PAP Meeting Notes
7/17/07

Jim Edge called the meeting to order. Following introductions, Jim reviewed the agenda and pointed out that the second meeting of the PAP would continue some of the preliminary work begun at the first meeting. He raised the question whether the order of the PAP and ASTAP meetings should be reversed so that the PAP followed immediately after the ASTAP and it was decided to postpone a decision until each group has met a couple of more times.

He then asked if there were additions to the agenda, and Kevin Campbell asked for an update on the issue of risk adjustors for children's mental health services. Ed Deery said that the ASTAP would receive more information on the topic from PWC on July 18, and that the technical discussion would better inform the policy discussion. It was agreed to postpone further discussion until after the legislative update item on the agenda.

Bob DiPrete raised the question of how the PAP and ASTAP would distinguish between policy and technical issues, and offered as a possible working definition that policy issues would generally involve decisions about what we should do in setting rates, while technical issues would generally involve decisions about what can be done to implement policy decisions. The PAP will frame policy issues for policy decision makers, and the ASTAP will explore technical issues within the framework of policy decisions. Kevin Campbell pointed out that in many cases the policy issue would be fairly straightforward (e.g., managed care should be maximized in the OHP) while the technical issues involved in accomplishing this policy objective would be more complicated. Bob noted that there would be considerable interplay between policy and technical discussions as the need for new policy decisions becomes evident in technical discussions and policy guidelines shape technical discussion.

Jim Edge provided a review of the results of the just-concluded legislative session:

SB 163 calls for sharing information between the mental health and physical health managed care plans.

SB 329 calls for the design and planning for extensive health reform statewide. This effort will address a wide range of issues including benefits, financing, eligibility and enrollment, delivery system, and federal law and regulation, with progress reports due to the Legislature in February of 2008 and a final planning document due about a year later. Jim noted that Barney Speight has been named to head up this planning effort and that he will bring extensive experience in health reform in Oregon and in Washington.

SB 1041 restores the four benefits that were to have been eliminated in 2006 but were not implemented due to delays in receiving federal permission.

HB 3501 addresses payments to "non-participating" hospitals that do not contract with a given health plan and sets such "non-par" payments at 80% of Medicare payment levels.

HB 3057 addresses all types of provider tax (managed care plan, hospital, and nursing home)

HB 5031 deals with the DHS budget, including such items as graduate medical education, the creation of a new physician incentive program funded at $7 million GF ($17 million, total funds) and the addition of cost of living adjustments (COLAs) of 3.6% in 2008 and 3.5% in 2009.

SB 3, HB 2640, and SJR 4 all address the Healthy Kids program, funding for which was referred to the voters in the form of an additional tobacco tax. If voters approve the tax in November, the Legislature will address Healthy Kids during their special session in February 2008. Jim noted that planning for the Healthy Kids Program will continue pending the outcome of that vote so that it will be possible to implement the program timely in the event that the funding is approved. Healthy Kids would include a DHS component (increasing CHIP eligibility to 200% FPL) and an OPHP component (increasing FHIAP eligibility) and creating a new program called the private insurance product which would make benefits comparable to OHP Plus available through a commercial insurance product.

HB 2469 addresses reauthorization of the TANF program and includes $3 million GF for transitional medical benefits.

HB 5031 includes budget notes to the DHS budget which can be viewed online by going to the Oregon Legislature web site at http://www.leg.state.or.us/comm/sms/SMS07Frameset.html . On the left where there is a place to enter bill number, enter HB 5031; then click on the Find field. These budget notes include:

1) a study on integrating mental and physical health systems
2) a report on MCO/hospital contracting
3) a report on type A and B hospital reimbursement
4) a study on reducing health disparities

Jim Edge also noted that the federal government is in the process of reauthorizing the CHIP program and that the debate is contentious on issues including direction on the allotment of funds to states and on how CHIP carryover will be handled and the availability of funds for CAWEM and CHIP programs.

Jim Russell asked whether the MCO provider tax rates are now in statute, and Jim and Lynn replied that that language was omitted before the bill passed.

Jim Edge then reminded the PAP that the Legislature directed DHS to bring actuarial analysis for the OHP "in-house" for the 09/11 per capita costs and subsequent work, and that this would require intense effort over the next few months, with a role for the PAP as implementation gets underway.

Discussion then turned to the issue of risk adjustors for children's mental health services, and Sandy Hunt and Pete Davidson of PwC stated that the have prepared materials explaining the current risk adjustment methodologies, including relative cost weighting factors and what would be involved in recalibrating those weighting factors (which they have not been requested to do).

Kevin asked whether PwC is looking into diagnosis-based risk adjustors in the high cost categories for children as well as for adults. Pete answered that PwC will provide statewide prevalence rates for children's diagnoses for the medium, high, and very high categories.

Kevin then asked if it is true that while physical health risk adjustors have a "floor" on risk for the plans, mental health risk adjustors do not. PwC answered that they would verify whether physical health plans have a risk corridor floor. NOTE: The next day the ASTAP received an update and there is a floor of .85 used for physical health risk adjustors.
Sandy noted that if it is a policy decision to continue with the current risk adjustment tool but to add boundaries, that can be accomplished late in the rate development process. However, if the risk adjustment tool is to be redesigned, that will require considerable work and a longer time and probably could not be done for the 2008 rates.

Kevin pointed out that boundary issues might include decisions on where to apply the weighting factors (e.g., to AB/AD without Medicare).

Lynn Read suggested that we await the outcome of the discussion in the 7/18 ASTAP meeting to decide whether there is an outstanding policy issue for the PAP to address, and then determine whether discussion of any policy issue can wait until the August PAP meeting or needs to be addressed through email and teleconference before that date. Kevin agreed to this approach, but pointed out that referring an issue back and forth between the PAP and ASTAP requires time and can end up being counterproductive if decision deadlines are missed . Sandy Hunt pointed out that the date that capitation rates are due to CMS is (she believes) November 1, 2007, implying that rates should be to the health plans for their review by October 1, 2007. Kevin reminded the group that his concern is that payment for children's mental health services is insufficient to cover the cost of care because the risk adjustment tool is "outdated" and needs to be revised, at least regarding boundaries and limits and application to categories of eligibles.

Discussion then turned to the issue of enrollment of women applying during the 3rd trimester of pregnancy. Following Lynn Read's summary of the document describing the issue and identifying several options, Bill Murray pointed out that the real issue is not the cost of maternity care vs. the maternity care case rate, but rather the cost of expensive newborns and their enrollment into the mother's health plan at birth.

Cindy Becker pointed out that there are two perspectives on the issue among FCHPs: 1) everyone should be enrolled in managed care, and 2) there must be adequate reimbursement for high cost cases.

Lynn Read reminded the PAP that there is no risk adjustment for the cost of newborn care, but only for the prevalence of children born into the plan and other children below age 1. Sandy Hunt pointed out that a few years ago, PwC investigated options for risk adjustment for newborns, including the distribution of high cost newborns among health plans.

Bob DiPrete asked whether that PwC investigation included the option of delaying enrollment of newborns until after they have been discharged from the hospital. Lynn Read pointed out that OHP applicants who are hospitalized are not enrolled in a health plan until they have discharged, with the exception of newborns whose mother is enrolled in the plan at time of birth.

Bill Murray asked whether there is data on the differences in cost for women and newborns when enrollment is in the 3rd trimester as opposed to earlier in - or before - the pregnancy. Lynn Read responded that the Actuarial Services Unit will look at this data within a few weeks, and that DMAP and PwC will work with ASU to identify the appropriate questions to investigate.

Ed Deery pointed out that past studies indicated a fairly consistent pattern of costs across health plans.

Cindy Becker pointed out that there remains the issue of whether women are being enrolled promptly upon being found eligible, and whether plans are notified promptly of this enrollment. Kevin Campbell asked about the feasibility of incentives to encourage women to enroll early in the pregnancy. Lynn Read commented that citizenship and identity verification slow the eligibility process somewhat and that if the pregnant woman does not choose a plan, enrollment is delayed until the monthly auto-enrollment takes place.

Charlene Yoder asked whether we have good information on the prevalence of high cost neonates by trimester of mother's enrollment and by health plan, and Lynn responded that actuarial services would try to get this data. Sandy Hunt pointed out that the implied question is whether there is a difference in cases and costs as distributed across FCHPs.

Bob DiPrete then summarized a document identifying key elements in a PAP work plan, including issues and critical dates. He requested that PAP members review this document and send suggestions for additional elements or revisions, within two weeks. Bob will then develop a draft work plan including critical tasks and critical dates, for the next 12 to 16 months. Lynn Read reminded the PAP that intensive work would be required regarding the development of per capita costs.

There was no public comment, and the meeting was adjourned.