

MEDICAID ADVISORY COMMITTEE

January 23, 2013

9:00 – 12:00pm

**General Services Building
Mt. Mazama Conference Room
1225 Ferry St. SE, Salem, Oregon**

	Time	Item	Presenter
1.	9:00	Opening Remarks	Co-Chairs
2.	9:05	Approval of Minutes – October 2012	MAC Members
3.	9:10	Oregon Health Authority <ul style="list-style-type: none"> • Report out from Oregon Health Policy Board mtgs • Update on CCO Transformation Plans 	Co-Chairs; Jeanene Smith, OHA
4.	9:40	Oregon Quality Metrics and Accountability Plan <ul style="list-style-type: none"> • Overview: Quality metrics and CCOs 	Carole Romm, OHA
5.	10:10	Break	
6.	10:20	Florida's Enhanced Benefit Reward (EBR) Program Evaluation - Lessons Learned <ul style="list-style-type: none"> • An overview of the EBR Program • Future of Florida's Medicaid Reform and the EBR Program 	R. Paul Duncan, Ph.D., Florida Medicaid Reform Evaluation Team
7.	10:50	Patient Activation and Health Care Reform <ul style="list-style-type: none"> • What is Patient Activation? • Patient Activation Model in the context of Medicaid and health reform 	Judith Hibbard, Ph.D.
8.	11:20	Consumer-Directed Health Care and Medicaid <ul style="list-style-type: none"> • Literature synopsis • Draft outline, white paper 	OHPR staff
9.	11:50	Public Comment or Testimony	
10.	11:55	Closing comments	
11.	12:00	Adjourn	Co-Chairs

1. Agenda
2. Draft meeting minutes, October 24th, 2012
3. MAC materials for January 8th 2013 Health Policy Board meeting
4. Staff memo to Health Policy Board, Jan. 8th 2013
5. Summary, Oregon's Medicaid Demonstration Accountability Plan
6. Presentation: Oregon Medicaid Accountability Plan
7. State approaches to consumer direction in Medicaid, 2007
8. Dr. Hibbard article: Plan design active involvement of consumers in health and health care, 2008
9. Staff CDHC white paper outline (*draft)

Oregon Health Policy Board

AGENDA

January 8, 2013

Market Square Building
1515 SW 5th Avenue, 9th floor
8:30 to 10:30 a.m.

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll 2013 Board meeting schedule Action item: Consent agenda: 12/11/12 minutes	Chair	X
2	8:35	Quality Metrics and Accountability Plan: Final agreement with CMS	Tina Edlund	
3	9:05	Governor's Budget	Mike Bonetto, Board Member	
4	9:35	Medicaid Essential Health Benefits: Review of feedback and final recommendation approval	Jim Russell, Co-Chair Medicaid Advisory Committee Oliver Droppers, OHA	X
5	10:00	Early Learning Council and Oregon Health Policy Board subcommittee meeting report	Carla McKelvey, Board Member	
6	10:15	Public Testimony	Chair	
	10:30	Adjourn		

Next meeting:

February 5, 2013

1:00 to 5:00 p.m.

Market Square Building

1515 SW 5th Avenue, 9th floor

Oregon Health Policy Board
DRAFT Minutes
December 11, 2012
1 p.m. to 5 p.m.
Multnomah County Commissioners Board Room
501 Southeast Hawthorne Blvd
Portland, OR 97214

Satellite locations:

Eastern Oregon University
Inlow Hall/Main Office 013
1 University Blvd
La Grande, Oregon 97850

RCC/SOU Education Center
Room 129B
101 South Bartlett
Medford, Oregon 97501

Deschutes County Offices
Barnes/Sawyer Rooms
1300 NW Wall Street
Bend, OR, 97701

**Tillamook Bay Comm.
College**
Room 214
4301 Third Street
Tillamook, OR 97141

**Lane County Health and
Human Services**
Room 258
151 West 7th Ave.
Eugene, OR 97401

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except Nita Werner.

Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).

Consent Agenda:

The November 11, 2012 minutes were approved unanimously.

Director's Report – Bruce Goldberg

Bruce Goldberg spoke about the progress of Oregon's health system transformation. He said the old way wasn't working because costs were too high, health outcomes were too low and too much money was being spent on fragmented care. He said there are five foundational elements in the transformation of Oregon's health care delivery system:

1. Coordinated and integrated benefits and services
2. One global budget that grows at a fixed rate
3. Metrics: standards for safe and effective care
4. Local accountability for health and budget
5. Local flexibility

Goldberg spoke about accomplishments so far, which include enrolling 600,000 Oregon Health Plan members into 15 CCOs across the state and obtaining the federal 1115 Waiver.

Goldberg said future issues include:

- Integrating dental care
- Ensuring robust provider networks to meet client needs
- Transforming care and paying for performance
- Accounting for "flexible" services
- Time and resources
- Penalties for failure to achieve cost, quality and access benchmarks

Goldberg said, in 2014, approximately 200,000 Oregon adults will be newly eligible for the Oregon Health

Plan through the Affordable Care Act. He said this will end the “health care lottery,” reduce medical bankruptcy, reduce cost shift, improve access to care and be life-changing for hundreds of thousands of Oregonians.

Oregon’s Health System Transformation presentation can be viewed [here](#).

Introductions and Meeting Procedure – Judith Mowry

Judith Mowry spoke about the process for testimony and feedback during the meeting.

Provider Panel: Care Coordination – Kristen Dillon and Bruce Abel

Kristen Dillon spoke about changes that she has witnessed so far because of health system transformation. She spoke about community cooperation and everyone being at the same table. Dillon said some of the challenges include allowing CCOs to have discretion and autonomy when it comes to setting up their services as well as the misalignment of the geographic boundaries, especially in rural areas. She spoke about issues surrounding provider and patient engagement. Dillon said contracting has been difficult with the historic rules of mental health agencies. She said financial reform has removed the budget to local level, which lacks the capability to build integration. Dillon also said in order to transmit patient information electronically, communities need help from the state

Bruce Abel spoke about the status of health system transformation and integration in Lane County. He said they have a strong board of directors with community partners and have already submitted their transformation plan. Abel said one of the biggest challenges ahead is integrating mental health and physical health services. Abel also described some of the innovative projects Trillium is working on, including standard health screening instruments for all providers, launching a shared care plan and treatment guidelines.

Feedback: Care Coordination – Judith Mowry

Judith Mowry asked for discussion regarding care coordination:

- What do you see as challenges and opportunities surrounding coordination of care for Medicaid recipients?
- What changes have you seen already or hope to see?

The feedback received included:

- Ensuring access to midwives and birth centers.
- A need for accreditation.
- Challenges surrounding integrating electronic records and the health information exchange.
- Community partners coming together.
- A need for more screening, a community resource team and “hotspotting” for individuals.
- Registered dieticians should be utilized more often in disease prevention.
- Unknowns about the structure regarding CCOs and community health workers.

Community Advisory Council panel: Community Involvement – Diane Hoover, Steve Weiss, Kaire Downin

Diane Hoover spoke about the transition from the MCO to CCO model. She said after the transition, there was increased participation across the community and an increased sense of optimism. She spoke about the challenges of Medicare reimbursement rates not keeping up with costs and the differences between mental health and physical health documentation requirements.

Steve Weiss spoke about community health strategies and involvement. He said during each public meeting, his CAC allows for 30 minutes of public comment. He said more than 50 public members have attended the meetings. Weiss said opening meetings to public has allowed many stakeholders to voice their views. Weiss also said more information about the delivery and finance model would help his CAC.

Kaire Downin spoke about the CAC for Linn Benton and Lincoln counties. She said the majority of the members are OHP consumers. Downin said ensuring that OHP members have access to midwives and birth centers is vital. She said midwives have fewer infants admitted to Neonatal Intensive Care Units, and their caesarian rates are much smaller than hospital rates, which reduces health care costs.

Feedback: Community Involvement – Judith Mowry

Judith Mowry asked for discussion regarding community involvement:

- If local CCO community engagement looked as you would envision, what would it look like?

The feedback received included:

- There should be less people between the patient and the right practitioner. There only needs to be one middle man.
- Information could be presented at meetings like a neighborhood association and presented repeatedly in order to reach as many types of communities as possible.
- More diversity is needed in the healthcare workforce so patients feel comfortable.
- CCO CAC meetings need to be public and public comment should be wanted, accepted and used.
- Focus on medical literacy. We have to create a language that people can understand- no jargon.
- Full community involvement is needed.
- A unified and simplified financial model would be best.
- There are many county barriers for rural residents.
- State support needed for community engagement.
- A simplified payment system that is provider friendly.
- Practice evidence-based medicine.

Medicaid Essential Health Benefits – Jeanene Smith and Rhonda Busek

Jeanene Smith gave an overview of the Medicaid Essential Health Benefits package. Smith said the package has gone through an extensive public process but they want to continue to receive as much feedback as possible. She said there will be a 30-day public comment period and then the package will be an action item for the Board in January.

Rhonda Busek spoke about the Oregon Medicaid Benchmark Benefits and the Medicaid Advisory Committee's (MAC) final recommendation. She said the key decision points for MAC included:

- Ensure alignment with Oregon's Triple Aim, Coordinated Care Organizations, and federal requirements in the ACA.
- Simplify, align, and streamline benefit coverage across the Oregon Health Plan.
- Aim to meet all health care needs of adult Oregonians eligible for OHP.

Busek said they wanted the package to be the least disruptive to current OHP members.

Final recommendations of the Medicaid Advisory Committee can be found [here](#).

Public Testimony

The board heard testimony from 17 people:

Deanna St. German, Kids Center, spoke about child abuse intervention centers. She said OHP clients would greatly benefit from partnering with the 20 child abuse intervention centers in Oregon. St German said child abuse is an area where future money can be saved in the state.

Alison Sutherland, Trillium Water Birth Center, spoke about midwifery and out-of-hospital birth. She said the state should enforce non-discriminatory language and encourage CCOs to contract with midwives and birth centers.

Jennifer Bills, Oregon Speech-Language & Hearing Association, spoke about access to services for

speech and hearing therapy. She said prevention and early intervention is key. Bills said because of the payment system, OHP members have limited access to services.

Nancy Becker, Academy of Nutrition and Dietetics, spoke about the role of registered dietitians in obesity prevention and treatment. She said nutrition services need to be available to all patients and these services need to be offered by registered dietitians, not community health workers.

Patty Boyd, Multnomah Education Service District, spoke about physical therapy challenges for schools. She said 90% of the pop she serves are OHP members. She said she has been receiving 100% denials on wheelchairs, which leaves students in pain and prevents them from coming to school.

David Subia, Medford resident, spoke about patient participation in care. He said clients need counseling about personal responsibility. He also suggested a participation review when clients reapply for benefits.

Benjamin Gerritz, advocate, spoke about the role of CCOs in HIV prevention and treatment. He said CCOs should be testing because it's cost effective and there is a high rate of undiagnosed cases. Gerritz said 20% of HIV positive Oregonians do not know their status and late diagnosis costs more to treat.

Tobi Rates, Autism Society of Oregon, spoke about exclusion of applied behavior analysis as a treatment for autism in the Essential Health Benefits Package. She said she believes Oregon is in violation of federal laws that requires coverage of applied behavior analysis. She said OHP should remove all limits on rehabilitative care.

John Hummel, Oregon Primary Care Association, said he is concerned that some people will try to curtail CCO legislation. He said there is a need for robust community advisory panels and a system of checks and balances to ensure CCOs are meeting community needs. He also said health care providers should be required to meet the same outcomes for all patients.

Steve Arnold, Multnomah County Adult Mental Health and Substance Abuse Advisory Council, said the consolidation of health services may reduce conversation about mental health services. He said time devoted to the conversation about mental health and substance abuse will be greatly reduced in the CCO Community Advisory Council model. He said family members, consumers, advocates, managers of funds and providers all need to be part of the conversation because they each bring critical knowledge and concerns to the table.

Heather Hack, licensed midwife, said midwives provide high quality care for low cost, which fits with the OHA's triple aim. She said midwives should be included in CCOs.

Wendy Markey, AllCare Community Advisory Council, spoke about having providers and partners at same table. She said there has been an increase in fragmentation and a loss of regional perspective. Markey said there is a need for collaboration between CCOs. She also said billing needs to be standardized for mental health and wrap-around services.

Vanessa Timmons, Oregon Coalition Against Domestic and Sexual Violence, spoke about the impact of domestic and sexual violence on community health. She said CCOs need to partner with community-based domestic and sexual violence organizations because the effects cross many boundaries.

Victoria Demchak, Asian Pacific American Network of Oregon, said the differences in race, ethnicity and language matter in health care. She said data collection standards should be improved and data should be collected at local levels. She also said there is a need to making Oregon's diversity more visible.

Jamie Sanchez, advocate, said providers don't have a full understanding of conditions and patients need informed choice. She said access to care has declined under CCOs.

Betsy Cunningham, Citizens Education and Advocacy, said CCOs have created a health care monopoly.

She said since the formation CCOs, patients are being denied pain medication and chronic pain is not being treated effectively.

Elaine Walters, Trauma Healing Project, said she has been hearing much feedback about including complementary and alternative health options. She said the identification and development of common evaluation measures would be a great benefit to the state.

Adjourn

Next meeting:

January 8, 2013

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 to 10:30 a.m.

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Oregon Medicaid Accountability Plan

January 8, 2013

Presentation to the Oregon Health Policy Board

What is the Accountability Plan?

- Addresses the Special Terms and Conditions that were part of the \$1.9 billion agreement with the Centers for Medicare and Medicaid Services (CMS).
- Describes accountability for reducing expenditures while improving health and health care in Oregon's Medicaid program, focusing on:
 - CCO reporting to state
 - State reporting to CMS
- Approved by CMS on December 18, 2012

Accountability Plan

- a. Quality Strategy
- b. State “Tests” for Quality and Access
- c. Measurement Strategy
- d. Quality Pool
- e. Expenditure Review
- f. Evaluation

Oregon's Medicaid Program Commitments to CMS:

- Reduce the annual increase in the cost of care (the cost curve) by 2 percentage points
- Ensure that quality of care improves
- Ensure that population health improves
- Establish a 1% withhold for timely and accurate reporting of data
- Establish a quality pool

Purpose of the Quality Strategy

- Address the Special Terms and conditions of the waiver and how Oregon proposes to meet them, including:
 - Transformation goals
 - Strategies for transformation
- Address how Oregon will meet federal requirements

Quality Strategy

Quality Assurance

- On-site reviews
- Quarterly and annual financial reporting
- Complaints, grievances and appeals reports
- Fraud and abuse reports

Quality Improvement

- 7 quality improvement focus areas for CCOs to choose from
 - Performance improvement projects (PIPs)
 - Rapid-cycle improvement (Plan, Do, Study, Act- PDSA)
- Contractual requirements
- Transparency
- Financial incentives

Quality Strategy Includes Supports for Transformation

- Transformation Center and Innovator Agents
- Learning collaboratives
- Peer-to-peer and rapid-cycle learning systems
- Community Advisory Councils: Community health assessments and improvement plan
- Non-traditional healthcare workers
- Primary care home adoption

State “Test” for Quality and Access

- Annual assessment of Oregon’s statewide performance on 33 metrics, in 7 quality improvement focus areas:
 - Improving behavioral and physical health coordination
 - Improving perinatal and maternity care
 - Reducing preventable re-hospitalizations
 - Ensuring appropriate care is delivered in appropriate settings
 - Improving primary care for all populations
 - Reducing preventable and unnecessarily costly utilization by super users
 - Addressing discrete health issues (such as asthma, diabetes, hypertension)

State “Test”

- 2011 = base year
- For 2013 and 2014, performance must not decline
- For remainder of the demonstration, performance must improve
- Significant financial penalties to the state if quality goals are not achieved

Measurement Strategy

Measurement Strategy: CMS requirements

- Quality and Access Measures for Quality Pool
- Transparency: Core measures and Quality Pool measures will be posted on OHA website by CCO
- First public reports expected late summer, 2013

Measurement Strategy: Timeline and Data Collection

- Baseline year: 2011
- Implementation year: 2012
- Measurement year: 2013 = year 1
- Administrative (claims/billing) data
- Hybrid measures (claims and other): OHA will work with CCOs to develop the most effective, least burdensome strategy for collecting this data, e.g.:
 - Surveys
 - Chart reviews

Quality Pool

Quality Pool

- A bridge strategy in moving from capitation to paying for outcomes
- Pool size will increase each year:
 - Year 1 = 2% per member per month (pmpm)
- 17 metrics in the 7 quality improvement focus areas selected by the statutorily created Metrics and Scoring Committee

Quality Pool Metrics

Behavioral health metrics, addressing underlying morbidity and cost drivers

1. Screening for clinical depression and follow-up plan
2. Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)
3. Mental health and physical health assessment for children in Department of Human Services (DHS) custody
4. Follow-up after hospitalization for mental illness
5. Follow-up care for children on ADHD medication

Quality Pool Metrics

Maternal/child health metrics reflecting the large proportion of women and children in Medicaid:

6. Prenatal care initiated in the first trimester
7. Reducing elective delivery before 39 weeks
8. Developmental screening by 36 months
9. Adolescent well care visits

Quality Pool Metrics

Metrics addressing chronic conditions which drive cost:

10. Optimal diabetes care
11. Controlling hypertension
12. Colorectal cancer screening

Quality Pool Metrics

Metrics to ensure appropriate access:

13. Emergency department and ambulatory care utilization
14. Rate of enrollment in Patient-Centered Primary Care homes (PCPCH)
15. Access to care: getting care quickly (Consumer Assessment of Healthcare Providers and Health Systems Survey (CAHPS): adult and child)

Quality Pool Metrics

16. Patient experience of care: Health plan information and customer service (CAHPS, adult and child)
17. Electronic health record (EHR) adoption and meaningful use

Quality Incentive Pool: How it will work

- All money in the pool is distributed every year
- Potential pool award determined by plan size (pmpm) with a minimum amount established as a floor for all CCOs
- CCOs can access \$ by meeting performance or improvement benchmarks

Quality Incentive Pool: How it will work

Two phases:

- Phase 1: Distribution by meeting improvement **or** performance target
- Phase 2: Challenge pool (remainder) distributed based on 4 metrics:
 - PCPCH enrollment
 - Screening for depression and follow-up plan
 - SBIRT
 - Optimal diabetes care

Expenditure Review

- 2 percentage point reduction in expenditure trend will be evaluated based on:
 - All services provided through CCOs over the course of the demonstration
 - Wrap-around payments to Federally Qualified Health Centers (FQHCs) for services provided through CCOs
 - Financial incentives and shared savings payments made to CCOs

Evaluation

- Ongoing monitoring with quarterly reporting and consistent feedback
- Mid-point, rigorous analysis of impacts
- Final comprehensive demonstration evaluation

Questions?

More information:

- OHA has posted the full Accountability Plan at www.health.oregon.gov
- More details on metrics at <http://www.oregon.gov/oha/pages/matrix.aspx>

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Governor's Balanced Budget 2013-2015

Oregon Health Policy Board
January 8, 2013

Mike Bonetto,
Governor Kitzhaber Health Policy Advisor



Governor's Balanced Budget

- Education – put children, families and education first
- Jobs – invest in jobs and innovation
- Costs – lower costs & increases efficiency

The Healthy People portion of the budget, which includes the Oregon Health Authority, helps meet those principles.

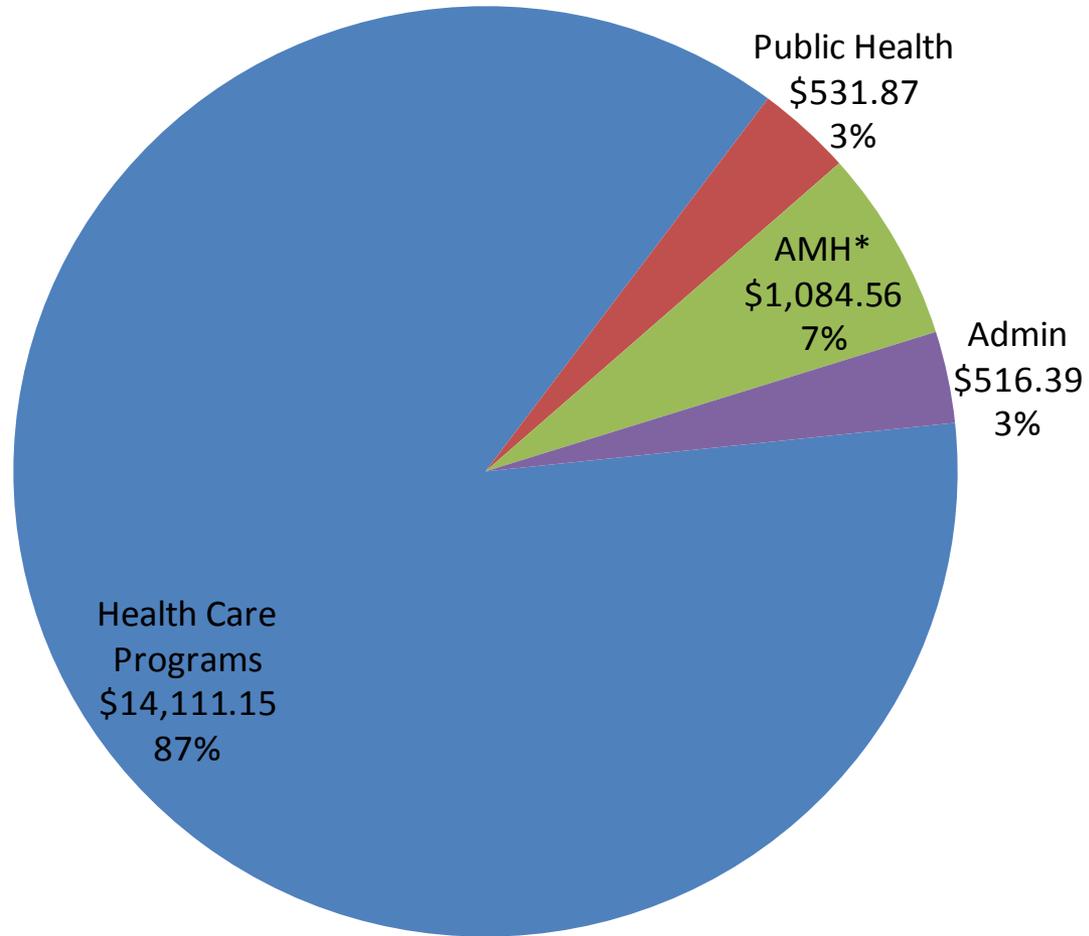
OHA Budget 2013-15

- Lowers cost of Oregon Health Plan
- Funds OHP to targeted and sustainable growth that meets agreement with CMS
- Increases access to health care coverage to more than 200,000 through Affordable Care Act
- Increases community mental health investments
- Supports strategic investments in prevention and management of chronic disease

Oregon Health Authority – Budget summary

- **\$16.2B Total funds**
 - \$2B General fund
 - \$8.1B Federal funds
 - \$2.3B Other funds
 - \$3.7B Other funds (Non limited- PEBB & OEBC benefits)
 - \$107.1M Federal funds (Non limited- WIC vouchers)
 - \$10.5M Lottery funds

Total Funds by OHA Program



*Includes Capital Improvement and Capital Construction (\$80M)

Oregon Health Plan - \$10.2 Billion

Funds OHP and lowers costs per agreement with CMS

- 4.4% increase in per capita expenses in year one
- 3.4% increase in per capita expenses in year two

Strategic investments

- \$4.6M – GF rural malpractice coverage
- \$30M - GF Health System Transformation Fund
- \$1.6M – GF for Patient Safety Commission

Expands coverage in Jan. 2014 – Health care costs 100% federally funded 2013-15

- ~ 200,000 through ACA.
 - 30% of state's remaining uninsured Oregonians
 - Reduced medical debt & cost shift, increased access to care

Oregon Health Plan, con't

Revenues

- \$808M - Designated State Health Program
- \$600M - hospital tax
- \$160M - general fund investments
- \$120M tobacco master settlement agreement

Addictions and Mental Health Division - \$1 Billion

43% increase in Oregon's community mental health and addiction treatment system

Community mental health

- \$10.0M – Strengthens community mental health services
 - \$1.5M – Funds Oregon Psychiatric Access Line for Kids
 - \$1.8M – Expands Early Assessment and Support Alliance to be statewide
 - \$5.2M – Increases supported housing services
 - \$1.5M – Expands supported employment services
- \$15M – Incentives from health system transformation fund for partnerships between CCOs and community mental health programs and providers.

Addictions and Mental Health, con't.

- \$45M – Reinvests savings from the 2014 Medicaid expansion into the community mental health and addictions treatment system
- \$41M – Increased community mental health capacity – supported housing, facility beds, peer-delivered services
- \$2.6M – Expands the intensive treatment and recovery services (ITRS) program that helps reunite and keep families together when parents enter treatment for drug and alcohol addiction.

Addictions and Mental Health, con't.

Oregon State Hospital

- Closure of Blue Mountain Recovery Center in January 2014
- Closure of 90 leased mental health beds at the Portland campus of Oregon State Hospital
- Closure of one geriatric ward at the Oregon State Hospital in Salem
- Opening of the Oregon State Hospital Junction City Campus in April 2015 - replaces closed beds.
- Restoration of the one-time reductions and saving listed above = limited investment of \$3 million for hospital system

Office of Private Health Partnerships - \$461.2M

With implementation of the ACA in Jan., 2014

- Phasing out of the Family Health Insurance Assistance Program, Oregon Medical Insurance Pool, and Federal Medical Insurance Pool

Public Health Division - \$531.9M

- Increases net GF investment over 2011-13 by ~\$1 million
- Makes strategic investments in innovative partnerships between local public health departments and CCOs from the Transformation Fund
- Protects funding for school-based health centers

Public employees

Oregon Educators Benefit Board - \$1.6 B

Increase in Other Funds and Other Fund Non-Limited to account for Home care workers benefit administration.

Public Employees' Benefits Board - \$1.76 B

Increase in Other Funds and Other Fund Non-Limited to account for expected payments to cover the Health Engagement Model

Furloughs

Eliminates furloughs and restores basic level of government services

PERS

Adjusts out-of-state benefits and caps cost-of-living increases, increasing purchasing power of state agencies & school districts

Questions?

MEMO

DATE: December 11, 2012
TO: Oregon Health Policy Board
FROM: Oregon Medicaid Advisory Committee
RE: Oregon Medicaid Benchmark Plan: Final Recommendation

Dear Chairs Parsons and Shirley and members of the Board:

After several months of meetings that involved thoughtful and detailed discussions, the Oregon Medicaid Advisory Committee (MAC) is pleased to present their final recommendation for Oregon’s Medicaid Benchmark benefit package. The recommended benefit package will fulfill the new Affordable Care Act (ACA) requirements that need to apply to any current or future Medicaid expansion population of non-pregnant adults, including individuals currently covered under the Oregon Health Plan (OHP) Standard program. The letter identifies the final recommendation, and describes the process and rationale for the recommendation. In addition, the MAC received public input, which is provided for your review. At the conclusion of this memo are several observations noted by the committee for future consideration.

Action Item	Request for endorsement of the committee’s final recommendation
Recommendation	The committee recommends the Oregon Health Plan <i>Plus</i> (for non-pregnant adults) to be the state’s Medicaid benchmark plan.
Key Decision Points	<ul style="list-style-type: none"> • Ensure alignment with Oregon’s Triple Aim, Coordinated Care Organizations, and federal requirements in the ACA. • Simplify, align, and streamline benefit coverage across the Oregon Health Plan. • Aim to meet all health care needs of adult Oregonians eligible for OHP.
Additional * Recommendations	<ul style="list-style-type: none"> • Restore and strengthen services and benefits historically covered for all populations by the Oregon Health Plan. • Monitor impact and minimize disruption around coverage and benefits for individuals that transition between OHP and Qualified Health Plans (QHPs). • Leverage federal opportunities through the ACA that support improvements in health and well-being of diverse segments of Oregon’s population, and promote fiscal sustainability of the Oregon Health Plan.

* Please see page 5 for more information about the additional recommendations.

Background

The federal Affordable Care Act requires states to select a benchmark benefit plan for any Medicaid expansion population of non-elderly, non-pregnant adults. The benchmark benefit plan refers to a comprehensive package of items and services known as “essential health benefits” (EHBs). Starting in January 2014, Medicaid benchmark or benchmark-equivalent plans must include all 10 categories of EHBs. Oregon will not be able to use the current set of benefits offered through OHP Standard for any of the state’s Medicaid current or future adult expansion populations. The current benefit package for OHP Standard does not meet benchmark or benchmark-equivalent coverage criteria because of limitations and exclusions of certain services such as rehabilitative services, physical therapy, occupational therapy, and speech therapy, among others. At the time of the passage of the ACA in 2009, it also did not provide a full hospital benefit.

States, including Oregon, have the option to provide a Medicaid benefit package for current or future expansion population(s) from the following benchmark plans:

- Largest federal employees health plan (Blue Cross Blue Shield)
- State employee health plan (in Oregon, Providence Statewide)
- Largest non-Medicaid HMO plan (in Oregon, Kaiser HMO)
- Secretary- approved package, including Traditional Medicaid package (OHP Plus)

Compared to OHP Standard, the benefit package for adults in OHP Plus already provides full benchmark coverage (i.e. all 10 categories of EHBs). If Oregon elects to expand coverage to individuals that become newly eligible for Medicaid starting in 2014 (non-pregnant adults aged 19-65 with incomes up to 138 percent of the federal poverty level (FPL)[†]—a new benchmark plan is required.

States also are required to select a commercial EHB plan. In August 2012, the Essential Health Benefits Work group, established by Governor Kitzhaber for the purpose of putting forward an EHB benchmark plan for Oregon’s individual and small group market, recommended the *PacificSource Preferred CoDeduct* small group plan. This plan will be used as the “base” for all plans offered inside and outside the Oregon Health Insurance Exchange in the *commercial individual and small group market*.

Committee Discussion

From July through October 2012, the committee worked to select a benefit package that will meet all federally required EHBs and fulfill the federal benchmark selection criteria. On October 24th, the committee made a preliminary recommendation to designate **OHP Plus** (for non-pregnant adults) as the basis for the state’s Medicaid benchmark plan. Over the four-month period, members discussed a range of issues that ultimately influenced the committee’s final recommendation. The committee received a series of briefs by Deborah Bachrach, a national expert and former Medicaid Director of New York on the federal ACA requirements.

[†] In 2012, 138% of FPL is \$15,415 for an individual; \$26,344 for a family of three in 2012.
http://www.kff.org/medicaid/quicktake_aca_medicaid.cfm

The committee's overall deliberation process and key decisions are summarized as follows:

- Adopted a set of decision-making principles to guide committee's work in selecting a Medicaid benefit package (see appendix A). Principles encourage alignment with Oregon's Triple Aim and Coordinated Care Organizations (CCOs), and desire to account for all health care needs of adult Oregonians eligible for OHP.
- Assessed federal requirements for states that are considering expansion of their Medicaid program in terms of mandatory and optional benefits a state may cover.
- Compared a side-by-side comparison matrix of Oregon's potential Medicaid benchmark plans: largest federal plan, Blue Cross Blue Shield; largest private HMO plan, Kaiser; largest state employee plan, the Providence Statewide plan (originally used to design OHP Standard); OHP Plus (≥ 21 adults); and OHP Standard.
- Examined Oregon's EHB plan for the individual and small group market, the *PacificSource Preferred CoDeduct* small group plan, and discussed potential impact on individuals and families as they transition ("churn") between OHP and Qualified Health Plans.
- Eliminated the largest federal plan, largest private HMO plan, largest state employee plan, and commercial EHB plan. The reason for elimination was that the committee opted to start with OHP for adults in designing the state's Medicaid benchmark benefit package.
- Determined that a single Medicaid EHB plan is the preferred option in Oregon. Offering more than one plan will likely create confusion for OHP enrollees, and lead to administrative costs and complexities for providers, practices, CCOs, and Oregon Health Authority (OHA).
- Examined federal cost-sharing requirements of the ACA, which allow states to adopt a cost-sharing structure that can include deductibles or co-payments.[‡] The committee agreed that although cost-sharing among Oregon's Medicaid expansion population may potentially generate marginal revenue, it would also create administrative challenges and barriers to accessing care for OHP beneficiaries. Furthermore, taking into consideration the state's experience with OHP Standard and cost-sharing, fact of limited cost-sharing in OHP currently, and acknowledgement that co-pays and deductibles serve as disincentives and deterrents in accessing and receiving vital services—the committee opted for no-cost sharing for any Medicaid expansion population.
- Adopted the final recommendation as it likely will minimize disruption for individuals that move among different benefit packages within OHP based upon available options, and recommendation met all seven decision-making principles.

Public Comment

Committee meetings were open for the public to attend and provide public comment. The MAC website also provided opportunity for individuals or groups to submit public comment electronically. Public comment was formally requested November 5th through November 19th. Over one hundred public comments were received during the formal public comment period.

[‡] Premiums are not allowed under the ACA.

In sum, the public comment received expressed favorable support for the committee's recommendation. While not within the decision parameters of the committee in developing their final recommendation, a considerable amount of public comment focused on specific benefits and services to Oregon's pediatric population and chiropractic community. A summary of all public comment received is attached for your review and generalized below (see attachment A).

- Several advocate groups and health professionals expressed their desire to increase coverage of particular services that include mental health counseling, newborn circumcision, and comprehensive dental coverage.
- Several comments raised the potential issue around the long-term financial sustainability of a comprehensive Medicaid EHB benefit package as a general concern if Oregon chooses to expand its Medicaid program in 2014.
- A few comments emphasized the importance of screening for HIV and other sexually transmitted infections, specifically per guidelines set forth by the Centers for Disease Control and Prevention (CDC). In Oregon, for individuals diagnosed as HIV-positive, all HIV antiretrovirals are covered in OHP without exclusions or formulary restrictions.
- Representatives of Oregon's nutrition counseling community contend OHP's current lifetime limit of five visits per individual is insufficient. They propose an increase of two visits per year for five years or until the underlying health issue is resolved. Generally, their recommendation is for the Medicaid Benchmark plan to support more "intense and sustained" preventive and intervention related nutrition counseling sessions for OHP enrollees.
- Numerous comments expressed the importance of expanding coverage of chiropractic services in OHP, as well as extending the role of chiropractors within the profession's scope of training and licensure. Generally, comments emphasized the need to support chiropractors of being able to treat all parts of the body (e.g. beyond spine adjustments).
- Individuals, parents, families, caregivers, and health care professionals of children diagnosed with Phenylketonuria (PKU) submitted a number of comments [*PKU is a condition in which infants are born without the ability to properly break down an amino acid called phenylalanine]. Comments expressed the need for lifetime coverage of treatments and related services necessary for individuals dealing with this metabolic condition. The specific recommendation was to cover PKU treatments for adolescents as they transition into adulthood.

Public Comment for the Medicaid Benchmark regarding coverage of specific services will be forwarded to the Health Evidence Review Commission (HERC). The HERC is responsible to develop and maintain a list of health services ranked by priority (i.e. the Prioritized List), from the most important to the least important, representing the comparative benefits of each service to the population to be served.

Additional Recommendations

As the federally-mandated body charged with providing direction to OHA on operation of the Medicaid program, the committee would like to offer its expertise and perspective on several additional recommendations. As the committee worked through this process, several important observations emerged. Members agreed these observations, albeit outside the scope of this recommendation, nonetheless merit mention for future consideration by the Board, OHA, or the MAC.

The intent of offering these observations is to inform future Oregon health policy aimed at improving the health and well-being of Oregon's Medicaid population. The comments are important considerations if Oregon is to fully recognize the original intent of OHP as well as leverage federal opportunities outlined in the ACA:

- Coverage of current OHP enrollees and services are maintained or strengthened across all populations including restoration, preservation, and expansion of comprehensive oral and vision care services for adults covered in OHP.
- Identify and implement strategies that reduce the potential for any adverse affects among individuals that lose, or gain benefits as they “churn” between OHP and Qualified Health Plans (QHPs).
- Develop meaningful, evidence-based, and non-punitive strategies that address the issue of personal responsibility in lieu of cost-sharing that will support improvements in health and wellbeing, and promote fiscal sustainability of Oregon's Medicaid program.
- Gradually expand and support primary and preventive services in OHP beyond federal EHB requirements to take into account the health care needs of diverse segments of Oregon's population.

The committee understands the prioritization involved with the policy development process and that, often, important aspects of Oregon's health system transformation cannot be immediately addressed. As the Board moves forward with its oversight of CCOs, the committee suggests identifying important issues such as those listed above to be addressed in the future. Such a process and expressed commitment will allow communities, families, and individuals in OHP to be assured these issues will receive adequate attention in Oregon.

In Closing

The committee recommends selection of the **Oregon Health Plan *Plus*** (for non-pregnant adults) as the basis for the state’s Medicaid benchmark plan starting 2014. Thank you for the opportunity to collaborate on this monumental reform of health care delivery for current and future Medicaid beneficiaries. We look forward in working with the Board in the future to ensure all Oregonians have access to comprehensive and integrated health care coverage.

Thank you for your consideration of this recommendation and the committee’s additional observations. We would be happy to provide any clarification and look forward to future collaboration. In closing, members of the committee appreciate the opportunity to support the Oregon Health Authority and the Board on this and many other issues that are central to the delivery of high-quality health care by the Oregon Health Plan and CCOs.

Sincerely



Rhonda Busek
Co-Chair, Medicaid Advisory Committee



Jim Russell, MSW
Co-Chair, Medicaid Advisory Committee

**Appendix A:
Oregon Medicaid Advisory Committee
Decision-making Principles for Medicaid Benchmark Coverage**

Background

The federal Affordable Care Act established a new Medicaid eligibility group of non-pregnant adults between 19-65 with incomes up to 138% Federal Poverty Level (PFL). As directed by the Affordable Care Act, States are required to provide Benchmark or Benchmark-equivalent coverage to adults in the new adult eligibility group as described under §1937 of the Social Security Act (DRA). This means the Medicaid benchmark could be:

- State’s full Medicaid package (e.g. Oregon Health Plan—Plus for adults)
- Largest federal employees plan
- Largest state employee plan (Providence Statewide)
- Largest private HMO plan (a Kaiser plan)

Oregon, as it considers the 2014 Medicaid expansion, will need to define its Medicaid Benchmark to the Centers for Medicare and Medicaid Services (CMS) for any of the state’s current or future adult expansion populations. The Medicaid Advisory Committee is charged with advising the Oregon Health Authority (OHA) and the Oregon Health Policy Board on the operation of Oregon’s Medicaid program, including the Oregon Health Plan (OHP). The committee is leading the effort to develop a recommendation for the Oregon Health Policy Board and the Governor’s Office to consider for the state’s Medicaid Benchmark plan. The committee will explore the federal requirements and available options in designing Oregon’s Medicaid Benchmark plan.

Proposed Principles

As the MAC is composed of consumers, providers serving Medicaid clients, and advocates familiar with safety net services, the MAC assumes a special responsibility to speak on behalf of the Medicaid population and how they experience the health care system. The committee adopted a set of decision-making principles to guide their work in selecting essential health benefits (EHB) as part of the Medicaid benefit package; a package that is the least disruptive to the Oregon Health Plan.

On August 22, 2012 the MAC met to initiate its work to develop a recommendation for Oregon’s Medicaid Benchmark plan. Members reviewed and considered an initial draft of decision-making criteria to guide the committee’s work in selecting an essential benefit package. Below is a revised set of decision-making criteria, now referred to as “principles.” The revised principles reflect the committee’s discussion and agreed upon changes including integration of a set of principles adopted by the MAC in 2011 to advise the OHA in past efforts to improve the OHP.

Adopted Principles

The committee formally adopted the set of principles on September 26. Revisions reflect a desire to incorporate changes that support and encourage alignment with Coordinated Care

Organizations in Oregon. Committee members also believe the principles should ensure alignment with the Triple Aim. Upon formal adoption, at a minimum, any final recommendation to the OHPB should support the principles listed below.

Table 1: Decision-making Principles for Medicaid Benchmark Coverage

1. Alignment with Oregon’s Triple Aim and Coordinated Care Organizations (CCOs)	✓
2. Ensure inclusion of all 10 statutory benefit categories and identify meaningful differences in coverage including wellness/prevention, behavioral, mental and dental services	✓
3. Acknowledge value-based benefits, potential cost-sharing relative to income, and flexible utilization of covered services to avoid future costs	✓
4. Appropriate balance of benefits among statutorily required categories so benefits are not unduly weighted toward any category	✓
5. Account for the health care needs of all adult Oregonians, focused on benefits that may address social determinants of health	✓
6. Consider impact on coverage and benefits for individuals that transition between OHP and Qualified Health Plans (QHPs)	✓
7. Consider administrative implications when selecting preferred benefit package including minimizing disruption to the Oregon Health Plan	✓

MEMO

DATE: January 8, 2013
TO: Oregon Health Policy Board
FROM: OHPR, Staff to the Medicaid Advisory Committee
RE: Selection of the Medicaid Benchmark and Health System Transformation

At the December 2012 Board meeting, members requested an explanation of how the Medicaid Advisory Committee's (MAC) recommendation for the Oregon Health Plan (OHP) Plus (non-pregnant adults) benefit package to serve as Oregon's Medicaid benchmark aligns with overall Transformation efforts in Oregon. This memo is provided in response to that request.

As outlined in the recommendation letter to the Board and in the December presentation, states are required to determine the benefit package they will use for current Medicaid expansion populations such as Oregon's OHP Standard beneficiaries, as well as future expansion populations should the State elect to expand in 2014. Because current OHP Standard benefits do not align with the Affordable Care Act's Essential Benefit requirements, the MAC spent several months reviewing other options and ultimately recommended that OHP Plus (for non-pregnant adults) be the state's Medicaid benchmark plan. Current transformation efforts were a major consideration in the MAC's review and recommendation process; several MAC members are involved with CCOs or other aspects of transformation and could speak directly to changes to the delivery of care to Medicaid enrollees. Some of the ways in which the Medicaid EHB recommendation supports transformation are outlined below.

- ***Offers Administrative Simplification to OHP Benefits to aid CCOs' Transformation Efforts***
With three separate packages in OHP (OHP Plus for children/pregnant women; OHP Plus for non-pregnant adults; and, current OHP Standard for expansion adults)—it can be administratively burdensome for the plans, providers, and members to manage benefits. Working to move all non-pregnant adults to a single package will help ensure that CCOs, providers, and members all understand the base benefits expected and can assure adequate access is available. This approach will also aid the CCOs by reducing time and resources spent on sorting out which OHP member is eligible for which set of benefits. This can reduce administrative overhead inside the CCOs, freeing them and their affiliated providers to focus on alignment across their new organizations, particularly for physical and behavioral health benefits, as well as work towards increased efficiency and quality of care.

Ideally, the MAC would like the adult package enhanced to what is currently offered to children and pregnant women in OHP Plus but were cognizant of the potential increased cost to the state. Committee members felt that aligning all the non-pregnant adults' benefits into a single benefit

package would serve as an initial step in streamlining benefits across Oregon's Medicaid populations.

- ***Enhances funding inside the Global Budget to the CCOs and their communities***

Providing a richer benefit to the OHP Standard population enhances the investment to CCOs and their communities by increasing the base payments to CCOs through enhanced benefit dollars for the OHP Standard population. This population will have fuller benefits in the essential benefit areas of rehabilitative and habilitative services, as well as durable medical equipment, anesthesia services, home health services, and dental services. This will support needed services to OHP members and the health of regional communities and will increase the CCOs' ability to enhance care coordination.

Oregon is looking to move further towards value-based payments to the CCOs, with the global budget and quality incentive pool as first steps. Streamlining the benefits for non-pregnant adults starts to blend available funding streams and supports CCOs to work within the global budget to control costs and increase efficiency of delivering care across the adult OHP population. This uniformity of benefits will facilitate a population-wide assessment and determination of the needs of non-pregnant adults within CCOS and their communities.

- ***Supports Patient-centered Primary Care Home and CCOs to meet the needs of the OHP members***

Transformed delivery systems will aim to provide much of the care needed by OHP members through Patient-centered Primary Care Homes (PCPCH). With the essential benefits obtained through the OHP Plus (non-pregnant adults) benefit package, there will be greater flexibility to get needed services that can return or maintain a member's health, such as occupational and speech therapy or physical/occupational therapy after specific surgeries. While there may be other individualized flexible benefits needed, primary care providers and their PCPCH teams, including community health workers and others will know that all non-pregnant adults in the CCO will be eligible for similar base levels of care needed to manage members' health care needs.

- ***Starts to restore OHP to its original design of a base set of benefits across a population***

Governor Kitzhaber's original vision of the Oregon Health Plan was to "get all the noses under the tent" and to ensure a base set of benefits for members delivered in a coordinated way at the community level. The original OHP started with aligned benefits across the non-pregnant members and the separate package of OHP Standard was created in 2003 to allow the State to maintain some coverage for Oregon's expansion population. Now with the Affordable Care Act, states are expected to offer a more robust package. Oregon and the Governor are simultaneously aiming to enhance care and lower costs through a transformed delivery system. Streamlining the benefits compliments the vision of the Oregon Health Plan both historically and as we move into the future.

**Medicaid Advisory Committee (MAC)
Summary of Public Comment/Testimony to Date December 31, 2012**

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Listed below: summary of public comment or testimony submitted the MAC (mac.info@state.or.us)

Individual	Organization	Summary of Public Comment received Nov 5th-19th and Dec. 13th-31st 2012	Date	Categories
Marilyn Durham	Individual	Ms. Durham has a son who is homeless, disabled by a traumatic head injury, and unable to work due to injury and illness. She hopes the new Medicaid EHB package will speed up the process for those who are disabled and need assistance.	12/26/2012	Disabled
Summary of Public Comment/Testimony received Nov. 5th-19th 2012				
Matthew Sinnott, MHA	Willamette Dental Group (WDG)	WDG supports the proposed benchmark for "new eligibles" under the ACA. WDG believe OHP Plus benefits are consistent with their approach to oral health and dental services. Further that by "defining a meaningful benefit for all Medicaid populations" would mitigate churn issues for Medicaid populations who churn between OHP plan coverage.	11/8/2012	Endorsement
Ted Amann, Director of Health System Development	Central City Concern	Central City Concern fully supports and endorses the preliminary recommendation of the Medicaid Advisory Committee to designate the Oregon Health Plan Plus (for non-pregnant adults) as the state's Medicaid benchmark plan. They believe this plan will provide a robust benefit package for people who are newly eligible for Medicaid benefits under the Affordable Care Act expansion, and provide consistent coverage as people move between eligibility categories. They also believe this approach will minimize administrative burdens and expenses for the Oregon Health Authority by avoiding the need to administer a new benefit package and coordinate benefits as people move between eligibility categories.	11/13/2012	Endorsement
Cherryl L. Ramirez, Director, AOCMHP	Association of Oregon Community Mental Health Programs (AOCMHP)	The AOCMHP was in support of the MAC's recommendation to designate the Oregon Health Plan Plus as the basis for the state's Medicaid benchmark plan. They agreed with the intent to simplify, align, and streamline benefit coverage across the Oregon Health Plan and to minimize disruption for individuals who move among different benefit packages within OHP.	11/20/2012	Endorsement
Estelle Womack	Individual	Ms. Womack believes Medicaid should be expanded to those without health care as far as finances allow and suggests a minimal sliding scale for payment so more people would be covered.	11/9/2012	Endorsement
Deb Kero	Individual	Ms. Kero believes that Chiropractors should NOT BE LIMITED to any specific area of the body. Would like for chiropractors to individually decide what areas they are capable to help people with and not have anyone decide for them.	11/10/2012	Chiropractic
Tom Clunie D.C.	Individual	Dr. Clunie is under the impression that the Benchmark is trying to limit chiropractic solely to spinal manipulations and does not agree with this. He states that chiropractors such as himself have spent years studying and passing on to their patients what it takes to be healthy and has helped many people avoid expensive surgery and drugs.	11/10/2012	Chiropractic
Jennifer Hunking	Individual	Ms. Hunking believes that chiropractors are great doctors who treat a wide range of conditions and is "thankful to have full access to doctors who do not push pills at her."	11/10/2012	Chiropractic
Vern Saboe, Jr, DC., DACAN., FICC., DABFP., FACO.	Individual	Dr. Saboe states that "The preliminary recommended Medicaid Expansion Benchmark Plan erroneously lists "Chiropractic" and "Naturopath: as if these were "services" rather than health care professions which is blatantly inappropriate. This inapplicable listing appears under EHB category 1. Ambulatory patient services" paradoxically the first service listed under this first category is "a. Primary care to treat illness/injury." Many chiropractic physicians across the state act in the capacity of primary care physicians providing evidence-based non-pharmacological interventions for most of the 60 most common conditions presenting in primary care and of course these colleagues treat injuries as well all of which are within our clinical training, scope and licensure. In conclusion, these preliminary recommendations for the Medicaid Expansion Benchmark plan must be amended to reflect this clinical reality."	11/10/2012	Chiropractic
Mrs. Ellie Dicker	Individual	Mrs. Dicker requests chiropractors be allowed to treat all parts of the body. Mrs. Dicker she has been helped by chiropractors for several different types of health issues. She states that chiropractors and naturopaths are health care professionals necessary to her well being and that they are her primary care physicians.	11/11/2012	Chiropractic
Kristin Piacitelli	Individual	Ms. Piacitelli requests that chiropractors continue to treat all parts of the body. Ms. Piacitelli claims has been helped by a chiropractor with a knee injury as well as shoulder pain, toe pain and hip pain at various points in time when no other health care professional helped her with those issues. States chiropractors are trained and experienced with helping people with much more than only the spine. Provided the same comment as Vern Saboe, Jr., on 11/10/2012.	11/12/2012	Chiropractic
Michael Sears, DC, IAYT	Individual	Dr. Sears states chiropractors are experts at evaluating, treating and relieving neuromusculoskeletal complaints, but this is just one aspect of chiropractic care. He states its underlying qualities are to shift the locus of control from external reliance on other to an internal control for one's self. Further that chiropractic care promotes wellness and asks to enable chiropractic care at the highest level of it's licensure to as many of our citizens as possible.	11/12/2012	Chiropractic
Dr. Rob Bodner, LMT, DC	Ridgeline Clinic	Dr. Rob is a chiropractor in Portland and sees a diverse clientele who come to him with an array of maladies. He believes he is a neighborhood doctor who treats various issues and conditions, and is most often seen for musculoskeletal conditions. He makes referrals when the condition is out of his scope of practice. He claims he is affordable compared to many MDs and DOs and that his care is patient centered. He says that the community would be the ones who suffered if the Benchmark plan severely limited the scope of practice for DCs.	11/12/2012	Chiropractic
Lynn Connors	Individual	Ms. Connors is a retired professional dancer who has been working in Oregon's public school system since 1999. Due to stressful work conditions and three accidents, she has been treated by a chiropractor. Due to the effectiveness of the chiropractic treatment, she is able to continue working. Would like to see that people have a choice when it comes to their healthcare.	11/12/2012	Chiropractic
Eric Grace	Individual	Mr. Grace requests that chiropractors continue to treat all parts of the body. He claims he has been helped by his chiropractor with a foot issue, hip issue, shoulder issue, and digestive issues when no other health care professional was able to help him. He states that chiropractors are trained and experienced with helping people with much more than only the spine. He provided the same comment as Vern Saboe, Jr., on 11/10/2012.	11/12/2012	Chiropractic
Penelope J. Levin	Individual	Ms. Levin requests that chiropractors continue to treat all parts of the body. She claims she has been helped by her chiropractor with a foot issue, hip issue, shoulder issue, and digestive issues when no other health care professional was able to help her. She states that chiropractors are trained and experienced with helping people with much more than only the spine. He provided the same comment as Vern Saboe, Jr., on 11/10/2012.	11/14/2012	Chiropractic
Cindy Holloway	Individual	Ms. Holloway has a chiropractor who uses gentle and highly skilled treatment of all muscle and tendon connections as well as cranial facial treatment. She claims she has had better progress with her than most. She does not want to see chiropractors limited to spinal treatment only.	11/14/2012	Chiropractic

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Jerit Fourman	Individual	Mr. Fourman provided the same comments as Dr. Sears on 11/12/2012.	11/14/2012	Chiropractic
JEFFREY LEVIN & PENELOPE LEVIN	Individuals	The Levins provided the same comments as Dr. Sears on 11/12/2012.	11/15/2012	Chiropractic
AJ & Margaret Flores	Individuals	AJ & Margaret Flores provided the same comments as Dr. Sears on 11/12/2012.	11/15/2012	Chiropractic
Sheila M. Walker	Individual	Ms. Walker has a host of musculoskeletal issues that are treated by her chiropractor, whose treatment has done more for her mobility than medication. She would like to see chiropractors be considered to treat beyond spine adjustments.	11/15/2012	Chiropractic
Joe Carroll	Individual	Mr. Carroll is an Oregon resident and patient who has seen a number of board-certified chiropractors in the state of Oregon, and is concerned that the state will be blocking them from any future role outside of neuromusculoskeletal issues. He has found great relief with issues that were not purely NMS and would like to see that chiropractic doctors are not limited from fully helping their patients.	11/15/2012	Chiropractic
Elise G. Hewitt, DC, CST, DICCP, FICC	Portland Chiropractic Group	Dr. Hewitt is a board-certified pediatric chiropractor who provides a comprehensive range of services for her young patients, including adjustments, additional imaging or laboratory testing as needed, other manual therapies, physiotherapies, nutritional supplements, dietary and lifestyle advice, exercise and postural rehab, as appropriate for each patient. In addition, provides wellness and preventative care for children. Her practice is 100% referral based from many health providers, including pediatricians, physical therapists, occupational therapists, lactation consultants, naturopaths and other chiropractors. She also refers to these and other providers as dictated by her patients' needs. She believes that rather than limiting chiropractors to a single service like manipulation, the DC's training and expertise should be used to fill the workforce gap and offer Oregonians an effective, cost effective option to meet their healthcare	11/15/2012	Chiropractic
Kate Adams LMT, LPTA #6704	Individual	Ms. Adams requests that chiropractors continue to treat all parts of the body. She has been helped by her chiropractor for arm, shoulders, feet, cranial bones, jaw, and leg bones, when no other health care professional helped her with those issues. She believed chiropractors are trained and experienced with helping people with much more than only the spine	11/18/2012	Chiropractic
Joseph E. Pfeifer, D.C.	University of Western States	Dr. Pfeifer encourage the Committee to expand the role of chiropractic physicians in the Oregon Health Plan Plus to include the range of services within the profession's scope of training and licensure.	11/19/2012	Chiropractic
Pamela A Jensen, EA	Individual	Ms. Jensen provided the same comments as Dr. Sears on 11/12/2012.	11/19/2012	Chiropractic
Timothy Hill	Individual	Mr. Hill proposes that coverage for "non traditional" therapies such as chiropractic, acupuncture and massage therapy, might be targeted as "Cadillac," given the "opposition to the Affordable Care Act." This might undermine the success of the project. He "would love to see this as the first steps toward a single-payer system, and understand that excellent coverage would be one of the major attractions to getting people enrolled."	11/3/2012	Coverage for non-Traditional Providers
Rosalie Czerwinski	Individual	Ms. Czerwinski would like for naturopaths, chiropractors and acupuncturists to be included in the plan. She states "they have been invaluable for many of us" and due to the care and instruction of these providers no longer takes any pharmaceuticals and as is in good health.	11/5/2012	Coverage for non-Traditional Providers
Joe Marrone	Individual	Mr. Marrone thinks the benefits package is reasonable and understands tradeoffs have to be made. He would like to see inclusions for dental benefits that would have large scale health benefits and some savings to general health down the road. He believes untreated dental problems are a major health problem that preventive care has a major impact on.	11/5/2012	Dental
Ruth McEwen	Individual	Ms. McEwen recommended that the durable medical equipment benefit needed to be re-examined for sufficient coverage as it cuts across all populatoins. She reinforced that appropriate DME can cause a person to be more independent and less dependent on other services in the system.	11/28/2012	Durable Medical Equipment
Anonymous	Individual	Individual is a dentist and claims the information provided does not specify who will qualify and for what plan and what the actual benefits may be. He would also like to see better reimbursement for providers serving OHP clients, because "without practitioners, there is no ACA, or OHP." He would like to for OHP clients to have "more skin in the game by	11/2/2012	Enhanced reimbursement
Julia Lager-Mesulam, LCSW, Director	Partnership Project	Mrs. Lager-Mesulam states that what is critical in decreasing the number of new HIV infections is to ensure that annual HIV screening or as needed is covered at 100%. To add to that list would also be STD and Viral Hepatitis screenings and treatments.	11/14/2012	HIV
Paul Denouden	Individual	Mr. Denouden would like to make sure routine HIV testing is covered and that a plan is put in place to proactively make sure it is done in patients per the recommended CDC guidelines, and for those who are HIV-positive that all HIV antiretrovirals are covered without exclusions or formulary restrictions.	11/16/2012	HIV
Kahreen Tebeau, Associate Director of Public Policy	Oregon Association of Hospitals and Health Systems	Ms. Tebeau on behalf of the OAHHS, believes that the selection of OHP Plus, and the Medicaid expansion itself, represents a huge opportunity to expand access and coverage for many of Oregon's most vulnerable people. Oregon hospitals are supportive of OHP Plus as the benchmark selection and believe that aligning benefits across the Medicaid program benefits patients, the State, and hospitals and other providers that deliver care to Medicaid clients. It promotes administrative simplification, and has the potential to lower costs downstream by providing more comprehensive coverage to the newly eligible— many of whom will have high health needs that have gone unattended due to lack of previous coverage. In the short term – should the Governor choose to opt-in to the Medicaid expansion– we all win. The federal government will pay 100% match for providing these benefits to the newly eligible for 3 years. However, in the longer term, as we wrestle with a potential state budget shortfall in funding the current Medicaid program, and as the federal match rate ratchets down to 95% by 2017 and 90% by 2020, Oregonians will have to find a way to fund this expansion	11/12/2012	Hospital Association
Rachel E. Seltzer, MD	Oregon Health & Science University	Ms. Seltzer provides recommendations to improve population health among Oregon's Medicaid population: 1) Access to information about health, and access to health services (including access to Medicaid programs) that is comprehensible. 2) Improved access to health services for Medicaid recipients. 3) Integration of behavioral health services is requisite for population health. 4) Inclusion of oral health services in the mainstream delivery system model. 5) Improve reimbursement for pediatricians and other providers treating children to help ensure that children have	11/6/2012	Population Health

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Individual	Organization	Summary of Public Comment received Nov 5th-19th and Dec. 13th-31st 2012	Date	Categories
Anonymous	Medicaid recipient	This person believes that the increasing coverage of non-disabled recipients is taking away from Medicaid funding for Medicaid services for the disabled, this "resulting in Oregon's system being a failure at what it claims to be doing for the APD population." Individual He believes that "connecting" Medicaid to Medicare standards also results in less dollars and services, resulting in a failing system for the APD population. Would like to see OHP disconnected from Medicare standards. States that "Medicaid is meant to look at in-home and community needs, Medicare institutionalizes recipients by looking at "in-home use only." Respondent would like to see three areas discussed in more depth: 1) Durable Medical Equipment, 2) Physical & Occupational Therapy, and (3) Coverage for homecare workers to assist their consumer employers while in the hospital. Another option is to consider connecting OHP to Medicare with no changes and use it as the Benchmark Plan, but also create an "APD Medicaid". For dual eligibles they could have the option of continuing with OHP or switching to APD Medicaid as the CCOs are doing. This would result in fluctuating the enrollment numbers for each plan but it would stop limiting and institutionalizing the APD population due to the rapid growth of the Medicaid population.	11/15/2012	Medicaid recipient
Alison Goldstein, LCSW	Individual	Ms. Goldstein would like to see mental health counseling services covered in the Benchmark plan.	11/15/2012	Mental health counseling
Laura Culberson Farr	Oregon Association of Naturopathic Physicians	Ms. Farr indicated that the OANP is encouraged that the Committee's preliminary recommendations include integrating naturopathic physicians as a provider type. She states that by listing naturopathic doctors among the provider types eligible to provide primary care will bring the Medicaid system in its entirety into alignment with both state and federal regulations relating to non-discrimination against providers. (ORS 414, Section 4, Chapter 80: S.2706 Affordable Care	11/19/2012	Naturopath
David B Lashley, MD, FAAP	Randall Children's Hospital	Dr. Lashley inquired about the coverage for newborn circumcision, which he claims "is a procedure covered by all commercial plans in the state and by some of the current Medicaid managed care plans."	11/4/2012	Newborn circumcision
Leah Brandis, RD,LD	Individual	Ms. Brandis is a member of the Oregon Academy of Nutrition and Dietetics and a Registered Dietitian in Oregon. She believes the current limit of the Essential Health Benefits for nutrition counseling is only 5 visits per lifetime and believes this is too low to provide significant outcomes in patients' chronic disease management. She proposes that the limit be increased to 2 visits per year for 5 years or until the issue is resolved	11/18/2012	Nutrition
Sonja L. Connor, MS, RD, LD	Endocrinology, Diabetes and Clinical Nutrition Oregon Health & Science University	Ms. Connor provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Nancy Becker MS RD LD	Individual	Ms. Becker provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Terese M. Scollard MBA RD LD	Individual	Ms. Scollard made the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition she writes for acute disease such as cancer of the head, neck and GI tract or other medical diagnoses that cause significant nutritional impairment and malnutrition, a minimum of 3 hours in the initial year of acute disease and 2 hrs/year thereafter until resolved is more reasonable for effective prevention and treatment and to better avoid rescue costs of malnutrition in hospital	11/19/2012	Nutrition
Tracy Ryan-Borchers, PhD, RD, LD	Individual	Ms. Ryan-Borchers provided the same comment re nutrition counseling as Ms. Scollard on 11/19/12.	11/19/2012	Nutrition
Patty Case, MS, RD	Oregon State University Klamath Basin Research & Extension Center	Ms. Case provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Angela Mathison Treadwell, RD	Umatilla-Morrow Head Start, Inc.	Ms. Mathison Treadwell provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Nicole Hanks	Individual	Ms. Hanks provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Carol Walsh, MS, RD, LD, CDE	The Corvallis Clinic	Ms. Walsh provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Kristie M. Gorman, RD, CSG, LD	Providence St Vincent Medical Center	Ms. Gorman provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition she claims that fewer people would be hospitalized and those hospitalized would likely have better health outcomes if they were followed by a dietitian to help manage their chronic diseases. Also she states that Oregonians should lead the way in preventing/delaying complications of chronic disease and helping our senior citizens reduce obesity.	11/19/2012	Nutrition
Ingrid Skoog	Individual	Ms. Skoog made the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition she states that the research clearly shows that a support system for behavior change results in better outcomes than knowledge only and that the RD represents a very cost effective partner in helping high risk individuals and those with already diagnosed chronic diseases improve their health and reduce long term health care costs	11/19/2012	Nutrition
Kati Thompson RD LD	Lambert House & Marie Smith Center	Ms. Thompson provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Kimra Hawk, RD, LD	Providence St Vincent Medical Center	Ms. Hawk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Joan Medlen	Individual	Ms. Medlen writes to encourage the availability of nutrition counseling and education for the Oregon Medicaid Benchmark Plan by increasing the number of visits for nutrition counseling as well as the number of dietitians available. She states that people with intellectual and developmental disabilities (IDD) are the types people she serves through the CCOs and that it is difficult to effectively counsel for any diagnosis for this population. She states that making nutrition counseling available through CCOs is in line with the Governor's vision for obesity reduction and prevention. She states that RDs are specialized in serving people with IDD to help and support them through these issues.	11/19/2012	Nutrition
Tina Gruner, M.S., R.D., C.D.E. I.D.	Individual	Ms. Gruner provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition

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Individual	Organization	Summary of Public Comment received Nov 5th-19th and Dec. 13th-31st 2012	Date	Categories
Ginger Terry, MA, RD	VA Medical Center, Roseburg, Oregon	Ms. Terry provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Angela Hermes, RD, LD, CLT	Nourishing Transitions	Ms. Hermes provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Cary Fardal, RD	Oregon State Hospital	Ms. Fardal provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Amy Floreen, RD, LD	Balance, Nutrition and Management Consulting	Ms. Floreen provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Kathy Schwab, MPH, RD	Providence Health & Services	Ms. Schwab provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Beth Schwenk, MS, RD, CDE	Providence Seaside Hospital	Ms. Schwenk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Erin Wicklund, RD, LD	Providence	Mr. Wicklund supports more nutrition counseling for improved outcomes and claims that 5 visits per lifetime is too low. He states that it takes time and access to follow up for patients to implement lifestyle changes.	11/19/2012	Nutrition
Joy Jordan, RD	Avamere Living	Ms. Jordan provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Vicki L Duesterhoeft, MS, RD, LD	Oregon State Hospital	Ms. Duesterhoeft provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Marilyn Bacon, RD, LD, CNSC	Individual	Ms. Bacon provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jacque DeVore, RD, MPH	Shriners Hospital for Children	Jacque Devore provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jennifer Lehman, RD, LD, CDE	Sky Lakes Diabetes Services	Ms. Lehman provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Karen Huntzinger, MS, RD, CSO	Salem Hospital	Ms. Huntzinger provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Cheryl Kirk, R.D., L.D.	Individual	Ms. Kirk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christopher M Konczyk, MS, RD, LD	Salem Health	Mr. Konczyk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Shannon Agee	Individual	Ms. Agee provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christina Heiberg, RD, LD	Providence St. Vincent Medical Center	Ms. Heiberg provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jane Eyre Schuster, RD, CDE	Diabetes Program Coordinator I Legacy Meridian	Ms. Schuster provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Niki Streatly, RD, LD	Strategic Nutrition, LLC	Ms. Streatly provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Allison Forney, RD	Individual	Ms. Forney provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Katie M. Dodd, MS, RD, LD	VA Southern Oregon Rehabilitation Center and Clinics	Ms. Dodd provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition, she works with the Veterans Health Administration in Southern Oregon coordinating a weight management program and providing medical nutrition therapy for patients in their homes for a variety of health reasons, including managing diabetes, heart disease, weight management, prevention of unintentional weight loss, dysphagia, among many other medical conditions. She claims that Initial education and counseling is important, but it is the follow-up that truly makes a difference. For her results in weight management patients, she provides "intense and sustained" counseling which means 8+ visits in a 4 month time period. For my patients in home care, follow-up varies from once per week to once per year, depending on their medical needs. She has also provided medical nutrition therapy to a patient with end stage liver disease for monthly visits and has seen the patient's quality of life improved and the cost to our health care system reduced.	11/19/2012	Nutrition
Joanna Helm	Oregon Health and Science University	Ms. Helm provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Michele Shrum Guerrero, RD, LD	Individual	Ms. Shrum Guerrero provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Natasha Luff, RD, LD	Individual	Ms. Luff provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Ron George	Individual	Mr. George provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Melissa Pence, RD, LD	Individual	Ms. Pence provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christen L Wiley, DTR	Individual	Ms. Wiley provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition

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Maureen McCarthy, MPH, RD, CSR, LD	Oregon Health & Science University	Ms. McCarthy provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Athena Nofziger RD,LD,CHC	Samaritan Lebanon Community Hospital	Ms. Nofziger provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
John Gobble, DrPH, RD, LD, MCHES	Medical Nutrition Therapy Northwest	Mr. Gobble provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Sareena Smith-Bucholz, BS	Oregon Health & Science University	Ms. Smith-Bucholz provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jennifer Kennedy RD, LD	Providence St. Vincent Eating Disorder Program	Ms. Kennedy provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Angela Johnson, RD, LD	Samaritan Bariatric Program	Ms. Johnson provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Valerie Edwards, MS, RD, LD	Providence Portland Medical Center	Ms. Edwards provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Andrea Q Vintro, MS, RD, CSSD, LD	The KOR Physical Therapy and Athletic Wellness	Ms. Vintro provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Ann Fujii, MPH, RD, LD, CDE	Individual	Ms. Fujii provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Verdie Hicks, CDM, CFPP	Green Valley Rehab	Ms. Hicks provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Denise Cedar, RD, LD, CDE	Individual	Ms. Fujii provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Andrea Smith, RD LD	Individual	Ms. Smith provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christine Poniewozik	Individual	Ms. Poniewozik provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Esther Teerman RDI, D	Individual	Ms. Teerman provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Erin Dooher, Clinical Dietitian	Samaritan Pacific Communities Hospital	Erin Dooher states that the current Benchmark plan for nutrition counseling is below and standard she is familiar with. She references diabetes as the "upcoming biggest concern for our country's medical expenses in the next 30 years." She states the current benchmark severely undeserving the following patients: Type 2 diabetes mellitus, Adult weight management, Pediatric weight management. She says for diabetes visits, they do 13 hours in the first year of diagnosis, and 2-3 visits/year in each subsequent year. This is a minimum standard fully reimbursed by Medicare. For pediatric obesity, they so six visits over regular intervals, and this is covered by many insurance plans. She proposes the limit be increased to a minimum of 2 visits per year for 5 years or until the issue is resolved.	11/19/2012	Nutrition
Theresa Anderson RD LD	Samaritan Diabetes Education	Ms. Anderson would like for nutrition intervention to be covered. She states that it is cost-effective and that many physicians and nurses do not have time to do nutrition counseling and have also not likely been trained to do it.	11/19/2012	Nutrition
Kathleen Huntington MS, RD, LD		Ms. Huntington believes a restriction to five nutrition counseling sessions, per lifetime, does not address the clinical needs of patients diagnosed with inborn metabolic errors (IEM). This arbitrary restriction compromises the goal of implementing preventative care that is a major tenet of the Newborn Screening system. The Oregon Medical Foods law passed in 1997, 2003 (Senate Bill 74) and 2009 (Senate Bill 9) indicates that – "...Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment...."	11/19/2012	Nutrition
Sandy Jolley, RD, CDE	Silverton Health	Ms. Jolley provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Sharon M. Fox, MHA	Children's Health Alliance	Children's Health Alliance believes it is important for the Medicaid Essential Health Benefit package to consider the following: 1) Habilitation services should be offered in parity with rehabilitation services for adults. We recommend that Oregon define "habilitation" based on the NAIC/HHS Uniform Glossary definition. 2) Coverage for drugs and biologics for use by children should consider children's' special needs and the stage in their life course. 3) Coverage for durable medical equipment should consider children's developmental course and implications for long term consequences. 4) Coverage which promotes physical, mental and behavioral health integration for children without requiring a defined diagnosis, e.g. mental illness. 5) Denial of certain services based on the Prioritized List and the current funding Line can have significantly different outcomes and life-long consequences for children when applied uniformly to children and adults.	11/19/2012	Pediatric coverage

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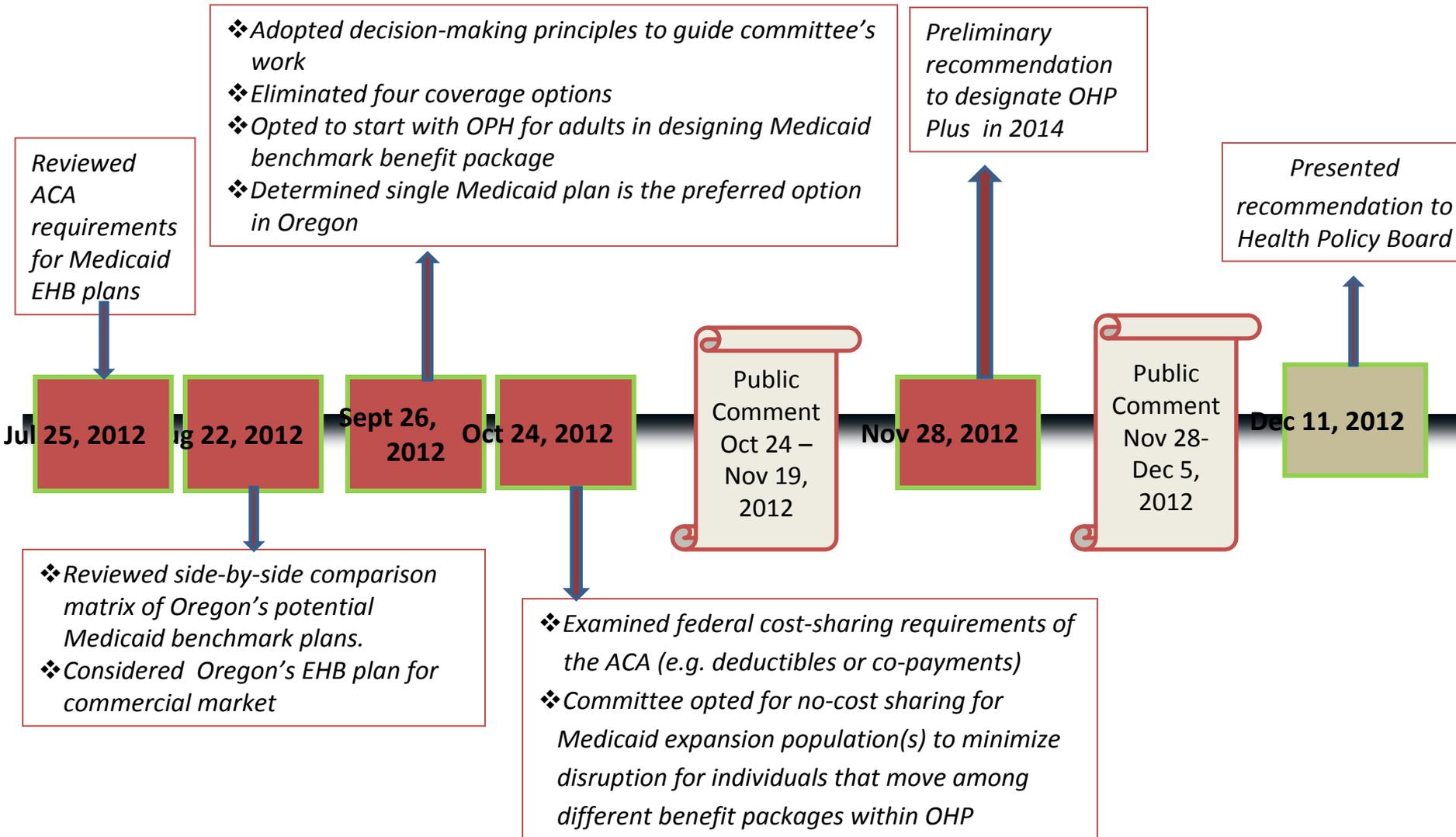
Individual	Organization	Summary of Public Comment received Nov 5th-19th and Dec. 13th-31st 2012	Date	Categories
Charlie Pioli	Individual	Mr. Pioli believes he has done a good job combating his PKU, which is inborn metabolic error, but believes that he and his family couldn't have managed without a strong healthcare plan. He drinks a powdered milk that acts as a substitute for regular protein; a single can of it is very expensive. Mr. Piolo request that he and his sister who also has PKU, and his family, be considered when a decision is made regarding the Benchmark.	11/14/2012	PKU
Chris Baillie	Individual	Mrs. Baillie has 3 children with PKU and has been dealing with this metabolic condition their whole lives and knows firsthand how expensive it would be to treat it if they didn't have insurance that covered their required metabolic food. <u>She hopes that her kids will never have to worry about how to get their food.</u>	11/14/2012	PKU
Adray Dull	Individual	Adray Dull is the parent of a child who requires Phenylade formula to maintain a normal healthy life. Their family is only able to afford the formula due to the coverage provided by their health care plan. They encourage the coverage of this formula.	11/14/2012	PKU
Michael D. Mann	Individual	Mr. Mann has two family members born with PKU who need a food supplement, which is very expensive. He asks that <u>the new health plan provide coverage for adults who need this type of food supplement.</u>	11/14/2012	PKU
Diane C Williams M.D.	Individual	Dr. Williams would like to see that adults with inborn errors of metabolism (such of PKU) be included on the insurance coverage. She states that these disorders are inherited and do not go away and that the medical foods are expensive and prohibitive for many people. Inability of stay on dietary control can result in significant difficulties and should be considered a medical necessity. Dr. Williams is a pediatrician and grandmother of a 12 year old child with PKU and can <u>attest to this important medical need.</u>	11/14/2012	PKU
Mary Jo Mann	Individual	Mrs. Mann has two children with PKU. She states that her family has been fortunate to have access to insurance coverage for her children's treatment and formula. She says the cost of coverage for this essential treatment is beyond the reach of the average person. She would like to see the Metabolic formula and low protein benefits for PKU and <u>other metabolic disorders be covered in the Essential Benefits.</u>	11/14/2012	PKU
Evan Kruse	Individual	Mr. Kruse would like to see the coverage for Medical Formula and low-protein foods and include lifetime coverage for <u>these items in the Essential Health Benefits package.</u>	11/14/2012	PKU
Makenzie L. Wesner	Individual	Ms. Wesner writes to express concern about Benefit 10 in the Illustration of Total Essential Health Benefits. She would like to see coverage of "Metabolic formula and low protein food for inborn errors of metabolism" for children and adults.	11/17/2012	PKU
Laura Goode	Individual	Ms. Goode writes to express the importance for insurance coverage for children, as well as adults with an EIM.	11/17/2012	PKU
B. Nicole Dean	Individual	Ms. Dean would like to see coverage of PKU for adults as well as children.	11/18/2012	PKU
Neil R. M. BuistMD	Individual	Dr. Buist would like to see coverage for PKU treatments for adults as well as children.	11/18/2012	PKU
Sarah C. Pearson	Individual	Ms. Pearson would like to see coverage of medical formula and medical low protein foods insured by private or public insurance groups, once children are grown.	11/19/2012	PKU
Laura Terrill Patten, Executive Director	Planned Parenthood Advocates of Oregon	Planned Parenthood Advocates of Oregon has reviewed the preliminary recommendation for the Medicaid Benchmark Plan and generally supports the comprehensive approach to women's health care coverage. However, there are a few items we would like to see addressed with greater specificity to better clarify and ensure consistent treatment of women who move between different benefits packages in Oregon: 1) Prescription birth control: We would like to see clarification in language regarding contraception and propose coverage of "All FDA-approved prescription contraceptive methods and devices" as outlined in ORS 743A.066. 2) Birth control services: in accordance with current law (743A.066), we would like to see clarifying language regarding related birth control services, "outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive." 3) Women's preventive health care screenings: mammography and pelvic exams/PAP tests are specifically listed in the preliminary recommendation, but "physical examination of the breast" as outlined in ORS 743A.108 is not. They would like to see that added.	11/16/2012	Reproductive Health
Wendy J. Edwards, MPA:HA	Samaritan Health Plans	SHP believes the proposed benchmark seems to go beyond the essential health benefit requirements and that OHP Standard better aligns with the ACA requirements. They identify three coverage areas where OHP Plus stands out from OHP Standard: 1) Chiropractic services, 2) Dental services, and 3) Stay limitations - there are no limitation on rehabilitative and habilitative services or devices in OHP Plus, specifically related to inpatient, massage, physical and occupational therapy and speech therapy. The Medicaid benchmark plan does not clearly explain the impact of funding limitations and the relationship to the prioritized list. They recommend that the MAC reconsider OHP Standard as the <u>recommended EHB for Oregon.</u>	11/8/2012	Recommend OH P Standard

Oregon Medicaid Essential Health Benefits

Recommendation from the Medicaid Advisory Committee

Jim Russell, Committee Co-chair
Oliver Droppers, Committee staff, OHP

OREGON MEDICAID BENCHMARK BENEFITS – DECISION TIMELINE



Public Input

- Public comment received via the email and submitted to staff
 - Initial comment period: November 5th thru 19th
 - Second comment period: December 13th thru 31st
- Received 100+ comments from interested parties
- Comments focused on increasing specific covered services and benefits
 - Appropriate comments forwarded to the Health Evidence Review Commission
- Comments generally supportive of recommendation

Medicaid Benchmark Decision-Making Principles

1. Alignment with Oregon's Triple Aim and CCOs
2. Ensure inclusion of all federal benefit categories and identify meaningful differences in coverage
3. Acknowledge value-based benefits, potential cost-sharing relative to income, and flexible utilization of covered services to avoid future costs
4. Appropriate balance of benefits among statutorily required categories so benefits are not unduly weighted toward any category
5. Account for the health care needs of all adult Oregonians, with a focus on benefits that may address social determinants of health
6. Consider impact on coverage and benefits for individuals that transition between OHP and the commercial market
7. Consider administrative implications when selecting preferred benefit package including minimizing disruption to OHP

Final Recommendation

Action Item Request for endorsement of the committee's final recommendation

Recommendation The committee recommends the **Oregon Health Plan *Plus*** (for non-pregnant adults) to be the state's Medicaid benchmark plan.

Key Decision Points

- Ensure alignment with Oregon's Triple Aim and Coordinated Care Organizations and federal requirements in the ACA.
 - Simplify, align, and streamline benefit coverage across the Oregon Health Plan.
 - Aim to meet all health care needs of adult Oregonians eligible for OHP.
-

Selection of Medicaid Benchmark & Transformation

- Offers Administrative Simplification to OHP Benefits to aid CCOs' Transformation Efforts
- Enhances funding inside the Global Budget to the CCOs and their communities
- Supports Patient-centered Primary Care Home and CCOs to meet the needs of the OHP members
- Starts to restore OHP to its original design of a base set of benefits across a population

Questions?

Medicaid Advisory Committee:

www.oregon.gov/OHA/OHPR/Pages/MAC/MACwelcomepage.aspx

Email: Mac.info@state.or.us

Oregon
Health
Authority

Update: Joint Early Learning Council/Oregon Health Policy Board Subcommittee

-Initial meeting held December 20:

1) First half of meeting devoted to organizational discussion:

- **Introductions**
 - *New*: Erinn Kelley-Siel , Director of DHS, will represent DHS on subcommittee
- **Review and confirmation of charter**
 - Charge, deliverables, timeline reviewed
- **Generation of guiding principles** for subcommittee work;
 - Principles drawn from foundational ELC/OHPB documents and DHS priorities; plus *new* principles considered for joint work
 - Themes included:
 - Focus on local (innovation, flexibility, empowerment)
 - Customer-driven/family focused
 - Simplification (e.g. experience of families, releases/information sharing for providers)
 - “Share” (communication, accountability, outcomes; a culture shift)
 - Reduce duplication (e.g. care coordination)
 - Coordinated and integrated care (all parties involved, e.g. DHS, CCOs, ELC)
- **Information Sharing**
 - Updates provided for Health System Transformation, Early Learning Council and Department of Human Services; common themes noted across transformation activities

2) Second half of meeting devoted to Prioritization Discussion

- **Subcommittee priorities**
 - The subcommittee began to identify short-term and long-term priorities for their work:
 - Short-term: what is needed immediately to inform anticipated Request for Applications (RFAs) for “early learning hubs”, future CCO contracts, etc.
 - Long-term: emphasis on culture change, simplification, innovations, etc.
 - Topics that emerging as possible priorities:
 - Outcomes (shared and/or coordinated e.g. kindergarten readiness; including tracking, streamlining)
 - Shared community assessment and planning
 - Care coordination across systems
 - Communication: enhanced /simplified; navigating privacy policies
 - Governance: cross system relationships (e.g. MOUs, transformation plans)
 - Data system plans across systems- mapping, gap analysis

Future meetings: ~bimonthly through 2013 (next: February 5th, 9-12)

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Charter: Early Learning Council/Oregon Health Policy Board Joint Subcommittee

Date Approved: 11/13/12 (OHPB), 11/15/12 (ELC)

AUTHORITY

HB 2009 established the Oregon Health Policy Board (OHPB), a nine-member board appointed by the Governor and confirmed by the Senate. The Board serves as the policy-making and oversight body for the Oregon Health Authority (OHA) and is responsible for implementing the health policy reform provisions of HB 2009. Since the Board's establishment, the passage of HB 3650 (2011) and HB 1580 (2012) have provided the framework for transitioning to an integrated and coordinated health care delivery system through Coordinated Care Organizations (CCOs).

SB 909 (2011) established the Oregon Education Investment Board (OEIB) and the Early Learning Council (ELC), a nine-member Governor-appointed committee. The Council is responsible for assisting the OEIB in overseeing a unified system of early learning services for the purpose of ensuring that children enter school ready to learn by kindergarten. HB 4165 (2012) expanded the Early Learning Council to serve as the state advisory council for the purpose of the federal Head Start Act. To fulfill this role, the Council was expanded to nineteen members. By February 2013, the ELC is responsible for submitting a report to the Legislature on a regional system of early learning services including the functions and administration of community-based coordinators.

Subcommittee membership & Governance

Executive Sponsors:

Jada Rupley, Early Learning Director

Tina Edlund, Chief of Policy, Oregon Health Authority (OHA)

Staff:

Dana Hargunani

Jennifer Gilbert

Subcommittee Members:

Pam Curtis, ELC

Teri Thalsofer, ELC

Janet Dougherty-Smith, ELC

Mike Bonetto, OHPB

Carla McKelvey, OHPB

Erinn Kelley-Siel, DHS

Scope

This subcommittee is responsible for developing strategies, a policy framework and a timeline to ensure alignment and/or integration between health care and early learning system transformation. The subcommittee will adopt guiding principles to direct their work (e.g. maximizing use of existing resources and decreasing duplication), with guidance from the founding principles of the OHPB and ELC. Key areas of focus for the subcommittee may include, but are not limited to: screening, care

Revision Date:

coordination, data, and metrics. The subcommittee will consider avenues for shared responsibility towards the outcome of kindergarten readiness for all Oregon children. The subcommittee will assess potential health and early learning policy impacts on the delivery system and outcomes for children and families. As requested upon adoption by the ELC, the subcommittee will be responsible for addressing implementation of screening tools.

Major Deliverables

- A set of guiding principles
- Assessment of key areas for potential alignment and/or integration across health and early learning, including review of existing evidence
- Strawperson proposal for alignment and/or integration of health and early learning policy and service delivery
- Proposal and timeline for establishing kindergarten readiness as a shared outcome

Exclusions or Boundaries

Policy implementation will not be carried out by this subcommittee. Recommendations will be brought forth to the Oregon Health Policy Board and Early Learning Council for decision-making. Prior legislative responsibilities and/or requirements placed on the Oregon Health Policy Board or Early Learning Council are excluded from this charter.

Dependencies

- Oregon Health Policy Board: health policy
- Oregon Education Investment Board: P-20 education policy
- Early Learning Council: early learning policy
- Metrics and Scoring Committee: CCO metrics
- Federal privacy policies: FERPA, HIPAA

Schedule

The joint subcommittee will meet bimonthly. The frequency of meetings may be altered to fit legislative timelines and/or other needs that arise. The subcommittee charter will end by December 2013 or when the ELC and OHPB accept their charter as completed.

Deliverable Timeline:

- 12/2012- Subcommittee convenes; guiding principles adopted
- 4/2013- Background work completed
- 8/2013- Strawperson proposal presented
- 10/2013- ELC, OHPB review completed
- 12/2013- Final proposal delivered

Revision Date:

MEMO

DATE: January 8, 2013
TO: Oregon Health Policy Board
FROM: OHPR, Staff to the Medicaid Advisory Committee
RE: Selection of the Medicaid Benchmark and Health System Transformation

At the December 2012 Board meeting, members requested an explanation of how the Medicaid Advisory Committee's (MAC) recommendation for the Oregon Health Plan (OHP) Plus (non-pregnant adults) benefit package to serve as Oregon's Medicaid benchmark aligns with overall Transformation efforts in Oregon. This memo is provided in response to that request.

As outlined in the recommendation letter to the Board and in the December presentation, states are required to determine the benefit package they will use for current Medicaid expansion populations such as Oregon's OHP Standard beneficiaries, as well as future expansion populations should the State elect to expand in 2014. Because current OHP Standard benefits do not align with the Affordable Care Act's Essential Benefit requirements, the MAC spent several months reviewing other options and ultimately recommended that OHP Plus (for non-pregnant adults) be the state's Medicaid benchmark plan. Current transformation efforts were a major consideration in the MAC's review and recommendation process; several MAC members are involved with CCOs or other aspects of transformation and could speak directly to changes to the delivery of care to Medicaid enrollees. Some of the ways in which the Medicaid EHB recommendation supports transformation are outlined below.

- ***Offers Administrative Simplification to OHP Benefits to aid CCOs' Transformation Efforts***
With three separate packages in OHP (OHP Plus for children/pregnant women; OHP Plus for non-pregnant adults; and, current OHP Standard for expansion adults)—it can be administratively burdensome for the plans, providers, and members to manage benefits. Working to move all non-pregnant adults to a single package will help ensure that CCOs, providers, and members all understand the base benefits expected and can assure adequate access is available. This approach will also aid the CCOs by reducing time and resources spent on sorting out which OHP member is eligible for which set of benefits. This can reduce administrative overhead inside the CCOs, freeing them and their affiliated providers to focus on alignment across their new organizations, particularly for physical and behavioral health benefits, as well as work towards increased efficiency and quality of care.

Ideally, the MAC would like the adult package enhanced to what is currently offered to children and pregnant women in OHP Plus but were cognizant of the potential increased cost to the state. Committee members felt that aligning all the non-pregnant adults' benefits into a single benefit

package would serve as an initial step in streamlining benefits across Oregon's Medicaid populations.

- ***Enhances funding inside the Global Budget to the CCOs and their communities***

Providing a richer benefit to the OHP Standard population enhances the investment to CCOs and their communities by increasing the base payments to CCOs through enhanced benefit dollars for the OHP Standard population. This population will have fuller benefits in the essential benefit areas of rehabilitative and habilitative services, as well as durable medical equipment, anesthesia services, home health services, and dental services. This will support needed services to OHP members and the health of regional communities and will increase the CCOs' ability to enhance care coordination.

Oregon is looking to move further towards value-based payments to the CCOs, with the global budget and quality incentive pool as first steps. Streamlining the benefits for non-pregnant adults starts to blend available funding streams and supports CCOs to work within the global budget to control costs and increase efficiency of delivering care across the adult OHP population. This uniformity of benefits will facilitate a population-wide assessment and determination of the needs of non-pregnant adults within CCOS and their communities.

- ***Supports Patient-centered Primary Care Home and CCOs to meet the needs of the OHP members***

Transformed delivery systems will aim to provide much of the care needed by OHP members through Patient-centered Primary Care Homes (PCPCH). With the essential benefits obtained through the OHP Plus (non-pregnant adults) benefit package, there will be greater flexibility to get needed services that can return or maintain a member's health, such as occupational and speech therapy or physical/occupational therapy after specific surgeries. While there may be other individualized flexible benefits needed, primary care providers and their PCPCH teams, including community health workers and others will know that all non-pregnant adults in the CCO will be eligible for similar base levels of care needed to manage members' health care needs.

- ***Starts to restore OHP to its original design of a base set of benefits across a population***

Governor Kitzhaber's original vision of the Oregon Health Plan was to "get all the noses under the tent" and to ensure a base set of benefits for members delivered in a coordinated way at the community level. The original OHP started with aligned benefits across the non-pregnant members and the separate package of OHP Standard was created in 2003 to allow the State to maintain some coverage for Oregon's expansion population. Now with the Affordable Care Act, states are expected to offer a more robust package. Oregon and the Governor are simultaneously aiming to enhance care and lower costs through a transformed delivery system. Streamlining the benefits compliments the vision of the Oregon Health Plan both historically and as we move into the future.

***Summary: Oregon's 1115 Medicaid Demonstration
Accountability Plan and Expenditure Trend Review***

Agreement that establishes the methods, measurements and accountability for Oregon's Health System Transformation.

The Oregon Health Authority has reached a final agreement with the Centers for Medicare and Medicaid Services (CMS) as required by the Special Terms and Conditions (STCs) of Oregon's Section 1115 demonstration. The agreement outlines the methods, measurements and accountability for the state's plan to improve health and lower costs for people served by the Oregon Health Plan/Medicaid. The signed agreement supports Oregon's move toward a model of outcome-based, coordinated care. It also points the way to a health care system that is flexible, transparent and sustainable in the future.

Oregon's Accountability Plan describes how Oregon and Coordinated Care Organizations will be held accountable for reducing the growth in Medicaid expenditures while also improving health care quality and access. The document also describes CMS's commitments to Oregon, including a significant federal investment to support health system transformation.

The Accountability Plan is divided into two sections:

Section A:

- Part I: Quality Strategy
- Part II: Statewide Tests for Quality and Access
- Part III: Measurement Strategy

Section B: Draft Expenditure Review Plan

Section A, Part I: Quality Strategy

Traditionally, a Medicaid Quality Strategy is the document by which states identify their vision and strategy for quality, oversight and compliance with federal regulations for managed care. With the Accountability Plan, both Oregon and CMS are shifting toward a new model, encouraging a broad array of supports that focus on continuous learning, rapid cycle improvement and transformation. The Quality Strategy describes how CCOs will be held accountable for a new model of care within Medicaid that relies upon increased transparency, clear expectations, and incentives for improvement.

Highlights include:

- *Oregon's goals* in the areas of lower costs, improved quality of care, access to care, experience of care, and population health;
- *Improvement strategies* that include both stimuli (such as transparency and incentives) and supports (e.g., significant investment in measurement, analytics and evaluation)

Section A, Part II: Statewide Tests for Quality and Access and Overall Demonstration Evaluation

Statewide Quality and Access Test:

CMS requires that the state conduct a rigorous annual assessment of quality and access to ensure that the demonstration's cost control goal is not being achieved at the expense of quality. If quality and access diminish at the statewide level the state will face significant financial penalties. Part II of the Accountability Plan also includes overall monitoring and evaluation plans to support rapid feedback and continuous quality improvement .

Evaluation:

Quarterly reporting and public reporting of data and metrics will be aimed at providing timely and actionable feedback to CCOs, the state, and CMS on an ongoing basis.

There will also be more formal evaluations conducted by external, independent contractors that will employ sophisticated analytic methods in order to determine whether changes in quality and outcomes resulted from the state's transformation activities.

Section A, Part III: Measurement Strategy

The measurement of progress is a critical feature of the demonstration project. By tracking achievement on a variety of metrics, Oregon will be able to evaluate CCO performance, and CMS will be able to evaluate Oregon's progress. Part III describes measurement strategies to support both CCO-level quality activities as well as statewide quality activities.

The metrics evaluate performance in access to care, member satisfaction with care, and quality of care in seven focus areas: (1) Improving behavioral health/physical health coordination; (2) improving perinatal and maternity care; (3) reducing preventable rehospitalizations; (4) ensuring care is delivered in appropriate settings; (5) improving primary care; (6) deploying care teams to reduce unnecessary and costly utilization by super-utilizers; and (7) addressing population health issues. (See page 4 of this document for a complete list of the measures.)

Oregon's performance on health care quality and access will be evaluated by CMS using the metrics that follow at the end of this document. CCO quality pool payments will be determined by performance on the metrics set, "CCO Quality Pool Metrics."

Section B - Draft Expenditure Trend Review:

Under Oregon's approved waiver, the state agreed to reduce the Oregon Health Plan's per capita medical expenditure trend (i.e., the increase in capitation) by 2 percentage points over the final three years of the demonstration.

The 2 percentage point reduction will be evaluated based on expenditures for:

- All services provided through CCOs over the course of the demonstration;
- Wrap-around payments to health centers for services provided through CCOs; and
- Incentives and shared savings payments to CCOs.

The 2 percentage point reduction in per capita spending growth will be measured from a 5.4 percent annual projected trend over the course of the waiver, as calculated by the Office of Management and Budget (OMB). Calendar year 2011 will serve as the base year. To meet the 2 percent reduction, increases in per capita expenditures cannot exceed 4.4 percent in the second year of the demonstration (July 2013 – June 2014) and 3.4 percent in the third year of the demonstration (July 2014 – July 2015).

In addition, the document includes a return on investment methodology to compare the savings to the infusion of federal dollars provided through the designated state health programs (DSHP) for health care transformation. Oregon will provide quarterly reports to CMS to monitor progress toward the 2 percentage point reduction goal and the return on federal investment.

Oregon Measures

CCO Quality Pool Metrics

The state's Metrics and Scoring Committee is responsible for identifying and adopting metrics by which CCOs will be held accountable for improved outcomes. The committee identified an initial set of 17 metrics, which were incorporated with few modifications by CMS into the Accountability Plan. Full specifications for these metrics are included in the Plan; 16 of these 17 metrics are also included in the metrics by which CMS will hold the state accountable.

- 1) Alcohol or other substance misuse screening, brief intervention and referral to treatment (SBIRT)
- 2) Follow-up care for children on ADHD medication (NQF #0108)¹
- 3) Follow-up after hospitalization for mental illness (NQF #0576)
- 4) Screening for clinical depression and follow-up plan (NQF #0418)
- 5) Mental and physical health assessment for children in DHS custody
- 6) Timeliness of pre-natal care (NQF #1517)
- 7) Elective delivery before 39 weeks
- 8) Developmental screening by 36 months (NQF #1448)
- 9) Adolescent well-care visits
- 10) Colorectal cancer screening
- 11) Controlling high blood pressure (NQF #0018)
- 12) Diabetes: HbA1c poor control (NQF #0059)
- 13) Total emergency department and ambulatory care utilization (visits/1,000 members)
- 14) Patient-Centered Primary Care Home (PCPCH) enrollment
- 15) Access to care (CAHPS² composite):
 - a. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?" (Adult)
 - b. "In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?" (Adult)
 - c. "In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed?" (Child)
 - d. "In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?" (Child)
- 16) Satisfaction with health plan customer service (CAHPS composite):
 - a. "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" (Adult)
 - b. "In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?" (Adult)
 - c. "In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?" (Child)
 - d. "In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?" (Child)
- 17) EHR adoption (Meaningful Use composite – three questions)

¹An NQF (National Quality Forum) designation indicates that the measure has been endorsed as meeting consensus standards for measuring and publicly reporting on performance.

² CAHPS – Consumer Assessment of Healthcare Providers and Systems survey

Oregon Accountability Metrics

The Accountability Plan also includes the 33 metrics by which CMS will hold Oregon accountable for financial penalties, which includes 16 of the CCO metrics:

- 1) Alcohol or other substance misuse screening, brief intervention and referral to treatment (SBIRT)
- 2) Follow-up care for children on ADHD medication (NQF #0108)
- 3) Follow-up after hospitalization for mental illness (NQF #0576)
- 4) Screening for clinical depression and follow-up plan (NQF #0418)
- 5) Timeliness of pre-natal care (NQF #1517)
- 6) Elective delivery before 39 weeks
- 7) Developmental screening by 36 months (NQF #1448)
- 8) Adolescent well-care visits
- 9) Colorectal cancer screening
- 10) Controlling high blood pressure (NQF #0018)
- 11) Diabetes: HbA1c poor control (NQF #0059)
- 12) Total emergency department and ambulatory care utilization (visits/1,000 members-2 rates)
- 13) Patient-Centered Primary Care Home (PCPCH) enrollment
- 14) Access to care (CAHPS³ composite-adult/child)
- 15) Satisfaction with health plan customer service (CAHPS composite-adult/child)
- 16) EHR adoption (Meaningful Use composite – three questions)
- 17) All-cause readmissions (NQF #1789)
- 18) Breast cancer screening (NQF #0031)
- 19) Cervical cancer screening (NQF #0032)
- 20) Medical assistance with smoking and tobacco use cessation (NQF #0027)
- 21) PQI 01: diabetes, short-term complications admission rate (NQF #0272)
- 22) PQI 05: chronic obstructive pulmonary disease (COPD) admission rate (NQF #0275)
- 23) PQI 08: congestive heart failure admission rate (NQF #0277)
- 24) PQI 15: adult asthma admission rate (NQF #0283)
- 25) Chlamydia screening in women (NQF #0033)
- 26) Comprehensive diabetes care: LCL-C screening (NQF #0063)
- 27) Diabetes: Hemoglobin A1c testing (NQF #0057)
- 28) Childhood immunization status (NQF #0038)
- 29) Immunization for adolescents (NQF #1407)
- 30) Well-child visits in the first 15 months of life (NQF #1392)
- 31) Child and adolescent access to primary care practitioners
- 32) Appropriate testing for children with pharyngitis (NQF #0002)
- 33) Provider access questions from Oregon Physician Workforce Survey (3 questions)

³ CAHPS – Consumer Assessment of Healthcare Providers and Systems survey

Oregon Medicaid Accountability Plan

January 4, 2013

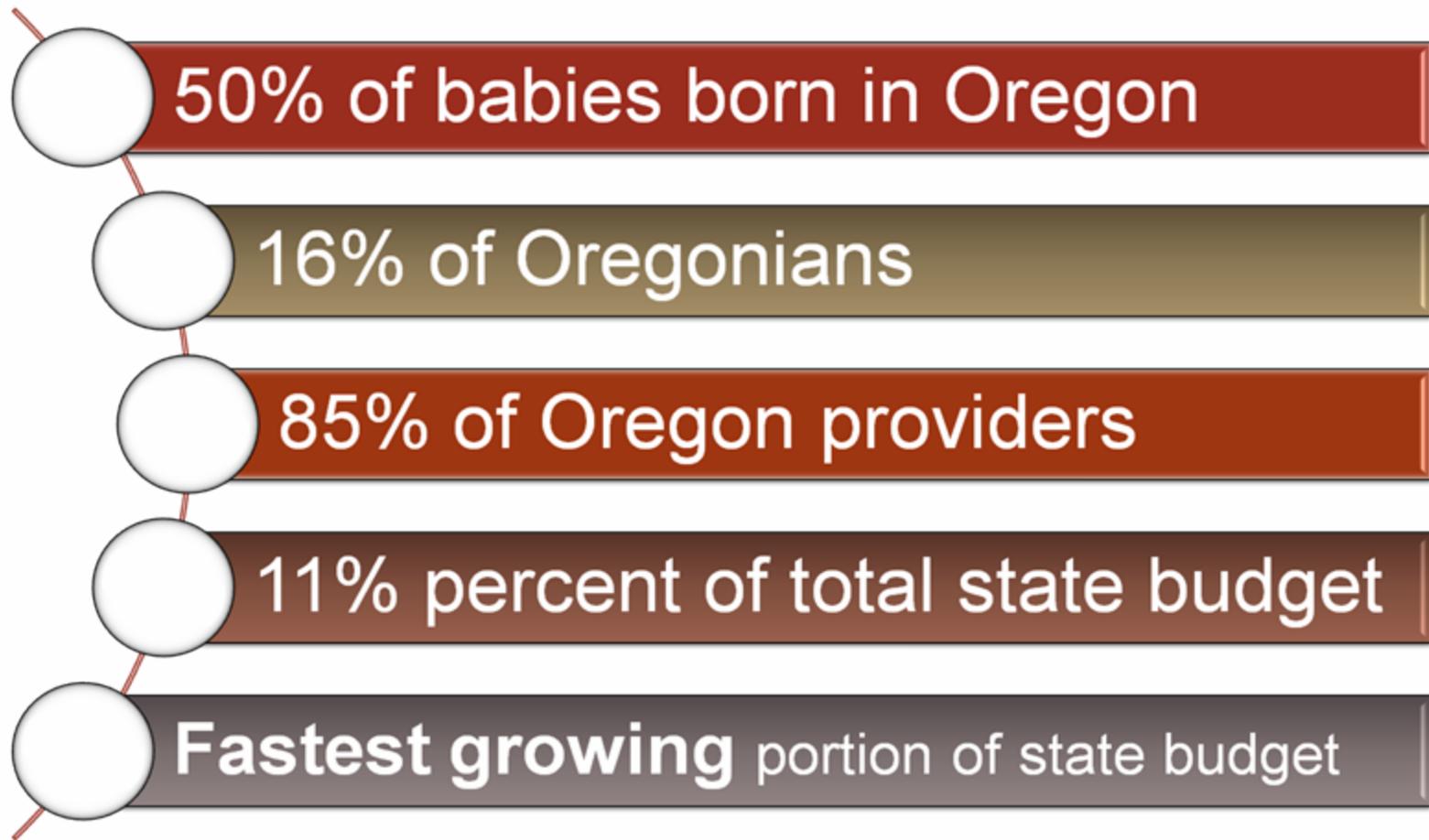
Tina Edlund

Chief of Policy

What we'll review today

1. Background: Oregon's health system transformation
2. Oregon's Accountability Plan
 - a. Quality Strategy
 - b. State "Tests" for Quality and Access
 - c. Measurement Strategy
 - d. Quality Pool
 - e. Expenditure Review
 - f. Evaluation

Context: Oregon's Health System Transformation



Achieving a three-part aim

- Reduce the annual increase in the cost of care (the cost curve) by 2 percentage points
- Ensure that quality of care improves
- Ensure that population health improves

Transforming the health care delivery system

Benefits and services are integrated and coordinated

One global budget that grows at a fixed rate

Metrics: standards for safe and effective care

Local accountability for health and budget

Local flexibility

Coordinated Care Organizations

Serving clients August 1, 2012

CCO Applicant Name	Service Area by County
AllCare Health Plan, Inc. - Mid Rogue Independent Physician Association, Inc.	Curry, Josephine, Jackson, Douglas (partial)
FamilyCare, Inc.	Clackamas, Marion (partial), Multnomah, Washington
Intercommunity Health Network CCO	Benton, Lincoln, Linn
PacificSource Community Solutions, Inc.	Crook, Deschutes, Jefferson, Klamath (partial)
Trillium Community Health Plan, Inc.	Lane
Umpqua Health Alliance - DCIPA, LLC	Most of Douglas
Western Oregon Advanced Health, LLC	Curry, Coos
Willamette Valley Community Health, LLC	Marion, most of Polk

Coordinated Care Organizations

Serving clients September 1, 2012

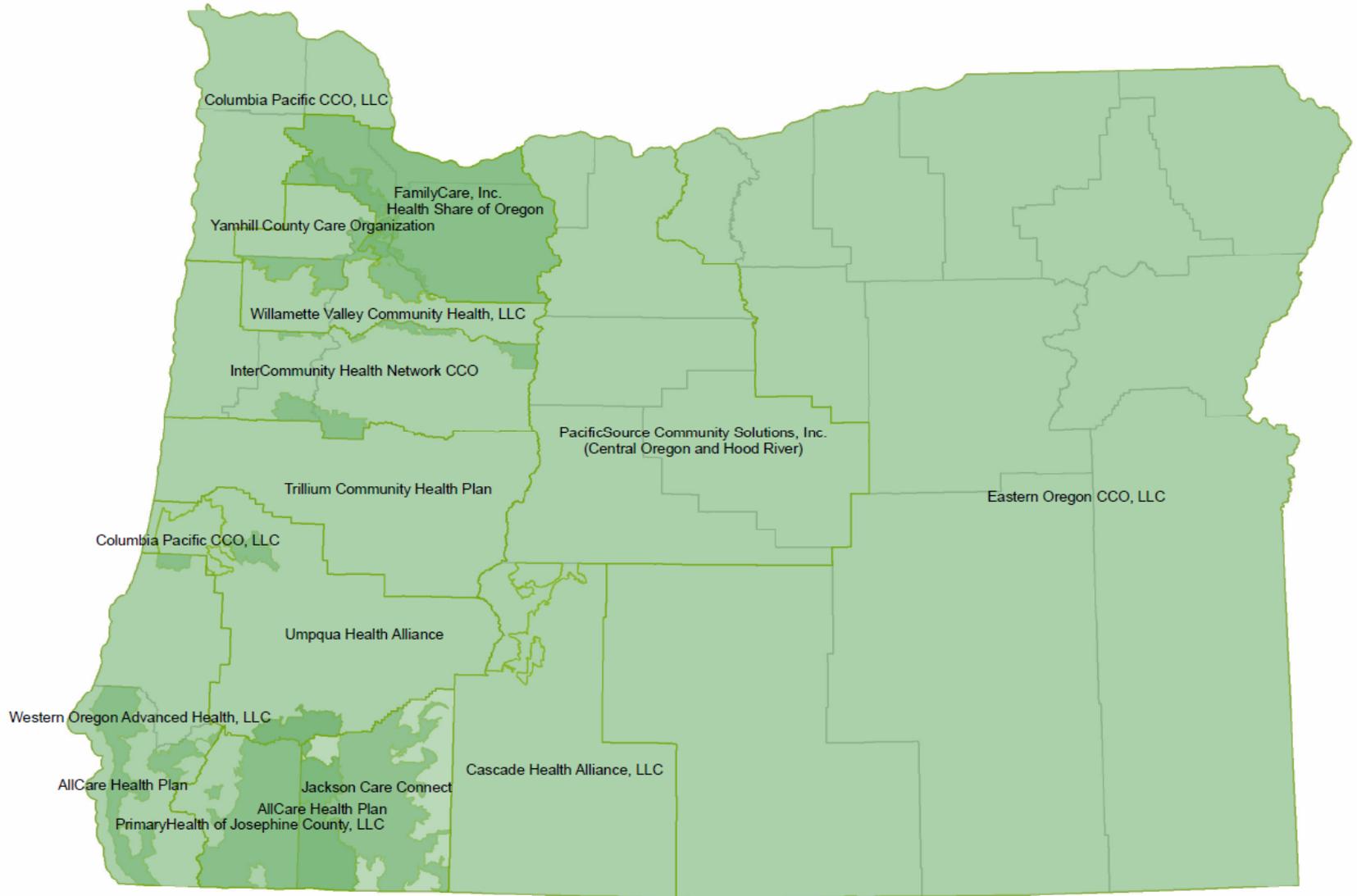
CCO Applicant Name	Service Area by County
Columbia Pacific Coordinated Care Organization, LLC	All of Clatsop, Columbia and Tillamook counties; parts of Coos and Douglas counties
Eastern Oregon Community Care Organization	Baker, Malheur, Union, Wallowa (Sept. 1); Sherman (Oct. 1); Morrow, Umatilla, Wheeler, Grant, Harney, Lake (Nov. 1); Gilliam (certified - date to begin serving clients pending)
Jackson Care Connect	Jackson County
PrimaryHealth of Josephine County, LLC	Josephine County and parts of Douglas and Jackson counties
Health Share of Oregon	Clackamas, Multnomah and Washington counties

Coordinated Care Organizations

Serving clients November 1, 2012

CCO Applicant Name	Service Area by County
Pacific Source - Columbia Gorge CCO	Hood River and Wasco counties
Yamhill County CCO	Yamhill County, parts of Marion, Clackamas and Polk counties

Coordinated Care Organization Service Areas



Accountability Plan

What is the Accountability Plan?

- Addresses the Special Terms and Conditions that were part of the \$1.9 billion agreement with the Centers for Medicare and Medicaid Services (CMS).
- Describes accountability for reducing expenditures while improving health and health care in Oregon's Medicaid program, focusing on:
 - CCO reporting to state
 - State reporting to CMS
- Approved by CMS on December 18, 2012

Accountability Plan

- a. Quality Strategy
- b. State “Tests” for Quality and Access
- c. Measurement Strategy
- d. Quality Pool
- e. Expenditure Review
- f. Evaluation

Oregon's Medicaid Program Commitments to CMS:

- Reduce the annual increase in the cost of care (the cost curve) by 2 percentage points
- Ensure that quality of care improves
- Ensure that population health improves
- Establish a 1% withhold for timely and accurate reporting of data
- Establish a quality pool

Purpose of the Quality Strategy

- Address the Special Terms and conditions of the waiver and how Oregon proposes to meet them, including:
 - Transformation goals
 - Strategies for transformation
- Address how Oregon will meet federal requirements

Quality Strategy

Quality Assurance

- On-site reviews
- Quarterly and annual financial reporting
- Complaints, grievances and appeals reports
- Fraud and abuse reports

Quality Improvement

- 7 quality improvement focus areas for CCOs to choose from
 - Performance improvement projects (PIPs)
 - Rapid-cycle improvement (Plan, Do, Study, Act- PDSA)
- Contractual requirements
- Transparency
- Financial incentives

Quality Strategy Includes Supports for Transformation

- Transformation Center and Innovator Agents
- Learning collaboratives
- Peer-to-peer and rapid-cycle learning systems
- Community Advisory Councils: Community health assessments and improvement plan
- Non-traditional healthcare workers
- Primary care home adoption

State “Test” for Quality and Access

- Annual assessment of Oregon’s statewide performance on 33 metrics, in 7 quality improvement focus areas:
 - Improving behavioral and physical health coordination
 - Improving perinatal and maternity care
 - Reducing preventable re-hospitalizations
 - Ensuring appropriate care is delivered in appropriate settings
 - Improving primary care for all populations
 - Reducing preventable and unnecessarily costly utilization by super users
 - Addressing discrete health issues (such as asthma, diabetes, hypertension)

State “Test”

- 2011 = base year
- For 2013 and 2014, performance must not decline
- For remainder of the demonstration, performance must improve
- Significant financial penalties to the state if quality goals are not achieved

Measurement Strategy

Principles for Metrics Selection

- Transformative potential
- Consumer engagement
- Relevance
- Consistency with existing state and national quality measures, with room for innovation when needed
- Attainability
- Accuracy
- Feasibility of measurement
- Reasonable accountability
- Range/diversity of measures

From OHPB Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics

Measurement Strategy

- Five important sets of metrics:
 - Core performance metrics
 - Metrics and Scoring Committee: Quality Pool Metrics
 - Child Health Insurance Program (CHIP) Core Set
 - Medicaid Adult Core Set
 - Seriously and persistently mentally ill special focus

Measurement Strategy: CMS requirements

- Quality and Access Measures for Quality Pool
- Transparency: Core measures and Quality Pool measures will be posted on OHA website by CCO
- First public reports expected late summer, 2013

Measurement Strategy: Measures selected

- Measurement year: 2013 = year 1
- Baseline year: 2011
- Final set of agreed upon measures

Measurement Strategy: Data Collection

- Administrative (claims/billing) data
- Hybrid measures (claims and other): OHA will work with CCOs to develop the most effective, least burdensome strategy for collecting this data, e.g.:
 - Surveys
 - Chart reviews

Quality Pool

Quality Pool: Metrics and Scoring Committee

- 2012 Senate Bill 1580 establishes committee
- Nine members serve two-year terms. Must include:
 - 3 members at large;
 - 3 members with expertise in health outcome measures
 - 3 representatives of CCOs
- Committee uses public process to identify objective outcome and quality measures and benchmarks

Quality Pool

- A bridge strategy in moving from capitation to paying for outcomes
- Pool size will increase each year:
 - Year 1 = 2% per member per month (pmpm)
- 17 metrics in the 7 quality improvement focus areas

Quality Pool Metrics

Behavioral health metrics, addressing underlying morbidity and cost drivers

1. Screening for clinical depression and follow-up plan
2. Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT)
3. Mental health and physical health assessment for children in Department of Human Services (DHS) custody
4. Follow-up after hospitalization for mental illness
5. Follow-up care for children on ADHD medication

Quality Pool Metrics

Maternal/child health metrics reflecting the large proportion of women and children in Medicaid:

6. Prenatal care initiated in the first trimester
7. Reducing elective delivery before 39 weeks
8. Developmental screening by 36 months
9. Adolescent well care visits

Quality Pool Metrics

Metrics addressing chronic conditions which drive cost:

10. Optimal diabetes care
11. Controlling hypertension
12. Colorectal cancer screening

Quality Pool Metrics

Metrics to ensure appropriate access:

13. Emergency department and ambulatory care utilization
14. Rate of enrollment in Patient-Centered Primary Care homes (PCPCH)
15. Access to care: getting care quickly (Consumer Assessment of Healthcare Providers and Health Systems Survey (CAHPS): adult and child)

Quality Pool Metrics

16. Patient experience of care: Health plan information and customer service (CAHPS, adult and child)
17. Electronic health record (EHR) adoption and meaningful use

Quality Incentive Pool: How it will work

- All money in the pool is distributed every year
- Potential pool award determined by plan size (pmpm) with a minimum amount established as a floor for all CCOs
- CCOs can access \$ by meeting performance or improvement benchmarks

Quality Incentive Pool: How it will work

Two phases:

- Phase 1: Distribution by meeting improvement **or** performance target
- Phase 2: Challenge pool (remainder) distributed based on 4 metrics:
 - PCPCH enrollment
 - Screening for depression and follow-up plan
 - SBIRT
 - Optimal diabetes care

Expenditure Review

- 2 percentage point reduction in expenditure trend will be evaluated based on:
 - All services provided through CCOs over the course of the demonstration
 - Wrap-around payments to Federally Qualified Health Centers (FQHCs) for services provided through CCOs
 - Financial incentives and shared savings payments made to CCOs

Evaluation

- Ongoing monitoring with quarterly reporting and consistent feedback
- Mid-point, rigorous analysis of impacts
- Final comprehensive demonstration evaluation

Questions?

More information:

- OHA has posted the full Accountability Plan at www.health.oregon.gov
- More details on metrics at <http://www.oregon.gov/oha/pages/metrix.aspx>

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State Approaches to Consumer Direction in Medicaid

By Jessica Greene, PhD, University of Oregon

Consumer-directed health strategies are increasingly being used to encourage people to make informed, cost-effective health care decisions.¹ Health savings accounts are the most notable of these strategies. While these approaches initially took root in the commercial and Medicare markets, state Medicaid agencies are also testing consumer-directed approaches in their programs.² For example, in West Virginia, Medicaid recipients who sign and abide by a pledge to be responsible health care consumers, receive more generous benefits than those who do not. In Florida, recipients now choose among health plans that differ in cost sharing and benefit limits, and they may “opt out” of Medicaid and use public funds to buy employer-sponsored coverage. Both Florida and Idaho have started programs to provide financial incentives for recipients who engage in wellness and healthy behaviors.

While these reform efforts have received considerable media attention, it is not widely known how many states are actually implementing consumer-directed approaches for Medicaid recipients. This issue brief summarizes findings from a recent survey of Medicaid agencies conducted to identify which of 17 consumer-directed approaches are being implemented and considered by states (Table 1).

Key Findings

The Trend Toward Consumer Direction in Medicaid is Growing. In mid 2006, Medicaid agencies reported, on average, having four of the 17 consumer-directed approaches already in place. By the end of 2007, on average, states planned to implement an additional 1.5 consumer-directed policies. The most common policies states planned to implement were disease management and Cash and Counseling programs. Cash and Counseling programs provide disabled and frail elderly recipients with a budget, out of which they purchase needed personal care services. Medicaid agencies reported that they were considering an additional three consumer-directed strategies on average for 2008 or later. Using financial incentives to encourage healthy behaviors was the approach most frequently considered.

Medicaid Agencies are Initiating Policies to Reward Health-Related Behaviors. At the time of the survey, one state reported using a financial incentive to encourage healthy consumer behaviors. Eight more states were planning to start a financial incentive program in 2007, and another 19 reported considering the strategy for the future.

Methodology

Forty-nine of the 51 state Medicaid agencies (including the District of Columbia) completed a short survey on consumer-directed health strategies during the late summer or fall of 2006 (response rate of 96%). For each of 17 consumer-directed strategies, respondents were asked whether the approach was part of the current Medicaid program, planned for 2006 or 2007, under consideration for 2008 or later, or not under consideration. The strategy did not have to apply to all Medicaid recipients in the state to count for the study. See Table 1.

This issue brief, developed through a national survey of Medicaid agencies, summarizes how states are incorporating a variety of consumer-directed strategies to help beneficiaries use health care dollars more efficiently.

Table 1. Medicaid Agency Plans to Implement Consumer-Directed Strategies (n=49)

Strategies	Current Strategy/ Planning for 2007	Considering for 2008 or later	Not Currently Considering	Did Not Report
Allocate Control Over Medicaid Funds				
Offer <i>Health Opportunity Accounts</i> or health savings account-like plans	5	11	32	1
Provide personal health accounts or vouchers for purchasing one's health coverage	5	5	36	3
Enable beneficiaries to use Medicaid dollars to purchase employer-sponsored health coverage	23	14	10	2
Offer cash and counseling program for home or personal care services	25	15	8	1
Incentivize Healthy Behaviors and Cost Effective Utilization				
Provide financial incentives for engaging in healthy behaviors	9	19	19	2
Provide optional Medicaid benefits to recipients engaging in healthy behaviors	6	12	28	3
Provide chronically ill beneficiaries individualized disease management assistance*	38	6	2	3
Use financial incentives to encourage use of cost effective health care (e.g., lower cost sharing for primary care than specialty care)	11	15	20	3
Recipient Financial Contributions to Care				
Require cost sharing at nominal levels (\$3)*	32	4	10	3
Require cost sharing at substantive levels (above nominal levels)	9	8	28	4
Set annual per recipient maximum Medicaid payment cap	3	3	39	4
Health Plan Choices				
Offer recipients a choice between health plans with different cost sharing arrangements	10	4	31	4
Offer recipients a choice between health plans with benefits that may differ in amount, duration, or scope	7	6	32	4
Assistance with Decision Support				
Provide in-person one-on-one counseling to assist recipients in making health plan choices	21	7	19	2
Provide telephone counseling to assist recipients in making health plan choices*	27	6	14	2
Contract with local community organizations to assist recipients in making health plan choices	17	7	21	4
Provide quality data for recipients to compare health plans	24	13	10	2

*Some of these strategies may be long-standing policies (e.g., co-pays for prescriptions) or part of a broader agenda (e.g., disease management or telephone counseling) and are not necessarily attributable to a consumer-directed movement.

Medicaid Agencies are Increasingly Allocating Control of Medicaid Funds to Recipients. By the end of 2007, half of all states (25) will offer Cash and Counseling programs. Another approach growing in popularity is enabling recipients to use Medicaid dollars to “opt out” of Medicaid and purchase employer-sponsored coverage with public funds. Twenty-three states report they will have an “opt out” program in place in 2007. While these programs are popular with Medicaid agencies, it is noteworthy that they may be less so with recipients. In the first seven months of the Florida program, fewer than five families used the Medicaid “opt out” to purchase employer-sponsored coverage.³

States are Interested in Health Savings Account-Like Plans. Five states are planning to offer a Health Opportunity Account (HOA) or another health savings account-like plan in 2007. HOAs, which were established as part of the Deficit Reduction Act of 2005 (DRA), are spending accounts coupled with a high deductible version of Medicaid. Similar to health savings accounts, HOA members pay for health care services initially from their opportunity account, and then out of their own pocket until they reach the deductible level. Since HOAs were designed for Medicaid recipients, the maximum out-of-pocket costs in HOAs are relatively low: \$250 for adults and \$100 for children. Once the deductible is reached, Medicaid covers the cost of health care services. The DRA authorizes 10 states to implement HOAs. Based on the number of states considering this approach, by the end of 2008 there will likely be the full 10 programs in place nationally.

States are Increasingly Providing Health Plan Quality Data to the Public. A key component of consumer direction is providing consumers with comparative information to help them make informed and cost-effective health care decisions. While “report cards” on quality are not new, states are increasingly providing health plan quality data to Medicaid recipients. By the end of 2007, almost half of all states (24) will provide comparative health plan quality data to recipients and an additional 13 states are considering doing so in the future.

Conclusion

This survey finds that consumer-directed strategies are increasingly being adopted and considered in Medicaid programs across the country. A number of these approaches are new and untested. While Cash and Counseling strategies do not necessarily apply to all populations and typically only cover personal needs services, there are key lessons from the Cash and Counseling demonstrations that should be considered:⁴

- 1. Consumer direction for Medicaid needs to include “counseling” as well as “cash.”** Cash and Counseling programs have acknowledged Medicaid recipients’ relatively low health literacy levels and created structured supports to assist recipients (or their representative), including home visits and monthly telephone calls. A related need will be for informational materials about new consumer-directed strategies to be appropriate for low literacy readers. Recent studies demonstrate that efforts to simplify health information can improve comprehension and decision-making.⁵ It will be important to test approaches and formats for presenting health plan comparisons to Medicaid recipients to see how best to present information to this population.
- 2. Consumer direction is not for all Medicaid recipients.** In Arkansas almost one in five participants who opted for Cash and Counseling voluntarily disenrolled from the program within a year.⁶
- 3. Consumer-directed strategies may not save money.** While disabled and elderly recipients randomized to Cash and Counseling programs had lower hospitalization rates and better quality of life, their overall Medicaid costs were slightly higher than those receiving traditional personal care services.⁷ It is possible that cost savings may not be achieved with other consumer-directed innovations as well. In fact, Health Opportunity Accounts are projected to increase Medicaid costs by 80 million dollars in the first five years of the program.⁸
- 4. The cost effectiveness of Cash and Counseling programs has been established through rigorous evaluation.** While program costs have not declined, the findings from evaluations suggest strongly that Medicaid is achieving better value for its money through Cash and Counseling. It will be critical to study the program costs and benefits of the new consumer-directed strategies that are implemented across the country. This will enable identification of new cost-effective programs and foster additional state replication of these programs.

Endnotes

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Plan Design and Active Involvement of Consumers in Their Own Health and Healthcare

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Enrollment in consumer-driven health plans (CDHPs), although still relatively limited, continues to grow.¹ One of the key appeals of the CDHP to employers is the belief that the financial incentives, enhanced choices, and increased information will stimulate consumers to become active, informed users of healthcare. In fact, an explicit goal of the CDHP approach is to encourage consumers to be better managers of both their health and their healthcare (ie, activated consumers).²

Evidence is emerging that consumers do change their behavior when in a CDHP. Consumers in CDHPs appear to be more cost-sensitive and reduce utilization and expenditures compared with those who stay in plans with traditional designs.³⁻⁵ Studies indicate that at least some of the reductions are for necessary care, including the discontinuation of prescription drugs for chronic diseases. Some studies indicate that CDHP enrollees are more likely to seek out information than those in a preferred provider organization (PPO).^{1,3} Finally, there is some evidence that more activated consumers are more likely to enroll in a CDHP in the first place.⁶ Thus, the evidence is mixed as to whether CDHP enrollment stimulates enrollees to become more active, informed managers of their health and healthcare.

In this analysis we examine the degree to which CDHP enrollees become more activated (take a greater role in managing their health and healthcare) after enrolling in a CDHP, and the degree to which those who are more activated adopt productive behaviors (eg, information-seeking, healthy). One hypothesis is that CDHP enrollment, with its incentives and information supports, encourages consumers to be actively in charge of their health. Alternatively, it may be that those who are already more activated are able to better manage within a CDHP, engaging in health-producing behaviors. Finally, both hypotheses may be true.

Specific research questions were the following:

- Do consumers who enroll in a CDHP become more activated over time compared with those who remain in a PPO?
- Are consumers who are more activated more likely to engage in information-seeking to inform their choices? More likely to engage in healthy behaviors? Do these choices occur more often in a CDHP?
- Are consumers who are more activated more likely to adopt new information-seeking or healthy behaviors over time? Do these choices occur more often in a CDHP?

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Objective: Underlying consumer-driven health plans (CDHPs) is the belief that the financial incentives, enhanced choices, and increased information will stimulate consumers to become active, informed managers of their own health and healthcare (ie, activated consumers). To examine this assumption, we assessed whether enrollees became more activated after enrolling in a CDHP and the degree to which those who were more activated adopted productive health behaviors.

Methods: This was a longitudinal study of employees of a large manufacturing company where a CDHP was offered along with a preferred provider organization in 2004. Two waves of survey data were collected with a final sample size of 1616 employees.

Results: The hypothesis that enrollees in a CDHP become more activated over time was not supported. However, the data suggest that those who were more activated were more likely to engage in the behaviors that CDHPs seek to encourage and to newly adopt these behaviors over time. This appeared to be true regardless of plan type.

Conclusion: Even though CDHPs do not appear to foster activation, they may provide a supportive environment for those who are more activated to manage their health. Encouraging enrollment based on enrollee readiness to take advantage of the CDHP environment may be more productive than relying on plan designs alone to activate enrollees once they are enrolled.

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For author information and disclosures, see end of text.

METHODS

Study Design

This is a longitudinal study of salaried and hourly employees of a large manufacturing company where 2 CDHPs were introduced at the beginning of 2004 alongside a PPO. The employer funded the personal care account in both CDHPs at the same level. The plans differed in the size of the deductible: one had a high deductible typical of such plans offered by employers,⁷ and the other had a more moderate deductible. For more details about the plan differences, see the article by Greene et al.⁵ Two waves of survey data were collected from a sample of employees, the first wave in the summer of 2004 (first year of enrollment) and the second wave in the summer of 2005.

The survey, which was administered using a mixed-mode approach (both Web and phone), asked respondents about their use of information and healthcare utilization decisions during the calendar year, as well as about their demographic characteristics.

The response rate in the 2004 survey was 79%, and the final sample size was 2104 employees. A follow-up survey in 2005 resurveyed the same respondents. Nine percent were no longer employed at the company at the time of the follow-up survey. The response rate in 2005 was 80% and the final sample size was 1616 employees. Data on plan enrollment for each employee was obtained from the company's administrative database and verified by the employee.

Study Population

The sociodemographic characteristics of the entire study sample are shown in **Table 1**, as well as the characteristics of enrollees in each plan type. Generally, the CDHP enrollees had more education and higher incomes, and were younger and in better health. The PPO enrollees were more likely to be hourly workers (compared with salaried workers). Finally, the CDHP enrollees had higher activation scores than those enrolled in the PPO.

Measures

The dependent measures used in this study relate to health information-seeking and healthy behaviors:

- *Health information-seeking*: Respondents were asked whether they had done each of the following in 2004 (or 2005 for the follow-up survey): (1) used any Web site for health information, (2) were persistent in asking a doctor to explain something until it was understood, and (3) used a telephone advice nurse or health coach.
- *Healthy behaviors*: Respondents were asked how often in a typical week they (1) limited fat in diet, (2) exercised regularly, and (3) ate 5 or more servings of fruits or vegetables in a day.

The main predictor variable was the Patient Activation Measure (PAM). The PAM, which assesses patient knowledge, skill, and confidence with respect to managing one's health and healthcare, was developed using qualitative methods, Rasch analysis, and classical test theory psychometric methods. The resulting measure is a unidimensional, interval-level, Guttman-like scale. The research to date has found the PAM to have strong psychometric properties, including content, construct, and criterion validity. Findings indicate the PAM predicts a range of behaviors, including healthy behaviors (eg, diet and exercise); disease-specific self-management behaviors (eg, adherence to drug regimens, monitoring, managing symptoms); behaviors in the medical encounter; and consumer-related behaviors (eg, using quality information, reading about side effects associated with a new drug).⁸⁻¹⁰ The PAM is scored on a theoretical 0-100 scale. Most scores fall within the range of 39-85. Activation has been shown to be changeable, with changes of 4 points on average after a 6-week intervention.¹¹ A 4-point change also is significantly linked with changes in behaviors. For example, Fowles found in an employed sample that individuals who ate breakfast, exercised regularly, or followed a healthy diet scored 4-5 points higher on the activation than did those who did not engage in each of the behaviors.¹²

The tables show the CDHP plan with higher and lower deductible options collapsed. Additional analyses were performed with the 2 CDHP plans separated out, and the differences were minimal. Although the analysis shows the collapsed version, where differences occur they are mentioned in the text. Thus, throughout the analysis, CDHP enrollees, shown as a single group, are compared with the PPO enrollees.

Analytic Approach

The analysis begins with bivariate assessments and moves to multivariate approaches. The control variables for multivariate analysis fall into 3 categories: health status, sociodemographic characteristics, and mode of survey administration. We used 2 measures of health status: a measure of self-rated health and number of chronic conditions. Sociodemographic measures include age, education (high school graduate or less, some college, college graduate, or more), race/ethnicity, sex, work type (salaried or hourly), and household income (<\$35,000, \$35,000-\$74,999, \$75,000+).

Other research has found that the mode of survey administration can have an independent effect on responses, particularly questions sensitive to the influence of social desirability.¹³ To control for any influence on responses that may be caused by mode of administration (Web or telephone,) we included mode as a control variable in multivariate analyses.

We began with an examination of degree to which these behaviors occurred in the baseline year (2004) in a CDHP-enrolled population and in the PPO-enrolled population. This analysis establishes the base rate of the behaviors in the 2 plan designs. Then we assessed the degree to which activation predicted each of the behaviors within each plan design. Next we examined the degree to which activation predicted the adoption of a new behavior in the second year of observation within each of the plan designs. That is, if the behavior was not performed in 2004, was it newly adopted in 2005? Also, to what degree does baseline activation predict the adoption of a new behavior? A sizable number of employees switched plan enrollment between 2004 and 2005. Of the 623 employees who were in the PPO in 2004, 269 (43%) switched to the CDHP in 2005. Of the 960 employees who were in the CDHP in 2004, 12 (1%) switched to the PPO in 2005. Because we wanted to observe what happens to people over time, we excluded the switchers from the analysis and only included those whose plan enrollment was stable from 2004 through 2005. Thus, the analysis followed a cohort of enrollees over the study period.

The characteristics of those who switched from the PPO to the CDHP in 2005 (n = 269) also were examined. Plan switchers tended to have more education and income than those who stayed in the PPO. The characteristics of switchers were more similar to those of the original CDHP enrollees than to those of employees who continued PPO enrollment (data not shown).

RESULTS

CDHP Enrollment and Activation Over Time

Table 1 indicates that those who chose the CDHP had higher activation scores than those who chose to stay in the PPO, suggesting that a CDHP may be more attractive to those who are more adept at managing their health. However, the findings indicate that enrollment in a CDHP did not result in significant gains in activation after a year of enrollment. The CDHP enrollees went from an average 2004 activation score of 64.1 to a score of 64.5. PPO enrollees went from an average

Table 1. Characteristics of Respondents by Plan Type in 2004^a

Characteristic	All (N = 1316)	CDHP (n = 973)	PPO (n = 343)
Male	60.3	60.1	60.6
Education^b			
High school graduate or less	35.7	32.5	45.0
Some college or vocational school	35.2	34.9	36.1
College graduate or more	29.1	32.6	18.9
Annual income^b			
<\$25,000	5.1	4.4	7.1
\$25,000-\$49,999	38.4	36.4	44.0
≥\$50,000	55.6	59.2	40.5
Marital status: married	71.5	73.6	70.7
Age, y^b			
22-35	11.9	12.6	9.6
36-50	42.6	45.7	33.5
51-62	45.6	41.6	56.9
Self-reported health very good or excellent^b	50.3	53.3	41.4
Hourly employee^b	52.8	49.2	63.0
Average patient activation score^c	64.1	64.6	62.8

CDHP indicates consumer-driven health plan; PPO, preferred provider organization.
^aValues are percentages unless otherwise indicated.
^bP < .001.
^cP < .05.

activation score of 62.6 to 63.0 during the same time period. None of the differences—either over time, within plan design, or across plan design—were statistically significant. Even after controlling for age, education, income, and self-rated health, there were no significant changes in activation scores from 2004 to 2005 for either CDHP enrollees or PPO enrollees.

Table 2a shows the percentage of CDHP and PPO enrollees who engaged in information-seeking and healthy behaviors in 2004 (base rate of behaviors). The CDHP enrollees were significantly more likely to have engaged in 1 of the information-seeking behaviors and 2 of the healthy behaviors. Table 2b shows the percentage of CDHP and PPO enrollees who adopted new behaviors in their second year of enrollment. Only those enrollees who did not perform the behavior in 2004 are included in the analysis. The CDHP enrollees were more likely to adopt only 1 of the information-seeking behaviors; adoption of a new healthy behavior was no more likely in either plan design.

Activation and Behaviors

In the next step in the analysis, we examined activation as a predictor of the performance of any of the examined behaviors and in the adoption of any of them as new behaviors.

■ **Table 2a.** Percentage of Respondents Who Engaged in Behaviors in 2004

Behavior	Percentage	
	CDHP (n = 954)	PPO (n = 337)
Information-seeking		
Used any Web site for health information ^a	49.0	35.5
Used a telephone advice nurse or health coach	16.0	16.2
Was persistent in asking a doctor to explain something until understood (strongly agree) ^b	35.1	29.1
Healthy (most days or every day)		
Limited how much fat in diet ^b	52.7	44.7
Exercised regularly ^b	54.0	47.3
Five or more servings of fruits or vegetables in a day	37.4	32.9
CDHP indicates consumer-driven health plan; PPO, preferred provider organization. ^a <i>P</i> < .001. ^b <i>P</i> < .05.		

■ **Table 2b.** Percentage of Respondents Who Adopted a New Behavior in 2005 (Among Those Not Reporting the Behavior in 2004)

Behavior	Percentage	
	CDHP	PPO
Information-seeking		
Used any Web site for health information (n = 647) ^a	24.2	14.8
Used a telephone advice nurse or health coach (n = 1037)	10.6	10.2
Was persistent in asking a doctor to explain something until understood (strongly agree) (n = 812)	18.3	18.0
Healthy (most days or every day)		
Limited how much fat is in diet (n = 620)	28.6	24.7
Exercised regularly (n = 606)	28.6	35.0
Five or more servings of fruits or vegetables in a day (n = 807)	18.6	20.3
CDHP indicates consumer-driven health plan; PPO, preferred provider organization. ^a <i>P</i> < .01.		

Table 3a shows the percentage of respondents scoring in the upper half of the PAM who either engaged in or did not engage in each of the examined behaviors in 2004. The data were broken out by plan enrollment type. Those who were more activated were significantly more likely to engage in 2 of 3 of the information-seeking behaviors whether they were enrolled in either the CDHP or the PPO. Those who were more activated also were more likely to engage in all 3 of the healthy behaviors than were those who were less activated. However, this was true only for the CDHP enrollees.

Table 3b shows the mean activation scores for those who adopted a new behavior in 2005 and those who did not. Only those who did not report engaging in the behavior in 2004 were included in this analysis. Those who were more activated were significantly more likely to newly adopt all 3 information-seeking

behaviors if they were in a PPO in 2005. The CDHP enrollees who were more activated were more likely to have adopted 1 new information-seeking behavior in 2005. Those who were more highly activated did not adopt new healthy behaviors in 2005.

Examining Activation and Behaviors Using a Multivariate Approach

Table 4a and **Table 4b** show the multivariate version of the analysis using logistic regressions to determine how much activation predicted engaging in the examined behaviors in 2004 or newly adopting the behaviors in 2005. In this analysis, education, income, self-reported health, sex, mode of data collection, and hourly versus salaried status were controlled for when the relationships were examined. The data are shown for the total sample as well as within

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Table 3a. Percentage of Consumers With Higher Activation Scores Who Did or Did Not Engage in Behaviors in 2004^a

Behavior	CDHP (n = 954)			PPO (n = 328)		
	No (%)	Yes (%)	P	No (%)	Yes (%)	P
Information-seeking						
Used any Web site for health information						
Higher activation score ^b	44.4	61.3	<.001	37.2	55.3	<.01
Used a telephone advice nurse or health coach						
Higher activation score ^b	51.4	58.6		27.2	81.2	<.001
Was persistent in asking doctor to explain something until understood						
Higher activation score ^b	35.6	83.7	<.001	28.6	49.2	
Healthy						
Limited fat in diet						
Higher activation score ^b	41.3	62.7	<.001	41.8	45.1	
Exercised regularly						
Higher activation score ^b	41.4	62.5	<.001	43.4	43.5	
Five or more servings of fruits/vegetables a day						
Higher activation score ^b	46.3	63.3	<.001	41.4	48.1	
CDHP indicates consumer-driven health plan; PPO, preferred provider organization. ^a Statistical differences in Patient Activation Measure scores were tested within the plan design (χ^2 test) ^b Scored in the upper 50% of respondents on the Patient Activation Measure.						

Table 3b. Percentage of Consumers With Higher Activation Scores Who Did and Did Not Adopt New Behaviors in 2005 (Among Those Not Reporting the Behavior in 2004)^a

Behavior	CDHP			PPO		
	No (%)	Yes (%)	P	No (%)	Yes (%)	P
Information-seeking						
Used any Web site for health information						
Higher activation score ^b	49.6	53.2		35.9	78.1	<.001
Used a telephone advice nurse or health coach						
Higher activation score ^b	56.3	55.0		39.6	75.0	<.001
Was persistent in asking doctor to explain something until understood						
Higher activation score ^b	41.9	83.0	<.001	30.9	67.4	<.001
Healthy						
Limited fat in diet						
Higher activation score ^b	48.5	53.7		45.0	48.9	
Exercised regularly						
Higher activation score ^b	43.4	53.4		49.4	53.8	
Five or more servings of fruits/vegetables a day						
Higher activation score ^b	49.8	52.0		48.3	55.0	
CDHP indicates consumer-driven health plan; PPO, preferred provider organization. ^a Statistical differences in Patient Activation Measure scores were tested within the plan design (χ^2 test). ^b Scored in the upper 50% of respondents on the Patient Activation Measure.						

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each plan type. In the cross-sectional analysis (Table 4a), we found that those who were more activated were more likely to engage in 2 of the information-seeking behaviors and in all 3 of the healthy behaviors in 2004. The findings from the multivariate analysis were similar: activation was a significant predictor of engaging in the behaviors, regardless of plan type.

Table 4b shows the multivariate analysis examining the contribution of activation to the adoption of a new behavior in 2005. This analysis had the same control variables as those

used in Table 4a. Only those who did not perform the behavior in 2004 were included in this analysis. The pattern here is similar to the one shown in Table 4a: all 3 of the information-seeking behaviors and all 3 of the healthy behaviors were predicted by activation. Three of the information-seeking behaviors were predicted by activation among PPO enrollees, whereas only 1 of the information-seeking behaviors was predicted by activation among CDHP enrollees. The new adoption of healthy behaviors was predicted by activation, but only among CDHP enrollees.

■ **Table 4a.** Odds Ratios for Patient Activation From Logistic Regression Models Predicting Health-Related Behaviors in 2004^a

Behavior	PAM Score		
	All (N = 1082)	CDHP (n = 803)	PPO (n = 279)
Information-seeking			
Used any Web site for health information	1.011 ^b	1.017 ^c	1.036 ^c
Used a telephone advice nurse or health coach	1.015 ^c	1.005	1.040 ^d
Was persistent in asking a doctor to explain something until understood	1.098 ^d	1.101 ^d	1.102 ^d
Healthy			
Limited how much fat is in diet	1.030 ^d	1.037 ^d	1.014
Exercised regularly	1.027 ^d	1.035 ^d	1.012
Five or more servings of fruits or vegetables in a day	1.025 ^d	1.030 ^d	1.011

CDHP indicates consumer-driven health plan; PAM, Patient Activation Measure; PPO, preferred provider organization.
^aControl variables included education, income, age, self-reported health in 2005, hourly vs salaried employee, sex, plan type, and survey mode.
^bP < .01.
^cP < .05.
^dP < .001.

■ **Table 4b.** Odds Ratios for Patient Activation From Logistic Regression Models Predicting New Health-Related Behaviors in 2005^a

Behavior	PAM Score		
	All	CDHP	PPO
Information-seeking			
Used any Web site for health information (n = 574)	1.025 ^b	1.007	1.089 ^c
Used a telephone advice nurse or health coach (n = 912)	1.020 ^d	1.007	1.065 ^c
Was persistent in asking a doctor to explain something until understood (n = 713)	1.090 ^c	1.086 ^c	1.092 ^c
Healthy			
Limited how much fat is in diet (n = 537)	1.017 ^d	1.018 ^d	1.018
Exercised regularly (n = 540)	1.019 ^d	1.017	1.025
Five or more servings of fruits or vegetables in a day (n = 701)	1.020 ^b	1.028 ^b	.999

CDHP indicates consumer-driven health plan; PAM, Patient Activation Measure; PPO, preferred provider organization.
^aOnly those who did not do the behavior or did not regularly do the behavior in 2004 were included. Control variables in the models included education, income, age, self-reported health in 2005, hourly vs salaried employee, sex, plan type, and survey mode.
^bP < .01.
^cP < .001.
^dP < .05.

DISCUSSION

It appears that those who were more activated were more likely to enroll in a CDHP. However, the hypothesis that enrollees in a CDHP become more activated over time was not supported by the data. Further, the data suggest that those who were more activated were more likely to engage in behaviors that CDHPs seek to encourage: information-seeking and healthy behaviors. Those who were more activated also were more likely to adopt a new behavior over time. This appears to be mostly true regardless of whether an individual was enrolled in a CDHP or a PPO.

The findings suggest that those who are activated will do better in either plan design. They are more likely to seek out information to inform choices and engage in healthy behaviors than those with lower activation levels both in PPOs and CDHPs. Even though CDHPs do not appear to foster activation, they may provide opportunities for those who are more activated to better manage their health.

We do know that interventions specifically designed to support activation, such as the Stanford Chronic Disease Self-management Course, do significantly increase activation.¹¹ Thus, it is possible to increase activation through targeted support. The CDHP does not appear to provide such support.

The data further indicate that consumers who are not activated are not likely to become so simply by enrolling in a CDHP. Those who are not activated are not as likely to become information seekers and take up healthy behaviors, even when given incentives and supports to do so.

It should be noted that the baseline survey in 2004 was 6 months after initial enrollment in the CDHP. It is likely that adoption of new behaviors occurred most frequently in those first 6 months. It is not possible to sort out the degree to which the behaviors reported in 2004 among the CDHP enrollees were newly adopted or long-standing behaviors. A further limitation of the study is that the behaviors themselves were self-reported.

Thus, CDHPs, with their greater access to information, may be a good choice for those who are more activated and prepared to take on a more active role in managing their health and healthcare. It may be more useful to think about encouraging enrollment based on enrollee readiness to take advantage of the CDHP environment rather than relying on such plans to activate enrollees once they are enrolled.

If CDHPs alone do not activate enrollees, then the key policy question remains: what will stimulate consumers to

Take-away Points

Consumers who are more actively involved in managing their own health and healthcare (ie, activated consumers) are more likely to enroll in a consumer-driven health plan (CDHP), but these plans do not appear to foster activation among their enrollees.

- Those who are more activated are more likely to engage in the behaviors that CDHPs seek to encourage (eg, information-seeking and healthy behaviors), and they are more likely to newly adopt these behaviors. However, this is true regardless of plan design.
- Encouraging enrollment based on enrollee readiness to take advantage of the CDHP environment may be more productive than relying on plan designs alone to encourage enrollees to become more active once they have enrolled.

become more effective managers of their health and healthcare? The healthcare costs that accrue because of unhealthy behaviors and poor self-management are increasingly well documented. Health insurers, employers, and other healthcare payers are exploring a number of strategies, including incentivizing specific behaviors, to influence consumer behaviors. The efficacy of these approaches is largely unknown. The findings reported here indicate that consumer activation is key to predicting a range of positive consumer behaviors. Testing approaches that stimulate activation may be a more efficient way to yield healthy consumer behaviors than trying to incentivize 1 behavior at a time.

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