OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

March 8, 2019

TO: Co-Chair Beyer, Co-Chair Nosse, and Members of the Joint Committee on Ways and Means Subcommittee on Human Services
FROM: Patrick Allen, Director, Oregon Health Authority
SUBJECT: March 7, 2019, Committee Questions

Dear Co-Chair Beyer, Co-Chair Nosse, and Members of the Joint Committee,

Thank you for the opportunity to present before the Joint Committee on Ways and Means Subcommittee on Human Services on March 7, 2019, regarding the Oregon Health Plan. Please find below responses to questions raised during that presentation. Please do not hesitate to contact me or my office if you have further questions.

1. **Senator Beyer and Senator Heard asked for more details on federal matching rates over time.**

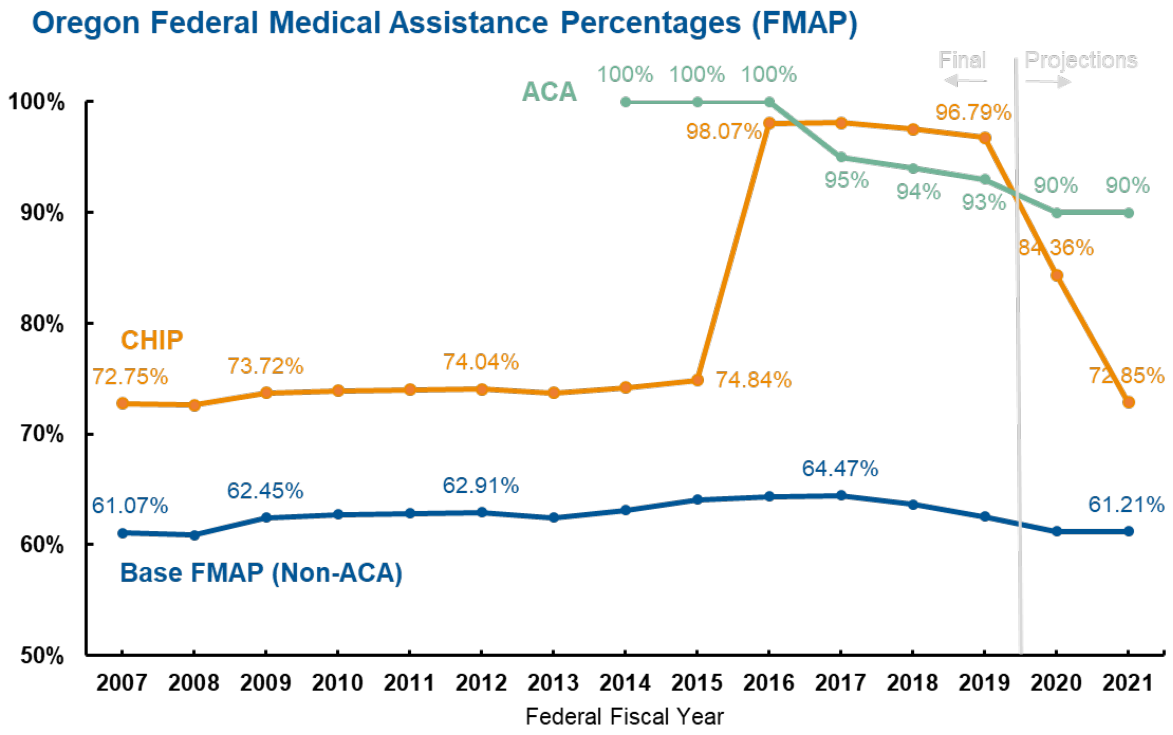
   The Federal Medicaid Assistance Percentage (FMAP) is the share of Medicaid benefit costs paid by the federal government. The base FMAP rates change annually and is driven by the ratio between the US and Oregon's per capita personal income. States with average per capita income receive an FMAP of 55%; based on higher or lower per capita income, states could receive an FMAP between 50% and 83%. Oregon's base FMAP is currently about 63%.

   Changes in FMAP rates do not immediately capture recent economic trends because the FMAP rate calculation relies on three-year averages beginning five years prior to the rate year. For example, the 2019 rate calculation uses per capita averages for 2014, 2015, and 2016. Due to this lag, a state could temporarily see a reduction in its FMAP rate even as its economy is declining, and vice versa.

   CHIP uses an enhanced FMAP calculated by reducing each state's Medicaid share by 30%. Note that this is not the same as raising the federal match by 30 percentage points, i.e., from 63% to 93%. Instead, it subtracts 3/10ths of the state portion, from 37% to 26%, making the federal match for CHIP about 74%. However, for 2016 through 2019, states received an extra 23 percentage points, so the Oregon's CHIP match is currently about 97%. This extra amount phases out, to 11.5 percentage points in 2020, and zero in 2021.

   The ACA expansion has its own federal match rate. This rate began at 100%, is 93% in 2019, and will stabilize at 90% starting in 2020.

Match rates from 2007 to 2021 are shown in this chart:



2. **Representative Nosse asked for more information on the distinction between Open Card and CCO.**

   In short, "open card" simply means not enrolled in a CCO. There are two main groups of people receiving Medicaid who are open card.

   The first group is people are not *enrollable* into CCOs. This includes people in the Citizen Alien-Waived Emergency Medical program (CAWEM) and Qualified/Specified Low-Income Medicare beneficiaries. These individuals, while part of the Medicaid caseload, do not have full OHP benefits. As of January 2018, this group had roughly 94,000 people.

   The second group is people eligible for full OHP benefits but for various reasons are not *enrolled* in a CCO. This includes people that have exemptions to CCO enrollment, such as Tribal Members, and people carrying Dual Eligibility (Medicare/Medicaid). As of January 2018, this group had roughly 97,000 people.

   More statistics about people in open card and CCOs are in the attached PDF file.

3. **Senator Heard requested more information about immunization and herd immunity.**

   The best information we can provide on this topic is in the attached presentation by Dr. Paul Cieslak, Medical Director for the Communicable Disease and Immunization program. The presentation discusses herd immunity, including thresholds for different diseases, on pages 11 and 12.

4. **Representative Nosse requested a list and/or map of "safety net clinics".**

   "Safety net clinics" and the "health care safety net" are terms that have come to define the array of clinicals around the state that provide health care opportunities for those who otherwise would have barriers to accessing quality health services. These barriers include lack of coverage, geographic isolation, language and culture, mental illness and homelessness. The terms include federally qualified

health centers, community health clinics, and rural health clinics. (Note that this is not an exhaustive list of every organization that provides critical health services in rural communities.)

A list and map of federally qualified health centers and community health clinics can be found at Oregon Primary Care Association's (OPCA) website (https://www.orpca.org/chc/find-a-chc).

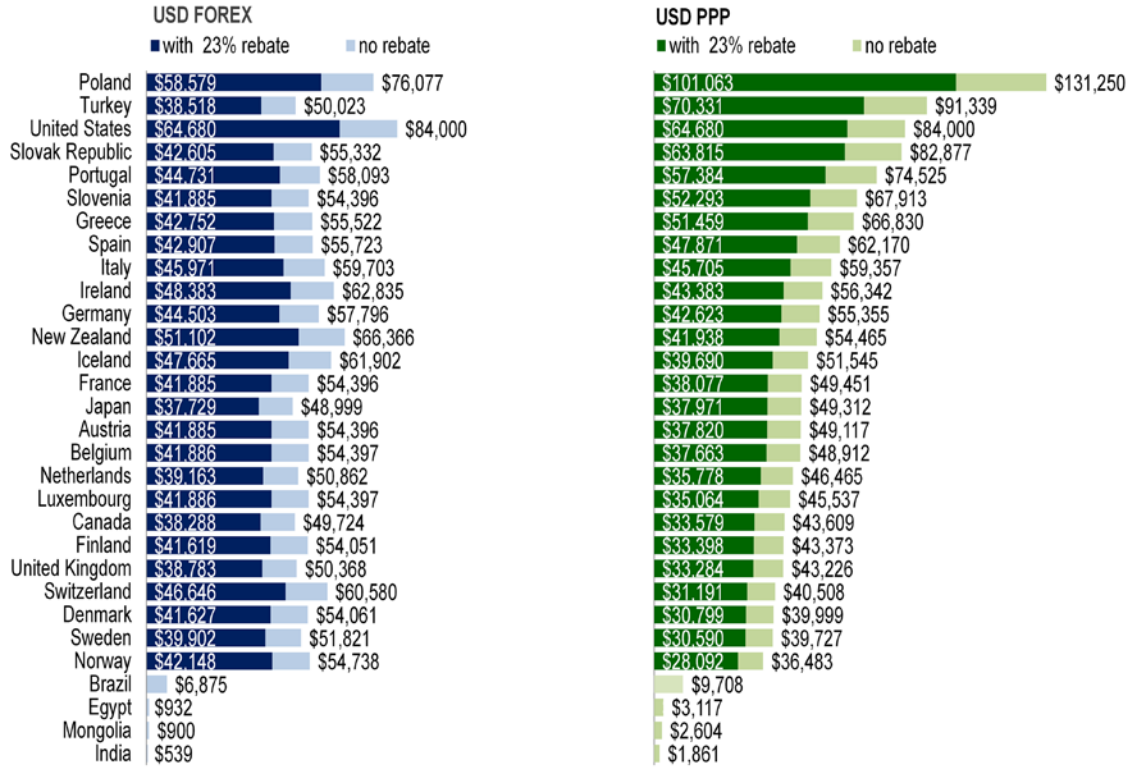
A list and map of rural health clinics can be found at the Office of Rural Health website (https://www.ohsu.edu/xd/outreach/oregon-rural-health/rural-frontier-facilities/clinics/rhc-directory.cfm).

5. **Senator Heard asked for more information on costs related to Hepatitis C treatment and pharmaceuticals.**

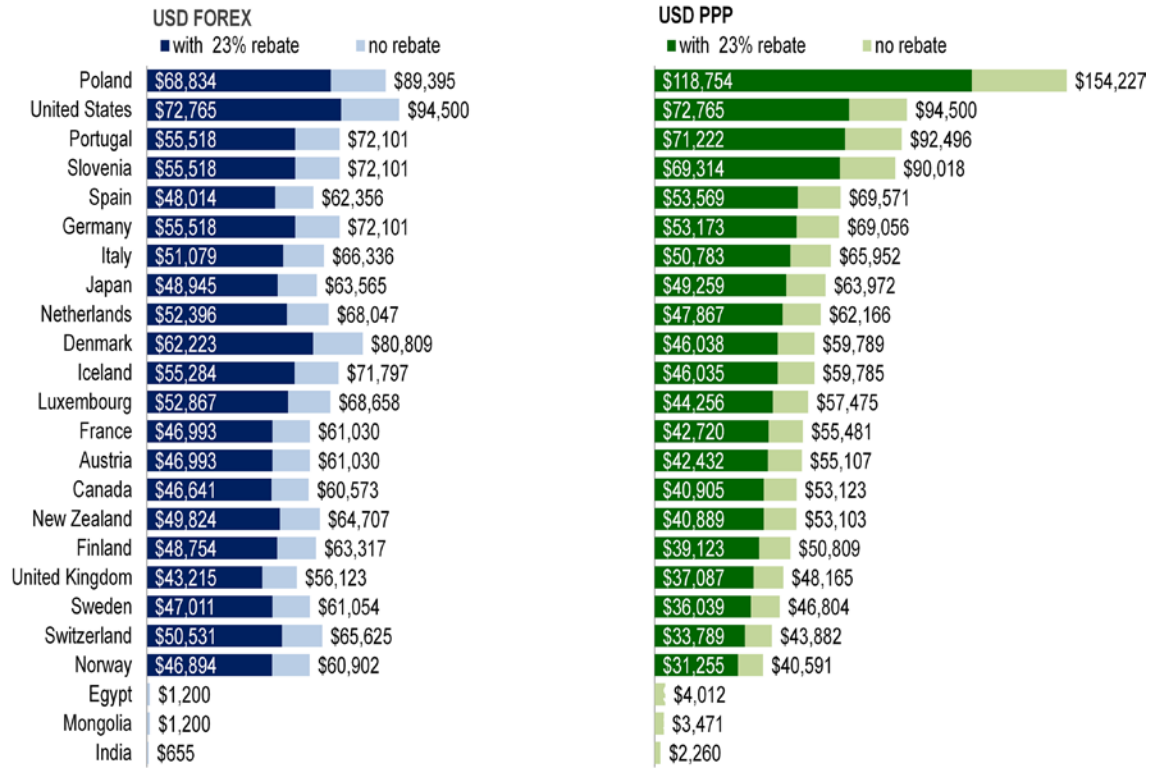
The price of treatments and pharmaceuticals for Hepatitis C, like many other treatments and drugs, can vary greatly from place to place, especially country to country. A study by the World Health Organization (https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002032) identified costs of two of the most frequently used Hepatitis C drugs, sofosbuvir and ledipasvir/sofosbuvir (commonly known as Harvoni), in 21 countries. From the study:

> Fig 1 shows the nominal (USD FOREX) and PPP-adjusted (USD PPP) prices of (A) sofosbuvir and (B) ledipasvir/sofosbuvir, with and without a 23% rebate (or price reduction). Dark blue bars show the nominal prices of the medicines assuming a 23% rebate. Light blue bars show the nominal prices of the medicines without rebate. Dark green bars show the PPP-adjusted prices of the medicines assuming a 23% rebate. Light green bars show the PPP-adjusted prices of the medicines without rebate.

(a) sofosbuvir price



(b) ledipasvir/sofosbuvir price



Again, please contact me or my office if you have any further questions. Thank you.

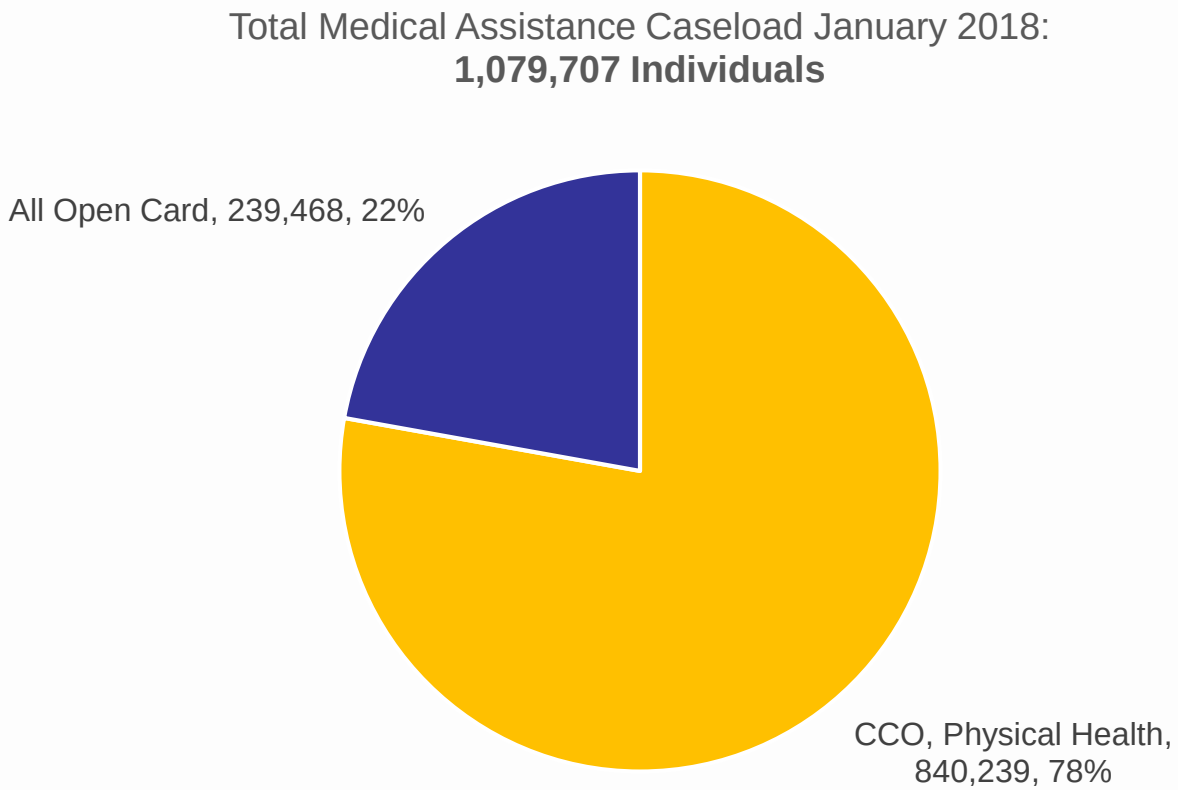
Open Card Data

May Legislative Days
House Health Care Committee
Monday, May 21, 2018

Patrick Allen, OHA Director

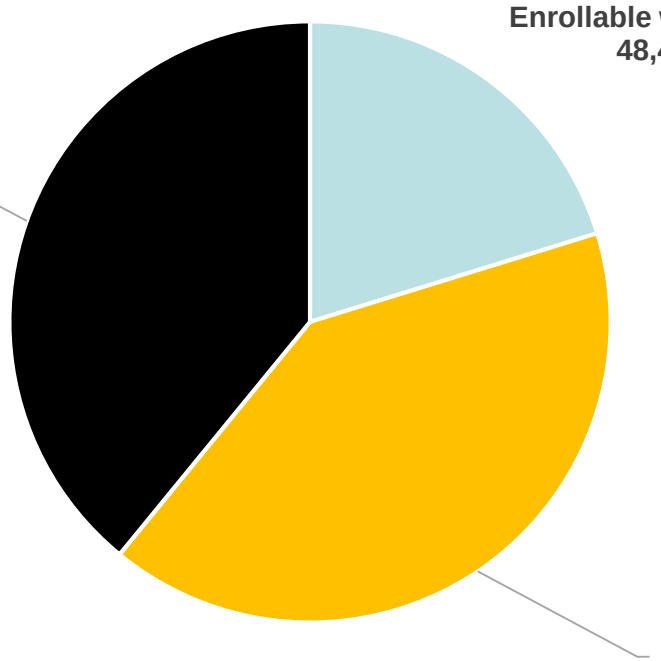
Oregon Health Authority

Open Card Population



Enrollable and Non-Enrollable

Total Open Card Population Jan 2018:
239,468 Individuals



Non-Enrollable includes people without full OHP benefits, such as CAWEM and people with Low-Income Medicare.

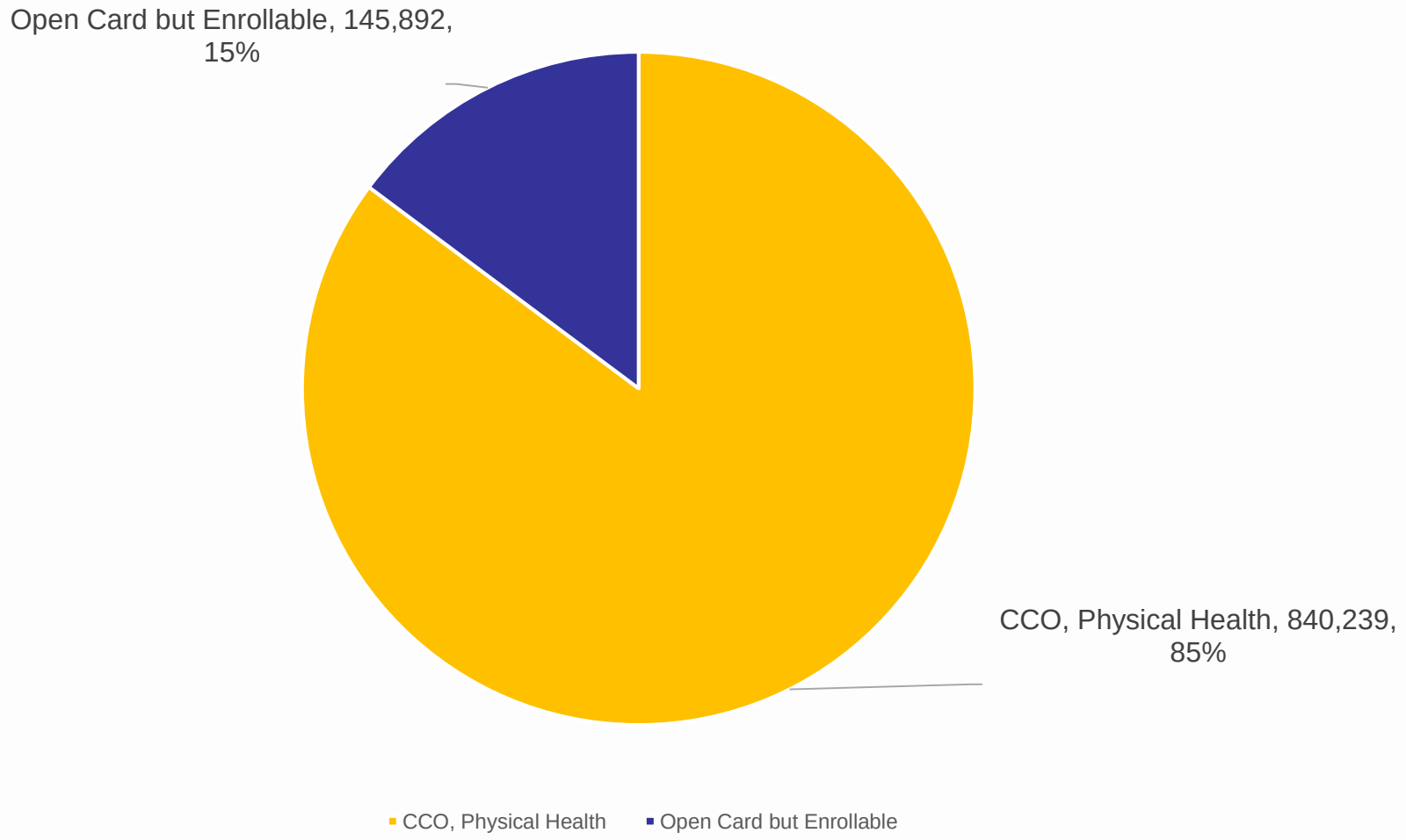
Enrollables are people that could be enrolled with CCOs but have an exemption to CCO enrollement, are enrolled in a limited benefit CCO, or are open card.

Oregon Health Authority

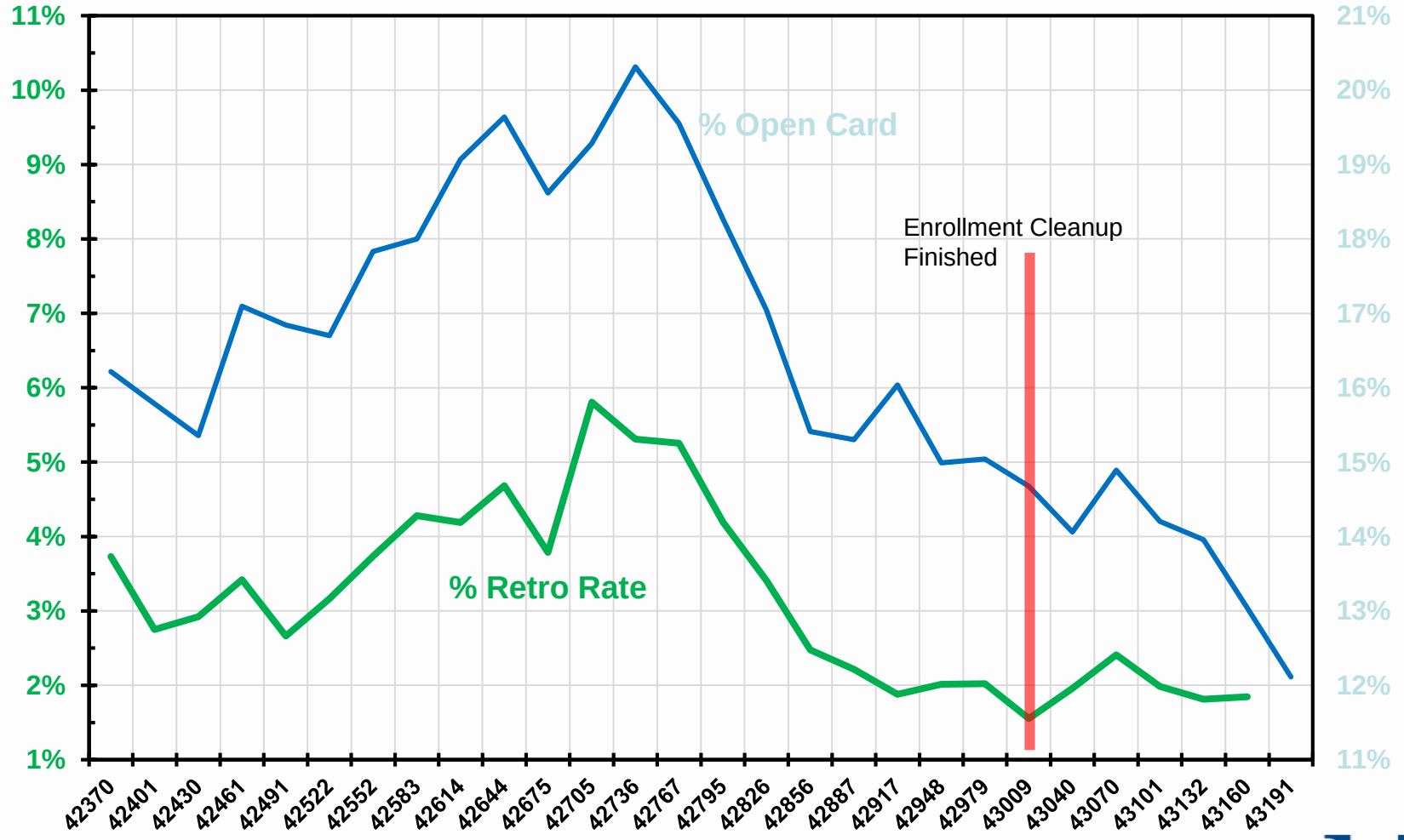
Open Card OHP Beneficiaries by Detail

Enrollable OHP Population Jan 2018

986,931 Individuals



OHP: Retroactive Estimates vs Percent in Open Card



Oregon Health Authority

Vaccinations and Vaccine-Preventable Diseases

Paul R. Cieslak, MD

Public Health Division

February 28, 2019

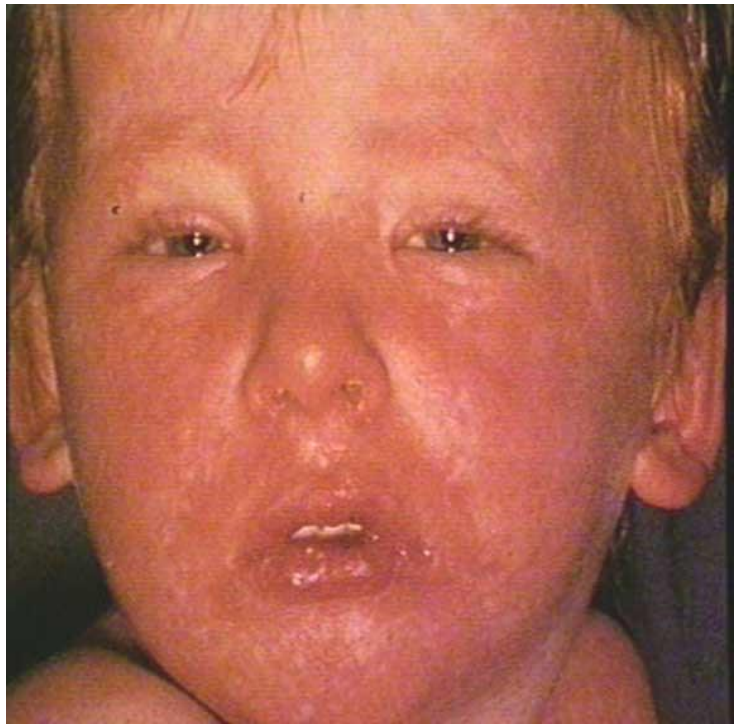
Vaccines prevent a lot of disease.

Disease	20th Century Annual Morbidity*	Reported Cases, 2016†	Percent Decrease
Smallpox	29,005	0	100%
Diphtheria	21,053	0	100%
Measles	530,217	69	>99%
Mumps	162,344	5,311	99%
Pertussis	200,752	15,737	91%
Paralytic polio	16,316	0	100%
Rubella	47,745	5	>99%
Tetanus	580	33	96%
Haemophilus influenzae b <5 y.o.	20,000	22	>99%

*JAMA 2007; 298:2155–63. †MMWR 2017;64:ND924–41.

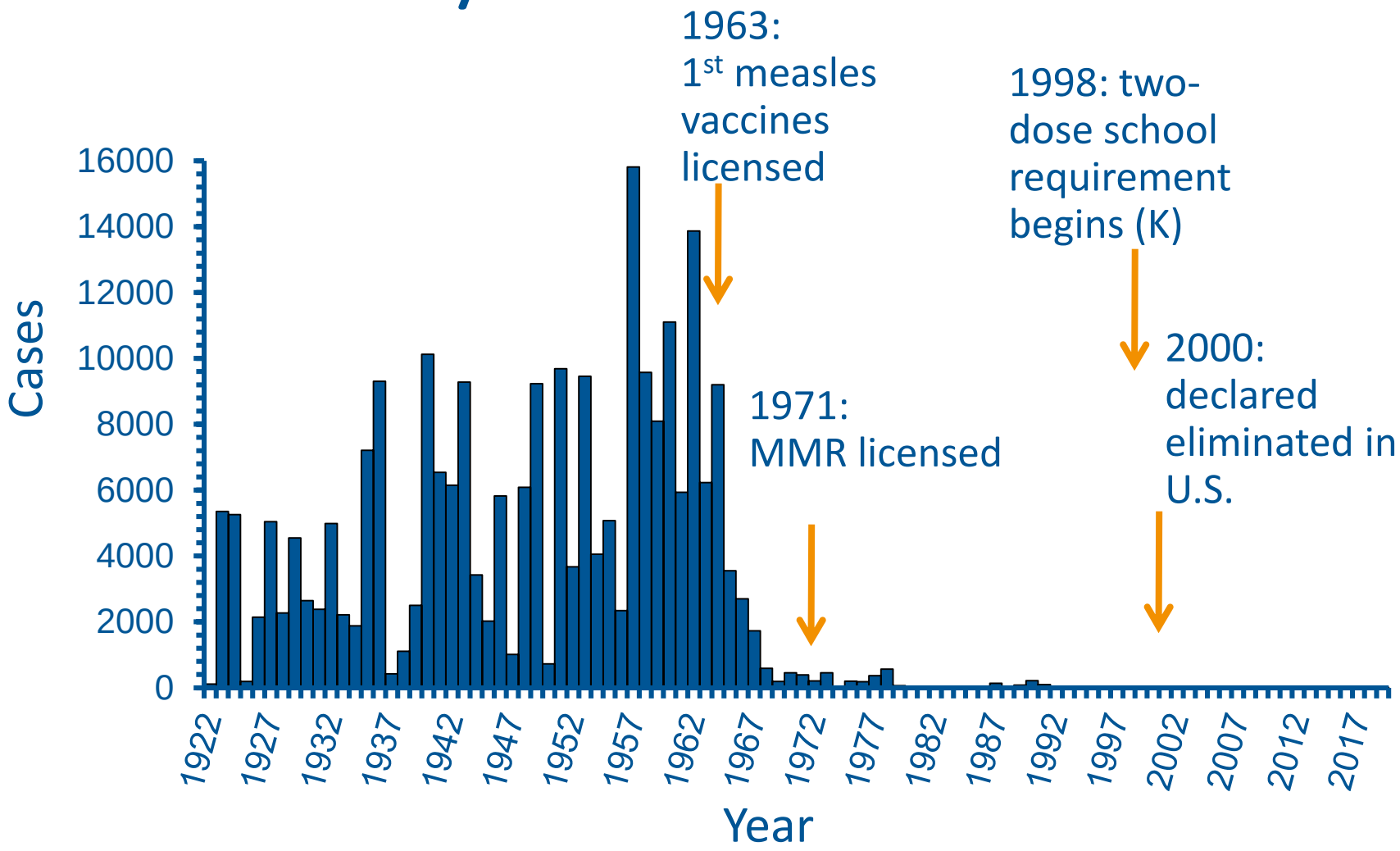
Virtually everyone got measles before a vaccine was developed.

- Nearly universal disease of childhood: 3–4 million cases
- ~500,000 reports to CDC
- 48,000 hospitalizations
- 4,000 cases encephalitis
- 450–500 deaths



www.cdc.gov/measles/about/history.html

Control of measles has been a public health victory.



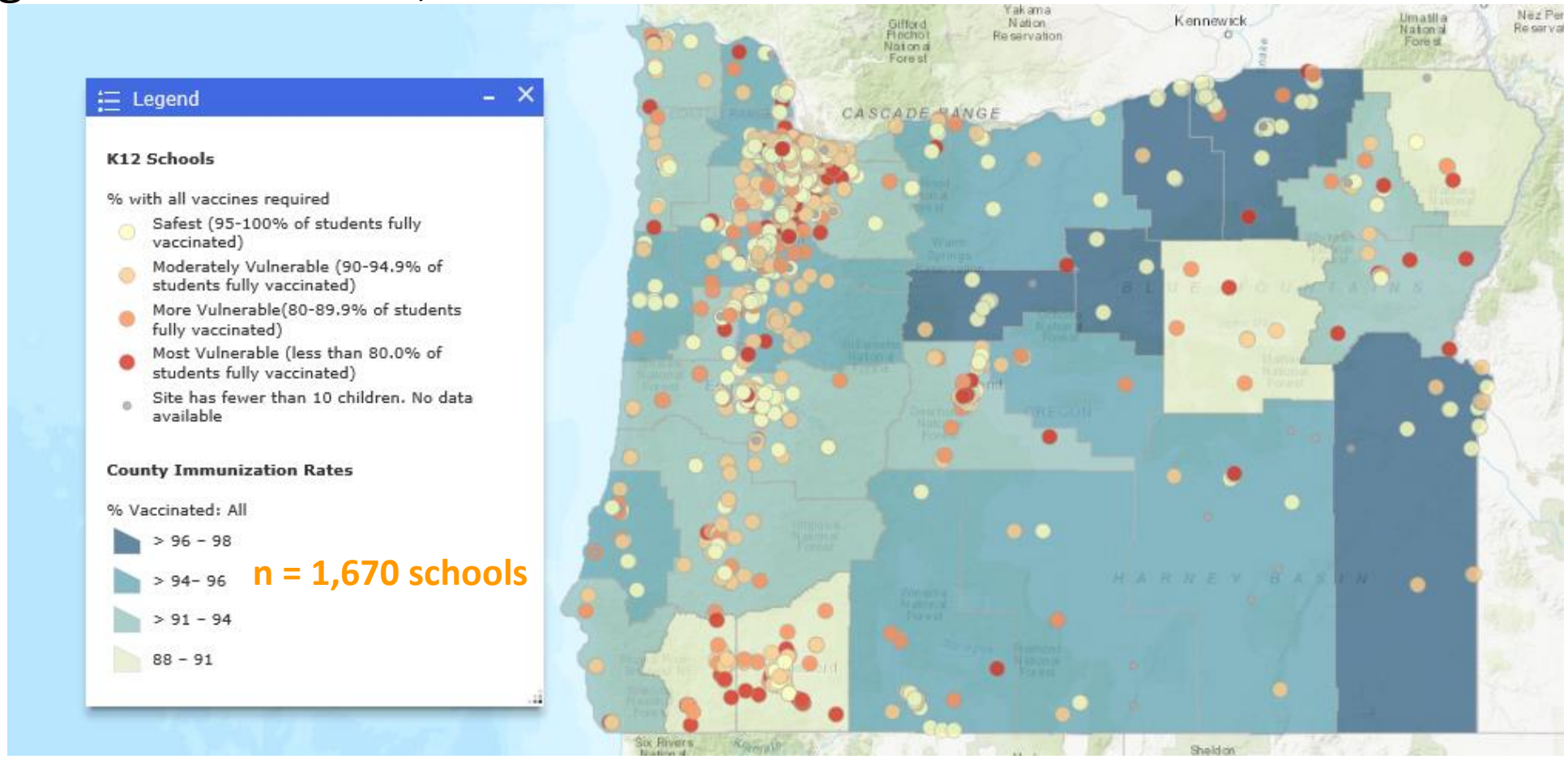
*data as of 26 Feb 2019

Vaccination is the key to controlling measles.

1. Maintain high population vaccination rates
2. Maintain high population vaccination rates
3. Maintain high population vaccination rates
4. Identify, test, isolate cases
5. Investigate to identify exposed, susceptible contacts
    a. Immunize
    b. Exclude school children, healthcare workers

Immunization rates, by school

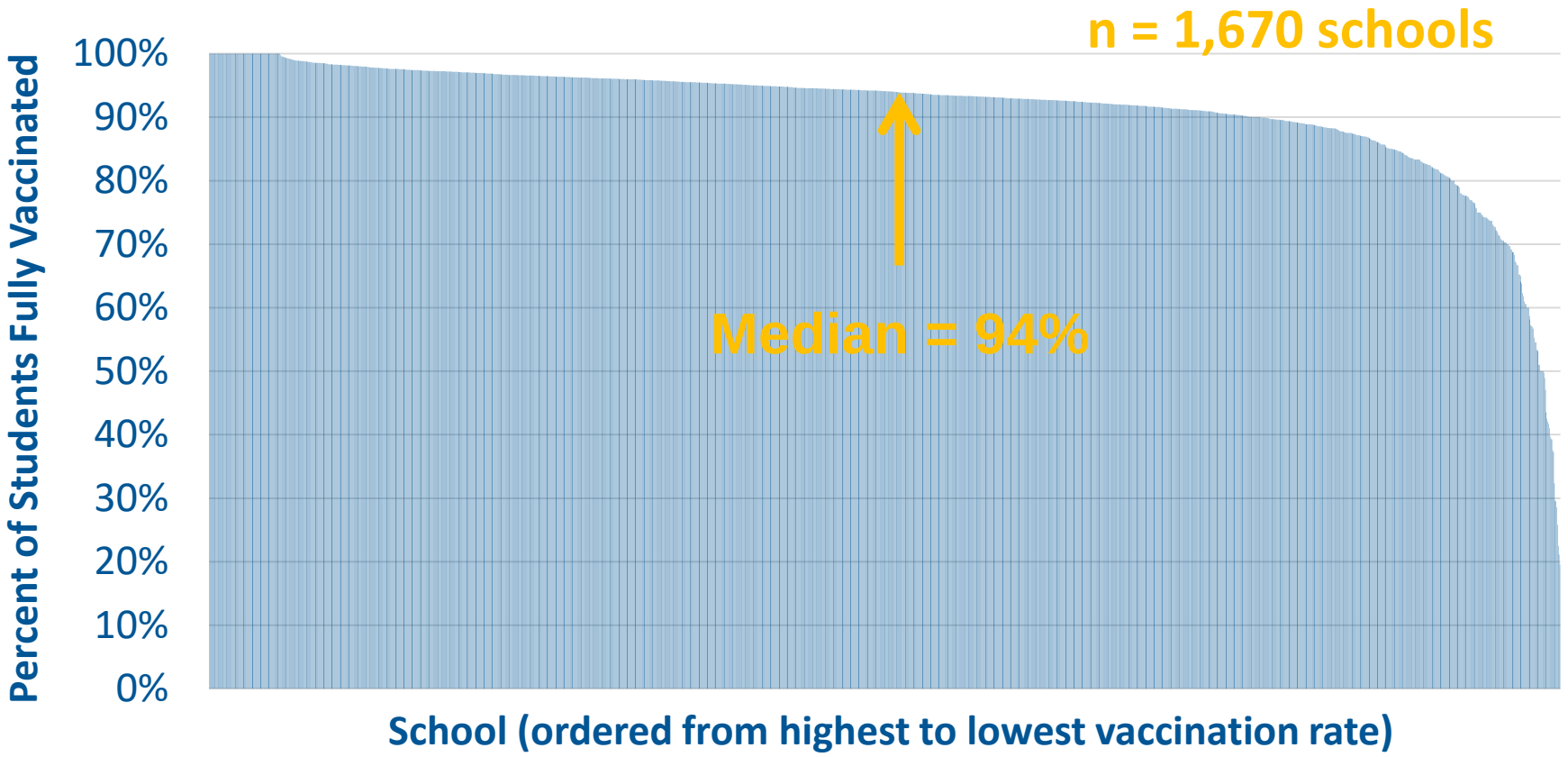
Oregon K–12 schools, SY 2017–2018



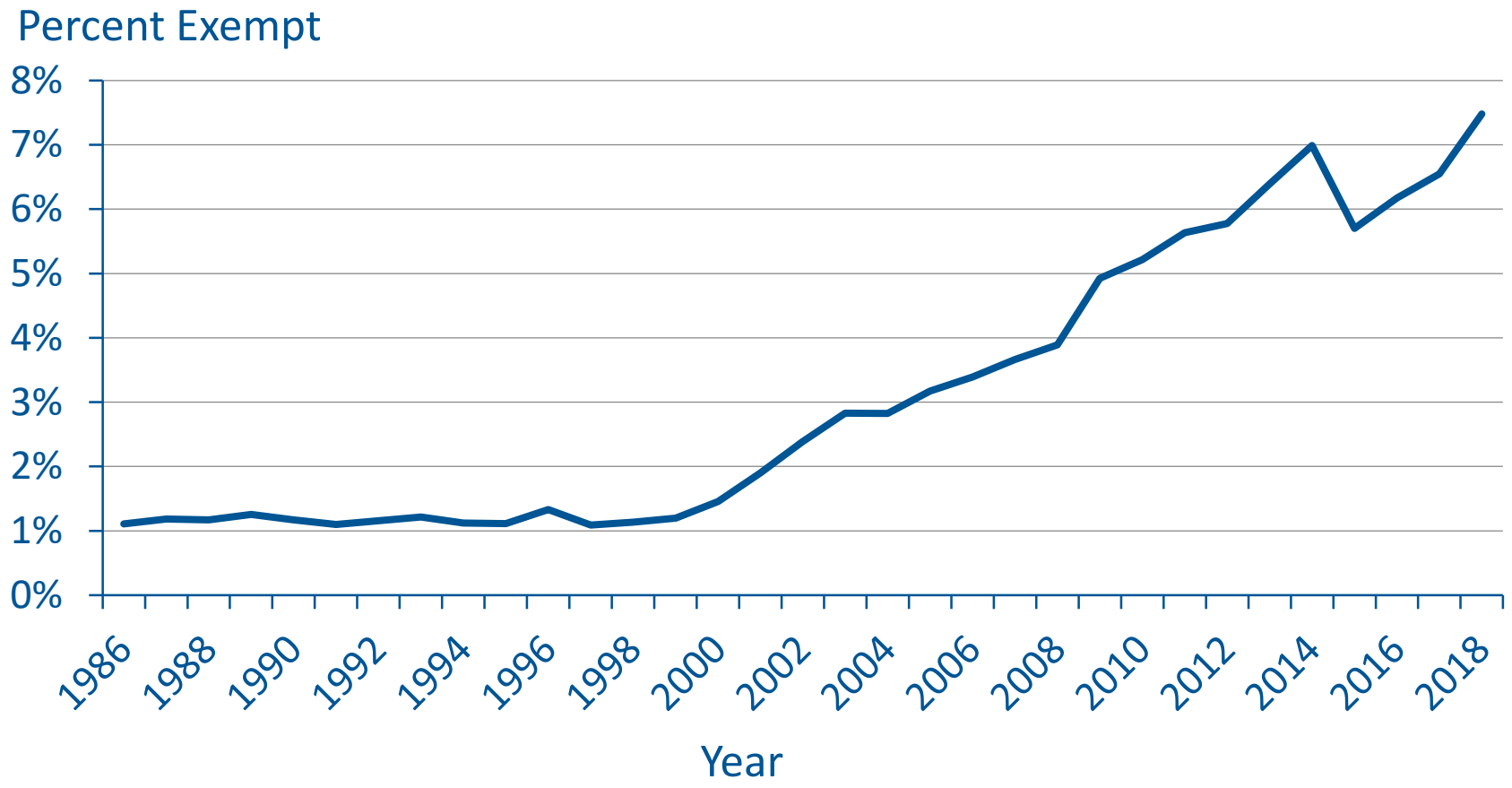
Overall, 96% of K – 12 students are vaccinated against measles.

- First dose coverage >95% for children attending preschool or certified daycare
- 2nd dose coverage >95% for kindergarteners
- 2nd dose coverage >97% for 7th graders

Vaccine completion rates, by school
Grades K–12, Oregon, 2018



Exemptions to vaccination requirements hit 7.5% Among kindergartners in 2018.



Oregon Immunization Program

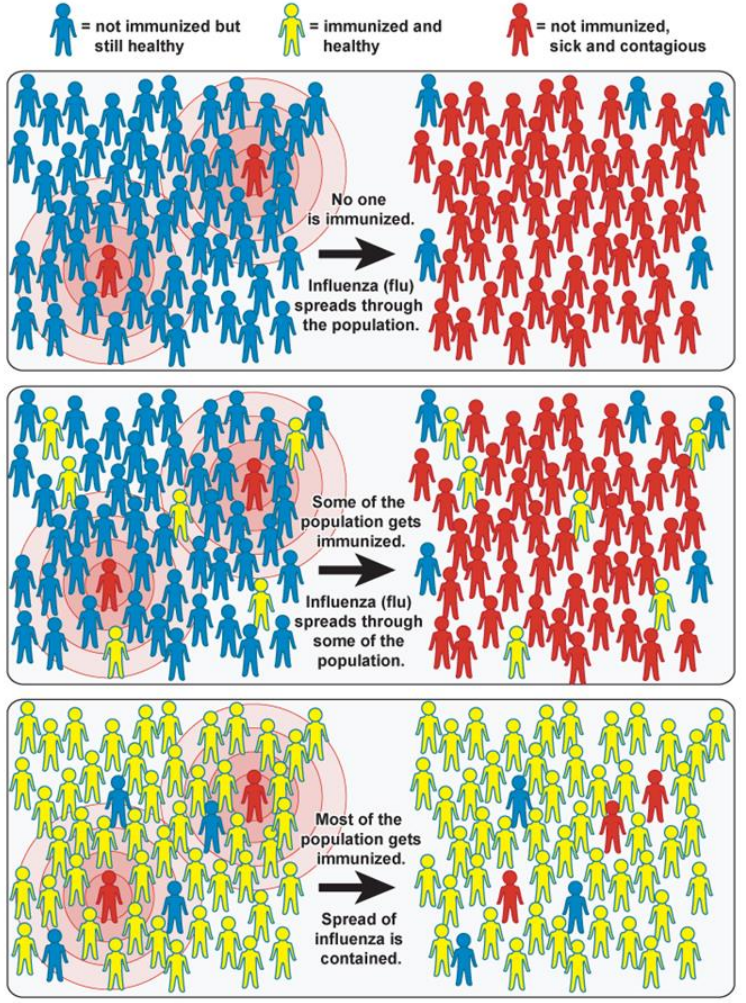
Most exemptions are for non-medical reasons.

K-12 Enrollment:	605,276	
Non-medical exemptions:	31,583	(5.2%)
Medical exemptions:	782	(0.1%)

Community immunity

(a.k.a. “herd immunity”)

The resistance to the spread of a contagious disease within a population that results if a sufficiently high proportion of individuals are immune to the disease, especially through vaccination.



“Herd immunity” depends upon how contagious the disease is.

Infection	R_0	Crude Herd Immunity Threshold
Diphtheria	6–7	83%–85%
Influenza	1.4–4	30%–75%
Measles	12–18	92%–94%
Mumps	4–7	75%–86%
Pertussis	5–17	80%–94%
Polio	2–20	50%–95%
Rubella	6–7	83%–85%
Smallpox	5–7	80%–85%
Varicella	8–10?	?

Fine PEM, Mulholland K, Scott JA, Edmunds WJ. Community Protection.
In: *Vaccines*, 7th edition. Plotkin S, Orenstein W, Offit P, Edwards KM. Elsevier Inc, 2018:1515.

70 cases in the current outbreak.

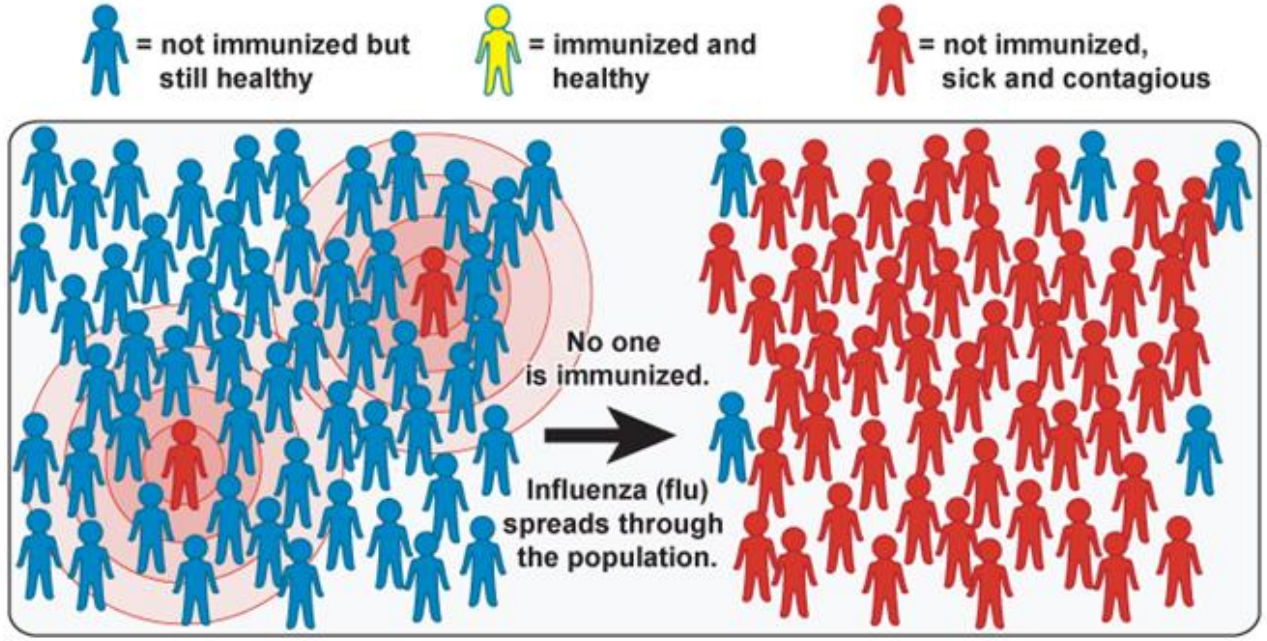
County	Confirmed Cases
Clark	65
King	1
Multnomah	4

All but 2 cases unvaccinated or no documentation of vaccination

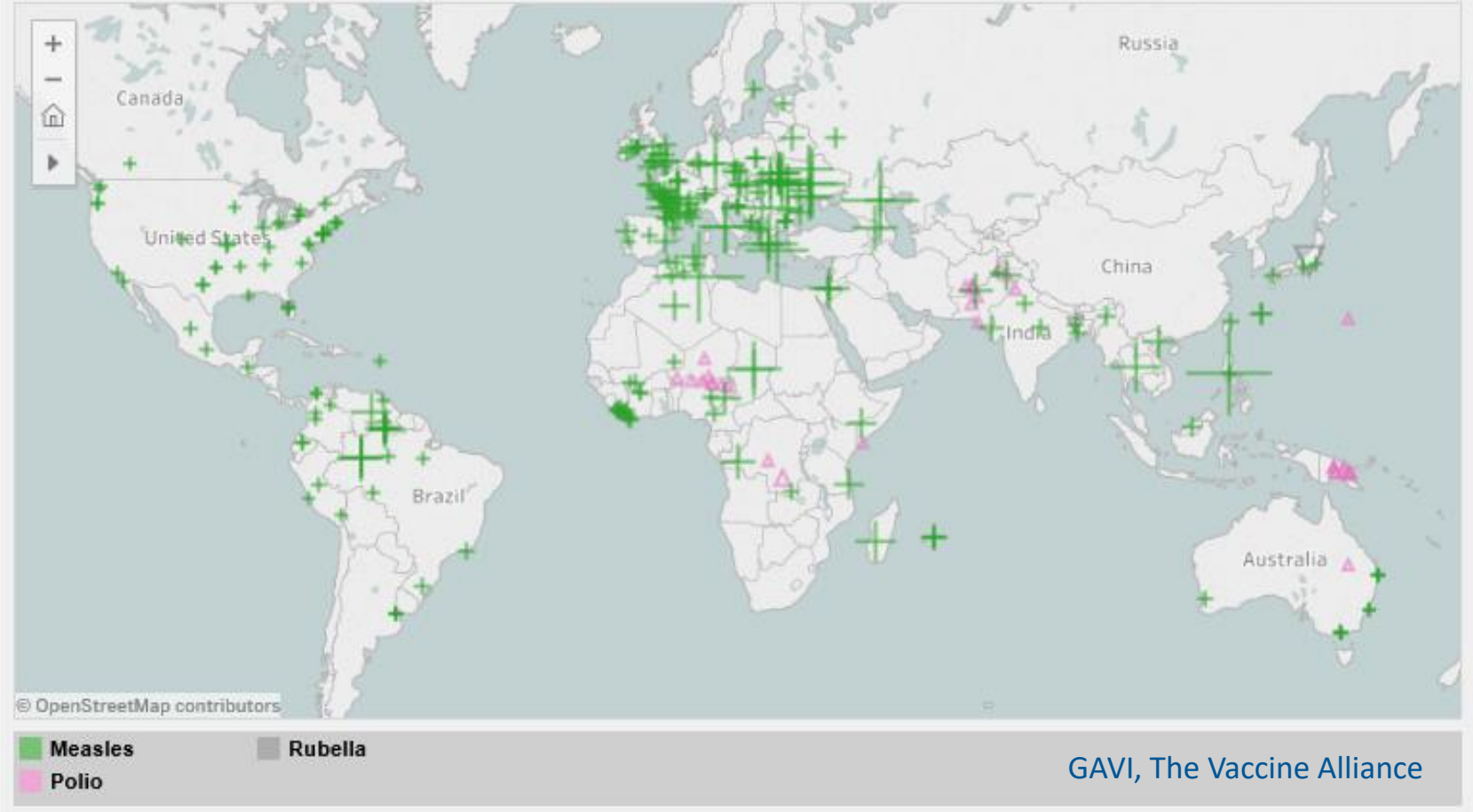
30 Dec 2018 – 26 Feb 2019

What happened?

Measles landed
in a susceptible population.



Many diseases are a plane ride away. Worldwide outbreaks, 2018

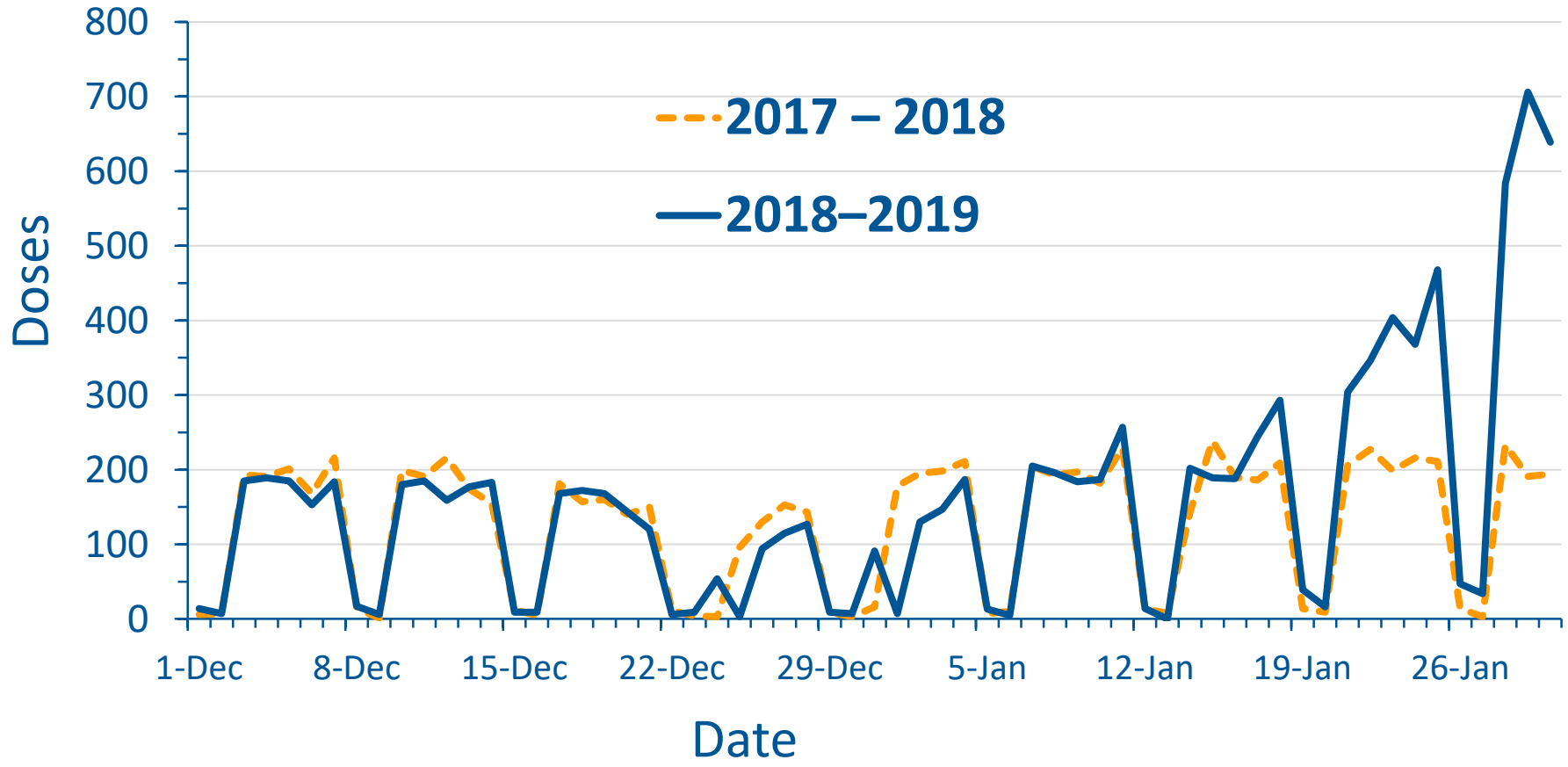


Questions
?

Oregon public health response to measles

- Activated Incident Management Team
- Coordinate with out-of-state colleagues and Oregon local public health authorities
- Guidance re: case investigation, contact follow-up, testing, isolation.
- Recommendations to providers
- Communication materials for public, including translations
- Testing at Oregon State Public Health Lab

Measles Immunizations
Oregon, December – January
2017 – 2018 vs. 2018 – 2019



Source: ALERT Immunization Information System

(Reportable) Vaccine-preventable diseases Oregon, 2012–2018*

	2013	2014	2015	2016	2017	2018
Diphtheria	0	0	0	0	0	0
Hepatitis A	28	14	26	15	20	23
Hep B, acute	34	34	28	21	24	20
Hep B, chronic	455	537	515	481	489	388
Measles	6	5	1	0	0	6
Mumps	3	1	3	27	67	17
Pertussis	486	406	593	192	248	495
Rubella	0	0	0	0	0	0
Tetanus	1	0	1	0	2	1

*data as of 31 Jan 2019

Immunization of 2-year-olds

Oregon, 2014–2017

Vaccination series	Percent up to date			
	2014	2015	2016	2017
4:3:1:3:3:1:4*	60%	64%	66%	68%
4:3:1:3:3:1†	66%	68%	70%	72%

*Fully immunized with 4 doses of DTaP, 3 doses IPV, 1 dose MMR, 3 doses Hib, 3 doses HepB, 1 dose Varicella, and 4 doses PCV. This is the official childhood vaccination series.

† The same series, minus PCV doses.

Source: ALERT Immunization Information System

Vaccine Safety Datalink Publications, 2018

- Naleway AL, Mittendorf KF, Irving SA, et al. Primary ovarian insufficiency and adolescent vaccination. Pediatrics 2018; 142(3):20180943.
- Kharbanda EO, Vazquez-Benitez G, Lipkind HS, et al. Risk of spontaneous abortion after inadvertent human papillomavirus vaccination in pregnancy. Obstet Gynecol 132(1):35–44.
- Jackson ML, Yu O, Nelson JC, et al. Safety of repeated doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine in adults and adolescents. Pharmacoepidemiol Drug Saf 2018; 27(8):921–5.
- Xu S, Clarke CL, Newcomer SR, Daley MF, Glanz JM. Analyzing self-controlled case series data when case confirmation rates are estimated from an internal validation sample. Biom J 2018; 60(4):748–60.

www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/publications.html

Vaccine Safety Datalink Publications, 2018

- Zerbo O, Modaressi S, Goddard K, et al. Vaccination patterns in children after autism spectrum disorder diagnosis and in their younger siblings. JAMA Pediatr 2018; 172(5); 469–75.
- Tseng HF, Sy LS, Qian L, et al. Pneumococcal conjugate vaccine safety in elderly adults. Open Forum Infect Dis 2018; 5(6):ofy100.
- Li R, Weintraub E, McNeil MM, et al. Meningococcal conjugate vaccine safety surveillance in the Vaccine Safety Datalink using a tree temporal scan data mining method. Pharmacoeipdemiol Drug Saf 2018; 27(4): 391–7.
- Daley MF, Shoup JA, Newcomer SR, et al. Assessing potential confounding and misclassification bias when studying the safety of the childhood immunization schedule. Acta Pediat 2018; 18(7):754–62.

www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/publications.html

Vaccine Safety Datalink Publications, 2018

- Kuntz J, Crane B, Weinmann S, et al. Myocarditis and pericarditis are rare following live vaccinations in adults. Vaccine 2018; 36(12):1524–7.
- Glanz JM, Newcomer SR, Daley MF, et al. Association between estimated cumulative vaccine antigen exposure through the first 23 months of life and non-vaccine-targeted infections from 24 through 47 months of age. JAMA 2018; 319(9): 906–13.
- Sukumaran L, McCarthy NL, Kharbanda EO, et al. Infant hospitalizations and mortality after maternal vaccination. Pediatrics 2018; 141(3):e20173310.
- McNeil MM, DeStefano F. Vaccine-associated hypersensitivity. J Allergy Clin Imnmunol 2018; 141(2):463–72.

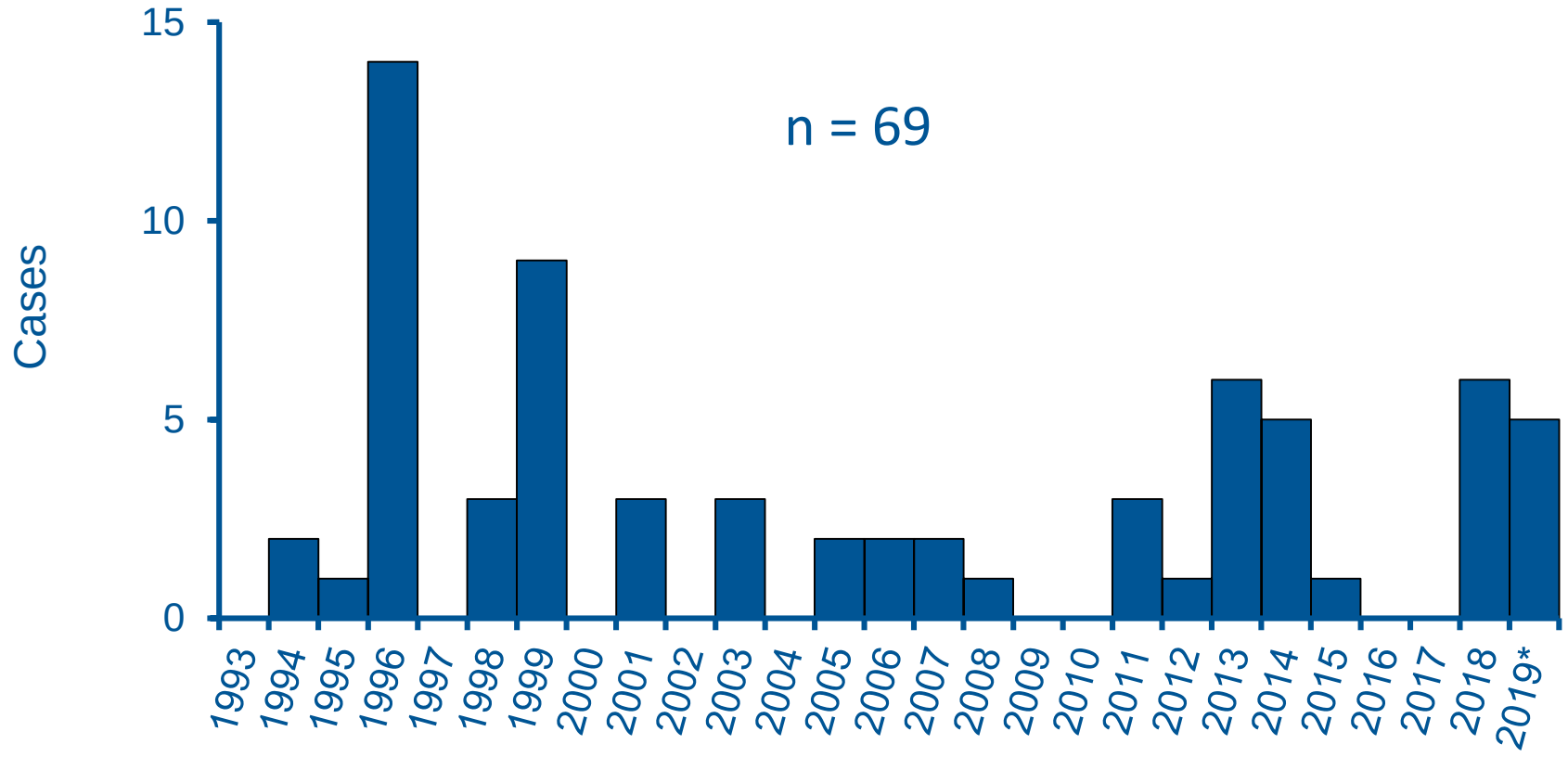
www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/publications.html

Vaccine Safety Datalink Publications, 2018

- Newcomer SR, Kulldorff M, Xu S, Daley MF, Fireman B, Lewis E, Glanz JM. Bias from outcome misclassification in immunization scheuld safety research. Pharmacoepidemiol Drug Saf 2018; 27(2):221–8.
- Daley MF, Clark CL, Glanz JM, et al. The safety of live attenuated influenza vaccine in children and adolescents 2 through 17 years of age: a Vaccine Safety Datalink study. Pharmacoepidemiol Drug Saf 2018; 27(1):59–68.
- Zhoe H, Thompson WW, Belongia EA, et al. Estimated rates of influenza-associated outpatient visits during 2001–2010 in six US integrated healthcare delivery organizations. Influenza Other Respir Viruses 2018; 12(1):122–31.

www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/publications.html

Oregon has had an average of <3 measles cases per year since 1993.



*data as of 26 Feb 2019