January 2012 DMAP Update

Coordinated Care Organizations

The Oregon Health Policy Board's wrap-up meeting before submitting the Coordinated Care Organization (CCO) Implementation Proposal to the legislature will be held Tuesday, January 24, from 8:30 a.m. to noon, with live streaming video available. For information, go to http://www.oregon.gov/OHA/OHPB/meetings/index.shtml.

Implementation time line

January	February	March
Board delivers implementation proposal to legislature.	Legislature considers CCO implementation proposal.	Subject to legislative approval and authority, Oregon submits request for federal permissions.
April - June		**July**
- CCO criteria publicly posted - *Request for Application* (RFA) and model contract posted - *Letters of Intent* to Oregon Health Authority - Evaluation of CCO applications - First CCOs certified		First CCOs will begin enrolling Oregon Medicaid members.

CCOs are local health entities that deliver health care and coverage for people eligible for Medicaid (the Oregon Health Plan) and also people covered by both Medicaid and Medicare. CCOs have one point of accountability for health outcomes and one budget that grows at a fixed rate for mental, physical and ultimately dental care. Qualified CCOs will bring forward new models of care that are patient-centered and team-focused. They will also have flexibility within the budget to deliver the outcomes expected of them. And finally, they will be governed by a partnership between all providers of care, community members and the stakeholders in the health system who have financial responsibility and risk.

Oregon is ready and moving forward. CCOs will give communities and health systems the tools they need. There has been extensive public comment on improved models of care for better health and lower costs. Local communities are coming together in unprecedented ways. Working closely with federal partners for the flexibility we need and up-front investments based on long-term cost reductions for both the state and the federal government, pending approval by Oregon legislature.

For more on Coordinated Care Organizations, visit www.health.oregon.gov/OHA/OHPB.

Health Evidence Review Commission holds first meeting

Background

The Health Evidence Review Commission will perform the duties of two abolished groups: the Health Resources Commission, which analyzed and disseminated information about the effectiveness and cost of medical technologies and their impact on the health of Oregonians, and the Health Services Commission which determined the Prioritized List of Health Services for the Oregon Health Plan, as well as the clinical and cost-effectiveness of those services.

Update

Governor Kitzhaber announced commissioner appointments to the Health Evidence Review Commission (HERC) last month and appointees have been confirmed by the Senate. The new commission will be made up of 13 individuals including medical physicians, a dentist, a public health representative, and a behavioral health provider such as a social worker, alcohol and drug treatment provider or psychologist or psychiatrist, as well as participants representing consumers, pharmacy, the insurance industry, and complementary and alternative medicine providers.

HERC held its first meeting on January 12. The commssion's goal is to make sure resources are not spent on unproven treatments or expensive interventions when less costly but just as effective treatments are available. HERC will:

- Develop and maintain a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served.
- Develop or identify and disseminate evidence-based health care guidelines for use by providers, consumers and purchasers of health care in Oregon.
- Conduct comparative-effectiveness research of health technologies.

For meeting minutes, future meeting dates, and Prioritized List information, go to http://www.oregon.gov/OHA/OHPR/HERC/index.shtml.

Consider eSubscribe to receive information and updates as soon as they are posted. Personalize what information you receive and delivery times and methods.

Telemedicine

OHP providers are increasingly using Telemedicine to serve their patients. Telemedicine can bring significant savings to Oregon and plays an important role in addressing physician shortages and improving patient outcomes. Providers submit claims from telemedicine consultations as with any other consultation. Because coding is the same, we are looking at ways to capture data about the frequency and patterns of use with OHP providers.

Recently, our Medical Director and Medical Services Manager toured OHSU's highly regarded telemedicine facility. Examples of successful uses include:

- Oregon Health and Science University's *Telemedicine Network* is one of the most comprehensive telehealth programs in the region. OHSU's and 10 hospitals around the state have immediate, around-the-clock access to pediatric intensive care specialists, stroke neurologists, neurosurgeons, and other specialty care not otherwise available in their community.

  Today, 10 hospitals around the state have immediate, around-the-clock access to OHSU's pediatric intensive care specialists, neonatologists and neurosurgeons. More than a quarter patients treated through the Network have been able to stay in their hometown hospital.

That's saved families — and their insurance plans — an estimated $500,000 in emergency transport costs alone.

- The FCC established the Rural Health Care Pilot Program. In 2007, Oregon was the fifth largest award recipient with a $20.2 million subsidy, administered through the Oregon Health Network.

  With agencies in 17 rural counties, Greater Oregon Behavioral Health Inc. is able to help reach residents in all corners of the state to help them secure mental health services. With the help of its Oregon Health Network connection, the pipeline to expert care and resources is in place.

- School-based Health Centers in Josephine and Douglas counties serve more than 2,000 uninsured children. A telemedicine connection in February 2011 now provides the ability to transfer patient records to the main Umpqua Community Health Center facility, consult with other physicians and help uninsured students enroll in the Oregon Health Plan.

Telemedicine, telehealth, and telecare. What's the difference?

Telemedicine is the practice of medical care using interactive audio visual and data communications; including delivery of medical care, diagnosis, consultation and treatment, as well as health education and the transfer of medical data.

Telehealth refers to an electronic system which enables the clinical management of an individual's condition at a distance or in their own home. For example, technology can enable a patient to monitor their own vital signs, such as blood pressure, pulse rate, or temperature.

Telecare is a term given to offering remote care of elderly and people with physical challenges, providing the care and reassurance needed to allow them to remain living in their own homes.

$22.5 million bonus for Children's Health Insurance enrollment

Background

Oregon's Healthy Kids has nearly accomplished their program goal of covering 95 percent of Oregon's children. A 2011 survey found a 5.6 percent rate of no insurance among children, down from 11.3 percent in 2009.

Family income levels determine eligibility for one of three tiers of Healthy Kids (Oregon Health Plan and Kids Connect) coverage. A family of four making less than $44,928 per year is eligible for no-cost coverage. A family of four making between $44,900 and $67,200 a year pays on average $50 per month for kids' coverage. Families with more income pay full-cost.

Update

The federal Department of Health and Human Services announced a bonus of nearly $22.5 million for Oregon, for increases in children's health insurance coverage. Since October 2010, Oregon has enrolled more than 53,000 kids under age 19 in state health insurance, well over the federal target set under the 2009 Children's Health Insurance Program Reauthorization Act.

In all, 23 states received bonuses totaling $296 million. Oregon's $22.5 million bonus is the fifth largest bonus awarded. Our northern neighbor, Washington, received nearly $17 million.

This is Oregon's third year of receiving a bonus under the federal law, including $15.1 million last year.

For updated information on other areas of interest

- **Oregon Health System Transformation** — To track the transformation process, visit http://www.health.oregon.gov/.
- **Medicaid Management Information System** (MMIS) — Stay up-to-date with news on claim processing and other transaction updates and changes through eSubscribe and Provider Matters.
- **Federal health care reform** — With our own health care reform already underway, Oregon is well positioned to implement the federal legislative changes. For more information, visit the Oregon Health Authority Web site at www.oregon.gov/OHA.
- **Continuous Improvement program** — Enabling DHS and OHA to continue providing quality services at a time when demand is outpacing revenue and create a culture of continuous improvement where change is driven by staff. For more information, please visit www.oregon.gov/DHS/transformation.

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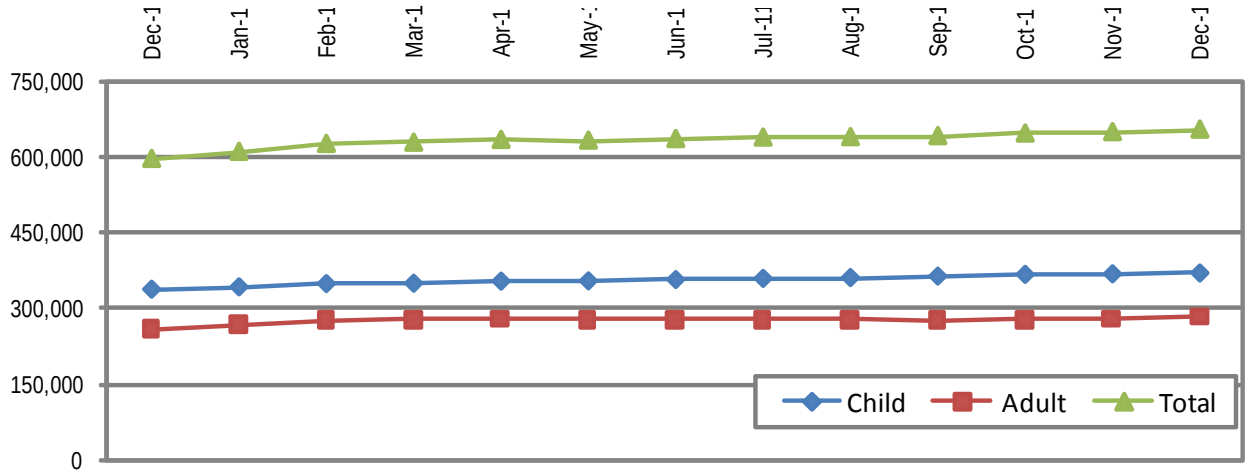
Demonstration and State Plan Amendment status

The following table outlines the status of Demonstration and State Plan Amendments (SPAs) under review by the Centers for Medicare and Medicaid Services (CMS).

Description *(new information is highlighted)*	**Status**	**Rule Change***
Demonstration Amendments		
No demonstration amendments are currently under review.	n/a	n/a
Medicaid SPA		
Targeted Case Management — Self sufficiency program	Submitted 3/17/10	No
Targeted Case Management — Children who are the responsibility of child welfare	Submitted 6/27/08	No
Provider rate change — 2011-13 budget item, rate changes for DME, Dental, Home Health, Clinical lab, Anesthetists and Ambulance. Other services using RVU method are revised for Physicians (non primary care), PT, OT, and speech.	Submitted 7/14/11	Yes
Pharmacy dispensing — 2011-13 budget item change with dispensing fee tier claim volume.	Submitted 7/20/11	Yes
1915(i) state plan option for Home Based Habilitation, HCBS Behavioral Habilitation, HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness — Allows additional flexibility in designing a complete care system for persons with chronic mental illness.	Submitted 7/29/10	Yes
Health homes — A health home model of service delivery that encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions per the Affordable Care Act.	Submitted 9/7/11	Yes
Dental — Reduce some dental services to pregnant women as a further reduction based upon the 11% biennial budget reductions.	Submitted 9/29/11	Yes
Hospital Disproportionate Share (DSH) process — Revise Upper Payment Limit and DSH Distribution method for DSH hospitals in order to maximize the use of the DSH allocation. This SPA will also address the companion letter to SPA 10-17, which requires a narrative description of the process used to determine the UPL.	Submitted 9/29/11	Yes
Nursing facility — This proposed amendment implements a change in the nursing facility rate setting methodology as adopted by Oregon's 2011 Legislative Assembly. Due to decreased state revenues, the Legislative Assembly elected to maintain the nursing facility rates in effect as of June 30, 2011 instead of allowing the normal "rate rebasing" process to proceed.	Submitted 9/29/11	Yes
Pharmacy and Therapeutics Committee — Pursuant to the passage of HB 2100, the DUR Board which is the current recommending body of Prior Authorization Criteria and federally required retrospective and prospective drug utilization review programs will be abolished. It will be replaced by a Pharmacy and Therapeutics committee that will bear the same responsibilities and assume Preferred Drug List (PDL) development responsibilities that will be based on safety, efficacy, and cost.	Submitted 10/18/11	Yes
Provider preventable conditions — Implement changes to federal law which mandates a prohibition of payments for Provider Preventable Conditions associated with health care acquired conditions.	Submitted 12/27/11	Yes
"Patient-Centered Primary Care Home" for non chronic conditions — A health home modeled after the Health Home SPA for chronic conditions.	Submitted 12/28/11	Yes

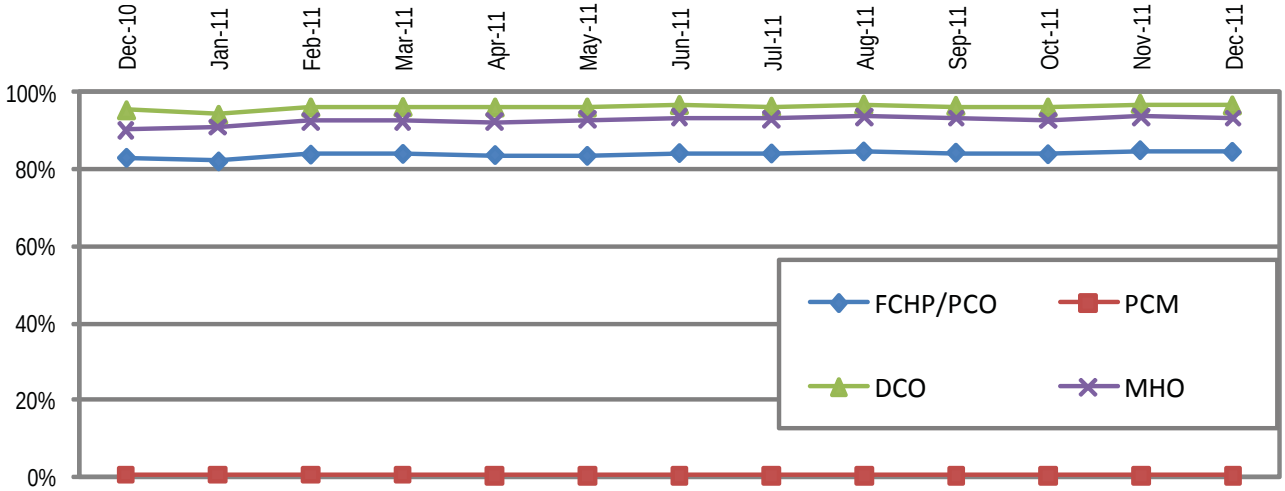
Enrollment Snapshot - December

Number of Oregonians on Medicaid: Total, Adults and Children



Medicaid Enrollment	December 2010	December 2011	Percent Increase
Children (18 and under)	337,498	369,723	9.55%
Adults	258,627	283,535	9.63%
Total	**596,125**	**653,258**	**9.58%**

Percent Enrolled in Managed Care: FCHP/PCO, PCM, DCO, and MHO



Managed Care Enrollment	December 2010	December 2011	Percent Increase
Fully Capitated Health Plans/ Physician Care Organizations	460,948	513,835	11.47%
Primary Care Managers	3,563	2,839	-20.32%
Dental Care Organizations	529,235	587,096	10.93%
Mental Health Organizations	500,704	566,947	13.23%

Administrative rule revision summary

The following items are partial program highlights; please see Rulebooks for details. Rulebooks can be viewed at www.dhs.state.or.us/policy/healthplan/guides/main.html.

Effective retroactive June 1, 2010

Visual Services

- Providers can now use any visual materials supplier to order frames, lenses, specialty frames, and miscellaneous items for fee-for-service, dual-eligible OHP clients with Medicare.
- Providers may resubmit claims to DMAP for visual materials from suppliers other than SWEEP Optical and receive appropriate reimbursement for dates of service retroactive to June 1, 2010.

The following items are effective January 1, 2012

Dental Services

- Rules revised to reflect the biennial changes of the Prioritized List of Health Services.
- Limits placed on some dental services for adult clients (age 21 and older). A provider announcement about these limitations can be found at https://apps.state.or.us/cf1/OHP/OHPadmin/files/11-848_1211.pdf.

General Rules

- As directed by HB 2103 (2011 Legislative Session), Medicaid will cover DUII-diversion treatment services.
- Expanded OHP Standard hospital coverage. This change makes OHP Standard hospital benefits the same as hospital benefits for OHP Plus clients.
- To comply with the Affordable Care Act (Section 6402(h)(2)), payments to providers will be suspended during credible fraud allegation investigations.

Pharmaceutical Services

- Removed the statutory requirement (HB 2100) of public consideration for Preferred Drug List pricing.
- Added prior authorization criteria for third line diabetic agents.
- Added a requirement for prior authorization of Food and Drug Administration newly-approved drugs for up to six months after their release.
- Limited first fill prescriptions for selected high cost drugs or those with adverse side effect profiles to a 15-day supply.
- Limitations changed to allow 100-day supply or 100 units for selected maintenance medications.
- Dispensing limitations changed to allow more than a 34-day supply when a package cannot be divided and includes more than a 34-day supply or the medication is used for oral contraception.

Oregon Health Plan (Managed Care)

- Incorporate Medicare Severity DRG for inpatient and APC for outpatient or alternative payments methods.
- Prioritized List funding line changes
- Replace Health Evidenced Review Commission and Health Resources Commission with new Health Evidence Review Commission (HERC).

Hospital Services

- As directed by Senate Bill 204, establish a uniform payment methodology for hospital outpatients (temporary amendment).
- Added provider preventable conditions claims will no longer be covered (temporary amendment).

Medical-Surgical Services

- Added birthing centers as covered provider types.