



Oregon Health Authority
Health Policy and Analytics Medicaid Waiver Renewal Team

Re: Comment on 1115 Medicaid Demonstration Waiver Renewal Application

January 7, 2022

The Oregon Primary Care Association, on behalf of its 34 members, whom collectively serve **one in six OHP patients** and make up a critical portion of the provider networks within CCOs, would like to express its gratitude for your work on the 1115 Medicaid Demonstration Waiver renewal and amendment application. We understand the opportunity this provides to further innovation as well as improve and strengthen the care members on the Oregon Health Plan (OHP) receive across the delivery system and coordinated care model.

The Oregon Primary Care Association is the non-profit membership association of Oregon's 34 community health centers, also known as Federally Qualified Health Centers (FQHCs), and FQHC Look-Alikes. Community health centers deliver exceptional primary care, including behavioral health and oral health care, to over **450,000 Oregonians living in urban, rural and frontier communities** who may otherwise not have access to care.

As one of the state's larger Medicaid provider networks, FQHCs are largely supportive of the strategies proposed in the policy concepts and application as a whole and we appreciate the inclusion of our association in early waiver discussions. We would like to offer our recommendations on a few select strategies, articulated below, for your consideration.

Advancing Health Equity

OPCA's member health centers have over 270 sites statewide and are in all but 2 counties in Oregon, and for those who are designated as rural or frontier sites, concern was expressed about the lack of rural or "locality" in OHA's definition of health equity as well as the lack of reference throughout the application. To be clear, we understand the health equity definition was done separately from this application, as part of the Oregon Health Policy Board, and we would be remiss in representing our member voices if we didn't articulate that lack of inclusion or application felt by our rural and frontier providers. For those who are on the frontlines serving rural or frontier patient populations, their locality and rurality is intrinsically understood as an inequity in their care, and the lack of this inclusion in the definition makes it difficult for providers and their patients to understand their role in helping the state reduce health inequities.

Recommendation (in blue):

Oregon will have established a health system that creates health equity when all people can reach their full potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender identity, sexual orientation, **locality**, social class, intersections among these communities or identities, or other socially determined circumstances.

And/or,

Achieving health equity requires the ongoing collaboration of all regions and **localities** of the state, including tribal governments to address: ...

3.2 Improving Health Outcomes by Streamlining Life and Coverage Transitions

Strategy 4: Covering more providers outside the medical model

In the context of today's racial/ethnic disparities in both COVID-19 cases and vaccination rates, the role of the CHW has become increasingly important, but often does not fit within the classical medical model for lack of mentorship, appropriate supervision, and financial incentive to enter the field. Many CHWs are left isolated, underutilized, or cannot stay employed due to lack of a living wage, at the same time that we watch disparities widen.

Recommendation: Ensure the roles articulated in the concept paper – Traditional Health Workers, Community Health Workers, navigators – are covered at a livable wage rate to promote the quality and quantity of these positions in our state. Expanding infrastructure so CHWs can provide services directly to OHP members and support for capacity building cannot be overstated. Engaging folks from rural communities and people of color should be a top priority moving forward as community members feel safe when they see health care workers that look like them.

Recommendation: If payors are required to focus on equity (and supporting THWs specifically), indicating where these funds come from is imperative. Building infrastructure, sustainable payments to these types of roles, and credentialing is a necessary step in implementation that is currently missing. It should be clear that this work is resourced as part of a CCOs global budget and/or separate funding needs to be earmarked for these services.

Strategy 5: Invest in CBOs/health equity spending

We understand the 1115 Waiver renewal is an integral part of a statewide strategy designed to center equity. However, we are concerned that multiple layers of additional administration are potentially being built “to support infrastructure for health equity investments.” There is a vast network of CBOs, Regional Health Equity Alliances, and CCO Community Advisory Councils in existence currently. CBOs have been a leading voice in the fight for health equity and equal access to health care. CBOs also have substantial trust in the community and are best positioned to provide culturally- and linguistically- appropriate outreach to communities, particularly those who are not currently engaged in the healthcare system.

Recommendation: We encourage the use of existing forums/channels, such as CCO Community Advisory Councils (CACs) and/or Regional Health Equity Coalitions, to drive community-level investment to avoid creating additional administrative overhead, and to ensure the largest investment can reach those who need it: the clients served by the CBOs and their community health centers.

Recommendation: Consider creating learning space for CBOs that have established themselves in the healthcare space to leverage connection and partnership with health systems in support of younger/newer CBOs.

3.4 Incentivizing Equitable Care

a) Upstream metrics

Community health centers are rooted in their communities – our model of care combines the resources of local communities with federal funds to establish “neighborhood” primary care homes in rural and urban areas. Integral to the communities they serve, FQHCs have also rooted their work in upstream health interventions, from job application assistance to transportation to the clinic. As social determinants of health have taken root and become shared language across the health systems and payors, FQHCs have often been at the forefront of piloting how to collect and utilize data that demonstrates a patients’ non-medical needs. OPCA and our members were instrumental in developing one of the first screening tools (Protocol for Responding to and Assessing Patients Assets, referred to as PRAPARE) and participated in the development of the Social Determinants of Health: Social Needs Screening and Referral metric referenced in the application. We recently completed a yearlong collaborative that partnered health centers with their CCO to assess not only screening methods but coding and referral processes. Incentivizing social needs is critical to reducing health inequities, and it must be done in tandem with both HIE and CIE initiatives across the state that link patients to community-based services and pay providers (Z-codes) for the inclusion of non-medical needs.

Recommendation: Screening tools (like PRAPARE) are generally administered by a clinician during a medical visit and the resulting information is contained in the medical record (as EMR allows). To better facilitate resources and ensure that social needs are addressed, screening tools could be administered at different entry points for Medicaid beneficiaries and the resulting data used to best meet their needs, rather than just held by the entity that screens.

Changes to Prescription Drug Benefits

Ability to define a preferred drug list for pharmacy benefits

We appreciate the inclusion of strategies to address the impact of pharmacy costs on Medicaid spending in Oregon and, would like to express our deep concern about the impact the strategies, as included, could have in terms of significant impacts on already deep Medicaid rebates as well as limiting choice for OHP patients.

A) Adopt a commercial style closed formulary approach

In response to a similar recent effort by Massachusetts to implement its own drug formulary for its Medicaid program, Georgetown’s Center for Children and Families stated that pursuing the demo CMS is currently supportive of, “would harm access to drugs as its unlikely that state will get discounts as deep as the ones offered under the Medicaid drug rebate program”¹. We understand that Oregon is electing to use CMS’ recommended pathway by including it in the demonstration, and want to ensure that the implementation of the proposed strategy does

¹ CMS Denies Massachusetts’ request to choose which drugs Medicaid covers. Modern Healthcare <<https://www.modernhealthcare.com/article/20180627/NEWS/180629925/cms-denies-massachusetts-request-to-choose-which-drugs-medicaid-covers>> accessed December 15, 2021.

account for disruptions to patients caused by changes (at any time) to formularies. Pharmacists at our FQHCs shared that “rebate managed formularies can cause a lot of disruption if rebate terms change and another drug becomes more favorable” and that one strategy to mitigate this impact, especially for patients who cannot change insurance plans to better fit their medical conditions, would be to build in strong grandfathering plans for drugs that are no longer covered under the new formulary. This must be done thoughtfully, and with intention, so that the goal of a closed formulary can be met without disruption or reducing access to drugs for a patient population that is already underserved and faces a number of inequities within our health care system. One of our member health centers shared the impact to their pharmacy program, which using the revenues it generates through programs like 340B and rebates, supports the following for their patients and the entire health center, including:

- *operating costs of 7 in-house, integrated pharmacies,*
- *access to medications for the uninsured and underinsured*
- *laboratory services*
- *7 FTE clinical pharmacists (who do diabetes and hypertension management, adherence support, transitions of care etc.)*
- *FTE support for an MA at our HIV clinic*
- *FTE support for drug assistance program enrollment*

While this is only one example, it is an example of how FQHCs do reinvest revenues and pharmacy savings (from the 340B program) back into patient care; that same health center fully understands the intention of tackling the drug spend in our state and believes that both strategies in this section would accomplish this. To ensure that this exercise in reducing prescription drug spend is done without the loss of “deep Medicaid rebates” or harming vulnerable patients by limiting/changing drugs, we recommend the following:

Recommendation: Any committee, workgroup or state commission charged with overseeing the development of a Medicaid formulary includes representation from entities who have clinical pharmacies that dispense to a large population of Medicaid beneficiaries, such as Federally Qualified Health Centers.

Thank you for your attention and consideration of our recommendations related to the 1115 Medicaid Demonstration Waiver. We look forward to continued partnership with the OHA in advancing the states equity goals and innovation within its Medicaid program. We are glad to provide clarification or additional information should it be needed.

Sincerely,



Danielle Sobel, MPH
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