

# Division of Medical Assistance Programs

January 23-24, 2007

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## CLIENTS WE SERVE

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Medicaid eligibility is limited to individuals who fall into specified categories and who are in financial need. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. These statutory categories can be classified into five broad coverage groups:

- Children
- Pregnant women
- Adults in families with dependent children
- Individuals with disabilities, and
- Elderly individuals

If the Oregon Health Plan (OHP) did not exist, the state would be required to provide Medicaid to these mandatory coverage groups. The federal Medicaid statute also establishes some optional eligibility categories based on a particular disease or condition (e.g., breast cancer). Because Medicaid is limited to those in financial need, the program imposes financial eligibility requirements. The financial requirements vary from category to category, but generally income eligibility for individuals and families is tied to the Federal Poverty Level (FPL). In Oregon, financial requirements and number<sup>1</sup> enrolled in the program are as follows:

- Children under age 19 – up to 185 percent FPL – 186,600
- Foster children – up to 49 percent FPL – 17,200
- Pregnant women – up to 185 percent FPL – 9,100
- Adults in families with dependent children (TANF families) – up to 49 percent FPL – 38,100
- Elderly individuals – up to 225 percent FPL – 30,100
- Persons who are blind or who have disabilities – up to 225 percent FPL – 60,900
- Uninsured parents and childless adults – up to 100 percent FPL – 20,700

Approximately 400,000 Oregonians are covered under Medicaid or the Children's Health Insurance Program (CHIP).

About 350,000 of these clients receive OHP Plus coverage. Clients receiving OHP Plus coverage include pregnant women, children under 19, people who are blind and people who have disabilities. Over half—60 percent—of OHP Plus clients are under age 19.

About 21,000 clients receive OHP Standard coverage. OHP Standard has been closed to new enrollment since July 2004.

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<sup>1</sup> All numbers are preliminary December 2006 enrollment figures

About 29,000 clients are covered by the:

- Qualified Medicare Beneficiaries (QMB) benefit package – 11,700
- Breast and Cervical Cancer Program (BCCP), or – 300
- Citizen Alien Waived Emergency Medical (CAWEM) benefit package – 16,300

Clients on the QMB benefit package receive help with their Medicare Part B premiums, coinsurance and deductibles. Women with BCCP coverage are not otherwise eligible for Medicaid but receive treatment for their cancer. The CAWEM benefit package covers emergency services and labor and delivery services for non-citizens.

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## DELIVERY SYSTEMS

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The Division of Medical Assistance Programs (DMAP) contracts with managed care plans to provide services to OHP clients in exchange for a monthly capitation payment for each enrolled client. Most OHP clients receive medical, dental, mental health and chemical dependency services through managed care plans. DMAP has contracts with 14 Fully Capitated Health Plans (physical health), 1 Physician Care Organization (physical health) and 7 Dental Care Organizations.

Clients who are not enrolled in a managed care plan receive services on a fee-for-service (FFS) basis, which is administered by DMAP. This means that medical providers bill DMAP directly for their services.

Medical providers include physicians; hospitals; dentists; pharmacists; federally qualified health centers; rural health clinics; medical equipment and supply providers; physical, occupational and speech therapists; hospice providers; ambulances; non-emergency medical transportation providers; addictions and mental health services providers; and others.

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## OUTCOMES

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Over 1.7 million people have had their health care covered by OHP since it began in 1994<sup>2</sup>—nearly one in three of all Oregonians have been on OHP at some point in their lives. Approximately 44 percent of Oregon's births in 2004 were covered under OHP. Today, OHP is the health insurance provider for 12 percent of all Oregonians and almost one-fourth of all Oregon children.

About 98 percent of the DMAP budget goes directly to provision of health care services. Oregon ranks 44<sup>th</sup> in Medicaid expenditures per eligible individual<sup>3</sup>; this is a reflection of benefit levels, payment rates and efficiencies realized because of the way Oregon delivers services (e.g., through managed care plans and the DMAP administrative process) and through the Prioritized List of Health Services.

Approximately 76 percent of OHP clients are enrolled in physical medicine managed care, with a current goal of 80 percent. Over 90 percent of OHP clients are enrolled in dental and in mental health

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<sup>2</sup> Based on count of unduplicated clients from beginning of OHP in July 1, 1994 to January 17, 2007

<sup>3</sup> Based on 2002 statistics from the Centers for Medicare and Medicaid Services

managed care. Managed care enrollment gives clients a medical home, providing better access to needed health services, coordinated care, and a delivery system focused on quality improvement.

In a May 2004 survey, approximately 84 percent of OHP clients rated their overall health care positively, which has been a consistent trend over the past five years.

Insuring children increases access to a medical home, enabling them to visit doctors and dentists regularly and reducing costly emergency room visits; this may also influence parents' health-care decisions. Good physical, mental and dental health positively influences school success. Health insurance increases opportunities for prevention and early diagnosis and reduces the chance of untreated chronic disease and severe medical conditions, leading to more costly care as conditions worsen. Insuring a larger share of Oregon's children would boost the state's childhood immunization rate, promoting public health for all children and reducing school absences. Reducing the number of uninsured Oregonians lessens the amount of uncompensated charity care by private providers and costs ultimately shifted to premiums paid by insured patients and their employers.

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### *MAJOR CHANGES DURING 2005-2007*

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In a response to the new prescription drug benefit offered by Medicare Part D, the 2005 Legislature passed SB 1088 to allow DHS to discontinue paying for drugs in classes of drugs covered by Medicare. This impacts clients who are eligible for both Medicare and Medicaid.

With SB 782, the 2005 Legislature exempted OHP Standard clients from paying premiums if their family income is no more than 10 percent of the federal poverty level. For those still required to pay premiums, this statutory change allows a grace period for premium payments of up to six months, and it requires clients to pay overdue premiums before they can be eligible again. It also eliminates the six-month disqualification period when someone fails to pay premiums.

Beginning June 1, 2006, clients in the CHIP program are made eligible for 12 months at a time instead of six months.

In October 2006, the Department submitted an application to the Centers for Medicare and Medicaid Services for a three-year extension of OHP demonstration project, which currently expires on October 31, 2007.

The Oregon Health Plan (OHP) Standard benefit package closed to new enrollment in July 2004 due to budget constraints. Decreasing enrollment was necessary to sustain the program through the end of the 2005-2007 biennium, this was accomplished through natural attrition.

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### *HISTORY OF THE PROGRAMS*

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In 1987, a group of citizens in Oregon conceptualized OHP as a means to insure more low-income Oregonians, regardless of age, disability or family status. OHP includes both public and private market components.

The private market components include:

- *The Oregon Medical Insurance Pool*, which is a high risk pool to serve uninsured people of any income who have pre-existing health conditions without other affordable insurance coverage, and
- *The Family Health Insurance Assistance Program*, which offers subsidies for employer-sponsored insurance for those with income up to 185 percent of the federal poverty level.

The public components include:

- **Medicaid.** In 1994, Oregon received waivers from the federal government allowing us to use Medicaid money to cover adults and couples with income under 100 percent of the federal poverty level in addition to those traditionally covered by Medicaid. Those traditionally covered include:
  - ◆ Low-income pregnant women and children
  - ◆ Blind, elderly and people with disabilities who are eligible for both Medicare and Medicaid
  - ◆ Families receiving assistance through the Temporary Assistance to Needy Families Program
- **Children's Health Insurance Program (CHIP).** In 1998, Oregon started offering a version of this optional federal program to children under age 19 who had family income up to 170 percent of the federal poverty level. Children enrolled in CHIP now can live in a family with income up to 185 percent of the federal poverty level.

Since 2003, significant changes have occurred in OHP related to the coverage of adults not traditionally covered by Medicaid:

- Budget constraints have necessitated repeated changes in the benefits provided to this population, now called OHP Standard, and the number of adults who can be covered.
- OHP Standard population has declined from a caseload of over 100,000 to its current level of 21,000 clients and has been closed to new enrollment since July 2004.
- The benefit package no longer provides routine vision, non-emergency medical transportation, therapies, certain medical equipment and supplies, non-emergency dental services, nor a full hospital benefit.
- The program is currently supported by provider taxes, client-paid premiums and matching federal funds.

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## PERFORMANCE MEASURES AND PROGRESS

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Two performance measures are directly related to the OHP:

- Routine health care provided to OHP clients
- Racial/ethnic variance of routine health care provided to OHP clients

*Routine health care:* People who have access to and use routine care have improved health outcomes, and health care delivery is more cost effective. Routine care allows diseases to be diagnosed and treated before becoming serious and debilitating. It promotes healthy lifestyles and wellness. A premise of OHP is to increase access to preventive and primary health care through routine health visits.

This performance measure is showing that Oregon is improving. The rates for adults and children increased in 2005 and are above the 2005 targets. From 2001 to 2005, the rate for adults increased 5.3 percentage points (from 70.4 to 75.7 percent), and the rate for children increased 2.7 percentage points (from 69.3 to 72 percent).

Increasing the proportion of clients in managed care and having a medical home facilitates this measure. Clients in fee-for-service have access to disease management and case management programs.

Clients in managed care use preventive and primary care services at higher rates than other clients. Managed care plans participate in quality improvement and prevention activities including performance improvement projects and measures. Past and present focuses include tobacco cessation, asthma, diabetes and prenatal care, early childhood cavity prevention, and childhood immunizations.

Barriers include health care providers who do not accept Medicaid clients and a lack of knowledge among some clients about the importance and necessity of routine health visits.

*Racial/ethnic variance of routine health care:* Reducing health disparity is a priority of the Department. This measure examines routine care provided to racial/ethnic groups.

Oregon is improving with this measure as well. The rates for race/ethnic categories increased in 2005, and all are above their 2005 targets. The following shows the rate increases from 2001 to 2005:

- Whites—3.3 percentage points (from 70.3 to 73.6 percent)
- Asian/Pacific Islanders—3.5 percentage points (from 64.8 to 68.3 percent)
- Hispanics—4 percentage points (from 69.4 to 73.4 percent)
- African Americans—4.3 percentage points (from 64.4 to 68.7 percent)
- Native Americans—4.3 percentage points (from 70.8 to 75.1 percent)

*In addition to these specific performance measures:* OHP supports measures in other parts of the Department. For example the Department, through its contracts with Medicaid managed care organizations, has undertaken a Performance Improvement Project that is focused on better collaboration and communication between mental health and physical health providers. The result is better care for those with mental illness thus potentially reducing the risk of teen suicide.

The Oregon Health Plan (OHP) contributes to the key performance measure of early prenatal care for low-income women. Most recent measures show that OHP clients may not be gaining in this area. While speculative, one likely cause is closure of the Standard benefit package, so fewer low-income women are already covered by Medicaid when they become pregnant. It is possible that some of them don't immediately know that they can now qualify because they are pregnant.

The Department requires its OHP managed care plans to track tobacco cessation efforts, and we have invested in the Free and Clear program and cover smoking cessation treatments.

One of the Department's goals is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%. We measure this goal by assessing the percentage of 24-35 month old children immunized by local health departments. The OHP contributes to that goal by paying for the office visit when a provider immunizes a child on the OHP. The federal government pays for the

vaccine itself, but not the office fee. We use the ALERT registry to measure the progress of this goal. Providers anywhere can use this registry to see if children are current in their immunizations. Physicians who use ALERT are more current with immunizing their patients than those who don't use the registry. We work with the OHP managed care plans to use ALERT and to enter their immunization information into the registry. We also enter immunization data from fee-for-service providers. In 2005, the percent of children immunized reached 73.5% for those children served by local health departments, which exceeds our goal for 2005. This rate continues to steadily increase.

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## *OUTSTANDING ISSUES*

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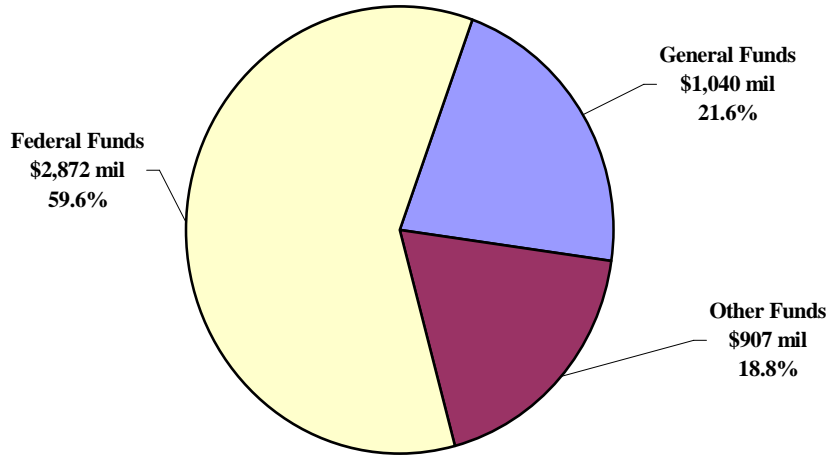
The sustainability of OHP is dependent on several factors. One factor is rising health care costs. Medical inflation is rising faster than general inflation. Pressures on the budget from increasing caseloads and medical inflation limit our ability to increase payments to some providers, such as physicians. This makes it difficult to recruit and retain providers. Clients who are unable to see a primary care provider often seek more expensive emergency care.

Another factor is unemployment. Unemployment affects both our caseload and revenue. It causes an increase in our caseload and a decrease in our revenue. Similarly, decreases in the availability of employer-sponsored health insurance impact caseload.

Federal policy changes impact caseload, benefits, delivery of services, administration of programs and funding. For example, the federal Deficit Reduction Act of 2005 will end Oregon's ability to tax Medicaid managed care plans in October 2009.

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**Division of Medical Assistance Programs (DMAP)  
Major Revenue Sources  
2007-09 Governor's Recommended Budget  
\$4,819 million Total Funds**

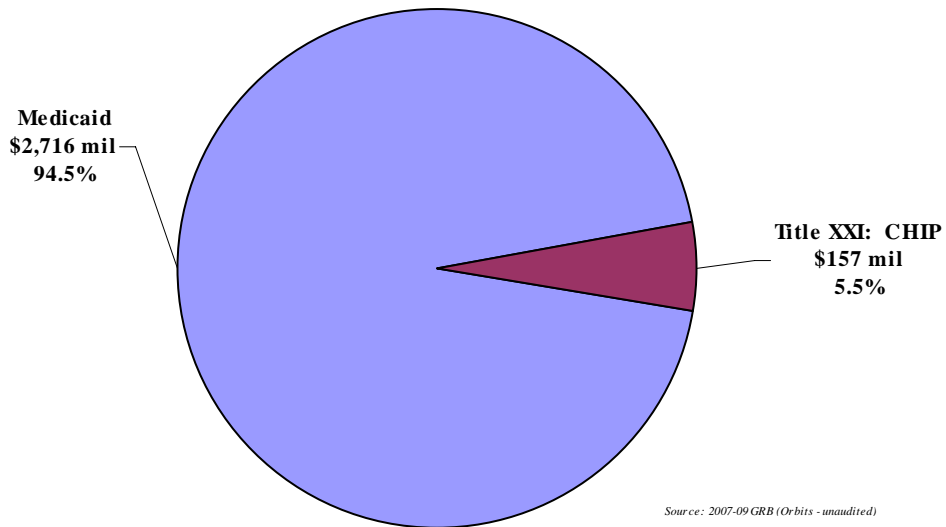


Source: 2007-09 GRB (Orbits - unaudited)

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**Division of Medical Assistance Programs (DMAP)  
Major Federal Funds Revenue Sources  
2007-09 Governor's Recommended Budget**

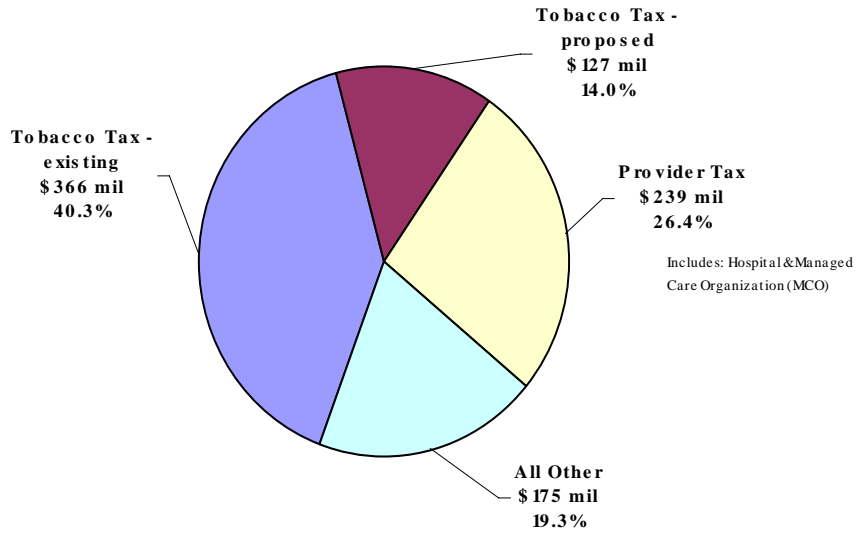
**\$2,872 million Federal Funds**



Source: 2007-09 GRB (Orbits - unaudited)

**Division of Medical Assistance Programs (DMAP)  
Major Other Funds Revenue Sources  
2007-09 Governor's Recommended Budget**

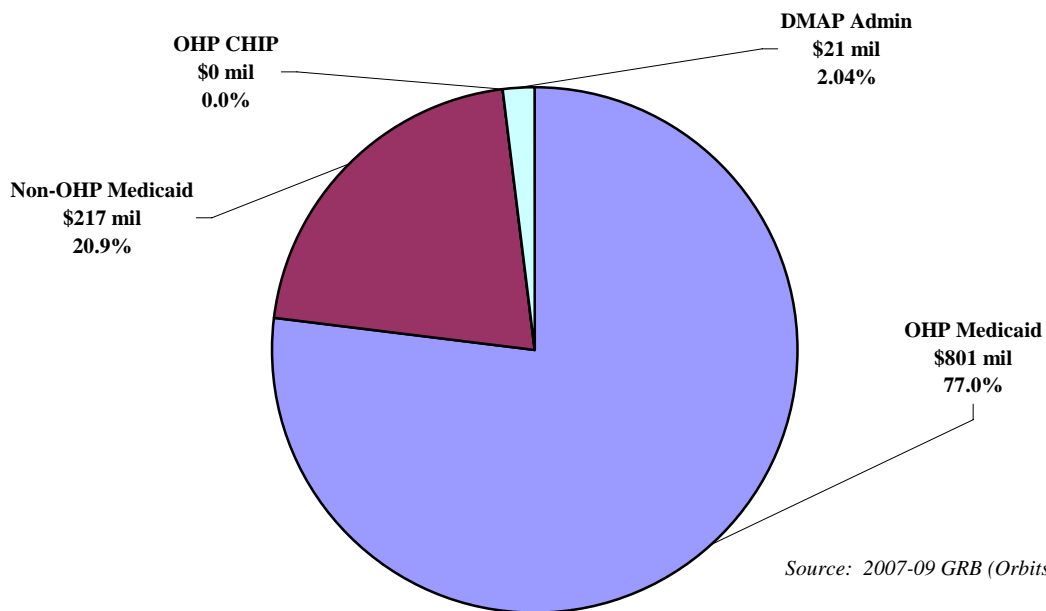
**\$907 million Other Funds**



*Source: 2007-09 GRB (Orbits - unaudited)*

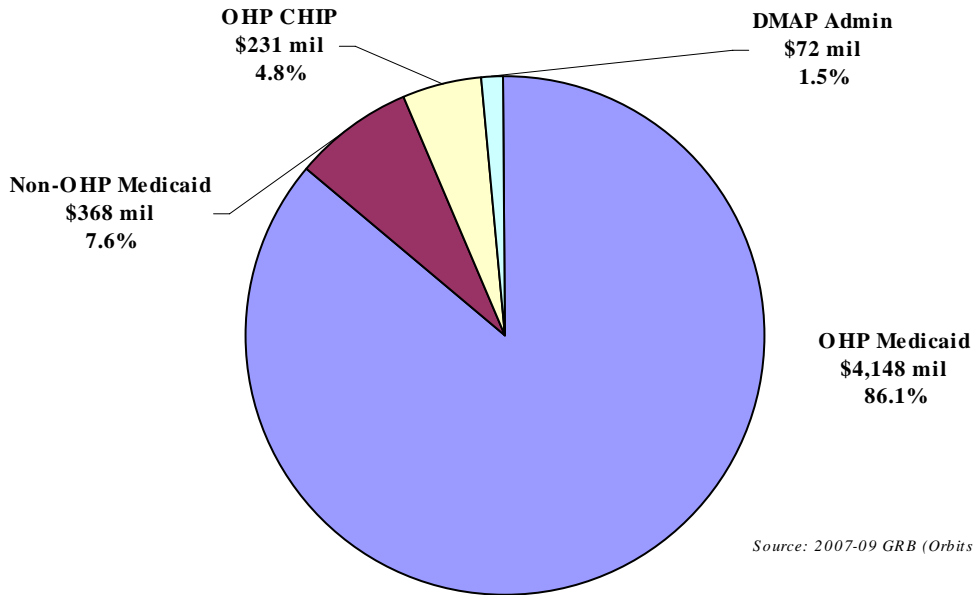
**Division of Medical Assistance Programs (DMAP)  
2007-09 Governor's Recommended Budget  
General Fund Use by Program**

**\$1,040 million General Funds**



*Source: 2007-09 GRB (Orbits - unaudited)*

**Division of Medical Assistance Programs (DMAP)**  
**2007-09 Governor's Recommended Budget**  
**Total Fund Use by Program**  
**\$4,819 million Total Funds**



Source: 2007-09 GRB (Orbits - unaudited)