Joint Task Force on the Bridge Health Care Program

Log of Revisions to the First Draft

Feedback Received Through 8/19/22

The Task Force received a first draft report on program design recommendations on August 5th and discussed revisions to the first draft at its August 9th meeting. Task Force members submitted additional comments after the meeting and a revised draft was posted for review on August 19th. A consolidated list of feedback and summary of revisions through August 19th is presented in the table below. Additional feedback received after this date is presented in the next section.

Rev #	Comment	Revision or Response
1	Request to expand narrative in the body of the report section titled "Plan Rates and Provider Reimbursements" to provide additional explanation of how the end of Medicaid continuous eligibility during the Public Health Emergency may affect reimbursements to FQHCs.	- Staff incorporated language from members describing Task Force concerns about loss of wraparound payments to FQHCs. - Proposed language on the Task Force recommendation was moved to the recommendations section of the report for consistency with overall report flow.
2	Request to add content from OHA's August 9th presentation of OHIS survey analysis to the body of the report.	- This content was added ("Oregon Health Insurance Survey findings").
3	Request to add to the introductory content of the recommendations section to note that the BHP would provide coverage for an estimated 55,000 people who are anticipated to lose Medicaid eligibility when the PHE ends.	- Staff incorporated language from members making this change to the content preceding the recommendations and to the executive summary.
4	Request to add a recommendation that OHA ensure the BHP payment methodology does not result in payments to safety net providers that are less than they receive for care of OHP members when wraparound payments under the Prospective Payment System (PPS) are taken into account. An additional request was made to use language that emphasizes maintenance of PPS payment *levels* but that is not prescriptive as to payment *mechanism*, to allow flexibility for OHA to consider other options to achieve this outcome beyond replicating the existing PPS model. An additional request was made to use language that is flexible to accommodate other PPS initiatives such as the Certified Community Behavioral Health Clinics model. An additional request was made to note that OH's approach to maintaining reimbursements to safety net providers should be clarified by phase 2 when OHP members would begin transitioning to BHP.	- This recommendation has been added (#8). - Clarifying statements have been added that the specific approach should be consistent with Oregon's broader goals for value-based care and should be implemented by phase 2 to prevent disruptions to FQHC reimbursements when OHP members transition to BHP. - The previous recommendation related to provider reimbursements was moved to the "Program and Plan Administration" section of the table to place both reimbursement recommendations in the same section.
5	Request to update recommendation on covered service package to replace "could" with "should" and standardize to format of other recommendations.	- This change has been made to recommendation #9.
6	Request to update recommendation on enrollee cost sharing to replace "could" with "should" and standardize to format of other recommendations.	- This change has been made to recommendation #10. - The sentence regarding federal waiver of the requirement for multiple BHP plan options was split out as a separate recommendation for clarity.

7	Request to relabel section on “federal and state funding” as assumptions rather than recommendations.	- These bullets have been moved to a new section labeled “fiscal assumptions” under the recommendations table. This section has been expanded to note assumptions regarding ARPA and state funding contributions discussed at the August 9th meeting.
8	Request to modify recommendation about providing the BHP on Oregon’s Marketplace to clarify that this refers to how people would access and enroll in the program *if they are not transitioning from OHP*. For OHP members who would transition to the BHP, the vision is that this transition would occur seamlessly. The reference to the marketplace in this recommendation does not address the pursuit of ‘optionality’ under a Section 1332 waiver (which is addressed in the fourth bullet under federal pathways). There was a request to refine language in the third and fourth recommendations to better clarify this.	- Staff have moved the recommendation on Marketplace enrollment in phase 3 to the section on Program and Plan Administration recommendations in order to better convey that this recommendation is not related to a 1332 waiver. - Staff carried through proposed language that enrollee coverage transitions from OHP to BHP in phase 2 should leverage existing CCO infrastructure.
9	Request to update the recommendation on aligning CCO procurement for the Bridge Program to OHP processes and timelines. Requests include emphasizing minimizing burdens to launch and operate the program over time; to engage CCO leaders in publicly accessible forum, not just the operations collaborative, and to broaden from “procurement” to “contracting.”	- These changes have been incorporated in recommendation #6.
10	N/A	The report was updated throughout to note that the Inflation Reduction Act, passed by Congress on Friday, August 12th, extended enhancements to the Advance Premium Tax Credits from the American Rescue Plan Act in 2021 by another three years. Previous versions described federal legislation as pending.
11	N/A	The report was updated throughout to note that states had not received notice as of August 19th, 2022 that the PHE would expire in October.
12	N/A	Content has been moved to final report template with formatting updates throughout to reflect standard LPRO style guide.
13	N/A	Front matter has been added, including: • Title page, acknowledgments, etc. • A cover letter from Co-Chairs Prusak and Steiner Hayward • An executive summary
14	N/A	All content other than appendices has been proofread. Minor copy edits have been made throughout the report.
15	N/A	Appendices will be finalized at a later date. • All public comment received as of August 29th will be added to the relevant appendix. • Copy editing of appendices will be completed by August 30th.

Additional Comments on the Final Draft

Received after August 19th

Staff received the feedback below after the revised draft report was posted to OLIS on August 19th. Staff prepared responses to each comment in the table below for discussion on August 30th.

These changes are not yet reflected in the final draft report posted to OLIS.

Rev #	Page	Comment or Suggested Edit	Proposed Edit
16	2	We note that coordinated care organizations do not administer wrap payments to federally-qualified health centers. We ask that the report clarify whether the capitation rate to CCOs includes an equivalent to wrap payments, or whether wrap payments may exist in a separate category of reimbursement apart from coordinated care organization capitation. If the summary is not the appropriate section of the revised draft report to raise this point, we suggest the report place the discussion in the appropriate section (likely on page 22 or on page 36 of the report).	On Page 22: "OHA makes quarterly "wraparound" payments to FQHCs to make up the difference between CCO (and third party) payments a clinic received for care of OHP members and what clinics would have been paid at their PPS rate (Oregon Health Authority, n.d.). These "direct payments" from OHA to providers are not reimbursed from CCOs' global budgets or reflected in CCO capitation rates for OHP members."
17	2	Also, while the report calls for no member cost sharing or premiums, we believe that if the blueprint necessitates cost sharing or premium payments that the Oregon Health Authority take an active role in facilitating the collection of cost sharing or premiums. As has been mentioned in task force meetings, not all CCOs possess the inherent capacity to administer private insurance-like functions.	Staff have not included references to cost sharing in the body of the report as members requested to avoid language that may imply endorsement of this plan design element. Page 61 on alternate plan design scenarios is revised as follows to address this point: "There was a strong preference to avoid deductibles, with smaller numbers of members indicating co-pays or fixed monthly premiums were least preferred choices. Members also noted concerns that CCOs and OHA do not currently collect premiums or co-pays for OHP, and the feasibility of new infrastructure to do so for BHP was a concern. Members preferred that if cost sharing was a necessary element of program design, that OHA rather than CCOs administer this element of the program." Staff acknowledge this issue will need emphasis in future drafts if the Task Force recommendations are updated to incorporate cost sharing.

18	2	We ask that the paragraph describing “silver loading” include a sentence to the effect that mitigation strategies must examine corresponding impacts to the exchange, not just premium increases for people earning more than 200% of the federal poverty limit.	On page 2: “Mitigation strategies will be needed to understand impacts to the exchange, address silver loading, and avoid premium increases for people earning more than 200 percent of the FPL.”
19	3	We suggest that the graph (Exhibit A) mark the declaration of the federal public health emergency, so that readers may view the impact of the declaration on insurance coverage rates. Alternatively, you may consider adding language regarding the impact of the public health emergency on page 6.	This point is addressed on p. 7 but expanded as follows: “Since the PHE declaration, Oregon’s overall uninsured rate fell from 6.0 percent to 4.6 percent between 2019 and 2021, reaching a historic low, with improvements for most racial and ethnic groups.” Staff will update data displays if time allows but need to balance this request against other report finalization efforts.
20	4	We similarly suggest that Exhibit B clearly mark when the federal government declared that the country is experiencing a public health emergency. Without a time scale to see how enrollment trends changed from 2011 and 2021, we believe that readers may not understand the impact of the public health emergency on enrollment trends. Alternatively, you may consider adding language regarding the impact of the public health emergency on page 6.	Addressed on p. 7 as described above
21	5	Since the concept of “churn” greatly informs the task force work, we ask that the report expressly discuss the impacts of churn on members and on the greater health care community. We suggest that the examination include how churn leads to delayed care, worse outcomes for members and more expensive care for which the state becomes responsible. We also submit that the report must examine the impact of churn on providers.	Pages 4-5 discuss churn and are expanded as follows: Churn disrupts access to care for people losing coverage and for those transitioning between coverage types. A review of literature on Medicaid (Sugar, et al, 2021) notes people experiencing churn are: • Are less likely to receive preventive care or refill prescriptions, • Are more likely to visit emergency departments or be hospitalized, • Report declines in overall health and harmful effects on the quality of their health care. Churn is also disruptive to health plans and health care providers, increasing administrative costs and undermining the management and monitoring of members’ care quality over time. (Sugar, et a., 2021) A 2015 study simulating Medicaid churn from pre-ACA data (2005–2010) estimated that the process of disenrolling and re-enrolling one person in coverage within a year incurred administrative costs between $400 and $600. A national study of Medicaid service utilization and costs estimated that churn resulted in a $650 per-member per-month increase in acute care costs (driven primarily by higher

			emergency department utilization and inpatient stays) and an overall $310 per-member per-month increase in total costs.
22	8	"People earning between 138-200% of the FPL **were** anticipated to be disproportionately impacted by disenrollment, as this group had seen substantial coverage gains during the pandemic, relative to people in other income groups (see Exhibit D)." I think "were" should be "are". It is a forward looking statement, and still true.	Page 8 revised as follows "People earning between 138–200 percent of the FPL are anticipated to be disproportionately impacted by disenrollment, as this group had seen substantial coverage gains during the pandemic, relative to people in other income."
23	14	We believe that the Oregon Health Authority could not implement a state-based exchange until at least 2026, given legislative approvals and the "stage gate" process required by the Oregon State Chief Information Office.	Oregon Health Authority indicates that while they cannot guarantee a specific date, the agency aims for this transition to occur by 2025. LPRO acknowledges the comment and revised p. 14 as follows: "This implementation of a Section 1332 waiver to offer this choice would require a state-based marketplace. OHA has indicated a goal of transitioning to a SBM by 2025, with recognition that this process will involve other parties such as the Legislative Assembly and the State Chief Information Officer."
24	15	We believe that in discussing a § 1332 Affordable Care Act innovation waiver on a basic health program that allows for optionality, the task force would also need to undertake an evaluation of the impacts of such a plan on the individual exchange. We also believe that the sentence regarding consideration of a "narrow 1332 waiver request as a mitigation strategy" include language to the effect that the waiver would address effects related to the end of "silver loading."	Page 15 revised as follows: "The Task Force left open the possibility of recommending the state explore a 1332 waiver and BHP-lookalike program in Phase Four, with recognition that this would require additional evaluation of effects to Oregon's Marketplace. […] The Task Force will make additional recommendations related to strategies to mitigate marketplace impacts of a BHP in December 2022, which may include consideration of a narrow 1332 waiver request as a mitigation strategy to address the discontinuation of most "silver loading" (described further on p. 29."
25	18	We remain unclear what is meant by the clause "House Bill 4035 encourages enhancement of the existing CCO delivery model[.]" We ask for clarification on this point.	For discussion at 8/30 meeting
26	18	We ask that the report also clarify that the essential health benefit benchmark plan becomes operative in Oregon after a rulemaking process by the Department of Consumer and Business Services and approval of the submitted benchmark plan by the Centers for Medicare and Medicaid Services.	Page 17-18 revised as follows: "In each state, EHBs are more specifically defined by reference to a "benchmark plan" that outlines the covered services and restrictions within the EHB categories for a given plan year. The state's benchmark plan is established through a DCBS rulemaking process and subject to CMS approval. Oregon's Marketplace benchmark plan for plan years beginning

			on or after January 1, 2022, is available through the DCBS Division of Financial Regulation (OAR 836-053-0012)."
27	18	We would also ask that the report include information discussing the actuarial values of the basic health program benefit designs in New York and Minnesota, for comparison purposes.	Staff do not have formal actuarial values for New York or Minnesota's plans but will see whether this can be obtained for inclusion in the second report.
28	19	I find the text describing the catastrophic plans out of sync with the pattern set by the bulleted text of the metal plans. Although there is no relevant AV threshold for catastrophic plans, seems like you could convey some of the same information. Also "and some low-income people" is vague. I'm not sure I have a less vague suggestion, but we could at least use the same language as the program… **Catastrophic** *plans have high deductibles with little coverage for routine care, and are only available to people ages 30 and younger, or others granted affordability/hardship exemptions.*	Page 19 revised as follows: "**Catastrophic plans,** with lower premiums but higher deductibles and OOP costs than other QHPs. These plans are only available to people age 30 and younger, or who qualify for hardship or affordability exemptions."
29	19	We ask that the actuarial value of both platinum-level plans (90% AV) and the Oregon Health Plan (100% AV) be included in the report. Including the actuarial values of the highest-tier "metal level" plan as well as the medical assistance plan will help readers understand relative benefit design.	Page 19 revised as follows: • "…gold plans, with an AV of 80 percent; • cost-sharing reduction (CSR) plans, with an AV of 94 percent; and • catastrophic plans… In contrast, OHP coverage has an AV of 100% and does not impose monthly premiums or other cost sharing on members."
30	21	the discussion on Medicaid premiums in Oregon should also include any examination from the cited report on impacts to providers and their experiences, if any.	The referenced article does not include findings related to provider experiences, but this topic can be addressed in the second report.
31	23	While it is true that House Bill 4035 (2022) requires the task force to examine how coordinated care organizations may be required to accept enrollees in the bridge program, the report does not examine if this provision is capable of being done without some corresponding responsibility on providers to also accept bridge plan enrollees. We ask that the report at least make note that the task force did not examine how provider acceptance rates may impact coordinated care organization legal responsibilities.	CCO requirements to maintain adequate provider networks are addressed on p. 24-25. Staff have noted this issue for discussion in October when actuarial analysis is available to inform discussion about provider reimbursements. Page 25 revised as follows: "One concern from Task Force members related to the possibility that providers could see reduced reimbursements for care of enrollees covered through the Marketplace who transitioned to the BHP, if the BHP reimbursed at a level closer to OHP. HB 4035 also does not address (and the Task Force did not discuss) whether CCO-contracted providers may be required to accept BHP patients, which may affect CCOs' ability to meet their own requirements. Actuarial analysis to estimate BHP capitation rates was not

			fully available at the time of this report (see "Feasibility Study Findings"), and Task Force discussions were preliminary and conceptual. Members noted the fragility of the existing health care delivery system due to workforce and financial strains from the pandemic. There was a desire to "keep providers whole," minimizing these potential impacts on provider reimbursements.
32	23	The report states that House Bill 4035 requires that the basic health program be provided through CCOs. We ask for clarity here, as the act specifies that if within the agency's legislatively adopted budget and within federal resources, the basic health program must be "offered" through CCOs.	Staff presentations to the Task Force to date have interpreted House Bill 4035 language "be offered by CCOs" to mean "coverage would be provided by CCOs."
33	26	While we support the advancement of value-based payments we believe that a basic health program poses more fundamental implementation challenges to coordinated care organizations. In terms of operations, coordinated care organizations will need to hurdle setup/enrollment issues, disenrollment procedures, educational materials for members and for providers, network development/provider contracting, case management, appeals and grievances, governance, financial reporting and other matters in order to successfully implement a basic health program. Even through the task force report recommendations call for the basic health program benefit design to fully align with the Oregon Health Plan, future subtle shifts between the approved basic health plan blueprint and the Oregon Health Plan may necessitate benefit design work on the part of the coordinated care organizations.	The flagged paragraph on p. 26 falls within the section on plan rates and provider reimbursements. Staff instead propose these revisions to pp. 31-32 as follows: "Additional CCO operational issues were identified in Task Force meetings that could pose implementation challenges for CCOs and required further exploration prior to program launch. These included: • Consideration of CCOs' infrastructure and whether it supported their ability to collect premiums or other OOP cost-sharing design elements, given that these are not elements of OHP. • Questions regarding how member assignment to CCOs would occur in regions served by multiple CCOs. • How BHP performance and financial reporting requirements may align or differ from OHP at launch and over time. • How OHA may operationalize any recommendation that CCOs should reimburse providers at higher rates for BHP than OHP covered services, given that CCOs typically negotiate their own provider reimbursement rates. • Whether CCOs would have sufficient time and advance notice of operational changes needed to launch or sustain the BHP, including enrollment and disenrollment procedures, case management, appeals and grievances, governance, network development, provider contracting and reporting requirements. • Need for educational materials for members and providers."
34	27	We believe that the $12-69 million projected surplus for the study population needs to factor in administrative costs into the possible capitation rates. Even capped, modest administrative allowances may have a material impact on the available funds that could support higher than Oregon Health Plan capitation rates.	Page 27 revised as follows: • "Estimated costs to cover to the study population were $317 million if providers were reimbursed for their care at OHP reimbursement levels. Estimated costs did not consider plan administration expenses or the cost of services other than EHBs provided by CCOs.

			• A projected surplus of $12–69 million for the study population suggested it would be possible for the BHP to support higher-than-OHP capitation rates paid to CCOs. The feasibility study provided initial cost estimates for planning purposes; additional actuarial analysis anticipated in fall 2022 will provide more specific cost estimates based on Task Force plan design preferences."
35	31	In addition to considering whether coordinated care organizations maintain sufficient infrastructure to collect cost sharing, we ask that the report highlight if the Oregon Health Authority's infrastructure is correspondingly robust to implement cost sharing in the medical assistance plan.	Page 31 revised as follows: • Consideration of CCOs and OHA infrastructure and whether it supported the collection of premiums or other OOP cost-sharing design elements, given that these are not elements of OHP.
36	35	We ask that recommendation number 2 (related to phased implementation) also call for the submission of a basic health program blueprint for federal approval on a timeline that harmonizes with coordinated care organization rate filings and with the individual/small group rate review process overseen by the Department of Consumer and Business Services. Alternatively, the recommendation might include a starting date calculated to avoid these various rate filing processes.	Since this proposed edit to the recommendations was received after the final draft was circulated for review, staff did not recommend an update for the September report.
37	36	Request to add a recommendation that the state ensure that OHP members receiving Long-Term Services & Supports don't lose those benefits if they're forced to transition from OHP to the BHP during redetermination;	Since this proposed edit to the recommendations was received after the final draft was circulated for review, staff did not recommend an update for the September report. Additional background information on this topic is included in the Q&A document. As noted there, LTSS are not covered through CCOs; they are covered through ODHS. The Q&A also discusses Oregon's pending waiver application to expand home and community-based services (a subset of LTSS) access up to 400% FPL. ODHS is overseeing this waiver application. The 1331 BHP funding formula is based on the costs of covering the Essential Health Benefits in commercial plans, which do not include LTSS. HB 4035 did not direct the Task Force to consider LTSS. Accordingly, the feasibility study presented in June did not examine the costs associated with including LTSS in the covered service package.
38	36	Request to add a recommendation that the state allow and incentivize CCOs to provide Health-Related Services (HRS) for BHP members, and that Oregon expand the SHARE initiative to apply to CCO provision of the BHP.	Since this proposed edit to the recommendations was received after the final draft was circulated for review, staff did not recommend an update for the September report.

			Additional background information on this topic is included in the Q&A document. OHA intends to allow and incentivize CCO spending on HRS for BHP enrollees within available funding.