

Oregon Health Plan 2

Section 1115 Quarterly Report



Demonstration/Quarter Reporting Period:
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I. Letter from the State Medicaid Director

The third quarter of the federal fiscal year of 2009 was momentous for the Oregon Health Plan. Most notable are the historical bills passed by the 2009 Legislature in June and the significant progress made towards resolving issues related to the implementation of the new state Medicaid Management Information System (MMIS).

Due to the recession, the Legislature faced a difficult budget cycle. Demand for social assistance programs was at peak levels while state revenues supporting these programs suffered huge losses. During the second quarter (FFY), the Legislature asked the Department of Human Services (DHS) to submit a list of options to reduce its budget by an additional 30 percent. The options painted a grim picture for medical assistance programs. However, I'm pleased to report that the final Legislatively Approved Budget for 2009-2011, while reducing some benefits and provider reimbursements, will actually allow Oregon to provide health care coverage to more Oregonians than before.

HB 2116, passed in June, establishes funding to support the new Healthy Kids program. The goal of Healthy Kids is to provide access to health care for 95 percent of Oregon children. With three programs designed for varying income levels, there will be something for everyone.

HB 2116 also provides enough funding to increase enrollment in OHP Standard to a biennial average of 50,000 low-income adults. With a much higher number of Oregonians who could qualify, the department plans on opening a new reservation list to ensure who gets to apply is determined in the most equitable way.

Another important piece of legislation passed in June was HB 2009, which establishes the Oregon Healthy Authority (OHA). All of the agencies included in this report, the Division of Medical Assistance Programs (DMAP), Addictions and Mental Health (AMH) and the Office of Private Health Partnerships, which administers FHIAP, will fall under the OHA. The goal of the OHA is to streamline government delivery of health-care-related services. Though we will be part of a new agency, we will continue to work closely with the remaining DHS divisions to ensure Oregonians receive health services in a seamless and efficient manner.

It's been an exciting legislative season; however, I would also like to highlight the activities that took place in the third quarter surrounding the implementation of the new MMIS. Through their tireless and sometimes heroic efforts, staff were able to resolve many of the issues caused by the new system and ensure a continuity of service for both clients and providers. We continue to work closely with contractor EDS to correct the remaining problems, and I look forward to describing our progress in future reports.

- Jim Edge, M.P.H., State Medicaid Director

II. Events affecting healthcare delivery

A. OHP Demonstration implementation and/or enrollment progress

Expansion of OHP Standard

In June, the Oregon Legislature passed HB 2116, creating a new tax on hospitals to fund and sustain the expansion of the OHP Standard program. Currently, OHP Standard covers approximately 24,000 low-income adults who do not qualify for traditional Medicaid programs covered under the OHP Plus program. With the additional funding, enrollment in OHP standard will increase to a biennial monthly average of 50,000.

Because there are many more Oregonians who would qualify than there are spots available, the task currently facing the department is to determine the most equitable way to open up OHP Standard for enrollment. When there was an opportunity to add 10,000 new clients in 2008, DHS chose to use a reservation list from which names were randomly drawn by a computer. Only those people whose names were drawn received an application.

During the reporting period, DMAP began meeting with stakeholders in order to build upon what was learned in 2008. DMAP is considering their recommendations and preparing requests for federal approval.

Oregon Health Authority

During the reporting period, the Oregon Legislature passed HB 2009, creating the Oregon Health Authority (OHA), one of the primary recommendations made by the Oregon Health Fund Board after a series of community meetings throughout Oregon last year. The goal of OHA is to ensure all Oregonians have access to high-quality, affordable health care by bringing all the state's health care services together under one umbrella.

OHA will be comprised of three divisions currently part of DHS, including the Division of Medical Assistance Programs, Public Health, and Addictions and Mental Health. The Authority will also include what is now the Office of Private Health Partnerships, the high-risk insurance pool (OMIP) and the Public Employees' Benefit Board. However, these entities will continue to work closely with the other two DHS divisions, Children, Adults and Families and Seniors and People with Disabilities.

OHA will be phased in over the course of the next two years. The Governor has appointed DHS Director Dr. Bruce Goldberg to oversee the transition. In turn, Goldberg has selected Tina Edlund, current Deputy Administrator for the Office for Oregon Health Policy and Research, as the OHA Deputy Director for Planning and Policy Implementation.

In addition to creating a plan to ensure all residents have health insurance, OHA is charged with creating two new databases. The first will be a new all-claims, all-payers database to track health care dollars. The second will track the health care work-force.

OHA will also develop reporting requirements for when insurance companies raise their rates, including reporting administrative cost increases separately and allowing the public 30 days to comment about the increases.

Changes resulting from legislation

HB 2116 also creates the Healthy Kids program. Some provisions will require state plan approval:

- 12-month continuous enrollment for all children covered under OHP
- Lifting the five-year ban for immigrant children

Find further detail regarding Healthy Kids later on in this report.

Sovereign States Drug Consortium

DMAP is in the process of joining the Sovereign States Drug Consortium, an alliance of six states to negotiate and acquire supplemental rebate agreements to the federal Medicaid rebates from drug manufacturers for drugs used through the states' Medicaid programs. Other member states include Iowa, Maine, Utah, Vermont, West Virginia and Wyoming.

During the reporting period, DMAP submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) with the newly revised Rebate Agreement, which will be signed by manufacturers. The agreement underwent substantial revisions and a thorough review process by the Department of Justice.

With CMS approval, the DMAP Pharmacy Program officially joined the Sovereign States Drug Consortium in June and will begin collecting supplemental rebates on drug products for the fourth quarter (FFY) of 2009.

B. Benefits

2009-2011 Budget Reductions: Vision and Dental Benefits

The 2009-2011 Legislatively Approved Budget passed in June limits vision and dental benefits for OHP Plus clients who are non-pregnant adults, 21 years and older.

- Vision:
Services eliminated include eye examinations for the purpose of prescribing glasses/contact lenses, fitting fees, glasses and contact lenses.

Exceptions exist if the client has one of the following medical diagnoses: pseudoaphakia, aphakia, congenital aphakia or keratoconus. Glasses and contact lenses will still be covered for clients who lack the natural lenses of the eye due to surgical removal or congenital absence.

- **Dental:**
Services eliminated include crowns; endodontics, except for anterior or bicuspid teeth, apexification/recalcification procedures; periodontics; removable prosthodontics, alveoplasty; and observational office visits.

Full dentures are restricted to once in a lifetime for recent edentulous, resin partial dentures, adjustments and repairs of dentures.

Vision and dental services for children ages 0 to 20 and pregnant women are not affected. Changes in benefits are subject to CMS approval.

Smoking Cessation Program

The Smoking Cessation Program offers a variety of resources to help fee-for-service clients stop smoking, including the Oregon Quit Line, a multiple-call counseling service. The purpose of the program is to eliminate health care disparities among the uninsured by removing barriers to tobacco cessation and to increase successive quit rates.

Studies have shown smoking cessation programs are most successful when nicotine replacement therapy (NRT), such as gum or patches, is combined with counseling. In order to better align the OHP fee-for-service program with this model, DMAP has initiated two new changes:

- Effective July 2009, clients will be able to order NRT through the Oregon Quit Line, removing the current barrier requiring clients go to their providers for a prescription.
- If a client gets a NRT prescription from their provider, the claim will trigger notification to the Quit Line, who would then call and invite the client to participate in counseling. Implementation is expected later this year.

Health Services Commission

Nothing to report. The only meeting of the full Health Services Commission during the reporting period was cancelled.

C. Grievances and complaints

- 1. Fee-for-service**
- 2. Managed care**

During the reporting period, DMAP and AMH continued to work around Medicaid Management Information Systems (MMIS) defects; however no trend surfaced as a direct result of the MMIS implementation to indicate

increased dissatisfaction with the delivery of physical or mental health services.

D. Quality of care

1. Fee-for-service

The following two topics will affect the quality of care for both fee-for-service and managed care clients.

Key Performance Measures

The Legislature approved new Key Performance Measures for DMAP that will be used to track quality performance over time. The measures can be broken down by managed care and fee-for-service, and by race and ethnicity. The four key performance measures are

- Adequacy of prenatal care for OHP clients
- Preventive Services for OHP children
- Preventive Services for OHP Youth and Adults
- Preventive Quality Indicators - Ambulatory Care Sensitive Conditions for Hospitalizations

Health Record Bank of Oregon

When the Health Record Bank of Oregon (HRBO) begins operation in January 2010, it will provide a secure repository for current medical records for OHP clients. Clients may view their records and authorize physicians, hospitals and other health care providers to view them as well. Access to more complete medical information will enhance providers' ability to make informed decisions regarding care of OHP clients, improve health outcomes and reduce the cost of unnecessary care.

In May, DMAP received five responses to the HRBO Request for Proposal (RFP) that qualified for evaluation. Responses had to include how the potential contractor will develop and operate a system to produce a personal health record that will function independently of any individual plan, provider or health care organization. The selected contractor will also be responsible for encouraging Medicaid clients and their caregivers to use the system, gathering as much current information as possible at each clinical encounter.

A review panel of five experts scored the proposals, and the HRBO team is in contract discussions with the company that received the highest score, WebMD. The team hopes to have the contract in place by the end of the fourth quarter (FFY) of 2009.

2. Managed care

Quality Improvement Workgroup

Quality Improvement Workgroup activities included reviewing findings from the External Quality Review, reviewing immunization rate performance both at the plan level and from a statewide basis, and reviewing and updating best practices from the managed care plans on smoking cessation strategies and interventions.

Quality Assurance and Improvement

The Quality Assurance and Improvement Unit began conducting its annual on-site quality improvement evaluation for each fully capitated health plan (FCHP) or dental care organization, including focus on these key elements:

- Grievance System: Complaints and Appeals
- Adverse events for any DMAP member
- Utilization - over and under utilization
- Access monitoring
- Follow-up by plan to EQRO review

Corrective Action Plans

The mental health organization, Greater Oregon Behavioral Health, Inc. (GOBHI) was placed on a formal corrective action plan to address issues found in their Information System Capabilities Assessment performed by our external quality review organization. There are two main issues:

- The Medicaid claim/encounter data processing and data analysis and reporting databases are obsolete and pose a security risk.
- The network operating system on GOBHI's Medicaid server is obsolete and poses a security risk.

Subsequently, GOBHI submitted a corrective action plan that has been approved by AMH. The new network operating system and Medicaid server are on track to be fully operational by September 2009.

E. Access

1. Fee-for-service

Disease Management

A statewide Disease Management contract for fee-for-service Medicaid clients was approved by CMS and began operating June 1, 2009. The contracted vendor, APS Healthcare, provides Disease Management and Medical Case Management services to fee-for-service Medicaid clients as a program-approved service.

2. Managed care

Physician Access Improvement Project

The CMS-approved demonstration project, the Physician Access Improvement Project, completed its one-year demonstration period on April 30. The project is designed to focus on strategies to improve prevention and primary care for OHP Medicaid recipients. By November of this year, the department will evaluate whether the managed care plans met the required performance targets. In addition, the state will conduct a learning/evaluation session with the plans to gather the best practices and strategies for increasing prevention and primary care services.

F. Managed care

1. Approval and contracting with new plans

Nothing to report.

2. Rate certifications

During the third quarter (FFY), the Actuarial Services Unit finished development of the underlying models for capitation rate setting. This laid the foundation for generating the October 2009 and January 2010 capitation rates efficiently and timely.

3. Enrollment and disenrollment

Nothing to report.

4. Health plan contract compliance

DMAP

Nothing to report.

AMH

- On June 30, 2009, AMH completed the end of the first OHP contract waiver for those administrative processes adversely impacted by the DHS MMIS System. Effective July 1, 2009, a second waiver provided to MCOs extended the date that normal contractual processes were waived by DHS.
- AMH completed a contract amendment to implement the American Recovery and Reinvestment Act (ARRA), as it pertains to OHP, effective July 1, 2009.
- During the reporting period, AMH monitored a continued increase in the percentage of hospital contracts gained by mental health organizations

(MHOs). This comes after a recent review by AMH of hospital/MHO contracting relationships.

5. Financial performance relevant to the Demonstration

Nothing to report.

G. Legislative activities

2009 Legislation

Several bills were passed during the 2009 Legislative Session that will have a significant impact on Oregon's medical assistance programs. Find details in other sections of this report.

- HB 2009 establishes the Oregon Health Authority (OHA). Over the course of the next two years, the OHA will assume authority over the health services and health insurance functions of DHS and the Department of Consumer and Business Services. The OHA will be responsible for reforming the health care system in Oregon, including the cornerstones of controlling costs, improving service delivery and increasing insurance options.
- HB 2116 establishes:
 - New taxes on insurers to fund the Healthy Kids program
 - New taxes on hospitals to fund and sustain the expansion of OHP Standard
- HB 2126 makes the Plan Drug List (PDL) enforceable for physical health drugs and adds mental health drugs to the PDL on a voluntary basis.
- HB 3259 establishes a reimbursement methodology between managed care plans and non-contracted DRG hospitals (those with 50 or more beds). This bill has no fiscal impact on DMAP, nor does it change managed care plans' capitation rates.
- SB 37 instructs DMAP to process supplemental payments to rural health clinics (RHCs) within 45 days of receipt of the completed billing form, effective May 2011. Managed care plans do not reimburse RHCs at 100 percent of cost. Supplemental payments are those DMAP pays to make up the difference.

Budget

With the passage of Senate Bill 5529 in late June, the Legislature laid out the 2009-2011 budget for DHS. However, more changes may occur when the Legislature reconvenes for a special session in February 2010. The reductions affecting DMAP are listed below. Find details in other sections of this report.

Implementing efficiencies:

- Obtain additional drug rebate funds
- Reduce the administrative budget
- Enforce the preferred plan drug list (PDL) for non-mental health drugs
- Create a voluntary PDL for mental health drugs
- Create a durable medical equipment sole source contract
- Expand electronic communication
- Improve third party liability identification and recovery

Reducing benefits:

- Limit dental services for non-pregnant adults
- Limit vision services for non-pregnant adults

Expand populations:

- Provide health care coverage to 80,000 more children through the Healthy Kids program
- Expands the OHP Standard program to a biennial monthly average of 50,000 low-income adults

Reduce reimbursement rates for providers:

- Reduce the hospital component of managed care capitation rates (affects hospitals with 50 or more beds)
- Take steps to reduce the expenditure trend for the 2009-2011 biennium in payments to Federally Qualified Health Centers and Rural Health Clinics
- Reduce capitation rates for managed care organizations by 3.75 percent
- Eliminate cost-of-living adjustments for fee-for-service providers

H. Litigation status

Clear Choice Health Plans Settles Suit

One of DMAP's contracted managed care plans, Clear Choice Health Plans, filed a suit against the State in 2003 regarding a disagreement over capitation rates for the Oregon Health Plan. The case was set to go to trial in March 2009, and Clear Choice was planning to sue for \$34 million in damages. However, in January 2009, Clear Choice and the State settled litigation, agreeing to mutual release, dismissal of all claims with prejudice, each party to bear the burden of its own attorneys fees and costs, and a payment to Clear Choice of \$1 million. The settlement became final in May, and the state made its payment to Clear Choice in July. Clear Choice continues providing services to OHP clients.

I. Operational issues related to:

1. OHP Plus
2. OHP Standard

The following operational issues apply to both OHP Plus and OHP Standard.

MMIS

During the reporting period, the department continued to address issues surrounding implementation of the new MMIS. Progress was as follows:

- The MMIS Business Support Unit developed a stabilization plan, which has resulted in a more focused effort to address major issues.
- Together, DHS and EDS made significant improvements to the electronic process that informs managed care plans which OHP clients are assigned to their plans. Staff worked with the plans to ensure they know how to navigate the new format in which the enrollment information is presented.
- The National Provider Identifier (NPI) task force completed testing, and new computer logic was put in place to remedy any remaining NPI issues.
- DHS and EDS corrected the faulty address logic and completed the initial mailing of the client coverage letters, which inform clients of their benefit package and other enrollment information.
- With the implementation of the new Provider Web Portal features, Provider Services staff helped providers learn to submit claims and adjustments online. Providers reported that using the Provider Web Portal is much faster and easier than using the paper forms.
- DMAP worked closely with managed care plans and fee-for-service providers to address any outstanding issues resulting from system errors that caused clients to be erroneously disenrolled from managed care.
- Both Client Services and Provider Services Units saw significant increases in call volume following the implementation of the new MMIS. This increase resulted in call wait times that exceeded agency standards. Both units developed actions plans to address the excessive wait times and improve customer service and satisfaction. Action plans included adding additional temporary staff in order to reduce the wait time between calls, as well as the talk time spent on each call. Even with an average of more than 700 incoming calls per day, Provider Services was able to reduce the average call wait time to less than two minutes. Client Services added a part-time evening shift and was able to eliminate a backlog of open hotline call records. The evening staff were then moved to day shift and contributed to the reduction of call wait times to less than one minute and total call talk time to approximately three minutes per call.

Claims

The Claims Unit made significant progress during this quarter on claims-suspense resolution, nearly eliminating the suspense backlog and maintaining a high level of

service. They also developed expanded reporting processes to ensure new federal stimulus requirements around prompt payment of claims are being met.

Transformation Initiative

DHS launched the Transformation Initiative in December 2007 in order to improve efficiency and effectiveness throughout the department. The initiative is designed to enable DHS to continue providing quality services in a time when the demand is outpacing revenue.

DMAP has identified several transformation initiatives for the division that will result in cost savings and/or increased efficiency. During the reporting period, DMAP made significant progress in the following initiatives.

- **Videoconferencing:**
DMAP held its first successful videoconference during the April Contractors' Meeting, with Oregon Health Management Services participating off site. Staff made videoconferencing available to all managed care organizations during the May Contractors' meeting.

The DMAP Policy & Planning Section also began using videoconferencing in April for its Durable Medical Equipment Policy Advisory Committee meeting. Instead of driving to Salem, representatives from the Lane Individual Practice Association and Lane County Legal Aid participated via videoconference at the local DHS field office in Lane County. Staff plan to coordinate more videoconferencing locations throughout the state for future meetings.

- **Electronic Communication:**
The Electronic Communication Initiative is now in effect. As of June 1, DMAP is no longer mailing provider communications. All provider communications are now delivered electronically using eSubscribe, an internet subscription service, and other electronic mediums.
- **Medicaid Information Technology Architecture:**
The goal of the Medicaid Information Technology Architecture (MITA) Planning Initiative is to improve administration of the Medicaid program by fostering integrated business and information technology. In May, the Centers for Medicare and Medicaid Services (CMS) approved the initiative's Pre-Advanced Planning Document (PAPD) and agreed to provide federal matching funds for the project. Staff are currently developing a request for proposal (RFP) to select a project manager.
- **Enforceable Plan Drug List:**
A giant step forward was made for the "Enforceable PDL" Initiative with the passage of passage of HB 2126. The PDL is a list of prescriptions determined to be the most effective drugs at the best available price in a class of drugs. At this time, the PDL serves only as a suggestion for health care providers, and

use of listed prescriptions is not mandatory. Effective January 1, 2010, DMAP will require a prior authorization for all physical health drugs not included in the PDL. In addition, DMAP will create a second PDL for mental health drugs. This will improve efficiency and reduce costs for the division.

3. FHIAP

Nothing to report.

4. Future Programs and Insurance products

Healthy Kids

HB 2116, passed by the Legislature in June, contains funding to provide medical coverage for 80,000 children by the end of the 2009-2011 biennium.

Subject to CMS approval, there will be three programs within Healthy Kids for children 18 years and younger:

- OHP Plus for children no more than 200 percent of the federal poverty level (FPL) – effective October 1, 2009
- Employer-sponsored insurance through the Federal Health Insurance Assistance Program (FHIAP)
 - Full premium assistance for children with family incomes no more than 200 percent FPL – effective October 1, 2009
 - Premium assistance on a sliding scale for children with family incomes between 200 and 300 percent FPL – effective January 1, 2010
- Private insurance option through the Office of Private Health Partnerships (OPHP) – effective January 1, 2010
 - Premium assistance on a sliding scale for children with family incomes between 200 and 300 percent FPL
 - Families with incomes above 300 percent FPL would be responsible for paying premiums in full

Staff engaged in activities during the third quarter (FFY) to ensure DHS and its partner agencies were prepared to reach out to and enroll as many of the 116,000 uninsured children in Oregon as possible when Healthy Kids legislation passed.

- DMAP established the Healthy Kids Outreach Advisory Committee, which addresses marketing, outreach, and enrollment strategies.
- DMAP prepared for two new outreach programs for Healthy Kids:
 - The Application Assistance Program, which will provide reimbursements to community organizations for outreach and for helping clients who need assistance completing the application form and obtaining necessary documentation; and
 - The Targeted Outreach and Enrollment Grants Program, which will provide outreach funding for groups and organizations to target minorities and hard-to-reach populations.

- In order to make it easier for families to apply for medical assistance, DHS launched a new OHP application form that can be submitted online.

III. Status of Corrective Action Plans

Nothing to report

IV. Evaluation activities and interim findings

Physician Workforce Survey

Fielding of the Physician Workforce Survey, a survey DMAP jointly administers with the Oregon Medical Association and the Office of Oregon Health Policy and Research, was completed during the reporting period. Analysis is underway. DMAP anticipates publishing a preliminary report in September and final results in the first quarter (FFY) of 2010.

OHP Demonstration Evaluation Interim Report

DMAP is reviewing the proposed outcome measures that will evaluate how well the Oregon Health Plan is performing for the next waiver submission. Staff are currently building a data set that will be used to assist in testing hypotheses. Staff expect to submit an interim evaluation report of the Demonstration to CMS by October 31, 2009.

Oregon Health Study

The 2008 OHP Standard Reservation list provided a unique opportunity for health researchers to study the impact of health care coverage. The random selection of names from the reservation list created two large, trackable groups of people where the only difference was health care coverage. This provided a unique opportunity to study the impact of health care coverage. DMAP's Analysis and Research Unit is collaborating with internationally renowned research organizations and scholars, including Joseph Newhouse, father of the landmark RAND health study, to participate in what is hoped to be another ground-breaking study in the field of health insurance.

Key players in the study include Harvard, MIT, Portland State University, Providence Health System's Center for Outcomes Research and Education (CORE), and the Oregon Health Research and Evaluation Collaborative (OHREC). The study, coordinated by RHW Sloan, is being conducted at no cost to the state, with funding provided by the Centers for Medicare and Medicaid Services (CMS).

The DMAP Analysis and Research Unit maintains a vital role in the study, such as obtaining CMS approval, creating the evaluation design and gathering the data, as well as contributing to the research, quality oversight, data integrity, ethics, partnerships, and research and evaluation questions. As the study progresses, staff will also coauthor publications and share in presenting the findings of the study.

The majority of the survey work is complete, and the study is entering into the second phase where researchers will evaluate the health of two groups and compile the administrative data.

The research team expects the study to take approximately three years. In addition to fulfilling the requirements for CMS, the results will demonstrate the value and benefit of providing access to health care coverage to people who are not eligible for traditional Medicaid programs. The Oregon Health Plan will be the first to show how the modifications made through waiver approvals of federal Medicaid regulations allow Oregon to provide higher-quality care to more people, without costing more.