

January 7th, 2021

Health Policy and Analytics Medicaid Waiver Renewal Team

Attn: Michelle Hatfield
500 Summer St. NE, E65
Salem, OR 97301

Re: Medicaid 1115 Waiver

Currently there are six Regional Health Equity Coalitions (RHECs) in the state of Oregon that cover 11 out of the 36 counties, and the Confederated Tribes of Warm Springs, including urban, rural and frontier regions (see below “About Regional Health Equity Coalitions”). RHECs involvement in the Medicaid waiver process has been with community and health equity at the forefront because we work firsthand with historically underserved populations and see the impact of inequities in our communities. We believe that community is the ultimate accountability point.

We also keep seeing firsthand, as we know has been the case for centuries, the ways that systems create and deliver the outcomes they are designed to. ¹These systems and institutions have been created to benefit a select group of people over time, while communities of color experience avoidable inequities due to structural racism (Agénor, et. al, 2017), and without intentional structural changes we are bound to keep repeating and perpetuating these inequities.

Through the legislative session, the passage of HB 3353, and through the waiver proposal drafting process the RHECs have advocated for targeted financial investments in community health equity, as well as clear sideboards and accountability points for entities who comprise the system. In recent meetings we have heard the OHA waiver team say they support a statewide oversight committee and the community investment collaboratives (CIC) model. The RHECs also support these two important interventions, and we have submitted public testimony advocating for them because they were designed to specifically address health inequities because *current efforts and investments are not working for our communities*. While the OHA waiver team expresses support, there is no financial allocation in the concept papers of the proposal to reflect that commitment, including how sideboards and accountability from OHA, CCOs, and other entities will be measured. Without a strong independent point of accountability for the asks in HB 3353, it falls on us RHECs to continually keep knocking on the doors of those in power to make small changes.

We ask for the following changes to reflect HB 3353’s work towards equity, and to demonstrate the necessary shifts in power and resources to address health inequities:

- 1.) **The commitment from OHA to have a line item in CCO budgets for the 3% regardless of ‘additional’ future federal funding.** That funding needs to be accounted for in the CCOs annual rates and contract rate sheets. We seek a clear request that the identified 3% of investments in health equity and SDOH be recognized as medical expenditures, we see this as a key to making these investments intentional and sustainable.

¹ Agénor, M., Bailey, Z.D, Bassett, M.T., Graves, J., Krieger, N., Linos, N. (2017). Structural Racism and Health Inequities in the USA: Evidence and Interventions. Lancet, 389, pp. 1453-63.

Section 2(1)(a) of HB 3353 explicitly says, “Require a coordinated care organization to spend up to three percent of its global budget on investments:

- “(A)(i) In programs or services that improve health equity by addressing the preventable differences in the burden of disease, injury or violence or in opportunities to achieve optimal health that are experienced by socially disadvantaged populations;
- “(ii) In community-based programs addressing the social determinants of health;
- “(iii) In efforts to diversify care locations; or
- “(iv) In programs or services that improve the overall health of the community”

The OHA’s draft application does not outline how these funds will be accounted for within the CCO budget.

- a. Please also include in the waiver concept that these funding allocations will be accounted for in the annual CCO rate development process (published here <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx>) and Contract Rate Sheets and that the funding available should be outlined in each CCO’s rate sheets.
- b. The most current rates are published here: <https://www.oregon.gov/oha/HPA/ANALYTICS/OHPRates/Oregon-CY22-Rate-Certification-CCO-Rates-Final-20211001.pdf>)

- 2.) **The waiver concept papers also need to include that a state-level oversight committee**, as established by HB 3353, will be charged with overseeing the 3% global budget spend and that the state-level oversight committee be housed in the Oregon Health Authority Office of Equity and Inclusion, as called for in HB3353.

The RHECs have collectively participated in and co-developed many OHA housed committees, from committees charged with Community Health Improvement Plans, Rules Advisory Committees, the PartnerSHIP, and many others. These models, while asking for the labor of communities most impacted to make recommendations on possible solutions, ultimately the decision making and execution is left to the state. **We ask there be a distribution of power more representative of the work that shapes these decisions via clear policies, practices, and procedures as defined by the oversight committee.**

Section 3 (6) of HB 3353 The authority shall convene an oversight committee in consultation with the office within the authority that is charged with ensuring equity and inclusion. The oversight committee shall be composed of members who represent the regional and demographic diversity of this state based on statistical evidence compiled by the authority about medical assistance recipients. The oversight committee shall:

- “(a) Evaluate the impact of expenditures described in subsection (2) of this section on promoting health equity and improving the social determinants of health in the communities served by each coordinated care organization;
- “(b) Recommend best practices and criteria for investments described in subsection (2) of this section; and

“(c) Resolve any disputes between the authority and a coordinated care organization over what qualifies as an expenditure under subsection a (2) of this section.

- 3.) The way the regional Community Investment Collaboratives CIC model is being designed, is for them to be directed by organizations, or members of organizations, that serve local priority populations that are underserved in communities served by the coordinated care organization, and should also be funded by any additional federal funds that are leveraged for these services.
 - a. **Please clarify that Community Investment Collaboratives will be independently funded with additional funds leveraged from the federal government.**
 - b. **As independent entities they will communicate with the oversight committee and have clear dispute process in the event of a dispute between CCOs, the CICs, and OHA.**
- 4.) **Please clarify should the Federal Government allow duplicate investment from the CIC and CCOs, then the State wide Oversight Committee will resolve disputes between these entities.**

Please show your support in this effort in redesigning the system and shifting power and resources to communities through clearly outlined and responsible allocation of funds and accountability.

Sincerely,

Reina Estimo
Rez Active representing Confederated Tribes of Warm Springs

Roberto Gamboa and Norma Ramirez
Eastern Oregon Health Equity Alliance (EOHEA) representing Malheur & Umatilla Counties

Esther Kim
Oregon Health Equity Alliance (OHEA) representing Clackamas, Multnomah & Washington Counties

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Mid-Columbia Health Equity Advocates (MCHEA) representing Columbia Gorge Counties

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Linn Benton Health Equity Alliance (LBHEA) representing Linn & Benton Counties

Annie Valtierra-Sanchez
SO Health-E representing Jackson & Josephine Counties

About Regional Health Equity Coalitions

Regional Health Equity Coalitions (RHECs) are autonomous, community-led, groups whose backbone organizations are non-governmental in nature. They 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 policy, system and environment changes.

There are six RHECs in Oregon that represent 11 Oregon counties and the Confederated Tribes of Warm Springs, including urban, rural and frontier regions. There is RHEC representation for Confederated Tribes of Warm Springs, as well as the following counties: Linn, Benton, Multnomah, Washington, Clackamas, Hood River, Wasco, Jackson, Jefferson, Malheur and Umatilla.