Memorandum

To: The Health Policy and Analytics Bridge Program Team

From: The Oregon Primary Care Association and Undersigned Members

Date: June 9, 2023

Re: Draft Blueprint for the Basic Health Plan

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 436,000 Oregonians. 41% of health center patients identify as a racial or ethnic minority, **18% are uninsured**, 68% are publicly insured (OHP, CHIP, and/or Medicare), 8% are experiencing houselessness, and 3% are veterans. At over 270 sites, spanning permanent clinics, mobile units, and school-based health centers. CHCs provide care to some of Oregon's most vulnerable populations, **including one in four Oregon Health Plan (OHP) members**.

We are grateful for the opportunity to provide comments on the Draft Blueprint for the Basic Health Plan on behalf of Oregon's community health centers. Of the patients they serve, approximately 35,000 (17%) are anticipated to lose their OHP coverage. While it is possible that some can afford a Qualified Health Plan on the marketplace or through an employer, without a Basic Health Plan, many will be caught in the insurance gap. While those patients can continue to receive high-quality, holistic care at their CHC, uninsurance is a barrier to simply getting people in the door to access care. Without insurance, patients may not know if they can afford care at point of service and, because of this, defer care until they find themselves in a health crisis. This is an avoidable health inequity which can be prevented by the establishment of a Basic Health Plan for patients who would fall into that gap.

Eligibility and Enrollment

Throughout the Task Force for the Bridge Health Program process and explicit in the enacting legislation, alignment with the Oregon Health Plan was a clear value. This commitment is demonstrated in the robust covered benefits and Coordinated Care Organization administration of the plan. This will allow for minimal disruption of benefits to the beneficiary. If possible, within Federal Rule we would encourage this value to be carried into the BHP's continuous eligibility period. Due to Oregon's recently approved 1115 demonstration waiver, all adult OHP beneficiaries will experience 2-year

continuous eligibility. This was established to enhance access to coverage and care, as annually navigating renewal processes is a significant burden. As all other elements of the BHP imitate those of OHP, we hope that 2-year continuous eligibility will be considered.

Additionally, while it is not a necessary aspect of the Blueprint, we urge the Oregon Health Authority, the Oregon Department of Human Services, and the Oregon Health Insurance Marketplace to communicate explicitly with partners and beneficiaries how former OHP members will be transitioned to the BHP. We appreciate the provisions made to meet the complex needs of those transitioning off of the marketplace, however, already there is substantial confusion reported by Oregon's CHCs from their patients rolling off of OHP who may be BHP-eligible in the future. As a mechanism for this transition is determined, we encourage clear and comprehensive guidance be developed and distributed.

Coordination of Health Care Services

We applaud the goal of preserving existing primary care homes, both for those who will be transitioning from the marketplace and from the Oregon Health Plan post-redetermination. This allows for continuity of care with trusted providers, ensuring that chronic illnesses continue to be managed and prevented and people's needs are met in the communities where they live and work. Partnering with existing community-based networks to support outreach and enrollment efforts will enhance equitable uptake of the plan for communities of greatest need. We encourage a similar approach be taken when the BHP falls under the administration of a State-Based Marketplace, upon its establishment. Efforts and funding should be allocated for the enhancement of health system literacy of both outreach and enrollment workers and plan beneficiaries so they can make that transition smoothly, without lapse of benefits, and in a way which maintains their existing provider network.

Premiums and Cost-Sharing

We support the continued alignment of the Basic Health Plan with the vision set forth by the Task Force for the Bridge Health Program, which included zero cost-sharing for enrollees. Research demonstrates that premium and co-pay costs are associated with low plan uptake and deferred care due to costs at point of service. These costs disproportionately impact communities of color and are most felt when moving from a plan with zero cost-sharing (like OHP). For these reasons, we are grateful to see this reflected in the draft Blueprint.

Benefits

We also support the close alignment of covered benefits to what is currently covered in the Oregon Health Plan. This will ensure that the shift from the Oregon Health Plan to the Basic Health Plan is unfelt by beneficiaries and that they will continue to access primary and preventative care in their existing provider networks. However, we do note that there are some elements of the state plan which are not made explicit in the draft Blueprint. We specifically speak to the following:

- The inclusion of health care interpretive services in a claim if that interpretive service is a part of the provision of a Medicaid service.
- The optional targeted case management benefit for specific priority populations, as outlined in the State Plan.
    - While the draft Blueprint does cover targeted maternity case management services, the Oregon Health Plan covers these services for other significant populations who experience health care inequities due to social determinants of health.
    - This creates inequitable access to vital care coordination resources as well as confusion for providers who may be referring patients to targeted case management services. Providers may not know who of their patient panel is on the BHP and who is on OHP and, because other services are identical, may not realize that they are referring patients to care outside of their benefits package.

While we acknowledge uncertainty around funding for the Basic Health Plan based on actual plan costs, we encourage consideration of including these benefits explicitly in the Basic Health Plan. As the federal funding accrues over time, we hope the plan benefits also become increasingly robust.

Provider Reimbursement

We recognize that provider reimbursement rates are complex negotiations involving providers, CCOs, and OHA. However, for the Basic Health Plan, we encourage that the floor for these rates be established with the understanding that they shall increase over time to above-OHP levels of reimbursement. Provider reimbursement is highly correlated with whether patients can access care; specifically, whether a patient has access to a regular source of care and experiences appointment availability are positively impacted by above-Medicaid reimbursement rates.

Additionally, in keeping with our prior testimony on the record for the Task Force on the Bridge Health Program, we urge continued consideration of cost-based reimbursement for Federally Qualified Health Centers and other safety net providers. As a result of the Public Health Emergency Unwinding, George Washington University anticipates that approximately 36,000 Oregonians currently on OHP and being seen at Oregon FQHCs will lose their eligibility for OHP. This is 17% of the FQHC patient population in the state. Without intervention, across all health centers it is expected that there will be a 10% revenue loss as a result of this shift. This revenue loss will not be the same across all clinics – some may experience a disproportionate share of this loss. It will also be absorbed in different ways – some health centers may leave critical open positions unfilled, while others may need to reduce hours and locations of mobile clinics or reduce services that are unreimbursed to maintain their network adequacy. All of these responses directly impact patient access to and experience of care. Failure to adequately reimburse FQHCs for cost of care will negatively impact their entire patient population and service array, not just the patients on the Basic Health Plan. We are grateful for the continued conversations regarding reimbursement we have had and the commitment to this goal in the Task Force Recommendations and hope that they will continue.

Sincerely,

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