OFFICE OF THE DIRECTOR
Kate Brown, Governor

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December 1, 2017

The Honorable Governor Kate Brown
254 State Capitol
Salem, OR 97301

RE: Oregon Health Authority Bi-Weekly Update on Ongoing and Emerging Issues

Dear Governor Brown,

As noted in my November 17, 2017 letter, the Oregon Health Authority (OHA) is instituting a formal issue resolution process to ensure that OHA leadership is aware of, understands the scope of, and implements effective resolutions to ongoing and emerging issues. We committed to provide you and legislators with bi-weekly updates about this work and to post regular updates to our website. This letter is our December 1, 2017 update, and it includes two sections: (1) an update on development of the formal issue resolution process framework and (2) updates on previously documented issues and newly documented issues. The key update is a current estimate of the financial impact of the dual eligible issue.

Once we establish the final template for our internal issue log, we will change the format of these bi-weekly updates to include a brief cover memo and the most recent version of the issue log. We note that these issues – both newly and previously documented – still require additional research and analysis to assess the cause, scope, impact, and next steps for resolution.

ISSUE RESOLUTION PROCESS UPDATE

The initial framework for the issue resolution process was provided to you in my November 9, 2017 letter. Since that time, OHA's chief financial officer (Laura Robison) and chief operations officer (Kris Kautz) have been working together to identify a project manager to chair the day-to-day work of the project team. During the month of December, initial meetings will be held to develop a charter, governance structure, and meeting schedule for this work.

While we establish the process framework, we have continued documenting issues and continued ongoing research and analysis into previously documented issues. An interim issue resolution team that was initiated in October to address the dual eligible and retroactive eligibility termination issues has continued to meet and oversee the research and analysis of those two issues.

NEWLY DOCUMENTED ISSUES AND UPDATES ON PREVIOUSLY DOCUMENTED ISSUES

Below is an update on previously documented issues, followed by a preliminary summary of newly documented issues since our last update. While we are continuing to add to the issue log and research known issues, we still note that this is likely not an exhaustive and final list of all known issues facing the agency. It is also likely that the details of these issues will evolve as we research them and consult in more detail with subject matter experts. This is not unexpected, given the complexity of OHA's programs and information systems and the lack of rigor and comprehensiveness in its research, analysis, resolution, and communication of significant operational issues. A cumulative list of issues documented to date is included as Attachment 1 to this letter.

Updates on Previously Documented Issues

This section is intended to provide an update on previously documented issues identified in the November 17, 2017 letter. The only issue for which we have updated information at this time is the dual eligible issue. We will continue to provide updates, as available, about documented issues in subsequent bi-weekly reports.

Dual Eligible Population

As summarized in the November 17, 2017 letter, OHA identified two issues related to the dual eligible population that occurred during 2014, 2015, and part of 2016: (1) OHA paid full capitation rates to Coordinated Care Organizations (CCOs) for some dual eligible members, rather than the correct (lower) capitation rates that reflect Medicaid as the payer of last resort (Issue 1); and (2) in some cases, dual eligible members were not properly coded in the Medicaid Management Information System (MMIS) with the appropriate eligibility category, leading to the federal government paying the 100% match rate associated with Medicaid-only Affordable Care Act (ACA) expansion members (i.e., MAGI Adults) in cases when the match rate should have been lower, or about 64% (Issue 2). OHA made system and process changes in 2016 to ensure that CCOs are paid the correct capitation rate for dual eligible members and that the correct federal match rate is claimed going forward. These system changes also corrected capitation rates retroactively to the beginning of 2016, and OHA has repaid over-claimed federal funds for 2016.

For 2014 and 2015, our analysis of the scope of this issue and next steps for resolution remain ongoing, including analysis of recoupment and repayment requirements and options. Updated estimates as of November 2017 are shown below. Estimates are shown separately for CCO capitation payments and fee-for-service (FFS) payments.

In total, we estimate that OHA overpaid CCOs $46.4 million. This includes $41.3 million that is still unresolved and $5.1 million that has already been recouped from CCOs for 2016. We estimate total overclaimed federal funds (for both CCOs and FFS) to be $58.7 million, which includes $44.9 million that is unresolved and $13.8 million that has already been refinanced for 2016. The $58.7 million estimate of overclaimed federal funds is an update of the $74 million estimate provided in the November 17, 2017 letter. The decrease in this estimate may be due to the impact of recoveries and other retroactive changes, but our analysis of the scope of any additional recoveries is ongoing. If ongoing research and analysis result in changes to these figures, they will be updated.

The $13.8 million that has already been refinanced includes $4.2 million of recouped funds (Issue 1) and $9.6 million to correct the federal match rate (Issue 2). The previous recoupments and refinancing for 2016 were completed in 2017. Additional detail is described below and shown in the tables below. Note that while we understand that these issues were corrected in the system for 2016 and forward, the tables show data for 2016 and 2017. It's possible that this data relates to clients with a different benefit plan and we are researching whether the 2016 and 2017 data is correct.

For CCOs, the estimates are broken out into the two separate issues – overpaid capitation rates (Issue 1) and federal funds claimed at the incorrect match rate (Issue 2). The total amount of unresolved overpayments to CCOs is $41.3 million ($36.6 million in federal funds and $4.7 million in general funds). The total amount of unresolved federal funds collected at the incorrect, higher match rate is $6.2 million. The total amount of overclaimed federal funds that has not been resolved is $42.8 million ($36.6 million due to the incorrect capitation rate and $6.2 million due to the incorrect federal match rate). If all overpayments to CCOs are recouped and the match rate is corrected (refinanced with general funds), the total impact to the general fund is a $1.5 million increase in general fund spending. Details are provided in Table 1 below.

Table 1: CCO Estimates

Calendar Year	Issue 1: Unresolved Overpaid Capitation to CCOs			Issue 2: Unresolved Incorrect Federal Match Rate	Issues 1 + 2: Total Unresolved Overclaimed Federal Funds	Issues 1 + 2: Total General Fund Impact/Increase (Assumes all overpayments recouped/ amounts refinanced)
	Federal Funds	General Funds	Total			
2014	$13,140,000	$2,068,000	$15,209,000	$2,176,000	$15,316,000	$108,000
2015	22,982,000	2,545,000	25,527,000	3,966,000	26,947,000	1,420,000
2016	429,000	125,000	554,000	48,000	478,000	-76,000
2017	12,000	4,000	16,000	2,000	13,000	-2,000
Total	$36,563,000	$4,742,000	$41,306,000	$6,192,000	$42,755,000	$1,450,000

As noted above, OHA has already recouped $5.1 million in 2016 capitation overpayments from CCOs and Dental Care Organizations (DCOs). Table 2 shows the amount recouped from each CCO and DCO.

Table 2: 2016 Capitation Overpayments Recouped by CCO and DCO

Coordinated Care Organization or Dental Care Organization	Total 2016 Overpaid Capitation Recouped
Access Dental Plan, LLC	$81
Advantage Dental Services, LLC	2,538
AllCare CCO	10,276
Capitol Dental Care, Inc.	470
CareOregon Dental	119
Cascade Health Alliance	4,842
Columbia Pacific CCO	217,486
Eastern Oregon CCO	439,961
Family Dental Care	84
FamilyCare, Inc.	6,849
Greater Oregon Behavioral Health	15,460
Health Share of Oregon	2,103,223
Intercommunity Health Network CCO	485,824
Jackson Care Connect	194,841
Managed Dental Care of Oregon, Inc.	145
Oregon Dental Services	973
PacificSource Community Solutions	89,639
PrimaryHealth of Josephine County	106,568
Trillium Community Health Plan	238,995
Umpqua Health Alliance	23,326
Western Oregon Advanced Health, LLC	164,389
Willamette Valley Community Health, LLC	802,501
Yamhill Community Care	160,672
Total	$5,069,260

For FFS clients, no capitation payments are made, so the only issue is that federal funds were claimed at the incorrect match rate. The total amount of overclaimed federal funds that has not been resolved is $2.1 million. If all amounts are refinanced with general funds, the total impact to the general fund is $2.1 million. Details are provided in Table 3 below.

Table 3: FFS Estimates

Calendar Year	Issue 2: Total Unresolved Overclaimed Federal Funds	Issue 2: Total General Fund Impact (Assumes all amounts refinanced)
2014	$698,000	$698,000
2015	1,025,000	1,025,000
2016	290,000	290,000
2017	126,000	126,000
Total	$2,139,000	$2,139,000

Note that we often receive notice from CMS that a client has been retroactively enrolled in Medicare coverage, and we are researching whether and how this affects our processes.

Newly Documented Issues

The following is a summary of newly documented issues since our last update. While the status of each issue, including our most recent estimate of the impact (if applicable), is included in the summaries below, many of these issues still require additional research and analysis. As such, we expect our understanding of the cause, scope, and impact of these issues to evolve.

Overwritten Eligibility Records

Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Preliminary estimates as of November 2017 indicate 1,200 individuals have been affected but financial impact is not yet known; additional research and analysis required.
Summary: This issue relates to specific situations where eligibility information is retroactively overwritten in the system when clients provide updated eligibility information. For example, a parent and child both apply for Medicaid on January 1, 2017 and the household income is 250% of the Federal Poverty Level (FPL). The child is eligible but the parent is not. In July 2017, the parent reports updated income information showing that household income is now 100% of the FPL, so the parent is now eligible. Due to this system issue, the July 1 eligibility information overwrites the original January 1 information in the system, showing that the parent was eligible all the way back to January 1. This system issue does not retroactively enroll individuals into CCOs, but additional research and analysis is required to determine whether any claims for services prior to the true eligibility date are being paid retroactively.

Alignment of Federal Financial Reports

Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: No financial impact; this is just a federal reporting change.
Summary: OHA provide various reports to the Centers for Medicare and Medicaid Services (CMS) to demonstrate compliance with federal requirements and ensure accurate federal funding. Two of these reports – CMS 64 and Schedule C – are not directly comparable because the CMS 64 reports all Medicaid expenditures (not just those associated with the 1115 Waiver) and the Schedule C reports only those expenditures associated with the 1115 Waiver based on the demonstration year shown on the CMS 64. The CMS 64 report is used to support OHA's claims for federal funding. CMS would like states with federal waivers to use Schedule C as the basis for reporting budget neutrality. OHA is working with CMS to determine next steps and whether revisions to reports are needed.

Non-Covered Services Included in Rates for Certain Certified Community Behavioral Health Clinics

Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: Some non-covered crisis respite services may be included in cost data reported to OHA for use in developing rates paid to Certain Certified Community Behavioral Health Clinics (CCBHCs). OHA is gathering

information from CCBHCs to determine the scope and impact of the issue and will determine next steps to adjust rates, as needed.

Common Credentialing Program Implementation
Status: Not yet completed; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: Under SB 604, OHA is required to establish a program and database to reduce burden for practitioners and provide credentialing organizations access to the information necessary to credential or re-credential all Oregon health care practitioners. As the legislature did not allocate state funds to finance this project, the timeline for development and implementation is dependent upon fee revenue. OHA is currently working with its contractor and stakeholders to plan the rollout process.

Please don't hesitate to contact me with any questions you may have.

Sincerely,

Patrick M. Allen
Director

CC: Fariborz Pakseresht, Director, DHS

Attachment 1 – Cumulative List of Documented Issues as of December 1, 2017

Below is a cumulative summary of documented issues as of December 1, 2017.This is likely not an exhaustive and final list of all known issues facing the agency. It is also likely that the details of these issues will evolve as we research them and consult in more detail with subject matter experts.

Dual Eligible Population
Status: Partially resolved; system changes implemented for 2016 and forward; additional research and analysis required for 2014 and 2015.
Estimated Impact: Updated estimates as of November 2017 show a total of $58.7 million in over claimed federal funds, mostly due to overpaid capitation payments and partially due to the incorrect federal match rate. Updated estimates show a total of $46.4 million in overpaid capitation payments (federal and general funds). If ongoing research and analysis result in changes to these figures, they will be updated.
Summary: OHA identified two issues related to the dual eligible population that occurred during 2014, 2015, and part of 2016: (1) OHA paid full capitation rates to Coordinated Care Organizations (CCOs) for some dual eligible members, rather than the correct (lower) capitation rates that reflect Medicaid as the payer of last resort; and (2) in some cases, dual eligible members were not properly coded in the Medicaid Management Information System (MMIS) with the appropriate eligibility category, leading to the federal government paying the 100% match rate associated with Medicaid-only Affordable Care Act (ACA) expansion members (i.e., MAGI Adults) in cases when the match rate should have been lower (about 64%). OHA made system and process changes in 2016 to ensure that CCOs are paid the correct capitation rate for dual eligible members and that the correct federal match rate is claimed going forward. These system changes also corrected capitation rates retroactively to the beginning of 2016, and OHA has repaid over-claimed federal funds for 2016. For 2014 and 2015, our analysis of the scope of this issue and next steps for resolution is ongoing.

Retroactive Terminations
Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Preliminary estimates as of July 2017 indicated $17.3 million in federal funds that may need to be repaid. It is still unclear whether these are all payment errors. As research and analysis are ongoing, the final figure is likely to change.
Summary: This issue relates to capitation and fee-for-service payments made, dating back to January 2014, in situations when OHA staff retroactively terminated eligibility without also retroactively terminating enrollment for certain clients. Initial documentation and discussion of this issue identified several possible causes. However, additional review and discussion of the initial documentation has prompted further research and analysis to ensure we are accurately identifying the issue, causes, scope, and appropriate resolution. While this research is ongoing, OHA has changed system privileges to appropriately limit authority to process retroactive terminations.

Bariatric Surgery Payments
Status: Partially resolved; rate adjustments processed and overpayments in process of being recouped.
Estimated Impact: $1.5 million in overpaid claims in process of being recouped.
Summary: Bariatric surgery claims from 2009 through 2015 were paid at an incorrect, higher rate than the appropriate Medicare reimbursement rate. Rate adjustments were processed in MMIS and recoupment of overpayments was initiated in October 2016. As of October 2017, most of the overpayments have still not been repaid by providers, resulting in an accounts receivable balance of $1.1 million. OHA will be following up with providers to ensure recoupment of overpayments.

Fee-for-Service Payments while Enrolled in CCOs
Status: Not yet resolved; system change request awaiting review and approval.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: There are situations in which a client is enrolled in a CCO but also has had fee-for-service (FFS) claims paid during the same time period. While some services are carved out and would be appropriately paid for on a FFS basis, some of the identified FFS claims do not meet this definition and should not have paid. An example of this occurred in December 2016, when pharmacy claims for CCO clients were paid on a FFS basis during a 3-day

period, resulting in payment of claims that may not have been covered by a CCO or would have been paid by the CCO at different rates (about a $165,000 impact to state funds). We are working to identify a process to stop processing certain claims when billed by a specific type of provider, as identified in the working draft report. As we further review these issues, additional change requests may be required.

Post-Delivery Coverage for CAWEM Plus Clients
Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Not yet known; it is still unclear whether these are all payment errors.
Summary: While preparing system changes required to implement HB 3391 (2017), OHA staff discovered a reporting and funding issue related to the Citizen/Alien-Waived Emergency Medical (CAWEM) populations. CAWEM clients receive coverage for emergency services, which we can claim federal funds for under Medicaid (Title 19). If a CAWEM client becomes pregnant, additional benefits are covered under CAWEM Plus to cover the unborn child. Under CAWEM Plus, the client's services are federally funded under the Children's Health Insurance Program (CHIP) (Title 21). Upon delivery, CAWEM Plus clients should transition back to the more limited benefits provided under CAWEM. Initial review indicates that this transition may not always occur if the client or the client's provider does not notify us of the delivery date. If this is the case, we may be providing coverage for which the client may no longer be eligible to receive and that we may be over-claiming federal funds and/or funds from the incorrect federal funding source. There also may not be an existing process to refinance such expenditures retroactively upon notice of delivery.

CAWEM Clients Enrolled in CCOs
Status: Resolved; eligibility corrected and overclaimed federal funds have been refinanced with general funds.
Estimated Impact: $25.7 million in payment errors and over-claimed federal funds.
Summary: Some CAWEM clients were incorrectly shown in MMIS as non-CAWEM clients for a period of time, incorrectly allowing them to be enrolled in CCOs and receive expanded benefits. Eligibility for this group was corrected in MMIS and federal funds were reclassified to general funds in the June 23, 2017 financial cycle.

Capitation Payments for Deceased and Incarcerated Clients
Status: Partially resolved; system changes implemented to address deceased clients but system change request in design for incarcerated clients.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: Capitation payments are made to CCOs at the beginning of each month to cover care for their clients during the month. If a client is incarcerated or dies, capitation payments should be retroactively adjusted to recoup any payments made after the date of incarceration or death. This is not occurring correctly in the system and capitation payments have not been fully recouped from CCOs. Currently, the system is recouping capitation payments for up to 12 months preceding the date the action is taken to note the date of death or incarceration.

Long-Term Residential Services Eligibility
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: Long-term residential services are provided to two different client populations through two distinct programs: (1) the 1915(i) Home and Community-Based Services (HCBS) State Plan Option provides serves clients requiring mental health services, and (2) the Oregon Supplemental Income Program Medical (OSIPM) serves clients who are aged, blind, or disabled. In the past, these two populations were aggregated into a single HCBS waiver, but they have been since been separated into the two distinct programs described above. Despite the separation of the programs, the same financial rules used to determine eligibility have continued to be applied to both programs, which may not be appropriate.

Case Mismatch Across Systems
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: There are situations where an individual in one system is incorrectly matched to a record in another system. This can cause errors in clients' demographic and contact information, eligibility data, and CCO enrollment data, risking incorrect payments and the need for recoupment, as well as clients' privacy. Manual processes are in place to identify and correct mismatches and report any privacy breach incidents. Additional research and analysis is required to identify and implement permanent resolution.

Payments to Institutions for Mental Disease (IMDs)
Status: Partially resolved; system changes implemented and retroactive adjustments made for overclaimed federal funds; additional research and analysis required to claim additional federal funds.
Estimated Impact: $9.7 million in over-claimed federal funds ($3.4 million related to capitation payments; $6.3 million related to FFS payments), which were refinanced with general funds in 2017; additional research and analysis required to quantify amount of unclaimed federal funds that can be pursued.
Summary: Federal funding cannot be used for expenditures associated with clients residing in an IMD. If the fact that a client is residing in an IMD is in the system at the time of payment, the capitation or FFS payment will be correctly funded with general funds only. However, we are often notified that a client was residing in an IMD after a payment has been processed, and the system did not have the ability to retroactively adjust the funding source. Systems changes have been implemented to correct this and retroactive adjustments were made in May and June of 2017. We also may not always timely reflect when a client is discharged from an IMD, which would allow us to resume claiming federal match funds. Additional analysis is required to quantify any federal funds that can be claimed and to ensure timely recognition of discharge dates going forward.

Payments for Certain Procedures Related to Termination of Pregnancy
Status: Partially resolved; system changes implemented and additional research in process to finalize amount to be refinanced.
Estimated Impact: Preliminary estimates as of October 2017 indicate $1.8 million in over-claimed federal funds. The final amount to be refinanced is being analyzed.
Summary: Three procedure codes that may be used to pay termination of pregnancy procedures were recently determined not to be eligible for federal funding. System changes have been implemented and additional analysis is in progress to confirm the final amount of federal funds to be refinanced.

Services Provided to Tribal Members at Non-Tribal Facilities
Status: Not yet resolved; change request in design.
Estimated Impact: Not yet known; additional research and analysis required but would increase OHA's ability to claim federal funds for these services going forward.
Summary: The Centers for Medicare and Medicaid Services (CMS) provided guidance that we can claim 100% federal funds match for services provided to tribal members at non-tribal facilities if the tribe has a coordination agreement with the provider. We have been claiming federal funds for these claims at a lower match rate. System changes are in process to automate the corrected federal match rate for these claims.

Enhanced Federal Funding for Preventive Services
Status: Not yet resolved; change request awaiting review and approval.
Estimated Impact: Not yet known; additional research and analysis required but would increase OHA's ability to claim federal funds for these services going forward.
Summary: Certain preventive services are eligible for a 1% increase in the federal funds match rate. The system is not currently configured to claim the enhanced match rate for these services. System changes to automate the corrected federal match rate for these claims are being reviewed.

Tribal Targeted Case Management Services
Status: Not yet resolved; change request in design.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: CMS has stated that targeted case management (TTCM) services related to social services programs provided to a subset of tribal clinics should be claimed at the traditional Federal Medical Assistance Percentages (FMAP) rate rather than at 100% federal funds match. System changes to automate the corrected, lower federal match rate for these claims are being reviewed.

Prescription Drug Rebate Credits
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Estimated $22.3 million in credit balances for drug rebates owed to labelers as of October 2017. As research and analysis are ongoing, the final figure is likely to change.
Summary: When we receive drug rebates, a portion of that rebate may be owed to a labeler. This information is not being captured in our financial systems to issue payment or post a credit against any outstanding invoices for labelers for its portion of the rebate. Our drug rebate revenues may be overstated, and we may need to repay labelers and/or apply credits to outstanding invoices from labelers.

Nursing Facility Coinsurance and Post-Acute Care Claims
Status: Not yet resolved; system change undergoing testing.
Estimated Impact: $14.1 million shift from Department of Human Services' (DHS's) Aging and Persons with Disabilities (APD) budget to OHA's Health Systems Division (HSD) budget.
Summary: Coinsurance payments for nursing facilities and post-acute care have been incorrectly hitting the APD budget, rather than the HSD budget, since September 2016 due to the unintended impact of a system change. These claims will continue to charge against APD's budget until the system change is implemented, but manual budget adjustments will be made in the interim. This did not result in any incorrect claiming of federal funds.

Prior Period Adjustments for Public and Private Providers
Status: Not yet resolved; change request awaiting review and approval.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: This change was initially suggested by auditors with the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) in October 2015 and relates to the FMAP rate applied to prior period adjustments. The OIG's position differentiated between public and private providers, as follows: (1) for public providers, the state should claim the FMAP rate in effect when the service was provided (not the rate in effect when the adjustment was posted); and (2) for private providers, the state should use the FMAP rate in effect at the time the was posted. Note that OIG auditors were preliminarily reviewing Oregon's Medicaid claim adjustments to determine whether to proceed with an audit. Based on their initial analysis, the OIG decided not to proceed with an audit.

Posting of Cash Payments
Status: Not yet resolved; additional research and analysis required.
Estimated Impact: Estimated $20 million in unposted cash revenue; research and analysis are ongoing and the final figure is likely to change.
Summary: OHA receives cash medical payments from the Division of Child Support (DCS) for clients in custody, and some of these payments have yet to be posted to the appropriate trust account in MMIS. Application of these revenues to the appropriate trust account will reduce state and federal costs for these clients.

Overwritten Eligibility Records
Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Preliminary estimates as of November 2017 indicate 1,200 individuals have been affected but financial impact is not yet known; additional research and analysis required.
Summary: This issue relates to specific situations where eligibility information is retroactively overwritten in the system when clients provide updated eligibility information. For example, a parent and child both apply for Medicaid on January 1, 2017 and the household income is 250% of the Federal Poverty Level (FPL). The child is eligible but the parent is not. In July 2017, the parent reports updated income information showing that household income is now 100% of the FPL, so the parent is now eligible. Due to this system issue, the July 1 eligibility information overwrites the original January 1 information in the system, showing that the parent was eligible all the way back to January 1. This system issue does not retroactively enroll individuals into CCOs, but additional research and analysis is required to determine whether any claims for services prior to the true eligibility date are being paid retroactively.

Alignment of Federal Financial Reports
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Estimated Impact: No financial impact; this is just a federal reporting change.
Summary: OHA provide various reports to CMS to demonstrate compliance with federal requirements and ensure accurate federal funding. Two of these reports – CMS 64 and Schedule C – are not directly comparable because the CMS 64 reports all Medicaid expenditures (not just those associated with the 1115 Waiver) and the Schedule C reports only those expenditures associated with the 1115 Waiver based on the demonstration year shown on the CMS 64. The CMS 64 report is used to support OHA's claims for federal funding. CMS would like states with federal waivers to use Schedule C as the basis for reporting budget neutrality. OHA is working with CMS to determine next steps and whether revisions to reports are needed.

Non-Covered Services Included in Rates for Certain Certified Community Behavioral Health Clinics
Status: Not yet confirmed; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: OHA learned that some Certified Community Behavioral Health Clinics (CCBHCs) may have included non-covered crisis respite services in cost data reported to OHA for use in developing 2017 rates paid to CCBCHs. OHA is gathering information from CCBHCs to determine the scope of the issue and will determine next steps to adjust rates, as needed.

Common Credentialing Program Implementation
Status: Not yet completed; additional research and analysis required.
Estimated Impact: Not yet known; additional research and analysis required.
Summary: Under SB 604, OHA is required to establish a program and database to reduce burden for practitioners and provide credentialing organizations access to the information necessary to credential or re-credential all Oregon health care practitioners. As the legislature did not allocate state funds to finance this project, the timeline for development and implementation is dependent upon fee revenue. OHA is currently working with its contractor and stakeholders to plan the rollout process.