

2011 Presentation

Joint Legislative Committee on Ways and Means

Reference Document

HEALTH CARE PROGRAMS

Medical Assistance Programs (MAP)

Public Employees' Benefit Board (PEBB)

Oregon Educators Benefit Board (OEBB)

Office of Private Health Partnerships (OPHP)

LETTER FROM HEALTH CARE PROGRAMS

Contributions to the OHA mission

The OHA division of Health Care Programs uses purchasing power to change how we deliver and pay for care. By consolidating most health care programs in the state, we're able to align public purchasing and reduce administrative costs, changing how we pay for care, establishing value-based benefits, and setting budget goals.

Health care is expensive and becoming more expensive by the day. Health care costs account for an estimated 16 percent of the state's General Fund budget, which currently is threatened by a \$3.5 billion shortfall. Everyone is feeling the squeeze: businesses struggle to provide their employees with health insurance and increasingly require employees to pay a greater share of the bill; public insurance rolls expand as deficits strain Oregon's budgets; individuals put off necessary care until health problems become emergencies. Left unchecked, this trend will undermine our best efforts to improve Oregonians' health. We're acting now to bend the cost curve. Using our purchasing power is one of the key steps in containing costs.

Using purchasing power to change how we deliver and pay for care will increase the value of health care while reducing costs. Through the Health Care Programs division, OHA purchases health insurance coverage for nearly one in four Oregonians, approximately 850,000 people. We can streamline costs by developing consistent policies across the patchwork of existing health care programs.

Beginning this year, with full implementation by 2013, OHA will be aligning provider payment with Medicare payment methodology (not rates) across all of the OHA health care programs. This includes Medicaid fee-for-service and managed care, Public Employees Benefit Board and Oregon Educators Benefit Board.

In 2012 and 2013, OHA will work with providers, purchasers and other stakeholders to target key cost, quality, and efficiency concerns. The agency will do this by introducing innovative payment methods that reward efficiency and outcomes like bundled payments and pay for performance. These changes will take place first within OHA health care programs and then throughout other health care programs.

The Health Care Programs division can take decisive actions to bring down health care costs. By using purchasing power to drive value, Health Care Programs can help bring medical costs in line with what is affordable to the state, businesses and consumers. Moving to patient-centered primary care will improve care coordination

and appropriate access to preventive services. These care improvements can reduce duplicative tests and services and prevent costly hospitalizations through better disease management. Current patient centered primary care home proposals target specific subsets of the population.

Programs and services within OHA Health Care Programs include the Medical Assistance Programs (OHP), Healthy Kids, Office of Private Health Partnerships, Public Employees Benefit Board, Oregon Educators Benefit Board, and Pharmacy Services.

As we move to meet the OHA triple aim — improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians and lowering or containing the cost of care so it is affordable to everyone — the programs and services within the agency's division of Health Care Programs will use their purchasing power to support innovative and efficient solutions to the system problems that currently drive costs.

**Medical Assistance Programs
(MAP)**

MEDICAL ASSISTANCE PROGRAMS (MAP)

Mission

Provide a system of comprehensive health services to qualifying low-income Oregonians and their families to improve their health status and promote independence.

Vision

Improved access to effective, high-quality services for low-income and vulnerable citizens through innovation, collaboration, integration and shared responsibility.

Goals

Specific goals of the division of Medical Assistance Programs (MAP) are to:

- Support effective and efficient systems that directly promote access to health care for low-income Oregonians.
- Support the entire health care provider system in Oregon by paying for needed services using federal matching funds to the extent appropriate.
- Maintain managed care enrollment at no less than 80 percent to promote access and to control health care costs.
- Decrease the number of people without health care coverage by expanding the percentage of people covered by the Oregon Health Plan.
- Improve the quality of health care for all Oregonians, especially for low-income Oregonians.
- Collaborate with legislators, advocacy groups, business partners, health care providers and the general public to improve health outcomes.
- Promote the use of prevention and chronic disease management services by all Oregonians, especially those with low incomes and special medical needs.
- Work with other insurers to improve health outcomes for all Oregonians.

Overview

The division of Medical Assistance Programs is the state Medicaid agency. It delivers affordable and effective prevention and treatment, reducing uncompensated care, and keeping costs in check through effective management.

Health care is delivered through Medicaid managed care organizations and private providers such as physicians; hospitals; dentists; pharmacists; federally qualified health centers; rural health clinics; medical equipment and supply providers; physical, occupational and speech therapists; hospice providers; ambulance

companies; non-emergency medical transportation providers; and addictions and mental health service providers.

The budget for this division funds Oregon's medical assistance program. Payments for services delivered to medical assistance clients represent most of DMAP's budget. The program is divided into three areas to align with federal requirements and match rates unique to each area.

Oregon Health Plan (OHP) Medicaid

OHP Medicaid serves clients eligible for traditional Medicaid, as well as other low-income adults who do not qualify for traditional Medicaid, but are eligible for Medicaid services through Oregon's Medicaid demonstration.

Children's Health Insurance Program (CHIP)

CHIP is a program for children and adolescents through age 18 living in households where the income is up to 200 percent of the federal poverty level. CHIP covers approximately 61,000¹ children, accounting for more than 10 percent of OHP enrollees.

Non-OHP Medicaid

This part of the budget covers services for populations not part of OHP. For example, payments cover certain services for women diagnosed with breast or cervical cancer and limited drug coverage for individuals receiving post-transplant services when the state's DHS Medically Needy program ended Jan. 31, 2003.

Revenue sources

The state and the federal government share the costs of providing OHP services to eligible low-income people.

- For clients eligible for Medicaid, the state pays 37.26 percent and the federal government pays 62.74 percent².
- For clients eligible for the Children's Health Insurance Program (CHIP), the state pays 26.08 percent and the federal government pays 73.92 percent³.

¹ Source: DHS DSSURS, November 15, 2010. DMAP Research and Analysis.

² The federal government sets this rate, and it fluctuates from year to year.

³ Ibid

The following table summarizes MAP’s revenue sources (in rounded millions). Numbers for this section are based on the 2011-13 Governor’s Balanced Budget.

Source	Amount (in rounded millions)	Description
General Fund	\$996	–
Other Fund	\$1,030	Other Funds include the Hospital Tax, Insurers Tax, Medicaid drug rebates, supplemental drug rebates, Law Enforcement Medical Assistance Fund (LEMLA), Tobacco Settlement funds, Third Party Recovery, local match payments
Federal Fund	\$3,131	Federal share of paying Medicaid/CHIP program costs
Total Fund	\$5,157	–

2009-11 accomplishments

More health care for more Oregonians

Children: Healthy Kids — health care was expanded to all Oregon children because MAP:

- Created an easier process for families – children don’t have to reapply every six months, asset tests have been eliminated for most families, and the time a child has to be uninsured before qualifying has been reduced from six to two months.
- Expanded access for CHIP and Medicaid eligible documented immigrant children.
- In concert with the Public Health division, secured a grant through the Children’s Health Insurance Program Reauthorization Act (CHIPRA). This outreach grant is to increase enrollment of children in Medicaid and CHIP.

Health care was expanded for adults and families because MAP:

- Opened the Oregon Health Plan (OHP) Standard Reservation List so low-income Oregonians have an opportunity to receive an application to enroll in the benefit package.
- Completed the procurement process to expand managed care enrollment into Curry, Lincoln and Tillamook counties beginning January 1, 2010 so that 80,000 Oregonians could access the health care they need.
- Opened the Citizen/Alien Waived Emergent Medical (CAWEM) prenatal program to four more counties. The pilot program in two counties provided prenatal care to women in the CAWEM program which ordinarily pays for emergency services and deliveries. Six counties now participate in the program to also provide prenatal care to women who otherwise don't have access to these services.

Cost controls for expensive pharmaceuticals

The enforceable Physical Health Preferred Drug List (PDL) analyzes the most effective prescription drugs at the best available price in each class. This will save several million dollars per biennium while still providing Oregon Health Plan clients with the most effective prescriptions. (Mental health drugs are not part of the enforceable PDL but are part of a voluntary PDL.)

Operations

The division:

- Put processes in place to ensure Oregon Medicaid collects enhanced federal funding under the American Recovery and Reinvestment Act.
- Demonstrated to the Centers for Medicare and Medicaid Service (CMS) that our increased coverage of Medicaid children and streamlining of enrollment and retention practices qualified Oregon for a \$1.6 million federal bonus under CHIPRA.
- Completed a physician access improvement incentive program, where every participating managed care plan increased utilization of preventive and primary care services for clients, positively contributing to the health of the population.

Access to care

DMAP achieved 80 percent enrollment in medical managed care and 95 percent for dental managed care, with medical managed care available in all but one county

statewide. Managed care enrollment provides access to high-quality and cost-effective care with an emphasis on prevention and the provision of primary care services, such as patient education and promotion of healthy lifestyles, to avoid more serious health complications and hospitalizations.

Quality of care

The Oregon Health Care Quality Corporation (Q-Corp) now provides data collection and quality-measure reports supporting DMAP efforts to monitor the quality of FFS healthcare beyond the contracted disease and medical case management services. A secure, interactive Web portal now helps doctors and nurses ensure that FFS patients receive high quality care in 11 scored categories, as well as provide support materials that encourage patients to take an active, informed role in their health care decision-making.

Partnerships

MAP also strengthened partnerships with stakeholders, tribal organizations, the provider community and contracted managed care plans in extensive outreach efforts to discuss options for budget reductions and legislative implementation, and to encourage use of the OHP Standard reservation list. Strengthened partnerships allow better delivery of health care services, promotion of prevention strategies and increased access to services.

Public Employees' Benefit Board (PEBB)



Activities and programs

The Public Employees' Benefit Board (PEBB) is currently included in the budget of the Oregon Department of Administrative Services (DAS) but is part of the Oregon Health Authority (OHA).

PEBB designs, purchases and administers the benefit program for benefit-eligible state employees. Its goal is to provide a high quality plan of health and other benefits for state employees at a cost affordable to both the employer and the employees.

The most valuable benefit in the program is health care coverage. The cost of health care continues to increase without evidence of a commensurate increase in measurable quality. This context frames the following PEBB vision statement and its elements.

Vision

PEBB seeks optimal health for its members through a system of care that is patient-centered, focused on wellness, coordinated, efficient, effective, accessible and affordable. The system emphasizes the relationship among patients and providers, their community and primary care. PEBB takes an integrated approach to health by treating the whole person.

Key elements of the PEBB vision are:

- An innovative delivery system that uses evidence-based medicine to maximize health and use dollars wisely;
- A focus on improving quality and outcomes, not just providing healthcare;
- Promotion of health and wellness through consumer education, healthy behaviors and informed choices;
- Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place;
- Accessible and understandable information about costs, outcomes and other health data for informed decision making; and
- Affordable benefits for the state and the employees.

PEBB serves its members and customers through six central functions.

- Program development collaborates with agencies, health plans and other benefit purchasers on programs to implement elements of the PEBB vision.
- Member services ensures that the benefit program meets all state and federal regulations.
- Benefit management system ensures the accuracy of benefit-related data shared among state payroll systems, health plans and other vendors.
- Contract services drafts and monitors contracts worth half a billion dollars annually.
- Communication services engages employees in the benefit program and the PEBB vision.
- Financial services accounts for PEBB funds, including the Revolving Fund and its subaccounts.

PEBB has planned short- and long-term actions to provide high-quality benefits that are affordable to the employee and the employer through implementation of the board's vision.

2011-17 six-year plans

- Provide high-quality benefits that are affordable to the employee and the employer.
- Provide excellent service to PEBB members, agencies and other customers.
- Enhance government services, and protect information and assets while controlling cost.
- Meet the information needs of PEBB members, agencies and other customers.
- Provide effective policies with clear direction.

2011-13 two-year plans

- Support employee and employer engagement in improving employee health through access to the right care at the right time and place.
- Offer plans that provide health care supported by the best available evidence.
- Promote a competitive marketplace by contracting with health systems that are accountable for their performance.
- Collaborate with partners to improve the market and delivery system.

PEBB has planned specific actions to provide excellent service and meet the information needs of members and customers, provide policies with clear direction, and enhance government infrastructure while controlling cost.

- Meet or exceed standards for response time.
- Survey customers annually; analyze and act on results.
- Maintain and improve the online benefits system.
- Develop and maintain comprehensive, user-friendly websites.
- Employ cost-effective, sustainable technologies to improve communication and reduce resource consumption.
- Continue to support agency efforts on employee health and wellness.
- Continue to seek agency input on benefit management and administration.
- Conduct audits to ensure that policies are applied equitably.
- Continue to solicit member and customer input on policies.
- Continue to support use of the benefit management system by state agencies.
- Improve contracting and analytical capabilities.
- Refine reporting of benefits information.

2009-11 accomplishments

Quality, affordable benefits

- PEBB continued to support the state's public health initiatives.
- PEBB continued to support agency worksite wellness activities and policies.
- PEBB achieved better controls through direct contracting for the majority of the medical, vision and dental plans.
- PEBB instituted additional performance measures for contracted plans and vendors.
- PEBB maintained its leadership role in health care purchasers' evaluation of commercial medical plans.

Services for members and customers

- PEBB met or exceeded response time expectations.
- PEBB continued to solicit input on services and plan designs from employees, agencies, plans and other customers.

Member and customer information needs

- PEBB used online media such as web-based seminars and streaming video to actively communicate with more employees about their benefits.
- PEBB continued to develop channels for employee and agency input.

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- PEBB incorporated employee and agency feedback on communication messages and media.

Policies and direction

- PEBB required all eligible employees to actively enroll in and declare eligibility for benefits for 2010 and 2011.
- PEBB continued to audit compliance with eligibility and enrollment rules.
- PEBB continued to clarify eligibility criteria and worked with agencies to correctly apply revised rules.

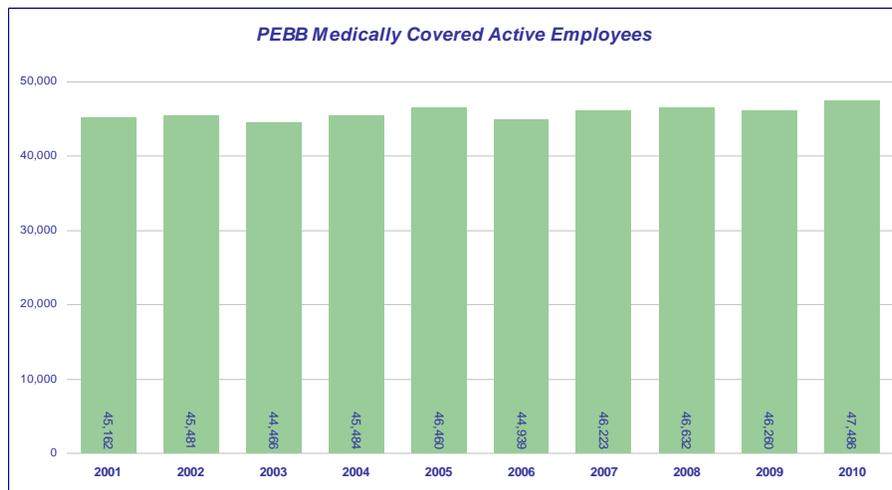
Efficient and effective infrastructure

- PEBB implemented an enhanced data system to analyze and report on utilization in the plans.
- PEBB made the benefit management system easier to use.

Trends

Census trend

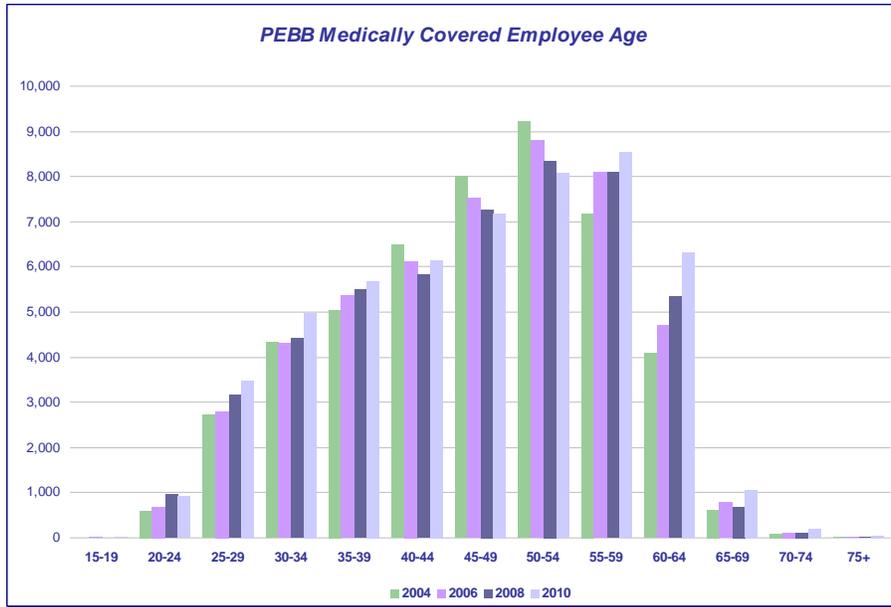
The following graph shows the number of employees enrolled in PEBB benefits per year.



Age trend

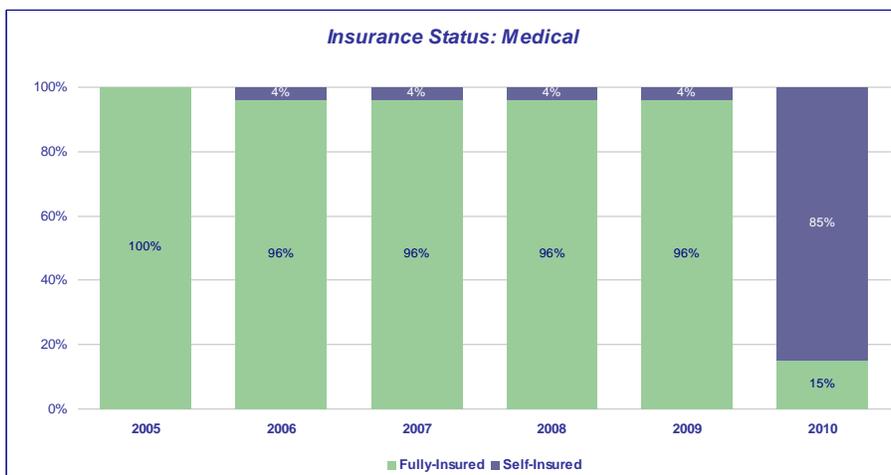
PEBB monitors age trends among its membership to ensure that its plans provide services that are appropriate for the population and to anticipate future needs. The following graph shows member age bands for 2004, 2006, 2008 and 2010.

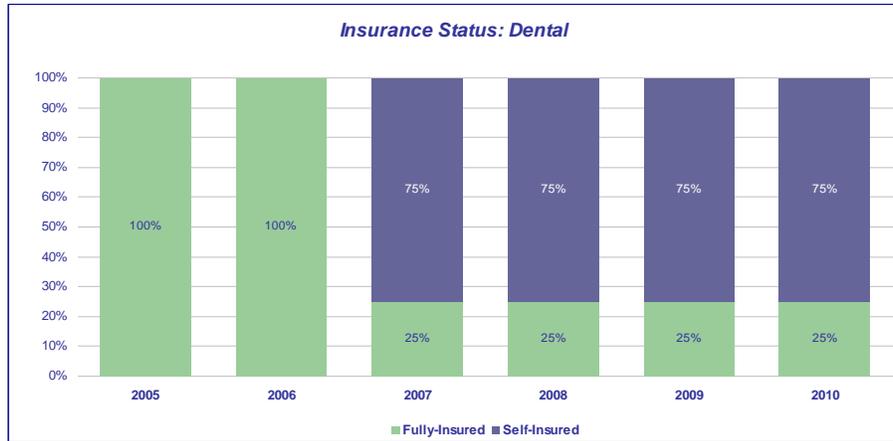
Currently, 43 percent of PEBB's active employee population is age 50 or older.



Self-insurance trend

PEBB began to self-insure plans in 2006, directly contracting for two regional medical plans administered by Samaritan Health System and Providence Health Plans. In 2007, PEBB began to self-insure the majority of its dental plans, which are administered by ODS. In 2010, PEBB began to self-insure its largest medical and vision plans, administered by Providence Health Plans and VSP respectively. In 2010, 85 percent of participants were enrolled in self-insured medical and vision plans, and 75 percent were enrolled in self-insured dental plans.





Revenue sources

Revenue from Other Funds pays for PEBB administration through an administrative assessment added to medical and dental insurance premiums and premium equivalents. The assessment cannot exceed 2 percent of monthly contributions from employees and employers (ORS 243.185). For 2011, PEBB has reduced the assessment from 0.6 percent to 0.4 percent.

PEBB also eliminated funding for annual open enrollment expenses. Printing and distribution costs were the main expenditure from this fund.

Revolving Fund

PEBB currently maintains two accounts within its Revolving Fund.

Stabilization account

PEBB has authority to use this account to control costs, subsidize premiums and self-insure. The Other Funds revenue source is primarily unused employer contributions for employee benefits. This account also holds proceeds generated when PEBB's life insurance carrier changed from a mutual organization to a public corporation.

Flexible spending account

PEBB operates two flexible-spending account programs for employees and maintains a non-limited fund to account for their administrative costs. The primary Other Funds revenue source for these programs is forfeitures from participants.

**Oregon Educators Benefit Board
(OEBB)**



Vision

The Oregon Educators Benefit Board (OEBB) is aligned with the vision of the Oregon Health Authority in creating a healthy Oregon. The OEBB vision is to provide high-quality benefits for eligible employees at the lowest cost possible and work collaboratively with members, educational entities and insurance carriers to offer value-added benefit plans that support improvement in members' health while holding carriers accountable for outcomes.

Key components of the vision include:

- An innovative system that provides evidence-based medicine to maximize health and utilize dollars wisely;
- A focus on improving quality and outcomes, not just providing health care;
- System-wide transparency through explicit, available and understandable reports about costs, outcomes and other useful data; and
- Encouragement for members to take responsibility for their own health outcomes.

Goals

The goal of OEBB is to provide high-quality medical, dental and other benefit plans for eligible employees at a cost that Oregon's educational entities, their employees and the taxpayers of Oregon can afford.

The statutes governing OEBB (ORS 243.860 to 243.886) outline specific criteria that OEBB must follow in considering whether to enter into a contract for a benefit plan. In September 2007, the board further defined those criteria and adopted guiding principles.

Guiding principles

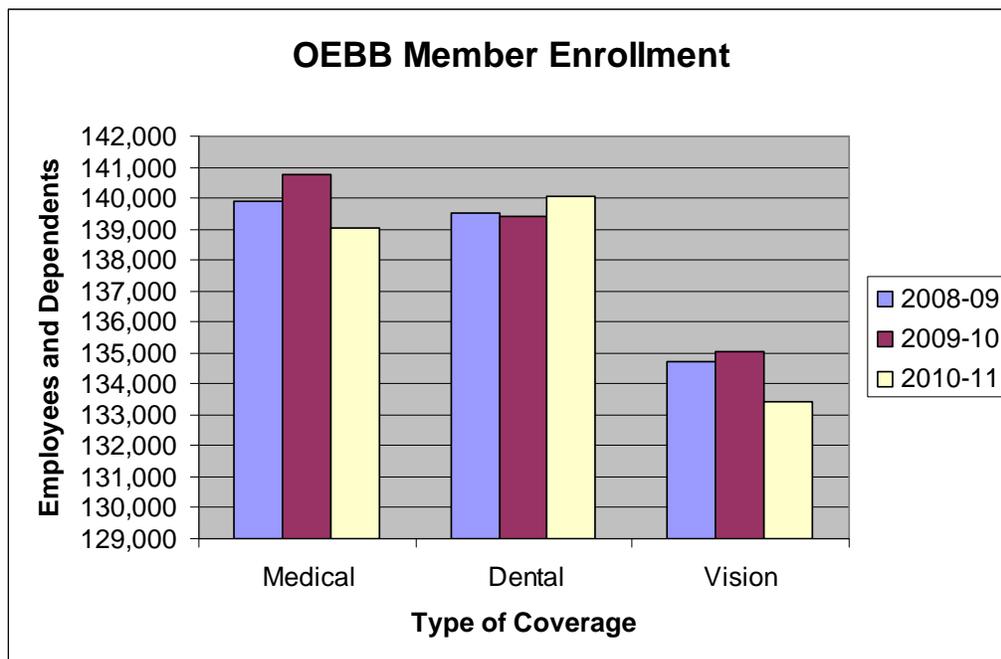
- OEBB will offer employees a range of benefit plans that provide high-quality care and services.
- OEBB will encourage competition in the marketplace in the areas of quality, outcomes, service and cost.
- In making its decisions, OEBB will consider plan performance in quality, administrative processes, costs and outcomes. It will promote system-wide transparency that provides comprehensive information on these issues.

- OEBB will offer a range of benefit plan designs that provide educational entities with the flexibility to choose options that meet their and their employees' financial and health needs.
- OEBB will encourage benefit plans and providers to offer members consistent access to care and services; integrated care systems that provide effective treatment; and personal and prompt service that meets customers' needs.
- OEBB will seek plans and providers that use creative and innovative methods and practices that are evidence-based or otherwise measurable.
- OEBB will recognize the impact of its decisions on employees' total compensation.
- OEBB will promote employee health and wellness through plan design components, disease and case management, and consumer education.
- OEBB will take into account the total costs of benefit plans, as well as employee cost-sharing for services, in offering a range of benefit plan designs.

Guiding principles of board operations

The board will operate as a cohesive unit that provides for open discussion on topics. The board also will operate in a transparent manner that fosters public trust, input and understanding of OEBB decisions and policies.

Who we serve



2011-17 six-year plan

- Keep medical rate increases at trend or below.
- Implement additional value-based benefit design changes supported by scientific evidence.
- Identify resources to support educational entities' health and wellness efforts.
- Continue to involve stakeholders in all aspects of policy development.
- Improve data systems to give educational entities reporting tools that support their business needs.
- Continue to operate in a transparent manner that fosters public trust, input and understanding of OEGB decisions and policies.
- Ensure the board operates as a cohesive unit that holds open discussion among its members.
- Continue to use workgroups to help the board make decisions based on analysis, discussion and development of options and recommendations. The board has established workgroups in three areas: business and operations, communications, and strategies on evidence and outcomes.
- Enhance the board's long-term communication plan.

2011-13 two-year plan

- Continue developing the "MyOEGB" Benefit Management System, giving OEGB staff and educational entities more control over the administration of benefit plans and the ability to access information related to benefit enrollments. The system provides benefit carriers with information allowing electronic enrollment of OEGB members into appropriate benefits and plan offerings.
- Continue supporting educational entity administration through an online enrollment system; the use of electronic invoices and fund transfers; and administrative reports that allow administrators to access and manage eligibility and enrollment information.
- Continue monitoring standards for customer response time and improving the board's administrative and customer service models. The board's goal is to meet OEGB member needs and provide administrative support allowing educational entities to manage their employees' benefits as efficiently as possible. Annual performance evaluations and surveys regarding OEGB and its carriers allow OEGB to assess how well these goals are being met.
- Continue transitioning the business side of OEGB onto the internet. The current infrastructure includes a secure Web portal, a single electronic payment process and help with training and development.
- Emphasize technology as a way to increase efficiency and convenience.

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- Minimize the threat of unauthorized data access, both internally and externally.
 - Mitigate the risks and costs that can result from improper security planning.
 - Prevent the compromise of information and network systems.
 - Regularly review existing security standards and practices in state government to ensure that OEGB meets enterprisewide security standards.
 - Continue developing and maintaining a comprehensive and user-friendly website and online benefit enrollment system.
 - Continue providing OEGB members with direct access to a central source of information.
 - Refine OEGB's communication plan; include member educational materials and educational entity tools and resources supporting the health of OEGB members.

OEGB supports the Oregon Health Authority's goal to improve the lifelong health of all Oregonians. OEGB is focused on improving the health status of its members and their access to quality care. The board is taking action to increase the quality, reliability and availability of care for all Oregonians, consistent with OHA's goal.

To facilitate the goals of OHA and OEGB, the board requires OEGB carriers to ensure that contracted physicians, providers and facilities render quality care at a sustainable cost. Facilities and providers may not be included in carrier panels if they do not meet these requirements.

- Quality care is consistent with evidence-based practice guidelines and within the context of individual clinical circumstances.
- Sustainable costs align with community reimbursement rates and, whenever possible, payment is made for outcomes rather than the provision of services.

2009-11 major accomplishments

- Designed and implemented additional benefit plans for Oregon's educational employees and their families. Life, disability, accidental death and dismemberment, long-term care, and an employee assistance program were added to the medical, dental, pharmacy and vision benefits previously available through OEGB.
- Emphasized preventive care through full coverage for 17 preventive services including well-baby care and immunizations, a tobacco cessation program and a weight management program.

- Enhanced the electronic, paperless benefit management and enrollment system allowing employees to enroll in benefits online, and providing online payment reconciliation and electronic transfer of premiums.
- Held the average per-employee monthly premium increase for medical coverage to 11.2 percent (below the 12 percent trend) during the first year's rate renewals (2009) and 6.8 percent (below the 11 percent trend) for the second year's rate renewals (2010).
- Implemented value-based plan design changes to provide incentives for chronic disease management and dis-incentivize several surgeries and procedures that evidence shows are over-utilized, ineffective, have questionable outcomes, or can have harmful side effects. Added an evidence-based weight management program.
- Established a weight management program and health and wellness support program improving health outcomes by reducing the prevalence of obese and overweight members, weight-related illnesses and increasing physical activity and healthy eating levels. In the first three months, more than 6,800 OEGB members were participating in the weight management program through meetings held at 210 worksite meeting locations.
- Implemented language from House Bill 2557 (2009) expanding the definition of an eligible employee to include part-time, PERS-eligible faculty and research staff working at public institutions of higher education who otherwise would not meet eligibility thresholds for either OEGB or PEBB.

Customer service delivery

OEGB continues to enhance efficiencies, creating a reporting repository for use by human resources or payroll staff responsible for employee benefits and allowing easy data migration through a payroll interface. OEGB also automated mid-year changes for members and enhanced e-mail communications for new hire and open enrollment documents. OEGB continues to conduct requested trainings on MyOEGB and to make presentations educating members on rate, benefit and plan design changes.

With collaboration from higher education and the Public Employees' Retirement System (PERS), OEGB implemented the administration of benefits for a newly eligible self-pay employee group created by HB 2557 (2009). OEGB added online benefit management system components to administer life, accidental death and dismemberment, long- and short-term disability, and long term care coverage. OEGB also added an employee assistance program for the 233 participating entities.

Performance measures

OEBB uses measures and checkpoints to evaluate progress and success in implementing its business plan with regards to customer service. The target sets the performance benchmark. Checkpoints are actions taken to evaluate progress or the success of efforts being developed as part of the business plan. The board is in the process of developing a set of measures designed to provide information to the board, educational entities, members and lawmakers.

Goal Excellent Customer Service	Measures or Checkpoint Percentage of customers who rate OEBB customer service as good or excellent* .	Target 90 percent
Overall Customer Service	2009 Member Survey Results	97 percent
Overall Customer Service	2010 Member Survey Results	89 percent

**2010 Member Survey used the terminology "satisfied or very satisfied" in place of "good or excellent"*

Results from the 2009 annual member survey indicated more than 97 percent of OEBB's members rated OEBB's overall customer service "good to excellent." Results from the 2010 member survey results show:

- 89 percent of members who reported having contact with OEBB were satisfied with OEBB's customer service (50 percent "very satisfied").
- 65 percent of members reported being satisfied with the plan offerings (25 percent "very satisfied").
- 87 percent of members reported they were satisfied with the information OEBB sent to them (46 percent "very satisfied").
- 89 percent of web users reported they were satisfied with the OEBB website (44 percent "very satisfied").

Quality and efficiency improvements

OEBB is committed to ongoing process improvement and continually identifying and implementing administrative efficiencies. The strategic plan for improving quality and efficiency provides for:

- Gathering information, data and input from educational entities to develop or modify plan designs for medical, dental, vision and optional benefit plans.

- Reviewing and evaluating proposals and existing contracts and negotiating rates to provide high-quality plans at the lowest possible cost.
- Identifying potential policy and plan design changes to improve quality of care and members' health status.
- Measuring provider performance based on improved quality of health services to members.
- Monitoring carrier compliance with performance standards set in vendor contracts.
- Maintaining a viable and secure electronic benefit management system to process enrollment, eligibility, premium collection and disbursement.
- Participating in key initiatives to reform the health care system in Oregon.

Revenue sources

ORS 243.880 established the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated through an administrative assessment included in premiums for OEBB benefits. The administrative assessment is capped at 2 percent of total monthly premiums. ORS 243.882 prohibits the balance in the account from exceeding five percent of the monthly total of employer and employee contributions for more than 120 days.

ORS 243.884 established the Oregon Educators Revolving Fund to pay premiums, control expenditures, provide self-insurance and subsidize premiums. There is no dedicated revenue source for the OEBB Revolving Fund other than interest earned on the premium collection pass-through.

Governor's Balanced Budget

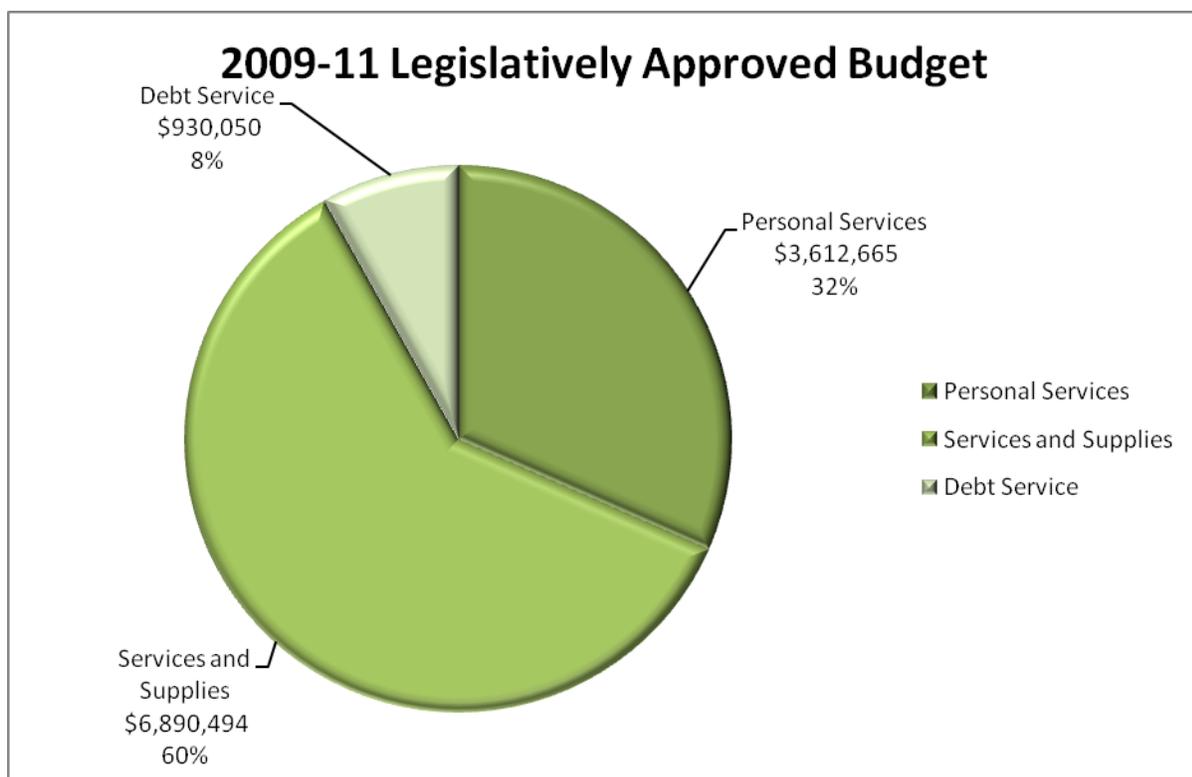
	GF	OF	OF-NL	FF	TF	Pos	FTE
2009-11 LAB							
OEBB Operations & Debt Service	-	11,433,209	-	-	11,433,209	22	21.75
Stabilization Fund (Premium Pass-through)	-	-	1,333,333,333	-	1,333,333,333	-	-
Subtotal	-	\$11,433,209	\$1,333,333,333	-	\$1,344,766,542	22	21.75
Transfer to Central Services	-	(\$429,243)	-	-	(\$429,243)	-	-
Pkg. 075 Nonlimited Administrative increase	-	-	\$104,666,667	-	\$104,666,667	-	-
Inflation Removal	-	(\$244,209)	-	-	(\$244,209)	-	-
Personal Services Reduction & Recon	-	(\$245,246)	-	-	(\$245,246)	-	0.25
Pkg 420 - Benefit Mgmt. System Feasibility Study	-	\$125,000	-	-	\$125,000	-	-
2011-13 Governor's Balanced Budget	-	\$10,639,511	\$1,438,000,000	\$0	\$1,448,639,511	22	22.00

Key budget drivers

- IT consultant costs for maintaining the viability of the MyOEBB system;
- State Data Center charges for data processing and storage;
- Program consultants costs for actuarial services, claims data warehousing and general consultation services;
- Attorney General costs; and
- Benefit cost increases reflected in the pass-through account used for collection and payment of premiums for health, dental, vision, life, disability, accidental death and dismemberment, long term care and employee assistance program benefits purchased by educational entities and their employees.

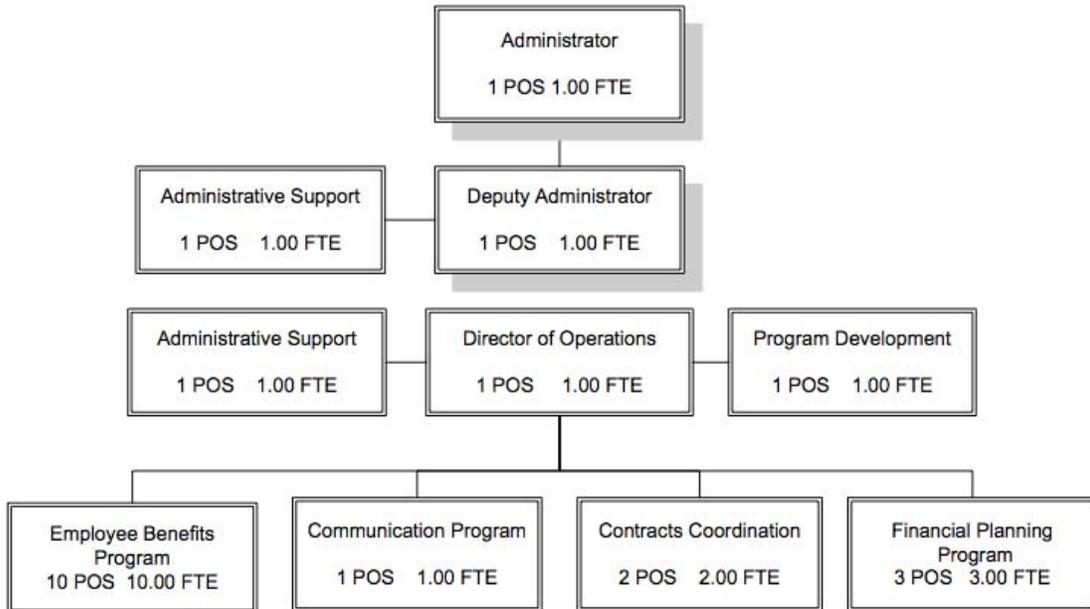
Debt service

OEBB bears the obligation to repay \$927,955 for certificates of participation issued for development of the MyOEBB Benefit Management System. MyOEBB supports administration of members' employee benefits and provides a source of real-time information for participating educational entities, insurance carriers and OEBB staff. MyOEBB provides an efficient and cost-effective way to administer benefits for nearly 150,000 employees and their dependents in 233 educational entities statewide.



Organizational charts

**Oregon Educators Benefit Board
Organization Chart
2011-2013
22 POS 22.00 FTE**



**Office of Private Health Partnerships
(OPHP)**



OFFICE OF PRIVATE HEALTH PARTNERSHIPS

The Office of Private Health Partnerships (OPHP) was created as the Insurance Pool Governing Board in 1987 to help reduce the number of uninsured Oregonians. The agency was renamed in 2006. In July of 2009, OPHP began transitioning into the Oregon Health Authority (OHA) as detailed in House Bill 2009 passed during the 2009 Legislative Session.

OPHP directly supports OHA's vision for *A Healthy Oregon* by reducing the number of uninsured Oregonians.

OPHP's programs offer consumer plan and provider choice as well as providing members premium assistance and access to health care information and resources, and allowing consumers to make informed decisions about their health care options. The quality, reliability and availability of care and the cost of care for both the insured and uninsured populations affects the lifelong health of Oregonians.

The agency's programs create a three-prong partnership between government, the private market and the insured. Since its inception, OPHP has designed, contracted, managed and administered programs that provide health care access to income-eligible individuals and families and to those who have been declined coverage due to pre-existing health conditions. Approximately 85 percent of OPHP's members do not qualify for other state health programs.

Combined, OPHP's programs provide access to health insurance coverage for approximately 25,000 Oregonians.

Overview

OPHP administers five programs that work to break down barriers to access, assist with health care costs, and educate program members, the general public, and members of the health industry. These five OPHP programs are closely connected, working across program lines to share talent, technologies, and other resources to accomplish the shared mission of the organization.

This cooperation between the programs creates efficiencies, and expands the capability of each program. The combined administrative cost of OPHP programs is less than six percent of total expenses.

Family Health Insurance Assistance Program

The Family Health Insurance Assistance Program (FHIAP) helps uninsured, income-eligible Oregonians afford private health insurance. The program subsidizes

a portion of the member's monthly health insurance premium. A member's subsidy level decreases as their annual income increases. FHIAP members are responsible for their own co-payments and deductibles. This model encourages self-sufficiency, assisting each member on the path to health independence.

Healthy KidsConnect

Healthy KidsConnect (HKC) is the private market insurance component or “mini-exchange” portion of the state's Healthy Kids program. Healthy Kids provides health insurance options for uninsured children age 18 and under, regardless of family income. HKC provides choices for families that earn too much to qualify for the Oregon Health Plan, but can't afford to pay the full cost of private health insurance premiums on their own. OPHP also administers the part of the Healthy Kids program that helps families pay for insurance at work, if an employer plan is available — Healthy Kids Employer Sponsored Insurance (HK ESI). Like FHIAP, an HKC member's monthly subsidy assistance decreases as the member's annual income increases. Families with income above 300 percent federal poverty level are not eligible to receive subsidies but can purchase insurance coverage for their children at full cost.

Oregon Medical Insurance Pool and Federal Medical Insurance Pool

The Oregon Medical Insurance Pool (OMIP) and the Federal Medical Insurance Pool (FMIP) offer guaranteed-issue health insurance coverage for individuals, regardless of income level, who are unable to obtain medical insurance because of health conditions. Both programs provide vital health security for people who would not otherwise have access to health insurance and care. OMIP also provides a way for Oregonians to continue insurance coverage after they have exhausted COBRA benefits and have no other options.

Information, Education and Outreach

The Information, Education, and Outreach (IEO) program supports OHA's mission by establishing and maintaining relationships with private and public sector partners. IEO trains employers, insurance producers (agents), industry professionals, and civic groups and educates consumers and stakeholders on the health care delivery system and state programs.

Who receives services

Over 75 percent of uninsured Oregonians earn between zero and 300 percent of the federal poverty level. For others, commercial market health insurance is not available due to pre-existing or chronic health conditions, regardless of income.

Combined these populations make up more than 80 percent of Oregon's uninsured, approximately 500,000 people; these are the Oregonians OPHP programs are designed to serve.

As a group, OPHP customers can be differentiated from Oregon Health Plan clients and those utilizing other state assistance programs. More of OPHP's program members are employed, with over 25 percent of the population having access to employer-sponsored or group insurance. OPHP program participants are required to pay a portion, based on income, of their own health insurance premiums. Members also are responsible for co-pays, deductibles, and other out-of-pocket costs, making them both a beneficiary and partner in program service and sustainability.

The need to address uninsurance in Oregon

According to the Office for Oregon Health Policy and Research, approximately 15.1 percent of the nation lacked health insurance in 2008. The rate of uninsured Oregonians is 16.5 percent, which equates to approximately 600,000 people without health insurance in Oregon and places the state 34th in the nation.

The costs of having this many Oregonians uninsured are high and affect all Oregonians. The insured are affected by the cost of higher premiums. Insurance companies see higher costs when the provider community shifts expenses related to uncompensated care, which often is delivered through the emergency care system. As the number of uninsured Oregonians increases, the costs shift to a smaller population of insured individuals and companies in the health care system.

According to OHPR, approximately 85 percent of people with health coverage obtain it through the private health insurance market. The remaining 15 percent of the insured population have health insurance through a public plan like a Medicaid managed care plan or Medicare coverage. Of those receiving state assistance, only about four percent obtain coverage through the private insurance market.

In states like Massachusetts, where an insurance exchange exists, a higher rate of public assistance comes through the private insurance market. The number of uninsured is kept low by utilizing the existing private health insurance marketplace, via the exchange. By leveraging the resources of multiple participants, including the consumer, insurance rates do not overwhelm public resources.

Although smaller in size and scope, OPHP programs operate on similar principles in addressing Oregon's high rate of uninsurance.

Guiding Principles

Supporting the triple aim

The Oregon Health Authority's Triple Aim is to improve the lifelong health of all Oregonians, to increase the quality, reliability, and availability of care for all Oregonians, and to lower or contain the cost of care so it is affordable to everyone. OPHP's programs work in support of these goals by reducing the number of uninsured Oregonians while maintaining plan and provider choice for its members. This directly affects lifelong health, and the quality, reliability and availability of care, and the cost of care for both insured and uninsured populations.

Providing health care access

Through subsidy assistance and cost sharing, OPHP programs help make health insurance more affordable for its members. FHIAP offers subsidy assistance ranging from a 100 percent subsidy for children whose family income is zero through 200 percent of the federal poverty level to a 50 percent subsidy for adults with incomes between 170 and 200 percent of the federal poverty level. Healthy KidsConnect and Healthy Kids employer sponsored insurance offer subsidies of 85, 90, and 100 percent to children with family incomes through 300 percent of the federal poverty level. The Oregon Medical Insurance Pool and Federal Medical Insurance Pool provide access to comprehensive health insurance coverage for people with chronic health conditions who cannot obtain commercial or public sector coverage, along with those who have exhausted other options.

By reducing cost, improving access, and sharing health information, OPHP programs help to increase each member's health security. Through sliding scale subsidy programs, where a member's subsidy decreases as their income increases, OPHP programs encourage each member's health independence.

Providing information and choice

As detailed in ORS 735.702, the Legislature charged OPHP with providing information about health benefit plans and the premiums charged for those plans, and with being a central source for information about resources for health care and health insurance. OPHP training seminars, publications, and Web site provide valuable information and education, and serve as a resource for members, employers, the self-employed, insurance agents, carriers, other state agencies, stakeholders, and the public.

Choice is an important component of OPHP programs. Members enrolled in an OPHP program have a choice of health plans and providers that best suit their needs. Minimum benefit standards are set to ensure that OPHP program enrollees have quality health insurance coverage, but beyond that minimum coverage level, the plan designs and provider networks provide significant options.

Partnering to share resources and costs

All participants, including insurers, employers, consumers, and the public sector have resources that can help reduce the number of uninsured Oregonians and provide access to improved care. OPHP's programs are designed to leverage available resources.

Partnering to develop and implement

OPHP has demonstrated the ability to develop public-private partnerships in response to the changes required in state and federal health care reform.

The implementation of OMIP in 1990 was a major state reform that created a health insurance option for individuals who could not obtain commercial insurance because of their pre-existing medical conditions. OMIP contracts with a large Oregon insurance company to serve as the third party administrator for the day-to-day operations of providing coverage, including claims administration, customer service, enrollment and billing, eligibility determination, case and disease management, and provider network contracting.

In 1997, the implementation of FHIAP provided premium assistance to individuals whose incomes were below 185 percent of the federal poverty level but had too much income to qualify for coverage under the Oregon Health Plan. Oregonians can use these subsidies with group and individual private sector health insurance plans that meet state or federal benefit coverage benchmarks. They also can use them for OMIP or FMIP coverage if a pre-existing medical condition prevents them from obtaining private sector individual coverage.

In 1998, the implementation of the state's alternative mechanism for portability included the creation of OMIP portability coverage for Oregonians who did not have access to commercial portability coverage. Most of those who qualify are individuals whose former employer is self-insured. The private-sector third party administrator (TPA) for OMIP also administers the portability coverage.

In 2004, implementation of the federal Health Coverage Tax Credit program (HCTC) created coverage under OMIP for individuals qualified for federal premium

subsidies because they lost their jobs due to foreign trade or they were covered under the Pension Benefit Guaranty Corporation due to employer bankruptcy.

In February 2010, implementation of HKC provided access to guaranteed-issue commercial health insurance coverage for children up to age 19 in households with income above 200 percent FPL, comparable to that provided in the Children's Health Insurance Program. OPHP contracts with five commercially licensed insurers to provide coverage either on a statewide or regional basis. The implementation included the administration of premium subsidies with each of the commercial carriers for children in households where the income is between 200 and 301 percent of the federal poverty level. In addition, HKC provides access to employer-sponsored insurance for those whose incomes are from zero to 301 percent of the federal poverty level.

In July 2010, the implementation of the Federal Medical Insurance Pool (FMIP) provided a federally supported high risk pool option for U.S. citizens and those lawfully present in the U.S. who have not had health insurance coverage for at least six months and have a medical condition that prevents them from obtaining commercial insurance. The private-sector TPA for OMIP also administers FMIP.

Partnering to optimize operational flexibility

OPHP relies on strong partnerships and the flexibility of program resources to develop, implement, and manage programs. Two new programs in 2010, HKC and FMIP, were built using these elements. OPHP will continue to work across programs in OHA and with partners to develop and implement changes that move Oregonians toward improved lifelong health, increased quality, reliability and availability of care, and affordable care.

Family Health Insurance Assistance Program

The Oregon Legislature established the Family Health Insurance Assistance Program (FHIAP) in 1997. FHIAP provides health insurance premium assistance to Oregonians who would not be able to afford health insurance on their own. This reduces the number of uninsured, and encourages a healthy Oregon by helping members access quality medical providers.

FHIAP supports the Oregon Health Authority's mission by:

- **Creating a path to health care independence**
FHIAP offers monthly premium subsidies to adults on a sliding scale, ranging

from 50 to 95 percent of the cost of insurance. All children under the age of 19 are subsidized at 100 percent regardless of income. The adult members' monthly subsidies decrease as their income increases. This sliding scale fosters self-reliance and continued movement toward health care independence. The sliding scale also aligns directly with the goal of more equitably sharing the cost of health care for the uninsured, reducing the number of uninsured at a minimum cost to the public.

- **Providing health care choice**

FHIAP offers members numerous health insurance plan choices. Each plan includes a health care provider network that offers members the opportunity to select their care provider. Giving members the option to change providers if they are unhappy with their care helps ensure that Oregonians receive quality patient care.

All FHIAP-subsidized plans offer comprehensive medical benefits including prescription drug coverage, affordable out-of-pocket costs, and a wide array of provider choice throughout the state. Weighing access and cost, members select the plan that best fits their family's medical and financial needs.

- **Partnering to share health care costs**

FHIAP is unique in that it relies heavily on the combined contributions of employers, employees, and state and federal governments, to provide assistance to the uninsured. FHIAP addresses the gaps between the cost of health insurance and what people can afford to pay.

Program design

Commercial health insurance is the primary private sector partner of FHIAP. The program structure reflects a three-pronged partnership between government, the commercial health insurance market and consumers to provide health care to the uninsured. FHIAP pays a portion of a member's monthly health insurance premium purchased through:

- An employer, if a plan is available; or
- An individual private market carrier.

If a member's employer offers health insurance coverage that meets minimum cost-sharing and benefit standards and contributes toward the premium costs, the member is required to enroll in employer coverage. This requirement leverages

private sector dollars, reducing taxpayer costs and increasing program capacity so more families receive premium assistance.

When employer insurance is not available, the program subsidizes individual market insurance premiums. FHIAP works with six of the largest domestic individual private market carriers in Oregon, including OMIP and FMIP, other programs administered by OPHP.

Uninsurance requirement: FHIAP requires that members be without health insurance for at least two months in order to be eligible for the program. The period of uninsurance (POU) is intended to reduce the number of Oregonian's without health insurance by targeting only uninsured individuals while discouraging people from dropping their existing coverage to join the subsidy program.

Who receives services and how services are delivered

FHIAP serves children and adults from 0 through 200 percent of the federal poverty level in both individual and employer sponsored health insurance options.

Adults in FHIAP can only receive subsidies if all eligible children in the family are covered by health insurance in the commercial market or through the Oregon Health Plan, FHIAP or Healthy Kids programs. FHIAP pays 100 percent of monthly premiums for all children living in homes where the income is less than 201 percent of the federal poverty level.

FHIAP staff annually assess applicant eligibility, manages member accounts, including monthly premium billing in the individual market, payment to insurers and subsidy reimbursements in the employer market. FHIAP staff also process member appeals and administrative hearing requests.

FHIAP mails applications in the order applicants put their name on the group or individual reservation list:

- Applications are sent out in date order when program openings become available.
- Families with members who don't qualify for group insurance, but with at least one who does, are placed on the group reservation list.

In August 2010 there were more than 45,000 people on the FHIAP reservation list.

This is the second time in the program's history that the reservation list reached more than 40,000 lives. Of the almost 45,000 on the list in August, approximately:

- 25,000 were adults;
- 15,000 were children; and
- 10,000 said they have access to employer-sponsored (group) insurance.

During the same period, FHIAP served approximately 7,200 members. Of those, approximately 3,200 were enrolled in employer-sponsored insurance, and approximately 4,000 were enrolled in individual coverage.

FHIAP provides subsidies to families with gross monthly incomes through 200 percent of the federal poverty level. A large number of members are at or below 100 percent of the poverty level. As of August 2010, FHIAP population was composed of the following enrollees by poverty level:

- Approximately 30 percent of members (group and individual) had incomes at or below 100 percent of the poverty level;
- Approximately 30 percent of members had incomes between 100 and 125 percent of the poverty level; and
- Approximately 40 percent of the members had incomes between 125 and 200 percent of the poverty level.

Quality and efficiency improvements

FHIAP works to promote improvements and efficiencies in the program. These activities range from improving the application process for members to sharing resources between programs to reduce administrative costs for the state. Combined, OPHP administrative costs are less than six percent.

During the last biennium, FHIAP:

- Simplified the program application;
- Implemented rule changes to simplify application paperwork and program requirements;
- Began a document imaging process;
- Simplified the language in forms and letters to reduce member questions;
- Worked to help build the database for the Healthy KidsConnect program; and
- Trained Healthy KidsConnect staff on eligibility and insurance.

Expenditures and revenues

FHIAP is funded through state General Fund appropriation, Federal funds, Miscellaneous Other Funds, and the Insurer's Tax.

As part of the Oregon Health Plan demonstration waiver, the subsidy program receives federal matching funds for Medicaid (Title XIX) and the State Children's Health Insurance Program (Title XXI). Additionally, FHIAP receives a small portion of the Insurer's Tax to provide subsidies for children.

The ARB budget includes 41 positions and (40.86) FTE to maintain the program.

Expected results in 2011-13

- FHIAP will support Oregon benchmark #55 (Percent of Oregonians without health insurance) by extending coverage to Oregon's uninsured population, to the maximum extent of available funding.
- Program staff will evaluate policies and procedures, seeking ways to further streamline internal operations and applicant and member processes.
- Program management will review operations to continually improve efficiencies.
- Program staff will coordinate with the Oregon Health Plan and Healthy Kids program.
- Information technology staff will work with program staff to implement database enhancements, including document imaging, to increase employee productivity and accuracy of information.
- In response to the Secretary of State's audit recommendations, program management will employ measures to enhance quality control through database enhancements and staff reassignment for performing quality assurance reviews.

Healthy KidsConnect

Healthy KidsConnect (HKC) was established with the passage of HB 2116 and signed into law on August 4, 2009. HKC helps families gain access to comprehensive insurance coverage for uninsured children by providing premium subsidies and partnering with private-market carriers to deliver services.

HKC is the commercial insurance component of Healthy Kids, Oregon's program that offers health care coverage to eligible uninsured children age 18 and under. Healthy Kids was established with a goal of enrolling 95 percent of Oregon's uninsured children with family income at or below 300 percent of the federal poverty level. HKC is designed for families that earn too much to qualify for the Oregon Health Plan, but can't afford to pay the full premium for their child's private health insurance. HKC also provides qualified families with access to employer-sponsored insurance (ESI) or group subsidies to enroll uninsured children into their employer's plan. Employer's plan must meet federal benefits guidelines to qualify.

HKC aligns with the Oregon Health Authority's mission by:

- **Expanding access to all Oregon's uninsured children**
HKC offers sliding scale subsidies for families whose income is between 200 and 300 percent of the federal poverty level (FPL). Expanding coverage to this previously under-served population provides opportunities for children to receive comprehensive health coverage. Families with income above 300 percent FPL pay full cost of insurance premiums.
- **Providing health care choice**
Families enrolling children in HKC have provider choice. Each plan includes a health care provider network that offers members the opportunity to select a provider that will best serve their child's health care needs.
- **Partnering to share health care costs**
HKC provides cost sharing among consumers, government and the private market through income-based subsidy payments for families whose annual income is 300 percent FPL or lower.

Program design

HKC's program structure creates a partnership between the commercial market, government, and consumers to provide health care for uninsured children.

HKC manages the request for proposal process for the HKC private-market health plan options. Currently, HKC contracts with five insurance carriers to provide health insurance benefits comparable to Oregon Health Plan Plus. The plan offers comprehensive health care coverage that includes dental, vision, mental health, pharmacy, and physical health care benefits.

Staff manage HKC member invoicing and payments and HK ESI employer plan benchmarking ensuring the plan meets federal standards. (The program) assists the Department of Human Services, Children, Adults and Families division with expediting annual program redetermination for HKC members and manages HKC member relations and ongoing carrier evaluations and relations.

An important measure of health care affordability is the consumer's total out-of-pocket expenses. To align with federal standards and ensure HKC insurance is affordable for the families that receive subsidies, OPHP set an out of pocket limit of five percent of the family's annual income for members who enroll in the private market HKC plans. If a family reaches the five percent limit, OPHP pays expenses above that amount. HKC out of pocket expenses include monthly premium, co-pays, co-insurance, and all other expenses related to health care and incurred under the insurance plan.

HKC expands coverage options to additional income levels, removing barriers to accessing health care coverage and building on existing programs already available to Oregon families.

Who receives services and how services are provided

OPHP helps families with incomes between 200 and 300 percent of the federal poverty level by paying 85 to 90 percent of their monthly health insurance premium and encouraging enrollment and active financial participation in their child's health care needs. Subsidized members are responsible for approximately 10 to 15 percent of the premium cost, depending on their income level. OPHP pays 100 percent of the premium cost for children enrolled in a parent's employer plan through HK ESI and whose household income is zero through 200 percent FPL.

Oregon's Healthy Kids effort is a innovative, multi-agency collaboration of the Oregon Health Authority's (OHA) Office of Healthy Kids, Medicaid Assistance Programs, and OPHP, the Department of Human Services (DHS), the Office for Oregon Health Policy and Research partnering with five private market insurance carriers, and community stakeholders. Each of these partners performs a vital role in marketing, application assistance, service delivery, and evaluation. This collaboration of public and private partnerships ensures "every kid is a Healthy Kid" and provides a seamless transition for children into health insurance coverage, regardless of income level.

There is one DHS application for medical assistance programs except FHIAP, including Healthy Kids and Healthy KidsConnect. Applications are submitted to

DHS for determination of family and child eligibility based on program rules and guidelines.

The applications of Oregonians who earn too much for the OHP component and meet HKC and HK ESI eligibility are forwarded to the Office of Private Health Partnerships. OPHP provides qualified families with information on carrier and employer options for enrolling in private insurance.

OPHP administers HKC health insurance plans and member reimbursement for HK ESI benefits available through a member's employer plan.

One of OPHP's key performance measures is customer satisfaction relating to the family's experience with the private market carrier that provides the child's insurance coverage. OPHP's goal is to have more than 90 percent of its customer's rate their experience with their carrier as "Good" or "Excellent" on a satisfaction survey.

Expenditures and revenues

HKC is funded with a combination of Federal Funds and Other Funds (Insurers' Tax), increasing the amount of federal dollars available to the state to help more families. Approximately 74 percent of HKC expenditures are Title XXI (CHIP) funds, with the balance matched by the member share plus Insurers' Tax funds. Insurers' Tax is collected through a one percent tax on private market health insurance premiums.

The ARB Budget includes 36 positions and 35.64 FTE for maintaining the program.

Expected results in 2011-13

- Continue implementation of the private-public partnership of the HKC model, or "mini-exchange" for children. This partnership could serve as the model for planning and implementing a larger insurance exchange.
- Build on existing OPHP programs and administrative structures for efficient implementation of health reform and improved access to health insurance for more children.
- Collaborate to provide customers seamless eligibility determination and enrollment for movement between DHS and OPHP programs when necessary.

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- Achieve excellent scores on two key performance measures: customer satisfaction with private market health insurance carriers and percentage of subsidized families who do not exceed their out of pocket expense limit.

Oregon Medical Insurance Pool

The Oregon Legislature established the Oregon Medical Insurance Pool (OMIP) in 1987 as the state's high-risk health insurance pool.

OMIP provides medical insurance coverage for all Oregonians denied adequate medical insurance coverage because of current or prior health conditions. OMIP partners with private market health insurers to help reduce the state's uninsured rate by providing insurance options to people who otherwise would be without health coverage.

OMIP also provides a way to continue insurance coverage for those who exhaust COBRA benefits and have no other options.

OMIP supports the Oregon Health Authority's mission by:

- Providing access for Oregon's uninsurable
- OMIP serves the highest medical risk individuals in the state who otherwise would not have access to health insurance due to pre-existing health conditions.
- Maintaining plan and provider choice
- OMIP offers four health benefit plans to accommodate the financial circumstances of individual enrollees. The plans differ in deductible amounts and other out-of-pocket costs which allows for varying premium amounts among the four plans.
- Promoting health management
- OMIP provides the necessary resources, such as disease management, pharmacy, and case management programs, to allow chronically ill Oregonians to better manage their conditions.

Sharing health care costs

OMIP is structured to distribute costs between the member and the private market. With commercial insurance plans, the total premiums generally cover the entire plan's costs for medical care and administration. However, OMIP member premiums cover about 50 percent of the program's total costs. The remainder is

covered through assessments Oregon law authorizes OMIP to collect from Oregon health insurance companies.

OMIP provides access to health insurance for thousands of Oregonians, helping reduce the number of people seeking emergency room services as a last resort. OMIP allows members to utilize a network of primary care providers and specialists in a manner that benefits Oregon's overall health care system.

OMIP and FMIP private-public program design

OMIP and the Federal Medical Insurance Pool (FMIP) contract with a third-party administrator (TPA), Regence BlueCross Blue Shield of Oregon. Regence BCBSO handles the pools' day-to-day operations, including eligibility, enrollment, customer service, data reporting, claims processing, prior authorization, pharmacy benefit management, case management and disease management.

OMIP staff work closely with the TPA to coordinate operational and policy issues and promote improvements in service delivery.

The administrative cost for the TPA plus the state program management and staff during fiscal year 2010 was less than five percent of total expenditures.

- OMIP administration: expenses for state administrative staff and supplies comprise less than one percent of total expenditures.
- TPA: the cost of the third party administrator comprise four percent of total expenditures.
- Insurance agent fees: OMIP pays a one-time \$75 fee to Oregon licensed agents who assist an applicant in completing the OMIP application and obtaining coverage. These fees comprise approximately 0.2 percent of total expenditures.

The TPA's administrative expense and agent fees increase as OMIP enrollment increases. OMIP pays the TPA a contracted dollar amount per enrollee per month for administration. Member premiums cover about 50 percent of the total program costs. The remaining 50 percent is covered by health insurer assessments. The insurers pass these assessments to the consumer through the individuals and companies insured under their private market insurance plans. Essentially, individuals and companies that pay for private insurance subsidize approximately 50 percent of OMIP's expenditures. This percentage has risen during the past several years from about 35 percent to its current level.

Who receives services and how services are delivered

The Oregon Medical Insurance Pool (OMIP) and the Federal Medical Insurance Pool (FMIP) are the high-risk health insurance pools for the State of Oregon. Oregonians served by OMIP and FMIP have been declined coverage by the individual health insurance market because of their medical conditions.

Additionally, OMIP serves individuals who have exhausted employer-based COBRA benefits and have no other available options to continue coverage; have left employment and moved out of their employer's plan service area and are not able to continue that coverage; or are eligible for the Federal Health Coverage Tax Credit (HCTC).

OMIP and FMIP benefit plans mirror those in the commercial group preferred provider option (PPO) health market. The plans include case management services, disease management programs, prior authorization requirements, a drug formulary, and higher benefits when enrollees choose to use participating providers.

OMIP and FMIP receive guidance from a ten member board. The Oregon Health Authority director appoints nine of these members. The director, or a designee of the director, also serves on the board.

Eligibility

Enrollees must be residents of Oregon when they enroll and demonstrate that they have lived in Oregon for at least 180 days during each benefit year. OMIP does not have a citizenship requirement for coverage or a required period of uninsurance.

The federal pool has a six-month period of no insurance requirement and enrollees must be U.S. citizens or lawfully present in this country.

Quality and efficiency improvements

- Enrollees received more help managing their health care and benefits.
- Expanded the range of diagnoses addressed by disease management programs.
- Enhanced promotion of no-cost classes for smoking cessation and self-management of chronic diseases.
- Promoted use of MyRegence website for enrollees to access a wide range of information about managing diseases and lifestyle, general knowledge about medical conditions and medication alternatives and history of claims.

- Promoted healthy lifestyles by offering paid weight loss programs through Weight Watchers.
- Took measures to control rising medical costs:
- Increased the number of available generic prescriptions from 59 to 72 percent of covered medications, thereby controlling the rate of increase in drug expenditures for OMIP;
- Increased the non-preferred drug co-payment to encourage generic drug use;
- Obtained a federal grant award to offset costs, support increased use of generic medications, and employ remote monitoring of individuals with complex multiple diagnoses in order to avoid emergency-room visits and inpatient admissions.
- Improved access to information for enrollees, stakeholders, and the general public by expanding the Web site to include more information and providing easier navigation for a variety of audiences including enrollees, health care policymakers, and insurers affected by the OMIP assessment.
- Revised significant sections of the benefit contract, the OMIP/FMIP Handbook, and the benefit plan summaries to make them easier to understand.
- Improved access to resources by contracting with the Department of Health and Human Services to implement the Federal Medical Insurance Pool (FMIP). FMIP will help stabilize the OMIP assessment through a shift of OMIP cost to the federal government.

Federal High Risk Pool (FMIP)

On April 30, 2010 Governor Ted Kulongoski sent a letter to the Secretary of HHS indicating Oregon's interest in administering the federally funded high-risk pool through the state's existing medical insurance pool (OMIP). HHS signed a contract with the state on July 12, 2010.

The biggest difference between FMIP and OMIP is funding streams. OMIP is funded by a combination of member premiums and an assessment on health insurance companies. The new federal high risk pool is funded by a combination of member premiums and funds from the federal government.

The federal pool is structured to be nearly identical to OMIP, but offers two insurance plans rather than four. A seamless and transparent structure simplifies the application process, aids in communicating the benefit plan details, and makes better use of program funds.

The existence of the new federally funded pool will have the affect of shifting future costs (new medically eligible enrollment) from OMIP to the federally funded pool. This may level out the cost of running the existing state pool over time.

Expenditures and revenues

OMIP is funded with member premiums and assessments on health insurance carriers licensed to do business in Oregon. By statute, OMIP premium rates for pool coverage cannot be more than 125 percent of rates established as applicable for individual risks in the commercial market. In 2008, the premiums were 25 percent above the market for comparable PPO plans; in 2009, they were 15 percent above the market.

FMIP is funded with member premiums and a \$66 million allotment from the Department of Health and Human Services as a result of the Patient Protection and Affordable Care Act. Funds from the federal allotment for the program period starting July 2010 and extending through December 2013 are forecast to serve 4,000 members with peak enrollment reaching 2,000.

OMIP/FMIP staff includes 9 positions and 8.50 FTE.

Expected results in 2011-13

- Enhance case management and disease-management programs to better control quality of care and manage medical-service utilization and costs for seriously ill enrollees.
- Work with the National Association of State Comprehensive Health Insurance Plans to develop new strategies to expand prescription drug discounts.
- Provide incentives to enrollees to use less expensive evidence-based prescriptions.
- Expand the number of enrollees who participate in disease management program services.
- Improve the ability to identify highest risk enrollees and provide interventions to avoid use of costly medical services.
- Enhance communication strategies to increase awareness and understanding of the program among enrollees, insurance agents, other state or federal agencies, providers, other state high-risk pools, the general public, and other interested parties.
- Broaden the base of the assessment OMIP collects from insurers, to make it more equitable.

Information, Education and Outreach

The Information, Education and Outreach (IEO) unit supports the Oregon Health Authority's mission of helping uninsured Oregonians receive health benefit coverage, by:

- Helping Oregonians make informed choices to meet their health care needs.
- IEO educates consumers to better understand the importance of health insurance, preventive care, and how to use the health care system appropriately and affectively.
- Partnering to increase awareness and maximize resources
- Partnerships are key to creating broad and consistent awareness of OPHP programs. Working with private-sector groups, such as producers and employers, allows IEO to expand its outreach and maximize collaborative resources.
- Reducing barriers to health insurance by promoting programs available to uninsured Oregonians.
- IEO provides uninsured Oregonians program information, eligibility requirements, and a trained insurance producer if needed, helping them better understand how to navigate the system, and intentionally access programs that meet their needs.

Private-public program design

IEO builds partnerships with private-sector businesses, health care professionals, member associations, community organizations, non-profits, carrier marketing staff, insurance producers, and other state agencies, to train and educate stakeholders and community members on the benefits and processes associated with Oregon's state insurance programs.

One of IEO's primary partners is the health insurance producer. Each month, the Insurance Division licenses over 150 new producers with a health care specialization and there are more than 1,900 insurance agencies in Oregon with producers who specialize in health insurance. When trained, these professionals extend outreach and awareness of OPHP programs like FHIAP and OMIP, as well as other state programs, such as the Oregon Health Plan, Healthy Kids, Healthy KidsConnect and the Oregon Prescription Drug Program.

Insurance producers also help members by explaining the costs associated with insurance, helping them apply to an insurance company, and explaining what is

covered under the plan. This saves the member time and eliminates confusion often associated with navigating the system alone.

IEO provides producers detailed training related to:

- Program application processes;
- Becoming a referral agent to assist members with completing their application;
- How to help reduce application “pends;” and
- How a producer can help expedite the insurance plan enrollment process.

IEO also trains and assists businesses to better understand state programs that support employer-sponsored insurance enrollment. When an employer’s insurance plan meets the criteria for FHIAP or HK ESI subsidies, IEO works with employers to educate their workforce on the value of enrolling their families into their employer’s plan, and assists employees with the state program enrollment process.

A third and critical partnership exists between the IEO staff and the contracted insurance carrier marketing personnel. OPHP’s outreach and training team assists in the production of marketing and customer education materials for carriers who manage the plans for state programs. These carriers have close relationships with insurance producers, strengthening OPHP’s position as a viable option for those who qualify for private market plans and employers whose plans meet the guidelines.

IEO partners with the community by serving as a centralized resource for information on health insurance, state insurance subsidy programs, employer health insurance assistance and more. Information is available online and through other electronic resources. IEO staff are a ready resource for carriers, employers, producers and health insurance customers.

Targeted education and outreach programs

IEO helps increase access to health insurance and health care by assisting consumers, employers, health insurance producers, human resources staff and other industry specialists to better understand state programs and services, and how to enroll and utilize services.

Producer referral program

IEO trains insurance producers on general health insurance information and about state programs that help insure Oregonians, as well as the changes in state insurance law. OPHP's Producer Referral Program meets the requirements of OAR 442-005-0110, requiring the agency to train health insurance producers on state health insurance programs so they can assist consumers seeking help in the purchase of individual health plans.

Licensed health insurance producers must attend an agency-sponsored training seminar and sign an agreement to participate in the program. Staff members link the general public with a producer in their regional service area. Referrals are assigned on a rotating basis to provide producers with an equal opportunity for the business.

Professional continuing education (CE)

IEO collaborates with professional industry associations to customize health insurance training and health care curriculum to meet professional association members' continuing education requirements. IEO then ensures the curriculum meets standards by working with the Insurance Division and association management staff to certify the training materials. These industry professionals are key influencers of consumers in the purchase of health insurance. In general, one trained agent and one trained human resource specialist can assist dozens of clients and employees in navigating the path to enrollment.

OPHP has developed low-cost informational webinars and continuing education programs with the National Association of Insurance and Financial Advisors (NAIFA) Oregon, Oregon Association of Health Underwriters (OAHU), Society for Human Resource Managers (SHRM), and others.

Statewide seminars provide these professionals with information about:

- The latest state and federal regulatory changes and reforms;
- OPHP programs;
- Public health benefit programs, including the Oregon Health Plan and the Oregon Prescription Drug Program;
- Non-traditional and non-insurance-based health care resources, such as rural or safety net clinics and public health departments;
- Group and individual markets; and
- Producer regulatory requirements.

Education and outreach

In addition to continuing education seminars and informational webinars, IEO has provided quarterly training to Oregon Department of Human Services (DHS) staff and monthly training to the agency's contracted outreach workers. Staff also share information on agency programs at industry conferences and outreach events.

IEO routinely presents at civic organization membership meetings, such as Chambers of Commerce and Economic Development Councils. These business-focused groups bring together key members of business and local community leadership, helping IEO disseminate its message and information broadly in a small, targeted setting.

Promotional and educational materials

IEO supports enrollment and education activities for FHIAP, OMIP, HKC and other state programs through training and development of promotional materials. Staff develop targeted materials, such as employee brochures, an employer guide (recognized as a model document by the U.S. Department of Health and Human Services), program member newsletters and "How to Apply" sheets. Many of these materials are available in several languages, including Spanish, Russian and Vietnamese.

Electronic communication tools

IEO maintains several websites and is in production for an online Health Insurance Learning Center (LC). The user-friendly health information site will explain health insurance to consumers and employers and provide streamlined access to forms, support materials and other state resources. Program and agency e-newsletters are sent quarterly to employers, producers, legislators, health care industry professionals and others. Tools such as a talking application wizard (visually walks and talks a person through filling out the FHIAP application), a program screening tool and other resources have been developed to help consumers navigate information and processes.

Expenditures and revenues

IEO is funded through state General Funds and miscellaneous Other Funds obtained through interest revenues on the agency's Other Funds treasury balance. As Other Funds are used, the interest revenues available for this unit will decline. There are no proposed changes in revenue sources for this program unit in the 2011-13 Agency Request Budget. The program funds two full-time permanent positions (2.00 FTE).

Expected Results in 2011-13

- Develop cost effective tools to reach a broader audience.
- Inform all Oregonians about what services are available and how to access them.
- Influence utilization of services.
- Help employers and families maneuver through the health care system.
- Develop innovative ways to perform outreach and provide education related to federal health care reform and OHA's statewide reform efforts.
- Improve communication with minority populations.
- Train and educate Department of Human Services (DHS) and Oregon Health Authority (OHA) staff, as well as other state employee staff, employers, carriers, producers, stakeholders, and the general public on health insurance options available to residents of the state.
- Explore ways to develop and improve on-line access to agency programs and basic health insurance information for consumers.
- Develop and refine new publications that reflect the changing health insurance marketplace in Oregon.
- Develop and refine new and low-cost ways to communicate to various stakeholders and the public through innovative methods such as e-mail, Web on-line access, webinars, interactive online learning, and other technologies as they emerge.

PROGRAM PRIORITIES

As the agency moves forward into a new biennium, the Oregon Health Authority will use the triple aim - improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians and lowering or containing the cost of care so it is affordable to everyone - to prioritize program selection and service delivery across the Health Care Programs. As the agency implements the triple aim the priorities of the individual programs will be considered and incorporated where appropriate.

The newly formed Health Care Programs area consolidates the Office of Private Health Partnerships, Oregon Educators Benefit Board, Public Employees' Benefit Board, Healthy Kids, and Medical Assistance Programs, strengthening program collaboration and integration. The alignment prioritizes: affordable coverage for program service populations and members; plan and provider choice; prevention and care management; and maximizing opportunities for education and outreach.

Additionally, as the division servicing OHP clients, Medical Assistance Programs has prioritized its programs and services using specific guiding principles:

- Prioritize the health care services delivered before reducing the number of people covered.
- Provide vulnerable Oregonians access to high-quality health care.
- Keep children healthy and safe.
- Use managed care organizations to deliver services when possible.
- Seek out and use evidenced-based practices.
- Promote prevention.
- Maximize federal matching funds.

Program/division priorities for 2011-13 biennium																				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Priority (ranked with highest priority first)	Dept. (division)	Program/div (Orbits B Level)	(Orbits A Level title)	(Orbits Sub-A Level title)	Program unit/activity description	Identify key performance measure(s)	Primary purpose program-activity code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or enhanced program (Y/N)	Included as reduction option (Y/N)	Legal req. code (C, F or D)	Comments on proposed changes to EBL included in GRB
Dept	Pgm/ Div																			
1	MAP-1	HS	Medical Assistance Prgms-OHP Payment	Physical Health	Fee for Service	The statutes implementing the Oregon Health Plan require, insofar as possible, that care be delivered in a comprehensive managed-care system. Providers in managed-care plans are paid at rates set by an independent actuary to reflect the reasonable cost of provider care. Services paid on a fee-for-service basis are paid at traditional Medicaid rates.	18,29,30 and proposed for 2011-2013: preventive services for OHP youth and adults, preventive services for OHP children, adequacy of prenatal care for OHP clients, ACS hospitalizations of OHP clients	12	322,036,298	78,721,557		710,149,831		\$ 1,110,907,686			N	Y	F	Healthy Kids Plan (POP505); OHP Standard (POP503); Enforceable Preferred Drug List (090-02); Enforceable Mental Health Preferred Drug List (090-03); limit dental (090-17); additional dental limits (090-24); eliminate dental (090-26); limit vision (090-29); limit pay to federally qualified health clinics (090-44); durable medical equipment sole source (090-47); eliminate certain optional services (090-72); eliminate fee-for-service COLA (090-85); SPD in-home care (090-X1); SPD limit income eligibility (090-X2)
2	MAP-2	HS	Medical Assistance Prgms-OHP Payment	Physical Health	Managed Care	The statutes implementing the Oregon Health Plan require, insofar as possible, that care be delivered in a comprehensive managed-care system. Providers in managed-care plans are paid at rates set by an independent actuary to reflect the reasonable cost of provider care. Services paid on a fee-for-service basis are paid at traditional Medicaid rates.	18,29,30 and proposed for 2011-2013: preventive services for OHP youth and adults, preventive services for OHP children, adequacy of prenatal care for OHP clients, ACS hospitalizations of OHP clients	12	583,997,493	339,535,873		1,579,000,120		\$ 2,502,533,486			N	Y	F	Healthy Kids Plan (POP505); OHP Standard (POP503); reduce diagnostic related group hospital rates to 90% (090-01); reduce diagnostic related group hospital rates to 80% (090-15); limit dental (090-17); additional dental limits (090-24); eliminate dental (090-26); limit vision (090-29); eliminate certain optional services (090-72); reduce capitation rates (090-84); SPD in-home care (090-X1); SPD limit income eligibility (090-X2); reduce diagnostic related group hospital rates to 72%
3	MAP-3	HS	Medical Assistance Prgms-OHP Payment	Physical Health	Client-related Adjustments	Federally qualified health center and facility cost settlements, children's developmental rehabilitation clinic expenditures, facility outlier payments, pass-through payments.		12	29,036,714	13,887,459		73,501,683		\$ 116,425,856			N	Y	F	Limit pay to federally qualified health clinics (090-44)
17	MAP-4	HS	Medical Assistance Prgms-OHP Payment	Physical Health	Leverage	Leverage components include limitation to allow for pass-through of federal and other funds according to agreements with local health departments and school districts, the Insurance Pool Governing Board and Oregon Health & Science University.		12		118,126,041		164,064,782		\$ 282,190,823			N	N	F	
18	MAP-5	HS	Medical Assistance Prgms-OHP Payment	Physical Health	All Other	This category is used for making any needed technical adjustments, funding modifications, and any other adjustments to limitation levels.		12						\$ -			N	N		
19	MAP-6	HS	Medical Assistance Prgms-OHP Payment	OHP Mental Health	Fee for Service	Mental health services are funded through managed care contracts with mental health organizations and fee-for-service options. Several types of organizations serve as MHOs, i.e., counties, regional government, a public benefits corporation and health plans.	Proposed for 2011-2013: child mental health services, adult mental health services	12	13,927,048	1,307,306		25,816,432		\$ 41,050,786			N	Y	F	Healthy Kids Plan (POP505); OHP Standard (POP503); eliminate fee-for-service COLA (090-85); SPD in-home care (090-X1); SPD limit income eligibility (090-X2)
20	MAP-7	HS	Medical Assistance Prgms-OHP Payment	OHP Mental Health	Managed Care	Mental health services are funded through managed care contracts with mental health organizations and fee-for-service options. Several types of organizations serve as MHOs, i.e., counties, regional government, a public benefits corporation and health plans.	Proposed for 2011-2013: child mental health services, adult mental health services	12	125,708,038	16,957,364		243,788,071		\$ 386,453,473			N	Y	F	Healthy Kids Plan (POP505); OHP Standard (POP503); reduce diagnostic related group hospital rates to 90% (090-01); reduce diagnostic related group hospital rates to 80% (090-15); reduce capitation rates (090-84); SPD in-home care (090-X1); SPD limit income eligibility (090-X2); reduce diagnostic related group hospital rates to 72%
21	MAP-8	HS	Medical Assistance Prgms-OHP Payment	OHP Mental Health	Client-related Adjustments	Not currently used		12						\$ -			N	N		
22	MAP-9	HS	Medical Assistance Prgms-OHP Payment	OHP Mental Health	Kids Intensive Services	Intensive mental health services are delivered to children through psychiatric day treatment programs and psychiatric residential placement.	Proposed for 2011-2013: child mental health services	12	10,161,489	100,000		19,233,178		\$ 29,494,667			N	Y	F	Healthy Kids Plan (POP505); eliminate fee-for-service COLA (090-85)
56	MAP-10	HS	Medical Assistance Prgms-OHP Payment	OHP Mental Health	All Other	This category is used to make any needed technical adjustments, funding modifications and any other adjustments to limitation levels.		12						\$ -			N	N		
57	MAP-11	HS	Medical Assistance Prgms-Non-OHP Payment	Medicare Modernization Act- MMA		Medicare Prescription Drug phased-down state contribution (Part D). Referred to as "Clawback."		12	143,671,604					\$ 143,671,604			N	N	F	
58	MAP-12	HS	Medical Assistance Prgms-Non-OHP Payment	QMB		Qualified Medicare Beneficiary clients meet criteria for both Medicare and Medicaid participation. MAP pays for Medicare Part A and Part B premiums (including coinsurance and deductibles).		12	4,398,115			7,632,945		\$ 12,031,060			N	Y	F	Enforceable Preferred Drug List (090-02); Enforceable Mental Health Preferred Drug List (090-03); eliminate certain optional services (090-72); eliminate fee-for-service COLA (090-85); SPD in-home care (090-X1); SPD limit income eligibility (090-X2)
59	MAP-13	HS	Medical Assistance Prgms-Non-OHP Payment	Medicare Buy-In		Transferred to SPD for 2009-2011.		12						\$ -			N	N		

Program/division priorities for 2011-13 biennium

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20		
Priority (ranked with highest priority first)	Dept. (division)	Program/div (Orbits B Level)	(Orbits A Level title)	(Orbits Sub-A Level title)	Program unit/activity description	Identify key performance measure(s)	Primary purpose program-activity code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or enhanced program (Y/N)	Included as reduction option (Y/N)	Legal req. code (C, F or D)	Comments on proposed changes to EBL included in GRB	
72	MAP-14	HS	Medical Assistance Prgms-Non-OHP Payment	All Other	Includes: 1) Breast and Cervical Cancer Program providing medical benefits for uninsured women diagnosed with breast or cervical cancer. 2) Citizen-Alien Waived Emergency Medical (CAWEM) provides emergency medical services to clients who are ineligible for Medicaid because they do not meet citizenship requirements. It now also covers prenatal benefits for CAWEM clients. 3) health insurance premiums paid to clients for reimbursement of employer sponsored insurance premiums. 4) Oregon Supplemental Income Program Medical covers clients with high medical needs that are over income for eligibility in other programs.		12	29,168,165	6,828,000			73,606,031		\$ 109,602,196			N	Y	F	Healthy Kids Plan (POP505); OHP Standard (POP503); Enforceable Preferred Drug List (090-02); Enforceable Mental Health Preferred Drug List (090-03); limit dental (090-17); additional dental limits (090-24); eliminate dental (090-26); limit vision (090-29); limit pay to federally qualified health clinics (090-44); durable medical equipment sole source (090-47); eliminate certain optional services (090-72); eliminate fee-for-service COLA (090-85)	
73	MAP-15	HS	Medical Assistance Prgms-CHIP Payments	Managed Care	The statutes implementing the Oregon Health Plan require, insofar as possible, that care be delivered in a comprehensive managed-care system. Providers in managed-care plans are paid at rates set by an independent actuary to reflect the reasonable cost of provider care. Services paid on a fee-for-service basis are paid at traditional Medicaid rates.	29,30 and proposed for 2011-2013: preventive services for OHP youth and adults, preventive services for OHP children	12		34,527,919			98,835,998		\$ 133,363,917			N	Y	F	Healthy Kids Plan (POP505); reduce diagnostic related group hospital rates to 90% (090-01); reduce diagnostic related group hospital rates to 80% (090-15); reduce capitation rates (090-84); reduce diagnostic related group hospital rates to 72%	
74	MAP-16	HS	Medical Assistance Prgms-CHIP Payments	Fee for Service	The statutes implementing the Oregon Health Plan require, insofar as possible, that care be delivered in a comprehensive managed-care system. Providers in managed-care plans are paid at rates set by an independent actuary to reflect the reasonable cost of provider care. Services paid on a fee-for-service basis are paid at traditional Medicaid rates.	29,30 and proposed for 2011-2013: preventive services for OHP youth and adults, preventive services for OHP children	12		9,234,009			28,474,318		\$ 37,708,327			N	Y	F	Healthy Kids Plan (POP505); Enforceable Preferred Drug List (090-02); Enforceable Mental Health Preferred Drug List (090-03); limit pay to federally qualified health clinics (090-44); durable medical equipment sole source (090-47); eliminate fee-for-service COLA (090-85)	
75	MAP-17	HS	Medical Assistance Prgms-CHIP Payments	Kids Intensive Services	Fee for Service	Intensive mental health services are delivered to children through psychiatric day treatment programs and psychiatric residential placement.	Proposed for 2011-2013: child mental health services			34,814			99,656		\$ 134,470			N	Y	F	Healthy Kids Plan (POP505); eliminate fee-for-service COLA (090-85)
76	MAP-18	HS	Medical Assistance Prgms-CHIP Payments	All Other		This category is used to make any needed technical adjustments, funding modifications and any other adjustments to limitation levels.	12							\$ -					N		
		HS	MAP Program Support & Administration	MAP Program Support					22,274,711	8,640,068		43,838,521		\$ 74,753,300							
		HS	MAP Program Support & Administration	MAP Director/Division Administration					2,050,126	30,490		1,093,908		\$ 3,174,524							

7. Primary purpose program/activity exists

- 1 Civil Justice
- 2 Community Development
- 3 Consumer Protection
- 4 Administrative Function
- 5 Criminal Justice
- 6 Economic Development
- 7 Education & Skill Development
- 8 Emergency Services
- 9 Environmental Protection
- 10 Public Health
- 11 Recreation, Heritage or Cultural
- 12 Social Support

19. Legal requirement code

- C Constitutional
- F Federal
- D Debt service

Within each program/division area, prioritize each budget program unit (activities) by detail budget level in ORBITS.

Document criteria used to prioritize activities:

MAP prioritizes its programs and services using the following vision, mission and principles that represent MAP's contribution to the DHS and OHA missions of assisting people to become independent, healthy and safe by receiving the right care, in the right place at the right time:

Vision:
Improved access to effective, quality medical services for low-income and vulnerable citizens through innovation, collaboration, integration and shared responsibility.

Mission:
Provide a system of comprehensive health services to qualifying Oregonians and their families to improve health status and promote independence.

- Principles:
- Reduce health care services before reducing coverage to people.
 - Provide vulnerable Oregonians access to high-quality health care.
 - Keep children healthy and safe.
 - Utilize managed care organizations to delivery services when possible.
 - Seek out and use evidenced-based practices.
 - Promote prevention.
 - Maximize federal matching funds.

Medical Assistance Programs contain 98% of the General Fund budget for Health Programs*

	General Fund (GF)	Other Fund (OF)	Federal Fund (FF)	Total Fund (TF)
Medical Assistance Programs	\$975	\$1,069	\$3,140	\$5,184
Office of Private Health Partnerships	\$18	\$445	\$88	\$551
Oregon Educators Benefit Board	\$0	\$1,449	\$0	\$1,449
Public Employees Benefit Board	\$0	\$1,414	\$0	\$1,414
Total Health Programs	\$993	\$4,377	\$3,228	\$8,598

**in rounded millions*

2011-13 Governor's Balanced Budget

(in rounded millions)

	GF	OF	FF	TF
2009-11 LAB (Dec 2010 E-Board)	770.7	1,073.4	4,185.0	6,024.1
Less: 2009-11 Governor's Allotment Reductions	(61.9)	14.2	(17.5)	(65.2)
2009-11 Spending Level	708.8	1,087.6	4,167.5	5,958.9
Caseload Changes (at current rates)	265.2	79.5	628.3	978.0
One-time money (including ARRA, Tobacco Settlement, Provider Tax Carryover)	616.8	(47.7)	(524.2)	44.9
Subtotal	1,590.8	1,119.4	4,271.6	6,981.8
<u>Payment Reductions</u>				
Managed Care 19% Rate Reduction	(211.6)	(29.7)	(405.1)	(646.4)
FFS 19% Rate Reduction	(112.8)	(18.4)	(231.3)	(362.5)
Subtotal Payment Reductions	(324.4)	(48.1)	(636.4)	(1,008.9)
<u>Benefit Changes</u>				
* Eliminate lines 473 through 511 from the prioritized list	(29.1)	(0.8)	(50.7)	(80.6)
* Continuation: Increase medical management and prior authorizations	(1.9)	-	(3.5)	(5.4)
* Continuation: New reimbursement methodology to pharmacies	(2.5)	(0.7)	(5.5)	(8.7)
* Continuation: Managed care co-payments	(0.9)	-	(1.5)	(2.4)
* Changes to the preferred drug list	(8.4)	(2.6)	(18.4)	(29.4)
* Improved contracting for durable medical equipment supplies	(0.5)	-	(0.8)	(1.3)
Subtotal Benefit Changes	(43.3)	(4.1)	(80.4)	(127.8)

2011-13 Governor's Balanced Budget

(in rounded millions)

	GF	OF	FF	TF
<u>Administrative Reductions/Continuous Improvement Savings</u>				
* Continuation of Administrative cost reduction measures	(1.2)	-	(1.2)	(2.4)
* Continuous Improvement				
* Improved eligibility processes, including identification of third party insurance	(5.2)	-	(7.5)	(12.7)
* Increase electronic transactions	(0.7)	(0.1)	(1.2)	(2.0)
* Improve accuracy of paying claims	(1.9)	2.1	0.3	0.5
Subtotal Admin Reductions/Continuous Improvement Savings	(9.0)	2.0	(9.6)	(16.6)
Health System Transformation	(239.2)	-	(405.5)	(644.7)
2011-13 GBB	975.0	1,069.2	3,139.7	5,183.8

POLICY AND PROGRAM ALTERNATIVES

To deliver health care coverage to low-income Oregonians who are eligible, Health Care Programs works closely with the Oregon Legislature, partners and stakeholders to recognize health care challenges, identify opportunities and propose realistic solutions.

Key budget drivers and issues

Unfortunately, due to the current recession and a poor economic forecast, the Governor's Balanced Budget (GBB) cannot meet all medical assistance needs covered in the Current Service Level budget of the division of Medical Assistance Programs (OHP).

Maintaining access to health care is the top priority — ensuring continuation of OHP's Standard program and support for uninsured low-income adults. However, budget cuts have forced OHA to retreat from many of OHP's critical challenges, including expanded access to health care for pregnant women and their infants or improving provider reimbursement rates to help ensure continued services to Medicaid clients.

Grouped by initiative, these are the challenges the MAP faces. Strategic initiatives and design considerations have been identified to meet the challenges.

Partnerships

Challenges	Opportunities
Primary care providers may leave the OHP managed care system if reimbursement rates do not increase. OHP enrollees may lose access to primary care, which could increase overall costs as they seek care from specialists or emergency rooms.	Increase reimbursement for physical medicine primary care services provided in the managed care delivery system to levels that fully compensate providers for those services. Managed care capitation rates would reflect an increase to 150 percent of Medicare for select procedure codes corresponding to primary care services.
Health care providers find it more difficult to continue caring for OHP enrollees and may stop accepting Oregonians with OHP if reimbursement rates do not stabilize.	Establish a fee-for-service reimbursement floor of 80 percent of 2010 Medicare rates for specific services covered by the Oregon Health Plan to improve client access to health care and improve fee-for-service providers' financial stability.

Challenges	Opportunities
Health care disparities persist among racial and ethnic groups and a lack of data about sub-groups of these populations hinder efforts to address disparities.	Work with Children, Adults and Families to enhance data collection systems to accept more categories of data regarding race and ethnicity.
Homeless OHP recipients tend to have high medical costs, and those costs decrease as their housing situation stabilizes. Local partners, such as counties, often bear the burden of providing services to this population.	Work with local partners who provide non-federal matching funds and targeted case management services. OHA staff would provide training, program management and support with 13 public health nurses stationed throughout the state.
Federally qualified health centers and rural health clinics are financially vulnerable because of the current billing cycle that delays OHP reimbursements.	Expedite payments to federally qualified health centers and rural health clinics, which are vital to ensuring access to low-income clients.

Prevention

Challenges	Opportunities
Uninsured low-income pregnant women above 185 percent of the federal poverty level (FPL) do not have access to Medicaid-paid prenatal care.	Raise OHP eligibility for uninsured low-income pregnant women from 185 percent of the federal poverty level to 200 percent.
Oregonians who receive OHP Standard coverage lack preventive and early treatment for dental, vision and some hospital services. This shifts the cost burden to providers and the insured, and results in poorer health outcomes for people who cannot afford treatment.	Restore the more robust OHP Plus benefit package for vision, dental and hospital services to the OHP Standard population.
Pregnant women who are undocumented, or who are documented but have not yet met the residency requirement, are denied paid prenatal health care through Medicaid, potentially resulting in negative birth outcomes. However, under the Children's Health Insurance Plan Reauthorization Act, Oregon has the option to use federal funding to provide coverage.	Expand statewide a successful seven-county program to deliver prenatal care statewide to uninsured low-income women who are undocumented or are documented but haven't yet met the residency requirement.

Challenges	Opportunities
<p>OHP recipients may not get preventive care and screenings if something they read in the OHP Handbooks confuses them, or they don't understand why to get care, or they don't know how to get an appointment or fill a prescription. They may then seek costlier care.</p>	<p>Create a Client Navigator Program within MAP to help clients who seek assistance work through the medical assistance system and overcome barriers to quality care, timely treatment, treatment options and preventive care.</p>
<p>Many Oregonians lack health insurance. They put off going to the doctor for preventive visits, often requiring more costly care. Those costs are shifted to consumers with private health insurance and health care providers who provide charity care.</p>	<p>Increase tobacco tax by \$1 per pack to support expanded eligibility.</p>

Access to quality, affordable health care

Challenges	Opportunities
<p>A lack of appropriate translation services remains a barrier to care for many Oregonians. Reimbursement to providers, whether through fee-for-service or capitation rates, does not currently cover translation services, although federal law mandates that providers make translation available at no cost to the patient.</p>	<p>Require interpreters to have Oregon Health Authority certification. Include interpretive services costs in capitation rates for managed care plans. On the fee-for-service side, create new provider type, interpreters, who enroll with us and bill us directly.</p>
<p>When the primary wage earner (PWE) in a two-parent household loses a job without good cause, the parents may have to choose between remaining together or splitting up in order to qualify for health care.</p>	<p>In partnership with Children, Adults and Families division of the Department of Human Services, MAP would eliminate the requirement that the PWE not be separated from their most recent job because of discharge for cause or voluntary termination. This would enable the parents to qualify for medical assistance.</p>
<p>The decrease in available employer-sponsored coverage and increase in the number of uninsured individuals are factors that increase cost-shifts to those who maintain health insurance coverage and increase the number of people applying for public medical assistance programs.</p>	<p>Expand enrollment by opening access to OHP Standard to uninsured low-income adults who are eligible.</p>

Challenges	Opportunities
<p>Children who would otherwise qualify for medical assistance but lack citizenship or legal residency documentation may receive limited services through the Citizen/Alien Waived Emergency Medical (CAWEM) program. As a result, they may lack access to preventive care. The rising number of uninsured results in more charity care by providers, uncompensated care costs being passed on to the insured and poorer health outcomes for people who cannot afford preventive and early treatment.</p>	<p>Allow undocumented children who meet other requirements to be eligible for OHP Plus under Healthy Kids.</p>
<p>Working families in Oregon with incomes above the current Supplemental Security Income (SSI) eligibility level who have children with significant SSI-level disabilities and high medical needs often lack access to medical care because they cannot afford private insurance or qualify for public medical assistance.</p>	<p>Through the Healthy Kids program, make OHP Plus available to those children under the age of 19 who meet the definition of disability under SSI and whose families earn 300 percent or less of the FPL.</p>
<p>OHP Standard offers a lesser benefit package than OHP Plus, denying needed benefits to thousands of enrollees and requiring providers to administer two benefit plans.</p>	<p>Restore the benefit package for OHP Standard clients to match the OHP Plus benefit package.</p>
<p>Seniors and People with Disabilities has identified five types of durable medical equipment that would do the most to increase independence for people who face the challenges of morbid obesity.</p>	<p>Extend OHP coverage to these classes of equipment to OHP clients who face the challenges of morbid obesity.</p>
<p>Women may be screened for breast or cervical cancer through a program in Public Health, but may lack the ability to pay for the medical care to address any issues that turn up in the screening.</p>	<p>Expand access to the Breast and Cervical Cancer Program (BCCP).</p>

Continuous Improvement Initiative

OHA and DHS launched the Transformation Initiative in December 2007 to improve efficiency and effectiveness throughout the department. Now known as Continuous Improvement, the initiative is designed to enable OHA and DHS to continue providing high-quality services during a time when the demand is outpacing revenue.

Completed initiatives

Since the initiative began, DMAP has completed the following:

Initiative	Results
<p>Electronic provider communications: The goal was to provide information to MAP providers in the most cost effective, timely and professional method. Per biennium, the MAP mailed an estimated one million provider announcements about updates to Oregon Health Plan (OHP) policies, benefits, rules and procedures.</p>	<p>MAP stopped mailing OHP provider announcements on June 1, 2009. The financial result is an estimated savings of \$606,000 or an annual savings of \$303,000 in print and postage costs.</p>
<p>Increase the percentage of providers billing electronically: The goal was to decrease the amount of paper claims processed and increase the percentage of providers who bill electronically from 85 to 95 percent, MAP focused on promoting the new Web portal billing feature to providers who have historically shied away from electronic billing.</p>	<p>Web portal billing reduced the rate at which claims suspend for review from five percent to less than one percent. It also provided real-time claim adjudication, allowing providers to correct any errors on the claim within minutes instead of weeks.</p> <p>The financial result is an estimated annual savings of \$102,000.</p>
<p>Streamlined the prior authorization (PA) process: This initiative found efficiencies and a simple, common process among the three entities that approved PAs. The focus was specifically in the area of receiving and entering information into the MMIS and identification of PA requests.</p>	<p>Streamlining the PA process and maximizing use of MMIS resulted in an estimated \$102,500 in annual savings by reducing the cycle time of the process.</p>
<p>Expanded the use of alternate methods for provider trainings: This initiative changed training delivery for providers from in-person classroom training to electronic training, such as NetLink, Webinar, videoconferences (VCON), Web-based self-tutorials and telephone conferences.</p>	<p>Changed the way MAP creates training materials by using CDs rather than hardcopy books. After initial investments in Webinar license and laptops, the return on investment is estimated at \$33,000 in annual savings due to reduced travel costs for both MAP staff who provide training, and providers who attend training.</p>

Initiative	Results
<p>Implemented videoconferencing for meetings with managed care organizations: This initiative implemented the use of videoconferencing (VCON) for monthly meetings with managed care organizations (MCOs). Most MCO representatives travel approximately two hours roundtrip to attend an average of six meetings per month in Salem.</p>	<p>By increasing the use of VCON, the initiative provided an opportunity for the managed care stakeholders to save in travel expense costs. Since MCOs had VCON equipment available to them, there was no investment expense to use the service.</p>
<p>Improved efficiencies in processing third party liability (TPL): This initiative focused on identifying efficiency improvements around third party insurance identification, verification and processing within the MMIS.</p>	<p>In collaboration with the Health Insurance Group (HIG), DMAP focused on eliminating the TPL referral backlog of 10,565 referral forms. HIG made changes to business processes and eliminated the backlog by August 2010, resulting in \$27 million in cost savings.</p>
<p>Streamlined the process for making changes to the Health Services Commission (HSC)'s prioritized list of health services: This initiative developed a simple, standard and efficient process for coordinating and implementing prioritized list changes.</p>	<p>Coordination between the HSC and MAP resulted in better understanding of the process among staff in both offices.</p>
<p>Created an enforceable preferred drug list (PDL): This initiative implemented an enforceable PDL for physical health drugs provided to clients in the fee-for-service delivery system.</p>	<p>The passage of HB 2126 by the 2009 Legislature authorized enforcement of the PDL. Implementation began on January 1, 2010, with savings estimated to be \$733,300 for 2010.</p>
<p>Streamlined the process for administrative reviews: This initiative standardized MAP's administrative review request process. The process for responding to providers or stakeholders regarding MAP payment decisions varied across work units.</p>	<p>All units adopted a standard review process to help reduce cycle time and established a standard turnaround time for disposition. The expected benefits are increased quality and measurement to help with continuous improvements once the standard process is stable.</p>
<p>Implemented the Lean Daily Management System (LDMS) tool for continuous improvement: This initiative provided the core tools and training to managers and staff on LDMS.</p>	<p>LDMS promotes teamwork and helps simplify communication, identify and solve problems, measure progress, establish goals for improvement and align work group activities with agency goals and priorities.</p>

Planned initiatives

In 2011 the medical assistance programs intend to streamline the:

- MMIS change request process;
- Targeted case management services and coordination process; and
- Client hearings process.

The approximate cumulative cost savings for all of the MAP initiatives since implementation is \$40 million. In some cases, the initiatives resulted in less workload, allowing the MAP to redeploy staff to areas of greater need. In addition to saving money, these initiatives shifted the MAP culture to one of continuous improvement; improved the quality of staff work; and improved how our clients and stakeholders receive information from us.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The reauthorization of the state Children's Health Insurance Program (CHIP) in February 2009 continues to have an impact on Oregon's CHIP program. The law continued the program and added significant new funding to CHIP state allotments through 2013.

CHIPRA allowed the state the option of receiving the CHIP match rate for children up to 300 percent of the federal poverty level, a provision that Oregon uses to serve children through the Office of Private Health Partnerships' Healthy Kids Premium Assistance and Healthy KidsConnect programs.

New initiatives to enroll currently eligible uninsured children

Oregon also has adopted new tools provided under CHIPRA, such as Express Lane Eligibility, to facilitate the enrollment of already-eligible uninsured children. For two years, Oregon has been awarded CHIPRA performance bonuses for increasing enrollment of already-eligible uninsured children in Medicaid and adopting specified measures to streamline enrollment and retention. Oregon's 2009 bonus was \$1,603,336, and in 2010, the bonus awarded to Oregon was \$15,055,255.

Changes in CHIP eligibility rules

Also under CHIPRA, the state implemented a provision that allows elimination of the five-year waiting period for Medicaid and CHIP that currently applies to children who are legal immigrants. This allows Oregon to use federal and state funds to

provide services to documented children who have lived in the United States fewer than five years.

American Recovery and Reinvestment Act of 2009 (ARRA)

Known as the “stimulus” bill, ARRA continues to have an impact on the state. ARRA included an \$87 billion temporary increase to the Federal Medical Assistance Percentage (FMAP), the Medicaid match rate states receive from the federal government for health care programs. The law automatically increased the FMAP by 6.2 percent for the “recession adjustment period” of October 1, 2008, through December 31, 2010. Additionally, as a state with a high unemployment rate, Oregon was eligible for an additional FMAP increase.

As a result of the ARRA legislation, Oregon’s FMAP went from the pre-ARRA level of 62.45 percent to 72.61 percent at the start of the 2009-211 biennium. Due to continuing increases in the unemployment rate, Oregon’s FMAP had risen to 72.97 percent by the time the recession adjustment period ended on December 31, 2010. ARRA also extended the Qualifying Individual (QI) Program through December 2010. This program pays Medicare premiums for low-income Medicare recipients with 100 percent federal match.

While ARRA did not resolve all of Oregon’s budget shortfalls, it saved the state from being forced to enact larger budget cuts or additional tax increases to meet balanced budget requirements while continuing to serve the populations most in need.

The Patient Protection and Affordable Care Act (ACA) of 2010

The ACA, enacted on March 23, 2010, brought a number of changes to Oregon’s medical assistance programs; many will have a long-term impact as Oregon implements provisions on the designated time lines.

Major program provisions with an impact in the 2011-13 biennium include:

- More stringent maintenance of effort (MOE) provisions first enacted in CHIPRA and ARRA. Under ACA, the state must maintain eligibility standards, methodologies and procedures that were in effect March 23, 2010. For adults, the MOE will expire when the state exchange system is operational on January 1, 2014. For children, the MOE is retained until September 30, 2019. If the state violates the MOE, all FMAP funding is at risk.

- The ACA extends the current CHIP reauthorization period through September 30, 2015.

While many of the ACA provisions that will have a direct impact on eligibility, benefits and policy will not go into effect until 2014, several provisions that affect current service delivery and operations are already being implemented and will impact DMAP and OHA throughout the 2011-13 biennium.

Major operational provisions with an impact the 2011-13 biennium include:

- Increases in the Medicaid drug rebate percentage for brand name drugs to 23.1 percent and generics to 13 percent, including drugs furnished to MCO enrollees. Most of the new increases in the rebate will accrue to the federal government rather than to the state;
- Expanded participation and improvements in the 340B pharmacy program;
- Revisions to the federal Medicaid pharmacy upper payment;
- Requirements for new child and adult health quality measures;
- Prohibition on federal payment for providing medical assistance for health care-acquired conditions;
- Option to provide health homes for enrollees with chronic conditions and increased FMAP for these services;
- Mandatory Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use;
- Requirement for state to screen providers under Medicare, Medicaid and CHIP; and
- Provisions for program integrity improvements including:
 - National provider identifier numbers;
 - Mandatory contracts with recovery audit contractor;
 - More stringent provider participation and termination procedures; and
 - Implementation of the national correct coding initiative.

The Education, Jobs and Medical Assistance Act of 2010

On August 10, 2010, HR 1586, the Education, Jobs and Medical Assistance Act of 2010, became law. This bill scaled back and extended the ARRA temporary FMAP increase for six months, through June 2011. Oregon's FMAP went from 72.97 percent on December 31, 2010 to 70.14 percent for January through March 2011 and to 68.25 percent for April through June 2011.

The Medicare and Medicaid Extenders Act of 2010

On December 15, 2010, HR 4994, the Medicare and Medicaid Extenders Act of 2010 became law. This law extended the Qualifying Individual Program through December 2011.

It also extended the Transitional Medical Assistance (TMA) program through December 2011. TMA helps low income families with children transition into jobs without losing their Medicaid for a period of time even if their income exceeds the allowable limit for eligibility. Both the Qualifying Individual Program and Transitional Medical Assistance had been slated to expire on December 31, 2010.

Conclusion

With the current state of the economy, it is more critical than ever that DMAP continue its work of ensuring access to health care for eligible, low-income Oregonians. As more people lose their jobs and employer-sponsored health insurance, the lack of preventive care will only exacerbate the cost-shifting that occurs when people use health care of the last resort, such as the emergency department, where treatment is the most expensive. Uncompensated hospitals and providers then pass these costs onto insured individuals and the underinsured population in the form of increased fees and premiums.

As the cost of health care and insurance premiums rise, particularly prior to the controls that are not due for implementation under ACA until 2014 or later, more and more people will be unable to afford to pay, creating the ongoing downward spiral that exemplifies our broken health care system. By breaking that cycle for as many Oregonians as possible, the Oregon Health Plan is one of the state's best defenses in our struggle to resuscitate Oregon's struggling economy.

HB 5100 (2010) budget note

During the 2010 special session, the Legislative Assembly issued a budget note in House Bill 5100 directing the Oregon Department of Human Services, division of Medical Assistance Programs (MAP) to work with hospitals, Oregon Health Plan (OHP) managed care plans and other stakeholders to study hospital reimbursement methods under OHP.

- The budget note directs the division to assess how the current reimbursement method could be modified to create a common reimbursement mechanism among a variety of payers and better contain hospital costs.
- It also directs the division to report results of the study to either the Interim Joint Committee on Ways and Means or Emergency Board by September 30, 2010, as well as to appropriate legislative policy committees and the Oregon Health Policy Board.

Actions taken

Reports were provided on the status of this budget note to the September 2010 Emergency Board.

Audits

Type of audit	Nature of audit	Status
Acumentra 2009 MMIS/AMH	External quality review	Completed
Acumentra 2011 ISCA/Physical and mental health managed care	External quality review	In progress
Behavioral rehabilitation services	Internal audit	Completed
Business continuity planning	Internal audit	Completed
Department of Administrative Services: Wireless communication devices	SOS audit — multi-agency	Completed

Type of audit	Nature of audit	Status
Disproportionate share hospitals audit	Federal review/audit (CMS)	In progress
DMAP desk review	Federal review/audit (CMS)	Completed
Family planning services	Federal review/audit (OIG)	In progress
FHIAP 2008 transfer over to OHP Standard	SOS audit	Completed
HCBS medically involved children's waiver	Federal review/audit (CMS)	Completed
HP SAS70 Type I (Drug Rebate Program)	Application controls review	Completed
HP SAS70 Type II (Drug Rebate Program)	Application controls review	Completed
Key performance measure integrity (rolling)	Internal audit	Completed
MIG-Medicaid program integrity review	Federal review/audit (CMS)	In progress
MMIS Certification as an internal controls review	Internal consult	Completed
MMIS Cost review	Federal review/audit (OIG)	In progress
MMIS General controls	Federal review/audit (OIG)	In progress
MMIS implementation — reporting and documentation provider payments	Internal audit	In progress
MMIS information technology controls	SOS audit	In progress

Type of audit	Nature of audit	Status
MMIS internal control roles and responsibilities	Internal consult	Completed
Payment error rate measurement (PERM) — FFY 08	Federal review/audit (CMS)	Completed
PERM — FFY 11	Federal review/audit (CMS)	In progress
Prior period adjustments	Federal review/audit (CMS)	In progress
Psychotropic medications prescribed to foster care children	Federal review/audit (GAO)	In progress
Small purchase order transaction system (SPOTS) — rolling	Internal audit	Completed
SPOTS card review — key controls	SOS audit	Completed
SPOTS card review — rebates	SOS audit	Completed
Statewide single audit year ending 6/30/09	SOS audit	Completed
Statewide single audit year ending 6/30/10	SOS audit	In progress
Targeted case management	Internal audit	In progress

KEY PERFORMANCE MEASURES

The division of Medical Assistance Programs uses three key performance measures (KPMs) to ensure the division is meeting its mission of helping Oregonians become healthier, more self-sufficient and safer by improving their access to medical services. Key performance measures are the highest level, outcome-oriented performance measures; the program also has many additional, more detailed measures for internal management and quality improvement.

2009-11 key performance measures

One cornerstone of the Oregon Health Plan is increasing access to preventive health services, thereby reducing unnecessary and more expensive health care in the hospital or emergency room setting. MAP currently uses three KPMs related to the provision of preventive services to gauge how well the division is meeting policy objectives.

Two of these measures assess the rate of preventive services provided to OHP clients using Lines 3 and 4 of the OHP prioritized list of health services. Because the prioritized list guides budget setting and the pricing of reimbursement to managed care plans, these measures link directly to OHP's reimbursement and policy priorities. However, because Oregon is the only state that funds health care according to a prioritized list, these measures do not allow comparisons with other states or payers.

The third measure is a national prevention quality indicator (PQI) that measures hospitalizations for some chronic¹ and acute² conditions called ambulatory care sensitive (ACS) conditions, where timely and effective ambulatory care (usually primary care) can help prevent or reduce the risk of hospitalization.

Evidence suggests that good preventive and primary care dramatically reduce the risk of ACS hospitalizations. Higher rates of ACS hospitalizations may indicate issues with accessing preventive services or access to primary care. However, sometimes ACS hospitalizations occur despite adequate use of primary and preventive care, especially among older and sicker patients.

¹ Chronic conditions include diabetes, asthma, congestive heart failure, COPD.

² Acute conditions include dehydration, bacterial pneumonia, urinary tract infection.

For these measures, a person year equals any combination of OHP members and their enrollment that totals to 12 months. For example, one person year could equal one member enrolled for 12 months or two members, one enrolled 3 months, one enrolled 9 months.

For this performance review, the 2009 calendar year is the most current year for which data are available³.

KPM 23: Preventive health care provided to OHP children

Purpose: This measures the utilization rate of preventive services per person year for OHP children from birth to 10 years old, based on line three of the prioritized list of health services.

Outcome: In 2009, MAP rate of 4.52 was higher than previous years, but slightly less than the 2009 target rate of 4.82 preventive services per person year.

Preventive services for OHP children birth through 10 years old

The rate is the number of preventive services per person year (higher rates are favorable).

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Actual Rate	3.61	3.20	4.32	4.45	4.52				
Target					4.82	4.85	4.90	4.95	5.00

How Oregon compares to other states: Because this measure is based on line 3 of OHP's unique prioritized list of health care services, there are no comparative rates.

KPM 24: Preventive health care provided to OHP youth and adults

Purpose: This measures the utilization rate of preventive services per person year for OHP youth and adults 11 years old and older, based on line 4 of the prioritized list of health services.

Outcome: In 2009, DMAP's rate of 0.99 exceeded the 2009 target of 0.91 per person year and was also higher than all previous years.

³ Because this year's data does not include Citizen-Alien Waived Emergency Medical clients, the numbers presented here are slightly different from the previous session's reports on these measures.

Preventive services for OHP youths and adults age 11 and older

The rate is the number of preventive services per person year (higher rates are favorable).

DATA	2005	2006	2007	2008	2009	2010	2011	2012	2013
Actual Rate	0.52	0.44	0.80	0.94	0.99				
Target					0.91	0.93	0.96	0.98	1.00

How Oregon compares to other states: Like KPM 23, there are no comparative rates because this measure is based on line 4 of OHP's unique prioritized list.

KPM 26: Preventive quality indicator (PQI) for ACS hospitalizations

Purpose: This measures the rate of ACS hospitalizations for nine chronic and three acute conditions per 100,000 person years of OHP members 18 years old and older.

Outcome: In 2009, DMAP's rate of 2,591 was slightly above the 2009 target rate of 2,536.

ACS hospitalizations of OHP clients (ages 18 and older)

The rate is the number of ACS hospitalizations per 100,000 person years (low rate favorable).

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Actual Rate	2,945	2,983	3,208	2,898	2,591				
Target					2,536	2,294	2,052	1,810	1,568

How Oregon compares to other states: The closest possible comparison for this measure is the ACS hospitalization rate calculated by the Office of Oregon Health Policy and Research (OHPR) in 2007 for the total Oregon population (1,084 hospitalizations per 100,000 people). The target rate for calendar year 2015 is 1,084 per 100,000 person years.

These rates are different because:

- Nationally, low-income populations, including the Medicaid population, consistently have higher (unfavorable) PQI rates than the total population. Social determinants such as long-term tobacco use and obesity occur

disproportionately among low-income people and contribute to many ACS conditions.

- DMAP used a newer software program to calculate the rate for OHP clients. Because DMAP's rate is based on 100,000 person years, each person year may represent one or more OHP clients. Meanwhile, the statewide rate is based on 100,000 unique people.

Proposed measures for 2011-13

Adequacy of prenatal care for OHP clients

This measure, proposed for 2009-11, has proven to be inherently unmeasurable because of near-universal use of global and bundled coding when billing for prenatal, delivery, and postpartum services.

In order to avoid costly chart reviews, MAP uses administrative data from its claim processing system to calculate measures, and does not have access to electronic medical records that would provide meaningful data for this measure. Therefore, MAP is asking to drop this measure until an accurate measurement process is available.

Preventive services for OHP clients (KPMs 23 and 24)

Because of their basis on the prioritized list of health services, these measures are unique to Oregon and cannot be compared with other national or in-state measures. MAP plans to replace these measures with more universal measure(s) that align with measures for preventive services within OHA and other states.

Conclusion

KPMs 23 and 24 showed a favorable trend from 2005 through 2009. Some of this increase may be due to the physician access improvement plan, a demonstration project of the fully capitated health plans that occurred between May 1, 2008, and April 30, 2009, with the goal of increasing client access to preventive care services, specifically those on lines 3 and 4 of the prioritized list.

In addition, all three measures improve when clients are enrolled in managed care and have a medical home. The MAP automatically enrolls clients in managed care. Managed care plans are responsible for providing all clients a medical home.

Because reducing health disparities is an OHA priority, MAP also has examined these three measures by variations of service provided to racial and ethnic groups. Please see the Authority's *State of Equity Report*⁴ for these rates. Steps toward reducing health disparities between populations include collaboration with the Office of Multicultural Health to promote cultural competency in MAP contracted managed care organizations, emphasizing language services for clients and expanding OHP to non-traditional Medicaid populations.

⁴ This report is available on the OHA Web site at www.oregon.gov/OHA/omhs/soe.

GLOSSARY OF TERMS

The following list of acronyms includes those in this reference document as well as some common acronyms used when discussing medical assistance programs and policy.

A

- ACS:** Ambulatory care sensitive
- AMH:** OHA Addictions and Mental Health division
- AMP:** Average manufacturer's price
- ARB:** Agency Request Budget
- ARRA:** Federal American Reinvestment and Recovery Act of 2009
- ASD:** DHS and OHA Administrative Services division

B

- BAM:** DAS Office of Budget and Management

C

- CAF:** DHS Children, Adults and Families division
- CAHPS:** Consumer assessment of health plans and systems
- CAWEM:** Citizen-Alien/Waived Emergency Medical
- CHIP:** Children's Health Insurance Program (formerly known as SCHIP)
- CMS:** Centers for Medicare and Medicaid Services
- COLA:** Cost-of-living adjustment
- CSL:** Continuing service level

D

DAS:	Oregon Department of Administrative Services
DHS:	Oregon Department of Human Services
MAP:	Medical Assistance Programs (previously DMAP)
DM:	Disease management
DME:	Durable medical equipment
DO:	Director's Office
DO:	Doctor of osteopathy
DOJ:	Oregon Department of Justice
DRA:	Federal Deficit Reduction Act of 2005
DRG:	Diagnostic related group (hospitals)

E

EBL:	Essential budget level (now continuing service level)
ED:	Emergency department
EDI:	Electronic data interchange
ENCC:	Exceptional needs care coordinator
EPSDT:	Early periodic screening, diagnosis and treatment
ESI:	Employer-sponsored insurance

F

FCHP:	Fully capitated health plan
FFS:	Fee-for-service
FFY:	Federal fiscal year
FHIAP:	Family Health Insurance Assistance Program
FMAP:	Federal medical assistance percentage
FPL:	Federal poverty level
FQHC:	Federally qualified health center
FTE:	Full-time equivalent
FY:	Fiscal year

G

GF:	General Fund
GME:	Graduate medical education
GO:	Governor's Office
GBB:	Governor's Balanced Budget
GRB:	Governor's Recommended Budget (now Governor's Balanced Budget)

H

HB:	House Bill
HIT:	Health information technology

HSC: Health Services Commission

I

IT: Information technology

K

KPM: Key performance measure

L

LAB: Legislatively Approved Budget

LFO: Oregon Legislative Fiscal Office

M

MD: Medical doctor

MHO: Mental health organization

MITA: Medicaid information technology architecture

MMA: Medicare Modernization Act

MMIS: Medicaid management information system

MCO: Managed care organization

MSA: Master Settlement Agreement

N

NEMT: Non-emergency medical transportation

O

OAR:	Oregon Administrative Rule
OF:	Other Funds
OFH:	Public Health Office of Family Health
OHA:	Oregon Health Authority
OHP:	Oregon Health Plan
OHPR:	Office for Oregon Health Policy and Research
OMA:	Oregon Medical Association
OPHP:	Office of Private Health Partnerships
ORS:	Oregon Revised Statute

P

PA:	Physician's assistant
PA:	Prior authorization
PBM:	Pharmacy benefit manager
PCM:	Primary care manager
PCO:	Physician care organization
PCP:	Primary care provider
PDL:	Preferred drug list (formerly the Plan Drug List)
PH:	OHA Public Health division
PICS:	Position inventory control system

PLM: Poverty level medical
PQI: Prevention quality indicators
POP: Policy option package

Q

QA: Quality assurance
QI: Qualifying individual
QI: Quality improvement
QMB: Qualified Medicare beneficiary

R

RHC: Rural health clinic
RN: Registered nurse

S

SB: Senate Bill
SBHC: School-based health center
SBHS: School-based health services
SCHIP: State Children's Health Insurance Program (now called CHIP)
SLMB: Specified low-income Medicare beneficiary
SPA: State plan amendment
SPD: DHS Seniors and People with Disabilities division
SSDC: Sovereign States Drug Consortium

SSI: Social Security Income

T

TANF: Temporary Assistance to Needy Families

TCM: Targeted case management

TI: Transformation Initiative

TMA: Transitional medical assistance

TPL: Third-party liability (also known as TPR)

TPR: Third-party resource (also known as TPL)