MEDICAID ADVISORY COMMITTEE
October 19, 2004

Present: Bruce Bliatout, Michael Garland, Kelley Kaiser, Rick Wopat, MD

Absent: Elizabeth Byers, Donna Crawford, Rosemari Davis

OHPR: Bruce Goldberg, MD, Bob DiPrete

OMAP: Lynn Read, Mary Reitan

Public: Liz Baxter

TOPIC	DISCUSSION	ACTION
Opening Remarks and Approval of Minutes	Kelley Kaiser, Chair, opened the meeting. The minutes from the Committee meeting on August 24, 2004, were approved as written.	Information item

TOPIC	DISCUSSION	ACTION
DHS Update on Budget Rebalance and Premiums	Lynn Read explained to members that the semi-annual DHS Rebalance will be presented to the Legislative Emergency Board on November 18. Caseload in OHP Plus currently is higher in all categories, especially in the non-cash payment Temporary Assistance to Needy Families (TANF) group. There is every incentive to ensure that applicants who may previously have been made eligible for OHP Standard are, instead, enrolled in the TANF program if they meet TANF eligibility criteria. Total tobacco tax revenue is down $19 million from the April Rebalance. DHS' caseload forecast model looks at several years of caseload history along with the most recent year. Caseload is higher than the model predicted. OHP Standard will not be addressed in the General Fund Rebalance as it is funded solely with provider taxes and premium revenue, matched with federal funds. OHP Plus will be addressed in November rebalance. The Department's rebalance plan will address problems and savings across the Department as a whole.	Information item

TOPIC	DISCUSSION	ACTION
DHS Update on Budget Rebalance and Premiums	A budget note from the 2003 Legislative Session allows DHS to Recommend a change in premium policy for OHP Standard. While the rebalance plan is not completed, it is expected the Department will recommend that premiums not be imposed for clients with incomes between 0-10% of federal poverty. If the recommendation is adopted, between 250 and 350 fewer clients will be served. This recommendation targets premium relief to those most financially vulnerable, as well as a disproportionate number of homeless and clients with mental conditions. The effective date for the change in premium policy would probably not occur until April 2005, at the earliest, depending on approval from Centers for Medicare and Medicaid Services (CMS) and administrative requirements to implement the change in policy. As of October 2nd, there were 45,000 clients on OHP Standard. 19,000 (42%) of those had income under 10% of federal poverty. The September Legislative Emergency Board directed DHS to provide an update on OHP Standard caseload at the next Emergency Board meeting. DHS is using the natural attrition strategy to reduce caseload from 55,000 to 24,000 clients and has been closely monitoring the program. Caseload decreased by 5,700 clients in September but was still above the projection by 800. On October 1st, 5,900 clients dropped off of Standard. Caseload was above projection by 1,500 clients on	Information item

TOPIC	DISCUSSION	ACTION
DHS Update on Budget Rebalance and Premiums	October 15. Department of Human Services (DHS) Cabinet will make the decision in November on whether to lower the federal poverty eligibility income level for OHP Standard. If the federal poverty eligibility income standard is lowered, it would not become effective until February 2005. Approval from the Centers for Medicare and Medicaid Services (CMS) is not required. DHS would provide them with a 60-day notice. The Legislative Emergency Board has asked DHS to report its decision at the meeting on November 18. Approximately, two-thirds of clients who currently receive OHP Standard have incomes below 50% of federal poverty. As caseload declines, there will remain a core population that tends to stay on programs longer which may create a dilemma for DHS in achieving its target caseload by attrition alone. Over the last few months, all clients statewide, below 10% of federal poverty, who were in danger of being disqualified for non payment of premiums, have had their premiums paid by premium sponsorship organizations. Michael Garland asked if the agency is working on administrative efficiencies. Lynn Read responded administrative efficiencies are being built in the Governor's Recommended Budget that will come out in December. Bruce Goldberg emphasized that the state must look at ways to stabilize health care costs, minimizing the increase.	Information item

TOPIC	DISCUSSION	ACTION
Governor's Small Work Group on OHP Reform	Bruce Goldberg explained several months ago the Governor formed a small group to put together a draft proposal on OHP reform to be sent out publicly to seek feedback. A draft document, Preliminary Draft #1, was prepared and discussions have occurred with managed care plan, provider, business and labor, advocate, and long-term care stakeholders as well as the Local Government Advisory Committee. The draft document will be revised with stakeholder input and presented to the Health Policy Commission in November. This November meeting will serve as a forum for broader public input. Dr. Goldberg asked the Committee for its comments. The major issue is how to create sustainability in the Oregon Health Plan (OHP). The last four years have been turbulent in the health care area with a progressive diminishing of benefits, followed by diminishing of population receiving health coverage. This past biennium's post Measure 30 budget was $10.2 billion, plus an additional $600 million of one-time spending. Projected revenue for 05-07 is approximately $11 billion, whereas the state's agency requested budget projections to continue current programs are approximately $12.8 billion for the 2005-07 biennium. The governor has about $11 billion to work with in preparing his Recommended Budget. The work group initially considered a proposal that looked at long-term goals. They quickly realized with current budget constraints, a proposal would have to be built on two tracks: 1) short-term and 2)	Information item

TOPIC	DISCUSSION	ACTION
Governor's Small Work Group on OHP Reform	how to build a future long-term plan. The draft proposal document focuses only on the short-term. There is a need to better align revenue with spending. The group looked at ways to create a health plan that was more sustainable and what are the options for cuts when the revenue is not there. Rick Wopat commented the draft document does not sufficiently recognize the OHP as part of the larger health care system which is fragmented, complex and costly. Options suggested for reforming the OHP will impact the larger health care system as costs will be shifted when people lose OHP coverage. Clients will seek care at emergency rooms, safety net clinics, etc. Michael Garland added short-term fixes need to be made but need to be persistently framed with a larger vision. There needs to be accountability. Rick Wopat suggested the work group look for ways for allowing different models to pool funding. One example would be to allocate funding to communities based on the number of people in the community. The community would then be able to control the provision of services. Committee members agreed that a model for integrating physical health, dental health, mental health and long-term care in those areas where possible would increase efficiency in access to services and	Information item

TOPIC	DISCUSSION	ACTION
Governor's Small Work Group on OHP Reform	more efficiency in managing costs. Michael Garland stressed that the model needed to be a contractual agreement with long-term accountability. Michael Garland indicated sustainability has to be linked with changes and improvements in the overall health care system. Bruce Goldberg noted that some private sector health systems integrate physical health and mental health. They do not have parity but do have integration for payment. Long term care is becoming a major economic issue due to the change in aged population demographics. Long-term care expenses will likely be astronomical in the future. Rick Wopat expressed concern around the imposition of a cap on health care cost increases stated in the draft document. Bruce Goldberg responded that it was not meant to be a statutory cap, and the intent was to create a discipline among legislators, providers and the health care system. Michael Garland suggested highlighting activities, e.g., budget management, would be a better avenue to promote discipline. Bob DiPrete indicated the work group was not directed to focus on options to bring in more revenue, but that the Medicaid Advisory Committee does not have the same limitation.	Information item

TOPIC	DISCUSSION	ACTION
Governor's Small Work Group on OHP Reform	Bob DiPrete agreed to draft the Committee's comments on the Preliminary Draft #1 of the report from the Governor's small workgroup on the OHP and e-mail to the Committee for any changes prior to being submitted as comments for consideration in the revised draft to be sent to the Health Policy Commission.	Bob Diprete will draft the Committee's comments on the Preliminary Draft #1 and e-mail to members for any changes.

TOPIC	DISCUSSION	ACTION
Health Policy Commission Access Subcommittee	Rick Wopat said the Access Subcommittee had just completed statewide hearings and community meetings and is compiling feedback to send on to the Health Policy Commission. The Subcommittee is looking at different models to provide access to basic preventive care and primary care to OHP Standard clients within available funding. The Subcommittee is looking at ways to provide better health care by strengthening the safety net around the state and utilizing state funding to move in that direction, which has been difficult due to fragmentation. There is more flexibility in the categorical OHP Plus group to design a model to provide prevention and disease management. The Committee will be looking at whether funds for OHP Standard can be increased to provide those services.	Information item
Safety Net Work Group	The Governor's Office formed a group to develop policy recommendations around safety net. Members include: legislators, representatives from school-based health clinics, Outside In, safety net clinics and the Office of Rural Health. The work group agreed upon a definition for safety net and will be finalizing policy recommendations over the next month. Recommendations will focus on: ▫ Strengthening the safety net ▫ Capacity ▫ Need for services ▫ Safety net financing issues	Information item

TOPIC	DISCUSSION	ACTION
Safety Net Work Group	Michael Garland expressed concern with what fits into the definition of safety net, and with the idea that a separate safety net system will always be necessary.	Information item
Other	The next Medicaid Advisory Committee meeting is scheduled for Wednesday, December 15, 2004, from 9:30 a.m. to 12:00 p.m, in Room 167A, State Capitol, 900 Court Street, N.E., in Salem.	

MEDICAID ADVISORY COMMITTEE

July 13, 2004

Present: Donna Crawford, Michael Garland, Kelley Kaiser, Rick Wopat, MD

Absent: Bruce Bliatout, Elizabeth Byers, Rosemari Davis

OHPR: Bruce Goldberg, MD, Bob DiPrete, Darren Coffman, Jeanene Smith

OMAP: Jim Edge, Mary Reitan

Other: Liz Baxter, OHPR; Allana McDonald, Legislative Assistant for Rep. Mitch Greenlick

TOPIC	DISCUSSION	ACTION
Introductions and Opening Remarks	Introductions were made by Committee members.	Information item
Approval of Minutes	The Committee approved the minutes of June 8, 2004, as written, with a few wording changes.	Minutes were approved
Governor's Initiatives	Bruce Goldberg explained the Governor's office has convened a small workgroup of 8 members (4 legislative members, and 4 members of the public with experience in health care policy). The OHP workgroup's charge is to seek ideas for strategic direction for the OHP in the future. The workgroup will seek input from stakeholders during the fall and then revise their thoughts based on that input. Their ideas will then be presented to the Medicaid Advisory Committee and the Health	Information item

Governor's Initiatives	Policy Commission for further public input in the fall. Rick Wopat expressed concern that potential solutions will not fit in all situations. Regional approaches need to be enabled. Rick would encourage members not to think about just one statewide approach. Jim Edge commented that members must realize that solutions involving Federal approval are taking much longer now. Michael Garland urged that solutions coming out of the discussions be based on: • values on which to base the solution • how proposed strategies relate to these values Bruce Goldberg said the Governor recently announced 3 initiatives to expedite coverage for uninsured children: 1. Raise asset limit test for Children's Health Insurance Program (CHIP) from $5,000 to $10,000. 2. Insurance Pool Governing Board to implement a "kids only" health plan for employers who currently do not offer any health coverage. 3. Implement an outreach/enrollment pilot in two counties. Michael Garland indicated there needs to be both an urban and a rural outreach/enrollment pilot.	Information item

OHP Update	Jim Edge presented background and an update on the Spry litigation. The judged ruled that the imposition of copayments for the OHP Standard population was illegal and ruled that premiums were not a form of cost sharing. Oregon discontinued copayments for OHP Standard on June 19. OHP Plus, however, still includes copayments within federal limits. Jim Edge also updated Committee members on strategies to retain some of the OHP Standard program after August 1st when state funding is no longer available. Enrollment was closed to new members on July 1. The Department of Human Services (DHS) will monitor the current OHP Standard population (currently, approximately 51,000 eligibles) over time to see if enrollment drops through attrition. Managed Care Organizations (MCOs) and hospitals have agreed to have a provider tax imposed in order to continue the OHP Standard benefit package at a reduced level and with reduced enrollment. Federal officials have approved the tax on MCOs. A waiver amendment was not required. The state is awaiting federal approval of Oregon's waiver amendment of the tax on selected hospitals. DHS anticipates that it will be able to provide a "core" benefit to approximately 24,000 OHP Standard clients when both provider taxes are approved. This number is not certain and will depend on attrition and other factors. If the hospital provider tax does not receive federal approval, DHS would need a lower target than 24,000.	Information item

OHP Update	The federal government has given verbal approval to some of Oregon's pending requests. DHS plans to implement August 1, pending written confirmation: • a reconfigured benefit package for OHP Standard which adds back outpatient mental health services, outpatient chemical dependency services, and provides a limited hospital benefit • a three-line movement on the Prioritized List of Health Services (Note: Since the time of this meeting, written CMS approval has been received for these requests.) DHS will be reporting to the legislature on cost sharing at the September Emergency Board and making recommendations on cost sharing to the November Emergency Board. The Medicaid Advisory Committee (MAC) has already made a motion that no premiums be imposed on clients with incomes between 0-10% of federal poverty. The Committee will take public input at its August 24 meeting to be used in developing recommendations to the Legislative Emergency Board on premiums and other cost sharing. Agencies are currently preparing budget proposals which will be incorporated into the Governor's Recommended Budget to the legislature. Agencies are also expected to submit policy packages and reduction packages.	Information item

OHP Update	Jim Edge suggested as an agenda item for the August Committee meeting: • review and recommend policies for new priorities • review and recommend policies for reductions A list of the DHS recommended Policy and Reduction packages will be posted on the DHS web-site on July 20. Jim Edge reminded the MAC that Centers for Medicare and Medicaid Services (CMS) has been unwilling to allow much flexibility in state requests to reduce cost in their programs. Last year, CMS awarded states a small increase in their federal match rate. Oregon's went from 60% to 62% for 15 months. The increase expired July 1st. Senator Smith has requested an extension. Oregon will not be eligible as it was disqualified for reducing the OHP Standard population. Jeanene Smith inquired whether the Spry lawsuit restricts nominal copayments for OHP Standard. Jim Edge replied that federal regulations do not mention copayments for an expansion population. Based on that, the judge's interpretation was to disallow any and all co-payments for the OHP Standard population. Premium sponsorship was discussed. Premiums for OHP clients were originally set by the Waiver Application Steering Committee. At that time, sponsorship was never discussed.	DHS recommended Policy and Reduction packages will be listed in the DHS web-site on July 20.

OHP Update	Private entities have recently come together to pay premiums for clients who are about to lose coverage due to non-payment of premiums. OMAP has requested legal advice from the Department of Justice (DOJ). DOJ cited three areas of concern: • When a provider pays a premium for a client that in turn benefits the provider, it suggests the possibility of an "anti-kickback" violation. • There is a limit on the dollar amount of donations contributed by health care providers (cannot exceed 25%). • "Statewideness" may be a concern in sponsorships. OMAP has crafted a policy describing the circumstances in which donations can be accepted from sponsorship organizations, reflecting the above legal interpretations. Meetings are being held between state officials and representatives from the sponsorship organizations to discuss legal issues and ramifications of premium sponsorships. Community Health Partnership, the sponsorship organization in Multnomah County, has informed OMAP that it will no longer be able to continue its participation as of July 1.	Information item

Approaches to Prioritizing Services	Bob DiPrete presented a brief history of how costs were contained prior to OHP implementation by reducing enrollment by tightening eligibility, by putting restrictions on the number of service units allowed (e.g., capping the number of hospital days per recipient per year), or by reducing provider payments. The prioritized list of health services developed by the Health Services Commission (HSC) replaced limits on the number of services with thousands of condition/treatment pairs grouped into lines and rank ordered by order of importance. The intent was to maintain coverage for everyone below 100% of federal poverty by moving the "coverage" line on the prioritized list up or down in accordance with available funding. However, the federal government has not been flexible in granting approval for this type of request. A report was developed in 2000 by the HSC and the Oregon Health Council recommending a new "basic benefit package", using a combination of cost sharing and the prioritizing of broad service categories. The Waiver Application Steering Committee (WASC) then redefined a basic benefit package for the new OHP Standard expansion population. An OHP 1115 Waiver Amendment and HIFA Waiver Application was submitted to the federal government in 2002.	Information item

Approaches to Prioritizing Services	Oregon faced a severe budget crisis during 2002-2003, resulting in further reduced benefits for clients eligible for OHP Standard, which required further amendments of Oregon's waivers. Bob noted that many states, including Oregon, have been seeking ways to reduce costs due to financial constraints. Strategies generally combine elements of the following four basic approaches to limiting services: • limiting units of service per person • limiting the dollar value of care covered • limiting the diagnoses covered • limiting the treatments covered Oregon is monitoring other states that have limited their benefit packages for expansion populations. Jeanene Smith provided members with a brief summary of re-designs in Medicaid in other states. Rick Wopat requested Jeanene Smith to provide cost data for office visits from the states surveyed. Michael Garland asked Jeanene Smith to check with other states for data on access outcomes.	Jeanene Smith will check with other states for data on access outcomes.

Approaches to Prioritizing Services	Bob DiPrete suggested that MAC members be kept informed of related issues that the Health Policy Commission and its work groups are reviewing, and that the MAC collaborate with these bodies wherever appropriate. Rick Wopat, member of both the MAC and the Health Policy Commission and Access Subcommittee, explained that Subcommittee's work. It is divided in three areas: • Assessment of access in rural health • Identifying crisis issues and creating short-term fixes • Restructure of the health care system The Subcommittee met last week to define necessary services for all Oregonians in terms of: • preventive • primary care (using the U.S. Public Health Services categories) • reproductive services The Health Policy Commission will be seeking input from the Medicaid Advisory Committee as it addresses these issues and others relating to coverage for Medicaid populations. Bob DiPrete noted that the Health Policy Commission will be revisiting the original OHP policy objectives in its discussions and suggested that the MAC use those same policy objectives as a	Information item

	starting point in developing its recommendations coming out of the August 24th meeting.	
Other	The August 24th meeting will include further discussion of what the MAC can do to support the work of the Health Policy Commission. This meeting will also include public input for DHS' letter to the November Legislative Emergency Board with DHS' recommendations on client cost sharing. The next Committee meeting will be held on August 24, 2004, from 8:30 am to 11:30 am, in Hearing Room B, State Capitol.	The Committee meeting on August 24 will include public testimony and discussion on recommendations on cost sharing.

TOPIC	DISCUSSION	ACTION

TOPIC	DISCUSSION	ACTION

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MEDICAID ADVISORY COMMITTEE
June 8, 2004

PRESENT: Rosemari Davis, Michael Garland, Kelley Kaiser, Rick Wopat, MD

ABSENT: Bruce Bliatout, Elizabeth Byers, Donna Crawford

OMAP: Jim Edge, Mary Greipp, Mary Reitan

OHPR: Bruce Goldberg, MD, Bob DiPrete

Guests: Diane Lund, Oregon Health Forum

TOPIC	DISCUSSION	ACTION
Introductions Approval of Minutes	Introductions were made by Committee members. The minutes from the last Committee meeting on May 12, 2004, were approved as written.	Information item

TOPIC	DISCUSSION	ACTION

OHP Update	Jim Edge presented a brief update to Committee members about the status of the Oregon Health Plan (OHP) waiver amendment requests with the Centers for Medicaid and Medicaid Services (CMS).
	
	Department of Human Services (DHS) and Governor's office staff participated in a conference call with Dennis Smith, Director, Medicaid and State Operations, and other CMS officials on June 4. Mr. Smith addressed all of Oregon's pending issues with CMS and confirmed the following decisions:
	
	• Approval of 3 lines of Oregon's request for a 30-line movement on the Prioritized List of Health Services.
	
	• Approval of the request for a reconfigured benefit package for the OHP Standard Program. Services included in the benefit package:
	  • physician services
	  • ambulance
	  • prescription drugs
	  • laboratory and x-ray services
	  • limited durable medical equipment and supplies
	  • outpatient mental health (reinstated)
	  • outpatient chemical dependency services (reinstated)
		Information item

TOPIC	DISCUSSION	ACTION

OHP Update	• emergency dental services
	• hospice services
	• limited hospital benefit
	  • emergency treatment
	  • evaluation and other diagnostics to determine diagnosis
	  • treatment of urgent conditions that prevent life threatening health deterioration
	
	• Disapproval of Oregon's request for flexibility to add or remove optional services on the OHP Plus benefit package without CMS approval.
	• Disapproval of the request for implementation of the Medical Expansion for persons with Disabilities and Seniors (MEDS) program.
	• Approval of the expansion to raise eligibility from 185% to 200% of the federal poverty level (FPL) on the state Children's Health Insurance Program (CHIP). However, Oregon currently does not have sufficient funding to take advantage of this approval.
	• Approval of the expansion of the Family Health Insurance Assistance Program (FHIAP) to 200% FPL. Oregon currently does not have available funding to take advantage of the approval.
		Information item

OHP Update	The policy from the Governor's office right now is to keep both the	Information item

TOPIC	DISCUSSION	ACTION
	CHIP and FHIAP programs at 185% of federal poverty. • Approval of the request to implement a PCO (partially capitated organization) program in the OHP. Kaiser Foundation has expressed interest in coming back to the program serving as a PCO. Other plans may be interested later. Approval of the managed care provider tax and the necessary rates needed to fund a reduced OHP Standard population when the state funding goes away on August 1 was discussed. Oregon's Fully Capitated Health Plans (FHCPs) have been notified of CMS' approval of the managed care tax and the plan to implement the reduced OHP Standard population on August 1. Oregon's pending approval from CMS on the request for waiver and State Plan amendment to implement a hospital provider tax was discussed. CMS is reviewing the requests and documentation submitted and a response should be forthcoming soon. State officials and hospital officials have all agreed on the tax.	
OHP Update	Two press releases will be sent out today. • The Oregon Health Plan (OHP) Standard program will be closed	Information item

TOPIC	DISCUSSION	ACTION
	to new enrollments as of July 1, 2004. This will begin the attrition process to get down to a number of enrollees that Oregon can afford. 24,000 to 25,000 enrollees may be sustained on OHP Standard if both the hospital and managed care provider taxes are available. • Medicaid co-pays for Oregon Health Plan's Standard clients will end June 19. The decision to discontinue co-payments for OHP Standard clients was the result of a court case, filed by Oregon Law Center, against both the federal government and State of Oregon challenging whether cost sharing could be implemented. Premiums and co-payments were challenged. The Court judge ruled that even though the federal government had approved co-payments, the practice was contrary to federal law for an expansion population. The ruling does not affect nominal fee-for-service co-payments for the OHP Plus population. Since co-payments were not mentioned in federal regulations for the expansion of programs, the judge ruled that co-payments may not be imposed on the Standard population.	
OHP Update	The judge did not consider premiums to be cost sharing and ruled that premiums are allowable and could continue as they currently exist. The judge's decision was based on the wording in the federal statutes and not the state. The federal government may appeal the court ruling.	A copy of the Legislative Budget Note on cost sharing will be provided to

TOPIC	DISCUSSION	ACTION
	The state is not planning to appeal. Oregon has been given 30 days to discontinue the use of co-payments for the OHP Standard population. Co-payments for OHP Standard will end on June 19. The Fully Capitated Health Plans (FCHPs) will have to make the necessary changes in their systems, and DHS will have to develop new capitation rates. Jim Edge indicated that DHS will be reviewing client cost sharing and will take into consideration the Committee's recommendation that no premiums be imposed on clients who have incomes below 10% of the federal poverty level. DHS will make recommendations to the Legislative Emergency Board in November on client cost sharing. Michael Garland said it would be valuable for the Committee to see the charge the legislature gave to the Department to make this report on cost sharing. Jim Edge explained there was a budget note in the DHS budget that directed OMAP to do that and will provide a copy of the Budget Note to the Committee.	Committee members.

TOPIC	DISCUSSION	ACTION
OHP Update	Bruce Goldberg said the Committee will be able to have some input into what gets developed and can bring ideas to a future meeting. Attrition down to a lower enrollment number for OHP Standard will begin on July 1. On August 1, state funding for OHP Standard will be discontinued, and the OHP Standard benefit package will be redefined. A decision has not yet been made on whether a lower federal poverty limit will be used to determine eligibility for the new limited Standard benefit. Analysis is currently being done in DHS to determine what the attrition rate will be for current eligibles leaving the program. Efforts are underway by advocacy organizations and others to pay for premium sponsorships for clients who cannot pay their premiums. Sponsorship will have an effect on the number of people who stay on the plan and the number of people who attrition off of the plan. Kelley Kaiser asked when will Oregon be notified of CMS approval on the hospital provider tax? Jim Edge explained hopefully this month. The hospital provider tax can be implemented retroactively. Higher payments will be made to hospitals in fee-for-service payments retroactively so that once the approval is received the calculations currently being used will stay the same.	Information item

TOPIC	DISCUSSION	ACTION
OHP Update	Bruce Goldberg added the state does not anticipate the timing of that decision to impact the changes that will occur in the OHP Standard program. Rick Wopat inquired how the decision would be made to lower the eligibility level for Standard? Jim Edge explained the issues of reducing the population by attrition has been discussed including representatives from the Governor's office and health policy makers from several agencies. The decision to use or not use a lower eligibility level, and when, was given to DHS. Gary Weeks, Director, DHS, is the ultimate decision maker on the overall policy with advice from the Office of Medical Assistance Programs, DHS Caseload unit and other stakeholders. The Caseload Unit uses mathematical models in order to project enrollment. Bruce Goldberg added that the agency has kept legislators informed and has sought their input during the whole process. Currently, the agency has only two tools available, the ability to open and close the program, and the ability to change the eligibility level. The agency does not have the authority to change the benefit package other than the change that the legislature directed in HB 2511 in the last Legislative session. CMS has approved that change.	Information item

TOPIC	DISCUSSION	ACTION
	The agency's priority is to provide as many services as possible for low income people within the law.	
OHP Update	Rick Wopat expressed concern that barriers are put up in order to reduce enrollment numbers as opposed to selective decision making to help the most vulnerable. Jim Edge indicated the agency feels constrained by the tools available to them. The State cannot selectively choose who is covered under the programs. Federal, state and Department of Justice interpretations place restrictions on the state. Bruce Goldberg has raised the possibility of using vulnerability in terms of disease status at a number of meetings. The federal government has been very explicit in not permitting states to base eligibility on health status in this way. The legislature may consider some changes in the law during the next Legislative session since the statues were not designed for today's environment. The Committee may want to weigh in on that process with the legislature. Bruce Goldberg said there have been two basic principles used in deciding how to lower enrollments: • Give priority to the most vulnerable. At this time, the only tool	Information item

TOPIC	DISCUSSION	ACTION
	the state has is to lower the eligibility level. • Maintain continuity of care and maintain continuous care for enrollees currently on the program and receiving regular ongoing care.	
OHP Update	This second principle has been one of trying to maintain continuity of care for those people who currently are on the plan and are receiving ongoing regular care. An example of this is somebody with HIV or chronic disease, with income at 75-95% of federal poverty and looking to continue to try to maintain some continuity of care. Rosemari Davis asked why are the legislators going to come back to the table to re-think or re-legislate the program? Jim Edge explained there is a group of legislators who have been very active and have had a high level of interest in the OHP and the legislation involving the OHP. They have been kept involved in what's been happening since the end of the Legislative session, and now realize that HB 2511 and HB 3624, two key bills in the last legislative session were passed in a world that doesn't look the same as it does today. Legislators assumed there would be funding to provide a reasonable benefit package to the OHP Plus and OHP	Information item

TOPIC	DISCUSSION	ACTION
	Standard population. The world has changed and it may now be necessary to make changes in the next Legislative session due to financial constraints. The cost of the OHP Plus benefit package will need to be re-evaluated so see if some of the optional services should still be covered. The Legislature may look at reinstating the 10 cent tobacco tax, lost when Ballot Measure 30 was defeated, which cost DHS $24 million for the Oregon Health Plan. The Committee was asked to provide feedback or ideas.	
OHP Update	Michael Garland asked if the Office of Oregon Health Policy and Research (OHPR) was involved in research in an effort to characterize the correlation between poverty and health status so legislators could see the implications on health status. Bruce Goldberg responded that his office is looking at the distribution of cost and illness across poverty levels, effects of premiums/co-payments and the impact on health status of those people who lost coverage because they couldn't make the payments, some of the community factors around what's going on in the emergency rooms as a result. In terms of access, they are looking at such things as ambulatory sensitive conditions, those illnesses which if treated properly through access to care in an outpatient setting don't end up in the emergency room or hospital, i.e. diabetics who are able to get their insulin. They are looking at ways to provide the right care, in the right	Information item

TOPIC	DISCUSSION	ACTION
	place, to the right people, and looking at what some of the changes have done to that. Rick Wopat said in regards to legislation being drafted for 2005, the Committee should not lose sight of this opportunity to provide input on restructuring the benefit package in a way that gives the agency more tools than they have right now. Bruce Goldberg reminded members that the Office of Oregon Health Policy and Research (OHPR) staffs both the Medicaid Advisory Committee and the Health Policy Commission and is key to helping develop and moving proposals forward in the legislature.	
OHP Update	He asked the Committee to tell his office what they want, or do they want his office to provide them with some ideas. Rosemari Davis responded she would like to see a menu of tried and true ideas. Bruce Goldberg said the main barrier is not having the flexibility to fully use the prioritized list, which was in the original design of the OHP.	Information item
OHP Standard Letter	The Committee reviewed and commented on the draft letter to the Health Policy Commission regarding limiting eligibility or limiting benefits for the new OHP Standard benefit.	The Committee approved to the draft letter to the Health

TOPIC	DISCUSSION	ACTION
	Michael Garland commented that the letter captures the intent of the last Committee meeting. The Committee approved the letter with changes. Rick Wopat recommended the letter be sent to a wider audience than just the Health Policy Commission, i.e., legislators, legislative staff and the Governor's Office. Bruce Goldberg indicated the Joint Interim Committee on Health and Human Services would be an appropriate body as well those legislators who were on the legislative committees that dealt with health issues during the last Legislative session. Bruce Goldberg will put together the appropriate list. Michael Garland inquired how many legislators would the letter be sent to and suggested a cover letter accompany the letter sent to individual legislators. Bruce Goldberg responded about 15 legislators, legislative staff, Governor's office and DHS staff.	Policy Commission with changes.

TOPIC	DISCUSSION	ACTION
Prioritizing OHP Benefits	Michael Garland explained the original intent of the OHP was to provide a basic benefit that served the most people. The prioritized list was established as the benefit benchmark for those qualifying for the Employer Mandate and for Medicaid. It operated on the assumption that a single basic benefit package made sense. OHP 2 showed there are populations for whom variability in the benefit package makes sense. What may be appropriate basic care for one group of people isn't really basic care for another group of people with special health care needs. Michael Garland suggested that we need to encourage a willingness to revisit the single method of prioritization and to urge the inclusion of epidemiological subsets in the OHP benefit package design. Rick Wopat expressed concern about having a different definition of a basic health care package for someone who has a chronic condition as opposed to someone who is healthy. Rick Wopat asserted that health policy is too commonly built on personal interest stories.	Information item

TOPIC	DISCUSSION	ACTION
	When an individual is asked what is important to them, it is often not about what makes the most sense in broad public policy but what is important for their individual needs. In terms of broad public policy, if the choice is between spending $100,000 on transplanting one	
Prioritizing OHP Benefits	liver, or $100,000 spent on immunizations for 50,000 people to prevent the disease that causes the liver disease, which is the better thing to do. Good public policy would stress that prevention is more important than treatment. The Committee needs to force the discussion on what provides the most benefit for the most people as opposed to providing a specialized benefit to an individual. Public policy becomes problematic when trying to set policy for special populations. Bob DiPrete added that identifying segments of the population that have certain health care needs for eligibility for specific benefit packages will have a definite impact on rate setting, greatly complicating that process. Kelley Kaiser said the Committee's goal is to challenge and seek different ways to improve health care.	Information item

TOPIC	DISCUSSION	ACTION
	Public policy needs to be set for the whole population.	
Status of New Members	Bruce Goldberg indicated that there is a list of potential new members being developed for the Committee. His office has looked at the statute that created the Committee and a list of names is being generated for the Governor's consideration. Dr. Goldberg asked for Committee input and to send Bruce suggestions and recommendations for new members. Rosemari Davis recommended that the statute on attendance for Committee members be re-examined and steps be taken to assure that members participate fully in the work of the Committee.	Committee members were asked to send Bruce Goldberg suggestions and recommendations for new members.
Other	The next Committee meeting is scheduled for Tuesday, July 13, from 9:30 am to 12:00 noon in Room 167A, at the State Capitol, 900 Court Street NE, Salem, Oregon.	The next Committee meeting is scheduled for July 13.
	Meeting was adjourned.	

MEDICAID ADVISORY COMMITTEE
May 12, 2004

Present: Bruce Bliatout, Elizabeth Byers, Rosemari Davis, Michael Garland, Rick Wopat, MD

Absent: Donna Crawford, Kelly Kaiser, Noel Larsen, DMD

OMAP: Jim Edge, Mary Reitan

CAF: Carolyn Ross, Sue Abrams

Dr. Wopat opened the meeting explaining the task was to gather information and take testimony on the Office of Medical Assistance Programs' (OMAP) proposals regarding continuing coverage for the OHP Standard population.

Introductions were made by the Committee to guests.

Committee minutes of April 29, 2004, will be voted on at the next meeting.

Status Review/CMS Update

Jim Edge, Assistant Administrator, OMAP presented a review of the history of the Oregon Health Plan (OHP) leading to where it is currently.

?OHP2? - approved by Centers for Medicare and Medicaid Services (CMS) is currently the program in place, but it is not sustainable.

?OHP3? - resulted from changes passed in HB 2511 during the 2003 legislative session. OMAP is awaiting approval from CMS on two requests:

- Revised OHP Standard benefit package (physician, ambulance, prescription drugs, laboratory, x-ray, medical supplies, outpatient mental health services, outpatient chemical dependency services, emergency dental, and limited hospital benefit).

- 30-line movement on the Prioritized List of health Services CMS has indicated they will only approve three lines:
  547 - Acute eye infections

548 - Foreign body in ear & nose, serious earwax impaction
549 - Dizziness (vertigo), problems in the balance system

?OHP4? - refers to further changes as a result of:

- Failure of Ballot Measure 30 (substantial revenue loss)
- Failure of Ballot Measure 30 resulted in DHS having to propose changes to the Legislative Emergency Board in the Agency Rebalance request.
- Changes approved by the Legislative Emergency Board:
  - Maintain OHP Plus at current levels with same benefit package
  - Maintain Children's Health Insurance Program (CHIP) and Poverty Level Medical (PLM) program, at current levels, at 185% of federal poverty
  - State funding will be eliminated for the OHP Standard program after August 1, 2004, in order to support the other programs.

DHS Proposals to Preserve OHP Standard

HB 2747, passed in the 2003 legislative session, authorized the use of provider taxes to fund the OHP.

- Managed Care Organization (MCO) provider tax:
  - MCO's support the tax
  - Tax will not require a federal waiver but requires CMS approval of new managed care capitation rates
  - CMS approved the request to tax the MCO's on April 15 to fund a limited OHP Standard benefit
  - The MCO provider tax is effective on May 1st.

- Hospital provider tax:
  - Requires a federal waiver to exempt Type A/B hospitals and Oregon State Hospital
  - Requires a State Plan Amendment (SPA) for new fee-for-service rates
  - Negotiations are continuing between the State and the Oregon Association of Hospitals and Health Systems and are going well.

Steps the State must take:

- Discontinue the State general-funded OHP Standard program on August 1.

- Must have all necessary approvals required to implement an OHP Standard program funded with provider taxes and Federal matching funds on August 1.

- Must have CMS approvals to move to the restructured OHP Standard benefit package on August 1 and move the line on the Prioritized List of Health Services.

DHS is optimistic that approvals will arrive in time to implement the new restructured OHP Standard program. Both Gary Weeks, Director, DHS and Senators Wyden and Smith's office are supportive and have been working with CMS to obtain the expedited approvals as quickly as possible.

- Policies and procedures must be in place to reduce the OHP Standard population to a sustainable level for 2005-2007.

Jim Edge explained there will be no state funds to fund the OHP Standard program beyond August 1st; the program will have a limited amount of provider taxes available. He asked the Committee to provide further discussion and input on the methodology for a limited OHP Standard benefit for about 24,000 enrollees and also to provide discussion and input of maintaining that population. OMAP has received approval on the Managed Care Organization (MCO) tax and is optimistic about getting approvals from the Oregon Association of Hospitals and Health Systems (OAHHS) and the federal government on the hospital tax.

Jim Edge explained that OMAP administers the benefit package for the Oregon Health Plan (OHP). Children, Adults and Families (CAF) determine eligibility for the OHP programs and a number of other programs.

Elizabeth Byers: Inquired how many clients who lost coverage due to failure to pay premiums came back into the OHP. Jim Edge responded around 6% of those who lost coverage from non payment of premiums came back into the program after the six-month lockout. He will provide the Committee with demographic data.

Jim Edge explained that the proposal the next speakers will make involves the possibility of using both attrition and lower income as the criteria for how to get down to a sustainable level to maintain this population. If there are more people in the program, the tools OMAP would have to work with are to either lower the federal poverty level or close enrollment for a period of time.

Michael Garland expressed concern over the language of a "sustainable" program and would like to advise that OMAP change their frame of reference and not talk about what is going on now in the OHP as a "sustainable" program because at best it is a bridge until the state changes its statutory assertion that the state has responsibility to assure access for all citizens. It is his observation there should be a very clearly defined intentional effort to bridge out of a crisis back into the something that fulfills the obligation the state put upon itself when it passed the first OHP.

Rosemari Davis asserted that provider taxes, both MCO and hospital, are to be used for a temporary interim situation and, in fact, the bill stipulates it. The state is looking at an interim plan, the best the state can do under a terrible situation.

OHP Standard Disenrollment and Enrollment Proposals

Carolyn Ross, Medicaid Program Manager, and Sue Abrams, Administrator, Office of Prevention and Transitional Benefits, CAF, presented disenrollment and enrollment proposals for OHP Standard. CAF was asked by OMAP to develop revisions to the OHP Standard policies that will manage and maintain a reduced number of OHP Standard recipients. The Committee was asked for feedback on this proposal.

The OHP Standard program will be closed to new applications on July 1. Applicants applying for OHP Standard prior to July 1, and clients transitioning from OHP Plus to OHP Standard will be covered. Cost shifts will be reduced by allowing clients to transition from Plus to Standard, e.g., a woman after she has a baby can transition from OHP Plus to OHP Standard as long as she meets the income criteria. This would serve the best interest of the client and prevent cost shifts to other programs.

A proposed rule reflecting this policy will be filed on May 14, with an effective date of July 1.

New clients will not be allowed to enroll after July 1, and only those who remain continuously eligible will be covered. Notices explaining the policy have been sent to clients.

In order for the program to be sustainable, the caseload must attrition down to approximately 24,000 enrollees by June 30, 2005. DHS does not believe it is feasible that caseload attrition alone will bring caseload numbers down far enough. The following model is proposed:

- Combination of attrition and disenrollment by Federal Poverty Level (FPL) to achieve a sustainable OHP Standard population. The income level of 100% FPL would be reduced, possibly in the 30-50% range of federal poverty in order to qualify for the program.

Due to so many budget and caseload unknowns, a major issue in considering this option is the timing of the implementation to the lower federal poverty criteria.

- Apply the reduce income limit as OHP Standard clients reapply and when evaluating OHP Standard eligibility for clients losing OHP Plus. Implementing a reduced income limit on a staggered schedule when certification periods end and when clients reapply would allow time to assess eligibility for other Medicaid programs and also create certainty for clients. The downside is that it would create a two-tiered system for a period of time as clients would be at different federal poverty levels.

Rick Wopat: Commented that even though the state would like to see people at the higher poverty levels covered, in reality the only way they would be covered is if people at the lower poverty levels were not signed up or lost their benefits. Barriers would be created for people for a variety a reasons until the federal poverty limit is brought down to a certain number. Carolyn Ross responded DHS is still in analysis of what numbers can be used.

Rick Wopat inquired about administrative costs for a program of 20,000 enrollees and how that compares to the program when it was 100,000. Carolyn said DHS had over 250 staff, just processing OHP applications, when the program was at its peak with over 100,000 enrollees. The new program will require 90 staff for 20,000 enrollees. At this time there are no funds allocated to staff the new OHP Standard program.

Jim Edge indicated that at the last Legislative Emergency Board, with the elimination of General Funds for the OHP Standard program, 40-50 positions were eliminated. In order to have an additional administrative component for eligibility determination, it would have to be funded from provider tax revenue, and DHS would have to go to the Legislative Emergency Board to request staffing. DHS has not made the decision whether to ask for more staff or absorb the workload with existing staff.

Carolyn Ross explained that DHS is considering two options when the OHP Standard program can be opened again to new enrollment:

- a reservation list
  - waiting times may be long
  - federal waiver required
  - would allow strict control on who enters the program
- open enrollment process
  - applicants would have equal opportunity
  - waiver is not required by CMS
  - difficult to project how many will actually apply

Michael Garland requested examples of circumstances in which clients lose OHP Plus eligibility and transitions to OHP Standard.

Sue Abrams presented examples:

- A pregnant woman losing protected eligibility after her pregnancy ends could transition to OHP Standard if she meets the income criteria.

- Disabled clients currently receiving OHP Standard who are waiting for eligibility to be determined for OHP Plus would be placed on OHP Standard.

Approximately 2,000 clients migrate on and off OHP Standard per month.

Rick Wopat reminded Committee members that the current waiver allows the state to lock enrollment or reduce the Federal Poverty Level (FPL) but does not allow the state to consider people based on health status only.

Jim Edge indicated we do not have the authority to use disease or level of illness as criteria in determining eligibility.

Elizabeth Byers inquired if women with breast or cervical cancer were covered. Jim Edge responded these women are covered by OHP Plus under a legislatively approved program.

Bruce Bliatout asked how people will be notified when the Standard program reopens for enrollment and expressed concern that people who need coverage most will not be notified. Carolyn Ross responded a decision on how to get the word out to the most people has not been made as yet. Sue Abrams said one option would be to use the same outreach methods CAF currently has in place.

Rick Wopat asked if clients enrolled in Temporary Aid to Needy Families (TANF) medical currently receive OHP Plus. Sue Abrams responded clients applying for TANF medical are usually single-parent families and are eligible if they meet the income criteria. TANF medical is a categorical program, set by federal law, and matched with federal funds.

Jim Edge explained that the Medically Needy Program was eliminated in February 2003. It was an optional Medicaid program primarily for aged and disabled adults, with incomes above 100% of federal poverty, who were able to spend down for their high medical needs, in order to receive OHP coverage. The Legislature proposed in 2003 to bring back a prescription drug benefit for this population but it does not appear it will be approved by the federal government due to the implementation of the Medicare Modernization Act, and due to the fact that they do not want us to do an expansion program when we are reducing other programs.

Jim Edge also explained the premium payments will continue. DHS has been directed to report to the Legislative Emergency Board in November on client cost sharing. Copayments is a different issue. Currently, there is a lawsuit against DHS to eliminate higher copayments for the OHP Standard population. Lower copayments would increase the cost per person in the program.

Elizabeth Byers inquired if there are other possible funding mechanisms that could be used, i.e., unpaid taxes. Rick Wopat explained the Legislative Emergency Board has made the decision that no state money will be used to fund OHP Standard after August 1.

Michael Garland asserted that more than a general announcement needs to be sent out when the program reopens. The state needs to look at existing networks to reach out to the special populations.

Rosemari Davis asked if there would be a gap in coverage between July 1 and August 1. Carolyn Ross explained clients already enrolled in the program would continue to be covered, and new applications prior to July 1 would continue to be processed. There will just be a benefit package change on August 1.

Rick Wopat reminded members that the role of the Committee is to advise OMAP on medical policy.

Jim Edge explained the Committee actually has two roles identified in HB 3653 during the 2003 Legislative Session, when the Oregon Health Policy Commission was established. The Committee will advise the Office of Medical Assistance Programs (OMAP) and is a subcommittee of the Oregon Health Policy Commission.

Rick Wopat said the Committee's task at this meeting is to advise on the two options DHS has proposed to bring the OHP Standard population down to a number for which it could afford coverage.

- close enrollment
- limit the federal poverty level

Sue Abrams indicated the state cannot achieve the numbers by only attrition, and it has seen an increase in enrollment during the last month.

Jim Edge added the downside of closing OHP Standard completely would be that 50,000 current enrollees would lose health coverage versus transitioning down to 24,000 over a 12 month period.

Rosemari Davis said the hospitals and managed care organizations supported the provider tax because it would be matched with federal dollars. Federal matching funds would be lost if an insurance model, e.g., safety net clinics was used.

Rick Wopat questioned if it would be in Oregon's best interest to use the provider taxes to carry a limited number of people on OHP Standard. An option would be to use the taxes to improve the OHP Plus benefit.

Jim Edge expressed concern that the federal government might discontinue the waiver if Oregon had no expansion program. Oregon would also lose its ability to use the Prioritized List of Health Services, which produces a cost savings in the program.

Michael Garland exaplained that the Committee can advise DHS for the short term to keep the momentum going but these issues should be brought to the Oregon Health Policy Commission for future long-term discussions.

- The Committee passed a motion to "regrettably" endorse DHS' proposed closure of the OHP Standard program, allowing for attrition, on July 1.

- The Committee passed a motion to advise against the use of lower Federal Poverty Levels (FPLs) to a number yet to be determined, in order to disenroll OHP Standard clients. (The Committee acknowledged that since OMAP staff had identified a combination of attrition and reduced income limit as the only feasible approach to meeting budget constraints, and the Committee had no alternatives to offer, the Committee fully expects that the OHP Standard income limit will be reduced despite the Committee's motion.)

- The Committee passed a motion to recommend that no premiums be imposed for enrollees who are at 0-10% of federal poverty.

- The Committee asked that Rick Wopat draft a statement to be shared with the Oregon Health Policy Commission, upon endorsement by the Committee, expressing the Committee's concern that the DHS' proposals are far from the original principles of the OHP and that changes need to occur to preserve the original intent.

- The Committee decided to put the reservation/waiting list as a topic for later discussion.

Rosemari Davis indicated if the reservation list is used, it would require a federal waiver and the feds are slow to approve waivers.

Jim Edge noted there is a distinction between reservation list and waiting list. If someone is determined eligible and put on a waiting list, there are legal ramifications. The Department of Justice has advised DHS not to use the waiting list. The Family Health Insurance Assistance Program uses a reservation list, just writing the names of applicants down until enrollment reopens.

Public Comment

Ellen Pinney, Executive Director, Oregon Health Action Campaign (OHAC) provided the following statements from OHAC:

- Stands united in support of Mary Lou Hennrich's comments at the last Committee meeting
- Supports an active and engaged Medicaid Advisory Committee
- Supports reduced federal poverty levels as opposed to attrition by failure to pay premiums. People with incomes 0-10% of federal poverty are the most vulnerable
- Maintaining 100% of federal poverty and sanctioning an attrition rate that will focus on the lowest income level is not in the best interests of protecting the most vulnerable
- Pleased that the state has reconsidered its opposition to premium sponsorships

- Believes that a capped program of 30-50% federal poverty should have no premiums imposed
- In a capped program, barriers to enrollment need to be minimalized
- Would like to see more accountability from William Earhart, Inc. on how premium sponsorship money is utilized
- If the state is limiting OHP Standard coverage, FHIAP income levels need to be re-evaluated, as they also use federal dollars.
- Agrees with OMAP's recommendations on today's proposal
- Recommends OMAP look for alternative funding mechanisms, e.g., the MEDCO pharmaceutical settlement
- Encourages OMAP to facilitate enrollment for OHP Standard clients who might be eligible for OHP Plus because of disability and to streamline that process.

Ellen Pinney indicated that one of the statements on the client notice was not clear and will create confusion for clients. Jim Edge responded OMAP will look into that.

Ellen Pinney suggested the Committee should look at OMAP's recommendations for legislation. She believes they are good legislative concepts.

Rick Wopat clarified that the Committee's not supporting reducing the federal poverty level is not an endorsement of eliminating premiums for people below 100% of federal poverty. They are two separate concepts.

Ellen Pinney responded if the state maintained coverage for enrollees at 100% of federal poverty and eliminated premiums for those enrollees with incomes at 0-10% of federal poverty, the most vulnerable would be protected.

Michael Garland asked that the Committee be included in the earliest review as OMAP's legislative concepts are being developed.

Committee members asked that the legislative concepts be e-mailed to them.

The next Committee meeting is scheduled for June 8, 2004, from 9:30 am to 12:00 noon in Hearing Room 350, State Capitol.

Medicaid Advisory Committee
April 29, 2004

Present: Michael Garland, Kelly Kaiser, Rick Wopat, MD, Bruce Blaitout, Elizabeth Byers, Rosemari Davis
Absent: Donna Crawford, Noel Larsen, DMD

OHPR: Bruce Goldberg, MD, Tina Edlund

OMAP: Lynn Read, Judy Mohr-Peterson, Mary Greipp, Mary Reitan

Invited Testimony:
Mary Lou Hennrich, board member, Oregon Health Action Campaign
Ed Blackburn, Central City Concern
Rod Clark, Klamath Alcohol and Drug Abuse, Inc.
Chad Niegel, Marion Polk Community Health Plan
Mike Shirtcliff, DMD, Advantage NW Dental Services

Public Testimony:
Ruby Haughton, CareOregon
Bob Joondeph, Oregon Advocacy Center

Call to Order/Approval of Minutes

Kelley Kaiser opened the meeting indicating the task for discussion would be around OMAP's proposal for closing enrollment for OHP Standard.

The Committee approved the minutes of March 18, 2004 as written.

Three main agenda items for discussion:

- Report from Judy Mohr-Peterson: Enrollment Trends over the past couple of years
- Recent Evaluation Studies of the OHP Co-Pay and Premium Issue - Tina Edlund
- Input from OMAP on closing enrollment for OHP Standard
- Invited and Public Testimony

OMAP Enrollment Trends - Judy Mohr Peterson, Office of Medical Assistance Programs

Judy Mohr-Peterson spoke from the handout, OMAP Enrollment Trends. The data provides a "big picture" to enable decision making.

Percentage of Oregonians Enrolled in the Oregon Health Plan and Uninsured The graph shows the percentage of Oregonians uninsured and the percentage of people on Medicaid/OHP.

Rick Wopat: Inquired whether the numbers reflected OHP enrollment in managed care or OHP participation (i.e., clients). Judy Mohr-Peterson responded it reflects the percentage actually on the Oregon Health Plan.

OHP Benefit Package - The chart reflects that OHP Plus has been increasing over time. Up to January 2003 OHP Standard was also increasing. Over the intervening year there has been a dramatic drop in the OHP Standard population.

The next graph looks at the benefit package from January 2003 through March 2004. The implementation of OHP Plus and Standard began in February 2003. March, 2003 reflects when the more significant of the benefits were dropped, including two weeks of having no prescriptions. (Benefits lost include: mental health, chemical dependency, durable medical equipment/supplies, dental, and vision.) The other significant date which accounts for a large drop was in May 2003 when the implementation of disqualifications for non payment of premiums was implemented. The largest overall number of people who were dropped for non payment of premiums occurred during that time period.

Rick Wopat: Asked what non-OHPs refer to? Judy Mohr-Peterson responded the Qualified Medicare Beneficiaries and what was the former Medically Needy program. The reason there wasn't a large drop between January 2003 and January 2004, even though the Medically Needy Program was eliminated, was that many enrollees also had a Medicare benefit and were still counted even though they didn't have the additional benefit they would have had in the Medically Needy program.

Elizabeth Byers: Understood that people in the Medically Needy category had some portion of their Medicare paid by Medicaid.

Judy Mohr-Peterson: Agreed. This group of people just don't have the full OHP benefit package and only receive the benefits that Medicare covers.

Judy Mohr-Peterson: On the back of the page is a table of numbers which is the first of the month count by OHP benefit package. The count is low compared to end of the month data, but it was data that was most readily available.

OHP Population by Age Group - actually includes the few non-OHP enrollees referenced above but, exclusive of CAWEM. Numbers on the back of the page reflect the changes in age demographics for January 2004. Children now make up more than half of the overall population, and there has been a significant drop in the 18-44 year old category due to the significant drop in OHP Standard.

Race and Ethnicity - Includes the OHP/Medicaid population in its entirety. What is notable is there has been a gradual drop-off in the proportion of people who are Caucasian and an increase in the proportion of people who are Hispanic during the last year. This is reflective of the drop-off in the OHP Standard population.

OHP Program Current Eligibles for January 2004 - This graph shows by county the geographic distribution for: Total Population, OHP Standard, OHP Plus without CHIP, CHIP and Total OHP Eligibles.

OHP Standard: Families and FPL - The graph looks at groupings by federal poverty level (FPL) between October 2002 and March 2004. Notable is these are adults with children and are spread relatively evenly across each federal poverty level grouping. However, the largest significant proportionate drop-off occurred in the 0-10% grouping between October 2002 and March 2004.

Rick Wopat: Inquired if there is any information on migration within the categories, e.g., someone with income from 0-10% of federal poverty in October 2002 moving to a higher federal poverty level later on?

Judy Mohr-Peterson: Tina Edlund's presentation may address that question.

OHP Standard: Singles/Couples by FPL -These are adults without children in the household. The majority are in the 0-10% of the federal poverty level, with many at 0%. There has been a slight drop-off proportionately in the 0-10% group, but not to the same degree as in the families.

Percentage Enrolled in Managed Care: The graph shows the percentage of

people enrolled in a Fully Capitated Health Plan as well as the Primary Care Case Management (PCCM) program. PCCM represents about 3-4 percentage points on each bar of the graph.

OHP enrollment is about where it was in 1995 with 69% people enrolled in managed care. The high point is shown in 1997, with 89% enrolled in managed care. The dramatic drop occurred in 2001 when some managed health plans chose to stop covering OHP clients or reduced their coverage area. Regence was the major health plan that dropped out of the OHP.

Enrollment in Managed Care Plus/Standard : 2003 to present *(February 2004)* - The reason there is a drop-off in all enrollment in managed care is because of the number of plans who have chosen not to take OHP Standard. March, 2003 showed the largest drop-off because a number of plans, when the OHP prescription drug benefit was not included for Standard clients, chose not to take on that risk. When the drug benefit was reinstated in April 2003, a few more plans decided to take on Standard, and it has remained relatively stable since.

Michael Garland: Inquired how is the falling off of interest in the OHP interpreted?

Judy Mohr-Peterson: In March 2003, OHP Standard enrollees not only briefly lost the prescription drug benefit, but also coverage for chemical dependency, mental health, durable medical equipment, and dental. Vision coverage was terminated in February. The Office of Medical Assistance Programs (OMAP) allowed plans the option to drop OHP Standard coverage if they so chose. Up to that point, plans had to take both the OHP Plus and OHP Standard. Plans had to make the choice to take on the risk of covering OHP Standard with the capitation payments OMAP pays. Some plans felt they wouldn't be able to manage that. In fee-for-service, the state does not have the option of not covering them.

There were a number of initiatives tied to enrollment for the OHP Plus population which accounts for some of the increases in managed care.

Fully Capitated Health Plans (FCHP)/Primary Care Case Management (PCCM)/Fee-for-Service (FFS) **-** Reflects the market share between plans for OHP Plus and OHP Standard.

This was taken as a one-day count on March 1, 2004. Nine of the 13 plans who take OHP Standard make up 50% of the overall market share of coverage for all the health plans. OHP Standard makes up 13% of the OHP population. One

additional plan has chosen not to take OHP Standard as of April 1. Those numbers are not included on this chart.

Michael Garland: Would like to understand why managed care plans either cannot or will not take clients under the new terms of the OHP Standard plan. His understanding is that OMAP does not hold them accountable for delivering the no longer sponsored services which would reduce their risk and would like to know why some plans stayed and some left.

Judy Mohr-Peterson: Plans who dropped OHP Standard did an analysis of their own population and population mix, looking at how many would be affected in their medical conditions by having a chemical dependency or mental health condition. The plans had no way of managing the impact on persons not being treated for their chemical dependency or mental health condition and how this would affect their medical condition. The plans felt that capitation payments would not be sufficient to cover the additional costs from a co-morbid mental health or chemical dependency condition. That would give rise to increased utilization/cost on the medical side for the services they were capitated to cover.

Kelley Kaiser: Another factor was copayments were imposed on the OHP Standard population at that time and managing that was a little bit different.

Rick Wopat: Plans felt if they couldn't manage the whole patient, they wouldn't be able to manage the risk in a way that's worth taking the risk. Medical costs would be driven up by not being also able to treat the mental health or chemical dependency condition.

Judy Mohr-Peterson: Agreed with Kelley Kaiser. Also, CareOregon, Tuality Alliance and FamilyCare are located in the Portland Metropolitan area and do not take OHP Standard patients. This had a lot to do with the population and provider mix in that area.

Rick Wopat: Some counties have the ability to come with alternatives to provide services for people with co-morbid conditions by forming collaborative agreements.

OHP Evaluation Studies - Tina Edlund, Office for Oregon Health Policy and Research (OHPR)

Tina Edlund presented findings gathered over the last year through the Oregon

Health Research and Evaluation Collaborative (OHREC), a collaborative of health services researchers. When the OHP 2 waiver went into effect, many outside researchers approached OMAP wanting to study the impact of changes that were made. Researchers also approached outside funders for research grant money. OHREC was formed as a collaborative effort to design meaningful evaluations that went outside of what the Office of Medical Assistance Programs (OMAP) already does internally.

OHREC's Vision: Provide the opportunity for collaborative effort among health services researchers focusing on the Oregon Health Plan.

Mission: To investigate, evaluate and effectively disseminate health services information in the interest of informing health policy in Oregon.

The real goal was to provide evidence for any policy changes that might be made. Projects mostly were paid for with grant moneys from the Robert Wood Johnson Foundation. Collaborators include: The Office for Oregon Health Policy and Research (OHPR) (provides staffing); Office of Medical Assistance Programs (OMAP); Family Health Insurance Assistance Program (FHIAP); and health services researchers from Oregon Health Science University (OHSU), Portland State University (PSU), Providence Health Systems and CareOregon.

OHREC research reports are available on the Office for Oregon Health Policy and Research web site.
Research includes:

- Administrative data review and analysis
  - OMAP databases to study the premium impacts
  - OHSU Emergency Department database
- Direct surveys were conducted on the Medically Needy population after that program was eliminated looking at the impacts on clients losing prescription drugs and their health status.
- Direct survey of OHP Standard and Plus clients enrolled in the program before the changes went into effect in February 2003. Clients will be followed for two years and surveyed every 6 months. 3,000 people have signed consent forms and agreed to participate in the survey.

Impacts on Access

- Higher unmet need for health care for those who lost OHP coverage

60% report unmet health care needs
80% report unmet mental health care needs

- Persons with chronic illness most likely to report unmet health care need
- Worry about cost was the primary reason for unmet health care

The impact was measured through a single question to clients. Have they needed care over the last 6 months? Have they delayed or put off care because of cost?

Impacts on Enrollment

- Enrollment in OHP Standard declined about 45% once the waiver changes went into effect
- Premium cost was the most common reported reason for loss of coverage • 76% have remained uninsured
- Low-income single adults have been the most susceptible to premium changes, with people at 0-58% of federal poverty most affected
- New enrollment among the 0% income group dropped sharply and has never returned to the levels before the waiver went into effect. 48% responded they would probably reapply if the premiums were decreased by $3 a month.

Impacts on Utilization

- Enrollees who lost coverage were nearly three times as likely to have no usual source of care. Having a usual source of care usually improves a person's continuity of care and health status over time.

- Those who lost coverage were more likely to skip filling prescriptions due to cost. 56% reported they were not filling prescriptions or skipping dosages because of the cost of their drugs versus 48% who remained enrolled in the OHP.

- Direct impacts to other parts of the safety net. People were 4 to 5 times more likely to go to the Emergency Department (ED) for health care once they lost coverage.

- This has increased among the very lowest income groups, and those with chronic conditions are much more likely to use the ED.

- Change in Type of Coverage and Type of Visit at OHSU ED:

- 17% increase at the ED by the uninsured during the first three months after these changes were made as compared to the same three-month period the year before.

The researchers wanted to find out how much of the increase was due to changes in the OHP and how much was really a result of an economy that has not been that great. It was found to be split half and half. About half of the people who were newly uninsured reported they had been on the OHP before. About half had come from employer sponsored insurance. Also found was:

- 20% decrease in visits by OHP-covered patients at the OHSU ED

- 37% increase in mental health related visits to the OHSU ED due to the drop of mental health benefits from the OHP Standard benefit package

- 200% increase in chemical dependency related visits at OHSU ED

- Loss of the Medically Needy Pharmacy program - 600 people were surveyed for six months after the program discontinued.
  - 61% of those previously enrolled have skipped doses or took less of their medications
  - 64% have gone without filling a prescription
  - 49% stopped taking some of their medications
  - 60% cut back on paying for food bills
  - 48.5% skipped paying bills or paid bills late in order to fill their prescriptions
  - 20.5% have actually added credit card debt specifically to pay for their prescription medications

The Robert Wood Johnson Foundation will fund a study over the next two years to look specifically at what happens in the OHP. The study will look at the kinds of cost shifts when benefits are changed in one area and does that show up in other areas of the program. Dr. Bob Lowe, OHSU, will study the impact statewide on the Emergency Departments. The Office for Oregon Health Policy and Research (OHPR) will be conducting the ongoing cohort study of the OHP Standard and Plus population who have lost coverage over the next two years. Researchers will also be looking at the actual specific barriers to coverage for children in this state. About 66,000 children under 185% of the federal poverty level remain uninsured.

Tina Edlund shared contact information with Committee members and guests.

Kelley Kaiser: Inquired if people had moved in their poverty levels since the changes went into effect? Have they switched between categories and changed their poverty level, and has OHREC been tracking them?

Tina Edlund: Commented she did not have that data readily available. The impacts have been most significant for people at zero income. Dr. John McConnell, Oregon Health Sciences University (OHSU), studied the actual impact of premium changes for administrative data and reported that he did see some shifting within poverty levels.

Dr. Goldberg invited Tina Edlund to report back to the Committee with some of that information at the next meeting.

Elizabeth Byers: Asked if OHREC had done research on people with treatable illness that have passed away because they were not able to receive the care they needed? Tina Edlund responded her office does not have this information.

Michael Garland: Asked to have the words, "effectively disseminate" on the Mission statement explained. He would like to see data disseminated not only to public bodies but to the general public.

Tina Edlund: Responded that OHREC has given presentations at Committees and staff briefings. Recently, legislators and legislative staff were surveyed to find out how best to provide them with this information, what format, and what venues so a better job can be done of providing information. OHREC also conducts monthly meetings, and public notices are sent out for those meetings.

Michael Garland: Asked if OHREC could adopt a way of disseminating information so that information isn't in the abstract but that it is always information in the context of the original intent of the OHP. This is necessary to provide the overall broad policy context.

Rick Wopat: Indicated he would like to see data on cost shifts not just within the OHP but within society. He would like the broader picture of what happens to the person who loses coverage for health care, not just in 3 or 6 months but out over a year. What is the cost to the individual from lack of insurance? What is the cost to the community of losing this insurance? Does that change over a period

of time? For decision making, where is the best investment? Health care providers need to have some sense of the scope of the cost to determine the scope of investment.

Tina Edlund: Responded the cohort will follow people losing coverage for the OHP over a two-year period so policy-makers will be able to see more of the broader context.

Elizabeth Byers: Requested that the issue of how having housing or not having housing affects utilization and access be studied.

OHP Standard '04-05' Policy Changes

Bruce Goldberg explained that due to the passage of House Bill 3653, his office now staffs the Medicaid Advisory Committee. The mission of the Committee is to provide input and guidance around substantive Medicaid policy issues.

The purpose of this discussion at is to provide input to OMAP on a proposal to limit enrollment in OHP Standard. As the result of recent Emergency Board actions and the state's financial crisis, there are no general fund dollars to continue to fund OHP Standard. There will likely be some revenue made available through provider taxes and the federal match dollars that accompany that revenue to preserve a limited OHP Standard program. Those revenue sources will not be enough to fund the current OHP Standard population.

The proposal for discussion limits enrollment in OHP Standard to a number sustainable based on the finances the state has available. The proposal would initially close enrollment on July 1. Applications processed and date stamped over April, May and June would be processed, and those people would actually come on to the OHP during July and August and some into September. There may actually be an increase in OHP Standard enrollment as enrollment has increased over the last couple of months.

Enrollment would close to new applications as of July 1, and there would be a natural month-to-month attrition off of the OHP due to:

- people not re-enrolling
- moving out of state
- no longer meeting eligibility qualifications

- disqualification from failure to pay premiums over a two-month period

OMAP proposed to follow that natural attrition over the course of the rest of the biennium. Once the finances of the revenue from provider taxes are known, there will be a clear target of the amount of enrollment that can be supported by those dollars. The amount is not yet clear because the details have not been finalized regarding provider taxes, and there has not been approval for provider taxes on the federal level yet. The funding amount should become clear over the next several months. Once that is known, OMAP will have a clear target of where enrollment should be as of June 30, 2005. If there is not provider tax enough revenue in the budget, OMAP's proposal would be to disenroll people based on poverty level in order to get down to a number that is sustainable. OMAP asked to for public input as well as input from the Committee around that plan.

Invited Testimony: Panel 1 -Mary Lou Hennrich, Ed Blackburn, Rod Clark

Mary Lou Hennrich, volunteer Board member of Oregon Health Action Campaign

Mary Lou Hennrich was asked to testify on behalf of Ellen Pinney, Executive Director. Ms. Hennrich has served in a long public health career to improve the health and lives of Oregon's poorest and most vulnerable people through direct services, as well as working to improve local and state health policy.

Ms. Hennrich provided to the Committee members and guests background information on the Oregon Health Plan. She explained that while many policy makers were extremely busy trying to build and maintain the health system, they lost sight of the fact that we had to exist within, and depend upon, the larger healthcare "system".

She provided comments on options to decrease the total number of OHP Standard enrollees covered today from 40,000 to an estimated 25,000 who would receive a benefit package that assures "physician services, ambulance, lab and x-ray, medical supplies, mental health and alcohol and drug outpatient services, prescriptions drugs, and limited emergency dental. A hospice and limited hospital benefit may also be included."

- The state's proposal to continue to allow covered persons to drop by attrition, i.e., normally occurring at 4,000 per month. Ms. Hennrich argued although

this option may appear to be the 'easiest' and 'least disruptive to continuity of care', it would be poor policy, resulting in many poorer people, between 0 and 50% of federal poverty losing coverage for failure to pay premiums while persons with higher incomes (50-100% federal poverty) would be able to find ways to have their premiums paid and remain covered.

- Establish a lower financial eligibility standard (under 100% of federal poverty), resulting in a targeted “cap" of 25,000. Current enrollees above that eligibility standard would be notified that their coverage would be terminated due to inadequate resources. This would be a difficult message for clients and the public to accept.

- Some combination of attrition and lowering the financial eligibility standard. Attrition that would not include dropping coverage due to non-payment of premiums for enrollees who are at 0-50% of federal poverty, and have documented mental illness, alcohol and drug or housing insecurity. Ms. Hennrich asked the Committee to review this option.

Ms. Hennrich asked the Committee not only to consider the impacts of these options on the lives of Oregon's poorest and most vulnerable residents but also on the under funded, fragile and vulnerable safety-net providers and clinics that continue to serve all residents of Oregon, whether they are uninsured, under-insured or Oregon Health Plan enrollees.

Many private physicians have stopped seeing OHP clients. The existence of safety-net clinics, such as Federally Qualified Health Centers, Rural Health Centers, School-based Health Centers, local governments and non profits that see people regardless of their ability to pay, using a sliding-fee schedule, are critical to health care in Oregon. The least harm to safety net clinics is vitally important. Any option would have negative impacts on the safety-net provider system. Ms. Hennrich believes persons with slightly higher incomes are lower utilizers of health services and have slightly more personal income to pay the safety net clinic on a sliding fee scale.

Ms. Hennrich indicated the state must address the larger healthcare "system" and increase funding of prevention and health promotion efforts at the individual and community level and continue to work together toward a more just and equitable society.

Ed Blackburn, Director of Health and Recovery Services, Central City Concern,

Portland.

Mr. Blackburn explained his agency has provided effective programs for people with very low incomes or homeless, primarily people who are multi diagnosed with primary care problems, chemical dependency addictions, mental health issues, long term unemployment, that contribute to long-term homelessness for people. Central City Concern serves about 10,000 unduplicated people a year. About 3,000 to 4,000 of those are in their primary care, chemical dependency and mental health programs. One of the outpatient clinics also integrates primary care and mental health services and supported housing for people that are homeless. The Community Engagement Program provides a mental health program, active case management, a multi-disciplinary program involving psychiatric primary care consumer mentors who work with the homeless people. That program was awarded one of the six best mental health programs in the country by DHS last year.

Due to the state's financial problems, Central City Concern is contemplating cutbacks in capacity. Multnomah County is closing two clinics. Hospitals are discharging patients too early causing them to seek care at the safety-net clinics. People will end up in hospitals, jails and the impact on the community will be dramatic.

Mr. Blackburn advocated that OMAP reverse the methodology used. The premium attrition method would cause people at 0-10% of federal poverty to be disenrolled from the plan first. When combined with no longer allowing premium sponsorship, would even increase that further. Central City Concern paid for 800 premiums last month. Multnomah County paid for over 1200. If premium sponsorships are not allowed, and the OHP Standard population is bought down to 25,000 enrollees at the same time, people at 0-10% of federal poverty would be almost liquidated from the Oregon Health Plan. That group are the highest utilizers of all hospitals and high-end ED services.

An income-based method of reducing the enrollment would be preferred as it is predictable. Data can be followed. Safety net clinics, chemical dependency or mental health providers cannot budget when enrollment in the OHP is dependent on payment of premiums. He noted the big issue is being able to plan for reductions in a way that is not going to put community-based programs out of business.

Mr. Blackburn said he would much prefer to know who is going to be

disenrolled from his plan, and when so his agency can budget correctly and have rational discharge plans for these people. He recommended using an income means test, start at one level. If that doesn't work, take to another level. Use premiums as a last resort.

The second thing he recommended was to extend the current premium payment system for at least two more months. Two months would be necessary to look at a permanent premium sponsorship system that would allow payments for people below a certain federal income means. Mr. Blackburn commented it doesn't make any sense at all to require premiums from people that have no income.

Mr. Blackburn strongly suggested that OMAP reverse its methodology on income reliance from premiums.

He believes there is a value in preserving the prioritized list, and the relationships with the hospitals and managed care plans, and it is important to preserve as much capacity in the Federally Qualified Health Centers (FQHCs), safety net clinics, the mental health and chemical dependency non profits.

Rod Clark (Rodney Roadrunner Clark), Attorney, Klamath Indian Tribes*, *Director, Klamath Alcohol and Drug Abuse

Mr. Clark informed the Committee of two points he wanted to discuss.

1) Tribes have broad-based support for the managed care provider tax proposal.

2) Changes in the Medicaid system have created a huge impact on Oregon's Indian tribes.

Mr. Clark explained that he currently runs the primary tribal treatment center for mental health and chemical dependency in Klamath County, and expressed appreciation that drug and alcohol and mental health services were added back into the OHP Plus benefit package. Mr. Clark expressed concern that dropping OHP Standard enrollees would be devastating to Klamath County. Klamath County already has the highest negative chemical dependency and mental health indicators in the state on a consistent basis.

His county fully supports the Managed Care Organization (MCO) provider tax proposal to preserve 20,000-25,000 OHP Standard enrollees.

Mr. Clark informed the Committee and guests that Medicaid services for American Indians and Alaska Natives are 100% reimbursed by the federal government and are part of Oregon's base budget. He explained that Senate Bill 878 passed last session and allowed American Indians and Alaska Natives applying for the OHP Standard benefit to be shifted to the OHP Plus benefit because it is 100% federally reimbursed. Eliminating OHP Standard coverage in August would lose the federal reimbursement. The impact would result in tremendous reductions to the drug and alcohol and mental health clinics in both the non-Indian and Indian communities.

Mr. Clark urged the Committee to please tell the governor that the MCO provider tax proposal is a means to at least to keep a part of the OHP Standard in place. Maintaining a portion of the OHP Standard would be at least something to build on.

Rick Wopat: Commented that one of the original precepts of the OHP was to not ration people. Dr. Wopat asked for comments on the concept of limiting the number of services as an alternative to rationing people. The option would limit the amount of services in order to maintain more enrollees on the OHP.

Ed Blackburn: A concept that preserves services to help homeless and low income become well would be worth looking into but would not be the best option if it cuts out those services. He would be interested in looking at the proposal.

Rick Wopat: Would suggest that no services would be cut that are above the line but there would only be a limited amount of them available. Other states have taken this approach.

Rod Clark: Believes the concept is not a bad idea and would increase the number of persons eligible for the entire benefit package but would put a lid on the amount of usage.

Mary Lou Hennrich: Agreed and said the concept should be discussed. She believes people should not be rationed; it is much easier to limit usage. The option should be discussed explicitly with the public. Word needs to go out to the people.

Elizabeth Byers: Asked what people did for health care before the OHP?

Ed Blackburn: More people had employer-sponsored health insurance 10 or 15 years ago. That is decreasing. People also used the hospital emergency rooms.

MaryLou Hennrich: Prior to the implementation of the OHP, many pregnant women would commit some misdemeanor to be admitted to the county jail in order to have their baby delivered in the hospital.

Invited Testimony: Panel 2 - Chad Niegel, Mike Shirtcliff

Chad Niegel - Marion Polk Community Health Plan (MPCHP)

Mr. Niegel informed the Committee that given the current budget constraints, the Fully Capitated Health Plans:

- Fully support the provider tax. Revenue should be put toward preventive medicine and where the money will be most effective. FCHPs would like the greatest amount of benefits for the greatest amount of people.

- Fully support HB 2511 and the core services of the standard benefit package outlined in the bill.

- Support the Medicaid Advisory Committee's proposal and all of the assumptions and steps of implementation in the proposal. The FCHPs have prioritized the currently capitated services:
  - Physician/Pharmacy services (combined)
  - Mental Health/Chemical Dependency services
  - Hospital (emergency services first)
- Propose a maximum enrollment for the Standard population in the counties where managed care is currently existing.

Bruce Goldberg: Clarified that the proposal was actually the state's proposal and asked the Medicaid Advisory Committee's and the public for feedback and input.

Michael Garland: Questioned the priorities mentioned and was not sure if they matched the priorities of the list.

Chad Niegel: Explained the priorities were what the FHCPs were prioritizing by. Support for the tax is not conditional on the priorities.

Mike Shirtcliff , President, CEO, Advantage NW Dental Services

Mr. Shirtcliff explained Advantage NW Dental Services is the second largest provider of OHP dental services in Oregon, and is owned by 300 dental providers.

HB 2511 added back a minimal dental benefit for which the dental community is grateful. They supported the provider tax. Dental providers also support the prioritized list as they believe there has to be an integrated package to deliver health.

Dr. Shirtcliff said as a dental provider, it would be difficult to go to his providers and explain to them that someone with more money and able to get on to the system would be ahead of someone 0-10% of federal poverty and not on the system. It would be hard in rural Oregon to justify those people being able to stay on the plan when someone less fortunate cannot be covered.

Rick Wopat: Thanked Dr. Shirtcliff for the all the work he has done for the people of Oregon.

Dr. Wopat asked if the dental providers had a choice between 50,000 people getting a whole dental package and 25,000 getting half a package, would they support a limited number of services.

Dr. Shirtcliff: Commented that he would also like to see changes in the OHP Plus program, which would eliminate some benefits to save money. Dental providers look at three things in dentistry: that patients not suffer, have a healthy mouth and be able to function. He indicated there is a level at which providers cannot go below in providing services in order to keep their license. Providers have to consider how much risk they can accept. That is probably the reason most of the health plans left.

Chad Niegel: Suggested it would be beneficial to look at what other states were doing with what types of impacts.

Public Testimony - Ruby Haughton, Bob Joondeph

Ruby Haughton, Legislative and Public Affairs Director for CareOregon

CareOregon is a Fully Capitated Health Plan, operating in several counties with about 85,000 OHP Plus enrollees.

Ms. Haughton responded to Michael Garland's question of why plans were no longer taking OHP Standard patients. CareOregon had the largest amount of OHP Standard population, about 25,000. After analysis, CareOregon found they were

spending more than 200% of their capitation rate on mental health and chemical dependency services for that population and subsidizing the Standard population with their Plus population, causing their financial status to enter the red. CareOregon's financial situation has improved, and they will be reconsidering OHP Standard enrollment.

She read a letter from Dave Ford, CEO to Governor Kulongoski strongly advocating for continuation of services for the current 47,000 enrollees on OHP Standard and shared the consequences of losing OHP Standard. Mr. Ford urged the Governor to take the opportunity to reform health care in Oregon, assemble a group of business and public leaders to save OHP Standard for 2004, and work to creating a viable program for the next biennium.

Bob Joondeph, Oregon Advocacy Center

Mr. Joondeph voiced the Oregon Advocacy Center's primary concern that the most vulnerable, especially those people with psychiatric disabilities, are not dropped from the OHP. He commented that it makes good sense to limit services but policy makers need to take into consideration that some individuals will need more services than the average citizen. He asked if there would be an exception process for people with disabling conditions whereby they would not be denied health care needs?

Questions and Feedback on the State's Proposal

Lynn Read and Mary Greipp, OMAP, responded to questions from Committee members and guests.

Rick Wopat: Asked Lynn Read and Mary Greipp what would need to be done in order to change the premium structure to remove premiums for people with incomes from 0-10% or 0-20% of federal poverty. He would like to see the cost evaluated on the premium piece for that population. Dr. Wopat indicated that it was a decision made that has a consequence that was not intended.

Michael Garland: Asked what is the rationale for not sponsoring patients?

Lynn Read: Responded that the Department of Justice has indicated that the current manner in which OMAP allows for premium sponsorship has three significant legal issues. OMAP has been working with advocate groups to find a way to resolve those. There was a proposal made to OMAP that may have

addressed two of the significant issues, but would need an Office of Inspector General opinion, and the sponsorship organization's finances would have to be reviewed in terms of funding streams. The third issue was not addressed and relates to a statewide benefit being available, treating all individuals in the OHP the same. Due to significant legal concerns, it was decided by the Department of Human Services that premium sponsorship be discontinued at this time. It may be possible to design a program in the future that would meet all criteria that would pass the Office of Inspector General and Centers for Medicare and Medicaid Services requirements.

Premiums for a certain subset of the population can be looked at. OMAP was directed to do an analysis by the legislature in a budget note last session on how premiums and copayments are impacting the population, and have been directed to present their findings at the September Emergency Board. OMAP was also directed to report to the November Emergency Board with any proposed changes premiums and copayments if there is a surplus in the budget. That would be the vehicle for OMAP to move forward any changes.

Lynn Read commented that currently it is unknown how much of the OHP Standard population would be preserved but if there were a defined bucket of money, there would be different ways in which it could be spent. Premium restructuring could certainly be looked at. A waiver amendment would need to be submitted for CMS approval.

Mary Greipp: Indicated as part of the ongoing evaluation efforts, there has been some effort already begun to look at eliminating premiums for the zero-income population, and what kind of offsets would be needed for the higher income populations to replace the revenues.

Lynn Read: Explained if revenue wasn't replaced by the higher income population, the number of people being covered would need to be reduced in order to make up for the reduced revenue.

Bruce Bliatout: Asked what was the time frame if premium sponsorship are discontinued.

Lynn Read: The last premium sponsorship payments that OMAP would accept were during this month of April. Eligibility was preserved for people that had premiums paid on their behalf for the month of May. No additional sponsorship payments would be accepted after April.

Ruby Haughton: Asked as Ms. Read as OMAP works through their proposal of looking at these three issues did she think that would be something that would come back next session to be discussed at different levels.

Lynn Read: Responded she would need to defer to the coalition that has been working on the proposal. She didn't know what their time frame would be.

Rosemari Davis: Indicated she was intrigued that the same message came from most of the individuals testifying at this hearing with regard to moving from planned restricting of future growth of the of the Standard population to one that is income means tested. The plan to close enrollment from OHP Standard starts in July. She asked would it be possible to move to income means testing as an alternative to what the proposal has.

Lynn Read: Stated it would be possible to do that in the future. But at this time OMAP needs to close enrollment and will submit notice to CMS by tomorrow that enrollment will close July 1. In order to stop the inflow of new eligibles as soon as possible, OMAP needed to take immediate action, but hopes that the dialogue from this hearing will help inform longer-term action.

Michael Garland: Assumed some decisions really had to be made to go forward in the short term. Proposals to preserve OHP Standard that couldn't be discussed in the short term but could be reviewed later:

1) Reduce number of services rather than rationing people
2) Lower the financial eligibility standard and then allow higher income persons to attrition off of the plans

Lynn Read: OMAP needed to take immediate action in closing enrollment. Modifying the proposal can continue to be discussed for the near term.

Bruce Goldberg: Explained that it would be possible to modify the current proposal, it is just the closure of enrollment that needs to be done immediately.

Mary Greipp: Asked members and guests to keep in mind that in regard to the proposal that was presented today that OMAP operate within many constraints given the very tight time frames for getting the program closed by July 1. So any proposal to be discussed has to take into account our current waiver agreement with the CMS and would a waiver amendment be needed. What are the statutory

limitations? How was the benefit package defined in HB 2511 and what flexibility there might be within that to redefine or modify the benefit package. She stressed that those are very important parameters to be working with.

Lynn Read: Mentioned one other very important consideration as we begin making choices is to preserve the delivery system that is in place. In terms of the managed care delivery system, benefit reductions, active disenrollment of clients versus attrition of established clients are all concerns that need to be considered.

Michael Garland: Asked if OMAP has that flexibility within the waiver to reduce below 100% of federal poverty.

Lynn Read: Explained that OMAP has that flexibility in a term and condition, with giving 60 days notice to the federal government. CMS has indicated that any active disenrollment is very problematic for them. There is another term and condition in the waiver that allows CMS veto authority. It asks if the waiver is meeting CMS' interests in order to allow Oregon to continue the demonstration. There will likely be negotiation with CMS around changing federal poverty level and active disenrollment.

Mary Greipp: Expressed concern that the notice drafted to CMS explain that Oregon will be closing enrollment but that at some point in the future they may need to lower the federal poverty standard. This point needs to be addressed with CMS as it will certainly impact their interests in allowing Oregon to proceed with the waiver.

Rosemari Davis: Emphasized that the provider tax needs to be made clear in everybody's mind that it is a temporary fix. The letter that Ruby Haughton shared brings out significant points about the public private partnership that occurred 10 years ago. Currently, the state is looking at the public participation. The private sector cannot do this alone.

Lynn Read: Indicated the letter being drafted does make reference working within an environment that brings us through the 2005-07 biennium. It doesn't talk about beyond that period.

The next Committee meeting will be held on May 12, in Salem.

MEDICAID ADVISORY COMMITTEE
March 18, 2004

PRESENT: Bruce Bliatout; Rosemari Davis; Michael Garland; Kelley Kaiser; Rick Wopat, MD

ABSENT: Elizabeth Byers; Donna Crawford; Noel Larsen; DMD

OMAP: Lynn Read, Mary Reitan

OHPR: Bruce Goldberg, MD, Administrator; Mike Bonetto, MPH, Director, Health Policy Commission

TOPIC	DISCUSSION	ACTION
Introductions and Welcome Approval of Minutes	Introductions were made by Committee members and the Office for Oregon Health Policy and Research staff. The minutes of September 23, 2003, were approved as written with one correction on page 9, The Medicaid Advisory Committee is administered by the Office of Oregon Health Policy and Research.	Information item

TOPIC	DISCUSSION	ACTION
	Bruce Goldberg explained HB 3653 moved the administrative function of the Medicaid Advisory Committee (MAC) under the Office for Oregon Health Policy and Research, with an advisory role to the Oregon Health Policy Commission, as of January 1, 2004. Today's task of the Medicaid Advisory Committee is to define: * How the Committee will function * How will it add value to the State * What has happened since September * Where do we go from here?	Information item
State Budget and Governor's Priorities	The Legislative Approved Budget from the 2003 session funded the Oregon Health Plan (OHP) with some changes. In order to fund coverage for the OHP Standard population, some benefit changes were required. The Legislature added back mental health and chemical dependency and funded a drug benefit for the new Medical Expansion for Disabled and Seniors (MEDS) program.	Information item

TOPIC	DISCUSSION	ACTION
OHP Post Measure 30	Rejection of Ballot Measure 30 by the voters resulted in a disappropriation, necessitating program reductions of approximately $116 million in General Fund, plus federal match, totaling approximately $300 million Total Funds, for the OHP during 14 months of the biennium. The disappropriation will begin on May 1st, and will create a huge financial loss to the OHP. The Governor has directed State Government to operate within available funding. His priorities for Medicaid are: 1) Protect coverage for current OHP Plus enrollees with current benefits. Those categorically eligible, pregnant women and children who are categorically eligible for Medicaid, with incomes up to 185% of federal poverty will receive the full range of services they currently receive including mental health, chemical dependency, and drugs. 2) Maintain the OHP waiver demonstration - If Oregon were to lose the waiver, it would cost the state millions of dollars. The foundation for prioritization of services must be maintained. 3) Maintain the current OHP delivery system - The managed care delivery system provides people a mechanism to receive care.	Information item
OHP Post Measure 30	The Governor does not have the ability to move funds from one budget to another. He is working with the Legislative Leadership and the Emergency Board to find options to move some money for his	Information item

TOPIC	DISCUSSION	ACTION
	three priorities. Rebalance options and program cuts are being reviewed to fund his priorities. Michael Garland: Will the federal government allow Oregon to continue the waiver if we drop the OHP Standard population? Lynn Read: The Centers for Medicare and Medicaid Services (CMS) have not responded to the question. They have told Oregon it must submit a request to amend the demonstration. From the State's perspective, the demonstration would still have a significant expansion population, including: • Children's Health Insurance Program (CHIP) to 185% of federal poverty • Pregnant women to 185% of federal poverty • Family Health Insurance Assistance Program (FHIAP)	
OHP Post Measure 30	The OHP demonstration does have a Term and Condition that gives Oregon three options as long as 60 days notice is provided to CMS: • Close enrollment for an undetermined amount of time	Information item

TOPIC	DISCUSSION	ACTION
	• Lower the federal poverty level on income for eligibility • Discontinue coverage - disenroll all clients from OHP Standard It isn't clear yet whether CMS will support Oregon's request. Bruce Goldberg: Oregon would have to present a case to CMS that we would maintain what was first built into the waiver and add expansion eligibles when we had the financial means to do so. The most important issue for CMS is if there will be any changes to OHP Plus population and benefit package. Other states with 1115 demonstrations have different coverage criteria. For example, some states allow only two prescriptions per month for their OHP Plus enrollees, with exceptions. Lynn Read: Generally, when state's have coverage restrictions for their categorical populations, they must have a fairly liberal exception process.	
OHP Post Measure 30	Michael Garland: How many enrollees will the OHP maintain services for in the categorical group? Lynn Read: About 350,000 categorical and limited benefit clients, excluding OHP Standard. Coverage would be lost for the current	Information item

TOPIC	DISCUSSION	ACTION
	46,000 OHP Standard enrollees. Rick Wopat: Is there any data on clients receiving OHP Standard a year ago who have been re-evaluated and now qualify for OHP Plus? Lynn Read: Figures are not available yet. When General Assistance was terminated on March 1, 2003, many were screened for SSI disability and then moved over to the OHP Plus benefit. Some clients formerly eligible under OHP Standard now qualify for Temporary Assistance to Needy Families (TANF). The increase in TANF is approximately 17,000 new eligibles. Rick Wopat: Did discontinuation of General Assistance and changes to OHP Standard push clients to apply for SSI disability assistance where they would not have prior to the cut? Lynn Read: Three drivers caused people to pursue disability assistance: premiums, copayments and the change in benefit package.	
OHP Post Measure 30	Rick Wopat: What are the demographics of clients being disqualified for non payment of premiums? Bruce Goldberg: About half of the clients being disqualified for non	Preliminary data will be shared with Committee members by e-mail.

TOPIC	DISCUSSION	ACTION
	payment of premiums had incomes at 0-10% of federal poverty. Rick Wopat: Are stats available on people dropping off due to diagnosis? He observes those with poor coping skills have the lowest incomes. What are the unintended costs for these people? Bruce Goldberg: Staff are reviewing the demographics of clients receiving coverage before the changes and at the current time. Preliminary data will be shared with Committee members by e-mail. We are seeing more patients with multiple problems than before even though they are still receiving assistance.	
Waiver and Provider Tax Status	Lynn Read indicated a waiver amendment request was sent to CMS in September, 2003 requesting approval of the following amendments to the 1115 Oregon Health Plan demonstration: • Allow DHS the ability to move the line on the Prioritized List of Health Services by 30 lines. CMS responded they would only permit a three-line move.	Information item
Waiver and Provider Tax	• DHS requested the ability to reduce some optional benefits for OHP Plus adults. CMS is not willing to give Oregon broad	Information item

TOPIC	DISCUSSION	ACTION
Status	authority. Oregon will have to submit specific requests. • DHS requested approval to redefine the OHP Standard Benefit Package, as a result from passage of HB 2511. The benefit package would be subject to cost sharing (premiums and copayments) and would be overlaid by the Prioritized List of Health Services. Core services would include: * Physician services * Ambulance * Prescription Drugs * Laboratory and x-ray services * Medical Supplies * Outpatient Mental Health * Outpatient Chemical Dependency services * Limited Emergency Dental Services Other medical services would be optional. When the redefined benefit package is implemented, it would initially include a limited hospital benefit, funded primarily by provider taxes. Oregon has not received formal approval from CMS, but they have indicated they would allow the new benefit package.	

TOPIC	DISCUSSION	ACTION
Waiver and Provider Tax Status	• DHS requested approval for expansion in the Children's Health Insurance Program (CHIP) to 200% of federal poverty. CMS has indicated they will approve the request. • DHS also requested CMS approval for expansion in the Family Health Insurance Assistance Program (FHIAP) to 200% of federal poverty. CMS has indicated they are prepared to approve the request. Michael Garland: How does FHIAP receive the federal match rate? Lynn Read: In 2002, the Federal government indicated they were interested in having people enrolled in employer-sponsored health coverage. Oregon crafted a waiver amendment request to provide this. Services for clients enrolled in FHIAP prior to November 2002 are matched at the Title XIX federal rate. Services for new enrollees are matched at the Title XXI rate. • DHS requested approval for the new Medical Expansion for persons with Disabilities and Seniors (MEDS) to provide drugs to seniors and persons with disabilities, with no drug coverage, with incomes up to 135% of the federal poverty level. CMS has indicated they will not approve this request. The new Medicare prescription drug bill, recently passed, will provide drug coverage to about 90% of the target population for the MEDS program. The	Information item

TOPIC	DISCUSSION	ACTION
	new Medicare drug benefit will begin in 2006.	
Waiver and Provider Tax Status	Oregon has not received anything officially from the Centers for Medicare and Medicaid Services (CMS) as yet. DHS will focus on planning around the Governor's priorities. Issues to be addressed: 1) Not move forward with implementing the MEDS program 2) Provide a General Funded drug benefit to approximately 300 former Medically Needy clients (HIV/AIDS/transplants). 3) Not move forward with expansion of CHIP to 200% of federal poverty. 4) Discontinue the OHP Standard program as of August 1. Notices will need to be sent out, systems changes, information made available to clients and providers. Questions remain whether there will still be a need for a Central Processing Branch or OHP Application Center. Dialog has begun with CMS about the Governor's priorities and whether Oregon will be allowed to maintain the Prioritized List of Health Services and the 1115 Demonstration. DHS is finalizing the numbers for the April rebalance. Hopefully, the declining caseload in OHP Standard will generate a savings with the current enrollment at 45,000. The budget initially assumed 85,000	Information item

TOPIC	DISCUSSION	ACTION
Waiver and Provider Tax Status	enrollees. There may also be some savings in Children, Adults and Families (CAF) and Seniors and People with Disabilities (SPD). DHS will propose moving those savings to the OHP along with an $8 million surplus that was originally targeted for the emergency hospital benefit for OHP Standard. These savings could be used to buy back some of the cuts in OHP. Money was budgeted for the restoration of Levels 12 and 13 in the Long Term Care System. It is not clear at this time whether this group will be restored. Rosemari Davis: Is CMS okay with the limited hospital benefit? Lynn Read: CMS has indicated they would approve a core benefit for OHP Standard with hospital as an optional service that would be part of the initial reconfigured benefit package. CMS will want more information on what is included in the limited hospital benefit. CMS will have to approve any revenue from provider taxes used to fund the Oregon Health Plan (OHP). Originally, it was assumed hospital provider taxes would provide: • A portion of the limited hospital benefit for OHP Standard • Retroactive eligibility • Rate increase to providers	Information item

TOPIC	DISCUSSION	ACTION
Waiver and Provider Tax Status	The Office of Medical Assistance (OMAP) has not assumed anything around that revenue in the budget rebalance. Negotiations are continuing between the Governor's Office, hospitals and Medicaid managed health care plans around provider taxes. The managed health care plans have indicated a desire that the State fund the Governor's priorities first and their taxes be used to fund the OHP Standard benefit. The hospitals indicated they want provider taxes to fund a hospital benefit for OHP Standard. Hospital and managed care provider taxes will not provide enough money to fund the full OHP Standard benefit for 49,000 clients.	Information item

TOPIC	DISCUSSION	ACTION
	Provider taxes are not a guaranteed resource yet as federal approval is required. The federal government is not comfortable with states using provider taxes and intergovernmental transfers to increase their federal Medicaid matching payments. Bruce Goldberg: The federal government has a huge deficit and is cracking down on states using non state dollars to draw down federal payments.	
Waiver and Provider Tax Status	Lynn Read: A number of states have provider tax requests in to CMS. Oregon also has requested approval for a nursing facility provider tax. CMS is focusing on "hold harmless", where provider taxes are matched with federal dollars and then paid back to the providers in the form of reimbursement. Rick Wopat: What degree of control does OMAP have over the dialog concerning provider taxes with CMS, legislators, hospitals and managed care plans? Lynn Read: The revenue from the provider taxes would be placed into distinct funds. DHS would be able to set the percentage of the tax. Michael Garland: A question about the waiver. Are OHP Plus and	Information item

TOPIC	DISCUSSION	ACTION
	FHIAP benefits driven by the Prioritized List of Health Services? Lynn Read: The Prioritized List of Health Services applies to everyone on OHP Plus. The Legislature made changes to the OHP Standard benefit during the 2001 Session. The List still applies to OHP Standard but overlays categories of service. Rick Wopat: Expressed concern with the state dropping people in order to rebalance the budget. It doesn't solve the health problem as they will be forced into using the emergency room. Prioritizing people through premiums and copayments have forced many off of the OHP.	
Waiver and Provider Tax Status	Bruce Goldberg: The original policy decisions did not recognize current outcomes. Lynn Read: Different choices could be considered if Oregon ends up with a capped OHP Standard group. Michael Garland: Has the state looked at the number of clients dropping off the OHP due to premiums as opposed to copayments. Bruce Goldberg: The current premium policy which disqualifies an enrollee for 6 months due to non payment of premiums is a major issue now and is being reviewed.	Information item

TOPIC	DISCUSSION	ACTION
PCO Update	HB 3624 directed the Department of Human Services to move forward with developing a Physician Care Organization (PCO) for a health services contractor that serves more than 200,000 members. The PCO program would grant additional access to clients by contracting with physician plans that choose not to become a Fully Capitated Health Plan. The PCO must be responsible for coordinating physical health services provided to an enrollee and may include certain outpatient hospital services. The Office for Oregon Health Policy and Research will develop criteria when a PCO would be allowed in an area that fits within the intentions and constraints of the legislature.	Information item
PCO Update	OMAP has convened a work group to: • draft the Request for Application (RFA) • draft a template for the PCO contract • begin modifications on the MMIS system • work with the actuary, PricewaterhouseCoopers, to assess PCO rates and the complexities of risk adjustments An amendment to the waiver was submitted to CMS in February. CMS has indicated a three month approval process.	Information item

TOPIC	DISCUSSION	ACTION
	Kaiser Health Plan has expressed interest in serving as a PCO with a September implementation date. Kaiser currently serves Oregonians in two urban areas, Portland and Salem. It is unclear at this time whether the PCO will serve both areas. Eventually, the RFA process could be used to go out to contract in other areas such as Jackson County.	
Par Non-Par	Hospitals and plans are working successfully in most areas of the state. When a hospital and plan could not reach a formal agreement regarding rates, OMAP had an administrative rule that required the plans to pay OMAP fee-for-service rates to the hospitals. The legislative session in 2003 attempted to bridge the gap between hospitals and plans who couldn't reach agreement on rates by drafting language in HB 3624. The Governor's Office, OMAP, the Office for Oregon Health Policy and Research, hospitals and managed health care plans have been meeting to come to a resolution that will work for all on this issue. Bruce Goldberg: Administrative Rules are in place but haven't been used as yet.	Information item
Recent OHP	Bruce Goldberg announced the Office for Oregon Health Policy and	Research briefs will be

TOPIC	DISCUSSION	ACTION
Research Briefs	Research has prepared several research briefs and reports on the changes and impact to the Oregon Health Plan. He will see that they are distributed to the Committee.	distributed to the Committee.
Oregon Health Policy Commission Update	Mike Bonetto: The Oregon Health Policy Commission (OHPC) was established during the 2003 legislative session by HB 3653 to serve as a policy-making body responsible for health policy and planning for the state. The Commission reports to the Office for Oregon Health Policy and Research.	Information item
Oregon Health Policy Commission Update	The Commission was to be comprised of 10 voting members and 4 legislative non-voting members. Nine of the voting members have been appointed. The tenth member will come from the business community. Two legislators, one from each caucus, in both the Senate and House would serve to provide easier access to move policy issues through the legislative process. Representative Jeff Kruse was appointed but has resigned from the House. Kerry Barnett will serve as chair of the Commission. Section 3, HB 3653 defines the functions of the Commission.	Information item

TOPIC	DISCUSSION	ACTION
	Functions are the same as the previous Oregon Health Council. Bruce Goldberg: The Commission has more flexibility to propose and draft legislation by having the legislators as non-voting members. Four areas have been identified by the Commission to measure objectives and performance: • Cost • Quality • Access • Health Status	
Oregon Health Policy Commission Update	The Commission is currently gathering data on the above objectives and is forming work groups with responsibility to develop short-term objectives and long-term goals. The Medicaid Advisory Committee will be asked to help identify areas of the OHP to bring to other work groups in order to set objectives and goals. The Commission will assign the work groups to gather data and then come back to the Commission with their recommendations.	Information item

TOPIC	DISCUSSION	ACTION
	Information will then be shared with the public for input. Work groups will vary in size. The Chair will determine the size of the group. Rick Wopat: The Commission will need to focus on keeping it simple without a lot of duplication of effort from the different groups. When a work group comes up with a certain goal, maybe it could be shared with the Medicaid Advisory Committee to determine whether the goal would fit in with the Medicaid population. Bruce Goldberg: An example would be "cost" (premiums/copayments). The Medicaid Advisory Committee would review the feedback on whether it fits or doesn't fit. Rosemari Davis: The Committee needs to have better depth, more members from the public than just from the provider community.	
Oregon Health Policy Commission Update	New members would need a formal orientation in order to be high functioning. The group will need to move from reactive to proactive behavior. Lynn Read: Applications have been sent in from prospective members but have not been yet acted on by the Governor's Office.	Information item

TOPIC	DISCUSSION	ACTION
	Rick Wopat: The Committee will need to focus on more than just Medicaid acute care issues. More focus is needed on long term care and mental health. One of the members should be from the long term care industry. Bruce Bliatout: Would like the Committee to do a self-evaluation in one year. They need to be informed about issues early on so that they could provide their expertise to help inform the Governor's Office to make the right policy decisions. Rosemari Davis: The Commission should identify its purpose and how the Committee should function, then find the members to carry that out. The goal and mission of the Medicaid Advisory Committee should be clear. Kelley Kaiser: The Commission needs to understand the expertise of Committee members. She would like to see the Committee redefined so that their message is heard.	
Oregon Health Policy Commission Update	Bruce Bliatout: As an advisory group member, he does not see the governor and legislators listening. The Committee has written many letters over the years with no response. Michael Garland: What data is necessary for the Committee to have in	Information item

TOPIC	DISCUSSION	ACTION
	order to make better judgments? We need to push broad social policy frames. Bruce Goldberg: Sees the Committee as advisory about Medicaid policy. He would like to discuss at the next meeting: • What is working • What is not working • What could be changed Mike Bonetto: The Committee needs a long-term vision and to dovetail the short-term goals in the long term. The next meeting will be used to sketch out the goals and mission of the Committee. Rick Wopat: The Committee needs to understand what its vision, mission and goals are. We need to focus on solutions and create clear goals.	
Oregon Health Policy Commission	Michael Garland: Recommends the Committee's role should be that described in HB 3653, section 3 (7); it would be more meaningful to the Commission:	Information item

TOPIC	DISCUSSION	ACTION
Update	• Reviews State Plan amendments, modifications in Medicaid operational protocols, applications for waivers to the Centers for Medicare and Medicaid Services proposed by DHS, and administrative rules for the state's medical assistance program or other health care programs.	
Next Meeting	The next Committee meeting will be held on Thursday, April 29, 2004, from 9:30 am to 12:00 noon, at the Oregon Medical Association, 5210 S.W. Corbett, in Portland.	The next Committee meeting will be held on April 29, 2004.