

Division of Medical Assistance Programs (DMAP)

DMAP 2009-2011 Budget

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Division of Medical Assistance Programs (DMAP)

Themes

- DMAP provides services that:
 - Strengthen the health of Oregon's workforce
 - Improve overall public health
 - Directly benefit people of all ages
- The need for medical assistance is increasing while the revenue that supports programs is decreasing
- Access to health care benefits the economy by promoting the health of individuals, families and the community as a whole
- DMAP provides health care to as many people as possible while maximizing the limited resources available
- DMAP has embraced the Transformation Initiative in order to operate more efficiently and cut costs wherever possible
- The Governor's Recommended Budget contains both significant investments and reductions

DMAP mission and goals

Mission

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

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 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
- Collaborate with legislators, advocacy groups, business partners, health care providers, Oregon tribes and the general public to improve health outcomes

DMAP mission and goals

Goals continued

- Promote the use of prevention and chronic disease management services by all Oregonians, especially those with low incomes or special medical needs
- Respond proactively to federal requirements and initiatives
- Monitor progress and provide input into Oregon health reform
- Work with other insurers to improve health outcomes for all Oregonians
- Collaborate with the private sector in research and development toward improving the effectiveness and efficiency of the medical care delivery system

DMAP programs

OHP Medicaid

- Federally mandated Medicaid populations:
 - Low-income children
 - Low-income parents of dependent children
 - Pregnant women
 - People 65 or older
 - People with disabilities
 - Currently covers approximately 384,000 people
- OHP Standard
 - Expansion program for impoverished adults who do not qualify for traditional Medicaid
 - Currently covers approximately 29,000 people
- Family Health Insurance Assistance Program (FHIAP)
 - Administered by the Office of Private Health Partnerships (OPHP)
 - Currently covers approximately 10,000 people

DMAP programs

Children's Health Insurance Program (CHIP)

- Children and adolescents through age 18 with household incomes up to 185 percent of the federal poverty level (FPL)
- Receives Title 21 (CHIP) federal match rate of 73.72 percent, higher than the Title 19 (Medicaid) match rate of 62.45 percent for OHP Plus and OHP Standard
- Currently covers more than 48,000 children, accounting for more than one in 10 medical-assistance enrollees in Oregon

DMAP programs

Non-OHP Medicaid

- Programs and services not part of the federally approved OHP demonstration project
 - Support for Medicare insurance premiums for approximately 81,000 low-income Medicare beneficiaries
 - Coverage for 380 uninsured women who need treatment for breast or cervical cancer
 - Limited drug coverage for 27 individuals receiving post-transplant services, formerly part of the Medically Needy program, which ended in 2003

OHP demonstration

Medicaid Waiver

- For more than 15 years, Oregon has administered the Oregon Health Plan as a federally-approved Medicaid demonstration, which continues to draw national and international attention
- Allows Oregon to receive federal matching funds to expand health care coverage to uninsured adults who do not qualify for traditional Medicaid programs
- Allows Oregon to use federal matching funds for health insurance premium subsidies to families and individuals under FHIAP, administered by OPHP
- Optimizes funding by use of a list of prioritized medical conditions and treatments, known as the *Prioritized List of Health Services*, established by the Health Services Commission (HSC)
- The current waiver continues through October 31, 2010

DMAP program support and administration

Program support and administration: 1.5% of the overall budget

- Health care financing
- Operating Medicaid and CHIP budgets
- Increasing access to Medicaid, especially for children
- Planning and development
- Quality assurance and monitoring of managed care plans and fee-for-service
- Coordination of federal reporting and federal match funds
- Communication to clients and providers
- Professional services contracts

DMAP organizational structure

Department of Human Services

Division of Medical Assistance Programs - Total FTE: 189.32

Budget and Finance

- Personnel/Staff Training/Diversity
- Administrative and Program Budgets
- Office Management
- Contract Clearinghouse and Financial Oversight
- Invoice Payment
- Actuarial/Pricings
- Federal Reporting
- Federal Matching Funds

Operations

- Encounter/Claims Management
- Claims Adjudication
- Customer Service (Clients and Providers)
- Electronic data interchange
- Medicaid Management Information System
- Provider Enrollment
- Facilities Settlements
- RN Hotline Coverage/Prior Authorizations
- Medical Claims Review

Policy and Planning

- Macro and Micro Policy Development
- FFS Rules and Contracts
- Policy Translated into Planning
- Federal Relations, Including State Plan Amendment
- Program Evaluation
- Medicare and Medicare Modernization Act (MMA) Coordination
- Eligibility Policy

Quality Improvement and Medical Section

- Quality Assurance and Improvement
- Hearings
- Administrative Reviews
- Clinical Decisions for Claims
- Disease Management
- Transplants
- Managed Care Organization (MCO) Management and Financial Solvency
- MCO Rules and Contracts

Research, Education and Development

- Government Affairs
- Documents for External Distribution, Rules, Reports, etc.
- Question/Answer Services
- Public Affairs, Information Management, Messaging and Marketing
- Special Projects, Analysis and Research
- Education and Training of Providers
- Waiver Management

Health Records Bank

- Establish/implement project goals/objectives
- Develop Advanced Planning Documents and other updates, presentation materials
- Contracts and contract administration
- Develop/evaluative Performance Standards and Measurement reports
- Review and approve communications plans
- Prepare and track project budget
- Direct/implement corrective action plans

Delivery of health care services

98.5% of budget goes directly to delivery of health care services

Western States' Ranking: Medicaid Expenditures per Eligible			
State	Rank	Spending	Number of Eligibles
U.S.		\$4,938	57,575,692
Montana	18	\$5,171	113,073
Wyoming	25	\$4,672	77,772
Colorado	27	\$4,572	524,760
Idaho	29	\$4,490	220,535
Washington	39	\$4,123	1,195,703
Oregon	44	\$3,647	590,236
Nevada	49	\$3,136	256,841
California	51	\$2,584	10,619,361
Average annual medical assistance spending per Medicaid recipient			
Source: CMS MSIS FY 2004			

Western States' Ranking: Medicaid Expenditures per Resident			
State	Rank	Spending	Number of Eligibles
U.S.		\$904	293,655,404
Washington	26	\$795	6,203,788
California	30	\$765	35,893,799
Wyoming	37	\$717	506,529
Idaho	38	\$711	1,393,262
Montana	45	\$631	926,865
Oregon	46	\$599	3,594,586
Colorado	49	\$521	4,601,403
Nevada	51	\$345	2,334,771
Average annual medical assistance spending per resident			
Source: CMS MSIS FY 2004			

Who receives medical assistance services

OHP Medicaid and OHP CHIP clients

- Low-income children
- Low-income parents with dependent children
- Pregnant women
- People 65 or older
- People with disabilities
- OHP Standard/expansion population

Non-OHP Medicaid clients

- Uninsured women who need treatment for breast and cervical cancer
- Medicare clients
 - Qualified Medicare beneficiaries with incomes less than 100% FPL – insurance premiums for Medicare Part A hospital, when eligible, and Part B outpatient, deductibles and copayments
 - Specified low-income Medicare beneficiaries between 100 and 135% FPL – insurance premiums for Medicare Part B outpatient

Who receives medical assistance services

Former Medically Needy clients

- 27 clients of the former Medically Needy program who are organ transplant recipients

Determining eligibility – Outside DMAP

- Children, Adults and Families (CAF) Division
- Seniors and People with Disabilities (SPD) Division

Where service recipients are located

County	Total population estimate	Average monthly number of clients 2007	OHP clients as percent of county population	Total expenditures
Baker	16,435	2,033	12%	\$3,874,500
Benton	85,300	5,137	6%	\$19,209,698
Clackamas	372,270	23,496	6%	\$84,553,889
Clatsop	37,440	3,693	10%	\$7,763,577
Columbia	47,565	4,305	9%	\$12,686,582
Coos	63,050	8,853	14%	\$38,040,499
Crook	25,885	2,065	8%	\$7,245,905
Curry	21,475	2,348	11%	\$3,001,934
Deschutes	160,810	11,901	7%	\$40,181,575
Douglas	104,675	13,673	13%	\$55,862,760
Gilliam	1,885	141	7%	\$1,652,234
Grant	7,580	704	9%	\$3,031,785

Where service recipients are located

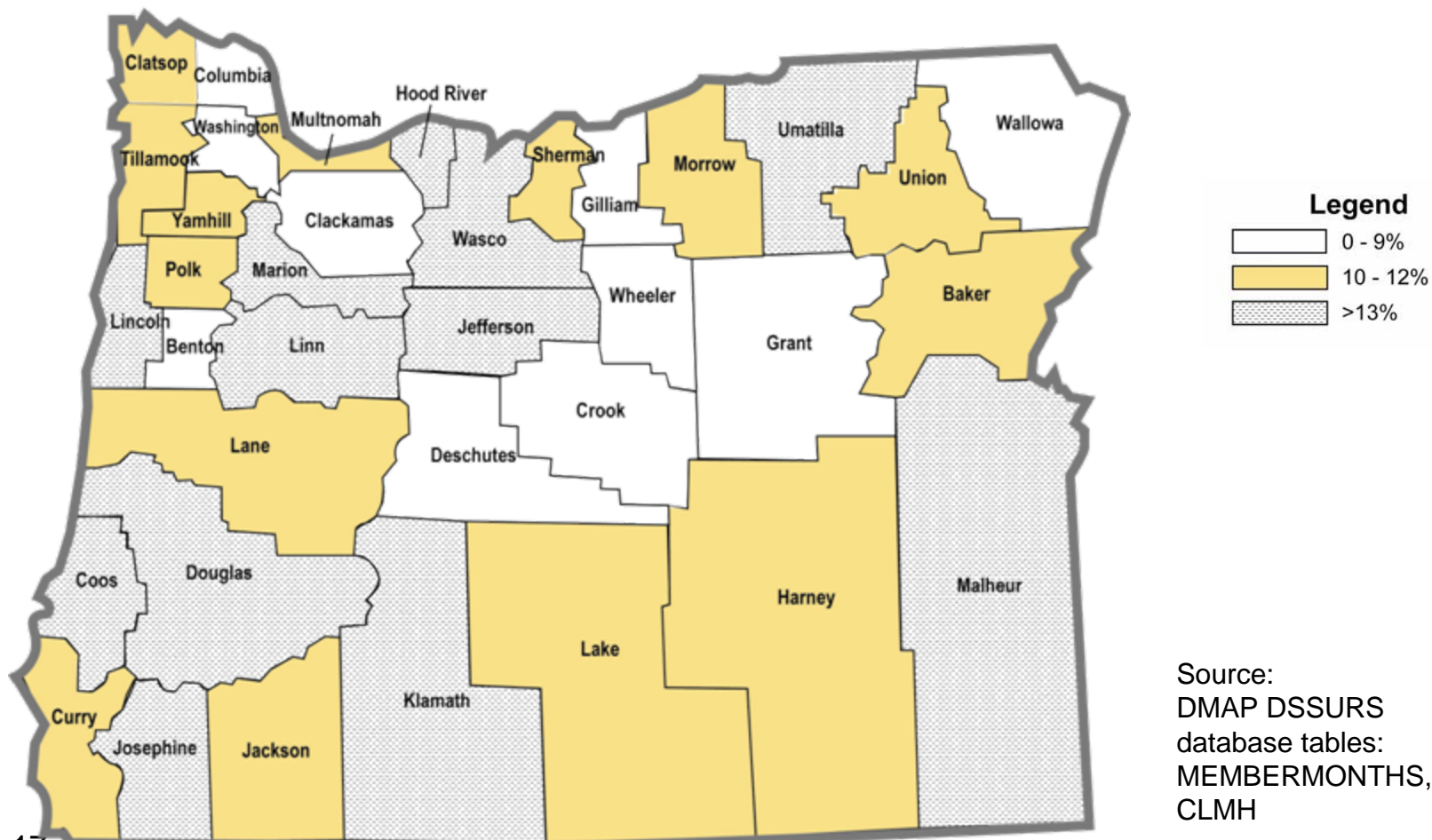
County	Total population estimate	Average monthly number of clients 2007	OHP clients as percent of county population	Total expenditures
Harney	7,680	833	11%	\$3,564,382
Hood River	21,470	2,828	13%	\$8,726,068
Jackson	202,310	21,573	11%	\$34,639,905
Jefferson	22,030	3,230	15%	\$8,839,671
Josephine	82,390	11,874	14%	\$50,273,383
Klamath	65,815	9,294	14%	\$35,428,638
Lake	7,565	918	12%	\$1,560,626
Lane	343,140	37,178	11%	\$129,844,852
Lincoln	44,630	6,055	14%	\$12,438,243
Linn	109,320	14,651	13%	\$52,516,889
Malheur	31,620	5,103	16%	\$10,319,038
Marion	311,070	45,012	14%	\$149,692,404

Where service recipients are located

County	Total population estimate	Average monthly number of clients 2007	OHP clients as percent of county population	Total expenditures
Morrow	12,335	1,402	11%	\$3,979,533
Multnomah	710,025	86,309	12%	\$351,264,077
Polk	67,505	7,863	12%	\$28,284,751
Sherman	1,855	198	11%	\$1,037,078
Tillamook	25,845	2,533	10%	\$3,894,673
Umatilla	72,245	10,274	14%	\$32,014,066
Union	25,250	3,079	12%	\$4,822,081
Wallowa	7,130	652	9%	\$2,004,170
Wasco	24,125	3,309	14%	\$11,045,734
Washington	511,075	36,840	7%	\$106,049,161
Wheeler	1,570	135	9%	\$293,221
Yamhill	93,085	10,063	11%	\$16,969,452

Where service recipients are located

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



Source:
DMAP DSSURS
database tables:
MEMBERMONTHS,
CLMH

Services provided

Benefit packages

- OHP Plus
- OHP Plus with Limited Drug
- OHP Standard
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Citizen-Alien/Waived Emergency Medical (CAWEM)

Covered Services	OHP Plus OHP with Limited Drug* CAWEM Plus	OHP Standard	CAWEM	QMB
Acupuncture	✓	Limited		
Chemical dependency	✓	✓		
Dental	✓	Limited		
Emergency/Urgent hospital care	✓	✓	✓	
Hearing aids and hearing aid exams	✓			
Home health	✓			
Hospice care	✓	✓		
Hospital care	✓	Limited		
Immunizations	✓	✓		
Labor and delivery	✓	✓	✓	
Laboratory and X-ray	✓	✓	Emergency	
Medical equipment and supplies	✓	Limited		
Medical transportation	✓	Limited	Emergency	
Medicare premiums, copayments (except for drugs) and deductibles	✓			✓
Mental health	✓	✓		
Naturopathy	✓			
Occupational therapy	✓			
Physical therapy	✓			
Physician care	✓	✓	Emergency	
Podiatry	✓	✓		
Prescription drugs	✓	✓		
Private duty nursing	✓			
Speech therapy	✓			
Vision care	✓	Limited		

*Drug coverage for this benefit package is limited to drugs not covered by Medicare Part D

DMAP partnerships

Managed care plans

- Fully capitated health plans
- Dental care organizations
- Mental health care organizations
- Physician care organizations

Fee-for-service providers

Associations

- Hospital Association
- Dental Association
- Durable Medical Equipment Association
- Oregon Medical Association

Advisory committees

- Medicaid Advisory Committee
- Rule Advisory Committees
- Consumer Protections Workgroup

Federal agencies

- Centers for Medicare and Medicaid Services
- Social Security Administration

State agencies and programs

- Office of Private Health Partnerships (OPHP)
 - Family Health Insurance Assistance Program (FHIAP)
- Oregon Department of Veterans' Affairs (ODVA)
- Oregon Department of Consumer and Business Services (DCBS)
 - Oregon Medical Insurance Pool (OMIP)
- Oregon Department of Administrative Services (DAS)
 - Oregon Prescription Drug Program (OPDP)

Oregon tribes

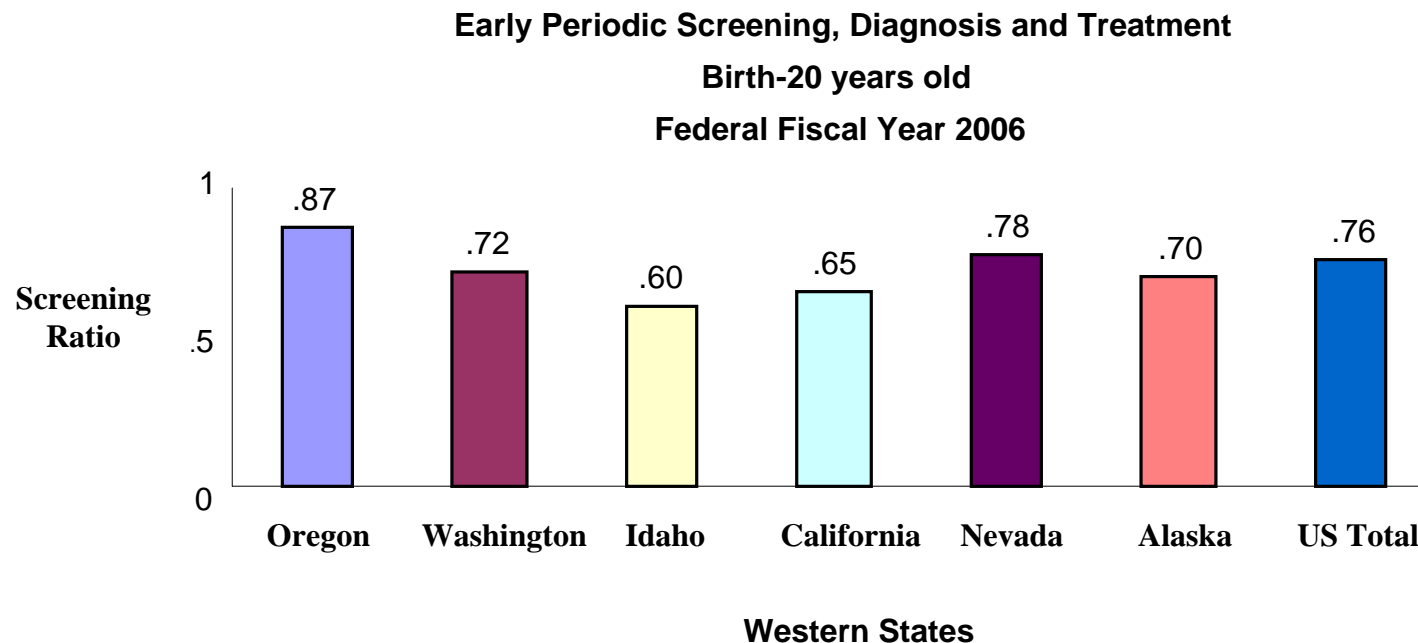
Community agencies and non-profits

- Health Care Safety-Net health clinics
- Oregon SafeNet
- Oregon Health Action Campaign
- Community outreach sites

Quality assurance efforts

Early periodic screening, diagnosis and treatment (EPSDT)

- The EPSDT ratio measures the rate at which children enrolled in Medicaid receive health screening services required by their state's periodicity schedule, adjusted by the proportion of the year they are enrolled
- High rates are favorable for this measure – at 0.87, Oregon is the highest among the five Western states



Quality assurance efforts

Percentage of covered children

- Children with health insurance are more likely to have a primary care provider and to have received appropriate preventive care, such as immunizations
- By keeping kids healthy, access to health care enables children to attend school regularly for better academic performance
- During 2007 OHP covered 25.1 percent of Oregon children under age 19
- Children make up approximately 36 percent of the OHP client population, compared to approximately 26 percent of Oregonian's general population

Quality assurance efforts

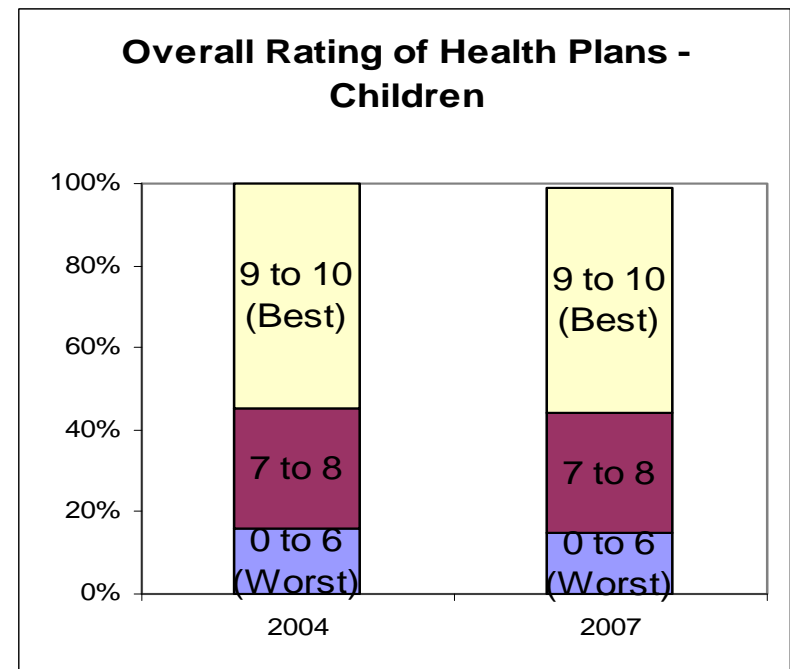
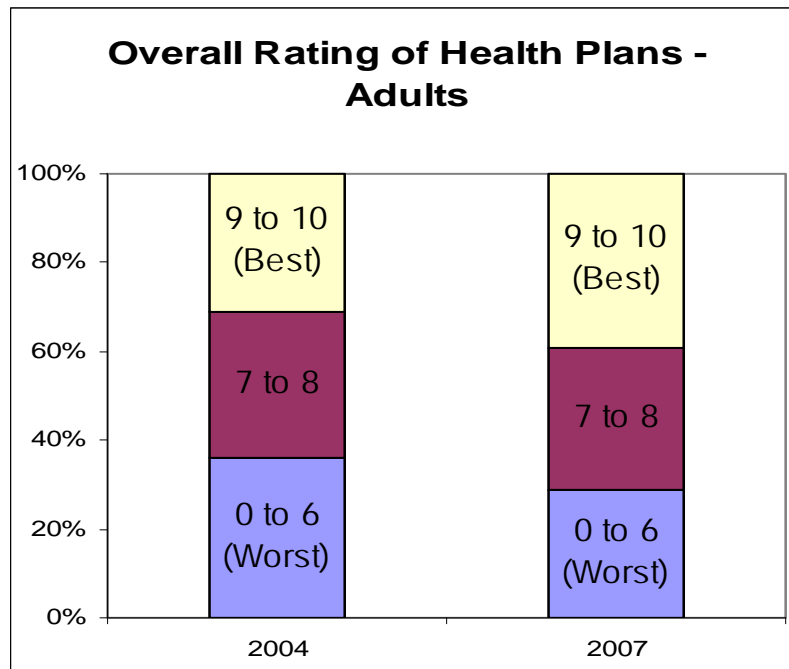
Provider participation

- DMAP partners with the Office for Oregon Health Policy and Research and the Oregon Medical Association to conduct the Provider Workforce Survey
- Survey goes to all active licensed physicians in Oregon – MDs, DOs and PAs
- Providers are asked about their practice, acceptance of Medicaid and future practice plans
- During 2006, 17 percent of providers closed their practices to Medicare and 21 percent to Medicaid, the majority citing reimbursement as the reason
- 72 percent of all physicians still reported providing charity care
- Survey will be conducted again in 2009, with questionnaires mailed in March

Quality assurance efforts

Client satisfaction

- Consumer Assessment of Health Plans and Systems (CAHPS) surveys people enrolled in fully capitated health plans and rates their satisfaction with their plan
- Comparison between 2003 and 2007 surveys for adults shows an increase in satisfaction with the care received, and surveys for children maintained satisfaction levels



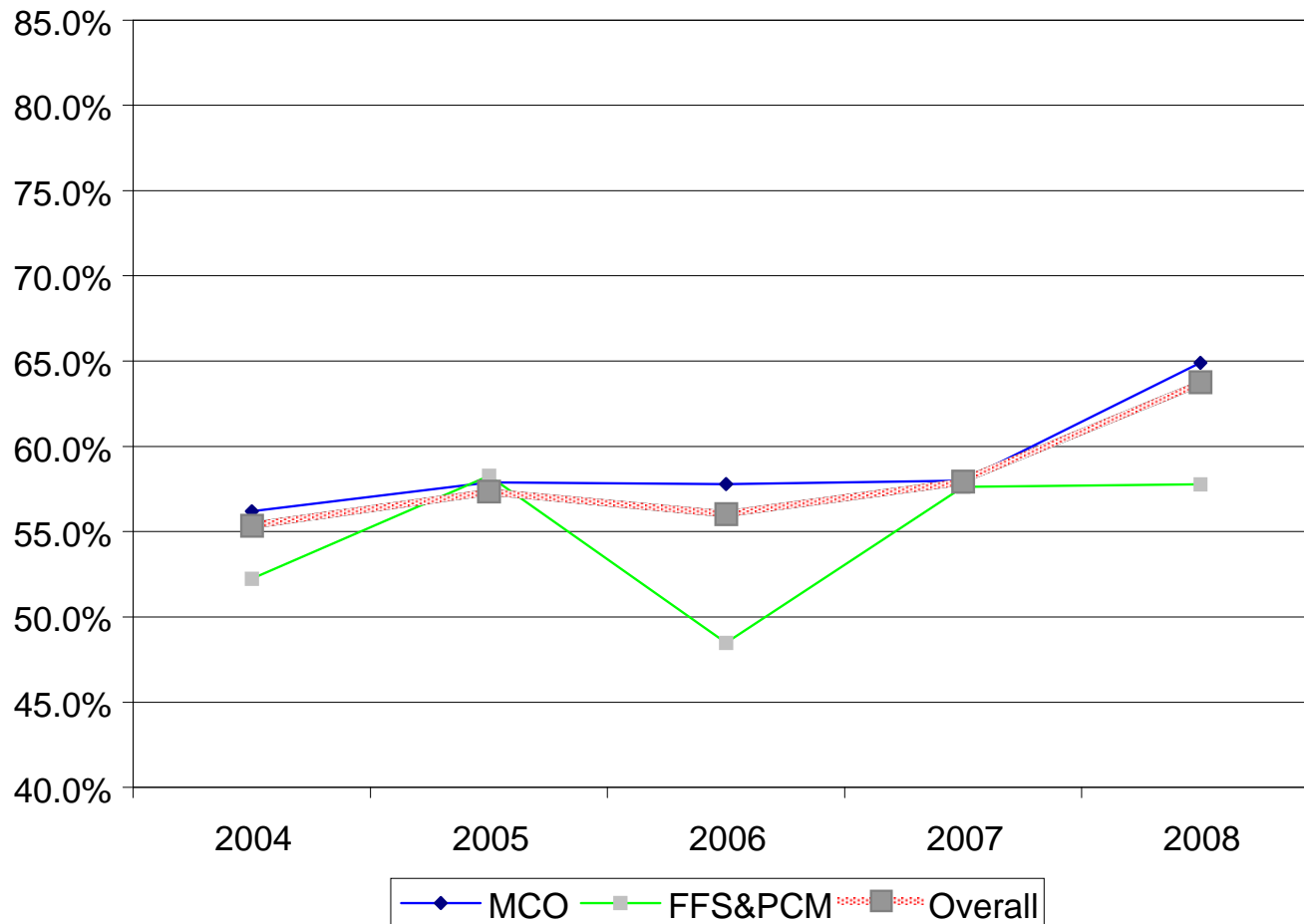
Quality assurance efforts

Contracted performance indicators

- Physical health plans measure childhood immunizations and asthma care
- Dental care plans measure preventive care services
- Chemical dependency organization has performance measures concerning services provided to pregnant members
- DMAP brings the Asthma and Immunizations programs within the Public Health Department together with the managed care plans through monthly meetings of Quality Improvement Coordinators and Medical Directors
 - The Asthma Program has a Web-based Resource Bank of free provider and patient materials that many plans use
 - The Immunization Program helps plans and their associated clinics by assessing clinics' immunization practices and providing clinic-specific feedback on improving childhood immunization rates

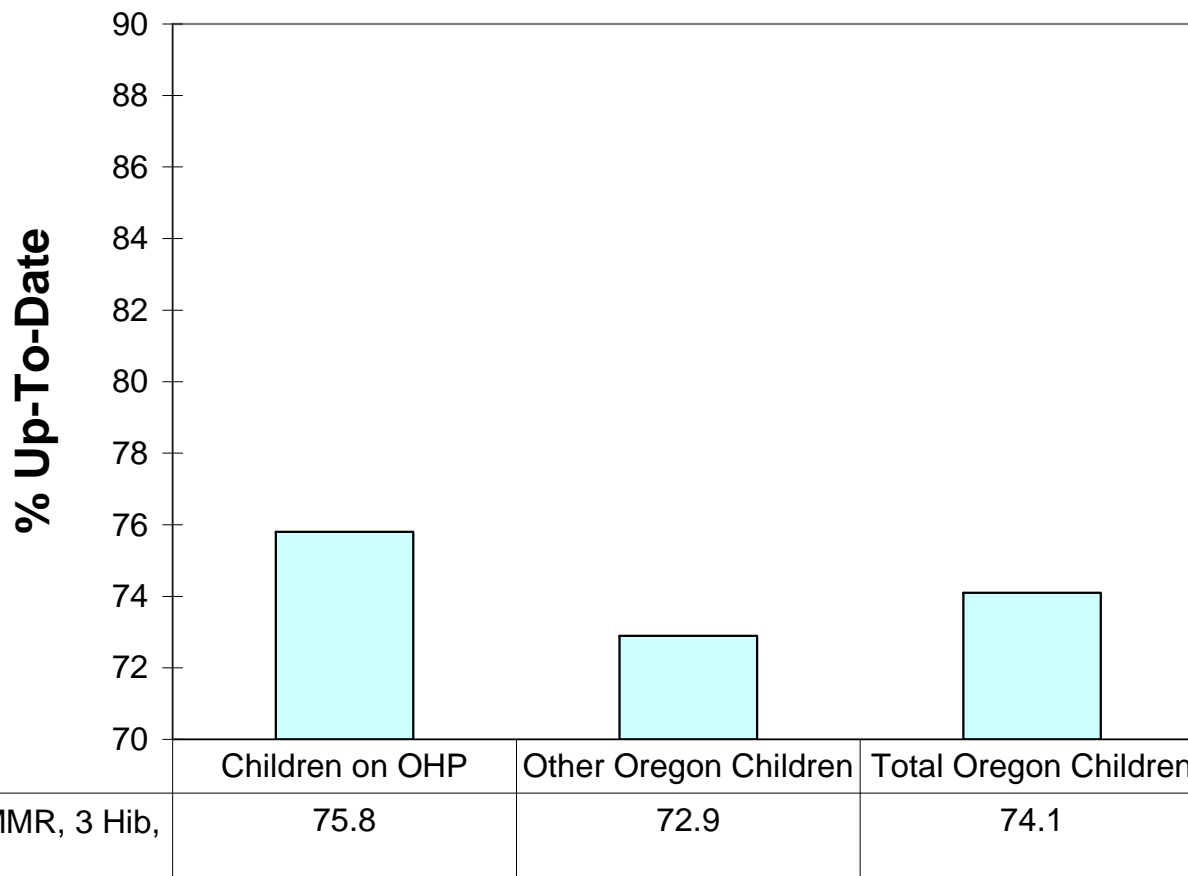
Quality assurance efforts

Immunizations of Children
Percent Up-To-Date
Ages 2 to 3 years



Quality assurance efforts

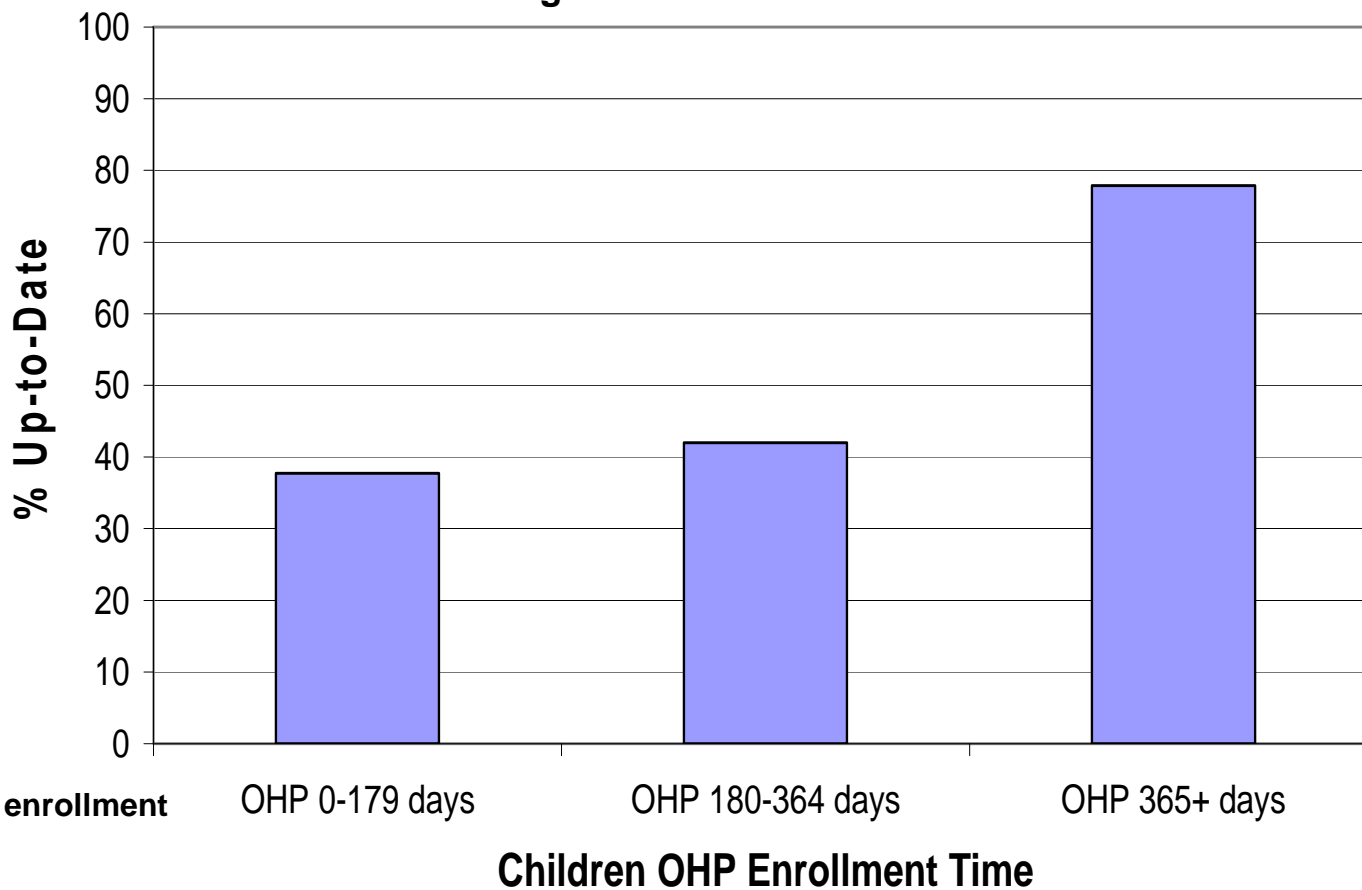
Immunizations of Children Percent Up-To-Date in 2007 Ages 24 - 35 Months



4 DTaP, 3 Polio, 1 MMR, 3 Hib,
3 HepB, 1 Varicella

Quality assurance efforts

**Immunizations of OHP Children
Percent Up-to-Date
Ages 24-35 Months**



Quality assurance efforts

Quality Improvement (QI) monitoring of managed care plans

- During 2008 DMAP revised the review process for managed care contracts to ensure the best value and the best service for clients
- Staff now make annual on-site visits to meet with representatives from each of the plans at their administrative office locations, allowing for easier collaboration and "real-time" quality improvement
- Every physical health plan and dental health plan received an on-site visit during 2008
- Instead of using only data from the previous year, staff now can examine both past and current information to check for contractual compliance
- If the plan is found to be deficient or out of compliance in any area, staff work with the plan to develop a corrective action plan

Quality assurance efforts

State Quality Improvement Action Plan

- Helps state agencies capitalize on their resources and influence to purchase health care wisely, reduce fragmentations and motivate innovations
- Goal is to develop a higher performing health care delivery system in Oregon
- DMAP is working with the Governor's Office, the Oregon Health Policy Commission (OHPC), other state health agencies, and other DHS divisions as part of the State Quality Improvement Team
- The team has identified and begun the initial work on the following strategy areas:
 - Patient safety
 - Primary care/prevention
 - Consumer engagement
 - Data collection/transparency
- The team is preparing a draft plan to present at the AcademyHealth technical assistance event scheduled for May 2009

Diversity

Serving a diverse population

- The Client Services Unit has several bi-lingual staff who work with clients in the recipient call center
- The Client and Provider Education Unit translates all client communications into nine different languages, with more available if needed
- Client communications also are made available in alternate formats, such as Braille and large print
- Managed care plans are required to provide interpretation and translation services
- Mandatory attendance for cultural competency training for staff
- Managers are trained on the value of hiring a diverse workforce
- Position descriptions include requirements for cultural competency

Health care disparities

What are health care disparities?

- Encompass unequal treatment, differences in access, quality and outcomes
- Exist "if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population."
 - *National Institutes of Health, Public Law 106-525*

Why is it important to address health care disparities?

- Inequalities, such as health care disparities, should not exist
- Health outcomes are improved by establishing a health care delivery system that focuses on the unique needs of the patient – key performance measures reflect this
- Linguistically and culturally appropriate care maximizes the effectiveness of limited health care resources

“U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services.”

- *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, March 20, 2002, Institute of Medicine

Health care disparities

What health care disparities exist in Oregon?

- Reports presented to the Legislative Emergency board in June and December 2008
- Reports are available online at www.oregon.gov/DHS/aboutdhs/legactivity

Health disparities

Access to health care

Percent of people saying they “always or usually” get the care, tests or treatment they need through their health plan	
Race and Ethnicity	Percent indicating “always or usually”
African Americans	68%
American Indians and Alaska Natives	53%
Asians, Native Hawaiians and Pacific Islanders	82%
Hispanics	59%
Whites	69%

Source: CAHPS® Survey 2007-Adult Medicaid

Health disparities

Health status: OHP clients and general Oregon population

Percent of people who reported their health status as “good or excellent”		
Race and Ethnicity	OHP clients	General Oregon population
African Americans	63%	75%
American Indians and Alaska Natives	45%	69%
Asians and Pacific Islanders	62%	90%
Latinos/Hispanics	66%	71%
Whites	55%	86%

Sources: CAHPS® Survey 2007-Adult Medicaid and Behavioral Risk Factors Surveillance Survey

Health disparities

Chronic conditions: OHP clients and general Oregon population

Chronic Conditions	OHP clients					General Oregon Population
	African Americans	American Indians/Alaska Natives	Asians	Latinos/Hispanics	Whites	
Asthma	26%	23%	17%	18 %	26 %	10 %
Diabetes	13%	13%	8%	10 %	11 %	6 %
Heart attack	6%	4%	6%	3 %	5 %	4 %
Heart disease	6%	4%	3%	3 %	5 %	4 %
High cholesterol	32%	36%	40%	31 %	39 %	32 %
High blood pressure	34%	33%	31%	17 %	28 %	23 %
Stroke	5%	4%	7%	2 %	6 %	3 %

Sources: CAHPS® Survey 2007-Adult Medicaid and Behavioral Risk Factors Surveillance Survey

Health disparities

Apgar scores

- Standard early measurement of newborn health – skin color, pulse rate, reflex irritability, muscle tone and breathing
- Range from zero to 10, with a score of seven or greater considered normal

Rates of newborns with a five-minute Apgar score of less than seven		
Race and Ethnicity	OHP clients	General Oregon population
African Americans	2.3%	2.8%
American Indians and Alaska Natives	2.5%	1.5%
Asians and Pacific Islanders	1.6%	1.1%
Latinos/Hispanics	1.3%	1.6%
Whites	1.7%	1.7%

Source: DHS, Vital Records, Center for Health Statistics, All Infant Data 2006

Health care disparities

What have we already done to address health disparities?

- Elevated the Office of Multicultural Health Services to the Director's Office
- Helped develop the Health Disparities Resource Guide, which addresses immunizations and vaccinations for children
- Only state to partner with community groups and contribute to the Center for Healthcare Strategies Toolkit
- Implemented the Behavioral Risk Factor Surveillance System (BRFSS) pilot program to collect a racial over-sampling of health conditions
- Proposed new key performance measures to track access to services and outcomes by race and ethnicity
- Worked with managed care plans and health clinics to provide linguistically appropriate and culturally competent care to OHP clients
- Developed linguistically appropriate and culturally competent outreach, such as educational videos and educational materials targeted to specific communities
- Track chronic diseases by race and ethnicity through the Disease Management program

Health care disparities

What have we already done to address health disparities?

- Consumer Assessment of Health Plans (CAHPS®) and Medicaid Health Risk Health Status surveys are over-sampled for race and ethnicity
- Collaborated with Oregon's African American Health Coalition to implement a REACH (Racial and Ethnic Approach to Community Health) grant, which funded a campaign to reduce preventable diseases in Oregon's African American population – an example now used by other state Medicaid programs
- Facilitated and coordinated a national grant for contracted managed care plans to “Improve Health Care Quality for Racially and Ethnically Diverse Populations in Medicaid Managed Care”
- Implemented the health services interpreter certification program
- Multiple workshops, work groups and partnerships

Health care disparities

What are our obstacles?

- Despite state and national efforts to eliminate them, health disparities persist, and some have become worse
- Lack of agreement on causes, scopes and solutions
- Awkwardness and anxiety toward addressing health disparities
- Perception that addressing health disparities is an option, not a necessity

What are our opportunities?

- State leaders and contracted managed care plans have demonstrated a willingness to address the issue and created an environment to take action
- Providers, health systems and employer-based insurers show an increased interest in tackling this issue
- Increased availability of organizational self-assessment tools, evidence-based practices, and federal agency resources

Health care disparities

What is our framework for action?

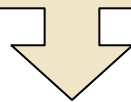
- **Long-term goal – a system of care that eliminates health disparities and improves the quality of life for racial and ethnic minorities**
- Identify the following for patients, communities and health care systems:
 - **Factors** – contribute to the success or failure of eliminating health care disparities, both short- and long-term
 - **Outputs** – activities, products and strategies that build on positive factors and reduce the impact of negative factors
 - **Outcomes** – demonstrate how the outputs contribute to eliminating disparities

Health care disparities

Logic model for addressing disparities

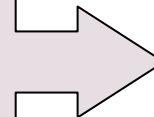
Factors to be addressed:

- **Individual** - Patient or provider beliefs, practices and attitudes
- **Community** - Public health, economic barriers, access to health care resources
- **Health Care System** - Commitment to eliminating disparities and increasing knowledge, tools and resources at individual and community levels



Outputs to address the factors:

- **Activities** - Active efforts to promote healthy behaviors, increase access, and promote culturally and linguistically appropriate care
- **Products** - Expanded health coverage, provider training, client education materials and policies
- **Strategies** - For communication, program evaluation, data collection and collaboration



Outcomes :

- **Individual** - Increased healthy behaviors, practice of and adherence to culturally appropriate treatment
- **Community** - Increased awareness of resources and access to them
- **Health Care System** - Resources, partnerships and framework in place to continue supporting outputs; a sustainable, measurable program

Health care disparities – next steps

Advisory committee to address health disparities

- Membership will reflect the racial and ethnic groups affected by disparities
 - African American Health Coalition, Inc.
 - Oregon Latino Health Coalition
 - Asian Health and Service Center
 - Northwest Portland Area Indian Health Board
 - Office of Multicultural Health Services
- Will help create and approve a plan to eliminate health disparities in Oregon
 - Strategies
 - Targets/goals
 - Measurements

Quality strategy changes

- Modify managed care plan contracts to prioritize the elimination of health care disparities

Investments and achievements

CAWEM Prenatal Services Pilot Project

- **Citizen-Alien/Waived Emergency Medical (CAWEM) benefit package** – Uses state and federal funds to provide emergency services, including delivery, for people who do not meet citizenship requirements
- **CAWEM Pilot Project** – Uses county funds to receive federal match dollars through CHIP to expand health care coverage for pregnant CAWEM clients to equal the OHP Plus benefit package
- Deschutes and Multnomah counties
- No additional impact on the state budget
- Pilot project is continued in the 2009-2011 budget
- Other counties have expressed interest in participating

Home health payments

- The 2007 Legislatively Adopted Budget mandated that Medicaid fee-for-service reimbursements to home health providers be increased to 75 percent of Medicare costs
- Increase was implemented effective January 1, 2008
- Prior to January 1, 2008, the reimbursement level was set at approximately 36 percent of costs
- The reimbursement increase expires June 30, 2009

Investments and achievements

Pharmacy program efficiencies

- Plan Drug List (PDL) incentives
 - Removed copayment requirements
 - Extended fill quantities from 34 to 90 days
- Sovereign States Drug Consortium
 - Oregon to join six other states to negotiate supplemental rebate agreements with drug manufacturers
- Prior authorization on below-the-line conditions
 - Ensures drugs are prescribed for funded medical conditions
 - Ensures medically appropriate use
 - Identifies potential client safety risks
- Pharmacy management program
 - Eliminated the mandatory lock-in requirement, limiting fee-for-service clients to one pharmacy
 - DMAP monitors clients' drug use on a case-by-case basis

Investments and achievements

Continuity of coverage

- Extended continuous certification period for Poverty Level Medical (PLM) children from six to 12 months to improve continuity of care
- Successfully transitioned 3,800 people to OHP Standard from the Family Health Insurance Assistance Program (FHIAP) after new federal policies affected the program's funding

Physician access improvement plan

- Demonstration project between May 1, 2008, and April 30, 2009
- Increase client access to preventive care services through contracted fully capitated health plans (FCHPs)

Investments and achievements

OHP Standard reservation list

- DHS had enough funding to open OHP Standard to increase enrollment to an average of 26,000 people
- To be as fair as possible, DHS developed a reservation list from which names would be randomly chosen by a computer
- More than 90,000 names were put on the list
- More than 30,000 applications were mailed between March and October
- Almost 10,000 people have been enrolled in OHP Standard from the reservation list

Medicaid Management Information System (MMIS) efficiencies

- Computerized claims processing and information retrieval system for OHP
- New MMIS was activated in December 2009
- Allows providers and staff to conduct business online and in real-time:
 - Eligibility verification
 - Claims and billing
 - Prior authorizations

Investments and achievements

Proposed elimination of Senior Prescription Drug Assistance Program

- Allows seniors without prescription drug benefits to purchase their drugs at the Medicaid price
- Better options now exist:
 - Medicare Part D
 - Oregon Prescription Drug Program
- Currently only three participants in the program

Health Records Bank

- \$5.5 million federal grant to create secure online database of health records
- Will provide medical information access to DHS, clients, providers and partners
- Greater access to information will improve quality of care, reduce costs and enhance patient engagement

Investments and achievements

Managed care enrollment

- During 2008 DMAP reached its 2007-2009 goal of 80 percent enrollment in physical medicine managed care
- Enrollment in managed care provides clients with a medical home, ensuring they have access to providers when needed

Revised OHP application

- Reduced from 12 to four pages, conditional questions moved to supplemental forms
- Easier to understand and complete
- Developed through collaboration with other DHS divisions, managed care organizations and client advocacy groups

DMAP Transformation Initiatives

Create an electronic communication system for providers

- Use electronic communication to update providers on policy and other information

Move to electronic-only billing

- Require providers to submit claims electronically using the MMIS Provider Web Portal

Streamline the prior authorization process

- Develop new processes and policies to ensure that providers receive timely, useful information and know how to use it
- Reduce prior authorization cycle times and decrease DMAP workloads

Expand the use of alternative methods for provider trainings

- Develop electronic formats for provider trainings, such as live, interactive training via the Internet
- Make it easier for providers to attend trainings, resulting in cost savings from trainers and providers traveling less

DMAP Transformation Initiatives

Expand use of videoconferencing for managed care organization (MCO) stakeholder meetings

- Increase use of videoconferencing for ongoing meetings with managed care representatives

Begin the Medicaid Information Technology Architecture (MITA) planning process

- Initiate a DHS Medicaid Information Technology Architecture (MITA) project
- Align technologies and processes that support transformation of the Medicaid program

Find efficiencies and value in the managed care process

- Explore options and opportunities within the managed care delivery system to make the system more efficient
- Increase the value of managed care and produce better outcomes

Create an enforceable Plan Drug List (PDL)

- As proposed in the GRB, reduce costs by enforcing the PDL
- Most effective drugs for the best possible price

DMAP Transformation Initiatives

“Pay for performance” system for MCOs

- Explore paying plans based on improved patient health and rate of preventive care rather than frequency of use

Institute end-to-end third-party resource (TPR) identification and recovery best practices

- Increase the use of cost avoidance and funds recovery best practices
- Reduce the amount of funds paid unnecessarily and increase recovery rates
- Identify third-party resources more comprehensively and earlier in the process
- Follow up on collections from other payers

Streamline the process for making changes to the Health Services Commission’s (HSC) prioritized list of health services

- Simplify process for coordinating changes to the prioritized list between HSC and DMAP

DMAP Transformation Initiatives

Time savings from DMAP initiatives will be reinvested to ensure timely and accurate benefit delivery and improved services

Transforming DMAP culture

- Approximately 90 percent of DMAP staff have had an introduction to Transformation
- Ongoing process in place to solicit staff ideas for improvement
- Huddles occurring in multiple sections
- Visual boards in use
- Weekly status reports to all staff

HSC List RPI - January 2009

- RACI (responsible, accountable, consulted, informed) chart developed; resulted in clarified roles and responsibilities
- Improved communication
- Metrics will measure a reduction in reconsiderations, provider appeal requests and not-covered denials

DMAP Transformation Initiatives

Use of videoconferencing for School-Based Health Services (SBHS) Program (part of DMAP Program Improvements Initiative)

- In collaboration with education school districts (ESDs), SBHS piloted the use of monthly videoconferencing meetings from May to December 2008
- Pilot established consistent communication among ESDs and DHS that:
 - Improved provider compliance with policies and procedures
 - Provided timely information and tools needed to improve the quality of these services in schools
 - Streamlined and standardized billing procedures, resulting in reduced billing errors
 - Increased savings by reducing travel time and money spent by DHS and ESDs
- Videoconference meetings with ESDs deemed very successful and are now scheduled to continue through the end of 2009

DMAP Transformation Initiatives

“Finding Efficiencies and Value in Managed Care” Initiative

- DMAP is working with OHPD to complete additional research and analysis to explore the feasibility of:
 - Competitive bidding
 - Impacts of service and/or contract consolidation
 - Impact on quality
 - Other opportunities for efficiencies or cost savings in managed care
- Steering committee established to guide this initiative – includes managed care participants

DMAP Transformation Initiatives

Challenges

- Bureaucratic, complex policies and processes
- Fragmented care with inconsistent health outcomes
- Unbalanced partner / provider relationships
- Loss of history and knowledge of policies and procedures due to:
 - High staff turnover
 - Overwhelming workloads
- Transforming cultural mindsets
- Increased need for metrics
- Initiative to create an enforceable PDL is dependent upon legislative action during the 2009-2011 budget process

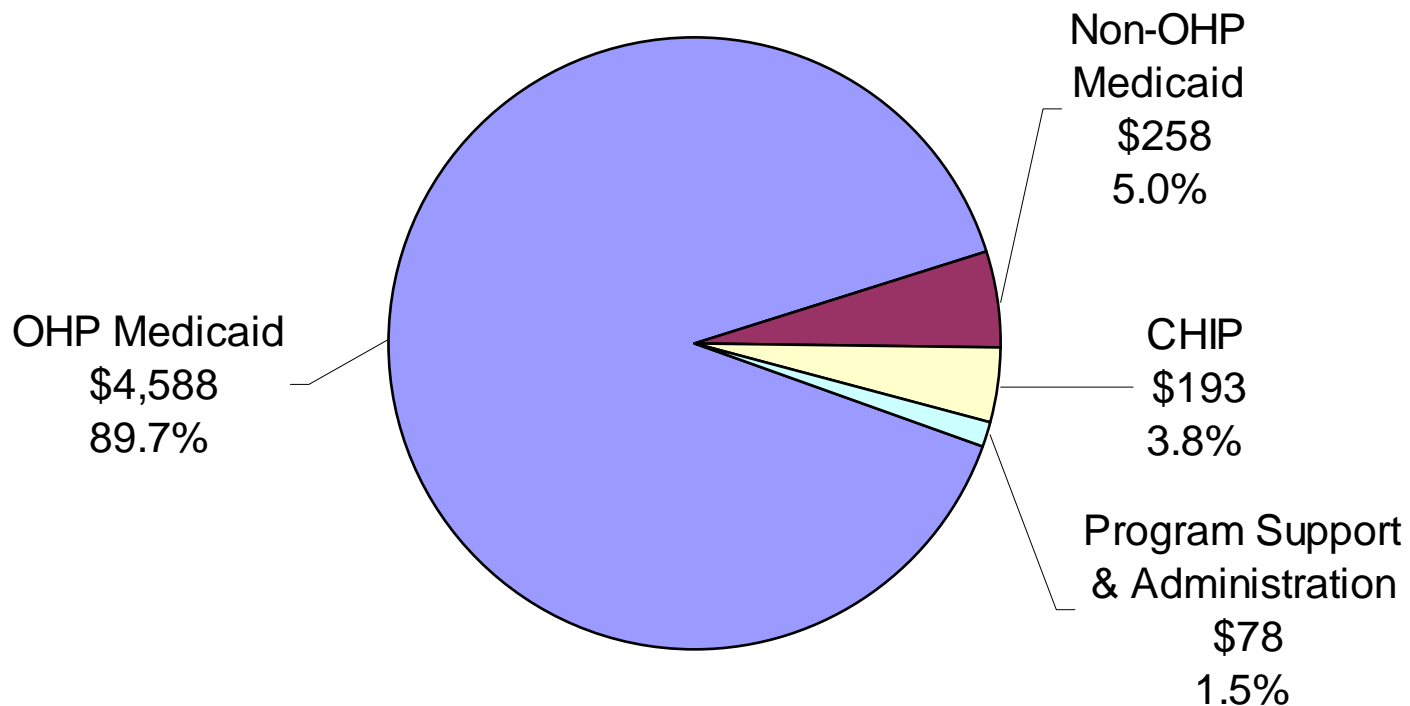
DMAP Transformation Initiatives

Opportunities

- Improved satisfaction for:
 - Clients through provision of seamless services
 - Partners / providers through achieving better health outcomes and sustainable business relationships
 - Employees through empowerment to create change
- Smarter use of resources resulting in increased reinvestment in other DMAP priorities
- Quicker dissemination of information
- Reduction in daily work errors
- Quicker processing time to complete daily work

2009-2011 DMAP EBL budget by program

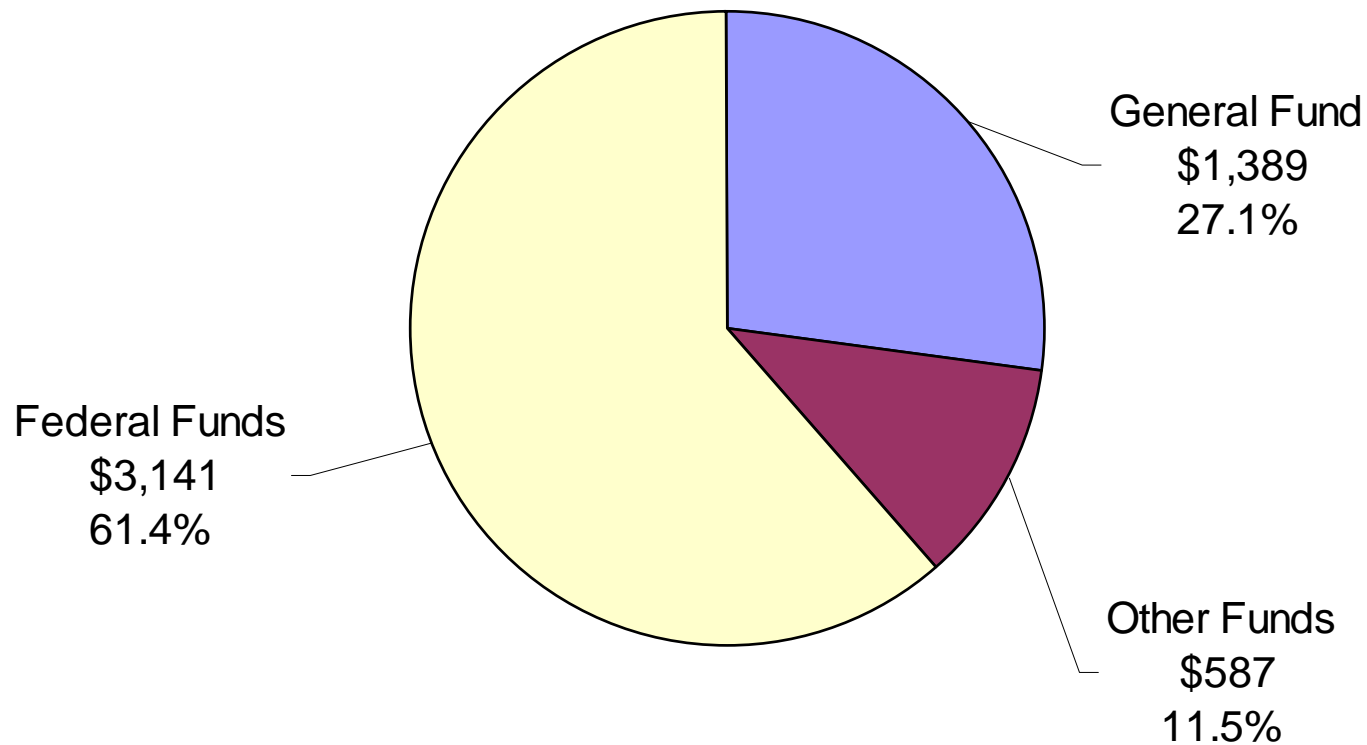
Division of Medical Assistance Programs Total by Program \$5,117 million



in rounded millions

2009-2011 DMAP EBL budget by fund type

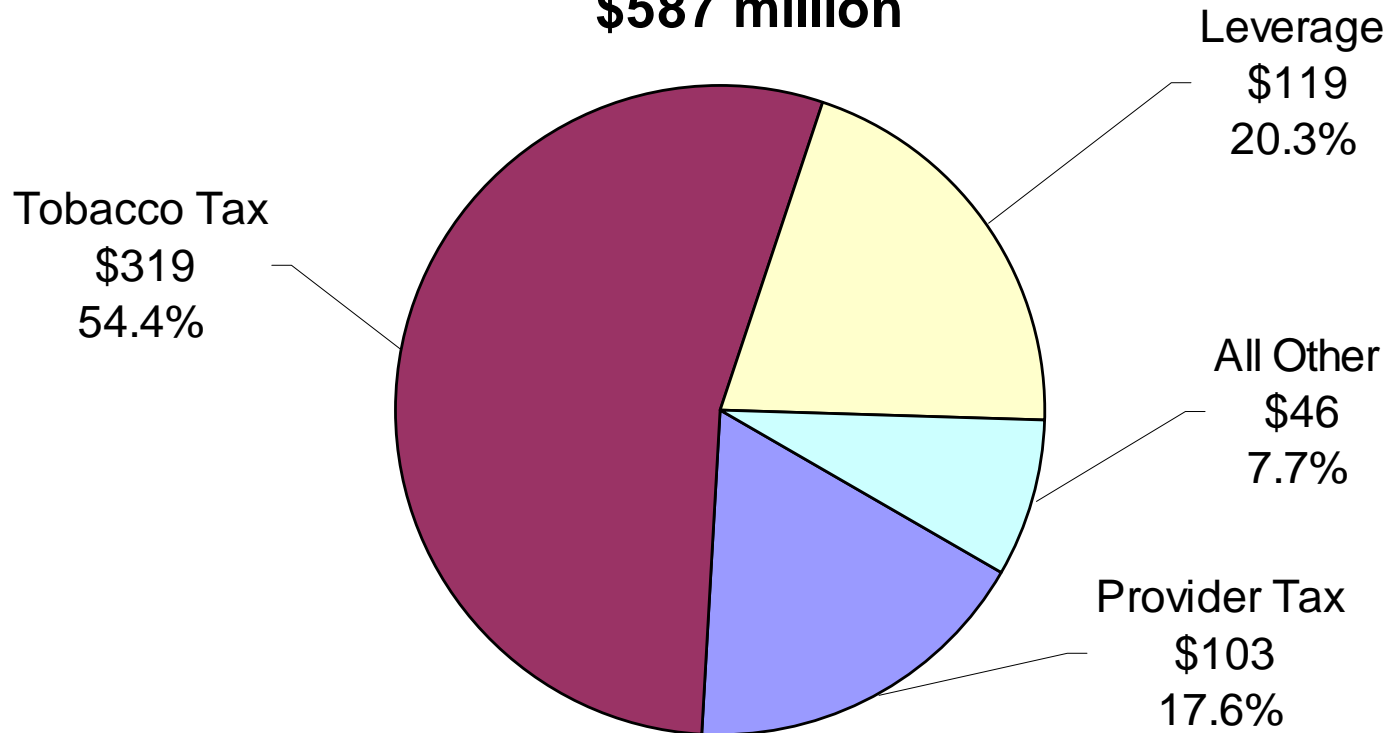
Division of Medical Assistance Programs Total by Fund Type \$5,117 million



in rounded millions

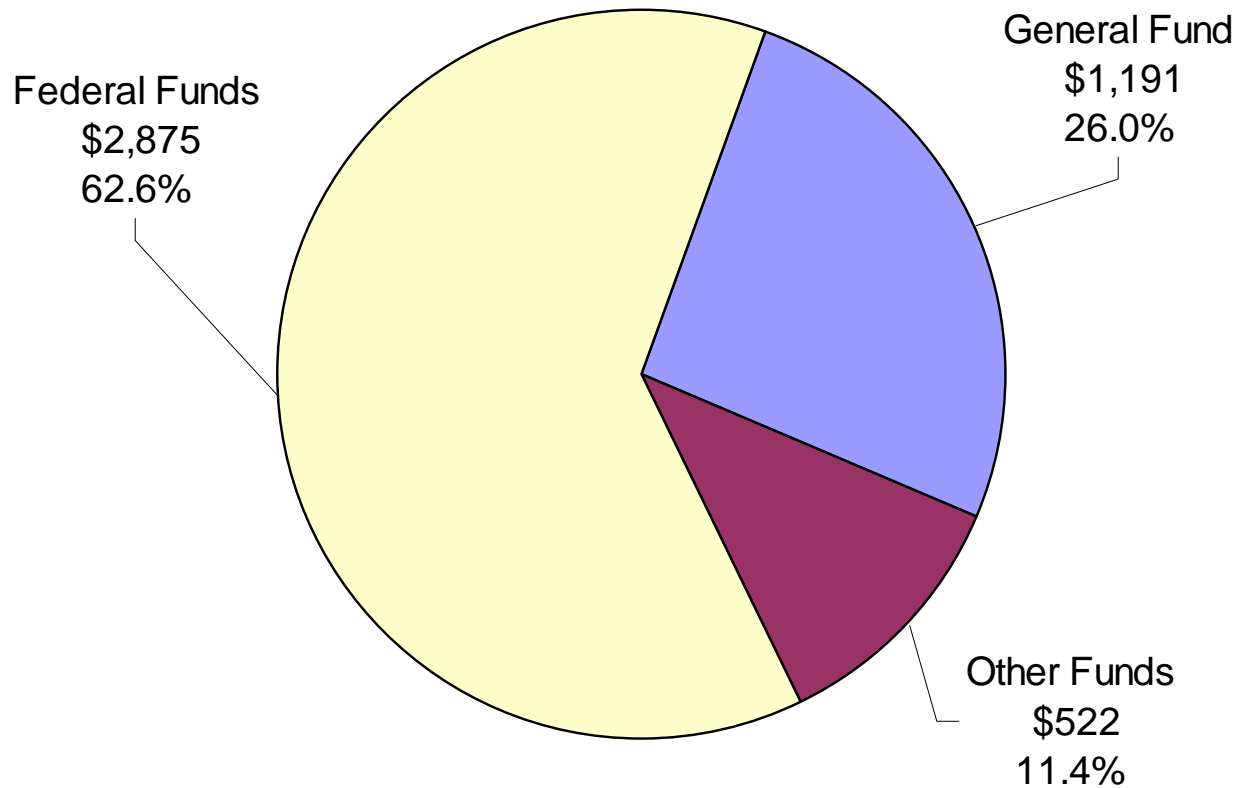
2009-2011 DMAP EBL budget by fund type

Division of Medical Assistance Programs Other Fund Distribution \$587 million



2009-2011 DMAP EBL distribution of funds

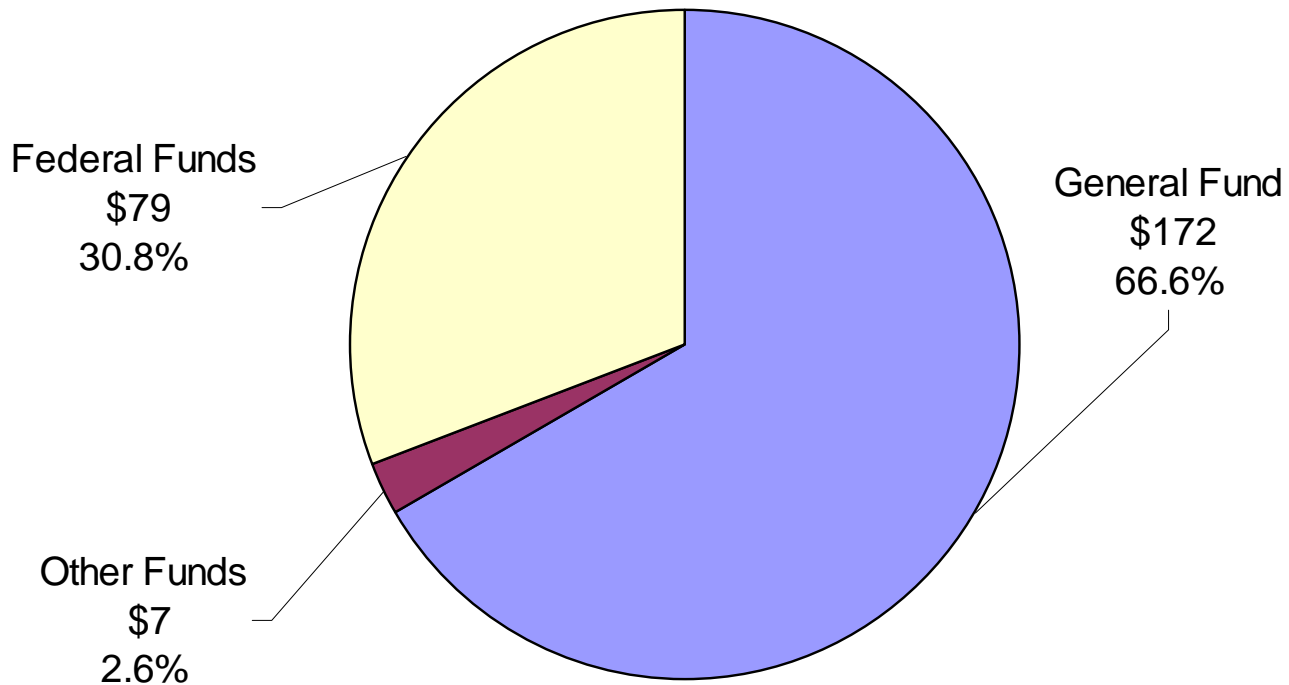
OHP Medicaid \$4,588 million



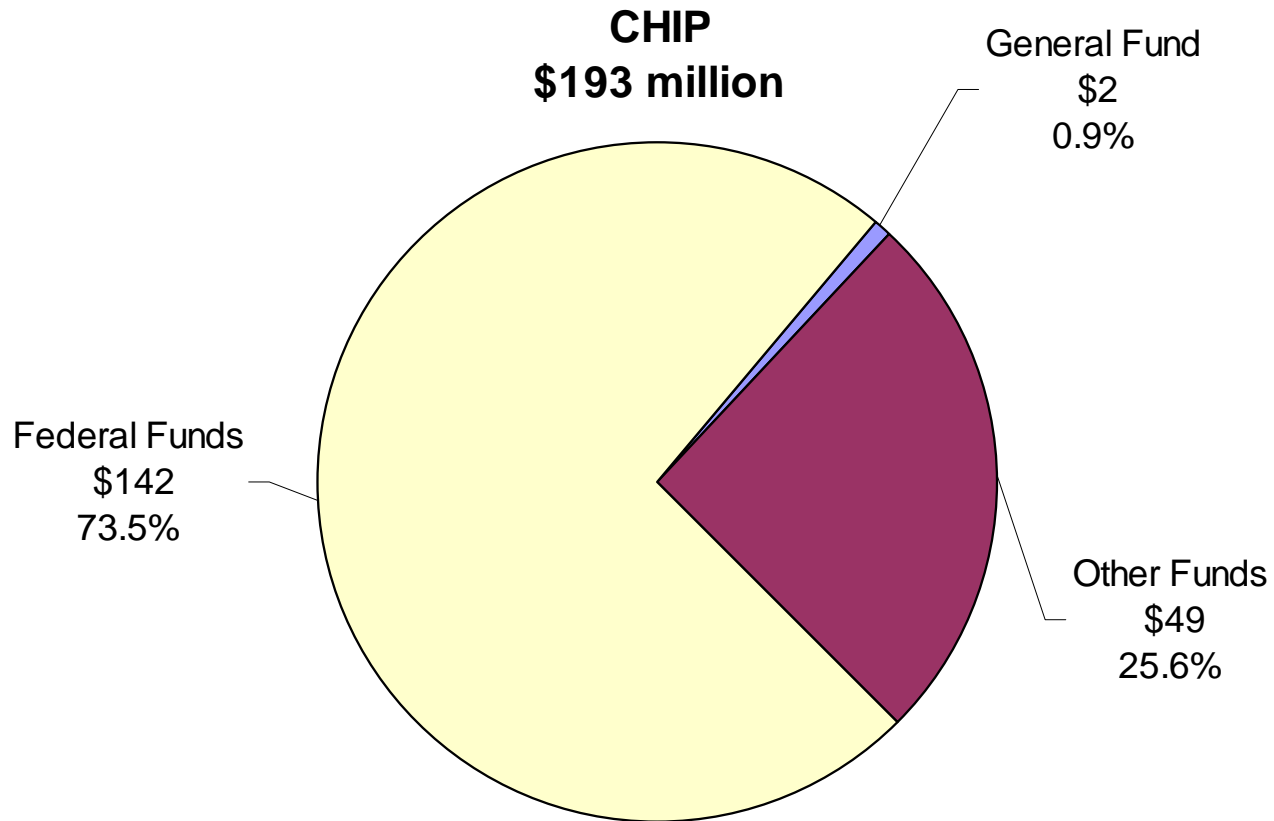
in rounded millions

2009-2011 DMAP EBL distribution of funds

Non-OHP Medicaid \$258 million

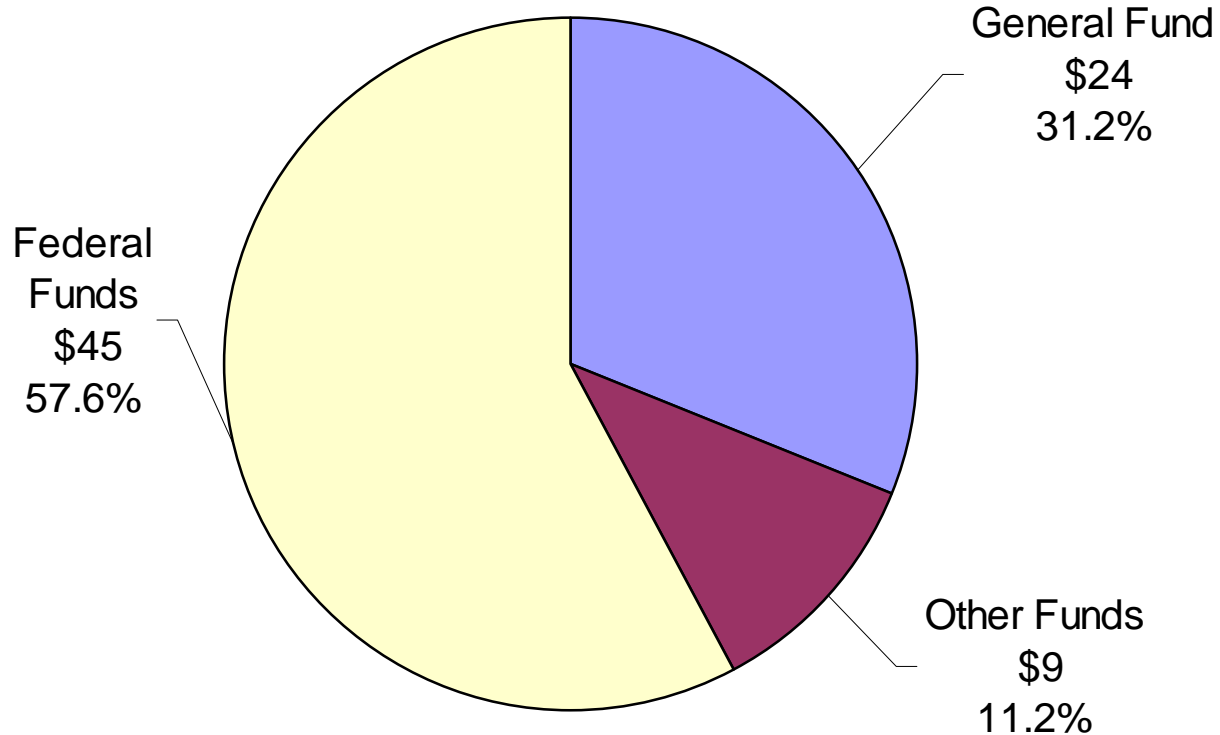


2009-2011 DMAP EBL distribution of funds



2009-2011 DMAP EBL distribution of funds

Program Support & Administration \$78 million



in rounded millions

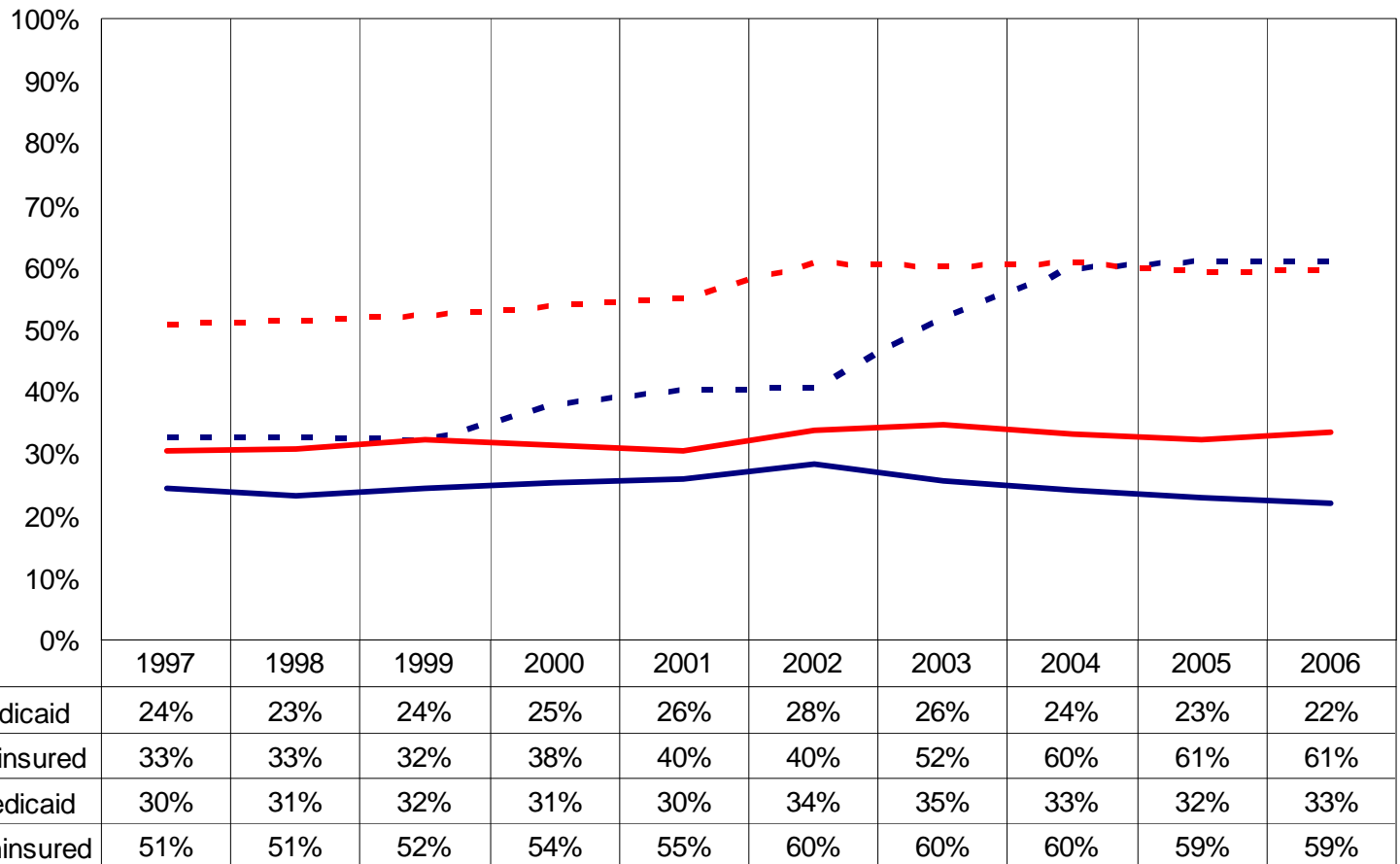
Caseload and budget drivers

Need for health care

- Oregonians are losing their health care coverage due to the economic downturn
- Oregon is experiencing an aging population with higher health care costs
- Two-thirds of adults in Oregon are either overweight or obese
- Cost shifts from the decrease in available employer-sponsored coverage and increase in the number of uninsured individuals

Caseload and budget drivers

1997-2006 ED Based Hospital Admissions: Oregon v. National



Caseload and budget drivers

Children and pregnant women

- An estimated 116,000 Oregon children and adolescents have no health insurance
- Uninsured low-income pregnant women above 185 percent of the FPL do not have access to Medicaid-paid prenatal care
- Uninsured low-income pregnant women must wait for eligibility determination before receiving paid prenatal care

Caseload and budget drivers

Access to providers, reimbursements and health care costs

- Providers limit their participation because reimbursement levels are low
- Some OHP clients cannot find providers willing to accept the low rates
- Health care costs are rising faster than general inflation
- Medical liability insurance continues to increase
- More than 20 percent of Oregon health care providers plan on retiring within the next five years

Caseload in biennial averages

OHP Plus	Biennium 2005-2007	LAB 2007-2009	Fall 2008 Forecast* 2009-2011
TANF-Related Medical	91,805	93,036	107,278
TANF-Extended	35,723	22,796	25,385
TANF Medical - subtotal	127,529	115,832	132,663
Poverty Level Medical - Women	10,216	11,083	12,034
Poverty Level Medical - Children	82,258	92,538	114,731
Aid to the Blind and Disabled	61,460	65,963	73,405
Old Age Assistance	30,235	30,563	31,620
Foster/Substitute Care	17,717	17,834	18,360
Children's Health Insurance Program	32,414	46,139	56,079
OHP Plus - subtotal	361,828	379,952	438,892

Caseload in biennial averages

	Biennium 2005-2007	LAB 2007-2009	Fall 2008 Forecast* 2009-2011
OHP Standard			
Families	7,327	11,397	11,442
Adults/couples	14,838	15,314	15,542
OHP Standard - subtotal	22,164	26,711	26,984
Other Medical Assistance Programs			
Citizen-Alien/Waived Emergency Medical	18,522	18,694	19,009
Qualified Medicare Beneficiary (no long-term care)	11,358	13,072	15,233
Breast and Cervical Cancer program	304	369	483
Other - subtotal	30,183	32,135	34,725

Caseload in biennial averages

	Biennium 2005-2007	LAB 2007-2009	Fall 2008 Forecast* 2009-2011
Total Medical Assistance Programs without SLMB	414,176	438,798	500,601
Specified Low-Income Medicare Beneficiaries (SLMB)	9,897	12,316	14,190
Total Medical Assistance Programs with SLMB	424,073	451,114	514,791
State Funds only Former Medically Needy/Transplant patients	44	26	9

*Excludes proposed expansion caseloads for children and OHP Standard

DMAP essential budget level

Caseloads

- All of the medical assistance programs administered by DMAP are designated as mandated caseload programs

EBL packages

- Phase-in costs of personnel and new programs not fully funded during the 2007-2009 biennium
- Phase-out costs of programs that are ending or one-time costs
- Inflation factors applied to program expenditures
- Forecasted increase in mandated caseloads
- Fund shifts for changes in federal match rates and adjustments for revenue shortfalls
- Technical adjustments shifting expenditures between divisions and budget categories
- Revenue shortfalls for Other Funds and Federal Funds

DMAP essential budget level

Provider taxes

- Includes phase-out of the hospital and Medicaid managed care taxes that sunset October 1, 2009
- Assumes the OHP Standard benefit package will continue with a biennial average of 26,000 clients, creating a revenue shortfall

Hospital component of managed care capitation rate

- Phase-out of 2007-2009 savings increases the Diagnostic Related Group (DRG) hospital component of the managed care capitation rate from the current reduced rate of 80 percent of cost back to 100 percent of cost

DMAP essential budget level

Inflation factors

- Standard inflation amounts
- Medical inflation amounts
- Budget and Management (BAM) Exception Committee-approved inflation of 9.6 percent

Tobacco tax revenue

- Fund shifts reflect a revised tobacco tax revenue projection for 2009-2011, causing a \$36 million General Fund shortfall

2009-2011 base to modified EBL “build”

	General Fund	Other Funds	Federal Funds	Total Funds	Pos	FTE
Base Budget	1,000,639,960	716,983,227	2,596,958,341	4,314,581,528	168	162.23
<u>Essential Packages</u>						
Pkg 010-Personal Services Adjustment	102,574	(5,980)	46,518	143,112	-	-
Pkg 021-Phase In	2,175,137	3,005,285	9,854,407	15,034,829	-	-
Pkg 022-Phase Out	25,588,664	(43,124,669)	(32,770,250)	(50,306,255)	-	-
Pkg 30 - Inflation	109,763,540	97,731,245	330,477,138	537,971,923	-	-
Pkg 040-Mandated Caseloads	253,212,974	37,960,427	428,057,172	719,230,573	-	-
Pkg 050-Fund Shifts	125,097,445	(184,976,754)	59,879,309	-	-	-
Pkg 060-Technical Adjustments	(127,100,643)	-	(178,179,822)	(305,280,465)	10	9.05
Pkg 070-Revenue Shortfall	-	(40,629,623)	(73,485,200)	(114,114,823)	-	-
Total Essential Packages:	388,839,691	(130,040,069)	543,879,272	802,678,894	10	9.05
Total Modified Essential Budget Level:	1,389,479,651	586,943,158	3,140,837,613	5,117,260,422	178	171.28

2009-2011 modified EBL to GRB “build”

	General Fund	Other Funds	Federal Funds	Total Funds	Pos	FTE
Adjustments to Achieve the Governor's Recommended Budget:						
Pkg 084 & 090-Dec.08 Rebalance/Analyst's Adjustments & Reductions	(413,203,430)	122,723,176	(497,159,779)	(787,640,033)	5	3.76
Total Adjustments:	(413,203,430)	122,723,176	(497,159,779)	(787,640,033)	5	3.76
Policy Packages included in the Governor's Recommended Budget:						
POP 503 OHP Standard Continuation and Expansion	-	358,948,838	603,233,371	962,182,209	4	3.52
POP 504 OHP Plus Restoration	-	110,000,000	184,906,166	294,906,166	-	-
POP 505 Health Care Coverage for Children	-	95,076,020	105,901,546	200,977,566	11	10.76
POP 506 DHS Caseload Reserve	-	12,416,492	20,871,691	33,288,183	-	-
Total Policy Packages	-	576,441,350	914,912,774	1,491,354,124	15	14.28
Total Governor's Recommended Budget	976,276,221	1,286,107,684	3,558,590,608	5,820,974,513	198	189.32

Essential budget level packages

Package 021: Phase-in

- New programs and expansion of non-mandated programs funded for less than 24 months during the 2007-2009 biennium
- Includes costs (or savings) for the additional months of funding needed to achieve the 24-month funding level

Package Detail	GF	OF	FF	Total Funds
Phase In of CAWEM Prenatal Pilot	-	1,755,000	4,226,699	5,981,699
Phase In of Durable Medical Equipment Reduction at 83.1% of Medicare	(130,799)	(69,195)	(319,861)	(519,855)
Phase In of Average Manufacturers Price Reduction - OHP	(258,380)	(131,620)	(622,461)	(1,012,461)
Phase In of Drug Management Actions Reduction - OHP	(732,442)	(373,109)	(1,764,519)	(2,870,070)
Phase In Graduate Medical Education	3,779,753	2,070,248	9,498,127	15,348,128
Phase In of POP 106-62 CAF Self Sufficiency	(482,995)	(246,039)	(1,163,578)	(1,892,612)
Total Package 021	2,175,137	3,005,285	9,854,407	15,034,829

Essential budget level packages

Package 022: Phase-out

- Programs permanently eliminated during the 2009-2011 biennium
- Removes costs (or savings) in the base budget for the months the program operated during 2007-2009
- Decreased costs (or savings) resulting from discontinuation of pilot project programs and other one-time costs that will not be continued

Package Detail	GF	OF	FF	Total Funds
Phase Out of Health Records Bank	-	-	(4,563,909)	(4,563,909)
Phase Out of Enhanced Managed Care payments due to ending of current Provider Taxes	-	(43,291,434)	(70,645,370)	(113,936,804)
Phase Out of Enhanced Hospital payments due to ending of current Provider Taxes	-	(22,044,777)	(35,641,543)	(57,686,320)
Phase Out of Managed Care Organizations' Physician Access Improvement Incentive Plan	(7,000,000)	-	(10,879,949)	(17,879,949)
Phase Out of additional Child Development Rehabilitation Center settlements	-	(1,062,466)	(1,695,754)	(2,758,220)
Raise Managed Care Rates to a 100% Diagnostic Related Group Cost Component	32,588,664	23,274,008	90,656,275	146,518,947
Total Package 022	25,588,664	(43,124,669)	(32,770,250)	(50,306,255)

Essential budget level packages

Package 030: Inflation and Price List Adjustments and Exceptions Committee Inflation and Consumer Price Index (CPI)

- 2.8 percent for general inflation and for non-state employee personnel costs (contract providers)
- General increases for services and supplies, capital outlay and special payments calculated using the general inflation factor and DAS price list
- 4.4 percent for medical services
- A utilization/trend inflation rate of 9.6 percent was applied to DMAP, as approved by the Budget and Management (BAM) Exceptions Committee

Package Detail	GF	OF	FF	Total Funds
General Inflation Increase of 2.8% for DMAP Administration expenditures.	398,828	196,672	816,041	1,411,541
Medical Inflation of 4.4% for DMAP expenditures.	41,327,475	30,111,344	109,043,015	180,481,834
Utilization/Trend Inflation of 9.6% for DMAP expenditures.	68,037,237	67,423,229	220,618,082	356,078,548
Total Package 030	109,763,540	97,731,245	330,447,138	537,971,923

Essential budget level packages

Package 040: Mandated caseloads

- Includes the mandated caseload, based on the Fall 2008 Forecast with corresponding inflation

Package Detail	GF	OF	FF	Total Funds
Forecasted Increase in Mandated Caseload	111,070,053	37,960,427	203,462,498	352,492,978
Pkg 040 Adjustments at GRB, reflecting expected caseload increase based on the Fall 2008 Forecast	142,142,921	-	224,594,674	366,737,595
Total Package 040	253,212,974	37,960,427	428,057,172	719,230,573

Essential budget level packages

Package 050: Fund shifts

- Adjustments to the Federal Medical Assistance Percentage (FMAP) from 61.48 to 62.70 percent and other applied fund shifts, based on updated information in the GRB

Package Detail	GF	OF	FF	Total Funds
Fund Shift - Federal Medical Assistance Percentage	(50,544,266)	(9,335,043)	59,879,309	-
Revised Tobacco Tax revenue projection for 2009-11 from Office of Economic Analysis	35,995,387	(35,995,387)	-	-
Fund Shift for inflated Other Funds Revenue	18,878,319	(18,878,319)	-	-
Fund Shift for inflated Tobacco Tax Funds	120,768,005	(120,768,005)	-	-
Total Package 050	125,097,445	(184,976,754)	59,879,309	-

Essential budget level packages

Package 060: Technical adjustments

- Technical budget adjustments, such as agency reorganizations and expenditure category shifts, which do not fit into the standard essential packages 010 – 050

Package Detail	GF	OF	FF	Total Funds
Transfer Medicare Buy-In to Seniors & People with Disabilities	(127,515,552)	-	(178,937,892)	(306,453,444)
Transfer Position Services & Supplies to Children, Adults & Families	(11,336)	-	-	(11,336)
Transfer Medicaid Management Information System positions to DMAP	426,245	-	1,258,070	1,684,315
Transfer Federal Fund Limitation to Administrative Services Division	-	-	(500,000)	(500,000)
Total Package 060	(127,100,643)	-	(178,179,822)	(305,280,465)

Essential budget level packages

Package 070: Revenue shortfall

- Includes only those Other Funds and Federal Funds expenditure reductions necessary to adjust the EBL to available revenues, normally budgeted in the base and/or essential packages 010 – 060
- EBL assumes the OHP Standard population will continue with 26,000 clients – package reflects the shortfall of funds for the continuation of 26,000 OHP Standard clients at the end of the current Provider Tax Program and after fund balances have been exhausted

Package Detail	GF	OF	FF	Total Funds
Revenue Shortfall – Provider Tax	-	(40,629,623)	(73,485,200)	(114,114,823)
Total Package 070	-	(40,629,623)	(73,485,200)	(114,114,823)

Essential budget level packages

Package 084: December 2008 Rebalance

- Includes December 2008 Rebalance roll-ups, which reflect the 2009-2011 biennium impact of actions taken at the December 2008 Oregon Legislative Emergency Board meeting
- Includes updated revenue forecasts

Package Detail	GF	OF	FF	Total Funds
Total Package 084	6,655,726	(1,664,839)	4,527,948	9,518,835

Package 090: Analyst adjustments and reductions

- Includes reductions made to achieve the GRB (explained in following slides)

Package Detail	GF	OF	FF	Total Funds
Total Package 090	(419,859,156)	124,388,015	(501,687,727)	(797,158,868)

Total Packages 084 & 090	(413,203,430)	122,723,176	(497,159,779)	(787,640,033)
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GRB proposed reductions

Total Funds reductions

Improving efficiencies

- Enforcing the Plan Drug List (PDL) – \$5.8 million
- Adding mental health drugs to the PDL – \$24.4 million
- Creating a sole-source contract for specialized durable medical equipment – \$0.3 million

Reductions in health care services and populations

- Eliminate dental services, routine vision care and certain Medicaid-optional services for approximately 125,000 clients – \$82.5 million (combined)
- Eliminate health care coverage for approximately 4,000 seniors and people with disabilities by transitioning them to a new waiver that lowers the income limits for eligibility to 150 percent of the FPL – \$126 million*
- Eliminate health care coverage for 1,700 seniors and people with disabilities by limiting coverage to only those people who need at least 80 hours per month of in-home care – \$21.3 million
- Partial elimination of OHP drugs – \$294.9 million**

*GRB number (overstates actual reduction)

**Funds restored through POP 504

GRB proposed reductions

Reductions in provider reimbursements

- Reduce payments to federally qualified health centers (FQHCs) and rural health clinics (RHCs) – \$2.9 million
- Do not implement the increase in capitation rates for Diagnostic Related Group (DRG) hospitals from 80 to 100 percent of cost – \$162.1 million
- (Intended) Reduce the capitation rates for DRG hospitals from 80 to 72 percent of cost – \$54.3 million*
- Reduce the capitation rates for all managed care organizations by 3 percent – \$67.7 million
- Eliminate cost-of-living adjustments (COLAs) for most fee-for-service providers – \$7.2 million

*GRB does not include reduction (although intended)

GRB proposed reductions

Administrative reductions

- Reduce Attorney General use by 10 percent by controlling the initiation of consultation services – \$0.1 million
- Reduce personal services budget by 4 percent – \$0.8 million*
- Reduce services and supplies budget by 2 percent – \$1.1 million

*GRB number (understates actual reduction)

GRB proposed investments

POP 503 – OHP Standard continuation and expansion

- Uses new provider taxes to replace those that sunset October 1, 2009
- Additional provider taxes will fund the expansion of OHP Standard from a biennial average of 26,000 to 75,000 low-income adults
- New clients would be added to the program starting October 2009, with the caseload reaching approximately 100,000 by the end of the 2009-2011 biennium
- To control costs and keep the budget within the expected revenue, the department would add new clients in a controlled manner, rather than immediately reopening the program to everyone who qualified

GRB proposed investments

POP 504 – Restoration of OHP Plus drugs

- In combination with Package 090 reductions to eliminate OHP drugs, POP 504 represents a fund shift of \$110 million from General Fund to Other Funds dollars
- Increases the tax on cigarettes by \$0.60 per pack and increases the tax on other tobacco products
- Includes \$10 million in additional provider tax revenue
- Resulting additional tax revenue would be available for federal match dollars at both Medicaid and CHIP rates
- If not approved, Legislature will need to identify another source of revenue to backfill the shortfall

GRB proposed investments

POP 505 – Health care coverage for Oregon’s children

- Allows all uninsured Oregon children under age 19 the opportunity to enroll in comprehensive, affordable health insurance
- All children up to 200 percent of the FPL would be eligible for the OHP Plus benefit package
- Takes full advantage of Medicaid and CHIP federal matching funds
- Timeline:
 - **July 2009** – Extensive outreach efforts would be initiated to enroll children who are eligible but not receiving benefits
 - **October 2009** – OHP eligibility income limits would be raised from 185 to 200 percent of the FPL
 - **January 2010** – Office of Private Health Partnerships would offer comprehensive, affordable coverage for children above 200 percent of the FPL and provide support for families who have employer-sponsored insurance

GRB proposed investments

POP 506 – DHS caseload reserve

- Provider tax dollars not used for health care coverage for children and OHP Standard clients would be set aside as a reserve for increasing caseloads

CHIP Reauthorization Act

Significant new CHIP funding through FY 2013

- Increases CHIP allotments through a \$0.62 increase in the federal tax on cigarettes and other tobacco products
- Allows states the option of receiving the CHIP match rate for children up to 300 percent of the FPL – this additional funding is expected to reduce the state fund cost of expanding health care coverage to children by \$23 million

New CHIP eligibility options

- Expand coverage with CHIP funding for pregnant women with incomes up to 300 percent of the FPL when certain conditions are met
- Expand coverage with Medicaid (Title XIX) match rates for providing health care to children above 300 percent of the FPL
- Use Medicaid and CHIP funds to provide coverage to legal immigrant children and pregnant women who were previously ineligible because they had not met the five-year residency requirement

CHIP Reauthorization Act

Requirements for documentation of citizenship

- Extends to CHIP the Medicaid citizenship documentation requirement established by the Deficit Reduction Act
- Allows states the option to use information already gathered by the Social Security Administration to document citizenship status
- Requires documents issued by federally recognized American Indian tribes to be used as documentation of citizenship
- Requires coverage of persons declaring U.S. citizenship without delaying, denying, reducing or terminating eligibility based on immigration status until a reasonable opportunity to present satisfactory documentation has transpired
- Requires that birth to a Medicaid mother be adequate documentation of U.S. citizenship for children

Effects of federal stimulus package

Increase of Federal Medical Assistance Percentage (FMAP)

- Increases states' Medicaid match rate by 6.2 percentage points for the "recession adjustment period," October 2008 through December 2010
- States with high unemployment, such as Oregon, may be eligible for an additional FMAP increase through December 2010
- CMS has calculated the combined increase in FMAP for Oregon to be 9.13 percentage points for the first two quarters – Oregon's regular Medicaid match rate is 62.45 percent

Effects of federal stimulus package

Requirements for FMAP increase

- Excludes:
 - Disproportionate share hospital (DSH) payments
 - Title XXI – Children’s Health Insurance Program
- States are not allowed to:
 - Claim increased match rates for any Medicaid expansion raising eligibility income standards above those in effect in July 2008
 - Have eligibility standards, methodologies or procedures in place that are more restrictive than those in effect in July 2008
- States must comply with “prompt pay” requirements
 - State must pay 90 percent of certain medical claims within 30 days and 99 percent of claims within 90 days
 - Provision may be waived only for exigent circumstances

Effects of federal stimulus package

Temporary increase in disproportionate share hospital (DSH) allotments

- Increases the DSH allotments to 102.5 percent for FFY 2009
- Further increases DSH allotments by another 2.5 percent for FFY 2010
- Oregon can access the increased allotment fund to the extent that it can provide the state share to draw down federal dollars

Other provisions

- Extension of moratoria and halt of seven new CMS regulations
- Extension of the Transitional Medical Assistance Program
- Extension of the Qualifying Individual Program
- New protections for American Indians

Opportunities and challenges

Vulnerable Oregonians have access to health care

- Restore the benefit package for OHP Standard clients to match the OHP Plus benefit package
- Improve continuity of care by increasing the OHP Standard eligibility period from six months to 12
- Raise OHP eligibility for uninsured low-income pregnant women from 185 percent of the FPL to 200 percent or beyond

Children are healthy and safe

- Grant immediate short-term eligibility to uninsured low-income pregnant women who show proof of pregnancy while full eligibility is being determined
- Expand the successful CAWEM Plus pilot project to provide the OHP Plus benefits to legal immigrant pregnant women who would otherwise receive coverage only for emergency services such as labor and delivery

Opportunities and challenges

Services are safe and available in communities when needed

- Establish a reimbursement formula for DRG hospitals to ensure an equitable payment structure and no decrease in payments for health care services
- Increase reimbursement rates for fee-for-service providers
- Provide incentives to providers to use a new Medicaid health record bank
- Expedite payments to federally qualified health centers and rural health clinics
- Increase Medicaid managed care capitation rates

DHS has the capacity to meet clients' needs

- Increase staffing to multiple sections to provide a higher level of customer service to OHP clients and providers
- Continue funding for positions supporting the new Medicaid Management Information System
- Use General Fund dollars to replace federal funding that expires in 2010 to support a Medicaid health record bank

Division of Medical Assistance Programs

Themes

- DMAP provides services that:
 - Strengthen the health of Oregon's workforce
 - Improve overall public health
 - Directly benefit people of all ages
- The need for medical assistance is increasing while the revenue that supports programs is decreasing
- Access to health care benefits the economy by promoting the health of individuals, families and the community as a whole
- DMAP provides health care to as many people as possible while maximizing the limited resources available
- DMAP has embraced the Transformation Initiative in order to operate more efficiently and cut costs wherever possible
- The Governor's Recommended Budget contains both significant investments and reductions