

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.

Possible topics include:

- Health Insurance Exchange
- Basic Benefit Package/Public Plan
- Provider Workforce
- Health Information Technology
- Long-term Care
- Patient Centered Primary Care Homes
- Strengthening the role of safety net
- ***Payment Reform***
 - Medicaid provider reimbursement
 - Community health workers

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.

Possible topics include:

- Reducing barriers to care
- Dual-eligibility
- Presumptive eligibility/prenatal care

- Access
 - Physician Access Improvement Project
- Language access
- Health care for undocumented kids
- OHP eligibility and enrollment
- OHP expansions
- Client wellness and health behaviors
- Healthy Kids
- Oregon Health Study
- Access to oral and behavioral health services
 - Track changes aligned with MAC guidance (2009 white papers)

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

DMAP 2009 Legislation - Status Update

| Bill # | Subject | Description | Status |
|---------|---|---|---|
| HB 2116 | Medicaid Expansion | Creates and funds Healthy Kids, and funds extension and expansion of OHP Standard. Creates assessment on insurance premiums, capitation payments to managed care plans, and hospitals to fund the Medicaid expansion. Provides for changes in reimbursement to hospitals and managed care plans. | State plan and waiver approval are needed from the Centers for Medicare and Medicaid Services, and are anticipated to be received prior to October 1st. The Healthy Kids aggressive marketing and outreach campaign will be launched in October. The reservation list for OHP Standard will be opened to new enrollment in October or November. |
| HB 2126 | Preferred Drug List | Allows prior authorization for non-mental health fee-for-service drugs pursuant to a Preferred Drug List (PDL), and a voluntary PDL for mental health drugs. | Implementation is scheduled for January 1, 2010. Work is underway to select the drugs that will be included on the PDL. |
| HB 3418 | Feasibility Report Regarding Reimbursement | Requires the Department to report to a Legislative Interim Committee on the feasibility of implementing a system for reimbursing health care delivered to Medicaid clients through primary care homes. The bill also allows the department to develop additional incentive improvement payments for managed care capitation rates and fee-for-service payments based on the goal of transforming the primary care delivery system to improve health outcomes. | The report is due June 30, 2010. Discussions are currently underway through DMAP's transformation initiative addressing these issues. |
| SB 37 | Rural Health Clinic Reimbursement | Requires DHS to insure that rural health clinics receive full reimbursement within 45 days for health services provided to persons enrolled in prepaid managed care health services | Implementation is scheduled for May, 2011, and requires only rule changes and minor systems changes to implement. |
| SB 154 | Repeals the Senior Prescription Drug Assistance Program | This program was created in the 2001 Legislative session. With the creation of the Oregon Prescription Drug Program, this program became obsolete and no clients are currently enrolled. | As no clients are currently enrolled in the program, only rule changes are needed to close the program, which is scheduled for January 1, 2010. |
| SB 5529 | DHS Budget Bill | Establishes DHS budget and identifies budget reductions and other savings for the 2009/2011 biennium. | A variety of effective dates are identified for the various budget reductions and savings, with work underway to complete the necessary rule changes, obtain CMS approval, and make system changes. |

CO-CHAIRS' 2009-2011 RECOMMENDED BUDGET

Division of Medical Assistance Programs

May 2009

Implement Efficiencies and Initiatives

Obtain additional drug rebate funds

- Revenue from drug rebates exceeds previous expectations
- Extra revenue reduces the General Fund need

Reduce administrative budget

- Vacancies would not be filled
- Costs for training, travel, office supplies, contracted professional services would be reduced
- DMAP would not be able timely and effectively meet all of its responsibilities

Enforce the Preferred Plan Drug List (PDL)

- Oregon has a voluntary PDL which could be enforced through the use of prior authorization
- Despite the high rate of voluntary compliance (70%) drug costs have not been contained
- Provides incentives to drug manufacturers to provide more aggressive supplemental rebates
- Clients would receive the most effective drugs at the best possible price

Add Mental Health drugs to voluntary Preferred Plan Drug List (PDL)

- Because they are carved out of managed care plans, mental health drugs make up more than 60% of OHP's fee-for-service prescription drug budget
- Eliminates co-payments for preferred mental health drugs and does not limit access to drugs
- Savings generated from supplemental rebates

Create a Durable medical Equipment (DME) sole-source contract

- Creates a sole-source contract for specialized rehabilitative equipment
- Ensures clients have timely access to quality equipment and service

Expand electronic communication (transformation initiative)

- Develop an electronic communication system for provider notices, reducing printing and mailing costs

Improve third party medical liability identification and recovery (transformation initiative)

- Improve methods for identifying other payers – currently based on information supplied by clients and providers
- Quicken process for entering third party resource information into the computer system
- Streamline procedures for recovering payments
- Both reduces unnecessary payments and improves cost recovery

Reduce Benefits

Limit dental services for non-pregnant adults

- Approximately 175,000 people would have coverage for dental care limited

Limit vision services for non-pregnant adults

- Approximately 175,000 people would lose coverage for routine vision care and glasses
- Only a small number of clients with medically necessary diagnoses to restore vision would qualify for coverage

Reduce Populations

None

Reduce Rates

Reduce the hospital component of managed care capitation rates

- Relates to hospitals with 50 beds or more
- These hospitals and managed care organizations continue to receive less reimbursement than the cost of services

Limit payments to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to lesser of Medicare or Medicaid rate

- Applies when Medicare is the primary payer and Medicaid the secondary payer
- Financial viability of some clinics may be compromised

Reduce capitation rates for managed care organizations (MCOs)

- MCOs would experience more difficulty in securing adequate provider participation and client access may be compromised

Eliminate fee-for-service provider cost of living adjustments for 2009/2011

- Providers would be less likely to serve OHP clients
- A possible reduction in access to health care would result in increased emergency department utilization

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

- DMAP will resume auto-assignment for managed care plans this month, beginning in Malheur and Polk counties. 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.
- DMAP continues to train providers, over the telephone and in one-on-one trainings, on how to use the Provider Web Portal. 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.
- DMAP has begun planning for next year's MMIS Conference. This national conference will be held August 15-19, 2010, at Portland's Oregon Convention Center with the theme of "Making Medicaid Information Sustainable."

Budget implementation update

Background

With the downturn in the economy, the revenue supporting government services is decreasing, while at the same time, the need for these services is increasing. In order to balance the budget, the Legislature faced some very difficult decisions, grappling with cuts to programs and services, tax increases and use of the "rainy day" fund. However, with the passage of Senate Bill 5529 in late June, the Legislature laid out the final 2009-2011 budget for DHS.

The 2009-2011 Legislatively Approved Budget (LAB) charges DMAP to reduce program expenditures by:

- Limiting dental services for non-pregnant adults
- Limiting vision services for non-pregnant adults
- Reducing reimbursement rates for providers:
 - Reduce the hospital component of managed care capitation rates (affects hospitals with 50 or more beds)
 - Take steps to reduce the expenditure trend for the 2009-2011 biennium in payments to Federally Qualified Health Centers and Rural Health Clinics
 - Reduce capitation rates for managed care organizations
 - Eliminate cost-of-living adjustments for fee-for-service providers

For more information about the LAB, visit www.leg.state.or.us/budget/home.htm. Though the Legislature has approved the 2009-2011 budget, more changes may occur when the Legislature reconvenes for a special session in February 2010.

Update

Benefit reductions - DHS is waiting for approval from the Centers for Medicare and Medicaid Services (CMS) of the dental and vision services reductions. In August, DMAP held Rule Advisory Committee meetings to discuss the draft Oregon Administrative Rules that incorporate the following reductions:

- Dental service reductions for OHP Plus non-pregnant adults, 21 years and older:
 - DMAP will no longer cover crowns; endodontics on molars; apexification/recalcification procedures; some periodontic procedures; alveoplasty; or office visits for observation.
 - DMAP limits full dentures to only those clients who are recently edentulous (extractions occurred within 3 months prior to making of denture).
 - Replacement of full dentures will not be covered, but replacement of partial resin dentures will be covered once every 10 years.
 - Partial cast metal dentures are no longer allowed.
 - Adjustments and repairs of dentures will be limited.
 - Denture relines are limited to once every 3 years.
 - Interim partial dentures will be allowed if at least one anterior tooth is missing, and are limited to replacement only every 5 years.

- Vision service reductions for OHP Plus non-pregnant adults, 21 years and older:
 - In general, DMAP will no longer cover eye examinations for the purpose of prescribing glasses or contact lenses (CPT codes 92002, 92004, 92012, 92014, and 92015); fitting fees (CPT codes 92340-92342); or glasses or contact lenses (CPT codes: V2020, V2025, V2100-V2615, and V2700-V2799).
 - DMAP will pay for these codes for non-pregnant clients 21 and older when the client has one of the following medical diagnoses: pseudoaphakia (ICD-9 V43.1), aphakia (ICD-9 379.31), congenital aphakia (ICD-9 743.35), or keratoconus (371.60-371.62).
 - DMAP will also still cover glasses and contact lenses for clients who lack the natural lenses of the eye due to surgical removal or congenital absence (cataracts, 366.00-366.09; congenital cataracts, 743.30-743.39).

FQHC expenditure reduction - DHS is working with the FQHC community to determine how to implement the required \$1 million reduction. Options under consideration include updating Outstationed Outreach Worker (OSOW) standards; and identifying efficiencies gained through the replacement MMIS and revised administrative operations.

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.

DHS plans to actively market Healthy Kids beginning in October. Already, media coverage of Healthy Kids and the efforts of community partners increased average OHP enrollment by 3,000 children during July.

Update

- DMAP continues to hold Information Sessions about the Application Assistance Program and the Targeted Outreach and Enrollment Grants Program.
- DMAP continues to receive Certified Application Assistance Organization applications. Once approved, organizations can send their employees and volunteers to the Certified Application Assister training sessions. So far, 35 organizations have applied to be Certified Application Assistance Organizations. This program will begin in October.
- The Request for Grant Proposal (RFGP) for the Targeted Outreach and Enrollment Grants is scheduled to be posted on the Oregon Procurement Information Network (ORPIN) Web site by the end of the month. The address is <http://orpin.oregon.gov>. DMAP expects to award approximately 20 to 40 of these grants by early November.

- The Office of Private Health Partnerships has issued a Request for Proposal (RFP) for options to be considered for Healthy KidsConnect, the private insurance option for families with incomes above 200% of the federal poverty level. Proposals are due September 25. OPHP plans on making Healthy KidsConnect available January 1, 2010.

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 programs covered 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. 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.

Once Oregon receives CMS approval to reopen the OHP Standard program using a new, continuously open reservation list, DHS will open the new list to the general public.

Once on the reservation list, all individuals have an equal chance of receiving an OHP Standard application via monthly drawings. Only those people whose names are drawn will receive an application.

Update

- DHS sent letters to the primary person listed for each of the approximately 51,000 active reservations that did not receive an OHP Standard application last year. The letter explained that to participate in future OHP Standard application drawings, they must contact DHS and ask to be on the new reservation list. So far, several thousand people have requested that their names be included on the new list.
- The department is currently waiting for CMS approval of the continuously open reservation list. If approval for the change has not been obtained by October, the list may not reopen until November.
- 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.

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. Three 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 efficiency 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 requirements will be effective January 1, 2010, and will improve efficiency and reduce costs for the division.
- **Pay for Performance** - This payment model would reward managed care plans for meeting certain performance measures for quality and efficiency, and possibly reduce payments in the event of medical errors or excessive administrative costs. DMAP is currently researching whether such a system would result in measurably better health outcomes and reduced health care costs, while maintaining successful relationships with the providers and plans that serve OHP clients.
- **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 administrative 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** - Following extensive stakeholder involvement at the August Rules Advisory Committee meeting:
 - DMAP has drafted the enforceable PDL for physical health drugs and voluntary PDL for mental health drugs. DMAP will present these drafts for review and additional stakeholder input at the next Drug Use Review Board meeting on September 24, and the next Rules Advisory Committee meeting on September 28.
 - DMAP also began posting the new Average Net Price (ANP) calculations to the OHP Web site at www.oregon.gov/DHS/healthplan/supp-rebate/main.shtml.
 - 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.
 - DMAP is also developing staff training material about the new prior authorization processes that will be effective in January. The material will also explain how clients currently prescribed non-PDL drugs will be affected by the January changes.

- Pay for Performance - DMAP continues to research available options.
- Third Party Liability and Recovery:
 - 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 (HIPP) program and the Private Health Insurance (PHI) program. This will allow all client insurance information to come to one place for processing.
 - This month, DMAP and the department's Office of Payment Accuracy and Recovery agreed to exempt clients with reported TPR from enrollment into managed care until their TPR has been verified. This change results in successful cost avoidance for the managed care plans and DHS.

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.

The team expects the CMS grant to be extended for another year to permit a full 15-month demonstration through March 31, 2011.

Update

- The HRBO project planning team is completing contract negotiations with WebMD, the selected vendor. The department anticipates signing a contract with WebMD this month.
- In addition, WebMD and the Oregon Community Health Information Network (OCHIN) will be collaborating on strategies to engage clients and providers effectively. A contract with OCHIN is also currently under discussion.
- Team members continue work on essential policy and procedural documents to support the operation of the HRBO.
- As of September 1, 2009, the HIIAC has been replaced by the Oregon Health Information Technology Oversight Council (HITOC), which is tasked with developing and implementing a statewide plan for electronic health information exchange. The HRBO anticipates that, like the HIIAC, the HITOC will recognize the HRBO's potential in helping build on the Oregon Health Fund Board's recommendations for implementing electronic health information exchange, which included:
 - All Oregonians should have access to a Personal Health Record by 2013.
 - Developing a statewide system for health information exchange that ensures that a patient's health information is available and accessible when and where it is needed.

- Making the HRBO inter-operable with electronic health record systems throughout the state is essential to the future operation of the HRBO.
- The HRBO should encompass strong privacy and security protections and resolve the issues of patients’ rights regarding the use and ownership of their personal health information.

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.
- DHS continues work on expanding the program to additional counties beginning in October 2009. The department has requested federal approval from CMS to add Benton, Clackamas, Hood River, Jackson and Lincoln counties to the program.

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 a state Medicaid and Children’s Health Insurance Programs (CHIP).

The department’s CHIPRA Outreach and Enrollment grant proposal 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. The CHIPRA Outreach Grant proposal provides the state with the mechanism to support the outreach efforts of these providers.

Update

- DHS expects a response from DHHS about the status of Oregon's CHIPRA grant application by the end of this month.
- The nine CHIPRA grant applicants that DHS submitted letters of support for were:
 - Klamath County Public Health - For Klamath, Douglas, Jefferson, Josephine and Lincoln counties
 - Covering Kids and Families in Eastern Oregon - For Union, Baker and Wallowa counties
 - Lincoln County Health and Human Services - For Lincoln County
 - CareOregon Outreach Program - For Portland area and 32 counties
 - Washington County Commission on Children and Families - For Washington County
 - YWCA of Salem - For Marion and Polk counties
 - Mercy Medical Foundation - For Deschutes, Jefferson, Crook counties and Warm Springs
 - Central Oregon Outreach Coalition - For Douglas County
 - Alliance for Children's Health and Equality - For Marion, Deschutes, Crook, Jefferson, Lincoln, Hood River, Wasco and East Multnomah counties, as well as Southern and Northeastern Oregon.

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.

- DMAP will send fee-for-service clients information about when the vaccination will become available, and where they can get the vaccine.
- DMAP will also coordinate with the Medicaid managed care organizations concerning their enrollees.



DMAP CAPE
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Governor Kulongoski submits appointments for Senate consideration

Governor Ted Kulongoski submitted the following nominees for volunteer service on the Oregon Health Policy Board and Health Information Technology Oversight Council. All of the nominees are subject to Senate confirmation.

The Senate will hold the confirmation committee hearing on September 29 and floor consideration on October 1. For more information visit:

<http://www.leg.state.or.us/agenda/>.

Oregon Health Policy Board Nominees

The Oregon Health Policy Board replaces two other health-related boards. The new board will oversee the Oregon Health Authority, a new state agency created by the division of the Department of Human Services. Over the next two years, all of the current state health care functions will be consolidated under the Oregon Health Authority.

The Oregon Health Authority, and its board, will be responsible for overseeing and coordinating all state health care services and implementing the health care reform provisions of House Bill 2009. This includes shifting the approach to health care toward an emphasis on early prevention, primary care, cost-containment and evidenced-based outcomes.

Eric Parsons (Chair), Portland
Lillian Shirley (Vice Chair), Portland
Michael Bonetto, Bend
Eileen Brady, Portland
Dr. Carlos Crespo, Portland
Felisa Hagins, Portland
Dr. Charles Hofmann, Baker City
Dr. Joe Robertson, Portland
Nita Werner, Beaverton

Health Information Technology Oversight Council Nominees

The Health Information Technology Oversight Council was created by the passage of HB 2009 within the Oregon Health Authority. It is charged with developing a statewide strategic plan for electronic health information exchange, coordinating public and private efforts to increase adoption of electronic health records, setting technology standards, ensuring privacy and security controls and creating a sustainable business plan to support meaningful use of health information technology to lower costs and improve quality of care.

Steve Gordon, MD (Chair), Eugene
Rick Howard (Vice Chair), Salem
Bob Brown, Portland

Brian DeVore, Hillsboro
Dr. Greg Fraser, Sublimity
Bridget Haggerty, Portland
William Hockett, Portland
Marie Laper, Corvallis
Robert Rizk, Hermiston
Sharon Stanphill, Roseburg
David Widen, Dayton

Overview of the Health Resources and Services Administration's State Health Access Program (SHAP) Grants Oregon's Grant Award

In September 2009, Oregon was awarded a five-year, competitive federal grant to support health care coverage expansion efforts. The federal Health Resources and Services Administration (HRSA) awarded \$70.9 million in grants to 13 states under the State Health Access Program (SHAP). 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.

Purpose of Grant

The HRSA SHAP grant is a new federal opportunity 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.

Proposal Overview

In June 2009, the Legislature passed House Bills 2116 and 2009, implementing many of the recommendations of the Oregon Health Fund Board (OHFB) for comprehensive health reform. The initiatives within these bills carry out the Board's vision of a healthy Oregon and universal access to coverage by 2015, by expanding coverage, improving quality, and containing costs.

- 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 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 that can be resources across all coverage populations and programs.
- 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.

Grant Activities and Timeline

Coverage Phase 1 – Children and Low-Income Adults

Grant years 1 & 2

October 2009 – September 2011

- **Children:** Expand insurance coverage via Healthy Kids to all children statewide using grant funding to ensure the effective enrollment of all children. Grant funds will:
 - Support implementation of aggressive, multi-faceted marketing and outreach strategies;
 - Streamline eligibility and enrollment processes through technical and other systems improvements;
 - Provide application assistance via eligibility workers stationed onsite in provider settings; and
 - Engage community partners in outreach and application assistance through development of educational e-training modules.
- **Low-Income Adults (up to 100% FPL):** Expand insurance coverage to low-income adults via OHP Standard using grant funding to ensure the effective enrollment of all segments of this difficult to track population. Grant funds will:
 - Support implementation of multi-faceted marketing and outreach strategies; and
 - Support communication strategies and provide application assistance to increase enrollment process efficiency.

Grant Years 3, 4 & 5

October 2011 – September 2014

- **Children:**
 - Complete implementation of streamlined eligibility and enrollment processes.
 - Evaluate children’s coverage expansion and outreach activities to improve outreach and enrollment processes.
 - Develop and implement strategies to enroll hardest to reach populations.
- **Low-Income Adults (up to 100% FPL):**
 - Evaluate low-income adults’ expansion and outreach activities to improve outreach and enrollment processes.

Coverage Phase 2 – Sustainable Coverage for All Oregonians

Grant years 1 & 2

October 2009 – September 2011

- Working Uninsured (above 100% FPL):
 - Support the implementation of a small business product and reinsurance strategy.
 - Support the development of a health insurance exchange.
 - Implement multi-share models in select Oregon communities, using grant funding for initial start-up costs.
- Sustaining Comprehensive Coverage:
 - Develop and establish the infrastructure to support a value-driven benefit model for use across all expansion approaches.
 - Develop and implement sustainable payment methodologies.

Grant years 3, 4 & 5

October 2011 – September 2014

- Working Uninsured:
 - Support the implementation of a health insurance exchange in the individual and small group markets, including developing products for potential “gap” populations (e.g., near elderly and young adults). Use grant funding to support necessary market reforms.
 - Support the continued implementation and evaluation of reinsurance and multi-share models.
- Sustaining Comprehensive Coverage:
 - Support the implementation of a sustainable funding source for coverage expansions.
 - Support the implementation of sustainable payment methodologies and other cost containment efforts. Further refine value-based benefit model.

Comprehensive Reform Evaluation and Monitoring

All grant years

October 2009 – September 2014

- Enrollment and Oregon Health Insurance Surveys:
 - Support an enrollment and disenrollment survey that will assess the effect of health insurance on enrollees in Oregon’s coverage expansion
 - Support an Oregon Health Insurance Survey that will evaluate the impact of Oregon’s coverage expansion initiatives on the uninsurance rate in Oregon
- Grant evaluation, reporting, and contract monitoring: Conduct all required evaluation, monitoring and reporting related to SHAP grant funded activities.