

January 7, 2022

Health Policy and Analytics Medicaid Waiver Renewal Team
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Salem, OR 97301

Submitted electronically via Oregon.gov/1115WaiverRenewal

RE: Oregon Section 1115 Oregon Health Plan (OHP) Draft Waiver Application for Renewal and Amendment

Dear Director Allen and Director Vandehey,

As the statewide advocacy and political voice for Planned Parenthood's two Oregon affiliates (Planned Parenthood Columbia Willamette and Planned Parenthood of Southwestern Oregon), Planned Parenthood Advocates of Oregon (PPAO) submits these comments regarding Oregon Health Authority's (OHA) draft waiver extension and amendment application for the Oregon Health Plan (OHP) demonstration program. In its draft application, Oregon is seeking to implement several changes to the program, with the main overarching goal of advancing health equity. These changes include implementing 24-months continuous eligibility for OHP enrollees age 6 and older, providing transitional social determinants of health (SDOH) services to vulnerable populations, and implementing a closed prescription drug formulary and excluding certain drugs, among others. As a trusted sexual and reproductive health (SRH) care provider, educator and advocate, we appreciate the opportunity to provide input on this draft application.

Planned Parenthood is a safety net provider for the populations in Oregon most in need of health services. Planned Parenthood operates 11 health centers across the state of Oregon and serves as a leading health care provider, educator and advocate of high-quality, affordable health care for women, men, non-binary individuals, and young people. Our health centers range in size and location from small rural clinic practices to larger metropolitan clinics. Every year, our health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for STIs, abortion, and other essential care to more than 60,000 patients annually. Approximately 50% of Planned Parenthood's patients use Medicaid coverage or other state-funded programs to access affordable, preventive care and are therefore likely to be affected by Oregon's draft application.

Medicaid is a vital part of the health care system and plays a major role in ensuring access to essential primary and preventive care services. Medicaid is critical to improving the health and well-being of individuals and families with low incomes across Oregon and the rest of the nation. In particular, Medicaid is a crucial program for people of reproductive age, enabling them to access necessary SRH and maternal health services. Approximately 1 in 5 women of reproductive age use Medicaid,¹ and

¹ Adam Sonfield, "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health," Guttmacher Institute (Mar. 9, 2017), available at <https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health#>.

roughly two-thirds of adult women enrolled in Medicaid are in their reproductive years.² For nearly half of women giving birth, Medicaid is the source of coverage for essential care, including prenatal and delivery care; recent data found that in 25 states 40 percent or more of births are covered by Medicaid.³ Finally, the program is the largest payer of reproductive health care coverage in the country,⁴ paying for 75 percent of publicly-funded family planning services.⁵

Because women make up the majority of Medicaid enrollees, they will be disproportionately affected by Oregon's draft application. In particular, Medicaid coverage of family planning services and supplies helps individual's health, lives, educational success, and economic empowerment. Moreover, due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population and will be further impacted by the draft application; 31 percent of Black women and 27 percent of Hispanic women are enrolled in Medicaid, compared to only 16 percent of white women.⁶

Due to Medicaid's outsized role for people of color, Medicaid is essential in narrowing health disparities and improving access to care for their communities. Indeed, research shows that Medicaid expansion has contributed to such reductions in racial disparities in health coverage, in particular for Black and Hispanic individuals.⁷ In addition, Medicaid expansion is associated with decreased disparities in some health outcomes for communities of color, including in infant and maternal health.⁸

As the political and advocacy voice for Oregon's two Planned Parenthood affiliates and for SRH, PPAO takes every opportunity to comment on Medicaid program features that increase or decrease access to care and impact people with Medicaid. Accordingly, our comments will address the following proposals:

- 24-months continuous eligibility for enrollees ages 6+;
- investing in social determinants of health (SDOH) transition services for vulnerable populations;
- the continued waiver of retroactive coverage; and
- implementing a closed formulary for adult OHP enrollees and excluding drugs with limited or inadequate evidence of clinical efficacy.

² "Medicaid's Role for Women," Kaiser Family Foundation (Mar. 28, 2019), available at <https://www.kff.org/medicaid/fact-sheet/medicaids-role-for-women/>.

³ In Oregon, Medicaid covers 43 percent of births, see Births Financed by Medicaid, Kaiser Family Foundation, available at <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁴ Usha Ranji, "Medicaid and Family Planning: Background and Implications of the ACA," Kaiser Family Foundation (Feb. 3, 2016), available at <https://www.kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/>.

⁵ Adam Sonfield et al., "Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980-2006," Occasional Report, New York: Guttmacher Institute, No. 38. (Jan. 2008), available at <https://www.guttmacher.org/sites/default/files/pdfs/pubs/2008/01/28/or38.pdf>.

⁶ *Supra* note 1, "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health."

⁷ Madeline Guth, et al., "Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care," Kaiser Family Foundation (Sep. 30, 2020), available at <https://www.kff.org/report-section/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care-issue-brief/>.

⁸ *Id.*

PPAO applauds OHA's commitment to advancing health equity through many of the requested changes in the draft waiver application. However, the policies around retroactive coverage and prescription drugs do not achieve the draft waiver's goal of advancing health equity. Therefore, PPAO urges OHA to remove these program features and proceed forward with the draft waiver application without them.

I. Twenty-four months continuous eligibility is an important program feature that increases access to care and can improve health outcomes for people with Medicaid, and OHA should proceed forward with this program feature.

Continuous eligibility is vital to ensuring that Medicaid coverage, such as OHP coverage, is stable, continuous, and accessible for eligible individuals. Continuous eligibility keeps people enrolled in Medicaid for at least 12 months regardless of changes in their income. This policy has been shown time and again to reduce the likelihood that Medicaid enrollees will lose their affordable health insurance coverage due to small fluctuations in income or burdensome administrative requirements.⁹ For example, a variety of Montana stakeholders, including health care providers and the state's Medicaid agency, have noted the benefits of this feature, which include: (1) stabilizing coverage, especially for seasonal workers; (2) improving continuity of care, particularly for preventive care services; and (3) saving on Medicaid administrative costs.¹⁰

Continuous eligibility is particularly important in ensuring access to essential SRH services for at least 12 months. Crucially, time is of the essence when accessing critical SRH services. Being unable to access SRH care can result in not only missed appointments, but also unintended pregnancies, undiagnosed STIs, and life-threatening cancers. People who utilize birth control and regular STI testing, including parents, cannot afford to be without Medicaid temporarily even for a few days time, let alone being without it for a month or longer; such a disruption in coverage could have enormous consequences on an individual's present and future health and lives, including educational and work commitments.

Moreover, continuous eligibility ensures that individuals who may experience income fluctuations or are unable to keep up with burdensome paperwork requirements, are also able to stay current on their medications and other health needs. A study by the Government Accountability Office (GAO) reinforces this positive effect, finding that enrollees covered by Medicaid for a full year reported fewer difficulties in obtaining necessary medical care and prescription medicine compared to those who were covered between one and eleven months.¹¹

In addition to comprehensive SRH services, PPAO underscores that the continuous eligibility feature is particularly important for people who currently qualify for OHA's pregnancy eligibility group and have recently given birth. As Oregon has not adopted the American Rescue Plan's state option to extend Medicaid postpartum coverage to a full year after delivery, continuous eligibility ensures continuity of

⁹ Jennifer Wagner and Judith Solomon, "Continuous Eligibility Keeps People Insured and Reduces Costs," Center on Budget and Policy Priorities (May 4, 2021), available at <https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-costs>.

¹⁰ "Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report," Social & Scientific Systems: Prepared for CMS (Jul. 22, 2019), available at <https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf>.

¹¹ "Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance," Government Accountability Office (Nov. 2012), available at <https://www.gao.gov/assets/gao-13-55.pdf>.

care during the critical postpartum period for OHA women and birthing people. Based on Centers for Disease Control and Prevention (CDC) data, up to 33 percent of pregnancy-related deaths occur between one week to one full year after childbirth.¹² Indeed, the Oregon Maternal Mortality and Morbidity Review Committee (OMMMRC) found several factors contributing to maternal deaths in the state, including: (1) inadequate access and missed opportunities to health care and medical services; (2) inadequate access to wrap-around services; (3) inadequate resources and missed screening opportunities for mental health and substance use disorder (SUD); (4) possible implicit biases toward homelessness, tobacco/drug abuse, mental illness, low income, alcohol abuse, etc.; (5) histories of intimate partner violence (IPV); and (6) untreated childhood physical and emotional trauma.¹³

Given the ongoing maternal health crisis, it is necessary that comprehensive Medicaid coverage enable individuals to seek diagnosis, treatment, and monitoring for chronic health conditions, especially in the postpartum period, when individuals are at elevated risk for experiencing pregnancy-related complications that could lead to death.¹⁴ Providing 24 months of continuous eligibility for these individuals means they would be able to continue accessing care from the same health care professionals that have served them throughout their pregnancies and who have the best sense of their health needs and risks. This would have the biggest positive impact on populations most impacted by maternal death in Oregon, including Black and Hispanic women.¹⁵

Finally, PPAO agrees with OHA that the continuous eligibility feature will be especially important after the public health emergency (PHE) ends in the United States. Nationally, enrollment in the Medicaid program increased by 16.2% from February 2020 to May 2021, and this increase is reflected in every state.¹⁶ As OHA notes in the draft application, implementing continuous eligibility is an effective method to preserve the coverage continuity gains that were achieved during the pandemic through the continuous coverage requirement in the Families First Coronavirus Response Act (FFCRA).¹⁷ Maintaining this continuity of coverage is crucial to prevent eligible OHP enrollees from losing coverage after the PHE ends.

Given the importance of 24 months of continuous eligibility in increasing access to timely SRH and maternal health services, in particular for people of reproductive age and women of color, PPAO supports this program change and urges OHA to proceed forward with it in their application to CMS.

¹² “Vital Signs: Pregnancy-related deaths,” CDC (May 7, 2019), available at <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>.

¹³ “Oregon Maternal Mortality and Morbidity Review Committee Biennial Report,” OHA (Jan. 1, 2021), available at https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/SiteAssets/Pages/Maternal-Mortality-Morbidity-Review-Committee/2020_MMRC%20First%20Biennial%20Report%20FINAL%204.1.21.pdf.

¹⁴ “Extend Postpartum Medicaid Coverage,” The American College of Obstetricians and Gynecologists, available at <https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage>.

¹⁵ *Supra* note 11, “Oregon Maternal Mortality and Morbidity Review Committee Biennial Report.”

¹⁶ Bradley Corallo and Avirut Mehta, “Analysis of Recent National Trends in Medicaid and CHIP Enrollment,” Kaiser Family Foundation (Oct. 29, 2021), available at <https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>.

¹⁷ FFCRA, § 6008(b)(3).

II. Investing in SDOH transition services for vulnerable populations will improve health outcomes, and OHA should proceed forward with these program features.

The social determinants of health, defined by the World Health Organization (WHO) as the “conditions in which people are born, grow, live, work, and age, and the wider set of forces and systems shaping the conditions of daily life” have become a frequently discussed concept in the areas of health and social services.¹⁸ Accounting for up to 90 percent of a person’s health status, SDOH are far-reaching, and include factors such as safe and affordable housing, access to education, public safety, the availability of healthy foods, local emergency/health services, and environments free of harmful toxins.¹⁹ PPAO emphasizes that while sometimes SDOH are discussed, researched, and pursued independently from racism, discrimination, and inequality, they are, in fact, intertwined. Indeed, SDOH are mostly responsible for health inequities and they are “shaped by the distribution of money, power and resources at global, national and local levels.”²⁰

PPAO supports OHA’s initiative to provide housing, health-related transportation, and food assistance, among other SDOH transition services, to vulnerable populations and urges OHA to proceed forward with these program features.

- A. Housing access is vital to improving health outcomes, in particular for women of reproductive age and people of color and therefore, OHA should proceed forward with providing transitional housing services, including rental assistance or temporary housing.*

Among SDOH, significant research and data show that homelessness and housing instability (frequently moving, falling behind on rent, facing eviction) are detrimental to one’s health. The health impacts of homelessness and housing instability are myriad:

- People who are chronically homeless face substantially higher morbidity in both physical and mental health,²¹ as well as increased mortality.²²
- Unstable housing situations can cause individuals to experience increased hospital visits, lead to loss of employment and employer-provided health insurance benefits, dramatically increase the risk of an acute episode of a behavioral health condition, including relapse of addiction in adults, and are associated with increased likelihood of mental health problems in children.²³

¹⁸ “Social determinants of health,” World Health Organization, available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

¹⁹ “Social Determinants of Health,” Healthy People 2030, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, available at <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.

²⁰ *Id.* at “Social Determinants of Health,” World Health Organization.

²¹ David L. Maness and Muneeza Khan, “Care of the Homeless: An Overview,” *Am Fam Physician* (Apr. 2014), available at <https://www.aafp.org/afp/2014/0415/p634.html>.

²² Colette L Auerswald, et al., “Six-year mortality in a street-recruited cohort of homeless youth in San Francisco, California,” *PeerJ* (Apr. 14, 2016), available at <https://peerj.com/articles/1909/>.

²³ See Will Fischer, “Research Shows Housing Vouchers Reduce Hardship and Provide Platform for Long-Term Gains Among Children,” Center on Budget and Policy Priorities (Oct. 7, 2015), available at <https://www.cbpp.org/research/research-shows-housing-vouchers-reduce-hardship-and-provide-platform-for-longterm-gains>; see also Linda Giannarelli et al., “Reducing Child Poverty in the US: Costs and Impacts of Policies Proposed by the Children’s Defense Fund,” Urban Institute (Jan. 2015), available at <https://www.urban.org/sites/default/files/publication/39141/2000086-Reducing-Child-Poverty-in-the-US.pdf>.

- When systemic barriers force people with low incomes to spend too much of their income on their rent, they cannot afford to pay for health care. In fact, many renters delay needed medical care because they are unable to afford it.²⁴
- People who are evicted from their homes, or even threatened with eviction, are more likely to experience health problems such as depression, anxiety, and high blood pressure than people with stable housing.²⁵ This exacerbates the heightened risk women, particularly women of color, have for experiencing depression,²⁶ anxiety,²⁷ and high blood pressure.²⁸

Crucially, stable housing has consistently been shown to lead to improved health outcomes, particularly among individuals who have past experiences with housing insecurity. These improved health outcomes include reduced psychological distress, intimate partner violence (IPV), behavior issues, and sleep problems.²⁹

It is also important to note that access to stable housing is vital for women and the LGBTQ+ communities. That is because women and the LGBTQ+ community are more likely to face economic insecurity at all stages of their lives, due to ongoing employment discrimination, overrepresentation in low-wage jobs, difficulty accessing affordable and comprehensive health care, and greater responsibilities for unpaid caregiving. As a result, housing assistance is vital for these individuals and their families.

Indeed, data show how critical housing is for people of reproductive age in obtaining needed SRH services. The Kaiser Family Foundation conducted a study evaluating access to reproductive health care

²⁴ “Renters Report Housing Costs Significantly Impact Their Health Care,” Enterprise (Apr. 3, 2019), available at https://www.enterprisecommunity.org/news-and-events/news-releases/2019-04_renters-report-housing-costs-significantly-impact-their-health-care; see also Munira Z. Gunja et al., “How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care,” Commonwealth Fund (Aug. 10, 2017), available at <https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and> (noting that even though health insurance coverage gains through the Affordable Care Act have reduced the share of women skipping or delaying care because of costs, in 2016, 38 percent of women age 19 through 64 still reported not getting the health care they needed because of costs).

²⁵ Alison Bovell & Megan Sandel, “The Hidden Health Crisis of Eviction,” Children’s Health Watch Blog (Oct. 5, 2018), available at <http://childrenshealthwatch.org/the-hidden-health-crisis-of-eviction/>.

²⁶ Paul R. Albert, “Why is depression more prevalent in women?,” 40 J. Psychiatry Neurosci. 219-221 (Jul. 2015), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4478054/> (noting the higher prevalence of major depression in women than in men); National Institutes of Health, Office of Research on Women’s Health, “Women of Color Health Data Book” p. 147 (Oct. 2014), available at <https://orwh.od.nih.gov/sites/orwh/files/docs/WoC-Databook-FINAL.pdf> (more women seek treatment for depression than men, though white, non-Hispanic women are more likely to receive treatment for depression than Latinx and Black women).

²⁷ “Anxiety Disorders,” Office on Women’s Health (last updated Jan. 30, 2019), available at <https://www.womenshealth.gov/mental-health/mental-health-conditions/anxiety-disorders> (reporting that women are twice as likely as men to get an anxiety disorder in their lifetime and noting that more American Indian/Alaskan Native women have generalized anxiety disorder than women of other races and ethnicities).

²⁸ *Id.* at “Women of Color Health Data Book” p. 121 (noting that Black women experience high blood pressure at a higher rate than Latinx or white, non-Hispanic women).

²⁹ “Follow-Up Family Options Study: Long-Term Housing Subsidies are Most Effective Intervention for Homeless Families,” National Low-Income Housing Coalition (Oct. 31, 2016), available at <http://nlihc.org/resource/follow-family-options-study-long-term-housing-subsidies-are-most-effective-intervention> (finding long-term subsidies had a range of positive impacts on adult and child well-being).

for women with low incomes in five communities across the United States and found that in each of the communities, a shortage of affordable housing (among other SDOH) resulted in women prioritizing food and shelter above preventive health care and family planning.³⁰ Planned Parenthood also conducted a survey assessing the SDOH-related needs of women of reproductive age and found the following:

- Women living at or below 300 percent of the federal poverty level (FPL) have high and varying SDOH-related needs, including access to stable housing.³¹ In fact, more than two-thirds of women say it is very or somewhat hard to pay for basics, such as housing.³²
- While the types of social needs varied, housing/having a steady place to live and support with utilities (such as heating and electricity) were among the most commonly reported.³³
- Black, Asian/Pacific Islander, and Hispanic women of reproductive age are more likely to report needing SDOH-related support, with Black women reporting the highest need for support in almost all areas.³⁴

Finally, as evidenced by the data from Planned Parenthood's study, people of color are disproportionately affected by homelessness and housing insecurity, and addressing this SDOH is critical for these groups. In Multnomah County alone, Black people face a greater risk of homelessness, making up 16.1% of the homeless population—more than double their share of the general population in the county, which is 7.2%.³⁵

Given the importance of housing as an SDOH that is integral to one's health and wellbeing, PPAO urges OHA to move forward with providing transitional housing services, including rental assistance or temporary housing.

- B. Transportation is necessary to enable individuals to get to and from their appointments and will increase access to SRH care, and therefore, OHA should proceed forward with providing health-related transportation for eligible OHP enrollees.*

Transportation, including non-emergency medical transportation (NEMT), is essential for many individuals enrolled in the Medicaid program and increases access to care. In FY2018 alone, there were over 60 million NEMT ride-days (days in which a Medicaid enrollee had at least one NEMT ride).³⁶

³⁰ Usha Ranji, et al., "Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities," Kaiser Family Foundation (Nov. 14, 2019), available at <https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/>.

³¹ "What about Her? — Assessing Social Determinants of Health Among Women of Reproductive Age," Planned Parenthood Federation of America (2020), available at https://www.plannedparenthood.org/uploads/filer_public/33/97/33976d5a-f402-4b14-ab68-671aa58a0f00/210115-hcip-sdoh-what-about-her-update-v2.pdf.

³² *Id.*

³³ *Id.*

³⁴ *Id.* (finding that Black women of reproductive age report the highest need for SDOH support in all surveyed areas except for intimate partner violence, where non-Hispanic white women report the highest rate of need for support).

³⁵ Latisha Jensen, "Black Residents of Multnomah County Face a Greater Risk of Homelessness," Willamette Week (Jan. 6, 2021), available at <https://www.wweek.com/news/2021/01/06/black-residents-of-multnomah-county-face-a-greater-risk-of-homelessness/>.

³⁶ "Mandated Report on Non-Emergency Medical Transportation," MACPAC (Jun. 2021), available at <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-5-Mandated-Report-on-Non-Emergency-Medical-Transportation.pdf>.

It is vital to note that many families with low incomes have lower vehicle ownership rates and less access to reliable transportation.³⁷ In addition, transportation barriers are often cited as barriers to accessing care, leading to rescheduled or missed appointments, delayed care, and missed or delayed medication use.³⁸ Notably, data from Iowa indicates that women, people of color, and younger people are significantly more likely to report a transportation barrier.³⁹

In particular, transportation barriers can affect people's access to health care services. These barriers may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes. Many individuals with low incomes do not have access to affordable transportation to get to and from medical appointments. For them, transportation issues can be a major barrier to needed health care, including receiving necessary postpartum contraception, pregnancy tests, Pap smears, and tests for sexually transmitted infections.

As transportation access has outsized importance in increasing access to timely SRH care, PPAO urges OHA to move forward with providing health-related transportation services in addition to the already provided NEMT services.

- C. Access to healthy and nutritious foods is another important SDOH to improve health outcomes and therefore, OHA should proceed forward with providing food assistance services, including links to the Supplemental Nutrition Assistance Program (SNAP).*

Importantly, extensive research has found that food insecurity is associated with poorer health outcomes.⁴⁰ Adults who experience food insecurity are also more likely to report lower health status overall than those with high food security.⁴¹ This includes: (1) women of color, who already have less access to healthy food,⁴² safe housing, and basic health care due to the intersections of structural

³⁷ Mobility Challenges for Households in Poverty, FHWA (2014), available at <https://nhts.ornl.gov/briefs/PovertyBrief.pdf>; Wolfe, M.K., McDonald, N.C., and Holmes, G.M., "Transportation Barriers to Health Care in the United States: Findings from the National Health Interview Survey, 1997-2017," Am. J. Public Health (Jun. 2020), available at <https://pubmed.ncbi.nlm.nih.gov/32298170/> (finding that Hispanic people, those living below the poverty threshold, Medicaid recipients, and people with a functional limitation had greater odds of reporting a transportation barrier after controlling for other sociodemographic and health characteristics).

³⁸ Samina T. Syed, et al., Traveling Towards Disease: Transportation Barriers to Health Care Access, J Community Health (Dec. 13, 2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/pdf/nihms646723.pdf>.

³⁹ Suzanne Bentler et al., "Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan," University of Iowa Public Policy Center (Mar. 1, 2016), available at https://ppc.uiowa.edu/sites/default/files/nemt_report.pdf.

⁴⁰ Craig Gundersen and James P. Ziliak, "Food Insecurity and Health Outcomes," Health Affairs (Nov. 2015), available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0645>.

⁴¹ Christian A. Gregory and Alisha Coleman-Jenson, "Food Insecurity, Chronic Disease, and Health Among Working-Age Adults," United States Department of Agriculture (July 2017), <https://www.ers.usda.gov/webdocs/publications/84467/err-235.pdf?v=4606.4>.

⁴² Treuhaft, Sarah & Karpyn, Allison, "The Grocery Gap: Who Has Access to Healthy Food and Why It Matters," PolicyLink & The Food Trust (2010), available at http://thefoodtrust.org/uploads/media_items/grocerygap.original.pdf.

racism, inequality, sexism, classism, xenophobia, and other systemic barriers; and (2) LGBT people, who are more likely than non-LGBT people to experience food insecurity.⁴³

Research shows that SNAP reduces poverty and food insecurity, and that over the long-term, these impacts lead to improved health and economic outcomes, especially for those who receive SNAP as children.⁴⁴ SNAP plays a critical role in addressing hunger and food insecurity in the communities of people of color⁴⁵ and the LGBTQ+ community.⁴⁶

Access to healthy and nutritious food is an essential SDOH and as such, PPAO urges OHA to move forward with its initiative to provide food assistance services, including linkages to SNAP, to vulnerable populations in need.

III. Retroactive coverage increases access to timely SRH care, and PPAO urges OHA to reinstate this program feature for all OHP enrollees.

As OHA is aware, federal law and policy requires states to pay for covered services provided to individuals during the three month period prior to the date of applying for Medicaid coverage, provided that the individual would have been eligible during that period.⁴⁷ This provision helps safeguard enrollees' continuous access to care when there are delays in determining eligibility. PPAO underscores that retroactive coverage has been a requirement of the Medicaid program since 1972; waivers of retroactive coverage are a departure from this long-standing requirement.

Retroactive coverage is critical to reducing individuals' medical debt, as well as financial strain on the health care system that stems from uncompensated care. When individuals have coverage, they are more likely to be able to receive the care they need in a timely manner, which enables the health care system to treat conditions before they become more serious and more costly. PPAO also underscores the importance of retroactive coverage during the COVID-19 pandemic, which has seen enormous increases in Medicaid enrollment⁴⁸ due to the ongoing employment and income fluctuations many individuals are experiencing.⁴⁹ Ensuring access to timely care for all Medicaid enrollees is more important than it has ever been.

⁴³ Brown, Taylor N.T., et al., "Food Insecurity and SNAP Participation in the LGBT Community," The Williams Institute (Jul. 2016), available at <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-and-SNAP-Participation-in-the-LGBT-Community.pdf>.

⁴⁴ "Chart Book: SNAP Helps Struggling Families Put Food on the Table," Center on Budget and Policy Priorities (Nov. 7, 2019), <https://www.cbpp.org/research/food-assistance/chart-book-snap-helps-struggling-families-put-food-on-the-table>.

⁴⁵ "SNAP Helps Millions of African Americans," Center on Budget and Policy Priorities (Feb. 26, 2018), available at <https://www.cbpp.org/research/food-assistance/snap-helps-millions-of-african-americans>; "SNAP Helps Millions of Latinos," Center on Budget and Policy Priorities (Feb. 26, 2018), available at <https://www.cbpp.org/research/food-assistance/snap-helps-millions-of-latinos>.

⁴⁶ Rooney, Caitlin, et al., "Protecting Basic Living Standards for LGBTQ People," Center for American Progress (Aug. 2018), available at <https://cdn.americanprogress.org/content/uploads/2018/08/10095627/LGBT-BenefitCuts-report.pdf>.

⁴⁷ 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914.

⁴⁸ *Supra* note 16, "Analysis of Recent National Trends in Medicaid and CHIP Enrollment."

⁴⁹ Paul Shafer, et al., "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible for Coronavirus Treatment Costs," Health Affairs (May 8, 2020), available at <https://www.healthaffairs.org/doi/10.1377/hblog20200506.111318/full/>.

Timely access to care is particularly relevant in the context of family planning care, as only a few days without contraception can result in an unintended pregnancy. Moreover, STIs that go untested and untreated can spread throughout communities and cause lifelong problems, including infertility and pelvic inflammatory disease.⁵⁰ Urinary tract infections are one of the most common infections women experience and are easily treatable, but without treatment, can result in emergency room care, which can cost a state nearly \$1,500 per patient.⁵¹

In addition, data shows that retroactive coverage has positively impacted individuals in states that have kept this feature in their Medicaid programs. In New Hampshire, in one 16-month period, 4,567 Medicaid expansion individuals benefited from the policy, which paid more than \$5 million for their medical expenses.⁵² Conversely, data show that the absence of retroactive coverage has increased financial burdens for people with low incomes, as well as safety net providers that serve those individuals. In Indiana, nearly 14 percent of the parent and caretaker relatives eligibility group needed retroactive coverage, and individuals in this group incurred medical costs averaging \$1,561 per person.⁵³ These costs would have been paid for by Medicaid if retroactive coverage was in place.⁵⁴ Finally, sixteen percent of providers in Indiana experienced increases in the provision of uncompensated care after retroactive coverage was waived.⁵⁵

Retroactive coverage also bolsters critical provider participation in the Medicaid program as providers know in advance that they will be adequately compensated, which means that patients are better able to meaningfully access care. Medicaid programs are already faced with provider shortages, with more than two-thirds of states reporting difficulty in ensuring provider participation in Medicaid.⁵⁶ Provider shortages are particularly acute for people who can get pregnant, as states are especially challenged in recruiting OB/GYNs. A report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) found that Medicaid managed care plans had extreme provider shortages, with only 42 percent of in-network OB/GYN providers able to offer appointments.⁵⁷

⁵⁰ Chlamydia: Fact Sheet, Centers for Disease Control and Prevention (Jan. 23, 2014), available at <https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm>.

⁵¹ Nolan Caldwell, et al., “How Much Will I Get Charged for This?” Patient Charges Top Ten Diagnoses in the Emergency Department,” Plos One Journal (Feb. 27, 2013), available at <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491>.

⁵² Conditionally Approved Waiver of Retroactive Coverage, NHDHHS (Dec. 21, 2015), available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf>.

⁵³ Letter to Director McGuffee, CMS (Jul. 29, 2016), available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf>.

⁵⁴ *Id.*

⁵⁵ Harris Meyer, “New Medicaid Barrier: Waivers ending retrospective eligibility shift costs to providers, patients,” Modern Healthcare (Feb. 9, 2019), available at <https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients>.

⁵⁶ “States Made Multiple Program Changes, and Beneficiaries Generally Access Comparable to Private Insurance,” Government Accountability Office (Nov. 2012), available at <http://www.gao.gov/assets/650/649788.pdf>; “Access to Care: Provider Availability in Medicaid Managed Care,” Department of Health and Human Services, Office of the Inspector General (Dec. 2014), available at <http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

⁵⁷ *Id.*

Yet, despite the shortages of OB/GYN providers, people who can get pregnant often rely on their OB/GYN providers as their main source of care.⁵⁸ Any policy, including the current lack of retroactive coverage, that reduces the availability of SRH providers in the Medicaid program can cause longer wait times for appointments and delays in accessing critical SRH. Due to the unique way women and people who can get pregnant experience the health care system, delays in access to OB/GYNs and other SRH providers can also impact their access to the broader health care system and result in them lacking access to other essential primary and preventive care. Sufficient provider participation is essential to ensure Oregon's success in improving health care delivery systems. Indeed, health care coverage is meaningless if patients are unable to receive care from quality providers in a timely manner.

For all the reasons set forth above and retroactive coverage's importance to accessing timely SRH care, PPAO urges OHA to reinstate retroactive coverage for all OHP enrollees.

IV. A closed prescription drug formulary for OHP adults and exclusion of certain drugs limits patient choice, including for contraceptives, and therefore, OHA should not proceed forward with these program features.

In the draft application, OHA seeks to implement a closed prescription drug formulary for OHP adults, with only at least one drug per therapeutic class. In addition to the closed formulary, OHA seeks to use its own review process to determine coverage of new drugs for OHP enrollees. OHA states that through this process, Oregon could “avoid exorbitant spending on high-cost drugs that are not medically necessary.”⁵⁹ PPAO strongly urges OHA to not proceed forward with these program features, as these changes are not waivable under Section 1115 and they dramatically narrow enrollee choice and access.

First, PPAO notes that Congress ensured that Medicaid enrollees have broad access to outpatient prescription drugs. Except for a very limited set of drug classes, state Medicaid programs cannot outright deny coverage of drugs produced by manufacturers participating in Medicaid's Drug Rebate Program. Section 1396r-8 of the Medicaid Act outlines these requirements for state Medicaid programs, including those that govern the development and use of a formulary.⁶⁰

Second, modifications to prescription drug policy should be developed to benefit patients, with a focus on decreased costs and a commitment to robust access and choice. OHA's closed formulary and proposed drug exclusions fail to offer sufficient safeguards to ensure that enrollees, including people who can get pregnant who benefit from a wide array of birth control choices, will continue to have access to the prescriptions that work for them. These changes also set a harmful precedent wherein drug cost is weighed more heavily than health care needs, absent patient input.

Importantly, many patients require significant trial and error to find the therapeutics best suited to their needs. This is particularly true for contraceptive care. For these patients, a closed formulary could be

⁵⁸ *Id.*

⁵⁹ Application for Renewal and Amendment: Oregon Health Plan 1115 Demonstration Waiver, OHA (Dec. 1, 2021), available at <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Renewal-Application.pdf>.

⁶⁰ 42 U.S. Code § 1396r-8.

particularly disruptive, given that access to the drug or device that works for them would not be guaranteed.

Finally, not only is it vital to safeguard enrollee access; ensuring that people have access to the contraceptive that works best for them reaps many benefits. A majority of women who access care through publicly funded family planning providers said birth control has allowed them to take better care of themselves or their families (63 percent), complete their education (51 percent), support themselves financially (56 percent), or keep or get a job (50 percent).⁶¹ Furthermore, greater access to all approved Food and Drug Administration (FDA) contraceptive methods⁶² would help improve health outcomes for pregnancy-related illness, injury, and death, especially for people who have medical conditions that may be exacerbated by pregnancy.⁶³ Implementing a closed formulary and restricting access to FDA-approved contraception will likely lead to worse health outcomes for all enrollees who need access to contraception of their choice.

Further, PPAO also strongly urges OHA to not adopt a closed formulary for HIV treatment medications, for the following reasons:

HIV is a highly individual disease. Different people living with HIV have different treatment needs based on their specific medical history and the resistance(s) to medication that may have developed in their bodies. As a result, people living with HIV and their healthcare providers need maximum flexibility to select an HIV treatment regimen that is right for them.

HIV disproportionately impacts people who are also experiencing challenges such as homelessness, mental illness, and/or substance-use disorder. Members of this population may need simpler, more manageable HIV treatment regimens (e.g., single-tablet regimens) to remain adherent to their medications, but closed formularies can restrict access to those regimens by not factoring social determinants of health into decision-making on coverage.

Utilization-management techniques used in a closed-formulary approach, such as prior-authorization requirements, can cause abandonment of treatment, especially for those already at risk of falling out of care. For people living with HIV, in particular, the consequences can be disastrous: Medication non-adherence can lead not only to poor health outcomes, but also to permanent resistance to a drug or entire class of drugs.

People who are living with HIV and in successful treatment cannot transmit the virus through sex. However, if people fall out of care, as utilization management can cause them to do, they can spread HIV to their sexual partners. Adherence is, therefore, a public-health issue as well as an individual one.

⁶¹ Jennifer J. Frost and Laura Duberstein Lindberg, "Reasons for using contraception: Perspectives of US women seeking care at specialized family planning clinics," *Contraception*, Vol. 87, Issue 4 (Apr. 2013), available at <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.contraception.2012.08.012.pdf>.

⁶² Birth Control Guide, Food and Drug Administration, available at <https://www.fda.gov/media/99605/download>.

⁶³ Megan L. Kavanaugh and Ragnar Anderson, "Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers," New York: Guttmacher Institute (Jul. 2013), available at <http://www.guttmacher.org/pubs/health-benefits.pdf>.

For all these reasons, it is considered best practice to ensure access to HIV treatment medications, even within a closed-formulary approach. This is why antiretrovirals are designated as a drug class “of clinical concern” within Medicare Part D, requiring Part D plans to cover all drugs within that class (rather than only two or more drugs, as for most classes). It’s also why the federal agencies responsible for ending the HIV epidemic direct states to “design their prescription drug formularies to minimize potential barriers presented by utilization management techniques so that Medicaid...beneficiaries can readily access all [HIV] regimens.”⁶⁴ Several states, including California, Colorado, and Illinois, have gone so far as to codify in statute protections from utilization-management techniques for Medicaid members living with HIV.

Oregon currently includes all U.S. Food and Drug Administration-approved HIV drugs on its Preferred Drug List, and the above-average health outcomes of Oregonians living with HIV reflects such public policies. Ensuring access to HIV treatment medications bolsters not just Oregon’s efforts to end the HIV epidemic, but the state’s commitment to eliminating health inequities as well, because Black, Latinx, and Indigenous Oregonians are more likely to be living with HIV, and more likely to experience poor HIV health outcomes (e.g., viral non-suppression). We hope that Oregon will remain aligned with best practice and the state’s own strategic goals by committing in its 1115 waiver application to maintain open access to HIV treatment medications.

For all the reasons set forth in this section, we strongly urge OHA to not proceed forward with the closed formulary and exclusion of certain drugs through OHA’s review process.

V. PPAO urges OHA to consider how open access to safety net providers and other community providers will create meaningful change for patient access and provider burden.

An important aspect of increasing access to and utilization of quality preventative and SRH care is patients being able to go to a trusted provider of their choice and where it is convenient for them. Planned Parenthood affiliates are contracted with the majority of coordinated care organizations (CCOs) in Oregon, but not all. When patients arrive at Planned Parenthood health centers needing urgent reproductive health care, they are often unable to serve them if they are not contracted with their CCO plan. Or, Planned Parenthood provides necessary care without reimbursement. In the past six months, Planned Parenthood Columbia Willamette served close to 400 patients who were covered by a CCO plan not contracted with them.

Ensuring there is ‘no wrong door’ for patient care is vital for patients to receive timely care, especially if they have traveled outside their community and cannot easily access alternate providers in a timely manner. Similar barriers occur when a patient’s plan changes to one which is not contracted with Planned Parenthood. Health center staff are often informing patients of a change in coverage and, if the new CCO is not contracted, their limited ability to offer patient care. This is wasteful for staff and stressful for patients.

Open access to safety net providers and other community providers would create meaningful change for patient access and provider burden. These services are often low cost yet carry high cost implications if

⁶⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120116.pdf>

not addressed in a timely manner. Claims data from these visits would inform CCOs of where patients are accessing care, and which providers they are choosing for specific services. This open access could even encourage new contracts with diverse providers.

VI. PPAO agrees with OHA that advancing health equity is paramount, and supports OHA in proceeding forward with several other equity-driven requests in the draft application and notes the importance of provider choice for OHP enrollees.

Advancing health equity is paramount in transforming the OHP program to effectively serve people with low incomes, including people of color, in Oregon. As discussed in detail in this comment letter, due to longstanding systemic barriers to economic advancement, these populations are disproportionately enrolled in the Medicaid program and experience worse health outcomes on several measures. To meaningfully address access to care and improve health outcomes for people with low incomes, including women of color, a comprehensive equity-driven approach must be taken.

OHA has included several requests and changes in the draft application to advance health equity. In addition to the proposals discussed at length in this letter, PPAO notes its support for the following proposals that increase access to care and ensure continuity of coverage for critical populations:

- providing continuous eligibility for children until their 6th birthday;
- providing an expedited OHP enrollment path for people who apply for SNAP benefits;
- retaining benefits and/or extending full OHP Plus Medicaid benefits to justice-involved individuals;
- providing transitional employment support services for vulnerable populations and benefits for people impacted by climate disasters and at high-risk for extreme weather;
- expanding the infrastructure needed to support access to services using providers outside the medical model, including personal health navigators and doulas; and
- investing in provider and community-based organizations' (CBO) infrastructure and capacity building.

Taken together with the other program features discussed in detail in this letter, these features provide a strong foundation to meaningfully make progress on health equity for Oregonians. PPAO urges OHA to move forward with these program features and work with community-based reproductive health care providers when implementing these changes.

Thank you for the opportunity to comment on the OHP draft waiver application. OHA has put forward a comprehensive approach in addressing health equity through several program features, which would have an outsized impact on women of color, in this draft application. Planned Parenthood urges OHA to move forward with seeking 24-months continuous eligibility for OHP enrollees ages 6 and over and investing in SDOH transition services for vulnerable populations, along with several other features. However, Planned Parenthood strongly urges OHA to reinstate retroactive coverage for all OHP enrollees and not proceed forward with the prescription drug policy changes proposed in the draft application. The continued waiver of retroactive coverage and prescription drug policy proposals undermine OHA's goal of advancing health equity by decreasing access to care and limiting patient choice.

If you have any questions about the issues raised in this letter, please do not hesitate to contact An Do, Executive Director, at an.do@ppaoregon.org.

Respectfully submitted,

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Planned Parenthood Advocates of Oregon