COALITION FOR A HEALTHY OREGON

Oregon's Voice for Community Based Health

February 7, 2024

Via email only

Co-Chairs Lieber and Kropf, Members of Joint Committee On Addiction and Community Safety Response:

For the record, my name is Henry T. O'Keeffe. I am the Vice-President of Health Care Policy at the Pac/West Lobby Group. I am here today on behalf of my client, the Coalition for a Healthy Oregon (COHO). As you likely know, COHO is a group of coordinated care organizations (CCOs) that serve nearly 370,000 of Oregon's Medicaid members through the Oregon Health Plan. CCOs comprise a public private partnership dedicated to comprehensively meeting the health needs of their members within their local communities.

COHO's vision is for local communities to deliver high-quality, cost-effective services to improve health and reduce health disparities. Since CCOs started in 2012, they have simultaneously comprised the cornerstone of local health, and the foundation of the Oregon healthcare system, writ large. This is particularly true in Oregon's rural and frontier areas. CCOs partner with their local communities with shared risk, creating shared responsibility, turning shared goals into shared success.

In that vein, it is the mission of CCOs to ensure that care is available to the communities that they serve utilizing finite resources provided to them by the State, and the qualified providers available to provide those resources. Thank you for taking public testimony about HB 4002, and its Dash 1 Amendment today. Keeping that in mind, we believe that there are several components of the Dash 1 Amendment to HB 4002 that should be modified to both advance patient safety, and prevent Medicaid fraud, waste and abuse.

1. **Prior Authorization**

First, Section 5, which discusses prior authorizations should be narrowed a little bit, to account for the nuances of dealing with drugs that have not yet been approved by the FDA but may be in the future, and current generics. We propose adding a few words to the definition and operative sections (new language in **bold**):

(1) As used in this section, 'medication-assisted treatment' means any medication and the dispensing or administration of the medication that is approved by the United States Food and Drug Administration for the treatment of substance use disorders, including opioid and opiate addiction, **on or before January 1, 2024**.

(2) The Oregon Health Authority shall prohibit coordinated care organizations and public payers of health insurance, when reimbursing the cost of medication-assisted treatment for treating substance use disorders, including opioid and opiate addiction, **except that where a generic drug exists, coordinated care organizations may require prior authorization for the reimbursement of the costs of the brand-name drug**.

2. **Network Adequacy – Credentialing Database**

Next, as it pertains to network adequacy, we believe that we should incorporate an existing program that the Oregon Health Authority has yet to implement, to the best of our knowledge. In 2015, the legislature passed HB 2231, which added a requirement to ORS 430.637, to require OHA to establish a provider database. See ORS 430.637(9). You can find the bill here for your reference: https://olis.oregonlegislature.gov/liz/2015R1/Downloads/MeasureDocument/HB2231

We propose adding a new section to HB 4002, in order to reduce the administrative burden faced by these providers who are statewide resources:

> **New Section: (1) The Oregon Health Authority must have the database described in ORS 430.637(9) operational no later than October 15, 2024.**

As an aside, we understand that the addition of the phrase "including but not limited to addiction treatment providers" to ORS 414.609(1) is meant to be a value statement, without legal impact. We believe that a more appropriate place for values statements would be a "Whereas Clause," rather than an amendment to an ORS, which by design usually has the force of law. Consequently, we would recommend eliminating Section 11, and placing that value statement in a "Whereas Clause" instead.

3. **Emergency Refills**

Finally, when it comes to emergency refills, first referenced in Section 7, we would like to propose some slight changes. We believe Section 7 should be amended as follows (new language in **bold**):

(1) **As used in this section, 'emergency refill' means a seven-day supply of the medication.**

(2) A pharmacist may prescribe and dispense emergency refills of medications for the treatment of opioid use disorder to a person who has **written** evidence of a previous prescription from a licensed health care provider.

(3) A pharmacist who prescribes and dispenses refills under this section shall:

a. Complete a patient assessment to determine whether the prescription is appropriate;

b. Document the patient visit and include notations regarding **written** evidence of the patient's previous prescription from the patient's licensed health care provider, information relating to the patient's treatment and other relevant information; and

c. Notify the patient's primary care provider, and the licensed health care provider who made the previous prescription, of the pharmacist's prescription for refills, to the extent permitted by state and federal law.

(4) The State Board of Pharmacy shall adopt rules to carry out this section including, but not limited to rules that allow a:

a. Pharmacist to apply for and obtain a registration number from the Drug Enforcement Administration of the United States Department of Justice as a mid-level practitioner; and

b. Pharmacy to store on the premises medications for the treatment of opioid use disorder.

(5) The rules adopted under subsection (3) of this section may not be more restrictive than what is permitted by this section.

(6) In adopting rules to carry out this section, the board shall appoint an advisory committee in accordance with ORS 183.333 that includes addiction specialists, emergency department physicians and primary care providers.

If OHP patients are being prescribed more medication than they actually need, it may constitute Medicaid waste, and if they are being prescribed medication that they are not taking at all, it may constitute Medicaid fraud. Consequently, it is important to ensure that emergency refills are delt with carefully, while OHP Members are treated with dignity. We believe that these additions strike the appropriate balance.

Please do not hesitate to contact me in the event you have any questions about these proposed changes to HB 4002, or if you have additional proposals to discuss.

Sincerely,

Henry T. O'Keeffe

Henry T. O'Keeffe
COHO Lobbyist