

Draft MAC OHP Dashboard Indicators

Overview			
Overall Goals	Area of focus	Key performance measures	Data Source
Obtain information about quality of and access to physical health services delivered to OHP clients	Physical Health	<ol style="list-style-type: none"> 1. Emergency Department utilization rates for asthma 2. EPSDT¹ screening rates 3. Cervical cancer screening rates 4. Breast cancer screening rates 5. Childhood immunization rates 6. LDL² screening rates for clients with AMI, CABG, or PCTA³ 7. % of pregnant women receiving adequate # of prenatal care visits while on OHP 8. Admission rates for short-term diabetes complications 9. % of enrollees with an office visit (not hospital) 	<ul style="list-style-type: none"> • MMIS/DMAP

¹ Early Periodic Screening & Diagnostic Treatment Services are regularly scheduled examinations for Medicaid-eligible recipients under the age of 22 to identify physical and mental health problems.

² Low-density Lipoprotein

³ AMI = Acute Myocardial Infarction; CABG = Coronary Artery Bypass Graft; PCTA = Percutaneous Transluminal Angioplasty

Medicaid Advisory Committee Concept Plan 2010

Overarching Goal: To fulfill the Medicaid Advisory Committee's (MAC) role as advisor to the Oregon Health Policy Board and the Oregon Health Authority on policy development and program administration of Oregon's Medicaid programs, including:

- Oregon Health Plan (OHP)
- Family Health Insurance Assistance Program (FHIAP)
- Healthy Kids
- Other programs using Title 19 and Title 21 funding

Strategic Issues for 2010

1. *Delivery System Reform*

With the cost of health care rising at an uncontrollable rate, it is imperative that Oregon reform its delivery system not only to curb the escalating costs but to improve the quality of care delivered. House Bill 2009 initiated action on several strategies aimed at comprehensive reform, many of which could have a substantial impact on the Medicaid population. The MAC will track both State and Federal movement on these initiatives and provide guidance as it pertains to the Medicaid population to relevant advisory and governing bodies.

Medium Priority:

- Patient Centered Primary Care Homes
- Provider Workforce
- Strengthening the role of the Safety Net

Progress reports/tracking of:

- Federal initiatives and the impact on OHP

2. *Oregon Health Plan Policy*

The Oregon Health Plan (OHP) was developed as a novel strategy for expanding access to health coverage by providing services which are proven effective and valued by Oregonians through the Prioritized List of Health Services. Oregon has capitalized on several CMS waivers since implementation of the Prioritized List to continue this tradition of innovation in high-quality health care delivery. However, opportunities to improve the OHP remain. The MAC will review policies and best practices in order to provide informed recommendation to the OHA on how to maximize the effectiveness and efficiency of the OHP.

High-Priority:

- Long-term care
- Wellness strategies targeting health behaviors

Medium Priority:

- Dual-eligibility
- Purchasing
- Scope, responsibility, and financing of Medicaid

- Presentation to understand full scope of Medicaid in Oregon including: funding, structures and services, and accountability

Progress reports/tracking of:

- Presumptive eligibility/prenatal care/CAWEM pilots
- OHP eligibility and enrollment
- OHP expansions
- Healthy Kids
- Oregon Health Study
- Access to oral and behavioral health services
 - Track changes aligned with MAC guidance (2009 white papers)
- OHA payment/delivery reform and its impact on Medicaid populations

3. Clinical Quality

The quality of care provided to OHP beneficiaries is a cornerstone of overall program effectiveness. A key driver in advancing quality initiatives is access to information illustrating the quality of care provided. The MAC has taken steps toward creating an easily-accessible OHP data dashboard which will provide information critical to furthering quality of care discussions. The MAC will use this dashboard as a context for advising the OHA on suggested quality improvement strategies and well as identifying areas of success.

Possible topics include:

- OHP Data Dashboard
- Contract Standards
- Quality Initiatives
 - Performance Improvement Projects (PIP) and what can be implemented outside of PIPs
- Quality of oral and behavioral health services
 - Track changes aligned with MAC guidance (2009 white papers)

4. Health Equities

Several populations disproportionately experience poor health outcomes. The first step to eliminating health disparities is the identification of affected populations and assessment of the scope of the problem. The MAC will use the OHP data dashboard and other relevant data sources to inform policy recommendations aimed at eliminating disparities where they exist and also preventing disparities before they occur.

Possible topics include:

- OHP Data Dashboard
- Data collection and reporting
- Ensuring advances in quality target all Oregonians
- Oregon Health Authority service integration
 - Connecting OHP beneficiaries with services that target other social determinants of health

REDUCTION OPTIONS
DIVISION OF MEDICAL ASSISTANCE PROGRAMS

Program Unit/Activity Description	GF	OF	TOTAL FUNDS	Is a Statutory Change needed to make this reduction? If so what is the statute that is affected?	What are the "lead time" assumptions for this reduction? (Please describe any notification of clients requirements, CMS approval, etc.)	Estimated number of people affected by this reduction (with Precast as the base).
Efficiencies						
Cost Allocate DMAP Admin Personal Services between Medicaid and Title XXI. The Division of Medical Assistance Programs is identifying administrative costs that could be allocated to both Medicaid (Title XIX) and the Children's Health Insurance Program (Title XXI), rather than just Medicaid. Administrative costs claimed under Title XXI are reimbursed at the program match rate, which is higher than Medicaid's 50% administrative match rate. This action will increase the amount of federal fund reimbursement for administrative costs.	\$ (458,000)	-	\$ -	No		No Client Impact
Administrative Reductions of 5% (in 1% increments). All DHS divisions are proposing reductions to their administrative budgets up to 5%.	\$ (951,000)	-	\$ (1,903,000)	No		No Client Impact
Reduce administrative burden to the MCOs. Projected savings of .5% effective July 1, 2010. This reduction would have the department lessen the administrative burden on managed care organizations (MCOs) and decrease their capitation payments by .5%. To the extent that the administrative burden doesn't decrease commensurate with the .5% capitation rate reduction, MCOs would have less money to pay for medical, dental, and mental health services for enrolled OHP clients.	\$ (2,330,000)	\$ (650,000)	\$ (9,386,000)	No	CMS approval needed (Rates/Contracts)	All managed care providers
Pay paper claims at 20 days. Effective January 1, 2011. The reduction would impose a 20-day lag between the date a medical claim submitted by paper is received and the date of payment. This reduction has no impact on clients. Providers submitting paper claims would experience a delay in their payments.	\$ (511,000)	\$ (168,000)	\$ (1,882,000)	No	After Stimulus FMAP Expires; MMIS Change Needed	Fee-For-Service Providers
Hemophilia sole provider/disease services management (DSM) RFP to mandate 340b price for all hemophilia drugs. Effective September 1, 2010. This reduction would have the department issue a request for proposal (RFP) to contract for a sole source provider to supply all hemophilia drugs at a mandated price, as provided by Section 340b of the Public Health Services Act. This reduction may impact where clients receive their drugs.	\$ (556,000)	\$ (87,000)	\$ (1,939,000)	No	CMS approval of a 1915b waiver; MMIS change needed	25 Clients
Mandatory mail order for fee-for-service chronic drugs. Effective September 1, 2010. This reduction would require clients who are in the fee-for-service delivery system and who need prescription drugs for chronic conditions to obtain their drugs through a contracted mail-order provider. Clients would no longer have freedom of choice in where they obtained these drugs.	\$ (128,000)	-	\$ (452,000)	No	CMS approval of a 1915b waiver; MMIS change needed	115,000 Fee-for-Service Clients

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Pull out of the Sovereign States Drug Consortium (SSDC) and negotiate rebates independently. Savings estimate is based on a 10% increase above current SSDC negotiated rebates. Effective January 2011. This reduction would have the department revoke its membership to the Sovereign States Drug Consortium (SSDC), which negotiates rebates on the behalf of member states, and independently negotiate rebates with drug manufacturers. This reduction would have no impact on services or outcomes. Would need an additional staff person classified as an Operational & Policy Analyst 2 (OPA 2) for the pharmacy program.	\$ (3,000)	\$ 10,000	\$ 14,000	No	CMS review to determine if a SPA is needed	Drug Manufacturers
Add mental health drugs to the enforceable Preferred Drug List (PDL). Effective September 1, 2010. This reduction would require adherence to the Preferred Drug List (PDL) for mental health drugs. Exceptions to the PDL would be administered by prior authorization. An enforceable PDL for mental health drugs would increase usage of preferred drugs from 66% to 80%. There would be no limitations on access to prescriptions for this reduction. Before being placed on the PDL, drugs are subjected to rigorous evidence review. Thereafter, prescribing and patient utilization behaviors are managed by the prospective and retrospective drug utilization reviews and provider education. This reduction would be a policy change that extends beyond the political agreements reached last legislative session on pharmacy issues.	\$ (2,711,000)	\$ 227,000	\$ (7,602,000)	ORS 414.325 ORS 414.336	CMS approval needed (SPA); MMIS change needed	570,000 Clients
Limit utilization of non-preferred drugs. Effective September 1, 2010. This reduction would eliminate the provision currently in statute that allows a prescriber to order a non-preferred drug and have it paid for by the Oregon Health Plan when a preferred drug for the treatment is on the Preferred Drug List (PDL). Safeguards would prevent any negative impact on clients. Savings would be realized in two ways: 1) through increased utilization of preferred drugs that have been found to be the most cost-effective while also judged to be efficacious based on a review of the clinical evidence available, and 2) from additional drug rebate revenue from manufacturers who benefit from having their drugs on a more restrictive PDL that increases their market share. This reduction would be a policy change that extends beyond the political agreements reached last legislative session on pharmacy issues.	\$ (1,030,000)	\$ (129,000)	\$ (3,534,000)	ORS 414.325	CMS approval needed (SPA)	115,000 Clients
Make Preferred Drug List (PDL) more restrictive through selection criteria. Effective January 1, 2011. This reduction would make more restrictive the criteria used to determine which drugs qualify for the Preferred Drug List (PDL). For example, drugs would have to be among the 25% cheapest in their class, as opposed to being among the 50% cheapest drugs in their class. Many new clients and their providers would have to switch from their current prescriptions to drugs making the list based on the new criteria.	\$ (512,000)	\$ (64,000)	\$ (2,218,000)	No		Clients

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Rates						
<p>Reduce Average Wholesale Prices (AWP) on 1,400 national drug codes by 5%. Effective October 2, 2009. A court settlement resulted in a 5% reduction to Average Wholesale Prices (AWP), a benchmark for prescription drug pricing. The Oregon Health Plan uses AWP as a basis for prescription drug reimbursement in the fee-for-service delivery system. The 5% reduction to AWP meant a 5% reduction to prescription drug reimbursement for pharmacies participating in the program. This reduction could cause some pharmacies to no longer serve OHP clients. Clients in rural areas may have to travel further to fill their prescriptions. Pharmacy groups have filed suits against a number of state Medicaid programs implementing this reduction.</p>	\$ (2,029,000)	\$ -	\$ (6,759,000)	No		Pharmacy Providers
<p>Change DRG hospital inpatient reimbursement to the Medicare payment methodology (for MCOs only). Projected savings of 2.0% effective January 1, 2011. This reduction would change the method for determining the amount paid in the capitation rates to managed care organizations (MCOs) for inpatient services provided by Diagnostic Related Group (DRG) hospitals (those with 50 beds or more). The method would switch from a cost-based calculation to one based on the Medicare payment system for DRG hospital inpatient services. Rates based on Medicare are typically less than cost.</p>	\$ (1,357,000)	\$ (522,000)	\$ (5,108,000)	No	CMS approval needed (Rates/Contracts)	FCHP and MHO Providers
<p>Change DRG hospital outpatient reimbursement to the Medicare Payment Methodology (for MCOs & FFS). Projected savings of 2.5% effective January 1, 2011. This reduction would change outpatient reimbursement to Diagnostic Related Group (DRG) hospitals (those with 50 beds or more) in both the managed care and fee-for-service delivery systems. In managed care, the method for determining the amount paid in capitation rates for outpatient services would switch from a cost-based calculation to one based on the Medicare payment system for outpatient services. In fee-for-service, reimbursement would switch from rates based on cost to the Medicare payment system for outpatient services. Rates based on Medicare are typically less than cost.</p>	\$ (1,090,000)	\$ (506,000)	\$ (4,397,000)	No	CMS approval needed (Rates/Contracts/SPA)	FCHP and PCO Providers; DRG Fee-For-Service Providers
<p>Eliminate Graduate Medical Education (GME) payments to hospitals effective July 1, 2010. This reduction would eliminate Medicaid payments to hospitals to offset costs associated with graduate medical programs. For example, residents may order more tests than experienced physicians. Over 75% of the funding goes to OHSU.</p>	\$ (3,644,000)	\$ (2,190,000)	\$ (18,541,000)	No	CMS approvals needed (Rates/Contracts/SPA)	Providers

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Withhold 1% of capitation rate for performance bonuses from Managed Care Plans with Payout in the 2011-13 biennium. Effective January 1, 2011. This reduction would withhold 1% of the capitation rates paid to managed care organizations (MCOs) for a performance bonus to be paid out next biennium. MCOs would have less money this biennium to pay for medical, dental, and mental health services for enrolled OHP clients.	\$ (2,738,000)	\$ (794,000)	\$ (9,690,000)	No	CMS approval needed (Rates/Contracts)	All managed care providers
Implement a 9.5% reduction to the 200 plus Durable Medical Equipment (DME) codes that Medicare reduced in January 2009. Effective September 1, 2010. This reduction would impose a 9.5% reduction in the fee-for-service delivery system for specific durable medical equipment (DME) codes, consistent with a reduction implemented in the Medicare program in 2009. A reduction in rates may cause some DME providers to stop participating in the program, creating access problems for clients in areas with few providers.	\$ (368,000)	\$ (30,000)	\$ (1,200,000)	No	Provider notification required	DME Providers
Keep trend flat for MCO rates through June 30, 2011. Effective January 1, 2011. This reduction would limit increases to capitation rates paid to managed care organizations (MCOs) effective January 1, 2011, which is the start of a new contract year and rate cycle. MCOs would have to continue to provide the same level of services but may not be able to pay providers adequately for their costs, possibly creating access problems. Some MCOs may have to spend reserves to maintain appropriate access.	\$ (4,949,000)	\$ 971,000	\$ (10,544,000)	No	CMS approval needed (Rates/Contracts)	All managed care providers
Implement a 5% reduction to the following fee-for-service rates: ambulance transportation services, durable medical equipment (DME), maternity case management, medical/surgical services, targeted case management, and vision. Effective September 1, 2010. This reduction would lower by 5% OHP rates in the fee-for-service delivery system for ambulance transportation services, durable medical equipment (DME), maternity case management, medical/surgical services, targeted case management, and vision. This reduction may have an impact on clients' access to services.	\$ (328,000)	\$ -	\$ (997,000)	No	CMS approval needed (SPA); MMIS change needed	Providers
Reduce the Diagnostic Related Group (DRG) hospital component of the capitation rates from 76% to 72%. Effective June 1, 2010. Diagnostic Related Group (DRG) hospitals and managed care organizations (MCOs) would continue to receive less reimbursement than their cost of services. MCOs would likely be pressured by hospitals to pay more than MCOs are paid in the capitation rates for those services. If MCOs pay more, this means less reimbursement (less than cost) for other providers, such as physicians. As a result, MCOs may have difficulty providing clients optimal access to medical services.	\$ (8,279,000)	\$ (1,329,000)	\$ (30,514,000)	No. Note: Stakeholders may be interested in amending Section 9, Chapter 736, Oregon Laws 2003, as amended by Section 17 of HB 2116 (2009 session).	CMS approval needed (Rates/Contracts)	DRG hospitals and Managed Care Organizations

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Benefits						
Eliminate certain Medicaid optional services. Effective date September 1, 2010. This reduction would eliminate certain services that are considered optional under federal Medicaid regulations for non-pregnant adults, age 21 and older, covered under the OHP Plus benefit package. These services are as follows: private duty nursing, prosthetic devices, hearing aids, chiropractic services, and podiatrist services. Clients needing these services would have difficulty becoming self-sufficient. Also, their overall health and quality of life would suffer.	(640,000)	-	(1,929,000)	No	CMS approval needed (SPA/Waiver/Rates/Contracts); MMIS change needed	147,000 Clients
Eliminate the remainder of Adult Dental (excluding pregnant women). Effective September 1, 2010. This reduction would eliminate all dental services for non-pregnant adults, age 21 and older, who are covered under the OHP Plus benefit package. Without dental coverage, clients' overall physical health would negatively be affected, especially for those who are seniors or have disabilities. This would lead to higher emergency room visits, shifting of costs onto fully capitated health plans (FCHPs) and hospitals. This uncompensated care provided by hospitals would ultimately lead to higher premiums for insured patients.	(7,475,000)	-	(23,223,000)	No	CMS approval needed (SPA/Waiver/Rates/Contracts); MMIS change needed	147,000 Clients
Populations						
Eliminate the Breast and Cervical Cancer Program. Effective January 1, 2011. This reduction would eliminate the Breast and Cervical Cancer Program that provides OHP Plus benefits to uninsured women who have been diagnosed and need treatment for breast or cervical cancer. Women currently on the program would lose health coverage to pay for their treatment. Newly diagnosed women would not have health coverage to start treatment.	\$ (1,801,000)	\$ (303,000)	\$ (8,073,000)	ORS 414.532 through ORS 414.540	CMS approval needed (SPA); MMIS change needed; Start date follows the lifting of ARRA restrictions	500 Clients
Offsets from reductions in SPD, CAF, AMH, ASD & PHD	\$ -	\$ -	\$ -	?		
DMAP impact of SPD SSI reduction: Limit eligibility for clients who are aged, blind, and disabled to 100% of SSI. Effective January 1, 2011.	\$ (22,756,000)	\$ (1,718,000)	\$ (65,740,000)	?		
Total	\$ (66,644,000)	\$ (7,282,000)	\$ (215,617,000)			
Target for Reductions	\$ (113,000,000)					
Remaining needed	\$ (46,356,000)					

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Medicaid Management Information System implementation

Background

The Medicaid Management Information System (MMIS) is the computerized claims processing and information retrieval system for the Oregon Health Plan (OHP). All states operate an MMIS to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

DHS contracted with Electronic Data Systems (EDS) to replace the old, out-of-date system with a new MMIS certified by the Centers for Medicare and Medicaid Services (CMS). The new system, activated on December 9, 2008, uses current technology allowing DHS staff to easily access, update, and analyze data. DHS now is able to keep pace with changes in claims volume, program/policy, technology and more.

All the basic, core functions of the new MMIS are operational; however, as with the implementation of any large, new computer system, the new MMIS has defects and is experiencing difficulties. DHS is expending considerable resources and working closely with EDS to resolve the remaining defects.

For more information on the new MMIS, visit www.oregon.gov/DHS/mmis.

Update

- Expansion of auto-assignment for managed care plans continued this month. This will allow the system to enroll clients into managed care plans automatically, ensuring an even distribution of clients among the plans. The auto-assignment process will also include a function to ensure newborns are enrolled in the same managed care plan as their mothers. By the end of this month, all counties will have auto-assignment of mental health, dental, and fully-capitated health plans. Auto-assignment for the physician care organization is planned for a later date.
- Provider training is continuing, both over the telephone and in one-on-one trainings, on how to use the Provider Web Portal. Statewide trainings will resume later this month. With the Provider Web Portal, most enrolled providers can use the Web site to verify client eligibility, request prior authorizations, file claims, find information on covered drugs, perform demographic maintenance (*e.g.*, updates to contact information and office hours) and determine whether a procedure/diagnosis is covered according to the client's OHP benefit package and/or the Prioritized List of Health Services.
- A leadership team has been formed to address financial, eligibility, and enrollment issues experienced by the managed care organizations (MCOs). A formal communications plan will also be developed to improve communications with MCOs on MMIS issues.

Healthy Kids

Background

HB 2116, signed into law by Governor Ted Kulongoski on August 4, contains funding to provide medical coverage for 80,000 children by the end of the 2009-2011 biennium. Staff across the department are working together to ensure DHS is able to reach out to and enroll as many of the 116,000 uninsured children in Oregon as possible.

In July, DHS launched the Healthy Kids Web site at www.oregonhealthykids.gov. This site provides basic information about Healthy Kids, a link to the online OHP application, and information for those interested in the Healthy Kids outreach programs - the Application Assistance Program and the Targeted Outreach and Enrollment Grants Program.

Update

- Information Sessions continue throughout the state about the Application Assistance Program and the Targeted Outreach and Enrollment Grants Program.
- The Request for Grant Proposal (RFGP) for Targeted Outreach and Enrollment Grants has been posted on the Oregon Procurement Information Network (ORPIN) Web site at <http://orpin.oregon.gov>. Proposals are due back November 4, 2009.
 - The Targeted Outreach Grant Organizations (TOGO) will conduct outreach activities for families who face health disparities or are considered “hard to reach.”
 - Approximately 20 to 40 grants ranging from \$20,000 to \$80,000 will be awarded through a competitive process. Grants will be awarded in November with an estimated agreement end date of June 30, 2010.
- Healthy Kids promotional materials (posters and brochures) are being distributed to DHS branch offices statewide, and an e-mail address has been opened for taking orders from interested partners (hkp.orders@state.or.us).
- Effective October 1, 2009, DHS raised eligibility income limits to 200 percent of the federal poverty level (FPL) and implemented other provisions identified in HB 2116.
- The Office of Private Health Partnerships is reviewing responses to the Request for Proposals for Healthy KidsConnect, the private insurance option for families with incomes above 200% of the federal poverty level. Healthy KidsConnect will be available on available January 1, 2010 for enrollment.
- DHS is still in discussion with CMS regarding provisions that affect children in families with incomes above 200 percent of the FPL, and is awaiting federal guidance on eligibility for “lawfully residing” immigrant children.

Expansion of OHP Standard

Background

HB 2116 created a new tax on hospitals to fund the expansion of the OHP Standard program. Currently, OHP Standard covers approximately 26,000 low-income adults who do not qualify for traditional Medicaid under the OHP Plus program. With the additional funding, enrollment in OHP standard will increase to a monthly average of 50,000.

Because there are many more Oregonians who would qualify than there are spots available, DHS chose to open a new reservation list, pending federal approval. Individuals on the 2008 reservation list will get first opportunity to get their names moved from the 2008 list to the new list.

Unlike the 2008 list, which was only open for one month, the new reservation list will remain continuously open throughout the biennium. The continuously open list will ensure fairness to those who signed up in 2008, while allowing individuals with changing financial conditions and health insurance status a chance to have their names drawn, so that the list is available to those in need when they are in need.

Update

- So far, over 19,000 individuals on the 2008 reservation list have asked to be added to the 2009 reservation list, in response to last month's mailing. In mid-November, DHS will send applications to individuals whose names are selected in a limited random drawing.
- The date of the second drawing is pending CMS approval of the continuously open reservation list.
- Once the list opens, the department plans to send notices to those on the reservation list at least every 12 months asking if they want to remain on the list and whether they need to update their contact information. This will ensure that only individuals who are still seeking health care coverage remain on the list. Individuals will also be reminded that they can apply for other programs at any time.

Transformation Initiative

Background

DHS launched the Transformation Initiative in December 2007 in order to improve efficiency and effectiveness throughout the department. The initiative is designed to enable DHS to continue providing quality services in a time when demand is outpacing revenue. For more information on the DHS Transformation Initiative, visit www.oregon.gov/DHS/transformation.

DMAP has identified several transformation initiatives for the division that will result in cost savings and/or increased efficiency. Each initiative is in varying stages of development depending on the scope of the project. Two notable initiatives are:

- Enforceable Plan Drug List (PDL) - The PDL is a list of prescriptions determined to be the most effective drugs at the best available price in a class of drugs. Once reviewed for safety and efficacy by the Drug Effectiveness Review Project and the Health Resources Commission, drugs with net prices at or below the Average Net Price (ANP) of the specified drug class are evaluated by the department's PDL Selection Committee, then placed on the PDL. In June, the Legislature passed HB 2126, which will require prior authorizations for all physical health drugs not included in the PDL. This requirement will be effective January 1, 2010, and will improve efficiency and reduce costs for the division.

- Third Party Liability and Recovery - This initiative aims to streamline the way the department identifies and applies third-party resource (TPR) information (e.g., private insurance or Medicare) to OHP client records, and to increase recoveries. Quicker identification and application of third-party resource information would allow DHS to lower costs in two ways:
 - Cost-avoidance - DHS avoids paying for services that should be paid by the TPR.
 - Recovery of funds - DHS is able to recover health care costs that the TPR should have paid.

Update

- Enforceable PDL:
 - At the Drug Use Review Board meeting on September 24, the Board reviewed the draft physical health and mental health PDLs and offered recommendations on the prior authorization (PA) criteria for non-preferred products (*i.e.*, drugs not listed on the physical health PDL).
 - The Pharmaceutical Services Rules Advisory Committee met on September 28 to review rule changes associated with the PDL changes and new PA criteria.
 - DMAP is currently developing provider communications about the PDL, including a pocket guide version of the PDL, several provider announcements, and promotion of Epocrates, which provides free access to the PDL on the Web and through mobile handheld devices.
 - Targeted outreach and material to the medical community will be led by DMAP Medical Director, Dr. Walter Shaffer. Outreach to the pharmacy community will be conducted in partnership by Ralph Magrish, DMAP Pharmacy Program Manager and Kathy Ketchum of the Oregon State University College of Pharmacy.
- Third Party Liability and Recovery:
 - The workgroup is developing a detailed communications plan to support ongoing communications with the initiative's steering body and core team leaders. The workgroup is also identifying metrics to measure the cost avoidance savings of Health Insurance Group (HIG) efforts.
 - DHS has implemented an action plan to expedite the processing of DHS 415H forms, used to report client TPR to DHS. DHS is also revising the form to incorporate information for two other insurance programs, the Health Insurance Premium Payment (HIPPP) program and the Private Health Insurance (PHI) program. This will allow all client insurance information to come to one place for processing.

Health Record Bank of Oregon

Background

When the Health Record Bank of Oregon (HRBO) begins operation in January 2010, it will provide a secure repository for current medical records for OHP clients. Clients may view their records and authorize physicians, hospitals and other health care providers to view them as well. Access to more complete medical information will enhance providers' ability to make informed decisions regarding care of OHP clients, improve health outcomes and reduce the cost of unnecessary care. For more information, visit the HRBO Web site at www.oregon.gov/DHS/hrb-oregon.

Update

- CMS has indicated that the grant will be extended for another year to permit a full 15-month demonstration through March 31, 2011.
- The HRBO project planning team is completing contract negotiations with WebMD, the selected vendor. While negotiations have been lengthy, the department expects to sign a contract this month.
- The project has received approval to proceed with negotiations with the Oregon Community Health Information Network (OCHIN) for a Client Services Contract. Services under this contract would engage and enroll Medicaid beneficiaries into the HRBO beginning in January 2010.
- Personal health records for children, particularly those in foster care, are scheduled to be available by April 2010.

CAWEM Prenatal Services Pilot Project

Background

In April 2008, DMAP began a pilot project in Multnomah and Deschutes counties to expand health care coverage for pregnant clients enrolled in the Citizen/Alien-Waived Emergent Medical (CAWEM) benefit package. Currently, CAWEM only covers emergency and delivery services for pregnant women who do not meet the citizenship requirement to qualify for the OHP Plus benefit package.

Under the pilot program, pregnant CAWEM clients are eligible for all of the same services covered by OHP Plus, including prenatal care, with the exception of termination-of-pregnancy and end-of-life services. The goal of the pilot project is to increase better health outcomes for newborns and to relieve some of the financial burden on counties, which are bearing the brunt of the health care cost for this population.

The additional services of the pilot project were made available without any further impact on the state budget. Multnomah and Deschutes counties provide from their own budgets the Children's Health Insurance Program (CHIP) match dollars to extend coverage to include prenatal care.

Update

- The pilot in Deschutes and Multnomah counties will continue through the 2009-2011 biennium.
- Client and provider communications have been distributed addressing the expansion to Benton, Clackamas, Hood River, Jackson and Lincoln counties.

CHIPRA Grants

Background

With the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA), the federal Department of Health and Human Services (DHHS) announced the availability of \$40 million in grants to help reach families whose children qualify but are not yet enrolled in Medicaid or the Children's Health Insurance Program (CHIP).

The department's CHIPRA Outreach and Enrollment grant proposal, called the Children's Health Equity Outreach Project (CHEOP), includes two components:

- Financial support for a state-administered grant program available to safety net clinics, county health departments, and/or school based health centers in Oregon communities to conduct culturally and linguistically competent outreach to targeted eligible uninsured children (U.S. citizen and legal immigrant children in undocumented or mixed documented families, with incomes less than 200% of the federal poverty level) and to support local development of coordinated outreach and enrollment.
- Resources to support the data needs of those entities awarded a CHIPRA grant, and to conduct the evaluation and reporting for the state's CHIPRA grant.

While the Oregon Healthy Kids program provides for grants to community organizations to conduct targeted outreach and enrollment, it excludes providers of health care services such as county health departments and school-based health centers. CHEOP provides the state with the mechanism to support the outreach efforts of these providers.

Update

The Office of Healthy Kids, working with the Public Health Division, received a CHIPRA grant to fund CHEOP. This grant will allow CHEOP to fund Oregon grants for health care providers to do outreach to support the following goals:

- Enroll and retain eligible children (citizens and legal immigrants) of undocumented or mixed documented families under 200 percent FPL in Oregon's Medicaid/CHIP programs;
- Build state capacity to coordinate/support effective Healthy Kids enrollment and retention.

The Request For Proposals (RFP) is expected to be released by the end of the year.

H1N1 vaccinations

Background

Pandemic H1N1 influenza (once referred to as "swine flu") is a new flu virus that causes respiratory illness in people. The Centers for Disease Control and Prevention (CDC) first detected this virus in the U.S. in April 2009. Officials say H1N1 continues to present similarly to seasonal flu in terms of severity.

The CDC expects the distribution of the new H1N1 vaccine to begin this October.

Update

The federal government will pay for H1N1 vaccinations, which will be available free of charge. DMAP will pay for the administration of the H1N1 vaccination for OHP fee-for-service ("open card") clients. Managed care plans will cover this cost for their enrollees.

- DMAP sent all OHP clients information about when the vaccine will become available, and where they can get the vaccinations.
- DMAP issued communications for all prescribers and pharmacies that explained how to bill for H1N1 administration and contained reminders about billing for seasonal flu vaccinations.

State Health Access Program Grants

Background

The SHAP grant is a new federal opportunity from the federal Health Resources and Services Administration (HRSA) to support state efforts to significantly increase health care coverage as part of a plan for comprehensive health reform. In June, the Office for Oregon Health Policy and Research (OHPR) submitted an application on behalf of the State.

- To qualify for \$7-\$10 million per year in funding, Oregon was required to demonstrate that it is on track to implement a comprehensive coverage plan over the next five years. While the grant allows some limited "pre-implementation" activities, funding is primarily intended to support the implementation of coverage to new populations.
- Matching 20% of the federal grant is required, which can be a combination of State, local, or private dollars. Waiver of the matching requirement is possible if financial hardship is demonstrated.
- States must provide a five year plan for increasing coverage in their application, while the initial grant award is only for the first year. States will be required to reapply for each subsequent year of funding.

In September 2009, Oregon was awarded a five-year SHAP grant to support health care coverage expansion efforts. HRSA awarded \$70.9 million in SHAP grants to 13 states. Oregon received \$9.96 million for the first year of the program, the second highest award.

Oregon has requested \$43.8 million over the five-year period; however, states must reapply each year. Subsequent years of funding are contingent upon meeting performance measures and the availability of federal funding.

Update

The grant funds will augment and strengthen current efforts to expand coverage and will assist implementation planning for broader coverage expansions. Sustainability of grant-funded activities will be ensured by partnering grant funds with the Oregon Health Fund Board (OHFB)'s currently proposed cost containment strategies.

Aligning with Oregon's legislative priorities, initial emphasis will be on implementing coverage programs for all uninsured children and for adults under 100% of poverty and then taking steps to provide affordable, sustainable coverage options for all Oregonians, including:

- A health insurance exchange;
- An affordable small business insurance product;
- Reinsurance strategies to reduce insurance costs; and,
- "Multi-share" models that would utilize contributions from employers, employees, and the community to finance health care for working uninsured.

Work will also begin on a “value-driven” benefit design and payment reform strategies.

- The benefit piece is integral to the coverage options outlined above to improve the quality of care and ensure insurance coverage is sustainable by curbing cost growth. This work would translate treatment effectiveness research into guidelines and benefit specifics and ensure the integration of a patient-centered, primary care home, along with other reform strategies that drive value.
- Reforming payment methodologies, such as episode-based payment structures, can further control costs and will complement work currently planned around reimbursement for patient-centered, primary care homes.

Portland-area and statewide access assessment

Background

Providers from all areas of practice and service delivery systems have participated in discussions of access as the state expands OHP coverage as mandated by HB 2116.

- To address concerns about possible primary care access issues in the Portland metro area, DMAP reviewed current information regarding access to care through safety net clinics, OHP managed care plans, and other primary care resources.
- To date, information reveals that, overall, the Portland metro area has sufficient capacity to enroll the additional clients who will become eligible under the OHP expansion, either through managed care or safety net clinics. Statewide analysis is in progress and expected to be completed by the end of the year.

Update

DHS and the Oregon Health Authority will continue to work with providers and professional associations regarding a broad range of topics related to access and capacity, including scope of practice issues.

- DHS is also exploring capabilities and options available through a provider directory on the new public Web portal at <https://www.or-medicaid.gov>.
- DMAP will continue to examine access issues and explore options for increasing primary care access.

OHP demonstration renewal

Background

The OHP Demonstration is due to expire at the end of October 2010. The Department of Human Services (DHS) must submit a renewal application to HHS by the end of October 2009 for review and approval. Federal approval would extend the demonstration project for another three years.

DHS is proposing a renewal application that would consist of:

- A three-year extension of all of the state's existing waivers and expenditure authorities;
- Technical changes to the current Demonstration to conform to new federal law— e.g., the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); and
- Integration, as the approval process moves forward, of amendments that have already been submitted and that CMS approves during the time they are also reviewing the renewal request.

Most changes, or amendments, to the OHP are not made at the time of the demonstration renewal, because they require legislative approval or statutory change. Demonstration renewals happen less frequently than Oregon legislative sessions and often do not correspond with the legislative calendar.

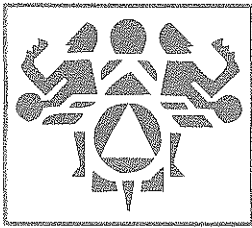
The state, therefore, generally requests changes after a legislative session ends. For example, after the 2009 session, the state requested demonstration amendments to enact SB 2116, the Healthy Kids Plan. When approved, they will be incorporated into the demonstration.

Update

OHP managed care plans, tribal leaders and other stakeholders have been provided an opportunity to comment on the state's proposed demonstration renewal request to CMS. These individuals are currently providing comment.



*DMAP CAPE
09-685 10/09*



**NORTHWEST
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September 23, 2009

Judy Mohr-Peterson, Medicaid Director
State of Oregon
Department of Human Services
Division of Medical Assistance Programs
500 Summer Street N.E., E-35
Salem, OR 97301-1079

Dear Ms. Mohr-Peterson:

The Northwest Portland Area Indian Health Board is a P.L. 93-638 Tribal organization that represents the nine federally recognized Tribes in the State of Oregon. On behalf of our nine Tribes, we are providing you with our recommendations in response to Mr. Jim Edge's letter (dated July 28, 2009) seeking comments from Oregon Tribes on the proposed change in the manner that DHS will manage a list of potential applicants for the Oregon Health Plan (OHP) Standard benefit package.

We acknowledge the State for its efforts to provide as many Oregonians as possible with quality health care and appreciate the challenge of that task. As you are aware, American Indian and Alaska Native (AI/AN) people suffer from disproportionately poorer health status than the general U.S. population. Yet, AI/ANs are under enrolled and do not utilize Medicaid and CHIP programs to the same extent as other Oregonians. There are many barriers to AI/AN enrollment and participation in Medicaid that include access issues, cultural barriers, fluctuating income, mistrust, and many who feel that their health care has already been paid for with millions of acres of land ceded to the United States, therefore do not feel that they should have to participate in a means tested program. Despite these barriers, there are solutions.

In light of these significant health disparities and under-enrollment and utilization in state Medicaid programs we propose that the State of Oregon include the following in its request to CMS:

1. Maintain an open-enrollment status in OHP for AI/AN people served by Indian Health Service (IHS) and Tribally-operated health facilities.

Since services provided to AI/AN people served by an IHS or Tribally operated facility are reimbursed to the State of Oregon at 100% FMAP, this request is budget neutral to the state. In 1976, Congress acknowledged the deplorable health conditions of AI/AN people and their under enrollment and utilization in the Medicaid program by amending the Social Security Act to grant IHS and Tribal health programs authority to collect Medicare and Medicaid reimbursements. Section 1880 made IHS hospitals (including those operated by Indian tribes) eligible to collect Medicare reimbursement, while Sec. 1911 made IHS and Tribal facilities eligible to collect reimbursements from Medicaid. An amendment to Sec. 1905(b) applied a 100 percent Federal Medical Assistance Percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Sections 1880 and 1911 were intended to bring additional revenue into the Indian health system in order to address the deplorable condition of Indian health facilities, many of which were in such a poor state they were unable to achieve accreditation. The application of a 100% FMAP to the Medicaid covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The Committee of jurisdiction observed that since the United States already had an obligation to pay for health services to Indians as IHS beneficiaries, it was appropriate for the U.S. to pay the full cost of their care as Medicaid beneficiaries. This action is consistent with the status of AI/ANs as a political designation.

In addition, the recently passed Indian provisions contained in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the American Recovery and Reinvestment Act of 2009 (ARRA) demonstrate Congress' intent to increase enrollment of AI/AN people into the Medicaid and CHIP programs. The legislation also directed CMS, acting through the state Medicaid program, to take necessary steps to "facilitate cooperation with and agreements between States and the Indian Health Service, Indian Tribes, Tribal Organizations or Urban Indian Organizations" regarding services." The CHIPRA legislation also included a \$10 million Tribal set-aside to increase outreach and enrollment in order to improve "access to, and delivery of, health care for Indians under Titles XIX and XXI." This request is consistent with the Congressional intent.

2. Reactivate the request to implement SB-878

SB-878 was passed in the 2003 Biennium legislative session and provides authority for an AI/AN people who are eligible for or receiving medical assistance described in ORS 414.025 (OHP Standard) to receive the same benefit package of health services described in ORS 414.835 (OHP Plus) if DMAP receives 100% FMAP for payments made to IHS or Tribal programs. A request to implement SB-878 was submitted to CMS in 2005, however communications with CMS staff indicated that the request would likely be denied on the basis that the request would be inconsistent with the strict scrutiny test applicable to race, color, or national origin classifications under Title VI of the Civil Rights Act of 1964 (Title VI).

It is Oregon Tribe's position, that this request does not violate Title VI of the Civil Rights Act. In fact under the Supreme Court's seminal decision in Morton v. Mancari, federal legislation which provides preferences to Indians is not subject to strict scrutiny, and will be upheld when rationally related to the Federal government's unique trust obligations to Indians. Because this request furthers the Federal government's unique trust responsibility to provide health care to Indians, it is not subject to strict scrutiny under Mancari and does not violate Title VI. In this regard, it is no different than the hundreds of other Federal Indian preference programs currently on the books. The current request would enhance access to health care for many needy AI/AN people in the State of Oregon, and is critical to ensure that these people receive health care. For these reasons, we respectfully request that the State re-initiate this request to CMS in the upcoming submission to implement changes in the OHP Standard plan.

In closing, I want to underscore a very important provision that Congress included in the American Recovery and Reinvestment Act of 2009. Congress included a provision that requires states to consult

with Tribes in the development of any Medicaid program changes that will have a direct effect on Indian people. The provision requires states *"shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations."*¹ In light of this very important provision, we urge Oregon to include our recommendations in its submission to CMS.

On behalf of our Oregon Tribes, we thank you for the opportunity to provide comments on the State's proposed changes for the OHP Standard Program.

Thank you for your attention to this very important matter!

Sincerely,



Joe Finkbonner, RPH, MHA
Executive Director

cc: Janna Starr, DMAP
Richard Acevedo, DHS Tribal Relations Liaison
Doni Wilder, IHS Portland Area Office

¹ Sec. 5006(e)(2)(A). Solicitation of Advice Under Medicaid and CHIP.