12/17/21 Oral Public Comment

My name is Colleen Reuland and I am the Director of the Oregon Pediatric Improvement Partnership.

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, in particular, 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.