MEDICAID ADVISORY COMMITTEE
June 22nd, 2016
9:00am-Noon
Oregon State Library, Room 103
250 Winter St. NE, Salem OR 97301

Webinar registration: https://attendee.gotowebinar.com/register/3520305647582851585
Call– In number: 888.398.2342; code: 3732275

Time	Item	Presenter
9:00	Opening remarks	Co-Chairs
9:05	MAC membership and recruitment	Co-Chairs
9:15	OHA access monitoring • FFS Access Monitoring Plan overview • OHA access monitoring methods	Jamal Furqan, OHA and Rusha Grinstead, OHA
10:00	Oregon Ombuds Advisory Council	Ellen Pinney, OHA
10:20	**Break**	
10:30	Health Evidence Review Commission (HERC) update • Overview of Prioritized List and dental benefits	Darren Coffman, OHA
11:00	OHP eligibility, enrollment and redetermination	Dr. Varsha Chauhan, OHA
11:30	Oral Health Work Group • Work plan update • Recruitment and roster review	Co-Chairs
11:45	Public Comment	
11:55	Closing comments	Co-Chairs

Next Meeting:
Wednesday, July 27th: 9:00 a.m. – 12:00 p.m.
Oregon State Library bldg. -Room #103
250 Winter St. NE, Salem, OR 97301

Medicaid Advisory Committee Membership (*as of June 2016)

ORS Requirements for MAC Membership	Members/Name	City	Race/ Ethnicity	Gender	Expertise	Term	Status/Notes
Licensed physician & Health Care Providers	Vacant						
	Marcia Hille	Aloha	C	F	Behavioral health providers; Executive Director	04-1-2015 thr 02-28-2017	1st term
	Janet Patin, MD	Reedsport	C	F	Physician	09-19-2014 thru 09-18-2016	Co-chair/2nd term
Two members of health care consumer groups that include Medicaid recipients	Laura Etherton	Portland	C	F	Health Policy/Safety Net	2-1-2015 thru 1-31-2017	1st term
	Leslie Sutton	Salem	C	F	Social Services/ DD community	01-08-2015 thru 01-07-2017	2nd term
Two Medicaid recipients, one of whom shall be a disabled person	Ross Ryan	Mt. Angel	C	M	OHP Beneficiary	2-1-2015 thru 1-31-2017	1st term
	Vacant						
Persons associated with health care organizations	Karen Gaffney	Eugene	C	F	Deputy, Lane County Health Services	04-1-2015 thr 01-07-2017	Co-chair/2nd term (CCO)
	Carol Criswell	Tigard	C	F	Health Navigator/Children	03-01-2015 thru 02-28-2017	2nd term
	Alyssa Franzen, DDS	Portland	C	F	Dentist/Care Oregon	2-1-2015 thru 1-31-2017	2nd term
Members of the general public	Glendora Claybrooks	Tualatin	B	F	OHP Beneficiary'Health Share CAC member	01-08-2015 thru 01-07-2017	1st term
	Bob Diprete	Amity	C	M	Former MAC Director, OHP Policy Expert	2-1-2015 thru 1-31-2017	1st term
Director of OHA or designee	David Simnitt	Salem	C	M	Health Policy Director, OHA	5-2-2016 thru 4-29-2018	1st term Ex Offico
Director of DHS or designee	Anna Lansky	Salem	C	M	Deputy Director, Office of Developmental Disability Services	06-01-2015 thru 05-30-2017	1st term Ex Offico/DHS

*** (Consisting of not more than 15 members appointed by the Governor ORS 414.211)**

Oregon's Medicaid Advisory Committee (MAC) is actively looking for individuals interested in helping improve the quality of care for Oregonians. Members appointed by the Governor can serve two, two-year consecutive terms.

The MAC, a federally mandated body, advises the Oregon Health Policy Board, the Oregon Health Authority and the Department of Human Services (DHS) on the operation of Oregon's Medicaid program: the Oregon Health Plan. The MAC also develops policy recommendations at the request of the Governor and the Oregon Health Authority. Current and past policy work includes:

- Developing a framework on oral health access in Oregon (2016)
- Submitting recommendations on 12-month continuous eligibility for adults (2015)
- Recommending the Alternative Benefits Benchmark Plan for Oregon's Medicaid expansion (2012)

The committee is particularly looking for members in the following areas: (1) a physician, (2) other health care providers; (3) individual currently covered by the Oregon Health Plan or members of health care consumer groups that include Medicaid recipients such as a coordinated care organization (CCO) consumer advisory group (CAC); (4) representatives from a hospital organization or integrated health system that partners with a CCO; and (5) members of the general public. Individuals from all areas of the State are encouraged to apply.

The committee seeks new members who can:

- Regularly attend committee meetings (fourth Wednesday of the month in Salem from 9-12pm)
- Contribute to policy-level discussions about the future of health care in Oregon
- Spend approximately 1-2 additional hours each month to prep prior to the meetings (i.e. review of meeting materials)

The MAC is committed to ensuring that a diverse group of individuals are welcomed to the table, and that committee recommendations are truly representative of the populations they are intended to serve. Members are able to join remotely on occasion via conference line and webinar. Direct travel expenses are reimbursed. If you are interested in helping to improve Oregon's Medicaid program through the work of the MAC, please contact Amanda Peden by phone (503-208-1010) or e-mail: Amanda.Peden@state.or.us.

Past meeting agendas and materials can be found on the MAC's website:
http://www.oregon.gov/oha/OHPR/MAC/Pages/index.aspx

Oregon FFS Access Monitoring Review Plan
Overview of Requirements

June 22nd 2016

42 C.F.R. § 447.203(b)

Jamal Furqan - Health Systems Division

Rusha Grinstead, MS, MPH, PMP - Health Policy & Analytics Division

Oregon Health Authority

Background

– November 2nd 2015: CMS issues final rule "Methods for Assuring Access to Covered Medicaid Services" in Federal Register Vol. 80 No. 211

- Access Monitoring Review Plan to be submitted July 1st 2016

– February 2016: OHA assembles team consisting of the Health Systems Division (HSD), Health Policy & Analytics (HPA) Division, and Actuarial Services Unit (ASU)

– April 12th 2016: CMS extends deadline for states to submit their plans to **October 1st 2016** in Federal Register Vol. 81 No. 70

– May & June 2016: OHA hosts several meetings with Tribal Governments to request public comment and present access plan overview

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Access Monitoring Review Plan Requirements

Data, sources, methodologies, baselines, assumptions, trends and factors, and thresholds that analyze and inform determinations of the sufficiency of access to care, which may vary by geographic location within the state and will be used to inform state policies affecting access to Medicaid services such as provider payment rates. (42 C.F.R. §447.203(b)(1))

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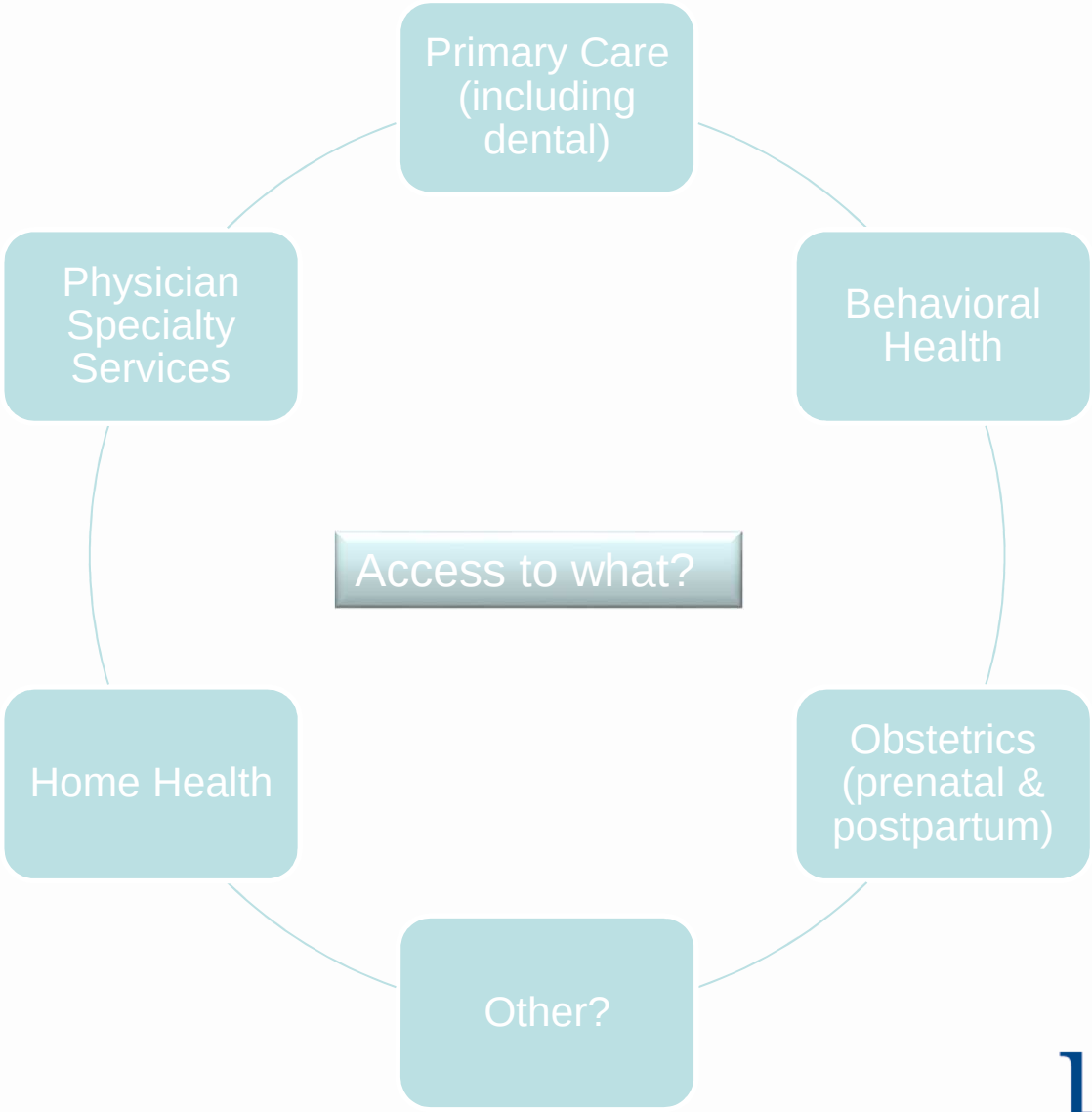
Monitoring Specific Service Categories



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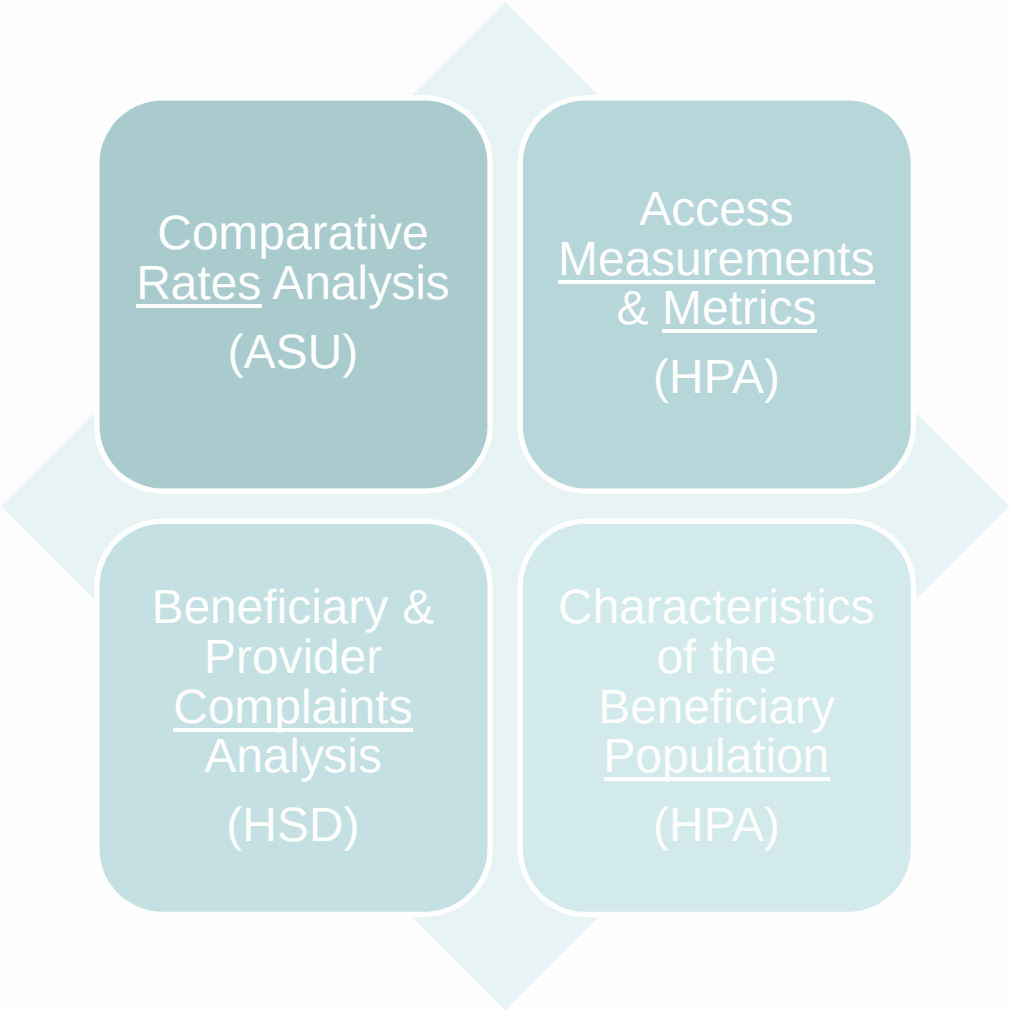
Oregon must complete a regional study of the following components



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	Measure	Source	Population	Medicaid	FFS	Rationale
Access to Care	Access to Mental Health Services (Whether individuals received MH service they needed. Whether service location was accessible to individuals)	Client services survey	Adult + Child	yes	Yes	Used by Block grant and DOJ
	Access to Emergency and urgent care (Whether individuals usually/always receive the care they needed)	Consumer Assessment of Health Providers and Systems Survey	Adult + Child	yes	Yes	CHIPRA measure, CCO incentive measure, waiver evaluation measure, State performance measure
	Access to routine care (Whether individuals always/usually received routine check-up when they needed)	Consumer Assessment of Health Providers and Systems Survey	Adult + Child	yes	Yes	CHIPRA measure, CCO incentive measure, waiver evaluation measure, State performance measure
	Access to specialists (Whether individuals usually/always found a specialist)	Consumer Assessment fo Health Providers and Systems Survey	Adult + Child	yes	Yes	CHIPRA measure
	Access to personal doctor (Whether individual has a personal doctor who knows their medical history)	Consumer Assessment fo Health Providers and Systems Survey	Adult + Child	yes	Yes	CHIPRA measure
	Access to emergency dental care (Whether individuals usually/always got emergency dental care when they needed)	Consumer Assessment fo Health Providers and Systems Survey	Adult + Child	yes	Yes	CHIPRA measure, chosen by Dental Metric Committee
	Access to a regular dentist (Whether individuals have access to a regular dentist)	Consumer Assessment fo Health Providers and Systems Survey	Adult + Child	yes	Yes	CHIPRA measure, chosen by Dental Metric Committee

	Measure	*Source*	*Population*	*Medicaid*	*FFS*	*Rationale*
Provider availability	Provider accepting new Medicaid patient	Physician Workforce Survey	Adult + Child	yes	Can be added starting 2016	waiver evaluation measure
	Provider currently with medicaid patients	Physician Workforce Survey	Adult + Child	yes	Can be added starting 2016	waiver evaluation measure
	Reason provider closed practice to Medicaid (Administrative burden, reimbursement rates, payer balance, complex patients, cost of liability insurance, non-compliant patient, other)	Physician Workforce Survey	Adult + Child	yes	Can be added starting 2016	waiver evaluation measure
	Ease of Referral for Medicaid patients (Usually/always able to refer patients to non-emergency hospital, SUD and MH service, diagnostic imaging, ancillary services, specialists)	Physician Workforce Survey	Adult + Child	yes	Can be added starting 2016	waiver evaluation measure

	Measure	*Source*	*Population*	*Medicaid*	*FFS*	*Rationale*
Utilization	Adolescent well-care visit	MMIS	Child	yes	yes	CCO Incentive Measure
	Childhood and adolescent visit with PCP	Billing claims	Child	yes	yes	State Performance Measure
	Well-child visit in first 15 months of life	MMIS	Child	yes	yes	State Performance Measure
	Follow up after hospitalization for MH services	Billing claims	Adult + Child	yes	yes	CCO Incentive Measure
	Follow up care for children prescribed ADHD medication	Billing claims	Child	yes	yes	State Performance Measure
	Initiation and engagement of alcohol and drug treatment	Billing claims	Adult + Child	yes	yes	State Performance Measure

Bottom Line

States must determine the “sufficiency of access to care” (42 C.F.R. §447.203(b)(1))

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Oregon FFS Access Plan: Challenges

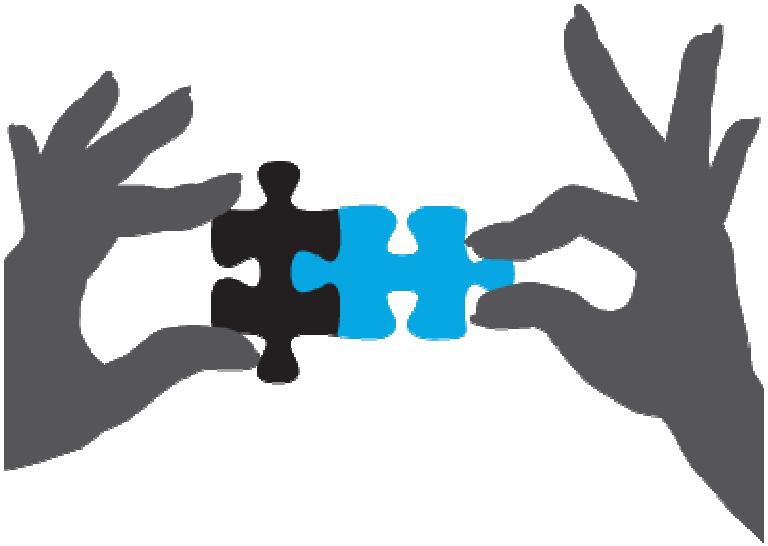
- Short timeframe to produce data & analytics for all service categories
- Infrastructure for beneficiary and provider complaints may not initially produce the most reliable data
- Various APMs implemented at CCOs make FFS rate comparisons more difficult

Questions?

Jamal Furqan

503-945-6683

Jamal.Furqan@state.or.us



Oregon Health Authority

State of Oregon
Health Evidence Review Commission
Prioritized List, Restored Dental Benefits and Back Pain Coverage Changes

June 22, 2016

Darren Coffman
Director, Health Evidence Review Commission

Oregon Health Authority

Health Evidence Review Commission

- Formerly Health Services Commission (1989-2011)
- 13 Governor-appointed, Senate-confirmed Members
  - 5 Physicians
  - Dentist
  - Public health nurse
  - Behavioral health representative
  - 2 consumer representatives
  - Complimentary & Alternative Medicine provider
  - Insurance industry representative
  - Retail pharmacist

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Prioritized List

- **The Prioritized List of Health Services** serves to prioritize healthcare services for the Oregon Health Plan, ensuring coverage for the most important services in maximizing population health while controlling costs.

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Medicaid Expansion Policy Objectives

- Improve health
  - Goal is not coverage/insurance but health
- Would rather cut benefits to save money rather than have people lose coverage or not pay providers fairly
- Cover benefits that are clinically effective and are most important to Oregonians
- Create a public, transparent process

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Assumptions of the List

- **Every person is entitled to a diagnosis**
  - Diagnostic office visit(s)
  - Imaging/lab
  - Biopsies
- **Each covered condition includes**
  - Prescription drugs
  - DME and supplies
  - Other ancillary services
- **Services Recommended for Non-Coverage do not appear on list**
  - Excluded in Department of Medical Assistance Programs administrative rules (e.g., infertility treatment)
  - Cosmetic services
  - Experimental treatments
  - Not effective for any condition

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Sample Prioritized List Line

Line number (funding line is 476 for this list)

Condition/Treatment descriptions (plain English approximations)

Reference to guideline notes

Line: 183
Condition: ACUTE LEUKEMIA, MYELODYSPLASTIC SYNDROME (See Guideline Notes 7,11,12,14)
Treatment: BONE MARROW TRANSPLANT
ICD-10: C88.8,C90.10-C90.12,C91.00-C91.02,C95.00-C95.02,D46.0-D46.1,D46.20-D46.9,D47.1,D47.3, D61.810,Z48.290,Z52.000-Z52.098,Z52.3
CPT: 36680,38204-38215,38230-38243,64505-64530,86828-86835,98966-98969,99051,99060,99070, 99078,99184,99201-99239,99281-99285,99291-99404,99408-99416,99429-99449,99468-99480, 99487-99498,99605-99607
HCPCS: G0396,G0397,G0406-G0408,G0425-G0427,G0463,G0466,G0467,S2142,S2150,S9537

Billing codes (ICD-10 are diagnosis; CPT and HCPCS are procedures)

If the diagnosis and the procedure appear on the same line, the service is covered said to “pair” (though it may be subject to a guideline note or coding specification)
If the line number where it “pairs” is above the funding line, it’s covered.

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Examples of non-dental Rankings in 2016

Funded Lines:

26	Schizophrenia
51	Appendicitis
143	Glaucoma
195	Breast Cancer
348	Dental Caries (Fillings)
360	Closed Fracture of Extremities
373	Strep Throat
407	Nonsurgical treatment for back condition
415	Migraine Headaches

Unfunded Lines:

479	Chronic Otitis Media
516	Esophagitis and GERD (long-term medical therapy)
527	Uncomplicated Hernia
565	Transplant for Liver Cancer
609	Sleep Disorders w/o Apnea
617	Common Cold

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Dental Rankings in 2016

Funded Lines:

57 Preventive Dental Services*
58 Emergency Dental Services
223 Basic periodontal*
271 Urgent Dental
348 Basic restorative*
349 Oral Surgery (includes extractions)
389, 416, 448 Basic Endodontics (root canals)
457 Removable prosthodontics (dentures)*
461 Retreatment of root canals, front teeth
472 Basic crowns*

Unfunded Lines:

496 Peridontal surgery/splinting
510,540 Retreatment of root canals, permanent bicuspid/premolar/molar
594 Advanced restorative (Inlays, onlays, gold foil, high noble metals)
604 Fixed bridges, overdentures
621 Orthodontia
622 Implants
649 Cosmetic services
650 Elective services

*Some benefits reduced in 2003-2009 for non-pregnant adults

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Dental Coverage Changes - Crowns

Legislature restored certain benefits for non-pregnant adults

Benefit	Prioritized List	Reduced Benefit	New benefit as of 7/1/16
Stainless steel crowns	Line 348 (basic restorative)	Non covered	For anterior primary teeth and posterior permanent or primary teeth.
Other crowns	Line 472 (Advanced restorative)	Not covered	Not covered

Oregon Health Authority

Dental Coverage Changes - Dentures

Legislature restored certain benefits for non-pregnant adults

Benefit	Prioritized List	Reduced Benefit	New benefit as of 7/1/16
Dentures (full)	Line 457	No replacement; only provided for recent tooth loss	Replacement once every 10 years, regardless of time of tooth loss
Dentures (Partial)	Line 457	Replacement every 10 years	Replacement every 5 years if appropriate

Oregon Health Authority

Dental Coverage Changes - Other

Legislature restored certain benefits for non-pregnant adults

Benefit	Prioritized List	Reduced Benefit	New benefit
Periodontal scaling and root planning	Line 223 (basic periodontics)	Once every three years	Once every two years
Periodontal maintenance	Line 223 (basic periodontics)	Once every twelve months	Once every six months
Full mouth debridement	Line 57 (preventive)	Once every three years	Once every two years

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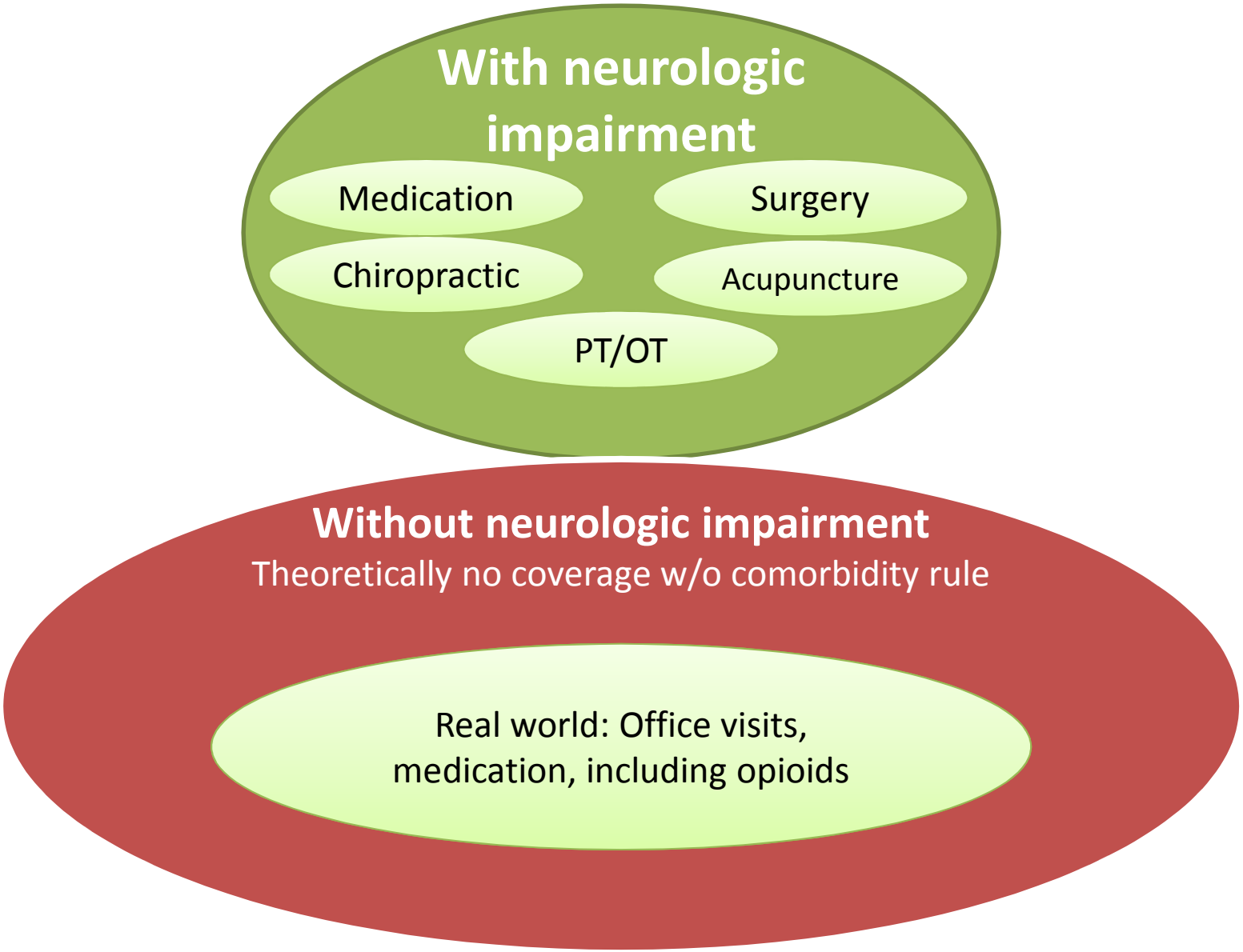
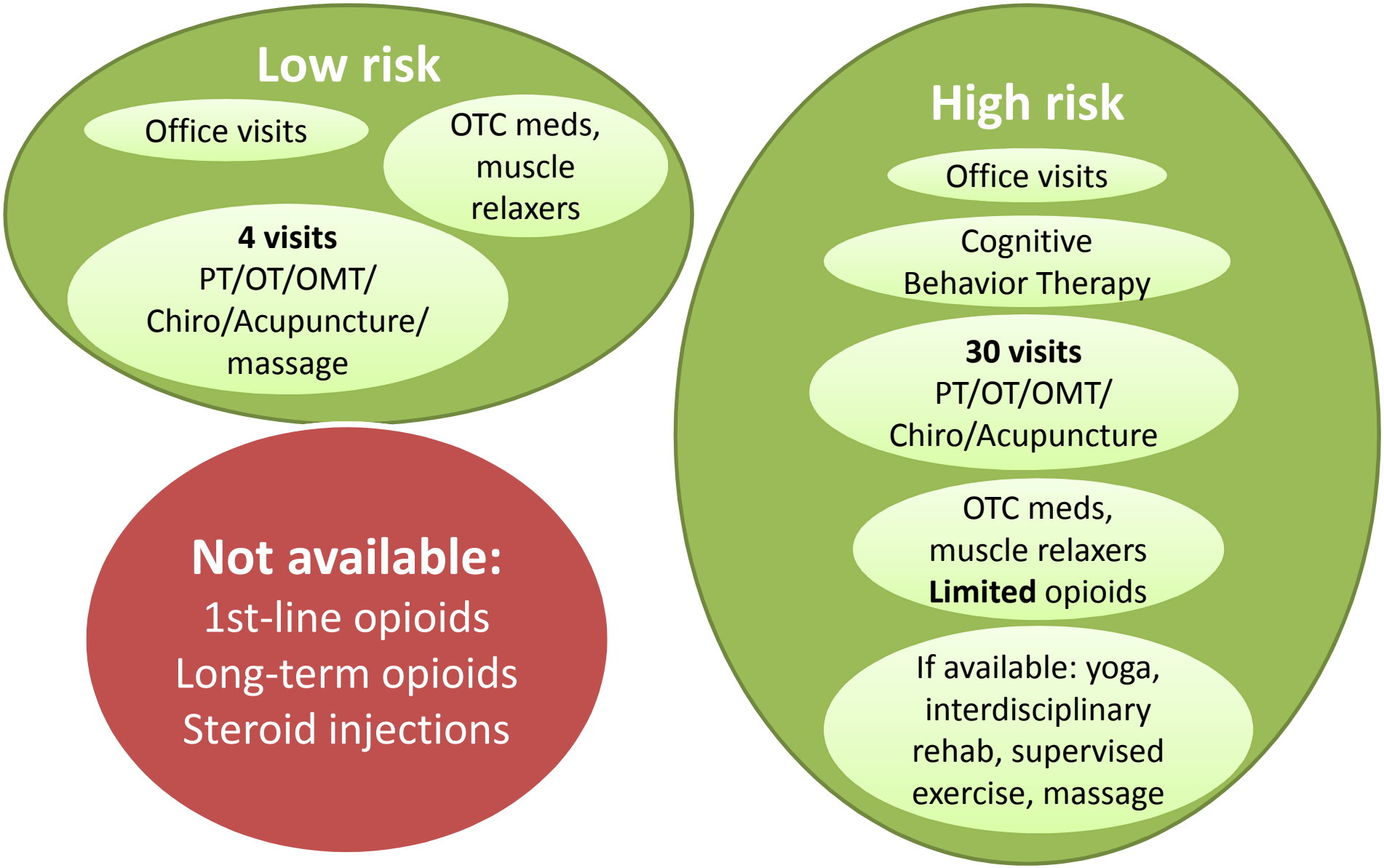
Current OHP Back Pain Coverage (simplified)



Back Pain Evidence Summary

- **New approach to "conservative care"**
  - Timely treatment aimed at prevention of chronicity/poor clinical outcomes
  - Focus on biopsychosocial approach
  - Encouraging patient activation
  - Focus on functional improvements
- **Surgery**
  - No more effective than self-care and medical management for most conditions
  - Significantly more costly/increased complications
- **Opioids**
  - Insufficient evidence for long-term benefit
  - Significant evidence of dose-dependent risk of harms

New Non-Surgical Treatment Buckets



Surgical Treatments

- **Surgery available for:**
  - High risk conditions
  - Conditions with good evidence that surgery helps more than conservative therapy
- **Non-urgent surgical conditions**
  - No coverage
- **Scoliosis**
  - Surgery for adolescents only

Oregon Health Authority

Health Systems Division

Information Memorandum Transmittal

Chris Norman, Manager
Delivery System Support Unit

Authorized Signature

Number: OHP-IM-16-023

Issue Date: 06/03/2016

Topic: Medical Benefits

Subject: Changes to Oregon Health Plan (OHP) benefit coverage effective July 1, 2016

Applies to:

- ☐ All DHS employees
- ☒ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☐ County DD Program Managers
- ☐ County Mental Health Directors
- ☒ Aging and People with Disabilities
- ☒ Other (please specify): Health Systems Medicaid/CHIP staff

Message:

Starting July 1, 2016, the Oregon Health Plan (OHP) will have the following changes to its benefit coverage:

- **Some more dental benefits for non-pregnant adults** – To learn more, read our provider letter *(issued May 31, 2016 to 1,100 dental providers)* and talking points.
- **Coordinated care organizations (CCOs) will cover applied behavior analysis services for CCO members** – To learn more, read our provider letter *(issued May 3, 2016 to 72 ABA providers)* and talking points.
- **Technical changes to the Prioritized List of Health Services to expand coverage for treatment of back conditions** – To learn more, read the Health Evidence Review Commission's fact sheet and technical changes summary.

If you have any questions about this information, contact:

Dental questions:	Sarah Wetherson, Policy Analyst; sarah.e.wetherson@state.or.us
ABA questions:	Lea Forsman, Policy Analyst; lea.forsman@state.or.us
Prioritized List questions:	Health Evidence Review Commission, herc.info@state.or.us

Oregon Health Plan

Talking points about OHP Plus dental coverage for non-pregnant adults starting 7/1/2016

Last updated 5/31/2016

Background info

Starting July 1, 2016, if the person's dentist orders it, the Oregon Health Plan (OHP) will cover the following benefits for non-pregnant adults with OHP Plus (BMM, BMD, BMH) benefit packages:

- Gum disease (periodontal) care every 6 months
- Deep cleaning for gum disease every 2 years
- Stainless steel crowns on back teeth (molars)
- Full dentures every 10 years and partial dentures every 5 years no matter how long the person has been without teeth. Even if dentures were denied in the past, on or after 7/1/2016, they may be covered if the person's dentist orders them.

Letter to affected members (mailed May 31, 2016)

The Oregon Health Authority (OHA) mailed a letter to approximately 18,000 members who receive dental services on a fee-for-service basis. The letter explains which dental services will be available starting July 1, if dentally appropriate.

CCOs will also notify their members about the change.

Questions and answers

What is changing?

Covered dental services for adults age 21 and over are increasing. Starting July 1, 2016, if the person's dentist orders it, OHP will also cover these:

- Gum disease (periodontal) care every 6 months
- Deep cleaning for gum disease every 2 years
- Stainless steel crowns on back teeth (molars)
- Full dentures every 10 years and partial dentures every 5 years no matter how long the person has been without teeth. Even if dentures were denied in the past, on or after 7/1/2016, they may be covered if the person's dentist orders them.

Who does this affect?

This change is for non-pregnant adults age 21 and over who are on OHP (benefit packages BMM, BMD or BMH).

Pregnant women and children under 21 already have these benefits, and that will not change. Pregnant women get these benefits under benefit packages CWX or BMP.

The coverage letter we sent you after you enrolled in OHP show the benefit packages you have.

Why was I told OHP doesn't cover dentures?

In the past, OHP only covered dentures for adults up to 6 months after losing their teeth. If you lost your teeth more than 6 months before your dentist ordered them, dentures weren't covered. On July 1, 2016, that will change – you may get dentures if your dentist orders them no matter how long ago you lost your teeth.

Can these services ever be denied?

Yes, they can be denied if they are not right for you or if it is too soon to replace your last set of dentures. You can ask your dentist to explain why. You can appeal a denial through your CCO's or dental plan's appeal process, and ask for a state fair hearing through OHA.

Why is this changing now?

OHA received money to expand dental coverage for adults on OHP.

Oregon Health Plan

Talking points about applied behavior analysis coverage
for coordinated care organization members starting 7/1/2016

Last updated 5/31/2016

Background info

On January 1, 2015, the Oregon Health Authority (OHA) added applied behavior analysis (ABA) services as a covered benefit for Oregon Health Plan (OHP) members with a diagnosis of autism spectrum disorder or self-injurious behavior due to a neurological dysfunction. This benefit was paid by OHA on a fee-for-service basis for all eligible members.

Starting July 1, 2016, CCOs will coordinate these services for their members.

Communication to affected members

CCOs will notify their members about this change.

Questions and answers

What is changing?

Starting July 1, 2016, CCOs will cover ABA services. The services must be ordered by a doctor or psychologist.

Now all ABA services are approved and paid for by the Oregon Health Authority (OHA). Starting July 1, 2016, CCOs will cover their members' ABA therapy.

OHA will still approve and pay for ABA services for people who are not in a CCO.

Are ABA services changing?

No, ABA benefits covered by OHP will stay the same. The change is in who approves and pays for ABA services. For people in CCOs, the CCO will approve and pay for them. For people who are not in a CCO, OHA will approve and pay for them, the same as now.

Why is this changing?

CCOs must coordinate all their members' medical, dental, mental and behavioral health care needs. This change allows CCOs to get information about their members' ABA service needs. This will help them coordinate all their members' health care.

Can a CCO stop or change ABA services that OHA approved?

A CCO cannot stop or change a course of ABA treatment that OHA has approved, even if it continues past July 1, 2016, for up to 90 days. You can finish ABA treatment that OHA approved.

On and after July 1, 2016, your doctor will need to ask your CCO to approve new sessions of ABA. Your CCO will tell you if it has a different approval process. If your CCO stops or reduces your services, you can appeal it through your CCO's appeal process, and ask for a state fair hearing through OHA.

Can I keep my ABA provider?

Most members will be able to keep their own provider. Please contact your CCO to see if they have a contract with your ABA provider.

Questions?

Please call your CCO or your ABA provider with questions about ABA services and coverage. If you are not in a CCO, you can call OHP Client Services.

Oregon Health Authority

UPDATE

VARSHA CHAUHAN

JUNE 22ND 2016

Jan 2015 Memo

OHP performance metrics should provide consistent, timely, and reliable program data to monitor Medicaid:

- Monthly applications
- Number of determinations or renewals
- Number of individuals determined ineligible for OHP by determination reason.
- The number of redeterminations and closures for probably the last 18 months (e.g. a dashboard) including how many individuals return after coverage is terminated.

Progress

- Dashboards to track data presented to leadership and community partners every month
- Focus on Renewal cycle, Backlog, and Call wait times
- Contracted with Linda Hammond to help develop a tool to collect and analyze the data- 4 months project

Challenges

- True source of data
- Validated data
- Multiple competing priorities
- Tool to collect and analyze the data
- We’re not yet 90 days out from our first closure date (March 31)

Next steps

Communication from OHA External Communication Director, BethAnne Darby and Project lead Kate Nass, mid July- a couple of months specific data(May and June's redeterminations).

How long is it taking for those individuals in the line for reapplications to get back onto OHP?

- Oregon Health Plan members receive notification and an application packet approximately 60 days before their renewal date. If a member does not respond before their renewal date, benefits are closed.
- Historically, approximately 45% of members whose benefits closed re-enrolled in OHP within 90 days. (This rate is based on data from October 2015.)
- Our first closure date this year was March 31, 2016. We do not yet have 90-day analysis available for 2016 closure re-enrollment or “churn” rate. Once this information is available, we will share it.

In case of people who are not renewed, are there patterns emerging to identify if it's a processing glitch or loss of eligibility? If it is a glitch, has OHA identified areas that need further attention and what to do about this? If it is a loss of eligibility, is there information about why people are losing eligibility?

- Renewal applications are prioritized and Member Services has implemented several strategies to help prevent inappropriate closure after a member has submitted a renewal application.
- For example, a dedicated team was created to process new applications through the Application Registration step, which allows for matching in ONE. This prevents closure for members who have submitted an application and have been registered.
- OHA resumed the renewal process in the spring and there has been three full renewal and closure cycles so far this year. We have found that approximately 60% of members renew benefits by their renewal date. At this time, the majority of closures seem to be caused by non-response.
- We have not encountered any glitches causing closure.

2016 Application Revision Timeline

- June 6 to June 30 – Feedback period
- July 1 to July 8 – Revisions and copy edit
- July 11 to July 15 – Leadership approval
- July 18 to July 22 – Final revisions and printing prep
- July 22 – Send to CMS, DOJ for approval
- July 22 to August 15 – Develop and finalize supplemental materials (Application guide, inserts, etc.)
- August 8 to August 30 – Translations and review
- September 6 – Print application and supplemental materials
- November 1 – Application released

Application feedback

Please submit feedback by June 30 to: tiffany.t.reagan@state.or.us

Oregon Health Plan
Enrollment and Renewals
Monthly Update

June 2, 2016

Oregon Health Authority

Today's agenda

- Introduction
- Oregon Eligibility (ONE) System update
- Oregon Health Plan Operations update
- Questions collected

Oregon Health Authority

Introduction

Welcome to the fifth Oregon Health Plan: Enrollment and Renewals *Monthly Update* meeting.

Today's presenters:
Varsha Chauhan, Chief Health Systems Officer
Sarah Miller, Project Director, Oregon Eligibility (ONE)

Oregon Health Authority

ONE System Update

- A new monthly release is scheduled to be implemented this week. It will include numerous defect fixes and system updates that will reduce operational workload.

- Testing began on the enhancement release that is scheduled for the end of June. It will include major changes to worker portal functionality (i.e. task search and document upload) and real-time MMIS enrollment from ONE

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Applicant Portal – Phase Three

- After our initial development through 50 community partners and expanded release through community agencies, the third and final phase is offering ONE to the public.

- OHA will fully launch ONE and make it directly available to Oregonians so they can access the application process themselves.

- In late summer, OHA will be expanding the use of the applicant portal with a soft launch to the public, while it prepares for a full launch in September.

Oregon Health Authority

OHP Operations update

- Performance data
- Current goals
- Concerns we have heard
- Successes we have had
- Questions collected

Oregon Health Authority

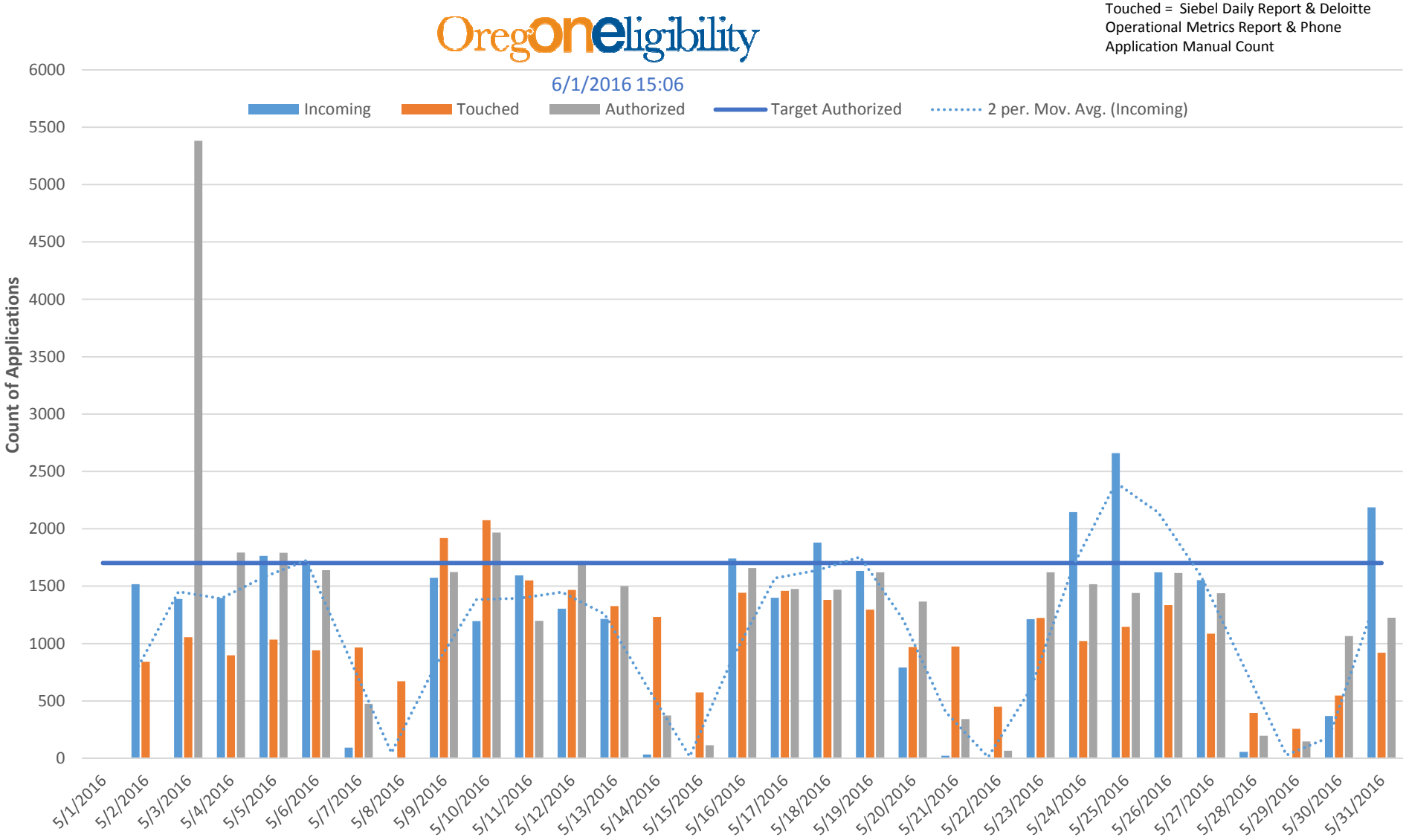
Member Services Performance Data

- May application processing performance
- May call performance
- 45-day application backlog
- Applicant Portal applications
- Overall Applications received

Oregon Health Authority

Member Services Monthly Application Processing Performance

Data Sources:
Incoming = Deloitte Operational Metrics Report
Touched = Siebel Daily Report & Deloitte Operational Metrics Report & Phone Application Manual Count



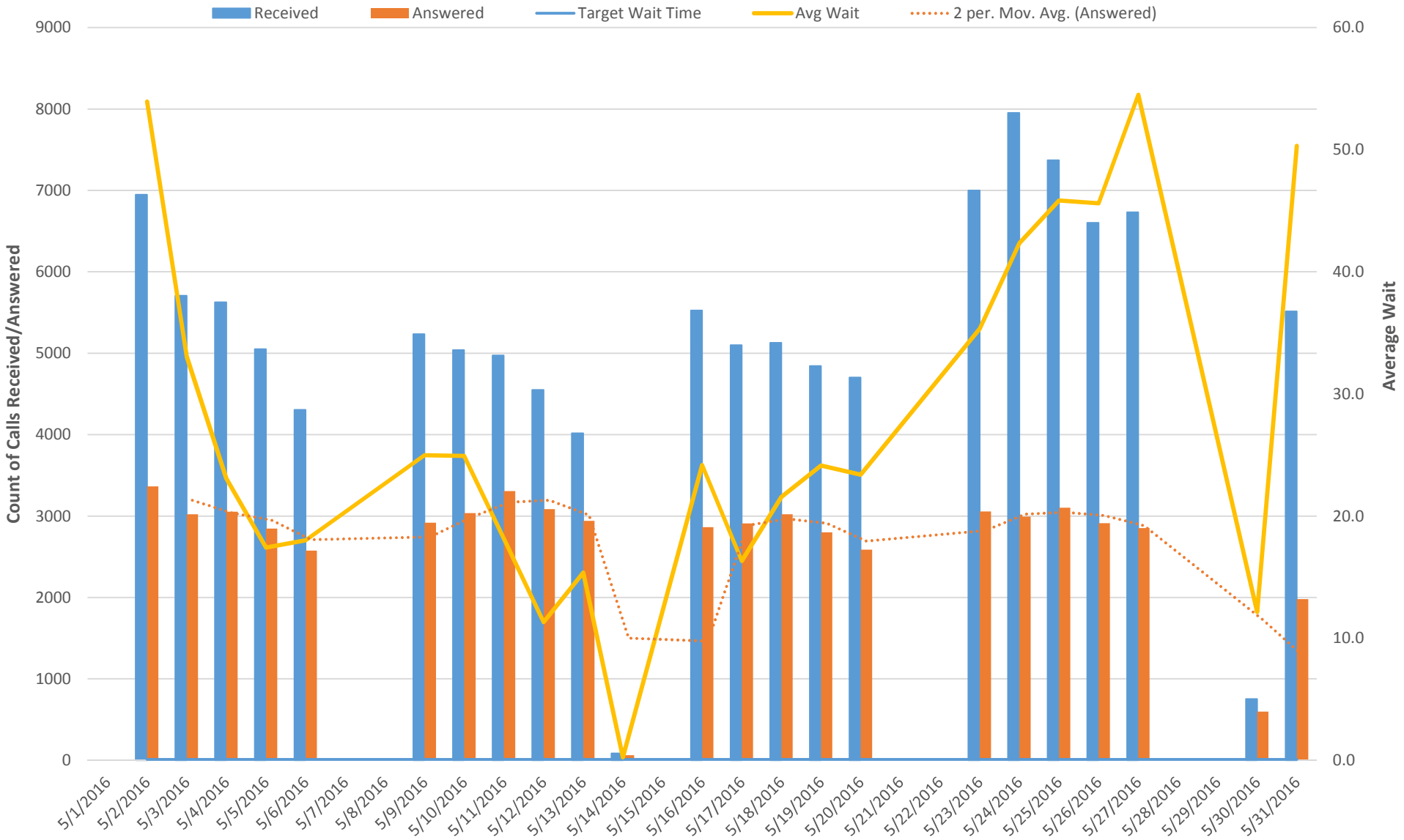
In May, there were 34,032 incoming, 32,458 touched and 37,843 authorized applications

Member Services Monthly Call Performance

Data Source: Interactive Intelligence housed in OHA OHP/Enrollment

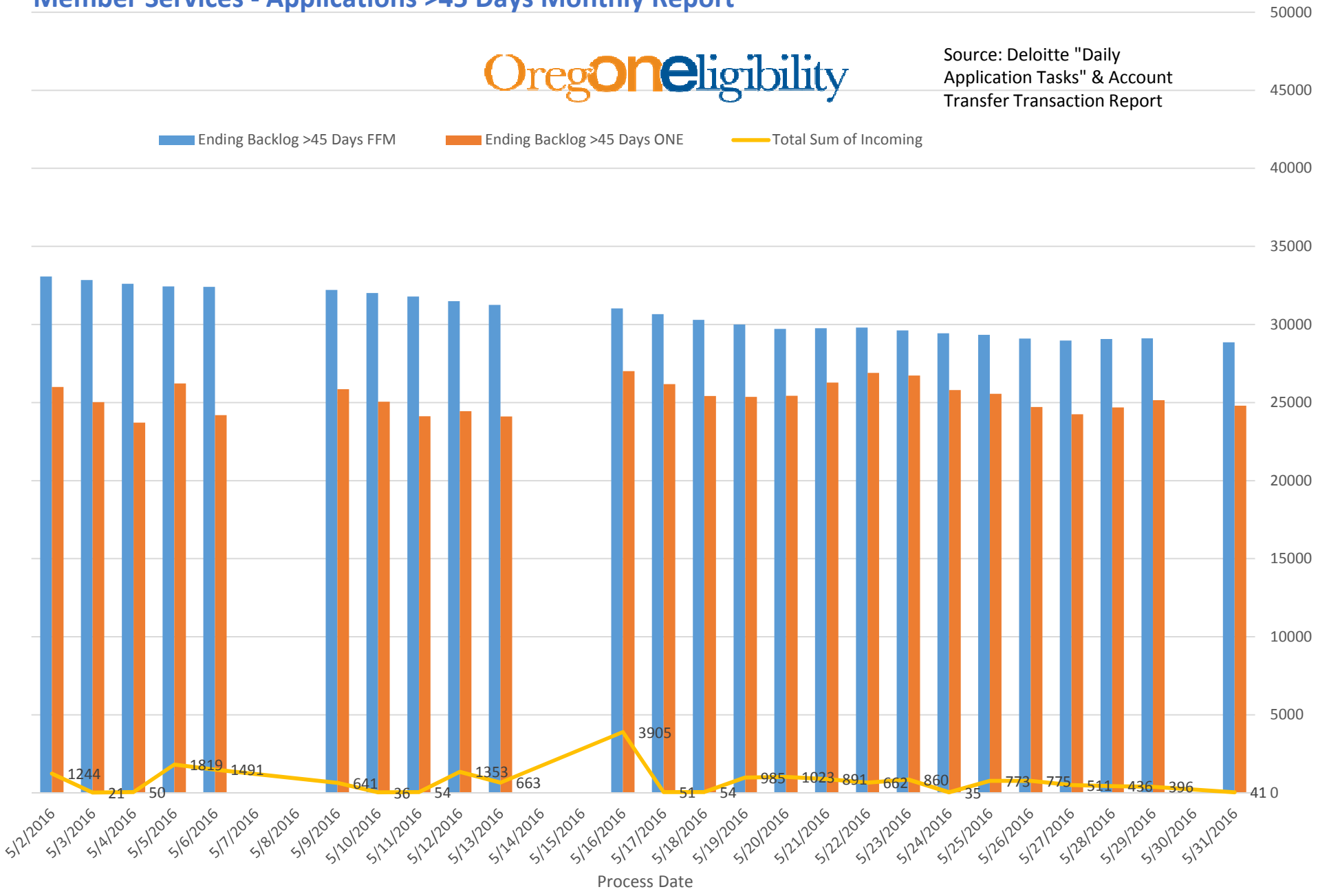
OregonEligibility

6/1/2016 15:08



A total of 121,866 calls were received and 63,054 calls were answered in May

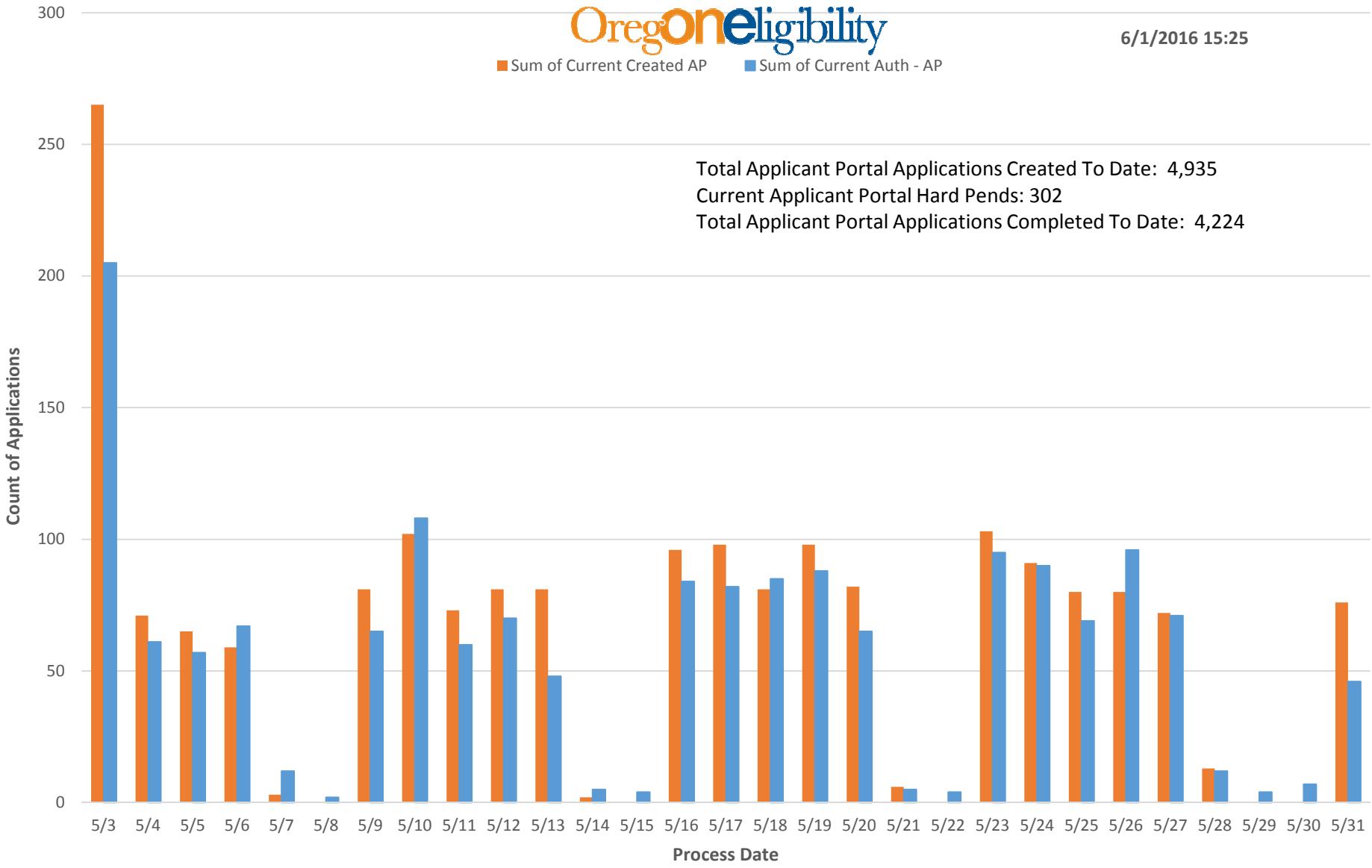
Member Services - Applications >45 Days Monthly Report



Applicant Portal - Applications Created/Authorized

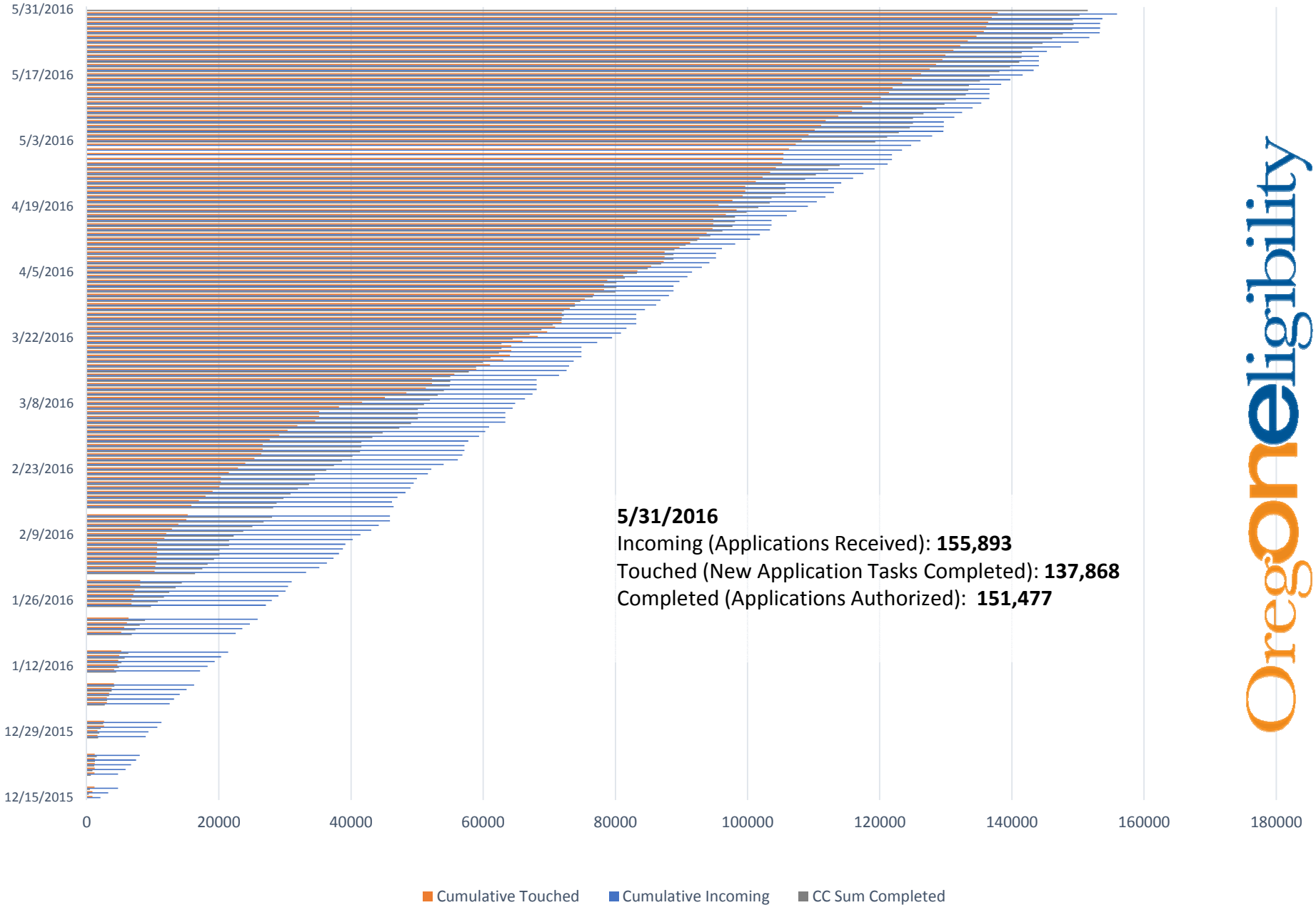
Source: Deloitte Report - Key Command Center Metrics

6/1/2016 15:25



Member Services - Sum of Applications Received, Touched & Completed

6/1/2016 15:20



OregonEligibility

Current Goals

- **45-day backlog:** We are currently re-evaluating our 45-day backlog and same-day processing goals to ensure goals align with our staffing levels.

- **Staffing:** Our current staff level does not meet the required processing volumes. We are finalizing staffing and operations plans to meet need.

- **Training:** ONE Refresher training for staff continues through June. Targeted trainings are also being developed for processes outside of the ONE system.

Oregon Health Authority

Concerns we have heard

Varying response times on urgent email requests

- Our pregnancy, urgent and priority application queues are being worked same day/next day. Follow-up requests after an application has already been submitted are one day to three weeks out, depending on the body of work. Requests sent to the new OHP Pregnancy Requests inbox are being worked within 24 to 48 hours.

Clarification needed on submitting address changes

- Operations is working to clarify best, most secure methods for submitting address changes for members, community partners and CCOs. Clarification will be shared as soon as it's available.

Backlog on processing member consent forms

- We have had a backlog with consent forms community partners and assisters submit, allowing them to assist a member. We are training our new weekend staff to process these forms, which will greatly reduce our backlog.

Oregon Health Authority

Successes we have had

- Workshops held with our imaging partners, Imaging and Records Management (IRMS) have helped reduce backlog, improve processes and increase staffing
- Our phone consultant, Chaves, received access to ONE and MMIS, so more information can be offered to members calling about status of applications
- Our consultant KPMG finished its initial assessment of Member Services operations, which highlights areas for improvement and opportunities
- Successful renewal and closure cycle

Oregon Health Authority

Renewals and closures - May

April 1: Renewal letters mail to 49,970 households (95,648 individuals)

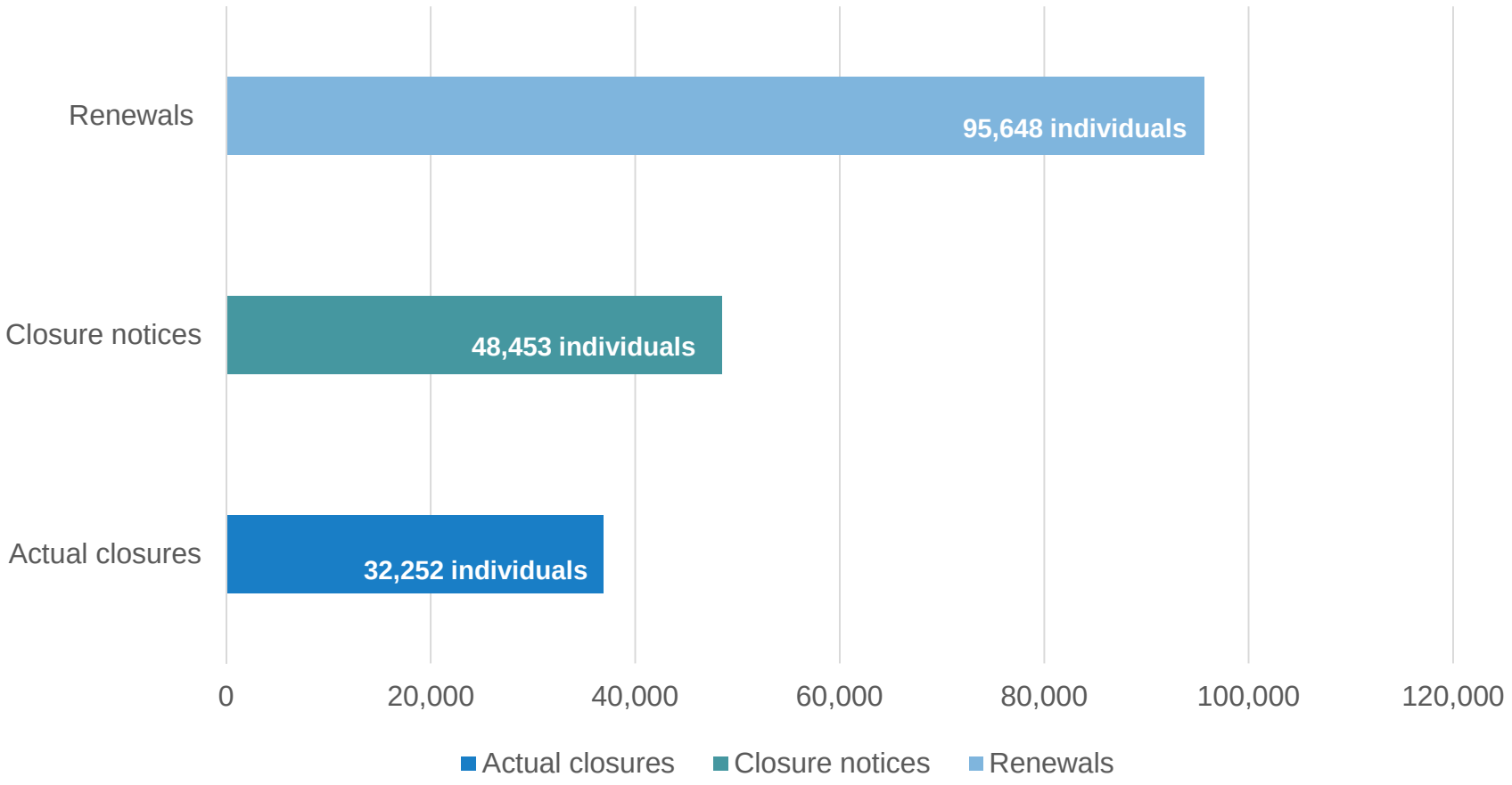
May 20: Closure notices mail to 48,453 individuals

May 31: 36,913 individuals actually closed

58,735 individuals out of 95,648 total individuals renewed in May, resulting in a renewal rate of approximately 61.4%

Oregon Health Authority

Renewals and closures - May



Oregon Health Authority

What else would you like to hear?

Your feedback is important to us.

Please let us know what additional information we should present at our monthly meetings.

Oregon Health Authority

Questions

Via webinar: Please use the chat function to submit your questions.

Via email:
Please email ohp.customerservice@state.or.us.

FAQ and other materials can be found at:
www.oregon.gov/oha/healthplan/pages/ohp-update.aspx

Oregon Health Authority

Application for Oregon Health Plan Coverage

USE THROUGH NOVEMBER 2017

Need help with this application?

Trained community partners across the state can help you fill out an application. It's free.

- Visit **OregonHealthCare.gov** to find community partners who can help you apply.
- Call OHP Customer Service at **1-800-699-9075** to get help or to ask for a list of community partners in your area. You can ask for help in a different language, too.

Who to include on this application

We need you to tell us about yourself and everyone else in your household. Your household includes the people below:

- You
- Your legal spouse
- Your children – include children of all ages you claim as dependents on your taxes
- Your live-in partner (only if you have a child together)
- Anyone else you include on your federal income tax return, even if they do not live with you

Please write clearly and give as much information as possible about each person. *If you are applying for more than four people, please make copies of Step 2 for those people.*

Important: Anyone living with you who is not on the list above and wants health coverage must fill out a separate application.

Required information

Questions marked with a "★" are required. If you do not answer these questions, your application will be delayed.

After completing all necessary pages, **SIGN** your application and mail or fax it to**:**

Mail: OHP Customer Service, P.O. Box 14015, Salem, OR 97309-5032

Fax: Use the fax coversheet (page XX) to fax your application to 503-378-5628.

OFFICIAL USE ONLY

Date of request	Received	Program	Branch	Case no.	Worker ID
		Case name			Route to
		Prime no.		SSN	App status
		Office use			

You can get this document in other languages, large print, braille or a format you prefer. Call us at 1-800-699-9075. We accept all relay calls or you can dial 711.

STEP 1 Primary contact

Please give the following information for your household's primary contact. This person must have permission from all people on this application to both submit their information and receive communications about their eligibility and enrollment.

★ 1 **Primary Contact: First/MI/last name**

★ 2 **Birthdate** | ★ 3 **Sex:** ☐ Male ☐ Female

★ 4 **If you are applying for coverage, do you have a Social Security number (SSN)?** *An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.*

☐ YES. If YES, give us your SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ NO. If NO, tell us why: ☐ Applied for SSN ☐ Newborn without SSN

☐ Refuses to obtain an SSN due to religious reasons

☐ Not eligible for an SSN based on immigration status

☐ Refuses to provide an SSN OR Does not have an SSN

☐ Does not have an SSN and may only be issued an SSN for a valid non-work reason

☐ Not applying for coverage

5 **Email:**

6 **Main phone:** (__ __ __) - __ __ __ - __ __ __ __ ☐ Home ☐ Work ☐ Cell

7 **Other phone:** (__ __ __) - __ __ __ - __ __ __ __ ☐ Home ☐ Work ☐ Cell

★ 8 **How do you want us to send you written material?** See the *Application Guide* for more information. ☐ Mail ☐ Email ☐ Text message

★ 9 **Do you need written materials in an alternate format?** ☐ YES. If YES, mark one below. ☐ NO

☐ Braille ☐ Oral presentation ☐ Computer disk ☐ Audio tape ☐ Large print

★ 10 **In what language do you want us to speak with you?**

★ 11 **In what language do you want us to write to you?**

★ 12 **Do you want to name an authorized representative?**

☐ YES. If YES, give us their information in ***Appendix B*** – Authorized Representative (page xx)

☐ NO

★ 13 **Do you have a home address?**

☐ YES. If YES, give us your home address.

☐ NO. If NO, tell us the State, ZIP code and County where you spend most of your time.

Street address: _____

City: State: ZIP code: County:

★ 14 **Do you have a mailing address that is different from your home address?**

☐ YES. If YES, give us your mailing address below. ☐ NO

Mailing address: _____

City: State: ZIP code: County:

STEP 1 Primary contact, continued

★ **15 Does anyone in your household live at a different address?** ☐ YES. If YES, ***complete a-c***. ☐ NO

a. Who: First/last name _____ Birthdate:_____

b. This person is:

Temporarily absent due to: ☐ Work ☐ Student ☐ Hospitalization ☐ Military ☐ Other

☐ Permanently out of the household

c. This person's address:_____

City: _____ State: _____ ZIP code: _____ County:_____

16 What is your ethnic or racial identity? (Check all that apply.) We ask about race and ethnicity to make sure everyone gets the best health care possible. *The answers to this question are optional and will not affect the decision about your coverage.*

If more than one ethnic or racial identity is chosen, please CIRCLE the ONE that best represents your primary identity.

African/African American/Black: ☐ African American ☐ African ☐ Caribbean
☐ Other African/African American/Black

American Indian/Alaska Native: ☐ American Indian ☐ Alaska Native
☐ Canadian Inuit, Metis or First Nation
☐ Indigenous Mexican, Central American or South American
☐ Other American Indian/Alaska Native

Asian: ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese
☐ South Asian ☐ Asian Indian ☐ Other Asian

Hispanic, Latino: ☐ Mexican ☐ Central American ☐ South American ☐ Other Hispanic, Latino

Pacific Islander: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Micronesian ☐ Tongan ☐ Other Pacific Islander

White: ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African
☐ Other White

Other: ☐ Other ☐ Unknown

Check here if you are declining to answer ☐

★ **17 Are you under age 19 and do you have an absent parent?**

☐ YES. If YES, who is your parent/guardian in the household?

First/last name_____ Birthdate: _____

☐ NO

★ **18 Do you plan to file a 2016 federal income tax return in 2017?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. What will your filing status be on your 2016 income tax return?

☐ Single ☐ Head of household ☐ Qualifying Widow(er)

Married filing ☐ Jointly ☐ Separately Spouse's name: _____

b. Do you have any tax dependents?

☐ YES. If YES, First/last name _____ Birthdate: _____

First/last name _____ Birthdate: _____

First/last name _____ Birthdate: _____

☐ NO

STEP 1 Primary contact, continued

★ **19 Are you a dependent on anyone's 2016 income tax return?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. Who is the tax filer? First/last name _____ Birthdate: _____

b. How are you related to the tax filer? _____

★ **20 Are you applying for health coverage?** You can apply even if you already have health coverage.

☐ YES. If YES, ***go to 21.***

☐ NO. If NO, and there is someone else you need to include on this application, ***skip to Step 2 (page XX).*** If there is no one else you need to include on this application, ***skip to Step 3 (page XX).***

★ **21 Are you an American Indian or Alaska Native?** ☐ YES ☐ NO

★ **22 Are you receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR do you have a parent or grandparent who is an enrolled member of a federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village?** ☐ YES ☐ NO

★ **23 Are you a U.S. Citizen?** ☐ YES. If YES, ***skip to 25.*** ☐ NO.

★ **24 Do you have an eligible immigration status?** We only use this information to determine eligibility. See the *Application Guide* for more information about eligible immigration statuses.

☐ YES. If yes, ***complete a-f.*** ☐ NO. If no, ***skip to 25.***

a. Immigration document type: _____

b. Document ID #: _____

c. Status: _____

d. Date status gained: _____

e. Have you lived in the U.S. since 1996? ☐ YES ☐ NO

f. Are you, your spouse or a parent a veteran or an active-duty member of the U.S. military? ☐ YES ☐ NO

★ **25 Do you live in and plan to stay in Oregon?** *Answer yes, even if you are in Oregon to look for work or because of a job.* ☐ YES ☐ NO

26 Tell us which coordinated care organization (CCO) you choose. You are not required to choose now. But if you do not make a choice now, a CCO will be selected for you based on where you live (unless the Tribal exceptions listed in the *Application Guide* apply to you). See the *Application Guide* for more information about choosing a plan.

1st choice: _____

2nd choice: _____

STEP 2 Additional household member – Person 2

Complete Step 2 for everyone in your household. **If there are more than four people in your household, make copies of Step 2 for each additional person.**

★ 1 **First/MI/last name**

★ 2 **Birthdate** | ★ 3 **Sex:** ☐ Male ☐ Female

★ 4 **Relationship to you:**

★ 5 **In what language does Person 2 want us to:** Write?_____ Speak? _____

★ 6 **If Person 2 is applying for coverage, do they have a Social Security number (SSN)?** *An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.*

☐ YES. If YES, give us their SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ NO. If NO, tell us why: ☐ Applied for SSN ☐ Newborn without SSN

☐ Refuses to obtain an SSN due to religious reasons

☐ Not eligible for an SSN based on immigration status

☐ Refuses to provide an SSN OR Does not have an SSN

☐ Does not have an SSN and may only be issued an SSN for a valid non-work reason

☐ Not applying for coverage

7 **What is Person 2's ethnic or racial identity?** (Check all that apply.) We ask about race and ethnicity to make sure everyone gets the best health care possible. *The answers to this question are optional and will not affect the decision about your coverage.*

If more than one ethnic or racial identity is chosen, please circle the one that best represents Person 2's primary identity.

African/African American/Black: ☐ African American ☐ African ☐ Caribbean
☐ Other African/African American/Black

American Indian/Alaska Native: ☐ American Indian ☐ Alaska Native
☐ Canadian Inuit, Metis or First Nation
☐ Indigenous Mexican, Central American or South American
☐ Other American Indian/Alaska Native

Asian: ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese
☐ South Asian ☐ Asian Indian ☐ Other Asian

Hispanic, Latino: ☐ Mexican ☐ Central American ☐ South American ☐ Other Hispanic, Latino

Pacific Islander: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Micronesian ☐ Tongan ☐ Other Pacific Islander

White: ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African
☐ Other White

Other: ☐ Other ☐ Unknown

Check here if you are declining to answer ☐

★ 8 **Is Person 2 under age 19 and do they have an absent parent?**

☐ YES. If YES, who is Person 2's parent/guardian in the household?

First/last name_____ Birthdate: _____

☐ NO

STEP 2 Person 2, continued

★ **9 Does Person 2 plan to file a 2016 federal income tax return in 2017?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. What will Person 2's filing status be on their 2016 income tax return?

☐ Single ☐ Head of household ☐ Qualifying Widow(er)

Married filing ☐ Jointly ☐ Separately Spouse's name: _____

b. Does Person 2 have any tax dependents?

☐ YES. If YES, First/last name _____ Birthdate: _____

First/last name _____ Birthdate: _____

☐ NO

★ **10 Is Person 2 a dependent on anyone's 2016 income tax return?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. Who is the tax filer? First/last name _____ Birthdate: _____

b. How is Person 2 related to the tax filer?_____

★ **11 Is Person 2 applying for health coverage?** They can apply even if they already have health coverage.

☐ YES. If YES, ***go to 12.***

☐ NO. If NO, and there is someone else you need to include on this application, ***skip to page xx.*** If there is no one else you need to include on this application, ***skip to Step 3 (page xx).***

★ **12 Is Person 2 an American Indian or Alaska Native?** ☐ YES ☐ NO

★ **13 Is Person 2 receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does Person 2 have a parent or grandparent who is an enrolled member of a federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village?** ☐ YES ☐ NO

★ **14 Is Person 2 a U.S. Citizen?** ☐ YES. If YES, ***skip to 16.*** ☐ NO.

★ **15 Does Person 2 have an eligible immigration status?** We only use this information to determine eligibility. See the *Application Guide* for more information about eligible immigration statuses.

☐ YES. If yes, ***complete a-f.*** ☐ NO. If no, ***skip to 16.***

a. Immigration document type:_____

b. Document ID #: _____

c. Status: _____

d. Date status gained: _____

e. Has Person 2 lived in the U.S. since 1996?☐ YES ☐ NO

f. Is Person 2, their spouse or a parent a veteran or an active-duty member of the U.S. military?

☐ YES ☐ NO

★ **16 Does Person 2 live in and plan to stay in Oregon?** *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO

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17 Tell us which coordinated care organization (CCO) Person 2 chooses. You are not required to choose now. But if you do not make a choice now, a CCO will be selected for Person 2 based on where they live (unless the Tribal exceptions listed in the *Application Guide* apply to them). See the *Application Guide* for more information about choosing a plan.

1st choice: _____

2nd choice:_____

STEP 2 Additional household member – Person 3

★ 1 **First/MI/last name**

★ 2 **Birthdate** | ★ 3 **Sex:** ☐ Male ☐ Female

★ 4 **Relationship to you:**

★ 5 **In what language does Person 3 want us to:** Write?_____ Speak? _____

★ 6 **If Person 3 is applying for coverage, do they have a Social Security number (SSN)?** *An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.*

☐ YES. If YES, give us their SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ NO. If NO, tell us why: ☐ Applied for SSN ☐ Newborn without SSN

☐ Refuses to obtain an SSN due to religious reasons

☐ Not eligible for an SSN based on immigration status

☐ Refuses to provide an SSN OR Does not have an SSN

☐ Does not have an SSN and may only be issued an SSN for a valid non-work reason

☐ Not applying for coverage

7 **What is Person 3's ethnic or racial identity?** (Check all that apply.) We ask about race and ethnicity to make sure everyone gets the best health care possible. *The answers to this question are optional and will not affect the decision about your coverage.*

If more than one ethnic or racial identity is chosen, please circle the one that best represents Person 3's primary identity.

African/African American/Black: ☐ African American ☐ African ☐ Caribbean
☐ Other African/African American/Black

American Indian/Alaska Native: ☐ American Indian ☐ Alaska Native
☐ Canadian Inuit, Metis or First Nation
☐ Indigenous Mexican, Central American or South American
☐ Other American Indian/Alaska Native

Asian: ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese
☐ South Asian ☐ Asian Indian ☐ Other Asian

Hispanic, Latino: ☐ Mexican ☐ Central American ☐ South American ☐ Other Hispanic, Latino

Pacific Islander: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Micronesian ☐ Tongan ☐ Other Pacific Islander

White: ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African
☐ Other White

Other: ☐ Other ☐ Unknown

Check here if you are declining to answer ☐

★ 8 **Is Person 3 under age 19 and do they have an absent parent?**

☐ YES. If YES, who is Person 3's parent/guardian in the household?

First/last name_____ Birthdate: _____

☐ NO

STEP 2 Person 3, continued

★ **9 Does Person 3 plan to file a 2016 federal income tax return in 2017?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. What will Person 3's filing status be on their 2016 income tax return?

☐ Single ☐ Head of household ☐ Qualifying Widow(er)

Married filing ☐ Jointly ☐ Separately Spouse's name: _____

b. Does Person 3 have any tax dependents?

☐ YES. If YES, First/last name _____ Birthdate: _____

First/last name _____ Birthdate: _____

☐ NO

★ **10 Is Person 3 a dependent on anyone's 2016 income tax return?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. Who is the tax filer? First/last name _____ Birthdate: _____

b. How is Person 3 related to the tax filer?_____

★ **11 Is Person 3 applying for health coverage?** They can apply even if they already have health coverage.

☐ YES. If YES, ***go to 12.***

☐ NO. If NO, and there is someone else you need to include on this application, ***skip to page xx.*** If there is no one else you need to include on this application, ***skip to Step 3 (page xx).***

★ **12 Is Person 3 an American Indian or Alaska Native?** ☐ YES ☐ NO

★ **13 Is Person 3 receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does Person 3 have a parent or grandparent who is an enrolled member of a federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village?** ☐ YES ☐ NO

★ **14 Is Person 3 a U.S. Citizen?** ☐ YES. If YES, ***skip to 16.*** ☐ NO.

★ **15 Does Person 3 have an eligible immigration status?** We only use this information to determine eligibility. See the *Application Guide* for more information about eligible immigration statuses.

☐ YES. If yes, ***complete a-f.*** ☐ NO. If no, ***skip to 16.***

a. Immigration document type:_____

b. Document ID #: _____

c. Status: _____

d. Date status gained: _____

e. Has Person 3 lived in the U.S. since 1996?☐ YES ☐ NO

f. Is Person 3, their spouse or a parent a veteran or an active-duty member of the U.S. military?

☐ YES ☐ NO

★ **16 Does Person 3 live in and plan to stay in Oregon?** *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO

---

17 Tell us which coordinated care organization (CCO) Person 3 chooses. You are not required to choose now. But if you do not make a choice now, a CCO will be selected for Person 3 based on where they live (unless the Tribal exceptions listed in the *Application Guide* apply to them). See the *Application Guide* for more information about choosing a plan.

1st choice: _____

2nd choice:_____

STEP 2 Additional household member – Person 4

★ 1 **First/MI/last name**

★ 2 **Birthdate** | ★ 3 **Sex:** ☐ Male ☐ Female

★ 4 **Relationship to you:**

★ 5 **In what language does Person 4 want us to:** Write?_____ Speak? _____

★ 6 **If Person 4 is applying for coverage, do they have a Social Security number (SSN)?** *An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.*

☐ YES. If YES, give us their SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ NO. If NO, tell us why: ☐ Applied for SSN ☐ Newborn without SSN

☐ Refuses to obtain an SSN due to religious reasons

☐ Not eligible for an SSN based on immigration status

☐ Refuses to provide an SSN OR Does not have an SSN

☐ Does not have an SSN and may only be issued an SSN for a valid non-work reason

☐ Not applying for coverage

7 **What is Person 4's ethnic or racial identity?** (Check all that apply.) We ask about race and ethnicity to make sure everyone gets the best health care possible. *The answers to this question are optional and will not affect the decision about your coverage.*

If more than one ethnic or racial identity is chosen, please circle the one that best represents Person 4's primary identity.

African/African American/Black: ☐ African American ☐ African ☐ Caribbean
☐ Other African/African American/Black

American Indian/Alaska Native: ☐ American Indian ☐ Alaska Native
☐ Canadian Inuit, Metis or First Nation
☐ Indigenous Mexican, Central American or South American
☐ Other American Indian/Alaska Native

Asian: ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese
☐ South Asian ☐ Asian Indian ☐ Other Asian

Hispanic, Latino: ☐ Mexican ☐ Central American ☐ South American ☐ Other Hispanic, Latino

Pacific Islander: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Micronesian ☐ Tongan ☐ Other Pacific Islander

White: ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African
☐ Other White

Other: ☐ Other ☐ Unknown

Check here if you are declining to answer ☐

★ 8 **Is Person 4 under age 19 and do they have an absent parent?**

☐ YES. If YES, who is Person 4's parent/guardian in the household?

First/last name_____ Birthdate: _____

☐ NO

STEP 2 Person 4, continued

★ **9 Does Person 4 plan to file a 2016 federal income tax return in 2017?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. What will Person 4's filing status be on their 2016 income tax return?

☐ Single ☐ Head of household ☐ Qualifying Widow(er)

Married filing ☐ Jointly ☐ Separately Spouse's name: _____

b. Does Person 4 have any tax dependents?

☐ YES. If YES, First/last name _____ Birthdate: _____

First/last name _____ Birthdate: _____

☐ NO

★ **10 Is Person 4 a dependent on anyone's 2016 income tax return?**

☐ YES. If YES, ***complete a-b.*** ☐ NO

a. Who is the tax filer? First/last name _____ Birthdate: _____

b. How is Person 4 related to the tax filer?_____

★ **11 Is Person 4 applying for health coverage?** They can apply even if they already have health coverage.

☐ YES. If YES, ***go to 12.***

☐ NO. If NO, and there is someone else you need to include on this application, ***skip to page xx.*** If there is no one else you need to include on this application, ***skip to Step 3 (page xx).***

★ **12 Is Person 4 an American Indian or Alaska Native?** ☐ YES ☐ NO

★ **13 Is Person 4 receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does Person 4 have a parent or grandparent who is an enrolled member of a federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village?** ☐ YES ☐ NO

★ **14 Is Person 4 a U.S. Citizen?** ☐ YES. If YES, ***skip to 16.*** ☐ NO.

★ **15 Does Person 4 have an eligible immigration status?** We only use this information to determine eligibility. See the *Application Guide* for more information about eligible immigration statuses.

☐ YES. If yes, ***complete a-f.*** ☐ NO. If no, ***skip to 16.***

a. Immigration document type:_____

b. Document ID #: _____

c. Status: _____

d. Date status gained: _____

e. Has Person 4 lived in the U.S. since 1996?☐ YES ☐ NO

f. Is Person 4, their spouse or a parent a veteran or an active-duty member of the U.S. military?

☐ YES ☐ NO

★ **16 Does Person 4 live in and plan to stay in Oregon?** *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO

---

17 Tell us which coordinated care organization (CCO) Person 4 chooses. You are not required to choose now. But if you do not make a choice now, a CCO will be selected for Person 4 based on where they live (unless the Tribal exceptions listed in the *Application Guide* apply to them). See the *Application Guide* for more information about choosing a plan.

1st choice: _____

2nd choice:_____

STEP 3 Additional questions for your household

★ **1 Did a community partner help you complete this application?**

☐ YES. If YES, ***give us their information in Appendix A*** – Community Partner assistance consent (page xx)

☐ NO

★ **2** You give OHA permission to check your information with state and federal databases by signing this application. You can give us ongoing permission to check your information in the future. If you choose to do this, you can opt out at any time by contacting OHA.

Would you like to authorize OHA to access the state and federal databases in the future?

☐ YES. If YES, ***how many years?*** ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ NO

★ **3 Is anyone on this application pregnant?** ☐ YES. If YES, ***complete a-c.*** ☐ NO

For b and c, provide your best guess, even if this person has not seen a doctor yet.

a. First/last name _____ Birthdate:_____

b. Due date *(MM/YYYY)*_____

c. How many children are expected? Leave blank if unknown _____

★ **4 Did anyone on this application have a pregnancy end (giving birth or losing a pregnancy) in the past three months?** ☐ YES . If YES, ***complete a-b.*** ☐ NO

a. First/last name _____ Birthdate:_____

b. Last date of pregnancy *(MM/YYYY)*_____

---

5 *Answering this question is optional and will not affect the decision about your coverage.*

Are you registered to vote at your current address? If you or anyone in your household is age 17 or older, a resident of Oregon and a citizen of the United States, you can register to vote or update your voter registration. *Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.* **If you are not registered to vote where you live now, would you like to apply to register to vote today?**

☐ YES ☐ NO

Please answer questions 6-15 only for people listed on your application who are applying for health coverage.

★ **6 Is anyone the primary caretaker for any children under age 19 who: 1) live with the primary caretaker and 2) are related to the primary caretaker, but are not the primary caretaker's own children?** *For example, a grandparent who is the primary caretaker for a grandchild.*

☐ YES. If YES, ***complete a-b.*** ☐ NO.

a. Primary Caretaker: First/last name_____ Birthdate:_____

b.Children: First/last name _____ Birthdate:_____

First/last name _____ Birthdate:_____

STEP 3 Additional questions for your household, continued

Please answer questions 6-15 only for people listed on your application who are applying for health coverage.

★ **7** **If a member of your household passed away recently, you may be able to get help paying for their medical bills.** If you would like to request help paying for their medical bills, please give us the following information about the deceased family member and add their information to ***Step 2.***

a. First/last name _____ Birthdate:_____

b. Date of death:_____

★ **8** **Does anyone have any unpaid medical bills from the past 3 months OR has anyone received free medical services in the past 3 months?** ☐ YES. If YES, ***complete a-b.*** ☐ NO

a. First/last name _____ Birthdate:_____

b. Which months? _____

★ **9** **Is anyone currently in prison/jail OR have they been released in the past 3 months?**

☐ YES. If YES, ***complete a-c.*** ☐ NO.

a. First/last name _____ Birthdate:_____

b. Date *(MM/DD/YYYY)* of: Entry:_____ Release/expected release:_____

c. Waiting for a decision on charges? ☐ Yes ☐ No

★ **10** **Is anyone 18 years old and a full-time high school student?**

☐ YES. If YES, First/last name _____ Birthdate: _____

☐ NO.

★ **11** **Is anyone eligible for or receiving Supplemental Security Income (SSI)?**

☐ YES. If YES, First/last name _____ Birthdate: _____

☐ NO.

★ **12** **Is anyone blind or permanently disabled?**

☐ YES. If YES, First/last name _____ Birthdate: _____

☐ NO.

★ **13** **Does anyone need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?**

☐ YES. If YES, First/last name _____ Birthdate: _____

☐ NO.

★ **14** **Was anyone receiving foster care in Oregon when they turned 18?**

☐ YES. If YES, First/last name _____ Birthdate: _____

☐ NO.

15 *Answering this question is optional and will not affect the decision about your coverage.*

Has anyone ever served in the U.S. Military?

☐ YES. If YES, First/last name _____ Birthdate: _____

☐ NO.

STEP 4 Income and deductions

★ **Does anyone listed on your application have income and/or deductions?**

☐ Yes. If yes, ***complete questions 1-3.*** If you need more room, make a copy of Step 4 before you complete it, or write the information on a separate sheet and include it with your application.

☐ No. If no, ***skip to Step 5 (page 15).***

1 **Does anyone on your application earn money from a job?** Tell us how much they make in gross wages/tips (before taxes) at each job. If self-employed, tell us how much net profit (income after all business costs have been deducted) this person makes.

☐ YES. If YES, ***give us their information below.*** ☐ NO. If NO, ***skip to 2.***

Job 1

a. First/last name _____ Birthdate:_____

b. Income source – Employer name _____

c. Gross pay amount: $ _____ per ☐ Week ☐ Every other week ☐ Month ☐ Twice per month ☐ Other:_____

d. Is this self-employment? ☐ YES. If YES, ***complete A-C.*** ☐ NO

A. Type of work: _____

B. *MM/YYYY*: Start date:_____ End date:_____

C. Self-employment expenses: $ _____

e. Does this employer offer health coverage?
☐ YES. If yes, ***complete Appendix C*** – Employer coverage (page xx) ☐ NO

Job 2

a. First/last name _____ Birthdate:_____

b. Income source – Employer name _____

c. Gross pay amount: $ _____ per ☐ Week ☐ Every other week ☐ Month ☐ Twice per month ☐ Other:_____

d. Is this self-employment? ☐ YES. If YES, ***complete A-C.*** ☐ NO

A. Type of work: _____

B. *MM/YYYY*: Start date:_____ End date:_____

C. Self-employment expenses: $ _____

e. Does this employer offer health coverage?
☐ YES. If yes, ***complete Appendix C*** – Employer coverage (page xx) ☐ NO

2 Does anyone on your application receive other income?

☐ YES. If YES, ***give us their information below.*** ☐ NO. If NO, ***skip to 3.***

See the *Application Guide* for examples. Be sure to tell us what type of income it is on the "Type of other income" line. *Do not include child support, veteran's payments, Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).*

Taxable Tribal Income – The tribal income types listed below may not be counted for the Oregon Health Plan eligibility determination, but you should still include this income in this section and tell us the type of tribal income it is. Include:

- Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties (not including per capita payments from casinos)
- Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Note: If you receive income from a tribe that is a per capita payment from a casino, enter that income and write "Per capita payments from casinos" for the "Type of other income."

Other income 1

a. First/last name _____ Birthdate: _____

b. Type of other income _____

c. *MM/YYYY*: Start date: _____ End date: _____

d. Amount: $ _____ per ☐ Week ☐ Every other week ☐ Month ☐ Twice per month ☐ Other: _____

Other income 2

a. First/last name _____ Birthdate: _____

b. Type of other income _____

c. *MM/YYYY*: Start date: _____ End date: _____

d. Amount: $ _____ per ☐ Week ☐ Every other week ☐ Month ☐ Twice per month ☐ Other: _____

3 Does anyone listed on your application claim the following types of deductions on their federal tax return: alimony paid, student loan interest, educator expenses, school tuition and fees, American Indian/Alaska Native income or other allowable expenses?

☐ YES. If YES, ***give us their information below.*** ☐ NO. If NO, ***skip to Step 5 (page xx).***

Deductions

a. First/last name _____ Birthdate: _____

b. Type of deduction _____

c. *MM/YYYY*: Start date: _____ End date: _____

d. Amount: $ _____ per ☐ Week ☐ Every other week ☐ Month ☐ Twice per month ☐ Other: _____

STEP 5 Other health coverage

★ **Is anyone on your application covered by, offered or eligible for health insurance?** Answer YES even if they decided not to enroll due to cost, quality of coverage or another reason. Answer NO if their only coverage is OHP. ☐ YES. If YES, ***give us their information below.*** ☐ NO

Other health coverage 1

a. First/last name _____ Birthdate:_____

b. Type of health insurance: ☐ Private ☐ Employer ☐ COBRA ☐ Medicare ☐ TRICARE
☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan ☐ Medicaid/CHIP

c. Plan information: Insurance company name: _____
Insurance company address:_____
Policy #: _____ Policy Group #: _____
Policyholder name: _____ Birthdate:_____
Relationship to policyholder: _____

d. Is this person unable to use the insurance?
☐ YES, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons
☐ NO

e. Is this person enrolled in Medicaid/CHIP in a state other than Oregon?
☐ YES. If yes, in which state?_____ Expected end date:_____
☐ NO

f. Is this employer sponsored health insurance?
☐ YES. If yes, ***complete Appendix C*** – Employer coverage (page XX)
☐ NO

Other health coverage 2

a. First/last name _____ Birthdate:_____

b. Type of health insurance: ☐ Private ☐ Employer ☐ COBRA ☐ Medicare ☐ TRICARE
☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan ☐ Medicaid/CHIP

c. Plan information: Insurance company name: _____
Insurance company address:_____
Policy #: _____ Policy Group #: _____
Policyholder name: _____ Birthdate:_____
Relationship to policyholder: _____

d. Is this person unable to use the insurance?
☐ YES, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons
☐ NO

e. Is this person enrolled in Medicaid/CHIP in a state other than Oregon?
☐ YES. If yes, in which state?_____ Expected end date:_____
☐ NO

f. Is this employer sponsored health insurance?
☐ YES. If yes, ***complete Appendix C*** – Employer coverage (page xx)
☐ NO

STEP 6 Read and sign

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know I may be subject to penalties or be liable for overpayments under federal law if I provide false or untrue information.
- I understand OHA will access my personal information stored on the state and federal databases.
- I know I must tell the Oregon Health Authority (OHA) if anything changes and is different from what I wrote on this application. I can call **1-800-699-9075** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**
- I have read and agree to the *OHA Notice of Privacy Practices* form found in the *Application Guide.* (You can find the *Application Guide* online at **www.OHP.oregon.gov**.)
- I have read the *Application Guide* and agree to all sections. (You can find the *Application Guide* online at **www.OHP.oregon.gov**.)

If you qualify for the Oregon Health Plan (OHP):

State law says that if you, or any other individual, qualifies for the Oregon Health Plan (OHP), then you, or the other individuals, automatically give OHA the right to payments from others who were legally liable to pay some or all of your medical expenses. This includes other health insurance, liability insurance or other individuals. It also includes any payments that are due to you because another person injured you. The right to the payment will not exceed the amount paid by OHP or your coordinated care organization.

I agree to notify OHA (or its designee) and my coordinated care organization when I am pursuing a claim against anyone who injured me or another member of my family who receives OHP and, when requested, to provide information that is needed to get the reimbursements.

By accepting Medical Assistance (OHP), you allow the state's Child Support Program to enforce medical support from non-custodial parents. This is also called assigning rights. It means you must help the Child Support Program find non-custodial parents unless there is a reason not to do so, such as domestic violence. If you are required to work with the Child Support Program to establish or enforce child support and you refuse, you may lose Medical Assistance. See the *Application Guide* for more information. If you have a reason not to help the Child Support Program, such as domestic violence, check the box below and list the reason.

☐ I cannot help the Child Support Program. Reason: _____
_____
_____
_____

Your right to a hearing

If you disagree with the decisions OHA makes about your eligibility for health coverage or you do not get a decision from us within 45 days, you have the right to request a hearing. You also have the right to choose an authorized representative to act on your behalf during the hearing process.

We encourage you to call us at **1-800-699-9075** to ask questions about your eligibility or the process, or provide us with additional information about yourself or your household.

You can request a hearing by calling **1-800-699-9075**. If you want a hearing, you must request it within 90 days of the date on the eligibility notice you will receive (in the mail or email). Your deadline to request a hearing does not change even if you contact us.

STEP 6 Read and sign, continued

Use of Social Security Number (SSN)

These federal laws and regulations say that anyone applying for medical benefits must provide an SSN: Federal laws - 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b). When you write your SSN on the application it means you give permission to OHA to use it and tell others about it for these reasons:

- To help us decide if you qualify for benefits. We will use the SSNs you provide to make sure the income and assets you listed on this application are correct. We will match information from other state and federal records, such as the Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security and unemployment benefits.
- To write reports about the Oregon Health Plan.
- To administer the program you apply for or receive benefits from, if necessary.
- To help us improve programs by doing quality reviews and other activities.
- To make sure we have given you the correct amount of benefits and to recover money if we have overpaid benefits.

SUPPLEMENTAL PAGES: APPENDIX A, B and C

- Use ***Appendix A*** to authorize a community partner organization to see and use your personal information to help you apply for health coverage.
- Use ***Appendix B*** to choose and tell us about your authorized representative if you have one.
- Use ***Appendix C*** to tell us about employer sponsored health coverage.

SIGN THIS APPLICATION

By signing this application, you confirm that you have permission from all people on this application to both submit their information and receive communications about their eligibility and enrollment.

If you have an authorized representative, that person may sign for you. If you are an authorized representative, you may sign here only if you and the applicant have completed and signed the Authorized Representative form (***Appendix B***).

★ Printed name	Signature	Date (MM/DD/YYYY)

HOW TO SEND YOUR APPLICATION

Send your signed application to us by mail or fax.

Mail: OHP Customer Service
P.O. Box 14015
Salem, OR 97309-5032

Fax: Use the fax coversheet (page XX) to fax your application to 503-378-5628.

THANK YOU FOR FINISHING THE APPLICATION
WHAT HAPPENS NEXT?

We will let you know soon what you and your family qualify for. If you don't hear from us within 45 days, call **1-800-699-9075**.

APPENDIX A Community partner assistance consent

1. Community partner organization name	2. Application assister name	3. Assister ID#

4. Address	5. City	6. State	7. ZIP code

8. Applicant name (first, middle, last)	9. Applicant date of birth

10. Names of other adults on your application

11. Total # of household members	12. # of household members over 18

APPLICANT: I agree to let the community partner organization and application assister listed above see and use my personal information to help me apply for health coverage.

If applying for, enrolling in, maintaining and/or changing my health coverage through a public medical program (includes the Oregon Health Plan, CAWEM and CAWEM Plus): I agree to let the Oregon Health Authority (OHA) share my application, enrollment details and status, plan benefits, and protected health information with the community partner organization and application assister listed above. The community partner organization is required to protect and keep any signed information private and safe. I authorize OHA to add this community partner organization and the application assister named above to my case file confirming that I allow this disclosure.

I understand that the community partner organization and the individual application assister **WILL**:	I understand that the community partner organization and the individual application assister **MAY NOT**:
• Tell me about what health insurance and financial help I may qualify for; • Help me enroll in and share my application information with a public medical program or a qualified health plan (QHP); • Help me in the language I prefer or refer me to other partners who can help me in the language I speak and understand.	• Charge me a fee for any assistance provided; • Choose or recommend a health insurance plan for me.

I understand that I must report accurate information on this application, and I must respond to any notice of missing or inaccurate information, when asked.

I may cancel permission for the community partner organization to help me at any time if I am enrolled in a public medical program. If I cancel this permission, I will tell OHA by calling **1-800-699-9075** or by faxing my request to **503-378-5628**.

I understand that if I cancel my permission, it will not apply to information that was already received and shared by OHA with the community partner organization or application assister; and the community partner organization or application assister may share this same information. OHA will not share information about mental health, HIV/AIDS, drug and alcohol treatment, or genetic testing without first getting authorization from me to do so.

13. Signature	Date

14. This authorization is valid for 1 year from the date of signing unless specified here:_____

You can return this form with your application or send it separately by: FAX to 503-378-5628 or by mail to OHP Customer Service, PO Box 14015, Salem, OR 97309-5032

OHP 6610 (Rev 01/16)

APPENDIX B Authorized Representative

You can choose a person called an authorized representative to talk to the Oregon Health Authority for you. If you'd like to choose an authorized representative, please use this form to tell us about the person you choose. You and your authorized representative must sign this form. If you chose an authorized representative before, the person listed below will replace them.

1. You can choose a person or an organization to be your authorized representative. If your authorized representative is: ☐ A person, ***complete a.*** ☐ An organization, ***complete b.***

   a. **Person:** Legal name (first, middle, last and suffix) _____

   Birthdate *(MM/DD/YYYY)*_____

   b. **Organization:** Organization name _____

   Organization contact name (first, middle, last and suffix)_____

   Organization contact birthdate *(MM/DD/YYYY)* _____

2. Authorized representative's mailing address			3. Apartment/Unit #
4. City	5. State	6. ZIP code	7. County

8. Phone

9. Email address

10. What is your relationship to the authorized representative?

☐ Power of Attorney ☐ Outside group ☐ Legal guardianship ☐ Executor ☐ Friend ☐ Spouse
☐ Statutory benefit payee ☐ Family member ☐ Parent of a minor ☐ Other: _____

11. Print applicant name	12. Applicant birthdate
13. Applicant signature	14. Date

AUTHORIZED REPRESENTATIVE: By signing below, I understand that I am liable for repayment of an overpayment if I knowingly withhold or give incorrect or incomplete information. I also understand that I must maintain the confidentiality of any information provided by the Oregon Health Authority, regarding the applicant and anyone listed on the application.

15. Print authorized representative name

16. Authorized representative signature	Date

You can return this form with your application or send it separately by:

- Fax to 503-378-5628 or
- Mail to OHP Customer Service, PO Box 14015, Salem, OR 97309-5032

OHA 0232 (Rev 06/16)

APPENDIX C Employer coverage – OPTIONAL

Complete this page for each employer who offers health coverage. This page is a tool that can be given to your employer to help answer questions about the coverage they offer. Make a copy if you have more than one employer to tell us about.

Employer information	Name: _____ Street address: _____ City: _____ State: _____ ZIP code: _____ Phone: _____
Employer health coverage contact	Who can we contact at your employer's office about this health coverage? Name: _____ Phone: _____ Ext: _____ Email: _____
Whose employer is this?	First/MI/last name: Birthdate:
Coverage this year	a. Will this employer offer health coverage this year? ☐ YES ☐ NO b. How much would this person pay in premiums to enroll in the lowest cost plan that meets the minimum value standard* offered only to employee (don't include family plans). If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs. Premium amount: $_____ ☐ I don't know How often:☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice per month ☐ Other: c. Is this person currently enrolled in this health coverage? ☐ YES ☐ NO d. Does this employer offer spouse/dependent coverage? ☐ YES ☐ NO
Will this coverage change next year?	☐ YES. If YES, **tell us how**. ☐ NO ☐ I don't know if this employer will make changes ☐ Employer will no longer offer coverage ☐ Employer will change the cost of premiums. The premium to enroll in the lowest cost plan that meets the minimum value standard* offered only to employee (don't include family plans) will be: Premium amount: $_____ ☐ I don't know How often: ☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice per month ☐ Other: When will this change take effect?:_____ ☐ I don't know:
Next year	a. Is this person enrolling in the employer's coverage next year? ☐ YES. If YES, when?_____ ☐ NO b. Does this person expect to drop employer coverage in 2016? ☐ YES. If YES, when?_____ ☐ NO

* The "minimum value standard" is met if the employer's plan pays 60% or more of the plan's share of the total allowed costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

OHP Fax Coversheet

IMPORTANT: The OHP fax machine receives hundreds of faxes every day. To ensure we receive all of your information, please:

- **DO** complete this coversheet and use it to fax us your materials.
- **DO NOT** fax one page at a time or fax all the front pages and then all the back pages.

Fax information

FAX to: 503-378-5628

Date:

# of pages:

Sender information

First name:

Last name:

Birthdate:

Phone:

Email:

Please give us your Client ID and or Case ID if you have them.

Client ID:

Case ID:

Document type

☐ OHP application

☐ Renewal form

☐ Proofs. For example, proof of income, proof of citizenship, etc.

Confidentiality Notice:

The information contained in this packet is confidential and legally privileged. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax - except its direct delivery to the intended recipient - is strictly prohibited. If you have received this packet in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete from your system, if applicable.

Oral Health Access Framework: Overview and Committee Work Plan

The Oregon Health Authority is uniquely positioned to work with CCOs and across divisions (Health Policy and Analytics, Health Systems Delivery, and Public Health) to coordinate activities to improve oral health outcomes for Oregonians. Recently, OHA expanded the capacity of its cross-divisional oral health program, with the hire of its first Dental Director, Dr. Bruce Austin (2015).

During the summer of 2016, OHA will commence an oral health strategic planning process to develop a coordination and alignment roadmap for oral health work across the agency: the OHA Oral Health Strategic Plan (OHA Strategic Plan). The OHA Strategic Plan will incorporate and build on:

- OHA-specific priorities and strategies in existing internal/external oral health plans, including the statewide *Strategic Plan for Oral Health in Oregon: 2014-2020* (Oregon Oral Health Coalition/Oregon Health Authority/Oral Health Funders Collaborative) and the *State Health Improvement Plan: 2015-2019* (OHA Public Health Division); and
- Emerging oral health priorities and strategies in the context of Oregon's Health System Transformation 2.0 efforts and other broad agency priorities, such as OHA's 10 priority areas, and Oregon's renewal of its 1115 waiver.

Oregon's Medicaid Advisory Committee (MAC) has the opportunity to inform OHA's ongoing strategic planning efforts with regard to oral health. Specifically, OHA has asked MAC to recommend a **framework** for defining and assessing oral health access for OHP members by addressing two foundational questions:

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should Oregon define access)?
2. What key data could be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?

The committee will review this issue in May-September of 2016 and will submit its recommendations to OHA by October 1st, 2016. The Committee's recommended framework around access to oral health for OHP enrollees will be incorporated into the OHA Oral Health Strategic Plan, which will be released by the end of 2016.

Date (2016)	Task Description
May 25 (MAC Mtg.)	• Introduce OHA request to develop the framework for assessing oral health access in OHP and committee work plan; present background on oral health for adults in Medicaid, summary of oral health delivery system in Medicaid, and summary of OHA strategic priorities and initiatives. *Committee approved creating an Oral Health Work Group to advise the committee on dental access framework.*

Oral Health Access Framework: Overview and Committee Work Plan

June	• Recruitment for Oral Health Work Group.
June 22 (MAC Mtg.)	• *MAC* approve *Oral Health Work Group* committee roster.
July 7 (Oral Health Work Group)	• Presentations on national/state model definitions and factors. • *Work Group* consider factors that help/hinder oral health access. Develop a working definition of access.
July 27 (MAC Mtg.)	• *Work Group* present list of key factors influencing access for OHP members and working definition of access.
August 11 (Oral Health Work Group)	• Presentations on model metrics/measures from dental work groups, strategic plans, national sources. • *Work Group* Develop and prioritize list of key data influencing access for OHP members.
August/September	• *Staff* draft memo on framework for oral health access in OHP per work group discussions.
September 20 (Oral Health Work Group)	• *Work Group* review and discuss draft memo on framework for oral health access in OHP.
September 28 (MAC Mtg.)	• *MAC* review and finalize draft committee memo on framework for oral health access in OHP for OHA.

Medicaid Advisory Committee: Oral Health Work Group						
Member Name	**Title**	**Organizational Affiliation**	**City**	**Race/ Ethnicity**	**Gender**	**Category**
Christina Couts	Community Health Worker	ShelterCare Homeless Medical Recuperation Program	Junction City	C	F	Consumer/ Advocate
Susan Filkins	Nutrition Consultant	Oregon Center for Children and Youth with Special Health Care Needs	Portland	C	F	Consumer/ Advocate
Dr. James Tyack	Dentist	Tyack Dental	Clatskanie	C	M	Provider
Kuulei Payne	Dental Hygienist	Winding Waters Medical Clinic	Wallowa	C	F	Provider
Dr. Lisa Bozzetti	Dentist/Dental Director	Virginia Garcia Memorial Health Center	Gresham	C	F	Provider
Heather Simmons	Medicaid Dental Services Director	PacificSource Community Solutions	Bend	C	F	CCO
Laura McKeane	Oral Health Integration Coordinator	AllCare Health	Grants Pass	C	F	CCO
Jim Connelly	VP of Network Development and Contracting	Trillium Community Health Plan	Eugene	C	M	CCO
Laura Bird	Director of Government Affairs/Policy Analyst	Northwest Portland Area Indian Health Board	Portland	NA	F	Tribal
Maria Ahrendt	Dental Manager	NAYA Clinic	Portland	C	F	Tribal
Kelle Adamek-Little	Health Administrator	Coquille Indian Tribe	Coos Bay	C	F	Tribal
Dr. Mike Shirtcliff	President	Advantage Dental	Redmond	C	M	DCO
Matthew Sinnott	Director of Government Affairs and Contracts	Willamette Dental Group	Hillsboro	C	M	DCO
Dr. Jeffrey Sulitzer	Chief Clinical Officer/Dental Director	InterDent/Capitol Dental	Happy Valley		M	DCO
Dr. Eli Schwarz	Dentist, Professor & Chair	OHSU School of Dentistry, Department of Community Dentistry	Portland	C	M	General Public
Tony Finch	Executive Director	Oregon Oral Health Coalition	Happy Valley	C	M	General Public