TO: Sen. Alan Bates and Rep. Nancy Nathanson, Co-Chairs, Human Services Subcommittee, Ways and Means

FROM: Dr. Mel Kohn, Director, Public Health Division

DATE: April 2, 2013

RE: Responses to questions at Health and Human Services Subcommittee hearing on February 18, 2013

This memo is in response to your request at our budget hearing in February for more information about our Breast and Cervical Cancer, Reproductive Health and Immunization Programs, the effects of implementation of the Affordable Care Act on these programs, and what efficiencies might be gained from transitioning these programs to Coordinated Care Organizations. That information is attached. Please let me know if you have additional questions or would like to discuss any of this information further.

Cc: Judy Mohr-Peterson
Bill Coulombe
Katy King

Breast and Cervical Cancer Program (BCCP)

Current eligible population: Approximately 77,000 Oregon women are eligible for screening services. Eligibility requires income <250% FPL, uninsured or underinsured (i.e. insurance does not fully cover screening services). Within the group of eligible women, those 50-64 who are low income, have not been screened in the past year and have no other source of health care reimbursement area a priority population and are the primary target for outreach.

Impact of ACA implementation: CDC estimates that the number of eligible women in Oregon will decrease to 26,000 as many women currently eligible for the Program will be able to get health insurance through Medicaid or CoverOregon.Although the number of women served by BCCP varies with the available budget, in recent years BCCP has served approximately 5,000-7,000 women, so even after ACA implementation the need for BCCP services will still far outstrip the program's current capacity. It's expected that after ACA implementation a higher percentage of eligible women will have limited education and/or English proficiency, and will be Hispanic or Asian. The targeted outreach services of BCCP will be especially important for these women, since they are less likely to be able to navigate the health care system and obtain screening services through other channels.

Current service delivery system: BCCP contracts with 299 providers to provide screening services who also provide either primary or specialty care. The program also contracts with the American Cancer Society for a call center that provides preliminary eligibility screening and connects women who are likely to be eligible to providers in their area with screening slots available.

BCCP providers also provide a variety of outreach and wraparound social service benefits for these women, including outreach to non-English speaking populations, and state BCCP staff also conduct outreach and educational activities around the state related to breast and cervical cancer.

As a result of SB433, which passed in 2011, since January 1, 2012 women eligible for BCCP screening who have positive screening tests can be presumptively enrolled for treatment benefits through the OHP. This appliesto all patients eligible for BCC services regardless of where they were screened or whether they were screened in the BCCP program.To presumptively enroll patients for treatment providers certify that the patient meets eligibility criteria and needs treatment on a form that is available on the BCC website and faxed to the OHP. Once presumptive eligibility is determined treatment can begin immediately. OHP then contacts the patient for additional information for their full eligibility determination process. Once full eligibility has been determined the patient's treatment is covered for one year, and can be extended if the provider certifies the need for continued treatment. Some women are found to be eligible for "regular" OHP once they are screened for eligibility. In November of 2012, we began to enroll those eligible women in the BCCP in CCOs.

Funding:BCCP screening services are funded solely with CDC and Susan G. Komen for the Cure funds (Please note the total amount for 2011-13 biennium)

11-13 Legislatively Approved Budget

OF: Komen Breast Cancer Screening $1,313,769

FF: Cancer Prevention and Control $4,622,604

TF: $5,936,373.

The treatment services provided under SB433 are funded with state and federal funds through the Medicaid program.

Opportunities for efficiencies by transitioning to CCOs: The women screened under the BCCP are not eligible for OHP and so fall outside of the group enrolled in CCOs both currently and after full implementation of the ACA. If CCOs were interested in including these women in their service population the BCCP could contract with CCO-affiliated providers. It's not clear that any efficiencies would be gained by transitioning this program alone to CCOs. However, if it were possible to have a full complement of health care services with all needed preventive services available for these women through CCOs, that would be preferable to having just the breast and cervical cancer screening services available.

Reproductive Health Program

Current eligible population: In 2012 the program supported providers who provided family planning services to 101,000 clients through a network of 64 agencies. The two funding streams for this program have different eligibility requirements. C-care funds are used to provide services on a fee-for-service basis to those who have an income under 250% FPL, are a US citizen, residents of Oregon and of reproductive age. Title X funds support services to patients of reproductive age who have no other source for payment.

Impact of ACA implementation:

The National Family Planning and Reproductive Health Association (NFPRHA) estimates[1] that approximately 50,000 current clients of this program would obtain OHP coverage through Medicaid expansion. In addition, an additional 11,000 clients could be expected to obtain health insurance coverage through Oregon's Health Insurance Exchange. This would leave approximately 40,000 current clients who would still need coverage provided by this program. In addition, it is estimated that there are another 54,000 women in Oregon who meet program eligibility criteria but are currently not being served by this program and would still have need for reproductive health services after ACA implementation . Thus after ACA implementation it is estimated that 94,000 (that is, 101,000 current clients – 61,000 who would get coverage under ACA + 54,000 not currently served and eligible after ACA) women would still need services provided by this program, which is about 7% less than the current number of women served, and includes these groups:

- Undocumented individuals
- Women with special confidentiality needs
- Individuals with gaps in coverage (e.g. churners, enrollments delays)
- Young women not covered through family insurance
- Individuals in the justice system
- Individuals opting out of the exchange due to high premiums and/or high deductibles

Current service delivery system: Services are delivered at 170 clinic sites across the state that include county health departments, FQHCs, primary care clinics, University health clinics, school-based health centers, Oregon Department of Corrections facilities and Planned Parenthood affiliates. Some of these clinics utilize both Title X and C-Care funding streams.

Clients at Title X clinics many not deny or reduce services they provide to a patient because of citizenship status or inability to pay, are required to apply a sliding fee scale and to offer a broad range of reproductive health services which may include: contraceptive counseling and management, STI diagnosis and treatment, gynecologic services, pregnancy diagnosis and counseling and infertility services. CCare reimbursed services are much narrower and include only contraceptive counseling and management (i.e. services to avoid unintended pregnancies). CCare covered services are provided at no

[1] RH Program conversation with Robin Summers, JD, Policy Director at NFPRHA, 02/12/13.

cost to clients. However, a client may be covered by CCare for contraceptive management yet also receive additional services using Title X funds (with a sliding fee applied).

Funding: Federal (Title X and Medicaid) and GF (used for 1:9 match for federal C-Care Medicaid funds) Please note the total GF and FF in 2011-13

11-13 Legislatively Approved Budget

GF: $6,127,547

OF: OMMP $1,150,000

FF: Title X Family Planning $4,835,171, Title XIX Match $57,173,503

TF: $69,286,221

Opportunities for efficiencies by transitioning to CCOs:

After full implementation of the ACA, there will still be substantial need for the services provided by this program for people outside of the group enrolled in CCOs. While it would be desirable to have the CCOs coordinate this care with a full range of health care services, because the group served by this program is not eligible for other Medicaid services it is not clear that any efficiency would be gained by moving this program into CCOs . In addition, monitoring compliance with the Title X requirements by clinics might be made more difficult by adding another organizational structure between the state, which must assure that the federal requirements are being met, and providers.

Immunization Program

Current eligible population: ThisProgram provides several population-based services (see below) which benefit all Oregonians. Also, public and private health care providers for children who meet federal eligibility criteria (enrolled in OHP, uninsured or American Indian/Alaska native) are eligible to receive no-cost vaccine for these children through this program. Children who are considered underinsured are eligible to receive no cost immunizations through this program at public clinics and clinics, Federally Qualified Health Centers or Rural Health Clinics. This Program also provides federal vaccines to some high risk adults who are uninsured and underinsured and served in public clinics.

Impact of ACA implementation: Currently about 15% of immunizations are given by local health departments and public safety net clinics in Oregon.As health care access increases with health reform the need for administration of vaccination at these clinics should decrease substantially. However, the program also carries out a number of population-based services that will not be decreased once the ACA is implemented, including: distribution of federal vaccine to public and private providers, tracking immunization rates, operating a statewide immunization registry for providers to use to check a patient's immunization status, providing technical assistance and quality improvement resources to providers, school exclusion clinics, providing immunization clinics in an emergency (such as a flu pandemic or natural disaster) and investigating outbreaks of vaccine-preventable diseases.

Current service delivery system: In 2012, 15% of all immunizations given in Oregon were given by local health departments and public safety net clinics. This percentage varies substantially in counties across the state, ranging from lows in Columbia (6%), Linn (7%) and Clackamas (7%) Counties, to highs in Baker (88%), Lake (98%), Morrow (99%) and Wheeler (100%) Counties. The population-based services administered by this program are administered by state and county public health staff.

Funding: Federal dollars for vaccine purchases (317 and Vaccines for Children). State General Fund ($2.2m for the 2011-13 biennium) supports staff at local health departments for this program. Federal Vaccine for Children funds used for vaccine purchase are not built into the immunization program budget; instead the state is issued a "line of credit" against which vaccine purchases are credited.

Opportunities for efficiencies by transitioning to CCOs: Better provision of vaccines to populations enrolled in CCOs will reduce the demand for immunization administration by this program; no rule change or legislation is needed for that transition. This will enable public health staff to focus more of their resources on delivering population-based services related to this program.