



January 6, 2022

Oregon Health Authority
Health Systems Division
Health Policy & Analytics Medicaid Waiver Team
500 Summer Street NE, E65
Salem, OR 97301

Re: Response to 2022-2027 Medicaid 1115 Demonstration Application

To the Health Policy & Analytics Medicaid Waiver Team:

This letter is in response to OHA's 2022-2027 Medicaid 1115 Demonstration Application proposal.

First, a brief description of who we are: New Narrative is a non-profit agency established in 1977 which provides mental health treatment services, housing programs, and peer support and mentoring services to adults with persistent and severe mental illness. We serve over 1,500 program participants each year and provide housing for 261 beds. Over 52% of our funding comes from Medicaid.

In recent years we've been expanding our programming to address social determinants of health (SDOH) in areas including housing, life skills training, transition into adulthood, equity and inclusion, improved access to services, and peer support. We have been expanding our funding sources beyond Medicaid in order to provide these services that positively impact SDOH because they are not covered by Medicaid in the traditional "medical necessity" model. We believe that wellness is supported by services that impact a wide array of SDOH beyond clinical health care and behavioral health care treatments within the medical model. Our vision is that program participants seeking services can thrive and live the life they choose, not just survive.

We are pleased to see that improving SDOH is the focus of the OHA 2022-2027 Medicaid Demonstration Application and would like to address each section of the proposal:

I. Maximizing coverage through the Oregon Health Plan

We support initiatives that will move Oregon closer to a ***universal health plan*** available to all, particularly traditionally disenfranchised populations. This focus aligns with our values of equity and inclusion.

In addition to the proposed strategies regarding extended OHP coverage for children under 6, continuous OHP enrollment for people ages 6 and up, and an expedited OHP enrollment path for SNAP benefit applicants, we particularly support the following additional proposals based on our values, mission, and experiences with our program participants:

1. Developing commercial insurance market reforms to improve coverage continuity and access to health care through the Oregon Health Insurance Marketplace and making it *easier to navigate the transition* from Medicaid to commercial coverage.
2. Continuing the implementation of Cover All People to support coverage for all individuals regardless of immigration status. We believe it is a violation of our basic values of equity and

inclusion and simply the value of human life to exclude individuals from coverage who do not have legal status in the U.S. but are here anyway to find a better life for themselves and their families. Our agency not only supports providing them with services, but also assisting them to find a path to legal residency so as to remove other barriers that impact their SDOH, such as jobs and housing.

3. Streamlining the OHP application process and making it easier and faster with initiatives such as allowing applicants to self-attest to their income and aligning the timing of eligibility renewal for OHP with other benefits such as SNAP and TNAF.

II. Improving Health Outcomes by Streamlining Life and Coverage Transitions

We at New Narrative strongly believe that SDOH have a profound impact on the quality of the health and well-being of our program participants. This is why over the last decade we have expanded our services beyond traditional mental health services to provide a wide variety of housing programs, life skills training, education and job support, and peer support and mentoring to provide socialization and a sense of community. We have found that life transitions such as incarceration, aging out of foster care, loss of employment, and discharge from prolonged hospital stays, to name a few, often disrupt the fragile support systems of our disenfranchised and vulnerable program participants. We strongly support the following proposals:

1. Provide continuous Medicaid coverage for people in custody, including the State Hospital and juvenile corrections. Currently, funding for our services is often interrupted when our program participants are transitioning from jail or from OSH which handicaps our ability to provide optimal care and sometimes a delay in admission into our programs.
2. Retain child eligibility levels for youth up to age 26, even if they don't have special needs. We have found that many young adults from age 18-25 who have come from at-risk and vulnerable families are simply not prepared for independence and require additional services and support to transition to adulthood.
3. Allocating funding to SDOH transition services to support members during life transitions. For example, we are currently piloting a Transition Team to support program participants transitioning in and out of residential treatment to help them find work and housing. This is funded by a one-time grant, so we will need additional funding beyond the first year. We advocate allocation of Medicaid funding to support such teams.
4. The expansion and funding of infrastructure at the community level for programming and capacity building needed to support services that improve SDOH ***outside of the medical model***. One example is our NorthStar Clubhouse which is part of the network of Clubhouse International, a model that supports mental health recovery, community engagement, and re-entry into employment. This is a highly successful program in terms of impact and outcomes for program participants and for the community but severely underfunded in Oregon and not billable under Medicaid. ***We very strongly believe that funding only services defined as "medically necessary" severely limits the potential for positive outcomes and thriving communities.***

III. Value-Based Global Budget

We support shifting resources to fund a value-based system that supports program participants as their health improves, not just when they are at the highest acuity of illness. We strongly advocate that a

higher percentage of funding being funneled to the community providers who actually perform the front-line services, and less funding being allowed for heavily layered bureaucracy in the CCO and county mental health organizations and system. We urge consideration of the following:

1. Ensuring that CCOs provide payment rates to community providers that are based on realistic, current economic realities such as the supply and demand of the labor force – the largest operating cost of any community provider – along with annual COLA increases in provider service contracts. Labor rates are skyrocketing for community providers who are hamstrung by static contracts that don't adjust for labor rate inflation and consumer price indices and don't allow for a reasonable operating overhead percentage. It is also a mistake to base rates on past spending given the current economic realities and the shift to covering services in support of SDOH.
2. A closed formulary could likely cause some problems for psychiatry, especially with the SPMI population. It is common that participants receive little to no benefit from the first- or second-line medications, and it requires trial and error of medications with less evidence. Sometimes when the right medication is found, it could be lifesaving. If a closed formulary is implemented, special consideration must be given to psychiatry, especially for the SPMI population, to ensure that we have access to a wide selection of medications and a simple, quick process to get authorization outside of the formulary. Burdening providers with the paperwork and bureaucracy of prior authorizations takes precious time away from expensive psychiatrists and psychiatric nurse practitioners, but more importantly, delays patient care and access. This could lead to negative outcomes and increased system costs (e.g. hospitalizations).

IV. Incentivizing Equitable Care

We support strategies that enable equitable care including improving cultural responsiveness, mitigate social stigmas and the harm of racism, and create equitable access. These strategies are in complete alignment with our mission and values. However, the issue with incentive measures is that they are often not what actually enables the desired outcome. Some comments and questions on the proposed strategies:

1. **Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity:**
 - a. One proposal in this section is to measure and incentivize “Meaningful Language Access to Culturally Responsive Health Care Services.” Assuming that the CCO scorecards will become the service provider scorecards, this puts the burden on the community providers to find or possibly develop said services. Where is the funding for this coming from? Even if funding is available, culturally responsive services are somewhat limited in the state. Where is the effort and investment in the development of culturally responsive services? How are we attracting culturally specific talent to this state? It appears it's all on the backs of community providers who have inadequate resources to make it happen.
 - b. Most of the “Upstream Health Equity Metrics” apply to children. What about upstream metrics for the adult population being served? Why just children?
2. **Redistribute decision-making power to communities:** We encourage OHA to push for membership on the Health Equity Quality Metrics Committee to include a significant number of representatives from community non-profit agencies that are boots-on-the-ground service

providers who have a front-line view of the served populations, challenges, and socioeconomic realities.

3. **Rethink the incentive structure to better advance equity:** It appears that OHA is trying to incent outcomes by paying the CCOs incentives across a variety of priorities; our concerns center around whether these incentives are actually passed on to frontline community providers, and if this new policy stance guarantees that there will be material pass through of funds to organizations where they are needed most. We also question the logic that the cost savings realized by the CCO model and the manner in which they were generated in the past 5 years are a net positive to our system; Oregon continues to experience some of the lowest ratings in the country in terms of access to care and quality of care, with the current staffing crisis in the sector demonstrating the latest iteration of the flow on effects of cost saving incentives. We advocate that whatever model is utilized takes into consideration that the CCO model must regulate cost responsibly and ensures providers are funded in a meaningful way to actually deliver services and produce materials results within our most vulnerable populations.

V. Focused Equity Investments

We consider this section of the Medicaid Waiver Application to be the most exciting and promising in that it indicates strong support for funding services that improve SDOH. Our comments on the subsections of this area are as follows:

1. **Invest federal funds toward infrastructure to support health equity interventions:** We believe that it is imperative that community organizations doing the actual front-line work receive funding to build capacity to serve our program participants with equitable and culturally appropriate programs that support improved SDOH and improved access to services. This could include such things as premium funding for bi-lingual staff including clinical and peer support, training for more culturally appropriate services, housing support, employment programs, and programs that support healthy community engagement, to name a few. Our sole concern about this part of the application is that the community investment collaboratives (CICs) may become another layer of bureaucracy that prevents adequate funding from flowing to front-line services providers. Creating statewide systems to support this proposal may help with communications, allocation, and establishing standards, but it may also add administrative burden that wastes funds and capacity and results in inadequate funding to front-line providers.
2. **Invest Federal Funds in community-led health equity interventions and statewide initiatives:** We support the concept of local management of CCO community funds. Our main concern here is the mechanism by which the CICs receive, manage, and distribute CCO community funds. We need a system that minimizes bureaucracy and administrative burden and provides more funding directly to front-line community providers.
3. **Grant community-led collaboratives resources to invest in health equity:** We strongly support additional federal investment to support health equity investment (HEI) grants. We are particularly in favor of a non-competitive process with requests for proposal that address



identified community needs. The examples of proposed HEIs that we are prepared to implement and/or to expand are increasing housing inventory, providing more housing supports and services, improving homeless/houseless outreach, increasing access to social and mental health supports, expanding culturally and linguistically responsive work force, and dismantling structural racism as well as destigmatizing mental health conditions. We have spent the last decade, and particularly the last five years, developing programs and defining our mission and values in all of these areas. Our concern in this area is that after the initial grant period the grants are renewable or that there is other funding made available for on-going support of these programs.

In summary, we at New Narrative support and are encouraged by the emphasis on funding services that improve SDOH and health equity outlined in this waiver application. The focus on SDOH is in alignment with our mission and vision and the needs of our communities here in Oregon and in our nation. We ask that minimization of administrative burden and bureaucratic layers become a priority in the implementation of these initiatives. We also ask that prioritization be given to making sure that as much funding as possible goes to the actual front-line community providers who are directly serving these populations and making an impact in communities throughout the state.

Sincerely,

A handwritten signature in black ink that reads "Julie Ibrahim".

Julie Ibrahim, LPC
Interim CEO