
Medicaid Advisory Committee

June 24, 2015

General Services Building
Salem, Oregon



Time	Item	Presenter
9:00	Opening Remarks <ul style="list-style-type: none"> Approval of Minutes – March and April 2015 OHA Update: CCOs and OHP Renewals 	Co-Chairs; Rhonda Busek, OHA
9:15	2015 Legislative Session - Outcomes	Brian Nieubuert, OHA
9:25	Medicaid 12 Month Continuous Eligibility <ul style="list-style-type: none"> Cost projections for 2017-19 	Co-Chairs; staff
9:40	Patient-Centered Primary Care Home Program (PCPCH)	Nicole Merrithew, OHA
10:10	Columbia Pacific CCO CAC <ul style="list-style-type: none"> Columbia Pacific CCO CAC membership and community engagement activities Council priority areas and implementation activities outlined in the CHIP 	Nancy Knopf, Columbia Pacific CAC
10:40	FamilyCare Community Advisory Council <ul style="list-style-type: none"> FamilyCare CAC membership and community engagement activities Council priority areas and implementation activities outlined in the CHIP 	Brett Hamilton, FamilyCare CAC
11:10	Break	
11:15	Medicaid 12 Month Continuous Eligibility (cont.) <ul style="list-style-type: none"> Committee direction/potential recommendations 	Co-Chairs; staff
11:45	Closing comments: July visit by Lynne Saxton	Co-Chairs

Update: OHP Enrollment & Redeterminations

Rhonda Busek, Interim Director,
Medical Assistance Programs, OHA

2015 Legislative Update

Brian Nieuburt

Legislative Coordinator for Health Care Programs, OHA

12-Month Continuous Eligibility for OHP Adults

Current Oregon Medicaid Policy

- Oregon's 2012 Section 1115 Waiver allows the state to enroll all OHP populations for 12-months
- Individuals determined eligible are enrolled in OHP for a 12-month *certification* period, but must report changes in circumstances affecting eligibility within 30 days of occurrence
- Changes that affect income eligibility and that must be reported are:
 - A change in source of income
 - Change in employment status (e.g. new job or job loss)
 - Change in earned income of more than \$100 or unearned income of more than \$50
- Circumstances affecting eligibility not related to income include but are not limited to:
 - Receipt or loss of health coverage
 - Change in pregnancy status of a household member
 - Change in household group membership (e.g. marriage)

12-Month Continuous Eligibility

Problem: Low and moderate-income parents and childless adults experience substantial income volatility throughout the year, which affects eligibility and can cause churning on and off Medicaid

Policy: 12-Month Continuous Eligibility

Allows beneficiaries to maintain coverage for up to one full year, even if individuals/families experience a change in income or family status

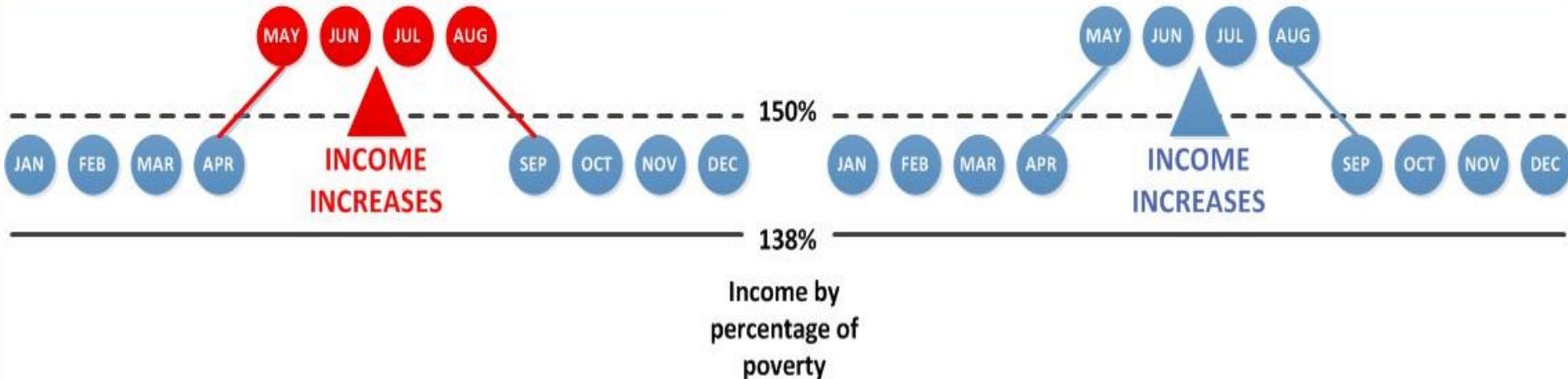
- Option for children since 1997; 32 states have adopted policy in their Medicaid or CHIP programs; 23 states have in both programs
- Federal policy has been an option for Medicaid adults since 2013
 - To date, only New York state had implemented the policy for their adult populations, likely due to financing barriers

Impact: Promotes coverage continuity for eligible individuals, despite fluctuations in income or other eligibility criteria, but also creates additional costs for a state

MEDICAID COVERAGE WITHOUT 12 MONTHS CONTINUOUS ELIGIBILITY



MEDICAID COVERAGE WITH 12 MONTHS CONTINUOUS ELIGIBILITY



Source: Adapted from Families USA Fact Sheet, August 2013

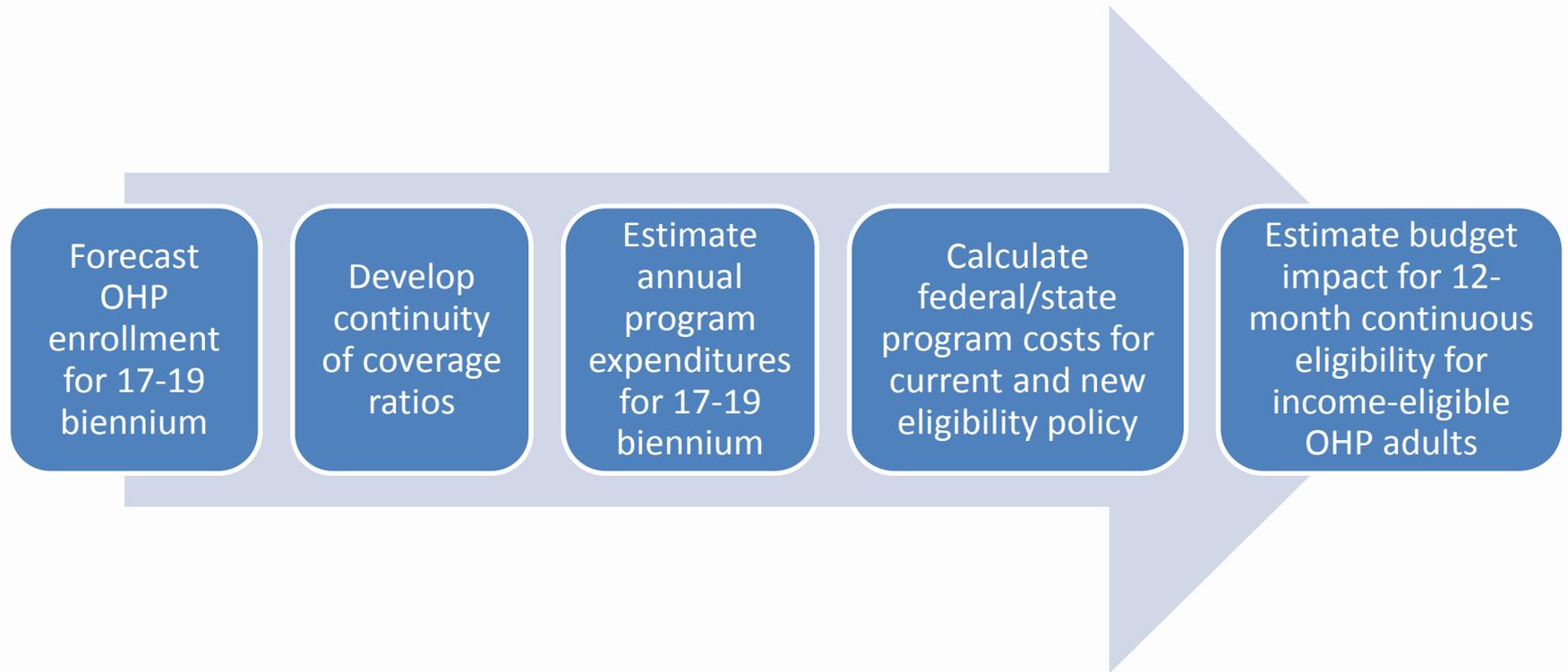
Financial Estimates of 12-Month Continuous Eligibility

Timeframe: 2017-19 biennium (July 1, 2017 – June 30, 2019)

Financing:

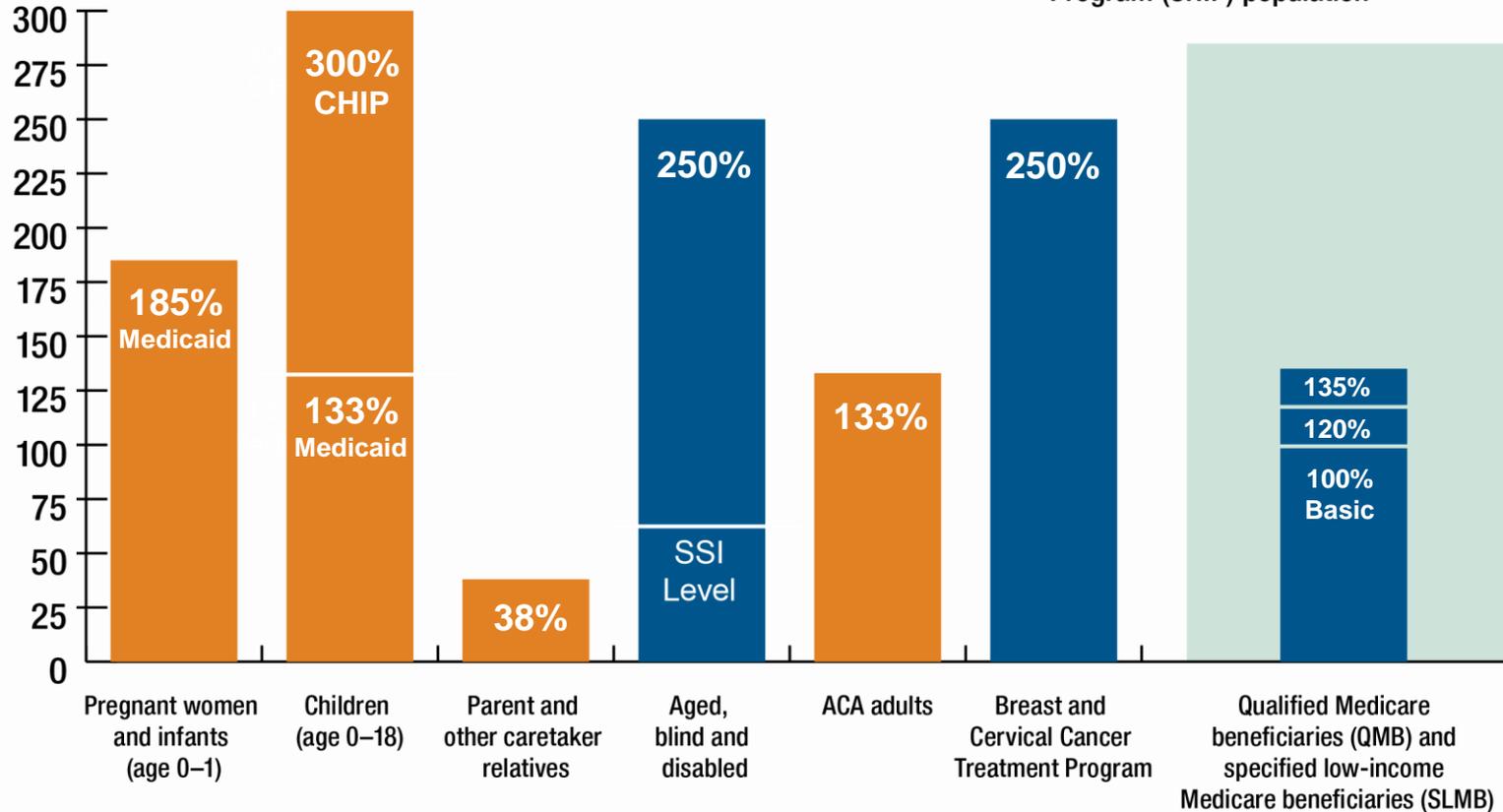
- Federal funding for Medicaid expansion (newly eligible) population drops from:
 - 100% in 2016, to
 - 95% in 2017, 94% in 2018, 93% in 2019, and 90% in years 2020 and beyond
- Based on research George Washington University, CMS determined that:
 - 97.4% of the cost should be financed at the enhanced matching rate available for newly eligible adults and
 - the remaining 2.6% at a state's regular Medicaid matching rate
- Estimated that states would likely receive a matching rate between 98.7% and 99.3% percent for their ACA expansion populations in 2014

Method for Determining Costs of 12-Month Continuous Eligibility for OHP Adults, 2017-19 Biennium



Approximate Federal Poverty Levels (FPL) for Medical Eligibility Groups in 2015

■ Traditional (non-MAGI)** Medicaid population
■ Modified Adjusted Gross Income (MAGI)* Medicaid/Children's Health Insurance Program (CHIP) population



Caseloads	Women: 18,656 Infants: 28,581	CHIP: 68,295 Medicaid: 320,356	53,097	121,267	388,674	623	QMB: 22,673 SLMB: 22,751
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* MAGI is the means-tested Medicaid/CHIP eligibility criteria.
 ** Non-MAGI has other eligibility criteria in addition to the means test.



Patient-Centered Primary Care Home Program Update

Nicole Merrithew, MPH
PCPCH Program Director

PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM

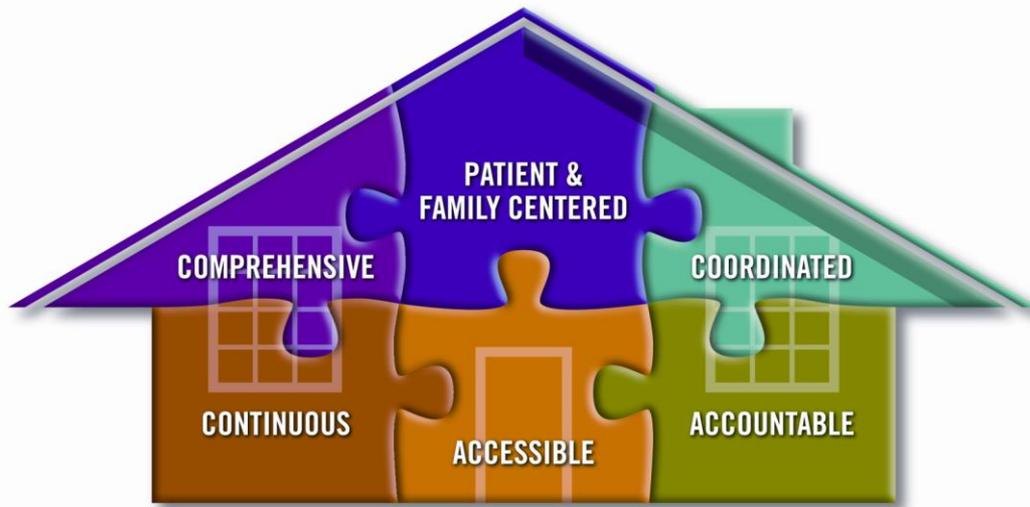
Oregon
Health
Authority

Patient-Centered Primary Care Home Program

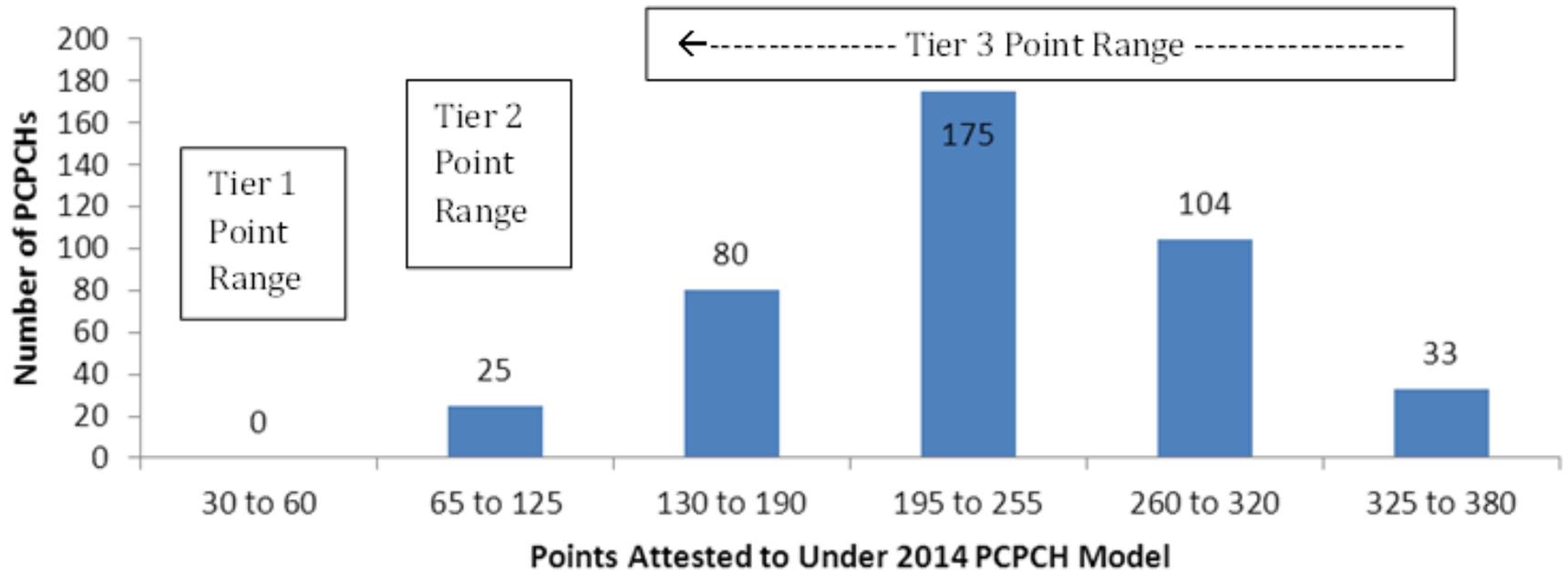
- HB 2009 established the PCPCH Program:
 - ***Create access to patient-centered, high quality care and reduce costs by supporting practice transformation***
- Key PCPCH program functions:
 - PCPCH recognition and verification
 - Refinement and evaluation of the PCPCH standards
 - Technical assistance development
 - Communication and provider engagement
- Goals:
 - All OHA covered lives receive care through a PCPCH
 - 75% of all Oregonians have access to a PCPCH by 2015
 - Align primary care transformation efforts by spreading the model to payers outside the OHA

Oregon's Primary Care Home Model

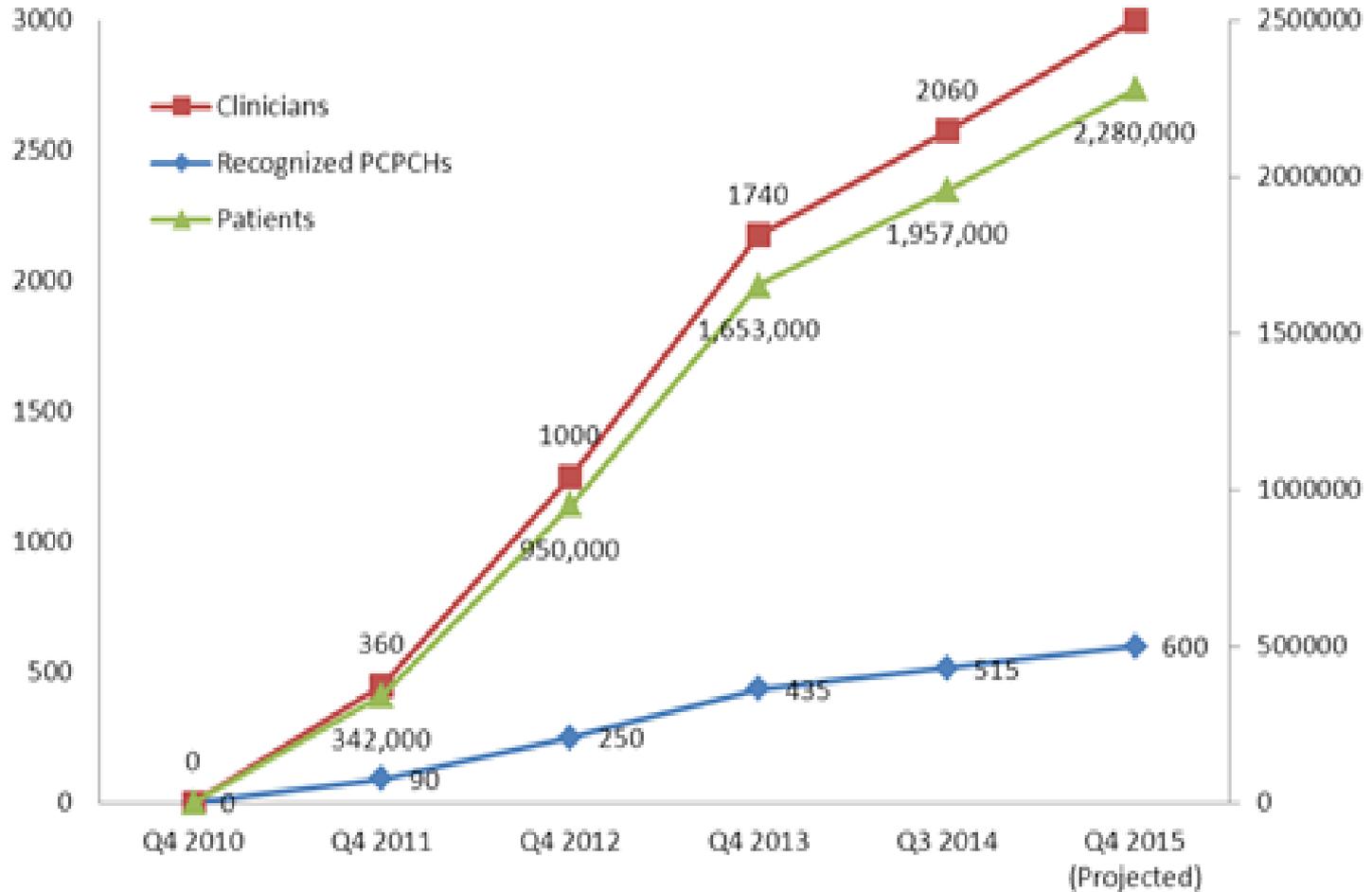
- The PCPCH model is defined by six core attributes, each with specific standards and measures.
- There are 10 “must pass” measures all clinics must meet.
- Clinics can achieve three different Tiers of recognition depending on the criteria they meet.



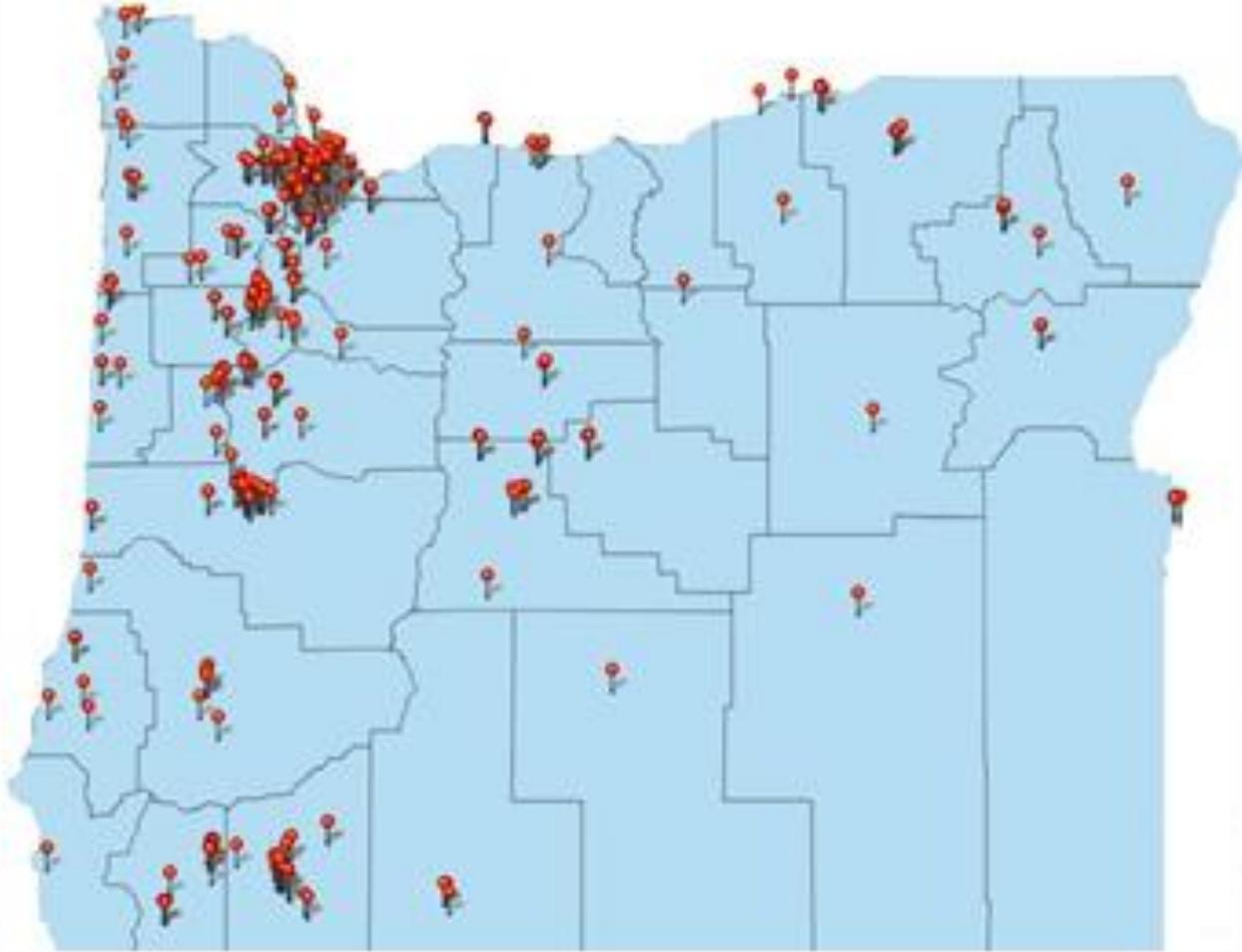
Distribution of Points by PCPCHs under 2014 Model



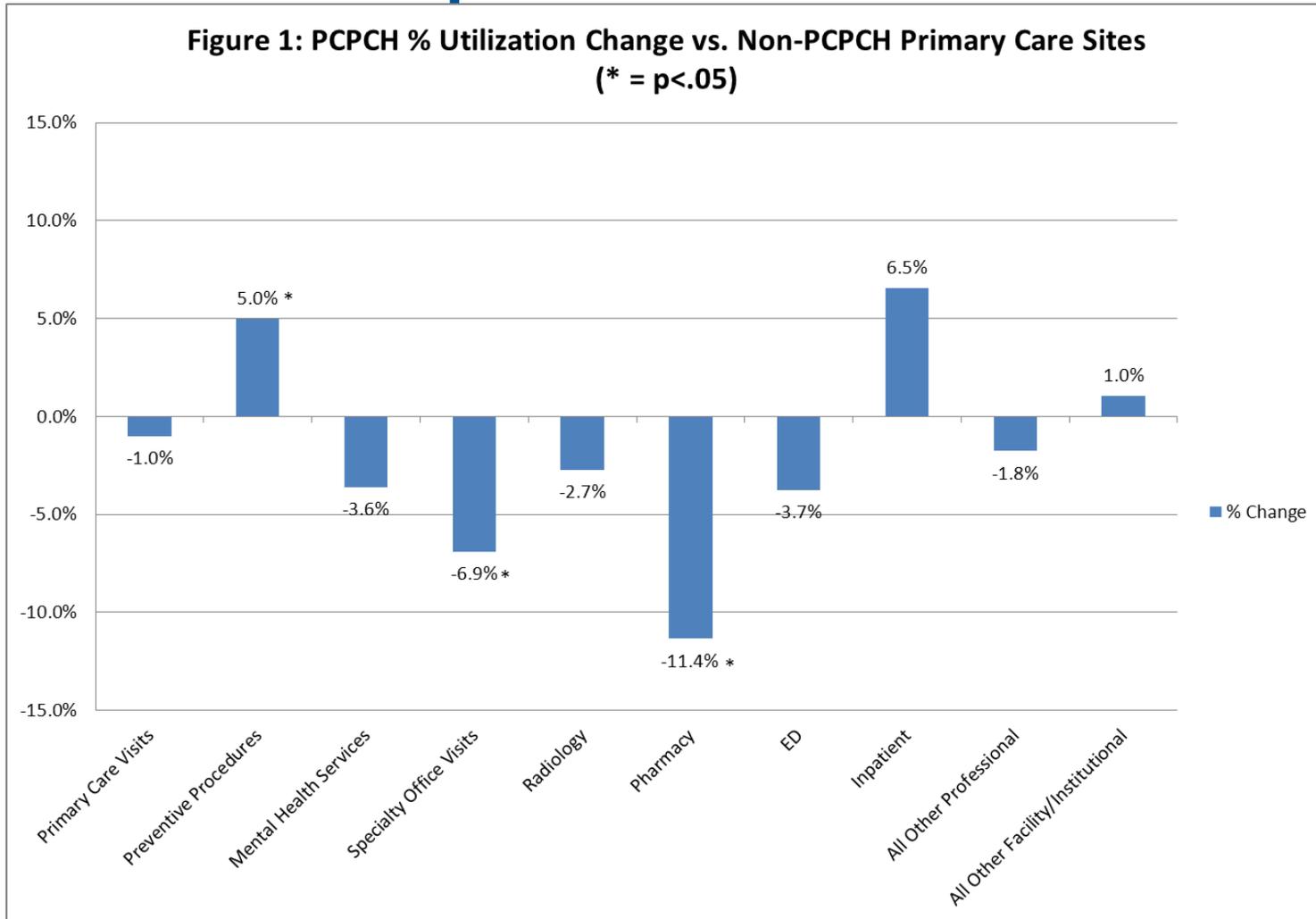
Practices, Clinicians and Patients - PCPCH Program 2010-2015



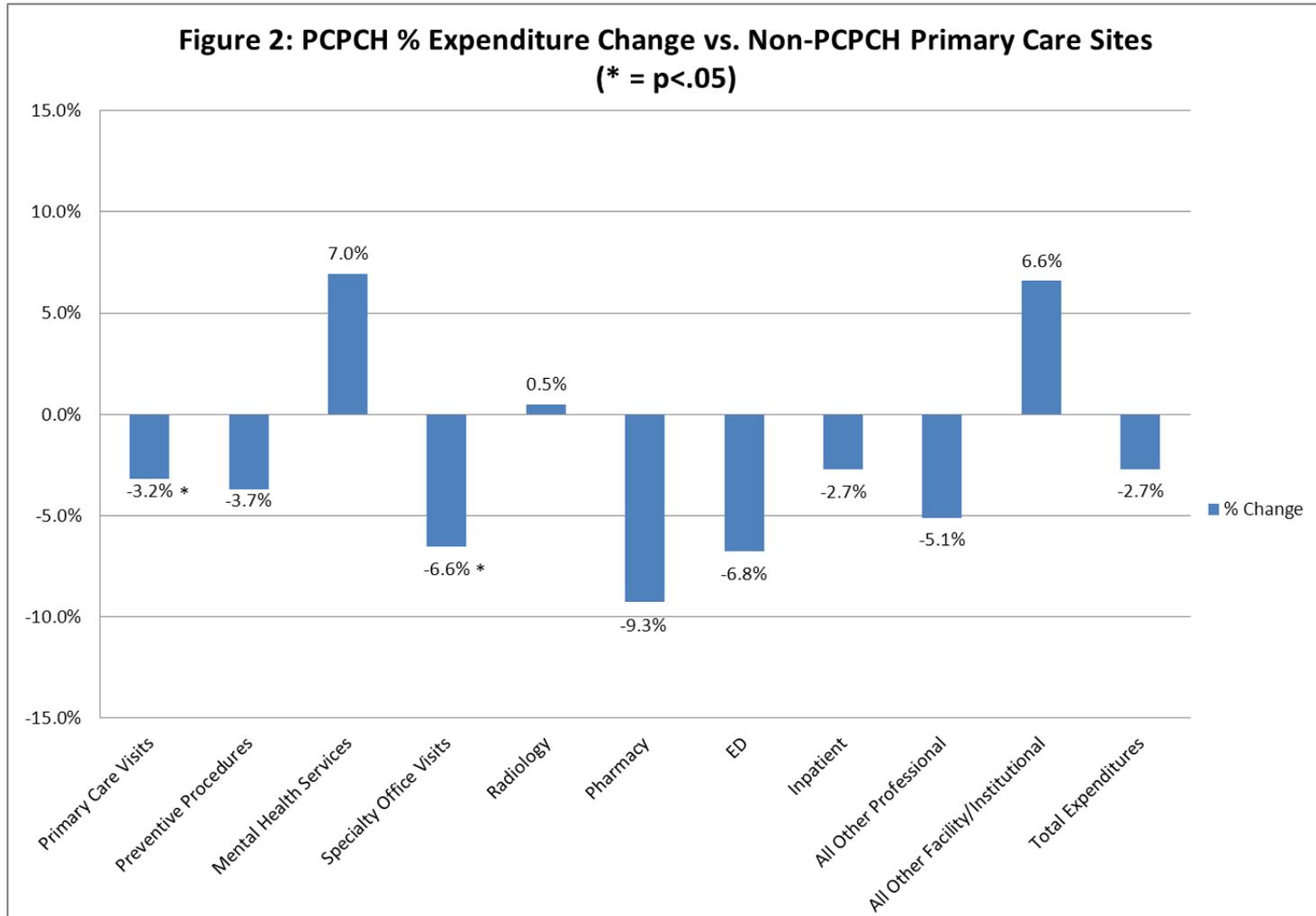
Where are PCPCHs?



Impact on Utilization

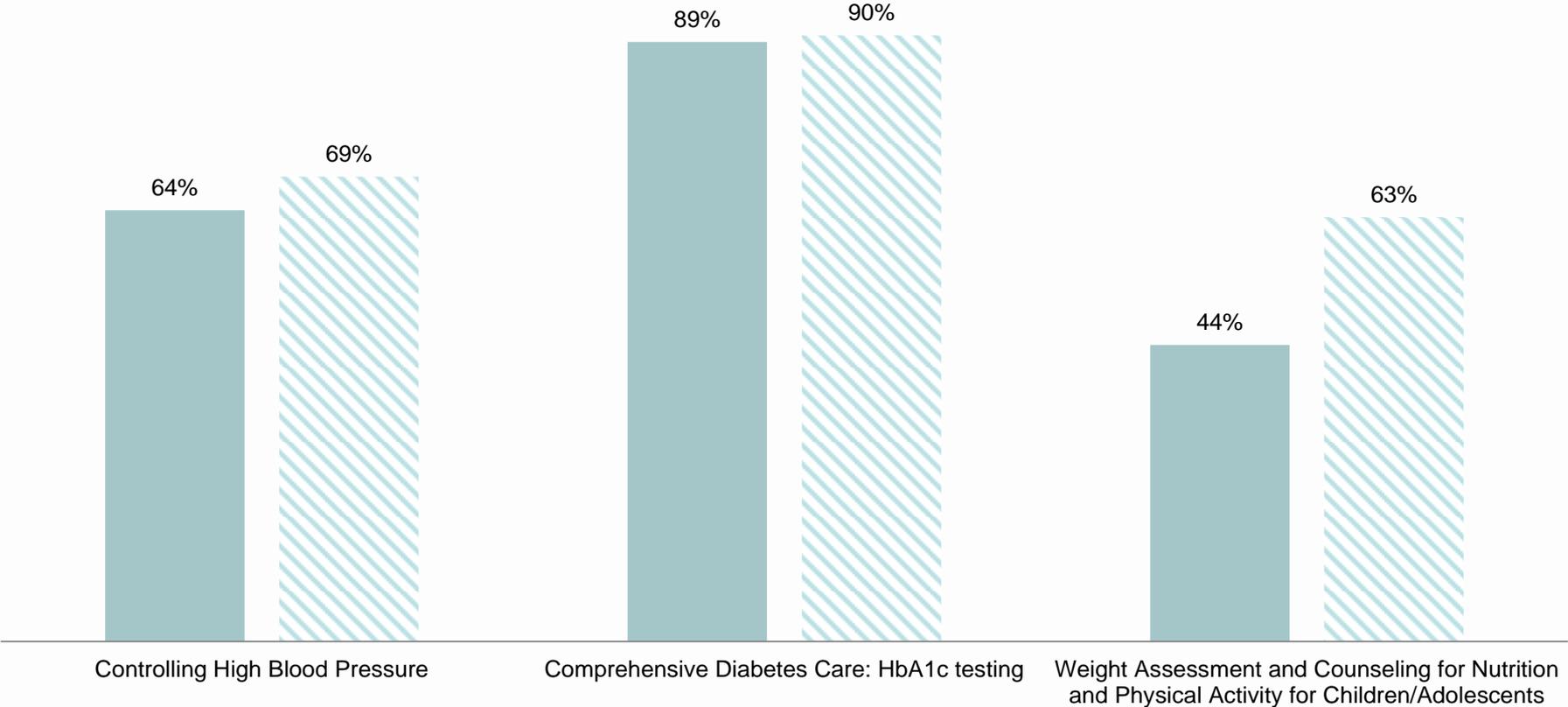


Impact on Expenditures



Clinical Quality Measures

■ HEDIS 2014 National 50thpercentile (Commercial) ▨ PCPCH



Measure	Mean PCPCH Clinic Score (n)	Mean Non-PCPCH Clinic Score (n)	Percent Difference	p-value
Chlamydia Screening	42.9% (175)	38.7% (130)	+10.9	0.011
Diabetes Eye Exam	62.4% (210)	59.9% (199)	+4.2	0.030
Diabetes Kidney Disease Monitoring	80.4% (210)	76.5 (199)	+5.1	<0.001
Appropriate Use of Antibiotics for Children with Sore Throats	83.4% (58)	75.0% (47)	+11.2	0.030
Well Child Visits in the 3 rd , 4 th , 5 th and 6 th Years of Life	63.3% (148)	55.3% (152)	+14.5%	<0.001

Oregon Health Care Quality Corporation. (2013). *Information for a Healthy Oregon: Statewide Report on Health Care Quality.*

Provider Perceptions

Improving outcomes

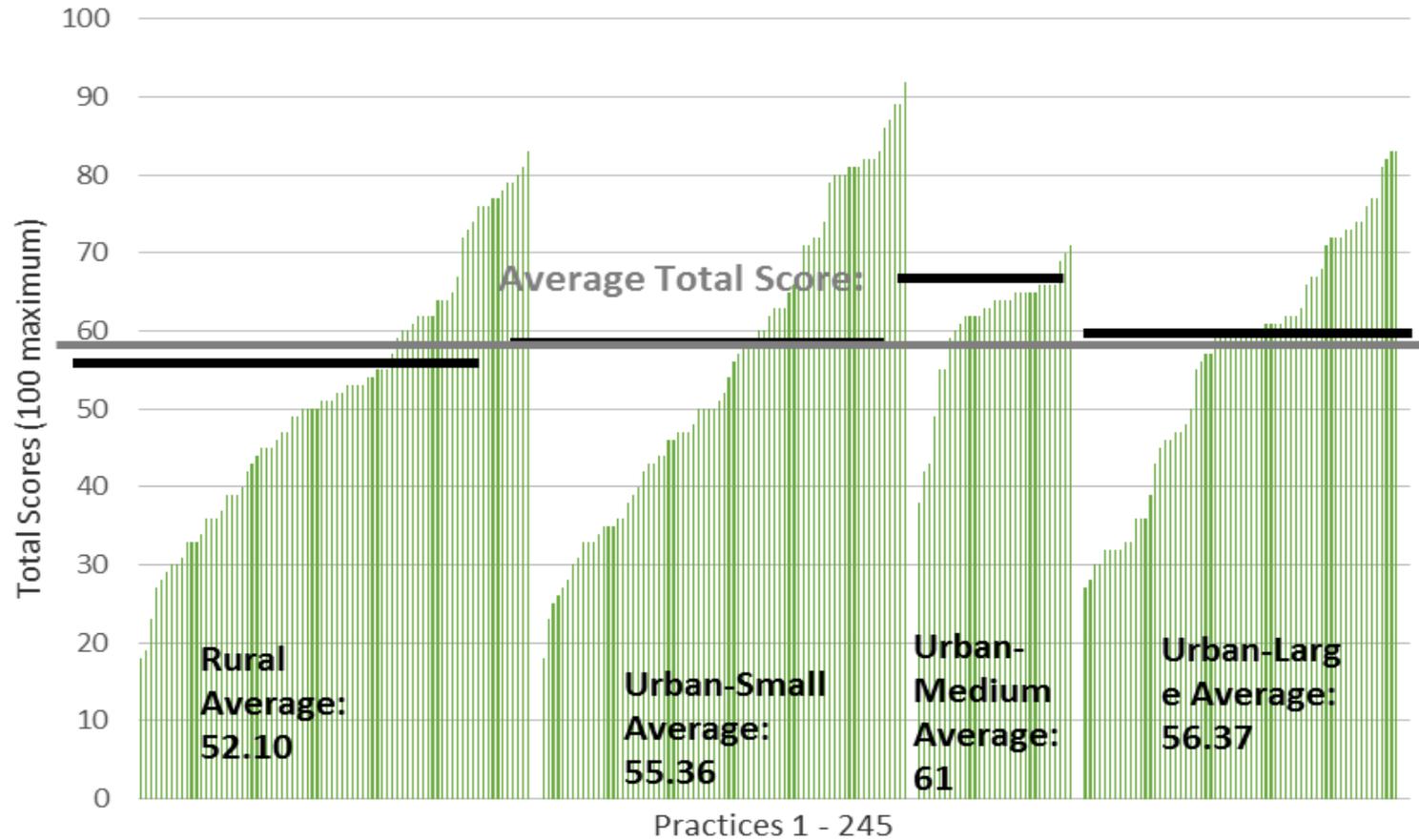
- 85% feel the model is helping their practice increase the quality of care

Improving access and experience of care

- 75% feel the model is helping their practice increase access to services
- 85% of those surveyed believe the PCPCH model is helping them improve the individual experience of care
- 82% report the model is helping them improve population health management

PCPCH Total Attribute Scores

Total Scores, Urban/Rural Categorization (N=245)



Recent Key Activities

- Focus on technical assistance
 - Patient-Centered Primary Care Institute
 - Site visits: clinical champion/practice coach team approach
- 3 STAR designation
- Payment Reform
 - 2013 Multi-payer agreement
 - SB 231

What's Next for PCPCH Program

- Continued focus on technical assistance
- PCPCH Standards Advisory Committee
 - Convening in 2015 to review the model
 - Focus on behavioral health & primary care integration
- Program Evaluation
 - Case study of 30 exemplary PCPCHs
- 2014 Annual Report



Thank you!

Nicole Merrithew, MPH
Director, PCPCH Program
nicole.merrithew@state.or.us

www.PrimaryCareHome.oregon.gov
pcpch@state.or.us



Columbia Pacific CCO

Community Advisory Council

Nancy Knopf, Columbia Pacific CAC

FamilyCare Health

PRESENTATION TO MEDICAID ADVISORY COUNCIL JUNE 10, 2015



FamilyCare Health: The Basics

Creating healthy individuals through innovative systems

Our Company

- FamilyCare just celebrated its 30 year anniversary.
- FamilyCare was the first Medicaid health plan in Oregon to integrate mental and physical health coverage into one plan beginning in 1996.
- We received “Best Place to Work” designation in 2012, 2013 and 2014.
- The entry level base salary has been at or above \$15.00 for the last two years.

Our Members

- Plan area: Clackamas, Multnomah, Washington and parts of Marion County
- Membership is approximately 130,000, more than 80,000 of whom were added due to Medicaid expansion.
- By percentage, FamilyCare is the fastest growing CCO in the state.
- Every member has an assigned Primary Care Provider.



Member Demographics

Between January 2013 and May 2015, FamilyCare's membership grew from ~45,500 to ~130,000.

The biggest population difference is the ratio of adults to children; in 2013, 68% of members were children.

Age	Count	%
Adults	79,150	61%
Children	51,086	39%
TOTAL	130,236	100%

Sex	Count	%
Female	66,818	51.3%
Male	63,418	48.7%
TOTAL	130,236	100.0%

Race/Ethnicity	Count	%
OHA Unspecified	28,228	22%
Asian	5,888	5%
Black	7,347	6%
White	65,209	50%
Hispanic	22,660	17%
Native American	904	1%
TOTAL	130,236	100%



Structure and Partners

Structure

- FamilyCare, Inc. is a 501(c)(4) public benefit corporation.
- Corporate structure is simple and transparent – revenue comes in from the State and is contracted directly with community providers.

Partners

- Because FamilyCare is a single entity, our key partners are our provider network and community stakeholders.
- Our Medical Advisory Panel is comprised of providers with whom we contract.
- We are also working with Health Share to coordinate a variety of areas including:
 - Non-Emergency Transportation
 - Flexible Benefits
 - Tri-County 911, focused on 911 high utilizers
 - Transgender Benefits
 - Healthy Columbia Willamette Consortium – Community Health Needs Assessment



Community Advisory Council

- The Community Advisory Council is comprised of FamilyCare community members and providers.
- Its purpose is to guide and participate in the planning and development of programs to improve the health of individuals residing in the metro area.
- The Council meets monthly, with quarterly meetings open to the public.
- Based on the Community Health Needs Assessment, the Council prioritized services in its Community Health Improvement Plan on the Transition-Aged Youth (TAY) population, ages 15-24. There are approximately 22,000 FamilyCare members in this age range.
- Specific focus areas includes:
 - Access to and engagement in care, specifically around mental health and substance use treatment.
 - Support in transitioning from child to adult healthcare systems, especially in the area of mental health services, and for youth exiting the foster care system.
 - A culturally-competent healthcare system that has understanding of the transition age youth population, and operationalizes best practices in services.



Challenges and Opportunities

- Authentic Consumer Voice vs. Advocate
 - Sharing lived experiences vs. Representing lived experiences
- Advisory vs. Operations
 - Recommendation vs. Authorization
- Tokenism vs. Engagement
 - Requirement of contract vs. requirement of success

Thank you for your attention.

Questions?

12-Month Continuous Eligibility for OHP Adults

Eligibility and Enrollment

- Populations considered for this analysis were selected based on whether income was the primary requisite for Medicaid eligibility

Table 1. Estimated Coverage for OHP Adults (19-64 Years) with Current Policy (i.e. no 12-Month Continuous Eligibility), 2017-19 Biennium

Eligibility Categories	Estimated Enrollment	Total Member Months of Coverage
Medicaid Expansion Adults	375,944	9,022,646
Aid to the Blind and Aid to the Disabled (AB/AD)	73,847	1,772,076
Parent/Caretaker Relative	44,270	1,065,953
Total	494,061	11,860,675

Source: OHA/DHS Office of Forecasting, Research and Analysis, Spring 2015 [Forecast](#)

Continuity Ratio

- Used similar approach to the Medicaid “continuity ratio” developed by researchers at George Washington University (GWU) in 2009

$\frac{\text{Average Member Months}}{\text{Total \# of Unduplicated Enrollees that Year}}$

= Continuity Ratio

100% Continuity Ratio = Everyone Was Enrolled for the Entire Year

Table 2. Continuity Ratios, 2017-19 Biennium

Eligibility Categories	Current Policy (%)	New Policy (%)	Difference
Medicaid Expansion Adults	68.2	78.7	+10.5
Aid to the Blind and Aid to the Disabled (AB/AD)	83.8	87.3	+3.5
Parent/Caretaker Relative	61.9	77.7	+15.8

Sources: George Washington’s analysis of Medicaid Statistical Information System Datamart for FY 2006-11; DHS/OHA Integrated Client Services data warehouse, 2008-2012

Program Expenditures

- Used per-member-per-month (PMPM) estimates
 - Average cost projections based on high-level OHP caseload and expenditure projections
 - Assumes coverage of OHP benefits remain constant and applies a fixed annual rate of growth of 3.4 percent

Table 3. Projected Program Expenditures, 2017-19 Biennium (PMPM)

Eligibility Categories	SFY 2018	SFY 2019	17-19 Biennium
Medicaid Expansion Adults	\$673	\$696	\$685
Aid to the Blind and Aid to the Disabled (AB/AD)	\$1,207	\$1,248	\$1,227
Parent/Caretaker Relative	\$716	\$740	\$728

Federal Financial Participation

- Federal funding for the AB/AD and Parent/Caretaker Relative adult groups for the 2017-19 biennium is estimated at 62.47%
- Federal funding for the Medicaid expansion population gradually decreases from 100% in 2016 to 90% in years 2020 and beyond
 - 2014 CMS guidance indicated that states would not receive the full-enhanced match rate for their Medicaid expansion population under 12-month continuous eligibility

Table 4. Federal Participation for Oregon’s Medicaid Expansion Population with New Policy (i.e. 12-Month Continuous Eligibility), 2017-19 Biennium

SFY Year	Estimated ACA Enhanced FMAP	12-Month CE FMAP for Adults	FMAP Reduction 17-19 Biennium
2018	94.50%	93.68%	-0.82%
2019	93.50%	92.68%	

Results

Table 8. Combined Estimated Cost for OHP Adult Populations, 2017-19 Biennium

	Current Policy	New Policy	Change 17-19 Biennium
Total Member Months of Coverage	11,860,675	13,595,021	1,734,346
PMPM Cost	\$770	\$759	N/A
Federal Share	\$7,649 million	\$8,664 million	\$1,015 million
FMAP	83.81%	83.58%	-0.22%
State Share	\$1,479 million	\$1,702 million	\$223 million
Total Program Cost 2017-19 Biennium†	\$9,128 million	\$10,366 million	\$1,238 million

†The change in combined program expenditure from “current policy” to “new policy” reflects a change in the ratio of clients due to changes in the continuity ratio for the respective adult populations resulting from the implementation of 12-month continuous eligibility. Because each eligibility group has a different program expenditure (PMPM), the combined weighted average PMPM is different when the ratio of member months changes.

Summary of Results

If a 12-month continuous eligibility policy were implemented for OHP adults for the 17-19 biennium:

- **Coverage Continuity:** estimated to increase total member months of coverage by nearly 15% over the biennium, resulting in 1,734,346 additional member months of coverage.
 - Continuity ratios are estimated to increase on average by nearly 10 percent for the three OHP adult populations.
- **Program Costs:** estimated to increase total program spending by \$1.23 billion
 - Additional federal revenue of \$1.01 billion
 - Additional state spending of \$223 million

Discussion and Future Considerations

- Original intent was to conduct a comprehensive cost-benefit analysis
- Potential program savings, include but are not limited to:
 - Prevent avoidable disruptions in care and non-urgent use of the emergency department;
 - Reduced coverage transitions: decreases in disenrollments, reenrollments, and redeterminations;
 - Administrative savings for states, health plans and providers; and
 - Greater potential return on investments in prevention and care management.
- Further analysis is needed to assess/quantify potential program savings

Public Comment or Testimony

Looking Ahead: Summer Schedule

- **July 22nd** meeting (Salem)
 - Lynne Saxton, OHA Director
 - Opportunity to directly engage OHA's new director; share with her the important work led by the committee
 - What questions or guidance would the committee like to share with Lynne?
 - Confirming 2 CACs
 - Finalize/adopt rec. on 12 month continuous eligibility
- **August – NO MEETING**
- **September 23rd** meeting (Salem)