

MEDICAID ADVISORY COMMITTEE

June 22, 2011
9:00 – 12:00pm
General Services Building,
Mt. Mazama Conference Room,
1225 Ferry St. SE, Salem, Oregon

AGENDA

	Time	Item	Presenter
I.	9:00	Opening Remarks	Co-Chairs
II.	9:10	Approval of Minutes	MAC members
III.	9:15	Legislative Update	Nicole Merrithew
VII.	9:25	The Quality Corporation: OHP Measurement and Public Reporting	Mylia Christensen
V.	9:55	Office of Client and Community Services <ul style="list-style-type: none">• Introduction to new office• MAC relationship to office• Client education	Cathy Kaufmann
VI.	10:40	Break	
IV.	10:50	Patient-centered Primary Care Homes <ul style="list-style-type: none">• Strategies for patient engagement• Group discussion	Nicole Merrithew
VIII.	11:20	Meeting re-cap and discussion	MAC Members
IX.	11:50	Public Comment	
X.	12:00	Adjourn	Co-Chairs

OREGON MEDICAID ADVISORY COMMITTEE

April 27, 2011 9:00 a.m. – 12:00 p.m.

**Oregon State Library,
Salem, Oregon**

MEMBERS IN ATTENDANCE: Carole Romm, RN, MPA; Jim Russell, MSW; Karen Berkowitz, JD; Rhonda Busek; Ellen Gradison, JD;
Mike Shirtcliff, DMD; Thomas Turek, MD;

PHONE PARTICIPANTS: Lenore Bijan; Meghan Caughey

PRESENTERS: Kai Guterman, Ellen Pinney, Tina Edlund, Ralph Summers, Nicole Merrithew, Michelle Mack, Vonda Daniels

STAFF: Nicole Merrithew, Kai Guterman

VISITORS: Eve Ford, Don Ross, Amanda Waldroupe

TOPIC	Key Discussion Points	Follow-up Action	Responsible Party
Approval of Minutes	A motion was made to approve the minutes as written. Minutes were approved.		
Legislative Update	Kai Guterman provided an update on the 2011 MAC legislative bill tracker document, and introduced Medicaid related bills to the Committee which have been moving through the legislative process, including SB 210 and HB 3311. See handouts: http://www.oregon.gov/OHPPR/MAC/docs/Meeting_Materials/2011_Materials/MAC_042711_Materials.pdf	Continue to update and distribute the MAC bill tracker every 2 weeks.	Kai Guterman
Oregon Health Authority Ombudsperson Update	Ellen Pinney, Oregon Health Authority (OHA) Ombudsperson, provided an overview of current work and first year priorities, including the complaint and grievance system consolidation and coordination. ➤ The OHA Ombudsoffice is tasked with identifying and implementing policies and practices for maximizing the ability of people eligible for receiving publicly supported services, to get the right care at the right time in the right place. ➤ Ellen will be convening an Ombudsperson Advisory Council, which will provide guidance to the Ombudsperson on emergent issues, and other ways to make the system work better for consumers. ➤ A coordinated complaint and grievance system will provide an easy to use complaint process whereby clients understand their rights to raise concerns, complaints will be collected from health plans in uniform ways, and statistics on complaints and grievances will be reported with greater transparency.		

Oregon Medicaid Advisory Committee Meeting Minutes April 27, 2011

<p>Coordinated Care Organizations Legislative Concept</p>	<p>Tina Edlund, Chief of Policy for the Oregon Health Authority provided an overview and update of the Coordinated Care Organization (CCO) legislative concept.</p> <ul style="list-style-type: none"> ➤ This CCO legislative concept has been drafted as House Bill 3650, which is currently in the Joint Health System Transformation legislative committee. ➤ This plan will create a transition for publicly funded health programs from managed care towards more accountable organizations, responsive to improved health outcomes, better quality of care, and decreased system costs. ➤ In its efforts to develop the CCO concept and plan implementation, the OHA has received federal support from the Centers for Medicare and Medicaid Services (CMS), who are assisting with policy development and regulations compliance. ➤ The MAC may have a role in providing feedback to this process. 		
<p>Patient-Centered Primary Care Home Implementation update</p>	<p>Nicole Merrithew, Medicaid Advisory Committee Director and Ralph Summers, Policy Advisor to the OHA, reviewed current efforts to implement Oregon’s Patient-Centered Primary Care Home (PCPCH) throughout the OHA (including the State Plan Amendment to CMS).</p> <ul style="list-style-type: none"> ➤ The PCPCH Standards Advisory Committee developed medical home standards, attributes, and measures in response to the Triple Aim, to improve health, improve the quality of healthcare, and to reduce costs. These standards can be tied to a new system of reimbursement payments to incentivize higher quality care. ➤ As the PCPCH implementation is phased in over time, payments will transition from Fee-for-Service (FFS) reimbursement towards a system including a Base Payment, Shared Savings (including Pay-for-Performance), and some remaining FFS items. ➤ Presenters solicited feedback from the MAC on implications of this model on the Medicaid population ➤ See handouts: http://www.oregon.gov/OHPPR/MAC/docs/Meeting_Materials/2011_Materials/MAC_042711_Materials.pdf 	<p>Solicit Feedback from MAC Members in regards to PCPCH measures from a consumer’s perspective</p>	<p>Nicole Merrithew</p>
<p>Medicaid Eligibility Redetermination Process</p>	<p>Michelle Mack, Vonda Daniels, Policy Analysts at the Department of Human Services, provided an update on current efforts to reform the Medicaid eligibility redetermination process, to eliminate or minimize paper applications.</p> <ul style="list-style-type: none"> ➤ Eligibility is re-determined on a 12 month cycle, and systems are now automated, such that most consumers do not need to re-file paperwork to maintain medical coverage. ➤ Other forms of state public assistance (SNAP, TANF, etc) can be bundled into one application, and Medicaid renewal can renew others services simultaneously, easing future re-application processes. ➤ Presenters discussed implications of HB 3536, which seeks to eliminate Medicaid coverage gaps for inmates/ residents of public institutions when they are released. 		

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Public Comment	None		
Adjournment	The meeting was adjourned at 12:00 pm.		

Next MAC meeting:

Wednesday June 22, 2011, 9:00 am - 12:00 pm, General Services Building, Mt. Mazama Conference Room, 1225 Ferry St. SE, Salem, Oregon

Medicaid Advisory Committee 2011 Legislative Session Bill Tracker

Bill #	First 2 Sponsors	Relating Clause	Summary	Priority Level*	Recent Actions (as of 5/16/11)	Comments
HB3650	JOINT SPECIAL COMMITTEE ON HEALTH CARE TRANSFORMATION	Relating to health; declaring an emergency.	Establishes Oregon Integrated and Coordinated Health Care Delivery System to replace managed care systems for recipients of medical assistance. Specifies criteria for coordinated care organizations. Requires Oregon Health Authority to seek federal approval to allow enrollment of individuals who are dually eligible for Medicare and Medicaid into coordinated care organizations. Requires authority to establish alternate payment methodologies for coordinated care organizations. Requires	1	6/8/11 - Assigned to Subcommittee on Capital Construction	HSTT Coordinated Care Organization bill
SB216A	BATES	Relating to medical assistance.	Prohibits Oregon Health Authority from taking actions that cumulatively increase cost to prepaid managed care health services organization of providing health services during one biennium by more than one percent without prior approval of Joint Committee on Ways and Means. Declares emergency, effective on passage.	1	5/26/11 - Public Hearing Held	
HB2103B	Request of Governor Kitzhaber	Relating to driving while under the influence of intoxicants.	Specifies that persons either convicted of driving while under influence of intoxicants or entering diversion agreements may use [third party resource to pay for] state medical assistance program to support medically necessary chemical dependency services related to screening interview, treatment program or diagnostic assessment.	2	6/10/11 - Passed Senate 6/14/11 - Passed House	

Medicaid Advisory Committee 2011 Legislative Session Bill Tracker

HB3311B	KOTEK, FREDERICK	Relating to birth outcomes; declaring an emergency.	Requires Oregon Health Authority to explore ways to improve birth outcomes for women of color] who face disproportionately greater risk of poor birth outcomes and to report to legislative committees in February 2012.	2	6/13/11 - Senate President Signed	
HB3536A	PARRISH, TOMEI	Relating to medical assistance; declaring an emergency.	Directs Department of Human Services and Oregon Health Authority to suspend, instead of terminate, medical assistance of medical assistance recipient who becomes inmate of local correctional facility for expected term of no more than 12 months. Requires department and authority to jointly report to Legislative Assembly no later than May 31, 2013, on feasibility of extending suspension requirement to medical assistance recipient who is incarcerated for more than 12 months. Declares emergency, effective on passage.	2	6/1/11 - Governor signed	
SB201A	BATES	Relating to medical assistance; declaring an emergency.	Authorizes Oregon Health Authority to approve transfer of 500 or more enrollees from one prepaid managed care health services organization to another if receiving organization accepts transferring organization's network of providers or allows enroll	2	6/10/11 - Senate President signed 6/14/11 - House co-speakers signed	
SB433	ROSENBAUM, TOMEI	Relating to treatment of cancer.	Expands eligibility for medical assistance for low-income and uninsured women diagnosed with breast or cervical cancer.	2	6/14/11 - Passed Senate 6/15/11 - Referred to Ways and Means	

Medicaid Advisory Committee 2011 Legislative Session Bill Tracker

HB3037A	COWAN, BEYER	Relating to senior services.	[Expands] Specifies that services provided to seniors through Oregon Project Independence [to] include support for community caregivers, health promotion services, options counseling and transportation services.	3	6/1/11 - Governor signed	
SB101A	Request of Governor Kitzhaber	Relating to health care; declaring an emergency.	Authorizes payment for dental services under Family Health Insurance Assistance Program and under private health option of Health Care for All Oregon Children program. Specifies requirements for dental plan to qualify for premium assistance under Family Health Insurance Assistance Program. Declares emergency, effective on passage.	3	6/8/11 - Assigned to Subcommittee on Capital Construction	
SB104	Request of Governor Kitzhaber	Relating to functions of the Oregon Health Authority; declaring an emergency.	In Family Health Insurance Assistance Program, eliminates asset criteria and authorizes Office of Private Health Partnerships to offer dental only plans, adopt definition of family by rule and adopt rules for recovery of overpayments of subsidies. Authorizes office to contract for or certify both individual and group health benefit plans. Removes requirement that office provide health benefit plans to small employers. Adjusts scope of authority of office to include functions performed for Family Health Insurance Assistance Program. Deletes obsolete definition of "referral agency" for purposes of home health services provisions. Permits Oregon Health	3	5/19/11 - Governor signed	

Medicaid Advisory Committee 2011 Legislative Session Bill Tracker

SB514A	MONNES ANDERSON	Relating to the Oregon Medical Insurance Pool.	[Expands eligibility for enrollment in Oregon Medical Insurance Pool to include parents of children who are unable to access health insurance coverage. Prohibits application of waiting period or preexisting conditions provision on children under age of 19 who seek enrollment in pool.] Requires Oregon Medical Insurance Pool Board to consider costs of reinsurance program for children’s coverage when determining sufficiency of funds in Oregon Medical Insurance Pool Account. Declares emergency, effective on passage.	3	5/23/11 - Governor signed	
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* Priority Levels are established as follows:

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

Relevant Deadlines:

June 1 – Deadline for Committees to HOLD Work Sessions on Second Chamber Measures

Patient-centered Primary Care Home Client Engagement

Client/patient engagement is a topic that must be considered as Oregon moves forward with the Patient-centered Primary Care Home (PCPCH) initiative. This includes engagement around the PCPCH concept, patient involvement in care delivery, and how PCPC homes are viewed by other stakeholders that either have direct contact with the client/patient or indirect contact. Such stakeholders include:

- Providers
- Health carriers/managed care plans
- Advocates and related stakeholders
- Employers

While the views of these stakeholders are critical, the patient remains at the core of the PCPCH concept and, therefore, the engagement strategy.

To increase the percentage of clients/patients embracing a PCPCH for themselves versus other options available to them, it has been suggested that a PCPCH engagement strategy be developed.

Given the broad stakeholder representation of the Medicaid Advisory Committee, OHA staff have requested that the group consider and provide feedback on:

1. Appropriate goals for a PCPCH engagement plan
2. Strategies for achieving those goals

Some points to consider include:

1. How do we communicate about PCPC Homes to illustrate how they differ from existing delivery models? What does it do for the client/patient and the providers/stakeholders?
2. Do the above stakeholders view PCPC Homes in a positive or negative light and how would that frame our communication/outreach strategy to clients/patients/stakeholders?
3. Do client generational differences, gender, race, ethnicity and economic status frame our communications differently?
5. Are there incentives (financial or non-financial) that would make a client/patient want to use a PCPC Home?
6. PCPC Homes have been shown to decrease cost and improve outcomes and patient experience, but are there perceived negatives to PCPC Homes? Does it reduce choice in provider selection? Does it focus the provider more on bad health behaviors of the client (tobacco, drug and alcohol use, etc) thus decreasing engagement on the part of the client/patient?

7. Will PCPC Homes add more flexibility and convenience for clients to receive health care?

This list of questions is not intended to be an all-inclusive list of considerations for developing an engagement strategy, but rather a list to stimulate discussion.

May 2011 DMAP Update

HB 3650 - Health Care System Transformation

Background

The state will face a significant shortfall in the next biennium. HB 3650 is a key strategy to reducing costs while improving quality. The Health Care System Transformation model follows the national health care reform's triple aim: 1) improve the lifelong health of all, 2) increase the quality, reliability and availability of care and 3) lower or contain the cost of care so it is affordable to everyone.

HB 3650 will coordinate health care for physical, dental, and behavioral health under new Coordinated Care Organizations (CCO) that would serve as the primary health care delivery system in the state. CCOs will serve as a single-point of accountability with a global budget to provide quality and coordinated access of physical, behavioral and dental health care to OHP clients enrolled within the organization. CCOs may be a single corporate entity or a network of providers organized through contractual relationships.

Update

The Joint Special Committee on Health Care began hearing public testimony on House Bill 3650. The bill creates *Coordinated Care Organizations*, which would be responsible for managing both the health and health care costs in local communities. The Joint Committee continues to meet over the next several Wednesday nights until it finalizes legislation for the full Legislature's consideration.

Oregon has a reputation for innovation when it comes to health care and the budget crisis has created an opportunity for our state that we cannot afford to waste. Our state leaders have made a commitment to ensure that none of the 600,000 people in the Oregon Health Plan will be dropped from health care. To meet that commitment, Oregon has embarked on a unique effort, *HB 3650 - Health Care System Transformation*, to bring coordinated, patient-centered care to our statewide delivery system. To make it happen, stakeholders from every part of the health-care and long-term-care system are involved in crafting a plan to achieve those savings. Some of the principles of HB 3650 goals are:

- Coordinate all benefits locally, including physical health, mental health and addiction services and oral health.
- Coordinate social supports that promote health and keep people out of high cost medical care.
- Include Oregonians who are eligible for both Medicaid and Medicare.
- Set budgets at levels that are sustainable, affordable and sufficient for best-practices; establish incentives for prevention efforts, and lower costs.
- Build on best practices in local communities in which health entities partner with each other and consumers, and are accountable for improved health.

National Dental Home Initiative partnership

Background

Untreated dental disease is progressive and can be devastating to children's long-term health, educational achievement, and overall success. *Oral Health* is integral to the healthy physical, social-emotional and intellectual development of every child. Dental caries is the most common childhood infectious disease and low-income children suffer twice as much from dental caries as children who are more affluent. 28 percent of all preschoolers between the ages of 2 and 5 suffer from tooth decay, but in Head Start programs, decay rates often range from 30-40 percent of 3-year-old and 50-60 percent of 4-year-old children.

Head Start is a national program for families living with low incomes that promotes school readiness by enhancing the social and cognitive development of enrolled children birth through five years, and their families. This is achieved through the provision of educational, health, nutritional, social and other services. Head Start's commitment to oral health is based on the premise that a child must be healthy to be ready to learn. Good oral health is essential to a child's overall growth and development, including the development of speech, language and behavior.

Update

We contract with eight Dental Care Organizations (DCOs) to provide dental benefits to OHP clients. Even though the majority of children enrolled in Head Start are also eligible and enrolled with OHP and receive dental care benefits, many children have never received a dental exam.

To promote oral health care we worked with Head Start Regional Workgroups, DCOs (which enroll over 92 percent of all OHP clients), and the Department of Education, to improve and identify strategies to resolve barriers for oral health care. The partnership led to activities such as trainings for Head Start staff on how to help families navigate the OHP system; and Open House clinics to provide assessments, prevention services and parent education to help connect families with their child's assigned dental provider.

We recently worked with Oregon's Head Start State Collaboration Director to develop a formal arrangement with the *Department of Education* and provide Head Start staff access to the OHP Provider Web Portal. Staff can now obtain eligibility and enrollment information and assist families in scheduling dental exams for their children.

The DCOs also developed a written guide to provide information to Head Start staff regarding OHP and DCO services. We also delivered a custom Webinar that received very positive feedback. The Webinar will be repeated on August 30. The Webinar curriculum includes an OHP overview; information on managed care and fee-for-service delivery systems and navigating the Provider Web Portal.

Head Start's distribution materials are available in Spanish, Russian, and large print. In addition to helping OHP clients access dental care, staff will provide non-enrolled families with information and application assistance for OHP's Healthy Kids program.

More good oral health news...

The Foundation of the American Academy of Pediatric Dentistry, *Healthy Smiles Healthy Children*, awarded the Dental Foundation of Oregon an *Access to Care* grant for its *Tooth Taxi*

Mobile Dental Clinic. Read about other effective Oregon programs in *Healthy Smiles Healthy Children's* 2010 Annual Report at www.aapd.org/upload/news/2011/4414.pdf.

The Dental Foundation of Oregon (DFO) is the philanthropic arm of the Oregon Dental Association. DFO recently adopted a new mission: improving oral health for Oregon's children. By narrowing the focus of the organization to children, the organization hopes to address the dental crisis facing the state's children early in their lives. Oregon children suffer from some of the worst oral health in the nation, and access to care is a significant challenge for thousands of children who live in rural communities throughout the state.

Oregon Health Care Quality Corporation

Background

DMAP contracts with Oregon Health Care Quality Corporation (Q-Corp) for managed care and fee-for-service data collection and quality-measure reports as part of our overall effort to monitor quality. In addition to Medicaid and Oregon Medicare, eight commercial health insurers participate with Q-Corp to voluntarily deliver information for medical groups, providers and public use. The annual report aggregates data from 1.88 million medical claims, 121 million pharmacy claims, and 3.2 million unique patients. The interactive web site can be accessed at <http://www.partnerforqualitycare.org/>.

The majority of the measures are accredited by HEDIS, and therefore provide national benchmarks for comparison.

Update

In May, we received a draft report that we have preliminarily shared with our managed care plan Medical Directors and the Oregon Health Policy Board. The report reflects information for the measurement year April 2009 through March 2010. It includes, for the first time, OHP fee-for-service data. Medicaid clients represent 5.7 percent of the total patients addressed in the report.

The report is useful for measuring ourselves against private and commercial data to learn our strengths and identify areas for improvement. The report includes five areas of care: women's preventative, diabetes, other chronic disease, utilization and pediatric care services. There are 20 measures rated within these five areas. Findings include:

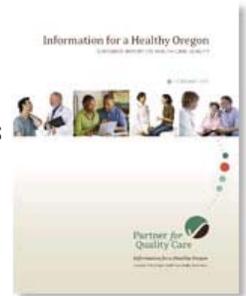
- Medicare Advantage plans achieved the highest rates on 9 of the 12 measures for which Medicare data was available.
- Commercial plan rates are higher than Medicaid rates on 15 of the 20 total measures.
- OHP achieved rates higher than commercial plans and Medicare Advantage plans on 3 of the 4 generic prescription drug measures in utilization area.
- OHP rates for diabetes, other chronic disease, and pediatric care are generally lower than rates for commercial and Medicare Advantage plans.
- OHP rates for breast and cervical cancer screening are far lower than commercial plans.

We are currently looking at policies and programs we can strengthen to improve results reflected for OHP. Strategies will be developed and metrics identified for ongoing monitoring.

Many of our current *Quality Improvement* projects already address the issues found in areas needing improvement. Projects in progress include partnering with Healthy Kids and DHS' Senior and People with Disabilities Division; our focus on medical homes; our new in-house medical management process with fee-for-service clients; and our federal grant application for *Patient Incentives for Chronic Diseases*.

Public Report on Health Care Quality in Oregon available

Oregon Health Care Quality Corporation collects information for more than 75 percent of primary care providers in Oregon and presents a blind public data annual report. This year's newly released 2011 Statewide Report on Health Care Quality: *Information for a Healthy Oregon* provides comprehensive information on primary care quality.



For the first time, the report includes multiple years of data submissions, beginning in calendar year 2007 through the first quarter of 2010. For more information on the trends, quality of care variances, and other beta (non-public) data, go to www.partnerforqualitycare.org/publications.php. The report also includes provider testimony on how the initiatives' report has changed their practice.

In other news

Regional meetings occurring throughout state

OHP bi-yearly Regional meetings are a venue to meet with branch staff and field offices from the Division of Children and Adult Families Division, Seniors and People with Disabilities, Child Welfare and the Area Agencies on Aging with representatives from DMAP, managed care organizations, and local providers to discuss topics relevant to the Oregon medical programs. This is an opportunity for attendees to get program updates and resource materials. Those unable to attend in person may also participate through video conference.

OHP Regional meetings are coordinated by the Office of Payment Accuracy and Recovery (OPAR) in conjunction with other DHS divisions. The meetings are held in various regions throughout the state to present information, updates and resources about Oregon medical assistance programs. For agendas and schedules go to www.oregon.gov/OHA/healthplan/managed-care/regionals.shtml.

State demonstration grant

Oregon was one of fifteen states selected by CMS to receive up to \$1 million in a state demonstration grant to integrate care for *dual-eligible* (enrolled in both Medicare and Medicaid) individuals. We received the maximum award of \$1 million. Through this grant, states will design innovative ways to meet the medical needs of the nation's lowest-income and chronically-ill citizens. Nationally, dual-eligible clients make up 15 percent of the Medicaid program but account for 39 percent of costs.

Medical Management Committee

Background

The Medical Management Committee provides a staff forum to systematically assure high-quality, consistent, and cost-effective health care to fee-for-service clients. The committee also assists with the development and review of new options for fee-for-service providers in health care management delivery.

The staff committee is composed of the Medical Director; managers and R.N.s from the Policy, Quality Improvement, and Medical Units; and as appropriate; Hearing representatives, Ombudsman, Health Services Commission, Health Resource Commission Medical Director, Seniors and People with Disability Medical Director, and Addictions and Mental Health Division representatives.

Update

The Medical Management Committee is nearing its first anniversary providing successful cross-Unit collaboration and fee-for-service oversight. The monthly meetings primarily focus on fee-for-service coverage issues. By reviewing difficult cases with all sections represented, case decisions are balanced and consistent. Cases are brought to the committee when a reviewer or provider requests assistance on service decisions.

Recent accomplishments include creating a new reporting tool, *Medical Management Service Request Summary*, tracking pneumonia for subsequent analysis, and adoption of *Medicare's 12 Medical Conditions* guideline for options to reduce payments rather than issue a payment denial.

HIPAA 5010 and NCPDP D.0

Background

Nationally, health care providers, including hospitals, pharmacies, dentists, billing clearinghouses, and mental health providers are required to upgrade to new electronic transaction standards, by 1/1/2012.

Update

HIPAA X12 version 5010, commonly referred to as 5010, is a set of standards that regulate electronic transmission of health care transactions, including eligibility, claim status, referrals, claims and remittances. 5010 standards will add new business processes and remove obsolete functionality.

NCPDP Version D.0 (National Council for Prescription Drug Programs), referred to as D.0, is the new standard for pharmacy on-line interactive electronic claims, eligibility inquiries and prior authorizations. D.0 standard improvements include facilitating coordination of benefits with third-party insurance plans, including Medicare and identifying patient copayment or coinsurance responsibility.

All entities who transact business electronically are required to upgrade to 5010 and D.0. The new standards significantly impact software requirements and upgrades which will ultimately support and provide:

- Consistency across the nation's health care transactions
- Accommodation of ICD-10 values (10/1/2013 requirement)

- New-use requirements introduced by the health care industry
- Clarification of usage and eliminate ambiguity
- Removal of data content that is no longer used
- Better reporting data for research

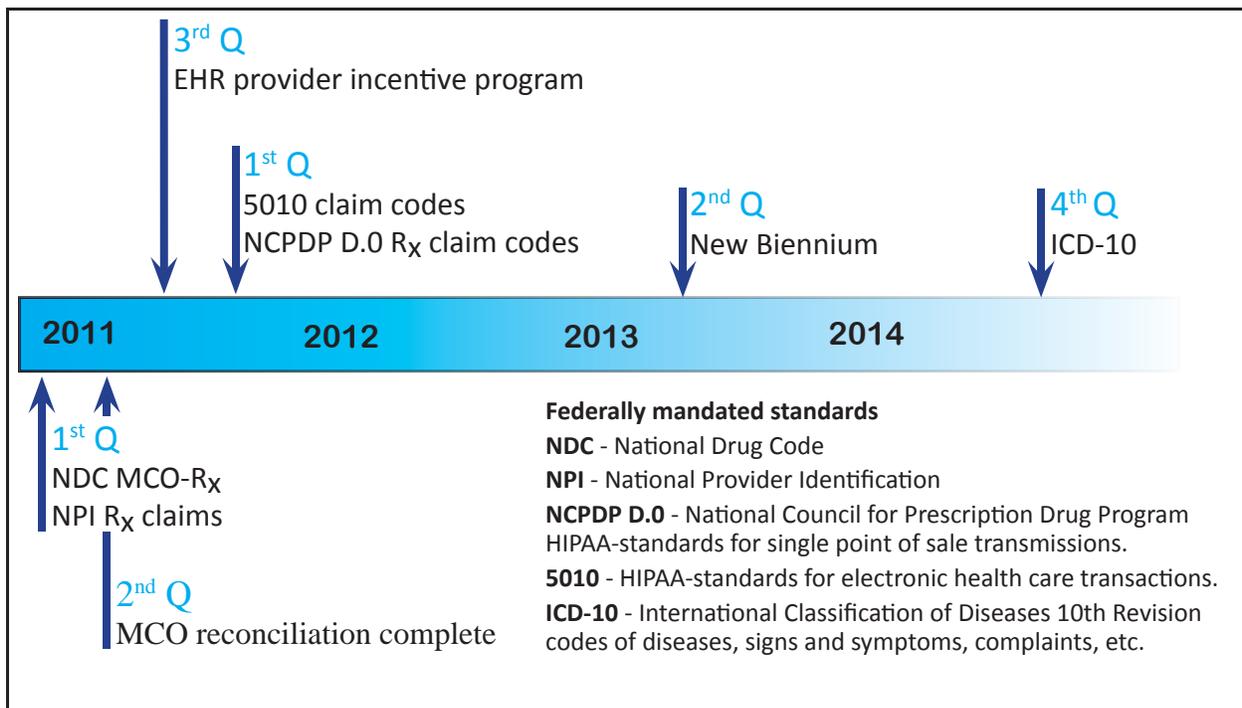
We continue to prepare for the new standards with system upgrading, testing, and work-around processes with our MMIS (Medicaid Management Information System), EDI (Electronic Data Interchange) policies and pharmacy management contractor. Significant changes to MMIS are required to receive and send electronic files in the new formats.

At this time, providers who bill on paper will not be impacted by 5010-related upgrades until ICD-10 codes are mandated October 1, 2013.

For updated information on other areas of interest

- **Oregon Health Authority (OHA) transition** — To track the transition process, visit the Transition Web site at www.oregon.gov/oha/transition. Click on the *submit your suggestions* link to share ideas for a smooth transition, or e-mail to HB2009.transition@state.or.us.
- **Medicaid Management Information System Implementation (MMIS)** — Stay up-to-date with news on claim processing and other transactions updates and changes by eSubscribing to [Provider Matters](#).
- **Federal health care reform** — With its own health care reform efforts already underway, Oregon is well positioned to implement the federal legislative changes. For more information, visit the Oregon Health Authority Web site at www.oregon.gov/OHA.
- **Continuous Improvement program** — Enabling DHS and OHA to continue providing quality services in a time when demand is outpacing revenue and create a culture of continuous improvement where change is driven by staff. For more information, please visit www.oregon.gov/DHS/transformation.

MMIS issues



Demonstration and State Plan Amendment Status

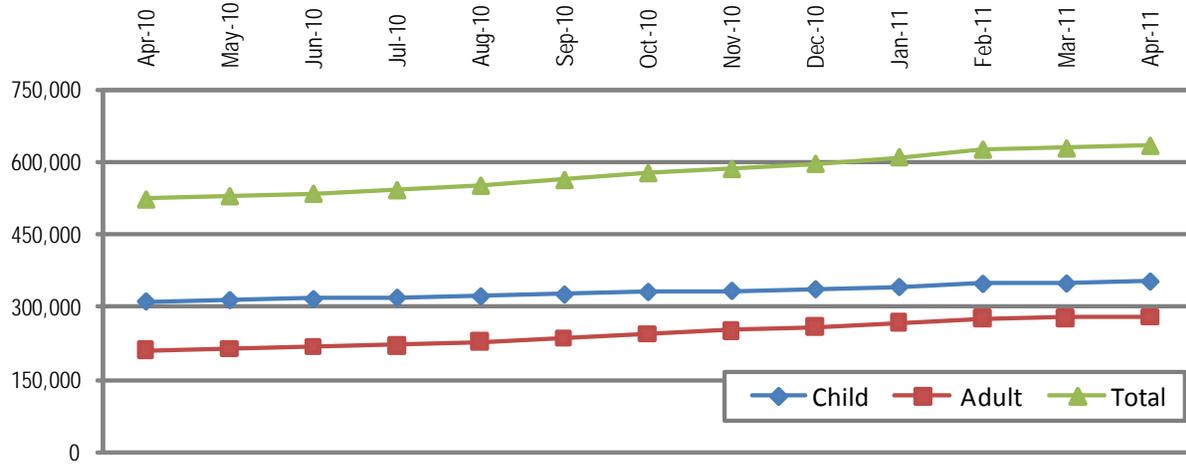
The following table outlines the status of Demonstration and State Plan amendments (SPAs) under review by the Centers for Medicare and Medicaid Services (CMS).

Demonstration Amendments		
Description	Status	Rule Change*
<i>No demonstration amendments are currently under review.</i>		
Medicaid SPA		
<i>TCM — Children who are the responsibility of child welfare</i>	Submitted 6/27/08	No
<i>TCM — Self sufficiency program</i>	Submitted 3/17/10	No
1915(j) state plan option for Home Based Habilitation, HCBS Behavioral Habilitation, HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness — Allows additional flexibility in designing a complete care system for persons with chronic mental illness.	Submitted 7/29/10	Yes
OHA Structure — Revised to reflect the change from DHS to OHA as the Medicaid agency.	Approved 4/4/11	Yes
<i>Personal Care</i> — Companion issue to SPA 10-22 CAF-personal care. CMS directed the state to have additional details to AMH reimbursement for personal care.	Submitted 1/21/11	Yes
<i>Payments outside the United States</i> — Section 6505 of the Affordable Care Act section (amends 1902(a)(80) of the Act) prohibits payments outside of the United States. States are defined to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Provisions include payment for outsourcing call centers or claims processing.	Submitted 4/5/11	No
Children's Health Insurance Plan (CHIP) SPA		
<i>Prenatal Care expansion</i> — Expand to Columbia, Crook, Douglas, Josephine, Jefferson, Morrow, Union and Wasco counties	Submitted 3/28/11	Yes
Oregon Administrative Rules (OAR) SPA		
<i>General Rules</i> — Add a definition for the National Correct Coding Initiative (NCCI) edits required by the Affordable Care Act. Also, included the NCCI edits in the provider appeal rules. 4/29/11		

*To view the entire Rule Notice, go to www.dhs.state.or.us/policy/healthplan/rules/notices.html.

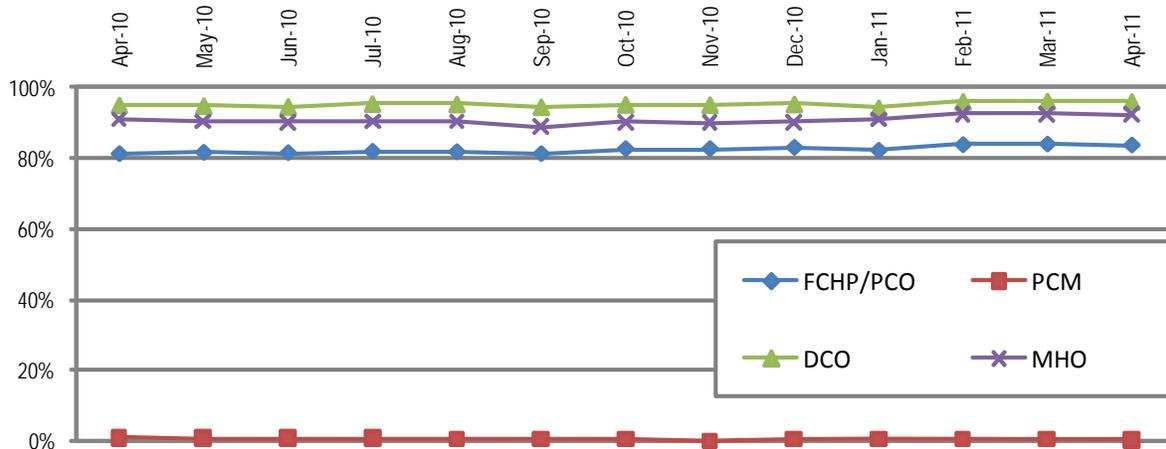
Enrollment Snapshot - April

Number of Oregonians on Medicaid: Total, Adults and Children



Medicaid Enrollment	April 2010	April 2011	Percent Increase
Children (18 and under)	312,191	353,512	13.24%
Adults	210,513	279,693	32.86%
Total	522,704	633,205	21.14%

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



Managed Care Enrollment	April 2010	April 2011	Percent Increase
Fully Capitated Health Plans/ Physician Care Organizations	393,535	493,626	25.43%
Primary Care Managers	4,678	3,199	-31.62%
Dental Care Organizations	460,865	566,073	22.83%
Mental Health Organizations	441,101	543,790	23.28%

June 2011 DMAP Update

2011 Tobacco Annual Survey

Background

Tobacco use is the leading cause of preventable death and disease in Oregon. Each year in Oregon, tobacco use kills nearly 7,000 people with an additional 800 lives lost to second-hand smoking. It claims more lives than motor vehicle crashes, suicide, AIDS, and murders combined.

Tobacco use costs Oregonians more than \$2 billion annually in direct medical expenditures and lost productivity due to early death.

Studies have shown that economic status is the single greatest predictor of tobacco use. Certain racial and ethnic groups, low literacy populations and those living in poverty, bear a disproportionate burden of tobacco use and related illnesses and deaths. In Oregon, direct Medicaid costs related to smoking are an estimated \$287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon.

Tobacco users want to quit smoking. In Oregon, among adult current smokers, 69 percent would like to quit smoking and 47 percent have tried to quit in the past year. While quitting is not easy, and may take several attempts, studies show that tobacco users are two times more likely to quit successfully if they receive help, specifically counseling and medication.

OHP clients receive tobacco cessation benefits and services, with nicotine replacement therapy prescription drugs exempt from copayments.

Update

This is the first year we have systematically assessed how our contracted managed care organizations screen for tobacco use and provide tobacco dependence and cessation services.

A survey was developed as a partnership between DMAP and the Public Health's Tobacco Prevention and Education Program (TPEP) in collaboration with the plans. One of the purposes of the survey is to help providers and other stakeholders find information in one location about the types of covered tobacco cessation services and how they are provided. The survey can be found at http://www.oregon.gov/OHA/healthplan/data_pubs/main.shtml under the Quality and Reporting section.

The survey, based on *Clinical Practice Guidelines*, includes identification of available services provided by the plans; their efforts to present information in a culturally competent manner; identification of counseling, outreach, and pharmacotherapy coverage; description of quality assurance activities, and an evaluation for calendar year 2010. A high-level category summary accompanies each plan's report. A brief summary follows.

Fully Capitated Health Plan tobacco cessation services that are available for members vary considerably by plan. While each plan provides some level of coverage for cessation counseling and medications, many do not routinely promote these available benefits to

members or ensure provider performance related to tobacco cessation, resulting in low utilization of services. Report highlights include:

Assessment: While all 15 plans have some method of identifying tobacco use status; only two report systematically assessing tobacco use status for every member.

All plans have some method of documenting tobacco use status at the provider level; four use electronic medical records and one is currently able to identify tobacco use at the plan level.

Counseling: All 15 plans provide some form of cessation counseling and cover individual counseling with primary care providers. In addition:

- Twelve cover individual counseling with other health professionals (e.g., nurse, health educator).
- Twelve cover group counseling in any form (primary care providers, other health professionals, specific curricula – such as the American Lung Association’s Freedom from Smoking program).
- Eight cover telephonic counseling (via Quit Line vendor or in-house).

Pharmacotherapy: All 15 plans provide coverage for nicotine patches, Wellbutrin and Chantix.

- Of the other four FDA-approved medications; nicotine gum, lozenges, nasal spray and inhaler:
 - Twelve cover nicotine gum; ten cover nicotine lozenges; six cover nicotine nasal spray; and six cover the nicotine inhaler.
 - Five provide coverage for all seven FDA-approved smoking cessation medications.
- Prescription drug products for nicotine replacement therapy do not require copayments. Regarding patient access:
 - Thirteen require a prior authorization for at least one of their covered products.
 - Six require enrollment in a counseling program to receive covered products.
 - Three require a documented quit date set before receiving covered products.

Dental Care Organizations also provide tobacco dependency and cessation services to OHP patients. Report findings include:

- Of the eight plans, seven have some method of identifying tobacco use status;
 - Four ask about tobacco use on health history forms or new patient forms.
 - Seven record tobacco use status in patient charts or medical history forms.
- Seven provide tobacco cessation counseling through dental providers, dental assistants, and/or registered hygienists.
- Seven refer patients to the Quit Line, and five make referrals to medical providers, primary care tobacco counselors, or other resources.

Oregon Health Leadership Council

Background

The Oregon Health Leadership Council is a collaborative organization working to develop practical solutions so health care and insurance is more affordable.

Formed in 2008, health plans, hospitals and physicians work together to identify and act on cost-saving solutions that maximize efficiencies while delivering high quality patient care. The Council is working on four initiatives: Payment and reimbursement reform; evidence-based best practices; value-based benefits, and administrative simplification.

Update

Administrative Simplification: At the request of the Oregon Health Authority, the Council is sponsoring a workgroup to develop standards for Electronic Data Information (EDI) transactions. Over 80 percent of our Medicaid providers use EDI systems. Dr. Goldberg notes that “as we work to make the health care system more efficient - and as providers face reduced rates - it becomes increasingly important to reduce red tape and administrative process. Providers can now spend more time giving care and less time doing paperwork.” The workgroup completed their first deliverable for EDI standardization of key insurance processes.

The work group is continuing work on developing an *Oregon Companion Guide for Institutional, Professional and Dental claims* (837 transactions). A draft guide is expected to be completed by July 1, 2011.

Note: In May, Governor Kitzhaber signed two related health reform bills. The bills will reduce red tape and simplify administrative processes for health care providers.

High Value Patient Centered Care Multi-payer model The Council launched this care model in October 2010, for patients with complex and chronic conditions.

Specially trained nurse care managers act as navigators to develop a personal relationship with the patient to assure quality health care. The Council sponsored a week-long training program in October for nurses to help build these and other skills.

Fourteen medical groups participating in the project have enrolled 3,600 patients with complex and chronic conditions in this pilot care model. OHP clients are participating in the pilot in Medford and Portland Clinics. The initial visit can take up to an hour – with the patient, care manager and team focusing on the patient’s goals and establishing a plan on how to accomplish some of the goals.

To date, outcomes are positive and show comparatively lower costs, which were primarily a result of lower visits to the emergency room; more appropriate use of the hospital; and high levels of patient satisfaction.

Joint Commission to offer Primary Care Medical Home Accreditation

Background

This group was previously named the *Joint Commission on Accreditation of Healthcare Organizations (JCAHO)*. The Joint Commission is an independent, not-for-profit organization and accredits and certifies more than 19,000 health care organizations, hospitals and programs in the United States. The Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Update

The Joint Commission will offer primary care medical home (PCMH) accreditation for ambulatory care organizations beginning July 2011. The accreditation focuses on how primary care physicians and interdisciplinary teams work with the patient. The accreditation combines the improvements in quality of care and patient safety achieved through accreditation.

Providers that meet the requirements of PCMH may have the opportunity for increased reimbursement from third-party payers, according to the Joint Commission. Applications are now being accepted from organizations. For more information, see <http://www.jointcommission.org>.

OHA to apply for Healthy Behaviors grant

The Centers for Medicare and Medicaid Services (CMS) recently announced up to \$10 million is available for state demonstration programs to identify strategies that produce long-term behavioral changes and reward Medicaid clients who adopt healthy behaviors. The goal is prevention, as spending on chronic conditions accounts for more than 75 percent of annual health care expenditures in the U.S. Behavioral incentive programs have shown some promise in specific settings, but they are largely untested in the Medicaid population.

In May, Oregon's legislative Ways and Means Committee approved our request to apply for the grant. The application must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of the condition.

MCO's Enrollment, Disenrollment, Eligibility and Marketing workgroup

Background

Managed Care Organizations meet monthly and work with DMAP to provide and enhance communication with DHS workers concerning enrollment and disenrollment of members, marketing strategies and member education issues to optimize customer service while keeping costs in perspective.

Update

The monthly workgroup has been working on a number of strategies to increase OHP client's *continuity of coverage*. Preliminary studies indicate that of those clients missing their OHP re-application deadline, 50 percent re-enroll with their same managed care plan within

two months and 80 percent within six months. The lack of timely re-application creates a service break for the client, and requires OHP *Standard* clients to place themselves back on the *Reservation List*.

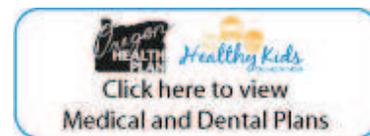
The MCOs are initiating a communication pilot to encourage their members to send in their OHP re-application on time. Although we currently send clients reminder letters, in addition to re-application packets, the expectation is that an additional message will prompt application timeliness. During the pilot, we will identify clients with a 45-day re-application deadline and forward the information to the MCOs. Participating MCOs will send reminder letters, conduct telephone calls, or both.

Another continuous improvement workgroup is studying returned client mail issues. The workgroup will analyze returned a 60-day sample to determine underlying issues in an effort to decrease the volume.

In other news

MCO coverage charts posted online

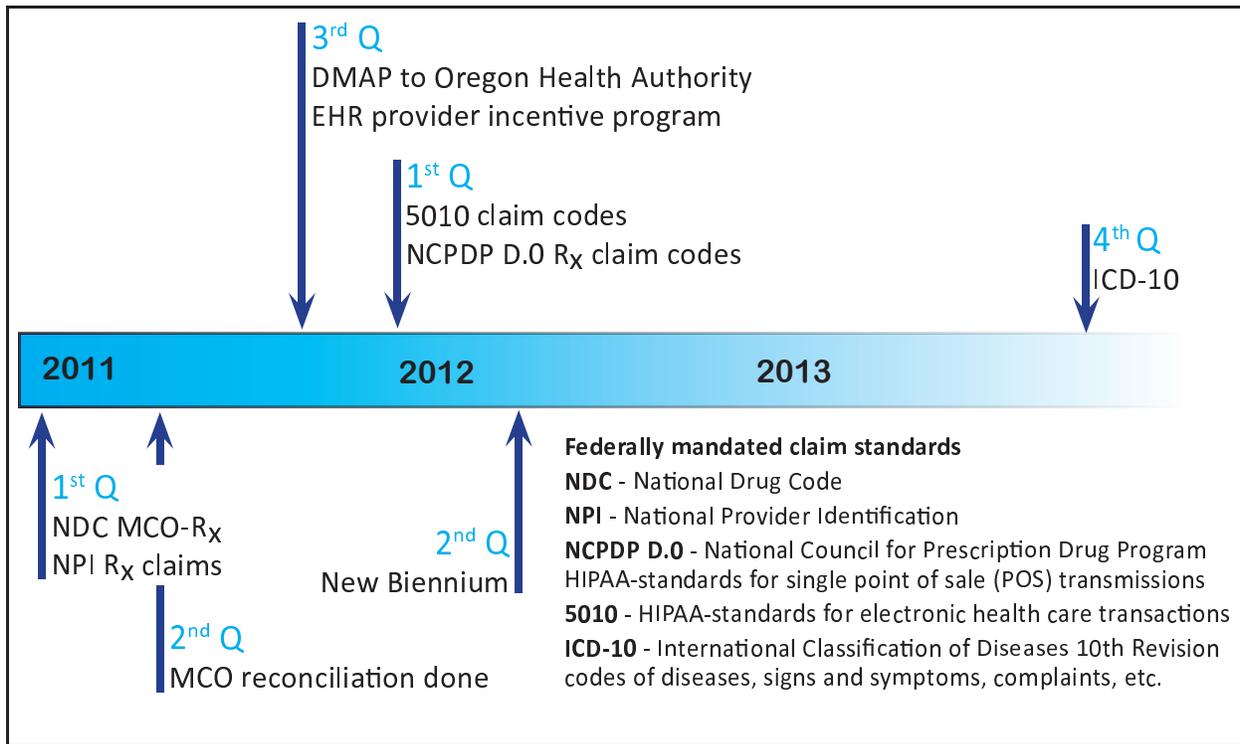
We now post managed care organizations' coverage information on our home Web page at www.oregon.gov/OHA/healthplan/managed-care/plans.shtml. The county charts explain mandatory and voluntary enrollment, show available plans, pharmacies, copayment requirements, and affiliated Medicare Advantage and mental health plans. Charts are provided in English, Spanish, Russian and Vietnamese.



For updated information on other areas of interest

- **Oregon Health Authority (OHA) transition** — To track the transition process, visit the Transition Web site at www.oregon.gov/oha/transition. Click on the *submit your suggestions* link to share ideas for a smooth transition, or e-mail to HB2009.transition@state.or.us.
- **Medicaid Management Information System (MMIS)** — Stay up-to-date with news on claim processing and other transaction updates and changes by eSubscribing to [Provider Matters](#).
- **Federal health care reform** — With its own health care reform efforts already underway, Oregon is well positioned to implement the federal legislative changes. For more information, visit the Oregon Health Authority Web site at www.oregon.gov/OHA.
- **Continuous Improvement program** — Enabling DHS and OHA to continue providing quality services in a time when demand is outpacing revenue and create a culture of continuous improvement where change is driven by staff. For more information, please visit www.oregon.gov/DHS/transformation.

MMIS time line



Demonstration and State Plan Amendment status

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

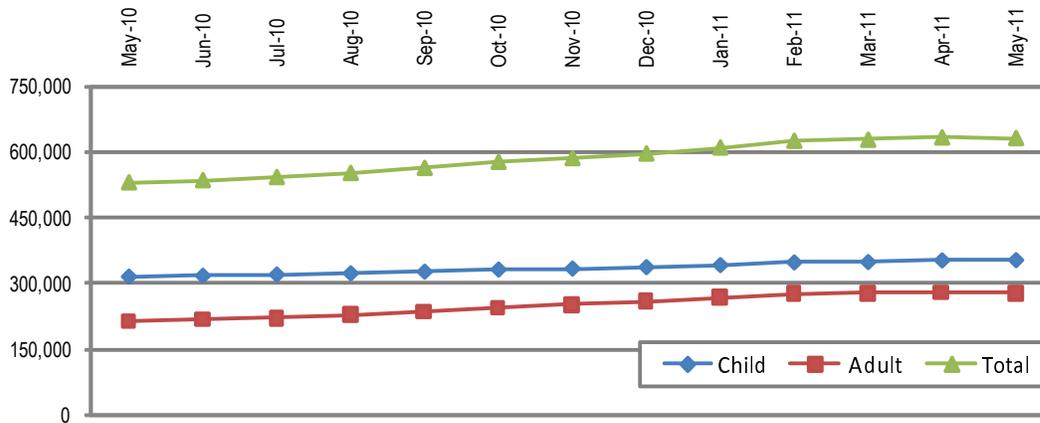
Demonstration Amendments		
Description	Status	Rule Change*
<i>No demonstration amendments are currently under review.</i>		
Medicaid SPA		
<i>Targeted Case Management — Children who are the responsibility of child welfare</i>	Submitted 6/27/08	No
<i>Targeted Case Management — Self sufficiency program</i>	Submitted 3/17/10	No
<i>1915(j) state plan option for Home Based Habilitation, HCBS Behavioral Habilitation, HCBS Psychosocial Rehabilitation for persons with Chronic Mental Illness — Allows additional flexibility in designing a complete care system for persons with chronic mental illness.</i>	Submitted 7/29/10	Yes
<i>Personal Care — Companion issue to SPA 10-22 CAF-personal care. CMS directed the state to have additional details to AMH reimbursement for personal care.</i>	Submitted 1/21/11	Yes

Medicaid SPA cont.		
<i>Payments outside the United States</i> — Section 6505 of the Affordable Care Act section (amends 1902(a)(80) of the Act) prohibits payments outside of the United States. States are defined to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Provisions include payment for outsourcing call centers or claims processing.	Submitted 4/5/11	No
Children's Health Insurance Plan (CHIP) SPA		
<i>Prenatal Care expansion</i> — Expand CAWEM Prenatal to Columbia, Crook, Douglas, Josephine, Jefferson, Morrow, Union and Wasco counties	Submitted 3/28/11	Yes
Oregon Administrative Rules (OAR)* - No corresponding SPA		
<i>American Indian/Alaska Native</i> — Clarify practitioner enrollment (2 rules)	Effective 7/1/11	
<i>Federally Qualified Health Centers</i> — Clarify practitioner enrollment (2 rules)	Effective 7/1/11	
<i>Law Enforcement Medical Liability Account</i> — Move from chapter 461 to 410 (2 rules)	Effective 7/1/11	
<i>General</i> — Add definition for the National Correct Coding Initiative (NCCI) edits and include in Provider Appeal rules	Hearing 6/17/11	
<i>General</i> — Add Oregon Health Authority definition	Hearing 6/17/11	
<i>General</i> — Conduct medical assistance eligibility determinations using OAR chapter 461 medical eligibility rules	Hearing 6/17/11	
<i>School-Based Health Services</i> — Align with current licensing board rules (3 rules)	Hearing 6/17/11	
<i>Durable Medical Equipment</i> — Expand access to diabetic supplies allowing both DMEPOS providers and pharmacies to dispense	Hearing 6/17/11	
<i>Pharmacy</i> — Update Prior Authorization (PA) criteria, PDL, and other changes	Hearing 6/17/11	
<i>Medicaid Electronic Health Record (EHR) Incentive program</i> — Rules to implement, administer and audit the new program (7 rules)	Hearing 6/17/11	

*To view the entire Rule Notice, go to <http://www.dhs.state.or.us/policy/healthplan/rules/notices.html>.

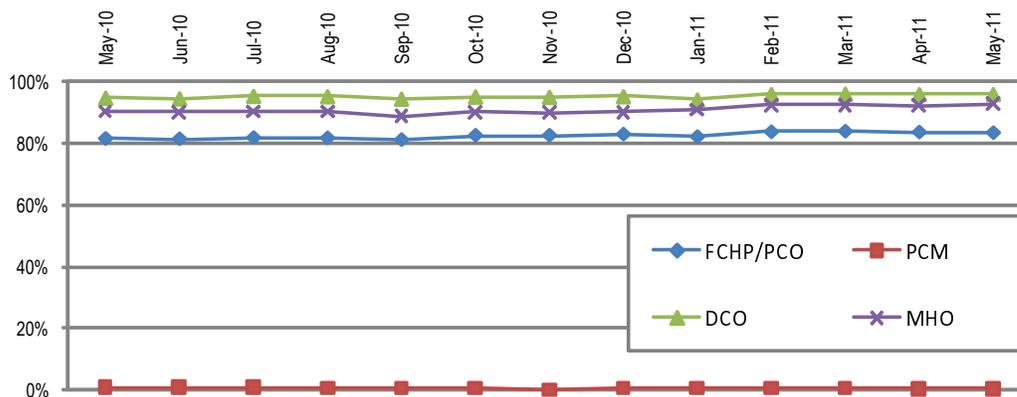
Enrollment Snapshot - May

Number of Oregonians on Medicaid: Total, Adults and Children



Medicaid Enrollment	May 2010	May 2011	Percent Increase
Children (18 and under)	314,933	354,094	12.43%
Adults	214,603	277,686	29.40%
Total	529,536	631,780	19.31%

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



Managed Care Enrollment	May 2010	May 2011	Percent Increase
Fully Capitated Health Plans/ Physician Care Organizations	400372	491359	22.73%
Primary Care Managers	4214	3166	-24.87%
Dental Care Organizations	465669	564414	21.20%
Mental Health Organizations	444001	546140	23.00%