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The Oregon Health Authority has proposed four key areas in which the 2022-2027 1115 Medicaid Waiver can create a more equitable health care system. Throughout this last year and a half of COVID-19 response, it has become clear that Oregon’s health care system includes many entities – including Local Public Health Authorities and Community-Based Organizations – and that coordination and alignment of strategies across this system is essential for improving health equity. This letter contains feedback and recommendations on the draft Policy Concept Papers 6.1-6.4 for the upcoming Medicaid Waiver from the Oregon Coalition of Local Health Officials Board (composed of all 32 local public health authorities in Oregon).

The theme and central request of this letter is for Oregon’s Coordination Care Organizations and the Oregon Health Authority to partner with LPHAs and CBOs when these organizations have existing relationships, programs, or knowledge within their communities. Collaborating and aligning strategies is essential to eliminating health disparities, and the COVID-19 response has only highlighted this need for coordination across the entire health system. Please consider the following recommendations for involving and partnering with LPHAs and CBOs as planning for the upcoming 1115 Medicaid Waiver continues.

**6.1 Coverage and Eligibility**

The vision of an Oregon with a low uninsured rate with no racial or ethnic inequities in coverage coincides with the functions and values of public health. Oregon’s LPHAs have long supported efforts to ensure all Oregonians have access to the full range of primary care services beyond emergency and maternity care. Several LPHAs in Oregon operate FQHCs, Rural Health Clinics and/or SBHCs, and all LPHAs provide essential reproductive care, maternal and child health care and support, immunizations, and STI testing and treatment to all people in Oregon regardless of medical coverage. In addition, LPHAs serve to ensure access to services for those Oregonians who might have significant barriers to accessing health care, such as people who are undocumented and/or uninsured.

*DRAFT potential Recommendations*

* **Recognize and support the role of LPHAs in providing preventative health services.** Expanding CAWEM through Cover All People is a starting point, but this strategy only provides emergency and maternal care. LPHAs will continue offering important preventative services, where needed, to people who are not able to access it elsewhere. CCOs and LPHAs should partner in this to provide a seamless referral process for people who will be served in both systems.
* **Partner with LPHAs to conduct outreach.** LPHAs are established organizations within their communities and have built relationships with health care providers, community members, and community-based organizations. CCOs should consult and partner with LPHAs to increase engagement and outreach in OHP enrollment, particularly in situations where a CCO covers multiple counties and may need to enlist different strategies for each one.
* **Remove barriers to enrolling in OHP.** One strategy listed is to allow for self-attestation of income when applying for OHP. CLHO is in support of this change as it will remove significant barriers to people who need timely health care.

**6.2 Equity-Centered System of Health**

Creating an equity-centered system of health and eliminating health disparities is the central mission of public health. Oregon’s LPHAs have been creating and managing programs in partnership with communities to remove barriers to health equity and to give all people in Oregon the opportunity to lead healthy lives. This alignment between LPHA and CCO goals for ensuring all people have access to the services and supports they need demonstrates the necessity of partnership and collaboration to enhance services and to reduce duplication.

*DRAFT potential Recommendations*

* **Uphold and avoid duplication of existing LPHA programs that support Oregonians during transition periods.** The key strategies listed for creating an equity-centered system of health are to identify destabilizing transitions and in order to provide support and care coordination. Oregon’s LPHAs already provide support in some of these transitions, such as nurse home-visiting programs postpartum and throughout a child’s first two years of life (CaCoon, Nurse Family Partnership, Babies First!, Family Connects, etc.). CCOs should partner with LPHAs to avoid parallel and duplicative efforts that can confuse participants in these programs.
* **Include LPHA services and programs in the Coordinated Transition Support package.** LPHAs offer many programs, such as WIC, nurse home-visiting, family planning, STI testing and treatment, and harm reduction programs that should be included in this package.
* **Partner with LPHAs to identify additional gaps in services.** LPHAs have been serving their communities for many years and have established relationships with community members, clinics, and community-based organizations. With this service and these relationships, LPHAs can provide a wealth of information on where there are gaps. For example, LPHAs have long provided support and services to their communities during emergency situations (wildfires, extreme weather events, etc.), and the COVID-19 pandemic created further opportunities for LPHAs to have contact with people during transition periods, such as release from correctional facilities. CCOs should consult and partner with LPHA in any community/gap assessments to gain valuable information from a knowledgeable and involved local organization.

**6.3 Future of CCO Global Budgets**

Upstream public health interventions seek to change the social determinants of health that create health disparities and keep people from opportunities for a healthy life. This is in line with the vision of providing CCOs with financial flexibility to address health inequities and invest in community health. This is another opportunity for CCOs to partner with LPHAs, CBOs, and other community partners to strengthen the work these organizations are already doing in their communities and to avoid duplication.

*Draft potential Recommendations*

* **Partner with LPHAs and community partners on identifying and investing in upstream solutions to health inequities.** Public health regularly works to identify and address upstream drivers of health, and many LPHAs and other partners have excellent ideas and proposals to address while lacking the funding to implement these solutions. CCOs should consult and partner with LPHAs and CBOs to explore solutions and find ways to braid funding streams together to implement these solutions.
* **Align CCO and Public Health “upstream metrics” to measure progress towards equity.** The entire health system must be aligned on definitions and measurements of equity if Oregon is to make meaningful progress on eliminating health disparities. This new five-year plan, combined with the Oregon Public Health Advisory Board’s revisiting of Public Health Modernization metrics, is an opportunity to establish and align efforts.
* **Work in partnership with LPHAs and CBOs to enhance community voice.** Many LPHAs already conduct significant community outreach for many of their programs and advisory councils. CCOs should partner in these efforts so community outreach is coordinated across the health system.

**6.4 Reinvesting Savings in Communities**

Oregon’s Public Health System has been working to center equity and eliminate health disparities in all aspects of public health work; however, a common barrier for implementing/expanding this work to the extent desired is availability of funding. Given the proposal for CCOs to take Oregon-generated federal savings and reinvest it into communities to reduce health inequities, this is another area in which CCO should partner with LPHAs and CBOs already doing this work within their communities.

*Draft potential Recommendations*

* **Include the public health system in the broader, statewide initiatives**. One example provided of a state-level effort is to diversify and geographically distribute the health care workforce. The public health workforce should be included in these efforts since this aligns with Public Health Modernization and since public health serves a diverse population and struggles to maintain a workforce in many rural settings.
* **Work closely with LPHAs in determining “health equity zones**.” Determining these zones will be a multi-step process, beginning with consulting with Regional Health Equity Coalitions to create a public engagement process, implementing that engagement strategy with communities, and creating the health equity zones based on the engagement process. LPHAs must be involved in each step of this process. They have essential knowledge of their communities, regions, and existing partnerships that can facilitate these health equity zones and avoid the pitfalls of establishing zones that do not work for the communities within those zones.
  + The voice of LPHAs is present but limited on the RHECs. OHA should incorporate methods for expanded LPHA participation (including different sized LPHAs and in various regions of the state) in this beginning stage.
* **Ensure LPHAs are involved in designing the health equity zones’ priorities.** One suggestion was for communities to use their Community Health Assessments and/or Community Health Improvement Plans to determine the priorities for their zones. LPHAs often lead these assessments and the creation of these plans along with community partners and use them as a basis for their work within their communities. This is a clear opportunity for the priorities and goals of these health equity zones and the work of LPHAs and community partners to align.