Medical Assistance Programs
Governor's Budget
2015–2017

Oregon Health Authority
Presented to the Human Services Legislative Subcommittee
on Ways and Means
March 12, 2015

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Mission and goals

Mission:

- Triple aim – better health, better care and lower costs

Goals:

- Determine eligibility and maintain enrollment for more than one million Oregonians
- Achieve the triple aim through use of coordinated care organizations
- As the state's Medicaid agency, provide oversight and ensure compliance with federal regulations for all Medicaid programs.

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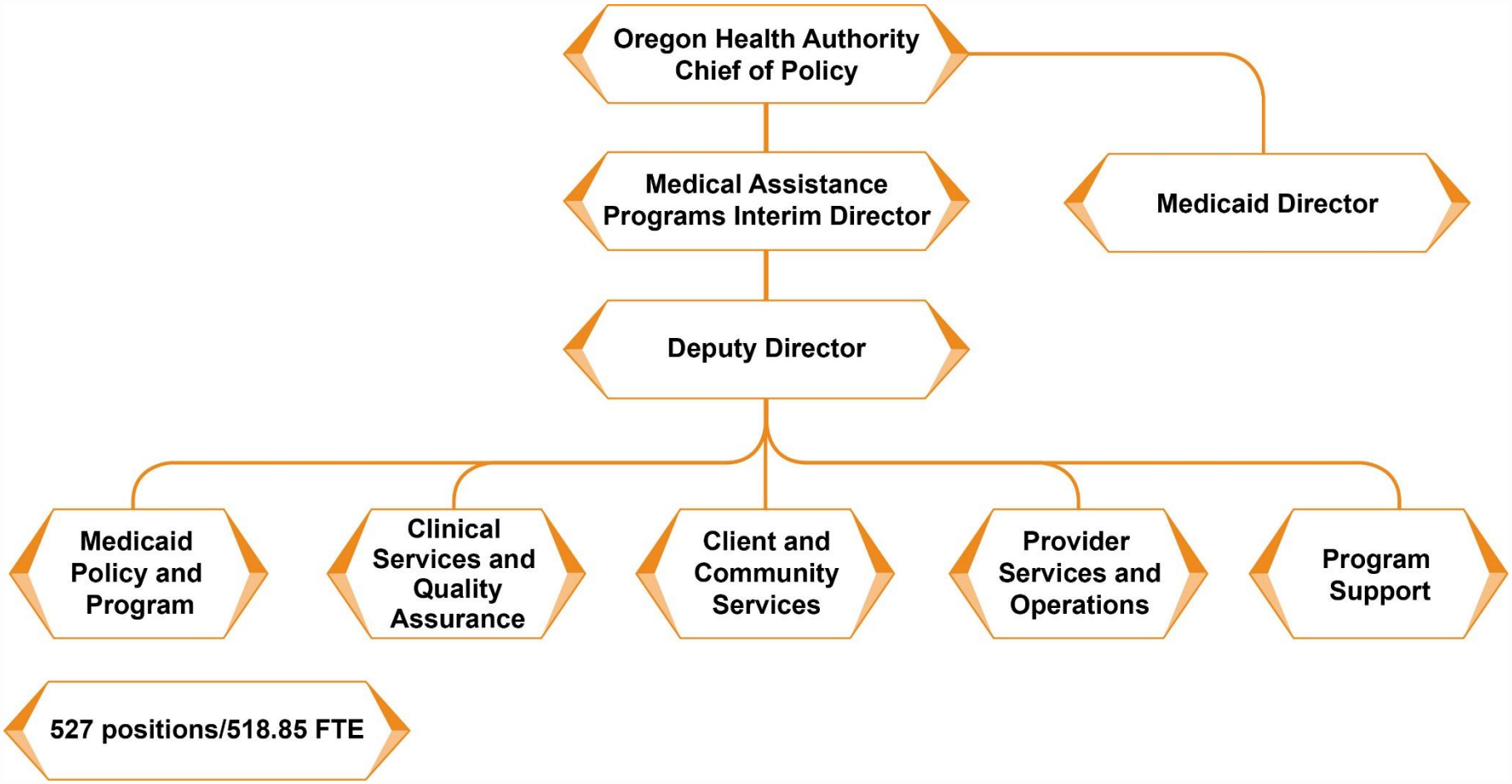
Summary of programs

Medical Assistance Programs (MAP) budget includes the following:

- Oregon Health Plan (OHP)
  - Medicaid and Children's Health Insurance Program (CHIP)
- NonOHP programs, such as:
  - Qualified Medicare Beneficiaries (QMB) program
    - Pays Medicare Part B premiums, deductibles and coinsurance
  - Payments to the federal government for Medicare Part D prescription drug coverage (clawback payments)
- Other programs, such as:
  - Pharmacy programs: Oregon Prescription Drug Program and CAREAssist (coverage for HIV clients)
- Program support
  - Accountable for health care system transformation and compliance for Medicaid programs

2015–17 MAP organization structure



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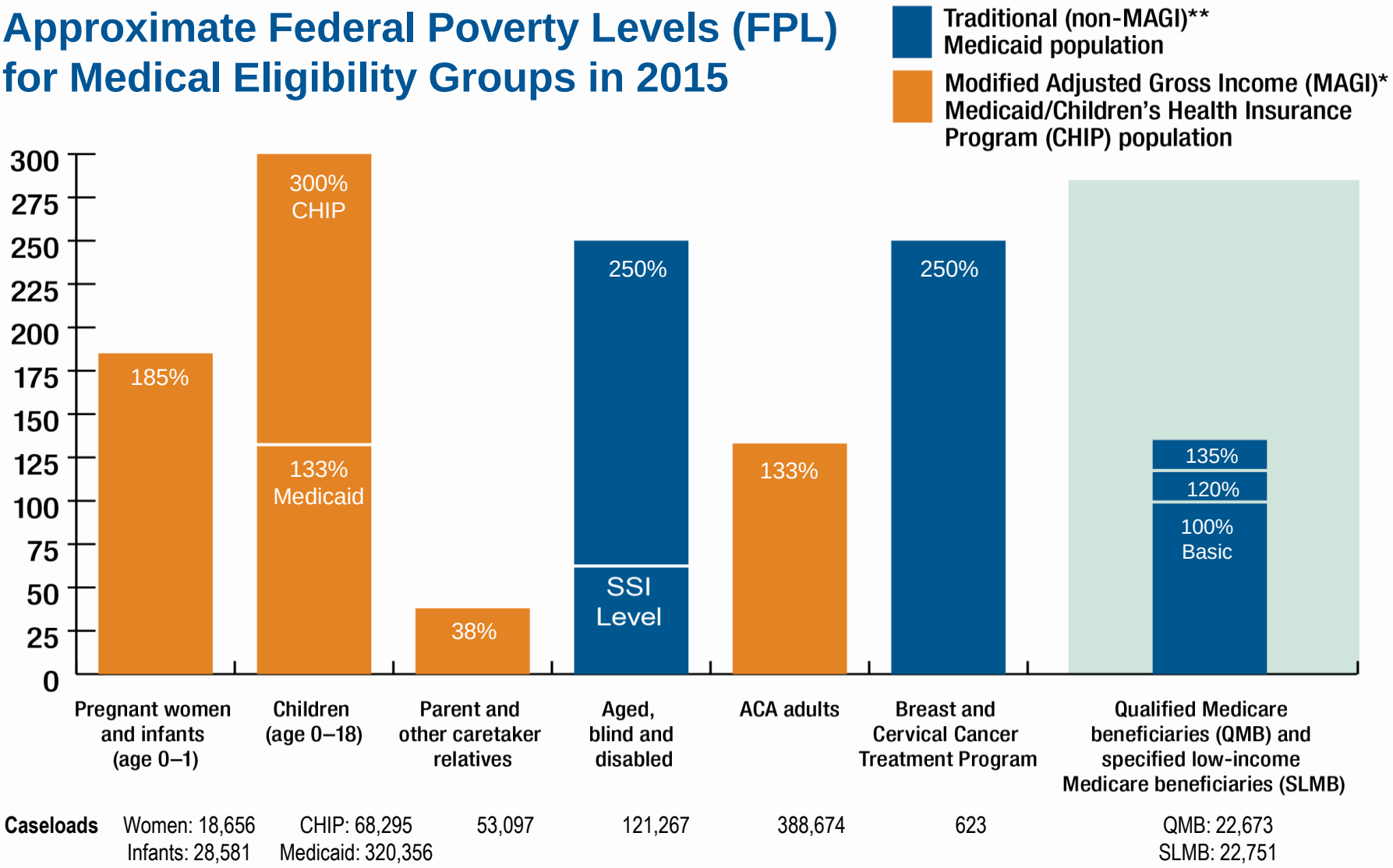
Approximate Federal Poverty Levels (FPL) for Medical Eligibility Groups in 2015



Caseloads	Women: 18,656 Infants: 28,581	CHIP: 68,295 Medicaid: 320,356	53,097	121,267	388,674	623	QMB: 22,673 SLMB: 22,751

* MAGI is the means-tested Medicaid/CHIP eligibility criteria.
** Non-MAGI has other eligibility criteria in addition to the means test.

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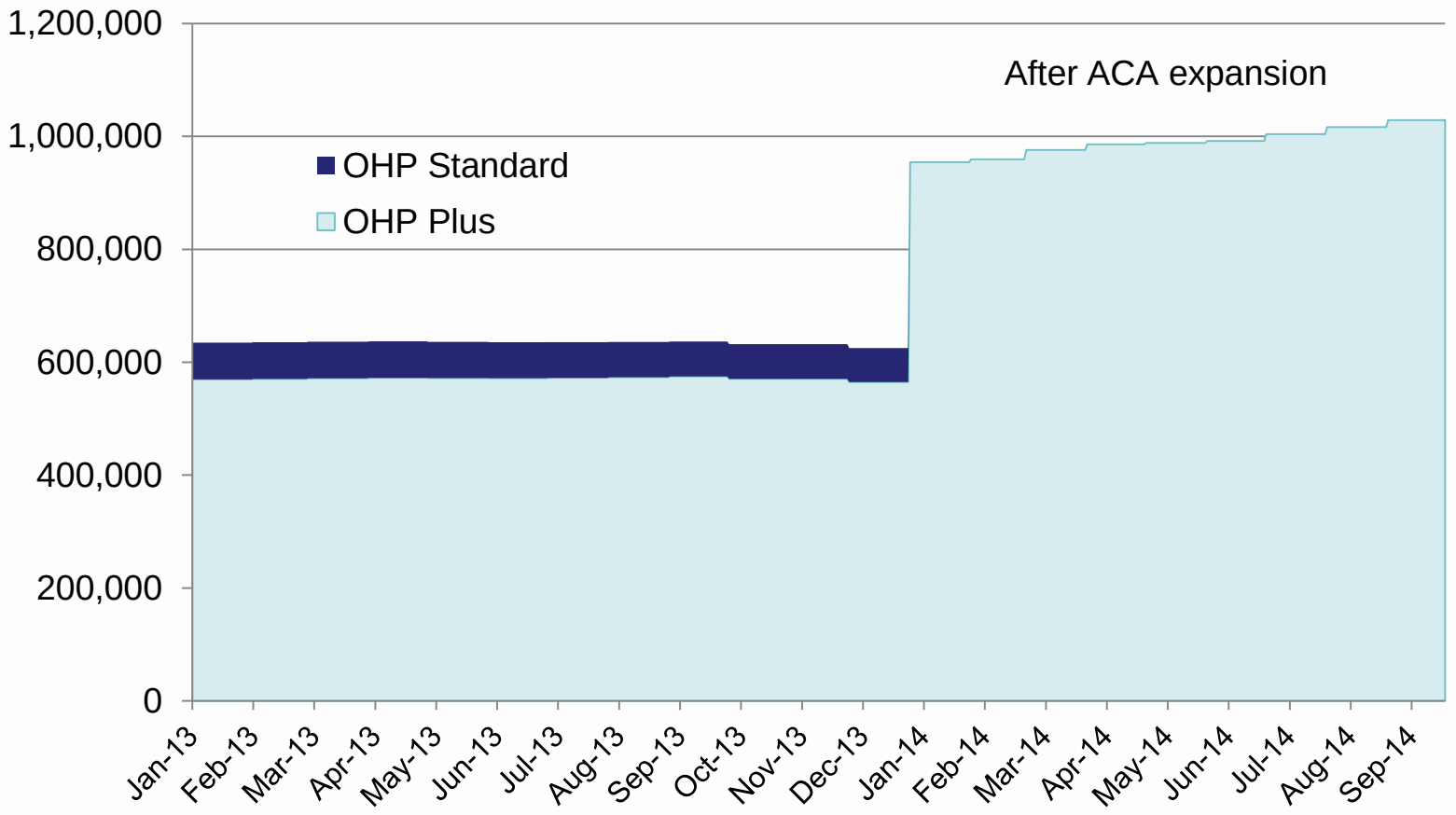
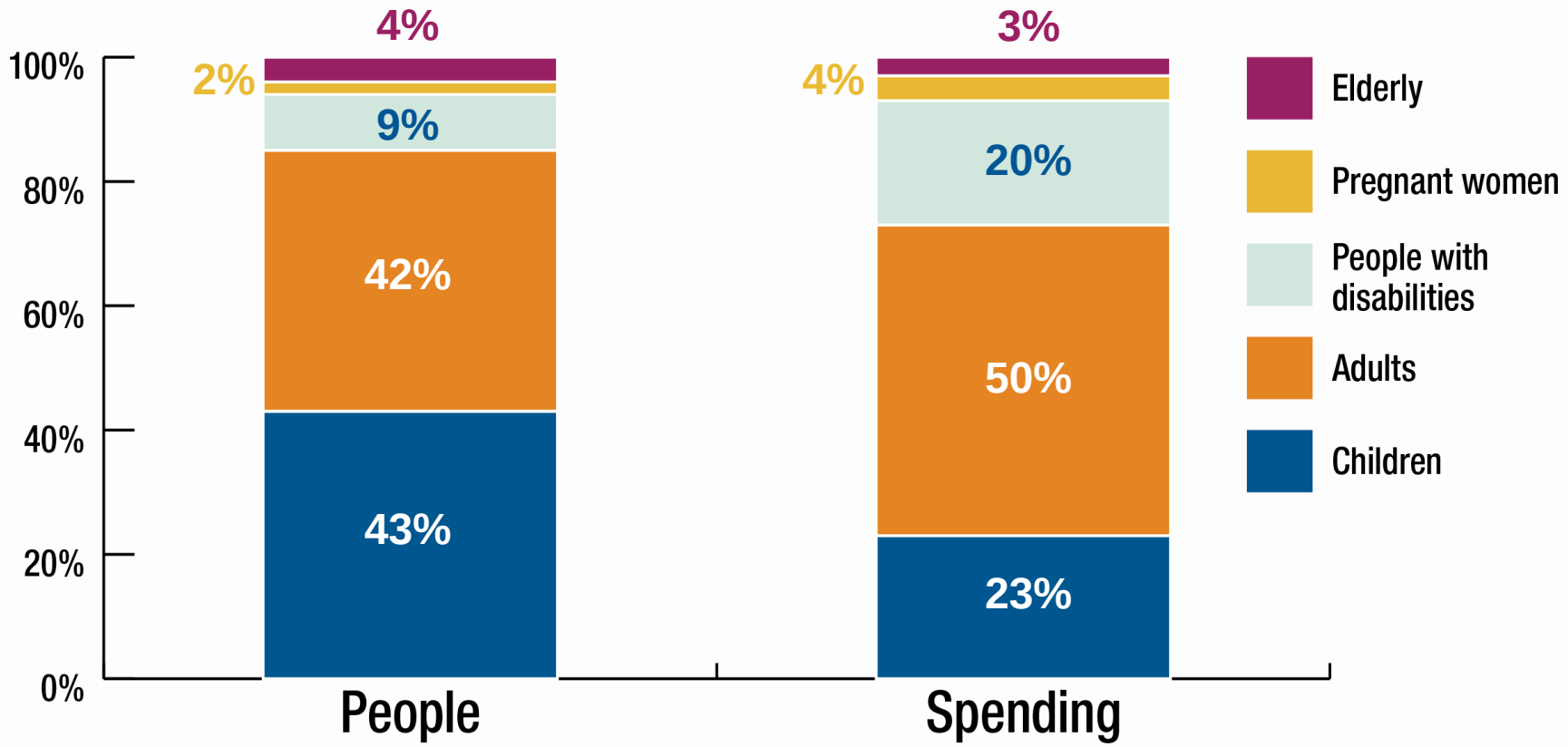
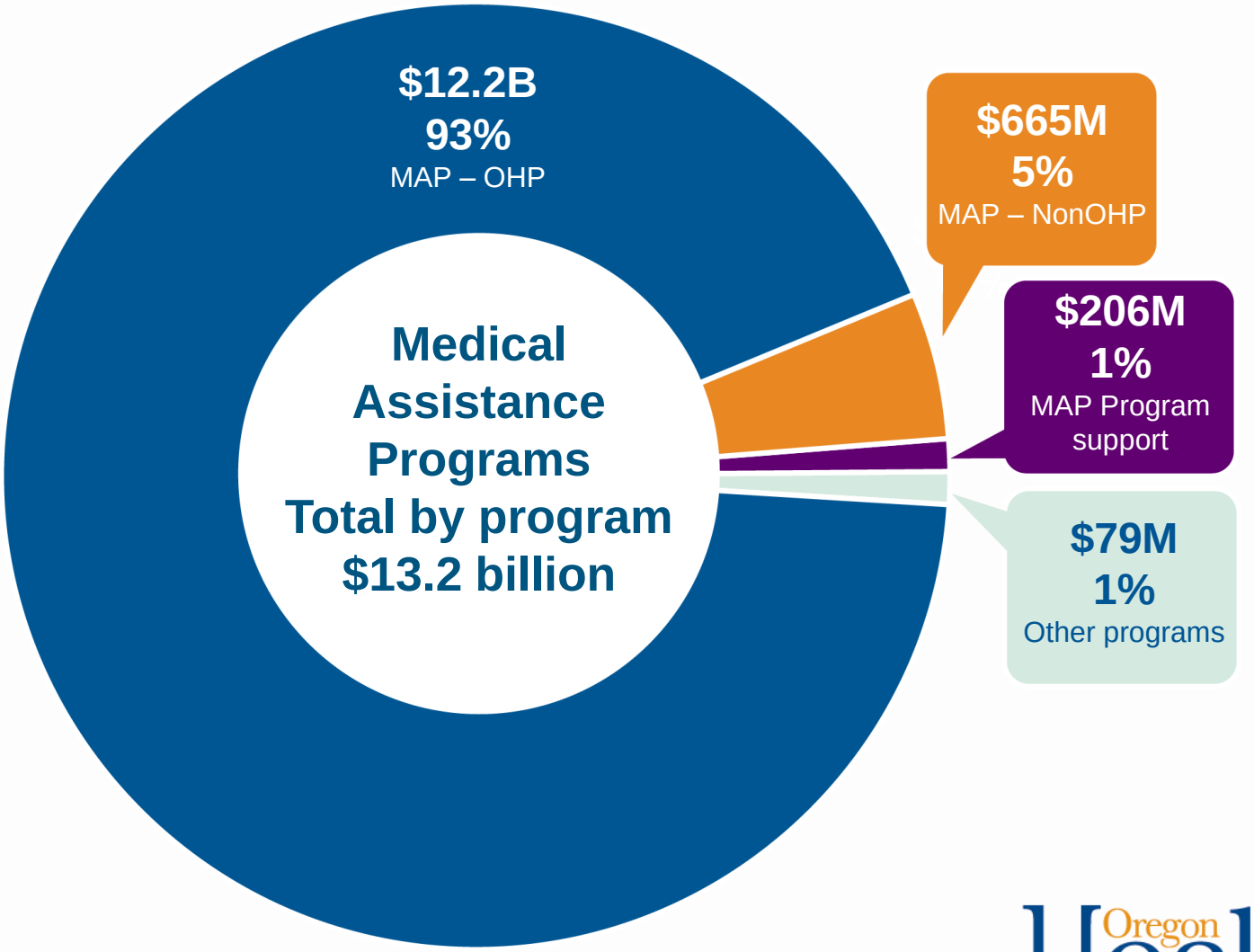
OHP caseloads



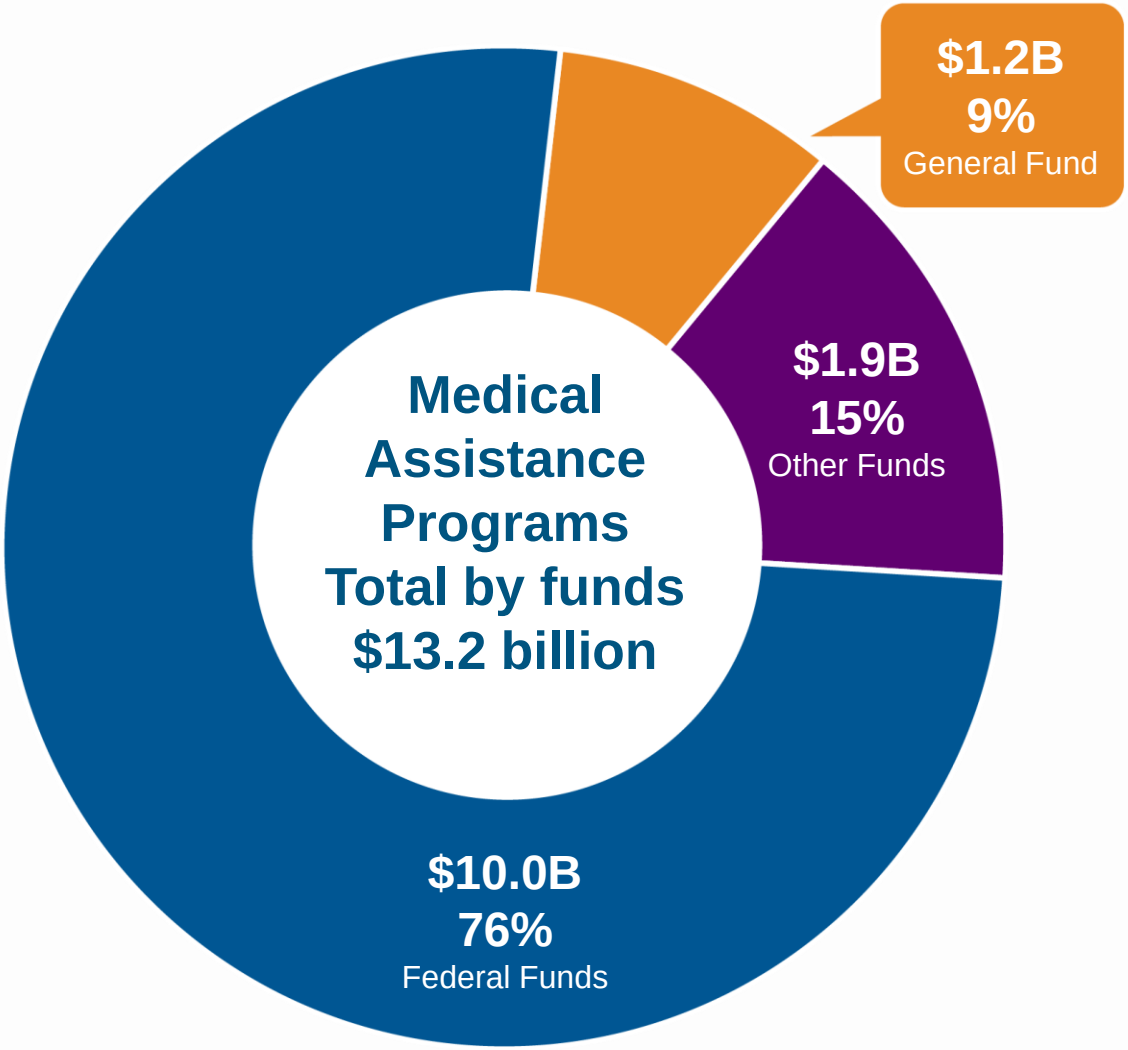
Comparison of OHP population groups and expenditures January–December 2014



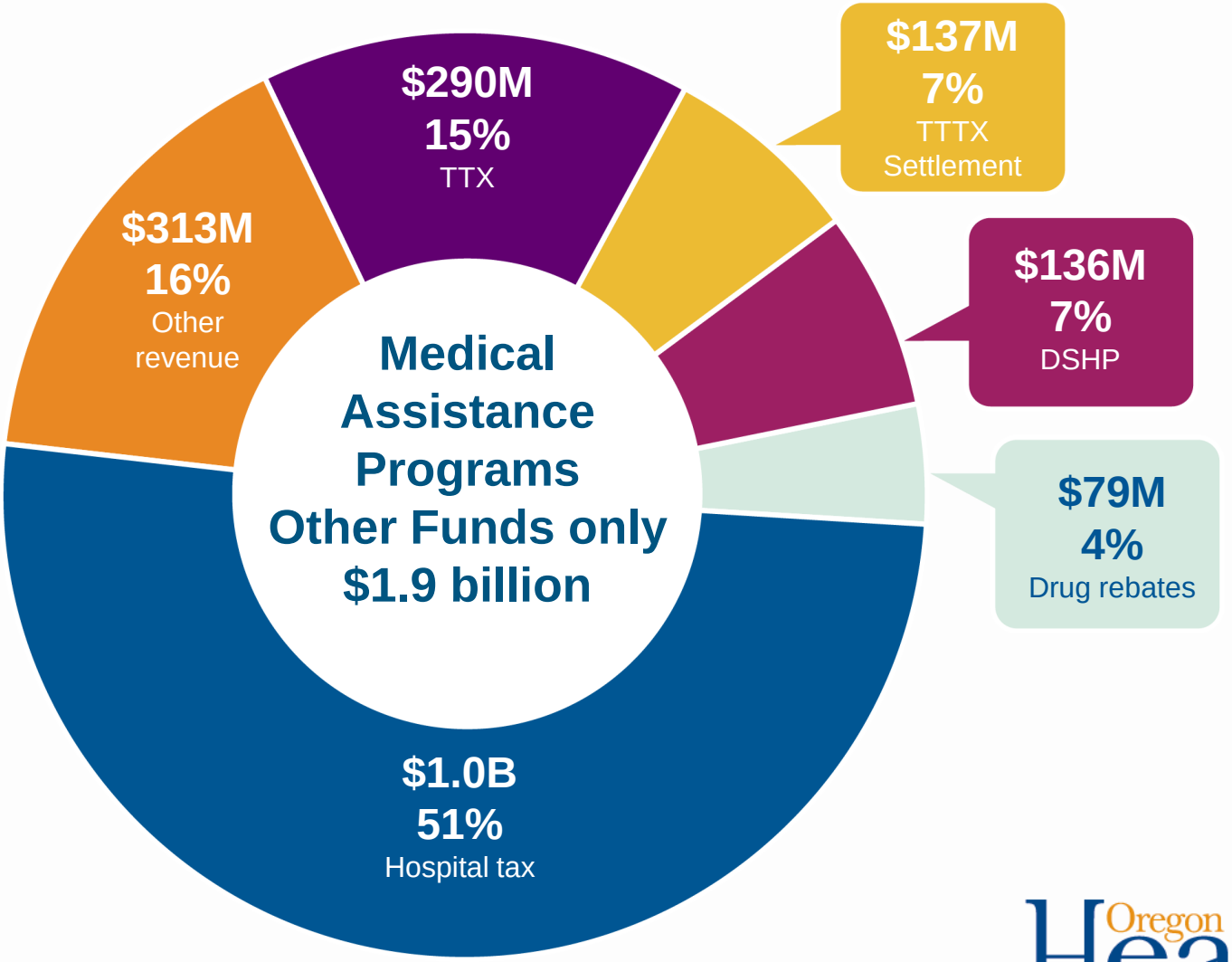
2015–17 Governor's budget



2015–17 Governor's budget



2015–17 Governor's Budget



Health System Transformation – Historical context

- Unsustainable health care cost increases
- Uncoordinated health care delivery system
- Federal health reform (Affordable Care Act)
  - Expansion of Medicaid

Health System Transformation
(launched 2012)

Change the health system to achieve better health, better care and lower costs through coordinated care organizations (CCOs)

- A local network of all types of health care providers working together to deliver care for Oregon Health Plan clients
- Integrate benefits and services — physical health, behavioral health, oral health
- One global budget that grows at a sustainable and predictable rate
- Accountable to performance metrics for safe and effective care
- Focus on primary care and prevention
- Use alternative payment methods that align payment with health outcomes

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Health System Transformation – Focus now on implementation and OHA accountability

State performance measures

- Annual assessment of statewide performance on 33 measures
- Financial penalties to the state if quality goals are not achieved

CCO incentive measures

- Annual assessment of CCO performance on 17 measures
- Quality pool paid to CCOs for performance
- Yr. 1 – Compare 2013 performance to 2011 baseline; Yr. 2 – 2014 performance compared to 2013

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Quality pool: Distribution

To earn their full quality pool payment, CCOs had to:

- Meet the benchmark or improvement target on at least 12 of the 17 measures; and
- Have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from quality pool went to the challenge pool. To earn challenge pool payments, CCOs had to meet the benchmark or improvement target on the four challenge pool measures:

- Depression screening
- Diabetes HbA1c control
- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- PCPCH enrollment

How did CCOs perform?

2013 incentive metrics

- Eleven out of 15 CCOs earned 100 percent of the quality pool
- Of the four who did not earn 100 percent, one earned 70 percent and three earned 80 percent
- Statewide improvement on all 14 of the incentive measures

2013 statewide metrics – for reporting to CMS

- Statewide improvement on nine of the 17 other measures
- On two measures, no improvement statewide or at the CCO level

2014 mid-year progress report shows continued improvements, notably:

- Emergency department utilization decreased by 21 percent
- SBIRT screening improved for all CCOs

CCO incentive metrics for 2015

Retired:	Early elective delivery
	Follow-up after medication for ADHD
Added:	Dental sealants for children
	Effective contraceptive use among women at risk of unintended pregnancy
Modified:	SBIRT for adolescents
	Dental health assessments for children in foster care
Challenge pool metrics:	SBIRT
	Depression screening and follow-up
	Diabetes HbA1c poor control
	Developmental screening

Hospital Transformation Performance Program (HTPP)

Overview

- Quality health metrics show how well hospitals are advancing health system transformation, reducing costs and improving patient safety.
- The HTPP outcome and quality measures were developed by the Hospital Metrics Advisory Committee (appointed by OHA Director).
- The program is approved through OHA's agreement with CMS.

Timeframe

- Year 1 (baseline year): October 2013 – September 2014
- Year 2 (performance year): October 2014 – September 2015
- Subsequent years with CMS and legislative approval

HTPP measures (first two years)

- The hospital quality measures are captured in two main focus areas**, hospital focused** and **hospital-CCO coordination focused**, which include domains and measures.
- There are six domains with 11 measures for the first two years of the program.

Focus area	Domains
Hospital	1. Readmissions
	2. Medication safety
	3. Patient experience
	4. Hospital-associated infections
Hospital-CCO coordination	5. Sharing emergency department information
	6. Behavioral health

HTPP funding and payment allocation

- Funds from a quality pool will be awarded to hospitals based on their performance on the measures.

- The first payments made in 2015 will be to hospitals that provided their baseline data. The total amount paid will be up to $150M. The hospitals will learn the exact amount in the pool at the end of March.

- The payments made in 2016 will be based on improvements between the baseline year and the performance year. The total amount paid will be up to $150M. The hospitals will learn the exact amount in the pool in May 2016.

Major program changes

Medicaid expansion under the Affordable Care Act

- Expanded eligibility to over 380,000 adults with incomes at 133 percent of the federal poverty level and below
  - Receiving 100 percent federal funding through calendar year 2016
  - Federal funding for ACA adults scales down as follows:
    - Calendar year 2017 - 95 percent
    - Calendar year 2018 - 94 percent
    - Calendar year 2019 - 93 percent
    - Calendar year 2020 and all subsequent years - 90 percent
- Receiving 100 percent federal funding for the former OHP Standard population as "newly eligible" starting January 2014

Major program changes

Eligibility processing

- MAGI Medicaid System Transfer Project
  - Adopting Kentucky system
    - Online portal for people to apply
    - Worker portal to streamline eligibility work
    - Real-time eligibility determinations
    - More automated redetermination/renewal process
    - Electronic/automated connection to Federally Facilitated Marketplace (FFM)
      - If someone is not eligible for Medicaid, information is sent to FFM to apply and vice versa

Major budget drivers

Health System Transformation – Sustainable growth

Expenditure growth reduction (2 percent test)

- Waiver requirement/agreement with federal government
- Per member per month (PMPM) growth targets for CCO enrollee expenditures
  - Baseline is calendar year 2011.
  - Increase of 4.4 percent for first year of 2013–15 biennium (one percentage point less than 5.4 percent).
  - Increase of 3.4 percent for each year thereafter through 2017 (two percentage points less than 5.4 percent).

Major budget drivers

Health System Transformation – Federal investment/agreement

Designated state health programs (DSHP) waiver:

- Provides federal match for services/programs not traditionally funded by Medicaid, allowing more state funds to be reinvested in OHP
  - $1.9 billion over five years of waiver
  - $376 million (total funds) in 2015–17 Governor's budget
- Must meet growth reduction target (3.4 percent) **and** improve on Quality and Access Test measures to retain funding
  - If 3.4 percent target is not met, DSHP is reduced by $68 million
  - Would result in a total loss of $188 million in federal funds per year

Major budget drivers

Other major impacts on budget

- Caseload forecasts
- Tobacco tax forecasts
- Other OHP cost drivers
  - Expensive treatment advances
  - Federally Qualified Heath Centers (cost-based reimbursement)

Proposed legislation

House Bill 2395

- Governor's bill to extend hospital assessment through September 30, 2017.*

House Bill 2421

- Governor's bill to make mental health drugs subject to preferred drug list. Allows mental health drugs to be included in global budgets of coordinated care organizations.

MAP and AMH integrated work

Internal transformation with AMH to:

- Better service integration at the CCO level
- Increase program efficiency and effectiveness
- Coordinate, standardize and align policies and policy interpretations for licensing, contracts, rate setting
- Improve accuracy, reliability, efficiencies and responsiveness
- Alignment of OHA functions to achieve results for Oregonians

Integrated work across OHA

- MAP, AMH and Public Health are partnering closely to ensure:
  - Removing barriers that may impede progress in achieving triple aim
  - Coordinated procedures regarding billing and rate structures

- Legacy Health Regional Psychiatric Emergency Services Project:
  - Will provide both psychiatric services and acute care hospitalization in the Portland metro area for people experiencing a mental health emergency.
  - OHA program areas are working together to support Legacy and partners (Adventist, Kaiser and OHSU) in the development of this project.