



January 6, 2022

Oregon Health Authority

Re: Comment on 1115 Demonstration Waiver Concept Papers

Submitted online via: 1115.WaiverRenewal@dhsosha.state.or.us

To our partners at the Oregon Health Authority:

On behalf of Project Access NOW (PANOW), I write to express our gratitude for your work on the 1115 Waiver Demonstration concept papers. PANOW is a non-profit in the tri-county area with a mission to improve our communities' health and well-being by creating access to care, services, and resources for those in need. We offer a suite of programs that promote access to care and social services, regardless of an individual's insurance status or type. Across PANOW programs, clients are low-income, from immigrant populations, non-English-speaking, and/or undocumented. **Today roughly 65% of our clients identify as Black, Indigenous, or people of color. Over 90% of the staff are bilingual and/or bicultural and roughly 60% are first- or second-generation immigrants, reflecting the communities the organization serves.**

We have read the policy concept papers and are in support of much of the strategies you propose. Specifically, we want to show our support of and recommendation for a few strategies within the following concept papers:

[Ensuring Access to Health Insurance for All People In Oregon](#)

We are supportive of each of the strategies outlined, in particular:

- *Strategy 2: Two-year continuous OHP enrollment for people age six and up, even if their income changes*

Through support and active implementation of policy change, such as the Affordable Care Act and Cover All Kids, **Project Access NOW has partnered with the state and others to enroll over 19,000 individuals in health insurance over the last 3 years, most of whom identify as Black, Indigenous, or people of color.** Over the past year, the temporary federal rules that ceased mandatory annual verification of income and other eligibility criteria has meant individuals can remain insured, have access to preventive services, and not worry that a change in employment means loss of access to healthcare. These protections have been especially valuable as the pandemic continues to evolve, resulting in a quickly changing and unpredictable social and economic landscape.

As an organization working every day with the communities most affected by these challenges, we believe this strategy would help extend the benefits we've seen during the pandemic and avoid the churn that often happens when people move, an application gets lost in the mail, or due to

translation and administrative challenges. **Language barriers and missing paperwork should not be a reason eligible people do not have access to healthcare.** Not only is this unjust, but costly as well. According to research from the National Institute of Health, nationally the value of uncompensated health care services provided to persons who lack health insurance is roughly \$35 billion annually.

- Strategy 3: A fast, easy way to get enrolled in OHP for people who apply for SNAP
During 2019-20 Project Access NOW partnered with DCBS to enroll individuals in unemployment benefits who were already seeking eligibility for OHP. Through this program we were able to cross-enroll individuals, improving the efficiency of not only non-profit staff time, but the individual's time, and minimizing potential trauma associated with asking personal questions about income, etc for multiple applications.
 - **Recommendation:** include OHP enrollment for other public programs beyond SNAP such as unemployment benefits and WIC.
 - **Recommendation:** Ensure the ONE system is capable of supporting cross-enrollment of programs, minimizing burden on application assisters system wide and avoiding duplication of questions for clients/patients.

Improving Health Outcomes by Streamlining Life and Coverage Transitions

We are supportive of each of the strategies outlined, in particular:

- Strategy 3: Providing social supports to members experiencing life transitions
Since 2016, Project Access NOW has partnered with the CCOs in the tri-county area to administer health-related service dollars for the CCO's members, including during the 2020 and 2021 heat waves, 2020 Oregon Wildfire emergencies, and pandemic housing crisis. The CCO determines who and what good is "in scope" and PANOW acts as the third-party administrator to connect the member with the item/service identified, often within hours of the request. Since its inception, PANOW has facilitated the delivery of over \$22 million in health-related services (such as emergency housing, transportation, and food assistance) in collaboration with our CCO partners. **This method of HRS dollar distribution is highly efficient because the collaborative model funds more than just the administrative process; it pays for the resource directly and avoids the lengthy, burdensome, and often unsuccessful referral process normally associated with accessing these services.**
 - **Recommendation:** It is important that the difference between funding for the maintenance and operation of the tool that supports referrals to a service/good and funding the cost of the actual good itself is clarified. In the current concept paper, both the "linkages" to a social resource (transportation or community-based food) **and** the resource itself are listed as options the CCO can pay for. Given the ease and low cost associated with referring relative to paying for a good/service, it is likely that referring out to another entity will be incentivized rather than paying for the good/service itself. If we are to ensure people have access to the services they need to get and stay healthy, investment in the referral alone – without payment for the underlying resource – will likely not in fact improve outcomes.

- **Recommendation:** *It will be important to articulate if Medicaid – CCOs – are meant to develop the infrastructure/staffing to support these transitions or if this can be outsourced to another CBO, with support from the Medicaid system. CBOs can and should be integrated into this process as they not only have the connections and built trust with clients but also in many cases (like ours) have already developed the infrastructure, networks, and workflows to access these resources efficiently.*

- **Strategy 4: Covering more providers outside the medical model**

In the context of today's racial/ethnic disparities in both COVID-19 cases and vaccination rates, the role of the CHW has become increasingly important, but often does not fit within the classical medical model for lack of mentorship, appropriate supervision, and financial incentive to enter the field. Many CHWs are left isolated, underutilized, or cannot stay employed due to lack of a living wage, at the same time that we watch disparities widen.

- **Recommendation:** *Ensure the roles articulated in the concept paper – Traditional Health Workers, Community Health Workers, navigators – are covered at a livable wage rate to promote the quality and quantity of these positions in our state. Expanding infrastructure so CHWs can provide services directly to OHP members and support for capacity building cannot be overstated. Engaging folks from rural communities and people of color should be a top priority moving forward as community members feel safe when they see health care workers that look like them.*
- **Recommendation:** *If payors are required to focus on equity (and supporting THWs specifically), indicating where these funds come from is imperative. Building infrastructure, sustainable payments to these types of roles, and credentialing is a necessary step in implementation that is currently missing. It should be clear that this work is resourced as part of a CCOs global budget and/or separate funding needs to be earmarked for these services.*

- **Strategy 5: Invest in CBOs/health equity spending**

We understand the 1115 Waiver renewal is an integral part of a statewide strategy designed to center equity. However, we are concerned that multiple layers of additional administration are potentially being built “to support infrastructure for health equity investments.” There is a vast network of CBOs, Regional Health Equity Alliances, and CCO Community Advisory Councils in existence currently. CBOs have been a leading voice in the fight for health equity and equal access to health care. CBOs also have substantial trust in the community and are best positioned to provide culturally- and linguistically- appropriate outreach to communities, particularly those who are not currently engaged in the healthcare system. If CBOs are the last to receive the “trickle down resources” from the Waiver, our state will fail to support the individuals most at risk of poor health outcomes. This has implications for Oregon’s post-pandemic economic recovery, our ability to return to “normal,” and [Oregon’s goal of eliminating health inequities by 2030](#).

- **Recommendation:** *We encourage the use of existing forums/channels, such as CCO Community Advisory Councils (CACs) and/or Regional Health Equity Coalitions, to drive community-level investment to avoid creating additional administrative overhead, and to ensure the largest investment can reach those who need it: the clients served by the CBOs.*



- ***Recommendation:** Consider creating learning space for CBOs that have established themselves in the healthcare space to leverage connection and partnership with health systems in support of younger/newer CBOs.*

We recognize you are submitting concept papers on behalf of all Oregonians and are grateful for the work you are doing to hear a variety of perspectives. We look forward to continuing to be a partner in helping achieve equity.

Thank you,

A handwritten signature in black ink, appearing to read "Carly", is positioned below the "Thank you," text.

Carly Hood-Ronick MPA, MPH
Executive Director