

**1115 Medicaid Waiver  
Verbal Public Comment<sup>1</sup>  
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**Oregon Health Policy Board (OHPB)  
December 7, 2021**

- We serve members throughout southern Oregon, a certified benefit corporation and this year we were named one of the top 200 certified benefit corporations in the world. The Oregon 1115 waiver is a huge piece of policy, and All Care will be given written comments about the waiver as a whole. But we wanted to highlight on this committee significant concerns around the current draft, specifically around the third-party equity silo concept and how it conflicts with the bipartisan bill of House Bill 3353. I can tell you that the current draft of the 1115 waiver does not align with the bill as written. To be clear, we are extremely supportive of incorporating more diverse voices and having a community accountability to ensure is that the health needs of all people are being met. Our concern is that these third-party equity silos bifurcate efforts and that they are unsustainable in a grants-based system. As someone who is part of the group who helped work on HB 3353, we were actively trying to move past this grants-based system to a sustainable funding model that could push large systems changes. These undefined groups that would be separate from current community efforts and locally based community advisory councils and all the amazing efforts that are currently being -- all of the efforts that are being pushed, it is our experience that the number one issue with sustainable equity investments for a community has been in fact the fact that CCOs don't have a true global budget. Not the lack of one or councils or community boards or locally based community organizations. Also, the 1115 waiver draft fails to call out many of the accountability measures in HB 3353 then assures community voices are included in spend can strategies, and efforts to hold CCOs and the OHA accountable. There will be a letter fully outlining these concerns later this week, we would ask you read it and consider the implications for the current draft waiver proposal and not following 3353 as written. Thank you for your time.

**Josh Balloch, VP Government Relations & Health Policy, AllCare Health**

- My name is Paul Terdal, a resident of northwest Portland, and I'm testifying as a member of the public and as a father of two Medicaid eligible children with disabilities on the 1115 waiver. I'm really expanding and following up on testimony I delivered last May to this board, that's in the record regarding two specific things. The EPSDT waiver provision and use of quality adjusted life metrics. Since my testimony seven months ago, I have met with a number of physicians and families on OHP who have struggled to access medically

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<sup>1</sup> Verbal comments were captured with transcription. Minor edit have been made to correct transcription errors and add punctuation for readability. Every effort was made to maintain the speakers' original statements.

necessary care for patients and children just to learn about the impact. Some very basic findings, many of the condition treatment pairs that are below the line for coverage are really debilitating but treatable. Denying coverage can lead to significant harm. A couple of key examples. Selective autism is two runs below the line, children who can't access care or are unable to participate in school and community settings, this was marked below the line because the commission found while the treatment was effective, the condition didn't matter much to patients. It was defunded. I think any patient you spoke to, or any parents would disagree with that. The other is physicians frequently reserve to code games to work around the prioritized list. Finding a different thing that can – would be covered which ends up distorting the record and creating additional bureaucratic obstacles that increase cost rather than reduce costs. To summarize, I would urge you to remove the existing provision on ETSOT to cover all medically necessary care for children as the law requires. And again, to stop using [indiscernible]. In my written testimony I have provided additional comments as well as issue base from disability rights Oregon topics.

**Paul Terdal**

- My name is Elizabeth Wright. I'm the program director of North Star Clubhouse in Portland, Oregon. North Star Clubhouse is a nonclinical program designed to provide people living with a mental health diagnosis a place to find structure, community, and peer support. It's requesting that language be either added to the current Oregon 1115 Medicaid waiver agreement, that would make it possible for Clubhouse programs in Oregon to build directly to OHA for the specific and unique services that Clubhouses provide in the state or clarify which paragraphs in the current waiver contain language specifically to allow this. Several states have already added language in the Medicaid waiver agreement that specifically allow clubhouse programs in those states to use billing codes created by the centers for Medicaid and Medicaid for that purpose. Clubhouse programs are very unique and provide a service that is sorely needed in our current mental health delivery system, specifically psychiatric rehabilitation, and ramped in-patient hospitalizations. Clubhouses are low cost and are open six to seven days a week, eight hours a day, without appointment. We've been able to navigate the COVID pandemic by keeping our doors open, and clubhouses provide a daily structure that are targeted in helping people prepare for employment, socialization and reintegrating into the community. Having the Medicaid billing would make a huge difference in our services. Thank you so much.

**Elizabeth Wright, Program Director of North Star Clubhouse**

- This has been very interesting to watch, thank you for letting me even participate. I have never done this before, so this will be my first time. I am a registered nurse in an emergency department here in Oregon, I have been for the last 14 years. I'm also a parent of a 9-year-old disabled little girl. I first of all everything that everyone on this call, this Zoom meeting does, a day in a life of themselves, thank you. I know how hard it is to be in the trenches of all of this. There are tough decisions that get made every day, and at one point there was 118 people on this call, and now there's 92, and I think you all individually and collectively do amazing work. I just really want to acknowledge that. I obviously as a parent of a disabled person am here to advocate for any streamlining of Medicaid benefits,

whether it's insurance, being equitable in decisions that are made, be advocated for, every decision that's made by this committee needs to have the forefront of the most that are underserved, and I am telling you that is the majority of the parents, that's the majority of the patients I care for in the emergency department. regularly, but it's also families like mine. Please don't forget us. We're small, but we're really important, and we are your litmus test. If we are not doing well, then the majority is not doing well. Don't just forget us, okay? Thank you very much.

**Lisa Ledson**

**CPOP Waiver Webinar #3-Spanish  
December 09, 2022**

- Me gustaria que los niveles para calificar al Sistema de salud fueran más altos.  
I would like for the standards or metrics for evaluation of health care to be higher.  
**Laura de La Fuente, Euvalcree Resource Center**

- Es importante que si hablamos de equidad! Creo vamos muy bien para lograr comuniddes saludables!

It is important that we do talk about equity! I think we are doing very well to achieve healthy communities!

Tambien que las personas mayores con MEDICARE, puedan recibir apoyo completo del OHP, todos sanos!, TODOS CUBIERTOS!

Also that older people with MEDICARE can receive full support from the OHP, all healthy! ALL COVERED!

**Kalli (Maria) Morales-Donahue, Euvalcree Resource Center**

- Los ingreso es muy poco porque no pueden subir mas porque lo que se piden no califican muchas familias

Income standards [for Medicaid] are too low, why can't these be increased? Because with [the income] asked lot of families still don't qualify.

**Delfina Andrade, Oregon Latino Health Coalition**

- Estoy de acuerdo que puede haber muchos recursos pero el problema siempre son los ingresos para poder acceder a ellos

I agree that there may be many resources but the problem is always the income to be able to access them

**Laura de La Fuente, Euvalcree Resource Center**

- Chat- Tomar en cuenta que unas familia sin un estatus migratorio no califica para recibir muchos beneficios como ayuda con pago de renta, comida, etc. A pesar de pagar impuestos es muy limitado para lo que ellos pueden calificar.

Es como nada más un poquito, añadiéndole al ingreso que se toma en cuenta, tomar en cuenta que hay familias mixtas que no cuentan con un estatus migratorio. Y en el caso de los padres a mi me ha tocado encontrar muchas familias que tienen dos o tres niños y no califican sus niños tampoco porque el ingreso que ellos ganan, es mas alto del permitido, y en realidad tomar en cuenta, ósea, yo tengo, servimos a todos en la organización no solamente a las familia hispanas y ver que muchas personas pueden

vivir con mil, dos mil dólares al mes porque califican para ayuda de renta, para ayuda como las estampillas de comida que reciben es un monto alto que les da para vivir una vida, pues no completamente desahogada, pero pueden vivir, tienen ayuda para pagar su renta, o una parte de su renta, y muchas de las familias que no tiene documentos, no califican para este tipo de beneficios, entonces hay veces que no pueden vivir con un ingreso lo suficientemente bajo para poder calificar para el programa del plan de salud.

A mi me gustaría que en los casos de familias mixtas pudiese suceder que se tomara en cuenta ese tipo de cosas, ingresar gastos que se les tomara en cuenta ciertas cosas, pues que a otras personas no se les toma en cuenta o bueno en este momento a nadie, pero por decir si pagan dos mil dólares de renta no, un ejemplo, ósea una familia grande que tenga que pagar dos mil, tres mil dólares de renta, dos mil quinientos, que pudiera contársele como ciertas deducciones porque en realidad no es realista que van a vivir con un ingreso de cinco mil dólares, cuatro mil. Y pues, pagan impuestos y todo pero a la hora de recibir beneficios pues no califican entonces no.

Y tengo otro comentario, ¿puedo? Ok entonces, también acerca de pues escuche que muchas personas no tienen la cobertura y la enfermedad se agrava pero también creo que a pesar de tener la cobertura al no tener la educación se puede agravar porque muchas personas, tengo personas, que no están adaptadas al sistema médico de aquí y tienen cobertura completa, son inmigrantes y tienen documentos, tienen cobertura completa, pero igual siguen esperándose hasta que llega el momento de una emergencia para ir. O me dicen, nada más hablo para checar si tengo la cobertura porque no la he necesitado, pero en caso de que llegue a tener una emergencia me gustaría. Y trato de decirle, no pues antes de llegar a esa emergencia, pero si me gustaría pues como mucha educación o que fuera un requerimiento que por lo menos tuvieran sus dos chequeos dentales al año y su revisión que fuera un requerimiento para poder continuar con su cobertura.

Chat box- Take into account that a family without immigration status does not qualify to receive many benefits such as help with paying rent, food, etc. Despite paying taxes it is very limited what they can qualify for.

Verbal -It's like just a little bit, adding to the income that is taken into account... take into account that there are mixed families that do not have immigration status. And in the case of parents, I have found many families that have two or three children and their children do not qualify either because the income they earn is higher than allowed, and actually take into account, I mean, I have, we serve everyone in the organization not only Hispanic families and see that many people can live on one thousand, two thousand dollars a month because they qualify for rent assistance, for help such as the food stamps they receive is a high amount that it gives them enough to live a life, that is not completely comfortable, but they can live, they have help to pay their rent, or a part of their rent, and many of the families that do not have documents, do not qualify for

this type of benefits, so there are times they cannot live on a low enough income to qualify for the health plan program.

I would like that in the cases of mixed families it could happen that those kinds of things were taken into account, enter expenses that would take into account certain things, well for other people are not taken into account or well at this time to anyone, but to say if they pay two thousand dollars of rent, no, for example, that is, a large family that has to pay two thousand, three thousand dollars of rent, two thousand five hundred, that they could be [allowed] certain deductions because in reality it is not realistic they will live on an income of five thousand dollars, four thousand. And well, they pay taxes and everything, but when it comes to receiving benefits, they don't qualify so they don't.

And I have another comment, can I? Ok then, also about why I heard that many people do not have coverage and the disease worsens but I also believe that despite having coverage by not having education it can get worse because many people, I have people, who are not adapted to the medical system here and they have full coverage, they are immigrants and they have documents, they have full coverage, but they still wait until the moment of an emergency to go. Or they tell me, I am just calling to check if I have coverage because I have not needed it, but in case I have an emergency I would like to. And I try to tell them well before arriving at that emergency, I would like for us to provide a lot of education or make it a requirement that they have at least two dental check-ups a year and their health [exam] that it was a requirement to be able to continue with their coverage.

**Nayeli Jimenez, Consejo Hispano**

- Quiero insistir en descentralizar la atención telefónica! Es decir que cada condado tenga su grupo de los telefonistas bilingües certificados en este plan de salud!

I want to insist on decentralizing the OHP customer service center! In other words, for each county to have its own group of certified bilingual telephone operators in this health plan!

**Kalli (Maria) Morales-Donahue, Euvalcree Resource Center**

- Si gracias, buenas tardes a todos, mi observación seria en caso de que alguna persona que tenga alguna discapacidad o alguna condición que necesita atención medica pero que sea una persona indocumentada pueda tener acceso más fácil a cobertura médica. Tuve un caso donde esta niña llevo de tres años inmigrante, no tiene estatus migratorio, y tiene parálisis cerebral y sus papas de repente, aunque reciben apoyo no pueden recibir todos los beneficios o las ayudas que necesitan por el estatus migratorio. Hay pudiera haber alguna consideración, para este tipo de casos donde la cuestión de cobertura médica es de alguna manera vital e importante ¿no? Para este tipo de casos.

Yes, thank you, good afternoon, everyone, my observation would be in case someone who has a disability or a condition that needs medical attention, but is an undocumented person- they should have easier access to medical coverage. I had a case where this girl arrived for three years as an immigrant, she does not have immigration status, and she has cerebral palsy and her parents suddenly, although they receive support, they cannot receive all the benefits or assistance they need due to their immigration status. There could be some consideration, for this type of case where the question of medical coverage is in some way vital and important, right? For this type of case.

**Alejandra, Unidos Bridging Communities**

- Buenas tardes a todos, soy Delfina Andrade. Pues yo no más estaba recalcando mas para lo de la compañera que dijo lo de los ingresos. A veces muchas familia que yo he trabajado el ingreso si, aunque sea muy alto a veces ellas no cubren todos sus gastos que tienen en la casa y ni así pueden calificar para que a veces sus hijos vayan a tener el medical o el OHP. Entonces si quiera que pudieran hacer mas para esas familias, que si suben un poquito mas los requerimientos de que piden y la otra opción es que lo ha visto es que hay muchas familias también que cuando les llenan las aplicaciones en varias clínicas o hospitales no les explican cómo es el sistema de navegar el OHP por que este año me toco familias que tienen el OHP hasta 8 años y no sabían y ellos siguen pagando su citas de dental y doctor y el dental es bien caro-eso es muy importante . No se como se puede trabajar con los clínicas y los hospitales que deben de hacer bien su navegación en ese programa para que todas las familias entienden que si lo tienen, que es lo que les cubre y hacia no tienen que estar pagando bilés ese es mi comentario gracias.

Good afternoon, everyone, I'm Delfina Andrade. Well, I want to emphasize more about the partner who said about the income. Sometimes many families that I have worked with have income, although it is very high, sometimes they do not cover all their expenses that they have in the house and even then, they don't can't qualify for OHP. So if you want you could do more for those families, what if the income requirements you ask for go up a little more and the other option is that you have seen it is that there are also many families that when they fill out the applications in various clinics or hospitals they do not explain how the system is to navigate the OHP because this year I have had families who have had the OHP for up to 8 years and they did not know and they continue to pay for their dental and doctor appointments and the dental is very expensive-that is very important. I don't know how you can work with the clinics and hospitals and require them to do navigation better in this program so that all families understand that if they have it, what it covers, and they don't have to pay bills. That is my comment thanks.

**Delfina Andrade, Oregon Latino Health Coalition**

- Hola, yo soy María. Trabajo para Mano a Mano. Si yo sigo con el comentario de mi compañera no recuerdo su nombre, pero yo pienso que es muy importante hacer algo

por los niños con discapacidades que no tienen un estado legal porque conozco una familia que se le terminó la cobertura a un joven después de los 18 o 19 años y el joven falleció porque la familia no pudo encontrar los recursos para pagar los medicamentos que él requería. Es muy importante y me gustaría que se extendieran estos beneficios o que dé pues de eso uvera como una transición o un programa que guíe a esas familias en los recursos por que si me ha tocado trabajar con unas familias que tienen niños con discapacidades y no tienen un estado legal y la verdad es que después que terminan su escuela que a veces les extienden unos dos años después de la high school se les termina los beneficios, los recursos y es muy difícil navegar el sistema si el joven o la joven no tiene un estado legal

Hello, I'm Maria. I work with Mano a Mano. I agree with my colleague, I think it is very important to do something for the children with disabilities who don't have a legal immigration status because I know a family whose coverage ended for their youth after he turned 18 or 19 and the youth died because the family was unable to find the resources to cover the medicine he needed. So it's very important and I'd like for benefits for youth to be extended or offer an extension of benefits for these families or some sort of transition or program to assist the families with guidance on resources because I've worked with families who have youth with disabilities who don't have a legal immigration status and the truth is shortly maybe after 2 years they graduate high school they lose their benefits and it's very difficult to navigate the system if the youth doesn't have a qualified legal immigration status.

**Maria, Mano a Mano**

- Hola buenas tardes, mi nombre es Guadalupe y trabajo para NW Family Services y es mi primera vez de estar en este grupo. Tengo una pregunta no se si se informó el día de hoy pero trabajo con familias para obtener el plan de salud de Oregon hay un senior con el que estoy trabajando tiene 76 años, tiene un seguro social bueno, no tiene documentos legales, no califica para ninguna seguridad y son personas que también están en alto riesgo que les puede pasar algo necesita una operación para la próstata y es difícil por que hemos buscado seguranzas por diferentes formas y no hay nada que pueda ayudarle. Quiero que puedan aceptar, trate de ayudarle con el seguro que esta brindando Kaiser y después de cierta edad esas personas no califican para obtener ese seguro de salud. Sire bueno que hiciera equitativo que no importe la edad que tengan para que puedan obtener ese seguro de salud como se planea hacer el próximo año y no se si a las personas de esa edad les afectaría no calificar yo prefería que califiquen las personas en general.

Hello good afternoon, my name is Guadalupe and I work for NW Family Services and it is my first time being in this group. I have a question, I don't know if it was reported today, but I work with families who are enrolling in the Oregon health plan, there is a senior I am working with, he is 76 years old, he has good social security number, he does not have legal documents, he does not qualify for any insurance and these are people who are also at high risk that something could happen to them. He needs an operation for

the prostate and it is difficult because we have sought insurance in different ways and there is nothing that can help him. I want coverage that will accept him, tried to help them with the insurance that Kaiser is providing and after a certain age those people don't qualify to get that health insurance plan. It would be good that it be made equitable that it does not matter how old they are so that they can obtain health insurance as it is planned to do next year and I do not know if it would affect people of that age if they did not qualify, I preferred that people in general qualify.

**Guadalupe, Northwest Family Services**

- Me gustaria que los beneficios con tarjeta abierta sean mas amplios y que lo tomen en mas lugares para que las personas tengan beneficios completos automaticos sin tener que esperar un periodo de tiempo con tarjeta abierta.

I would like to see open card benefits be expanded and accepted in more places so that people have automatic full benefits without having to wait for the open card time frame to end.

**Laura Arias, Northwest Family Services**

- Voy a tratar de ser breve porque no quiero que se nos vaya el tiempo. Pero a lo que quiero llegar es esto, cuando yo empecé hace 3 años hacer las aplicaciones de OHP, cuando llega un caso que estaba abierto en otro lado ya me impedía continuar con la aplicación. Ahora no, ahora se va completamente y resulta que hay casos ya atrasados desde casi 2 meses. Y luego cuando hablamos por teléfono ya en otra ocasión lo dije, yo sé que hay muchos telefonistas, pero son insuficientes para todos los que estamos haciendo este trabajo. Entonces este se detiene mucho. Es realmente importante que vuelvan aplicar en el sistema y si ya está abierto un caso con el nombre de la persona que estamos aplicando, pues que se impida el proseguir aplicando para que no, ni detenga, ni se multiplique, no se copien las aplicaciones. Y además en la respuesta sea más rápida sobre todo porque todavía estamos en esto de la pandemia. Realmente necesitamos que en el mismo tiempo, ya me dijo un telefonista, un barón que me contesto, era importante que al mismo día me respondieran porque si no se iban atrasando como ahorita que ya van un mes de atraso en respuestas. Gracias.

I'm going to try to be brief because of time. But what I am trying to get at is this, when I started 3 years ago doing OHP applications, and I came across an application where a case would be open elsewhere, it prevented me from continuing with the application. Now it's different, the application will now go through and it turns out that there are already delayed cases going back to 2 months. I've already mentioned this before, when we call by phone, there are many operators but not enough for all of us who are doing this work, which slows things. It's truly important to reapply in the system and if a case is already open with the name of the person we are applying for, then the system should prevent us from continuing to apply. This will avoid delays, multiple applications, or duplicates, and getting a quicker answer when calling, especially since we are still in this pandemic. I was told by an operator that it was important that we are getting

answers the same day as this would help with delayed work. Thank you.

**Kalli (Maria) Morales-Donahue, Euvalcree Resource Center**

- Un comentario más, me ha tocado ver hay ocasiones que también como le digo familias mixtas que en realidad llegan al límite al fin del mes. Y muchas veces pierden la cobertura porque ya cuando les tocan renovar, gana a veces 10 dólares más y pierden la cobertura. Y me ha tocado ver a personas que tienen ingresos y cuando hicieron la aplicación dicen que no estaban trabajando y la renovación vino automática entonces no, a pesar de que la carta decía que tenían que reportar cambios no reportan y ya están trabajando. Incluso a veces tienen ingresos mayores a los de otras familias que no califican. Y esto es un comentario que yo lo he visto en lo personal y también lo he escuchado de clientes de OHP. Entonces no se si pudiese ver un sistema, como un filtro de donde se pudiese ver donde una persona ya está teniendo ingresos o que se pudiese investigar un poquito más a fondo el ingreso de esa persona. Porque, esto ya paso hace como tres años, tuve una familia que no tenía un estatus migratorio los papas, mas que tres de los hijos, y uno no tenía estatus migratorio. Pero la persona que me ayudo a trabajar en su caso, investigo como todo el historial de empleo del papa, trabaja aquí, paro de trabajar aquí, no sé dónde se metió esa persona del cp line pero pudo ver todo eso del papa y de todos modos los niños seguían calificando, los adultos no calificaban pero pudo ver todo ese historial del papa y pudo ver que estaba trabajando. Entonces hay veces que me pregunto como en otras ocasiones donde las personas ya trabajan no es visible para OHP y según haciendo la renovación automática. Y no es como que quiera que no le den los beneficios pero si en ocasiones se me hace un poco injusto que hay personas que tienen menos ingresos y no califican y tienen la honestidad de reportar los cambios o sus ingresos y otras personas tienen un ingreso mayor y en ocasión tienen beneficios, y pues no, como que esta desigualdad también de, y sé que es cosa con el sistema pero que hubiese un filtro o algo que pudiese ir más allá para que pues pudiese dar un poquito más de igualdad también a la cobertura.

One more comment, I have seen occasions where, how can I say it- mixed families that actually reach the limit at the end of the month. And many times they lose coverage because when they have to renew, sometimes they earn 10 dollars more and they lose coverage. And I have had to see people who have income and when they completed the application they said they were not working and the renewal came automatically so no, despite the fact that the letter said that they had to report changes, they do not report and they are already working. Sometimes they even have higher incomes than other families who don't qualify. And this is something that I've seen personally and I've also heard from OHP clients. So I don't know if I could see a system, like a filter where you could see where a person is already having income or that you could investigate that person's income a little more thoroughly. Because, this already happened about three years ago, I had a family that did not have immigration status, the parents, only three of the children, and one did not have immigration status. But the person who helped me work on his case investigated the entire employment history of the dad, where he

worked and where he no longer worked. I don't know where that person from the OHP customer service line went but he was able to see all everything about the dad and everyone. Anyway, the children still qualified, the adults did not qualify, but he could see all that history of the dad and he could see that he was working. So there are times when I wonder how on other occasions where people already work, it is not visible to OHP and doing the automatic renewal accordingly. And it's not like I want you not to give them the benefits, but sometimes it seems a bit unfair to me that there are people who have less income and don't qualify and have the honesty to report the changes or their income and other people have a higher income and sometimes they have benefits, and well no, like this inequality also, and I know it's something with the system but if there was a filter or something that could go further so that it could give a little more equality to the coverage.

**Nayeli Jimenez, Consejo Hispano**

- Me gustaría: Que los beneficios con tarjeta abierta sean más amplios o lo tomen en más lugares para que las personas tengan beneficios completos automaticos sin tener que esperar un periodo de tiempo con tarjeta abierta. Que existan beneficios medicos para personas con CAWEM o indocumentadas con cualquier tipo cancer, ya que estas enfermedades son bien costosas y muchas familias no pueden costiarlas.

I would like: For the benefits with open card to be broader or that it would be accepted by more [providers] so that people have automatic full benefits without having to wait for a period of time with open card. That there be medical benefits for people with CAWEM or undocumented people with any type of cancer, since these illnesses are very expensive, and many families cannot afford them.

**Laura Arias, Northwest Family Services**

- Estoy de acuerdo con Guadalupe. que ojalá pudieran ayudar con el plan de salud de Oregon a personas mayores de 65años y que no tienen un status migratorio. eso sería muy Buenos para esas personas y que no tienen ningún ingreso..

I agree with Guadalupe. that I wish they could help with the Oregon health plan for people over 65 years of age and who do not have an immigration status. That would be very good for those people and who do not have any income

**Celia Lopez, Virginia Garcia Memorial Health Center**

- Abogar para un plan de salud completo independientemente de la edad.

Advocate for a comprehensive health plan regardless of age.

**Monica Tovar, Virginia Garcia Memorial Health Center (Federally Qualified Health Center)**

- Voy de acuerdo con el comentario de Monica

I agree with Monica's comment  
**Anadelia Aguilar, Tillamook Family Health Center**

**Health Equity Committee (HEC)**  
**December 9, 2021**

- Many in the medical field have difficulty understanding why community groups continue to push for system changes to reduce health inequities. The most common quote I hear is “Well, that is already a law, and we have a policy.” When we look at Systemic Oppression and inequities within our society, the law of generality, or one size fits all approaches, protects positions of power.

Oppression, evidenced through discrimination, is systemic in our society. It is more than individual acts of violence, segregation, or discrimination motivated behavior and actions. Oppression is endemic in our institutions and has the effect of exclusion. It is a part of our society and inextricably linked to the equality rights of marginalized populations.

The systems we have designed to be equal to all, and best for the majority, are clearly disenfranchising a large segment of our communities. By not structurally building supports for differences in economic circumstance, racially disparate impacts, barriers in literacy, physical abilities, and negative attitudes towards LGBTQ+ folks, the oppression of these groups continues. “Well, that is already a law, and we have a policy.” Stop and reflect. Ask yourself the following questions:

1. Are we actually following the law?
2. How does this policy affect different people?
3. How do our practices affect different people?

After we have answered these questions and critically analyzed those answers. Are we recognizing the power of an organization or field societally and how that power results in societal privilege and benefit to the exclusion of marginalized people?

HB 3353 explicitly says CCOs are to “spend” their global budgets on specific investments. (Reference: Section 2(1)(a) of HB 3353). Instead, the OHA’s draft application tells CCOs to give money to a newly formed third party that would “grant out” funds. The OHA’s draft waiver request ignores the legislative directive to cause CCOs, at the local level, to engage the entire community in making health investments. (Reference Section 2(3)(a) & (b) of HB 3353).

The 1115 Draft waiver does not call out the many of the accountability measures in HB 3353 that ensures community voices are included in the spending strategies and effort to hold both CCOs and the OHA accountable. The bill says that in order for these dollars to be counted as this 3% they have to be part of “... a plan developed in collaboration with or directed by members of organizations or organizations that serve local priority populations that are underserved in communities served by the coordinated care organization.” ) That these investments must include voices from priority and underserved populations in the development of that plan. To include current entities and power structures that exist in the Community Health Assessment and Community Health Improvement plan will uphold the law of generality in each CCO’s region.

There is also clear direction that these investments either show “practice-based or community-based evidence” giving CCO the flexibility need to innovate with new community organizations that likely serve smaller populations of underserved communities.

AllCare asks the OHA to change Oregon’s 1115 Waiver Request, in the following areas: 1.) Removal of the third party equity silos.

- a. Should a third party entity be involved, it shall be directed by a majority of underserved community members, and members of organizations or organizations that serve local priority populations that

are underserved in communities served by the Coordinated Care Organization. Underserved community members shall also be the ultimate decision makers of local funding.

- 2.) Make clearer the request that the identified 3% of investments in Social Determinants of Health and Equity be recognized as Medical expenditures. This is key to making these investments sustainable, and not relying on a “grant” model.
- 3.) Make clearer a request for full federal funding of these important upstream investments.

CCO’s have demonstrated that they can drive regional, collaborative change within the regions that they serve. Historical and contemporary injustices have persisted underneath the CCO’s programs within the regions they serve. These injustices that persist have been for multiple reasons.

The Oregon Health Authority for example did not fund the Office of Equity and Inclusion sufficiently over the last waiver time period to audit how CCO’s were focusing Quality Improvement plans to eliminate racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Coordinated Care Organizations did not leverage existing contract language to focus Quality Improvement plans to eliminate racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Oppression endemic in regional institutions of power that excluded voices affected by economic circumstance, racially disparate impacts, barriers in literacy, physical abilities, and negative attitudes towards LGBTQ+ folks, to further perpetuate inequities in the State. Some of these regional institutions have directly targeted, and dismantled coalitions of the aforementioned community groups, to protect the law of generality and positions of power.

The Office of Equity and Inclusion has, in partnership with this committee, created a very robust equity analysis tool as part of waiver implementation. AllCare asks that this framework be used when determining future policy for implementing this waiver and the Oregon Medicaid Program. This tool could be used as a roadmap in all policies to understand if Oregon Medicaid is:

1. Actually follow the law?
2. How does this policy affect different people?
3. How do our practices affect different people?

HB 3353 has created a regulatory framework and funds to radically address our system and the financial components to make it successful. It is now up to the OHA, CCO’s, Hospital Systems, Medical Groups, and Individual provider offices to treat this the same as regulatory requirements around HIPAA, CLIAA, OSHA, and the Joint Commission, to overhaul the system to achieve the goal of eliminating healthcare inequities in ten years.

**Stick Crosby, AllCare Health**

**Medicaid Advisory Committee  
December 15, 2021**

- Hello, Medicaid Advisory Committee Members. My name is Sarah Spansail. I live in Medford, and I am the chair of the Jackson County Community Advisory Council with AllCare CCO. While we support the extra focus on HealthEquity and other positive changes in the waiver or like children staying in as insured until the age of 6. I'm here today to speak in opposition to the draft waiver as written. House Bill 3353 is seen as a way to increase the accountability of CCO's especially when it comes to supporting and serving those who are typically underserved. It's a way to continue to build on the community relationships we've already established, enabling us to create more sustainable and long-term projects in order to create real community transformation. Unfortunately, the draft presented is siloing out dollars into a new undefined entity with no specific geographic or membership makeup. While I understand some community partners were engaged in the drafting of the waiver and many of the changes in it, are positive, it is disappointing that the Community Advisory Councils were not invited to participate more deeply in the internal process and offer feedback. Our councils have been working hard to support the health of our communities for more than 7 years and have invested over \$1.2 million in that effort. We've accomplished this through a collaborative process and ensures our OHP members representatives like me and others have an equal voice to our community partners. Our request to this community is that the draft 1115 waivers changed to reflect House Bill 3353 as it is written and secondly as these changes are made to the waiver OHA should work with our Community Advisory Councils. On these internal processes as we are important stakeholders. The flexibility and sustainability of these funds are critical to supporting otherwise underfunded programs that focus on the most vulnerable and underserved people in our communities, so please change the waiver and ensure that our Community Advisory Committees are partners in that process. I appreciate your time. Thank you.

**Sarah J. Spansail, Chair of the Jackson County Community Advisory Council**

- My name is Patti Maloney; I work with Soundview Medical Supply. We are an incontinence supplier and we do a lot of business with beneficiaries who have Care Oregon OHP and the managed care programs. I will be writing something up, but I wanted to put in a comment, because when you're putting in the waivers, and there's a lot of talk about opening up care, care inequity and allowing people eligibility to be longer periods of time. What we're really concerned about is continued care and, within the continued care, those continued care requirements. Especially during COVID, the 1135 waiver was very vague, and it's pretty simple. It does say that sufficient health care items and services are available to meet the needs of individuals enrolled, which is something that you had up on the OHA website. That also includes that providers who give these services are in good faith—get reimbursed. I'd like to drill down a little bit on that and talk about those requirements for the continued care. We work with customers or beneficiaries that have permanent life-long conditions, and there was never anything in the language for the waivers about not being able to go to the doctor. Telehealth was something that was talked

about, but when you're talking about a population that is mentally or physically disabled, they really have to rely on somebody else to do those things for them. The pandemic had things shut down, their care providers could not bring them to appointments or have the ability to have a telehealth appointment. We were unable to get these continued care requirements as renewals—they're considered prescriptions. Doctors whose offices were closed. It's just really looking at the requirements for the continued care, and I think that falls right into the health equity. Thank you.

**Patti Maloney, Soundview Medical Supply**

**Designing the future of OHP: Workshop #3**  
**December 16, 2021**

- We understand the state of Oregon faces considerable challenges ensuring residents have access to quality affordable care and applaud the agency's goals of improving equity in closing gaps in health disparities. Aligned in that priority we believe in building more just equitable healthcare system and believe diversity, equity, and inclusion are essential to the discovery of new medicines that people of all backgrounds should have access to treatment and heartened by the state's commitment to improving that. However, Oregon's proposal to impose a closed formulary would not promote the state's laudable goals of advancing health equity. Your concept papers and the presentation tonight highlighted known existing health disparities, and some of the issues that led to these among OHP members and communities of concern. Research shows that limiting formulary choice can lead to worsened health outcomes and ultimately can increase costs to the system rather than producing the intended savings. The pandemic has had harmful effects on the social, economic, and healthcare related outcomes among lower income and racially and ethnically diverse groups, therefore timely access to provide a recommended medicine is central to reversing that trend, decreasing avoidable healthcare utilization and costs and reducing mortality. The proposed amendment will impede access to medically necessary drugs for more than 700,000 Oregonians, and it raises serious concerns about the long-term impacts. Moreover, the proposed amendment doesn't meet fundamentals of 1115 waivers, and picks and chooses which parts of Medicaid rebate statute to abide by. We will be submitting full comments in more detail but appreciate the time and -- to briefly speak here tonight. In summary, pharma believes closed formulary proposal is ill advised for both legal and policy reasons and should be withdrawn from this application. Thank you.

**Dharia McGrew, PhRMA**

**CPOP Waiver Webinar #3-English  
December 17, 2021**

- My name is Christian Moller-Andersen and I am executive director for A Smile for Kids. This is a public comment on behalf of A Smile for Kids: EPSDT Guidelines from CMS are addressed in the following way in the waiver draft application: only services above line 471 in list of prioritized health services are covered for children. HERC is working to recommend including handicapping malocclusion to OHA, but not in 2022. If OHA doesn't include handicapping malocclusion (currently line 618) in 2023 or 2024, this EPSDT exclusion in the draft application will continue to block OHP kids from braces if they don't suffer from Cleft palate or a craniofacial anomaly for the next five years. This is a serious barrier to equitable access for kids from underserved populations who have severe need for braces to remedy problems with eating, speaking, sleeping, and breathing. This is the direct opposite of equitable access.

*Mi nombre es Christian Moller-Andersen y soy director ejecutivo de A Smile for Kids. Este es un comentario público en nombre de A Smile for Kids: las guías de EPSDT de CMS se abordan de la siguiente manera en el borrador de la solicitud de exención: solo los servicios arriba de la línea 471 en la lista de servicios de salud prioritarios están cubiertos para niños. El HERC está trabajando para recomendar incluir la maloclusión como discapacidad a la OHA, pero no en 2022. Si la OHA no incluye la maloclusión como discapacidad (actualmente línea 618) en 2023 o 2024, esta exclusión de EPSDT en el borrador de la solicitud continuará impidiendo, durante los próximos cinco años, que los niños del OHP obtengan aparatos ortodónticos si no sufren de paladar hendido o anomalía craneofacial. Esta es una barrera grave para el acceso equitativo de los niños de poblaciones desatendidas que tienen una gran necesidad de aparatos ortodónticos para remediar problemas para comer, hablar, dormir y respirar. Esto es todo lo contrario del acceso equitativo.*

**Christian Moller-Andersen, Executive Director for A Smile for Kids**

- Our organization works across sectors on population-based improvement efforts, with the common purpose of improving the health of the children and youth of Oregon. A key component of our mission to ensure that all efforts are informed by parents, youth, and young adults. As an organization and person deeply committed to and experienced with systemic change, we have found developing reliable and meaningful measures has always been a critical tool to drive and inform valid improvement efforts that impact the health of children. What is measured, and HOW it is measured, is WHAT will be focused on. Given that nearly 40% of Oregon's Medicaid-insured are children (the majority age demographic of enrollees) and because Medicaid provides insurance for the majority of children of color in our state (60% of Black children, 65% of Latino children, and 57% of AI/AN children), we are extremely supportive of the elements of the waiver that focus on children and focus on addressing structural racism. Both areas of focus are root sources of where the drivers of inequity begin and are sustained. Within OHA's and OHPB health equity definition and aims, a key component we see for children in Medicaid/CHIP is the intentional inclusion of "disability".

- For children with special health care needs in Oregon, OHP IS the safety net for addressing and covering their medical, behavioral, oral and care coordination needs.
- To highlight? underscore? the magnitude of children (and their families) that count on Medicaid/CHIP to provide access, quality and coordinated care - according to the 2021 Child Health Complexity data, there are 145,000 children enrolled in Medicaid/CHIP, which is more than 1 in four children, have some level of medical complexity, with 50,000 having a complex, chronic condition.

We have significant concerns with the Waiver proposal related to Incentivizing Equitable Care. We appreciate and overall support the intent and purpose of the upstream and downstream metrics. However, the current proposal will result in no metric that will ensure equitable access to, or receipt of, high-quality care for children with special health care needs - in the very program meant to ensure these children's needs are met. The upstream measures proposed, although critical in addressing some of the historical inequities and social challenges faced, do not contain metrics focused on children and youth with disabilities. The etiology of children with disabilities is different than adults, in that a majority are not caused by lifestyle or life circumstances that could be addressed by upstream efforts. The current proposal calls for "downstream metrics" that would ensure quality, access, and outcomes of the health care system to ONLY be chosen from the CMS Medicaid Adult and Child Core Sets and potential MCO Quality Rating System.

- I personally know the metric set and identification of which metrics go into that set well as I am one of the only measure stewards that is not NCQA. I do not believe that narrowing our measures to this CMS Core Set - which need to be applicable to all 50 states, will allow Oregon to reach their goal of eliminating health inequities by 2030.
- There are NO metrics for the population of children and youth with special health care needs. While there is one metric focused on children who experience asthma, this is just one condition of the hundred chronic conditions that children experience. The result – we will have no quality metrics and levers to ensure quality for a population that this program is meant to serve.
- There are NO metrics focused on the essential and critical function of care coordination and care integration that are essential for CYSHCN and central to the CCO model. When this function is not measured and assured in a high-quality way, the responsibility inevitably falls on the family and the child, which can result in poor health outcomes, school absenteeism, and child risk for out of home placement.
- The metrics included in the Core Set focused on behavioral health that could be considered for inclusion in the downstream set, do not measure or focus on the innovative models of behavioral health that Oregon has been known to support including IBH and dyadic behavioral health. In Oregon, nearly two in five (38%) children have three or more social complexity factors, majority of which are aligned with adverse childhood events, for which behavioral health is an essential service for which equitable access and quality care is needed. In the current proposal, there would be no metrics to ensure this quality and innovation would continue.

We have seen the transformative and integral power that the metrics and metrics tied to incentives to galvanizing improvements in quality. As an organization that works with and hears from parents, youth, and young adults every day, we hear consistently and persistently how their access and care coordination needs continue to be unmet. It is imperative that the metrics program is designed in a way such that metrics of quality can be considered is an essential component to ensuring equitable access and high-quality care for this population, and therefore we strongly recommend reconsideration of the waiver language related to the downstream metrics. We are ready and willing to partner on solutions that could address these concerns should there be an opportunity.

*Somos una organización estatal que nuestra organización trabaja en todos los sectores en esfuerzos de mejoramiento basados en la población, con el propósito común de mejorar la salud de los niños y jóvenes de Oregon. Un componente importante de nuestra misión es garantizar que todos los esfuerzos sean informados por padres, jóvenes y adultos jóvenes.*

*Como organización y persona profundamente comprometida y experimentada con el cambio sistémico, hemos descubierto que desarrollar medidas confiables y significativas siempre ha sido una herramienta fundamental para impulsar e informar esfuerzos válidos de mejoramiento que impactan la salud de los niños. Lo que se mide, y CÓMO se mide, es en lo QUÉ se enfocará.*

*Dado que casi el 40% de los asegurados por Medicaid de Oregon son niños (la mayoría de edad demográfica de las personas inscritas) y en particular, los niños de color están cubiertos por Medicaid, porque Medicaid ofrece seguro para la mayoría de los niños de color en nuestro estado (60% de los niños negros, 65% de los niños latinos, y 57% de los niños indio americano/nativo de Alaska), apoyamos mucho los elementos de la exención que se enfocan en los niños y se enfocan en abordar el racismo estructural. Ambas áreas de enfoque son fuentes fundamentales de donde comienzan y se sostienen los impulsores de la inequidad.*

*Dentro de la definición y los objetivos de equidad en salud de OHA y OHPB, un componente importante que vemos para los niños en Medicaid y CHIP es la inclusión intencional de "discapacidad".*

- Para los niños con necesidades especiales de atención médica en Oregon, el OHP es la red de seguridad para abordar y cubrir sus necesidades médicas, conductuales, dentales y de coordinación de atención. ¿A destacar? ¿subrayar? La magnitud de los niños (y sus familias) que cuentan con Medicaid/CHIP en Oregon para brindar acceso, calidad y atención coordinada: según los datos de 2021, los datos de complejidad de la salud que tienen complejidad médica son los datos de Child Health Complexity, hay 145,000 niños. Entonces, más niños inscritos en Medicaid/CHIP, que es más de 1 en cada cuatro niños asegurados públicamente, tienen una condición médica compleja. algún nivel de complejidad médica, con 50,000 que tienen una condición crónica compleja.*

*Tenemos preocupaciones significativas con la propuesta de exención relacionada con el incentivo de la atención equitativa. Apreciamos y apoyamos en general la intención y el*

*propósito de las métricas ascendentes y descendentes. Sin embargo, la propuesta actual no generará métricas que aseguren el acceso equitativo o que niños con necesidades especiales de atención médica reciban atención de alta calidad. - en el mismo programa destinado a garantizar que se satisfagan las necesidades de estos niños.*

*Las medidas preliminares propuestas, aunque críticas para abordar algunas de las desigualdades históricas y los desafíos sociales, no contienen métricas enfocadas en niños y jóvenes con discapacidades. La causa de los niños con discapacidades es diferente a la de los adultos, en el sentido de que la mayoría no son causadas por el estilo de vida o las circunstancias de la vida que podrían abordarse mediante esfuerzos previos.*

*La propuesta actual que pide "métricas posteriores" es que están ancladas a este conjunto trimestral. No hay métricas para la población de niños y jóvenes con necesidades especiales de atención médica en ese conjunto y sin embargo, este es el programa que se supone que les garantiza la calidad. No hay métricas relacionadas con la coordinación de la atención o la integración de la atención, y no hay métricas relacionadas con la salud del comportamiento que aborden la complejidad social que sabemos que experimentan dos de cada cinco niños. Esperamos ser su socio si está dispuesto a considerar soluciones y esperamos que esto pueda tomarse en cuenta para los niños importantes a los que sirve Medicaid. eso garantizará que la calidad, el acceso y los resultados del sistema de atención médica SOLO se elijan de los conjuntos básicos para adultos y niños de Medicaid de CMS y el potencial Sistema de calificación de calidad de MCO.*

*Personalmente, conozco bien el conjunto de métricas y la identificación de qué métricas entran en ese conjunto, ya que soy uno de los únicos administradores de medidas que no es NCQA. No creo que reducir nuestras medidas a este conjunto básico de CMS, que debe ser aplicable a los 50 estados, permita que Oregon alcance su objetivo de eliminar las inequidades en salud para 2030.*

- NO existen métricas para la población de niños y jóvenes con necesidades especiales de salud. Si bien hay una métrica enfocada en los niños que experimentan asma, esta es solo una condición de las cien condiciones crónicas que experimentan los niños. El resultado: no tendremos métricas ni palancas de calidad para garantizar la calidad para una población a la que este programa está destinado a servir.*
- NO hay métricas enfocadas en la función esencial y crítica de la coordinación e integración del cuidado cuidado que son esenciales para CYSHCN y centrales para el modelo CCO. Cuando esta función no se mide y asegura de manera de alta calidad, la responsabilidad inevitablemente recae en la familia y el niño, lo que puede resultar en malos resultados de salud, ausentismo escolar y riesgo de que el niño sea colocado fuera del hogar.*
- Las métricas incluidas en el conjunto básico se centraron en la salud conductual que podría considerarse para su inclusión en el conjunto descendente, no miden ni se enfocan en los modelos innovadores de salud conductual que se sabe que Oregon respalda, incluyendo IBH y*

salud conductual para padres e hijos. En Oregón, casi dos de cada cinco (38 %) niños tienen tres o más factores de complejidad social, la mayoría de los cuales están alineados con eventos adversos de la infancia, para los cuales la salud del comportamiento es un servicio esencial para el cual se necesita acceso equitativo y atención de calidad. En la propuesta actual, no habría métricas para garantizar esta calidad y la innovación continuaría.

Hemos visto el poder transformador e integral que tienen las métricas y las métricas vinculadas a incentivos para impulsar mejoramiento en la calidad.

Como una organización que trabaja y escucha a los padres, jóvenes y adultos jóvenes todos los días, escuchamos de manera consistente y persistente cómo sus necesidades de acceso y de coordinación de atención siguen sin satisfacerse.

Es imperativo que el programa de métricas esté diseñado de tal manera que las métricas de calidad puedan considerarse un componente esencial para garantizar el acceso equitativo y la atención de alta calidad para esta población, y por lo tanto, recomendamos enfáticamente reconsiderar los conceptos de exención relacionado con las métricas posteriores.

Estamos listos y dispuestos a asociarnos para encontrarsoluciones que podrían abordar estas preocupaciones en caso de que haya una oportunidad.

**Colleen Reuland, Oregon Pediatric Improvement Partnership (OPIP)**

- I know you folks were predominantly going over the Medicaid eligibility piece of OHP. To my understanding, EBT food stamps also falls under this, is that correct.

I'm an enhanced resident services case manager who works in the downtown area with folks who are in largely subsidized housing. Basically, what I'm running into is increasing needs for folks who, you know, live on the economic margins, they're losing access to their providers, a lot of them just haven't connected with folks and in an awful long time, and right now it is an absolute nightmare for them to get certain paperwork from things like social security for updated benefits award statements and the like. I know a lot of communication happens on the back end, but I have noticed folks who are just getting their food stamps turned off for lack of recertification, and I don't know if your arm of OHP is sort of caught up in that but it's extremely problematic. It is very traumatizing for folks and it's causing food insecurity and instability. At least through covert COVID, it would be great if some kind of waiver could be, or process procedure established so that folks aren't required to jump through hoops to maintain benefits they've already been certified for. Like it's usually just to, you know, quantify their income status, and I have to imagine the number of people who substantively improve their income to a point where they're no longer, where they go from full eligibility for food stamps, to no eligibility for food stamps This is got to be much smaller than the amount of work the state requires on their behalf to maintain.

*Sé que ustedes estaban revisando principalmente la parte de elegibilidad de Medicaid del OHP. Según tengo entendido, los cupones de alimentos EBT también se incluyen en esto, ¿es correcto?*

*Soy un administrador de casos de servicios para residentes, que trabaja en el centro de la ciudad con personas que viven en viviendas en gran parte subsidiadas.*

*Básicamente, con lo que me encuentro es una necesidad creciente de personas que, ustedes ya conocen, viven en los márgenes económicos, están perdiendo el acceso a sus proveedores, muchos de ellos simplemente no se han conectado con la gente y en mucho tiempo, y en este momento es una absoluta pesadilla para ellos obtener ciertos documentos de cosas como el seguro social para declaraciones actualizadas de autorización de beneficios y similares. Sé que se produce mucha comunicación tras bastidores, pero he notado personas a las que simplemente les están poniendo alto a sus cupones de alimentos por falta de recertificación, y no sé si la rama de OHP tiene que ver con eso, pero es extremadamente problemático. Es muy traumático para la gente y está causando inseguridad alimentaria e inestabilidad. Al menos a través de cobertura de COVID, sería genial si se pudiera establecer algún tipo de exención o procedimiento de proceso para que las personas no tengan que pasar por obstáculos para mantener los beneficios para los que ya han sido certificados. Como si fuera sólo para, usted sabe, cuantificar su estado de ingresos, y tengo que imaginar la cantidad de personas que mejoran sustancialmente sus ingresos hasta un punto en el que ya no están, donde pasan de elegibilidad total para cupones de alimentos, a no elegibilidad para cupones de alimentos. Esto tiene que ser mucho menor que la cantidad de trabajo que el estado requiere en su nombre para mantener.*

**Travis Small**

**Oregon Health Policy Board  
January 4, 2022**

- I'm here to clarify the stance of regional health equity coalitions with regards to the concepts in that 1115 Medicaid waiver application. Specifically, this group wants to be clear we strongly support and are advocating for the community investment collaboratives model. We participated in cowriting House Bill 3353, and to help carry forward the vision and goals in the bill, we also participated in the waiver workgroup related to focus, equity, investments concept. We also developed a set of principles to guide that process, and previously we, as we stated to the Oregon Health Policy Board here back in August, it is our hope that all waiver concepts will be aligned with the principles, which also reflect the asks in House Bill 3353 which prioritize target investments and efforts to populations and communities who have been most impacted by historic and contemporary injustices and health inequities, shift power and decision making authority to community voice, create opportunities to build sustainable infrastructure, systems, and programs that recognize, reconcile, and rectify historical and contemporary injustices. Support community leadership development, build and rebuild trust between health systems and communities. We know it cannot be done in silos, so we are calling to action OHA, our allies, and partners, our CCO partners to join us in advocating for this necessary and fundamental shift. Especially ask that they trust the wisdom of communities that they are meant to serve and join us in this effort. We are also calling to action OHPB members, if parity and delivery of services of health equity are a priority, please help support this effort to shift power and resources to communities through your positions of leadership. Thank you.

**Annie Valtierra-Sanchez, Director of Regional Health Equity Coalition in Southern Oregon**

- I serve as executive director for Smile for Kids. Thank you for allowing me to speak on this issue, and a special thanks to Dr. Santa for your earlier questions about EPSDT. Smile for Kids is an Oregon private 501(c)(3) non-profit organization that funds orthodontic treatment for youth in all of Oregon's 36 counties. We have existence since 2004, because Oregon excludes OHP kids from orthodontic treatment unless there's severe cases involved. We are disappointed OHA has requested that CMS renew the state's authority to restrict coverage for treatment services identified during EPSDT screenings too those services that are consistent with the prioritized list of health services for individuals above age 1. We think this waiver is unnecessary for OHA to achieve its programmatic goals, and we're especially concerned about its impact on children with handicapping malocclusions. In all other states, the Medicaid program covers medically necessary orthodontic services for children who have this severe and life-altering condition. Handicapping malocclusion can interfere with eating, speaking, sleeping, smiling, and normal social relating, it can affect physical and social emotional development of children. Its impact can be felt over a lifetime, in the loss of achievements in education, possibilities of employment, and a reduction in overall health and wellness, including mental health. Hundreds perhaps thousands of Oregon's most vulnerable children are currently denied access to critical and medically necessary care, care that should be covered as part of the EPSDT benefit. As Smile for Kids does its best to fill this gap, we have resources to serve only about 60 new applicants each year and usually have around 200 active kids during non-COVID time in braces. We have filed more detailed

written comments, but the bottom line is that we urge OHA to reconsider its request to waive these EPSDT requirements. Thank you very much.

**Christian Moller-Andersen, Executive Director for A Smile for Kids**

- AllCare Health is supportive of many of the parts of the waiver, including the increase of overall enrollment in CCOs, keeping healthcare continuity for members as they transition from different settings in an attempt to create flexibility and invest that stream and creating metrics to make sure those investments happen. There's still concerns around the draft waiver when -- to create new healthcare silos that does not properly align with the bipartisan supported bill of HB 3353. Regions across Oregon are complex and priority populations have different needs in the same region. Example one, Spanish speaking community Jackson County is different and has very different barriers than the Spanish-speaking community even in Brookings, which only 60 miles away. The new silos that are proposed in the new waiver are said to be empowering community but there's no definition of what the community is. Regions are not defined, membership is not defined because of this lack of clarity, there's going to be gaps where communities are missed, and creating silos in health equity separated from the whole system will make these gaps even more pronounced. Equally concerning is how these new groups will submit to the OHA for grant dollars. There are two major concerns for this. One, the significantly weakens local control, and two, HB 3353 was designed to hold both CCOs and the OHA accountable. How can these new entities hold the OHA accountable if they are beholden to the OHA for grants? This new silo sets back five years what CCOs and the CCO's community advisory counts have been doing. They've never had a true global budget our councils have been stuck giving out grants as opposed to giving multi-year community -- funding for community projects. AllCare's Community Advisory Council highlighted many of these prongs they would have loved to have funded but were not able to do and they would think 3353 would make it more sustainable. I know I've run out of time but I want to make sure that as we're moving forward that there's more effort to actually close the gap and that as you are incorporating these comments into the process, that the Oregon Health Authority does a much better job of actually bringing in people to actually say, are we actually getting what we're trying to do as you're making changes to the actual final waiver that you end up proposing. I would also strongly encourage including Community Advisory Councils, especially considering a large part of their membership is made up of actual Oregon Health Plan users. Thank you for the opportunity to testify today.

**Josh Balloch, VP Government Relations & Health Policy, AllCare Health**

- I'm the public policy director for Disability Rights Oregon. I would like to say that Disability Rights Oregon finds many of the new ambitious ideas in this waiver to be exciting and we are very supportive, but we continue to have very serious concerns about how OHA uses quality or quality adjusted life years in how it has prioritized its list. As well as we do not support the continued waiver of EPSDT. I have had many conversations with OHA related to quality, and frankly feel like I'm not getting a clearance about how it's used today. It is very clear that the quality score was at the heart of much of the score that was done, at least up until 2013, possibly to 2017. It was also clarified quality was not -- we did not rescore all the

scores that were done before 2013, which was the overwhelming majority of conditions and treatments were scored using a quality adjusted life year model and is still ranked with that score today. Quality adjusted life years is a deeply discriminatory measurement that devalues the life of people with disabilities. It treats people who have chronic disease and disability as if their life is worth a fraction of what the life of a healthy person is. It is not based on science, it does not have any value outside of the opinions of healthcare professionals, of what they believe the quality of life is for somebody with a disability. The health professions are well documented as being discriminatory and biased against people with disabilities. Yet it is still a score that has been incorporated and at the heart of our prioritized list. DRO is asking that we disavow the quality adjusted life year and rescore using a nonbiased matrix, the prioritized list so that people with disabilities are not disproportionately impacted by the prioritized list.

**Meghan Moyer, Disability Rights Oregon**

- We're extremely supportive of the waiver focused on addressing structural racism and children. within the definition, a key component for children in Medicaid and CHIP is the intentional inclusion of disability for children with special healthcare needs the Oregon Health Plan is the SafetyNet for their medical, behavioral, oral, and care coordination needs. In Oregon, 145,000 publicly insured children, that's more than one in four, have medical complexity. We hear from parents and young adults consistently and persistently about how their access to and care coordination needs continue to be unmet. We have significant concerns about the waiver proposal related to incentivizing equitable care. Measures that are incentivized have been shown to be critical tool to focus on specific populations for which improvements are desperately needed. The current proposal will result in no metrics that will incentivize equitable quality care for children with special healthcare needs. The very program meant to ensure these children's needs are met. The upstream metrics proposed, though critical in addressing some of the historical inequity and social challenges faced, do not contain metrics focused on children with disabilities. The ideology of disabilities with children is different than adults, the majority are not caused by lifestyle. The current waiver calls for downstream metrics to only be chosen for this core set. In the set, there are no metrics for children and youth with special healthcare needs. There are no metrics for focus on care coordination and complex health management. The metrics included focus on behavioral health, do not measure integrated behavioral health or behavioral health. The metrics program must be designed in a way that ensures equitable access to high-quality care for children, youth with special healthcare needs and we strongly recommend reconsideration of the waiver language related to downstream metrics. Thank you for your time.

**Colleen Reuland, Oregon Pediatric Improvement Partnership (OPIP)**

- We appreciate the opportunity to support the renewal of Oregon's Medicaid waiver to improve health equity. Comagine Health is a national nonprofit healthcare consulting organization. We've been working collaboratively with patients, providers, payers, and community-based organizations for 40 years in Oregon to provide care management and quality improvement services as well as cost and quality data management. Comagine

Health supports continuous enroll of adults and children in the Oregon Health Plan. We partner with OHA to monitor health outcomes for Medicaid beneficiaries. We have maintained an all-payer claims database since 2010 in Oregon, that allows us to track cost, quality, and utilization indicators in the commercial, Medicare, and Medicaid markets. Our all payer claims database can follow individuals over the years even if they change insurance companies or markets. Enrollment data show that individuals are moving from OHP to self-pay and back. Such churn increases health risk to individuals and the loss of claims diminishes the completeness of quality and cost data. Comagine Health supports expanding funding of community-based organizations and traditional health workers to address health inequity. Community-based organizations frequently rely on grant funding to deliver services, a model insufficient to support sustainable infrastructure needed to scale. Comagine Health assists these organizations to engage with the emerging community health information exchange in Oregon. We help them build infrastructure and standardized workflow for referral to evidence-based self-management programs they provide and to receive payment from Medicare and Medicaid. Thank you for the opportunity to support Oregon Health Authority in its Medicaid waiver application.

**Richard Gibson, Comagine Health**