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**RE: PacificSource Community Solutions Comments on 2022-2027 § 1115 Medicaid  
Demonstration Waiver Draft Application**

Dear Ms. Hatfield:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 commercial, Medicaid, and Medicare Advantage members in four states. PacificSource Community Solutions (“PacificSource” or “we”) is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia Gorge, Marion & Polk Counties, and Lane County. Our mission is to provide better health, better care, and better value to the people and communities we serve.

Thank you for the opportunity to provide comment on the Oregon Health Authority (“Authority”) draft application for the next § 1115 demonstration waiver with the Centers for Medicare and Medicaid Services (“CMS”). As with our previous correspondence to the Authority regarding the draft concept papers, we divided our comments into sections for ease of use and navigation.

**Table of Contents**

|                                                                       |    |
|-----------------------------------------------------------------------|----|
| Opening Comments .....                                                | 2  |
| Comments on Sections .....                                            | 4  |
| Section I. Program Description.....                                   | 4  |
| Section II. Waiver and Expenditure Authority .....                    | 10 |
| Section III. Eligibility .....                                        | 11 |
| Section IV. Benefits and Cost Sharing .....                           | 11 |
| Section V. Delivery System and Payment Rates .....                    | 12 |
| Section VI. Finance and Budget Neutrality .....                       | 12 |
| Section VII. Implementation Plan .....                                | 12 |
| Section VIII. Evaluation Plan .....                                   | 13 |
| Section IX. Quality Strategy .....                                    | 15 |
| Section X. Strategies to Align with Tribal Partners’ Priorities ..... | 15 |
| Section XI. Public Notice .....                                       | 16 |

## Opening Comments

In our initial comment letter to the Authority dated June 22, 2021 (first comment letter), we pointed out how Oregon pioneered the approach to serving Medicaid members. It is worth re-iterating here that in the state's 2016 waiver renewal, the application noted that "Oregon's current [waiver] began groundbreaking health system transformation through the coordinated care organization model." The CCO model, the application noted, "is more financially sustainable and has already accrued significant savings to the federal government[.]" More importantly, the collaborative approach has allowed Oregon to address key health indicators, like decreased emergency room visits and hospital admissions for short-term diabetes complications, while increasing member satisfaction and primary care access. As the Authority continues this successful demonstration, we must not lose sight of the fact that at its core, the Oregon Health Plan must deliver timely, cost-effective health care for Oregonians.

In addition to taking on responsibility for physical, oral and behavioral health care, this pioneering program also tasks CCOs with broad responsibility for addressing social determinants of health for members of the Oregon Health Plan. Addressing social determinants of health mirrors our commitment to provide better health, better care, and better value to the people and communities we serve. We carry out this commitment by establishing local health councils, who govern our work as a CCO and also make community-driven reinvestment decisions. While we helped stand up these health councils, we only retain one seat out 15, meaning that we do not exert control over the direction of community investments made by the health councils. Investment funds derive from our decision as a nonprofit to cap margins at two percent, freeing resources for community investment. We also share half of the Quality Incentive Metric funds with the health councils, who may use the funds to make additional investments in the community. Investments made by the health councils may be rooted in addressing issues adjacent to the Oregon Health Plan, but can potentially benefit the entire community. Consider the following:

- Through our support of and under the strategic direction of the Columbia Gorge Health Council, the local community has made over than \$11 million in key investments focusing on housing, food, transportation and mobility; equitable access to health care and services, fostered social connection and communication, and supported services for vulnerable youth.<sup>1</sup>
- Similarly, over the course of ten years the Central Oregon Health Council invested over \$35 million in such initiatives as permanent supportive housing, integrating primary care and behavioral health care, increasing access to fresh foods, and establishing crisis stabilization centers.<sup>2</sup>

Adding up these shared savings and the health council portion of the quality incentive metric funds, we can point to over \$100 million in community investments over the course of ten years.

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<sup>1</sup> See Columbia Gorge Health Council, *Programs We Support* (available at <https://www.cghealthcouncil.org/programs-we-support/>; Central Or. Health Council, *Community Investment Profile* (available at [https://cohealthcouncil.org/wp/apps/uploads/2020/02/community-inves\\_44347887.pdf](https://cohealthcouncil.org/wp/apps/uploads/2020/02/community-inves_44347887.pdf)).

<sup>2</sup> See Central Or. Health Council, *Community Investment Profile* (available at [https://cohealthcouncil.org/wp/apps/uploads/2020/02/community-inves\\_44347887.pdf](https://cohealthcouncil.org/wp/apps/uploads/2020/02/community-inves_44347887.pdf)); *Funded Initiatives* (available at <https://cohealthcouncil.org/funded-initiatives/>).

This brings us to concerns about how the application characterizes to the extent CCOs invest in their local communities. Throughout the application, the Authority argues that CCOs have not markedly increased spending on “health related services,” noting that on average 0.7% may be attributable to HRS.<sup>3</sup> As we noted in our first letter, CCOs can only administer health-related services under the strictures developed by the Oregon Health Authority. We observed then that a number of requirements established by the Authority can make health-related services expensive and cumbersome to administer, as well as impede broader use or adoption of health-related services. While these requirements are well intentioned (like requiring a tie to a treatment plan), we noted that they can have unintended consequences. Providers that become well versed with health-related services maximize use of these funds, but other providers may not have the staff or inclination to access these funds. This can have unintended, inequitable outcomes. Perhaps outside of the waiver process, the Authority may convene a truly collaborative effort with CCOs and other stakeholders to examine and make recommendations on HRS spending.

Furthermore, we noted in our first comment letter that while CCOs do their best to administer health-related services in a manner consistent with regulations, CCOs find out months after an expenditure whether such expenditure qualifies for favorable treatment by the Authority. Lastly, because health-related services (including community-based health-related services) require a high degree of compliance, CCOs devote considerable administrative supports to assisting communities in navigating these requirements. For the PacificSource CCOs, we have seen our community shared savings model operate in a manner that achieves the objectives of community-based health-related services with less administrative cost and more community decision-making.

Thus, while 0.7% may be an accurate representation of spending that meets HRS regulatory requirements to be counted as such, this figure does not broadly account for all the community investments CCOs undertake.

Providing timely, cost-effective health care is a complex undertaking, and Medicaid managed care is indeed complex. Through this application, the Authority proposes to take on matters far outside of the conventional direct medical care delivered and paid for by CCOs. In our first comment letter, we touched on the “Oregon Way” of policy development – that is to say, a collaborative approach with a multitude of stakeholders and the public. We noted that the Oregon Way works not only across regions and sectors, but also across the branches of government. In that first comment letter, we stated it was crucial that the Authority involve state agency partners like the Oregon Housing and Community Services Department, the Department of Environmental Quality, and county and city governments. For example, in order for the state’s Alcohol and Drug Policy Commission to develop a strategic plan to reduce Oregon’s substance use disorder rate through prevention and recovery, no less than eleven agencies assisted the Commission in inventorying the current system for addressing substance use prevention and treatment.<sup>4</sup>

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<sup>3</sup> See Or. Admin. R. 410-141-3735.

<sup>4</sup> See Or. Alcohol & Drug Pol. Comm., *2020-2025 Oregon Statewide Strategic Plan* 68 (available at [https://www.oregon.gov/adpc/SiteAssets/Pages/index/Statewide%20Strategic%20Plan%20Final%20\(1\).pdf](https://www.oregon.gov/adpc/SiteAssets/Pages/index/Statewide%20Strategic%20Plan%20Final%20(1).pdf)).

We understand now that at least some interagency work is underway, so we would ask the Authority to take into account how state services provided by multiple agencies will be delivered seamlessly for Oregonians. For example, portions of the expanded waiver clearly impact the mission of the Oregon Housing and Community Services Department (OHCS), who administer several programs meant to address homelessness prevention. We believe that the Authority and the OHCS should ensure that the involvement of the health care system in homeless prevention does not create “wrong doors” or barriers to Oregonians seeking assistance. Likewise, the application should be clear how when youth and adults in custody receive health care through the corrections systems, or through the health care system to prevent the kinds of system overlap that can lead to gaps in coverage.

Finally, we foresee great challenges ahead in building and sustaining a capable workforce that delivers direct health care to Oregon Health Plan members. We expect to see an emergency funding package for behavioral health providers introduced in the 2022 short legislative session in Oregon, but those efforts will need sustained action to maintain the workforce. As we develop metrics that focus on vulnerable members, those metrics will place further stress and demand on providers. None of us – the CCOs, the Authority, or other community partners – can realize the lofty goals of the demonstration waiver without skilled professionals in the community to carry out the work.

## Comments on Sections

### Section I. Program Description

On [page 5](#) of the draft application, regarding the research hypotheses, we agree with the Authority that measuring improvements in care delivery may provide a better picture than measuring savings.

On [page 6](#) of the draft application, we believe that the Authority missed an opportunity to highlight the significant social determinants of health initiatives that CCOs perform. In addition to the work we outlined above on page 2 regarding community-driven investment, CCOs have knitted together community resources through the Connect Oregon initiative.<sup>5</sup> Connect Oregon acts as a network of health and social service providers, ensuring that CCOs and community-based organizations can connect CCO members with needed services. Likewise, the application could have highlighted the work CCOs accomplish through individualized care management – i.e., directly working with members to connect them to housing, food, transportation, and utilities; following through with medical needs like filling prescriptions, and helping arrange for health care appointments or to find behavioral health, dental and medical providers. Our teams frequently tailor a care plan and approach with members based on individual needs.

On [page 10](#) of the draft application, regarding the effect of state controls over the cost of growth in federally-regulated Medicare Advantage plans, we raise again – as we did in our initial comment letter – that it is unclear how the Authority can make changes in the Medicare Advantage market that would have the effect of controlling cost growth in that market. Federal

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<sup>5</sup> Connect Oregon, (available at <https://oregon.uniteus.com/>)

law preempts states from regulating Medicare Advantage plans, with the exception of chartering the entities that may offer the plans and regulating those entities' financial solvency.<sup>6</sup> Given that contract requirements are established and enforced by CMS, and payments come substantially from federal funding, it seems unlikely that CMS will also waive regulations to allow the Authority to establish substantive regulation over Medicare Advantage plans.<sup>7</sup> It seems unreasonable to expect that Oregon could effect a reduction in Medicare Advantage plan spending that would accrue to the federal government.

On page 15 of the draft application, as an initial matter, we believe that maximizing coverage in the Oregon Health Plan is impacted as much by ensuring that currently-eligible people enroll in coverage, as it is broadening the criteria for eligibility. We support public-private partnerships like the one with 300 organizations and 1,500 individual assisters to support members in enrollment.<sup>8</sup> As the Authority considers how to bolster its capacity to determine eligibility, funding can allow community partners to take on the work of navigating the Oregon Health Plan enrollment process or timely transition members to commercial coverage if the person no longer may receive Oregon Health Plan benefits.

On page 16 of the draft application, we note in support of continuous enrollment that this change may allow members with complex treatment needs to establish a plan before they face potential disenrollment. Members must arrive at a place of trust with their providers, and care managers must take the time to learn a member's prioritized need and goals. For example, continuous enrollment would assist CCOs with members presenting with severe and persistent mental illness, members with substance use disorders, and members with chronic medical needs or unmet oral needs.

On page 17 of the draft application, we believe that as part of a comprehensive plan to ensure that people in the custody of an institutional system retain Oregon Health Plan benefits, the Authority also consider robust data sharing and coordination processes. Planning in parallel with the policy ask, and building on the successes of data sharing in other contexts, will help ensure that this idea succeeds in practice.

On page 20 of the draft application, we believe that the intent of the request is to ensure that a youth with special health care needs would automatically transition from youth benefits to adult benefits. If that is the case, we support efforts that would make the transition for this vulnerable population more seamless.

On page 21 of the draft application, we remain unclear on what basis the Authority will determine eligibility for services. Setting and determining eligibility could potentially extend benefits to hundreds of thousands of Oregon Health Plan members. We would ask that the Authority establish a broad-spectrum workgroup, including CCOs and community, to establish practical eligibility criteria.

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<sup>6</sup> See 42 C.F.R. § 422.402.

<sup>7</sup> See Nat'l Ass'n of Ins. Commissioners, *White Paper on Regulation of Medicare Private Plans* 20 (Sept. 10, 2008) (available at [https://www.naic.org/documents/committees\\_b\\_senior\\_issues\\_medpp\\_white\\_paper\\_final.pdf](https://www.naic.org/documents/committees_b_senior_issues_medpp_white_paper_final.pdf)).

<sup>8</sup> Or. Health Auth., *Oregon Health Plan Certified Community Partners* (available at <https://www.oregon.gov/oha/HSD/OHP/Pages/Community-partners.aspx>).

On page 22 of the draft application, CCOs in rural areas may not be able to marshal transportation resources for members in ways that may be practicable in urban areas. For instance, because in Oregon local jurisdictions regulate the practices of transportation network companies (TNCs; i.e., ridesharing), many cities may not even allow the practice within their limits. Only three jurisdictions in the state contain mass transit districts considered by the American Public Transportation Association as “larger transit agencies” – Portland, Salem and Eugene.<sup>9</sup> This means that in rural areas, CCOs may need to rely more on non-emergent medical transportation, which do not benefit from the efficiencies of scale that public transit or broadly-available TNC coverage may offer, and are thus an expensive option to provide transportation. CCOs may also be in a position to have to deny benefits for transportation in rural areas. We believe the application should acknowledge that real challenges may exist in the cost-effective provision of this benefit in rural areas.

On page 28 of the draft application, we first want to draw attention to our earlier note concerning community-driven investment. The premise contained within the application – that changes to the capitation model are needed because CCO spending has not markedly changed – depends on a narrow interpretation of health-related services spending. CCOs engage community partners in a variety of ways including Quality Incentive Metrics performance activities, investments in clinical programs, ways to increase access to non-clinical goods and services, and broad-based community-based investments. Not all of these qualify as “health related services,” but they do create meaningful ways of involving broad stakeholders in how CCOs prioritize their work. We recommend that we build upon or adapt the committees, workgroups and partnerships CCOs currently support to further the objectives listed in the bullets on pages 28 and 29.

On page 29 of the draft application, we have a number of questions about how the base budget is to be calculated under the concept in the application. Overall, we note that the draft application does not speak to the actuarial soundness of the base budget or the budget trending forward. More particularly, five-year-old data may be pretty stale; consider the state of the economy and the health care sector in 2016. If older historical data establishes the rates, the capitation process runs the risk of insufficient funding, necessitating more dramatic adjustments to adjust to present-day needs. Utilizing data that reflects membership during the federally-declared public health emergency similarly skews the data. Next, extending the base rate out over two biennia places extreme significance on what assumptions the Authority selects as part of historic trend. Furthermore, considering how frequently Oregon and the federal government make changes to benefits, policy and program changes, it seems likely that the assumptions may have to be adjusted to be appropriate for the projection period. Generally the Oregon Health Plan membership population provides reasonably predictable historical data on which to base budgets. However, five years may be too long of a time period to make inferences, even if the goal is increased stability.

Finally, the second bullet notes that the budget would include HRS spending over a period of five years. We would note that unless the budget takes into account year over year spending,

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<sup>9</sup> See *Amer. Pub. Trans. Ass’n*, Oregon TransitLinks (available at <https://www.apta.com/research-technical-resources/public-transportation-links/oregon/>).

using five years of historical data on HRS could result in less funding. We should also note that a “predictable” budget for social determinants of health services would likely entail a capitated rate to CCOs for a member’s needs. CCOs will have the task of balancing costs that go to behavioral health, physical health, prescription drugs, and community investments.

The majority of our comments on the community investment collaboratives may be found on page 9 of this comment letter. However, here we do wish to raise a question with respect to how a recent Oregon law affected this application. Under Oregon law, a “global budget” is the “total amount established prospectively by the Oregon Health Authority to be paid to a CCO for the delivery of, management of, access to and quality of the health care delivered to members of the CCO.”<sup>10</sup> In 2021, the Oregon Legislative Assembly enacted House Bill 3353, which directs CCOs to spend “up to three percent” of its global budget on among other things, programs or services that improve health equity – which we should point out may be well beyond what the health care community traditionally considers health related services.<sup>11</sup> It is unclear from the application whether or not the Authority plans to prospectively pay CCOs this percentage as directed by state law, or if a CCO that did not spend three percent or more on items enumerated in the legislation would see an upward adjustment to the global budget to account for Oregon law. Finally, we do request clarification if it is the Authority’s view that House Bill 3353 affects the actuarial soundness of rates.

On page 30 of the draft application, regarding the proposal to trend the base rate forward in a predictable way over five years, we can envision a scenario where the Authority establishes the CCO global budgets utilizing data from a five-year span, then informing rates in the upcoming five-year span. This results in potentially an 11-year window between adjustments. For context, this idea would be akin to using pre-CCO era data to inform next year’s rates. This long timespan has the potential for the base data to be very different from the projection period, requiring many adjustments along the way.

In terms of the request to trend the base budget at the statewide health care cost growth target, it is worth noting that the cost growth target program contains relief valves for “justified” variations in health care cost growth beyond the 3.4% target. This is essential to acknowledge for the base budget, because wholly unanticipated events could occur years out. For example, the ongoing COVID-19 pandemic drove dramatic increases in demand for certain types of health care services. This demand, along with a multitude of other pressures, has led health care providers – those providing behavioral, dental, or physical health care – to resign in greater numbers amidst ‘Great Resignation,’ so success in recruiting and retaining staff has become essential. As salaries increase to maintain enough providers, CCOs could well experience cost growth exceeding 3.4%. A budget that is fixed at a 3.4% rate of growth will need more than targeted rate adjustments.

Turning to the portion of the request that details a commercial-type, closed formulary approach, we agree that the Authority should pursue permissions that seek to lower the cost of

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<sup>10</sup> Or. Rev. Stat. § 414.025.

<sup>11</sup> 2021 Or. Laws ch. 467, § (2)(a). The bill does not direct all 3% toward health equity, but also requires spending out of that 3% on community programs addressing social determinants of health, diversifying care locations, and enhanced payments to certain providers and support staff that can make certain demonstrations.

prescription drug spending in Oregon. However, we would ask for clarification that the Authority is not requesting through the waiver permission to establish a preferred drug list (PDL). The concept of a PDL does not address the prodigious increase in pharmaceutical prices, will not realize as much savings due to rebates – especially if rebates accrue to the Authority versus CCOs – and do not address the rise of specialty and professionally administered drugs in Medicaid pharmacy spend.

The idea of considering a more evidence-based approach to cover prescriptions that have moved to market via the Food and Drug Administration's accelerated approval pathway appears reasonable. We believe that by limiting coverage for pharmaceuticals not granted approval through the traditional approach, Oregon can ensure that it allocates precious public resources to pharmaceuticals with a clear demonstrable clinical benefit. We request that the Authority clarify the request to review coverage to those pharmaceuticals where the FDA granted accelerated approval, but the drug in question has not yet gone through required postmarketing clinical studies.<sup>12</sup> This would incentivize the completion of those studies without foreclosing future coverage of a prescription drug that proves to be clinically effective.

Finally, if the Authority moves forward with the request in the application regarding a closed formulary and does not request the evidence-based approach discussed above, we ask if the Authority will remove the prescription drug spending from the value-based payment calculations, given that the state would occupy the field of prescription drug management.

On page 37 of the draft application, regarding the Authority's goal to redistribute power to communities in setting metrics, we believe that providers who closely serve community members affected by health inequities should also be given due consideration for inclusion on this potential Health Equity Quality Metrics Committee. Additionally, going back to our general comments on page 4 that state and local government partners should be consulted on the development of the demonstration waiver, we wonder if representation by other agencies who have parallel responsibilities should also provide input on these equity metrics.

In terms of the proposal to close gaps in equity by tailoring metrics to subpopulations, we believe that such focus, while well intentioned, can also place undue pressure on the communities being uplifted by the measured work. Oregon clearly experiences wide and deep disparities amongst our racial groups, but in stratifying the downstream metrics by race and ethnicity and that CCOs must meet the improvement targets for each race/ethnicity in order to receive our quality pool dollars, the Authority risks creating scenarios where communities receive pressure by CCOs in an effort to earn full payout. We can collectively learn from the Authority's rollout of the COVID-19 vaccine metric in 2020 to inform experiences in setting metrics to advance health equity. In undertaking the efforts necessary to meet the vaccine metric, we worked through historic distrust of health care and government systems among the populations we needed to reach – particularly the Black/African American, Native American/Alaska Native, and Pacific Islander communities. While community partners, health care entities and CCOs worked diligently to address access needs and to promote vaccination, historic and present trauma complicated the work.

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<sup>12</sup> See 21 C.F.R. § 314.510.

We also worked through privacy concerns; because people within certain communities have close and even familial relationships, some culturally-specific organizations and community leaders were hesitant to discuss vaccine status of fellow community members. This hindered the success of certain outreach efforts (e.g., individual phone calls).

On pages 38-39 of the draft application, the Authority seeks to create “community investment collaboratives” (CICs). In our first comment letter, we raised a number of concerns about the formation, structure, and governance of what was then termed “health equity zones.” While we appreciate the Authority fine-tuning its original concept, we nonetheless wish to raise a number of concerns again and ask for clarification.

First, in our first comment letter to the Authority we believed that the proposal to create health equity zones appeared to create a “parallel, possibly siloed process that could undermine existing efforts to meaningfully engage with the communities we serve.” In this application, the request is that Oregon receive federal investment to “support capacity-building” among CICs. One could infer from the application that in supporting capacity building among CICs, the Authority wishes to support existing entities that can serve the role as convener and investor in communities. In the next paragraph though, the application discusses how CICs might leverage existing organizations, implying that the CICs may be new organizations. We would ask for more clarity regarding whether the Authority will turn to existing organizations to fulfill the role of CIC, or if the Authority will insist on parallel organizations within communities.

The Authority, CCOs, and Community Advisory Councils have invested considerable time and resources into developing and executing the community health assessments and the community health improvement plans. The assessment and the plan to meet the issues must improve population health outcomes through collaboration and investment, reflect the needs and priorities of the entire community, and reduce the burden on stakeholders and community members who participated in similar efforts.<sup>13</sup> With all the effort that has gone into this important work, to burden community members with another round of planning and development seems inapposite to the Authority’s current goals.

If indeed the intent of the application is to utilize federal investment to foster new organizations, the issues we raised in our first comment letter regarding funding and accountability still apply. In our first comment letter, we noted that CCOs like PacificSource rightly remain accountable for effective program administration and metrics. Administering federal public funds takes adherence to many regulations and guidance. It is a necessary burden, but a burden nonetheless. It takes time and organization to meet such a burden, and when working with communities it also takes significant facilitation. Thus, it is unclear if CICs will also be accountable to the Authority, or if the CCOs in the area will nonetheless remain responsible for accountability. Are the CICs meant to govern the local work of a CCO? Given that the application contemplates CICs managing part of the CCO expenditures on health equity under state law, we also question whether the community advisory councils will lose responsibility for

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<sup>13</sup> See Or. Health Authority, *CCO Guidance: Community Health Assessments and Community Health Improvement Plans 1* (October 17, 2019) (available at <https://www.oregon.gov/oha/HPA/dsi-tc/CHACHPTechnicalAssistance/CCO-Guidance-CHA-CHP.pdf>).

oversight. If not, we request clarity for how the Authority envisions community advisory councils' and CICs' roles vis-à-vis each other.

In terms of funding, we noted in our first comment letter that the health equity zones appeared related to the accountable communities of health ("ACH") model utilized in Washington State to address health care and social-needs related projects.<sup>14</sup> We believe ACHs appear to blend attributes of the four health councils PacificSource helped stand up in our communities and the CCOs as they exist in Oregon. Given that we have a model to look to for guidance, we ask the Authority to detail how inclusion of CICs in Oregon adds to the system built up over a decade. How would CICs remain sustainable? Are there governance issues inherent in layering the CICs into the current framework, if that is the intent? Will the Authority, local government or the CCOs be responsible for oversight and accountability? Will funds directed to CICs be excluded from the CCO rate development process? Will capacity building for the CICs include reporting to the Authority? How would the CICs account for actions designed to further equity objectives?

Answers to these questions are warranted because if history is an indication, CCOs may eventually be responsible for funding a greater or total portion of the CICs. We observed when reviewing the description of the health system transformation in Oregon (page 7-8 of the draft application) the mention of the patient-centered primary care home (PCPCH) model. We recognize that model fulfills a vision of better health, care and lower costs for our members. Initially, the PCPCH model received support from various federal pilot projects, like the Comprehensive Primary Care model, and time-limited supplemental payments under the Affordable Care Act.<sup>15</sup> However, the 2019 CCO 2.0 contracts contained requirements for increased support of PCPCHs and by 2020, providers subscribed to the model received reimbursement by the CCOs primarily through the global budget.

The questions we raise should not imply we see no value in community-driven investments in health equity. Far from it – as we have discussed, we live this value every day in the responsibilities we carry out in the CCO service areas' community governance model we serve. Instead, we believe true success in this space will arise from more organic community involvement and decision-making. We do not see any incongruence between the Authority setting general standards and challenging communities to meet those standards as a way to receive federal investment.

## Section II. Waiver and Expenditure Authority

We have no specific comments on this section.

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<sup>14</sup> We note that the ACH model in Washington state derives its funding through a State Innovation Model Round Two Test Grant; due to legislative changes in the state and challenges associated with self-sustaining funding, Washington state will likely need to apply for another 5-year tranche of federal funding to maintain the ACH model.

<sup>15</sup> Or. Health Auth., *Patient-Centered Primary Care Home Program: Payment Incentives* (available at <https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Payment-Incentives.aspx>).

### Section III. Eligibility

On page 53 of the draft application, we would reiterate our earlier general concern about ensuring seamless and efficient delivery of state services in partnership with other units of government.

### Section IV. Benefits and Cost Sharing

On page 66 of the draft application, in terms of determining which members may receive transition supports, we believe it is important to understand how the Authority will establish specific eligibility criteria it will apply and the amount/nature of documentation a member must supply in order to show eligibility. We remain unclear if the Authority intends to adjudicate eligibility in the same manner it plans to do in terms of income eligibility, or if more up-front work would be necessary.

Relatedly, the eligibility criteria also determine how many members may receive these proposed transitory benefits. Later in the application, the Authority estimates that nearly 375,000 members may be eligible for housing, food, transportation and employment assistance due to their status of being “at risk” of homelessness. This estimate may vary greatly depending on how the Authority counts those “at risk” of becoming homeless, and what an at-risk member must prove to show eligibility. Depending on how the Authority counts “at risk,” the estimated number of members eligible for services may be greatly higher. This accuracy in measuring and counting extends to the estimated number of members vulnerable to climate events. In Oregon, climate events such as flooding, wildfire, extreme heat, and drought have increased in frequency.<sup>16</sup> These events affect rural and urban members of the Oregon Health Plan alike, sometimes simultaneously. Without an understanding of how to measure the criteria, it is possible that this request covers far more than the 129,549 members thought to be eligible for benefits.

On page 68 of the draft application, we would reiterate our comment earlier concerning transportation resources. Turning to the climate supports proposal, we note that as a CCO, we delivered on supporting our members’ acute needs during Oregon’s recent spate of wildfires. On an ongoing basis, we also use diagnosis data to identify those members who are at highest risk of adverse events due to extreme weather and adverse weather conditions, such as smoke, so that we can conduct outreach and connect those members to supports that keep them safe and their conditions well-managed. We applaud the Authority including these supports in the waiver application. We do believe the application should have objective criteria in place to determine which of these services effectively address health inequities, lower costs and lead to better health outcomes.

On page 75 of the draft application, we would reiterate here that it is important to understand more detail about the assessment tools utilized to determine whether an individual is at risk of homelessness, or vulnerable to extreme climate events; i.e., who administers the assessment, how responsible parties share the information with others, how will the benefit itself be administered, etc.

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<sup>16</sup> See Dalton, M.M., and E. Fleishman, Oregon Climate Change Research Institute, Ore. State. Univ., *Fifth Oregon Climate Assessment* 31-79 (2021) (available at <https://blogs.oregonstate.edu/occri/oregon-climate-assessments/>).

On page 76 of the draft application, we had raised in our first comment letter several barriers to fully realizing the potential of traditional health workers that could be addressed, whether in this particular waiver or through some other policymaking mechanism. We agreed then that traditional health workers need stable funding, but there are considerable barriers to traditional health workers operating in the community and receiving Medicaid funding for their services. The Authority could clarify or address certificate of approval requirements and supervision requirements. Next, coordinated care organizations and community-based traditional health workers may have different expectations about the requirements necessary to accept heavily regulated Medicaid funds in a sustainable payment model—including background checks, insurance, treatment plans, documentation, etc. While removal of the treatment plan requirement certainly helps facilitate the delivery of services, the change also needs to be part of a larger re-examination of traditional health worker regulation.

Additionally, we request clarification on how the Authority understands the term “recovery peer,” as it is used in this portion of the waiver application. Oregon law creates specialized pathways for those individuals working as family support specialists, peer support specialists, peer wellness specialists, and youth support specialists.<sup>17</sup> We presume that recovery peer would encompass those peer specialists whose scope of work includes assisting individuals in their recovery from behavioral health and substance use disorders, but would request confirmation.

Finally, it was our understanding that the state’s Traditional Health Worker Commission recommended enhancements to the waiver which, in our review, do not appear to have been integrated into the application. It is our understanding that the Commission made recommendations on all the types of traditional health workers licensed in Oregon, but the application only references recovery peer traditional health workers.

On page 77 of the draft application, please see our comments on page 8 of this letter regarding a more evidence-based approach to covering prescription drugs approved through accelerated pathways.

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

On page 80 of the draft application, please refer to our comments on the proposals regarding the capitated budget starting on page 6.

On page 82-83 of the draft application, please refer back to our comments on page 5-6 of this comment letter.

#### Section VI. Finance and Budget Neutrality

We have no specific comments on this section.

#### Section VII. Implementation Plan

Our only comments on this section of the draft application have to do with the implementation of the community investment collaboratives. The implementation schedule for years one through three includes funding for “equity infrastructure” supports. We take this to mean funding for

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<sup>17</sup> Or. Rev. Stat. §§ 414.025(10), (20)-(21) & (27).

community investment collaboratives, but it could also refer to the community-based capacity building mentioned earlier in the application. We request clarification on this point; we believe that an implementation plan must include a realistic timeline for when community investment collaboratives would be ready to deliver investments and demonstrate accountability.

### Section VIII. Evaluation Plan

We wish to bring up a few general comments about this section before we raise specific concerns with the evaluation plan. We acknowledge that the measures for evaluating the demonstration's effectiveness depend on the results of the negotiation between CMS and the Authority. This creates difficulty in providing feedback on the methods and measures, of which CCOs like us must understand and meet. At the very least, we believe that the Authority should have included conceptual logic models for each hypothesis to facilitate testing and review in this public comment period.

We also observed that the Authority planned to rely on surveys as one of the primary tools for evaluating the demonstration. Surveys require sizeable resources to carry out, and can become even more costly if surveyors experience reduced response rates.<sup>18</sup> Surveys may also need multiple methods of follow-up (SMS, e-mail, regular mail, telephone), and will likely need to be crafted in culturally and linguistically appropriate ways to fully understand how the demonstration project may or may not be reducing health inequities. Effective surveys also need to account for comparisons by containing sampling methods that allow for comparison by race/ethnicity or other characteristics of interest (i.e., over-sampling). We believe that surveys will themselves require funding to maximize effectiveness and accuracy. This is particularly true if the Authority intends on utilizing community-based organizations to conduct the surveys. The Authority may have to take on even more capacity building and direct support of organizations surveying communities.

Without funding of community surveys, we believe that results may not illuminate whether or not a particular aspect of the demonstration waiver made a difference. Surveys without adequate support may be designed in a way that do not minimize response bias or other forms of sampling bias. For example, surveying individuals with landlines and with few address changes might yield much different results than if a survey uses SMS communications and surveys those with frequent address changes.

Additionally, we wish to make one more general note on evaluating social determinants of health spending and the impact on members. Funding to address social determinants of health will always be finite, largely determined by federal matching funds and the state's General Fund. No social program can comprehensively assist the entirety of the Oregon Health Plan community. This leads to an issue with measurement – because of the finite nature of existing efforts to address social determinants of health, it may be extraordinarily difficult to understand the true scope of the need because current efforts necessarily triage who may be supported and the nature of the support provided. To truly address social determinants of health, the Authority

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<sup>18</sup> See Kennedy & Hartig, Pew Research Center, *Response rates in telephone surveys have resumed their decline* (Feb. 27, 2019) (available at <https://www.pewresearch.org/fact-tank/2019/02/27/response-rates-in-telephone-surveys-have-resumed-their-decline/>).

must expand its thinking to capture the true extent of the need in all CCO regions, rather than focusing on HRS spending.

On page 95 of the draft application, the Authority makes the statement that wishes to gauge how policies outlined in the waiver application will “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.” The revised evaluation areas, however, do not clearly show how they relate back to improved care coordination, integration or care delivery. We believe it may be worth re-phrasing the evaluation question to create a testable goal. One possible approach may be to ask “Does continuous coverage improve how care is delivered to members?”

On page 96 of the draft application, we recommend that the evaluation area drafted for focus areas number two be re-drafted to better test the question presented; namely, that community-driven decision making will reduce health inequities.

Regarding focus area number three, we wish to raise several concerns. First, as a point of clarification, we ask if the Authority meant that instead of “operationalizing incentive metrics to evaluate the impact of those changes on reducing health inequities,” the plan consists of developing an equity-driven process that would first define the metrics before taking the step of making the metrics operational. After all, we understand that the Authority may pursue state legislation in 2023 to create a new equity-focused metrics committee. More to the point, we believe that members of the community must collectively consider and select metrics that take into account historical injustices in health care and resulting health inequities. We noted earlier in our comment letter how we wished to avoid creating scenarios that placed undue pressure on communities to conform to health care service; without well-developed metrics that very scenario might come to pass.

On page 100 of the draft application, relating to Hypothesis 1, we ask if the Authority will clarify that “HRS investments” does not constitute a method or measure of testing the hypothesis.

We believe that in order to fully evaluate Hypothesis 1, the Authority will need to collect and analyze data regularly. We are cognizant that the Authority will need to implement the data collection system required under 2021 House Bill 3159.<sup>19</sup> Does the Authority intend to evaluate the hypotheses in the demonstration waiver through the use of the data collected under the authorization granted by that act? Or will the Authority be able to piece together data from multiple sources? We raise this point because we do not believe that the CMS core measures would provide the kinds of information necessary to evaluate how the hypotheses unfold in practice. In particular, it is not our understanding that the CMS core measures do not comprehensively or accurately portray health status. If measuring health status becomes key to understanding whether or not health inequities decreased in Oregon due to this demonstration, then the Authority may need different data.

Regarding Hypothesis 2, we would reiterate our comments above regarding the use of surveys. In our estimation, Hypothesis 2 may prove difficult to determine whether the measured outcome

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<sup>19</sup> 2021 Or. Laws ch. 549.

is influenced by more consistent data collection or by policy changes (namely, in the development of metrics). The Authority will need to develop robust and strict controls to draw a direct connection between provider billing practices and quality improvement efforts through metrics.

On page 101 of the draft application, relating to hypothesis one we agree that kindergarten readiness is a laudable goal – but it may not be a method or measurement that proves the hypothesis that earlier Oregon Health Plan enrollment may result in greater quality of life. Kindergarten readiness may serve as an indicator that earlier health interventions do improve children's quality of life, but one might not necessarily be able to draw that conclusion from empirical data. We would suggest that the Authority re-draft the measure to better draw a direct connection between continuous enrollment and health outcomes.

Relating to hypothesis two, we wish to point out that CCOs do not simply offer health care services alone. Setting aside the community investments CCOs make, CCOs provide care and community coordination, case management, intensive care treatment services (that require care coordination with community partners), coordination with the Oregon Department of Human Services with key population members, and so on. We believe that the hypothesis must acknowledge that Oregon is building on a successful program of collaboration and community health, and the hypothesis must clearly demonstrate that the packages of social determinants of health supports improve health outcomes as compared with that current baseline.

We also question how the Authority intends to measure the effectiveness of improved integration and stabilization. A successful transition might be measured quantitatively, through a period of years, but it is unclear how long a period of time equals a successful transition. The potential measures of a successful transition include self-reported measures of stability and security, but depending on how and when the questions are asked, the Authority could receive mixed results. Plus, self-reported measures would need to take into effect the work beyond health care services that CCOs already provide to ensure a more accurate measure of change. Finally, in line with our other comments, we think the Authority needs to take into account the effect workforce shortages may have on the demonstration evaluation. Here, time to first appointment with certain providers (especially behavioral health providers) may not be affected in any directly measurable way by continuous coverage. Indeed, more utilization of behavioral health services may end up increasing the time to first appointment, if the behavioral health workforce is not bolstered.

## Section IX. Quality Strategy

We have no specific comments on this section.

## Section X. Strategies to Align with Tribal Partners' Priorities

On page 140 of the draft application, we generally support the request to remove prior authorization for American Indians and Alaska Natives. The application notes challenges with treatment for substance use disorders for enrolled tribal members. For our part, we do not require prior authorization for medication-assisted treatment and counseling for substance use disorder. We would note that when the Oregon Legislative Assembly took up prior authorization

changes in the 2021 legislative session, it did not make any substantive changes to the prior authorization requirements for any Oregon Health Plan members.<sup>20</sup>

We support the conversion of the Special Diabetes Program for Indians (SDPI) to a Medicaid benefit; this move would both ensure sustainability of the program and also recognize the sovereignty and self-determination of tribal nations and how they want to address this important health issue.

Likewise, we support the inclusion of tribal-based practices as a covered benefit. We do believe the application must include provisions to create a payment methodology for reimbursement of tribal traditional health workers, a class of traditional health worker created by House Bill 2088 (2021). We also have questions on who will assure the Authority that services were offered and utilized by Oregon Health Plan members within tribal communities, and what constitutes the most appropriate funding source for carrying out these practices.

While we support in principle the request to offer a social determinants of health payment for currently unreimbursed services, the proposal must be structured in such a way that the end result preserves sovereignty, promotes accountability, and can be accomplished without undue administrative burden.

#### Section XI. Public Notice

We have no specific comments on this section.

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Please do not hesitate to contact me with any questions or comments. Thank you for your time and consideration.

Sincerely,



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<sup>20</sup> See 2021 Or. Laws ch. 154 (Enrolled House Bill 2517).