

January 7, 2022

Health Policy and Analytics Medicaid Waiver Renewal Team
Attn: Michelle Hatfield
500 Summer St. NE, E65
Salem, OR 97301
Submitted via email: 1115Waiver.Renewal@dhsosha.state.or.us
RE: Oregon Section 1115 Waiver

Dear Ms. Hatfield:

Kaiser Permanente appreciates the opportunity to submit comments on Oregon's Section 1115 Demonstration Waiver. Kaiser Permanente (KP) is the largest private integrated healthcare delivery system in the U.S., delivering health care to 12.4 million members in eight states and the District of Columbia.¹ To provide care and coverage to Oregon Health Plan (OHP) members, KP serves nearly 65,000 Oregonians as a delegated subcontractor to Health Share of Oregon in the Portland metro area and PacificSource in Marion and Polk counties, on a capitated basis. Kaiser Permanente also participates as a primary care provider under PacificSource in Lane County. Additionally, Kaiser Permanente is a delegated Dental Care Organization within the Health Share of Oregon network serving members in the Portland metropolitan area. Kaiser Permanente supports programs and policies that ensure all individuals have access to affordable, high-quality health care, and applauds OHA for its efforts to prioritize the impacts of health disparities, inequities, and social determinants of health (SDOH) for OHP beneficiaries. We support the creation of a more equitable health care system, and throughout this comment letter, we indicate our support of policies that eliminate or reduce health disparities.

Collaboration across Coordinated Care Organizations (CCOs), community organizations, and with state and county agencies will be critical to meeting Oregon's 2022-2027 waiver goals, including:

- Creating a more equitable, culturally- and linguistically- responsive health care system,
- Helping contain costs by providing quality health care,
- Investing in equitable and culturally appropriate health care, and
- Ensuring everyone can get the coverage they need.

As individuals and as organizations, our communities now more than ever during the global pandemic are being stretched to do more with their existing resources. Collectively we have a shared responsibility to improve community health, and a critical component of this goal is improving engagement across our communities. While we are supportive of most of the components of the OHA proposal, there are elements of the proposal that are of concern or require additional detail. Kaiser Permanente offers the following comments on the 1115 waiver proposal:

Continuous Coverage: Consistent with our support of universal coverage and our support of Cover All People, we applaud OHA's efforts to initiate continuous enrollment for children up to the age of 6 and transitioning youth. We also support OHA's proposal to implement two-year continuous eligibility for all OHP members. Continuous eligibility will keep people covered, mitigate churn, and allow members to access their providers for care without disruption. Kaiser Permanente has long supported access to coverage, including by providing subsidized coverage to thousands of Oregonians through our Charitable Health Coverage Programs, and working to bridge care when families move between payers and coverage

types. We will continue to support access to coverage and look forward to working with the state to fill gaps between Cover All People and those ineligible for subsidies on exchange.

Global Budget and Rate Alignment: Kaiser Permanente understands that OHA plans for CCO rates to be in alignment with their global budget for capitation increases. We respectfully request that CCOs be included in the rate setting process, and that federal actuarial soundness requirements continue to be a part of this alignment effort. This is particularly important in rating periods when plan rates increase more rapidly than the global budget. We could see such changes in upcoming rating periods as the long-term impacts of COVID and delays in treatment increase in prevalence.

Expedited enrollment for SNAP enrollees: We applaud OHA's proposal to allow for expedited enrollment in OHP because of existing SNAP enrollment. Kaiser Permanente supports efforts to connect SNAP members to Medicaid and other services/resources in the community. As part of Kaiser Permanente's enterprise-wide SNAP Enrollment Project, KP launched an intervention in Oregon to assess how we can optimally target, engage, and connect potential enrollees with application assistance provided by partner organizations. More than 20,000 KP members in Oregon and SW Washington received application support for this critical food security program. KP has a national Food for Life strategy that involves screening and deploying multiple interventions to address food insecurity among our members, including SNAP enrollment support, medically tailored meals, and partnerships with food distribution partners. We look forward to working with the CCO community and OHA to design this initiative.

Quality: The current draft of the OHP 1115 waiver notes that the quality strategy is forthcoming. As the state works through the structure of a future quality strategy, Kaiser Permanente offers the following comments about this effort:

Kaiser Permanente supports quality programs that bring transparency, encourage high quality care, timely access, and patient satisfaction developed for Medicaid, including public reporting on clinical outcomes and patient satisfaction. In all cases, we encourage OHA to use tested, national quality and access standards to support alignment with the broader health care community in the state. Further, we support efforts to ensure quality and access through equity-driven performance metrics. Key principles we encourage OHP to consider as the quality strategy is developed include:

1. **Limiting Complexity:** Using nationally endorsed measures (e.g., National Quality Forum, National Committee for Quality Assurance, Dental Quality Alliance) will limit complexity in tracking and reporting.
 - a. OHA should continue to adopt the specifications for nationally endorsed measures as they are and refrain from making state-specific revisions.
2. **Use Multipayer Measures:** We believe there should be alignment of measures across states and programs (e.g. Medicare, Medicaid, and Marketplace).
3. **Outcomes Over Process:** Measuring the outcomes and consumer satisfaction (CAHPS) with health plans and their delivery systems, and publicly reporting the results of those measurements is a strong incentive for plans and providers to improve the quality of the services they provide.
4. **Phased Implementation:** Changes to the existing quality measurement effort for OHP should be implemented thoughtfully, in phases:
 - a. Phase 1: Initial measurement and testing period
 - b. Phase 2: Public disclosure of performance
 - c. Phase 3: Implementation of quality incentive programs

5. **Focus on Disparities and Equity:** Particularly for Medicaid, quality measurement should focus on addressing disparities and prioritize health equity
 - a. The plan and provider community should be engaged to identify measures that will support reduction in disparities and improve health
 - b. For measures where OHA wants to incentivize CCOs and providers to address disparities in outcomes/quality within populations that have historically been marginalized, we recommend that OHA craft a thoughtful stakeholder engagement strategy with meaningful participation of members from these groups in advance to mitigate the risk of adverse consequences to these communities.
 - c. In cases where it is difficult to ascertain numerically whether interventions have been successful in impacting inequities in outcomes across specific populations (e.g. denominator is too small, interventions may take >1 year or more to demonstrate impact, etc.), we recommend that OHA seek qualitative data from CCOs to better understand the work CCOs have already undertaken to address the systems/processes/policies driving these inequities.
 - d. We support efforts to use nationally recognized dental measures for OHP members.
6. **Measures Should be Tested for Validity for the Medicaid Population:**
 - a. Measures that are new and impact a smaller number of members or for sub populations should be assessed at the CCO or plan level first, and then later used for community reporting and incentives.
7. **Plan Engagement and Transparency is Critical in the Development of the Measure Set:**
 - a. CCOs should be engaged in measure selection, the development of benchmarking, measurement period, weighting of measures.
 - b. As OHA has proposed that the measures for the incentive metrics program should be drawn from CMS's Core set of Medicaid measures, we advocate that OHA engage with CCOs and providers to develop and provide public comment to CMS well in advance of the selection of these measures for each program year.
 - c. In cases where OHA is incentivizing CCOs to address outcomes within populations where the denominator may be exceedingly small (e.g., specific race and ethnic groups, members with a disability, etc.), we encourage OHA to develop criteria that establishes the minimum denominator required for the CCO to be held accountable to meeting a target for the measure. If no minimum denominator is established for CCOs, we encourage OHA to provide guidance to CCOs regarding the establishment of value-based contracts for sub populations, given that the number of members attributed to health care agencies or similar systems for these populations may be extremely small.

Advancing Equity, Social Needs, SDOH: Kaiser Permanente is addressing social needs in a variety of ways. KP was instrumental in launching the largest Community Information Exchange (CIE) to date in Oregon. Connect Oregon (also known as Thrive Local within KP) brings partners across the region and state together in an online, searchable social services resource directory and community network that allows healthcare and social service providers to connect with each other and make closed-loop referrals. Connect Oregon already includes partners in 19 of 36 counties in Oregon and will be live in 35 of 36 Oregon counties in 2022. Connect Oregon allows KP and hundreds of other partners throughout the state to connect people to the programs that improve health outcomes.

Kaiser Permanente has also developed a variety of social health interventions over the past several years; examples include:

- Resource Access Centers- a dedicated partnership with Impact NW, a Portland-based social service organization. Impact NW Resource Access Specialists are co-located at KP medical clinics across the region to provide information and referrals to patients with social needs.
- Housing for Health- a variety of strategies and projects including Metro300, an investment of over \$5 million to address senior homelessness in the Portland metro area.
- Medical-Legal Partnerships- a new partnership with Legal Aid Society of Oregon will launch in early 2022 to provide dedicated services to KP patients facing housing-related legal issues.

Kaiser Permanente appreciates OHA's long history of and commitment to innovation in care delivery to better support OHP members through innovative models of care. As the state works through the waiver proposal, we note that over the period of the demonstration, the delivery of many of the social needs related programs will move from a fee for service model of care to a capitated design. Given this change, funding and operations will be critical to meeting the goals of the waiver as noted earlier. Many services proposed in this waiver request (e.g., climate supports, the coordination of transportation for evacuation) are not areas of current CCO competency, and will require the development of new partnerships, assessments, and community engagement. Further, defining eligibility for new services will be critical, including the development of rates and infrastructure to support these services as they are delivered. As we drive toward delivering equitable health outcomes, Kaiser Permanente is committed to incorporating race and ethnicity segmentation into all quality performance reporting. We support the use of social factors that impact health in this effort and look forward to working with the state to reduce variation in experience of care based on race and ethnicity. To accomplish this, we encourage OHA to use national standards and guidance for capturing, documenting, and using Social Determinants of Health (SDOH) and social needs data. We encourage the state to work with national partners to develop and fund open-source solutions to promote the secure exchange of SDOH data information among health and social service providers.

Supporting Members During Life Transitions: OHA proposes to develop and fund a defined set of SDOH transition services to support members in need during life transitions. These include a variety of transitions including people experiencing homelessness, people vulnerable to extreme weather events; people transitioning out of justice systems and behavioral health institutions, Youth with Special Health Care Needs (YSHCN) to the age of 26 and youth who are child welfare-involved and transitioning in and out of foster care homes.

Kaiser Permanente agrees that providing health care services and coordinated care during a serious life transition (corrections involvement) and critical life stage (youth, and often youth of color being over-represented), could improve lifelong health and save long-term costs across multiple systems. We however note that the implementation of this benefit set will take time for CCOs to build and manage these services. The CCOs should be included in the development of these benefits and rate structure. It is particularly critical that OHA and the CCOs have a common understanding of these services, the universe of providers available to offer them, as well as the methodology by which these will be factored into capitation and risk adjustment.

In sum, Kaiser Permanente supports efforts to expand and integrate services that are deeply rooted in evidence and support a broad scope of social needs including housing and food assistance, employment

supports and health-related transportation, but request that the state work with CCOs to determine the eligibility, provider type and enrollment processes, network adequacy, rates, and other administrative processes to deliver these services to this group of members. CCOs and community organizations will need time to implement this effort. We encourage OHA to work with CCOs and community providers to develop realistic timelines for these services to be integrated into the CCO model.

Coverage for Evidence-Based Prescription Drugs, Single Closed Pharmacy Formulary: OHA proposes to adopt a commercial-style closed formulary approach for adult members, including at least a single drug per therapeutic class. In addition, the waiver application seeks to waive the federal Medicaid requirement for states to cover all drugs approved by the Food and Drug Administration (FDA).

We support efforts to prioritize patient access to clinically proven, effective drugs, and believe that plans and providers are best positioned to exercise discretion about which drugs should be covered, particularly in cases when there is limited or inadequate clinical efficacy. We support reforms that address the root causes of the high cost of prescription drugs and endorse efforts allowing insurers to use their power as part of the health care system to drive investment toward therapies that provide the greatest benefit for patients. We welcome the opportunity to work with OHA and the CCO community to allow the plans/providers to design programs that support their members best and offer flexibility to cover drugs that best meet the needs of the members, including the use of generic drugs.

Kaiser Permanente strongly opposes the use of a single closed formulary, and requests that OHA make the use of the statewide formulary optional for entities like KP that already have in place a robust, clinically driven, cost-effective formulary.

The Kaiser Permanente integrated model of care allows for an innovative approach to prescription drug coverage and purchasing for our members. At KP, we begin with teams of expert physicians and clinical pharmacists who collaborate to evaluate each medication's clinical value and safety. To conduct evaluations, we look to evidence both from published clinical trials as well as from our own electronic health record system where we can determine how well different medications perform among our members. Conducting these evaluations is the first step in developing cutting-edge, evidence-based formularies in-house, in a process led by clinicians who understand our patients' needs. Beginning with this rigorous approach ensures physicians and other clinicians can prescribe medications that work best for our patients.

Once we have conducted the initial evaluations, Kaiser Permanente's pharmacist contracting team works directly with drug manufacturers to negotiate drug prices. Our contracting efforts are focused on assuring that our purchases are receiving the best possible value for their dollar, especially when competing medications that perform similarly are available. Our pharmacy contracting team actively seeks to negotiate contracts prior to generic drug availability to ensure optimal access for our members to new generic drugs.

Our clinicians consistently prescribe according to our formulary guidelines with these factors in mind:

- **Trust in our evidence-driven, clinician-led approach:** Our prescribers trust our formularies because they know they are grounded in clinical evidence and built-in partnership with their expert colleagues. The evaluation of drugs for any disease or condition is led by both pharmacists and specialists in our medical groups who focus on treating that disease or condition. Drugs are placed on the KP formulary based on their efficacy and safety. Not only is this good medicine but choosing the most efficacious

drug the first time reduces downstream costs by ensuring positive outcomes, minimizing extra visits to the doctor or hospital, and eliminating prescription change costs.

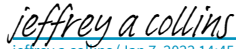
- **Single integrated system:** Our integrated model allows us to be more efficient in making purchasing and prescribing decisions. Our providers are members of a single community and we use a common clinical infrastructure and electronic health record system, which makes it easier to share reliable information and evidence about drugs across our system.
- **Systemwide contracts:** We manage many traditional pharmacy benefit manager functions internally, including formulary maintenance and negotiation of contracted drug prices. KP's incentive is to purchase drugs at the lowest possible cost, and the different components of our integrated system are free of conflicts of interest since they are all part of the same broader organization.
- **Generic drug purchasing:** To achieve discounts on drugs, we leverage our purchasing power and unique ability to move market share among competing therapies that results from the confidence our clinicians have in our evidence-based formularies. Kaiser Permanente has long been an industry leader in generic utilization. More than 91 percent of drugs prescribed in our system are generic, which exceeds market averages of 89 percent.² Our evidence-based approach to designing pharmacy benefits helps facilitate competition between drugs, often leading to preference for high-quality generic drugs. Our pharmacists and the Permanente Medical Group physicians collaborate closely to develop our formularies, analyzing available evidence for each drug and making recommendations. When generics perform just as well or better than a more expensive brand drug, they prevail within Kaiser Permanente. Every 0.1 percent increase in generic utilization saves our system \$28 million. These savings help us invest in care delivery and quality initiatives that benefit our members.
- **Detailing restrictions:** Kaiser Permanente's medical groups have chosen to significantly restrict direct-to-clinician marketing by pharmaceutical sales representatives. Instead, pharmacist drug education coordinators actively provide our prescribers with unbiased, up-to-date information on medications. Additionally, prescribers can reach out to our pharmacists to ask specific questions about a medication.
- **Pharmacy excellence:** Pharmacists have access to the full patient electronic health record system as well as to the prescriber if questions or concerns arise, improving the safety of our medication use processes. Our pharmacists actively track medication adherence for patients with chronic conditions and regularly communicate with them on how to take their medications most effectively.
- **Mandating A Single Formulary Increases Costs for Medicaid and the Entire Health Care System:** Mandating CCOs and their partners to use a single formulary for our OHP members will dramatically increase costs due to several factors. First, it will disrupt the efficiencies and quality benefits inherent to our integrated system. Second, we would expect new reluctance by manufacturers to provide KP with price concessions on drug utilization attributed to OHP patients. Third, moving utilization from products on the KP formulary that have been contracted at favorable acquisition costs to products on the OHP formulary would increase the unit cost KP would experience. Lastly, KP's generic penetration rate is considerably higher than the U.S. average. Any decrease in this rate in favor of more expensive brand-name drugs on the OHP formulary would create a significant increase in KP's drug spend. There would also be increased operational and administrative costs to administer a separate formulary.

Because this proposal would change our cost structure, we anticipate that OHP rates would need to be adjusted upward to recognize the increase in costs, both from a service standpoint as well as from administration. This should certainly be factored into any savings estimate.

Finally, at this time, when the federal and state governments are planning for the redetermination of Medicaid members post-pandemic, such disruption in prescription drug coverage would be unwise. Once redeterminations are reinstated, many Medicaid members will be transitioning between coverage types (exchange, commercial), and moving from one formulary to another within the same integrated care/coverage model would be disruptive, costly, and clinically unnecessary. It is for these reasons that we reiterate that OHA make the use of the statewide formulary optional for entities like KP that already have in place a robust, clinically driven, cost-effective formulary.

In sum, Kaiser Permanente stands ready to work with OHA and our partner CCOs on the implementation of the Oregon Section 1115 waiver. Thank you for considering our comments. If you have questions, please contact me, Jeff Collins (Jeffrey.A.Collins@kp.org) or Shannon McMahon (Shannon.Mcmahon@kp.org).

Sincerely,


jeffrey a collins (Jan 7, 2022 14:45 PST)

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