OFFICE OF THE DIRECTOR

Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

MEMORANDUM

TO: The Honorable Sen. Elizabeth Steiner Hayward, Senate Co-Chair
The Honorable Rep. Dan Rayfield, House Co-Chair
Subcommittee on Human Services

FROM: Janell Evans, Budget Director, Oregon Health Authority

DATE: February 15, 2017

SUBJECT: Responses to February 13 Public Hearing Questions

During OHA's presentation on the Health Systems Division before your committee on Monday, February 13, committee members asked question that required additional follow-up. Here are those questions and our responses:

Sen. Winters: For clarity, it would be helpful if you had a definition of what each eligibility system covers OHA versus DHS. So we can look at overlap and duplications.

> For OHA, the ONE system determines eligibility using MAGI (Modified Adjusted Gross Income)[1] methodology and a rules engine. Application data is entered into the system, and the system makes the determination. For DHS, the DHS Client Maintenance legacy system records determinations made by workers and entered into the system.
>
> These following programs are determined by the DHS Client Maintenance legacy system. They cannot be determined in the ONE system.
>
> - Aid to the Blind and Disabled (ABAD)

[1] MAGI is the figure used to determine eligibility for premium tax credits and other savings for Marketplace health insurance plans and for **Medicaid** and the Children's Health Insurance Program (CHIP).

- Old Age Assistance (OAA)
- Foster, Substitute and Adoption Care
- Qualified Medicare Beneficiary (QMB)
- Breast and Cervical Cancer Treatment Program (BCCTP)

These programs can be determined by both systems: the OHA using the ONE system; or through the DHS Client Maintenance legacy system.

- Parent Caretaker Relative
- Pregnant Women
- ACA Adults
- Children's Medicaid
- Children's Health Insurance Program (CHIP)
- Former Foster Care Youth Medical
- Citizenship/Alien-Waived Emergency Medical (CAWEM) – Regular
- Citizenship/Alien-Waived Emergency Medical (CAWEM) – Prenatal

Sen. Steiner Hayward: The ONE is not capable of managing missing information. If someone submits an incomplete application. The state has made effort to follow-up. Other states don't actively help. I'm interested in the pros and cons of this decision.
Sen. Winters: And what would be the cost difference?

We are aware of some variation in how states approach incomplete applications. In Oregon, we place phone calls to members at the time of application review to inform them of any missing information. We try to resolve issues over the phone. If we can't, we send the member a letter outlining what's missing with the specific page number(s) highlighted.

According to federal statute, we are required to establish a date of request (DOR) with minimal information – the member's name, date and signature on their application. In the ONE system, however, we can't establish a DOR without the member being registered—which requires a personal identifier—so the member will not be "seen" by ONE unless we do the registration in ONE through the manual renewal process. If we do not complete the registration, the member's benefits will close for non-response.

Today, about 32 percent of paper applications are incomplete or missing information at any given time.

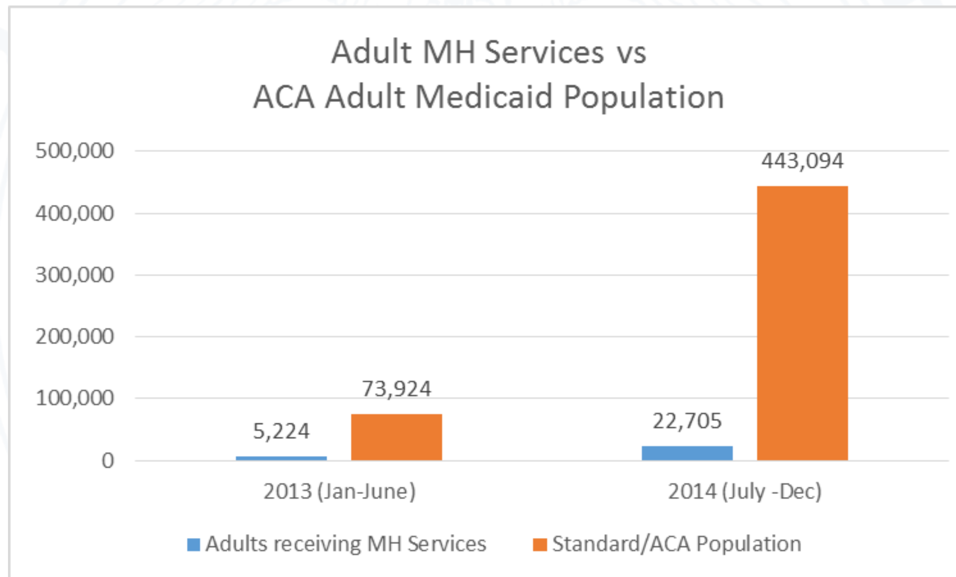
In the future, approximately 15 percent of OHP applications will be paper applications; the remainder will be renewals through the ONE system or account transfers from the Federally Facilitated Marketplace (FFM).

The risk to existing members having their membership closed for non-response remains if or when a member chooses to renew using a full (paper) application rather than the simplified ONE renewal form.

We would have to do more research to determine the benefits and financial implications of intensifying the outreach we do to members with missing information on their applications.

Sen. Winters: Perhaps a matrix would be helpful—to understand the population eligible under the ACA Adult population and how they could be healthier.

In 2013, before the ACA expansion, OHA provided mental health services to about 5,224 adults or seven percent of those in the Oregon Health Plan Standard population. Post ACA expansion, OHA provided mental health services to more adults, about 22,705 individuals, but it only amounted to about five percent of the expanded ACA adult population, as shown in the following chart:



There was an increase in the number served, but proportionally the number was less, which indicates that the population as a whole was healthier.

Pre ACA, those covered through the OHP Standard Plan had benefits matched with state funds at 36%. We have been unable to quantify the number of uninsured individuals who relied entirely on state General Funds for payment of their mental health services. Post ACA expansion, individuals benefits were paid with federal funds of 100%.

Rep. Buehler: (Slide 15: OHP/Medicaid Forecast) How is it that there is such little volatility in 2 years? Why would your forecasting model not account for changes in the economy? Inflation factors, number of eligible, would like more information.
Sen. Winters: When the economy is good, need should go down. If you're telling us there will be no changes, there's something wrong with your model.
Rep. Rayfield: It would be interesting to factor in how much of the ACA population shifts with min wage, and with redetermination, how much that shrinks the ACA pop, etc.

Generally the forecast is developed by measuring the number of clients expected to enter or transfer into the caseload and the number of clients expected to transfer out or exit the case load. These measurements can be impacted by a variety of factors including demographics, the economy, enrollment changes and redeterminations on eligibility. The forecasting model individually looks at 12 different subgroups or caseloads within the Medicaid caseload.

Different caseloads can show very different patterns. Some forecasting caseloads increase based primarily on population growth, while other caseloads shrink during strong economic expansions. To some degree, those factors can cancel each other out for the total Medicaid caseload, even though some groups are growing and others are shrinking. Overall, the total Medicaid caseload is forecast to shrink (-5.8%) in the 2017-2019 biennium. (See the *Biennium Averages for Fall 2016 Forecast* table below). For example, caseloads, such as Old Age Assistance, show very steady growth based on the demographics of the aging population. Other caseloads, such as ACA Adults, have slower population growth, but are more sensitive to economic factors and therefore are currently declining. The number of new entries to each caseload is forecast based on the population growth of the relevant age group and the recent history.

Most of the recent volatility in the caseload was driven by several factors including: 1) large numbers of new clients from the ACA expansion, 2) the changing eligibility system, 3) and the processing of renewals for confirmation of continued eligibility. Over the last year, there has been a pretty substantial decline in caseload driven by clearing the backlog of redeterminations for eligibility. This had a significant impact on the ACA Adult population and Children's Medicaid, both large caseloads.

Economic growth is always slowest to reach the poorest clients. It takes a long sustained expansion to reach those at the bottom of the economic ladder. The most recent year of data from the American Community Survey (ACS), 2015, was actually the first year to show declines in the number of Oregonians in poverty since the start of the ACS in 2006. We believe recent improvements in the economy are reflected in the more economically sensitive groups, although the

impact is obscured over the last year by the processing of the redetermination backlog, which has also caused declines in those same groups.

Sen. Steiner Hayward: (Slide 16: Caseload Comparison) Why do we switch pregnant women from ACA to pregnant population, and why do we have a different rate, and what's the match rate? **Sen. Gelser:** I heard two different things as the benefit package for pregnant women. Need clarity.

The ACA Adult eligibility category received 100 percent federal Medicaid funding for calendar years 2014, 2015, and 2016. For subsequent years, the federal match is as follows:

- 95 percent for calendar year 2017
- 94 percent for calendar year 2018
- 93 percent for calendar year 2019
- 90 percent for calendar year 2020 and all subsequent years

The Pregnant Women eligibility category receives the regular Medicaid match rate (e.g., approximately 64 percent).

When a women in the ACA Adult eligibility category notifies OHA that she is pregnant, the state is required to switch her to the Pregnant Women eligibility category because the woman now qualifies for a traditional Medicaid eligibility category.

When the state is determining eligibility, either at the time of application or at renewal, federal law requires that the state must evaluate eligibility first for traditional Medicaid categories. If the individual does not qualify for any traditional Medicaid category, the state then evaluates for potential eligibility under the ACA Adult category and the enhanced federal match rate.

Women who go from ACA Adult population to the Pregnant Women eligibility category will not lose any coverage. They will still have the full Oregon Health Plan (OHP) benefit package as all other Medicaid and CHIP eligibility categories.

It is important to note that pregnant women are eligible to receive slightly more, or more frequent, dental services. This slightly broader coverage for pregnant women is for the health and well-being of the developing unborn child. Many of these services are considered necessary to identify or eliminate infection, prevent disease and lower caries-causing bacteria for the pregnancy and for the health of the unborn child. For example, OHP covers root canals on first molars for pregnant women, but not for non-pregnant women. OHP also covers additional fluoride treatments and additional scaling and root planning treatments for pregnant

women. Some of these additional or expanded services are also available to non-pregnant adults when they are considered “high risk” for more extensive disease.

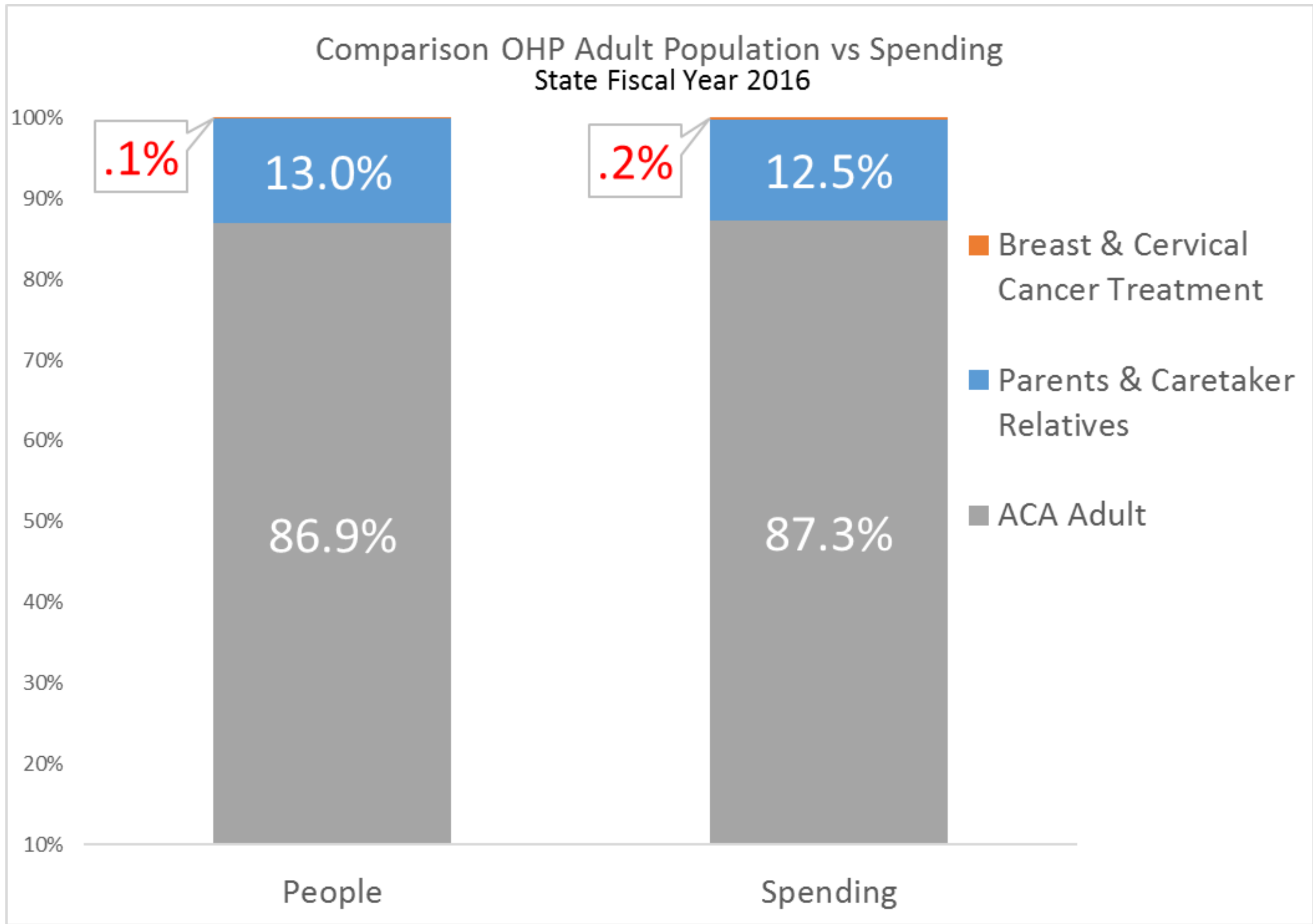
Sen. Winters: (Slide 19: Other Funds) What are the organizations that we are doing the match for in the leverage portion?

The following entities provide funding to OHA to leverage Medicaid matching funds:

- Oregon Health & Science University (OHSU) – For graduate medical education payments, disproportionate share payments, University Medical Group reimbursement, and poison control costs
- Public School Districts & Education Service Districts – For Medicaid administrative claiming, school-based health services
- County Public Health – Targeted case management
- County Juvenile Justice – Behavioral rehabilitative services
- Oregon Department of Education – For Medicaid administrative claiming associated with the Early Learning Division’s Healthy Start Healthy Families program

Sen. Steiner Hayward: (Slide 22: Comparison of Populations and Spending) The 53% of cost for adults is not evenly distributed to the 47%. Can we look at this more closely, dissect it? What are trend lines? **Sen. Winters:** Ages 19-64; chronic diseases starts in this age group – how is this accounted for? **Sen. Steiner Hayward:** More granularity would be helpful.

The adult group in the chart includes Parents & Caretaker Relatives, Breast & Cervical Cancer Treatment, and ACA Adults. The ACA Adult population is the overwhelming majority (87%) of this group. The following graph shows the breakout of the adults group into these three populations and provides comparison to each adult group’s spending.

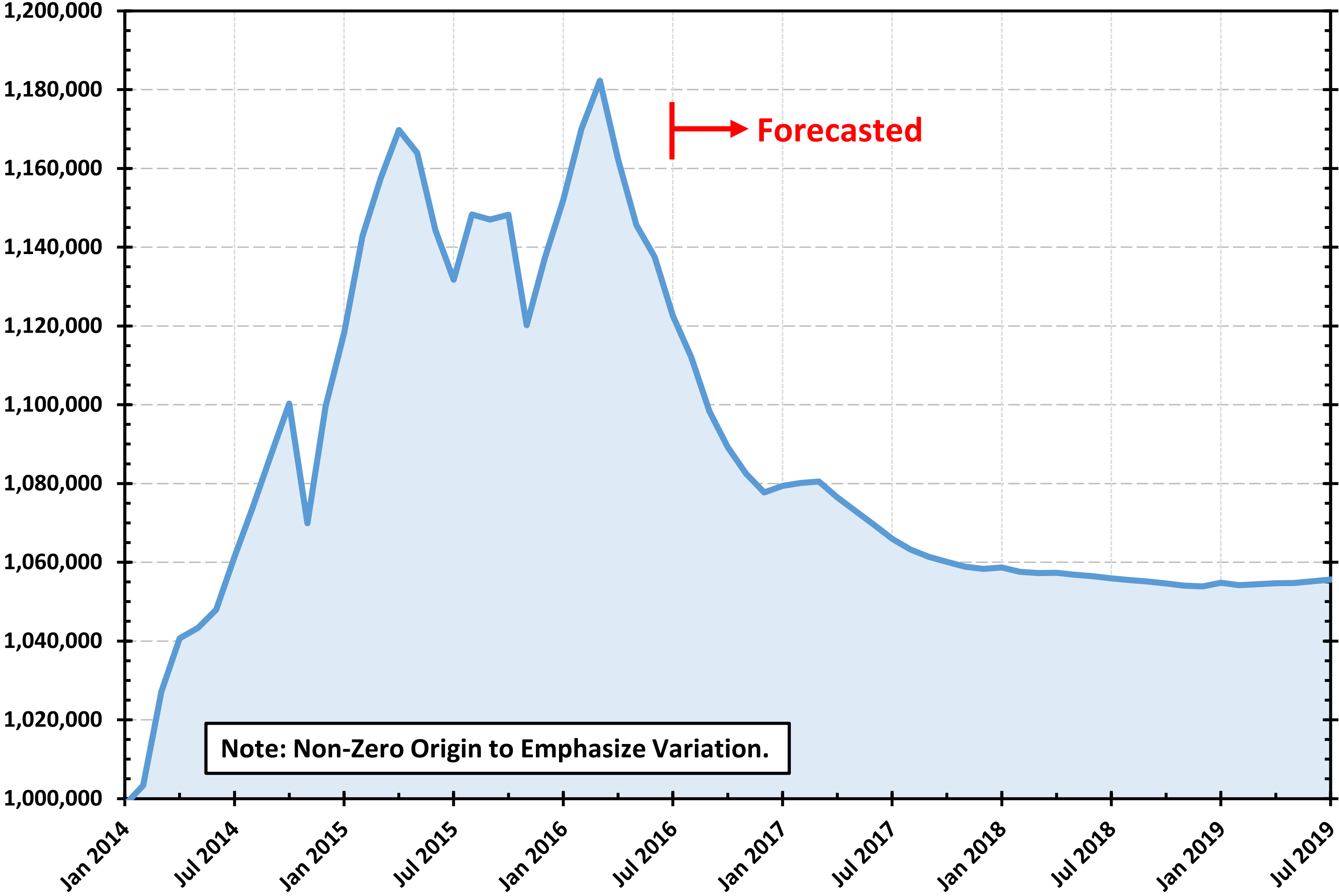


For the purposes of rate setting and budgeting, the ACA Adult population is divided into three age bands, more accurately account for costs in this population. The following table provide the age bands, the average monthly caseload in each band, and the projected average per-member-per-month cost for each age band for the 2017-19 biennium:

ACA Adults Age Bands	2017-19 Average Mo. Caseload	PMPM
19-44	225,881	$455.29
45-54	68,624	$782.73
55-65	60,645	$884.57

TABLE: Biennium Averages for the Fall 2016 Forecast

Biennial Averages	2015-17 Biennium Spring 16 Forecast	2015-17 Biennium Fall 16 Forecast	2015-17 Biennium Change	*% Change Between Forecasts*	Fall 2016 Forecast 2015-17	Fall 2016 Forecast 2017-19	Fall 2016 Forecast Change	*% Change Between Biennia*
MEDICAL ASSISTANCE								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	0.6%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	1.1%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	6.5%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	4.2%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	**1,048,498**	**1,043,045**	**-5,453**	**-0.5%**	**1,043,045**	**982,661**	**-60,384**	**-5.8%**
Other Medical Assistance								
Breast & Cervical Cancer Treatment Program	359	356	-3	-0.8%	356	237	-119	-33.4%
Citizen-Alien Waived Emergent Medical - Prenatal	2,257	2,168	-89	-3.9%	2,168	2,075	-93	-4.3%
Citizen-Alien Waived Emergent Medical - Regular	46,339	47,007	668	1.4%	47,007	45,036	-1,971	-4.2%
Qualified Medicare Beneficiary	24,061	24,234	173	0.7%	24,234	27,036	2,802	11.6%
Other Subtotal	**73,016**	**73,765**	749	1.0%	**73,765**	**74,384**	**619**	**0.8%**
Total Medical Assistance	**1,121,514**	**1,116,810**	**-4,704**	**-0.4%**	**1,116,810**	**1,057,045**	**-59,765**	**-5.4%**
Medicare Part A	6,522	6,518	-4	-0.1%	6,518	6,888	370	5.7%
Medicare Part B	118,626	118,532	-94	-0.1%	118,532	130,332	11,800	10.0%


OHP/Medicaid
1,200,000
1,180,000
1,160,000
1,140,000
1,120,000
1,100,000
1,080,000
1,060,000
1,040,000
1,020,000
1,000,000
Forecasted
Note: Non-Zero Origin to Emphasize Variation.
Jan 2014
Jul 2014
Jan 2015
Jul 2015
Jan 2016
Jul 2016
Jan 2017
Jul 2017
Jan 2018
Jul 2018
Jan 2019
Jul 2019