

Medical Assistance Programs

The division of Medical Assistance Programs (MAP) is the state Medicaid agency, which delivers services to over 660,000 people, or one in six¹ Oregonians.

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 health services for low-income and vulnerable citizens through innovation, collaboration, integration and shared responsibility.

Goals

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 (OHP).

Improve the quality of health care for all Oregonians, especially for low-income Oregonians.

¹ Source: PSU Population Research Center, 2011 Oregon Population Report & Tables, available at <http://pdx.edu/prc/annual-oregon-population-report>.

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.

Programs

MAP's program budget includes three components: OHP-Medicaid, OHP-Children's Health Insurance Program (CHIP) also known as Healthy Kids, and Non-OHP.

OHP-Medicaid

The OHP-Medicaid budget covers services for Oregon's traditional and expansion Medicaid populations.

- The traditional Medicaid population meets federal Medicaid requirements, and receives OHP Plus benefit coverage².
- The Medicaid expansion population comprises uninsured adults (age 19 or older) with family incomes no more than 100 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid or Medicare. This population receives OHP Standard benefit coverage³.

The current hospital tax allows MAP to support a monthly average of 60,000 adults through the OHP Standard program over the current biennium.

² OHP Plus is a comprehensive benefit package with medical, dental, mental health and prescription drug benefits. Adults age 21 and older have limited optical coverage (for medically necessary conditions only). For a detailed benefit chart, see <https://apps.state.or.us/Forms/Served/oe1418.pdf>.

³ OHP Standard provides most of the same benefits as OHP Plus, with a limited dental benefit. Services not covered by OHP Standard include routine dental care, hearing aids/exams, home health and private duty nursing, physical/occupational/speech therapy, and optical services.

OHP-Children's Health Insurance Program (CHIP)

CHIP is a program for children from birth to age 6 with family incomes between 133 percent and 201 percent of the FPL, and for children from age 6 to age 19 with incomes between 100 percent and 201 percent of the FPL. The CHIP population also receives OHP Plus benefit coverage.

Non-OHP

MAP's Non-OHP budget covers the following specific populations:

- **Citizen/Alien Waived Emergency Medical (CAWEM) clients**, who are ineligible for OHP Plus or OHP Standard coverage solely because they do not meet the Medicaid citizenship or immigration status requirements⁴.
- **Breast and Cervical Cancer Medical Program:** Women 40 and over, with incomes of no more than 250 percent FPL, and no health insurance coverage are eligible for screening and diagnostic services through the Public Health Division's Breast and Cervical Cancer program. If a woman is diagnosed with breast or cervical cancer through this screening program, she is presumed eligible for OHP Plus benefit coverage under the Breast and Cervical Cancer Medical program, an optional Medicaid program. The woman remains eligible for the medical program until she reaches age 65, obtains other coverage or is no longer in need of treatment for her breast or cervical cancer.
- The **Qualified Medicare Beneficiary Program** serves people who have family incomes no more than 135 percent of the FPL. The program covers Medicare deductibles, co-insurance and co-payments.
- **Former Medically Needy clients** who receive drug coverage limited to those necessary for direct support of their organ transplants. The Medically Needy program was eliminated Jan. 31, 2003, but continued drug coverage for this population was legislatively approved in 2004. 20⁵ clients receive this coverage.

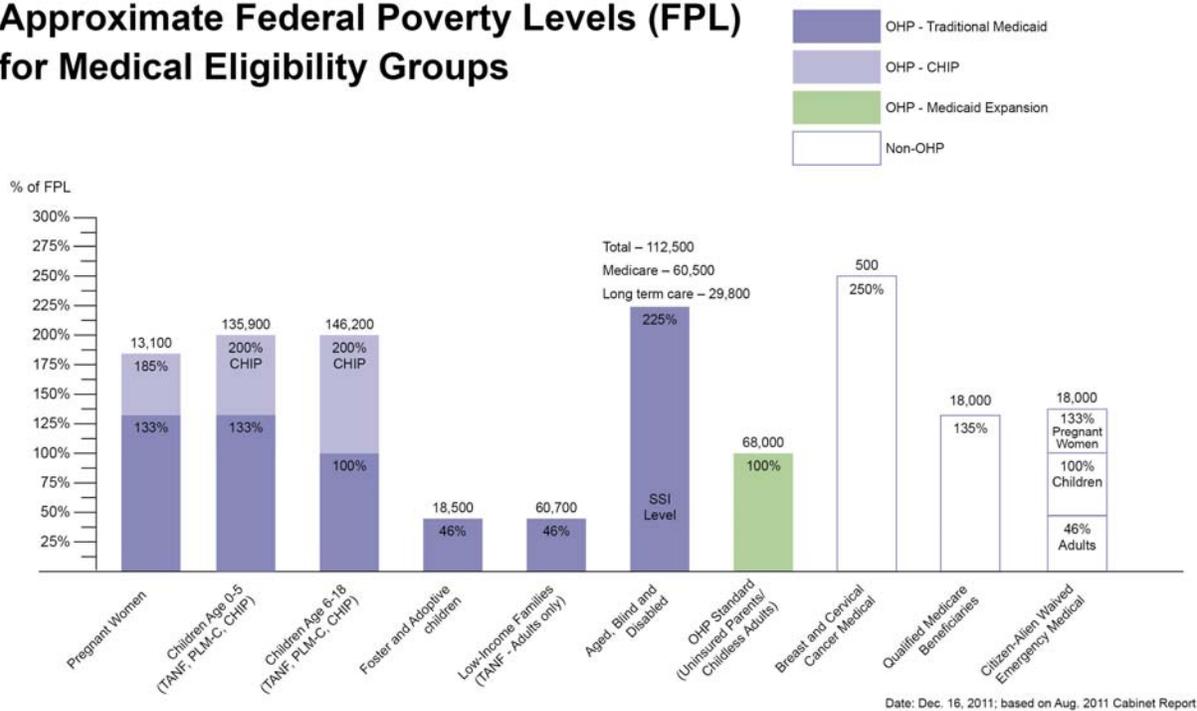
⁴ CAWEM benefits are limited to emergency services, which include labor and delivery.

⁵ Source: DHS DSSURS, Apr. 15 2012, DMAP Data Informatics Unit

Payments for services delivered to medical assistance clients represent 95 percent of MAP's budget:

- Because MAP coverage is limited to those in financial need, the program imposes financial eligibility requirements tied to the FPL.
- The following chart shows the approximate FPL requirements for clients who are part of the OHP and non-OHP medical assistance populations.

Approximate Federal Poverty Levels (FPL) for Medical Eligibility Groups



Administration

The remaining five percent of MAP's overall budget is program support and eligibility/caseworker staffing for the OHP Central Processing Center.

Program support includes staffing and contracts that support functions such as:

- Policy and planning: Developing policies to implement medical assistance programs;
- Quality improvement and medical management: Quality assurance and improvement monitoring of the managed care, coordinated care and fee-for-service delivery systems;
- Budget and finance: Oversight and coordination of the budget, actuarial capitation rates and pricing, as well as oversight and coordination of federal reporting and federal matching funds;
- Operations: Managing all aspects of health care financing operations for medical assistance programs.

Four percent of MAP's budget supports the **OHP Central Processing Center**, which processes approximately 30 percent of all medical assistance applications⁶.

- The purpose of the OHP Processing Center is to process medical applications, including enrollment into the appropriate programs, for eligible Oregonians.
- It provides daily service to members, prospective members and community partners.

MAP's administrative budget also includes the **Office of Healthy Kids**: Healthy Kids is children's no-cost or low-cost health care coverage for low-income families. Since its inception in 2009, the children's uninsurance rate has dropped by nearly half. The Office of Healthy Kids (OHK) uses an innovative outreach and

⁶ DHS Children, Adults and Families Division. Presentation to House Human Services Committee, Feb. 7, 2011. Available at <http://www.oregon.gov/DHS/aboutdhs/budget/2011-2013/docs/caf-ss.pdf>. The other 70 percent of applications are processed by DHS field staff.

education strategy, working closely with community partners, to ensure qualified families join the program and stay in the program.

- OHK works daily with local community partners with an emphasis on people who have access to populations who have been eligible for health coverage in the past but did not enroll for a variety of reasons.
- OHK contracts with 29 outreach grantees and 123 Application Assistor organizations that provide direct application assistance to families; helping approximately 8,016 children enroll into coverage since the program began. Their efforts through the end of the biennium will allow Oregon to continue to reach out to uninsured children and help keep eligible children enrolled when they come up for their annual redetermination of eligibility and families must resubmit application information. In addition to the direct application assistance that these organizations provide, it is the additional community based outreach and ongoing education that connect and support all families to the health care coverage that their children need. It is estimated that Healthy Kids will enroll approximately 7500 more children into coverage by the end of the biennium.
- The primary goal of OHK initially was to enroll 100,000 of Oregon's eligible children which was exceeded by more than 10% resulting in all but 5.6% of Oregon's eligible children enrolled in health care coverage. The OHK's goals have evolved to include keeping children and teens enrolled in health care coverage, and focusing on the small percentage of children and teens who are eligible but who are not currently enrolled in a health care program.
- The OHK is currently funded by the state's provider tax and matched with federal Medicaid/CHIP funds. The costs of the program remain stable and only change when responding to increases in publication costs, travel and workload. With another 230,000 newly eligible Oregonians anticipated for Medicaid/CHIP coverage in 2014, the OHK will be poised to provide application training and program support with the many changes coming as a result of the Affordable Care Act.

Another portion of MAP’s administrative budget is **Pharmacy Programs:**

- Pharmacy Programs provide all Oregonians access to reduced priced drugs through the Oregon Prescription Drug Program (OPDP). OPDP also provides consolidated purchasing power for the Oregon Education Benefit Board by jointly purchasing prescription drugs with state of Washington through the NW Drug Consortium. Pharmacy Programs also provides health insurance to persons who are HIV positive through CAREAssist, Oregon’s version of the Ryan White AIDS Drug Assistance Program.

2011-2013 budget reductions

Due to the severe revenue shortfall, MAP was required to reduce its OHP budget by more than 11 percent. Because most of the OHP budget is dedicated to paying for health care services, the reductions affected payment rates for most health care providers and services. It also required reducing the capitation rates paid to contracted managed care organizations.

The only rates that remained the same were fee-for-service primary care rates, and most maternity case management and obstetric services rates.

July 2011 reductions

Reduction area	Description
Contracted transportation brokerages	Administrative budget allowance reduced 5 percent.

August 2011 reductions

Reduction area	Description
Ambulance service rates	Reduced 2.7 percent
Anesthesia service rates	Base rate reduced from \$24.19 to \$21.20.
Clinical laboratory service rates	Reduced 4 percent (from 74% to 70% of the 2010 Medicare Clinical Lab fee schedule).

Reduction area	Description
Contracted mental health service rates	Reduced rates and contracted provider capacity by 11.5%.
Dental service rates	All reimbursement reduced 5 percent
Durable medical equipment rates	Rates for complex rehabilitation/wheelchair codes reduced 4.6 percent (priced at 90.5% of 2010 Medicare Fee schedule). Non-Medicare covered codes reduced 7.6 percent Rates for all other Medicare-covered codes included on DMAP's fee schedule priced at 80% of 2010 Medicare Fee schedule.
Home health service rates	Reimbursement reduced one percent (from 75% to 74% of Medicare costs reported to DMAP). Medical supply (acquisition cost) daily maximum rate reduced from \$75 to \$50.
Maternity case management rates	G9011 –Case Management Visit Outside the Home reduced to \$21.45 (50% of G9012 – CM Visit). Changes to billable codes: <ul style="list-style-type: none"> • Either G9002 or G9005 can be billed, but not both, and only if the client's case has been managed for at least three months. • G9009 – partial case management and G9010 – high risk case management no longer covered.
Medical supply rates and limitations	Utilization limitations added to incontinence supplies and gloves. Claims submitted for more than the amount listed below require prior authorization: <ul style="list-style-type: none"> • Incontinence supplies – limited to 200 per month. • Gloves – limited to 2 boxes (100 pairs) per month. Rates for all Medicare-covered codes included on DMAP's fee schedule priced at 80% of 2010 Medicare Fee schedule.

Reduction area	Description
Mental health and chemical dependency service rates	<p>Fee-for-service (FFS) outpatient rates reduced to:</p> <ul style="list-style-type: none"> • 110% of Medicare for codes reimbursed by Medicare; or • 66% of billed charges. <p>FFS Provider Specific Rates reduced 11.5 percent.</p>
Pharmaceutical service rates	<p>Clozaril Management rate reduced from \$18.72 to \$10.</p> <p>Changed thresholds for dispensing fee tiers and reduced dispensing fees. Also</p> <ul style="list-style-type: none"> • <30,000 claims = \$14.01 • 30,000-50,000 claims = \$10.14 • >50,000 claims = \$9.68
Physician and other professional service rates	The Relative Value Units (RVU) conversion factor reduced from \$27.82 to \$26.00 (priced at 72% of Jan 2010 nationwide Medicare).
Prosthetics and orthotic rates	<p>Rates for “L codes” reduced 2.3 percent (priced at 83% of 2010 Medicare Fee schedule).</p> <p>Rates for all other Medicare-covered codes included on DMAP’s fee schedule priced at 80% of 2010 Medicare Fee schedule.</p>

September 2011 reductions

Reduction area	Description
Managed care organization rates	Capitation rates reduced approximately 10 to 11 percent

January 2012 reductions

Reduction area	Description
Dental service coverage	<p>Limited coverage of the following procedures:</p> <ul style="list-style-type: none"> • Dentures, denture rebases and relines • Periodontal work (scaling and root planing, full mouth debridement) and follow-up treatment (periodontal maintenance)

Reduction area	Description
	<ul style="list-style-type: none"> • Root canals on molars
OHP Prioritized List coverage	<p>Coverage ends at line 498, eliminating coverage for the following treatment/condition pairs:</p> <ul style="list-style-type: none"> • Medical and surgical methods to treat keratoconjunctivitis (inflamed or infected cornea)
OHP Prioritized List coverage, continued	<ul style="list-style-type: none"> • Talk therapy to treat mutism (inability to talk in certain situations) • Surgery to remove hemorrhoids; removal of a blood clot in a hemorrhoid • Surgery to place tubes in the ears, remove tonsils or repair certain injuries to the ear canal due to Chronic Otitis Media (chronic fluid or infection in inner ear) • Surgery to treat rectal prolapse (rectal tissue that falls through the anal opening) • Surgery to correct otosclerosis (a bone growth in the inner ear that can cause hearing loss) • Removal of foreign body in ear/nose • Surgery to treat anal fistula (tear in the anal wall or in the connection between the anus and the skin) • Surgery to treat fractures of the vertebral column (a broken bone in the back that has not injured the spinal cord) • Counseling for conduct disorders (<i>e.g.</i>, delinquency or disruptive behavior) • Drainage or removal to treat disorders of the breast (cysts, non-cancerous lumps) • Drainage of infected areas, destruction of lesions, and repairs of injuries not resulting from childbirth to treat disorders of the vagina • Drainage of infected areas or collections of fluid to treat cysts of Bartholin's gland

Health system transformation

Senate Bill 1580 (2012 Regular Session) launched Coordinated Care Organizations (CCOs), which form the center of Oregon's health system transformation efforts.

- CCOs are local health entities that deliver all health care for OHP clients.
- A local network of providers coordinates care at every point – from where services are delivered to how the bills are paid.

CCO implementation provides a direct connection to Oregon's 10-year goals (*i.e.*, outcomes) for achieving the triple aim of health care: better health, better care, and lower costs.

Better health

CCOs will focus on prevention, using primary care homes and community health workers to coordinate care, for improved health outcomes such as:

- Decreased chronic disease rates, including mental health
- Decreased tobacco use rates
- Improved self-reported health status

Better care

The previous system that delivered services to over 85 percent of OHP clients was complicated and fragmented:

- 16 managed care organizations delivered physical health care services
- 10 mental health organizations delivered mental health care services
- 8 dental care organizations delivered dental care services

The remaining 15 percent who could be enrolled in managed care received services from providers who bill MAP directly for reimbursement on a fee-for-service (FFS) basis. Rate reductions and a lack of payment incentives make it difficult to always locate FFS providers available or willing to treat OHP clients.

Behavioral health issues and chronic conditions are major drivers for negative health outcomes and high health care costs. When these conditions go unrecognized or untreated, they lead to more expensive care (*e.g.*, emergency department visits) for what becomes an unmanageable condition.

CCOs will reduce fragmentation and focus on the “whole patient” through a redesigned delivery system featuring:

- Integration and coordination of benefits and services
- Local accountability for health resource allocation
- Standards for safe and effective care
- A global budget indexed to sustainable growth

With increased resources to coordinate care, CCOs can address behavioral health issues that lead to poor physical health outcomes. Increased awareness of behavioral health issues and chronic health conditions in all health care settings can get clients the right care at the right time, avoiding the need for more expensive care.

CCOs will also care for more of the OHP population than the previous managed care delivery system, which means fewer people seeking care on a FFS basis. This includes Breast and Cervical Cancer Medical Program clients, HIV/AIDS patients, and other higher-risk populations who will benefit from the local, coordinated care structure and community supports that CCOs will be responsible to establish and maintain.

Lower costs

The current health system is unsustainable. Health care costs are increasingly unaffordable to individuals, businesses, the state and local governments.

Inefficient health care systems bring unnecessary costs to taxpayers.

- Research shows that 30 percent of health care spending is due to waste and inefficiency and that approximately 80 percent of health care costs are driven by 20 percent of the population.
- When budgets are cut, services are slashed, as demonstrated by the many reductions MAP implemented in the current biennium.

Reduced administrative overhead in CCO contracts, a single point of accountability for client health (the CCO), and a single global budget all support greater efficiency and accountability in health care spending.

Under an agreement with the federal government, Oregon will reduce the projected growth in health care spending by 2 percent in two years through improved health outcomes and reduced waste and inefficiency. The projected total state and federal savings are \$11 billion over ten years.

A third-party analysis estimated that savings due to CCO implementation would be more than \$1 billion in state and federal funds within three years, and more than \$3.1 billion over the next five years.

2011-2013 accomplishments

More health care for more Oregonians

Increased OHP Standard hospital benefits so all Medicaid-eligible Oregonians have access to scheduled, medically appropriate, inpatient and outpatient hospital care and surgeries, in addition to emergency hospital services. This change makes OHP Standard hospital benefits the same as hospital benefits for OHP Plus clients.

Opened the Citizen/Alien Waived Emergent Medical (CAWEM) prenatal program to seven more counties. Now in 15 counties, the program covers prenatal care for CAWEM-eligible pregnant women who would otherwise only receive health care coverage for emergency services and deliveries.

Operations

Put processes in place to ensure Oregon Medicaid collects Medicaid drug rebates for managed care prescriptions and physician-administered drugs under the federal Deficit Reduction Act and the Patient Protection and Affordable Care Act.

Implemented system and business process changes to comply with OHA Administrative Simplification and HIPAA 5010 requirements for electronic health care transactions.

Established new policies, provider enrollment and system processes to support the Patient-Centered Primary Care Home program.

Access to care

Worked with managed care plans on a renewal reminder strategy to help ensure that clients enrolled in managed care remember to reapply for OHP benefits before their OHP eligibility ends.

- Timely reapplication not only ensures that clients keep their OHP benefits, but that they remain enrolled in their current medical and dental plans.
- 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.

Expanded the list of services covered when provided by Limited Access Permit (LAP) Dental Hygienists within their scope of practice. LAP dental hygienists can provide dental hygiene services without the supervision of a dentist in certain settings for patients who may not be able to otherwise access dental care services.

Increased client access to diabetic supplies by allowing pharmacies to bill MAP for these supplies using their point of sale systems. Before this system change, pharmacies could only bill DMAP for these supplies as enrolled medical supply providers using the professional medical claim format.

Quality of care

Extended contract with APS Healthcare for Medical Case Management and Disease Case Management, which serves an average of 60,000 fee-for-service OHP clients through the Oregon Health Plan Care Coordination Program (OHPCC). This contract is now in its third year.

- In a recent survey, 97.6% of OHPCC clients rated that they were very satisfied with the overall quality of the program⁷.
- OHA is investigating the feasibility of adding Medicare-Medicaid clients, and additional risk populations previously excluded from the OHPCC contract, in order to help transition these populations to the Coordinated Care Organization environment.

⁷ APS Healthcare Client Satisfaction Survey (initial results, not yet released)

Participated in the High Value Health Leadership council's Statewide Commercial and Public Medical Home Demonstration Pilot. This two-year pilot project goes through February 2013. Administrative support with this project is provided by APS Healthcare as part of their contractual support for medical homes.

Tobacco cessation

In Oregon, direct Medicaid costs related to smoking are an estimated \$287 million per year (approximately 10 percent of total annual Oregon Medicaid expenditures). MAP partners with contracted medical and dental plans and the Office of Public Health to promote tobacco cessation strategies.

2011 is the first year MAP has systematically assessed how contracted Managed Care Organizations screen for tobacco use and provide the required tobacco dependence and cessation services benefit to Oregon Health Plan members.

Positive gains have been made with tobacco cessation efforts since 2004⁸.

- Among OHP medical and dental plan members, smoking prevalence declined from 41% in 2004, to 39% in 2007 to 31% in 2011.
- For people not enrolled in a medical or dental plan, smoking prevalence significantly declined from 41% in 2004, to 29% in 2007, and 21% in 2011.

Partnerships

MAP also strengthened partnerships with stakeholders, tribal organizations, the provider community and contracted managed care plans in extensive outreach to discuss options for budget reductions, legislative implementation, Health Systems Transformation, and HIPAA 5010 and NCPDP D.0 implementation. Strengthened partnerships allow better delivery of health care services, promotion of prevention strategies and increased access to services.

Revenue sources

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

⁸ Source: 2011 CAHPS Survey (initial results, not yet released)

- For clients eligible for Medicaid, the state pays 37.09 percent and the federal government pays 62.91 percent⁹.
- For clients eligible for the Children’s Health Insurance Program (CHIP), the state pays 25.96 percent and the federal government pays 74.04 percent¹⁰.

The following table summarizes MAP’s revenue sources (in rounded millions).

Numbers are based on the 2013-15 pre-audit Agency Request Budget, which includes a Policy Option Package to transfer two programs from APD to MAP. This transfer, which is budget neutral at the state level, provides better alignment for delivering health care to Oregon Health Plan clients.

Source	Amount (in rounded millions)	Description
General Fund	\$1,836	–
Other Fund	\$678	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	\$5,891	Federal share of paying Medicaid/CHIP program costs
Total Fund	\$8,405	–

⁹ Rates provided are for Federal Fiscal Year 2012. The federal government sets this rate, and it fluctuates from year to year.

¹⁰ Ibid