Memorandum

To: Co-Chair Steiner Hayward, Co-Chair Prusak, and Members of the Task Force

From: Marty Carty, Director of Government Affairs

Date: August 9, 2022

Re: Bridge Health Care Program, Plan Design Part 3

The Oregon Primary Care Association (OPCA) is a non-profit organization, with a mission to support Oregon's 34 community health centers (CHCs), also known as federally qualified health centers (FQHCs), in leading the transformation of primary care to achieve health equity for all. Health centers deliver integrated primary, behavioral, and oral health care services to over **416,000 Oregonians**. 41% of health center patients identify as a racial or ethnic minority, 20% are uninsured, 10% are experiencing homelessness, and 3% are veterans. Community health centers provide care to some of Oregon's most vulnerable populations, including **one in six OHP members**.

We write to offer comment on the Bridge Health Care Program. OPCA believes that the Bridge Plan is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity and other social determinants of health. Racial inequities are a fundamental root cause of health disparities, including unequal access to health insurance coverage – during the Public Health Emergency (PHE), Black and African American Oregonians experienced an unprecedented increase in coverage. These are upstream health equity gains Oregon cannot afford to lose – systemic disenfranchisement must not be perpetuated by the Bridge Health Program.

Unintended Consequences

Oregon's Medicaid redetermination will not occur in a vacuum. The end of the PHE will touch off changes to many programs impacting the lives of the target population of adults between 138-200% FPL. For example, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) currently functions under a temporary waiver which allows visits to be conducted remotely – these visits are mandatory to receive benefits. The end of the PHE will eliminate this provision after 90 days and all services will be required to be delivered in-person. WIC-enrolled parents will face new challenges of scheduling, transportation, and potential disenrollment for non-compliance. This will happen concurrently with Medicaid redetermination to an overlapping population, as eligibility for WIC extends to 185% FPL. Additionally, throughout the PHE, people on the Supplemental Nutrition Assistance Program (SNAP) have received emergency allotments, which allows them to receive the maximum monthly benefit for their household size or an increase of at least $95/month if they are already receiving their maximum benefit amount. Even though, in Oregon, SNAP eligibility extends to 200% FPL, benefits may decrease drastically at the end of the PHE with little to no increase in income. **Families should never have to choose between feeding themselves and their children or accessing health care.** Designing a program which requires even minimal cost-sharing or other barriers to entry could create this dilemma. Oregon has an opportunity to create a program that is broadly accessible to those who face the most barriers to health coverage and care, and we urge the Task Force to prioritize that accessibility.

Plan Development

We urge the Task Force to eschew designing the Bridge Plan from a scarcity perspective – while we know the actuarial analysis is preliminary and based on pre-COVID-19 data, it does indicate that a Bridge Plan with zero out-of-pocket costs, OHP-like benefits, and above Medicaid reimbursement is feasible. Additionally, based on revenue forecasting during the 2022 Legislative Session, Oregon is functioning at a surplus and the use of General Funds to support the Bridge Plan, if necessary, is a viable option. HB 4035 and the preliminary Fiscal Impact and Budget Reports during the 2022 legislative session explicitly allow the Task Force to advise use of General Funds as a part of their report and we encourage Task Force members to consider this option before cutting benefits, adding enrollee costs, or lowering provider reimbursement rates. **These cost-saving mechanisms** are all associated with greater barriers to entry, reduced access to care, unintended negative consequences, and may **undermine the overall success of the Bridge Program.**

As the Task Force drafts their September report, OPCA advocates for a plan which:

- **Prioritizes continuous benefits based on current OHP covered services, including routine oral care and behavioral health care.** Preventative oral care reduces emergency room visits and prevents periodontal diseases and chronic illnesses, resulting in cost saving for the entire health care system. Additionally, studies show that integrated behavioral health care reduces severity of depression in patients, provides patients with a better overall experience in health care, and reduces overall costs in health care due, in part, to reduced emergency care visits. Failing to provide expansive services will raise costs of care because of unmet needs, push costs to the state later down the road, and inhibit uptake of the Bridge Plan.
- **Reimburses at rates which are higher than Medicaid and use a cost-based model, such as value-based pay, that adjusts for patient demographics and needs.** As mentioned in previous OPCA public comment, we urge Task Force members to consider the complex health needs of certain historically underrepresented populations, including those who identify as BIPOC, LGBTQIA2S+, and/or have experience with other social determinants of health, and allow for reimbursement adjustment based on their unique health needs.
    - In the most recent advanced readings, we noted that current data collection methods **do not allow disaggregation by race and ethnicity.** We urge the Task Force to **include data collection which disaggregates** by race, ethnicity, age, gender identity and sexual orientation, ability, socioeconomic status, and geographic location to best understand the needs of the Bridge Plan population and enhance efforts towards health equity. The Colorado Public Option has implemented this type of deidentified data collection, as referenced in a recent United States of Care report.
- **Prioritizes zero out-of-pocket costs to enrollees, which includes premiums, copays, deductibles, and coinsurance.** We emphasize that individuals moving from Medicaid will be accustomed to no out-of-pocket costs and an abrupt shift to any amount of enrollee cost -- even the smallest premium or copay -- could deter them from both enrolling in coverage and accessing covered services.
    - As stated earlier in this testimony, enrollees could also be experiencing loss of other benefits due to PHE unwinding and/or the benefit churn point, incurring higher costs of living. It is vital that the Bridge Program and subsequent Basic Health Plan do not add to this financial burden for those who may be already struggling to afford basic goods and resources.
- **Provides enhanced reimbursement to safety net providers, specifically Federally Qualified Health Centers (FQHC's), who are now and will likely continue to care for this population.** As mentioned in previous OPCA testimony, the testimony of United States of Care, and OHA advanced readings, FQHCs currently receive Medicaid reimbursement (which is below cost) and PPS wrap payments (which is a cost-based payment) for the redetermination population. As individuals move off Medicaid and onto the Bridge Plan, CHCs will no longer receive adequate, cost-based payments for services as they lose PPS

wrap – this will impair their entire service array, not limited to the population impacted by redetermination. **While we recognize that this is not federally required for a BHP, we urge members to consider options which mitigate this impact, including expanding eligibility for PPS wrap payments to 200% FPL.**
    - CHCs offer many otherwise unreimbursed services that PPS payments are intended to help offset, such as school-based health centers, expanded dental services, mobile clinics, and many others. These programs will be threatened if CHC funding does not remain intact.
    - Current data indicates that as many as 41,000 current CHC patients could be in the target demographic for the Bridge Program. This means that up to 82% of the target population could be cared for in CHCs, as we do not anticipate that a change in coverage will cause patients to change their care home. Failure to adequately reimburse for care provided to this population would severely undermine CHC service provisions.
- **Clearly articulates a comprehensive engagement and outreach strategy** – this looks like consistent, culturally inclusive messaging about plan benefits, eligibility, costs, and enrollment pathway. We strongly advocate for a no-wrong-door approach, wherein all system navigators can support potential enrollees.