to be evaluated by these factors of health.