LPRO: Legislative Policy and Research Office

OREGON HEALTH PLAN

BACKGROUND BRIEF

OVERVIEW

As of July 2016, a little over 1 million Oregonians were enrolled in the Oregon Health Plan **(OHP)** and Children's Health Insurance Program **(CHIP)** programs coverage, which is funded through Medicaid. Medicaid is funded by a mix of federal and state dollars and provides benefits based on Oregon's Prioritized List of Health Services. The current Prioritized List of Health Services can be found here.

Medicaid provides coverage for the aged, blind and disabled and coverage is available for households with incomes that do not exceed 133 % of the Federal Poverty Level **(FPL),** 185% of FPL for pregnant women and infants, and up to 300% for all children in foster care, adopted children and children in families with household incomes up to 300% of FPL. Children's Health Insurance Program **(CHIP)** is also available for children with household incomes up to 300% of FPL. People with Medicaid coverage may also have Medicare benefits or private coverage through an employer or individual policy.

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OREGON HEALTH PLAN (OHP)

OHP is Oregon's Medicaid program. There are several health care programs available for low-income Oregonians through OHP:

- OHP Plus for children ages 0-18 and adults ages 19-64;
- OHP Plus Supplemental for pregnant adults ages 21 or older; and
- OHP with Limited Drug for adults who qualify for both Medicaid and Medicare Part D.

The federal matching rate for the Affordable Care Act 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.

Coverage - Benefits and services covered by OHP include:

- Chemical dependency care
- Dental services;
- Hearing exams and hearing aids;
- Home health;
- Hospice care;

- Hospital care;
- Immunizations & vaccines;
- Laboratory tests and X-rays;
- Maternity, prenatal, and newborn care;
- Medical care provided by physician, nurse practitioner or physician assistant;
- Medical equipment & supplies;
- Medical transportation;
- Mental health care;
- Physical, occupational and speech therapy;
- Prescription drugs; and
- Vision services.

OHP SERVICE DELIVERY SYSTEM

On August 1, 2012, Coordinated Care Organizations **(CCOs)** became the primary delivery system for OHP services.

Due to federal law, state policies or because a CCO or other Managed Care Organization **(MCO)** 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 MCOs, such as fully capitated health plans **(FCHPs)** or physician care organizations **(PCOs)**.

The delivery system is enhanced by 19 federally qualified health centers **(FQHCs)**, 21 Indian and Tribal Health Services **(HIS)**, six of which are FQHCs and 495 Patient-Centered Primary Care Homes **(PCPCHs)**, as well as numerous Rural Health Clinics **(RHCs)** and hospitals that serve 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. 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.

Currently, there are 16 fully integrated CCOs, that are providing comprehensive physical, behavioral, and dental health services. 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.

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. They develop new models of care and have more flexibility than the prior delivery systems.

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 CCO 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.

Additionally, each CCO is 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 to CCOs and assist CCO providers and governance boards to develop strategies that support quality improvement and innovations in care.

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.

To ensure costs are reduced by improving quality and not through withholding care, CCOs and the state are held to a quality metrics. There are financial incentives for CCOs for achieving performance benchmarks. The Quality and access quarterly reports can be found at: http://www.oregon.gov/oha/Metrics/Pages/ccos.aspx.

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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