



500 Summer St NE E35

Salem, OR, 97301

Voice: 503-945-5772 or 1-800-527-5772

FAX: 503-373-7689

TTY: 711

www.oregon.gov/OHA/healthplan

Following are documents related to the state's request to the Centers for Medicare and Medicaid Services (CMS) for a waiver amendment to the Oregon Health Plan.

1. The concept paper submitted to CMS on July 22, 2011, regarding increasing the Oregon Health Plan Standard (OHP Standard) Hospital benefit package
2. A letter requesting feedback and comments from stakeholder groups
3. A letter requesting feedback and comments from Oregon Tribes and Tribal representatives
4. Comments submitted by the following Organizations and individuals
 - a. Nicole Merrithew for the Medicaid Advisory Committee
 - b. Bob Joondeph, Executive Director, for Disability Rights Oregon
 - c. Karen Berkowitz, Attorney at Law, for the Oregon Law Center
 - d. Onofre Contreras, Director of Public Policy and Community Engagement, for the Oregon Health Action Campaign
5. The formal request sent to CMS



Increasing the Oregon Health Plan Standard (OHP Standard) Hospital benefit package

Concept Paper July 26, 2011

Prepared for the Centers for Medicare and Medicaid Services by the Oregon Health Authority, Division of Medical Assistance Programs

Overview

Since 1994, the state of Oregon has operated a Medicaid demonstration, the Oregon Health Plan (OHP),¹ under Section 1115 of the Social Security Act. OHP currently provides health insurance to about 600,000 individuals.

On February 1, 2003, Oregon implemented the OHP Plus and OHP Standard portions of the demonstration. OHP Plus is the comprehensive benefit package the state provides to individuals eligible under Oregon's Medicaid and Children's Health Insurance Program (CHIP) state plans.² OHP Standard is the reduced benefit package the state provides to adults with incomes up to 100 percent of the federal poverty level (FPL) who are eligible only by virtue of the existing Section 1115 demonstration.³ This package has very limited hospital benefits.

The change

Oregon would like to increase OHP Standard's limited hospital benefits to the same level as OHP Plus hospital benefits. The change in benefits requires an amendment to the state's Section 1115 demonstration. We will submit a formal request following the time allowed for comment.

Premiums under the reconfigured OHP Standard benefit package will remain as outlined in the state's demonstration renewal effective November 1, 2010.

¹ Project number 21-W-00013/10 and 11-W-00160/10

² Demonstration Populations 1, 3, 4, 5, 6, 7, 8, 12, 14 and all Title XXI CHIP State Plan children

³ Demonstration Populations 9, 10, 11, 17 and 18

Funding

Hospital tax revenues provide the funding for the state's share of OHP Standard expenditures. A legislatively-approved increase in the hospital tax provides funding for the increase in OHP Standard hospital benefits.

The state will fund this request within Oregon's current OHP budget neutrality agreement.

Background

Under the approved Special Terms and Conditions (STCs) of the state's existing Section 1115 demonstration, the OHP Standard benefit package consists of a core set of fixed services. The benefits are overlaid by Oregon's Prioritized List of Health Services.

The fixed set of services for OHP Standard includes:

- Physician services
- Ambulance
- Prescription drugs
- Laboratory and x-ray services
- Medical supplies
- Outpatient mental health
- Outpatient chemical dependency services
- Emergency dental services
- Hospice
- Limited hospital benefits

The current OHP Standard limited hospital benefit covers only emergency services and hospital admission through the emergency department for conditions for which prompt treatment would prevent life-threatening health deterioration.

The OHP demonstration has proven to be a valuable framework to provide health insurance to low-income Oregonians. In the recently released report, "The Oregon Health Insurance Experiment: Evidence from the first year,"⁴ researchers from Harvard School of Public Health (HSPH), Massachusetts Institute of Technology (MIT), the National Bureau of Economic Research (NBER), and Providence Health & Services found the OHP Standard program substantially expands access to and use of medical care for low-income adults in Oregon. Consumers reported they significantly increased their use of outpatient, pharmacy and even the limited hospital services, and their physical and mental health were *substantially* better after a year of OHP Standard insurance coverage. They were also much less likely to have to borrow money or go into debt to pay for their care.

⁴ "The Oregon Health Insurance Experiment: Evidence from the first year," published as working paper 17190 by the National Bureau of Economic Research, July 7, 2011

Effects of the change

By enhancing the OHP Standard benefit package, the state will be able to provide coverage for necessary inpatient procedures for conditions that have not reached the life-threatening stage. For example, this increase in benefits would allow an OHP Standard client to receive inpatient cancer treatment, respiratory therapy or necessary cardiac surgery before a condition becomes critical.

Oregon believes that making this change at this time will be extremely helpful as the state moves toward the 2014 expansion of coverage to everyone with incomes to 133 percent of the FPL. It will bring the OHP Standard benefit package a step closer to meeting “essential health benefits” coverage requirements as described in section 1302(b) of the Patient Protection and Accountable Care Act of 2010.

Public process

The state is currently engaged in a tribal and stakeholder consultation process consisting of requests for written comments via letter or e-mail and face-to-face verbal input at tribal and community stakeholder meetings.

Next steps

Oregon plans to implement the increased OHP standard benefit on January 1, 2012. In order to accomplish this, the state would like to submit a formal request by August 25, 2011, and to work with CMS in the meantime to address any uncertainties or concerns in order to gain timely approval.

500 Summer Street NE, E49
Salem, Oregon 97301-1079
Voice – (503) 945-5772
FAX – (503) 373-7689
TTY - (503) 378-6791
www.oregon.gov/OHA

July 26, 2011

To: Oregon Health Plan Stakeholders

From: Judy Mohr Peterson, Director
Division of Medical Assistance Programs
Oregon Health Authority

Subject: Opportunity to comment on Oregon Health Plan (OHP) changes

This letter is to give you information and an opportunity to comment on the state's upcoming requests to the federal Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) for approval to implement two changes the 2011 Legislative Assembly made to Oregon's medical assistance programs.

OHA will seek approval from CMS for 1115 Demonstration (waiver) amendments for the following changes to the Oregon Health Plan (OHP):

Moving the funding line on the Prioritized List of Health Services by deleting funding for 13 lines

The 2011 Legislative Assembly directed OHA to request CMS approval for the state to move the funding line on the 2012 Prioritized List of Health Services from line 512 to line 498.

The Prioritized List, developed and managed by the Oregon Health Services Commission with a great deal of public input, consists of 692 lines, each naming a condition and the treatments for the condition. The commission ranks the lines in order of importance to the entire population, factoring in clinical effectiveness and cost.

The Legislature uses the Prioritized List to allocate funding for Medicaid and the Children's Health Insurance Program (CHIP). Each legislative session, the Legislature establishes a "line" on the list as the cutoff point for coverage. Services above the line are funded; those below the line are not. This change would move the funding line up, eliminating funding for lines 499-511. While there are treatable conditions on lines 499-511, they are not in and of themselves life-threatening (see attachment A).

Diagnostic services are available for all conditions on the Prioritized List, whether funding is available or not. A diagnostic service can include laboratory tests, x-rays, antibiotics and other services as appropriate for the diagnostic visit, including patient

education to prevent reoccurrence. If at the diagnostic visit the physician concludes that the situation is more substantial, coverage may be available for a more precise diagnosis on a funded line.

There is also a safety net for some uncovered conditions built into the implementation of the Prioritized List because of the co-morbidity rule. The co-morbidity rule, briefly summarized, says that the state will cover uncovered conditions if they are seriously affecting a covered condition and if treating the uncovered medically-related condition will significantly improve the treatment of the covered condition. Alternatively, if an uncovered condition worsens to the point that the diagnosis code changes to a covered condition, then coverage is available.

Increasing the OHP Standard hospital benefit

The state will also ask for approval from CMS to increase the limited OHP Standard hospital benefits to the same level as OHP Plus hospital benefits.

The OHP Standard benefit package consists of a core set of fixed services, including:

- Physician services
- Ambulance
- Prescription drugs
- Laboratory and x-ray services
- Medical supplies
- Outpatient mental health
- Outpatient chemical dependency services
- Emergency dental services
- Hospice
- Limited hospital benefits

The current OHP Standard limited hospital benefit covers only emergency services and hospital admission through the emergency department for conditions for which prompt treatment would prevent life-threatening health deterioration.

This change will remove the current restrictions that apply to the OHP Standard benefit and provide for full inpatient hospital coverage. This will be a positive change for all individuals who receive benefits under the OHP Standard program.

Hospital tax revenues provide the funding for the state's share of OHP Standard expenditures. A legislatively-approved increase in the hospital tax provides funding for this increase in the program's hospital benefits.

OHA appreciates your interest in the OHP and its impact on consumers. We will consider all feedback as we develop the requests to CMS for these amendments. Please share this information with any individuals or groups who may be interested in or affected by the changes.

We will accept written comments through August 19, 201. Please send your comments to Janna Starr; Division of Medical Assistance Programs; Oregon Health Authority; 500 Summer St. NE; Salem, OR 97301-1079 or janna.starr@state.or.us.

We look forward to your feedback and suggestions.

13-Line Reduction – Prioritized List of Health Services¹

2012 Line	Condition	Line Description	Number of individuals affected
499	Keratoconjunctivitis	Medical and surgical methods to help with inflamed or infected corneas (the clear outer portion of the eye)	1,159
500	Mutism	Talk therapy for a person who is unable to speak in certain situations	4
501	Hemorrhoids	Surgery to remove hemorrhoids that are causing pain or issues with stools; removal of a blood clot in a hemorrhoid	970
502	Chronic Otitis Media	Surgery to place tubes in the ears and/or remove the tonsils in children with chronic fluid or infection in the inner ear; repair of certain injuries to the ear canal	9,532
503	Rectal Prolapse	Surgery to replace rectal tissue into its correct location when it falls through the anal opening	176
504	Otosclerosis	Surgery to correct a bone growth in the inner ear that can cause hearing loss	63
505	Foreign Body in Ear/Nose	Removing a foreign body (e.g. a Q-tip end) from the ear or the nose	2029
506	Anal Fistula	Surgery to correct a tear in the anal wall or a connection between the anus and the skin	904
507	Fractures of the Vertebral Column	Surgery to repair a broken bone in the back that has not injured the spinal cord	1,179
508	Conduct Disorders	Counseling for children with conduct disorders such as delinquency or disruptive behavior	1,843
509	Disorders of the Breast	Drainage or removal of breast cysts (collections of fluid) or removal of non-cancerous breast lumps	1,193
510	Disorders of the Vagina	Drainage of infected areas, destruction of lesions, and repair of injuries to the vagina not resulting from childbirth	3,700
511	Cysts of Bartholin's Gland	Drainage of infected areas or collections of fluid in the vaginal area	522

¹ The "Number of individuals affected" column represents utilization totals per line for the period of 2006-2008. Counts may be duplicated, as individuals may have used services from more than one of the 13 lines.

500 Summer Street NE, E49
Salem, Oregon 97301-1079
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FAX – (503) 373-7689
TTY - (503) 378-6791
www.oregon.gov/OHA

July 14, 2011

To: Oregon Tribal Representatives

From: Judy Mohr Peterson, Director
Division of Medical Assistance Programs
Oregon Health Authority

Subject: Opportunity to comment on Oregon Health Plan (OHP) changes

This letter is to give you information and an opportunity to comment on the state's upcoming requests to the federal Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) for approval to implement a number of changes the 2011 Legislative Assembly made to Oregon's medical assistance programs.

You will hear for the first time with this letter about changes to the Prioritized List of Health Services and an increase in the OHP Standard hospital benefit. This is your official opportunity to provide comments and consultation to the Oregon Health Authority (OHA) as we seek CMS approval for the 1115 Demonstration (waiver) amendments needed to implement these Legislative actions.

You may have heard about the provider rate reductions¹ or the Patient Centered Primary Care Home program when the group discussed upcoming State Plan Amendments (SPAs) at recent tribal 770 meetings. These meetings have been a source of valuable feedback. While the required comment period on these two changes has ended, this letter will provide you with more details and an opportunity for additional comments and feedback.

OHA will seek approval from CMS for 1115 Demonstration (waiver) amendments for the following changes to Oregon's medical assistance programs:

Moving the funding line on Oregon's Prioritized List of Health Services by deleting funding for 13 lines

¹ Per the Memorandum of Agreement, the tribal encounter rates are not subject to these reductions. The reductions also do not apply to Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs).

The 2011 Legislative Assembly directed OHA to request CMS approval for the state to move the funding line on the 2012 Prioritized List of Health Services from line 512 to line 498.

The Prioritized List, developed and managed by the Oregon Health Services Commission with a great deal of public input, consists of 692 lines, each naming a condition and the treatments for the condition. The commission ranks the lines in order of importance to the entire population, factoring in clinical effectiveness and cost.

The Legislature uses the Prioritized List to allocate funding for Medicaid and the Children's Health Insurance Program (CHIP). Each legislative session, the Legislature establishes a "line" on the list as the cutoff point for coverage. Services above the line are funded; those below the line are not. This change would move the funding line up, eliminating funding for lines 499-511.

The impact of the change on tribal members and entities will be no greater and no less than the impact on the general population. While there are treatable conditions on lines 499-511, they are not in and of themselves life-threatening (see attachment A).

There is also a safety net for some uncovered conditions built into the implementation of the Prioritized List because of the co-morbidity rule. The co-morbidity rule, briefly summarized, says that the state will cover uncovered conditions if they are seriously affecting a covered condition and if treating the uncovered medically-related condition will significantly improve the treatment of the covered condition. Alternatively, if an uncovered condition worsens to the point that the diagnosis code changes to a covered condition, then coverage is available.

Increasing the OHP Standard hospital benefit

The state will also ask for approval from CMS to increase the limited OHP Standard hospital benefits to the same level as OHP Plus hospital benefits.

The OHP Standard benefit package consists of a core set of fixed services, including:

- Physician services
- Ambulance
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- Laboratory and x-ray services
- Medical supplies
- Outpatient mental health
- Outpatient chemical dependency services
- Emergency dental services
- Hospice

- Limited hospital benefits

The current OHP Standard limited hospital benefit covers only emergency services and hospital admission for conditions for which prompt treatment would prevent life-threatening health deterioration.

This change will remove the current restrictions that apply to the OHP Standard benefit and provide for full inpatient hospital coverage. This will be a positive change for all individuals, including tribal members, who receive benefits under the OHP Standard program.

Hospital tax revenues provide the funding for the state's share of OHP Standard expenditures. A legislatively-approved increase in the hospital tax provides funding for this increase in the program's hospital benefits.

OHA will seek approval from CMS for State Plan Amendments (SPAs) for the following changes to Oregon's medical assistance programs:

Provider rate reductions

Due to the state's severe budget shortfall, the Division of Medical Assistance Programs (DMAP) will reduce OHP provider rates in the 2011-2013 biennium in order to meet an overall OHP budget reduction of more than 11 percent. These rate reductions will have no impact on Indian Health Services or tribal 638 services. (Please see footnote on page 1)

The reductions affect most health care providers and services, including pharmacies. The approved budget, however, specifies that OHA may not reduce primary care reimbursement. Thus, primary care rates are not scheduled to change. Primary care reimbursement is based on a combination of procedure codes and provider types. It includes certain evaluation and monitoring visits and preventive medical services in combination with practitioners designated as primary care providers. Designated primary care providers are family practice, general practice, pediatric, Obstetrics/Gynecology, internist, certified nurse practitioner, physician assistant and Public Health clinic.

Please see Attachment B for more information on specific rate reductions.

Patient Centered Primary Care Homes

As part of the state's Health Care Transformation efforts, OHA plans to implement Patient Centered Primary Care Homes (PCPCH) throughout Oregon's Medicaid program.

Under the PCPCH model, people have more than a doctor. They build a relationship with a team of health care professionals who comprise their medical

home. This team focuses their efforts on wellness and prevention, coordination of care and active management and support of individuals with chronic conditions or special health care needs. The PCPCH bases services on a patient- and family-centered approach to all aspects of care.

Implementing this initiative will require modification of three sections of Oregon's Medicaid State Plan.

- 1) Section 2703 of the federal Affordable Care Act (ACA) opens the door for states to implement PCPCHs for individuals with multiple chronic conditions, any one chronic condition and risk of others or a serious mental illness. Oregon's SPA to implement this provision defines the core services of a PCPCH, the specific chronic conditions, qualifications for providers, and the reimbursement methodology and amounts.
- 2) We will also amend the state plan to provide monthly payments to primary care providers enrolled with the Medicaid program who meet Oregon's PCPCH standards to provide services to patients who do *not* meet the chronic condition criteria of the federal Accountable Care Act as described under 1) above. Again, the patients must voluntarily agree to participate in the PCPCH model of care, and there will be the same tiered per-member/per-month reimbursements.
- 3) OHA will also propose modifications to the sections of the state plan related to Federally Qualified Health Centers, Rural Health Clinics and Indian Health Service clinics. Modifications to these sections of the Medicaid State Plan will authorize DMAP to make PCPCH payments to these types of clinics in addition to the clinic's encounter rate for medically appropriate diagnostic and treatment services.

OHA appreciates your interest in the OHP and its impact on tribal members and entities. We will consider all feedback as we develop the State Plan and waiver requests for these changes. Please share this information with any individuals or groups who may be interested in or affected by the changes.

Please send written comments by August 19, 2011 to Helena Scheratski; Division of Medical Assistance Programs; Oregon Health Authority; 500 Summer St. NE; Salem, OR 97301-1079 or helena.scheratski@state.or.us.

We are planning a meeting with tribal medical clinic and health program directors to discuss the waiver and State Plan amendments. We look forward to further discussions with and comments from them, as well as comments you may submit to Ms. Scheratski.

13-Line Reduction – Prioritized List of Health Services²

2012 Line	Condition	Line Description	Primary reason(s) for ranking	Number of individuals affected
499	Keratoconjunctivitis	Medical and surgical methods to help with inflamed or infected corneas (the clear outer portion of the eye)	Low impact on health, low effectiveness	1,159
500	Mutism	Talk therapy for a person who is unable to speak in certain situations	Very low impact on health	4
501	Hemorrhoids	Surgery to remove hemorrhoids that are causing pain or issues with stools; removal of a blood clot in a hemorrhoid	Low impact on health	970
502	Chronic Otitis Media	Surgery to place tubes in the ears and/or remove the tonsils in children with chronic fluid or infection in the inner ear; repair of certain injuries to the ear canal	Low impact on health	9,532
503	Rectal Prolapse	Surgery to replace rectal tissue into its correct location when it falls through the anal opening	Low impact on health	176
504	Otosclerosis	Surgery to correct a bone growth in the inner ear that can cause hearing loss	Low impact on health	63
505	Foreign Body in Ear/Nose	Removing a foreign body (e.g. a Q-tip end) from the ear or the nose	Very low impact on health, moderate need to seek care	2029
506	Anal Fistula	Surgery to correct a tear in the anal wall or a connection between the anus and the skin	Low impact on health	904
507	Fractures of the Vertebral Column	Surgery to repair a broken bone in the back that has not injured the spinal cord	Low impact on health, low effectiveness	1,179

² The “Number of individuals affected” column represents utilization totals per line for the period of 2006-2008. Counts may be duplicated, as individuals may have used services from more than one of the 13 lines.

2012 Line	Condition	Line Description	Primary reason(s) for ranking	Number of individuals affected
508	Conduct Disorders	Counseling for children with conduct disorders such as delinquency or disruptive behavior	Very low effectiveness	1,843
509	Disorders of the Breast	Drainage or removal of breast cysts (collections of fluid) or removal of non-cancerous breast lumps	Low impact on health	1,193
510	Disorders of the Vagina	Drainage of infected areas, destruction of lesions, and repair of injuries to the vagina not resulting from childbirth	Low impact on health	3,700
511	Cysts of Bartholin's Gland	Drainage of infected areas or collections of fluid in the vaginal area	Very low impact on health	522

Attachment B

OHP Rate Reductions

Program	Reduction	When
Clinical Lab	Reduce overall fee schedule by 4 percent.	August 1, 2011
Dental	Reduce dental rates by 5 percent.	August 1, 2011
Medical Supplies and Equipment	Reduce rates to 79 percent of Medicare rates with a higher percentage for specified supplies (e.g. ostomy) as agreed upon with the provider industry. ³	August 1, 2011
	Pay unlisted procedures at acquisition cost plus 20 percent.	August 1, 2011
Prosthetic devices	Pay 100 percent of Medicare rates	August 1, 2011
	Pay unlisted procedures at acquisition cost plus 20 percent.	
Home Health	Reduce fee schedule by 1 percent and no re-base of fee schedule in 2012.	August 1, 2011
	Decrease rates for daily supplies to \$50.	August 1, 2011
Hospital	Hospital tax rate will increase to generate revenue to enhance the OHP Standard hospital benefit.	July 1, 2011
Maternity Case Management	Reduce non-in home visit rates.	August 1, 2011
Pharmacy	Change thresholds for dispensing fee tiers. ⁴	August 1, 2011
	Decrease Clozaril Management to \$10.	July 1, 2011
Relative Value Units (RVU) except for primary care and obstetric services	Reduce the base unit conversion factor for most RVUs. ⁵	August 1, 2011
Transportation Brokerages	Reduce administrative budget allowance by 5 percent.	July 1, 2011

³ The percentage of 79 percent may change as we continue to meet with the provider industry.

⁴ The tiered system bases the fees paid to pharmacies to dispense prescriptions on each pharmacy's total annual claims as reported by the pharmacy in an annual survey. The 2011-13 reductions lower the baseline volume on each tier rather than lowering the actual fees. This system applies to all pharmacies: retail independent, institutional, mail order, compounding and 340 programs. Retail chain-affiliated pharmacies receive dispensing fees at the lowest tier, regardless of volume.

⁵ The resource-based relative value unit (RVU) is the value for service CMS established for purposes of paying Medicare claims. RVUs rank the resources used to provide the service, including physician and other staff time and equipment costs, and compare the resulting values to other services. Services that require higher resources get higher RVUs. To determine fees, a service's RVU is multiplied by a dollar conversion factor based on geographic differences in cost and other factors. The state reassessed these conversion factors and reduced them for 2011-13.

We will also reduce rates for the following programs, but these changes do not require SPAs or waiver amendments. We are providing this information so you have a complete picture of all of the rate reductions.

Program	Reduction	When
Ambulance	Reduce fee schedule by 2.7 percent for emergency ambulance providers. ⁶	August 1, 2011
Alcohol and Drug	Reduce the A&D fee schedule to achieve a reduction of 11.5 percent.	August 1, 2011
Managed Care Organizations (MCOs)	Contract with managed care plans based on 10 percent budget reduction for 24 months. Primary care will not face the same level of reductions in order to help maintain access to health services.	September to October, depending on MCO.
Mental Health	Reduce capacity for children's state hospital services; reduce the MH fee schedule to achieve a reduction of 11.5 percent.	August 1, 2011

⁶ This service is under the 1915(b) Transportation waiver. There will be an opportunity to comment on this program with the renewal of this waiver.



Oregon

John A. Kitzhaber, Governor

Medicaid Advisory Committee

1225 Ferry Street SE, Ste. C

Salem, OR 97301

(503) 373-1779

FAX (503) 378-5511

August 19, 2011

Janna Starr
Special Projects Unit
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer St. NE
Salem, OR 97301

Dear Ms. Starr,

The Medicaid Advisory Committee (MAC) strongly supports increasing the Oregon Health Plan (OHP) Standard limited hospital benefit to the same level as the OHP Plus hospital benefit. This change will not only preserve and improve the health of Medicaid recipients, but also eliminate confusion among providers that was caused by administration of two separate benefit packages. The Division of Medical Assistance Programs (DMAP) should also consider creating a single dental benefit package for OHP and OHP Plus as a strategy to promote preventive services and contain costs.

The following comments are a compilation of MAC member recommendations; however, these have not been discussed by the Committee as a whole. That being said, the recommendations are consistent with MAC priorities and past discussions.

DMAP should continue to pursue strategies for promoting prevention and wellness. Expanding the hospital benefit for OHP Standard clients increases access to non-emergent services, which the Committee commends; however, it is still not a strategy truly centered on prevention. Employing Peer Wellness Coaches to work with those most at-risk of developing and/or exacerbating chronic conditions could prevent OHP clients from ending up in the hospital at all. A robust program focused on teaching and supporting patients with self-management strategies would be fiscally wise. More detailed recommendations around this approach can be provided upon request.

It is recognized that program changes are necessary due to the current fiscal climate, however every effort must be made to ensure that the burden is not shifted to the vulnerable populations that the OHP serves. Additionally, it appears that women and children may be disproportionately affected by the proposed service cuts. For example, roughly one-quarter of the proposed service line cuts correspond to conditions that only affect women.

Further, the proposed prioritized list service cuts are inconsistent with two of the Medicaid Advisory Committee's Guiding Principles for Oregon Health Plan Service Efficiencies:

- Value-based benefits including prevention and allowing for flexibility of covered services *to avoid future costs*; and
- A focus on behavioral health care intervention.

Many of the conditions for which services will no longer be provided may result in continued pain and progressively poor health for many OHP clients. When some of these conditions become more serious and require extensive treatment, the treatment may be covered, but at greater expense both fiscally and socially. For example, one of the primary ways to bend the cost curve involves early mental health intervention, appropriately timed to the developmental stages when these conditions emerge, often in adolescence and early adulthood. DMAP should carefully consider the potential unintended consequences and future costs associated with curbing coverage of services associated with conduct disorders.

The MAC acknowledges that there are difficult decisions that must be made during times of fiscal strain and hopes that DMAP will ensure every effort is made to preserve the benefits provided to those highly impacted by the economic downfall. Thank you for the opportunity to continue our dialogue and collaboration on operation of Oregon's Medicaid program.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicole Merrithew". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Nicole Merrithew, MPH
Director, Medicaid Advisory Committee

>>> "Bob Joondeph" <bob@disabilityrightsoregon.org> 8/19/2011 5:01 PM
>>>

Janna,

Thank you for this opportunity to comment.

As you know, since the OHP was created the line has only moved in one direction when state finances are limited. When the state has more money, it has chosen to expand the number of people covered. Each movement of the line has raised the question of what is an essential benefits package. I have raised this question many times over the years and state officials generally respond that there is no clear answer. In one sense, the answer is political: the line will have moved far enough when the people of Oregon think it has. This is the "we'll know it when we see it" position. The other answer is that CMS will make the ultimate call.

My sense from reviewing the list is that there are many moving parts to how a line change will affect individuals. In some cases, other lines will support services. In some, a provider will choose to give treatment because it is humane or cost effective to avoid, for example, repeated future visits to the emergency department to deal with painful ear infections. And so, issues of cost-shifting and medical ethics will come into play in some instances.

While I have no medical training, it appears that some of the disorders on targeted lines will only receive treatment after the underlying condition has done severe damage. For instance, Otosclerosis and Chronic Otitis Media would be treating only after they have resulted in hearing loss. For other conditions, I do not have sufficient information to know if the conditions that they may cause or be associated with that will remain above the line are reversible. If not, cutting coverage would seem to contradict the principle of preventive care and maintenance of chronic conditions.

At the least, I would hope that in considering movement of the line, we consider more nuanced risk factors for failing to provide treatment. The risk of creating an irreversible and potentially disabling condition should receive heightened consideration for coverage.

Regarding the hospital benefit, I believe that it furthers the policy objectives of the OHP.

Best regards,

Bob Joondeph
Executive Director
Disability Rights Oregon

cc: John Mullin, OLC
Terri Fraser, CMS

On 7/27/2011 1:32 PM, Janna STARR wrote:
Oregon Health Plan Stakeholder --

As directed by the 2011 Legislature, the state will request approval from the federal Centers for Medicare and Medicaid Services (CMS) for two changes to the state's 1115 Demonstration (waiver) as follows:

- 1) To move the funding line on the Prioritized List of Health Services from its current position at line 512 to line 498; and
- 2) To increase the Oregon Health Plan (OHP) Standard limited hospital benefits to the same level as OHP Plus hospital benefits.

Pending CMS approval, the Oregon Health Authority will implement both changes on January 1, 2012

The attached letter will give you background and details on each of the changes.

This is your opportunity to comment on these proposed changes. The Oregon Health Authority will accept written comments through August 19, 2011. Please send your comments to Janna Starr; Division of Medical Assistance Programs; Oregon Health Authority; 500 Summer St. NE; Salem, OR 97301-1079 or janna.starr@state.or.us.

Janna Starr
Special Projects Unit
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer St. NE
Salem, OR 97301
503-947-1193
Janna.Starr@state.or.us

OREGON LAW CENTER

KAREN BERKOWITZ
(503) 473-8321 (direct)
KBerkowitz@oregonlawcenter.org

August 17, 2011

Janna Starr
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer St NE
Salem, OR 97301

Re: Proposed Changes to Oregon's 1115 Waiver

Dear Janna:

I am submitting these comments on the proposed changes to the Oregon 1115 Medicaid Waiver, on behalf of the Administrative Law Taskforce, a group of Oregon advocates from the Legal Aid community who routinely represent low income individuals in Oregon Health Plan cases.

1. Proposed change to the OHP Standard hospital benefit:

Changing the OHP Standard hospital benefit so that it will be the same as the hospital benefits for OHP Plus is a positive step that will help to preserve and improve the health of medicaid recipients. We support Oregon's request to change the 1115 waiver to increase access to hospital benefits for OHP Standard clients.

2. Proposed change to the OHP prioritized list of covered health services:

We cannot support Oregon's request to amend the 1115 waiver to cut 13 lines from the list of covered services on the prioritized list. While this was a legislative mandate, the impact of the cuts will be devastating to thousands of low-income people, including women, children and many other individuals who are elderly or have disabilities.

First, we should look at who is impacted by these cuts. There is a disproportionate impact on women and children. For women, 3 of the 13 conditions that will no longer be covered, 23%, affect women only. If we consider the number of people affected by just those 3 conditions, there is a similar disproportionate impact on women. There are 5415 women affected by these 3 lines based on 2006-2008 utilization. That's also at least 23% of the people affected by these cuts.

The impact on children is also huge. The lines for Otitis, foreign body, and conduct disorders are entirely or mostly childhood issues. These three represent 13,404 affected individuals, out of

August 17, 2011

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23,274 – over 57%. The numbers are likely to be much higher since this data is based on 2006-2008 utilization, and we now have so many more children on the Oregon Health Plan. We should be concerned that Oregon is reducing covered services for children at the same time that the state is trying to expand coverage to more children. Given the importance of EPSDT for children, it is unfortunate that the “T” (treatment) is being further eroded.

Many of the conditions and treatments that are no longer covered by the Oregon Health Plan are the same conditions and treatments that are routinely covered by group and individual health insurance policies. That is true of the 13 condition/treatment pairs that Oregon is proposing to cut. As we move toward insurance coverage for the vast majority of our population under the Patient Protection and Affordable Care Act, we should not be creating even more of a two-tiered health care system, where the most vulnerable people have the least robust health care coverage. Individuals should receive coverage for the same medical conditions, whether they are on Medicaid, Medicare, group insurance, or receive subsidized help through FHIAP or the Health Insurance Exchange.

These service cuts undermine the basic values of the Oregon Health Plan, including prevention, alleviating pain and suffering, impact on lifelong health if the condition isn't treated, whether early treatment prevents further complications, and the cost of early treatment compared to future cost of care if early treatment isn't provided. Many of the conditions for which services will no longer be provided will result in continued pain and progressively poor health. When some of the conditions become more serious, they may be covered, but at greater expense. Why not treat the condition early when it is less serious and less expensive to treat?

Treatment of some of the conditions may provide simple solutions that will preserve a high quality of life and prevent long-term social and health problems which are extremely costly to society. One example is Otosclerosis, which, according to the line description, can result in hearing loss. Rather than correcting the problem before there is hearing loss, the individual will have to wait until there is hearing loss and then qualify for hearing aids, which will be replaced every few years for the lifetime of the individual. Hearing loss affects the quality of life, including learning, social interaction and the ability to work. The better policy would be to treat the condition before it becomes a lifelong problem. The same considerations apply to Chronic Otitis Media. The failure to properly treat chronic ear infections when ear tubes are required could also lead to hearing loss and resulting speech and learning delays in children.

One of the primary ways to lower the cost of health care involves early mental health intervention. Eliminating coverage for Conduct Disorders in children is incompatible with this goal and inconsistent with a health care system that seeks to preserve a high quality of life.

Many of the conditions that will no longer be covered are conditions that cause pain. The affected individuals will either seek treatment from their provider and be billed for services that they can't afford and can't pay, or they will use the hospital emergency room, and drive up health care costs that way. Cuts of this nature will drive health care back to an emergency based model of care. Rather than focusing on the cost to the state, these cuts must be viewed in terms

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of the impact on health care costs generally. The cuts will drive up health care costs by forcing more people to use emergency services or wait until the condition worsens and will be covered under the Oregon Health Plan, but at greater cost.

Making changes to the covered services under the prioritized list is premature given the changes that will likely occur as Oregon moves toward an outcomes based system for health care. On the federal level, the Department of Health and Human Services will be creating standards for health care benefit packages. Oregon should delay any changes to the OHP prioritized list until we see the outcomes of federal and state healthcare changes.

To our knowledge, the Oregon Health Authority has not studied the impact of previous cuts to the prioritized list on health outcomes. Before considering further cuts, OHA should do a comparative study of the health outcomes of individuals with full access to health care and individuals with OHP coverage and its limited benefit package.

Thank you for considering these comments.

Very truly yours,

Karen A. Berkowitz
Attorney at Law



August 19, 2011

Janna Starr janna.starr@state.or.us
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer St. N.E.
Salem OR 97301

Subject: OHP line changes 512 to 498/Increase OHP Standard hospital benefit

Dear Ms. Starr:

Oregon Health Action Campaign would like to comment on OHP changes outlined in your July 26, 2011 letter for public comment regarding Oregon's forthcoming request to CMS to approve the implementation of two 2011 Legislative Assembly changes to Oregon's medical assistance programs.

1) Moving the Funding Line

OHAC is concerned with the gradual erosion of health services available to OHP recipients. As an example, the removal of 502 (Chronic Otitis Media) will impact almost 10,000 children with ear fluid/infections. During hard economic times, we are troubled by decisions that balance budgets on the backs of the most vulnerable. OHAC opposes this further cut in services and believes that alternative fiscal remedies can be found to expand access, improve care, and contain costs-- consistent with both federal mandates and recently passed House Bill 3650.

2) Increasing OHP Standard to OHP Plus Hospital Benefits

OHAC supports the expansion of the OHP Standard benefit package to the same level as OHP Plus. We are encouraged that hospital tax revenues can be utilized to provide expanded services.

Respectfully,

Onofre Contreras
Director of Public Policy and Community Engagement
Oregon Health Action Campaign
Onofre@ohac.org

Cc: Jason McNichol – Interim Executive Director
John Mullin – OHAC Board Member



August 26, 2011

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Sebelius:

Since 1994, Oregon has operated a Medicaid demonstration program, the Oregon Health Plan (OHP),¹ under Section 1115 of the Social Security Act. OHP currently provides health insurance to more than 600,000 individuals.

Oregon requests approval from the Centers for Medicare and Medicaid Services (CMS) to amend the state's Section 1115 demonstration to increase the limited OHP Standard hospital benefit to the same level as the OHP Plus hospital benefit.

Background

On February 1, 2003, Oregon implemented the OHP Plus and OHP Standard portions of the demonstration. OHP Plus is the comprehensive benefit package the state provides to individuals eligible under Oregon's Medicaid and Children's Health Insurance Program (CHIP) state plans.² OHP Standard is the reduced benefit package the state provides to adults with incomes up to 100 percent of the federal poverty level (FPL) who are eligible only by virtue of the existing Section 1115 demonstration.³ This package has very limited hospital benefits.

Discussion of amendment request

The state requests approval to increase the limited OHP Standard hospital benefits to the same level as OHP Plus hospital benefits.

Under the approved Special Terms and Conditions (STCs) of the state's existing demonstration, the OHP Standard benefit package consists of a core set of services. The benefits are overlaid by Oregon's Prioritized List of Health Services.

¹ Project number 21-W-00013/10 and 11-W-00160/10

² Demonstration Populations 1, 3, 4, 5, 6, 7, 8, 12, 14 and all Title XXI CHIP State Plan children

³ Demonstration Populations 9, 10, 11, 17 and 18

The set of services for OHP Standard includes:

- Physician services
- Ambulance
- Prescription drugs
- Laboratory and x-ray services
- Medical supplies
- Outpatient mental health
- Outpatient chemical dependency services
- Emergency dental services
- Hospice
- Limited hospital benefits

The current OHP Standard limited hospital benefit covers only emergency services and hospital admission, usually through the emergency department, for conditions for which prompt treatment would prevent life-threatening health deterioration.

By enhancing the OHP Standard benefit package, the state will be able to provide coverage for necessary treatments for conditions that have not reached the life-threatening stage. For example, this increase in benefits could allow an OHP Standard client to receive inpatient cancer treatment, respiratory therapy or necessary cardiac surgery before a condition becomes critical.

Oregon believes that making this change at this time will be extremely helpful as the state moves toward the 2014 expansion of coverage to everyone with incomes to 133 percent of the FPL. It will bring the OHP Standard benefit package a step closer to meeting “essential health benefits” coverage requirements as described in section 1302(b) of the Patient Protection and Accountable Care Act of 2010.

Premiums under the reconfigured OHP Standard benefit package will remain as outlined in the state’s demonstration renewal effective November 1, 2010.

Hospital tax revenues provide the funding for the state’s share of OHP Standard expenditures. This revenue source will also fund the increase in OHP Standard hospital benefits.

The state will fund this request within Oregon’s current OHP budget neutrality agreement. We have attached budget neutrality calculations for the change.

Conclusion

The OHP demonstration has proven to be a valuable framework to provide health insurance to low-income Oregonians. In the recently released report, “The Oregon Health Insurance Experiment: Evidence from the first year,”⁴ researchers from Harvard School of Public Health

⁴ “The Oregon Health Insurance Experiment: Evidence from the first year,” published as a working paper 17190 by the National Bureau of Economic Research, July 7, 2011

(HSPH), Massachusetts Institute of Technology (MIT), the National Bureau of Economic Research (NBER), and Providence Health & Services found the OHP Standard program substantially expands access to and use of medical care for low-income adults in Oregon. Consumers reported they significantly increased their use of outpatient, pharmacy and even the limited hospital services, and their physical and mental health were substantially better after a year of OHP Standard insurance coverage. They were also much less likely to have to borrow money or go into debt to pay for their care.

The state's desire is to work collaboratively with CMS in moving this amendment request through clearance as quickly as possible. Oregon plans to implement the increased OHP standard benefit on January 1, 2012. In order to accomplish that, we respectfully request expedited CMS review.

Thank you in advance for your expedited review of this amendment request. If you have any questions or would like further information, please do not hesitate to contact me at (503) 945-5768.

Sincerely,

Judy Mohr Peterson, Ph.D.
Director, Division of Medical Assistance Programs
Oregon Health Authority

CC:

The Honorable Jeff Merkley, U.S. Senator
The Honorable Ron Wyden, U.S. Senator
The Honorable Earl Blumenauer, U.S. Representative
The Honorable Peter DeFazio, U.S. Representative
The Honorable Kurt Schrader, U.S. Representative
The Honorable Greg Walden, U.S. Representative
John Kitzhaber, Governor
Michael Bonetto, Governor's Health Policy Advisor
Bruce Goldberg, Director, Oregon Health Authority
Bruce Hanna, Speaker, House of Representatives
Arnie Roblan, Speaker, House of Representatives
Peter Courtney, Senate President
Donald Berwick, Administrator, CMS, CO
Terri Fraser, Project Officer, CMS, CO
Steve Rubio, CMS, CO
Jeffrey Silverman, CMS, CO
Carol Peverly, CMS, Region X
Wendy Hill-Petras, CMS, Region X
Janice Adams, CMS, Region X