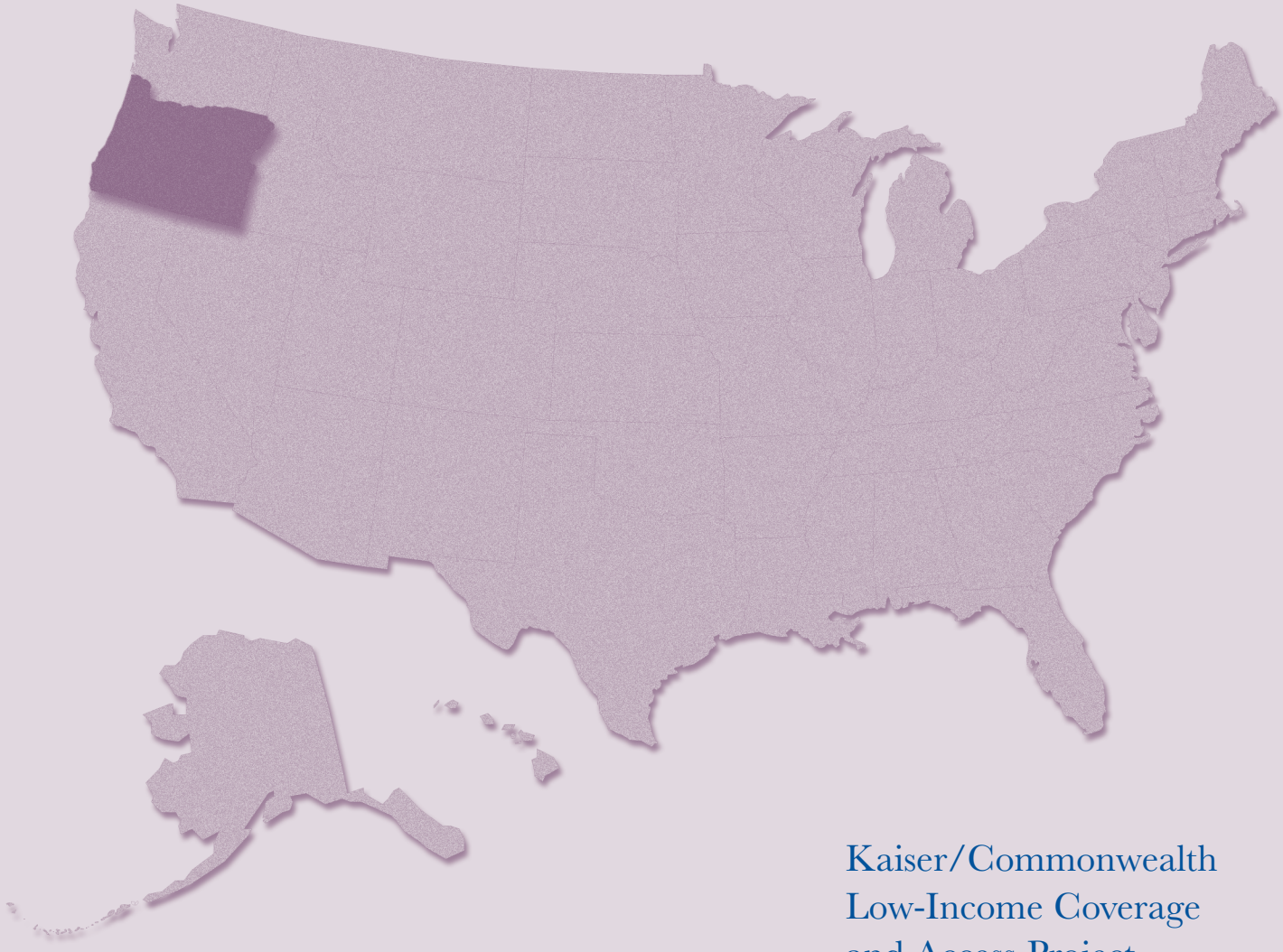
Managed Care and Low-Income Populations: Four Years' Experience with the Oregon Health Plan



Kaiser/Commonwealth Low-Income Coverage and Access Project

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THE HENRY J. KAISER FAMILY FOUNDATION

KAISER/COMMONWEALTH LOW-INCOME COVERAGE AND ACCESS PROJECT

The Henry J. Kaiser Family Foundation and The Commonwealth Fund are jointly sponsoring *The Low-Income Coverage and Access Project* to examine how changes in the Medicaid program and the movement toward managed care are affecting health insurance coverage and access to care for the low-income population. This large-scale project, initiated in 1994, has examined the impact of changes in eight states: California, Florida, Maryland, Minnesota, New York, Oregon, Tennessee, and Texas. Information is being collected through case studies, surveys and focus groups to assess changes in health insurance coverage and access to care from the perspectives of numerous key stakeholders — consumers, state officials, managed care plans, and providers.

MANAGED CARE AND LOW-INCOME POPULATIONS: FOUR YEARS' EXPERIENCE WITH THE OREGON HEALTH PLAN

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ACRONYMS

AAA	Area Agencies on Aging
AFDC	Aid to Families with Dependent Children
AFS	Adult and Family Services
CHIP	Children's Health Insurance Program
COIHS	Central Oregon Independent Health Services
DCO	Dental Care Organization
DHR	Department of Human Resources
ENCC	Exceptional Needs Care Coordinator
EQRO	External Quality Review Organization
ERISA	Employee Retirement Income Security Act
FCHP	Fully Capitated Health Plan
FFS	Fee-for-Service
FHIAP	Family Health Insurance Assistance Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
MCO	Managed Care Organization
MHDDSD	Mental Health and Developmental Disability Services Division
MHO	Mental Health Organization
MPR	Mathematica Policy Research, Inc.
OADAP	Office of Alcohol and Drug Abuse Programs
OHP	Oregon Health Plan
OHPPR	Office of Health Plan Policy and Research
OMAP	Office of Medical Assistance Programs
PCCM	Primary Care Case Management
PCO	Physician Care Organization
PHP	Prepaid Health Plan
RFA	Request for Application
SDSD	Senior and Disabled Services Division
SPMI	Severely and Persistently Mentally Ill
TANF	Temporary Assistance for Needy Families

EXECUTIVE SUMMARY

This 1998 update of the 1994 case study of the Medicaid component of the Oregon Health Plan (OHP) and its effect on low-income populations revisits issues identified earlier. The focus is on how programs have matured and are affecting access to care and the safety net for low-income populations. This is one of a series of updates Mathematica Policy Research, Inc., (MPR) is developing of seven state health care system case studies. Information for this update comes largely from interviews conducted during a week-long site visit to Oregon in December 1997. Other sources include MPR's earlier work on the OHP (Gold, Chu, and Lyons 1995). A separate report reviews in detail Oregon's experience with expanding its health plan to serve populations with special needs, including aged, blind, and disabled individuals and those needing behavioral health care.

BACKGROUND

The Medicaid component of the OHP aims to expand coverage to all Oregonians whose incomes are below the poverty level with savings generated both by instituting managed care for almost all beneficiaries and by the design of the benefit package, which uses a priority list to define covered conditions and treatments.

In our review of the OHP's first year (1994), we concluded that Oregon managed the transition to the OHP with relatively little disruption of health care and administrative systems. Contributing to the smooth transition were the generous time frame for plan implementation; the state's solid base of existing managed care plans, both for Medicaid and commercial populations; the consensual style of decision making**;** and the initial focus on transitioning only those eligible for Medicaid because of low-income.

The main concern expressed in the original study was how much of the planned eligibility expansion would be possible given fiscal constraints and growing uncertainty about the employer mandate, which was crucial to the original design but increasingly in jeopardy. In addition, there were questions about how well Oregon would manage the more difficult process of bringing special Medicaid populations — aged, blind, and disabled individuals — into the managed care plan.

KEY FINDINGS

1. The basic structure of the OHP's Medicaid component remains in place.

The original structure of the OHP's Medicaid component remains largely intact with some changes made to generate efficiencies. The main changes made in response to fiscal constraints are the introduction of premium contributions on a sliding scale ranging from $6 to $28 per month and tighter eligibility standards set by instituting an assets test and using an average of three months of income (rather than a single month's income). The OHP relies now more than ever on fully capitated health plans (FCHPs). At the end of 1997, 14 FCHPs were participating (down from 20 in 1994), with 34 of 36 counties covered by at least one and 87 percent of eligibles enrolled in them.

2. The program has been expanded to virtually all Medicaid-eligible populations.

The major changes in the program are associated with the effort to move special Medicaid populations — the aged, blind, disabled, and children in substitute care — into the OHP, a transition that occurred as planned in a separate phase beginning in 1995. At year-end 1997, 67 percent of aged eligibles, 83 percent of blind and disabled eligibles, and 72 percent of children in substitute care were in FCHPs. Fifty-five percent of those eligible for both the Medicare and Medicaid programs were in the OHP. To facilitate this transition, three enhancements were made to the program: (1) drawing attention to existing benefit coverage for "comorbidities" (uncovered conditions related to covered conditions); (2) requiring each managed care plan to hire and train at least one exceptional needs care coordinator (ENCC); and (3) establishing an ombudsman's office to advocate and solve problems for clients.

3. Behavioral health care benefits have been integrated into the managed care model.

The other major change in the OHP since its first year is that chemical dependency and mental health benefits have been integrated into the managed care model. Separate approaches were used for each of these. Chemical dependency benefits were integrated into the general managed care contracts beginning in January 1995. In contrast, Oregon "carved out" mental health benefits, which are being provided by mental health organizations (MHOs).

The mental health component was introduced slowly, beginning with a demonstration. A key consideration in the design was minimizing adverse effects on providers who were part of the mental health care safety net. In structuring separate arrangements for mental health care, Oregon tried to minimize complications for care coordination and accountability. For example, antipsychotic and antidepression

medications were ultimately covered on a fee-for-service basis so that FCHPs could treat patients with mild mental illness without receiving approval from MHOs. However, the mental health component has just been implemented statewide and controversies remain, particularly in individual counties.

4. Oregon's implementation experience continues to be relatively smooth, but challenges remain.

The expansion of the OHP required the Office of Medical Assistance Programs (OMAP), which operates the OHP, to work closely with a number of new agencies and providers with traditionally different operating philosophies. Despite these challenges, the transition appears to have been relatively smooth; OMAP credits its use of a cross-agency task force and the active involvement of advocacy groups in implementation planning.

A key future challenge is maintaining performance, particularly when resources for staffing and information systems are limited. While OMAP leadership continues to consist of experienced career staff members, many have left to join health plans or to help other states implement managed care programs. Oregon's ability to develop encounter data and other information infrastructure is limited by competing operational demands, including the need to divert scarce resources to address the year 2000 conversion of its systems. Maintaining good collaboration and communication among diverse stakeholders also appears to be more challenging in the operational stage than in the implementation period, because the focus shifts to competing issues or demands.

5. While eligibility remains open to those below the poverty level, Oregon struggles to achieve its broader coverage objectives.

The OHP remains open to all those with incomes below the poverty level (as well as pregnant women and children with family incomes below 133 percent of the poverty level), though Oregon has tightened its eligibility determination rules and imposed a premium-sharing requirement (on a sliding-scale basis). However, total enrollment in the program has stagnated, with a decline since 1994 both in the number of new eligibles and in the traditional Medicaid eligibles who were enrolled in the Phase I implementation period.

Many suspect that the decline reflects both the enactment of Temporary Assistance to Needy Families (TANF), the new federal welfare program, and the imposition of premium payments. The latter is viewed as contributing to "churning," since enrollees

who miss six months of premium payments are disenrolled and must pay accumulated premiums before they can reenroll. This feature is likely to encourage individuals to seek care only when they are sick.

Both fiscal constraints and an increasingly conservative political climate in the state have limited Oregon's ability to meet its broader coverage objectives. An employer mandate requiring businesses to either offer coverage or contribute to a state pool was a key feature of the original plan. However, the mandate expired when the 1996 deadline for receiving federal exemption from the Employee Retirement Income Security Act (ERISA) was not met. To support alternative coverage measures and put the OHP on a more secure fiscal footing, a new tobacco tax was enacted in November 1997.

The state is developing a Family Health Insurance Assistance Program (FHIAP) to provide progressive, direct subsidies to Oregonians with incomes below 170 percent of the poverty level who are ineligible for Medicaid. Revenue from the new tobacco tax will be used to underwrite FHIAP and the planned expansion of the OHP under the federal Children's Health Insurance Program (CHIP) to all children under age 19 in families with incomes up to 170 percent of the poverty level. These efforts will also include additional outreach to those already eligible but not enrolled in the OHP. But expanded eligibility under CHIP is limited to children in families without insurance, and some of the funding being made available by the tobacco tax is being used to underwrite existing costs of the OHP rather than to expand coverage.

6. While the priority list has undergone some revision, benefits remain more comprehensive than before the OHP, and the priority list itself has not been a major tool for fine-tuning program expenditures.

The priority list used to specify benefits under the OHP has been modified to accommodate the integration of special populations (aged, blind, and disabled individuals), to remedy some shortcomings in behavioral health coverage, and to address some specific problems as they have arisen. The line between covered and uncovered services has been moved somewhat to help manage expenses against budget constraints, but such benefit cuts have been limited by the need to secure federal approval and by the perceived reluctance of the state legislature to cut benefits directly. Some find this limited use of the priority list to solve budget issues encouraging given fears that the list would be used to make major cuts in the program. Others find it disappointing that the list and the ability to move the benefit line has not been viewed as more of a fiscal management tool. Some view the ability to move the line as a key

feature of the original program and one that was important in selling the program to policymakers and the public.

7. Plan participation remains high, but there has been some erosion.

The 14 health plans that now participate in the OHP vary by ownership and delivery model. Four small plans — QualMed, Pacificare, PACC, and Coordinated Health Care Network — did not renew their contracts with the state in 1995, citing small enrollment and changes in corporate strategy. Their withdrawal did not have much of an operational effect on the OHP, but because of their largely shared characteristics (for-profit, publicly traded plans without a strong community base) their departure was considered significant. Remaining plans say they are committed to the program and appear to regard capitation payments as adequate. This could change if capitation rates tighten and fiscal pressure on plans increases.

Risk adjustment remains an important issue for a number of plans and providers that feel they have been adversely affected. These include CareOregon, jointly sponsored by the Multnomah County and Oregon Health Sciences Center, which serves 2.5 times as many HIV-infected clients as any other plan. The OHP has been exploring risk adjustment models and intended to implement one in mid-1998.

8. The OHP has led to a growing penetration of managed care in rural Oregon.

All but two Oregon counties are served by at least one FCHP. Eighty percent of the OHP eligibles outside of the Portland metropolitan region (defined as Clackamas, Columbia, Multnomah, Washington, and Yamhill counties) are enrolled in an FCHP. In response to the OHP and the growing penetration of managed care in rural Oregon, many providers have organized into physician networks or independent provider associations. Some now contract directly with the state rather than subcontract to a private managed care organization (MCO), a phenomenon the OHP refers to as “regionalization.”

9. Stakeholders agree that the OHP has improved access, largely because it has expanded coverage.

Before the OHP, lack of insurance and provider shortages were perceived as the major barriers to care. After four years of the OHP, the consensus is that overall access to care in the state has improved, largely because more people are covered. (At year-end 1997, there were 93,867 expansion eligibles enrolled in the OHP.)

Physician shortages remain an issue in Oregon, though the OHP has increased the number of physicians participating in Medicaid. The most serious provider participation problem appears to involve dentists. Originally, the capitation rate was underestimated and there was a high rate of need for dental services in the OHP population. Subsequently, the OHP has increased payments to dentists and carved out dental care exclusively to separate dental care organizations (DCOs). Improvement in access to dental care is viewed as a major achievement of the OHP.

In general, most stakeholders do not appear to perceive that the priority list or the movement of special Medicaid populations (aged, blind, and disabled individuals) into managed care has hurt access. They support the measures taken to safeguard the special populations (e.g., the ENCC and ombudsman). However, concerns remain about such issues as the timely resolution of disputes and best use of the ENCCs and ombudsman.

10. Oregon's safety net is stressed.

Virtually all safety net providers participate in the OHP, which by design had few specific provisions to protect them (except during the Phase II behavioral health expansion). This was deliberate state policy to offer all participating providers a level playing field. The safety net has been stressed both by the introduction of managed care as part of the OHP and by separately enacted limitations in state property taxes.

Concrete data on how safety net providers are faring is very limited. The safety net providers in Clackamas and Multnomah counties report that their overall patient volume has decreased but that the proportion of uninsured patients remains roughly the same, despite expanded coverage. In addition, safety net providers previously receiving cost-based reimbursement as federally qualified health centers (FQHCs) (which are now being phased out under the Balanced Budget Act of 1997) have had their revenue reduced because such financing is excluded under the Oregon waiver. Safety net providers also express concern over inequities associated with adverse selection, some of which has been documented and is now being addressed.

In response to some threats of clinic closings, the 1997 legislature approved $3.1 million in transitional funding for safety net providers. In April 1998, the state announced that this funding would be distributed to 18 community health care providers.

CONCLUSIONS

Oregon provides, for the most part, an encouraging experience at a time when many states are moving to introduce managed care more broadly into their Medicaid and other programs for low-income populations. Almost all Oregonians in the OHP are now in managed care models, including many who are eligible for both Medicare and Medicaid. Staggered program implementation and the involvement of all interested parties in the planning stages contributed to community buy-in and a generally smooth transition. Oregon also benefited from being a small state (only 3.2 million residents) with a well-respected governor to lead the development of the initiative, from having a substantial history of experience with managed care as a delivery model, and from having a consensus-style approach to program planning. These conditions do not exist in many other states.

As experience with the OHP continues, it will be important to monitor the program's ability to maintain eligibility and coverage in the face of fiscal constraints. While the enactment of the tobacco tax provides some relief, securing adequate resources to support coverage and protect the safety net remains a challenge for Oregon. The other major challenge appears to be maintaining the administrative resources needed to fix known problems and anticipate future ones. These include:

- creating a sound information infrastructure to support better risk adjustment;
- developing techniques for dealing with care coordination issues associated with the dually diagnosed; and
- securing the continuing cooperation of all stakeholders to address care management issues, particularly for the chronically ill and those with special needs.

A. INTRODUCTION

The Oregon Health Plan (OHP) is a major state initiative for health care reform that has captured national attention. This multifaceted and ambitious effort has sought to achieve more universal coverage through both public and private insurance initiatives, simultaneously restructuring health benefits and health care delivery to enhance efficiency and stretch the available resources to expand coverage. Originally, the OHP had four components: overhauling the state's Medicaid program, mandating employer-provided health insurance, setting up a medical insurance pool for high-risk individuals, and creating an incentive for small businesses to offer health insurance. Enacted primarily in 1989 and 1991, the OHP now has three components operational, the largest of which is Medicaid (Table 1).[1] This paper reviews the experience of OHP after four years of operation**,** focusing on the Medicaid program as did the in-depth case study of the OHP's first year prepared by Mathematica Policy Research, Inc. (MPR) in 1995.

The Medicaid component of the OHP aims to expand coverage to all Oregonians below the poverty level with savings generated both by instituting managed care for almost all beneficiaries and by designing the benefit package to use a "priority list" to define conditions and covered treatment pairs. In making these changes, the state drew on the flexibility provided by Section 1115 waiver authority granted by the Social Security Act to the secretary of the Department of Health and Human Services.

The Medicaid component was implemented in two year-long phases. In 1994, Oregon focused on the Phase I population: those eligible for Medicaid/OHP mainly because of poverty and not necessarily "categorically limited." This subgroup consists primarily of children, pregnant women, and poor adults. Initially left out (partly at their request) were children in substitute care and the aged, blind, and disabled.[2] They were integrated into the OHP as the Phase II population in 1995. Also planned as part of Phase II was the expansion and integration of behavioral health services into the OHP.

[1]In addition to Medicaid, the two additional operational components are the Oregon Medical Insurance Pool, which was launched in 1990 and covers roughly 5,000 Oregonians otherwise unable to obtain health care coverage because of preexisting conditions, and a voluntary employer-sponsored health insurance program administered by the Insurance Pool Governing Board, which was established in 1987 and covers roughly 32,000 individuals (Table 1).

[2]Children in substitute care refers to children age 18 and younger who are in the legal custody of the state office for Services to Children and Families and have been placed outside the parental home.

Table 1

Oregon Health Plan (OHP)
Eligibles by Program[1]

Total OHP Eligibles	Approximate Number
Medicaid*	335,000
Oregon Medical Insurance Pool (OMIP)*	5,000[2]
Insurance Pool Governing Goard (IPGB)*	32,000[3]
Family Health Insurance Assistance Program (FHIAP)	20,000[4]
Children's Health Insurance Program (CHIP)	17,000[4]
Total Population (Oregon)	3,200,000

SOURCES: Family Health Insurance Assistance Program (FHIAP). FHIAP Summary, October 1997. Oregon Department of Human Resources, Office of Medical Assistance Programs.

Oregon Department of Human Services, Office of Medical Assistance Programs, Enrollment and Disenrollment Reports, 1997.

Oregon Medical Insurance Pool, Statistical and Financial Reports, 1997.

Statistical Abstract of the United States 1997.

*Operational at the time of the site visit.
[1]All figures are for December 1997 unless otherwise noted.
[2]Actual enrollment.
[3]This figure is for 1996.
[4]Expected eligibles (programs implemented July 1998).

Starting from a solid base of managed care experience in both the public and private sectors, the OHP was able to transition and expand enrollment in 1994 with relatively little disruption of the health care and administrative systems. A delay in implementation caused by a lengthy federal approval process helped ease the transition. The delay gave the Office of Medical Assistance Programs (OMAP) extra time to build capacity under the 1915(b) waiver, permitted needed planning to occur, allowed for more people already on Medicaid to shift into managed care, and intensified local support for the initiative.

All licensed health maintenance organizations (HMOs) in Oregon participated initially. Fully capitated plans were relied on more than originally anticipated, and nearly all enrollees self-designated their plan from among the choices offered to them. About 120,000 new enrollees were added to the previous Medicaid enrollment of approximately 250,000. The priority-list feature of the program, while controversial outside of Oregon, appeared to be widely accepted within the state because of the process used to develop it, the level of the cutoff for covered conditions and treatment, and the careful way it was implemented by the state and by health plans.

The 1994 case study suggested that the future would be the critical test for the OHP. Key concerns included how well the program and its eligibility expansion would be maintained given fiscal constraints and growing uncertainty about whether an employer mandate, a key piece of the original program design, would be implemented. In addition, Phase II would test Oregon's capacity for implementation, because it brought to the forefront a host of issues, including the integration into managed care of Medicare and Medicaid requirements, private and public health providers, and behavioral health, and the integration of Medicaid and direct service delivery programs to address populations with special needs.

This paper provides an overview and brief analysis of the changes in the OHP over its four-year history with a view toward that federal policymakers and other states can learn from the Oregon experience. This general overview is complemented by two separate papers that provide more detailed analyses of specific questions raised in year one. One paper explores Oregon's ability to realize its goal of universal coverage by affecting both public and private programs. Another examines Oregon's integration of special populations (the aged, blind, disabled, and the dually eligible subgroup) and behavioral health into managed care. Because of these separate, more detailed efforts, these important topics are referenced in this paper only to the extent that they highlight the general OHP experience.

This and other papers on the OHP are based largely on a week-long site visit to Oregon made in early December 1998 along with document review and Mathematica Policy Research, Inc.'s (MPR's) earlier work on the OHP (Gold, Chu, and Lyons 1995). The Oregon study is one of a number of state case studies MPR is conducting under contracts from the Henry J. Kaiser Family Foundation and The Commonwealth Fund. The others include California, Florida, Maryland, Minnesota, Tennessee, and Texas, each of which is restructuring its health care system for Medicaid and other uninsured populations. By focusing on how the movement to managed care is affecting low-income populations and their access to health care services, these analyses will be useful to other states and other efforts to shape the rapidly evolving development of managed care systems and health reforms for these populations.

B. OVERVIEW OF THE OHP STRUCTURE AND INITIATIVE

In the first part of this section, the basic design and structure of the OHP Medicaid component, which has remained mostly intact since 1994, is reviewed. Then the key changes in the structure of the program since 1994, including the eligibility expansions, expiration of the employer mandate, expansion and integration of behavioral health benefits, and changes in plan contracting, are highlighted. Finally, larger contextual changes, such as changes in welfare reform and the Children's Health Insurance Program (CHIP), that affect the OHP are explored. In the second section, the implications of these changes are addressed as the OHP experience over time is examined. Those already familiar with the OHP's structure and first-year experience may wish to skim or skip Section 1. Those desiring more detail should see the earlier paper.

1. Review of the OHP's Basic Structure

Phase I of the OHP was implemented in February 1994, following approval of the federal Section 1115 waiver in March 1993 after extensive review and negotiations lasting more than two years. Equity and access appeared to be the main motivating factors behind development of the OHP. In 1987, the highly publicized death of a child who potentially could have been saved by a transplant spurred a lengthy debate over who and what ought to be covered under Oregon's Medicaid program. Extensive formal and informal discussions essentially involved, at some level, all stakeholders in Oregon.

Before the OHP, Oregon had significant experience with managed care and the managed care base existing in its commercial and Medicaid markets. When the OHP's Medicaid component was implemented, HMOs enrolled one-third of Oregon's total state population. At the time of waiver submission, Oregon already had half of the Aid to Families with Dependent Children (AFDC) population enrolled in managed care, though many were in only partially capitated arrangements.

a. Eligibility and Enrollment

When originally implemented, the OHP eliminated Medicaid's categorical and asset restrictions on eligibility and extended the program to residents with incomes below 100 percent of the federal poverty level (FPL) (from a previous threshold level of 50 to 65%). The OHP covered all legal Oregon residents with incomes below the poverty level and any others who qualified under existing Medicaid policy (including pregnant women and children with family incomes below 133 percent of the FPL).

OHP used a contractor (HealthChoice) to handle most information dissemination and preliminary eligibility screening for Phase I. Information sessions were held throughout the state and a toll-free information line was provided. In 1994, eligibility was assessed on the basis of a single month's income. Eligibility was determined monthly for the traditional Medicaid population, and every six months for the expansion population.[3] Responsibility for eligibility determination varied by type of OHP eligibility. Those eligible for cash assistance were enrolled in person. All others, including those eligible for noncash-assistance-related Medicaid, applied by mail. Beneficiaries were supposed to choose a health plan at the time of enrollment and were provided with a comparison chart of the options. According to OHP officials, fewer than 10 percent of enrollees failed to make a voluntary selection of health plans and had to have one assigned.

Phase I enrollment went smoothly, though some issues remained outstanding. After the first year, long-term financial viability of the program was in question because of an unexpectedly high number of expansion enrollees relative to traditional Medicaid-eligible enrollees, which adversely affected the federal match for the OHP because of the way the federal waiver was structured. The second issue involved turnover in enrollment under the OHP. This turnover stemmed from the lack of an automatic

[3]Expansion eligibles are nonpregnant adults and children born before October 1, 1983, who are not otherwise categorically eligible and whose incomes are below 100 percent of the FPL.

process for those losing cash assistance under month-to-month rules to retain eligibility under the OHP and also because voluntary reapplication rates for the OHP were below expectations. Turnover may add to health plan expense and can limit the ability to manage care.

b. Benefit Package

The OHP benefit package is based on a ranked priority list of condition/treatment pairs. The list was developed through a legislatively established process led by the Oregon Health Services Commission using such criteria as ability to avert death and cost of care.[4] An open process and deliberate effort to insulate the process from political pressures resulted in a credible priority list that was not an issue within the state, though there was some national controversy.

Condition/treatment pairs located above an established threshold, often referred to as "above the line," are included in the benefit package; those "below the line" are not covered. Diagnosis is always covered, and when a condition/treatment pair is covered, all medically appropriate ancillary services are covered.

In the first year, 565 of 696 treatment pairs were covered.[5] This basic benefit package included the following:

- preventative services to promote health and reduce risk of illness;
- comfort care or hospice treatment for terminal illnesses, regardless of the ranking of the conditions on the priority list;
- ancillary services ranging from prescription drugs to physical therapy if they are medically appropriate for a covered condition/treatment; and
- most transplants.

[4]Other ordering criteria include public health risk, medical effectiveness, prevention of future costs, and if it is a preventative service, family planning service, or maternity care (Health Services Commission 1997).

[5]Before implementation, the list was modified to meet federal concerns about the Americans with Disabilities Act.

This benefit package was considered more comprehensive overall than the previous Medicaid package. It also added new benefits for adult Medicaid beneficiaries, including dental care, transplant, and hospice services. In the first year, behavioral health benefits continued to be covered under traditional Medicaid.

The priority list was not a major issue for health plans or providers in the first year, although they had differences of opinion about its value. Provider support appeared to have been increased by the willingness of health plans to allow their associated physicians some flexibility regarding service below the cutoff line. Still, in the first year, it seemed that some types of below-the-line services were less likely to be provided, particularly if they were very expensive.

c. Plan Participation

In the first year, the state contracted with managed care organizations (MCOs) that were either fully capitated health plans (FCHPs) or partially capitated physician care organizations (PCOs) to provide the basic medical care benefit package, including dental care.[6] In addition, a primary care case management (PCCM) option was used either alone or as a complement to FCHPs and PCOs in parts of the state judged to have insufficient managed care capacity. Any organizations that met the plan standards in such areas as access, quality, and financial solvency were eligible to participate in the OHP as FCHPs or PCOs. Plans were responsible for establishing their own provider networks and were not required to contract with any particular providers (e.g., federally qualified health centers or FQHCs).

Twenty health plans were participating at year-end 1994, including 16 FCHPs, 4 PCOs, and 5 dental care organizations (DCOs). Participating health plans included all 8 commercial HMOs and 12 health plans that serve only OHP eligibles. In sum, about 70 percent of those eligible for the OHP were enrolled in FCHPs in late 1994, with five plans dominating the market. HMO Oregon, a Blue Cross Blue Shield plan, was the largest, with 37 percent of the total prepaid health plan (PHP) enrollment. The other large plans included Kaiser Permanente and Care Oregon, each of which had 9 percent of the total PHP enrollment.

[6] When the dental care benefit was included in the FCHP capitation, the FCHP either delivered dental care itself or subcontracted to a dental care organization (DCO). In some cases, however, the state did contract directly with some DCOs to deliver the dental care benefit.

Capitation payments were calculated for each of 13 eligibility categories using historical data for providing the services associated with condition/treatment pairs on the priority list. The rates accounted for managed care efficiencies and were developed for five geographical regions. Plans and providers generally considered the payment rates adequate in the first year. Payment rates were better than traditional Medicaid though still less than commercial rates. At the outset, payment rates were less controversial in Oregon than in some other states, perhaps because of the state's approach to the process, which involved all stakeholders in Oregon.

d. State Administration and Oversight

From the beginning, OMAP within the Department of Human Resources (DHR) was responsible for the implementation, administration, and oversight of the OHP. OMAP retained essentially all activities except for some enrollment activities (involving other DHR divisions and the contracted enrollment broker) and some quality assurance activities (charged to the external quality review organization or EQRO). To handle its responsibilities, OMAP reorganized its functions and hired staff with needed expertise. During the initial site visit, the team observed that OMAP staff members were clearly well respected. Their expertise, along with a tight administrative structure, contributed to well-coordinated administration and oversight efforts.

Implementation of Phase I of the OHP was smooth and relatively uneventful. The state's ability to mount a strong implementation and oversight effort was facilitated by several factors: the wealth of prior experience with managed care, the extensive planning that took place before the waiver was approved, the decision to defer integration of important and particularly vulnerable subgroups until the second phase, and an implementation approach considered a joint endeavor between public and private stakeholders and high-caliber state staff. In addition, Oregon had an extensive and well-developed managed care infrastructure with respected and experienced plans, all of which participated in the OHP. At the end of year one, some concern was expressed that the state staff would be recruited away, thereby jeopardizing effective administration of the program.

2. Summary of the Most Important Structural Changes 1994–1998

a. Expansion to Include Aged, Blind, Disabled, and Children in Substitute Care

As originally planned, roughly 68,000 persons who receive old-age assistance and aid to the blind and disabled and 10,500 children in substitute care were integrated as

part of Phase II (Table 2). At year-end 1997, roughly three-quarters of Phase II eligibles were enrolled in managed care: 67 percent of aged eligibles, 83 percent of aged blind/aged disabled eligibles, and 72 percent of children in substitute care were enrolled in FCHPs. Fifty-five percent were dual eligibles (individuals eligible for both Medicare and Medicaid).

Advocates were concerned about whether managed care and the use of the OHP priority list would be fully responsive to the needs of the Phase II population. To address these concerns, the following three enhancements were carried out as part of the Phase II implementation: (1) highlighting of an existing "comorbidity" rule, which extends coverage to care on the priority list but otherwise uncovered (i.e., as "below the line") when it affects care for "above the line" conditions, (2) adding a contract requirement that each managed care plan hire and train at least one exceptional needs care coordinator (ENCC) to navigate and coordinate care for the Phase II population, and (3) establishing the ombudsman's office (in OMAP) to advocate and problem solve for clients in conjunction with the ENCC. Already in place was a provision allowing any enrollee to receive an exemption from participating in managed care if special coordination of care was needed or if third-party funding other than Medicare was involved. All plans participating in Phase I of the OHP were required to participate in the Phase II rollout. (Special provisions applied for those dually eligible for Medicare and Medicaid, as discussed below.)

b. Expansion and Integration of Behavioral Health into Managed Care

Oregon planned to deliver chemical dependency and mental health benefits on a fee-for-service (FFS) basis in the first year and then expand and integrate these benefits into managed care as part of Phase II in the beginning of 1995. This expansion and movement of behavioral health into the OHP involved two additional agencies — Mental Health and Developmental Disability Services Division (MHDDSD) and Office of Alcohol and Drug Abuse Programs (OADAP) — in planning, implementation, and oversight.

Though both chemical dependency and mental health benefits were part of the OHP's Phase II, they were integrated in different ways. Chemical dependency benefits were incorporated as part of the "physical health benefit" delivered by the FCHPs beginning in January 1995. This decision reflected the philosophy of the leadership of Oregon's OADAP at that time, which strongly believed that chemical dependency services were an integral part of medical care and should be delivered through the medical model. What ultimately prevailed was OADAP's argument that the current

underutilization of chemical dependency benefits was actually costing the plans *more* money.

In contrast to this strategy of full integration, Oregon decided to offer an expanded mental health benefit model through a carve-out to mental health organizations (MHOs). To provide adequate transition time, the time frame for this change was longer than it was for chemical dependency. Mental health was folded into managed care in 1995 with a demonstration in 20 counties covering 25 percent of OHP eligibles. Beneficiaries in the demonstration were eligible for expanded mental health benefits. Previously, Medicaid mental health coverage for adults was limited to services for those who posed a threat to themselves or others. Eligibles not in the demonstration counties continued to receive limited mental health coverage under traditional FFS Medicaid.

After a state-sponsored demonstration evaluation showed that MHOs could provide improved access at lower costs, the legislature authorized a statewide expansion of mental health benefits. In July 1997, all OHP eligibles were covered for extended mental health benefits, and MHOs were expected to be in every county by the end of 1997.

Table 2

OHP Enrollment Over Time

Year[1]	Total State Population (millions)	Total Eligibles	Total Phase I Eligibles	*Phase I Eligibles* Current Eligibles[2]	Percent of Total	Expansion Eligibles[3]	Percent of Total	Phase II Eligibles	Percent of Total
1994	3.09	287,830	287,830	188,368	65	99,462	35	0	0
1995	3.15	364,060	289,995	176,680	49	113,315	31	74,065	20
1996	3.20	346,876	269,647	170,454	49	99,193	29	77,229	22
1997	—	335,504	256,342	162,475	48	93,867	28	79,163	24

SOURCES: Oregon Department of Human Resources, Office of Medical Assistance Programs, *Enrollment and Disenrollment Reports*, and *Statistical Abstract of the United States 1997.*

[1]All figures represent enrollment in December of the year indicated.
[2]Current eligibles are traditional Medicaid recipients.
[3]Expansion eligibles are beneficiaries who are newly eligible as a result of OHP expansions.

c. Eligibility Changes, Expansion, and Financial Requirements for Poverty

Because of difficulties with financial viability in the first year (as well as in response to negative press about potential instances of enrollment of individuals with high incomes who met the one-month test), the 1995 state legislature enacted some measures to reduce expenditures. Eligibility was tightened to discontinue coverage of full-time college students (reinstated by the legislature in 1997 for students eligible for Pell grants), to require a three-month income average (rather than one month's income) for eligibility determination, and to implement a $5,000 asset test. The same legislature reduced capitation rates and directed OMAP to begin assessing monthly premiums to the OHP expansion population (a sliding scale ranging from $6 to $28 per month).[7]

A new tobacco tax, enacted in November 1997 by a 55 to 45 margin, put the OHP on more secure financial footing for the immediate future. It authorized an additional $.30 per pack tax on cigarettes and 30 percent tax on other tobacco products. How to allocate the anticipated $150 million in revenue that would be accumulated over the two-year period covered by Oregon's budgeting system was a key issue of debate between the legislature and the governor. Ultimately, the compromise reached was that roughly 45 percent of funds would go to expand eligibility and 55 percent to maintain the current program.

At the time of the team's visit, the state was preparing to further expand eligibility through financing provided by the tobacco tax increase and through federal funds made available under CHIP.[8] As planned before CHIP was enacted, part of the tobacco tax funding will be used for the development of the Family Health Insurance Assistance Program (FHIAP). FHIAP will provide progressive, direct subsidies to people with incomes of up to 170 percent of the FPL who do not earn enough to buy insurance from their employer or the individual market and are not eligible for Medicaid.[9] FHIAP is expected to cover 10,000 to 20,000 additional Oregonians and is slated to begin in July 1998 (Table 1). The tax money is also being used to reinstate coverage for the approximately 1,800 Pell grant–eligible college students who were removed from OHP eligibility in 1995.

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[7]Little hard evidence now exists of the effects of this change, but a study is under way.

[8]CHIP was enacted as part of the federal Balanced Budget Act of 1997 to expand insurance coverage to uninsured low-income children.

[9]FHIAP will provide coverage though the OHP for both adults and their dependent children, although OHP children who qualify under Medicaid or the expansion criteria will be encouraged to participate through that program.

d. Expiration of Employer Mandate

An employer mandate requiring that businesses offer insurance to roughly 165,000 employees themselves or pay for coverage through a state pool, a major piece of the OHP design, was never implemented. The mandate was repealed after the 1996 expiration of a deadline set by the 1993 state legislature for obtaining federal exemption from the Employee Retirement Income Security Act (ERISA). The employer mandate was the key private-sector reform aimed at achieving universal coverage. Its demise forced Oregon to reexamine how it can achieve its original broad coverage goals.

The effort to enact a tobacco tax (discussed above) was undertaken to continue progress on the broad coverage objective. With the demise of the employer mandate provision, the OHP shifted its emphasis toward a public insurance model, although private insurance components remain important (as witnessed by FHIAP). The key unresolved issue appears to be whether expansion through the OHP and voluntary private insurance reforms and subsidies will be sufficient to provide access to insurance for all Oregonians and how far the state is from its original goal of universal coverage. The state does not yet know exactly how many more people will be covered through planned OHP expansions such as FHIAP and CHIP.

3. Concurrent Contextual Changes

Evolving federal and state health policy has created both opportunities and quandaries for the OHP. Temporary Assistance for Needy Families (TANF), a result of the 1996 welfare law, eliminated the automatic link between income assistance for families and Medicaid coverage. In addition, the Balanced Budget Act of 1997 created CHIP under Title XXI of the Social Security Act. This new title provides block-grant funding to states to initiate and expand health insurance coverage for uninsured low-income children. Their influences on the OHP are reviewed below.

a. Approach to TANF and Implications

Persons eligible for TANF will continue to meet OHP eligibility requirements, and individuals losing cash assistance are still eligible for the OHP for one year.[10] The main issue stemming from the transition to TANF and the Oregon Option — Oregon's welfare reform program initiated one month before the enactment of TANF — is whether these individuals are being enrolled in the OHP programs for which they are eligible. Even though the state cites an automatic process that enrolls persons getting off TANF into the OHP, some community members felt that "cracks in the system" resulted in eligible

[10]After six months, persons who left welfare to work must meet some income standards to remain eligible for the OHP.

persons being unaware that they qualify for coverage and not being enrolled automatically. Although welfare rolls and the number of traditional Medicaid eligibles continue to drop, there are essentially no data supporting or refuting the claim that eligibles are being lost when they transition from TANF.

b. Approach to Children's Health Insurance and Implications

As a result of CHIP, Oregon plans to extend coverage to an additional 18,000 children and enroll more of those already eligible but unenrolled through enhanced outreach. Oregon will cover children under age 19 in families with incomes less than 170 percent FPL using the current OHP delivery system and benefit structure (Table 3). At the time of the site visit, Oregon was still working to finalize and submit its recommendations for CHIP. The state has since received approval for this plan from the Health Care Financing Administration (HCFA) (June 12, 1998).

The state anticipates that the active outreach accompanying CHIP will increase enrollment by approximately 8,000 persons under 100 percent of the FPL who are eligible but not enrolled. Oregon plans to reserve some tobacco tax funds to finance this increase in enrollment. What will happen to these funds should this target not be reached is not clear.

A key issue regarding Oregon's approach to CHIP involves the state's use of funds available from the new tobacco tax enacted in the 1997 legislative session to help finance the OHP. When Congress passed the 1997 Balanced Budget Act, the Oregon state legislature had adjourned its biennial session and was not scheduled to return until 1999. As a result, no money was allocated for CHIP, which requires a state match of federal funds, and the state did not intend to request additional funds by calling a special legislative session.

However, the state had access to funds for CHIP from the new tobacco tax that was designated for two OHP expansions: (1) creation and operation of FHIAP and (2) an eligibility expansion to include all children under age 12 up to 170 percent of the FPL.[11] Oregon decided to use the tobacco funds originally allotted for the expansion to children under age 12 as matching funds for CHIP because the federal government will pay approximately 72 percent of CHIP (Title XXI) costs compared with the federal share of approximately 60 percent for Medicaid (Title XIX). Still, Oregon will not receive the maximum amount of federal dollars because of a lack of adequate matching funds. To maximize match and coverage possibilities, the state continues to explore possibilities

[11] Fifty-five percent of tobacco tax revenue was dedicated to OHP maintenance measures.

for using CHIP funds through the FHIAP program because most children eligible for the FHIAP program will also be eligible for the CHIP program. Thus, while CHIP expands eligibility and financing for the OHP, its potential effect is muted because the state had already planned expansion to most of the same population. In fact, the state estimates that the total number of children covered under CHIP will be less than estimated under the originally planned tobacco tax expansion to children under age 12 up to 170 percent of the FPL because CHIP money can be used only for uninsured children, whereas funds available under Medicaid (Title XIX) can be used for both insured and uninsured children. Thus, CHIP resulted in a shift in emphasis in the OHP from an exclusively income-based eligibility screen to one that also considers prior insurance coverage.

c. Changes in Political Environment

The Oregon legislature has become considerably more conservative over time, and little support now exists for expanded eligibility and financing for the OHP. Because the program is not budget neutral, as in some other states, money from outside the program must be incorporated to maintain its stability. Since the beginning of the OHP, OMAP has gone before the emergency board almost every year to ask for additional money to cover budget gaps.

Table 3

OHP/CHIP Eligibility for Children Under Age 19

		Under 1 Year Mother Not on Medicaid	*Under 1 Year Mother on Medicaid*[1]	*1–5 Years*	*6–18 Years*
Under 100% of FPL	With Insurance	OHP	OHP	OHP	OHP
	Without Insurance	OHP	OHP	OHP	OHP
100%–133% of FPL	With Insurance	OHP	OHP	OHP	Not eligible
	Without Insurance	OHP	OHP	OHP	CHIP[2]
133%–170% of FPL	With Insurance	Not eligible	OHP	Not eligible	Not eligible
	Without Insurance	CHIP	OHP	CHIP	CHIP

SOURCE: OMAP www.omap.hr.state.or.us/library/Chiptable.jpg

[1]OHP PLM coverage for pregnant women from 133 percent FPL to 170 percent FPL and the children born to them on OHP (until age 1) is targeted to begin March 1, 1998.
[2]The CHIP Program is targeted to begin July 1, 1998.

Originally, Oregon intended to use the priority list to account for all budget shortfalls by reducing benefits (rather than reducing the number of persons eligible). Some conservative members, the team was told, feel that the OHP is not sustainable economically and that the priority list is not the tool for managing state financial exposure that Governor Kitzhaber claimed when arguing for its enactment. The team also perceived greater emphasis in 1997 on ideological debate concerning the role of government in delivering services such as health care. It is unclear whether resources to sustain the OHP were ever seriously threatened, but this concern was obviated by the passage of the tobacco tax in November 1996. A key factor favoring support is the fact that the OHP now serves a broad cross-section of Oregonians (approximately 500,000 Oregonians have been enrolled in OHP at some point), many of whom reside in districts served by conservative representatives who are traditionally the most vocal in their opposition to the OHP.

C. PROGRAM EXPERIENCE IN KEY OPERATIONAL AREAS

This section reviews the experience of the OHP over the past four years. Trends in overall enrollment, benefits, eligibility processes, MCO participation, rate-setting, provider participation, and state oversight and administration of OHP are broadly examined. Included is an overview of the implementation of the two major changes in Phase II because an understanding of these changes is essential to understanding the broader OHP experience. A more complete description and analysis of the Phase II expansion are included in a separate report.

1. Trends in Enrollment Levels Over Time

For the most part, the expansion in Medicaid eligibility under the OHP occurred in 1994 and, to a lesser extent, in 1995 (Table 2). Since then (but without taking into account the current CHIP expansion), the number of new eligibles has actually declined, as has the number of traditional eligibles brought into the plan under Phase I. Although more individuals are now enrolled in managed care under the OHP than after the first year of the program, this growth reflects the expansion of managed care under Phase II. This expansion added about 75,000 to 80,000 individuals to managed care, contributing to roughly an 18 percent growth in OHP enrollment since 1994 (through 1997).

Two reasons seem most likely to explain the stagnation in OHP enrollment under the program. First, as previously noted, plans, providers, and advocates suspect that a decline in enrollment of the former AFDC population and overall churning of the OHP population continues to be an issue, though little data exist to assess these concerns. One year after the enactment of TANF, the state realized a 28 percent drop in its

welfare caseload. The traditional Medicaid population fell roughly 5 percent and the expansion population dropped roughly 4 percent in the same period. The decline in these two eligibility categories continues. Still, the overall number of uninsured in Oregon has not increased (OHPPR April 1997).

As previously discussed, plans, providers, and advocates sense that people are being lost in the transition to TANF — that is, persons formerly receiving AFDC benefits who are eligible for the OHP remain unenrolled. State officials, however, do not report this as a problem, noting that individuals disenrolling from TANF are still eligible for the OHP for one year. From the data the team has, it is not possible to know whether Oregon is experiencing a decline in enrollment as a result of "cracks" in the system.

The second possible reason for the stagnation in enrollment relates to the imposition of premium contribution requirements in 1995. Under the terms of this policy, individuals who miss premium contributions are disenrolled after six months; before they can reenroll, they must repay the accumulated premiums (up to 36 months). Some speculate that this policy is an important factor contributing to enrollment turnover or "churning" because it encourages individuals to seek care (and thus incur payment obligations) only when they are in serious need of it. Plans are concerned that eligibles are paying premiums only when care is urgently needed. This adds to plans' expense, as the cost of care needed at that time is not covered by the capitation payment because of the limited number of months the eligible is enrolled. This pattern does not allow the health plan to spread the enrollees' "risk" out over time. It also limits the ability to manage care and provide preventive services. At the time of the team's visit, no data were available to establish the scope of this problem, but the state's Office of Health Plan Policy and Research (OHPPR) was planning to study the relationship between enrollment drop-off and the imposition of premiums.

2. Trends in Benefit Design

The OHP's priority list and associated list of covered services have not undergone major changes since the inception of the program, but the lists have been modified both to accommodate the implementation of Phase II and to address some specific problems as they have arisen. In addition, the line between covered and uncovered services has been moved somewhat to help manage expenses against budget constraints. However, both federal and internal state constraints limit the extent to which this can be done. On the whole, the Medicaid benefit package remains more comprehensive than it was before the OHP was implemented.

In response to budget pressures, some benefits were cut by a series of line movements reducing the number of condition/treatment pairs covered. As of February 1, 1997, the benefit package included 578 of 745 condition/treatment pairs on the priority list and all diagnostic procedures. However, the use of the list as a mechanism to remedy budget shortfalls has been limited by HCFA, and federal approval for further line movement to reduce coverage is expected to be difficult to obtain.

Expanded mental health benefits were initiated for 25 percent of the OHP population in 1995 and for the entire OHP population in 1997. The new benefits covered mild and medium mental health needs in addition to care for the severely and persistently mentally ill (SPMI). In effect, this change resulted in expanded mental health benefits primarily for adults, because children were eligible for full mental health benefits as part of early and periodic screening, diagnosis, and treatment coverage.

In response to concerns about how the priority process would affect the ability of the Phase II populations to receive services and keep needed benefits, the benefit package was reviewed by stakeholders to ensure that conditions (such as comfort care) disproportionately affecting the aged and disabled population were included on the priority list. This effort helped ease advocate concerns.

To further address concerns about the adequacy of the benefit package for the aged and disabled, the existing “comorbidity” rule was highlighted. This rule extends coverage to care falling “below the line” if such care affects the success of treatment being delivered for covered conditions. An example of such care is fungal infections for people with diabetes. Although fungal infections are located below the line, treatment of this condition is often required in appropriate care for diabetes, which is above the line.[12] Because plans are still relatively flexible in providing below-the-line care, application of this rule has not been a big issue. Nonetheless, advocates feel this rule is important because it allows for another avenue of redress in cases where beneficiaries feel they are being denied needed care.

[12]The May 1998 revision to the priority list identified foot care as a covered service for people with specific diagnoses, such as diabetes, where a person is likely to have compromised circulation.

3. Eligibility Processes and Phase II Expansion

a. Implementation Experience: The Aged, Blind, Disabled, and Children in Substitute Care

Although the Phase II population could have the most to gain from Medicaid managed care through greater care coordination, efforts to extend managed care to the subgroups that made up the Phase II population were more complicated because of the special needs of these individuals and because the state and plans had less experience using managed care in this context. The involvement of a number of new agencies and providers with traditionally different operating philosophies also made the Phase II implementation more complicated.

Despite these challenges, transitioning the Phase II population into managed care seemed to go relatively smoothly overall, though specific data or evidence about this process are very scarce. The use of one-to-one choice counseling and a continuity-of-care form (identifying current care needs to prevent a gap in care) apparently prevented any horrible scenarios and placed beneficiaries in appropriate plans. OHP credits the success of the Phase II transition in large part to the efforts of a cross-agency task force, which included representatives from OMAP, other agencies, and various advocacy organizations who met and developed criteria on specific aspects of the Phase II transition. Since implementation of Phase II, plans and advocacy groups note that their participation and input are still sought, such as in developing contract standards and rules, but they feel less like partners in the decision-making process. Operation of the specific measures put in place to address Phase II needs has proven more difficult, with inconsistency in resolution of beneficiary issues across agencies and high variability in the scope of the ENCC role.

Because of the special needs of the Phase II population, the OHP provided the option to exempt individuals under certain circumstances. Criteria included third-party funding (other than Medicare), care coordination issues, and other special needs. Exemptions also are granted for individuals who have commercial coverage in addition to OHP coverage. Some were concerned that a significant number of individuals would be granted exemptions from PHP enrollment (receive benefits from PCCM or under FFS).

The state has been fairly satisfied with its ability to enroll the Phase II population into managed care. Senior and Disabled Services Division (SDSD) records show that exemptions for its aged, blind, and disabled clientele have grown from roughly 4 percent in May 1996 to 10 percent in September 1997. Most exemptions are granted because of third-party coverage (e.g., enrollment in a private Medicare HMO).

b. Implementation Experience: Behavioral Health

The decision about how to implement the managed care provisions for mental health benefits in Phase II was highly politicized, involving local government politics and county government issues of authority and revenue. Counties were concerned that integrating behavioral health services into the general managed care contract would destabilize the county mental health safety net delivery system. There also was a more general concern about the ability of FCHPs to deliver quality mental health care to a SPMI population under managed care, and likewise, about the counties' ability to deliver mental health care to those with mild to medium mental illnesses under managed care.

In response to these concerns, a number of measures were implemented to help protect the safety net and ensure an adequate delivery system for the range of services. Separate contracts were awarded to MCOs for mental health services. Although existing MCOs would be allowed to compete, all bidders were required to complete a planning process with the local mental health associations in their service areas to ensure the maintenance of viable community mental health programs. This concern was also considered in making decisions on contract awards (as discussed further in a companion paper). The mental health agency, MHDDSD, also tried to educate all mental health providers about managed care and help them plan for the expected range of services.

Despite the demonstration phase, delays, and requirements for planning, statewide implementation has been rocky. In fact, at the time of the site visit, three counties were suing the state in an effort to stop the OHP's movement of mental health into managed care because they feel so strongly that the program undermines their county's mental health system and their authority to operate it. Nevertheless, Oregon is continuing to implement mental health managed care statewide, building on the initial demonstration in 25 counties.

The decision to allocate responsibility for chemical dependency and mental health to FCHPs and MHOs, respectively, has proved problematic in some respects from an operational perspective because these needs and their associated services are not distinct. Care coordination is inherently more complicated when it involves two organizations with potential responsibility to manage overlapping care. The Phase II structure includes features that aim to minimize the potentially adverse effects associated with this bifurcation. For example, antipsychotic and antidepression medications are covered on a FFS basis so that a primary care physician in a FCHP can manage a patient's mild mental illness without having to receive permission for

payment from an MHO. In addition, costs associated with these medications are not included in the FCHP capitation rate but rather are paid on a FFS basis to address the issue of coordinating payment between FCHPs and MHOs. These and other issues (such as coverage of laboratory tests used jointly for somatic and mental health care) are discussed in the separate paper described in the introduction.

c. Experience with the Administrative Side of Enrollment

The administrative process for eligibility determination remained essentially the same after the first year, although fewer resources appeared to be devoted to active outreach and more agencies became involved because of the Phase II population. Adult and Family Services (AFS), SDSD, Area Agencies on Aging, and Services to Children and Families determine eligibility for the state.[13]

The state no longer employs an enrollment broker to educate and enroll beneficiaries. Instead, the state agencies listed above provide enrollment education and (with the exception of AFS) one-to-one choice counseling for their expansion population clients. State prison labor assists with enrollment processing by answering phones. Individuals can enroll in person at the agencies listed above or mail in an application. At the time of enrollment, OHP eligibles choose a DCO for dental care, an FCHP for physical health care (including chemical dependency services), and an MHO for mental health care.

Enrollment in OHP plans for the Phase II eligibles differs for those covered only under OHP from those who are dually eligible (eligible for both Medicaid and Medicare) to account for the federal protections afforded the latter group. In contrast to the standard set of plan options available for all other OHP members, dual eligibles have three alternatives. First, dual eligibles have the option of choosing a PHP in the OHP that also is a Medicare HMO. Four of the six plans fall into this group: Providence Good Health Plan, HMO Oregon, Kaiser Permanente, and SelectCare.[14] When dual eligibles elect this option, they are automatically enrolled in that plan for both Medicaid and Medicare services. These plans can then effectively coordinate care between Medicaid and Medicare, reducing service fragmentation and eliminating the incentive to shift costs.

[13]The area agencies on aging (AAs) contract with Senior and Disabled Services Division (SDSD) to administer Medicaid in some counties. Thus, the term SDSD/AAA is used to refer to this single system of branch offices.

[14]SelectCare recently became part of the Providence System.

Second, dual eligibles can elect enrollment in prepaid plans under the OHP that are not Medicare HMOs. In this situation, Medicare services continue to be paid on an FFS basis. Third, two Medicare HMOs (Pacific Care and QualMed) are not also prepaid plans under OHP. Dual eligibles in these plans can continue to receive their Medicaid services in a FFS arrangement. Thus, a dual eligible will never be enrolled in two different prepaid plans. Dual eligibles also elect a DCO and MHO at the time of enrollment to cover benefits that are provided under the OHP but otherwise not through Medicare.

4. Trends in Managed Care Organization Participation

Except for the elimination of the PCO option, the OHP has basically maintained its original contracting structure: All plans meeting the standards specified in the request for application (RFA) are eligible to apply and participate in the OHP. The OHP has issued RFAs for selected areas (e.g., rural counties) based on need, but no new statewide RFA has been issued since 1996. However, contract requirements were modified to accommodate the needs of Phase II, including the addition of the ENCC in each plan and referrals of at least 50 percent of chemical dependency services to essential community providers.

Currently, the state holds contracts with three types of MCOs, all of which are fully capitated for a specified set of benefits: FCHPs, DCOs, and MHOs. Dental care was carved out exclusively to DCOs in 1996 to encourage dental provider participation and ease administrative complexities. Mental health was carved out to MHOs as a result of a highly politicized decision-making process for the planned expansion and integration of behavioral health into the OHP. One of the main issues was the ability of the program to preserve access to the traditional county-based system.

At the end of the first year (1994), 20 health plans were participating in the OHP, including 16 FCHPs and 4 PCOs.[15] At the end of 1997, 15 FCHPs were participating (see Table 4). Eighty-seven percent of eligibles are enrolled in FCHPs and 34 of 36 counties are covered by at least one FCHP. PCOs were phased out consistent with the state's goal for plans to assume full risk as the market matured. Some PCOs converted to FCHPs and others were subsumed by existing FCHPs. PCCM is still used in counties without an FCHP, for eligibles with third-party insurance and for eligibles with care

[15]In addition, five DCOs were participating.

coordination issues and special needs. To qualify for PCCM, an eligible must be granted an exemption (based on the criteria stated above). This administrative mechanism, as well as reimbursement incentives favoring PHPs, discourages use of the PCCM option.

Health plans participating in the OHP vary in ownership and employ diverse delivery models. However, there has been some erosion in plan participation. QualMed, Pacificare, PACC, and Coordinated Health Care Network did not renew their contracts with the state in 1995, citing low enrollment and changes in corporate strategy. These four plans were small — Pacificare was the largest, ranking ninth in the OHP in July 1996 with 10,035 enrollees — and their loss did not seem to generate much concern within OMAP. The reaction likely will be different if capitation rates become tighter and growing fiscal pressure on plans causes participation to decline.

The most serious implication of the plan participation erosion to date appears to be the fact that those withdrawing tended to be for-profit, publicly traded plans, often without a strong community base. Other plans interviewed noted that they were likely to remain committed to the program, but wondered about the equity of an arrangement in which responsibilities were not shared evenly across plans in the state. Although this study did not involve an analysis of the financial status of health plans, it appears that plans continue to regard premiums as adequate.

Table 4

Trends in Managed Care Enrollment for Fully Capitated Health Plans (FCHPs) by Health Plan

	January 1995		*January 1996*		*January 1997*		*December 1997*	
	Number of Enrollees	OHP Market Share (%)	Number of Enrollees	OHP Market Share (%)	Number of Enrollees	OHP Market Share (%)	Number of Enrollees	OHP Market Share (%)
Total OHP Eligibles	295,582		364,688		349,525		335,504	
Total FCHP Enrollees	228,488	100.0	293,345	100.0	293,525	100.0	271,683	100.0
CareOregon	19,693	8.6	23,879	8.1	27,430	9.3	24,922	9.2
Cascade Comprehensive Care	4,893	2.1	5,376	1.8	5,396	1.8	5,815	2.2
Central Oregon IHS	0	0.0	1,420	0.5	13,889	4.7	17,858	6.6
Columbia Managed Care	759	0.3	0	0.0	0	0.0	0	0.0
Coordinated HealthCare Network	1,123	0.5	1,505	0.5	0	0.0	0	0.0
Evergreen Medical Systems	2,032	0.9	1,770	0.6	1,796	0.6	1,100	0.4
Family Care	9,302	4.1	10,292	3.5	11,093	3.8	10,997	4.0
Intercommunity Health Network	3,380	1.5	6,274	2.1	11,135	3.8	9,722	3.6
Kaiser Permanente	19,579	8.6	18,805	6.4	20,303	6.9	19,586	7.2
Medford Clinic[1]	4,205	1.8	5,132	1.7	0	0.0	0	0.0
Mid-Rogue IPA	0	0.0	3,796	1.3	4,115	1.4	4,323	1.6

	January 1995		*January 1996*		*January 1997*		*December 1997*	
	Number of Enrollees	OHP Market Share (%)	Number of Enrollees	OHP Market Share (%)	Number of Enrollees	OHP Market Share (%)	Number of Enrollees	OHP Market Share (%)
ODS Health Plan	15,378	6.7	25,360	8.6	35,504	12.1	32,464	11.9
Oregon Health Management Services	3,990	1.7	3,734	1.3	9,202	3.1	9,542	3.5
PACC Health Plan	5,316	2.3	4,068	1.4	0	0.0	0	0.0
PacifiCare	10,039	4.4	11,529	3.9	0	0.0	0	0.0
PrimeCare	5,432	2.4	0	0.0	0	0.0	0	0.0
Providence Good Health Plan	9,647	4.2	17,842	6.1	22,534	7.7	23,078	8.5
QualMed	3,175	1.4	1,775	0.6	0	0.0	0	0.0
Regence HMO (HMO Oregon)[2]	85,847	37.6	121,526	41.4	105,377	35.9	84,884	31.2
RHEI Health Plan (SureCare)	10,467	4.6	12,067	4.1	11,343	3.9	15,017	5.5
Select Care[3]	12,817	5.6	14,977	5.1	12,310	4.2	10,667	3.9
Tuality Health Care	1,468	0.6	2,218	0.8	2,098	0.7	1,708	0.6

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Enrollment and Disenrollment Reports.

[1]Oregon Health Management Service took over Medford Clinic in October 1996.
[2]The decline in enrollment occurred in part because a key provider group split off.
[3]SelectCare has since become part of the Providence System.

In 1997, 12 DCOs and 10 MHOs were participating in the OHP. At year-end 1997, there were 12 managed MHOs in the state and a total of 278,477 enrollees (Table 5).[16] All the contract MHOs have associations with or are sponsored by community mental health programs; two "private" programs contract with the FCHPs to provide mental health services to their members. (Treatment of behavioral health is addressed more fully in the separate paper described in the introduction.)

5. Trends in Payment Rates and Risk Adjustment

The methodology for establishing capitation rates has remained the same over time, although the number of individual eligibility categories for which capitation payments are calculated has increased from 13 to 14 (the state added Old Age Assistance Medicare, Part B only). The rates assume managed care efficiencies that were calculated on the basis of experience. Developing adequate capitation rates for the Phase II population was not an issue because the state had historical data for this population. In general, plans and providers currently consider the rates adequate.

Capitation payments are typically adjusted when the priority list is reviewed, barring special circumstances. In October 1994, dental care rates were raised 40 percent following reports of access problems; a review of these rates indicated that they did not meet reasonable costs. In 1995 and 1996, facing fiscal pressures, the OHP reduced capitation rates by adjusting for greater managed care savings and expected reductions in the benefit package. Providers were vocally upset about the reduction in rates, calling attention to underfunded services. In 1997, the legislature approved rate increases (funded by the tobacco tax) for targeted areas, such as transportation. Discounting changes in enrollment across categories, overall capitation rates went up 1.4 percent in 1995, down 0.5 percent in 1996, and up 9.1 percent in 1997. The 1996 decrease is largely attributed to the removal of 25 covered lines in the benefit package.

Risk adjustment is an important issue for a number of plans and providers that feel they are adversely selected. One plan, CareOregon, which was jointly sponsored by Multnomah County and Oregon Health Sciences University, has documentation from OMAP showing that it enrolls more than 2.5 times as many HIV-infected clients as any other plan (OMAP November 11, 1996). Other plans and providers (mostly safety net)

[16]Two additional MHOs joined the OHP as of January 1998.

Table 5
Managed Care Enrollment for Dental Care Organizations (DCOs) and Mental Heath Organizations (MHOs) by Health Plan
December 1997

Dental Care Organization (DCOs)		
	Number of Enrollees	*OHP Market Share (%)*
Total DCO Enrollees	279,849	100.0
Capital Dental	65,342	23.3
Cascade Dental	9,077	3.2
Frontier Dental	1,064	0.4
Hayden Family Dental	2,639	0.9
Jefferson Dental	6,471	2.3
Kaiser Dental	946	0.3
Managed Dental	25,860	9.2
Multicare Dental	14,280	5.1
Northwest Dental	13,107	4.7
ODS Dental	73,812	26.4
Roseberg Dental	9,968	3.6
SouthCoast Dental	10,748	3.8
Williamette Dental	46,535	16.6
Mental Health Organizations (MHOs)		
Total MHO Enrollees	278,477	100.0
Accountable Behavioral Health	10,372	3.7
Ceres Behavioral Health	5,214	1.9
Clackamas County Mental Health	16,942	6.1
Deschutes County	8,186	2.9
Greater Oregon Behavioral Health	29,929	10.7
Jefferson Behavioral Health	59,100	21.2
Lane Care MHO	30,346	10.9
Mid Valley Behavioral Care	44,261	15.9
Multnomah Caapcare	56,437	20.3
ODS	5,257	1.9
Providence Behavioral	10,734	3.9
Tuality Healthcare MHO	1,700	0.6

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Enrollment and Disenrollment Reports.

have expressed concern over uneven distribution of very sick OHP members (e.g, transplant and cancer patients). Because the capitation rates are calculated assuming a normal distribution of OHP enrollees, some plans and providers are concerned about their financial viability. The state is exploring risk adjustment models and intends to implement risk adjustment in June 1998.

6. Trends in Provider Participation and Network Development

Plans are responsible for establishing their own provider networks and, in general, are not mandated to contract with any particular providers (e.g., FQHCs). The one exception is that plans must refer at least 50 percent of their chemical dependency services to traditional community providers. Every FQHC and rural health center has a provider contract with at least one plan.

In response to the OHP and the growing penetration of managed care in rural Oregon, many providers have organized into physician networks or independent provider associations (IPAs). For example, the local provider community in central Oregon formed an FCHP known as Central Oregon Independent Health Services (COIHS). Like the Roseburg SureCare Plan and Mid-Rogue Valley IPA, COIHS was formed because physicians wanted to contract directly with the state rather than subcontract to a private MCO. By removing the middleman and retaining local control, these organizations feel they are better able to produce timely, quality feedback to manage care. The state refers to this phenomenon as regionalization of the OHP.

Provider payment rates vary by plan, and many plans share risk with providers. Plans noted that provider payment rates are still lower than commercial reimbursement, but better than before the OHP for all providers except FQHCs. FQHCs feel that the loss of cost-based reimbursement for which they were eligible under FFS Medicaid has threatened their financial stability (in conjunction with a loss in county revenues resulting from a series of cuts in property taxes).

Traditionally, Oregon has had a shortage of physicians. Even though the OHP has increased the number of physicians participating in Medicaid, capacity and distribution of providers is still an issue. For example, 95 percent of primary care physicians participate in the OHP, but capacity is still inadequate in some regions. Inadequate supply and participation persist for some specialties. The most serious problem with provider participation to date involves dentists. The supply of dentists in Oregon reportedly is inadequate to serve all populations (public and private). In addition, dental participation was low and demand for services by OHP members was high because adults were entitled only to emergency dental care before the OHP.

To encourage participation and growth of the dental provider network, the state increased reimbursement to more reasonable levels in October 1994 (the state discovered that the original rates were miscalculated and underestimated by roughly 40 percent) and carved out dental care exclusively to DCOs. Dentists are building individual networks, and now DCOs serve 35 of Oregon's 36 counties. Although access continues to be a problem in some areas because there are not enough dentists to meet the need, the state considers access to dental care to have improved dramatically over time.

7. Evolution of State Oversight and Administration

OMAP continues to be ultimately responsible for administration and oversight of the OHP, although this role has become inherently more complex. Because of the demands associated with the Phase II expansion, administration and oversight responsibilities are more diffuse and involve several additional agencies.

The structure of the OHP under Phase II means that OMAP works differently with each of the three sister agencies most closely associated with these initiatives. SDSD, whose clientele includes virtually all of the aged, blind, and disabled, worked closely with OMAP during implementation to address specific issues related to the Phase II population, such as ensuring continuity of care. SDSD continues to be involved in resolving administrative issues facing the aged, blind, and disabled. MHDDSD was a key implementation actor, taking the lead in developing the delivery system for mental health, defining quality assurance, and writing the contracts. It continues to monitor the contractors. OADAP was responsible for developing the additional 21 contract standards adopted to safeguard access to quality chemical dependency services and traditional providers. OADAP continues to monitor chemical dependency providers as part of its licensing activities.

Coordination among all relevant OHP agencies, both within the Medicaid portion of the program and more broadly, is a current issue that is likely to receive increased attention over the coming years. The OHPPR (formerly the Office of the Health Plan Administrator) does not administer any part of the OHP, but facilitates communication and coordination among the agencies involved and provides policy analysis and recommendations on OHP issues.

The state continues to cultivate a collaborative approach to oversight and monitoring despite the increased complexity arising from the number of agencies involved. Reconciling the differences in mission and philosophy among the more service-oriented program offices and divisions that became involved with Phase II, such

as SDSD and OADAP, and the other OHP actors, such as OMAP, was challenging. For example, the state is currently addressing coordination issues among the numerous points at which a beneficiary can register a complaint (state client hotline, plan hotline, ENCC, SDSD, OADAP, ombudsman, etc.). In addition, the state wants agencies, plans, and providers to embrace the recovery model, which assumes that all individuals can improve their quality of life and level of functioning. Adopting the recovery model will be a change for some who subscribe to models focusing on maintenance therapy or crisis intervention. Coordination and communication across agencies, plans, and providers clearly are considered essential to successful implementation, especially for Phase II, and require ongoing effort.

Now that Phase I and Phase II are fully implemented, the state is increasingly dedicating resources to analysis and evaluation to address issues related to quality assurance, fiscal solvency, and enrollment. There is a growing focus on learning more about how well the program is functioning. Finally, the EQRO has completed a number of projects since the first year, including focused studies on asthma, diabetes, depression, and quality of care in the neonatal intensive care unit, medical record reviews for DCOs, and encounter data analysis and validation.

From the perspective of oversight, there is general concern about the resources available to run the program, particularly for staffing and information systems. As in other states, attracting and retaining qualified staff is a constant challenge. Staff turnover continues to raise concerns about the state's ability to effectively administer the program. Jean Thorne, the original director of OMAP and later the governor's federal policy coordinator for health policy issues, has now been appointed education reform team leader and thus is no longer involved in the OHP. Although the remaining OMAP leadership consists of experienced career staffers, many OMAP staff members have left for the private sector (health plans) or to help other states implement managed care programs. Resources allocated to information systems are limited in Oregon and are necessarily dedicated to keeping the current system functioning. In addition, like other states, Oregon has been hampered by the need to divert scarce resources to addressing the Year 2000 conversion of its systems.

D. OHP'S IMPACT ON ACCESS TO CARE AND THE SAFETY NET

In Oregon, as in most states, little good information is available on patterns of care. Thus, this assessment of how access has changed under the OHP is necessarily incomplete and largely qualitative.

1. Expansion and Coordination of Coverage

Before the OHP was adopted, lack of insurance was perceived to be the major barrier keeping Oregonians from obtaining adequate health care. Other problems included physician shortages in some parts of the state, language and cultural barriers, and lack of transportation. Access for Medicaid beneficiaries was perceived to be relatively good, with high rates of physician participation. Access was poorer in some rural areas, owing to limited provider availability and less willingness to participate in Medicaid. Most who were previously Medicaid eligible found their access to providers relatively unaffected by the shift to managed care because generally (at least in urban areas) the shift to Medicaid managed care had occurred under a 1915(b) waiver before the OHP was implemented. In fact, a 1996 satisfaction survey of the Phase I population showed that 90 percent of respondents were satisfied or very satisfied with the OHP.

After four years, the consensus is that overall access to care improved under the OHP largely because of the expansion in the number of people covered (at year-end 1997 there were 93,867 expansion eligibles). More providers are involved in the OHP than were involved under traditional Medicaid. For example, access to dental providers has improved even though it is still problematic. Still, safety net providers were quick to point out that insurance should not be equated with access, and that access problems still exist. Those beneficiaries with barriers to care — because of either chronic conditions requiring many optional services needing gatekeeper approval or the inability to speak English — have not experienced improved access to care. Only OHP beneficiaries who can easily navigate the system are experiencing improved access.

Advocates and others feared that having the benefit package based on a priority list would negatively affect access, especially for the Phase II population. But the evident success of Phase I in maintaining benefit access, in addition to generous reimbursements and the implementation of the ENCC program, helped assuage Phase II fears. Advocates were supportive of the special measures taken (i.e., the ENCC and ombudsman) to safeguard Phase II access to needed care. Nonetheless, advocates feel that important improvements need to be made in the operation of these safeguards. For example, the effectiveness of ENCCs across plans was broadly viewed as inconsistent. Advocates cited examples that illustrated this concern about the ENCCs' timely resolution of issues and the variability in the roles and responsibilities of the ENCC across plans. Advocates and providers exhibited varying knowledge of the ENCC's role. Many providers had not yet begun to use the ENCC's services.

Inconsistency in the resolution of beneficiary issues across offices was a larger issue cited by both advocates and some state staff. The number of avenues available to beneficiaries to lodge concerns (e.g., ENCC, plan, ombudsman, SDSD, etc.) have resulted in a variable process. The state noted that this process is being addressed. Finally, advocates feel that the language used to define the comorbidity rule is difficult to understand, which makes it hard to apply.

In the first year, a major concern was whether sufficient funding would be in place to maintain coverage and benefit levels for the long term. This question of funding still remains an issue, though the level of benefits appears to be stable. The use of the priority list to account for budget shortfalls has been nullified by indications that federal approval for any further line movement reducing covered services will not be forthcoming. The biggest threat, then, is maintaining coverage of existing populations and extending it to the 11 percent of the population that remains uninsured.[17] In 1995, some changes were made in eligibility criteria to help offset budget shortfalls. How Oregon will maintain its current coverage in the face of fiscal constraints remains to be seen.

2. The Safety Net and Access to Care for the Uninsured

Oregon's safety net consists of a variety of providers, including private physicians who see low-income patients, hospital emergency rooms, community and migrant health centers, and county health departments (some of which provide primary care services). Under the OHP design, few specific provisions protect safety net providers (outside the Phase II behavioral health expansions). This situation represents deliberate state policy to offer providers a level playing field. Plans are not required to contract with safety net providers (except for the requirement to refer 50 percent of services to traditional chemical dependency providers), but virtually all safety net providers participate in the OHP.

Although the OHP did help relieve some of the pressure on the safety net by enrolling more people, the net effect of the OHP is a safety net provider system that is under considerable stress. The safety net providers in Clackamas and Multnomah counties report that their overall patient volume has decreased, but that the proportion of uninsured and insured patients has remained roughly the same. In Multnomah County, the proportion of uninsured health department clients hovered at 70 percent

[17]From the implementation of the OHP to 1996, the number of uninsured dropped from 18 percent to 11 percent; among children, the number of uninsured dropped from 21 percent to 8 percent (OHPPR April 1997).

from 1993 to 1996. Further, under a Section 1115 waiver, clinics and FQHCs were previously guaranteed reasonable reimbursement at rates that met their annual costs, in recognition of the fact that the broader scope of services they offer (e.g., enabling services such as outreach and interpretation) reduced their revenues (federal policy changed with the 1997 Balanced Budget Act).

Funding streams have been further altered by a series of ballot measures reducing property taxes and decreasing county funding for the safety net. In Multnomah County, payment has decreased about 30 percent since the OHP took over, yet safety net providers are seeing the same mix of insured and uninsured patients. One provider felt that all of these changes have forced safety net providers to focus on Medicaid and, in effect, triage Medicaid and the uninsured in an effort to survive. The implications are potentially severe for the 11 percent of Oregonians who remain uninsured, as resources typically used to cross-subsidize their care disappear, clinics close (e.g., Burnside, a clinic for the homeless), and staff is reduced. Also, safety net providers, in particular, report an increase in the number of underinsured (those with inadequate coverage or high premiums). This purportedly growing segment of the population is counted as "covered" though their access is hampered and their care underfunded.[18]

Safety net providers say they see a clientele that is often sicker or more challenging and therefore more costly. Both Multnomah and Clackamas counties reported an increase in non-English-speaking clients who require translation services that are not adequately covered by the OHP capitation payment. Safety net providers have documentation showing that they see a disproportionate share of the more costly HIV and chemically dependent patients. For example, CareOregon had twice as many OHP enrollees in treatment for chemical dependency than the average plan and roughly 30 percent more than the next closest plan.[19] Safety net providers expressed frustration at not being able to call attention to the inequities caused by their adverse selection of high-risk, intense service users. Capitation rates were calculated assuming a normal distribution of clients. Because safety net providers are seeing more difficult populations, they have to look to other sources of funding.

The issue of risk adjustment is inextricably linked to the survival of the safety net. This issue has forced Oregon to address whether safety net providers should receive

[18]The underinsured come from the privately insured market; the OHP is generally considered to have a generous benefit package.

[19]These figures cover May 1996 through May 1997 and include only persons age 12 and above.

state financial support and if such support should come from Medicaid or from more specific carve-outs.[20] The first-year concern that the OHP would unintentionally weaken the safety net (primarily for those who remain uninsured) has been borne out and is particularly worrisome as universal coverage becomes increasingly untenable because of a lack of resources and political will. It took the threat of clinic closings by the Multnomah County Health Department, which would have initiated serious unraveling of the safety net, to prompt the 1997 legislature to approve $3.1 million in transitional funding for safety net providers while this issue is addressed. In April 1998, it was announced that these funds will be distributed to 18 community health care providers to "ease the stress created by tax measures and managed care business practices...[and]… help clinics keep their doors open" (*Portland Business Journal,* April 4, 1998). However, the history of this provision is unclear. Study interviews suggest that it was developed with limited involvement of key safety net providers.

E. CONCLUSIONS

The state, advocates, plans, and providers believe that the long planning process involving a cross-section of stakeholders "sitting at the table" was essential to the OHP's success. This time-intensive method ensured a well-thought-out program structure. The staggered integration of the Phase I and Phase II populations and behavioral health benefits allowed for extensive planning to address special issues, such as heightened concern for continuity of care, in a proactive manner. The inclusive planning and incremental implementation approach contributed to community buy-in and smooth transitions. After four years, the OHP enjoys a favorability rating of 70 percent and has established itself as part of the Oregon culture. This statewide support and commitment to the OHP has been instrumental in carrying the program through tough issues, especially continued financing.

Oregon decided to ration services rather than ration people in its design of the OHP. In the face of budget shortfalls, the state reduced benefit scope rather than restrict eligibility. However, Oregon's experience thus far suggests that there is a limit to how much it can reduce benefits and still maintain the numbers covered or extend coverage to more people. The state is experiencing pressure not to manipulate the priority list. Year after year and during very strong economic times for the state, OMAP has been forced to go before the emergency board to ask for money to cover shortfalls in the budget. Because the benefit package will not likely be reduced, the tobacco tax provides an important infusion of money to maintain short-term fiscal viability of the

[20]The state is exploring risk adjustment models and plans to implement some risk adjustment in June 1998.

program. Unfortunately, Oregon's approach to financial pressure — reducing benefits rather than people — may not be sufficient to provide for long-term financial stability of the OHP. The effect the new tobacco tax will have on long-term financial stability is unclear. What is clear is that the issue of OHP funding will persist and will fuel legislative efforts to cut back the OHP or prevent further expansions.

Oregon found that managing the ongoing operation of Medicaid managed care differs from implementing it and is harder in some ways. Maintaining managed care involves ongoing quality assurance that is significantly different from the surveillance required of the traditional FFS system. The use of encounter data to identify, define, and analyze issues is paramount, but unsophisticated information systems and poor-quality encounter data inhibit Oregon's ability to conduct necessary analysis and evaluation. Hard data and analysis are especially important to support policy decisions in light of the political nature of the OHP. Oregon has come to recognize the importance of setting up and following through on clear expectations for data collection and analysis to facilitate monitoring efforts.

Further, because operation with the focus on day-to-day details is less exciting than implementation, retaining and attracting staff is a problem. Oregon has found that the initial excitement of implementing the OHP has worn off now that the key structures and processes are in place. With the emphasis shifting from implementing new features to maintaining ongoing progress, the next challenge is keeping agency enthusiasm and staff commitment levels high.

Oregon's experience with implementing Phase I and Phase II populations and benefits emphasizes the importance of inter- and intraorganization communication. When diverse populations are served by numerous agencies and providers with varying philosophies, open communication and coordination are important for success. Coordination of benefits across plans and resolution of grievances across agencies, for example, require organizations to work to learn each other's language. Maintaining open communication requires substantial and consistent effort. Oregon has been quite successful in keeping agencies and plans informed and active. What seems to be more difficult is ensuring that "lower levels" are aware of program structure and changes. For example, interviewed plans emphasized the role and importance of the ENCC in identifying needs and coordinating care for Phase II enrollees. However, many of the providers interviewed were unaware of the ENCC's role and said they rarely thought of using an ENCC to help coordinate care. This communication gap may be limiting the ability of some program measures like the ENCC to realize their full potential.

Key Issues to Monitor in the Future

Given the past experience of the OHP, the following are key questions for future study:

- To what extent has the imposition of premiums affected eligibility, the cost of care, program efforts to create continuity of care, and the ability of plans to really manage care?

- Is managing the care of OHP beneficiaries producing better patient health and more efficient practices?

- How effectively are the state's analysis and evaluation efforts evolving to accommodate data availability and systems capabilities?

- How is the safety net faring and what are the implications for the uninsured?

- What effect will risk adjusters have on plans, providers, and populations?

- How will the state resolve the care coordination challenges presented by the dually diagnosed?

- Will mental health and physical health services ultimately be integrated and managed through one organization, or will there be a movement to separate services even more (e.g., pulling chemical dependency back out)?

- Will the OHP be able to sustain long-term financial viability, will sufficient funding be in place to maintain coverage and benefit levels, and will the program be able to expand to cover more of those still left uninsured?

- Will political support for the OHP be maintained as the governor changes and term limits force turnover in the state legislature beginning with the next election cycle?

As experience with the OHP grows, so does the value of continued study of the OHP experience.

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