Background Brief on …

Oregon Health Plan

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Overview

As of June 2014, more than 970,000 Oregonians received Oregon Health Plan **(OHP)** coverage, funded through Medicaid and the Children's Health Insurance Program **(CHIP)**.

Both Medicaid and CHIP are funded by a mix of federal and state dollars and provide benefits based on Oregon's Prioritized List of Health Care Services. http://www.oregon.gov/oha/healthplan/pages/priorlist.aspx

- Medicaid provides coverage for the largest portion of OHP members, serving pregnant women, families with income that qualifies them for Temporary Assistance to Needy Families **(TANF)**, other adults with income that is low but above TANF levels, seniors, people with disabilities, all children in foster care, all children who are adopted, and children in families with incomes that are 138 percent of the federal poverty level or lower. People with Medicaid coverage may also have Medicare benefits or private coverage through an employer or individual policy.

- CHIP covers children ages 0-18 with family income from 138 through 300 percent of the Federal Poverty Level **(FPL)**. Children with CHIP coverage may not have Medicare benefits or private coverage and still be eligible for CHIP.

Services and coverage are the same under OHP for the Medicaid and CHIP programs, and the Oregon Health Authority's **(OHA's)** Division of Medical Assistance Programs **(DMAP)** administers both the Medicaid and CHIP components of OHP.

Oregon Health Plan (OHP)

Eligibility and enrollment - As of June 2014, the OHP has experienced an increase of more than 357,000 since January 1, 2014. Today, more than 970,000 Oregonians are enrolled in the Oregon Health Plan. This exceptionally large increase is due to the passage at the federal level of the Patient Protection and Affordable Care Act **(ACA)**, and the choice made by Oregon to expand Medicaid under the terms of the ACA to adults with incomes that are 138 percent or less of the FPL.

To help streamline the enrollment of new members into OHP, the federal government allowed OHA to implement a simplified, "fast-track" enrollment process, using data from the Supplemental Nutrition Assistance Program **(SNAP)** to identify Medicaid-eligible individuals. About 140,000 of the new OHP eligibles were enrolled through this process.

The federal matching rate for the ACA expansion population is 100 percent of all costs through (calendar year) 2016. The match percentage goes to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent for 2020 and beyond. The average FMAP for Medicaid is about 64 percent, and for CHIP it is close to 74.5 percent. These rates are projected to be approximately the same for the 2015-17 biennium.

When the ACA expansion began, Oregon discontinued the OHP Standard program. This program has provided coverage since 2002. The coverage consisted of a reduced benefit package to a limited number of low-income adults not eligible for TANF-related medical eligibility but with incomes 100 percent of the FPL or lower. Those members became part of the ACA expansion in January 2014 and are eligible for full OHP benefits.

The Office of Private Health Partnerships **(OPHP)** was also discontinued with the implementation of the ACA. From its inception in 1998, OPHP helped nearly 200,000 Oregonians gain health insurance and access to health care coverage through premium subsidy programs such as the Oregon Medical Insurance Pool **(OMIP)**, The Family Health Insurance Assistance Program **(FHIAP)** and Healthy KidsConnect.

Under the ACA, no one can be denied coverage due to pre-existing conditions like the OMIP population might have been in the past. People who have been denied coverage in the past can now qualify for the same health coverage at the same cost as everyone else. In addition, the OHP is open to more Oregonians and the Marketplace will provide access to coverage for others who are uninsured. Therefore, OPHP closed its programs on December 31, 2013.

Coverage - Benefits and services that people on the OHP 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;
- Most services to aid in fertility; and
- Weight loss programs.

OHP Service Delivery System

On August 1, 2012, Coordinated Care Organizations **(CCOs)** became the primary delivery system for OHP services, significantly supplanting the managed care delivery systems in existence at the time including fully capitated health plans **(FCHPs)**, primary care management **(PCM)**, and physician care organizations **(PCOs)**. CCOs deliver health care and coverage for most people on the Oregon

Health Plan, including those who are also covered by Medicare.

During the 2013-15 biennium, approximately 90 percent of people in OHP were enrolled in CCOs. CCOs receive a set amount of money per enrollee in return for providing the physical, dental, and behavioral health services for which a person is eligible. They also receive incentives based on quality and access to care. Prior to the implementation of CCOs, enrollees received dental and behavioral health services through OHP stand-alone dental care and mental health organizations.

Due to federal law, state policies or because a CCO or other managed care organization may not provide services in some parts of the state, approximately five percent of OHP enrollees receive their care through the Fee-for-Service **(FFS)** system. FFS means the state directly pays providers for services. A significant portion of the FFS population is comprised of those with federal exemptions from mandatory managed care enrollment such as Medicare or documented Tribal heritage.

Approximately another five percent of Medicaid and CHIP enrollees are served by other types of existing managed care organizations such as FCHPs or PCOs.

The delivery system is significantly enhanced by 19 FQHCs, 21 Indian and Tribal Health Services (**IHS**, six of which are FQHCs) and 495 Patient-Centered Primary Care Homes **(PCPCHs)**, as well as numerous Rural Health Clinics **(RHCs)** and hospitals that provide access to OHP members.

Coordinated Care Organizations (CCOs)

House Bill 3650 in 2011 and Senate Bill 1580 in 2012 transformed the OHP delivery system through the creation of CCOs. Created in response to escalating health care costs from an inefficient health care system, 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 the OHP.

As of July 1, 2014, 16 CCOs were in existence and fully integrated, providing comprehensive physical, behavioral, and dental health services. Among the primary aims of service integration, the major goals of CCOs are early identification of conditions and disorders that may need treatment, and placing a priority on prevention in order to avoid disease and future medical conditions altogether to the greatest extent possible. These are strategies that are proven to improve health and health outcomes for members.

CCOs are locally established throughout Oregon and each operates on its own single, or global, budget with a methodology that allows for growth at a fixed rate from year to year. CCOs are accountable for the health outcomes of the population they serve and these outcomes are monitored closely by OHA and the federal government.

CCOs are governed by a partnership among health care providers, community members, and stakeholders. The CCOs have financial responsibility and risk.

CCOs are bringing forward new models of care that are patient-centered and team-focused. They have more flexibility than any prior systems to pay for services that improve health and quality, but were not previously able to be reimbursed.

CCOs can also pay Traditional Health Workers **(THWs)** such as Community Health Workers **(CHWs)**, Peer Wellness Specialists, and Doulas.

The Oregon Health System Transformation Center is the state's hub for health system innovation and improvement, and is key to encouraging the widespread adoption of the coordinated model of care. The Center's goal is to increase the rate of innovation needed to deliver better health care at lower costs, and to improve the health of Oregonians. The Center supports CCOs by organizing Learning Collaboratives, a Council of Clinical Innovators, as well as conferences, workshops, and technical

assistance to entities throughout the delivery system.

Each CCO is also assigned an Innovator Agent, who works for OHA and serves as a single point of contact between the CCO and OHA. Innovator Agents provide data-driven feedback to CCOs and assist CCO providers and governance boards develop strategies to support quality improvement and innovations in care, and gauge the CCOs' impact on health.

Each CCO is required to convene a Community Advisory Council **(CAC)** that is comprised of consumers—who make up a majority of the membership—representatives of the community, and local government. CACs meet regularly to ensure that the health needs of the community are brought forth to, and met by, the CCO.

Federal Transformation Waiver

Through an agreement with the federal government that specifies all aspects of Oregon's Health System Transformation, Oregon is receiving an investment of $1.9 billion over five years (July 2012-June 2017) to prevent cuts in the OHP through the transition to CCOs. In exchange, the state has agreed to reduce the *per capita* growth of Medicaid/CHIP costs by one percentage point (from 5.4 percent annual growth to 4.4 percent) by the end of the first year, and two percentage points (to 3.4 percent) by the end of the second year of the waiver. Through this reduction in medical inflation, the federal government will recoup its investment in five years and the cost of Oregon Medicaid/CHIP is projected to 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 are held to metrics around quality. There are financial incentives for CCOs for achieving performance benchmarks. Quality and access quarterly reports can be found at: http://www.oregon.gov/oha/Metrics/Pages/ccos.aspx.

Additionally, the state is investing in the professional work force needed to support CCOs, including the creation of a student loan repayment program for primary care physicians and training of more than 300 community health workers by the end of 2015.

More on the Transformation waiver and associated reports can be found at: http://www.oregon.gov/oha/healthplan/pages/waiver.aspx.

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