

Medical Assistance Programs

Mission

The mission of the Oregon Health Authority (OHA) is to help people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

The Division of Medical Assistance Programs (DMAP) contributes to this mission by providing a system of comprehensive health services to qualifying Oregonians and their families to improve their health status and promote independence. DMAP partners with contracted managed care organizations and stakeholder groups to ensure a focus on quality of care, access to care and preventive care. This focus in turn lowers the cost of delivering health care.

Goals

The goals of DMAP are to:

- 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 no less than 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.
- Improve the quality of health care for all Oregonians, especially for low-income Oregonians.
- Collaborate with legislators, advocacy groups, business partners, health care providers and the general public to improve health outcomes.
- Promote the use of prevention and chronic disease management services by all Oregonians, especially those with low incomes and 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 health care delivery system.

History

The Oregon Health Plan (OHP) was formed in response to conditions that threatened the social and economic health of the nation – the rising costs of medical care and the growing number of people unable to afford such care.

During the late 1980s, millions of Americans had no guaranteed medical benefits. They didn't qualify for public assistance (Medicaid), were not insured by an employer and couldn't afford individual coverage. Approximately 18 percent of all Oregonians, and more than 20 percent of our state's children, had no medical coverage. They were, in effect, excluded from our health care system.

Instead of seeking early preventive care, these uninsured individuals sought emergency care as a last resort when their illnesses became severe. When emergency department doctors are not compensated, the care isn't really free. Instead, this care is funded by “cost-shifting” – increasing the costs of medical bills and insurance premiums for individuals who do have insurance.

States traditionally responded to rising health care costs by reducing the number of people eligible for public assistance coverage and reducing Medicaid reimbursements to providers. In the private sector, employers reduced or dropped coverage for their workers¹. The result was ever-escalating costs as more people were priced out of coverage, causing even more cost-shifts.

¹ According to the 2008 Oregon Employer Survey published by the Oregon Employment Department, 62 percent of Oregon businesses with two or more employees offer health insurance to full-time employees and 19 percent to part-time employees. Accessed 8/4/10 at http://www.qualityinfo.org/pubs/employer/three_rs.pdf. Most recent data available.

As conditions worsened, Oregon's practice of fully insuring only traditional Medicaid-eligible individuals, while neglecting the rest of Oregon's uninsured poor, no longer made sense. Beginning in 1987, a group of health care providers and consumers, business and labor representatives, insurers and lawmakers agreed on a common objective – to keep Oregonians healthy. They agreed that:

- All citizens should have access to a basic level of health care.
- Society is responsible for financing care for people with low incomes.
- There must be a process to define a “basic” level of care.
- The process must be based on criteria that are publicly debated, reflect a consensus of social values and consider the good of society as a whole.
- The health care delivery system must encourage use of services and procedures that are effective, appropriate and discourage over-treatment.
- Health care is just one important factor affecting health; funding for health care must be balanced with other programs that also affect health.
- Funding must be explicit and economically sustainable.
- There must be clear accountability for allocating resources and for the human consequences of funding decisions.

OHP, which emerged from these discussions, was Oregon's attempt to reform publicly sponsored health care with input from all participants, including taxpayers, providers, insurers, business, labor and consumers.

During 1991 the Department of Human Services (DHS) began the process of Medicaid reform and expansion by requesting a federal waiver to Medicaid rules. Beginning Feb. 1, 1994, following federal approval of the waiver (also known as the OHP demonstration project), Oregon embarked on a five-year program to make Medicaid available to tens of thousands of people who previously did not qualify, even though their family incomes were below the federal poverty level.

Thanks to the OHP demonstration, instead of covering all medical services for a limited Medicaid population, OHP covers both the traditional Medicaid population and the expanded OHP population using a prioritized list of services, known as the Prioritized List of Health Services.

Since 1994 DHS has received federal demonstration renewals, currently allowing the program to continue through Oct. 31, 2013.

Today, Oregon is again facing the challenges that inspired the creation of the Oregon Health Plan— Rising health care costs and depressed economic conditions that threaten the sustainability of the health care system.

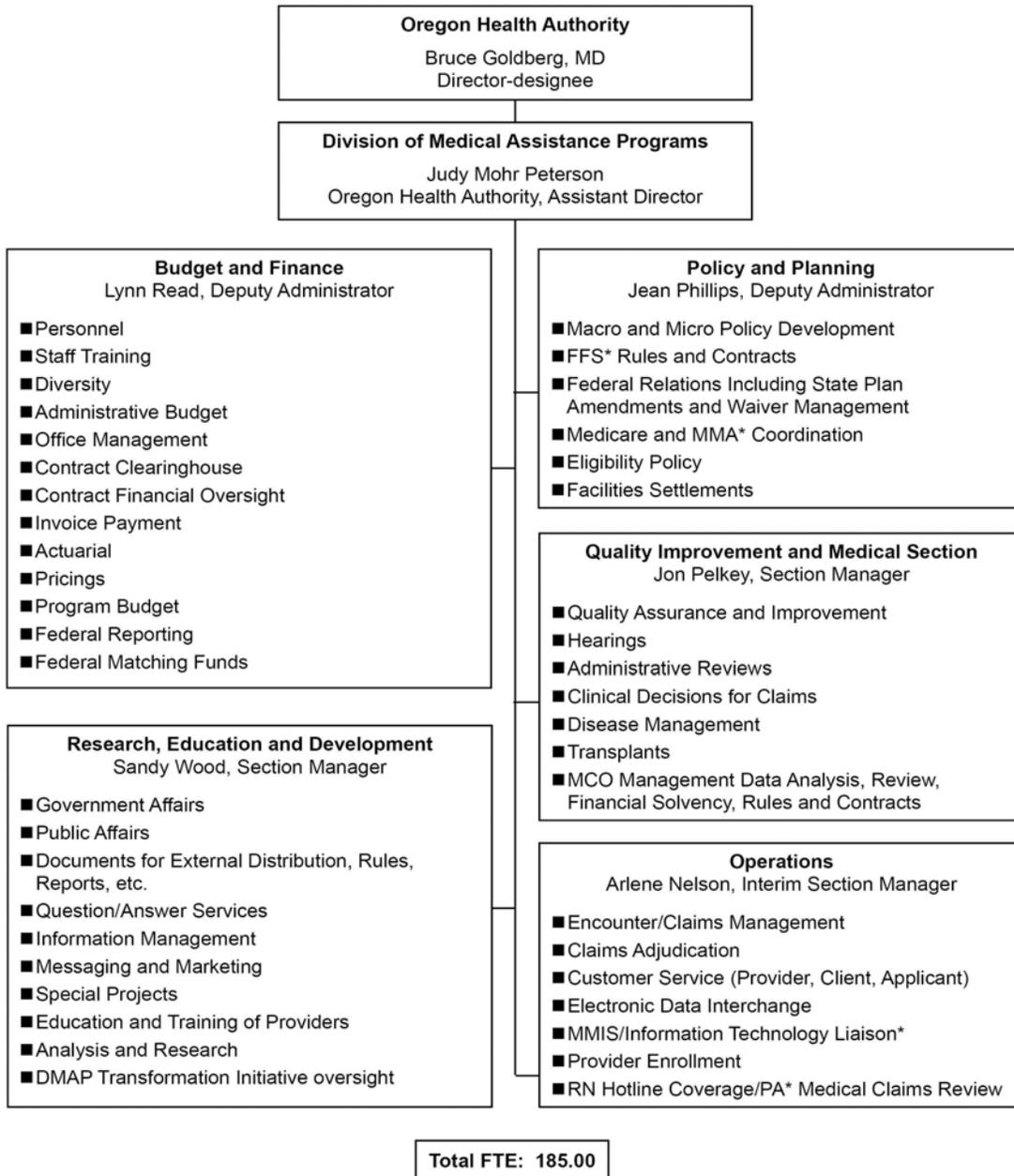
In Oregon, the 2009 Legislative Assembly established the Oregon Health Authority, Oregon Health Policy Board, and the Healthy Kids, and authorized additional funding to expand enrollment in the OHP Standard program.

Thanks to this landmark legislation, as well as the federal American Recovery and Reinvestment Act and the Affordable Care Act, general awareness of public health care options has never been higher. It has increased the number of eligible clients DMAP serves and has brought the mission of ensuring health care access into greater focus than ever before.

As DMAP moves to the Oregon Health Authority, we are tasked to look for new and innovative ways to provide access to quality, affordable health care. We need to reform health care delivery, to ensure affordable health access and quality at the same rate that we expand health care coverage.

Organizational structure

OHA, through DMAP, administers physical medicine, dental and chemical dependency coverage under OHP.



*Acronyms

FFS Fee for Service

MMA Medicare Modernization Act

MCO Managed Care Organization

MMIS Medicaid Management Information System

PA Prior Authorization

RN Registered Nurse

Administration

One percent of DMAP's overall budget is program support (administration). Administration includes activities and coordination essential to operating the Medicaid and Children's Health Insurance Program (CHIP) budgets.

Program support includes those functions associated with increasing access to Medicaid for eligible Oregonians. These functions include:

- Planning and developing policies to implement medical assistance programs;
- Providing quality assurance and improvement monitoring of the managed care plans and fee-for-service delivery systems;
- Providing oversight and coordination of the budget, actuarial capitation rates and pricing;
- Providing oversight and coordination of federal reporting and federal matching funds; developing communication plans to manage information disseminated internally and externally; and
- Managing all aspects of health care financing operations for medical assistance programs.

In addition to functions performed by division staff, approximately 32 percent of the administrative budget pays for professional services contracts.

99 percent of DMAP's budget goes directly to providing/delivering health care services. Oregon ranks 32nd in the United States for Medicaid expenditures per eligible individual². This is a reflection of benefit levels, payment rates and efficiencies realized because of the way Oregon delivers services (*e.g.*, through MCOs and the DMAP administrative process) and the Prioritized List of Health Services.

²Source: Centers for Medicare and Medicaid Services, MSIS FY 2008 – most recent data available.

Western States' Ranking: Medicaid Expenditures per Eligible ³			
State	Rank	Spending	Number of Eligibles
U.S.		\$4,876	60,334,468
Wyoming	9	\$6,479	77,661
Montana	14	\$5,963	109,773
Idaho	18	\$5,700	221,557
Colorado	24	\$5,216	572,249
Washington	29	\$4,942	1,180,401
Oregon	32	\$4,728	520,269
Nevada	36	\$4,351	259,794
California	49	\$2,988	10,791,945

Western States' Ranking: Medicaid Expenditures per Resident ⁴			
State	Rank	Spending	Number of Residents
U.S.		\$967	304,059,724
Wyoming	24	\$945	532,668
Washington	28	\$891	6,549,224
California	31	\$877	36,756,666
Idaho	35	\$829	1,523,816
Montana	45	\$677	967,440
Oregon	46	\$649	3,790,060
Colorado	47	\$604	4,939,456
Nevada	49	\$435	2,600,167

Determining program eligibility

While DMAP administers medical assistance programs as part of the Oregon Health Authority, DHS divisions determine eligibility for those programs. Eligibility depends on the age, living situation, income and medical condition of the applicant. DHS Children, Adults and Families Division (CAF) and DHS Seniors and People with Disabilities Division (SPD) determine eligibility for other programs as well, such as for cash benefits, food assistance, long-term care and other support services.

Who receives services

Through the Oregon Health Plan, approximately 530,000⁵ Oregonians are covered under Medicaid or the Children's Health Insurance Program (CHIP). Most of these clients receive OHP Plus coverage.

³ Source: Centers for Medicare and Medicaid Services, MSIS FY 2008 – most recent data available. Average annual medical assistance spending per Medicaid recipient.

⁴ Ibid. Average annual spending per resident.

⁵ Source: DHS DSSURS, May 15 2010, DMAP Research and Analysis

Medicaid clients

In Oregon, there are two types of Medicaid-eligible populations: Those who fall into federally-defined categories eligible for traditional Medicaid and low-income Oregonians who are not eligible for traditional Medicaid, but are eligible for OHP Standard benefits as part of Oregon's Medicaid expansion population authorized by the OHP Medicaid demonstration.

Because Medicaid is limited to those in financial need, the program imposes financial eligibility requirements. The financial requirements vary from category to category, but income eligibility for individuals and families generally is tied to the federal poverty level (FPL).

Federal Poverty Level (FPL) Monthly income guidelines Effective Jan. 1, 2010				
Size of Family	100%	133%	185%	201%
1	\$ 903	\$1,201	\$1,670	\$1,815
2	\$1,215	\$1,615	\$2,247	\$2,441
3	\$1,526	\$2,030	\$2,823	\$3,067
4	\$1,838	\$2,444	\$3,400	\$3,694
5	\$2,150	\$2,859	\$3,976	\$4,320
6	\$2,461	\$3,273	\$4,553	\$4,947
7	\$2,773	\$3,688	\$5,130	\$5,573
8	\$3,085	\$4,102	\$5,706	\$6,200

Traditional Medicaid

The federal Medicaid statute identifies more than 25 different eligibility categories for which federal matching funds are available. These statutory categories can be classified into these broad coverage groups:

- **Children:** In Oregon, this includes children in substitute care, such as foster care or for whom adoption assistance payments are made; and children under age 19 with family incomes no more than 133 percent of the FPL.

Since June 2009, Medicaid enrollment has increased by 39,829 children due to Healthy Kids expansion, constituting an 18 percent increase in the number of Medicaid-enrolled children.⁶

- **Low-income families with dependent children**, including those who are receiving or are eligible to receive cash assistance under Temporary Assistance for Needy Families (TANF). In Oregon, these families remain eligible for medical coverage for up to 12 months after their cash assistance ends.
- **Pregnant women** with family incomes no more than 185 percent of the FPL.
- **People who are age 65 or older or are blind or disabled**, and
 - Are eligible for Supplemental Security Income (SSI), or
 - Qualify for long-term care services and have a family income under 300 percent of the SSI level.

If OHP did not exist, the state would be required to provide Medicaid to mandatory coverage groups in order to draw down federal funds. The federal Medicaid statute also establishes some optional eligibility categories based on a particular disease or condition (*e.g.*, breast cancer).

Medicaid expansion (OHP Standard)

Meanwhile, OHP Standard covers uninsured adults (age 19 or older) with family incomes no more than 100 percent of the FPL who are not otherwise eligible for Medicaid or Medicare.

Due to cuts in the state's General Fund, OHP Standard closed to new enrollment in mid-2004. Since that time the program has relied primarily on provider taxes as its state revenue source, whose funds are then used to match federal Medicaid dollars.

This funding source is limited and previously necessitated limiting enrollment to a biennial average of 24,000 clients. However, due to an expanded hospital tax

⁶ Source: Office of Healthy Kids, 8/13/10.

passed by the 2009 Oregon Legislative Assembly, there is now funding for another 35,000 adults to enroll in OHP Standard.

The current hospital tax allows DHS to support a monthly average of 60,000 adults through the OHP Standard program over the next biennium. At its peak in April 2002, the OHP Standard program supported 111,000 adults.

Since re-opening the reservation list Nov. 1, 2009, DHS has held nine drawings for OHP Standard applications and enrolled nearly 7,000 Oregonians in the OHP Standard program⁷. Starting in July 2010, DHS began drawing 20,000 names each month to increase the enrollment pool, and anticipates that OHP Standard enrollment will increase to an average of 60,000 lives by July 2011.

Children's Health Insurance Program (CHIP) clients

CHIP is a program for children from birth to age 6 with family incomes between 133 percent and 201 percent of the FPL, and for children from age 6 to age 19 with incomes between 100 percent and 201 percent of the FPL.

In Oregon, CHIP covers approximately 54,000⁸ children, accounting for more than 10 percent of OHP enrollees. Children who are eligible for CHIP receive OHP Plus.

Since June 2009, CHIP enrollment has increased by 10,374 children due to Healthy Kids expansion. This constitutes a 22 percent increase in the number of CHIP-enrolled children.⁹

Citizen/Alien Waived Emergency Medical (CAWEM) clients

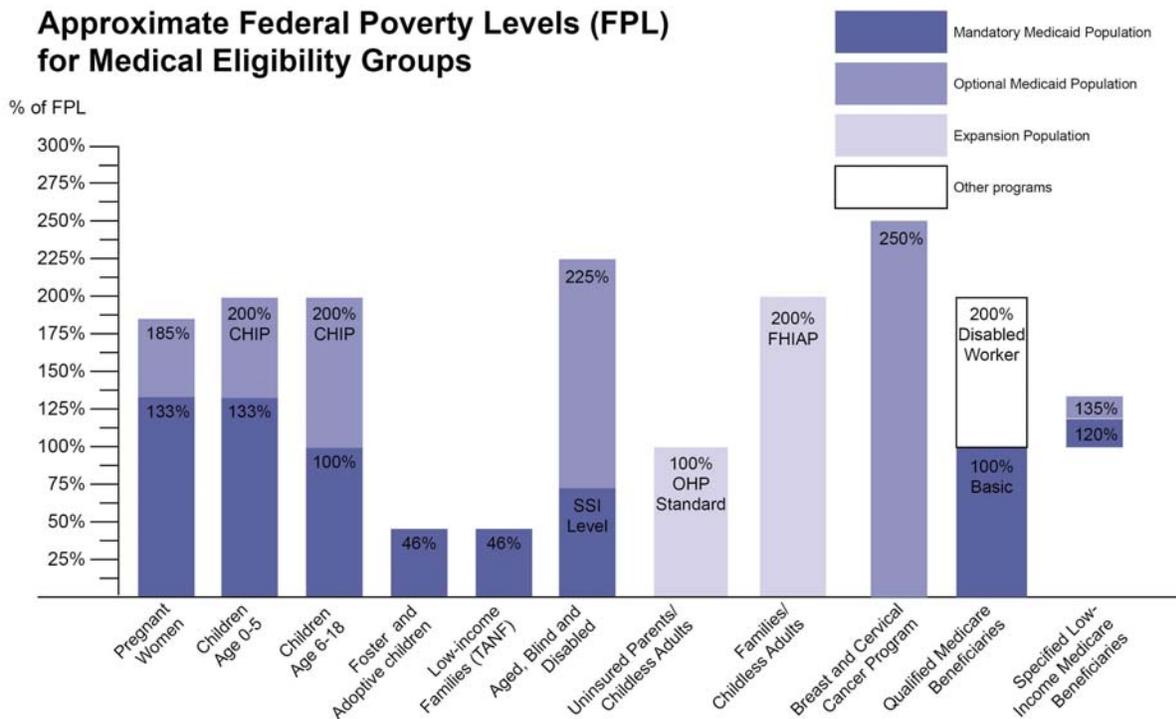
People who are ineligible for OHP Plus or OHP Standard coverage solely because they do not meet the Medicaid citizenship or immigration status requirements are eligible for limited medical assistance through the CAWEM program. Except for citizenship and immigration status, CAWEM clients must meet the same eligibility requirements, including income and resources, of the medical program they would otherwise be eligible to receive.

⁷ OHP Standard Monthly Report dated 8/1/10.

⁸ Source: DHS DSSURS, May 15 2010, DMAP Research and Analysis

⁹ Source: Office of Healthy Kids, 8/13/10.

The following chart shows the approximate FPL requirements for clients who are part of the mandatory and optional Medicaid populations, as well as for clients who are eligible because of the OHP demonstration project.



- Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (which is equivalent to approximately 225% of the FPL); otherwise, these populations are eligible up to the SSI level.
- The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low-income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of the FPL must enroll in FHIAP if they have employer-sponsored insurance. Parents and childless adults over 100% of the FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

Non-OHP Medicaid clients

Women with breast and cervical cancer

Women under age 65 who are diagnosed with breast or cervical cancer through the Public Health Division’s Breast and Cervical Cancer Early Detection Program (BCCP) are presumed eligible for all OHP Plus services, including mental and dental health care.

- A BCCP client presumed eligible for OHP Plus remains eligible until she reaches age 65, obtains other coverage or is no longer in need of treatment for her breast or cervical cancer.

- Women 40 and over, with incomes of no more than 250 percent FPL, and no health insurance coverage are eligible for BCCP screening and diagnostic services.

Medicare clients

Medicare clients may receive DMAP assistance through the following services and programs:

- **Qualified Medicare beneficiaries** – The Qualified Medicare Beneficiary Program serves people who have family incomes no more than 100 percent of the FPL. The program covers Medicare deductibles, co-insurance and co-payments. This program is funded with state funds matched with federal funds.
- **Medicare Part D** – The federal Medicare Modernization Act of 2005 (MMA) created Medicare Part D, under which Medicare clients became eligible for Medicare prescription drug benefits beginning Jan. 1, 2006. This was a change for dual-eligible clients (*i.e.*, clients who are eligible for both Medicare and full OHP Medicaid coverage). These clients previously received their prescription drug benefits through Medicaid. DMAP no longer covers prescription drugs for any class of drugs covered by Medicare Part D, because federal regulations prohibit the state from claiming federal match in those circumstances. Medicaid still pays and receives federal matching funds for drugs in classes not covered by Medicare Part D such as barbiturates, benzodiazepines and over-the-counter drugs. DMAP continues to pay for limited over-the-counter medications covered by Medicaid.

MMA requires states to pay the federal government 90 percent, initially, of what would have been the state's share of drug costs prior to passage of the Act for dual-eligibles enrolled in Medicare Part D (with annual inflation factors). The state's share is referred to as the "clawback." Over 10 years, this amount is scheduled to decline to 75 percent.

Limited drug coverage for certain former Medically Needy clients

Since spring 2003 the Oregon Legislature has appropriated General Fund dollars to provide limited drug coverage for clients who were organ transplant recipients whose coverage ended when the Medically Needy program was eliminated Jan. 31, 2003. These clients are covered for drugs necessary for the direct support of their transplants. The program currently covers 21¹⁰ clients.

¹⁰ Source: DHS DSSURS, May 15 2010, DMAP Research and Analysis

Where service recipients are located

For each county, this chart shows the number and percentage of OHP clients, and total OHP expenditures for 2009. Client counts are a one-day count on May 15, 2010. Total expenditures include capitated (managed care), fee-for-service, and non-OHP expenditures.

County	Total population ¹¹	Number of OHP clients ¹²	Percent of OHP clients	OHP expenditures ¹³
Baker	16,450	2,427	14.8%	\$9,686,777
Benton	86,725	6,510	7.5%	\$25,983,074
Clackamas	379,845	34,532	9.1%	\$137,826,040
Clatsop	37,840	4,897	12.9%	\$14,740,505
Columbia	48,410	6,006	12.4%	\$23,971,481
Coos	63,065	11,129	17.6%	\$44,418,684
Crook	27,185	3,237	11.9%	\$12,919,695
Curry	21,340	2,869	13.4%	\$11,450,912
Deschutes	170,705	18,434	10.8%	\$73,574,807
Douglas	105,395	17,397	16.5%	\$69,435,875
Gilliam	1,885	213	11.3%	\$850,137
Grant	7,525	932	12.4%	\$3,719,850
Harney	7,715	1,084	14.1%	\$4,326,521
Hood River	21,725	3,347	15.4%	\$13,358,733
Jackson	207,010	30,907	14.9%	\$123,357,739
Jefferson	22,715	4,447	19.6%	\$17,749,114
Josephine	83,665	15,488	18.5%	\$61,816,568
Klamath	66,350	11,378	17.1%	\$45,412,507
Lake	7,600	1,159	15.3%	\$4,625,865
Lane	347,690	48,606	14.0%	\$193,998,972
Lincoln	44,700	7,604	17.0%	\$30,349,508
Linn	110,865	18,830	17.0%	\$75,155,344
Malheur	31,720	6,690	21.1%	\$26,701,500
Marion	318,170	59,172	18.6%	\$236,170,580
Morrow	12,540	1,951	15.6%	\$7,786,940
Multnomah	724,680	108,025	14.9%	\$431,155,392
Polk	68,785	10,300	15.0%	\$41,109,933

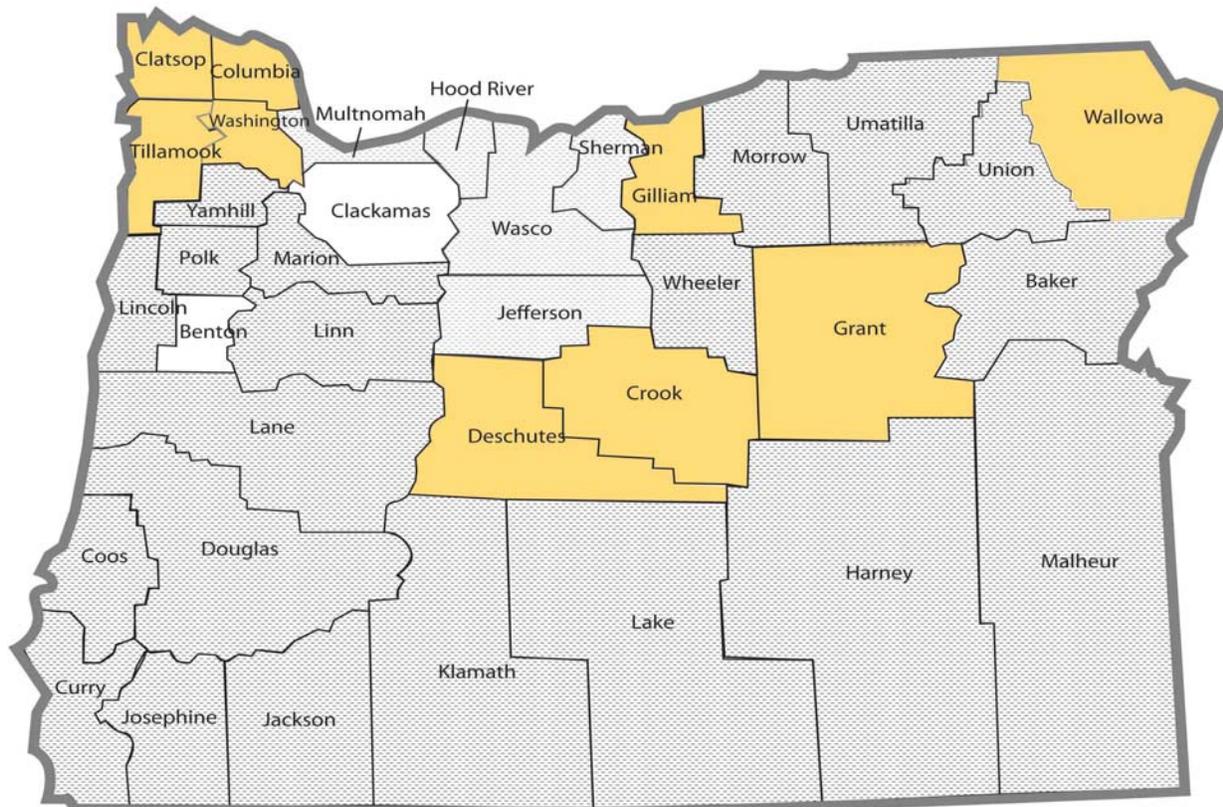
¹¹ Certified Estimates for Oregon, Its Counties and Cities, 1 July 2009. Population Research Center, Portland State University, February 2010. <http://www.pdx.edu/prc/>

¹² Data extracted from the DMAP DSSURS database tables.

¹³ Ibid.

County	Total population ¹¹	Number of OHP clients ¹²	Percent of OHP clients	OHP expenditures ¹³
Sherman	1,830	238	13.0%	\$949,919
Tillamook	26,130	3,196	12.2%	\$12,756,053
Umatilla	72,430	12,781	17.6%	\$51,012,239
Union	25,470	3,758	14.8%	\$14,999,139
Wallowa	7,100	846	11.9%	\$3,376,602
Wasco	24,230	4,073	16.8%	\$16,256,384
Washington	527,140	52,864	10.0%	\$210,993,739
Wheeler	1,585	218	13.8%	\$870,094
Yamhill	95,250	13,963	14.7%	\$55,729,903

OHP clients as a percentage of the estimated population per Oregon county - 2009



Legend

- 0 - 9%
- 10 - 12%
- >13%

Source: DMAP DSSURS database tables: MEMBERMONTHS

Biennial caseload averages

Medical assistance program	2007-2009	LAB 2009-2011¹⁴	Forecast 2011-2013¹⁵
OHP Plus			
TANF-Related Medical	92,536	113,160	140,318
TANF-Extended	22,820	25,877	31,281
TANF Medical – subtotal	115,356	139,036	171,599
Poverty Level Medical - Women	10,928	12,635	13,612
Poverty Level Medical - Children	91,248	140,188	158,292
Aid to the Blind & Disabled	65,810	74,626	87,008
Old Age Assistance	30,901	32,107	35,104
Foster/Substitute Care	17,741	19,065	20,306
Children's Health Insurance Program (Title XXI)	45,487	69,391	80,316
OHP Plus – subtotal	377,472	487,049	566,238
OHP Standard			
Families	9,081	18,396	23,667
Adults/couples	14,967	27,759	35,500
OHP Standard – subtotal	24,047	46,154	59,167
Other medical assistance programs			
Citizen-Alien/Waived Emergency Medical	19,097	22,838	26,135
Qualified Medicare Beneficiary (no long-term care)	12,973	14,710	16,801
Breast & Cervical Cancer program	364	441	571
Other – subtotal	32,434	37,989	43,507
Total programs	433,954	571,193	668,911

¹⁴ DHS Caseload Unit. The biennial averages for LAB 2009-2011 are based on the statistically derived Spring 2009 DMAP Forecast modified by DMAP Budget to adjust for the Healthy Kids initiative.

¹⁵ DHS Caseload Unit. Forecast 2011-2013 biennial averages are 'statistically' derived.

Services

DMAP helps approximately 900,000¹⁶ Oregonians biennially to achieve optimum physical, mental and social well-being through:

- **Partnerships:** DMAP collaborates with partners, stakeholders and over 30,000 health care providers to deliver health care services, promote prevention strategies and increase access to services.
- **Prevention:** DMAP ensures comprehensive health care coverage for uninsured, low-income Oregonians. DMAP also works with the contracted managed care organizations who deliver health care services to over 80 percent of the clients served by DMAP to ensure a focus on preventive care.
- **Access to quality, affordable health care:** DMAP delivers services to approximately 530,000¹⁷ people, or one in seven¹⁸ Oregonians. Through DMAP, health care services reach approximately one in three¹⁹ Oregon children, and more than 40 percent²⁰ of Oregon births.

Services provided

The physical health, mental health, chemical dependency and dental services covered by OHP are based on the Health Services Commission's (HSC) Prioritized List of Health Services. The list is arranged to keep conditions and treatments that have the best potential for good health outcomes toward the top. Covered services are referred to as being "above the line" of coverage and include:

- Prescriptions;
- Physician services;
- Check-ups (medical and dental);

¹⁶ Source: DHS DSSURS, June 2010. Number of unduplicated clients for the 2007-2009 biennium.

¹⁷ Source: DHS DSSURS, May 15 2010, DMAP Research and Analysis

¹⁸ Source: DHS DSSURS, May 15 2010, DMAP Research and Analysis; PSU Population Research Center, 2009 Oregon Population Report & Tables

¹⁹ Ibid.

²⁰ Source: Oregon Vital Statistics 2007 Annual Report, Volume 1, Table 2-14. 2007 is the most recent data available. <http://www.dhs.state.or.us/dhs/ph/chs/data/annrep.shtml>

- 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.

Treatments and conditions that are not covered include:

- Treatment for conditions that get better on their own;
- Treatment for conditions that have no useful treatment;
- Treatments that are not generally effective;
- Cosmetic surgery;
- Gender changes; and
- Infertility services.

The Centers for Medicare and Medicaid Services (CMS) approves all changes to the list. When needed, the line is adjusted based on budget and other factors.

DMAP provides coverage to clients based on the following benefit packages:

- OHP Plus;
- OHP Plus with Limited Drug;
- OHP Plus – Supplemental Benefits;

- CAWEM Plus;
- OHP Standard;
- Qualified Medicare Beneficiary (QMB); and
- Citizen-Alien/Waived Emergency Medical (CAWEM).

Each benefit package covers a different set of services:

- OHP Plus covers services above the line on the prioritized list. For children (under age 21), it also covers certain dental and vision services available to pregnant adults through the OHP Plus – Supplemental Benefits package.
- OHP Plus with Limited Drug covers the same services as OHP Plus, with the exception of prescription drugs covered by Medicare Part D.
- OHP Plus – Supplemental Benefits covers certain dental and vision services for pregnant OHP Plus clients age 21 and over.
- CAWEM Plus covers most OHP Plus and OHP Plus – Supplemental Benefits services for pregnant CAWEM clients living in certain Oregon counties.
- OHP Standard covers the services above the line on the prioritized list, with some exceptions (see the OHP Coverage by Benefit Package chart on the next page).
- Medicare premiums, co-pays, co-insurance and/or deductibles are paid for clients with QMB coverage.
- Only labor and delivery services for pregnant women and emergency medical services are covered under CAWEM.

Oregon Health Plan benefit plan coverage

DHS will pay for services that show a "✓." Limited services are covered at a reduced level.

Covered services		OHP Plus; OHP with Limited Drug*		OHP Standard	CAWEM	CAWEM Plus	QMB
		Children and pregnant women	Non-pregnant adults				
Acupuncture		✓	✓	Limited		✓	
Chemical dependency		✓	✓	✓		✓	
Dental	Basic services including cleaning, fillings and extractions	✓	✓			✓	
	Urgent/immediate treatment	✓	✓	✓	Emergent only	✓	
	Other services	✓	Limited			✓	
Hearing aids and hearing aid exams		✓	✓			✓	
Home health; private duty nursing		✓	✓			✓	
Hospice care		✓	✓	✓		✓	
Hospital care	Emergency treatment	✓	✓	✓	✓	✓	
	Inpatient/outpatient care	✓	✓	Limited		✓	
Immunizations		✓	✓	✓		✓	
Labor and delivery		✓	✓	✓	✓	✓	
Laboratory and X-ray		✓	✓	✓	Emergent only	✓	
Medical care from a physician, nurse practitioner or physician assistant		✓	✓	✓	Emergent only	✓	
Medical equipment and supplies		✓	✓	Limited		✓	
Medical transportation		✓	✓	Emergent only	Emergent only	✓	
Medicare premiums, copayments (except for drugs) and deductibles							✓
Mental health		✓	✓	✓		✓	
Physical, occupational and speech therapy		✓	✓			✓	
Prescription drugs		✓	✓	✓		✓	
Vision services	For medical and emergent treatment	✓	✓	✓	Emergent only	✓	
	For glasses or contact lenses	✓	Limited			✓	

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

OHP offers more services and places more limitations than are listed here. This chart is meant to be a guide, not OHP policy.



How services are delivered

Physical health fee-for-service

Fee-for-service (FFS) is the method of paying providers a fee for the health care services they provide. Approximately 80 percent²¹ of FFS providers bill electronically, accounting for approximately 93 percent²² of all FFS claims. DHS uses a pharmacy billing and information system that allows pharmacists to review a prescription for potential drug interactions at the time of dispensing and, at the same time, submit bills electronically and receive confirmation of payment for the claim. More than 99 percent of pharmacies use this point of sale billing system.

Medical providers include:

- Physicians;
- Hospitals;
- Dentists;
- Pharmacists;
- Federally qualified health centers;
- Rural health clinics;
- Medical equipment and supply providers;
- Physical, occupational and speech therapists;
- Hospice providers;
- Ambulances;
- Non-emergency medical transportation providers; and
- Addictions and mental health services providers.

²¹ EDI Support Services report, dated 6/29/10

²² Ibid.

Managed physical health care

DHS currently uses three managed care delivery systems for physical health care:

- Fully capitated health plans (FCHPs);
- Physician care organization (PCO); and
- Primary care managers (PCMs).

FCHPs and PCOs coordinate the health care needs of their members. OHP clients enrolled with an FCHP or PCO have guaranteed access to health care 24 hours a day, seven days a week.

Currently 15 FCHPs and PCO provide physical health services and approximately 855²³ providers serve as PCMs. One chemical dependency organization operates in Deschutes County. Clients outside Deschutes County receive chemical dependency services from their FCHP/PCO or on an FFS basis. Average enrollment percentages for 2009²⁴ were:

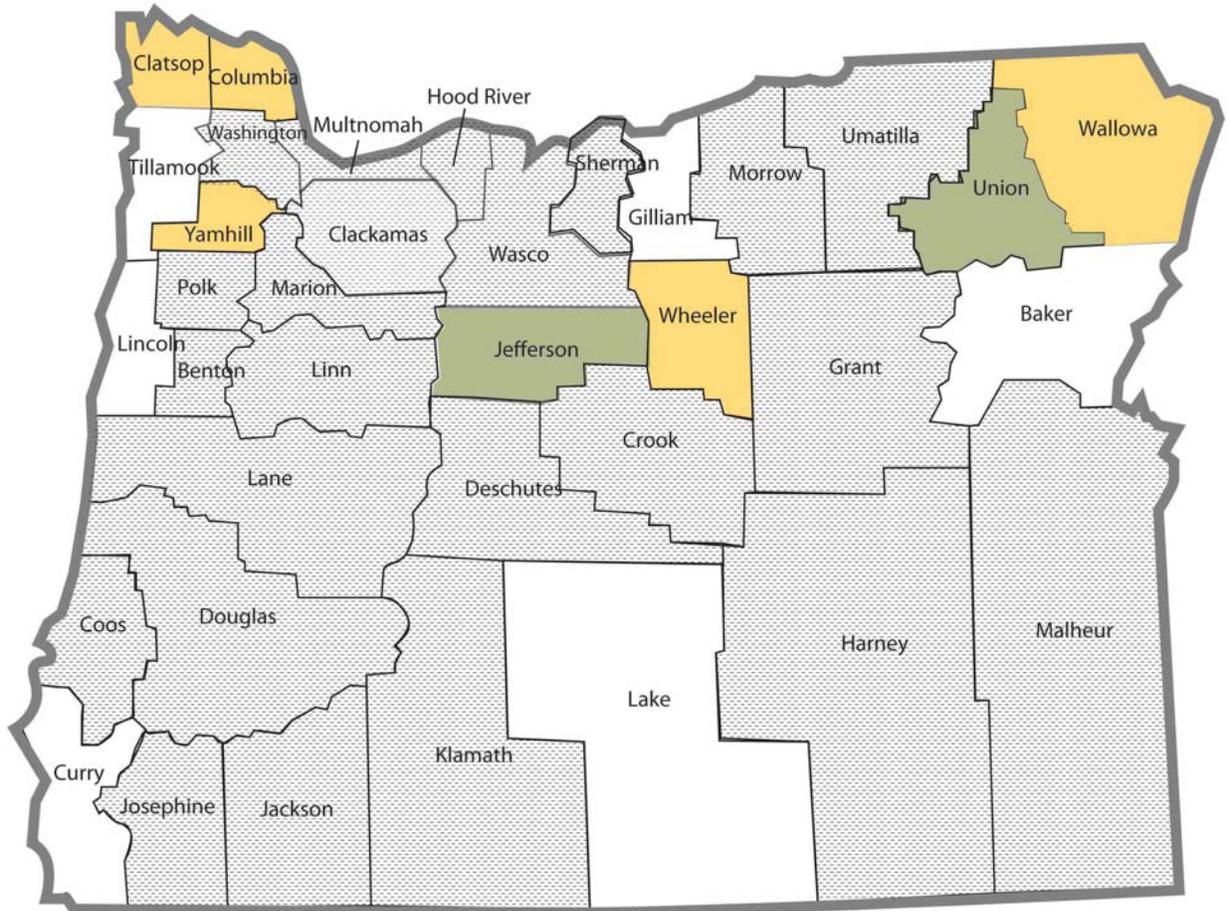
- 78.5 percent in FCHPs and PCOs, and
- 1.1 percent with PCMs.

In December 2009, DMAP exceeded its goal of 80 percent enrollment in FCHPs and PCOs.

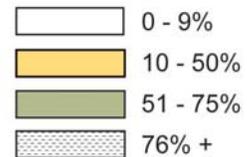
²³ Source: DHS DSSURS, July 2009, DMAP Research and Analysis.

²⁴ Source: DHS DSSURS, December 15 2009, DMAP Research and Analysis. These percentages do not include clients who are receiving benefits from one or more of these programs: Breast and Cervical Cancer Program, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Citizen-Alien/Waived Emergency Medical benefits.

**Percentage of OHP clients enrolled in a Fully Capitated Health Plan
or Physician Care Organization - 2009**



Legend

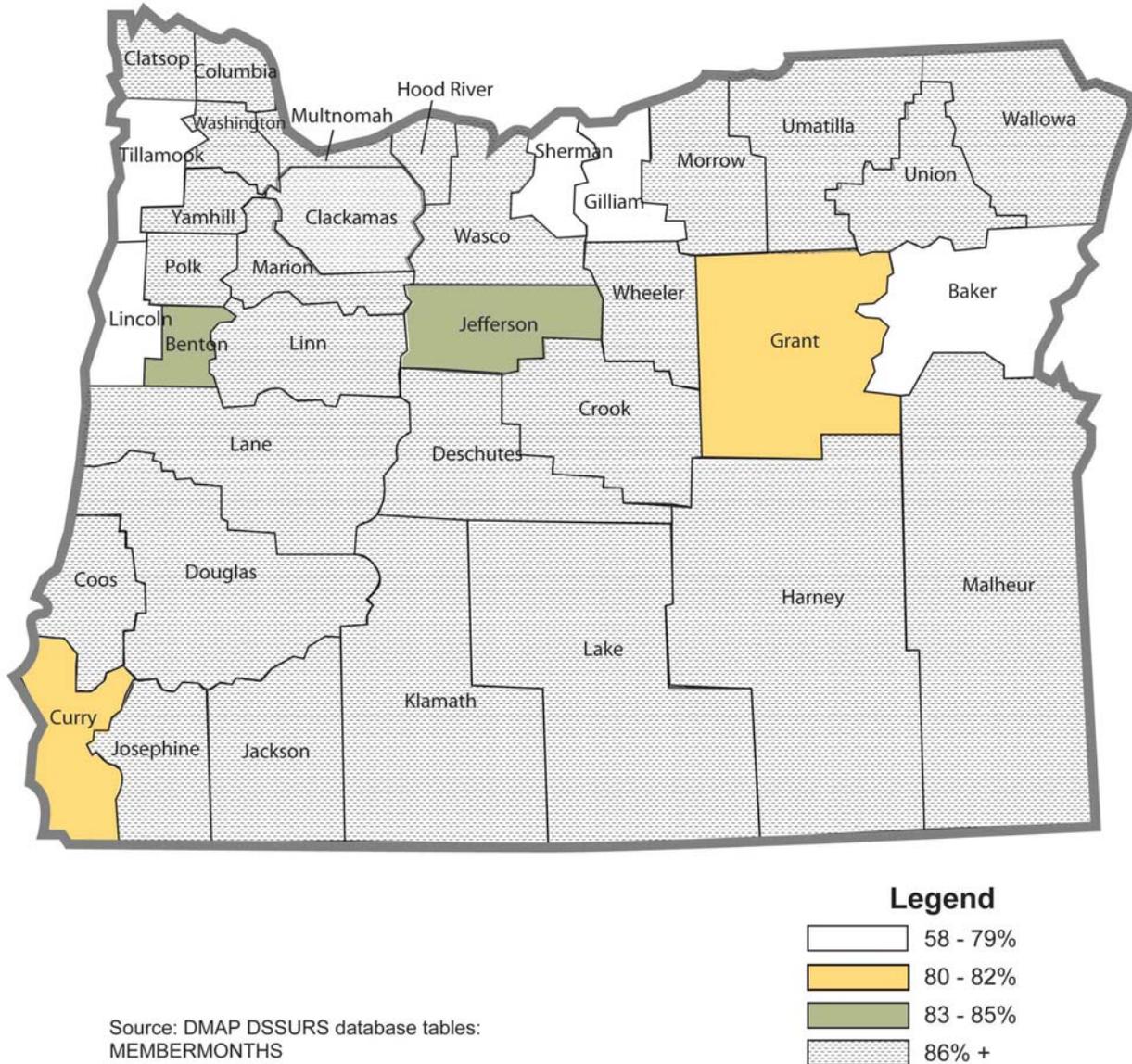


Source: DMAP DSSURS database tables:
MEMBERMONTHS

Dental services

DMAP currently contracts with eight dental care organizations (DCOs) to provide dental care. DCOs coordinate the dental care needs of their members. Nearly 95 percent²⁵ of all clients statewide are enrolled in a DCO.

Percentage of OHP clients enrolled in a Dental Care Organization - 2009



²⁵ Source: DHS DSSURS, May 15 2010, DMAP Research and Analysis. These percentages do not include clients who are receiving benefits from one or more of these programs: Breast and Cervical

Mental health services

More than 90 percent²⁶ of OHP clients receive their mental health care through mental health organizations (MHOs). Nine MHOs provide mental health services. MHOs coordinate and provide mental health care services for their clients. OHP clients who are not enrolled in an MHO receive mental health services on an FFS basis through community mental health programs.

Costs for mental health services are included in DMAP's budget. However, the OHA Addictions and Mental Health Division (AMH) is responsible for:

- Negotiating, administering and monitoring mental health managed care contracts; and
- Coordinating with DMAP to develop administrative rules for OHP.

Why these services are significant to Oregonians

OHP has a significant impact on all Oregonians. OHP:

- Has covered health services for more than 2.024 million people²⁷ since it began in 1994 (nearly one in three Oregonians have been on OHP at some point);
- Covered nearly 44 percent of Oregon's births²⁸ in 2007; and

Cancer Program, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Citizen-Alien/Waived Emergency Medical benefits.

²⁶ Source: DHS DSSURS, May 15 2010, DMAP Research and Analysis. These percentages do not include clients who are receiving benefits from one or more of these programs: Breast and Cervical Cancer Program, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Citizen-Alien/Waived Emergency Medical benefits.

²⁷ Source: DHS DSSURS. The number of distinct Client ID's issued to person eligible for the Oregon Health Plan from 1994 to present. This number is derived from combining information from Sybase Archives, the Legacy DSSURS warehouse archives, and 7-year eligibility records from the current EDS/HP DSS warehouse archives, and 7-year eligibility records from the current EDS/HP DSS warehouse database.

²⁸ Source: Oregon Vital Statistics 2007 Annual Report, Volume 1, Table 2-14. 2007 is the most recent data available. <http://www.dhs.state.or.us/dhs/ph/chs/data/annrep.shtml>

- Provides health care coverage for 14 percent of all Oregonians and 31 percent of Oregon children as of May 2010²⁹.

Managed care enrollment increases access to a medical home, providing better access to needed health services, coordinated care and a delivery system focused on quality improvement. DMAP continues to exceed its goal of 80 percent enrollment in managed physical health care. More than 90 percent³⁰ of OHP clients are enrolled in dental and in mental health managed care.

Health care coverage increases opportunities for prevention and early diagnosis. It also reduces the risk of untreated chronic disease and severe medical conditions. Lack of early treatment leads to more costly care as conditions worsen.

Reducing the number of uninsured Oregonians lessens the amount of uncompensated charity care. Costs for uncompensated care are cost-shifted to premiums paid by insured patients and their employers, and increased costs for medical services for everyone.

Insuring children increases their access to a medical home, enabling them to visit doctors and dentists regularly and reducing costly emergency department visits. This also may influence parents' health care decisions. Good physical, mental and dental health positively influences school success. Insuring a larger share of Oregon's children would boost the state's childhood immunization rate, promoting public health for all children and reducing school absences.

How performance is measured and level of performance

In addition to the OHA's key performance measures (KPM), DMAP uses other gauges to measure how effectively taxpayer dollars keep Oregonians healthy. These include the percentage of children under the age of 19 covered by OHP; rates of use and early and periodic screening, diagnosis and treatment (EPSDT); OHP provider participation rates; OHP client satisfaction as measured through survey data; and contracted performance indicators.

²⁹ Source; DHS DSSURS, May 15 2010, DMAP Research and Analysis

³⁰ Ibid.

Early periodic screening, diagnosis and treatment (EPSDT)

EPSDT is the child health component of Medicaid. It is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. EPSDT is designed to address physical, mental and developmental health needs. Screening services to detect physical and mental conditions must be covered at periodic intervals, as well as diagnostic and treatment coverage. Federal law – including statutes, regulations and guidelines – requires that Medicaid cover a comprehensive set of benefits and services for children, different from adult benefits. OHP, using its unique Prioritized List of Health Services, covers all early periodic screening, diagnoses and most treatments recommended by the EPSDT program.

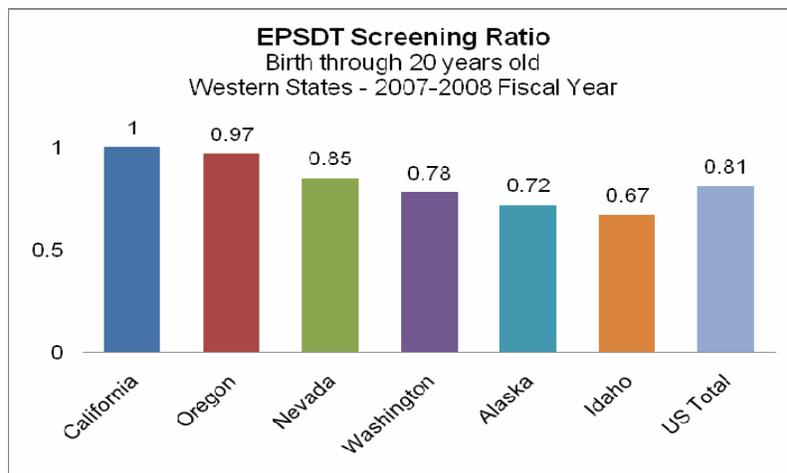
Elements of EPSDT:

Early	Identifying problems early, starting at birth
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Doing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
Diagnosis	Performing diagnostic tests to follow up when a risk is identified
Treatment	Treating the problems found

The following screening 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.

The following graph and table show that Oregon has the second-highest screening ratio of all Western states and is higher than the U.S. average.

EPSDT Screening Ratio Birth through 20 years old Western states and U.S. total ³¹	
California	1.00
Oregon	0.97
Nevada	0.85
Washington	0.78
Alaska	0.72
Idaho	0.67
US Total	0.81
2007-2008 Federal Fiscal Year	



Percentage of covered children

Health insurance provides access to health care. Children with health insurance are more likely to have a primary care provider and to have received appropriate preventive care, such as immunizations. OHP contributes to reducing the uninsured

³¹ Source: CMS, 2007-2008 FFY, www.cms.gov. Most recent data available.

rate. OHP covered 31.8 percent (or 298,600) of Oregon children under age 19 during 2009³², up from 26.5 percent (or 248,100) for 2008³³.

Provider participation

DMAP, the Office for Oregon Health Policy and Research, and the Oregon Medical Association collaborate to conduct the Oregon Physician Workforce Survey³⁴. All active licensed physicians (Medical Doctors, Doctors of Osteopathic Medicine and Physician Assistants) in Oregon are surveyed about their practice, acceptance of Medicaid and future practice plans. In 2009, the last year the survey was conducted:

- Fifty-two percent reported that they were open to Medicaid patients with no limitations.
- Eighteen percent reported that they are completely closed to Medicaid, an improvement over the 2006 rate of 21 percent.
- Fifteen percent reported that they are closed to new Medicare patients, an improvement over the 2006 rate of 17 percent.

While reimbursement is the largest reason for closing practices to new patients, 74 percent of all physicians still report providing charity care.

The percentage of responding psychiatrists reporting being completely open to new Medicaid patients has nearly doubled, from 27 percent in 2006 to 53 percent in 2009.

Contracted performance indicators

In addition, DMAP includes performance indicators in contracts with its managed care plans. These measures may change over time. Currently, the physical health plans measure childhood immunizations and asthma care provided to children and

³² Source: DHS DSSURS, DMAP Research and Analysis; PSU Population Research Center, 2009 Oregon Population Report & Tables.

³³ Source: DHS DSSURS, DMAP Research and Analysis; PSU Population Research Center, 2008 Oregon Population Report & Tables.

³⁴ Source: 2009 Oregon Physician Workforce Survey.
http://www.oregon.gov/DHS/healthplan/data_pubs/reports/pws-2009.pdf

adults. The dental care plans measure dental preventive care services provided to children and adults. The chemical dependency organization has performance measures concerning services provided to pregnant members. Starting in 2011, DMAP will not require plans to use the asthma care measures. However, plans may continue their focus activities on asthma if they choose. Replacing the asthma care measures are a set of measures concerning time to first service from plan enrollment date by type of service. This measure will enable plans to more closely manage new enrollees. The measure looks at time elapsed from a new member's first plan enrollment date by the type of service first received. The types of service included in this measure are outpatient, inpatient and emergency department.

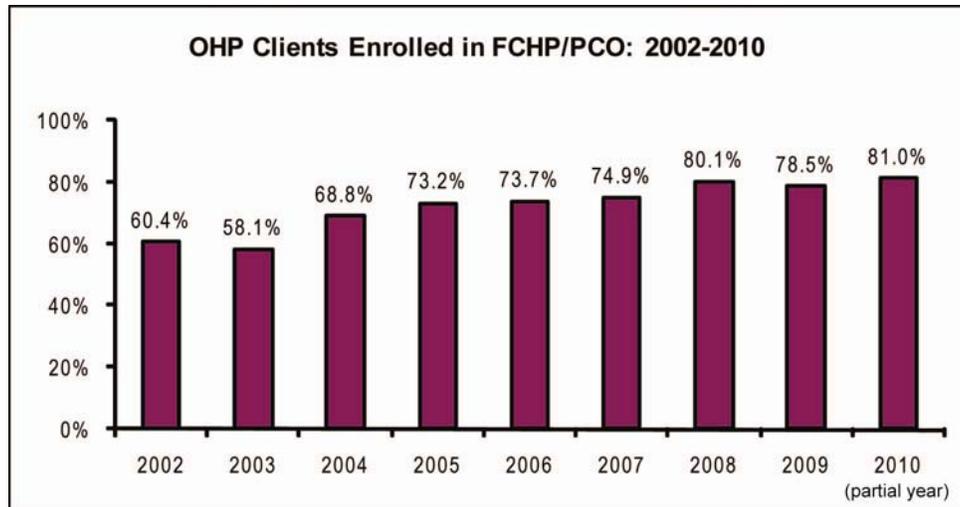
In addition, DMAP uses its contracted indicators as a vehicle to connect the plans and Public Health Division (PHD) to improve care. DMAP brings the asthma and immunizations programs together with the contracted managed care plans through the regularly scheduled monthly meetings of the Quality Improvement Coordinators and Medical Directors. These programs are a valuable source of educational resources and guidance for improving care to OHP clients, as well as assistance to the plans in providing measurement instructions and data interpretation. The Immunization Program helps the plans and their associated clinics by assessing clinics' immunization practices and providing clinic-specific feedback on improving childhood immunization rates. The Asthma Program has a Web-based resource bank of free provider and patient materials that many plans use.

Quality and efficiency improvements

Managed care enhancements

DMAP is actively working to continue to increase the percentage of clients enrolled in managed care. The figure below³⁵ is an average annual count of FCHP/PCO enrollment.

³⁵ DMAP Research and Analysis



The decrease in 2003 is due to many plans dropping OHP Standard clients because of the difficulty managing the health of these clients when their benefits were reduced. When OHP Standard benefits changed again in August 2004, all plans except one resumed service to this population, and that plan resumed OHP Standard coverage in January 2007.

Managed care organizations (MCOs) have an incentive to keep their members healthy and out of the hospital. They emphasize prevention and the provision of primary care services to avoid more serious hospitalizations. In addition, MCOs prioritize chronic disease management, patient education and promotion of wellness and healthy lifestyles. OHP clients benefit from enrollment in managed care in several ways:

- Guaranteed access to appropriate health care 24 hours per day, seven days per week.
- A "medical home" with an assigned primary care provider (PCP) or with a primary care manager (PCM), who provides or coordinates medical services and treatments and assists with any necessary referrals to specialists. In dental care organizations (DCOs), this is referred to as a "dental home."
- A focused approach to raising awareness of preventive services including well-child checks and immunizations, as well as preventive adult exams and immunizations such as pap screens, mammograms, and flu and pneumonia immunizations, are covered under the OHP benefit package. This focus promotes optimal health for clients by prevention and/or early diagnosis and intervention of many diseases.

- Access to an exceptional needs care coordinator (ENCC), who is a specialized case manager employed by an OHP medical plan for clients who are aged, blind, disabled or have special health care needs. ENCCs help coordinate health care services for members, such as assisting with obtaining special medical supplies or equipment.

DMAP uses many strategies to foster enrollment in managed care, such as:

- Ensuring clients who move are automatically re-enrolled in the plan they were in, if it's available in the new area.
- Auto-enrolling clients into MCOs weekly unless they already have selected a plan or are exempt. This allows newly eligible individuals to be enrolled into managed care more quickly.
- Reinforcing the importance of managed care enrollment with field staff at every opportunity and at the monthly field managers' meetings.
- Auto-enrolling former clients into their previous MCO after a break in enrollment.
- Continuing work with DHS Seniors and People with Disabilities Division (SPD) to improve client-choice counseling to encourage enrollment when SPD clients meet managed care enrollment criteria.
- Expanding managed care availability. DMAP most recently expanded managed care access in Curry, Lincoln and Tillamook counties.
- Monitoring quality improvement and maintaining oversight of managed care.

Assisting OHP clients with appropriate care

OHP Care Coordination (OHPCC)

In June 2009, DMAP contracted with a new health care services company, APS Healthcare, to provide disease management (DM), medical case management (CM) and nurse triage/advice telephone services to fee-for-service (FFS), non-Medicare clients. APS Healthcare uses a predictive modeling methodology to determine which clients are at risk for high health care costs and use.

The contracted services include:

- Comprehensive, holistic client focused interventions, health assessments, case management, discharge coordination, medication management, and community resource linkage with an emphasis on establishing a medical home for clients.
- A 24-hour-a-day, seven-day-a-week nurse triage/advice telephone service to an average of 55,167 eligible FFS clients.

Specific goals include:

- Identify and engage clients who will benefit from disease management or medical case management services;
- Reduce ambulatory care sensitive hospitalization and non-emergent utilization of emergency departments. *Ambulatory care* means medical office or clinic based health services and *sensitive* means the condition can be treated in the office/clinic setting. With high-quality, community-based primary care, hospitalization for these illnesses can often be avoided;
- Reduce barriers and gaps in healthcare and access to care;
- Improve quality of care, and build clients' self-management skills; and
- Improve integration and coordination between health needs and community resources.

Partners for Quality Care

This year, DMAP also contracted with the Oregon Health Care Quality Corporation (Q-Corp) for FFS data collection and quality-measure reports as part of DMAP's overall effort to monitor the quality of FFS healthcare beyond the contracted disease and medical case management services. A secure, interactive Web portal will help doctors and nurses ensure that OHP patients receive high quality care in 11 scored categories, as well as provide support materials that encourage patients to take an active, informed role in their health care decision-making.

This contract supports the efforts of DMAP's new Medical Management Committee, whose goal is to establish processes to monitor and ensure high-quality, cost-effective and medically appropriate care provided to OHP FFS clients.

DMAP Medical Management Committee

This committee will establish FFS Quality Improvement and Utilization Management action plans, addressing access and quality of care concerns in client referrals, service denials, and other DMAP business processes.

The group will provide consultation and recommendations for various medical appropriateness reviews, including prior authorization, payment reconsideration, comorbidity review, Prioritized List placement, and review of new procedures and technologies.

CAWEM Plus project

The Citizen-Alien/Waived Emergency Medical (CAWEM) benefit package covers only emergency and delivery services for pregnant women who do not meet the citizenship requirement to qualify for the OHP Plus benefit package. Under the CAWEM Plus pilot program, pregnant CAWEM clients in six Oregon counties are eligible for all of the same services covered by OHP Plus, except for termination-of-pregnancy and end-of-life services.

The goal of the pilot project is to increase better health outcomes for newborns, who will be U.S. citizens, and to relieve some of the financial burden on counties bearing the brunt of the health care costs for this population.

The additional services of the pilot project were made available without any further impact on the state budget. Participating counties provide from their own budgets

the Children's Health Insurance Program (CHIP) match dollars to extend coverage to include prenatal care.

The project has an average monthly enrollment of 1,122 women with an average of 6.4 prenatal health care visits per mother.

Pharmacy program efficiencies

Preferred Drug List

DMAP's pharmacy program continues efforts to control prescription drug costs. The physical health preferred drug list (PDL) that was implemented Jan. 1, 2010, now requires prescribers to request prior authorization for any physical health drugs not listed on the PDL. DMAP anticipates cost savings from enforcement of the physical health PDL to be \$4.4 million Total Funds (TF) over the remainder of the biennium (Jan. 1, 2010, to June 30, 2011).

Drugs listed on the physical health PDL and the new mental health PDL do not require copayments, which gives both pharmacies and clients further incentive to explore the benefits of using preferred drugs.

The PDL identifies the most effective and safe drugs for the majority of patients, based on the information available. Oregon researchers and experts have carefully considered the comparative safety and effectiveness of the drugs recommended for inclusion on this list. Of the drugs recommended, only those representing the best value to the OHP are included.

Effective Jan. 1, 2011, DMAP will expand the current PDL from 35 drug classes to 77 classes. The expanded PDL will be the basis of the Oregon Health Authority's statewide PDL, mandated by HB 2009.

Prior authorization requirements

Currently, DMAP may require prior authorization for selected drugs or categories of drugs in the following general situations:

- To ensure the drugs are prescribed for funded medical conditions;
- To ensure medically appropriate use or to address potential client safety risks associated with a particular drug or drug category, as recommended by the Drug Use Review Board and adopted by DMAP;
- To ensure medically-appropriate use of non-PDL physical health drugs.

Sovereign States Drug Consortium

DMAP is now part of the Sovereign States Drug Consortium (SSDC), a multi-state supplemental rebate pool. Drug manufacturers offer rebates, supplemental to federal Medicaid rebates, to state Medicaid programs to increase the utilization of their products and, ultimately, to increase market share.

The SSDC is an alliance of seven state Medicaid programs (Iowa, Maine, Oregon, Utah, Vermont, West Virginia and Wyoming). The SSDC negotiates supplemental rebate agreements for these seven states as a single entity, pooling their Medicaid prescription numbers. This harnesses the economy of scale for negotiating with manufacturers, allowing each state to pay only a fraction of what they otherwise would for these drugs.

Change in pharmacy reimbursement methodology for ingredients and dispensing fees

Currently, DMAP reimburses pharmacies at a percentage of the Average Wholesale Price (AWP), which drug manufacturers set. However, AWP has little bearing on the actual cost of prescription drugs.

DMAP is currently soliciting a contractor to survey the more than 700 enrolled pharmacies that serve DMAP clients on a rolling basis. The survey will provide actual invoices for the products that reflect the transaction between the pharmacy and wholesaler or between a chain distribution center and its retail outlets.

Pending CMS approval, DMAP will implement the following changes to ensure that fee-for-service reimbursement reflects the actual costs of filling prescriptions:

- An “Average Actual Acquisition Cost” Model for the cost of prescription drugs plus an expanded dispensing fee with an effective date of Jan. 1, 2011;
- A revised dispensing fee structure. The fee structure will move from being based on provider type (*i.e.*, retail, long-term care, Mail-order, 340B) and instead be based on the actual cost of dispensing the prescription.

Hemophilia factor and clinical supports contract

DMAP has awarded a contract to the OHSU Hemophilia Treatment Center (HTC) at the Children's Development Resource Center (CDRC) to provide anti-hemophiliac factor (AFH) and comprehensive clinical support to OHP clients affected by hemophilia and other bleeding disorders beginning Oct. 1, 2010. Approximately 15 clients currently receive factor products from other pharmacies.

The benefits of this contract include:

- Program savings of an estimated \$1.75 million TF over the 2009-2011 biennium;
- All products and services will come from the HTC. Therefore, all OHP hemophilia patients will receive the same quality and continuity of care. Factor products will continue to be delivered to the patient's residence and clinical support is available to them 24 hours a day, seven days a week;
- Under the contract, the HTC Medical Director will be available to provide peer-to-peer mentoring to all health care professionals who treat the patient to enhance continuity of care and ensure adherence to the patient's treatment plan.

Managed care organization (MCO) drug rebates

In accordance with the Affordable Care Act of 2010, DMAP will begin collecting CMS drug rebates from drug manufacturers for Medicaid MCO utilization. DMAP has worked with the MCOs to develop processes to capture the necessary data elements from encounter claims and will begin submitting invoices for MCO utilization to manufacturers in Nov. 2010, after needed MMIS changes are completed. The invoices will request rebates for MCO utilization from dates of service Mar. 23, 2010 (the effective date of the Affordable Care Act) through the end of third quarter 2010. DMAP plans to continue MCO drug rebate invoicing in the 2011-2013 biennium.

Medicaid Health Information Technology (HIT) planning³⁶

With HB 2009, the Oregon Legislative Assembly passed historic legislation to promote comprehensive health care reform, including a major Medicaid expansion and health care delivery system reforms intended to expand access, promote quality, and contain costs. Many of these reforms rely on the secure exchange of health data (*i.e.*, health information exchange) to be effective.

³⁶ Source: *Oregon Medicaid HIT Planning Advance Planning Document (HIT P-APD)*. Oregon Department of Human Services, 2/1/10.

Through the American Recovery and Reinvestment Act, the federal government has also made available resources and funding opportunities to support state-level health information exchange (HIE) activities.

In February 2010, DHS submitted Oregon's Medicaid HIT Planning Advance Planning Document (HIT P-APD) to the Centers for Medicare and Medicaid Services. This document outlines how DHS/OHA will reform existing information technology architecture to align with the OHA vision of providing information, when and where it is needed, to improve health and health care, through HIE. Due to the strength of this application, Oregon was awarded one of the largest grants for states of its size³⁷.

Efforts in Oregon's Medicaid HIT Planning project include:

- Incentive program activities and roadmap including audit and oversight strategies;
- Electronic health record (EHR) adoption initiatives, including provider outreach and communications;
- Internal planning related to Medicaid providers' use of EHRs, DHS/OHA Shared Services Architecture, and privacy/security; and
- Initiatives to support statewide HIE efforts, including funding for the Medicaid portion of the HIE, local HIO planning, and health profiles for Oregon's foster children population.

Oregon's State Medicaid HIT Plan will identify goals for EHR adoption and participation in the incentives program for Medicaid providers. The state HIE project team will participate in the development of those targets, along with planning related to EHR adoption strategies and initiatives.

Oregon expects to submit its draft State Medicaid HIT Plan (SMHP) and Medicaid Implementation Advance Planning Document (IAPD) to CMS by October 31, 2010.

³⁷ Source: *Health Information Exchange: A Strategic Plan for Oregon*. Oregon HITOC, 6/17/10.

Division summary

With the current state of the economy, combined with the attention that recent state and federal health care reform has brought to the public health care system, it is more critical than ever that DMAP continue its work of ensuring access to health care for eligible, low-income Oregonians.

In addition, more Oregonians are covered by public medical assistance programs than ever before. The 2009 legislative session made great strides in expanding health care coverage for Oregonians; now the focus must turn to health care access and quality to provide the optimum physical, mental and social well-being mandated by the OHA mission.

- 99 percent of DMAP's budget goes directly to providing and delivering health care services, serving one in seven Oregonians.
- Over 80 percent of DMAP's clients are served through contracted physical health, mental health, and/or dental health MCOs.
- DHS estimates that in the next biennium, the number of clients DMAP serves will increase to nearly 670,000 clients. This is a 25 percent increase over the number of clients served today.
- In 2009, 52 percent of Oregon's physician workforce reported that they were open to Medicaid clients with no limitations.

The OHA is guided by the Triple Aim to 1) improve the lifelong health of Oregonians; 2) improve the individual's experience of care; and 3) reduce per capita costs. DMAP supports this aim by:

- Working to increase managed care enrollment, expand managed care availability, and monitor MCO quality;
- Identifying and exploring new avenues to provide timely, appropriate services and improve quality of care for FFS clients;
- Controlling prescription drug costs, historically one of the fastest-growing Medicaid services in terms of expenditures; and

- Supporting statewide health information exchange efforts with Medicaid Health Information Technology planning. When health data for Medicaid clients is aligned with all their providers and the divisions who serve them, then we are another step closer to providing integrated care that enhances the client's well-being while eliminating the cost of duplicate or unnecessary services.