Equity-Centered System of Health Concept Paper
1115 Waiver Demonstration

Summary of Request

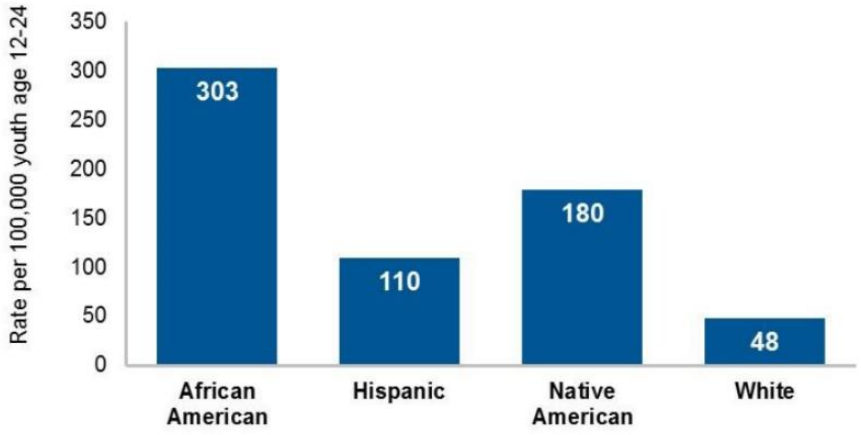
Oregon will request a waiver from CMS' institutional rules to establish an equity-centered system of health by improving transitions across systems, closing gaps in coverage and care, and providing defined packages of services and supports for health-related social needs related to those transitions.

Problem and Background

One of the most challenging and precarious situations for an OHP member to navigate is during periods of significant transition, where they may become ineligible due to being incarcerated, are discharged from an institutional setting without stable housing, or are otherwise houseless or face housing insecurity, or go through significant life events that can be destabilizing, especially from a behavioral health perspective (e.g., going in/out of foster care or bringing home a new baby), or any intersection among these transitions. Ultimately, members are often left to navigate multiple complex systems independently because our state health care system is not designed to align and coordinate with other social systems and providers in a way that allows everyone to come together to support people in accessing systems more seamlessly. These challenges are exacerbated for tribal members, communities of color, and people with disabilities as systems often lack the infrastructure and resources to provide culturally and linguistically appropriate care and services and often do not meet people where they are at.

As an example, despite Oregon's great success in enrolling hundreds of thousands of adults onto the OHP under state Medicaid expansion, the justice-involved population faces complex barriers to enrollment upon release from incarceration. This is of particular concern given the high prevalence of chronic and infectious disease, and untreated mental illness and addiction disorders faced by this population. Failure to provide a link to health insurance and health care services for transitioning inmates has a major impact on recidivism rates and the rising health care costs that health reforms aim to combat. And for both youth and adults, people of color are grossly over-represented among those incarcerated in Oregon due to historic oppression and systemic racism. In Oregon, males and persons of color are disproportionately incarcerated compared to other demographic groups. The youth incarceration rate is 6 times higher for African American youth than for white youth.

Youth incarceration rate per 100,000 population by race/ethnicity: Oregon, January 2018

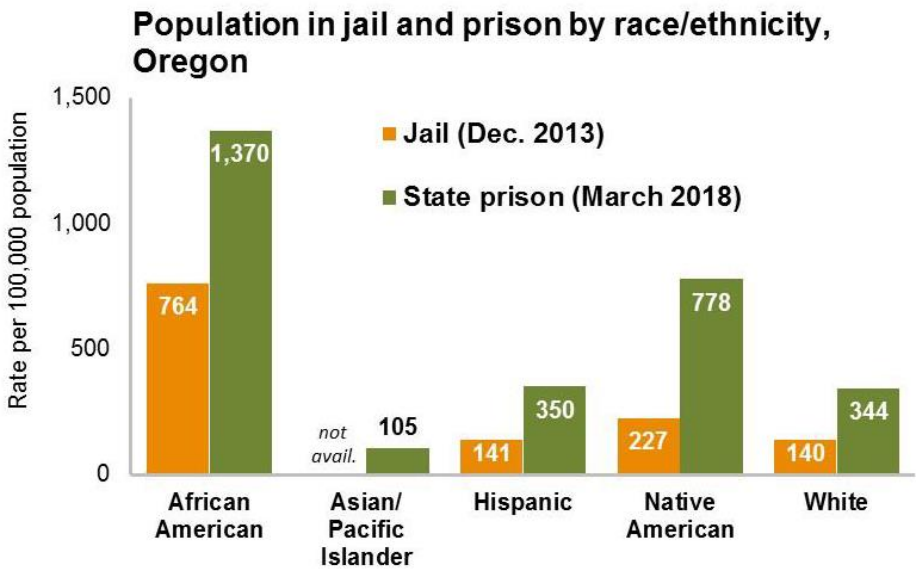


Note: All other races shown exclude Hispanic ethnicity. Rates for other groups not available.

Source: Oregon Youth Authority

The pattern of disparities by race/ethnicity is very much the same for the Oregon county jail and prison population.

Population in jail and prison by race/ethnicity per 100,000: Oregon 2018



Note: All other races shown exclude Hispanic ethnicity.

Source: Bureau of Justice Statistics (jails) and Oregon Department of Corrections (prisons)

People need supports outside of the health care system to succeed through these transitions. Over the last decade it has become clear that health services alone cannot address health conditions without also ensuring that critical social needs such as housing, food,, and other basic needs are met. While quality and timely health care services are essential, research shows that a person's socio-economic status, behaviors, and physical environment are the

primary drivers of health, contributing as much as 80 percent to health outcomes. In order to ensure healthcare can be effective in addressing illness and ultimately promoting health, the system needs to treat the whole person.

For those who suffer from housing instability, this means integrating housing navigation, care coordination and resources to help obtain and maintain stable and healthy housing for individuals and their families/households whenever possible. This would include a focus on providing more culturally and linguistically appropriate and trauma informed services to our tribal communities, communities of color, and the disability community,[1] which have been historically and are currently under engaged and underserved by the healthcare system and are disproportionately represented in homeless statistics. This also includes a need to particularly focus on improving care coordination and ensuring continuity of coverage across transitions for the most medically and socially complex members in the behavioral health system, especially when it comes to culturally responsive providers.

Vision, Goals and Process:

Vision: **Oregon establishes an equity-centered system of health that ensures people have access to the services and supports they need (health care or otherwise) to achieve optimal health and well-being, especially through times of transition.**

An "**equity-centered system of health**" is a novel concept that builds off person-centered care[1] by recognizing that individuals cannot fully take charge of their own health and experience of care when the system plays a significant role in shaping the environment, including the choices or lack of choices presented to the person.

Striving towards an equity-centered system of health challenges our state to ensure that the system providing health services creates an environment where all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, age, social class, intersections among these communities or identities, or other socially determined circumstances.

Goals

- Enhance care coordination and non-clinical supports for members transitioning across systems to improve outcomes, including flexibility around eligibility and coverage.
- Remove barriers to accessing critical, culturally, and linguistically appropriate health services for OHP members.
- Prioritize groups of people who are currently experiencing inequities so that Oregon's Medicaid program achieves equity in its system of health.

Process and Potential Strategies to Achieve Goal

The steps below outline the process needed to achieve our goals. Identifying opportunities to extend Medicaid coverage, enroll members into a CCO, and ultimately connect them to needed services is at the heart of interrupting and reducing the cycles of behavioral health crises, homelessness, incarceration, and recidivism. Financial impacts could have a favorable multiplier effect not only for Medicaid, but for local law enforcement and corrections systems, county jails, state, and federal prison costs, etc.

Step 1. Identify the destabilizing transitions that could be most improved by temporary, enhanced care coordination and case management.

Public, partner and stakeholder engagement has indicated that the following transition periods are the most disruptive to members and potentially costly to the system. These transitions are particularly challenging due to the potential risks a member may face if they lose coverage or care while dealing with unmanaged chronic conditions, behavioral health challenges or social factors. Focusing on the transition itself allows for enhanced supports and services for members who may be undiagnosed and would otherwise slip through the cracks. OHA will work with partners to continue to refine this list of transitions faced by members

Situations that will have Coordinated Transition Supports:

- Transitioning in/out of the corrections system, including those at youth facilities
- Transitioning from acute care hospital stays while suffering from housing insecurity or who are homeless
- Transitioning in/out of residential psychiatric treatment facilities, including youth, with an eye to wrap around service and health related social needs that are critical for successful stabilization
- Transitioning in/out of foster care homes, including those who age out of foster care
- Transitioning into the postpartum period following birth (infant and family)
- Prevention of an imminent mental health crisis or recovery from a mental health crisis

Step 2. Define the Coordinated Transition Support package of services and supports for each of the identified transitions.

Waiver authority can allow for new structures in the Medicaid system that facilitate the elimination of health inequities with a large focus on “in lieu of services” (ILOS) utilizing alternative and community-based services that address members health-related social needs. Using ILOS helps increase funding to the community and remove billing barriers that traditionally alienate partners and CBOs, by encouraging streamlined access to services that most closely meet members’ needs.

OHA will work with CMS, partners and stakeholders to determine the specific supports and services to be included in the Coordinated Transition Supports for each key transition, including identifying the triggering event, eligibility and appropriate financial strategies. These packages are a mix of recommended medical and non-medical services and will include services such as:

- Health-related social needs (e.g., increasing wraparound services and supported housing services to ensure members are able to secure and maintain housing while addressing their core health and service needs.)

- Care coordination services (e.g., supporting warm handoffs across systems,supportives services preceding diagnosis/services earlier in the engagement process, pre-treatment)
- System navigation supports (e.g., housing navigation, childcare navigation)
- Extended coverage (e.g., 30 days of OHP coverage prior to release from state and federal Department of Corrections facilities in Oregon)
- Specific recommended medical services (e.g., dyadic therapy for foster care transitions)
- Specific recommended access to providers (e.g., peer-delivered services, community health workers)

Step 3. Improve the behavioral health system to better support members, especially at times of transition, and throughout the lifespan.

The Oregon Health Plan offers a healthy benefit package of behavioral health services; however, Oregon faces several challenges re behavioral health capacity, workforce and access. Capacity and workforce are being approached by working on investments of state dollars to strengthen those issues. Those investments will help access to services by making them more available and will focus on ensuring culturally responsive and linguistically appropriate providers are available to members. However, to fully achieve the level of access to services Oregon desires, key changes need to be made in the Medicaid system through waiver authority.

For kids, these changes focus on improving access to behavioral health care throughout the state by expanding or extending coverage, ensuring access to the appropriate level of care, and preventing multi-system involvement by removing stigma and normalizing access to holistic care.

For older adults this includes integrating better depression, suicidality and metabolic screening practices for adults with behavioral health conditions who are aging within the system, and often experiencing transitions of care unique to this population.

This includes opportunities to upgrade the behavioral health crisis system and to increase the use of peer-based services and community health works. This would also expand opportunities to utilize on culturally-specific practice-based treatments that are respectful of the population being served.

Step 4. Ensure that providers and partners in non-clinical settings have the infrastructure, training and support necessary to participate as a care partner for members.

In order to provide whole-person care, coordination and partnership with providers and partners in non-clinical settings will require an investments in infrastructure linking Medicaid with social service providers as well as limited non-clinical services. This links closely to opportunities presented by new “in lieu of services” strategies, and strengthening expectations for recommended social supports and behavioral health supports for members in ICC.

Step 5: Improve the screening processes to ensure that people who are engaged with multiple systems are identified for these enhanced coordination supports and get the care they need.

CCOs have matured and now have well-developed intensive case management/intensive care coordination (ICC) teams to respond to OHP member needs related to physical health, behavioral health and substance abuse/assessment/treatment, dental needs and NEMT for transport to Medicaid services and Health Related Services policies governing those non-reimbursable services or items that are linked to health outcomes. However, individuals that may have even greater needs for all of these benefits may well be "outside" of the reach of a CCO. All CCO benefits are predicated on OHP eligibility, enrollment and subsequent capitation and assignment to a CCO in their area of residence.

In order for the state to ensure care coordination (a core tenant of CCOs), it is necessary to expand the mechanisms that are utilized to screen for care coordination and ICC.

Policies and Strategies:

This concept paper describes how waiver authority can allow for new structures in the Medicaid system that facilitate the elimination of health inequities with a large focus on in lieu of services utilizing alternative/community-based services to facilitate transitions of care from institutional settings, such as jails, prisons, and IMDs, and better access to health related and SDOH services. To do this, Oregon will request waivers to traditional requirements associated with clinical-based criteria for qualification of services and payments. These will instead be supplemented by social determinant-based criteria, such as houselessness, and increased involvement in multiple systems or levels of care, which can trigger the use of intensive care coordination services that utilize community-based organizations, when critical to provide equity-based care instead of or in addition to medical-based organizations.

Proposed waiver strategies

Waive traditional requirements for the use of clinical-based criteria for some services and payments for the purposes of Coordinated Transition Supports

Oregon requests waivers to traditional requirements associated with clinical-based criteria for qualification of services and payments. This will allow Oregon to support members going through defined transitions to access the Coordinated Transition Supports listed above, to provide specific services and supports “in lieu of medical services” for health-related social needs that go beyond standard, reimbursable services.

What does this mean for OHP members?

OHP members who experience certain situations or transition in and out of different systems would see enhanced supports and coordination during that time of transition. Those supports would be pre-defined and would include both expanded medical supports, like access to traditional health works, as well as things that substantially support a person’s health outcomes but aren’t typically considered medical care (for example, removing barriers to obtaining or maintaining housing).

Maintain and initiate early Medicaid enrollment in for incarcerated individuals, as well as those in other institutional settings, and assessment for ICC

This strategy supports two different populations who face similar barriers and challenges.

Incarcerated individuals:
Allow OHP applications to be completed up to 30 days prior to the DOC's inmate release date and immediate CCO enrollment once eligibility is established.

A planful in reach and outreach process already exists between DOC medical staff and local probation and parole partners. However, there is no current possibility for care coordination and intensive case management of a DOC-releasing inmate with a Coordinated Care Organization in the area that the inmate is returning to because of the current systems delays inherent in Oregon's OHP Eligibility and CCO capitation steps.

This strategy also includes a sub-strategy specific to streamlining transitions and extending coverage for individuals who are charged with a crime and booked into local jails/corrections facilities prior to adjudication or who are completing sentences served in local jails or corrections facilities and released to the community.

Additionally, this would be mirrored for children, and would establish and/or maintain OHP/CCO coverage for youth involved in the juvenile system.

Institutionalized individuals:
The strategy would be to maintain eligibility for individuals enrolled in the Oregon State Hospital (OSH) for at least a portion of their stays (first 30 days after admission and/or at the point the person no longer needs OSH level of care), CCOs could be engaged longer and be fiscally responsible for coordination of transitions. In addition, this could relieve some general fund burden that OSH current exerts on the OHA budget.

There are also a disproportionate number of people of color that are admitted into OSH. CCOs may work harder to connect people in need of intensive care to community-based services and avoid escalation to the point of needing OSH services. This would reward the CCOs and more importantly avoid the use of restrictive levels of care such as OSH.

What does this mean for OHP members?

For members who transition in and out of corrections facilities or certain residential care facilities, this means OHP coverage would be maintained or extended, in some scenarios, to ensure access to care coordination during a portion of the time that a member is incarcerated or institutionalized to support a streamlined transition back to OHP coverage.

Extend OHP Eligibility to every child at the point of diagnosis of behavioral health needs

Early intervention in childhood behavioral health conditions has demonstrated the potential to decrease the lifetime impacts of mental health conditions and foster awareness, self-management/self-regulation and recovery. If otherwise disabling conditions are identified early in life, the supports necessary in school, community and family settings can be appropriately

provided. In addition, families benefit from inclusion in the assessment and treatment models as respected partners and the expert on their own child's needs.

For these purposes, this sub-strategy requested in Oregon's 1115 CMS Waiver focuses on the request to extend OHP Eligibility/CCO Enrollment to every child at the point of diagnosis of behavioral health needs. Eligibility of the child would not be dependent on the parent's current income or insurance status but be independent of those factors and allowed to remain in place as long as either the behavioral health need and/or the need for ongoing treatment exists and/or the youth is determined eligible as an adult (having aged out of the system).

What does this mean for OHP members?

OHP eligibility and CCO enrollment would assure that each youth with an identified behavioral health condition rapidly receives the appropriate evidence-based assessment and access to the appropriate treatment setting and Level of Care (LOC) indicated by their needs, even if their family's income would have otherwise made them ineligible for OHP.

Extend OHP eligibility from birth to 26 years of age to support the behavioral health Continuum of Care for children

Oregon has (as have other states) experienced challenges in meeting the needs of young adults with behavioral health needs as they transition from child services (at either age 18 or 21) to adult health services. Oregon's Continuum of Care for OHP Eligible/CCO enrolled children is a robust system that exceeds what is available for those youth with commercial insurance plans. This is also true of the transition from youth to adulthood with the most intensive and strongest evidence-based models available only until this transition. A common transition during these years are youth "aging out" of the child welfare and foster care system but not yet stable with self-management of their behavioral health condition or able to financially support their own needs and care.

This sub-strategy focuses on matching the current science on brain development and would provide developmentally appropriate services and supports to young adults between the ages of 18 and 26 years of age.

This would allow children and young adults to remain with the current continuum past their 18th birthday. It would support a reduction in unnecessary transitions between systems and providers. And, it would address significant gaps in our continuum that contribute to expensive system problems and incarceration. Allowing current children's services funded by Medicaid be billed birth to 26 would allow flexibility with CCOs and Oregon Administrative Rules to continue to provide the evidence-based services they have received up until that point in their life.

Many youth and young adults current "drop off" of services after leaving the children system and child serving agencies (child welfare, OYA etc). They do not come back to the BH because the adult system is so different and often does not address needs through the developmentally appropriate lens (I.e. young adult). Many of these children and young adults are from communities of color, LGBTQAI +, members of Oregon Tribes and have experienced homelessness, IDD or poverty.

Ultimately, maintaining OHP Eligibility/CCO Enrollment for this population would create or maintain stability for young adults and have far-reaching system impacts in terms of cost

savings and leverage partnerships at the community system level (law enforcement, incarceration, education, housing, etc).

What does this mean for OHP members?

Young adults with behavioral health needs could continue to receive OHP coverage to support care coordination and services as they transition to adulthood.

Establish an enhanced match rate to support development and upgrade of a unified, statewide behavioral health crisis system

In response to federal requirements that states stand up 988, Oregon must develop a robust crisis system, including a call center. To do so will require information technology to develop and operate the call center service, and it will need to be coordinated with other elements of this concept paper, such as Coordinated Transition Supports.

This has the potential to reduce health disparities and health inequities by developing a new access point for historically underserved people in Oregon and to develop an alternative for people who are unwilling to call 911 because they do not want police involvement. This has the potential to be transformative for underserved communities and communities of color.

988 and a robust crisis system can be the front door for people experiencing any mental health or substance use crisis. It could match people to immediate and appropriate care and divert them from the emergency department and the criminal justice system.

What does this mean for OHP members?

While this strategy doesn't directly impact OHP members, if an enhanced match rate is achieved, there is a potential for increased investment and an urgency to establish a statewide mobile crisis system.

Use of Peer-based services and Community Health Workers

Allow recovery peers to be paid for providing services outside of a traditional treatment plan (i.e., pre- and post -reatment) or alternatively utilize in lieu of services to again allow for services outside of typical medical model that address social needs of individuals, as described in crisis strategy and further describe later around housing supports. This strategy may be folded into the Coordinated Transitions Supports strategy.

This would create more equitable access to services and supports by expanding peer access utilizing community-based services that could encourage people to access medical services if needed or avoid them if alternatives are more viable and helpful. People with substance use and mental health disorders are disproportionately impacted by lack of access to health care, in addition to barriers to behavioral health care.

What does this mean for OHP members?

This strategy provides additional ways of engaging people into care and offers increased support during early recovery that can lead to better outcomes.

Reserved capacity for children in Child Welfare

Children in child welfare custody in Oregon have challenges accessing the right care, at the right time for the right duration - specifically as it relates to Psychiatric Residential Treatment Services (PRTS). This strategy would support reserved capacity for children in the custody of Child Welfare for this level of care.

It would allow a percent of the capacity for PRTS to be accessed by children in Child Welfare that meet medical necessity by providing a reserved capacity payment through Medicaid to "hold the bed" for a specific population in the custody of the state.

Children in child welfare are disproportionately from communities of color and from families that are experiencing substance use disorder and impacted by poverty.

What does this mean for OHP members?

This would allow child welfare and children in the care of the state to begin to get access to the right services, the right time, the right duration, especially as it relates to children who need PRTS.

Tribal-specific strategies

OHA is committed to working with the Nine Federally Recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure Tribal health care objectives are achieved while respectfully honoring tribal traditional based practices and upholding the government to government relationship between the sovereign nations and the state. In meetings to date, tribes have identified a number of priorities for consideration within the waiver, including:

- Including definitions and additional coverage for tribal-specific practices
- Reducing administrative burden around billing and reimbursement
- Continuing existing programs that work well