Major Budget Drivers and Environmental Factors

♦ **DHS Revenue Losses.** The 2004 defeat of Ballot Measure 30 created a budgetary shortfall of $37.6 million in Tobacco Tax Funds for OMAP in 2005-07. Also, the Emergency Board eliminated General Fund dollars used to provide coverage for clients on the OHP Standard benefit package beyond July 31, 2004. Additionally, a court order eliminated the copayment requirement for OHP Standard clients effective June 19, 2004, thus stopping another funding source.

The 2003 legislature approved two partial replacement sources:

- A Medicaid Managed Care Organization tax implemented May 1, 2004, and
- A hospital tax approved by CMS August 17, 2004, effective retroactively to July 1, 2004.

The state closed enrollment to new OHP Standard applicants July 1, 2004, in order to contain costs and reduce OHP Standard enrollment to about 24,000 by June 30, 2005.

♦ **Medicare prescription benefit.** The Medicare Modernization Act (MMA) will introduce Medicare Part D for prescription drugs in January 2006. Under current state law, clients dually eligible for Medicare and Medicaid will be able to choose to participate in either the federal Medicare Part D drug benefit program or continue to receive Medicaid-equivalent prescription benefits through the state. Should Oregon's estimated 50,000 dual eligibles choose to continue receiving their prescription coverage through the state, the state will be entirely responsible for the costs through General Funds. Federal regulations prohibit states from claiming federal match in these circumstances.

The MMA requires states initially to pay the federal government 90 percent of what would have been the state's share of drug cost prior to passage of the MMA for dual eligibles enrolled in Medicare Part D. Over 15 years, this amount will decline from 90 percent to 75 percent. This is referred to as the "clawback." The fiscal impact of the clawback may not be fully known until October 2005.

Senate Bill 88 would eliminate eligibility for Medicaid-equivalent prescription drug coverage when Medicare Part D takes effect January 1, 2006. *See OMAP proposed legislation on Page 32 for additional information.*

- **Rising health care costs** result in increased pressure to reduce benefits and caseloads, and/or adjust fee-for-service reimbursement levels.
- **The Medicaid Management Information System.** MMIS is a main-frame computer, an important electronic tool in managing OHP. Data submitted by health plans and fee-for-service providers is used to pay claims, set future reimbursement rates, meet federal reporting requirements, provide information to state policy makers, and measure program performance and quality. The system tracks medical eligibility for over 400,000 Oregonians. MMIS also processes 2,475,000 claims monthly from health care providers, but originally it was designed to handle only 260,000 per month.

  As advances in information technology continue and program complexities increase, the replacement of Oregon's outdated system (it's almost 25 years old) becomes critical. MMIS replacement, approved by the Legislature, is scheduled for 2005-07 and will be 90 percent federally funded. Maintenance and operation of the system, however, will be 75 percent federally funded.

- **Outreach programs.** Both the Family Health Insurance Assistance Program (FHIAP) and CHIP have specific outreach programs, which generate additional demand for services. Also, the Governor initiated "Kid Care," an outreach effort that OMAP implemented as a pilot in Hood River and Lincoln counties during August 2004. In addition, outreach for the Food Stamp program increases participation in the medical assistance programs administered by OMAP.
- **State economic trends**. The relative health of the Oregon economy affects the amount of federal funds available for matching general fund service dollars. According to the Oregon Employment Department, our unemployment rate continued to hover around seven percent in October 2004. Many of the "working poor" who receive OHP benefits hold minimum-wage jobs that do not routinely provide health insurance benefits. Therefore, while federal participation may drop as the Oregon economy improves, the need for OHP coverage continues.

OMAP Program Changes Over the Last 10 Years

1994

- Oregon implemented a Medicaid demonstration, called the Oregon Health Plan (OHP), expanding Medicaid to include Oregonians under 100 percent of Federal Poverty Level (FPL) who were not traditionally eligible for Medicaid. They received the basic health care benefit package using the Prioritized List.

1995

- Medicaid elderly, people with disabilities, and children in foster care/substitute care are folded into the Basic health care benefit package.
- Chemical dependency benefits added to OHP.
- Mental health benefits added to OHP for about 25 percent of the client population.

1997

- Mental health benefits added to OHP for remaining client population (HB 3445).

1998

- Coverage for Pell Grant-eligible college students added.
- Poverty Level Medical (PLM) program expanded to cover pregnant women and newborns with income between 133 percent FPL and 170 percent FPL.
- Children's Health Insurance Program (CHIP) began, extending coverage to uninsured children in families with incomes up to 170 percent FPL .

2002

- Breast and cervical cancer program began.
- Pharmacy management program began, limiting clients to one pharmacy. Simultaneously, pharmacists began using the Practitioner Managed Prescription Drug Program that identified the most cost-effective drugs.
- The disease management program started targeting clients with specific health conditions and providing case management.

2003

January

- Implemented voluntary copayments for clients receiving fee-for-service outpatient services ($3) or prescription drugs ($2 generic/$3 brand).
- Revised the Prioritized List by removing eight lines of services. None of the services dropped were for life-threatening or serious conditions. Some of the conditions that were no longer covered included treatment for acne, hives, and tear duct problems.

February

- Basic benefit package renamed the OHP Plus benefit package.
- Expanded coverage for pregnant women and children under 19 from 170 percent FPL to 185 percent FPL.
- Created the OHP Standard benefit package. This benefit package had fewer services than the OHP Plus benefit package. Differences included:
  - Elimination of:
    - Coverage for vision exams and eye glasses;
    - Non-emergency medical transportation;
    - Most medical equipment;
    - Hearing aids and hearing aid examinations.
  - Reduced dental benefits;
  - Mandatory client copayments for most services (in fee-for-service and managed care);
  - Increased premium and copayment amounts;
  - Required six months of being uninsured;
  - Penalties (i.e., disqualification) initiated for failure to pay premiums.

- Began roll-out of Senior Prescription Drug Assistance Program.
- Eliminated coverage for survival priority levels 15-17 in the long-term care system. Many of these individuals also lost their OHP medical coverage.
- Eliminated coverage for the Medically Needy program (see April 2003 change).

March

- The following services were eliminated from the OHP Standard benefit package:
    - Remainder of dental benefit;
    - Medical supplies;
    - Outpatient mental health services;
    - Outpatient chemical dependency services;
    - Prescription drugs (reinstated on March 14, 2003).
- Moved beginning date of eligibility for new OHP Standard clients to the first of the month following eligibility determination.
- Reduced reimbursement rates to Diagnosis Related Group (DRG) hospitals (50 beds or more) by 12 percent for inpatient services and outpatient services. Eliminated outlier payments to DRG hospitals except for infants under age one served in Disproportionate Share Hospitals.

April

- Eliminated coverage for survival priority levels 12-14 in the long-term care system. Many of these individuals also lost their OHP medical coverage.
- Reinstated state-funded coverage for anti-rejection (transplant) and anti-viral (HIV) drugs for former Medically Needy clients (SB 5548).

- Began auto-enrolling clients into Fully Capitated Health Plans (FCHPs) with a goal of 70 percent enrollment (HB 3624).

2004

January

- Restored outlier reimbursements for qualifying inpatient admissions to all in-state and contiguous DRG hospitals.
- Increased reimbursement rates to DRG hospitals to the levels in effect prior to the March 2003 reduction.

March

- Increased DRG Unit Values to 80 percent of Medicare rate, plus 100 percent of Medicare Capital. Increased outpatient rate to 80 percent of cost.

June

- Eliminated copayments for clients on the OHP Standard benefit package (court order).

July

- Closed OHP Standard benefit package to new enrollment.

August

- Dropped the number of services covered on the Prioritized List from 549 to 546.
- The following services were eliminated from the OHP Standard benefit package:
    - Hospital services not included in the limited hospital benefits;
    - Acupuncture, except for treatment of chemical dependency;
    - Chiropractic and osteopathic manipulation;

- Home health care;
- Nutritional supplements taken by mouth;
- Occupational therapy;
- Physical therapy;
- Private duty nursing;
- Speech therapy.

♦ The following services were added to the OHP Standard benefit package:

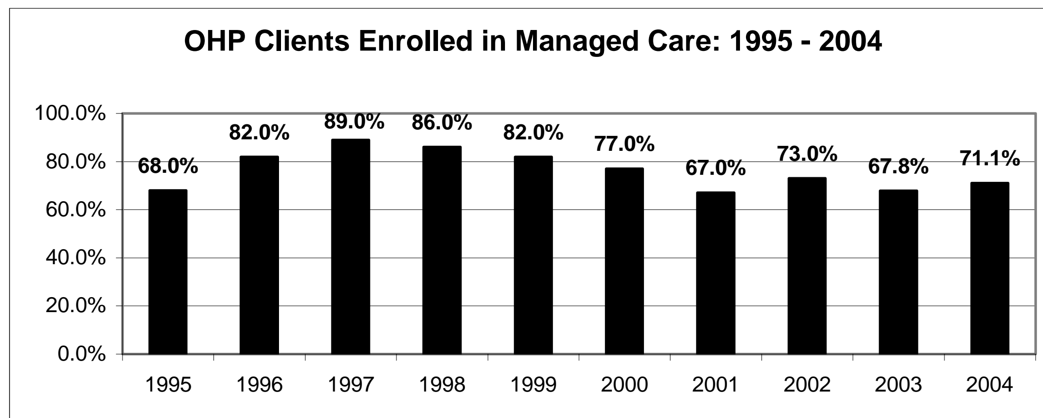
- Limited emergency dental services (does not include teeth cleaning, orthodontia, fillings or other routine services);
- Outpatient chemical dependency;
- Outpatient mental health;
- Selected medical equipment and supplies.

Cost Containment and OMAP Program Improvements

Managed Care Enhancements

Enrollment in managed care

OMAP had a goal of achieving, at a minimum, 70 percent enrollment in managed care, and has now exceeded that minimum level. As the following chart shows, managed care enrollment dropped in 2003, but has been increasing in recent months. OMAP is actively working to continue to increase the percent of clients enrolled in managed care. Figures include those enrolled in FCHPs as well those enrolled with a Primary Care Manager. The dip in 2001 represents some plans leaving OHP.



The decrease in 2003 is due to the fact that many plans stopped accepting the new OHP Standard clients. When the OHP Standard benefits changed in August 2004, all the plans except one resumed service to this population.

OMAP uses several strategies to foster enrollment:

♦ Ensure clients who move are automatically re-enrolled in the plan they were in, if it's available in the new area.

- Auto-enroll clients into FCHPs every month unless they have already selected a plan or do not meet the criteria.
- Reinforce importance of managed care enrollment with field staff at every opportunity and at the monthly field managers meetings.
- In March 2005, former clients will be auto-enrolled into their previous managed care plan after a break in enrollment.
- Since dual Medicare/Medicaid eligible clients are not auto-enrolled because of federal regulations, OMAP and Seniors and People with Disabilities (SPD) are working on improved client choice counseling and increased enrollment when their clients meet mandatory managed care criteria.
- Corrected the computer system to change the process of enrolling newborns into plans. Note: Savings of $350,000 related to this action were reflected in the DHS rebalance for April 2004.
- OMAP auto-enrolls clients in a dental care organization (DCO) if there is only one plan in their area. In multi-DCO areas, OMAP will introduce a system enhancement in March 2005, that will allow OMAP to auto-enroll clients in DCOs.
- While OMAP considered enrolling clients who have major medical insurance, the FCHPs have twice rejected the idea. The FCHP would become responsible for recoveries, and at the same time, OMAP would reduce their capitation rates.

Physician Care Organizations

CMS has approved the plan to bring physician care organizations (PCOs) into our managed care delivery system options, planned for the spring of 2005. Our first goal has been to get the system in place and the first PCO on

board. Capitation rates are developed for the PCO model. MMIS is ready to handle the PCO model. A request for applications has been issued.

- The first stage procurement is for the participation of Kaiser Permanente in the Portland metropolitan area and the Salem/Keizer area. This is to comply with directions in HB 3624 to contract with "a prepaid group practice health plan that serves at least 200,000 members in this state." The PCO contract is targeted to begin May 1, 2005.
- The second stage will be outreach to counties where there are no FCHPs (or not enough FCHP capacity to serve the entire area) to see if there is interest in the provider community in forming a PCO. Outreach will begin early in 2006 to reflect changes in the Medicare Modernization Act.

Administrative Services Organizations

HB 3624 directed the Department to contract with FCHPs, on a budget neutral basis, to manage administrative services for fee-for-service (FFS) clients for the following services:

- Pharmacy, excluding mental health drugs;
- Durable medical equipment and supplies;
- Non-emergency medical transportation in areas without transportation brokerages;
- Inpatient and outpatient hospital services.

Analysis of key developmental issues has been completed, including: (1) Federal regulations governing ASO arrangements; (2) Use of ASO services by other state Medicaid agencies; (3) Preliminary assessment of budget neutrality by select functional activity; and (4) Discussions with FCHPs concerning a model ASO program.

The analysis suggests that ASO activities focused on utilization and case management of inpatient and outpatient hospital services hold the greatest near term potential for improved management of the FFS program.

The Department proposes to undertake a limited number of demonstration projects in select geographic regions to document improved utilization patterns and cost neutrality. This strategy, carefully crafted, can be achieved during the transition from legacy to new Medicaid Management Information Systems. Based upon the evaluation of the demonstration projects and the improved flexibility provided by the new MMIS system, ASO arrangements can be aggressively expanded, both geographically and by function.

Managed care contracts

OMAP is exploring strategies to increase flexibility in the contract process to allow more time to secure necessary federal approvals for legislatively directed changes. Ideas include moving the start date back or increasing the duration of contracts. We are also reviewing regulatory timelines with federal officials.

Business Practices and Automated Information Technology

- Centralization of all fee-for-service prior authorizations in OMAP (for speech therapy, audiology, hearing aids, occupational therapy, physical therapy, home health services, private duty nursing, and durable medical equipment and supplies) is underway, and is intended to provide consistency and cost savings.
- The OMAP Health Financing Operations section is initiating a work effort to pay all claims the right way the first time, thus reducing problems such as claims suspensions, adjustments, incorrect denials, and

provider refunds. The proposed year-long initiative involves enhanced staff and provider training as well as systems improvements.

- Plans began using electronic funds transfer (EFT) in the present MMIS computer system on October 1, 2004. OMAP offered EFT options to other providers, beginning with hospitals in November 2004.
- The process and schedule for correcting encounter data have been revised and incorporated into the October 2004 contracts. One criterion for determining a cut-off date for correction of "old" encounter data is whether the data directly affects the rate/risk adjustments for capitation payments.
- The new Medicaid Management Information System (MMIS) is scheduled to replace the outdated computerized system in 2005-2007. New software and equipment will allow a stable environment for processing claims from providers each month and support business process re-engineering.
- Increased recovery efforts in Medicaid audit, Medicaid overpayment and third party resources (i.e., health insurance) were initiated in the Department in January 2005. Staff costs in Department-wide Support Services and Children, Adults and Families will be offset by an expected net recovery revenue of $2.7 million General Fund in 2005-07. The net recovery is estimated at $0.2 million General Fund in 2003-05.

Quality Improvement

- Beginning October 2003, annual onsite reviews of managed care plans were reduced to once every three years. Plans will submit annual reports to OMAP that will be used to evaluate plans in the interim period. Onsite reviews will focus on unresolved issues around processes and procedures. This will save approximately 1200 hours annually, or an estimated $52,000 of managed care staff time that can now be focused on other

areas. DHS staff time reduced on this activity is estimated to be 1,000 fewer hours annually at $35,000. Note: Staff reductions were taken during the April 2004 rebalance.

- Performance measures were modified February 2004 to decrease managed care organization burden in their measurement while increasing their usefulness to managed care organizations to target areas for improvement. This will save an estimated 700 hours of managed care staff time annually, valued at approximately $29,400, that can now be focused on improving access to and quality of health care.
- OMAP has been working with plans' quality improvement staff to develop criteria for standardizing complaint and appeals reporting, scheduled for completion in December 2004. The criteria will be incorporated into the contracts in the next contracting cycle.
- Since September 2003, Quality Improvement and Project PREVENTION meetings have been combined. This saves an estimated 275 hours of managed care plan staff and OMAP staff hours annually, valued at approximately $10,000.

Complaint and Grievance Procedures

- OMAP developed comparative reports on plan performance, including complaints, and provided them to plans for their review in December 2004. These reports will be provided on a quarterly basis.
- The Oregon Administrative Rules on the grievance, denial, appeal and hearing processes were amended effective June 1, 2004, to reflect changes in federal law. Clarifying language was included in the June 2004 contract amendments. Sample letters and notices were developed as resource material for plans. Best practices were shared and discussed.

Pharmacy Benefits

Pharmacy Benefits Manager

HB 3624 requires Oregon to use a pharmacy benefits manager (PBM). A PBM, among other things, may purchase drugs in bulk at reduced rates, may provide case management, and may review drug utilization. In theory, an OMAP-contracted PBM would manage prescription drugs for fee-for-service clients and allow FCHPs to contract with the PBM.

OMAP convened a broad-based group of managed care plans and pharmacy stakeholders to design what a responsive PBM would look like that would meet the requirements of HB 3624. A completed fiscal analysis determined this would not be cost neutral to implement as a stand-alone project. OMAP determined it was unlikely CMS would approve a stand-alone procurement for a PBM since CMS has required the Department to incorporate into the MMIS procurement the PBM functions (claims processing and provider utilization management). However, the Department took the opportunity to use all of the design work done by the stakeholder workgroup to define its requirements for the PBM function in the new MMIS. This functionality is expected to be available at some time during the phased-in implementation of the new MMIS in 2005-07.

Drug Utilization Reviews

The state contracts with the Oregon State University School of Pharmacy (OSU) and other contractors to administer various cost saving initiatives. Those initiatives currently in place include:

- A Poly-pharmacy Review Program that focuses on patients using 15 different drugs in 180 days. This program results from Section 20 of HB 3624, and it allows the Department to conduct prospective drug utilization review when a patient's drug use exceeds 15 unique drugs in a

six-month period. OSU reviews cases and contacts the provider to recommend medically appropriate prescribing modifications. OMAP's Medical Director reviews selected cases and may request recommendations from the Drug Utilization Review (DUR) Board. The Medical Director has authority to impose restrictions if the provider does not cooperate with the DUR recommendations.

- Section 22 of HB 3624 prohibits the Department from requiring prior authorization for drugs not on the Practitioner-Managed Prescription Drug Plan (PMPDP) drug list. However, the Department still is able to use the PMPDP as a cost saving initiative. In contract with OSU, the Department implemented a Preferred Drug List (PDL) Educational Initiative that provides feedback to physicians who prescribe high volumes of non-PDL drugs. This initiative includes a general comparison of PDL adherence by class for the individual prescriber compared to peers. It also has included change requests for specific patients on non-PDL drugs and facilitates a change by coordinating the communication between the prescribing physician, the pharmacy and the patient. The change requests focus on particular PDL classes.
- The state through OSU recently implemented a voluntary Half-Tablet and Dose Consolidation Initiative for selected antidepressants that works similarly to the Poly-pharmacy Review Program.
- The Partnership for Psychiatric Medication Access project has a budget-related component that includes writing educational letters to prescribing physicians on specific psychiatric prescribing issues such as duplication, dosing, and compliance.
- The state, in contract with First Health Services Corporation, uses the long-standing Retrospective Drug Use Review program that includes writing letters to prescribing physicians on many clinical issues. To

avoid overlap with other programs, the DUR program focuses on narcotic use and new information from the Federal Drug Administration.

- Using available tools, such as the Oregon Maximum Allowable Cost list for fee-for-service clients, OMAP is saving approximately $1 million per month.

Durable Medical Equipment (DME) and Supplies

The Department centralized prior authorization (PA) of DME on May 1, 2004. The cost of DME was impacted by the inconsistencies in the former process. The 2003 Legislature approved the DHS budget with a reduction of $5 million (Total Funds), half of which was identified as savings in centralizing DME and other services, such as therapies. OMAP will achieve the remaining reduction by continuing to identify sensible savings opportunities such as rate reductions, more stringent criteria, identification of least costly alternatives, etc. In November 2004, OMAP concluded its work with providers and representatives from managed care plans in this rate reduction effort. Based on recommendations from the DME cost reduction workgroup, the following are initiatives OMAP implemented to reduce DME costs:

- Effective March 1, 2004, OMAP implemented rate reductions of up to ten percent in the following categories: respiratory, manual wheelchair bases, power wheelchair bases, hospital beds, diabetic supplies, urological supplies and incontinence supplies.
- Effective July 1, 2004, OMAP reduced rental payments for some supplies from a maximum of 16 months of rent to 13 months of rent.
- Effective August 1, 2004, OMAP based reimbursement on the lesser of the manufacturer's suggested retail price, the provider's usual charge to the public, or the maximum allowable reimbursement rate set by OMAP.

- Effective August 1, 2004, for clients residing in congregate living environments, OMAP required DME providers to assure supplies are identified and labeled for use only by the specific client for whom the supplies/items are intended.
- Effective August 1, 2004, OMAP implemented dispensing restrictions. For example, if a provider dispenses a three-month supply of diapers, the provider cannot send another shipment until the client is down to a 15-day supply.
- Effective January 1, 2005, OMAP reduced the allowable number of incontinence supplies to 220 per month unless documentation is provided for an increased amount.

Hospital services

OMAP provides comprehensive case management, including concurrent review, with the Disease Case Management and Medical Case Management Programs in contract with McKesson Health Solutions. OMAP's projection and goal for these programs is to achieve a five percent savings in program costs. The programs target clients who have high medical costs and have high utilization of medical services. The first year of the program has helped the state avoid at least $6 million in medical costs.

OMAP now contracts with the Oregon Medical Professional Review Organization, Inc. (OMPRO) to prior authorize about 300 selected inpatient and outpatient surgeries per month. Examples of the selected services are hysterectomies and laparoscopic growth removal. The contract with OMPRO also reviews 200 hospitalizations per quarter to determine if the hospitalization or length of stay was appropriate. These two services cost $17,200/month. Although retro-review is not as effective as concurrent review, it does save money if the determination is that the patient should have been on observation stay or if the hospitalization did not meet the

medical necessity criteria for acute care treatment. It has enabled OMAP to recoup inappropriately paid funds exceeding the monthly amount OMAP paid for OMPRO's services. For example, the first quarter of 2004 resulted in a program savings of approximately $114,000, compared to the $51,600 paid to OMPRO for all services, yielding a net savings of $62,400.

Essential and Policy Option Packages

The following is a summary of the packages and adjustments that were incorporated in the development of the 2005-07 budget for the Office of Medical Assistance Programs. Expanded descriptions of each package listed in the table below follows this summary.

	General Funds	Other Funds	Federal Funds	Total Funds	Pos	FTE
Base Budget:	630,561,926	679,802,995	2,262,679,965	3,573,044,886	173	166.07
Essential Packages:						
Pkg 010 - Vacancy Factor, Non PICS Personal Services	260,953	35,771	417,850	714,574	0	0.00
Pkg 021 - Phase-In	(1,595,017)	(21,664,779)	(3,127,252)	(26,387,048)	0	0.00
Pkg 022 - Phase-Out	(57,611,468)	(44,047,138)	(326,945,388)	(428,603,994)	0	0.00
Pkg 030 - Inflation	57,264,986	102,389,417	274,673,758	434,328,161	0	0.00
Pkg 040 - Mandated Caseload	20,797,813	14,500,821	59,439,425	94,738,059	0	0.00
Pkg 050 - Fund Shift	196,923,152	(164,766,249)	(32,156,903)	-	0	0.00
Total Essential Packages	216,040,419	(113,552,157)	(27,698,510)	74,789,752	-	-
Essential Budget Level	846,602,345	566,250,838	2,234,981,455	3,647,834,638	173	166.07
2005-07 Governors Recommended Budget						
Pkg 084 - November 2004 E-board	38,475,114	(21,403,437)	41,861,039	58,932,716	0	0.00
Pkg 090 - Analysts Adj.	(95,306,354)	22,674,244	(114,584,566)	(187,216,676)	0	0.00
Policy Pkg 103 - Partially Restore OHP Standard Benefit Package	-	184,385,683	287,632,561	472,018,244	4	4.00
Policy Pkg 110 - Medicare Modernization Act Implementation	132,602,802	(24,569,478)	(187,403,695)	(79,370,371)	0	0.00
Policy Pkg 111 - Medicare Modernization Act Cost Avoidance	(130,065,723)	-	-	(130,065,723)	0	0.00
Policy Pkg 143 Type A&B Hospital Reimbursement	(108,360)	-	(169,629)	(277,989)	0	0.00
Gov. Rec. Budget	792,199,824	727,337,850	2,262,317,165	3,781,854,839	177	170.07

Base Budget: This is the 2003-05 Legislatively Adopted Budget as of the April 2004 Emergency Board with personal services increased to 2005-07 costs. This would include estimated costs of 2005-07 merit increases, any step increases planned for employees in the 2005-07 biennium and 24 months of any step increases granted to employees in the 2003-05 biennium.

Essential Packages

010 Vacancy Factor and Non-PICS Personal Services --The Vacancy factor calculation projects budget savings reasonably expected from staff turnover in the 2005-07 biennium. Non-PICS Personal Services cost adjustments are for inflation on items that are not included in the PICS-generated total. They include unemployment assessments, overtime, temporaries, and shift differentials.

Package 010: Non PICS Personal Services Adjustment

Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
The Vacancy factor calculation projects budget savings reasonably expected from staff turnover in the 2005-07 biennium.	(6,318)	(1,884)	(6,432)	(14,634)
The Department of Administrative Services (DAS) will assess the agency for its share of costs associated with the Pension Obligation Bonds issued in October 2003. The collection from the agency will be used by DAS to make the semi-annual debt service payments.	267,271	37,655	424,282	729,208
Total	**260,953**	**35,771**	**417,850**	**714,574**

021 Cost of Phased-in Programs and One-Time Costs – This package is related to new programs and expansion of non-mandated programs funded for less than 24 months during the 2003-05 biennium, but needing a full 24 months in the 2005-07 biennium. The costs for the additional months of funding needed to achieve the 24-month funding level are included in this package. Phase-in costs in this budget structure are:

Package 021: Phase In

Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
Phase-in drug cost savings from the management action requiring prior authorization for clients who have 15 or more drug prescriptions within a 180-day window and the management action regarding mental health cost containment.	(1,007,750)	(293,553)	(2,152,262)	(3,453,565)
Phase-in transfer of payment to the Insurance Pool Governing Board for the Family Health Insurance Assistance Program.	-	(21,371,226)	-	(21,371,226)
Phase-in of 3-line reduction to covered services under the prioritized list of health services.	(594,285)	-	(982,904)	(1,577,189)
Phase-in of service and supply costs related to positions transferred from the Seniors and People with Disabilities cluster to Office of Medical Assistance Programs.	7,018	-	7,914	14,932
Total	**(1,595,017)**	**(21,664,779)**	**(3,127,252)**	**(26,387,048)**

022 Cost of Phased-Out Programs and One-Time Costs – This package is related to any programs permanently eliminated during the 2003-05 biennium, and to remove costs in the base budget for the months the program operated during 2003-05. Phase-outs are also related to decreased costs resulting from discontinuation of pilot project programs and other one-time costs that will not be continued in the 2005-07 biennium. The decreased costs from phased-out programs in this budget structure are:

Package 022: Phase Out

Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
Removes expenditures for OHP standard based on April 2004 E-Board.Phase-out of the OHP Standard Medical Assistance Program .	(56,903,846)	(15,631,522)	(119,968,262)	(192,503,630)
Phase-out of empty limitation for amounts unscheduled in the April 2004 rebalance.		(27,292,038)	(204,457,232)	(231,749,270)
Phase-out three one-time contracts that were related to assistance with OHP issues and a lawsuit filed against OMAP and DHS by COIHS, a managed health care plan. Also being phased out are temporary appointments, mass transit tax, empty limitation and special payments to the Department of Administrative Services for the Office for Oregon Health Policy and Reasearch.	(707,622)	(1,123,578)	(2,519,894)	(4,351,094)
Total	**(57,611,468)**	**(44,047,138)**	**(326,945,388)**	**(428,603,994)**

030 Inflation and Price-List Adjustments --The standard inflation factor of 2.4 percent and the Department of Administrative Services (DAS) Price List were used for calculating general increases for Services and Supply, Capital Outlay, and Special Payments. Biennial inflation factor exceptions were requested and received for Medical Services at 5.0 percent (2.4 percent standard inflation plus an additional 2.6 percent). The utilization and actuarial inflation rates were provided by Pricewaterhouse Coopers (PwC), the contracted actuary for OMAP. For Non-OHP, an incremental inflation amount was used to align with the Centers for Medicare and Medicaid Services' increase in Medicare Part B premium rates. Medical inflation for both cost of services and utilization rates continues to be a significant driver of the Medicaid budget.

Package 030: Inflation and Price List Adjustments

Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
Inflation				
Trend (utilization and cost) for Oregon Health Plan Medicaid expenditures	49,039,013	95,750,186	247,337,775	392,126,974
Trend (utilization and cost) for Oregon Health Plan Children's Health Insurance Program expenditures	(1,002,527)	3,456,764	6,484,649	8,938,886
Cost increase for Medicare Part B premium payments	8,917,522	3,073,386	20,188,359	32,179,267
Standard inflation for Office of Medical Assistance Program's administrative expenditures. *(Note: Package 090 includes an action to delay implementation of inflation until January 2006.)*	310,978	109,081	662,975	1,083,034
Total	57,264,986	102,389,417	274,673,758	434,328,161

040 Mandated Caseloads – This package includes only programs that have been designated as "mandated" in the DAS budget instructions. Mandated caseload costs reflect the changing costs from caseload and/or cost-per-case

fluctuations, plus related inflation. Inflation factors were developed in three increments, one at 2.4 percent for base costs; an additional one at 2.6 percent for a combined medical inflation of 5 percent; and one to adjust for utilization/trend factors.

The forecasted increase in the Oregon Health Plan mandated caseload including Standard Inflation. The base forecast was trended on seven years of historical data. It assumed that historic trends are indicative of future patterns for the rate at which participants leave eligibility groups (survival), move among eligibility groups (transfer) and the rate at which clients enter groups from the outside (inflow). As necessary, the 2005-07 base forecast was adjusted to reflect the anticipated impact of policy adjustments. Policy adjustments include the General Assistance program, which was eliminated and later restored, and the elimination of the Medical Expansion for persons with Disabilities and Seniors (MEDS) program, which was not restored in 2003-05. The 2005-07 caseload forecast also excludes the Families and Adults & Couples participants, which were terminated effective August 2004, by the legislative Emergency Board at the April 2004 Rebalance. *(See Package 103 for partial restoration of OHP Standard Benefits.)*

Package 040: Mandated Caseload

Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
Forecasted increase in Oregon Health Plan Medicaid mandated caseload, including associated inflation.	19,446,271	13,115,858	53,855,407	86,417,536
Forecasted increase in Oregon Health Plan Children's Health Insurance Program caseload, including associated inflation.	-	1,064,023	2,817,855	3,881,878
Forecasted increase in mandated caseload for Qualified Medicare Beneficiaries and Medicare Part B Premium participants.	1,351,542	320,940	2,766,163	4,438,645
Total caseload and associated inflation	**20,797,813**	**14,500,821**	**59,439,425**	**94,738,059**

050 Fund Shifts – This package reflects significant budgeted funding changes in existing programs. Fund shifts affecting this budget structure are:

Package 050: Fund Shifts

Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
Federal Match Rate Change				
Fund Shift – Change in the federal medical assistance percentage for Oregon Health Plan expenditures to 61.61%.	31,359,658	-	(31,359,658)	-
Fund Shift - Change in the federal medical assistance percentage for Non-Oregon Health Plan expenditures to 61.61%.	1,169,800	-	(1,169,800)	-
Fund Shift – Change in the federal medical assistance percentage for Children's Health Insurance Program expenditures to 73.06%.	(372,555)	-	372,555	-
General Fund Replacement				
General Fund replacement of Tobacco Tax Funds. The Tobacco Tax Revenue for 2005-2007 is not expected to increase at the rate of growth in the programs.	110,366,257	(110,366,257)	-	-
Other Fund Shift				
Fund Shift – Tobacco Tax Forecast. Tobacco tax revenue projection lowered, with corresponding increase in General Fund.	12,191,776	(12,191,776)	-	-
Fund Shift – Tobacco Settlement revenue removed from OMAP budget, with corresponding increase in General Fund.	42,208,216	(42,208,216)	-	-
Total Fund Shifts	**196,923,152**	**(164,766,249)**	**(32,156,903)**	**-**

Package 084 – This package reflects the 2005-07 biennium impact for actions taken at the November 2004 Oregon Legislative Emergency Board meeting that affected the Office of Medical Assistance Programs.

Package 084: November 2004 Emergency Board

Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
Increased caseload, primarily in TANF.	43,244,608		67,695,896	110,940,504
Increased caseload in the Children's Health Insurance Program	3,344,694		8,906,932	12,251,626
Expenditure savings in fee-for-service and managed care.	(23,052,805)	-	(36,406,608)	(59,459,414)
Adjustments to tobacco tax revenue.	16,668,501	(16,668,501)	-	-
Fund adjustments for third party recovery, Medicaid audit recovery and expenditures for Native Americans.	(1,729,883)	(4,734,936)	1,664,819	(4,800,000)
TOTAL	**38,475,115**	**(21,403,437)**	**41,861,038**	**58,932,716**

Package 090 – The following adjustments were recommended by BAM analysts:

Package 090: BAM Analyst Recommended Adjustments				
Package Detail	General Funds	Other Funds	Federal Funds	Total Funds
Constrain Rate of Increase:				
Fee-for-service and administrative actions, which could include actions, such as enhanced disease management, concurrent review of hospitalizations, enhanced management of pharmacy costs, medical transportation efficiencies, limited cost-of-living increases for providers, limited reimbursement for graduate medical education, etc.	(22,596,730)	(1,359,006)	(37,721,220)	(61,676,956)
Increase payments to managed care plans for the hospital component of the capitation rates to 90% (from 72% in the 2003/05 biennium) rather than the 100% that would otherwise be assumed.	(17,277,155)	-	(27,504,285)	(44,781,440)
Reduce/Eliminate Services:				-
Eliminate dental services for OHP Plus adults (123,000 clients). Would not apply to pregnant women.	(12,189,265)	-	(19,081,297)	(31,270,562)
Eliminate vision benefit for OHP Plus adults (123,000 clients). Would not apply to pregnant women.	(2,072,245)	-	(3,243,930)	(5,316,175)
Other reduction actions, which could include limitations on prescription drugs, hospital days, etc.	(1,955,155)	(187,268)	(3,340,936)	(5,483,359)
Reduce Populations:				
Actions in SPD programs can also impact OHP eligibility for some clients, such as SPD actions related to General Assistance, relative adult foster care, employment initiative program, and limited enrollment in the Aged and Physically Disabled Waiver (3,125 clients).	(14,715,804)	(666,867)	(24,080,282)	(39,462,953)
Other:				
Use Tobacco Settlement funds to reduce GF expenditures	(24,500,000)	24,500,000	-	-
Special Payment to the Department of Administrative Services, Office for Health Policy and Research.	-	391,638	391,637	783,275
Analyst Recommended reduction relating to the Commission on Children and Families.	-	(4,253)	(4,253)	(8,506)
TOTAL	**(95,306,354)**	**22,674,244**	**(114,584,566)**	**(187,216,676)**

Policy Option Packages

Policy Package 103: Partially Restore OHP Standard Benefit – This policy package restores: 1) A restricted benefit package for a limited number of eligible Standard clients; 2) Staff necessary to administer the program and determine eligibility for the program; and 3) Funds to pay for the contracted vendor to collect premiums. The Department eliminated staff to administer and operate the Standard program and funds for the premium contract when General Funds were eliminated for clients receiving the Standard Benefit Package. House Bill 2747, approved by the 2003 Legislative Assembly established both a Medicaid Managed Care Organization (MCO) tax and a Hospital tax. These taxes now serve as the state fund source to operate a capped program for OHP Standard clients. DHS estimates the MCO and hospital tax revenues, along with matching Federal funds, will be sufficient to support approximately 24,000 OHP Standard clients in 2005-07 and selectively increase provider reimbursement rates. Impact for OMAP is $472.0 million Total Funds, $0 General Funds, $184.4 million Other Funds, and $287.6 million Federal Funds.

Policy Package 110: Medicare Modernization Act Implementation – Implements the Federal Medicare Modernization Act, which provides prescription drug benefits for clients dually eligible for Medicare and Medicaid.

This package reflects the fiscal and programmatic impacts of the new federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, which creates a Medicare prescription drug benefit called Medicare Part D. Effective January 2006, states will no longer be eligible for federal Medicaid matching funds for Medicare/Medicaid dual eligible drug coverage. Dual eligible beneficiaries will receive their drug benefits through Medicare unless they opt out of Medicare Part D. States will be required to pay the federal government for a portion of the Medicare drug benefit provided to

Medicare/Medicaid dual eligibles. States may provide additional drug benefits, but they will not receive federal match for these expenditures with a few minor exceptions. Senate Bill 88 (policy package 111) has been submitted to eliminate the requirement for a Medicaid-equivalent prescription drug benefit that would be funded only with state funds. Removing this current statutory requirement for a Medicaid-equivalent prescription drug benefit would mitigate a large portion of the expanded cost to the state.

Estimates of the impacts of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 are very preliminary. The Centers for Medicare and Medicaid Services (CMS) is still in the process of determining how the details of the Act will be implemented. Impact on the pharmacy program budget is currently estimated at ($79.4) million Total Funds, $132.6 million General Funds, ($24.6) million Other Funds, and ($187.4) million Federal Funds. There is an additional impact on Seniors and People with Disabilities and Department Wide Support Services.

Policy Package 111: Medicare Modernization Act Cost Avoidance – Eliminates Medicaid-equivalent prescription drug coverage for dual Medicare/Medicaid eligibles. This policy package will eliminate Medicaid-equivalent prescription drug coverage for dual Medicare/Medicaid eligibles when the Medicare Part D drug coverage begins January 1, 2006, unless there are federal matching funds available. This policy package requires a statutory change, which is contained in Senate Bill 88.

Background: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 created a Medicare prescription drug benefit called Medicare Part D. Effective January 2006, states will no longer be eligible for federal Medicaid matching funds for Medicare/Medicaid dual eligible drug coverage. Dual eligible beneficiaries will receive their drug benefits through Medicare unless they opt out of Medicare Part D. States

may provide additional drug benefits, but they will not receive federal match for these expenditures with a few minor exceptions.

Current state law requires the state to fill the gap between what the Part D plans will provide and what Oregon's Medicaid program provides even though no federal match is available and current state law also requires a state-funded drug benefit for Medicare/Medicaid dual eligibles who choose not to participate in the Medicare drug program. Impact is estimated at ($130.1) million Total Funds, and ($130.1) million General Funds through cost avoidance.

Policy Package 143: Type A & B Hospital Reimbursement – This policy package changes the reimbursement methodology for Types A and B hospitals and rural critical access hospitals (hospitals with less than 50 beds) serving managed care clients.

The Centers for Medicare and Medicaid Services has informed the Department of Human Services/Office of Medical Assistance Programs that the current methodology in statute requiring the Department reimburse Type A and B and rural critical access hospitals at 100 percent of their costs for services to a client covered by a managed care organization is in direct violation of federal law. This policy package and accompanying legislative concept seek to change the methodology to one that would result in these hospitals being reimbursed by managed care organizations at either a separately negotiated rate or a rate prospectively determined by the Department's contracted actuary to be 100 percent of the hospitals' costs. There would be no retrospective cost settlement made by the Department. This change would bring Oregon into alignment with federal laws for services provided on or after August 13, 2003. Impact is estimated at ($0.3) million Total Funds, ($0.1) million General Funds, and ($0.2) million Federal Funds.

OMAP Proposed Legislation

Oregon and the Medicare Modernization Act

The Department introduced Senate Bill 88 which eliminates eligibility for Medicaid-equivalent prescription drug coverage for dual Medicare/Medicaid eligibles when Medicare Part D provides a drug benefit beginning January 1, 2006. The statutory language for the bill is permissive rather than mandatory in order to allow the legislature to offer programs for dual eligibles, should funds be available, such as allowing a drug benefit through the transition of moving from Medicaid to Medicare.

Need for Policy Change

Under the Medicare Modernization Act (MMA), Medicare recipients will be eligible for a Medicare prescription drug benefit beginning January 1, 2006, called Medicare Part D. Under current State law, people dually eligible for Medicare and Medicaid will be able to choose to participate in either the federal Medicare Part D drug benefit program or continue to receive Medicaid-equivalent prescription benefits through the State. Should these dual eligibles choose to continue receiving their prescription coverage through the State, the State will be entirely responsible for the costs through general funds. (Federal regulation will prohibit states claiming federal match in these circumstances.)

Impact if Not Approved

♦ The federal government currently pays for approximately 60 percent of dual eligible drug benefit costs. With the implementation of Part D, no federal matching funds will be available to assist with the cost of this

coverage for those who choose to enroll in Medicaid, but not for Medicare Part D.

- For those dual eligibles who enroll in Medicare Part D, the State would be required to "wrap around" the Medicare Part D benefit with 100 percent general funds, paying for drugs not covered by a beneficiary's Part D drug plan.

Facts

Regardless of the outcome of this bill, the MMA requires states to pay the federal government 90 percent, initially, of what would have been the State's share of drug cost prior to passage of the Act for dual eligibles enrolled in Medicare Part D. Over 15 years, this amount will decline to 75 percent. This is referred to as the "clawback." The fiscal impact of the clawback may not be fully known until October 2005.

- The number of clients impacted is about 50,000.
- The Part D benefit is intended to provide comprehensive drug coverage for Medicare beneficiaries. The MMA requires the availability of at least two drugs from each class of drugs.

Other Possible Solutions

None. A statutory change is necessary to avoid significant additional costs to the Department.

Fiscal Impact

Without this bill, we will pay approximately $128.2 million in General Funds based on the information available at this time. However, most of the information necessary to definitively determine the fiscal impact is not available, such as:

- What drugs won't be included in Part D formularies for which the State would pay 100 percent of their costs with General Funds?
- What incentives will clients have to enroll in Part D coverage instead of receiving coverage from the State?

The State may not have answers to these questions until October 2005. The fiscal impact estimate will change as the State receives new information about the implementation of the MMA.