

# Medicaid Advisory Committee

**July 25, 2012**  
**General Services Building**  
**Salem, Oregon**

# Agenda

- 9:00am: Opening remarks
- 9:10am: Approval of minutes – (Delayed until August)
- 9:15am: Patient-Centered Primary Care Homes
- 9:35am: OHA Updates
- 9:50am: Break
- 10:00am Oregon Health Plan Clients: Member  
Transition to CCOs
- 10:45am Oregon Medicaid Beneficiaries & Essential Health  
Benefits (EHBs): Orientation
- 11:20am Public comment
- 11:30am: Meeting re-cap
- 11:45am: Adjourn

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# **Patient-Centered Primary Care Homes (PCPCH)**

**Nicole Merrithew, MPH  
Office for Oregon Health Policy and  
Research**



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# OHA Update

Jeanene Smith MD, MPH  
Administrator

Office for Oregon Health Policy and Research



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**BREAK**

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# Member Transition to CCOs

Cathy Kaufmann, Administrator,  
Office of Client and Community Services

July 25, 2012



# What we'll talk about today

- Member transition plan & timelines: who will enroll, who won't, and when
- Member notices
- OHA customer service through transition
- Time for questions

# Approach to member transition

- Continuity for members; continuity for plans
- Provide help and minimize confusion
  - Important to emphasize what isn't changing
  - Need to assure members that their benefits stay the same
- Continue to raise awareness of the new model of care
- Special support for clients with significant health needs

# Member Transition Plan

- Current physical health plan members
- Current fee-for-service or “open card” members
- Exemptions to CCO enrollment
- New member enrollment

# Transitioning current physical health plan members

- Members will follow their current physical health plan into a CCO.
  - Includes currently enrolled tribal members and people eligible for both Medicaid and Medicare (though these members can opt in or out at any time).
- While a physical health plan is still on the path to becoming a CCO, it will retain existing enrollees (though members may choose a different plan at redetermination or for cause).

# Transitioning current physical health plan members

CCO completes readiness review

Wave 1: June 25

Members sent 30-day Transition notice (legally required)

June 29

CCO assumes care for members; OHA sends members CCO coverage notice.

August 1

Wave 2: Aug. 1

Aug. 2

Sept. 1

Wave 3: Aug. 31

Aug. 31

Oct. 1

Wave 4: Oct. 1

Oct. 2

Nov. 1

# Transitioning Fee-for-Service (FFS) or “open card” members

- FFS members who are not exempt from enrollment will move into CCOs on Nov. 1<sup>st</sup> (after the 4<sup>th</sup> and final wave)
- The first CCO in any region may take on the mental health care of the FFS members in the region (and the mental health cap rate) through Nov. 1<sup>st</sup> if the MHO is going away.
  - Most FFS clients have an open card for physical care, but are enrolled in a mental health organization (MHO).
  - Clients will keep their current MHO through the CCO

# Transitioning current FFS members

CCO completes  
readiness review.

**Wave 1: June 25**

FFS Members of  
MHO sent 30-day  
notice that mental  
health care moving  
into CCO.

**June 29**

Member follows  
MHO to CCO for  
mental health care  
only; Member sent  
coverage notice.

**August 1**

Member sent 30-  
day notice that  
physical health  
care moving into  
CCO.

**Oct. 1**

CCO assumes care  
for physical as well  
as mental health;  
Member sent  
coverage notice.

**Nov. 1**

<u>Wave 2:</u>	<u>Aug. 1</u>	<u>Aug. 2</u>	<u>Aug. 1</u>
<u>Wave 3:</u>	<u>Aug. 31</u>	<u>Aug. 31</u>	<u>Sept. 1</u>
<u>Wave 4:</u>	<u>Oct. 1</u>	<u>Oct. 2</u>	<u>Oct. 1</u>

# Support for members with significant health needs

- FFS high need / risk members being identified now.
- Their current needs, care plan, outstanding prior authorizations and referral patterns will be reported to the CCO care coordination staff (or others as requested).
- Members currently active in Disease Management or Care Coordination programs will have an RN or health coach working with them to facilitate the transition.

# Members who won't move into CCOs

- Tribal members who do not opt in
- Members who are eligible for both Medicaid and Medicare who do not opt in
- CAWEM
- CAWEM Prenatal
- Clients with Third Party Liability (TPL)
- Clients who request a third trimester pregnancy exemption (*exemption grandfathered out Jan. 2013*)

# How new members will enroll in CCOs

- New members who do not qualify for an exemption will be enrolled in the available CCO in their region.
  - If more than one CCO is available, members may choose in which CCO to enroll.
  - If no CCO is available, members may choose from any available MCO.
- New members who enroll before CCO options are available but too late to receive a 30-day notice will receive CCO information along with their MCO coverage letter.

# Client Notices

- 30-day Transition notice
- Coverage letter

# 30-Day Transition Notice

- All members will receive this legally required notice 30 days before they move into a CCO.
- This notice includes:
  - The name of a member's current health plan;
  - Basic information about CCOs;
  - The name of the CCO (if available) into which the member will move;
  - Where to call with questions.

# Coverage Letter

- All members will receive this legally required notice on the day CCO coverage begins
- The coverage letter is a standard MMIS-generated notice
  - To provide more information about CCOs, we will include a supplemental sheet.
  - OHA will provide a draft of this to CCOs by the end of June for review and comment.

# OHA customer service through transition

- OHA is directing all CCO questions from members to one phone number at the OHP processing center
  - Added 28 additional temporary staff to call center there
  - Added a new phone line to ensure phones don't shut down if call volume is high
- All front line staff (Processing center, DHS field, call center and client services staff, etc.) will be trained on CCO changes, notices and timelines starting next week through the end of July.
- Commonly used web pages being updated
- Sharing information with stakeholders and advocates

Questions?

[www.health.oregon.gov](http://www.health.oregon.gov)

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# Essential Health Benefits: Medicaid Benchmark Benefit Plan Development

Jeanene Smith MD, MPH

Administrator

Office for Oregon Health Policy and  
Research

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# ACA requires setting two types of essential benefit-based plans for 2014:

**Commercial:** Individual and small group health plans will be required under the Affordable Care Act to offer Essential Health Benefits (EHBs) to serve as a “reference plan”/minimum benefit floor Inside *and* outside of the Exchanges

**Medicaid:** Option to provide all newly-eligible adults with a benchmark benefit package that meets the minimum essential health benefits available in the Exchanges

- States can define the benchmark to provide full Medicaid benefits to those who are newly eligible, or from a set of other choices.

# Essential Benefit 10 elements

Must include items and services in 10 categories identified by the HHS:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment (to comply with federal mental health parity)
6. Prescription drugs
7. Rehabilitative AND Habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

# Setting Oregon's Commercial Essential Health Benefit- the work so far

# Essential Health Benefits in the Commercial Market

- EHBs must include the 10 HHS identified service categories with no annual or lifetime dollar limits
- Cost sharing and actuarial value guidance to be provided later
- Each state must select a benchmark plan that reflects the scope of services offered by a typical employer plan, from one of 10 plans identified by the federal government
  - The largest plan in the three largest small group products (3);
  - The three largest state employee health benefit plans (3);
  - Three federal employee health benefit plans (3); and
  - The largest commercial non-Medicaid HMO (1)

# Commercial EHB Workgroup

- The EHB Workgroup was established by the Governor and chartered by the ORHIX Board and the OHPB in April 2012
- The Workgroup included representation from the following:
  - Majority of the major commercial health plans
  - Insurance agents/brokers
  - Mental Health care representative
  - Dental care representative
  - County representative
  - Consumer advocates
  - Small business owners
  - Liaisons from the OHPB and the Exchange Corporation Board

# The Commercial Market EHB Process

The EHB Workgroup discussed the impact of certain benefits on the overall cost of a benchmark plan and its impact on the small group and individual market. Key decision points included:

- Using decision-making principles focused on federal requirements, health equity, and limiting marketplace disruptions
- Considering the overall affordability of the benchmark plans and the relative impacts to premiums
- Comparing the benchmark plans with plans currently offered in the individual market, the Oregon Medical Insurance Pool, and the Oregon Health Plan
- Understanding the initial benchmark plan can be re-evaluated in two years

# The Commercial Market EHB Recommendation

- PacificSource Preferred CoDeduct, one of the small group plans, was selected as the reference plan for the commercial market with the following supplements:
  - Pediatric Vision – The federal BlueVision “High Plan”
  - Pediatric Dental – HealthyKids dental package
  - Prescription Drugs – Default to Regence Innova Rx plan
  - Habilitative Services – Noting a need to work on defining “parity” in terms of developing a package similar to rehabilitative services
- The Workgroup's final recommendation is out for public comment through July 30, 2012 and will be assessed by the Exchange Corporation Board and the OHPB in August
- SB 91 rules process underway to set Oregon’s base bronze & silver plan cost-sharing

# Current Medicaid benefit design 101

# Medicaid Mandatory Benefits

- Physician services
- Hospital services (inpatient and outpatient)
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Medical and surgical dental services
- Rural and federally-qualified health center services
- Family planning
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health care for persons eligible for nursing facility services

# Medicaid Optional Benefits

- Prescription drugs
- Clinic services
- Dental and vision services and supplies
- Prosthetic devices
- Physical therapy and rehab services
- TB-related services
- Primary care case management
- Nursing facility services for individuals under 21
- Intermediate care facilities for individuals with mental retardation (ICF/MR) services
- Home- and community-based care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice services

# Medicaid Benefits Design – Varies Across States

- Most states cover basic, mandatory benefits, with optional benefits depends on state generosity – “medical necessity”
- Many states put limits on utilization of services - #Rx’s, #days in hospital, etc to control costs
- Nominal copays for some categories of eligibility – limited by fed regulations
  
- ***In Oregon:***
- Oregon’s Prioritized List of Health Services is unique
- Is the “limitations and exclusions” underlying the benefits of OHP Plus and OHP Standard main elements
- Serves as a benefit cost control method and ensures evidence-based benefits

# Oregon Has Long History With Evidence-Based Benefit Design

Prioritized List of Health Services – uses evidence for defining Oregon Health Plan benefits since 1994

- Developed and maintained by the Health Services Commission (HSC), now the Health Evidence Review Commission (HERC)
- Services are prioritized according to impact on individual and population health, based on best available evidence
- Services necessary to determine a diagnosis are covered; list is used to determine coverage of treatments/follow-up visits
- Ancillary services such as prescription drugs and durable medical equipment are covered for conditions in the funded region
- Legislature determines funding level (about 3/4 of lines are covered)

# Oregon's Prioritized List of Health Services

Line Number	Examples of Services	Coverage
1 101 201 301 401 501	Maternity care Treatment of moderate to severe head injury Medical therapy for acute pancreatitis Treatment for rheumatic heart disease Laser therapy to prevent retinal tear Treatment for benign breast disorders	 Covered
551 651	Treatment for plantar fasciitis Treatment for acute viral conjunctivitis	Not Covered 

# ACA requires setting Oregon's new Medicaid Benchmark for 2014 – work ahead

# ACA Medicaid Benchmark Benefits

- Would apply to the new, Medicaid eligibility group of non-pregnant adults between 19-65 with incomes  $\leq$  133% FPL
- Also requires coverage for former foster children at all income levels up to age 26 (starts 2014)
- States will receive enhanced federal assistance (FMAP) for “newly eligibles” within the adult group
  - 100% in 2014-16
  - 95% in 2017
  - 94% in 2018
  - 93% in 2019
  - 90% in 2020 and beyond

# Medicaid Benchmark Benefit requirements under ACA

States are to provide benchmark/benchmark-equivalent coverage described under §1937 of the Social Security Act, as modified by the ACA

- Requirements from the Social Security Act § 1905(a) outline
  - mandatory benefits that states **must** cover
  - optional benefits states **may** cover

PLUS, as per the ACA:

- Include at least the same 10 essential benefit categories as required for the private market benchmark

# Medicaid Benchmark Benefit requirements under ACA

Medicaid Benchmark plan design selection options:

- The largest federal employees benefit plan
- The largest state employee benefit plan
- The largest private HMO benefit plan
- Possibly also the most common small group market plan-  
(But not confirmed yet by regulation)
- OHP Plus

**Or** seek HHS Secretary Approval for a Benefit Plan

**But Must Include as a Minimum:**

*All the mandatory services as well as the 10 essential health benefits elements*

# What about OHP Standard?

- OHP Standard was developed in 2003 to apply to Oregon's expansion adult population, both parents and single adults
- It was developed thru a similar process, under the "Secretary Approved Plan" option
- It was less "rich " than the original OHP plan, now called OHP Plus in attempts to afford to cover more people
- It didn't, at the time of the passing of the ACA, have all 10 elements of the required essential benefit elements so would not meet current Benchmark requirements
- The population it serves will be part of the new expansion population group

# Lots of Questions - but need to go forward

- Federal guidance does not answer all of the questions
- Commercial EHB selection went first as timing is critical as the Exchange needed clarifications quickly in order to issue requirements for Qualified Health Plans, and feds want Oregon's choice by Fall 2012
- Selection of the commercial EHB benchmark was also necessary to determine "metal level" plans to meet deadlines for SB 91
- Supreme Court ruling on ACA raised questions for states moving forward with Medicaid expansion, yet need to redefine OHP Standard to fit new requirements even to continue to cover who we do today in January 2014

# Next Steps for Medicaid Benchmark Plan

- CMS will be providing additional guidance on EHBs for Medicaid
- Oregon, as it prepares for the 2014 Medicaid expansion, will need to define its Medicaid benchmark to CMS, anticipating a public process through the Medicaid Advisory Committee by Fall 2012
- Will need to examine the current OHP Plus, OHP Standard benefits and look at the new ACA requirements and choices
- Also will need to consider the needs of the new population and their current other commercial options , such as common individual and group plans, hi-risk pool (OMIP), and the new commercial EHB benefit recommendation
- Care transitions need to be considered for those who may move to and from Medicaid and the Exchange benefit plans

# Potential MAC Workplan on Benchmark

- **August** - Review what guidance we have in detail, and initial discussion of principles to consider to aid decision-making
- **Sept** - Detailed benefit comparisons and start to narrow choice
- **October** – Ongoing discussion and potential candidate for selection
- **Public input process** - at all meetings and on potential selection between October and November meetings
- **November** – Finalize selection with review of public input
- **Updates/Discussions with the Policy Board** - throughout the process and discussion with them on the final recommendation
- **Medicaid program** will need to submit a State Plan Amendment in 2013 for approval before can be used for the expansion population starting in January 2014

# Questions?

- Background materials and from the Commercial EHB Workgroup process available at :  
<http://cms.oregon.egov.com/oha/OHPR/pages/ehb/index.aspx>
- Will be updating the MAC website with Medicaid Benchmark background materials and process materials as we go forward

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# Public Comment



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# Meeting Re-cap Action Items



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**Adjourn**

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