

Office of Medical Assistance Programs Mission and Goals

Mission

To plan and implement medical programs assuring access to basic care for eligible clients

Goals

- ◆ Increase access to health care for low-income Oregonians.
- ◆ Improve the quality of health care, and receipt of preventive services by low-income Oregonians, thereby improving their health.
- ◆ Contain health care costs.

Historical Perspective

Introduction

The Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) coordinates the operation of the Medicaid portion of the Oregon Health Plan (OHP) and directly administers OHP physical and dental health coverage. OMAP's three main budget areas are OHP-Medicaid, OHP-Children's Health Insurance Programs (CHIP) and non-OHP Medicaid.

Planning for the Oregon Health Plan had its beginnings in the late 1980s when a task force convened around a common desire to keep Oregonians healthy. The group was composed of health care providers, consumers, business and labor leaders, insurers and lawmakers.

They agreed that:

- ◆ All Oregonians should have access to a basic level of health care.
- ◆ Society is responsible to finance care for poor people.
- ◆ There must be a process to define a basic level of care.
- ◆ The process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole.
- ◆ The health care delivery system must encourage use of services that are effective, appropriate and discourage over-treatment.

They also agreed to be good stewards of public resources by requiring that:

- ◆ Funding for health care must be balanced with other programs that also affect health.
- ◆ Funding must be sustainable and explicit.
- ◆ There must be clear accountability for allocating resources and for the human consequences of funding decisions.
- ◆ The plan would reduce cost shifting to emergency rooms and charity care.
- ◆ The plan would place emphasis on managed care, preventive care, early intervention and primary care.
- ◆ The plan would not cover ineffective care.

Implementation of the OHP involved two major components: Medicaid reform and expansion, for which OMAP has responsibility, and insurance reform, which is the responsibility of other state agencies.

Medicaid Reform and Expansion

In 1991 the Department began the process of Medicaid reform and expansion by requesting federal waivers to Medicaid rules in order to provide coverage to populations not included in traditional Medicaid. The former Health Care Financing Administration (HCFA) approved the first five-year Medicaid demonstration project. OMAP began covering approximately 100,000 newly eligible persons in 1994, originally offering one basic health care benefit package. The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) approved the most recent waiver in July 2004.

The state Health Services Commission created, and still maintains, the List of Prioritized Health Services that lists 730 pairs of medical conditions and treatments. The Legislature determines how many lines of paired conditions and treatments will be funded. Currently the first 546 lines are covered. *See OMAP Appendix A, OHP Prioritized List of Health Services for examples.*

Success of the Oregon Health Plan

In the past 11 years, Oregon's Medicaid waivers have allowed hundreds of thousands of Oregonians to access health care coverage who would not have been eligible under a traditional Medicaid program, including healthy adults, children and pregnant women in households with higher income levels. The state was able to claim Medicaid match for clients enrolled in the Family Health Insurance Assistance Program. OHP was designed to contain health care costs by enrolling clients in managed care. Oregon also instituted a prioritized list of health conditions and treatments to triage health care spending, putting a high priority on preventive care.

See the OMAP Appendix B for additional Oregon Health Plan results.

Medical Assistance Programs

The Office of Medical Assistance Programs (OMAP) administers three main categories of medical assistance programs: Oregon Health Plan (OHP)-Medicaid, OHP-Children’s Health Insurance Program (CHIP), and non-OHP Medicaid.

Together, OHP-Medicaid and OHP-CHIP operate under a Section 1115 demonstration waiver and Health Insurance Flexibility and Accountability (HIFA) waiver, known as the OHP Medicaid Demonstration.

Persons who qualify for OHP-Medicaid or OHP-CHIP receive services through either a direct coverage program administered by OMAP, or through the Family Health Insurance Assistance Program (FHIAP). FHIAP, the premium supplement portion of the OHP demonstration, is administered by the Insurance Pool Governing Board under an interagency agreement with DHS. Under this agreement, DHS serves as Oregon’s single state Medicaid agency.

OHP-Medicaid

Almost all persons eligible for Medicaid (a.k.a., Title XIX of the Social Security Act) in Oregon now receive their Medicaid services under the OHP Medicaid Demonstration project. OMAP provides most non-institutional Medicaid services via OHP. Long-term care Medicaid services are available to persons eligible under the OHP, but are provided separately by DHS Seniors and People with Disabilities (SPD). Mental health services were integrated into OHP in 1995 and the Office of Mental Health and Addiction Services administers services through DHS contractors and local partners.

The following chart is a brief description of the groups eligible under OHP-Medicaid for one of the benefit packages administered by OMAP. The next

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section, entitled OMAP Benefits, describes the services covered in the two OHP benefit packages.

Medicaid Population	OHP package
Persons receiving cash assistance under Temporary Assistance for Needy Families (TANF), which serves single- and two-parent families	Plus
Families who transition into employment and leave cash assistance programs	Plus
Children in foster care or for whom adoption assistance payments are made	Plus
Children ages 0-5 in households with incomes up to 133 percent of the Federal Poverty Level (FPL) and children ages 6-18 with incomes up to 100 percent of the FPL. This program is called Poverty Level Medical for Children	Plus
Pregnant women and their newborns with incomes under 185 percent of the FPL. This program is Poverty Level Medical for pregnant women	Plus
Persons who are age 65 or over (Older Americans Act) and eligible for the federal Supplemental Security Income (SSI) program	Plus
Persons who are blind or disabled and eligible for the federal Supplemental Security Income program	Plus
Persons who meet federal criteria for presumptive eligibility based upon disability determination	Plus
Other uninsured Oregonians (citizens and certain qualifying non-citizen residents) with incomes under 100 percent of the FPL who are not eligible for Medicare	Standard

OHP-CHIP

In 1998, Oregon launched the Children's Health Insurance Program (CHIP) that receives enhanced federal match under the Title XXI program. OHP-CHIP covers uninsured children who are not eligible for traditional Medicaid in the following categories:

- ◆ Children 6-18 with family income between 100 and 185 percent FPL.
- ◆ Children from birth through 5 with family income between 133 and 185 percent FPL.

OHP Eligibles

The following bar graph displays the OHP eligibility categories and the income requirements of each expressed as a percentage of the federal poverty level (FPL). Using this graph and the FPL chart, we find that, in 2004, a parent with three school-age children (family of four) applying for CHIP would have had monthly income of less than \$2,906 to qualify for the children's coverage.

Eligibility Categories and Federal Poverty Level	
TANF	48%
PLM-W	185%
PLM-CH age 0-5	133%
PLM-CH age 6-18	100%
Old Age/Disabled*	73%
Blind *	76%
CHIP	185%
Families-Standard	100%
Couples/Single-Standard	100%

* Aged, blind and disabled populations meeting long-term care criteria are eligible up to 300 percent of the SSI level (which is equivalent to approximately 225 percent of the FPL); otherwise, these populations are eligible up to the SSI level.

Federal Poverty Level (FPL) Effective February 2004			
Number in family	100%	133%	185%
1	\$776	\$1,032	\$1,435
2	1,041	1,384	1,926
3	1,306	1,737	2,416
4	1,571	2,089	2,906
5	1,836	2,442	3,396
6	2,101	2,794	3,887
7	2,366	3,147	4,377
8	2,631	3,499	4,867
9	2,896	3,851	5,357
10	3,161	4,204	5,848
Each add'l	265	352	490

Non-OHP Medicaid

The Non-OHP portion of OMAP's budget covers populations that are not part of the OHP demonstration project, such as a small group of low-income Medicare eligibles.

The Non-OHP Medicaid program serves Oregonians in the following eligibility groups that are federally mandated:

- ◆ **Qualified Medicare Beneficiaries** have incomes up to 100 percent of the federal poverty level (FPL). DHS pays for an eligible's Medicare Part A and Part B premiums, and any applicable coinsurance and/or deductibles up to the Department's fee schedule.
- ◆ **Specified Low-Income Medicare Beneficiaries** have incomes between 100 percent and 120 percent FPL. DHS pays only their Medicare Part B premiums with regular matching federal funds.
- ◆ **Qualified Individuals have income from 120 up to 135 percent FPL.** DHS pays only their Part B premiums, but at a 100 percent federal match rate, up to the Department's federal allotment.
- ◆ **Dual eligibles.** Non-OHP Medicaid also pays Medicare Part B premiums for low-income Oregonians, including traditional OHP-Medicaid recipients who are dually eligible for Medicaid and Medicare.

For more information about these programs for Medicare beneficiaries, see the Seniors and People with Disabilities (SPD) section.

While OMAP administers DHS medical assistance programs, other offices within DHS determine eligibility for OHP benefits, depending on the age, living situation and medical condition of the applicant. DHS Children, Adults and Families and DHS Seniors and People with Disabilities determine OHP eligibility for their populations, as well as for cash benefits, food stamps and other support services.

See the OMAP Appendix C for more information on caseloads.

OMAP Benefits

OHP-Medicaid

In February 2003, the Department replaced the original OHP Basic benefit package with the OHP Plus package and created the more limited OHP Standard benefit package. OMAP offers parallel benefits for Citizenship-Alien Waived Emergency Medical services:

- ◆ **The OHP Plus** package offers comprehensive health care services to children and adults who are eligible under traditional, federal Medicaid rules (e.g., aged, blind, disabled, TANF recipients).
- ◆ **The OHP Standard** reduced package of benefits for adults covers most fundamental services. OHP Standard recipients must pay premiums of \$6-20 a month to maintain coverage. These recipients do not qualify for services under a traditional Medicaid program. *See the OMAP Appendix D for more information on how traditional Medicaid works.*
- ◆ **Citizenship-Alien Waived Emergency Medical (CAWEM)** is a federally mandated program that covers non-citizens for only emergent medical services, including childbirth. Recipients must meet all eligibility standards, other than citizenship, for either Plus or Standard OHP.

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2004 OHP Coverage by Benefit Package		
Covered Services	OHP Plus	OHP Standard
Physician services	✓	✓
Dental	✓	Limited emergency only
Hospital care	✓	Limited
Emergency/urgent hospital services	✓	✓
Prescription drugs	✓	✓
Laboratory/X-ray services	✓	✓
Immunizations	✓	✓
Mental health services	✓	✓
Chemical dependency services	✓	✓
Vision care	✓	Eye disease treatment only
Hospice care	✓	✓
Home health	✓	none
Medical equipment and supplies	✓	Limited *
Acupuncture	✓	Chemical Dependency only
Chiropractic & osteopathic manipulation	✓	none
Physical/Occupational/Speech therapy	✓	none
Hearing aids & hearing aid exams	✓	none
Private duty nursing	✓	none
Medical transportation	✓	Emergency only

* Limited to only diabetic supplies, respiratory equipment, oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

Non-OHP Medicaid Assistance

OMAP offers some types of assistance that are not included in the OHP Medicaid Demonstration.

- ◆ Federally mandated benefits for Medicare eligibles:
 - **Qualified Medicare Beneficiaries (QMBs)** receive payment for Medicare Part B premiums, and any applicable coinsurance and/or deductibles not paid by Medicare.

- **Specified Low-income Medicare Beneficiaries (SLMBs)** with incomes between 100 percent and 135 percent FPL have their Medicare Part B premiums paid.
- Certain QMB/SLMB recipients are eligible for OHP Plus under OHP-Medicaid in addition to this benefit.

Non-OHP, Non-Medicaid OMAP benefits

- ◆ In February 2003, OMAP began offering the **Senior Prescription Drug Assistance Program (SPDAP)** to low-income Oregonians age 65 and older. For a fee, the SPDAP card allows participants to buy prescriptions at Medicaid rates at participating pharmacies. Eligible persons have income and resources that are too high for Medicaid and they lack prescription coverage.
- ◆ Low-income women who are diagnosed with **Breast or Cervical Cancer** through a free screening and diagnostic services program may receive treatment through Non-OHP Medicaid.
- ◆ The **SB 5548 Clients** are former Medically Needy (MN) recipients who continue to receive a limited prescription benefit, at the direction of a budget note accompanying SB 5548, after the Medically Needy program ended January 31, 2003. Their eligibility is based on certain medical conditions (transplant recipients and HIV/AIDS patients) and their participation in the Oregon Supplemental Security Income MN program on that date. The SB 5548 benefits are paid exclusively with General Fund dollars.

OMAP Service Delivery

Clients qualifying for the OHP Plus and OHP Standard benefit packages administered by OMAP receive their health care services through one of three delivery systems:

- ◆ A capitated, risk-based arrangement with **managed care organizations (MCOs)**;
- ◆ A **fee-for-service** system of individual health care providers who are paid for services as they are provided and billed.
- ◆ A **primary care manager (PCM)** delivery system in which providers are paid on a fee-for-service basis and also receive a monthly fee for case management

Most clients receive their care from a primary care practitioner who is a contracted provider for an MCO.

Managed Care

Managed care under OHP-Medicaid and OHP-CHIP takes several basic forms:

- ◆ A Fully Capitated Health Plan (FCHP) provides physical health services and chemical dependency services.
- ◆ A Mental Health Organization (MHO) provides outpatient and acute inpatient mental health services. See the Office of Mental Health and Addiction Services (OMHAS) section for more information.
- ◆ A Dental Care Organization (DCO) provides preventive dental care, restoration of fillings, and repair of dentures.
- ◆ A Chemical Dependency Organization (CDO) provides chemical dependency services (currently the only plan is in Deschutes County).

- ◆ A Primary Care Manager (PCM) provides physical health services.
- ◆ A Physician Care Organization (PCO) is a partially capitated plan that provides physical services only. This newly defined type of MCO is scheduled to begin providing services in the spring of 2005.

The plan, or plans, an OHP client belongs to depends on where the person lives and which types of managed care are available in that area. When health plans have capacity to handle all the eligible OHP clients in a given area, clients are required to choose one of those plans. Some OHP clients are exempt from mandatory enrollment in managed care, such as American Indians, Alaska Natives, or people with specified health conditions.

See the OMAP Appendix E for more information on Fully Capitated Health Plans and Dental Care Organizations.

Provider Reimbursement

Traditionally, services provided through OHP managed care have been reimbursed using rates based on the reasonable cost of providing the service. An independent actuary under contract to the state sets these rates. There are three types of payment systems within OHP:

- ◆ **Capitation**—Managed care plans are paid a set amount per enrolled member per month, called capitation payments, to provide and manage members' health care. Capitation rates are set by an independent actuary, PricewaterhouseCoopers. Physical health, mental health, dental and chemical dependency services are all available through this managed care model. The managed care organizations guarantee access to care through their panel of providers.
- ◆ **Fee-for-Service**—Providers billing OMAP on a fee-for-service basis are paid at Medicaid rates, adjusted by legislatively approved inflation

factors. Access to care depends on availability of providers and service capacity.

- ◆ **Primary Care Managers (PCMs)**—OMAP pays these contractors (e.g., physicians, physician assistants, nurse practitioners, and naturopathic physicians), a small fee to manage their OHP clients' health care. PCMs bill OMAP for care provided via the fee-for-service method. Federally qualified health centers, rural health clinics, tribal health clinics, county health departments and similar organizations also can serve as PCMs.

Managed care contracts

DHS issues a Request for Applications for Fully Capitated Health Plans, Dental Care Organizations, Physician Care Organizations, Chemical Dependency or Mental Health Organizations. DHS staff reviews the applications to determine if organizations meet 14 basic standards regarding capacity to provide the contracted services and financial solvency. Both the Oregon Department of Justice and the federal Centers for Medicare and Medicaid Services review the model contracts for legal sufficiency and federal Medicaid compliance. DHS administers the managed care organization contracts and performs periodic evaluations of services provided.

Fee-for-service provider enrollment

Providers (e.g., physician, pharmacist, medical transportation, durable medical equipment supplier) may apply to OMAP to provide services on a fee-for-service basis to clients who don't receive services through an MCO. Applicants must submit proof of appropriate licensure or certification. OMAP staff verifies that they meet all requirements, then conducts reference checks to see if the providers are in good standing in their field. If an application is approved, OMAP assigns the provider an identifying number and instructs them on how to bill for Medicaid and other OMAP services.

OMAP Organizational Chart

