End HIV/STI Oregon Statewide Planning Group (OSPG) Meeting Notes

February 19, 2025, 1:00 - 4:00 p.m.

Announcements

- Pete Singson, MD is the new Medical Director for the HIV/STD/TB Section. Welcome Pete!
- Chime In is offering incentivized, anonymous health surveys and HIV testing for this year's data collection cycle (summer 2025). Please contact the Chime In team if you'd like to help spread the word!

Oregon's response to federal changes

As shown in this video, Governor Kotek is committed to standing up for all Oregonians and for Oregon values. She is committed to protecting access to reproductive and gender affirming care and upholding civil liberties for all people, including women, LGBTQ+ people, immigrants, and people of color. Governor Kotek's team is analyzing the president's executive orders and their potential impacts. This work will be ongoing.

Currently, Governor Kotek and OHA Director Dr. Hathi have instructed OHA to make no changes to programs and services. Federal funding agencies have not communicated specific changes to OHA either. Oregon has laws that prohibit discrimination based on gender identity, that support access to gender affirming care, and that prevent state and local police from helping with federal immigration enforcement efforts.

OHA HIV/STD/TB Section staff attend state and national meetings to stay informed of changes at the federal level and analyze their impacts on Oregonians. OHA has convened a federal response team with representatives from multiple state agencies, including the Department of Justice. This group is addressing a range of issues, including reproductive health and harm reduction. The HIV/STD/TB section will communicate relevant information as it becomes available.

Resources:

- Oregon Criminal Justice Commission
- Find your local legislators.
- Contact the Governor at Governor.Kotek@oregon.gov or 503-378-4582.
- Contact Attorney General Dan Rayfield at AttorneyGeneral@doj.oregon.gov

SSI/SSDI Pilot Project

The Oregon Housing Opportunities in Partnership (OHOP) program helps people living with HIV (PLWH) who have low or no income achieve and maintain housing stability and avoid homelessness. In turn, this helps improve their access to and engagement in HIV care and treatment. In 2025, the OHA HIV/STD/TB Section, OHOP launched a pilot project with the Oregon Department of Human Services (ODHS) Collaborative Disability Determination Unit to assist PLWH applying for public benefits. The Collaborative Disability Determination Unit serves individuals with disabilities across ODHS program areas (e.g., Self-Sufficiency, Aging and People with Disabilities (APD), Developmental Disabilities)

OHA has identified the need for this project both within and outside of OHOP. Approximately 50% of clients involved in OHOP, Victor Fox Cultivate Housing Services (a program by EOCIL), and the Oak Program (a program by HIV Alliance) report having zero income. A recent survey of Ryan White HIV case management clients in Part A (the Portland metro five-county area) found that nearly half (46%) reported having a disability and more than one-third (38%) reported zero income. Approximately one quarter (23%) of Ryan White case management clients in Part B (the 31 counties that comprise the "Balance of State") also reported zero income.

The ODHS Collaborative Disability Determination Unit is an ideal partner as it 1) has a statewide reach, 2) offers rural Oregon access to experts in the field, 3) is modeled after a successful program, and 4) has an 86% success rate. ODHS has a general Assistance Program that serves homeless presumptive Medicaid consumers—providing housing assistance, utility assistance, a small cash grant, and assistance with applications and appeals for Social Security disability benefits. ODHS Disability Benefits Law program staff assist APD and Area Agency on Aging consumers with applications and appeals for Social Security disability benefits. ODHS makes disability determinations for APD Oregon Supplemental Income Program medical coverage and has a State Family Pre-SSI/SSDI Program that assists Temporary Assistance for Needy Families (TANF)-eligible adults with disabilities with their Social Security applications and appeals.

OHOP has trained its team of OHOP Housing Coordinators, created an internal referral process, and developed scripts and expectations for the team.

The phased timeline for this project (2025-2029) includes:

- Year 1: Assist OHOP housed clients and clients on the waitlist
- Year 2: Assist clients in the Balance of State
- Year 3: Assist Part A clients
- Year 4: Implement the program statewide

To measure success, ODHS will assess timeliness and accuracy, while OHOP will monitor the number of people referred, the number of and reasons for denials, the number of people and amount awarded, and the length of the wait time to receive benefits.

After launching the pilot program in 2025, staff have learned and adjusted some practices. The program now involves less paperwork and allows clients to sign documents electronically. Staff are also exploring the use of text messages to improve client communication.

Discussion

- Really phenomenal work to everyone involved with this important and impactful program.
- Q: Is there a limit or goal that is set in stone based on the program budget?
    - A: We are starting with OHOP clients since they are a small group with a high need for financial support. Each year, our goal is to learn, improve the implementation process, and expand the program.
- Q: How is the success rate measured?
    - A: Of the people we work with, we will track the proportion that completed the process and are receiving benefits. Of the people that are not eligible, we will track the proportion who were referred to other services that can benefit them.
- Q: How are we ensuring that we are communicating this new resource to the people who need it most, including LGBTQ+ people, people of color, and people who speak Spanish?
    - A: Many Disability Benefits Law liaisons are bilingual. They also work with interpreters. As part of the pilot project, we will evaluate our success working with different populations.
- Q: Is this project for Part B?
    - A: For year 1, it will serve OHOP clients. We hope to expand the project in subsequent years.
- Q: Will this service be available to people who have SSDI and need help due to a lapse in services or changes related to their disability?
    - A: The program will serve a range of clients, including new clients and people who were previously denied assistance.
- Q: Are these services free of charge?
    - A: Yes.
- Q: If a person has back pay, does the program take that back pay from them?
    - A: No.
- Fundraising could help address homelessness.

CAREAssist: A Key Player in Ryan White Services in Oregon

CAREAssist is Oregon's AIDS Drug Assistance Program (ADAP). ADAP is a federally funded program administered by Health Resources and Services Administration (HRSA), under the Ryan White Program. Each year, CAREAssist provides financial support to approximately 4,000 people living with HIV (PLWH) to cover insurance, medical/dental premiums, medical/dental copays, and medications.

The 340B Drug Pricing Program

The 340B Drug Pricing Program is a federal program also administered by HRSA. Eligible providers who serve low-income persons are known as covered entities. Covered entities can purchase outpatient medications at a discount and are then able to obtain reimbursement through insurance when applicable. The purpose of the 340B Drug Pricing Program is to stretch scarce resources as far as possible, reaching more eligible people and providing more comprehensive services. CAREAssist is a covered entity, as well as many others (e.g., federally qualified health centers, rural health centers, HIV clinics, homeless clinics, critical access hospitals).

CAREAssist currently contracts with more than 30 pharmacies across the state to dispense medications to eligible clients. These contract pharmacies are covered entities that are required to collect the insurance reimbursement that is owed to CAREAssist and remit this payment through the program's pharmacy benefits manager (PBM). CAREAssist currently uses 340B allowable reimbursements to fund approximately 80% of its budget. These funds are also used to support case management, housing, behavioral health, and early intervention and outreach services.

Manufacturer 340B Policy Changes

Since 2020, drug manufacturers have been changing their policies, making it harder for covered entities to obtain discounts. HRSA currently has limited authority to intervene. To date, CAREAssist has been able to mitigate these policy changes without service disruption (i.e., federal carve out, manufacturer waivers, process changes and manufacturer compliance). CAREAssist will conduct additional assessments this year and review other program models to address additional savings loss/potential savings loss.

Manufacturer Lawsuits

HRSA continues to try to stop manufacturers from making 340B program changes without federal approval. Several manufacturers have sued the federal government. So far, HRSA has not been able to end restrictions on contract pharmacy program models. Several manufacturers recently filed a new lawsuit seeking to end insurance reimbursement by implementing a rebate only model.

State-Level Response

Many states have enacted law or introduced bills to prevent manufacturers from restricting drug pricing through contract pharmacy arrangements. So far, the courts have upheld these state laws.

Two similar bills have been introduced (HB 2385, SB 533) in the Oregon 2025 legislature that aim to make it unlawful for drug manufacturers to interfere directly or indirectly with a pharmacy or drug outlet acquiring 340B pricing, delivering 340B medications to health care providers, or dispensing 340B medications. These bills would also make it unlawful to request additional data, unless approved by HRSA. One bill has been introduced (HB 2057) that would not require that drugs be labeled as 340B drugs in a claim for repayment.

You can learn more from the Oregon Primary Care Association, by attending CAREAssist Advisory Group meetings, and by participating in OSPG meetings and contributing to the development of Oregon's new five-year comprehensive plan.

Discussion

- If it were not for CAREAssist, I would not get medications. THANK YOU CAREAssist.
- Q: Can you share what would happen if we lost CAREAssist income?
    - A: CAREAssist program income supports not only CAREAssist, but also housing, behavioral health care, enhanced case management services, and early intervention services across the state. 340B has been under attack for decades, and these attacks have gained momentum.
- Any loss of Part B supplemental income would impact our programs. It's hard to predict the total impact; we are monitoring this situation constantly.
- ADAP seems to be caught in the middle of disagreements between pharmaceutical companies and hospitals. Many people don't understand that ADAP exists in every state and does not provide health care services directly.
- Q: How well briefed is the Oregon Professional Delegation on this policy issue? Are advocacy efforts needed?
    - A: It seems that awareness has increased substantially in recent years. However, the pharmaceutical industry has many lobbyists. OHA is creating an educational fact sheet that partners can use if desired. There are also some national 340B advocacy materials that OPCA may share later.

Oregon Legislative Session

A number of bills currently being discussed in the Oregon Legislature have the potential to impact HIV/STI services. The following organizations presented information about these bills.

Oregon Primary Care Association (OPCA): 340B Legislation

OPCA is the voice of Oregon's Federally Qualified Health Centers, who deliver integrated medical, dental, and behavioral health services to more than 470,000 Oregonians at more than 270 locations statewide.

House Bill 2385 and Senate Bill 533
Pharmaceutical manufacturers have imposed restrictions on federally qualified health centers and other 340B covered entities since 2020. Since then, eight states have enacted contract pharmacy access protections, and many others have introduced legislation this year.

OPCA's 340B legislation involves two bills:

1. HB 2385 seeks to make it an unlawful practice for drug manufacturers to interfere directly or indirectly with a pharmacy or drug outlet acquiring 340B drugs, delivering 340B drugs to certain health care providers or dispensing 340B drugs.
2. SB 533 seeks to create a civil penalty for drug manufacturers that interfere directly or indirectly with certain entities acquiring 340B drugs, delivering 340B drugs to certain health care providers or dispensing 340B drugs.

HB 2385 and SB 533 were modeled after legislation in states that have successfully enacted contract pharmacy restriction prohibitions and include all covered entity types.

A public hearing for SB 533 is scheduled for February 27. If you'd like to provide testimony, contact Marty Carty at 503-228-8852, x239 or mcarty@orpca.org.

House Bill 2057

HB 2057 would prohibit PBMs from requiring 340B covered entities to place a marker on all 340B dispensed drugs. For many years, manufacturers have used claims identifiers to discriminate against 340B covered entities. This bill is likely to be amended.

Pharmacies don't know whether a drug is a 340B drug when it's dispensed. This is determined days after the date of disbursement. To reduce the administrative burden, OPCA has supported HB 2057. This bill benefits FQHCs (such as the Ryan White Clinic in the Multnomah County Health Department). It decreases the administrative burden for contract pharmacies and improves transparency.

Among Medicaid claims where reporting was mandatory, 25% - 49% of drug treatments used modifiers for 340B eligible drugs. Among Medicaid claims for self-administered drugs across all payers, only 50% of branded, 340B-eligible pharmacy claims used a 340B modifier at entity-owned pharmacies; This proportion fell to less than 1% at contract pharmacies. Pharmacy chains have stated they will *not* add claim modifiers at the point of sale.

Discussion

- Q: Are legislators aware of HB 2057?
    - A: Representative Rob Nosse introduced this bill for OPCA. OPCA has also been working with PBMs. However, drug manufacturers have concerns, and it's possible that an amendment will be drafted to address their concerns.
- Q: Can you summarize why drug manufacturers have imposed restrictions on 340B covered entities?
    - A: The 340B program allows covered entities to purchase drugs at a discount, which means the drug manufacturers make less money. If the number of covered entities declines, then manufacturers are positioned to make more money.
    - For CAREAssist, limiting the number of pharmacies that are covered entities could create serious problems related to medication access in rural areas.

Caring Ambassadors

Caring Ambassadors Program is a national nonprofit advocacy organization based in Oregon City. Caring Ambassadors provides education, support, and advocacy for people living with chronic diseases, focusing on lung cancer and hepatitis C. Additionally they host the Oregon Viral Hepatitis Collective and HepEliminationRoom.org.

Senate Bill 844 created the Prescription Drug Affordability Board (PDAB) to evaluate the cost of prescription drugs and determine whether they present an affordability challenge for consumers and health systems in Oregon. PDAB's review will inform rulemaking criteria for evaluating drugs, such as health inequities, the number of Oregon residents prescribed the drug, and the price of the drug in Oregon. The board has studied the prescription drug distribution and payment system in Oregon and the generic drug market and provided recommendations to the legislature. The Oregon Legislature acted on the board recommendations by passing Senate Bill 192 in June 2023. PDAB meets once per month. There are opportunities to get involved and help ensure that consumer voices are heard.

Upper payment limits: 1) are a complex issue, 2) will not reduce out-of-pocket costs to the consumer, 3) may reduce access, and 4) disrupt a fragile healthcare system.

Pharmacy Benefit Manager (PBM) Reform is intended to:

- Help expand patient choice for pharmacies by 1) stopping PBMs and payors from defining "specialty drugs" that steer patients from their pharmacy of choice, 2) stopping mandatory mail order, 3) requiring PBMs and payors to accept any willing pharmacy, and 4) prohibiting unfair and deceptive pricing models like spread pricing and claw backs of payments.
- Pass along PBMs' savings from rebates to the health plans and patients.
- Ban PBMs from using discriminatory formularies by 1) following new federal section 504 rules barring use of discriminatory measures like quality adjusted life years to inform formulary and utilization management, 2) banning non-medical switching, therapeutic equivalent, 3) banning alternative model plans, and 4) broadening access to generics (Note: biosimilars are not generics).
- Delink PBM profit from list price.
- Create a uniform preferred drug list and prior authorization criteria for Medicaid.

Independent pharmacies are going out of business, and Oregon ranks #2 in the country for the least amount of pharmacies per population. The establishment of dispensing fees for all prescriptions is being proposed in Oregon (HB 3212). The fee would vary (e.g., $10-$20) depending on the volume. These fees will be passed on to consumers at the point of sale. The bill has no consumer protection language. Pharmacies support this bill. Caring Ambassadors invites others to get involved in efforts to address this bill. Legislators need to hear from patients.

Resources:

- Value of Care Coalition
- Ensuring Access through Collaborative Health (EACH) Coalition

Discussion:

- Q: How can we prepare for the possibility that Oregonians may not be able to afford HIV medication in the future?
    - A: Trust that Oregon is working to maintain its programs and is committed to supporting PLWH.
    - Reaching out to our representatives and political leaders can help.
    - If eligible based on income, PLWH should apply for CAREAssist.
- Q: Why does Oregon have such a low ratio of pharmacies to people?
    - A: It's possible that Oregon may have different reimbursement rates compared to other states. We also have many rural areas, and Rite-Aids and Bi-Mart pharmacies have closed.
- Q: How can we help?
    - A: Contact Lorren at Caring Ambassadors to get involved.
- PDAB's work does not impact CAREAssist clients.
- Please note that CAREAssist's PBM operates differently than other PBMs. CAREAssist's PBM does not set any rates or collect any additional fees outside of the contract with OHA.

- The Oregon Viral Hepatitis Collective meets monthly from 5:00 - 6:00 p.m. on the second Wednesday of the month. Contact Lorren if interested.
- Chime In offered HIV and hepatitis C testing to clients last year. It was clear that many people lacked information about hepatitis C treatment. Chime In data collected from people who injected drugs will be released soon.

Cascade AIDS Project (CAP)

CAP is the oldest and largest community-based provider of HIV services, housing, education, and advocacy in Oregon and Southwest Washington. Two of the bills that CAP is championing right now are 1) HB 2942 and 2) HB 2943.

Why was HB 2942 introduced?
HB 2942 aims to allow pharmacists to credential and enroll as "in-network providers" with health plans and CCOs and bill for services provided within their scope of practice in the same manner as other providers.

In 2021, HB 2958 was signed into law, expanding the prescriptive authority of pharmacists to include HIV pre- and post-exposure prophylaxis (PrEP and PEP). This allowed Oregonians to access these critical medications by going to the pharmacy instead of having to wait for an appointment with a primary care provider. What we have found, however, is that many pharmacists have not been prescribing PrEP/PEP.

Currently, health plans and CCOs are not required to credential and enroll pharmacists at "in-network providers." Since they are considered "out-of-network" providers, the health plan routes their claims for reimbursement through the pharmacy dispensing billing department as opposed to medical billing (where claims for reimbursement submitted by other providers are processed). The claims are denied since the claim is for services provided and the pharmacist is not an "in-network" provider. Technically, a pharmacist could contact the insurer to try and get the claim re-routed through the appropriate channels, but this is a lengthy process and rarely results in a paid medical claim for the pharmacist. Rather than navigating this burdensome process, knowing they aren't going to be able to count on getting reimbursed for their services, many pharmacists have opted out of prescribing PrEP altogether.

What's involved when prescribing PrEP?
The protocol for prescribing HIV PrEP is very involved. Before prescribing a patient HIV PrEP, a provider must:

- Engage in a clinical assessment with a patient to determine their eligibility for the medication using CDC guidelines.
- Order a set of labs for the patient to confirm that they are HIV-negative and have good kidney functionality.
- Review lab results and follow-up with the patient to inform them of their results and their determined eligibility.

- Inform the patient of the medication they are being prescribed, how to take it, and how it may affect their body.

PrEP is also dispensed in 90-day quantities, and a patient must get lab work done once every 90 days to confirm that they are still HIV-negative and that their kidneys are continuing to function properly. A provider must review the results of these labs before refilling a patient's prescription.

Who is disproportionately impacted by HIV?
- People ages 55-64 (HIV prevalence)
- People ages 25-34 (new diagnoses)
- Black/African American people
- Hispanic/Latino people
- Men who have sex with other men
- Rural communities, and more.

How will HB 2942 solve the issue?
Allowing pharmacists to credential and enroll as "in-network" providers would streamline the billing process and make it easier for them to be reimbursed for the services they are providing. This will incentivize more pharmacists to exercise the full extent of their prescriptive authority and be willing to prescribe PrEP and PEP (and other medications that have an involved protocol).

The lifetime medical cost saved by avoiding one HIV infection is $322,064 (2012 USD adjusted for inflation). Oregon averages approximately 200 new cases each year. $322,064 x 200 = $64.4M in lifetime savings per year.

Discussion about HB 2942:
- Some insurance companies are only paying for a 30-day (not 90-day) supply of medication.
- Prior authorizations are becoming a pain to go through.
- The OSU School of Pharmacy and others have been working hard to train pharmacists and pharmacy technicians to do this work.
- Q: Does reimbursement impact private health plans and Medicaid and Medicare the same way?
    - A: I'm uncertain. However, the language in recent bills suggests the issue may be relevant to both private and public insurers.
- The Oregon AETC website includes pharmacy prescribed PrEP educational resources, as well as access to provider lists for PEP/PrEP.
- Right now, the only retail pharmacy that I know has stated that their pharmacists are prescribing PrEP is Safeway, and only a select few of them.
- Q: Were there other barriers for pharmacists, like comfort or time involved in prescribing PrEP?
    - A: It seems that reimbursement has been the primary concern, but those concerns may warrant exploration, too.

Why was HB 2943 introduced?
This bill seeks to require hospitals to conduct opt-out HIV and syphilis testing on all emergency department patients already receiving other bloodwork. There are persistent subsets of people at high risk for HIV and/or syphilis infection whose only interaction with any kind of medical care is at the emergency department. Oregon has seen increases in syphilis and congenital syphilis. HIV transmission rates are also concerning. Undiagnosed infections fuel the spread of these infections, which can be effectively treated, preventing further transmission. More screening = less transmission = less cases = less burden on public health systems.

Who is disproportionately impacted by syphilis?

- Individuals ages 20-39
- American Indian and Alaska Native people
- Black/African American people
- Hispanic/Latino people
- Native Hawaiian/Pacific Islanders
- Rural communities
- Men who have sex with men

For more information, see CAP's HB 2943 policy brief.

Discussion About HB 2943:

- I think it is important to address the impact of this legislation on congenital syphilis. Emergency/Urgent care should be seen as prenatal opportunities.
- Q: Can you state which organizations are opposing this bill?
    - A: The Oregon Hospital Association, the Oregon Medical Association, the Coalition of Local Health Officials, and others.
    - The bill may be unlikely to pass due to the opposition.
    - If there is a need to simplify the bill, perhaps it would help to focus on congenital syphilis.
- Q: Have other states passed similar legislation?
    - A: Not to my knowledge. I imagine this is due to similar opposition.
- Hepatitis C may have more traction because more Oregonians are impacted by HCV than by HIV alone.
- Q: Have they considered including HCV, Chlamydia, or gonorrhea testing in this bill? It seems like these tests would be beneficial.
    - A: I'm not sure. I will follow up and find out.
- There was no communication with the Viral Hepatitis Collective about this bill.
- Routine screening initiatives require funding for screening and linkage to care for people who test positive. This becomes a greater concern with hepatitis C screening since the prevalence is high.
- Addressing congenital syphilis is a priority. While more screening is needed, implementation is challenging. Health care providers have many existing requirements to navigate. In addition, syphilis test results can take days; This delay creates more work for public health programs that must follow up with patients.

- Q: Does the bill address which type of syphilis testing will occur? Antibody testing alone can miss syphilis infection.
    - No, it doesn't.
- Thank you for a spirited discussion and a great meeting!