

Division of Medical Assistance Programs

History

The Oregon Health Plan (OHP) was formed in response to conditions that threatened the social and economic health of the nation – the rising costs of medical care and the growing number of people unable to afford such care.

In the late 1980s, millions of Americans had no guaranteed medical benefits. They didn't qualify for public assistance (Medicaid), were not insured by an employer and couldn't afford individual coverage. About 18 percent of all Oregonians, and more than 20 percent of our children, had no medical coverage. They were, in effect, excluded from our health care system.

Instead of seeking early preventive care, these uninsured individuals sought emergency care as a last resort when their illnesses became severe. When emergency department doctors are not compensated, the care isn't really free. Instead, the cost of this expensive care is funded by “cost-shifting” – increasing the costs of medical bills and insurance premiums for individuals who do have insurance.

States traditionally responded to rising health care costs by reducing the number of people eligible for public assistance coverage and reducing Medicaid reimbursements to providers. In the private sector, employers reduced or dropped coverage for their workers¹. The result was ever-escalating costs as more people were priced out of coverage, causing even more cost-shifts.

As conditions worsened, Oregon's practice of fully insuring only traditional Medicaid-eligible individuals, while neglecting the rest of Oregon's uninsured poor, no longer made sense. Beginning in 1987 a group of health care providers and consumers, business and labor representatives, insurers, and lawmakers agreed on a common objective – to keep Oregonians healthy. They agreed that:

- All citizens should have access to a basic level of health care.

¹ According to the Oregon Employee Benefits report for 2005 published by the Oregon Employment Department, 60 percent of Oregon businesses with two or more employees offer health insurance to full-time employees and 12.5 percent to part-time employees.

- Society is responsible for financing care for people with low incomes.
- 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 and procedures that are effective and appropriate, and discourage over-treatment.
- Health care is one important factor affecting health; funding for health care must be balanced with other programs that also affect health.
- Funding must be explicit and economically sustainable.
- There must be clear accountability for allocating resources and for the human consequences of funding decisions.

OHP, which emerged from these discussions, was Oregon’s attempt to reform publicly sponsored health care with input from all participants including taxpayers, providers, insurers and consumers.

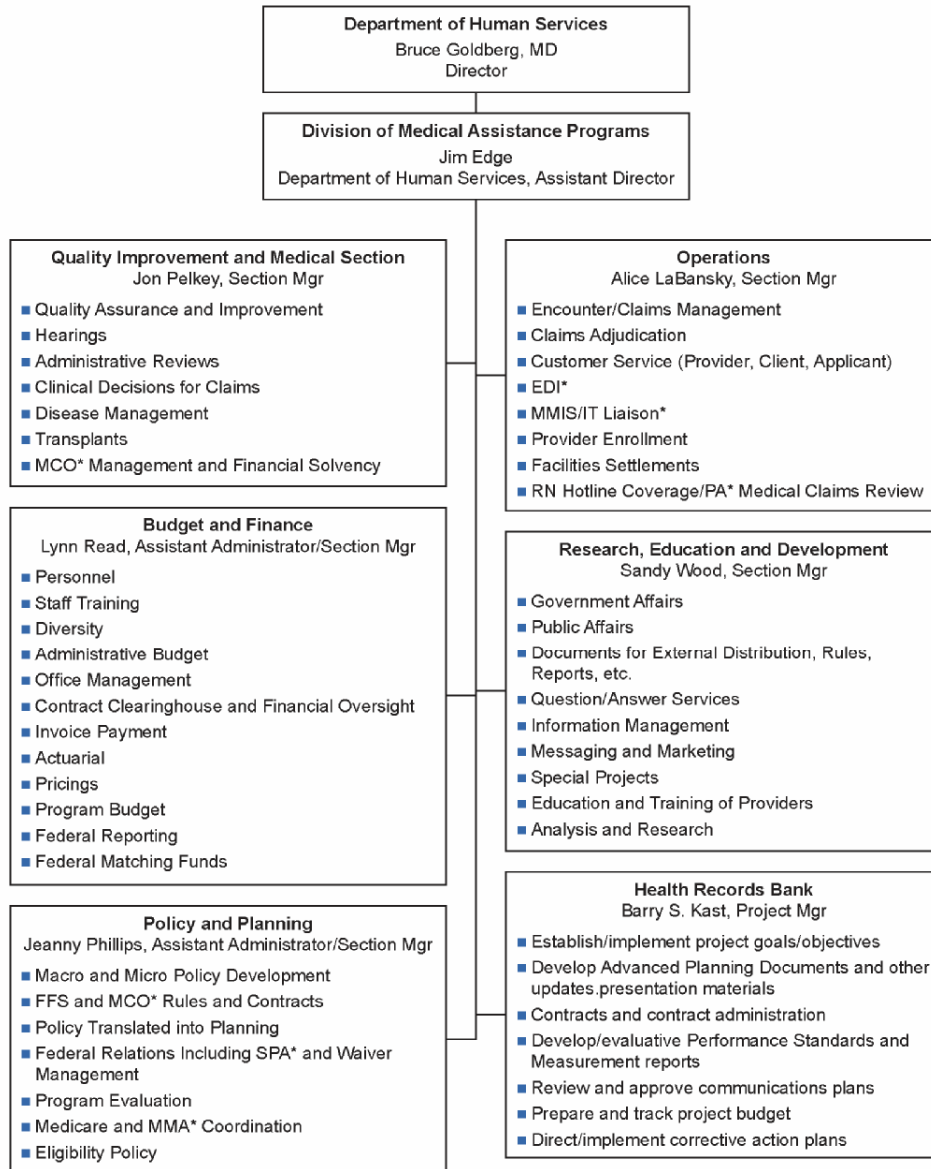
In 1991 the Oregon Department of Human Services (DHS) began the process of Medicaid reform and expansion by requesting federal waivers to Medicaid rules in order to provide coverage to populations not included in traditional Medicaid and to provide a benefit package based on a list of prioritized medical conditions and treatments.

Beginning February 1, 1994, following federal approval of the OHP demonstration, Oregon embarked on a five-year program to make Medicaid available to tens of thousands of people who previously did not qualify, even though their family incomes were below the federal poverty level (FPL). Essentially, instead of covering all medical services for a limited Medicaid population, OHP covers both the *traditional* Medicaid population and the *expanded* OHP population using a prioritized list of services, known as the Prioritized List of Health Services.

Since 1994 DHS has received consecutive demonstration renewals allowing the program to continue through October 31, 2010.

Organizational structure

DHS, through DMAP, administers physical medicine, dental and chemical dependency coverage under OHP.



Total FTE: 180.13

*Acronyms

| | | | |
|-----|------------------------------|------|--|
| DHS | Department of Human Services | MCO | Managed Care Organization |
| EDI | Electronic Data Interchange | MMIS | Medicaid Management Information System |
| FFS | Fee-For-Service | PA | Prior Authorization |
| IT | Information Technology | RN | Registered Nurse |
| MMA | Medicare Modernization Act | SPA | State Plan Amendment |

Administration

The Division's administrative budget is approximately 1.5 percent of the overall budget and includes activities and coordination essential to operating the Medicaid and Children's Health Insurance Program budgets. Program support includes those functions associated with increasing access to Medicaid for eligible Oregonians, with special attention to Oregon's Medicaid-eligible children. These functions include planning and developing policies to implement medical assistance programs; providing quality assurance and improvement monitoring of the managed care plans and fee-for-service delivery systems; providing oversight and coordination of the budget, actuarial capitation rates, and pricing; providing oversight and coordination of federal reporting and federal matching funds; developing communication plans to manage information disseminated internally and externally; and managing all aspects of health care financing operations for medical assistance programs. In addition to functions performed by Division staff, approximately 45 percent of the administrative budget pays for professional services contracts.

Approximately 98 percent of DMAP's budget goes directly to providing/delivering health care services. Oregon ranks 44th in the United States for Medicaid expenditures per eligible individual². This is a reflection of benefit levels, payment rates and efficiencies realized because of the way Oregon delivers services (e.g., through MCOs and the DMAP administrative process) and through the Prioritized List of Health Services.

| State | Ranking | Spending | Number of Eligibles |
|---------|---------|----------|---------------------|
| U.S. | | \$4,938 | 57,575,692 |
| Montana | 18 | \$5,171 | 113,073 |

| State | Ranking | Spending | Number of Residents |
|------------|---------|----------|---------------------|
| U.S. | | \$904 | 293,655,404 |
| Washington | 26 | \$795 | 6,203,788 |

² Based on 2004 statistics from the Centers for Medicare and Medicaid Services (CMS)

| | | | |
|---|-----------|----------------|----------------|
| Wyoming | 25 | \$4,672 | 77,772 |
| Colorado | 27 | \$4,572 | 524,760 |
| Idaho | 29 | \$4,490 | 220,535 |
| Washington | 39 | \$4,123 | 1,195,703 |
| Oregon | 44 | \$3,647 | 590,236 |
| Nevada | 49 | \$3,136 | 256,841 |
| California | 51 | \$2,584 | 10,619,361 |
| Average annual medical assistance spending per Medicaid recipient Source: CMS MSIS FY 2004 | | | |

| | | | |
|--|-----------|--------------|------------------|
| California | 30 | \$765 | 35,893,799 |
| Wyoming | 37 | \$717 | 506,529 |
| Idaho | 38 | \$711 | 1,393,262 |
| Montana | 45 | \$631 | 926,865 |
| Oregon | 46 | \$599 | 3,594,586 |
| Colorado | 49 | \$521 | 4,601,403 |
| Nevada | 51 | \$345 | 2,334,771 |
| Average annual spending per resident Source: CMS MSIS FY 2004 | | | |

Determining program eligibility

While DMAP administers DHS medical assistance programs, other divisions within DHS determine eligibility, which depends on the age, living situation and medical condition of the applicant. DHS Children, Adults and Families Division (CAF) and DHS Seniors and People with Disabilities Division (SPD) determine eligibility for their populations, as well as for cash benefits, food stamps, long-term care and other support services.

Who receives services

OHP Medicaid and OHP CHIP clients

Medicaid eligibility is limited to individuals who fall into specified categories and who are in financial need. The federal Medicaid statute identifies more than 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,
- People with disabilities, and
- People age 65 or older.

If OHP did not exist, the state would be required to provide Medicaid to mandatory coverage groups in order to draw down federal funds. 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 FPL.

| Federal Poverty Level (FPL) Monthly income guidelines Effective January 23, 2008 | | | |
|---|-------------|-------------|-------------|
| Size of Family | 100% | 133% | 185% |
| 1 | \$ 867 | \$1,153 | \$1,604 |
| 2 | \$1,167 | \$1,552 | \$2,159 |
| 3 | \$1,467 | \$1,951 | \$2,714 |
| 4 | \$1,767 | \$2,350 | \$3,269 |
| 5 | \$2,067 | \$2,749 | \$3,824 |

| | | | |
|---|---------|---------|---------|
| 6 | \$2,367 | \$3,148 | \$4,379 |
| 7 | \$2,667 | \$3,547 | \$4,934 |
| 8 | \$2,967 | \$3,946 | \$5,489 |

Approximately 421,833 Oregonians³ are covered under Medicaid or CHIP.

Most of these clients receive OHP Plus coverage. The following groups are eligible for OHP Plus coverage:

- Low-income families with dependent children who are receiving or are eligible to receive cash assistance under Temporary Assistance for Needy Families (TANF). These families remain eligible for medical coverage for up to 12 months after their cash assistance ends.
- Children in foster care, substitute care or for whom adoption assistance payments are made.
- Children under age 19 with family incomes under 185 percent of the FPL.
- Pregnant women with family incomes under 185 percent of the FPL.
- People who are age 65 or older or are blind or disabled, and:
 - ◆ Are eligible for Supplemental Security Income (SSI), or
 - ◆ Qualify for long-term care services and have a family income under 300 percent of the SSI level.

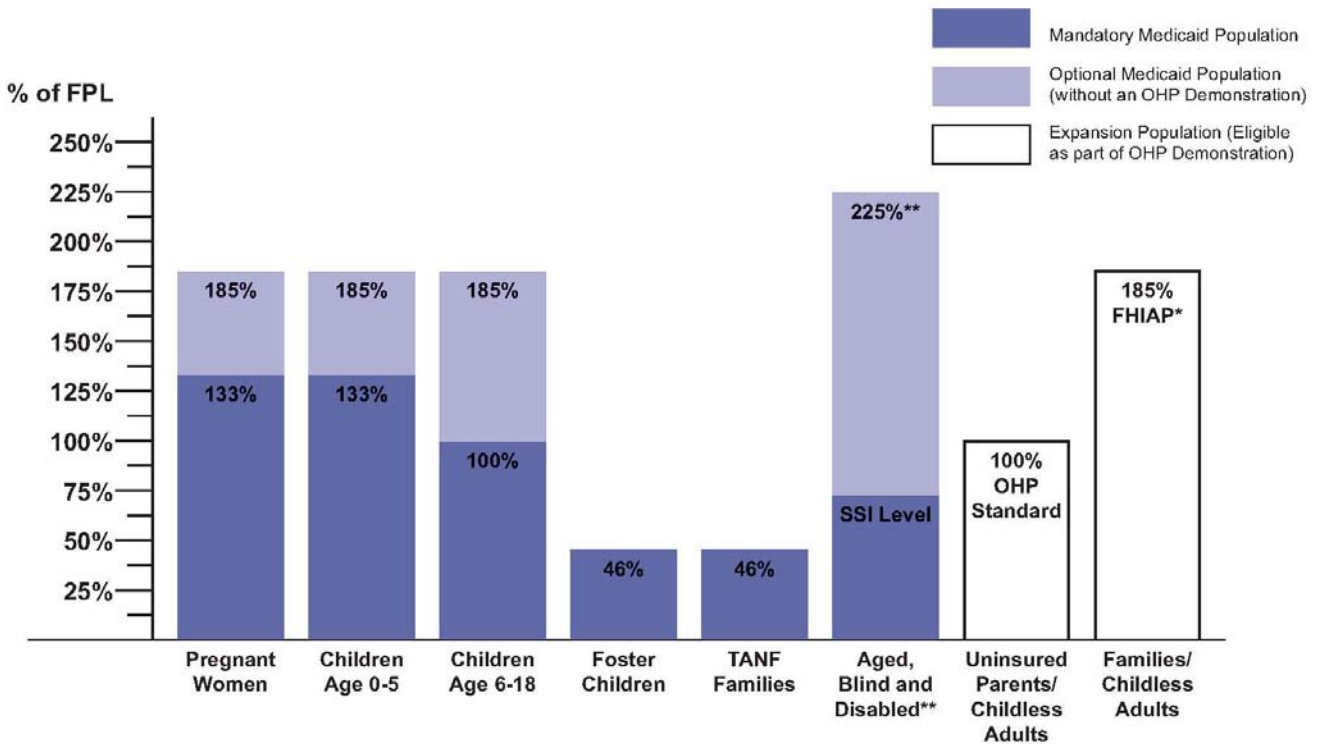
Uninsured Oregonians with family incomes under 100 percent of the FPL who are not otherwise eligible for Medicaid or Medicare and are age 19 or older are eligible for OHP Standard coverage.

³ Based on Spring 2008 forecast, which includes actual counts and forecasted numbers for 2007-09 biennium. See Medical Assistance Programs – Biennial monthly averages table for 2009-2011 for forecast enrollment numbers.

People who are ineligible for OHP Plus or OHP Standard coverage solely because they do not meet the Medicaid citizenship or immigration status requirements are eligible for limited medical assistance through the Citizen-Alien/Waived Emergency Medical (CAWEM) program. Except for citizenship and immigration status, CAWEM clients must meet the same eligibility requirements, including income and resources, of the medical program they would otherwise be eligible to receive.

The following chart shows the approximate FPL requirements for clients who are part of the mandatory and optional Medicaid populations, as well as for clients who are eligible because of the OHP Demonstration Project.

Approximate Federal Poverty Levels (FPLs) for OHP eligibility groups



* The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low-income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of the FPL must enroll in FHIAP if they have employer-sponsored insurance. Parents and childless adults over 100% of the FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

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

Non-OHP Medicaid clients

Women with breast and cervical cancer

Women ages 40 to 65 with family incomes under 250 percent of the FPL, who are diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Early Detection programs may receive medical benefits from the Breast and Cervical Cancer Program. The Early Detection program is administered by the DHS Public Health Division through county health departments and tribal health clinics. After determining eligibility, the client receives all Medicaid services including mental and dental health care. A client is eligible until she reaches age 65, obtains other coverage or ends treatment.

Medicare clients

Medicare clients may receive assistance through the following services and programs:

- **Insurance Premiums** – Oregon pays a limited number of Medicare Part A hospital premiums for clients who are covered by both Medicaid and Medicare. The state also pays the Medicare Part B outpatient benefit premiums for OHP clients who have family incomes under 135 percent of the FPL. Paying the premiums for these clients makes Medicare the primary payer and offsets the costs DHS incurs for capitation and fee-for-service payments.
- **Qualified Medicare Beneficiaries** – The Qualified Medicare Beneficiary Program serves people who have family incomes under 100 percent of the FPL. The program covers deductibles, coinsurance, co-payments and Medicare premiums. This program is funded with state funds matched with federal funds.
- **Specified Low-Income Medicare Beneficiaries** – Specified Low-Income Medicare Beneficiaries (SLMB) are Medicare beneficiaries who have family incomes over 100 percent and under 135 percent of the FPL. The state pays Medicare Part B premiums only, for these clients.
- **Medicare Part D** – The Medicare Modernization Act (MMA) created Medicare Part D, under which Medicare clients became eligible for Medicare prescription drug benefits beginning January 1, 2006. This was a change for dual-eligible clients (i.e., clients who are eligible for both Medicare and full OHP Medicaid coverage). These clients previously received their prescription

drug benefits through Medicaid. The state no longer covers prescription drugs for any class of drugs covered by Medicare Part D, because federal regulations prohibit the state from claiming federal match in those circumstances. Medicaid still pays and receives federal matching funds for drugs in classes not covered by Medicare Part D such as barbiturates, benzodiazepines and over-the-counter drugs. The state continues to pay for limited over-the-counter medications covered by Medicaid.

MMA requires states to pay the federal government 90 percent, initially, of what would have been the state's share of drug costs prior to passage of the Act for dual eligibles enrolled in Medicare Part D (with annual inflation factors). The state's share is referred to as the "clawback." Over 10 years this amount is scheduled to decline to 75 percent.

Limited Drug Coverage for Certain Former Medically Needy Clients

Since spring 2003 the Oregon Legislative Assembly has appropriated General Funds to provide limited drug coverage to certain clients whose coverage ended when the Medically Needy program was eliminated January 31, 2003. Former Medically Needy program clients who were organ transplant clients are eligible under this program. Organ transplant clients are covered for drugs necessary for the direct support of their transplants. The program currently covers 26 clients⁴.

⁴ Based on Spring 2008 forecast, which includes actual counts and forecasted numbers for 2007-09 biennium. See Medical Assistance Programs – Biennial monthly averages table for 2009-2011 for forecast enrollment numbers.

Where service recipients are located

The following chart shows the number of clients in each county, the percentage of OHP clients in each county and the amount DMAP paid in 2007 to provide their health care coverage.

| County | Total Population Estimate ⁵ | Avg Monthly Number of Clients 2007 ⁶ | OHP clients as % of county population | Total Expenditures |
|------------|--|---|---------------------------------------|--------------------|
| Baker | 16,435 | 2,033 | 12% | \$3,874,500 |
| Benton | 85,300 | 5,137 | 6% | \$19,209,698 |
| Clackamas | 372,270 | 23,496 | 6% | \$84,553,889 |
| Clatsop | 37,440 | 3,693 | 10% | \$7,763,577 |
| Columbia | 47,565 | 4,305 | 9% | \$12,686,582 |
| Coos | 63,050 | 8,853 | 14% | \$38,040,499 |
| Crook | 25,885 | 2,065 | 8% | \$7,245,905 |
| Curry | 21,475 | 2,348 | 11% | \$3,001,934 |
| Deschutes | 160,810 | 11,901 | 7% | \$40,181,575 |
| Douglas | 104,675 | 13,673 | 13% | \$55,862,760 |
| Gilliam | 1,885 | 141 | 7% | \$1,652,234 |
| Grant | 7,580 | 704 | 9% | \$3,031,785 |
| Harney | 7,680 | 833 | 11% | \$3,564,382 |
| Hood River | 21,470 | 2,828 | 13% | \$8,726,068 |
| Jackson | 202,310 | 21,573 | 11% | \$34,639,905 |
| Jefferson | 22,030 | 3,230 | 15% | \$8,839,671 |
| Josephine | 82,390 | 11,874 | 14% | \$50,273,383 |
| Klamath | 65,815 | 9,294 | 14% | \$35,428,638 |
| Lake | 7,565 | 918 | 12% | \$1,560,626 |
| Lane | 343,140 | 37,178 | 11% | \$129,844,852 |
| Lincoln | 44,630 | 6,055 | 14% | \$12,438,243 |
| Linn | 109,320 | 14,651 | 13% | \$52,516,889 |

⁵ Population Research Center, Portland State University, December 2007

⁶ Data extracted from the DMAP DSSURS database tables: MEMBERMONTHS, CLMH

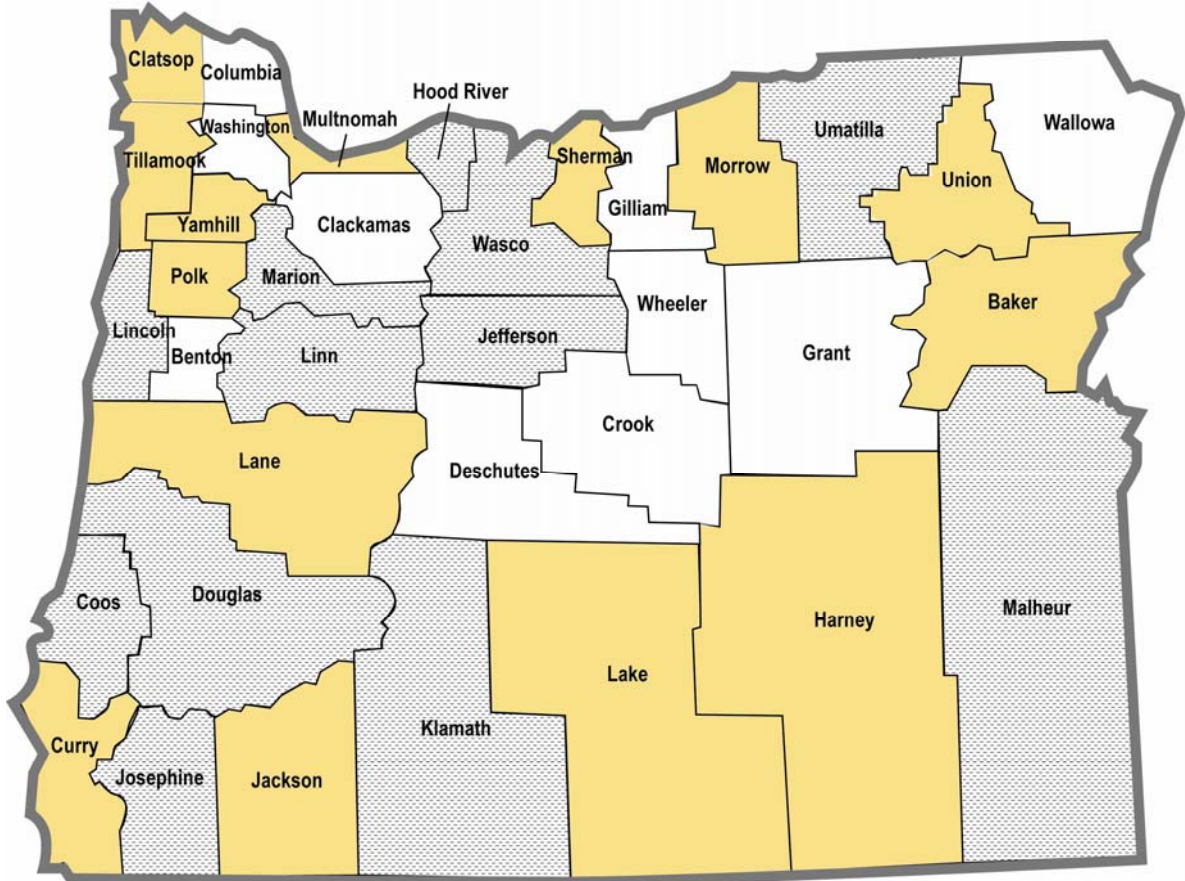
| | | | | |
|-----------|---------|--------|-----|---------------|
| Malheur | 31,620 | 5,103 | 16% | \$10,319,038 |
| Marion | 311,070 | 45,012 | 14% | \$149,692,404 |
| Morrow | 12,335 | 1,402 | 11% | \$3,979,533 |
| Multnomah | 710,025 | 86,309 | 12% | \$351,264,077 |
| Polk | 67,505 | 7,863 | 12% | \$28,284,751 |
| Sherman | 1,855 | 198 | 11% | \$1,037,078 |

| County | Total Population Estimate ⁷ | Avg Monthly Number of Clients 2007 ⁸ | OHP clients as % of county population | Total Expenditures |
|---------------|---|--|--|---------------------------|
| Tillamook | 25,845 | 2,533 | 10% | \$3,894,673 |
| Umatilla | 72,245 | 10,274 | 14% | \$32,014,066 |
| Union | 25,250 | 3,079 | 12% | \$4,822,081 |
| Wallowa | 7,130 | 652 | 9% | \$2,004,170 |
| Wasco | 24,125 | 3,309 | 14% | \$11,045,734 |
| Washington | 511,075 | 36,840 | 7% | \$106,049,161 |
| Wheeler | 1,570 | 135 | 9% | \$293,221 |
| Yamhill | 93,085 | 10,063 | 11% | \$16,969,452 |

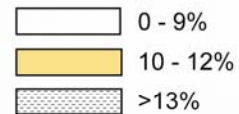
⁷ Population Research Center, Portland State University, December 2007

⁸ Data extracted from the DMAP DSSURS database tables: MEMBERMONTHS, CLMH

OHP clients as a percentage of the estimated population per Oregon county - 2007



Legend



Source: DMAP DSSURS database tables:
MEMBERMONTHS, CLMH

Medical Assistance Programs – Biennial monthly averages

| | Biennium 2005-2007 | LAB 2007-2009* | Spring 2008 Forecast 2009- 2011* |
|---|-------------------------------|---------------------------|---|
| OHP Plus | | | |
| TANF-Related Medical | 91,805 | 88,728 | 95,495 |
| TANF-Extended | 35,723 | 25,890 | 28,109 |
| TANF Medical – subtotal | 127,529 | 114,618 | 123,604 |
| | | | |
| Poverty Level Medical - Women | | | |
| Poverty Level Medical - Children | 10,216 | 10,825 | 11,380 |
| Aid to the Blind & Disabled | 82,258 | 84,680 | 86,352 |
| Old Age Assistance | 61,460 | 65,362 | 70,735 |
| Foster/Substitute Care | 30,235 | 30,546 | 31,555 |
| | 17,717 | 17,361 | 17,556 |
| Children's Health Insurance Program (Title XXI) | 32,414 | 41,801 | 45,484 |
| OHP Plus – subtotal | 361,828 | 365,193 | 386,668 |
| | | | |
| OHP Standard | | | |
| Families | 7,327 | 9,743 | 8,099 |
| Adults/couples | 14,838 | 15,998 | 13,027 |
| OHP Standard – subtotal | 22,164 | 25,741 | 21,126 |
| | | | |
| Other Medical Assistance Programs | | | |
| Citizen-Alien Waived Emergency Medical | 18,522 | 17,501 | 18,633 |
| Qualified Medicare Beneficiary (no long-term care) | 11,358 | 13,026 | 14,945 |
| Breast & Cervical Cancer program | 304 | 372 | 512 |
| Other – subtotal | 30,183 | 30,899 | 34,091 |

| | | | |
|---|----------------|----------------|----------------|
| <u>Total Medical Assistance Programs</u> | | | |
| <u>w/o SLMB</u> | 414,176 | 421,833 | 441,885 |
| Specified Low-Income Medicare Beneficiaries ** (SLMB) | 9,897 | 12,316 | 14,190 |
| <u>Total Medical Assistance Programs</u> | | | |
| <u>w/SLMB</u> | 424,073 | 434,149 | 456,075 |
| State Funds only Former Medically Needy/Transplant patients | 44 | 26 | 9 |

* Based on Spring 2008 forecast, which includes actual counts and forecasted numbers for 2007-2009 biennium. Does NOT include additional caseload estimates from any Agency Policy Option Packages

**Numbers from SPD. SMB and SMF P2s (medical premiums only) through July 2008

Forecast by OFRA based on average rate of increase over last year

Services

DMAP administers coverage for three main categories of medical assistance programs:

- OHP Medicaid,
- OHP Children’s Health Insurance Program (CHIP), and
- Non-OHP Medicaid.

DMAP assists more than 700,000 Oregonians⁹ annually to become healthier, more self-sufficient and safer by:

- Improving access to needed, effective medical services for low-income and vulnerable citizens through innovation, collaboration and shared responsibility with health care providers throughout Oregon;
- Providing a system of comprehensive health coverage to qualifying Oregonians and their families to improve their health status and promote their ability to be more productive members of society; and
- Enhancing the health of all Oregonians by contributing to the strength of the entire Oregon medical care delivery system and decreasing cost-shifting to private-sector medical premiums.

Services provided

The physical health, mental health, chemical dependency and dental services covered by OHP are based on the Health Services Commission’s (HSC) Prioritized List of Health Services. The list is arranged to keep conditions and treatments that have the best potential for good health outcomes toward the top. Covered services are referred to as being above the “line” of coverage and include:

- Prescriptions,
- Physician services,
- Check-ups (medical and dental),
- Diagnostic services for all conditions,
- Family planning services,

⁹ Number of unduplicated clients for 2007

- Maternity, prenatal and newborn care,
- Hospital services,
- Comfort care and hospice,
- Dental services,
- Alcohol and drug treatment,
- Mental health services, and
- Vision services.

Treatments and conditions that are not covered include:

- Treatment for conditions that get better on their own,
- Treatment for conditions that have no useful treatment,
- Treatments that are not generally effective,
- Cosmetic surgery,
- Gender changes, and
- Infertility services.

The Centers for Medicare and Medicaid Services (CMS) approves all changes to the list. When needed, the “line” is adjusted based on budget and other factors.

DMAP provides coverage to clients based on the following benefit packages:

- OHP Plus,
- OHP Plus with Limited Drug,
- OHP Standard,
- Qualified Medicare Beneficiary (QMB),
- Specified Low-Income Medicare Beneficiary (SLMB), and
- CAWEM.

Each benefit package covers a different set of services:

- OHP Plus covers services above the line on the prioritized list.
- OHP Plus with Limited Drug covers the same services as OHP Plus, with the exception of prescription drugs covered by Medicare Part D.

- OHP Standard covers the services above the line on the prioritized list, with some exceptions (see the OHP Coverage by Benefit Package chart on the next page).
- Medicare premiums, copays, coinsurance and/or deductibles are paid for clients with QMB coverage.
- Medicare premiums are paid for clients with SLMB coverage.
- Only labor and delivery services for pregnant women and emergency medical services are covered under CAWEM.

OHP Coverage by Benefit Package

| Covered Services | OHP Standard | OHP Plus | OHP with Limited Drug |
|--|----------------------|----------|-----------------------|
| Acupuncture | Limited ¹ | X | X |
| Chemical dependency services | X | X | X |
| Dental | Limited ² | X | X |
| Emergency/urgent hospital services | X | X | X |
| Hearing aids and hearing aid exams | | X | X |
| Home health | | X | X |
| Hospice care | X | X | X |
| Hospital care | Limited ³ | X | X |
| Immunizations | X | X | X |
| Labor and delivery | X | X | X |
| Laboratory and X-ray | X | X | X |
| Medical equipment and supplies (DME) | Limited ⁴ | X | X |
| Medical transportation | Limited ⁵ | X | X |
| Mental health services | X | X | X |
| Occupational, Physical, Speech therapy | | X | X |
| Physician services | X | X | X |
| Prescription drugs | X | X | Limited ⁶ |
| Private duty nursing | | X | X |
| Vision care | Limited ⁷ | X | X |

¹ Limited to chemical dependency related treatment

² Limited to emergency treatment

³ Limited to medically appropriate diagnostic services and treatment for urgent/emergent conditions

⁴ Limited to diabetic supplies, respiratory equipment, oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies

⁵ Emergency ambulance only

⁶ Limited to OHP covered drugs not covered by Medicare

⁷ Eye disease treatment only

Other Benefit Packages

- **Citizen-Alien/Waived Emergency Medical (CAWEM)** covers only emergency services or labor and delivery.
- **Qualified Medicare Beneficiary (QMB)** Medicaid pays for Medicare Part B premiums, applicable coinsurance (except on drugs) and/or deductibles not paid by Medicare.
- **Specified Low-Income Medicare Beneficiary (SLMB)** Medicaid pays for Medicare Part B premiums.

NOTE: Some clients may have more than one benefit package (e.g., A client may have OHP with Limited Drug benefits and coverage for Medicaid-paid Medicare Part B premiums and cost sharing.)

How services are delivered

Physical health FFS

Fee-for-Service (FFS) is the method of paying providers a fee for the health care services they provide. Approximately 61 percent¹⁰ of FFS providers bill electronically, accounting for approximately 74 percent¹¹ of all FFS claims. DHS uses a pharmacy billing and information system that allows pharmacists to review a prescription for potential drug interactions at the time of dispensing and, at the same time, bill electronically and receive confirmation of payment for the claim. More than 99 percent of pharmacies use this point-of-sale billing system.

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

Physical medicine managed health care

DHS currently uses three managed-care delivery systems for physical health care:

- Fully Capitated Health Plans (FCHPs),
- Physician Care Organizations (PCOs), and

¹⁰ Average for 2007

¹¹ Average for 2007

- Primary Care Managers (PCMs).

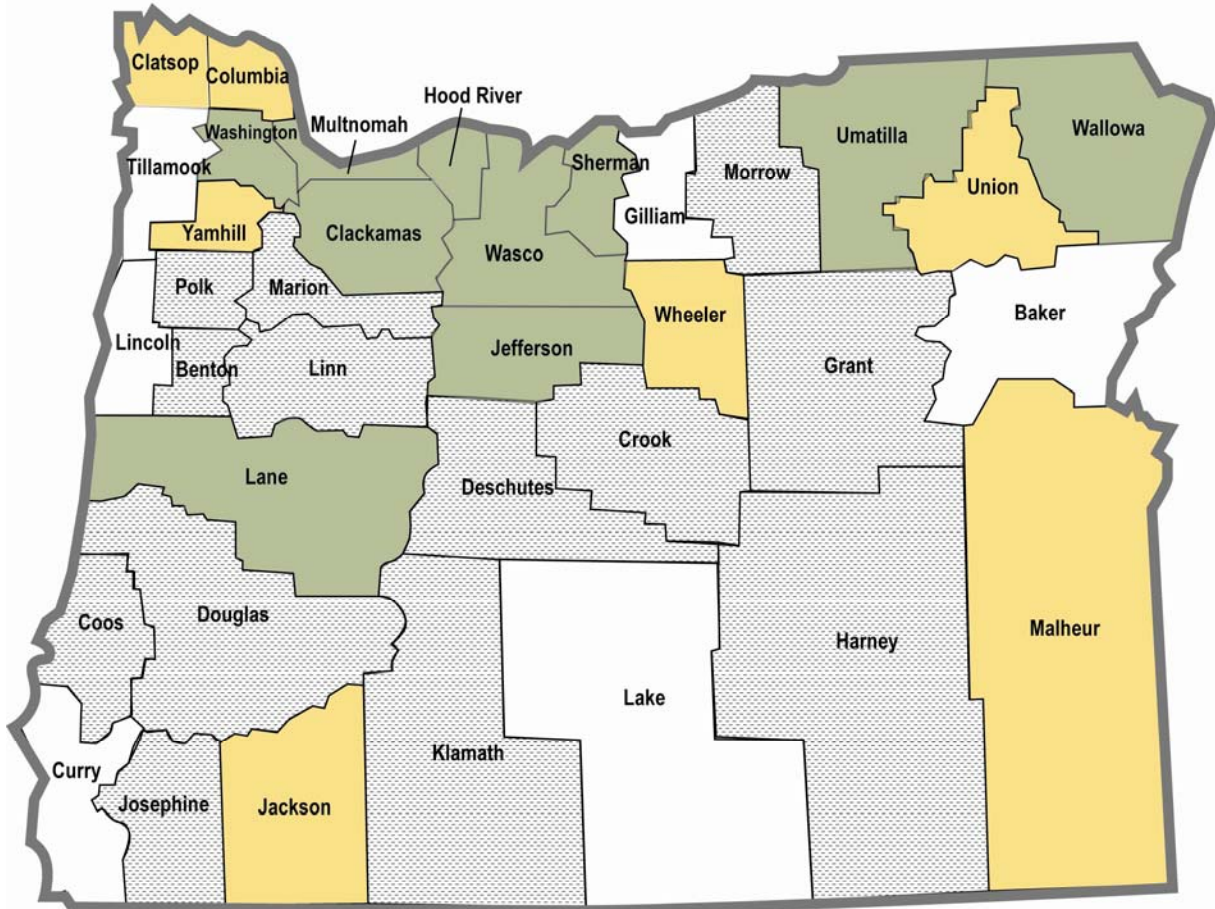
FCHPs and PCOs coordinate the health care needs of their members. OHP clients enrolled with an FCHP or PCO have guaranteed access to health care 24 hours a day, 7 days a week.

Currently 15 FCHPs and PCOs provide physical medicine services and about 1,200 providers serve as PCMs. One chemical dependency organization operates in Deschutes County. Clients outside of Deschutes County receive chemical dependency services from their physical medicine FCHP/PCO or on an FFS basis. Average enrollment percentages¹² for 2007 were:

- 74.9 percent in FCHPs and PCOs, and
- 2.3 percent with PCMs.

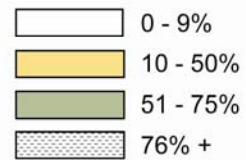
¹² These percentages do not include clients who are receiving benefits from one or more of these programs: Breast and Cervical Cancer Program, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Citizen-Alien/Waived Emergency Medical benefits.

**Percentage of OHP clients enrolled
in an FCHP or PCO - 2007**



Source: DMAP DSSURS database tables:
MEMBERMONTHS

Legend

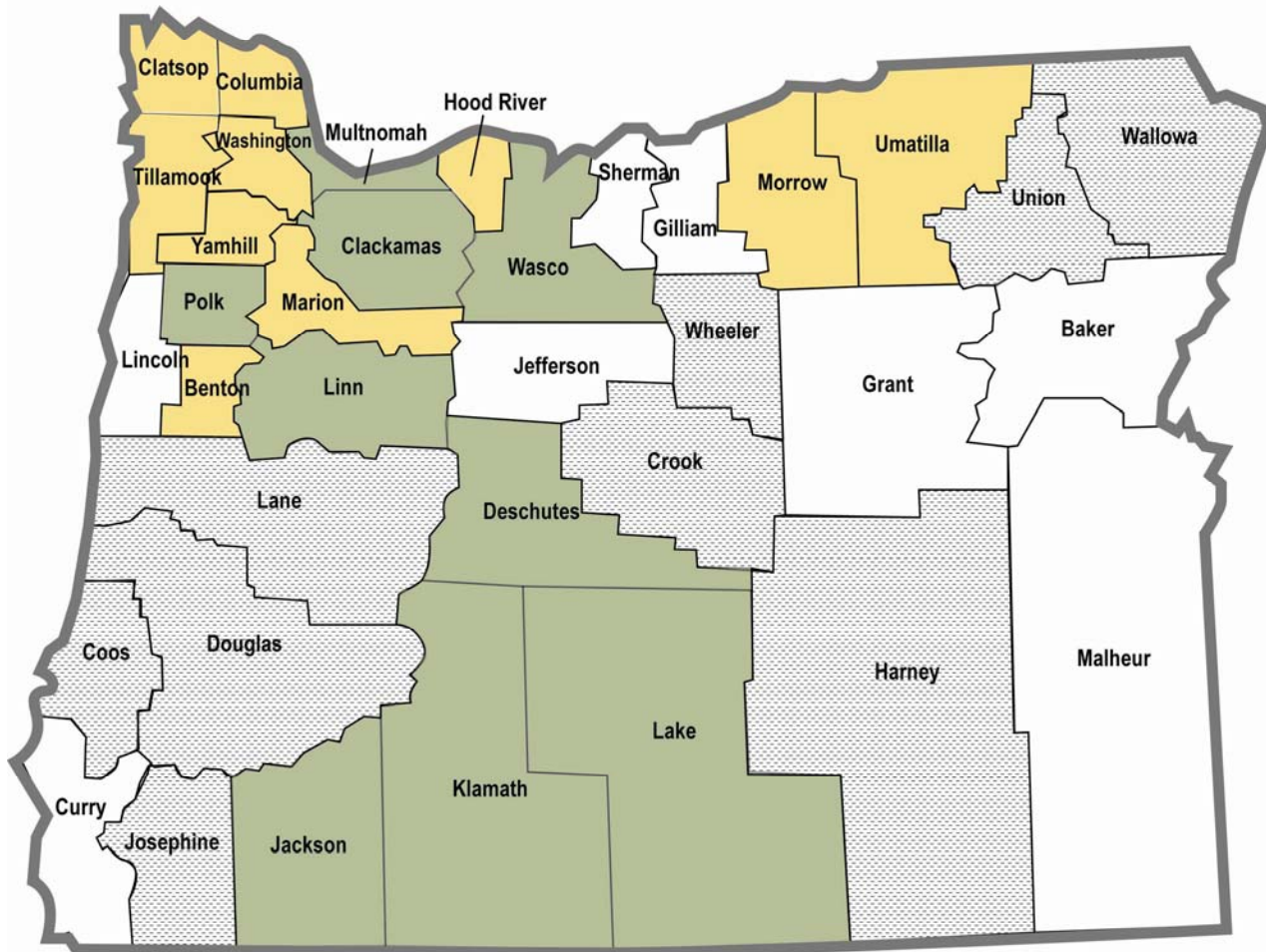


Dental services

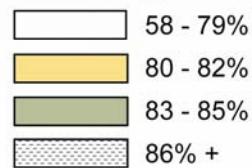
DMAP currently contracts with seven dental care organizations (DCOs) to provide dental care. DCOs coordinate the dental care needs of their members. More than 90 percent¹³ of all clients statewide are enrolled in a DCO.

¹³ Average enrollment for 2007. These percentages do not include clients who are receiving benefits from one or more of these programs: Breast and Cervical Cancer Program, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Citizen-Alien/Waived Emergency Medical benefits.

Percentage of OHP clients enrolled in a DCO - 2007



Legend



Source: DMAP DSSURS database tables:
MEMBERMONTHS

Mental health services

Most OHP clients, more than 90 percent¹⁴, receive their mental health care through mental health organizations (MHOs). Nine MHOs provide mental health services. MHOs coordinate and provide mental health care services for their clients. OHP clients who are not enrolled in an MHO receive mental health services on an FFS basis through community mental health programs.

Costs for mental health services are included in DMAP's budget. However, the DHS Addictions and Mental Health Division (AMH) is responsible for:

- Negotiating, administering and monitoring mental health managed care contracts
- Coordinating with DMAP to develop administrative rules for OHP

¹⁴ Average enrollment for 2007. These percentages do not include clients who are receiving benefits from one or more of these programs: Breast and Cervical Cancer Program, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Citizen-Alien/Waived Emergency Medical benefits.

Why these services are significant to Oregonians

OHP has had a significant impact on all Oregonians. OHP:

- Has covered health services for more than 1.875 million people since it began in 1994 (nearly one in three Oregonians have been on OHP at some point in their lives);
- Covered nearly 44 percent of Oregon's births in 2007; and
- Provides health care coverage for 12 percent of all Oregonians and 25 percent of Oregon children

In July 2008, DMAP reached its 2007-2008 goal of 80 percent enrollment in physical medicine managed care. Counting PCM enrollment, DMAP actually met this goal in April 2008.

More than 90 percent¹⁵ of OHP clients are enrolled in dental and in mental health managed care. Managed care enrollment increases access to a medical home, providing better access to needed health services, coordinated care and a delivery system focused on quality improvement.

Health care coverage increases opportunities for prevention and early diagnosis. It also reduces the risk of untreated chronic disease and severe medical conditions. Lack of early treatment leads to more costly care as conditions worsen.

Reducing the number of uninsured Oregonians lessens the amount of uncompensated charity care. Costs for uncompensated care are ultimately cost-shifted to premiums paid for by insured patients and their employers.

Insuring children increases their access to a medical home, enabling them to visit doctors and dentists regularly and reducing costly emergency department visits. This also may influence parents' health care decisions. Good physical, mental and dental health positively influences school success. 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.

¹⁵ Average enrollment for 2007.

How performance is measured and level of performance

DMAP conducts the following surveys

- **Customer satisfaction** – The Consumer Assessment of Health Plans and Systems (CAHPS) is a survey of children and adults enrolled in Fully Capitated Health Plans in which they rate their satisfaction with their plan. A comparison of 2004 and 2007 survey results by plan for both children and adults showed an increase in satisfaction with the care they received. One-third of the plans providing services to children showed improvements in consumer satisfaction. Two-thirds of the managed care organizations demonstrated significantly higher satisfaction scores among the adult population.
- **Provider participation** – In collaboration, the Office for Oregon Health Policy and Research, the Oregon Medical Association, and DMAP conduct the Provider Workforce survey. All active licensed physicians, (MDs, DOs, and PAs) in Oregon are surveyed about their practice, acceptance of Medicaid, and future practice plans. The most recent survey indicated that there is an increasing number of providers whose practices are completely closed to both Medicare and Medicaid, (17 percent and 21 percent respectively). While reimbursement is the largest reason for closing practices to new patients, 72 percent still report providing charity care. The survey raised specialty and geographic access as concerns that influenced the decision not to participate as Medicare/Medicaid providers. For example, 21 percent of the providers reported they are never able to obtain outpatient chemical dependency services and 21 percent indicated they are never able to obtain inpatient mental health services for Medicaid clients. Geographic concerns are epitomized by Oregon's northwest region where more than 33 percent of the providers indicated plans to retire within the next five years.

Early periodic screening, diagnosis and treatment (EPSDT) Program

The EPSDT Program is the child health component of Medicaid. It is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. EPSDT is designed to address physical, mental and developmental health needs. Screening services “to detect physical and mental conditions” must be covered at periodic intervals, as well as diagnostic and treatment coverage. Federal law – including statutes, regulations and guidelines – requires that Medicaid cover a comprehensive set of benefits and services for children, different from adult benefits. The OHP, using its unique Prioritized List of Health Services, covers all early periodic screening, diagnoses and most treatments recommended by the EPSDT program.

Elements of EPSDT:

| | |
|-----------|---|
| Early | Identifying problems early, starting at birth |
| Periodic | Checking children's health at periodic, age-appropriate intervals |
| Screening | Doing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems |
| Diagnosis | Performing diagnostic tests to follow up when a risk is identified, and |
| Treatment | Treating the problems found. |

| EPSDT Screening Ratio Birth through 20 years old Western states and US total | |
|---|-------------|
| Oregon | 0.87 |
| Washington | 0.72 |
| Idaho | 0.60 |
| California | 0.65 |
| Nevada | 0.78 |
| Alaska | 0.70 |
| US Total | 0.76 |
| 2006-2007 Federal Fiscal Year | |

This ratio measures the rate at which a state's Medicaid/CHIP children receive health screening services required by their state's periodicity schedule, adjusted by the proportion of the year they are enrolled.

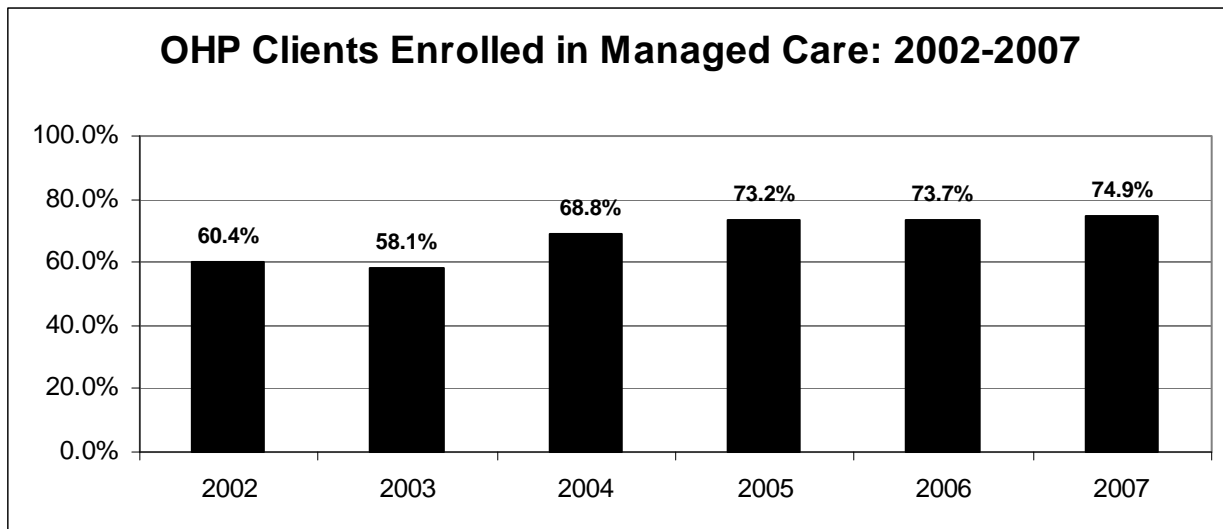
The table shows that Oregon has the highest, and more favorable screening ratio of Western states and is higher than the U.S. average.

Quality and efficiency improvements

Managed Care Enhancements

In July 2008, DMAP reached its 2007-2008 goal of 80 percent enrollment in physical medicine managed care. Counting PCM enrollment, DMAP actually met this goal in April 2008¹⁶. DMAP is actively working to continue to increase the percentage of clients enrolled.

The figure below is an average annual count of FCHP/PCO enrollment.



The decrease in 2003 is due to many plans dropping OHP Standard clients because of the difficulty managing the health of these clients when their benefits were reduced. When OHP Standard benefits changed again in August 2004, all plans except one resumed service to this population, and that plan resumed OHP Standard coverage in January 2007.

Clients benefit from enrollment in managed care in several ways, including:

- Guaranteed access to appropriate health care 24 hours per day, 7 days per week
- A "medical home" with an assigned Primary Care Provider (PCP) or with a PCM, who provides or coordinates medical services and treatments and assists

¹⁶ These percentages do not include clients who are receiving benefits from one or more of these programs: Breast and Cervical Cancer Program, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Citizen-Alien/Waived Emergency Medical benefits.

with any necessary referrals to specialists. In dental care organizations (DCOs), this is referred to as a "dental home."

- A focused approach to raising awareness of preventive services, including well-child checks and immunizations, as well as preventive adult exams and immunizations such as paps, mammograms, and flu and pneumonia immunizations are covered under the OHP benefit package. This focus promotes optimal health for clients by prevention and/or early diagnosis and intervention of many diseases.
- Exceptional Needs Care Coordinator (ENCC) is a specialized case manager who is employed by an OHP medical plan for their clients who are Aged, Blind, Disabled or have special health care needs. ENCCs help coordinate health care services for members, such as assisting with obtaining special medical supplies or equipment.

DMAP uses many strategies to foster enrollment in managed care:

- Ensure clients who move are automatically re-enrolled in the plan they were in, if it's available in the new area.
- Auto-enroll clients into MCOs weekly unless they have already selected a plan or are exempt.. This allows newly eligible individuals to be enrolled into managed care more quickly.
- Reinforce the importance of managed care enrollment with field staff at every opportunity and at the monthly field managers meetings.
- Auto-enroll former clients into their previous MCO after a break in enrollment.
- Since dual Medicare/Medicaid-eligible clients are not auto-enrolled because of federal regulations, DMAP and SPD continue working on improved client choice counseling to encourage enrollment when their clients meet managed care enrollment criteria.
- DMAP has issued a Request for Applications for Yamhill, Clatsop and Columbia counties. This will increase the amount of managed care in this area. Additionally, managed care was successfully rolled out in Jackson County in 2008.

Physician Access Improvement Plan

The Physician Access Improvement Plan is a demonstration project that will occur between May 1, 2008, and April 30, 2009. The goal of the demonstration is for contracting FCHPs to increase client access to preventive care services, specifically lines 3 and 4 on the Prioritized List adopted by the Health Services Commission (HSC).

Participating plans submitted Access Improvement Plans to DMAP that showed how they propose to engage in specific activities, strategies and interventions designed to improve access to the target services. Upon DMAP approval, plans began receiving a prospective incentive payment of \$5.00 per member per month for the duration of the 12-month demonstration project. DMAP developed a baseline and performance target goals for each participating plan. During the demonstration project, DMAP will review and evaluate the contractors' performance, if a contracting plan fails to meet the target goal, the contractor will be required to refund full or partial incentive funds based on the targeted performance achievement by the contractor. Currently, all FCHPs are participating in the Physician Access Improvement Plan.

OHP Standard opened to limited new enrollment

OHP Standard was closed to new enrollment in mid-2004 when General Fund support was withdrawn. Since that time, the program has relied primarily on provider taxes as its state revenue source. This funding source is limited and has necessitated limiting enrollment to a biennial average of 24,000 clients. Through attrition, OHP Standard enrollment dropped to fewer than 19,000, making it possible to open the program to new enrollment to achieve the biennial average of 24,000.

Because the number of individuals who would qualify for OHP Standard is significantly greater than the funding available, the department worked with a group of stakeholders to establish an enrollment system that would provide everyone an equal opportunity to apply for one of the limited new places in the program. Key elements of the new enrollment process were:

- A vigorous statewide outreach and marketing campaign that ensured as many Oregonians as possible were aware of the health care coverage opportunity. *As a result of these efforts, more than 91,000 people placed their names on the list.*

- From January 28 through February 29, 2008, Oregonians who thought they, or someone they knew, might be eligible for OHP Standard put their names on the OHP Standard reservation list. Confirmation postcards were mailed weekly to people whose names were placed on the reservation list.
- Beginning in March, the department began drawing names from the reservation list and sending OHP Standard applications to those individuals whose names were drawn. The department uses a recognized random-selection technique to draw the names.
- From March through July 2008, 3,000 names were drawn monthly. Based on the number of applicants who have been found eligible from previous months' drawings, this number was increased to 6,000 for the August drawing. At this time, the department plans to draw names and mail applications to 6,000 people in September and a final round of 3,000 in October.

Quality Institute for Oregon

The Healthy Oregon Act required the development of a Quality Institute for Oregon. The Institute will be established as a publicly chartered public-private organization and will lead Oregon toward a higher performing health care delivery system. To achieve its goals the Quality Institute will first pursue the following priorities:

- Set and prioritize goals for Oregon in the areas of quality improvement and transparency. Measure and report progress. Regularly update the goals and encourage continuous improvement.
- Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Develop nationally accepted metrics.
- Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization and patient outcomes.
- Ensure the collection and timely dissemination of meaningful and accurate data about providers, health plans and patient experience.
- Advise the Governor and Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency.

Health Record Bank of Oregon – a new approach to patient safety

DMAP has received a \$5.5 million federal grant to create a secure online database of health records. The Health Record Bank will provide medical information access to the department, Medicaid patients, health care providers and other partners. Once operational, the Health Record Bank will:

- Improve quality of care by providing otherwise unavailable information about previous tests, lab results, diagnoses and health system visits; this will allow for better-informed clinical work-ups and facilitating care coordination.
- Reduce costs by decreasing duplication of tests, procedures, office and emergency room visits, and hospitalizations.
- Enhance patient engagement by providing more easily accessible information, together with decision support tools, and instructions that will likely result in better partnership and participation.

Leading OHP clients to appropriate care

Since October 2002, DMAP has contracted with a health care services company to provide a Disease Management Program (DM) and Nurse Triage/Advice telephone service to FFS clients with specific chronic conditions. The contract is ending and DMAP will use the renewal opportunity to move the program to one that:

- Provides comprehensive, holistic focused client interventions rather than the current focus on five defined conditions.
- Moves program eligibility and participation selection criteria from the traditional five specific diseases to a predictive modeling methodology that targets clients who, through the predictive modeling process are determined to be at risk for high health care cost and resource utilization.
- Continues to provide a 24-hour, 7-day a week Nurse Triage/Advice telephone service to all FFS clients.

In addition, DMAP will award one contract to implement a Local DM Program Pilot Project. The purpose of the project is to determine if a community-based DM program would offer advantages and flexibility to the client and DMAP and contribute to improved clinical outcomes.

Medicaid Management Information System (MMIS)

MMIS is an important electronic tool in managing OHP. Data submitted by MCOs and FFS providers are used to:

- Pay claims,
- Set future reimbursement rates,
- Meet federal reporting requirements,
- Provide information to state policy makers, and
- Measure program performance and quality.

The system tracks medical eligibility for more than 700,000 Oregonians annually. MMIS also processes approximately 2.5 million¹⁷ claims each month from health care providers, although it was originally designed to handle only 260,000 per month.

As advances in information technology have continued and program complexities increased, the replacement of Oregon's outdated system (now more than 25 years old) has become critical. The MMIS replacement, approved by the Oregon Legislative Assembly, is scheduled for implementation in 2008. Design and development has been federally funded at approximately 90 percent. Maintenance and operation of the system will be 75 percent federally funded under current Centers for Medicare and Medicaid Services (CMS) regulations.

The new MMIS will provide many technological improvements to support provider needs, among them a secure, self-service Web portal that allows providers to do the following online:

- Submit, update and view claims in real-time,
- Check real-time client eligibility and enrollment information,
- Apply to become a Medicaid provider, and
- Request and track prior authorizations.

¹⁷ 2007 monthly average.

A major benefit of the MMIS Web-based service will be to enable Medicaid providers to receive more responsive payment processing. Another benefit of the new MMIS will be better data and reporting, enabling improved financial decision-making about OHP policies.

DHS is currently coordinating more than 40 provider trainings in 34 cities in and around the state and creating resources, including an online training course for providers, who are unable to attend a training. Most DHS staff will receive a fundamentals training; many staff will receive other targeted trainings based on their needs and system use.

Pharmacy program efficiencies

Pharmacy incentive program

The 2007-2009 Legislatively Adopted Budget created incentives for clients and pharmacies to use drugs included on DMAP's Practitioner-Managed Prescription Drug Plan Drug List (PDL). PDL drugs are evaluated for clinical quality first and then selected based on high quality at the best available price. Thus, the increased use of PDL drugs maintains or improves health outcomes while reducing the cost of drugs.

Client copay requirements were removed for preferred drugs on DMAP's PDL in March 2008. Clients often are unable to pay copays and put in a situation of going without medication or asking pharmacies to waive the copay. Copays are also removed from the pharmacy reimbursement so, if not collected from the patient, it is absorbed by the pharmacy. Thus, eliminating copays on preferred drugs provides an incentive to both clients and pharmacies to use the preferred drugs.

When medically appropriate, prescription fill quantities were extended to 90 days, rather than 34 days, for generic PDL drugs starting March 2008. This provides an additional convenience for clients, cuts workload volumes for pharmacies and eliminates two dispensing fees for DMAP. Again, this provides additional incentive for pharmacies and clients to use PDL drugs.

It is still too early to evaluate the effect of these incentives at moving market share to preferred products. However, DMAP is in the preliminary stages of preparing an RFP for supplemental rebates from drug manufacturers as a result of implementing these incentives.

Pharmacy management program

The 2007-2009 Legislatively Adopted Budget eliminated the mandatory lock-in requirement. Previously more than 50,000 fee-for-service clients were required to use a single independent pharmacy or a particular chain of pharmacies. This mandate was administratively burdensome because clients could ask to change pharmacies within 30 days of the lock-in or for emergent needs (e.g., pharmacy did not carry a needed drug, clients experienced an emergency while out of town).

Beginning in January 2008, DMAP streamlined the workload and focused the Pharmacy Management Program on clients who are most likely to benefit from a pharmacy lock-in. DMAP now monitors clients' drug utilization on a case-by-case basis using criteria reviewed by the Drug Use Review Board.

Prior Authorization on prescriptions for below-the-line conditions

The 2007-2009 Legislatively Adopted Budget expanded the number of drugs that require prior authorization to ensure that the medications are prescribed for covered conditions. Drugs used predominantly for insomnia (not covered by OHP) were subject to prior authorization beginning October 1, 2007. Similarly, drugs used predominantly for fibromyalgia (not covered by OHP) were subject to prior authorization beginning April 1, 2008.

Currently, DMAP may require prior authorization for selected drugs or categories of drugs in the following general situations:

- ◆ To ensure that the drugs are indicated for funded medical conditions.
- ◆ To ensure medically appropriate use or to address potential client safety risk associated with the particular drug or drug category, as recommended by the Drug Use Review Board and adopted by DMAP.

Pharmacy reimbursement adjustment

The 2007-2009 Legislatively Adopted Budget included a budget adjustment for the Deficit Reduction Act mandate to use the Average Manufacturer Price (AMP) to calculate and pay Federal Upper Limit for multi-source drugs. DMAP expected to save \$1 million in General Funds in the 07-09 biennium as a result of this change. However, the use of AMP as the basis for pharmacy reimbursement was challenged in federal court and an injunction in January 2008 prevented the publication and use of AMP.