Medicaid and non-Medicaid share

- In 2014, to support Meaningful use, OHA secured 90-10 Medicaid funding for the design, development, and implementation (DDI) of the Provider Directory
- In 2015, HB 2294 was passed which allows the OHA to expand Health IT beyond the Medicaid program and charge fees
- Use of the Provider Directory beyond Medicaid users must be cost allocated (fees)
- The cost allocation share is based on a calculation that is based on a ratio of Medicaid to non-Medicaid (e.g., Medicaid providers/Non-Medicaid providers).
- We are working on the share % and who would be considered a Medicaid user vs. non-Medicaid user.
- The share % that is attributed to Medicaid is covered by CMS at 90%. State general fund (GF) covers 10%. The non-Medicaid share can be covered by other sources including fees and state GF.
- The calculation and plan requires CMS approval and will be requested when fees can support the non-Medicaid costs.

User phasing approach

Now – Plan	Go Live – "Early Access"	After Go Live – Expanded access
Engage Medicaid and non-Medicaid stakeholders	Limit PD to support Medicaid uses; establish value and stabilize the directory	Full set of data to support use cases
Develop adoption plan, including tiers	Minimum Viable Product: limited data or functionality, data quality may be lower	Support non-Medicaid share with fees
Develop fee models, timelines, sustainability plan, and cost allocation	Work to expand access: Approve sustainability plan and cost allocation	Onboard non-Medicaid and Medicaid users
Develop and execute communications plan with milestones; monitor/adjust	Continue to build functionality and add data that support all uses	

PDAC feedback

Oregon Health Authority