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Background Brief on . . .

# Oregon Health Plan

The Oregon Health Plan (**OHP**) provides access to health care through a combination of public and private insurance plans. For public programs provided directly by the state, OHP bases benefits on a prioritized list of health care services. Currently, more than 650,000 Oregonians have access to health care through OHP. The program has three components:

- The first two components, OHP Plus and OHP Standard, are offered through both Medicaid and the Children's Health Insurance Program (**CHIP**). CHIP is a separate federally and state-funded program that expands coverage to children ages 0-18 with family income through 200 percent of the Federal Poverty Level (**FPL**).
- Medicaid is the largest component of the OHP, serving pregnant women, low-income families, children and seniors, people with disabilities, children in foster care and children who are adopted.
- The third component, also funded under Medicaid and CHIP, is offered through the Office of Private Health Partnerships as premium subsidies through the Family Health Insurance Assistance Program (**FHIAP**), the Healthy Kids Employer-Sponsored Insurance (ESI) program and Healthy KidsConnect, the state-contracted private coverage program.

The Oregon Health Authority's (**OHA's**) Division of Medical Assistance Programs administers the Medicaid and CHIP public insurance components of OHP.

FHIAP provides subsidies for the purchase of private health insurance by low-income, uninsured families with incomes through 200 percent of the federal poverty level; FHIAP also subsidizes commercial premiums in amounts based on family size and income.

The Healthy Kids Employer-Sponsored Insurance (ESI) program offers premium subsidies for children's coverage when family income is above 200 through 300 percent of FPL.

Healthy KidsConnect, the state-contracted private coverage program, provides premium subsidies to children in families with incomes from above 200 through 300 percent of the FPL, with coverage under contracted carriers.

### **OHP Plus**

*Eligibility* - As of January 2012, there were 540,757 children and adults in the OHP Plus population. People eligible for OHP Plus include low-income elderly and people with disabilities, people eligible for Temporary Assistance for Needy Families (**TANF**), children eligible for Medicaid and CHIP, pregnant women, and low-income foster children. Children may also opt to enroll in private coverage under FHIAP instead of Medicaid and CHIP. Generally, many Medicaid-eligible adult enrollees and low-income families, may not have assets (with some items excluded such as a person's house and car) over \$2,000 for an individual, \$3,000 for a couple or \$10,000 for TANF recipients actively participating in the JOBS program. There is no asset limit for pregnant women and most children.

*Coverage* - Benefits and services that people on the OHP Plus receive include (with some co-pays and limitations):

- Prescriptions;
- Physician services;
- Check-ups (medical and dental);
- Diagnostic services for all conditions;
- Family planning services;
- Maternity, prenatal, and newborn care;
- Hospital services;
- Comfort care and hospice;
- Dental services;
- Alcohol and drug treatment;
- Mental health services; and,
- Vision services.

Services not covered include:

- Conditions that get better on their own;
- Conditions that have no useful treatment;
- Treatments that are not generally effective;
- Cosmetic surgery;
- Gender changes;
- Most services to aid in fertility; and,
- Weight loss programs.

### **OHP Standard**

*Eligibility* - As of January 2012, there are 69,739 people in OHP Standard. Eligibility for the program includes parents and adults/couples who are not eligible for OHP Plus. Enrollees must be age 19 or older, not be eligible for Medicare, and family income must be under 100 percent of the FPL. Enrollees cannot have over \$2,000 in assets (with some items excluded such as the person's house or car).

During the current biennium, hospitals paid taxes to support the program. The revenue generated was enough to cover a monthly average of 60,000 enrollees during the 2011-2013 biennium. Because OHP Standard enrollment is limited by the available tax revenue, OHA uses a reservation list to add new people to the program. In October 2009, OHA opened the reservation list to gather more names. The list remains open and as of July 1 2012, contained the names of approximately 111,000 individuals. OHA randomly selects names and mails applications to individuals on a periodic basis to achieve caseload targets.

*Coverage* - OHP Standard covers basic services (with some limitations), such as:

- Hospital services;
- Physician services;
- Lab/x-ray;
- Prescription drugs;
- Diagnostic services for all conditions;
- Alcohol and drug treatment;
- Mental health services;
- Maternity, prenatal, and newborn care;
- Emergency transportation;
- Comfort care and hospice;
- Emergency dental; and,

- Some durable medical equipment and supplies (diabetic supplies, respiratory, oxygen).

Services not covered include:

- Nonemergency transportation;
- Routine vision services;
- Services related to hearing aids;
- Dental services (besides emergency);
- Most medical equipment and supplies;
- Acupuncture (except for treatment of chemical dependency);
- Chiropractic and osteopathic manipulation;
- Home health care;
- Nutritional supplements;
- Occupational, physical and speech therapy; and,
- Private duty nursing.

Some OHP Standard clients pay premiums for their coverage. Monthly premiums are based on the person's income, and range from \$9 (for those whose incomes are at 10 to 50 percent of the FPL) up to \$20 per month for those with incomes at 85 to 100 percent of the FPL. Persons with incomes below 10 percent of the FPL do not pay premiums. People who owe past due premiums are disenrolled at their annual eligibility determination. These individuals are not eligible to re-enroll until they pay their past premiums and the program is open to new enrollment.

### **The OHP Service Delivery System**

Traditionally, people in OHP have received health care services through managed care organizations. There are three managed care delivery systems: fully capitated health plans (**FCHPs**), primary care management (**PCM**), and physician care organizations (**PCOs**). As of August 1, 2012, Coordinated Care Organizations (**CCOs**, described below) became the primary delivery system for OHP services.

During the 2011-13 biennium, approximately 80 percent of people in OHP were enrolled in FCHP/PCO programs similar to health maintenance organizations (HMOs) in that FCHPs receive a set amount of money per enrollee in return for providing the services for

which the person is eligible, including inpatient hospital care. Prior to the advent of CCOs, FCHPs primarily served OHP clients with physical health services. PCOs provide the same range of services as FCHPs, except for inpatient hospital services. There were two PCOs.

Approximately one percent of OHP enrollees receive their care through a PCM. This care includes preventive, primary care, and specialty services managed by a physician, nurse practitioner, or other provider.

Due to federal law, state policies or because a managed care organization may not provide services in some parts of the state, approximately 19 percent of OHP clients received health care on a fee-for-service basis during the biennium, meaning the provider bills the state directly for services.

Prior to the implementation of CCOs, enrollees who were eligible for dental and mental health services through OHP received care through stand-alone dental care organizations and mental health organizations. These services operate similarly to FCHPs in that dental and mental health plans receive a set amount of money per enrollee to provide health care benefits for which the person is eligible.

### **Coordinated Care Organizations**

Over the last two legislative sessions, Governor Kitzhaber and lawmakers passed bipartisan, landmark legislation (House Bill 3650 in 2011 and Senate Bill 1580 in 2012) to transform the OHP delivery system through creation of CCOs. CCOs are networks of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under OHP.

CCOs integrate OHP mental health services and dental services with physical health services. Mental health will be integrated as CCOs form; dental health is required be integrated by 2014. This will improve early identification and prevention, ultimately improving health and health outcomes for clients.

CCOs will be local and will have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs will be accountable for health outcomes of the population they serve. They will be governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

Health benefits will not be reduced in the CCO environment; however, CCOs will have more flexibility to pay for services that improve health and quality, but were not previously able to be reimbursed. In addition, CCOs will be able to pay nontraditional health workers who can coordinate care and help patients navigate the delivery system.

### **Federal Waiver**

Through agreement with the federal government, Oregon will receive an investment of \$1.9 billion over five years (beginning July 2012) to prevent further cuts in OHP through the transition to CCOs. In exchange, the state has agreed to reduce the per capita growth of Medicaid costs by two percentage points (from 5.4 percent annual growth to 3.4 percent) by the end of the second year. Through this reduction in medical inflation, the federal government will recoup its investment in five years and the cost of Medicaid will be reduced by \$11 billion over the next 10 years (in total funds).

To ensure costs are reduced by improving quality and not through withholding care, CCOs and the state will be held to strong criteria and metrics around quality. There will be financial incentives for CCOs for achieving performance

benchmarks. In addition, the state will be investing in the work force needed to support CCOs, including creation of a student loan repayment program for primary care physicians and training 300 community health workers by the end of 2015.

CCOs were created in response to escalating health care costs, due in large part to an inefficient health care system. More than 1,200 Oregonians provided input through eight community meetings that were held around the state, and another nearly 200 people met in work groups to help create the framework for CCOs.

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