Multnomah County
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Program # 40016A - Medicaid/Medicare Eligibility

Version 3/31/2009 s

Priority: Basic Needs

Program Offer Type: Existing Operating

Related Programs:

Program Characteristics:

Lead Agency: Health Department

Program Contact: Marcy Sugarman

Executive Summary

Medicaid Enrollment assists uninsured and under-insured Oregonians gain access to health services by providing application and enrollment assistance and advocacy, to families and children applying for Medicaid benefits (Oregon Health Plan (OHP), Medical Assistance Assumed (MAA), Medical Assistance for Families (MAF), Temporary Assistance For Needy Families (TANF), Family Health Insurance Assistance Program (FHIAP), and State Children’s Health Insurance Program (S-CHIP); Oregon Prescription Drug Program (OPDP); Kaiser Child Health Program. The Medicaid Program operates under contract with the State Division of Medical Assistance Programs (DMAP).

Program Description

The program goals are 1) educate the uninsured population about OHP and other state insurance expanded services; 2) increase the number of clients who complete the OHP enrollment process; 3) increase access to health care services, particularly for pregnant women and children. Medicaid Enrollment Eligibility Specialists are stationed in Health Department clinical sites using outreach strategies to screen individuals for Medicaid programs, expedite applications to ensure prompt coverage, monitor Medicaid enrollees, particularly those at high risk, to assure continuity of coverage and care, and recertify for continuity of coverage. Insurance coverage under Medicaid provides access to preventive medical, dental, and mental health services and care for hard-to-cover pre-existing conditions and costly medications. The program aims to provide dignified access to health care for all citizens in collaboration with existing Multnomah County services and community partners.

Program Justification

Medicaid Enrollment addresses the Basic Needs strategy to provide access to care, including behavioral and physical health, by securing insurance coverage for eligible individuals. In addition, the program addresses the strategy to educate, prevent, and/or intervene to keep individuals from experiencing health or economic crisis due to lack of coverage; assist individuals with enrollment in the appropriate Medicaid program, and assist individuals whose coverage has been denied or terminated, the opportunity for reinstatement of benefits. Approximately 90% of MCHD eligible clients select CareOregon. Multnomah County is CareOregon's single largest Medicaid provider.

Performance Measures

Measure Type	Primary Measure	Previous Year Actual (FY07-08)	Current Year Purchased (FY08-09)	Current Year Estimate (FY08-09)	Next Year Offer (FY09-10)
Output	Annual number of clients screened	31,947	26,000	32,200	32,500
Outcome	Uninsured children in Multnomah County insured through program	10,435	11,550	12,200	12,300
Efficiency	Annual number of clients screened per FTE	3,200	3,450	3,450	3,500
Outcome	OHP retention rate for adults	61.0%	60.0%	60.0%	50.0%

Performance Measure - Description

1) Output: Reflects service volume.
2) Outcome: Uninsured children insured as a direct result of Medicaid Enrollment Program.
4) Outcome: OHP retention percentage-Fiscal year total of adults who remain covered through two six month certification periods. OHP coverage for adults closed to new enrollment (July, 2004) and has dropped significantly. It is important to note that 1) The percentage of adults now covered by Medicare, OMIP (medical insurance pool through the state for high risk coverage), and private employer sponsored insurance has stabilized as a result of the program's active retention efforts.
Additionally, 2,000+ referrals received from MESD nurses (1,530 kids insured as a result); 791 referrals from SBHC (346 kids & 69 adults insured as a result).

Legal/Contractual Obligation

The Medicaid Enrollment Program is on contract with the State Division of Medical Assistance Programs (DMAP) to provide application and enrollment assistance to all OHP/Medicaid eligibles including education regarding managed health care. Information shall include establishing a Date of Request (DOR) or effective date of coverage, managed medical, dental, and mental health care, covered services (including preventive and emergent), client rights and responsibilities, and the grievance and appeal process.

Revenue/Expense Detail

	Proposed General Fund	Proposed Other Funds	Proposed General Fund	Proposed Other Funds
Program Expenses	2009	2009	2010	2010
Personnel	$670,257	$662,216	$372,093	$987,505
Contracts	$10,580	$0	$3,080	$0
Materials & Supplies	$45,018	$17,122	$29,884	$6,920
Internal Services	$0	$135,526	$8,887	$167,933
Subtotal: Direct Exps:	**$725,855**	**$814,864**	**$413,944**	**$1,162,358**
Administration	$22,111	$0	$21,581	$0
Program Support	$107,986	$0	$102,274	$0
Subtotal: Other Exps:	**$130,097**	**$0**	**$123,855**	**$0**
Total GF/non-GF:	**$855,952**	**$814,864**	**$537,799**	**$1,162,358**
Program Total:	**$1,670,816**		**$1,700,157**	
Program FTE	10.00	9.00	5.00	15.00
Program Revenues				
Indirect for dep't Admin	$47,371	$0	$70,434	$0
Fees, Permits & Charges	$0	$0	$0	$1,162,358
Intergovernmental	$0	$814,864	$0	$0
Program Revenue for Admin	$0	$0	$0	$0
Total Revenue:	**$47,371**	**$814,864**	**$70,434**	**$1,162,358**

Explanation of Revenues

These services are currently funded based on last years actual program costs. CGF funded program expansion, so that they became part of our base cost and are now elibible for reimbursement.

Significant Program Changes

Last year this program was: #40016A, Medicaid/Medicare Eligibility
This offer now includes most of the staff previously included in 40016B, funded last year with CGF. There is now sufficient State revenue to support the expanded program. More clients were screened as a result of a new patient intake workflow to ensure all potential Medicaid eligible families with pregnant women and children were screened for Medicaid benefits prior to receiving services. Through this process the Medicaid Program staff established a fiscally responsible business practice that would directly support revenue to the Health Department. The workflow standardized how patients were screened for medical benefit eligibility, identified best business practices for primary care, and assured that all patients received benefits they were eligible for. All new patients were scheduled with Eligibility Specialists prior to their medical visit to initiate the application process for medical benefits and establish a date-of-request or effective date of coverage. All medical expenses incurred from that day forward would be billed to Medicaid if eligibility criteria was met. Established patients were screened semi-annually to ensure continuity of coverage. Additional Local 88 positions were funded using funds made available by Local 88's approval of a wage freeze for FY 2010.