February 3, 2025

Senator Wlnsvey Campos, Co-Chair
Representative Andrea Valderrama, Co-Chair
Joint Ways and Means Human Services Sub-Committee
900 Court Street NE
State Capitol
Salem, OR 97301

SUBJECT: January 30 Subcommittee Questions

Dear Co-Chairs and Committee Members:

Please find below information requested by members of the Joint Ways and Means Human Services Sub-Committee at the January 30 meeting on Oregon's Medicaid program.

1. **Does OHA track how many people covered by the Oregon Health Plan are receiving care through a primary care physician on regular basis?**

   The Patient-Centered Primary Care Home (PCPCH) Program at OHA tracks the number of CCO members enrolled in a PCPCH which is reported annually by CCOs. As of 2023, 95.1 % of OHP CCO members were enrolled in a PCPCH.

2. **What data exists on cost differences for managed care/coordinated care organizations (CCOs) vs. fee-for-service (FFS) models?**

   An Oregon-specific answer would require additional time to furnish. However, the Medicaid and CHIP Payment and Access Commission (MACPAC) publishes a variety of reports in this area. A table that breaks down total Medicaid spending by state and category can be viewed here. A report that summarizes managed care's effect on outcomes can be viewed here.

3. **Are there individuals that have a fee-for-service arrangement that are also enrolled with a CCO?**

   Medicaid can offer specialized services that are outside of the CCO structure to members of CCOs. These services are "carved-out" of the CCO contracts and are offered statewide through OHA Fee-For-Service (FFS), also known as "open card." Coordination between the CCO and FFS is required for carved-out services in most cases.

   Carved-out services include: mental health residential treatment, Behavior Rehabilitation Services (BRS), School Based Health Services (SBHS), Home and Community Based Services (HCBS), psychotropic medications, and Planned Community Birth. The full list of carved-out services can be found in Exhibit B.9 (non-covered services with care coordination) and Exhibit B.10 (non-covered services without care coordination) of CCO contracts.

4. **Should youth in foster care be carved out into their own CCO? What would it take to create that?**

   OHA will be conducting a new procurement process for CCOs, and there will be opportunity for Oregonians to provide input on any needed changes or additions. The CCO procurement process is an excellent opportunity for advocates to provide information on new concepts, risks, and opportunities.

5. **What has OHA done to monitor/improve network adequacy for FFS members?**

   OHA is taking many steps to improve FFS network adequacy:
   - Rates: Medicaid has established a comprehensive rate review process for FFS rates that ensures that rates are 80% of Medicare rates or 90% of CCO rates. This process is ongoing and sustained by the FFS quality assurance and operations team within Medicaid.
   - Member Communication: OHA has created a FFS handbook for all FFS members and updates it quarterly so that members better understand their benefits. This handbook is shared with new members, once a year with all members, and discussed in follow-up calls with care coordinators.

- Advisory Committee: Medicaid actively and directly works with members and advocates on access issues and quality of care through the Lived Experienced Advisory Panel for Open Card.
- Provider Supports: The FFS quality assurance and operations team is working closely with FFS care coordination contractors to provide additional technical support to providers to ensure they are fully aware of benefits for Open Card members. .

6. Is OHA's FFS system required to provide the same network adequacy standards as CCOs?

Network adequacy for FFS and CCOs is defined in OAR 410-141-3525. In 2024, the FFS quality assurance and operations team began to monitor and ensure that the provider types, access, and availability standards are being assessed for capacity.

7. Are we measuring health outcomes in relation to insured rates of the population?

The OHA strategic plan dashboard tracks overall health data. Over the past decade, Oregon has seen improvements across many public health metrics. For example:

- 2020 marked the first year that Oregon saw a decrease in e-cigarette use among 11th graders and use has continued to slowly decline in 2022 (11%). From 2019-2023 Oregon saw a 27% decline in prevalence of adult smoking.
- Oregon has seen steady declines in high-risk prescribing practices. One example is that overlapping benzodiazepine opioid prescribing has decreased by over 60% since 2015 and is down 20% since 2020.
- In 2016 89% of community water systems met health-based standards. In 2023, 94% of community water systems met health-based standards.
- New HIV infections declined more than 30% between 2012 and 2020.

The Public Health Division houses several data dashboards that provide additional information on public health metrics. Below is a selection of some of the dashboards the Division provides:

- Immunization dashboards

- Sexually transmitted disease dashboards
- Reportable disease dashboards
- Healthcare associated infections dashboards
- Environmental Public Health, Oregon Tracking Data Explorer (scroll down for Health Outcomes Data links)
- Oregon Adult Chronic Conditions Dashboard
- Overdose Prevention Data Dashboard

The Public Health Division publishes several other dashboards and reports on public health metrics and is happy to provide additional links and information at any time.

8. Out of the Healthier Oregon population of roughly 100,000 people how many are undocumented?

The information that OHA collects on the OHP application about citizenship and immigration status is solely for the purpose of determining eligibility for benefits. If an applicant answers “no” when asked if they are a US citizen, they are then asked whether they have an “eligible immigration status”. If they do, they select that status from a drop down menu. There is no question that identifies a person as “undocumented” and no information about their status is collected if it is not an “eligible immigration status”.

9. What are the other system changes to streamline enrollment for OHP Bridge other than CCO auto-assignment?

Since OHP Bridge launched in July 2024, a handful of opportunities to improve system functionality and streamline enrollment have been identified. Implementation of CCO auto assignment will enable OHA to implement new coverage effective date logic for OHP Bridge. This will ensure eligible individuals are enrolled more quickly than the current logic, which (for purposes of federal compliance) includes a lag between eligibility determination and enrollment in active coverage.

Additionally, OHP Bridge does not currently allow for temporary FFS coverage. Traditional OHP relies on temporary FFS coverage for a variety of scenarios including address changes, waiting for CCO assignment and enrollment in third

party coverage. As gaps caused by the lack of OHP Bridge Open Card are identified, manual changes are implemented in the short-term and longer-term system changes considered.

10. Are federal funds dependent on American Rescue Plan Act (ARPA) subsidies for the OHP Bridge program?

The OHP Bridge Trust Fund receives quarterly federal payments determined by the Section 1331 funding formula. Per this formula, the state receives roughly 95% of what individuals would have received to purchase coverage on the Marketplace. Because Marketplace tax credits are currently higher due to American Rescue Plan Act (ARPA) subsidies, OHP Bridge revenues are also higher than they would be without the enhanced subsidies. The potential loss of those subsidies would reduce per-member federal payments to the state on behalf of OHP Bridge members.

The precise impact on the OHP Bridge program due to the loss of enhanced tax credit is complicated, as lower tax credit levels could affect marketplace enrollment, which in turn affects marketplace premiums. OHA is currently working with outside actuaries to develop estimates of the revenue impact on the OHP Bridge program in 2026 and beyond that considers the complexity of the individual health insurance market.

OHA currently operates OHP Bridge based on recommendations from the Joint Task Force on the Bridge Health Care Program, which recommended the benefit cover CCO-administered OHP services using OHP reimbursement rates with no member costs. The Task Force report further stated:

> "The proposed design could be affected by expiration of premium tax credit enhancements established in the American Rescue Plan Act (2021) and renewed in the Inflation Reduction Act (2022). These tax credit enhancements will expire at the end of 2025 in the absence of further action by Congress and would reduce federal revenue for Oregon's BHP. The state will need to monitor this issue over time as more information is available."

Also based on recommendation from the Task Force, OHA launched the OHP Bridge Advisory Committee in October, responsible for offering recommendations regarding Trust Fund spending. The Committee is specifically focusing on plan design options for consideration in the event of ARPA expiration.

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Please do not hesitate to reach out if there are any further questions. Thank you.

Sincerely,

Emma Sandoe

Emma Sandoe, PhD, MPH
Medicaid Director