

Community Health Workers: Policy Recommendations



**OFFICE OF MULTICULTURAL HEALTH AND
SERVICES**

**Alberto Moreno, MSW
Migrant Health Coordinator**



Who are Community Health Workers?



- **Community Health Workers (CHWs) are trusted community members who promote health in their own communities**
- **CHWs bridge the gaps between communities and the health care and social service system**
- **CHWs make important contributions to preventing disease and promoting health, increasing access to care, reducing health care costs, diversifying our workforce, and decreasing health inequities**

Community Health Worker Roles



The National Community Health Advisor Study (1998), funded by the Annie E. Casey Foundation, identified seven core roles of CHWs:

1. Providing cultural mediation between communities and the health care and social service system
2. Providing culturally-appropriate and accessible health education and information
3. Assuring that people get the services they need
4. Providing informal counseling and social support
5. Advocating for individual and community needs
6. Providing direct service
7. Building individual and community capacity

History of Community Health Workers



- CHWs have been integral members of the U.S. health care system for more than 30 years
- Oregon has a rich history of CHW programs:
 - Indian Health Service has employed CHWs since the 1960s
 - El Niño Sano Program in Hood River was founded in migrant and seasonal farmworking communities in the late 1980s
 - Neighborhood Health Clinics, Inc., employed African American CHWs in Portland during the 1990s
 - Parish Health Promoter Program of Providence/El Programa Hispano, CHW programs at Benton County Health Department, among others, have continued the Oregon tradition of innovation in the CHW field

Current Environment of Oregon



- Significant demographic changes in past twenty years
- Significant health disparities persist
- Health inequities are linked to adverse social conditions, which CHWs are uniquely positioned to address
- Barriers to accessing health services are attributable to language, cultural differences in health seeking behavior, and a workforce that lacks diversity
 - Resulting in adverse health outcomes and increased utilization costs
- Success of this model indicates the need to develop a coordinated, statewide planning process to develop policy regarding:
 - Standardization, education and training, sustainable funding, evaluation, and empowerment and advocacy

Benefits of Community Health Workers



- Assisting individuals and families in obtaining and maintaining health insurance coverage
- Increasing access to and use of preventative education, screenings, and treatment services
- Reducing unnecessary use of urgent care
 - Cost-savings
- Improved self-management of chronic diseases
- Strengthening patient health literacy and culturally competent provider practices
- Building capacity in communities to address the underlying causes of ill health

Benefits of CHWs: Cost-Savings



- *The Effectiveness of a Community Health Worker Outreach Program on Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, with or without Hypertension:*
 - Average savings of \$2,245 per patient
 - Improved quality of life
- *Measuring Return on Investment of Outreach by Community Health Workers:*
 - Increased use of primary and specialty care; and reduced use of urgent care, inpatient and outpatient behavioral health care use
 - Return on investment (ROI): 2.28:1
- *CHRISTUS Community Health Care Management for the Uninsured: Quality Management Committee Annual Report:*
 - Average annual cost for care among program participants decreased by \$10,000 or 58%
 - Over a three year period, the ROI was 3.84:1

Challenges Facing the CHW Workforce



- **Low wages**
- **High turnover**
- **Limited job security**
 - Dependence on grant funding
- **Lack of appreciation and recognition on the part of other health care professionals**

Best Practice Models



- **Minnesota and Massachusetts have developed and implemented comprehensive policies that enable the appropriate utilization of the CHW model**

Best Practice Models: Minnesota



- CHWs integrated into MN's mainstream health care system
- 2005: CHW “scope of practice” and standardized, statewide credit-based curriculum developed and implemented
- 2007: MN legislature approved direct hourly reimbursement of CHW services under Medicaid
- 2008: CMS approved Medicaid State Plan Amendment authorizing hourly payments for CHWs supervised by Medicaid-approved physicians and advanced practice nurses
 - Supervisors expanded to include dentists, public health nurses, and mental health providers
- Only state to establish Medicaid reimbursement for a full spectrum of CHW activities across all covered health services
 - First to establish a sustainable funding stream

Minnesota Statute



MS 256B.0625, Subdivision 49, Community Health Worker

- (a)** Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:
- (1)** received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or
 - (2)** at least five years of supervised experience with an enrolled physician, advanced practice registered nurse, registered nurse, or dentist, or at least 5 years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

- (b)** Community health workers must work under the supervision of a medical assistance enrolled physician, advanced practice registered nurse, registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.
- (c)** Care coordination and patient education services covered under this subdivision include but are not limited to services relating to oral health and dental care.

Best Practice Models: Massachusetts



- First state to have CHWs leading the certification effort
- Section 110, chapter 58 of the acts of 2006 (Health Care Reform), charged MA Dept. of Public Health with convening a statewide advisory council to conduct an investigation relative to:
 1. Role and funding of CHWs by public and private entities
 2. Increasing access to health care, particularly Medicaid-funded health and public health services
 3. Eliminating health disparities among vulnerable populations
 4. Interpreting the results and developing recommendations for a sustainable CHW program
- 2007: Massachusetts Association of CHWs (MACHW) given seat on state's expanded Public Health Council
- Broad-based policies and consistent and powerful advocacy ensure continued integration of CHWs in state health reform efforts

Models of Sustainable Financing



- **Public insurance: Medicaid**
 1. Medicaid Managed Care
 2. Medicaid Section 1115 Demonstration Waiver
 3. Medicaid Administrative Costs
 4. Direct reimbursement
- **Government general funds**
 - Budgets include line item coverage for CHW positions
- **General operating budgets of organizations**
 - Non-governmental companies or businesses, including hospitals and managed care organizations
 - Integrate CHWs into operating budget through directly employing CHWs, or contracting with CBOs for CHW services

Policy Recommendations



1. Sustainable financing for CHW services that includes statewide policy initiatives for funding and public/private partnerships
 - Medicaid reimbursement for a full spectrum of CHW activities across all covered health services
2. Codified educational curriculum that uses adult/popular education approaches, is accepted by academic health education institutions and preserves all CHW roles
3. Voluntary certification process based on educational curriculum program, including “grandfathering” provisions
4. Workforce development resources, including training, career development, and continuing education
5. Occupational regulation, including standardization of core competencies, functions, supervision structure, and position integrity
6. Guidelines for common measures to be used in research and evaluation related to CHWs
7. Policy platform that enables integration of CHW model into state health care system
8. Commission a statewide advisory council to make an investigation and study relative to CHWs in Oregon
 - The Council shall be charged with interpreting the results of the study and develop actionable recommendations for a sustainable statewide CHW program

Tobacco Control Integration Project

Report to the Medicaid Advisory Committee

February 23rd, 2011

Cathryn Cushing, TCIP Lead

Oregon Public Health Division, Health Promotion and
Chronic Disease Prevention Section



TCIP Guiding Principles

1. Tobacco control **projects arise from within each division** and are guided by people within that division.
2. TCIP's priorities are to implement **systems, procedures, and policies** that assist employees and populations served by DHS/OHA Divisions in reducing tobacco use.
3. TCIP Steering Committee members **share information and lessons learned**, with each other and throughout DHS/OHA.

Department of Human Services (DHS) / Oregon Health Authority (OHA)

Addictions and
Mental Health
Division (AMH)

Administrative
Services Division
(ASD)

Children, Adults,
and Families
Division (CAF)

Division of Medical
Assistance
Programs (DMAP)

Public Health
Division (PHD)

Seniors and People
with Disabilities
Division (SPD)

Health Promotion/
Chronic Disease
Prevention (HPCDP)

Tobacco Prevention/
Education Program
(TPEP)

TCIP

TOBACCOFREE
oregon

Oregon
Health
Authority

TCIP =

What the Tobacco Prevention and Education Program (TPEP) knows about tobacco control

+

What the DHS/OHA Divisions know about their clients and workforce

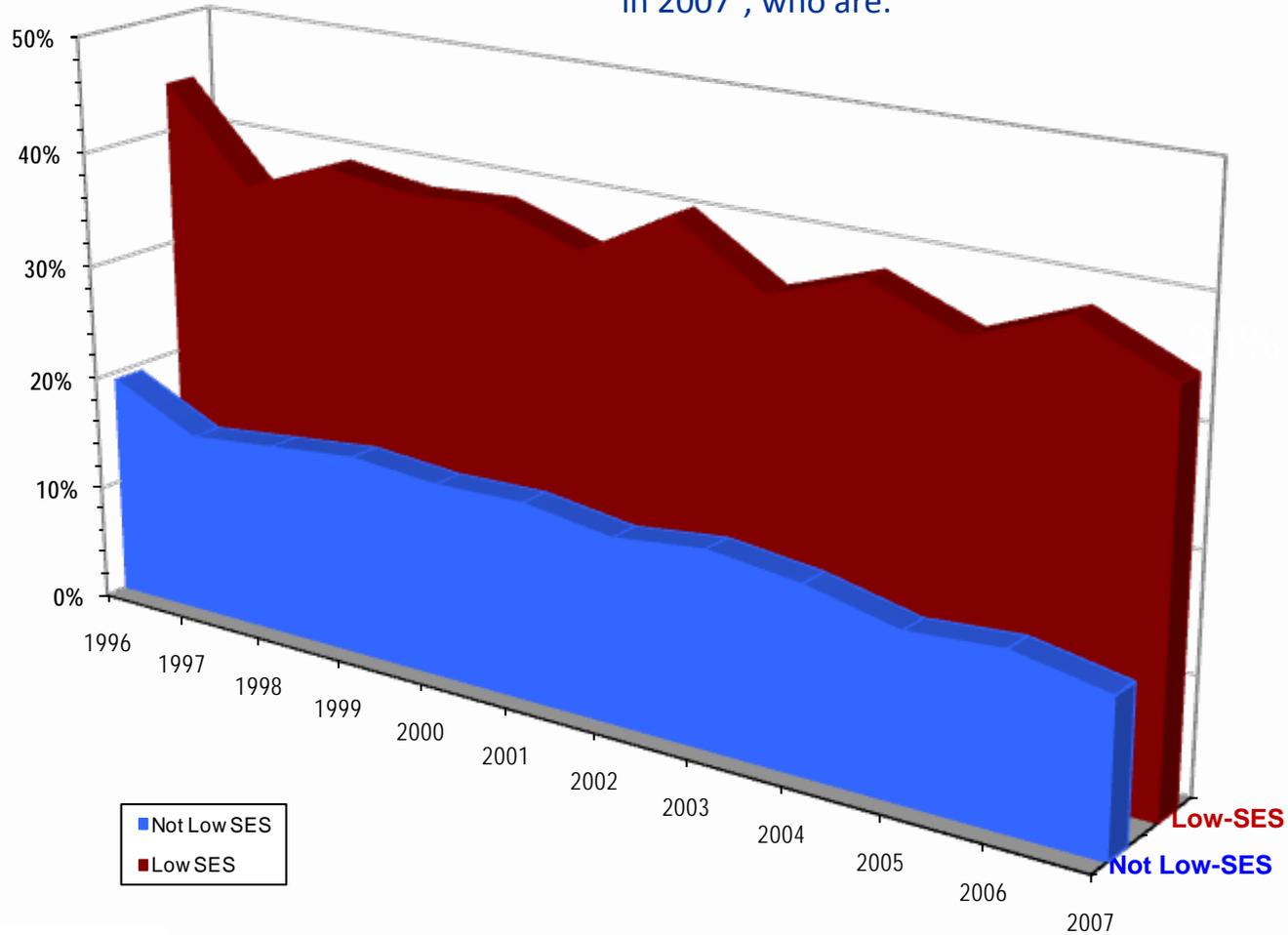
Why this work is important

Low Socio-Economic Status (Low-SES)

“Economic status is the single greatest predictor of tobacco use in the United States. Americans living below the federal poverty line are 40% more likely to smoke than those living at or above the federal poverty line.”

Tobacco Use Disparities

Smoking prevalence among Oregon adults in 2007*, who are:



Tobacco Use Disparities

Smoking and Temporary Assistance for Needy Families (TANF)

- Current maximum monthly TANF benefit for a family of three = **\$528**
- Pack a day (@\$5.00), per month (\$150)^a = **28%** of TANF monthly max.
- Two packs a day (@\$5.00), per month (\$300)^b = **57%** of TANF monthly max.

a = 57% of every day smokers; b = 43% of every day smokers

Tobacco Use Disparities

Smoking and the Supplementary Nutrition Assistance Program (SNAP, formerly Food Stamps)

- Average household monthly SNAP benefit = **\$250**
- Pack a day (@\$5.00), per month (\$150)^a = **60%** of SNAP monthly average
- Two packs a day (@\$5.00), per month (\$300)^b = **120%** of SNAP monthly average

a = 57% of every day smokers; b = 43% of every day smokers

Tobacco Use Disparities

Food *Insecurity*

In 2008, a study published in the Archives of Pediatric and Adolescent Medicine concluded that living with adult smokers **doubles** the rate of food insecurity, and **triples** the rate of severe food insecurity.

Tobacco Use Disparities

Smoking prevalence among Oregon adults

- With annual incomes *more* than **\$50,000** = **9.6%**
- With annual incomes *less* than **\$15,000** = **32.9%**

- Insured (including private) = **13.2%**
 - Uninsured = **31.9%**
 - Medicaid (OHP) = **37.0%**

- Medicaid (OHP) cost, per year, to treat smoking-attributable disease = **\$287M**

Oregon's Medicaid Cessation Success

- Plans required to offer cessation services since 1996
 - #6 on Prioritized List
 - Emphasis on prevention
 - First state with this requirement
 - Requirement includes behavioral counseling and medications

Challenges

- Where you live dictates type of service
- Evidence has progressed over time
- Guidelines are too complex

Tobacco Cessation Minimum Standards

- Standard services – clear guidelines
- Evidence-based services
- Accountability for prevalence

**Want to save
\$1,825 a year?
Stop smoking.**

**SMOKEFREE
oregon**



Raising the Price of Tobacco

- Higher prices reduce the number of kids who smoke – a 10% increase in the price of tobacco reduces the number of kids who smoke by 6 or 7%. Most smokers start smoking as children.
- Higher prices help people quit using tobacco – for every 10% increase in the price of tobacco, there is a 4% decrease in sales (consumption).

Smokers reap the most benefit from higher cigarette prices

- better health,
- reduced health care costs,
- reduced exposure to secondhand smoke

Also, funds received through higher prices go toward increased state services.

Contact Information

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Medicaid Advisory Committee 2011 Legislative Session Bill Tracker

Bill #	Relating To	Summary	Priority Level*	Last Three Actions (2/18/2011)	Comments
HB2382	Relating to medical assistance coverage of patient centered primary care home services.	Requires Oregon Health Authority to reimburse patient centered primary care homes for services provided to medical assistance recipients.	1	01/21/11 - Referred to Health Care with subsequent referral to Ways and Means. 01/11/11 - First reading. Referred to Speakers desk.	
HB2398	Relating to integrated mental health services.	Removes option for Oregon Health Authority, in contracting with prepaid managed care health services organizations to provide services in medical assistance program, to contract with separate providers for physical health services and mental health	1	02/21/11 - Work Session scheduled. 02/11/11 - Public Hearing held. 01/21/11 - Referred to Human Services.	
HB2464	Relating to medical assistance for individuals with disabilities who are under 19 years of age.	Expands definition of categorically needy persons eligible for medical assistance to include individuals with disabilities who are under 19 years of age. Authorizes Oregon Health Authority to impose premiums or cost-sharing for specified individuals	1	02/23/11 - Public Hearing scheduled. 01/21/11 - Referred to Human Services. 01/11/11 - First reading. Referred to Speakers desk.	
HB3337	Relating to purchase of prescription drugs; declaring an emergency.	Authorizes state Medicaid agency to participate in Oregon Prescription Drug Program. Declares emergency, effective on passage.	1	02/16/11 - First reading. Referred to the desks of the Co-Speakers.	
SB210	Relating to the rate of reimbursement for primary care practitioners; declaring an emergency.	Requires Oregon Health Authority to reimburse primary care practitioners directly or through prepaid managed care health services organizations based on Medicare reimbursement rate. Declares emergency, effective on passage.	1	02/23/11 - Public Hearing and Possible Work Session scheduled. 01/18/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	

SB216	Relating to medical assistance.	Requires Oregon Health Authority to increase capitation rates paid to prepaid managed care health services organizations if changes in medical assistance benefits increase overall cost to organizations by one percent or more.	1	02/23/11 - Public Hearing and Possible Work Session scheduled. 01/18/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	
HB2231	Relating to cigarettes taxes; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	Increases cigarette tax. Applies increase to cigarettes distributed on or after January 1, 2012, and to existing inventories of cigarettes not yet acquired by consumers as of January 1, 2012. Takes effect on 91st day following adjournment sine die	2	01/21/11 - Referred to Revenue. 01/11/11 - First reading. Referred to Speakers desk.	Portion of the moneys shall be credited to the Oregon Health Plan Fund
HB2377	Relating to Medicaid reimbursement of type B hospitals.	Modifies definition of 'type B hospital' for purposes of Medicaid reimbursement rates to require hospital to have five-year average operating margin of five percent or less. Requires Oregon Health Authority to prescribe methodology by rule for deter	2	01/21/11 - Referred to Health Care. 01/11/11 - First reading. Referred to Speakers desk.	
HB2751	Relating to medical assistance; declaring an emergency.	Requires Oregon Health Authority to prescribe eligibility requirement for Oregon Supplemental Income Program medical assistance that excludes from income considered available for costs of care of recipient of Social Security disability benefits an a	2	01/21/11 - Referred to Health Care. 01/11/11 - First reading. Referred to Speakers desk.	

HB2799	Relating to information about alternatives to hospital emergency department care.	Requires Oregon Health Authority to provide specified information to medical assistance recipient who receives care or treatment in hospital emergency department for condition that does not require emergency care or treatment.	2	01/21/11 - Referred to Health Care. 01/11/11 - First reading. Referred to Speakers desk.	
HB2857	Relating to regulatory requirements for health services providers; declaring an emergency.	Requires Oregon Health Authority to establish pilot program to implement uniform electronic processes for collecting data from health services providers that serve medical assistance recipients. Declares emergency, effective on passage.	2	01/21/11 - Referred to Health Care with subsequent referral to Ways and Means. 01/11/11 - First reading. Referred to Speakers desk.	
HB3194	Relating to medical assistance for adults eligible for Social Security disability benefits; declaring an emergency.	Requires that medical assistance be provided to individuals who qualify for Social Security disability benefits but do not receive Medicare coverage due to five-month waiting period for Social Security disability benefits or 24-month waiting period	2	02/09/11 - First reading. Referred to the desks of the Co-Speakers.	
SB201	Relating to medical assistance; declaring an emergency.	Authorizes Oregon Health Authority to approve transfer of 500 or more enrollees from one prepaid managed care health services organization to another if receiving organization accepts transferring organization's network of providers or allows enroll	2	01/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	
SB211	Relating to prepaid managed care health services organizations.	Requires Oregon Health Authority to give preference in contracting to prepaid managed care health services organizations that are community focused, have experience with medical assistance recipients and have established relationships with provider	2	02/23/11 - Public Hearing and Possible Work Session scheduled. 01/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	

SB214	Relating to provider claims for health services to medical assistance recipients; declaring an emergency.	Requires Oregon Health Authority to reconcile claims made by and payments due to prepaid managed care health services organizations no later than 90 days after effective date of Act and to pay claims identified within 30 days. Requires authority to	2	02/23/11 - Public Hearing and Possible Work Session scheduled. 01/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	
SB433	Relating to treatment of cancer.	Expands eligibility for medical assistance for low-income and uninsured women diagnosed with breast or cervical cancer.	2	01/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	
HB2098	Relating to mental health drugs; declaring an emergency.	Authorizes Oregon Health Authority to require prior authorization for coverage of mental health drug not on drug list of Practitioner-Managed Prescription Drug Plan. Declares emergency, effective on passage.	3	01/21/11 - Referred to Health Care. 01/10/11 - First reading. Referred to Speakers desk.	
HB2105	Relating to the Oregon Health Authority; declaring an emergency.	Requires Oregon Health Authority to establish one or more pilot projects through which authority shall contract with managed care entities to establish capitation rates for payment of mental health drugs. Directs authority to report to Legislative A	3	01/21/11 - Referred to Human Services. 01/10/11 - First reading. Referred to Speakers desk.	
HB2725	Relating to general assistance; appropriating money; declaring an emergency.	Creates General Assistance Program in Department of Human Services to help support Oregon residents who have disabilities and are pursuing Supplemental Security Income and Social Security disability benefits by providing monthly cash assistance, med	3	01/21/11 - Referred to Human Services with subsequent referral to Ways and Means. 01/11/11 - First reading. Referred to Speakers desk.	

HB3037	Relating to senior services.	Expands services provided to seniors through Oregon Project Independence to include support for community caregivers, health promotion services, options counseling and transportation services.	3	02/08/11 - Referred to Human Services. 02/01/11 - First reading. Referred to the desks of the Co-Speakers.	
SB101	Relating to health care; declaring an emergency.	Authorizes payment for dental services under Family Health Insurance Assistance Program and under private health option of Health Care for All Oregon Children program. Authorizes Oregon Health Authority to provide packages of health services to spec	3	01/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	
SB104	Relating to functions of the Oregon Health Authority; declaring an emergency.	In Family Health Insurance Assistance Program, eliminates asset criteria and authorizes Office of Private Health Partnerships to offer dental only plans, adopt definition of family by rule and adopt rules for recovery of overpayments of subsidies. A	3	02/14/11 - First reading. Referred to the desks of the Co-Speakers. 02/10/11 - Third reading. Carried by Bates. Passed. 02/08/11 - Second reading.	
SB184	Relating to health care; appropriating money; prescribing an effective date; providing for revenue raising that requires approval by a three-fifths majority.	Establishes Oregon Health Access Fund and continuously appropriates moneys in fund to Oregon Health Authority for specified purposes. Creates Core Health Safety Net Integrity Program in authority to provide moneys to support health care safety net	3	01/14/11 - Referred to Health Care, Human Services and Rural Health Policy, then Ways and Means. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	

SB514	Relating to the Oregon Medical Insurance Pool.	Expands eligibility for enrollment in Oregon Medical Insurance Pool to include parents of children who are unable to access health insurance coverage. Prohibits application of waiting period or preexisting conditions provision on children under age	3	02/21/11 - Public Hearing and Possible Work Session scheduled. 01/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	
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*** Priority Levels are established as follows:**

- 1 = Major change to Medicaid benefits / program structure
- 2 = Less significant impact to Medicaid benefits / program structure
- 3 = Of interest to the MAC, but no direct impact to Medicaid program



THEODORE R. KULONGOSKI
Governor

January 6, 2011

Nicole Merrithew
Medicaid Advisory Committee
Oregon Office for Health Policy
1225 Ferry St SE, Suite C
Salem, OR 97301

Dear Ms. Merrithew:

Please pass along to the entire board my sincere appreciation for the service and dedication of you and your colleagues on the Medicaid Advisory Committee during my administration.

I have always believed that government can make a positive difference in the lives of our citizens, and the service of you and your colleagues have delivered an enduring confirmation of that belief for the people of Oregon. I want you to know that your work has sustained the efforts of my administration and enabled us to realize a record of accomplishments that would not have been possible without your generous and dedicated service.

I thank all of you for your service, and I wish all of you the best in your future endeavors.

Sincerely,

THEODORE R. KULONGOSKI
Governor

TRK:ngd

Medicaid Integrity

Background

Program integrity denotes everything from developing strong policy on client benefits and eligibility to rules and statutes that allow for enforcement. Program integrity extends to all areas of our operation and our duty to address and resolve findings related to fraud, waste and abuse within and across our partnership entities.

DMAP's broad responsibility under the *Medicaid Integrity Program* is to review Medicaid provider activities, audit claims, identify overpayments, and educate providers on Medicaid program integrity requirements.

Update

As part of the Patient Protection and Affordable Care Act (PPACA or ACA), Medicare, Medicaid and CHIP programs must establish procedures to mitigate the risk of fraud, waste, and abuse within each category of participating provider or supplier beginning **March 25, 2011**. The procedures must include criminal background checks, multi-State database inquiries, and random or unannounced site visits. Every health care provider and supplier is required to comply with and agree to participate as a condition of enrollment as a provider of OHP services.

To implement this ACA reform item, we are redesigning our Medicaid provider and supplier enrollment application.

Our latest *Medicaid Integrity Program* report from the Centers for Medicare and Medicaid Services (CMS) noted current *effective OHP practices* that demonstrate our strengths and commitment to program integrity. We contribute CMS' recognition to the collaborative and cooperative relationship with our contracted managed care organizations and other partners. The CMS recognition also applauded our extensive provider training program.

Provider Services

Background

With the arrival of MMIS, our Provider Services Unit has been encouraging providers to use the capabilities, efficiencies and features of the new Provider Web Portal. The Portal is a free electronic data exchange that performs many of the same efficiencies provided by private Electronic Data Interchange (EDI) Clearinghouses. The self-serve real-time Portal allows smaller practices and individual health care providers to access information on claim/payment status, prior authorization status, client eligibility and benefit plan information, managed care enrollment, and third-party liability.

Update

In January, our Provider Services Unit (PSU) had a daily average of nine Representatives available to answer provider phone and e-mail questions. PSU receives over 10,000 calls a month (an average of over 450 calls per business day or 50 calls per hour).

Together with helping solve technical issues, Representatives inform and educate providers on where to find information through our self-service alternatives.

Beginning **February 15**, PSU is shifting resources to help providers and their practices with in-depth problem solving with a focus on complex issues. Callers not experiencing complex or technical difficulties will be redirected to the self-service options of the Provider Web Portal, Automated Voice Response (AVR) telephone tool, or the Electronic Data Interchange (EDI) system.

Education and Training

To provide quality service and meet our providers' training needs, we continue to add to the lineup of provider education tools. The latest offerings are live call-in *phone forums* helping providers with the National Correct Code Initiative¹ (NCCI). We hope the format will engage and stimulate a lively and informative interaction between providers and guest speakers. Post-training surveys and evaluations will let us know if the *phone forums* are well-received.

Client Services

Denied or Reduced Service Decisions

An OHP client currently receives a *Notice of Action* when their plan or DMAP denies or reduces a service or benefit prior authorization. We have made significant changes to this notice, creating easy-to-follow instructions for OHP managed care clients to request an Appeal or Administrative Hearing when a medical service or benefit authorization is denied. A workgroup of managed care organization representatives and departmental staff collaborated on the simplified correspondence. The materials clearly explain to the client what it means when they receive a *Notice of Action* letter and what options are available to contest the action.

The *Notice of Action* packet tells OHP managed care plan enrollees about their choices to either submit an Appeal to the plan or request a DMAP Administrative Hearing, or to simultaneously request both. Plan members may also request an Administrative Hearing if dissatisfied with the plan's Appeal decision. (Fee-for-service clients can request a DMAP Administrative Hearing.)

The changes are part of our ongoing efforts to improve our communications and materials for the individuals who receive coverage under the Oregon Health Plan.

OHA Ombudsman

The OHA Ombudsman, a newly created position funded through the Healthy Kids legislation, is dedicated solely to issues related to medical assistance programs. The

¹ *National Correct Code Initiative: DMAP will be implementing all of the NCCI edits on April 1, 2011. NCCI edits are a code set created by the Centers for Medicare and Medicaid Services to promote coding guidelines and control incorrect coding combinations reported on claims. The edits are applied to services claimed by the same physician, for the same patient, for the same date of service and prevent improper payment when incorrect code combinations are listed.*

ombudsman will serve as a trusted intermediary between OHA, clients and stakeholders, and represents the interests of the public by investigating and addressing reported complaints and grievances. The goal is to develop a proactive, transparent resolution process.

One of the Ombudsman's first projects has been to reinvigorate and expand the *Complaints and Grievance* workgroup using a systematic process to consolidate all client complaints and grievances that affect public-sponsored health care. Workgroup participants will include staff from DMAP and other agencies, Department of Consumer and Business Services (regulating private health insurance), legal advocates, managed care plans, and OHP clients.

To provide comments and suggestions for the process, please contact the OHA Ombudsman, Ellen Pinney at 503-947-2347 or email Ellen.Pinney@state.or.us.

Administrative Law Judges

The Office of Administrative Hearings announced that we have been assigned five dedicated Administrative Law Judges (ALJ) for client Administrative Hearings. This constructive change means Judges now have the opportunity to develop an in-depth understanding of DMAP-specific program policies and nuances, such as the Prioritized List. Dedicated judges will also contribute to consistent policy application. This change aligns with our *Continuous Improvement Process* as the ALJs work with us, saving them, and previously randomly assigned Judges, research time becoming familiar with our program and changes as they are updated.

OHP Standard Enrollment

The average monthly enrollment goal of 60,000 in the OHP Standard program was reached during the month of November 2010.

While overall enrollment could reach 70,000 as the remaining applications are processed, this will only be for a limited time as clients leave the program and enrollment declines. We are closely monitoring to ensure the 60,000 monthly average is not exceeded for the two-year budget cycle. To manage enrollment, DHS/OHA did not conduct random selection drawings in January and February 2011.

OHP Standard Coverage Period Extended

Another highlighted goal reached by the OHP Standard program is the implementation of a 12-month certification period. Eligible applicants and current enrollees who qualify on or after **March 1, 2011**, will be granted 12 months of benefits if they meet their premium requirements. Previously, the certification period was six months. This change will also contribute to maintaining the monthly average enrollment goal of the OHP Standard program.

Operations

MMIS Certification

The federal MMIS Certification Team spent the last week of January with us testing for our *Final Documentation for Certification* review. The certification team ran the system through

reporting scenarios and asked numerous questions, which we were able to answer before the week ended. The certification team acknowledged DMAP staff did an outstanding job, were knowledgeable and presented the replacement system very well.

The final day was an exit conference and we spent the time sharing observations instead of discussing findings and issues that would preclude our certification. Preliminarily, the only Corrective Action Plan (CAP) we expect to see is the need to develop short and long-term Disaster Recovery plans. We expect to receive the *Final Documentation for Certification* within the next 30 days.

For More Information

- **Oregon Health Authority (OHA) Transition** — To track the transition process, visit the Transition Web site at www.oregon.gov/oha/transition. Click on the “submit your suggestions” link to share ideas for a smooth transition or e-mail HB2009.transition@state.or.us.
- **Federal Health Care Reform** — With its own health care reform efforts 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 us to continue providing quality services in a time when demand is outpacing revenue and create a culture of continuous improvement where change is driven by staff. www.oregon.gov/DHS/transformation.

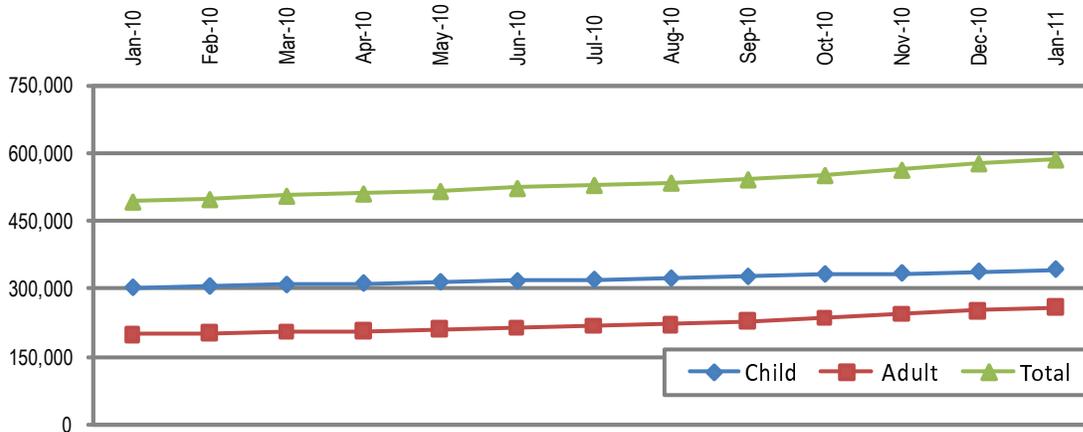
Demonstration and State Plan Amendment Status

The following table outlines the status of Demonstration and State Plan amendments (SPAs) under review by the Centers for Medicare and Medicaid Services (CMS). To view the entire notices of rule making, go to www.dhs.state.or.us/policy/healthplan/rules/notices.html.

Demonstration Amendments		
Description	Status	Rule Change?
No demonstration amendments are currently under review.		
Medicaid SPAs		
Targeted Case Management — These amendments make technical adjustments to existing programs and will neither affect benefits to clients nor DMAP operational procedures. Note: A CMS moratorium on rules for targeted case management has delayed the process.		
• TCM - Children who are the responsibility of child welfare	Submitted 6/27/08	No
• TCM - Self sufficiency program	Submitted 3/17/10	No
Condition of eligibility — Current policy requires clients to pursue Third Party coverage as a requirement to get Medicaid. This is a technical amendment to include Medicare coverage.	Withdrawn 1/25/11	Yes
1915(i) state plan option for Home Based Habilitation, HCBS Behavioral Habilitation, HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness — The 1915(i) option allows additional flexibility in designing a complete care system for persons with Chronic Mental Illness.	Submitted 7/29/10	Yes
Hospital — Never events (HAC). Submitted to implement changes to prevent the payment of health care acquired conditions. These are conditions that would have been reasonably avoided through the application of evidence-based practices.	Submitted 8/13/10	Yes
Tribal Consultation — CMS requirement to add a state tribal consultation process into state plan.	Submitted 9/30/210	No
OHA structure- Revised to reflect the change from DHS to OHA as the Medicaid agency.	Submitted 1/7/11	Yes
Estate recovery- Revised to clarify that the state recovers for any allowable medical assistance payments made on behalf of the individual	Approved 1/18/11	Yes
RAC — Affordable Care Act section 6411 requires the State to establish programs to contract with one or more Medicaid Recovery Audit Contractors (RAC) for the purpose of identifying underpayments and overpayments.	Submitted 1/26/11	No
Personal Care — Companion issue to SPA 10-22 CAF-personal care. CMS directed the state to have additional details to AMH reimbursement for personal care.	Submitted 1/21/11	Yes
Children's Health Insurance Plan (CHIP) SPAs		
None at this time		

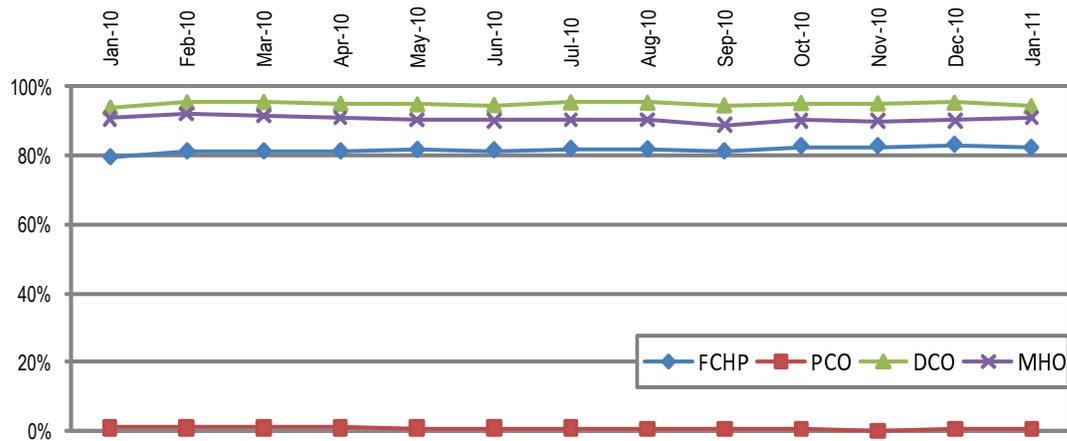
Enrollment Snapshot - January

Number of Oregonians on Medicaid: Total, Adults and Children



Medicaid Enrollment	January 2010	January 2011	Percent Increase
Children (18 and under)	303,026	342,272	12.95
Adults	202,734	267,717	24.27
Total	505,760	609,989	17.09

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



Managed Care Enrollment	January 2010	January 2011	Percent Increase
Fully Capitated Health Plans/ Physician Care Organization	372,868	466,247	25.04
Primary Care Managers	5,255	3,515	-33.98
Dental Care Organizations	440,537	535,207	21.49
Mental Health Organizations	425,869	516,045	21.17