Medicaid Advisory Committee Meeting Notes
2006

January 25

February 22

March 22

April 26

June 28

July 26

September 27

October 25

November 15

Medicaid Advisory Committee
January 25, 2006
10:00 am – 12:30 pm
Hearing Room 50
State Capitol

Present: Elizabeth Byers, Donna Crawford, Michael Garland, Tina Kotek, Yves Lefranc, MD, Carole Romm, Jim Russell, Dick Stenson, Thomas Turek, MD, Carmen Urbina, Mike Volpe, Rick Wopat, MD

Absent: Bruce Bliatout, Kelley Kaiser

OMAP: Lynn Read, Mary Reitan

OHPR: Jeanene Smith, MD, Bob DiPrete, Tina Edlund

Other: Jen DeVoe, MD, OHSU

Opening Remarks

Tina Kotek, Chair, called the meeting to order. Introductions were made by the Committee. Tina indicated at the Senate Interim Committee on Child Welfare on January 24, it was reported that 44% of the births in Oregon are covered by the Oregon Health Plan (OHP).

The Committee approved the minutes of December 1, 2005, as written.

Data Update

Carole Romm indicated she has been working with Carmen Urbina and Michael Garland and the Office of Oregon Health Policy and Research (OPHR) to obtain reporting data that would help the Committee move forward in their understanding about the Medicaid program.

Lynn Read, Interim Assistant Director, Office of Medical Assistance Programs (OMAP), explained the document presented from the workgroup summarizes by large category groups who is being served and shows over time some changes from previous months and the previous year of what's happening in those category groups.

Michael Garland suggested a denominator be added indicating the percentage of technically eligible persons in these categories that are actually being served. Being able to see the population that is left out is extremely important and will provide background for the Committee in terms of how they will advise on policy making.

Lynn Read said OMAP would work with OHPR to see what data might be available. Much of the data would come from the Oregon Population Survey. Based on the 2004 Oregon population survey, our programs covered 24% of the children in Oregon.

Carole Romm added the Oregon Population Survey (OPS) will be coming up again this summer.

Lynn Read explained that the data in the document is preliminary data and cautioned that these are not the final numbers. Clients may be eligible for the programs retroactively by as much as three months.
The summary document breaks out:

- OHP Plus
- Children's Health Insurance program
- OHP Standard
- Other medical assistance programs

Tina Kotek reminded members that they need to be comfortable with indicators which are not the best numbers but there are numbers out there that can give them a sense of the relative need. The year's comparison is really helpful. It shows that we've lost 16,000 clients from a year ago, a 40% decline. It's important to see that trend. Tina asked what the rationale is behind calling the clients "eligibles".

Lynn Read replied that the agency is trying to change that. The term has been used for years. The intent now is to use the word clients.

Rick Wopat commented that trending tells a story. Dr. Wopat asked if the decrease in Poverty Level Medical (PLM) children and the increase in TANF-related medical was a change in policy or the result of economic outcome.

Lynn Read responded that most likely clients who previously would have come in on PLM that are now are coming in through other eligibility doors. Some of the reasons may be that in early 2002 the federal government told states they needed to pay particular attention to what programs clients were being made eligible for. Field staff started more paying attention to whether someone really qualified for Temporary Assistance to Needy Families (TANF) Non-Cash rather than Poverty Level Medical (PLM).

Rick Wopat inquired about TANF-Extended? Lynn Read responded there are three types of medical assistance available that are associated with the TANF program. TANF earlier was known as the Aid to Families with Dependent Children program and that changed with Welfare Reform in 1996. The federal government disassociated Medicaid from the cash assistance welfare program, and the TANF program was set up. There is a component that is cash assistance but there is also a non-cash component for someone who could have met the old AFDC criteria. It may be someone who has applied for assistance and is required to do a job search before they actually start receiving cash. In the meantime, the person can receive medical assistance. Extended Medical is on the back end where someone has been receiving TANF cash assistance and now no longer qualifies by virtue of having higher income. If clients meet certain criteria, they are eligible for medical for an extended period of time following the end of their cash assistance even though their income is higher now than would have qualified them before.

Rick Wopat would like to see the data show how long people are actually in the programs. He believes it's important because people look at this as static populations when they are really not. At any one time, there may be between 12% and 15% of the population in the Medicaid program. Between 1995-2000, it was touching one-third of the people.

Lynn Read explained for a one-year time period it's likely that there would be average of 400,000 people in the Medicaid/CHIP program and yet 600,000 unduplicated clients would have been served. OMAP would be able to do some analysis on what percent of a client category has been eligible for 6 months, 12 months, 18, months, up to 7 years. The database is up to 7 years. There is a lot of movement between eligibility groups. If the client changes eligibility group during that time, the eligibility would be counted as continuous in all groups.

Carole Romm asked that the data be made easy to understand because it is complex.

Michael Garland said the Committee should try to shape clarity on those questions they want to see regularly and get this regular flow of data. He would like to have a fairly consistent set of background data against which the Committee would be able to measure policy options that are dropped in front of them.

Dr. Lefranc asked if the data they are looking for is how many clients stay on the programs for years? Rick Wopat responded it is more about how broad a program is this. How many people in our state at one point, whether a year or two years, are in a situation where they need to rely on one of these programs for their health care or for assistance. Most people, who have never touched these programs, believe there is a small percentage of people who are on Medicaid all the time and don't realize that it is a program that touches a lot of people for short periods of time. Lynn Read replied that OMAP can count unduplicated clients that have been served over any defined period of time up to 7 years, and there is some information that it can be compared to that comes out of the Population Survey.

Bob DiPrete said his office looked at how many people had lived in Oregon for the unduplicated count for OHP clients. He recalls that the count was over 25%, perhaps 30%, of clients who had been on some program associated with the OHP.

Carmen Urbina said the data is an important element for the Medicaid Advisory Committee (MAC) in order to see transparency, just to take care of what she calls the "myth of poverty in Oregon". It brings out that we are dealing with a crisis, lots of folks on poverty, and will aid the Committee to see the real situation that our community is actually facing. It's more transparent and the Committee can actually tell a story based on numbers.

Michael Garland said the Committee, as an advisory committee, wants to be able to see the effects of policy decisions. For instance, the precipitous drop in OHP Standard for adults and couples came from a policy decision. The Committee would be able to connect the flow of these lines with policy choices on the one hand or changes in the world on the other to be able to see the world relative to policy choices made inside and outside of OMAP.

Tina Kotek asked if the Committee could enumerate what the questions are to tell the story of policy changes. Not only do we want to know the depth of how many folks were touched by the program but the kind of numbers that can show the success of continuity of care. That could drive some of the policy changes. It doesn't make sense to have someone keep coming on and off a program because those gaps cause problems in terms of the financial stability of someone and/or their health status. Why are they off the program? Did they make more money or were there other reasons why they were off the program? This information would be very helpful.

OMAP/DHS Update

Lynn Read gave an update on the presentation she made to the Senate Interim Committee on Children's Health on January 24, and provided the Committee with a handout of the medical assistance eligibility groups. Lynn wanted to set the stage for the interim committee in terms of whom it is we serve in our Medicaid and CHIP programs, show there are various doors in which people come through and that children are eligible in our programs with family incomes up to 185% of federal poverty.

Increases over a 5½ year period for just children:

- TANF Extended Medical combined with non-cash TANF children: 145%
- CHIP: 54%
- Foster care/substitute care: 45%. The increase is driven largely with the methamphetamine epidemic and its impact on child welfare needs.
- Children with disabilities: 72%.

Children with disabilities is a group of children that Oregon could do more for. Some states have looked at disregarding parents' income and providing more supports around respite and personal care.

A new opportunity coming out of the Federal Budget Reconciliation Act would allow states as an option to pick up a program for disabilities. This would allow parents with incomes up to $300 of federal poverty to buy into the Medicaid program for their children.

The next chart provides demographics for the children served. Approximately three-fourths of the children (male and female) served by

Medicaid are under age 13. It then breaks out the population by race and ethnicity. This comparison group includes both adults and children.

OMAP will try to obtain information for comparison on how the Oregon population of children is distributed by county. The distribution of uninsured children by county is not available at this time. Tina Edlund will talk about the uninsured children's population by regions in her presentation.

Medicaid provided coverage in 2004 for 44% of the births in Oregon, up from 40% in 2001.

221,000 of the 228,000 children represented have a very comprehensive benefit for medical/dental/mental health services under the Oregon Health Plan. 7,000 of the children represented are children in the Citizen Alien Waived Emergency Medical (CAWEM) program, and are only entitled to emergency medical benefits.

Dr. Lefranc asked if there is any data on how many deliveries were covered by CAWEM. Lynn Read responded about 10% of the deliveries were CAWEM and about 34% being regular Medicaid. Oregon births for 2004 were 45,400. Of the 20,000 of the total births paid by Medicaid, 4,800 were in the CAWEM program.

Action item
Lynn will provide the document to Committee members.

Dr. Wopat asked if a statement he had heard was true: that one in four births in Oregon is to Hispanic parents.
Dr. Lefranc commented that he read an article that stated the fastest growing group of Latinos is third generation Latinos.

Tina Kotek said the largest group of uninsured children is Hispanic Latinos. The big question now is what happens to the child after delivery.

Lynn Read indicated 26.6% of the Medicaid population is identified as Hispanic, including the 7,000 CAWEM children.

Tina Kotek asked the (MAC) to include the chart Lynn Read presented to the Legislative Interim Committee on Children's Health that shows all of the OHP populations. Increases in the foster care caseload should be explored.

Adults who lost coverage in OHP Standard were not receiving the services they needed in terms of mental health or substance abuse treatment to be good parents and that might have an impact on foster care caseloads outside of the methamphetamine issues.

Dr. Wopat said there are numbers of OHP clients but we don't know how many people qualify for the programs that are not enrolled on them.

Carmen Urbina asked if utilization data can be obtained on medical visits for CAWEM children. Lynn Read indicated that there is some data relating to broad diagnosis categories for the CAWEM population as a whole which could be broken out for just the children's population.

Lynn Read updated members on the status of the three pending waivers submitted to CMS. DHS has not had any further action by the federal government on the waivers:

- Change in premiums for OHP Standard
- Flexibility around the Maintenance of Effort and the possibility of utilizing some of the remaining $1.1 million in the Legislative Emergency fund for either an expansion of CHIP or extending the length of eligibility for CHIP children
- Change in benefits proposed for July

Oregon continues to be told that the Premium and the Maintenance of Effort waiver requests are moving forward for decision.

Rick Wopat asked about the current status of the DHS budget shortfall. Lynn Read responded that DHS reported the $172 million shortfall to the Legislative Emergency Board in January and proposed some savings and management actions. $4 million was also proposed in administrative actions/savings. The Legislative Emergency Board delayed action on the request and requested an update in April when new caseload figures are available.

DHS is engaged in activities of validating and monitoring caseload projections because that is what is largely driving the shortfall.

- $119 million was related to caseload and cost per case within the OHP
- $87 million related to caseload in the OHP

The biggest drivers for OMAP were increases in TANF and the program serving people with disabilities.

DHS will be working with the State Controller and a team on tracking expenditures and revenue, improving the forecasting process with an independent review by the Department of Administrative Services (DAS). Monitoring caseload trends will be done on a real-time basis. A workgroup will also be formed, including four legislators, to look at how eligibility is being administered and review eligibility standards to make sure the right services are going to the right people. The group will explore additional efficiencies in DHS, and work with providers and stakeholders to insure fiscal accountability in terms of improving our financial management.

Jim Russell inquired how disability is determined for children in the disabilities program. Lynn Read responded it is SSI related.

Action item:
Lynn Read will provide the MAC with a spreadsheet of eligibility criteria for the different programs.

Healthy Kids

Erinn Kelley-Siel, Health Policy Advisor with the Governor's Office, pointed out that the Governor is very committed to moving forward an agenda to allow Oregon in 2007 to have a plan in place to provide every child, up to age 19, with basic access to health care. The Governor requests that the MAC play a major role in helping his office develop the policy around that particular plan which will become part of his proposed budget in December, 2006 and part of his of his legislative agenda in 2007.
Erinn provided some background on the Governor's perspective around the role and why the Governor decided to make the request of this particular group to do this work, what she believes the work entails, what some of the timelines could be to get it done. The Governor plans to release detail around what he is hoping the plan includes, more specifically, in his State-of-the-State address in February. Erinn will be attending the MAC meetings over the next several months to serve as a resource.

The Governor has stated plainly from the first day he came into office that kids for him are a priority, and he really wants children to be the first

thought on people's minds, whether it's education, public safety, juvenile crime prevention, child welfare, or children's health. His message around health care from the start has been an access-driven message. With children, in particular, that has played itself out in the area of school-based health. He has been very committed to the school-based health center model. When the Governor first took office in 2003, he worked to restore and preserve funding for school-based health centers and fought for additional funding in 2005. The legislature supported that which has enabled the state to add school-based health centers in five additional counties. By the end of the biennium, there will be 47 certified school-based health center sites. Some components of that model are particularly interesting to the Governor, and some will not work for his Healthy Kids Plan. The access piece in the model is not only good for the youth but is also good for their families. School-based health centers see children of parents who don't have insurance as well as children with insurance. The centers particularly help working parents as they don't have to take time away from work to take their child to see a clinician. Children appreciate the centers for a variety of reasons. Some kids feel comfortable telling their parents when they need to see a physician or mental health specialist, and some kids don't. The issue of mental of health in school-based health is something that the Governor has been tune with, and the access point that that plays for children and meeting those needs has been a huge issue for him. His commitment to school-based health is unwavering and is driven by the benefits to kids and parents, and communities.

In some communities, school-based health centers are not a great model. It's just not economically viable for school-based health centers to locate in some areas of the state. As the Governor is developing his Healthy Kids Plan, those dynamics are very much on his mind. The issue of access, the benefits that school-based health brings for kids and families but then we also the need to keep in mind that school-based health is not the only way that schools can be a resource to kids and families for health access.

The second thing the Governor has done is he worked with the Insurance Pool Governing Board (IPGB) after some legislation passed to create a children's group plan for uninsured small businesses. For the first time this enabled small employers in Oregon that perhaps couldn't afford to provide their employees with private health coverage but maybe could afford to provide coverage just for the dependents of those employees. The drive was always to make it affordable as possible for small business to meet kids'

needs so it still has very comprehensive benefits although it does not include dental. Coverage can be subsidized through FHIAP if the employee qualifies for the subsidy. The plan came on line on March 2005. Only 10-12 employers have actually purchased it, and there are only about 40 kids covered under it. The legislative statute in July 2004 that gave authority to create the plan had an uninsurance requirement causing fewer businesses to participate. The IPGB is working to change that. Small employers and families are really struggling with affordability for private coverage even when the state tries to design what it considers to be the most affordable, most basic plan for kids for small business. The issue of affordability has been huge issue for the Governor when he looks at the possibility of expanding services provided for kids who are currently not eligible for the federal programs. What can the state do for those kids whose family incomes are too high to qualify for OHP, CHIP or FHIAP to make coverage more affordable?

The third area is the significant number of children who currently don't have insurance in the state. OHPR estimates about 50% are eligible but not enrolled in our existing programs. We know we can make a huge impact if we do a better job with the programs we have with outreach, enrollment and retention.

Erinn Kelley-Siel said that provides a high-level perspective on how the Governor's been approaching this issue during his term in office to date, what he's learned, where he would like to see this conversation go and some of the key priority issues going forward. A public process needs to be held around this conversation, and also to have experts like the MAC come together to give advice on it. The Governor very much wants to engage the MAC in that conversation as opposed to creating an entirely new group of people to do it and believes the MAC are the most qualified as they are familiar with the programs, have the expertise, and are ready to hit the ground running. The MAC has credibility in the community, and the Governor would like to be able to capitalize on that. The Governor's Office is very committed, through this process, to the idea of having public hearings around the state to solicit input on these issues. The Governor's Office has resources that the MAC can utilize as well in the Office of Health Policy and Research (OHPR) and all the state agencies, and they stand ready to support the MAC in the work. The Governor will articulate some very specific things in his State-of-the-State address he is committed to in terms of how his plan is put together. Hopefully it will guide a little bit of the

MAC's discussion. Other things will to be open that they will need the MAC's advice and assistance around. This is the beginning of a dialogue over the next several months as the MAC and the Governor's Office work through some of those things together.

Tina Kotek believes a public process will be helpful for buy-in around whatever ideas come out. She summarized that the MAC will have very specific things that the Governor will want them to look into after his State-of-the-State speech.

Erinn Kelley-Siel added that there are some areas that she has talked about already that would be easy to highlight within which a lot of this work will fall:

- Benefit design and the kinds of benefits offered to kids. Erinn anticipates this work taking the longest and requiring the most outside expertise. OHPR applied for some grant monies focused on the waiver renewal process that can be utilized to help the MAC through this exercise.

- Access – kinds of access and how are kids accessing the plan. It's possible to start to structure a work plan going forward in some high-level areas and when the Governor comes forward, with more specifics, adjustments can be made.

- Timeline - The Governor has a very limited amount of time over this next year to get this work done and is really hoping for recommendations back from the MAC by May. Those are the deadlines the Governor's Office has internally to submit legislation and then after that legislation is submitted, they have to build the budget in the fall. The deadline for any legislative change in the budget requests is early in the summer. There is time sensitivity to all of this for the Governor's Office. Erinn hopes the work won't go beyond what the MAC thinks is possible in the next couple of months.

Carole Romm asked about the parents of children who are insured or uninsured and how that impacts the children's access. She asked for clarification of a statement in the Governor's speech in January when he mentioned the OHP Standard population.

Erinn Kelley-Siel responded that this is an incremental step for the Governor toward a broader vision that creates Oregon becoming a state where every person has access to health care. The Governor has charged the Health Policy Commission's (HPC) to frame this broader discussion with some short and long-term incremental goals to moving toward that broader vision of access for everybody. At the same time, he really believes there needs to be some incremental steps to show that we're really moving in that direction. He, as a former insurance commissioner, fully appreciates the dynamic between kids' insurance and their parents being insured and is sensitive to that. The Governor is trying to focus first on kids and is more than willing to accept a recommendation that the next area of focus for the state needs to be parents and the reasons why. He really wants the MAC, over the next 4-5 months, to concentrate on what it would actually take for the state to cover every child. It will be very difficult to touch on the area of outreach, retention and enrollment without touching on the issue of parents. The Governor is very appreciative and sensitive to that point. There are 609,000 uninsured individuals in the state, and we've got to start walking up the mountain. For the Governor, the first part of the climb is kids.

Donna Crawford asked for a description of what a school-based health center is. What kids would be eligible, would they be doing prevention screening, offer any therapies, what access would there be? If there is a school health clinic in one school, would that enable kids to go to that clinic from other school?

Tina Kotek noted that the school-based health centers around the state serve about 7% of children in the schools, provide primary care and preventive care and are usually staffed by nurse practitioners and are part of the safety net. Not every area has the capacity to have one. They are effective because they provide age-appropriate care to students, with preventive services, mental health and primary care in a setting that's convenient for the students who are in the schools. The clinics are located mostly in high and middle schools although there are a few in elementary schools. An elementary student theoretically could receive services at one of those schools. If a school district has a school-based health center they tend to serve all the schools in the area.

Donna Crawford asked what kind of access a student with a disability would have. Would students with cognitive disabilities be able to benefit from this program if they didn't initiate the access?

Tina Kotek explained that is a very important question that goes to the question of a larger educational policy of where the students with disabilities are. If they in the schools, she would say yes. You would have to make sure that the folks in the clinics had the particular skill sets to handle particular issues. The question would be if the student is not actually in the school. Tina did not know the answer to that.

Erinn Kelley-Siel added one of the things that really impressed the Governor about the model was just the breadth of service that the school-based health center offers. In several communities her office has seen that these centers actually take it upon themselves to open their doors on weekends and stay open even in the summer. There are limitations to the clinics so they cannot be relied upon as the only resource. Her office certainly recognizes those limitations but they do believe the school-based health centers are invaluable especially when it comes to serving kids.

Tina Kotek added that many school-based health centers are affiliated with or are Federally Qualified Health Centers (FQHC's) in their communities so they are able to offer additional services, such as oral health.

Dr. Lefranc asked if there is any data about the demographics, the distribution and the barriers why 50% of the kids are not enrolled when they could be.

Erinn Kelley-Siel responded she believes there is a lot of data and later in the presentation members will hear about some research that was just released last week about some of the challenges that kids and families are facing to enrollment. Certainly through the Robert Wood Johnson Covering Kids initiative throughout the state, Ellen Pinney and her group have done some great work and have some very concrete recommendations about policy changes the state could make to improve that number.

Dr. Wopat commented that in the OHP distribution of kids, 40% of them are five years and under and don't attend school. The vast majority of children he would see in his clinic are not school-age children. The Committee needs to broaden that out and keep the perspective of where the need is.

Michael Garland welcomes the opportunity to be working on this part of the problem and believes that this has to be from the beginning fully articulated

with a vision of climbing the rest of the mountain. If we don't, on the way up that mountain, there's the age 19 or 21 where people fall off the cliff again. He believes the MAC is charged to be thinking about the children as part of a whole package instead of just children.

Erinn Kelley-Siel responded the Governor's Office will be working very hard on that, partly through the Health Policy Commission (HPC). The MAC will be very connected to the HPC discussion around access and the uninsured to really look at identifying some targets around the bigger issues and how the state can move toward those as they are looking at access.

Information on Health Insurance and Children – Tina Edlund

Tina Edlund, Research and Data Manager, Office of Health Policy and Research, opened the presentation by explaining:

- Lack of coverage leads to unmet health care needs
  - Uninsured children are half as likely to receive preventive care and half as likely to have seen a doctor in the last year
  - Uninsured children are more than 5 times more likely to report having an unmet need
- Lack of coverage impacts the use of emergency room visits and hospital admissions
  - Lack of timely and ambulatory care results in greater number of hospitalizations, especially for certain conditions like asthma
  - Preventive care linked to continuity of care with a provider can lead to decreased hospitalizations
- Lack of appropriate health care puts kids at risk at schools
  - Kids in poor health actually miss more days in school
  - Kids who weren't treated for health conditions such as asthma perform more poorly in school.

OHPR has been responsible for a number of years for monitoring the health insurance status in the state through the use of the Oregon Population Survey (OPS), a statewide household survey that has been conducted every two years since 1990.
The last population survey was conducted in 2004 and included 4,500 households, representing 11,595 individuals. The respondent that answers the questions actually answers the subset of questions for every individual in

the household. It's quite a demanding survey for large families to participate in.

OHPR conducted a special study last summer on the African-American population because the 2004 survey gave highly unreliable results. OHPR worked with the Office of Multicultural Health and Portland State University actually conducted a special survey on the African-American population in the summer of 2005. The response was improved and the numbers were much better than the 2004 survey.

Kids were tracked from age 0-17 years to match the census. OHPR's purpose was to track kids who would qualify for the SCHIP program which goes up to age 18.

- In 1990 there were 19.9% uninsured kids through age 17.
- In 1996, only 7.6% of kids in the state were uninsured, an all-time low. That was due a combination of a really robust economy and a very strong health plan in the state. If the 18th year is added, the number increases to 13% uninsured kids in 2004, representing over 117,000 children.
- In 2004, uninsured kids rose to 12.3%. When the 18th year is added, the percentage of uninsured kids rises to 13%, representing over 117,000 uninsured children.

Distribution of Uninsured Children by Race and Ethnicity

- Caucasian: 87.4% of the Oregon population and 78.1% of the total uninsured kids
- African/American: 1.7% of the Oregon population, 1.8% of the total uninsured kids
- American Indian: 1.0% of the Oregon population and 2.1% of the total uninsured kids
- Hispanic: 9.6% of the Oregon population, 36% of the total uninsured kids

The total population numbers include both children and adults.

Poverty Status of Uninsured Children

- 18.5% of uninsured children have a family income less than 100% of federal poverty level

- 53% of uninsured children have a family income between 100-200% of federal poverty level
- 77% of uninsured children have a family income below 300% of federal poverty level

Geographical distribution of uninsured kids

20% - Eastern Oregon
10% - Portland Metro

Geographical distribution cannot be broken out by county.

Uninsured kids with long-term medical disability (defined as a year or more mental, developmental, physical or learning disability)

- 9%, or 9,700 children, were identified as having a long-term disability by their parents

Respondents who were currently insured were asked in the Oregon Population Survey if there was any time in the 12 months that they had a period of uninsurance.

- 84,000 kids, under age 19 years, experienced a gap in insurance sometime during the last year in addition to the 117,000 currently uninsured children.

Tina Edlund summarized:

- Children without health insurance are less likely to get routine well child care, have worse access to health care and use medical and dental services less frequently than insured children.
- In Oregon there are 117,000 children under the age of 19 years currently without health insurance.
- About 53% may qualify for public coverage.
- Another 84,000 children have experienced some gap in their coverage during the year.

Information on Health Insurance and Children – Jen DeVoe, MD

Dr. Jen DeVoe, Family Physician, currently at Oregon Health Sciences University, worked with OHPR to conduct the study on health insurance and children.

The purpose of the study was to look at a population of children who are eligible for the current OHP, either Medicaid eligible or SCHIP eligible. The population easiest to identify and had similar eligibility was the Food Stamp population. A random sample of about 84,000 families with children between the ages of 1 and 19 years was drawn from that group. The assumption was that these families live with incomes below 185% of the federal poverty level, have been able to enroll in Food Stamps but many of them have not been able to be enrolled in the Oregon Health Plan (OHP). Researchers looked at who are they, why are they not enrolled and what are some of their barriers.

This data represents the entire Food Stamp population who are somewhat connected to state programs but many are not connected to the medical assistance programs. About 11% of the clients reported current uninsurance at the time of the survey. The uninsured children were more likely to be:

- Hispanic
- Older than 14 years of age
- Living in a household earning between 133% and 185% of federal poverty level
- Have uninsured parents or parent

Over half of the uninsured children had employed parents:

- 15% of children had private insurance
- Children who had public insurance - about 74% reported having current OHP coverage
- Children who were uninsured – 11%
- About 85% of the respondents reported that they were the mother of the child
- Over 50% of the parents of uninsured kids were employed.
- Over 80% of the children had the specific parent respondent report they were uninsured

Insurance coverage gaps are more concerning. Over one-fourth of parents of children who had coverage reported a coverage gap within the last 12 months. The gap ranged from less than one month up to 12 months. One-third of the gap group had over 6 months of uninsurance.

Why did the child go without health insurance coverage

- 20.7% of the respondents believed that their child was not eligible for Oregon Health Plan (OHP) because of income. People with income less than 50% of federal poverty and all the way up to 185% of federal poverty believed this.
- 20.3% reported that their child had been covered under the parent's employer-sponsored health insurance but was no longer eligible (due to reasons like job change or shifting to part-time work).
- 16.5% reported that they could not afford to pay the premiums for insurance provided at work.

Other reported reasons for children's coverage gaps:

- Significant problems with the OHP application process
- Missing the OHP re-certification window
- Confusion about OHP premiums and children's eligibility if parents were no longer eligible

Why the child was uninsured:

- Money owed to OHP for back premiums when adults were dropped from health plans
- Owning a business but not being able to afford insurance and having to wait 6 months to apply for OHP coverage
- Employer does not offer insurance, parent cannot afford insurance, and was denied by OHP
- Divorced or separated parents who hadn't followed through with insurance for their child
- Children who had been enrolled in the OHP, and when the state went after their dads to contribute to the coverage, the dad would retaliate on the mother who would then be afraid to re-enroll the children.

Tina Kotek expressed hope that more of an effort would be made to go after the "deadbeat" dads to provide health coverage for their children. She would like to see this type of data be sent out.

In the past 12 months:

- 1 in 3 uninsured kids did not visit a primary care provider
- 4 out of 5 uninsured kids did not receive necessary dental care
- Uninsured children were 6 times more likely to have no usual source of care

- 3 times more likely to go to the Emergency Department for regular care
- Almost 20% of children continuously enrolled in the OHP had prescription needs that prescriptions went unfilled.

Parents were asked to identify three changes that would make it easier to stay enrolled:

- 72.6% said it would be easier if they did not have to re-enroll their child in the OHP every 6 months
- 35.5% said it would be easier if their child did not have to go without health insurance coverage for 6 months
- 34.1% would like to apply on-line

In conclusion

- Despite eligibility for public or private coverage, Oregon's low-income families have children who are uninsured or experience gaps in the healthcare coverage.
- Cost and administrative hurdles are the major reasons that families are not carrying insurance coverage for their children.
- Lack of health insurance is associated with significantly higher rates of unmet healthcare needs for many of Oregon's children.
- Many of these children have parents who are employed; however, no employer-sponsored coverage is offered, premiums are too expensive or dependent coverage is not available.
- Children are more likely to remain uninsured if their parents are also uninsured.
- Gaps in coverage lead to the same problems as not having any coverage at all.

Policy Implications

- Targeting efforts to maximize enrollment and retention of eligible children:
  - Eliminating or reducing the required period of uninsurance
  - Simplifying the OHP renewal process
  - Extending the OHP re-enrollment period from 6 to 12 months
  - Streamlining the OHP application process
- Explore ways to lower the cost of coverage for families who have access to employer-sponsored insurance.
- Explore ways to contain the rising cost of healthcare.

Dr. Lefranc asked if language barriers were considered a factor for parents in re-enrolling their children. Dr. DeVoe responded the survey was administered in Spanish as well as Russian. There were about 500 Spanish respondents. Language as well as literacy is a big issue.

Elizabeth Byers commented that she works with Oregon Health Action Campaign, and more specifically, with the health help line, where calls come from people from all over the state who are having challenges participating in the OHP.

Elizabeth indicated that SCHIP has never been advertised and that Children's Health Insurance information traditionally does not go out in free or reduced lunch applications.

One of the major things Elizabeth Byers doesn't see is data showing parents not applying for SCHIP for their children because there are no providers who will take SCHIP coverage in their area.

Elizabeth Byers added that many clients, when they move out of TANF and become employed, are not told they have a year that they can continue programs they had through TANF that support them to make that strong stand for independence. It's not department policy not to tell people but it seems to very often get lost. There is a big education and advertising component which has always been missing.

Dr. DeVoe responded that about 5% parents surveyed said they would not want to enroll their children, and of that group, 10% of parents reported it was because they could not see a provider if they had OHP coverage.

Dr. DeVoe said the full report will soon be available on the web page.

Other States' Initiatives

Dr. Jeanene Smith, Acting Administrator of the Office for Oregon Health Policy and Research, presented background on the SCHIP (State Children's Health Insurance Program).

The SCHIP started nationally in 1997. Oregon implemented SCHIP in 1998. It has allowed over 4 million children access to health coverage that wasn't available prior and is primarily aimed at working families to get their children covered with incomes somewhat higher than Medicaid poverty

levels. The match rate is much more attractive, about 73 cents of every dollar spent on the SCHIP program. There's a lot of evidence that says this program is working. Children are receiving better health care, more access, they are less likely to go the emergency room or be admitted to the hospital. The SCHIP waiver is up for re-authorization on a national level in 2007. A lot of information will be coming out on SCHIP overall. Dr. Smith plans to attend a national conference on the 10 years of SCHIP next month and hopes to bring information back to share with the Committee.

How are the states across the nation doing?

- 8 states, including Oregon, are below 200% of federal poverty level
- 30 states are at 200% federal poverty level
- 13 states are higher at 250-300% of federal poverty level

New Jersey is at 350% of the federal poverty level.

200% of federal poverty translates to a yearly income for one person of $19,000 and $38-39,000 per year for a family of four. These figures will change somewhat next month when the new federal poverty level numbers are released.

Rick Wopat asked if 350% was a cap. Dr. Smith responded that 300% is what is usually seen.

The state must apply with a waiver amendment to CMS and show budget neutrality, that they didn't spend more by administering the program a little different than if they administered the program in the traditional way.

Benefits - Some states just expanded their Medicaid and don't have a real separate SCHIP program. Some states have implemented a very different SCHIP.

States had to follow some specific standards. The benefits have to be either:

- Same as the federal employee benefits
- Same of the state employee benefits (PEBB)
- Same as the largest health maintenance organization in the state
- Must be actuarially equivalent to one of the above 3 plans

Cost Sharing

- States may impose cost sharing but it has to start at 150% and it can't exceed 5% of the family's annual income.

- States may charge premiums, enrollment fees, co-payments and/or deductibles. No co-pays are allowed on preventive or immunization services.

Crowd-out

The feds were concerned about crowd-out – people dropping their own options for coverage.

- States are required to monitor "crowd-out" and have protections against this.
- Some states have set waiting periods. Oregon currently requires a 6-month uninsurance period.
- Waiting periods can create gaps in coverage for children, which can impact their health. New York has no waiting period and has seen no significant "crowd-out", nor have many other states with short waiting periods.

Examples of SCHIP in other states:

- **Dr. Dinosaur (Vermont)** – brands children's programs under one umbrella program
  - Covers children and teens under 19 years
  - Covers up to 300% of federal poverty
  - monthly charges to families above certain income level
  - Broad-based benefits, including mental health, dental and vision

- **Kid Care (Florida)**
  - Links Medicaid children's programs to its Healthy Kids SCHIP program which is administered separately as a non-profit
  - One card issued for all programs. Eligibility for any one program done by the state internally
  - Partners closely with schools for outreach and enrollment
  - MediKids – receives both SCHIP dollars and Medicaid dollars for children at higher levels of income
  - Behavioral Health Network – provides specialized services for children with serious behavioral health needs and the severely disabled populations.

Some families are able to buy into the Florida Healthy Kids insurance when they are above 200% of federal poverty.

West Virginia Children's Health Insurance Program (WVCHIP)

- Covers children age 18 and younger, not otherwise eligible for Medicaid, up to 200% of federal poverty
- 12-month re-certification period
- No co-pays for family incomes under 150% of federal poverty
- Aligned with their West Virginia Public Employee Insurance Agency and use the same fee schedule to pay providers.

"All Kids Plan" - Illinois

- Program will be implemented in July 2006
- Focus is to cover all uninsured children beyond the current Medicaid /SCHIP
- Covers up to age 19
- Must be uninsured for 6 months or parents lost employment
- Subsidies will be offered towards private insurance when cost effective
- Cost sharing - sliding scale based on family income, can include co-pays, premiums and co-insurance except for preventive or immunizations
- 12-month re-certification period

The aim is for every kid to have a "medical home".

States have a lot of flexibility in designing their children's programs.

Dick Stenson asked what the level of penetration of insurance programs is. Dr. Smith responded in Florida their children's uninsurance rate was down 5-6%.

Action item:

Jeanine Smith will be asked provide an update on the SCHIP programs at next month's MAC meeting.

Medicaid Advisory Committee (MAC) Draft Work Plan

Bob DiPrete will draft a work plan from January through June, and send out electronically to the Committee in the next couple of days so they can become familiar with it for discussion at the next meeting. Public hearings will probably be held in April. The Committee will work through February and March to get more information and also to start framing questions that

they will want to make recommendations on. Questions will need to be framed in such a way that they are appropriate to take out to the public hearings in April.

The Governor has indicated he wants all children covered so some of the eligibility work will have more to do with whether there is going to be a subsidy and how much, or whether some children above the income level will require their families to pay the full price themselves. Other areas of work:

- 6-month uninsurance requirement – whether to keep it or move to something less stringent
- Assets – the Governor may be inclined to move away from the current asset limitations
- Benefits – The MAC needs to discuss what's included in the benefit package, where there will be cost sharing, if any, and at what level of income there will be cost sharing so that people will have to pay something to access benefits
- Delivery System/Capacity - need to ensure that the child is able to be seen by a provider when he needs care
- Reimbursement

Bob DiPrete attended the Senate Children's Health Committee yesterday, chaired by Senator Monnes-Anderson, who was very receptive to what the Medicaid Advisory Committee (MAC) was doing and asked that they come back each month to update her committee on their progress. Senator Monnes-Anderson said her committee would also have requests for the MAC because they are also working toward expanding coverage for children. The MAC work plan at some point will also reflect what the Children's Health Care Committee is trying to accomplish. Senator Monnes-Anderson intends to sponsor a legislative bill on covering more children coming out of the work being done by the legislature.

The MAC will be receiving requests from the Governor's Office and the legislature on this topic over the same time period.

Carole Romm expressed concern on the workload and suggested that the Committee have sub-groups that could meet between Committee meetings and bring recommendations back to the larger group.

Dick Stenson asked if the sub-groups would fall under the public meetings requirements. Tina Kotek responded they would.

Rick Wopat encouraged the MAC to do as much work electronically as possible. Sharing draft information, soliciting feedback can be done without having to come together with face-to-face meetings.

Tina Kotek suggested that the Committee work on recommended action-type issues at the MAC meetings. The MAC does not want to lose sight of the whole parallel process around the waiver. Tina asked if half of the meeting time should be devoted to the children's health insurance issues and the other half on the other issues.

Carole Romm asked about the timeline on the waiver.

Bob DiPrete said DHS will be submitting a request for an extension of the current demonstration waiver which may not have any large-scale changes in it. There will be a deadline if a statutory change is needed.

Lynn Read indicated the waiver submittal process timeline:

- Oregon has to notify Centers for Medicare and Medicare Services (CMS) of their intent to renew the waiver by April 30, 2006.
- The renewal application will need to be submitted by October 31, 2006. This will be prior to the Governor finalizing his budget and the legislature convening. One approach is to move forward with something that is similar to what exists today or what will exist in the next several months as the waiver renewal.

Carmen Urbina suggested the MAC have extended meeting times.

Dr. Wopat reminded members that the MAC is a specialty group whose role is to provide guidance and recommendations to the Health Policy Commission.

Other

The next meeting of the Medicaid Advisory Committee is scheduled for Wednesday, February 22, 2006, from 10:00 am to 2:00 pm, at the Card Room, Mission Mill Museum, 1313 Mill Street, SE, in Salem.

Meeting adjourned.

Medicaid Advisory Committee
February 22, 2006

Present: Elizabeth Byers, Donna Crawford, Michael Garland, Kelley Kaiser, Tina Kotek, Carole Romm, Jim Russell, Dick Stenson, Thomas Turek, MD, Carmen Urbina, Michael Volpe, Rick Wopat

Absent: Bruce Bliatout, Yves Lefranc, MD

OHPR: Bob DiPrete

OMAP: Jim Edge, Jean Phillips, Mary Reitan

Tina Kotek, Committee Chair, opened the meeting. Introductions were made by members.

Minutes from the last Committee meeting on January 25, 2006, were approved as written.

Tina Kotek indicated that the current role of the Medicaid Advisory Committee (MAC), based on the Governor's letter, is to provide recommendations around the Governor's Healthy Kids initiative.

Proposed Strategic Approach

- The Healthy Kids initiative is one component of insuring health care for all Oregonians.
- The MAC will need to stay within the timelines of the waiver
- The MAC is an advisory group
- Policy recommendations are to be based on evidence-based research
- The MAC will coordinate with other groups (Oregon Health Policy Commission (OHPC), Health Resources Commission (HSC) to set the framework for discussion.

Michael Garland inquired about the relationship between the Governor's initiative and the waiver renewal.

Bob DiPrete responded that there is an overlap as changes will need to be made to the Oregon Health Plan (OHP), Family Health Insurance Assistance Program (FHIAP) and the Children's Health Insurance Program (CHIP).

DHS will submit a waiver application for extension of the current OHP Demonstration waiver with minor changes. There will be larger changes after the legislative session, and a waiver amendment can be submitted at any time.

Jim Edge commented on the waiver renewal process. The Department of Human Services (DHS) will submit a letter of intent to Centers for Medicare and Medicaid Services (CMS) in April 2006. In October 2006, the waiver application will be submitted for October 2007 when the waiver expires. A waiver amendment would be submitted to CMS if the Healthy Kids Plan is adopted by the Legislature after October 2006.

Tina Kotek shared concern of a larger health care issue in that parents would also need to receive coverage.

Rick Wopat added that the state would need to apply for a waiver amendment for any new ideas requiring legislative action.

Jim Russell said that any changes with budget implications would need to be thought through within the next few months in order to be placed in the Governor's Recommended Budget.

Michael Garland emphasized that the MAC needs to keep in mind the price tag for any change and where the money would come from. This issue needs to be addressed.

Tina Kotek responded that the MAC may have to focus on children eligible for the programs now and propose increases in enrollment in stages.

Jim Russell asked if the timeline for the MAC work plan was confirmed. Bib DiPrete said it was.

Michael Garland indicated that assuring policy recommendations are evidence based would require a lot of interplay between the MAC and the Office of Health Policy and Research (OHPR) to identify problems and outcomes.

Bob DiPrete added that holding public hearings would generate more feedback.

Delivering Services to Kids with Disabilities

Kathryn Weit, with the Oregon Council for Developmental Disabilities, said members of the Council are appointed by the Governor. Their role is one of advocacy and education for children with disabilities issues. The Council serves children, from 0-18 years of age, with developmental disabilities and children with special health care needs.

Families with children with disabilities often face obstacles in accessing health care to meet their children's needs.

1. Private health care that doesn't address the needs of kids
2. Families coming on and off the OHP

Seniors and People with Disabilities (SPD has two Medicaid Model Waivers that do not apply the parents' income when determining eligibility.

- Medically Fragile Children (Hospital)
    - 25 Medicaid eligible "Medically involved" kids on vents, tube fed and require 24 hours/7 days per week care receive waivered services.

- Behavior (ICFMR) - Kids with significant behavioral issues
    - 58 kids are growing up in the nursing facilities with an average stay of 6-10 years. They will then move to the adult system.

A budget note during the last legislative session directed the Council to look at kids with disabilities in Oregon and explore a waiver option.

34 states waive parental income as a requirement in determining eligibility. Some states require copays.

The developmental disabilities system has 800 children in care. The big question for the Council is how to keep kids out of nursing homes and receiving care in their own homes.

The federal Budget Reconciliation Act has provision for a Family Opportunity Act option that would allow families to buy-in for health care for children with special health care needs.

Medicaid Waiver Options:

- Develop a waiver that would ignore parental income for medically involved children (Model or TEFRA Option)

- Develop a waiver for children with severe emotional disabilities that would allow children to remain at home and still receive needed treatment. (TEFRA Option)

- Look into the Family Opportunity Act option for families to "buy into" Medicaid.

Tina Kotek requested more information be provided to the MAC on the Family Opportunity Option.

Rick Wopat requested more information on comparable costs for nursing homes versus in-home care for the MAC to determine the best value.

Kathryn Weit said she would provide the requested data to the MAC. The Medically Fragile program requires families to provide 8 hours per day of in-home care.

Donna Crawford indicated that the MAC needs to consider quality of life for kids as well as cost factors when making policy decisions.

Michael Garland added the MAC needs to articulate the core values at stake as well as cost.

Elizabeth Byers indicated that Oregon is the only state without Early and Periodic Screening, Diagnosis and Treatment (EPSDT). She suggested it be included in the waiver. Darren Coffman responded that EPDST screenings are still being done for children.

Issues on Covering Kids and Parents

Tina Edlund, Research and Data Manager, OHPR, presented data from a study on the effect of parents' insurance coverage on access to care for low-income children. The data used was from a survey during the late 1990's, prior to the budget impacts on states.

Coverage Impacts

- Children residing in states with expanded public health insurance programs that cover parents participated in Medicaid at a 20% higher rate than those who live in states with no expansions.
- Massachusetts expansion to parents had a 14% increase in Medicaid coverage for children
- 81% of kids in Medicaid participate as opposed to only 57% of kids in states without family coverage
- 75% of uninsured children eligible for Medicaid or SCHIP have at least one parent who is uninsured
- Low-income children with insured parents are twice as likely to have health insurance as children with uninsured parents. Less than half of children (48%) with an uninsured parent have health insurance.

Access and Utilization Impacts

- Extending coverage to children of the working poor significantly increases their access to utilization of health services.
- There is continuity of care with family coverage.
- Having an uninsured parent decreases the likelihood a child will have a medical visit by 4.1%.
- Having an uninsured parent decreases the likelihood of a well-child visit by 4.3%.

Kelley Kaiser inquired when children have coverage and parents do not, how one would encourage them to take the child for the medical visit. Michael Garland responded insured children will go to the medical visit. Uninsured kids will not have a medical visit.

Rick Wopat said the MAC must consider the cost to bring more children onto programs. Outreach has a cost.

Donna Crawford believes covering both kids and parents would be a good recommendation for the Governor. The MAC is charged with developing accurate information in order to present the recommendation.

Emergency Department Utilization by Kids

Heidi Allen, Researcher at OHPR, had previously worked at OHSU in their Emergency Department and presented data from a study on Emergency Department utilization by kids.

Non urgent visits are the major issues for Emergency Departments (ED). The concern is they could have been prevented.

25% of all ED visits are non urgent.

One study found that non-citizen children had 74% lower per capita health expenses than children who were citizens but the ED usage was three times greater. Language barriers and access to medical care were some of the factors.

In 2005, ED usage was 50% greater for children receiving Medicaid.

Colorado and New York didn't have a significant increase in ED utilization for newly enrolled Medicaid children, but did have an increase in access to services.

A study by Bob Lowe, OHSU, of Oregon children, under age 18, residing in the Tri-County, found ED usage by:

- 20% of children with private health insurance
- 9% of uninsured children
- 41% of children receiving OHP

Safety net clinics refer children to the ED when they don't have the capacity to serve them.

Uninsured children are less likely to use the ED than children with private health insurance or receiving OHP benefits.

A comparison of Oregon children who did not use the ED:

- Uninsured kids 85.7%.
- Kids with private insurance 85.1%
- Children receiving OHP 74%

Rick Wopat asked if there were reasons for non-urgent visits.
Heidi Allen explained that access to care is a complicated issue. Geographic location and clinic schedules can be barriers. When parents don't have other

resources for health care, they are more likely to bring their children to the ED.

FHIAP Overview

Rocky King, Administrator, Office of Private Health Partnerships, presented an overview on Family Health Insurance Assistance Program (FHIAP).

- FHIAP was created in 1997 as a state-fund-only expansion of the Oregon Health Plan (OHP).
- The first subsidies were paid to buy into private health insurance in July 1998.
- In 2002, FHIAP began receiving federal matching funds through the OHP 1115 and HIFA waivers.
- Currently, the program serves over 16,700 Oregonians, including 4,600 children

Guiding Principles

- not an entitlement program
- operates on a fixed budget
- responds to real life issues of families with limited income-FHIAP pays 50-90% of premium costs
- extends health coverage to the uninsured with 6-month uninsurance
- emphasizes health insurance for children
- promotes equity in health care financing

FHIAP staff found that people coming off of Medicaid had difficulty finding their way through the matrix of private health insurance in the individual market.

FHIAP Eligibility

- must meet income requirements-under 185% of federal poverty
- must have investments and savings under $10,000
- must be uninsured for previous 6 months
- cannot be eligible or enrolled in Medicare
- children must be enrolled first

FHIAP has both the Group and Individual market to enroll people.

- Group – If the person's employer's coverage meets the benchmark, he/she must enroll for Group coverage. When the member sends in a copy of his/her pay stub showing the deduction for health insurance, FHIAP will reimburse the member 50-90% for the subsidy portion of his share of the premium. 5,500 to 6,000 are enrolled in the Group plan, with 45% being children. Businesses have dropped coverage for employees from 69% to 60% over the last 5 years.

- Individual – Members select insurance plan from one of 8 FHIAP-certified carriers. Members apply to the carrier for insurance. Once accepted, the carrier will notify the member he/she has been accepted and bill FHIAP for the entire premium. FHIAP will then bill member for his/her share of the premium. When the premium payment is received, FHIAP pays the carrier and the member will have coverage. 10,000-11,000 members are enrolled in the Individual plan.

13,000-14,000 are currently on FHIAP's waiting list. Approximately 4,500 kids could be eligible for CHIP but parents have decided to keep them enrolled in FHIAP's private insurance instead. Some of the reasons are:

- 12-month continuous eligibility for kids is important for parents
- better access to providers
- less stigma-kids can see a provider with insurance card.
- some families want a hand up, not a hand out – some help in case of a major health crisis

Employer contribution:
- $110 per month – Group market
- $221 per month – Individual market

The Individual market is currently closed to new enrollment.

Most employers have coverage but many have opted out of dependent coverage. Employers cover employees but are not covering dependents. The average length of a member's enrollment in FHIAP is over 2 years. Members enrolled in Oregon Medical Insurance Pool (OMIP), the high-risk plan, stay in longer.

Dick Stenson asked about federal match. Rocky King responded the federal match rate for Title 19 is 61% and Title 21 is 72%. 80% of enrollees receive Title 21 match and 19% of enrollees received Title 19 federal match.

The average capitation payment:

- Group - $114 per member per month
- Individual - $201 per member per month
- OMIP - $366 per member per month

Tina Kotek indicated the FHIAP program was based on the assumption that there should be greater employer participation.

Chronic Disease Management

Darren Coffman, Executive Director, Health Services Commission, noted that the weighted average of the 2006 OHP managed care contracted rates for all services for Poverty Level Medical (PLM), SCHIP and Temporary Assistance for Needy Families (TANF) children under the age of 19 years is $137.12 per member per month. This includes physical health, mental health and dental services. 11% of the population is under one year of age as opposed to 2% for the FHIAP population.

Darren Coffman explained the Health Services Commission (HSC) is reviewing the 17 categories for prioritization of health services. A higher emphasis will be placed on chronic care and disease management and lower emphasis on acute services. The HSC agreed to revise the definition of the categories, focusing on preventive services:

- primary services (immunizations)
- secondary (screening for cancer, diabetes, heart disease)
- tertiary prevention (treat to prevent complications in established disease)
- other services to alter the course of the disease but not necessarily preventing the disease

The HSC is looking at criteria that focus on population health

- how common is the disease
- how effective is the treatment
- what is the impact on health life years

- what is the cost of not treating the disease
- what are the population effects outside of the condition (mental health, tuberculosis, etc.)

Services will be integrated in the new categories in keeping with the original intent of the Prioritized List.

Jim Russell asked if the criteria would include the whole OHP population (OHP Plus and OHP Standard) and would it also include the uninsured.

Darren Coffman responded it would also include the uninsured. He asked is it better to cover more people with a limited benefit package? The workgroup working on restructuring the List prioritized categories:

- maternal/newborn care
- primary prevention
- secondary/screenings
- tertiary prevention
- reproduction

Carole Romm inquired if tertiary prevention would be placed high on the list for the OHP Standard population. Darren Coffman responded it wouldn't.

The workgroup will be looking at the criteria on how immunizations will affect the whole population.

Carmen Urbina suggested that the workgroup explore ethnicity. Some diseases affect certain ethnic groups more than others. Darren Coffman said vulnerability of populations could be added as another criterion. He added that the review of the Prioritized List should be wrapped up by July. A survey was sent out to stakeholders, and the feedback will be blended into the process at the May HSC meeting.

Delivery System Issues

Jim Edge, Deputy Administrator, Office of Medical Assistance Programs (OMAP), explained that the OHP delivery system has one-fourth of its clients in fee-for-service and three-fourths of its clients are in managed care. The goal is to increase clients in managed care to 80%. Issues:

- managed care plan capacity

- access to health providers
- unmet need –
  - uninsured
  - underserved, e.g., clients on open card do not have guaranteed access to a dentist
- payment rates - Oregon has a shortage of health care providers and providers are becoming less willing to participate due to low reimbursement rates.

In 2004, 12.3% of all Oregon were receiving OHP benefits. Of that total, 23.9% of Oregon children were in OHP.

In June 2005, fee-for-service (FFS) claims provided to children on the OHP under 19 years were primarily:

- 51,584 - Medical-Professional services
- 29,874 - Drug claims

In managed care, medical encounters provided to children on the OHP, under age 19, in June 2005:

- 80,923 - Medical-professional services
- 15,798 – Dental
- 45,572 – Drug claims

Total services used by children on the OHP, under age 19, in June 2005:

- 52.4% - Medical/Professional
- 17.2% - Drug

Number of procedure or prescriptions in June 2005 for children on the OHP, under age 19:

- 18,660 procedure codes - Emergency room
- 10,321 procedure codes - Laboratory (includes some by not all imaging)

Capitation rates for children on the OHP under age 19 in June 2005:

- 10,706 – Physician office visits
- 12,291 – other physician

Physician and drugs were services children used most.

Rick Wopat asked where the high-cost neo-natal cases fell. **Jim Edge will provide the Committee with that data.**

Carole Romm inquired about the issues in covering more children. Jim Edge responded that they would have to look at plan capacity, and physician outpatient capacity and drugs would see an increase.

Carole Romm asked if the reimbursement rate remained the same, would it still be possible to take care of the increase in children. Jim Edge said the managed care system is able to pay higher rates so access is better but in the FFS system, low reimbursement rates are problematic, especially in the physician category.

Tina Kotek added that there also will be a delivery system issue as there is no managed care in some of the rural counties. Jim Edge responded that DHS is looking at implementing a partially-capitated model in those counties.

School Health Centers in Southern Oregon

Tina Kotek explained Peg Crowley, Executive Director of Community Health Center, in Jackson County, was unable to attend the meeting and submitted her presentation as a handout.

Multnomah School Health Services

Barbara Neely, Director of School Health Services for the Multnomah County ESD, explained that the School Health Services (SHS) partnered with Multnomah County Health in January 2000 to provide health screening and referral services to its 8 school districts. They also contract with Clackamas County to provide screening and referral services.

SHS nurses sent applications to the parents of uninsured kids and referred them to the Educational Service District (ESD) for help with enrollment to the Oregon Health Plan (OHP).

- 2000-2001 - 58 children enrolled in the OHP
- 2001-2002 - 147 children enrolled in the OHP
- 2002-2003 - Multnomah County SHS partnered with Kaiser Permanente. An outreach eligibility specialist was hired for the ESD.

School nurses have played a pivotal role in the school setting to refer uninsured children to the OHP.

The EDS maintains a data system to track demographics. Nurses in the school setting act as the triage to make sure children become enrolled and also in keeping them enrolled.

Multnomah County ESD, as part of their outreach efforts:

- conducts health fairs
- meets with parents at parent-teacher conferences
- has a website dedicated for outreach

Tina Kotek asked what's needed to reach more children. Barbara Neely responded some of the barriers:

- 6-month enrollment
- 6-month uninsured waiting period
- plan/provider capacity

Tina Kotek also inquired if the School Health Services submitted Medicaid administrative claims. Barbara Neely said yes but the money goes back to the Multnomah County ESD to be used for all school services not just medical.

Multnomah County's School-Based Health Centers have partnered with Multnomah County Health Department to provide a coordinated effort in delivering services.

School-Based Health Centers provide diagnosis and treatment.
School Nurse Services provide prevention and referral services.

School Based Health Centers

Bob Nystrom, DHS Public Health, said School-Based Health Centers (SBHCs) are in their 20th year of providing services. SBHC's were originally developed as an access model to provide accessible healthcare to youth with emphasis on:

- health care access
- health prevention messaging

School-Based Health Centers (SBHCs) deliver a core set of primary health care services (physical, mental, preventive) to children:

- in an identifiable school space
- during regular scheduled times
- by qualified health professionals
- in a collaborative relationship with the local educational and healthcare community

There are 45 certified SBHCs in 17 Oregon counties:

- 38 high schools
- 7 middle schools
- 8 elementary schools
- 1 K-8 school
- 1 K-12 school

In 2004-05 Oregon's SBHCs served:

- 17,702 clients
- 54,650 primary health care visits
- 40,000 Oregon students have access to an SBHC

The 2005 Legislative Session expanded SBHCs to 5 additional counties.

Access to Care Impact

- 29% students reported having another source of receiving health care
- 71% would not have their needs met if the SBHC was not there

Prevention messages: 74% of students reported receiving the prevention messages.

Future capacity: State and local funding is a priority. 16 counties currently do not have SBHCs.

Considerations:

- reasonable growth rate
- long-term sustainability
- range formula cost of living
- core vs. expanded model funding level
- state program office infrastructure

Tina Kotek asked what the impact would be on SBHCs if more kids were covered. Bob Nystrom answered the Centers may already be seeing these children, and some have another resource for health care.

Donna Crawford inquired about the cost for students. Bob Nystrom explained the SBHCs either use a sliding scale fee or bill insurance. 7% of Oregon children currently have access to School-Based Health Centers.

Oregon Primary Care Association (OPCA)

Craig Hostetler, Director, OPCA, explained the OPCA is a non-profit organization that provides advocacy on a state and federal level and operations support to Federally Qualified Health Centers (FHQC's) and safety-net clinics.

FQHC's are funded by federal grants, public and private health insurance, and local and private grants. All Oregonians are served and not turned away regardless of ability to pay. A sliding scale fee is charged based on a person's income.

FQHC's provide comprehensive health services, including primary and specialty medical care, dental, preventive, mental health services, and other support services. The enabling services provided consume 50% of their budget:

- medical transportation
- interpreter services
- case management services

In 2004, FQHC's provided services for

- 206,090 patients
  42.4% were uninsured
- 83,235 children under age 19
  27,289 were uninsured (33%)
- Chronic conditions as primary diagnosis
  - 5,279 - asthma
  - 8,203 - diabetes
  - 2,228 - heart disease
  - 11,462 – hypertension

Craig Hostetler encouraged the MAC to look beyond kids to adult coverage. 81% of children who received services at an FQHC had an uninsured parent. SCHIP needs to be marketed more than it is now.

Capacity can expand with dollars. Issues:

- Opportunities for new federal grants have been exhausted
- Fewer specialists are accepting OHP clients
- Safety-net clinics are becoming less able to take on more clients
- Decrease in federal funding

When a clinic is financially stressed, it will drop the enabling services. Enabling services save more money than the medical visit.

Rick Wopat asked if the FQHC model is sustainable in light of current funding streams. Craig Hostetler responded that the issue really is that they may lose a health center with federal budget cuts because they rely on Medicaid reimbursement by not providing a medical home (enabling services).

Elizabeth Byers asked if there was an issue with a person who was enrolled in the OHP but felt more comfortable using the FQHC for services which is not reimbursed.

Craig Hostetler responded it is an issue that needs to be addressed. Issues multiply for those who come for dental services.

MESD Health Insurance Program

Susan Rasmussen, Manager, Child Health Program, Kaiser Foundation, indicated that in 2004, through collaboration with Kaiser Foundation and Multnomah County, the child health program started. The plan subsidizes the health insurance premiums for children in elementary school, kindergarten through 6th grade, who are not covered by any other health insurance, with family incomes up to 250% of federal poverty. It also does not have citizenship requirements for eligibility.

1,100 children have been covered since 2004. Kaiser has made the enrollment form a simple one-page form. Kaiser subsidizes 100% for children of families enrolled in college.

Carole Romm asked why isn't outreach and enrollment marketed through the school system? Susan Rasmussen responded that the capacity of the school system to deliver these services would need to be explored.

Rick Wopat asked if we should develop a model that provides 24-7, 365 days per year. School-based health clinics are an improvement of what currently exists but may also create barriers:

- no evening coverage
- children have to wait till they have money to receive care

The MAC needs to make decisions that make the most sense in achieving the best in the delivery system.

Tina Kotek asked MAC members: what type of model do we want and what can we afford?

Health Plans: Mid Valley IPA

Dean Andretta, Mid Valley IPA (MVIPA), also known as Marion/Polk Community Health Plan, explained the plan has:

- 35,000 enrollees
- 2/3's are children
- 12% are under 1 year of age
- 35% are between 2 and 10 years of age
- 18% are between 10 and 18 years of age

MVIPA became a Fully-Capitated Health Plan (FCHP) in 2001 and contracts with every physician in Marion and Polk counties with the exception of the 500 Kaiser physicians.

- 185 primary care physicians
- 240 physicians see children
- 24 pediatricians
- 5% of population served has no insurance
- uses a sliding fee scale for payment
- 40,000-45,000 persons are uninsured in Marion/Polk counties; 8,000

are children and 1/3 of those are receiving services in MVIPA clinics in some capacity

- access to children's health care is easier to find than care for an adult with a chronic condition
- MVIPA serves:
  40% - OHP clients
  5% uninsured

Rick Wopat commented that there are 50,000 Hispanics in Marion/Polk Counties. How does the Marion/Polk IPA address that?

Dean Andretta responded there is an FCHP and a pediatric clinic in Woodburn that serves most of the Hispanic population. Approximately 85% are receiving OHP benefits. Specialty care is still an issue.

Bob DiPrete asked if the federal government allocates more money to cover more people, are there steps the FCHP can start now to have the capacity to serve additional people.

Dean Andretta responded there is a physician recruitment issue. 100 new physicians will be needed in the next 3-5 years to replace retiring physicians. Malpractice is also an issue.

Rick Wopat commented that there are not enough physicians coming through the pipelines. FCHP's will need to start looking at recruiting nurse practitioners.

Mike Volpe inquired what enables MVIPA to keep going when other managed care plans have left the market. Dean Andretta said that MVIPA has tried to have direct relationships with the providers, has been able to reduce their administrative cost somewhat, and has paid attention to benefits.

Kelley Kaiser remarked the plans that remain are community-based with local providers involved from start-up.

Intercommunity Health Network

Kelley Kaiser, Executive Director, Intercommunity Health Network (IHN), said her plan has contracted for services from three local hospitals in Linn-Benton County. IHN was created in 1993 and began serving OHP clients in

February 1994. Their mission was to guarantee access to health care and it is the only safety-net clinic in their area.

IHN is run by Samaritan Health Physicians and contracts with the local FQHC. The goal is to provide health care to all clients in their system.

Public Hearings

Bob DiPrete is working on locations for public hearings in April. Proposed hearing sites:

- Portland Metro area -
- Southern Oregon - Medford or Klamath Falls
- Coast – Newport or Coos Bay
- Eastern/Central Oregon – Pendleton, LaGrande or Bend

Michael Garland asked who is being sampled. Bob DiPrete answered the uninsured.

Bib DiPrete would like to receive feedback from families, providers, advocates, and stakeholders at the public meetings.

Rick Wopat suggested contacting the Office of Rural Health which has a lot of demographic information when looking for the most beneficial location to hold the public meetings.

Carmen Urbina said the correlation of social economic status and issues of access should also be considered.

A small MAC workgroup will meet prior to the next meeting. Bob DiPrete asked for volunteers to work with him and Carmen Urbina.

Bob DiPrete will send out a preliminary plan on how to conduct the public hearings and a survey on how the MAC should prioritize recommendations.

Other

The next Medicaid Advisory Committee meeting will be held on Wednesday, March 22, 2006, from 10:00 am to 2:00 pm, in room 167A, State Capitol, 900 Court Street, NE, in Salem.

Meeting adjourned.

Medicaid Advisory Committee
March 22, 2006
Hearing Room A, State Capitol

Present: Elizabeth Byers, Donna Crawford, Michael Garland, Tina Kotek, Yves Lefranc, MD, Carole Romm, Jim Russell, Michael Shirtcliff, DMD, Thomas Turek, MD, Michael Volpe

Absent: Bruce Bliatout, Kelly Kaiser, Dick Stenson, Carmen Urbina, Rick Wopat, MD

Opening Remarks

Tina Kotek, Chair, gave an overview of the agenda for the meeting.

Governor's Perspective

Erinn Kelley-Siel, Governor's Office, met with the Medicaid Advisory Committee (MAC) Co-Chairs to walk through some of the things that came out of the Governor's State of the State address. The Governor's Healthy Kids Initiative includes both an insurance component and an access component. Discussion around school-based health and that part of the Healthy Kids program will be happening in parallel with the work the MAC is doing but outside of this group. Erinn offered to provide updates to the MAC.

The Governor wants all children covered through age 18. The MAC will be focusing on the other two pieces of the Governor's plan:

- The uninsured kids who are eligible for but not enrolled in existing federal/state (FHIAP, CHIP and OHP). There are some things the state could do differently to retain kids in those programs, improve retention and also improve outreach and enrollment efforts.
- For those families who are above 200% of the federal poverty, can we offer through this plan that will help maximize affordability and incent enrollment in an insurance product to cover these children and improve their access to health care.

Erinn shared the Governor's guiding principles:

- All uninsured Oregon children up to age 19 be eligible for coverage.
- Every child insured through the Plan to have the same card.

- Entry into the Plan be streamlined, using existing programs, partnerships with schools, health care providers and non-profits to simplify the enrollment process.
- All kids up to 200% of the federal poverty level be eligible for comprehensive coverage through the existing Oregon Health Plan (OHP) and Family Health Insurance Assistance Program (FHIAP) benefit models.
- Kids in families with incomes above 200% of the federal poverty level will be eligible to purchase comprehensive (including mental health and dental benefits), affordable group coverage, paying premiums and co-pays for services on a sliding scale based on family income.

Every child enrolled in the Healthy Kids Program, Children's Health Insurance Program (CHIP), or OHP will have the same medical card but not necessarily have the same benefit structure supporting that card. The policy objective is to start to try to break down the different perceptions of public versus private programs. In terms of the benefit or cost sharing, there would be distinctions, but on the card, there would not be.

Erinn asked the MAC to think creatively around what some counties are doing through school nurse outreach to families, helping manage families and helping them navigate the system and actually getting them connected to a medical home.

Dr. Lefranc said he would like to hear more about the school-based health clinics. He believes that is one of the most important places to secure health care for all the children. He asked if it would be possible when kids enroll in school, that they would be automatically enrolled in OHP so it is one single process.

Erinn Kelley-Siel responded that would be one approach to look at for school-age kids. We would have to have a similar approach with non-profit providers, early Head Start, Oregon pre-kindergarten and pre-schools to make sure we are getting to those families as well.

Approval of February Minutes

The minutes from the last MAC meeting on February 22 were reviewed and approved as written. A summary of the important discussion points in the minutes was also provided to members.

Legislative Committees

Rick Berkobien, Senate Committee Administrator, who staffs some of the Interim Legislative committees, presented a broad overview of the legislative committees working on health care. Rick highlighted two of the Legislative committees:

- Senate Children's Health Care Committee
- Senate Commission on Health Care Access and Affordability – includes 20 members and 4 legislators. The Commission is looking at short-term, more immediate fixes to: cost, access and quality issues. The Senate Commission is also focusing on the big picture of health care reforms. Their work is similar to the work of the Oregon Health Policy Commission. The two groups are working very closely together, and members from the other groups are invited to Commission meetings.

The Medicaid Advisory Committee and the Oregon Health Policy Commission will be invited to the next Senate Health Commission on Access and Affordability on April 14 to exchange ideas.

The Senate Children's Health Committee will meet on April 3rd. Senator Laurie Monnes-Anderson had two Legislative Concepts drafted, LC 155 and LC 175 which will be discussed at the April 3rd hearing. Rick will send the drafts electronically to MAC members. One is a very early draft of a comprehensive kids' health care bill, also called Healthy Kids.

Senator Monnes-Anderson has said she wants to work closely with the Medicaid Advisory Committee (MAC) on the Governor's plan and wants to invite the public to the April 3rd hearing to give feedback on the LC drafts. She wants the public to tell her what they think should be different on the drafts.

Rick Berkobien said that he has not heard of any children's health care bills coming from the House as yet, but Sandy Thiele-Cirka, committee administrator, could give more information to members.

Tina Kotek added that she and Carole Romm hope to have a set of recommendations from the MAC that can be used by all the groups working on children's health coverage.

Michael Garland shared his concern about confusion for the public with different groups working on the same issues. Rick Berkobien explained his role is to keep involved with all groups working on health care so that they are sharing some common themes and some common messages.

Action Item:

Rick Berkobien requested that MAC members, who are unable to attend the April 3rd hearing and want to comment on the LC drafts, to e-mail comments to him a few days prior to the hearings so that he can consolidate the comments and get them out to the legislative committee members.

Public Meetings Update

Tina Kotek explained the MAC is charged with the role of developing recommendations for the Governor's Healthy Kids Plan.

Heidi Allen, Office for Oregon Health Policy and Research (OHPR), gave a brief overview on the progress in setting statewide public hearings to solicit feedback from parents to develop recommendations for the Governor's Healthy Kids program.

Proposed locations for public meetings:

- Medford
- Bend
- Corvallis/Lebanon
- Portland
- Portland (multicultural stakeholders)
- Newport
- LaGrande

Representatives from the MAC, OHPR, Office of Medical Assistance Programs (OMAP), Children and Family Services (CAF), and Family Health Assistance Insurance Program (FHIAP) will be available at the meetings to answer specific questions or concerns from people.

The format of the public meetings will include:

- Introduction by a Medicaid Advisory Committee member – will introduce recommendations the MAC has had consensus on
- PowerPoint presentation outlining the context of where the OHP is now and feedback on what the Healthy Kids Plan should look like (enrollment, insurance options, benefits, what cost sharing is possible for families)
  - People will break out into small discussion groups
  - Summary of recommendations from discussion groups
  - A brief survey will be handed out at the end of the presentation
  - A student from Portland State University will summarize feedback from each meeting.

Michael Garland suggested a summary report be sent to all people who participated at the meetings.

OHPR and the Oregon Health Action Campaign (OHAC) are working together to seek locations for the meetings and child care. OHAC will utilize community partners in order to get the message out to get stakeholders at the meetings.

OMAP is crafting the draft message, flyer and PowerPoint presentation.

The goal is to have an audience of parents with varying income levels, especially those with incomes about 200% of federal poverty who could really participate meaningfully in the discussion about cost sharing at those levels and about what benefits are important to them.

The dates, times and locations (schools) have been selected to accommodate parent participation. OHAC will distribute flyers and will also use the media to advertise the meetings. FHIAP will partner to provide outreach in communities as they work with insurance groups.

Northwest Health Foundation has also agreed to partner in this effort and has donated funds.

Dr. Lefranc inquired about outreach with small business owners. Heidi Allen responded they are also seeking to capture small employers' and self-employed feedback.

Michael Garland emphasized that recruiting and the demographic of participants are essential pieces. The dynamic of the conversation changes and the nature of the question changes depending on who is in the room. Both parents and small employers would need to be at the table. Questions would need to be structured for both groups.

Tina Kotek suggested inviting representatives from small business to the May MAC meeting.

Heidi Allen said most of the focus for the public meetings has been around parents and their voice.

Dr. Lefranc added that the small business voice is also needed to explain why they cannot afford health insurance for their employees. For people with incomes over 300% of federal poverty, there will be cost sharing and the small business owners need to be included as they will also be sharing the cost.

Michael Garland identified two target populations:

- Parents of children with family incomes up to 300% of federal poverty
- People who represent the small employer interest of the community which will vary by locale.

Dr. Lefranc recommended a third group: health clinics that see OHP patients based on the limited reimbursement and are already overwhelmed by the demand for health care. Adding 17,000 more kids will be a tough sale without additional provider reimbursement.

Michael Garland responded that the Senate Committee on Children's Health Care, the House Task Force on the Oregon Health Plan and the Senate Commission of Health Care Access and Affordability should focus on provider reimbursement issues in order to bring the kids on.

Tina Kotek added that it's important that the MAC send a strong message to legislators that resources for provider reimbursement will be needed if 17,000 children are added to the Healthy Kids program.

Elizabeth Byers suggested the MAC meet with providers and stakeholders at a separate meeting prior to the parent meeting.

Michael Garland suggested three things that are important for the public meetings:

- The makeup of the audience
- Discussion topic
- Methodolgy for analyzing feedback and deciding how the MAC will make use of it.

Heidi Allen gave a brief overview of what the PowerPoint presentation would contain.

Dr. Lefranc indicated the MAC needs to ask parents what the barriers are in getting their children enrolled. He believes the MAC should concentrate on what the barriers are to getting and keeping kids enrolled; what would be the easiest way to enroll their child, things that the state can really provide.

Heidi Allen responded that the three main discussion topics were:

- Benefit package
- Cost sharing
- Outreach, enrollment and retention

Michael Garland added the information the MAC takes back from the public meetings will be largely driven by the initiating questions in the discussion groups.

Dr. Lefranc suggested one question to ask parents would be what they are willing to trade off in order to buy insurance.

Michael Shirtcliff, President of Advantage Dental, asked if vision and dental would be part of the benefit package.

Tina Kotek responded that the goal is to cover children with family incomes up to 200% with a comprehensive benefit, including dental and vision. For those with incomes over 200%, benefits would be up for discussion.

Heidi Allen said the idea was to frame the question around what parents would want to pay for a health plan that looks more like a private plan. Would they be willing to pay a deductible that a private insurance plan has or would they want to have a plan that look more like the OHP where they pay premiums and co-payments.

Dr. Lefranc believes the OHP should also offer a commercial-look-a-like insurance plan for persons over a certain income who are unable to afford real commercial insurance. He cautioned against offering a whole menu of options as there would be a huge overhead and a lot of costs for very little benefit. The MAC needs to be very clear on what will be offered.

Tina Kotek added there needs to be clarity of what information would be presented at the meetings.

Dr. Lefranc recommended a question around access be the first question.

Donna Crawford said that each meeting should be structured the same way in order to obtain the best outcomes.

Action Items:
A summary report of the public meetings will be posted on the OHPR website.

Representatives from small business will be invited to the May MAC meeting.

Carole Romm, Michael Garland and Carmen Urbina will work with Bob DiPrete and Heidi Allen to craft the questions the MAC comes up with today into the best format that gives the best information about values and the needs of kids.

Healthy Kids: Eligibility and Enrollment
Jeanene Smith, MD, MPH, presented four preliminary recommendations from the MAC on the Healthy Kids program for eligibility and enrollment.

1. 12-month continuous enrollment for children eligible for the Healthy Kids program rather than the 6 months currently in effect for OMAP program.
    a. 12-month enrollment is consistent with group coverage; many children will be covered through group-subsidized coverage.
    b. Increasing the enrollment period will reduce gaps in coverage and will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.

Donna Crawford recommends continuous enrollment and commented that enrollment of kids is most of the time based on enrollment of the parent.

2. The uninsurance requirement be reduced from the current 6 months to a shorter period, possibly 2 months as it would:
    a. prevent significant risk of reduced health status
    b. act as a deterrent against dropping existing health coverage and encourage continuation of employer contributions to finance coverage for Oregon's children

Elizabeth Byers indicated that she has not seen crowd-out in any of the OHP programs. It was initially a concern for the state.

Dr. Lefranc suggested including a sentence that if a parent loses a job, that the insurance requirement for a child with a chronic illness would be waived.

Dr. Lefranc indicated when an employer covers health insurance for their employee but not for dependents, there needs to be an option for parents to buy in to children's health care. A mechanism needs to be put in place to capture the variance in income levels above 200% of federal poverty for people who have become unemployed. Kids with chronic disease need to be covered and should never be bargained.

Tina Kotek summarized:

- Eliminate period of uninsurance
- Monitor for crowd-out
- Priority be given to kids with chronic disease, if elimination of the period of uninsurance is not possible.

3. Eliminate the asset limit for the Healthy Kids program. If it cannot be eliminated, have it raised above the current $10,000:
    a. Cost of health coverage prevents families from attaining self-sufficiency
    b. Availability of parents' assets should not interfere with expanding health coverage to uninsured kids since those assets could be depleted within days of a serious medical event.

Craig Kuhn, Family Health Assistance Insurance Plan (FHIAP), explained that FHIAP counts residential/personal property in addition to one house

and car as assets in determining eligibility. His office sees income as the number one reason for denial of FHIAP eligibility, not assets.

Tina Kotek asked if the MAC should accept the asset definition that is currently in SCHIP versus FHIAP's broader definition.

The MAC agreed to look at the asset test in more detail later.

4. Outreach and retention methods developed and tested in the Covering Kids pilot programs be adopted in the Healthy Kids Programs:

a. The policy objective in the Healthy Kids program is to cover children whether they are above or below 200% of federal poverty guidelines.
b. Of the 117,000 estimated uninsured children in Oregon, 60,000 are within the Medicaid/CHIP income guidelines but are not enrolled in those programs.
c. The Covering Kids pilots have developed ways to reach parents of these children and to increase the chances they will complete applications on behalf of their children. These methods can increase participation by eligible children in the Healthy Kids program.

Tina Kotek suggested that re-enrollment and retention also be included.

Michael Garland recommended that aggressive outreach and appropriately-funded public education methods be adopted.

Michael Volpe asked if children who were not living with their families would be targeted with outreach. Elizabeth Byers responded they would. Outside Inn and White Bird in Eugene provide outreach to homeless youth and non-custodial youth.

Dr. Lefranc asked how the Healthy Kids program would be funded. How is the OHP funded?

Lynn Read responded the Governor spoke of using the tobacco tax in his State-of-the-State speech. Lynn responded to Dr. Lefranc's question of how the OHP is funded:

- 40% State dollars
    - 50% General Fund

    - 50% Other Funds (combination of tobacco tax, provider taxes, hospital and managed care taxes, settlement money, and some others)
- 60% federal matching funds

Tina Kotek asked what the MAC should say about parents being covered. Michael Garland said the MAC should also add that this is intended to be part of a larger program of every Oregonian having access to health care. Research suggests that the most effective way to have kids covered is to also cover parents.

Tina Kotek summarized the MACs recommendations:

1. Support 12-month continuous enrollment in Healthy Kids
2. Recommend no period of uninsurance and monitor for crowd-out. If this was not possible, priority would be given to kids with a chronic disease.
3. Support no asset limit for Healthy Kids, or that it be raised above the $10,000 limit used for FHIAP
4. Support aggressive outreach and funding
5. Added the importance of parents to get their kids covered as a fifth recommendation

Healthy Kids – Benefits/Recommendations

Dr. Jeanene Smith presented the paper on issues for further MAC recommendations, her office outlined four key benefit questions that they needed to get some recommendations around.

1. Given that Healthy Kids benefits are to be comprehensive including hospital, physician, lab and x-ray, prescription drugs, dental and mental health, and vision for families above 200% of federal poverty, how should copays and coinsurance and deductibles be structured to balance affordability for families and the state? Should cost sharing be scaled to family income or capped as a percentage of annual family income?

Darren Coffman, Director of the Health Services Commission, indicated that OHPR has contracted with an actuarial firm, Mercer, which will help the MAC price out a benefit package for families above 200% of federal poverty that could provide coverage for their children. James Mathison, of Mercer Consulting, developed a model that can load data from the PriceWaterhouseCooper's (PWC) per capita cost report. Mercer will then

be able to assist the MAC in making decisions about the different levels of cost sharing that would work for different populations above 200% of federal poverty.

Carole Romm added the MAC could take different types of cost sharing for income levels and prioritize recommendations.

Darren Coffman mentioned the Health Services Commission (HSC) hosted statewide community forums in 2001 to solicit feedback on cost sharing. He will provide the feedback to the MAC. Citizens favored:

- Premiums as first choice
- Copayments
- Coinsurance – percentage of bill

Oregonians with family incomes between 100% and 185% of federal poverty were surveyed. Deductibles were not taken into consideration.

Tina Kotek reminded members that this committee is to advise on what is the best model for children's health care. The MAC needs to recognize restraints that are already in place. The budget is a secondary conversation right now.

Michael Garland explained the challenge for the MAC from the Governor's Office is to put together a vision that relates to the frame that he has put forth. He indicated the MAC needs to take the following into consideration in developing recommendations:

- Economics – know what the fiscal economic picture will be
- Political Model – what can we make happen during the next legislative session?
- Ethical principles – what will be traded off?
- Evidence-based – what is the known data?

Michael Volpe commented that it is important to explore all programs the Legislature is working on to make sure existing programs are not pushed aside to make way for new programs.

Tina Kotek requested that cost sharing be included:

- At what income level does cost sharing end?

- At what income level could families buy into a product that would be more affordable for them?
- Should cost sharing be capped or scaled to family income?

Michael Garland would like to have four core questions developed around the following at the public meetings:

- Affordability
- Subsidies
- Enrollment
- Employer insurance

2. What group coverage options will families above 200% of federal poverty be able to purchase, e.g., OHP managed care, PEBB, FHIAP? Under what circumstances will parents be able to choose between these options?

3. Given that we currently offer OMAP and FHIAP programs to those below 200% of federal poverty and Healthy Kids will extend eligibility for those programs to children above 200% of federal poverty, at what income level should premium subsidies end because affordability is not a barrier?

4. Besides the uninsurance requirement, how should the Healthy Kids plan be structured to best incentivize employers who currently offer coverage for their employee's dependents to continue offering that coverage?

Elizabeth Byers indicated that some health insurance plans don't provide coverage for necessary services.

Dr. Lefranc added that some employers have high deductibles, copays or only offer catastrophic coverage. Members are underinsured. We need to look at what employers can afford. Some employers would go out of business if they had to provide a mandatory health benefit.

Action Items:
James Mathison, Mercer, will be invited to the MAC meeting on April 26.

Discussion will be focused around employer coverage at the April 26 meeting.

FHIAP Benefits

Kelly Harms, FHIAP introduced Craig Kuhn, Administrator.

Craig Kuhn explained the FHIAP benchmark for the Family Health Insurance Assistance Program (FHIAP) for the group market benefits. If a plan meets these categories, it is approved. If it does not, it is rejected.

- Lifetime maximum - $1,000,000
- 6-month pre-existing condition waiting period
- annual deductible - $1,000 per individual
- member coinsurance level – 30%
- out-of-pocket maximum (include deductible) - $4,000 per individual
- member coinsurance level for prescription drugs - $15 or 50%, whichever is greater

Of the group plans that FHIAP reviews, 7% to 10% are rejected due to:

- cost sharing too high
- no pharmacy benefits offered by the plan
- plan has a $100,000 or less annual maximum

FHIAP reviewed 20 Health Savings Account plans. Only one passed the benchmark due to high cost sharing.

Kelly Harms added the FHIAP benchmark meets the actuarial equivalent of Medicaid mandated benefits. The combined value of this benchmark meets that actuarial minimum benefit. Some plans that FHIAP subsidizes offer more benefits with low, affordable cost sharing.

Craig Kuhn added that the mandatory federal benefits are available through the benchmark.

Carole Romm asked if there were limitations on the number of service units in the mental health area that do not exist for the OHP.

Darren Coffman responded some plans have limitations on the number of days/hours for mental health and chemical dependency. Flexibility varies from plan to plan.

Lynn Read added the OHP has certain limitations on mental health and chemical dependency. A comparison has not been made with all the

limitations in the Administrative Rules and how they would compare with the different plans that FHIAP might offer.

Action Items:
Craig Kuhn will provide the MAC with FHIAP's benchmark for the individual market.

Kelly Harms will also prepare a report on the demographic data on the distribution of people and choice within the plans.

Family Budget and Health Coverage Costs
Heidi Allen, OHPR, said the Oregon Health Research and Evaluation Collaborative did a study on health care affordability to Oregonians. For this meeting, Portland/Vancouver was used as an urban area for comparison to Eastern Oregon representing the rural area. Their quest was to get an idea of how much money families can contribute to health care (through premiums, co-pays and deductibles) depending on:

- how many wage earners are in the home
- how many children in the home
- monthly income (measured by Federal Poverty Level Guidelines)
- monthly expenses
- geographic area (rural vs. urban)

2004 budgets and federal poverty levels were used in this study.

Calculations and Assumptions:

- *Housing*
  - Housing was based on the Department of Housing and Urban Development's fair market rents.
- *Food*
  - Food costs were based on the US Department of Agriculture's Food Plans.
  - Budget uses the "low-cost" plan. The second lowest plan was calculated.
  - Assumes a very basic diet with almost all food prepared at home.
- *Transportation*
  - Transportation costs per mile are from the IRS cost-per-mile rate, which includes cost of gas, insurance, vehicle registration fees,

maintenance and depreciation. Varies by rural and urban area, and number of parents in family.
    - Budget assumes only non-social trips (work, school, church, errands) for 1st adult, and only work trips for 2nd adult.
- *Child care*
    - Costs were based on child-care centers and vary by urban vs. rural locations and assume a 4-year old for pre-school purposes.
- *Taxes*
    - Taxes include federal personal income, federal Social Security and Medicare payroll taxes, state income taxes, local income and wage taxes. Does not assume property taxes on home ownership.
- *Budgets assume*
    - all families are renters
    - all adults work and income is from work
    - adults take advantage of tax credits

  Persons living in rural areas pay less taxes than those living in urban areas.
- *Other Expenses*
    - clothing
    - personal care expenses
    - household supplies
    - reading materials
    - school supplies
    - estimated as 27% of housing and food costs

Health care was not included in calculating budgets.

When family incomes are at 250% of federal poverty, the family will have discretionary income.

- The budgets do not include debt, or higher than normal interest rates that might affect families with less than perfect credit.
- Estimates are conservative (particularly regarding child care, housing and food).
- Other factors beyond health care compete for discretionary income.
- Budget does not include recommended savings or catastrophic expenses.

Dr. Lefranc recommended members and guests to read “The Working Poor-Invisible in America”.

Action Item:
Michael Garland asked that the study be sent to MAC members in electronic form.
The Powerpoint presentation will also be posted on the OHPR website in the MAC section.

Heidi Allen's e-mail address if MAC members had questions:
Heidi.allen@state.or.us

Next Meeting
The next meeting will be held on Wednesday, April 26, from 10:00 a.m. to 2:00 p.m., in room 137 A&B, Human Services Building, 500 Summer Street, NE, in Salem in order to reach consensus on the recommendations.

Elizabeth Byers requested a discussion at the next meeting on undocumented children and prenatal care for mothers of undocumented children.

Meeting adjourned.

Medicaid Advisory Committee
April 26, 2006
10:00-2:00 pm
Room 137A & B, Human Services Building

Present: Bruce Bliatout, Elizabeth Byers, Michael Garland, Kelley Kaiser, Tina Kotek, Carole Romm, Jim Russell, Michael Shirtcliff, DMD, Dick Stenson, Thomas Turek, MD, Carmen Urbina, Michael Volpe

Absent: Donna Crawford, Yves Lefranc, MD, Rick Wopat, MD

OHPR Staff: Jeanene Smith, MD, MPH, Bob DiPrete, Darren Coffman, James Mathison (Mercer), Tina Edlund

OMAP Staff: Lynn Read, Jeanny Phillips, Mary Reitan

DCBS Staff: Joel Ario

Opening Remarks
Tina Kotek, Chair, opened the meeting and explained the format for the meeting.

Approval of March Minutes
The minutes from the last meeting on March 22nd were approved as written.

Public Meetings
Carole Romm participated in the Medicaid Advisory Committee (MAC) public meeting in Newport along with Jim Russell and Elizabeth Byers. She shared that the group of attendees was small but engaged in discussion around:

- families with incomes above 250% of federal poverty should be able to make a substantial contribution to purchase health care benefits
- agencies need to be creative in their thinking on enrollment and outreach methods to reach people

Elizabeth Byers maintained that a significant number of people who were workers would have their lives impacted as well.

Parents commented that the more children there are in a family, the more difficult it is to pay higher premiums.

Michael Shirtcliff participated in the public hearings in Medford and Bend and, although a few parents attended, he believed the discussion was rich.

- parents commented that the medical ID card should not look like that of the OHP, an entitlement program
- parents agreed premiums were a better choice than co-payments
- confusion on the part of small business on how to enroll employees

- parents who could buy into private health insurance shared concern that copays and deductibles are too high.

Bob DiPrete said one of the participants at the Medford public hearing was the financial director of a Federally Qualified Health Center (FQHC). FQHC clinics are having tremendous difficulty maintaining coverage on employees' dependents. The Healthy Kids Plan would be a tremendous help to workers and their families.

Elizabeth Byers recommended that Spanish-speaking families be provided materials in Spanish so they can participate.

Bob DiPrete added that more meetings will be needed in communities with language barriers to explore the best way to provide outreach.

The Multicultural stakeholders public hearing will be held on May 3rd in Portland. The MAC will provide information to stakeholders prior to the meeting. Carmen Urbina will facilitate that meeting. Michael Garland, Carmen Urbina and Bruce Bliatout will meet prior to the meeting in order to broaden the understanding of the Healthy Kids Plan.

Actuarial Information

Darren Coffman presented three handouts:

- chart – 2006 Federal Poverty Levels for families with incomes of 100% to 300% of federal poverty
- current OHP Plus Benefits – a comprehensive benefit package with the exception of infertility, diagnosis treatment which is not covered and below the funding line on the Prioritized List of Health Services; does not impose deductibles, copays on children, lifetime maximum or out-of-pocket maximum.
- Healthy Kids Plan Cost Sharing Examples for family incomes over 200% of federal poverty. The Governor believes children should receive a comprehensive benefits package comparable to OHP Plus. Examples include different forms of cost sharing. Different plans in the market were examined for cost sharing in both an HMO-like plan and a PPO-like plan.
- An HMO-like plan would have the least cost sharing. A PPO-like plan would be typical of a private insurance benefit with coinsurance of 20% used for most services. Vision would be a covered service for all children.

Michael Garland suggested two questions the MAC should consider when making their recommendations:

1) Fairness and access of benefits
2) Distribution of burden with cost-sharing. Will this way of sharing costs intensify the burden on families?

James Mathieson, Mercer actuary, presented an overview of the pricing project for the Healthy Kids Plan. Pricing assumed utilization and cost for children:

- PLM, TANF, CHIP kids: 0-1 years of age - 4,100 uninsured
- PLM, TANF, CHIP kids: 1-5 years of age - 31,000 uninsured

- PLM, TANF, CHIP kids : 6-18 years of age- 82,600 uninsured

Assumed Premium Subsidies

% FPL	*% Subsidy*
200-250%	60%
250-300%	50%
300-350%	30%
350-400%	20%

Plan Designs Priced

HMO with $5 office visit and $50 copay for inpatient stay
HMO with $10 office visit and $100 copay for inpatient stay
PPO with $500 deductible, 20% coinsurance, $4k out-of-pocket max.

Administrative Cost

- $20 per person per month (slightly higher than OHP at $18.50)
- Plans with low cost sharing would have high premiums.
- In Preferred Provider Organizations (PPO) costs are very high for the sickest.

Carole Romm commented that sometimes a short-term gain could turn into a long-term loss for a person.

Dr. Turek added that families should be given the opportunity to select whether they want to buy into an insurance plan if they are willing to pay and how much risk they are willing to take.

James Mathieson said people may decide to pay higher premiums to avoid risk. Out-of-pocket costs are highest for PPO coverage for a family with a sick child with income between 200-250% of federal poverty. Risk for a sick person could be spread out in plans by using premiums instead of co-insurance/deductibles.

Michael Garland shared concern that the greater the sickness, the more intense the burden will be on families, and suggested the MAC may want to say this is a greater problem that needs to be addressed.

Outreach to Uninsured Children

Ellen Pinney, Oregon Health Action Campaign (OHAC) said children in 42 states have one-year continuous enrollment in health coverage. In Oregon, the Centers for Medicare and Medicare Services (CMS) has just recently approved one-year continuous enrollment for CHIP children only. Oregon can now meet its Maintenance of Effort (MOE) requirement by giving one-year continuous enrollment coverage to CHIP children with family incomes up to 200% of federal poverty. This will take place on June 1st. Ellen Pinney said OHAC supports:

- alignment with Family Health Insurance Assistance Program (FHIAP). Covering every child spreads risk and keeps costs down.

- 6-month uninsurance requirement being reduced. Oregon should study impacts of individuals and employers dropping coverage.
- eliminating the asset limit. 36 states have no asset limits. Administratively, states have found assets to cumbersome to verify. Add: Administrative costs associated with asset verification.
- aggressive outreach – OHAC recommends one-stop shopping for OHP and FHIAP. Families should be provided with other insurance options in order to make an informed choice on health coverage.
    - School lunch programs should be linked to medical programs
    - More availability of applications
    - OHAC recommends on-line applications and self-declaration of income.
- comprehensive training essential for field offices
- centralized rather than field eligibility determinations

Children in Private Insurance Market

Joel Ario, Administrator of the State Insurance Division, presented an overview of the key trends in the private health insurance market.

Oregon's insurance market is a $5.7 billion business. 10 health plans provide health coverage to 98% of the market. The Insurance Division has regulatory oversight on individual and small group insurance with the principal regulatory focus on individual, portability and small employer groups that cover approximately 450,000 Oregonians.

Three-fourths of Oregon companies employ fewer than 10 employees; 96% have fewer than 50 employees. More than 80% of Oregonians work for companies with more than 10 employees; 41% work for companies with more than 50.

Trends – Rate Increases

2003-2004 – 12-15%
2005-2006 – 8-9%

Regence will be reducing its premium by 16% as of July 1. The moderation in premium increases is due to:

- insurer profit levels are up – 2005 levels accelerated
- increased cost sharing
- managed care – PPO is the cheapest way to provide health care

Michael Garland asked in designing features to make the Healthy Kids Plan sustainable, how would reducing copays/deductibles and charging premiums affect the market? Joel Ario responded that it is less expensive to provide health care to children.

Joel Ario explained the fundamental regulatory strategies:

- pooling risk – large employers with over 500 employees would pay one common rate and share risk
- looking at rate issues/profitability of cost and quality
- transparency in the market place – providing consumers with information on costs

- cost and quality – keep cost down while increasing quality

Carole Romm asked if the Insurance Division recommends not segmenting pools. Joel Ario responded most expensive insurers can only be charged 2 times more than the least expensive insurer. The Insurance Division keeps tight rate bands on pooled risk in plans.

Review/Discussion of Draft Healthy Kids Recommendations

Preliminary Eligibility and Enrollment Recommendations

1. The MAC recommends that children eligible for Healthy Kids be enrolled for 12 continuous months rather than the 6 months currently in effect for OMAP programs, for the following reasons:

   The MAC recommends adding c. Produces administrative efficiency.

2. The MAC recommends that the uninsurance requirement be reduced from the current 6 months to no period of uninsurance, with regular monitoring of "crowd-out" of those already insured dropping their coverage to enroll in the Healthy Kids Plan. However, if there is a need to impose an uninsurance requirement it should be less than 6 months to prevent the impacts found from the interruption of health coverage and that the requirement is waived for children with diabetes or chronic diseases.

   The MAC recommends no period of uninsurance and regular monitoring of "crowd-out."

3. The MAC recommends that there be no asset limit for the Healthy Kids Plan. However, if that is not feasible, the asset limit should be raised above the current $10,000 limit for FHIAP to a higher limit such as $25,000 for the following reasons…

   The MAC recommends no asset limit for the Healthy Kids Plan, and add:
   c. *Produces administrative efficiency and alignment with other programs.*

4. The MAC recommends that there be aggressive outreach and public education for the Healthy Kids Plan and that those efforts would be appropriately funded at a defined percentage of the overall program cost. These efforts would aim to…

   The MAC recommends deleting c. and e. and adding:
   c. Pursue best practices to increase enrollment
   d. Produces administrative efficiency

The MAC recommends adding:

5. Maximize federal dollars to enroll children up to 300% of federal poverty

Preliminary Recommendations on Healthy Kids Plan: Benefit Structure

1. Healthy Kids Plan's Benefit Services
   The MAC agreed with the recommendation

2. Healthy Kids Plan's Benefit Package's Cost Sharing

   The MAC agreed with the recommendation.

3. Healthy Kids Plan – Delivery System
   The MAC agreed with the recommendation.

4. Coordination Among Healthy Kids Plan Components
   The MAC recommends changing the first paragraph to read:
   There will be three components to the Healthy Kids program: OHP Plus, FHIAP, subsidized employer-sponsored insurance and the state pool which will offer premium subsidies.

5. Healthy Kids Plan and Employer Sponsored Insurance
   The MAC recommends adding implement to "Investigate and implement measures.…

Proposed Format and Content for Report and Discussion

- Report brief
- Letter of transmittal to Governor
- Background report and reasons for Healthy Kids Initiative
- Recommendations
- Appendices
  - description of public hearing
    - who attended
    - materials presented
    - feedback

Michael Garland suggested adding a Table of Contents.

Action item:
Jim Russell asked that children's mental health be added to the May agenda.

Next Steps

- The revised recommendations will be circulated to MAC members with feedback to Jeanene Smith by May 4. A phone conference will be held on May 11, at 10:00 am to make decisions on the final document.
- A press release will be sent out.
- The next meeting of the Medicaid Advisory Committee will be held on May 24th.

Meeting adjourned.

Medicaid Advisory Committee
June 28, 2006
10:00 am – 12:00 pm
Room 167, State Capitol

Members Present:
Elizabeth Byers, Michael Garland, Tina Kotek, Yves Lefranc, MD, Carole Romm, Michael Shirtcliff, DMD, Thomas Turek, MD, Michael Volpe, Rick Wopat, MD

Members Absent:
Bruce Bliatout, Donna Crawford, Kelley Kaiser, Jim Russell, Dick Stenson, Carmen Urbina

OHPR: Jeanene Smith, MD, MPH; Bob DiPrete; Darren Coffman, Sarah Post

Opening remarks, Tina Kotek, Chair

Approval of April Minutes
The minutes from the last Medicaid Advisory Committee (MAC) meeting on April 26, 2006, were approved as written.

Elizabeth Byers requested two agenda items be added for discussion at the next meeting:

- Medical care for undocumented children and adults
- The MAC needs to be receiving regular reports from the Expanded Access Coalition on undocumented children

Dr. Lefranc commented that health care for undocumented kids is a very large issue needing to be addressed. Most of these kids are in the school systems. Children with chronic conditions and those needing vaccines would not be covered under the Citizen Alien Waived Emergent Medical program (CAWEM) which only pays for emergency services for undocumented people.

California Outreach Model
Eli Hall, independent consultant for California and former Oregon state health administrator, presented an overview of the California Outreach Model and how they are improving outreach and retention.

- Use of technology to improve outreach and enrollment
- Use of outreach coalitions
- Underlying programs that need to be in place to make the other two factors successful

California is in the midst of a serious drive to cover 100% kids with insurance. There is a ballot measure to raise the tobacco tax by $2.60 per pack. Most of that money would fill in the gaps between the SCHIP program and the Medicaid program and covering some slightly higher-income children as well as covering all undocumented children.

There has been a strong movement through local counties to support and put the ballot measure on for November. A lot of the innovation in outreach and enrollment has happened at the county level.

Two outreach coalitions, Solano County (Skip Outreach Coalition) and Santa Cruz County (Children's Health Outreach Coalition) have brought together many groups that are involved with kids (school districts, primary care providers, county government, public health, WIC and child care programs). A statewide telephone survey estimated that 2/3's of uninsured kids would be eligible for either SCHIP or Medicaid. The outreach coalitions have received grants to fund full-time outreach workers throughout the state. Santa Cruz has set up a hotline for people to obtain eligibility information.

In some counties, outreach coalitions have been organized by the Commission of Children and Families. In others, they have been organized by the county health departments. The coalitions have started special health plans for children who are not currently covered by public insurance. Those plans, called Healthy Kids, provide coverage for uninsured undocumented kids and kids with family incomes between the 300% of federal poverty and the SCHIP level of poverty. Funding comes from the local level through a patchwork of funding streams. The proposed ballot measure would extend coverage, beyond the 5-year period of the grants, throughout the state.

Technology has been helpful to the outreach coalitions in enrolling children into the right program. California has one statewide system, Health-E-App, implemented to enroll kids into SCHIP. The application currently has been reduced to about 4 pages and is available on-line as an Internet-based application. California only allows certified application assisters, who have completed training, to use the on-line system and counsel applicants on eligibility. The advantage of this model is that the certified assister, even though not an eligibility worker, can log on to Health-E-App, enter the applicant's data and get a real-time estimate of whether the applicant will be eligible. Most are employed by other agencies, e.g., school districts, WICS, community clinics, county health departments.

Local communities wanted not only children screened for eligibility in Medicaid programs but also the parents and approached the First Five Foundation. The Foundation has now built one application model, One-E-App, and is being piloted in 5 counties to screen adults as well as kids. Eli Hall believes at some point One-E-App and Health-E-App will merge. One-E-app provides a funnel approach to screen people into different benefit programs, both state and local. Verification documents will be stored as electronic information and can be retrieved to be attached to re-enrollment applications.

The Governor has proposed to spend $20M on outreach and enrollment coalitions in counties. Money would be given to the 20 counties that had the most uninsured children. Some additional money would be given to counties who wanted to submit applications.

Dr. Lefranc inquired about storing electronic data on undocumented kids which may cause immigration issues. Eli Hall responded that Health-E-App screens kids but doesn't keep a record. One-E-App keeps a record but does not record whether the applicant is

undocumented. Safeguards have been built into the electronic system. Most undocumented people don't seem to be concerned that the electronic record system will be problem.

Dr. Wopat asked if California had metrics to measure the success of these programs. Eli Hall said most the counties have an estimate of the percentage of uninsured kids who enroll and re-enroll. They have done satisfaction surveys with families on how happy are they with the enrollment and outreach process and the care provided. California has performance measures on immunizations and visits.

California will need outside funding to cover all kids and sustain enrollment. The governor is totally committed to covering all kids. California did not fund any expansion during the last legislative session due to their huge budget deficit.

California has funding advantages that Oregon doesn't have: a huge foundation, CCS, that provides health care to critically ill children; health plans reserves; and counties that have spare money. California also received waiver approval from CMS to use federal matched dollars to cover the uninsured. They cannot use the matched dollars to cover the undocumented.

Action Items
Michael Garland requested a placeholder for future discussion on how California is reaching out to provide coverage to uninsured adults.

Elizabeth Byers commented that coverage doesn't necessarily mean equal access and requested a presentation at a future meeting.

Office of Health Policy and Research (OHPR)
Jeanene Smith, MD, MPH, Acting Administrator, OPHR, commented that while attending the Academy of Health Services Research meeting in Seattle last weekend, she met with Ian Hill, one of the reviewers of the California Outreach projects. A website, www.coveringallkids.org has a lot of the evaluations done by Urban Institute, Mathematica and others. California provided coverage for 88,000 additional uninsured kids.

Gretchen Morley, Director of the Oregon Health Policy Commission, has been working with the commissioners to develop a five-year strategic health reform plan.

Dr. Wopat added that the directive of the Health Policy Commission was to create a plan of universal coverage, to be phased in over 5 years, to the Legislature in its next session.

OHPR has secured a two-year grant via a national drug settlement called the Attorney General's Consumer and Prescriber grant and has received approved from the Legislative Emergency Board. OHPR is partnering with the Oregon State University School of Pharmacy using the evidence-based drug reviews, over the next 6-9 months, to develop a curriculum for physicians around the state to realize how the whole drug approval

process works, what off label and on label mean and what are their choices, and how to obtain more information on evidence-based reviews.

The Veteran's Administration received a similar grant and will be focusing on pain management.

OHPR also is contracting with the Health Information, Privacy and Security Collaborative. Dr. Jodi Petit will take the lead to look at what are best practices for privacy and security of health information, primarily the transfer of information between physicians' offices and hospital. She will collect the state's best practices, what the statutes say in those states, what needs to be changed to make the transfer a more secure and private transfer. A state implementation plan around the governance of electronic medical records will be developed and will feed into the development of some national health information privacy and security standards.

Healthy Kids Framework

Erinn Kelley-Siel, Governor's Office, thanked the Committee for all their work on the Healthy Kids Recommendations report. The MAC led the discussion which has been really meaningful around disposal of family income and cost-of-living issues as it relates to the urban and rural differential. Participants also took a good hard look at families with incomes of 200% up to 300% of federal poverty and where they stood in terms of their income issues. Many legislators have used the slides that the MAC presented in their districts.

Erinn presented a high-level view of the three areas of work on the Healthy Kids plan.

Three workgroups (Department of Human Services (DHS), Office of Private Health Partnerships and Insurance Division) are working to create the group product, offered as a private insurance product and available to families at all income levels to purchase. The product, using the MAC's recommendations, would be a comprehensive benefit package offered in a way that is affordable to families. The Insurance Division and the Office of Private Health Partnerships are currently defining what that product will look like, and what the state would be seeking in proposals from insurance carriers and managed care plans in terms of the benefit offered through that pooled product.

Another group is working on the administrative issues, what is it going to take for the agencies to work together collaboratively so that the plan is seamless up from ground level for families. In terms of the administrative logistics, they are trying to minimize the financial cost of the bureaucracy and maximize the benefit going out to families.

The third group is focusing on the outreach effort. The agencies have been asked to put together the framework for a model. Money would be targeted to communities of color, to community outreach and to building community coalitions that are known to work.

The Governor's office will invite others to enter into discussion. A series of special focus meetings will be held to provide external feedback before the Healthy Kids Plan rolls out

in terms of the full 2007 Legislative package. Draft language on the Legislative Concept must be submitted by July 14.

Dr. Lefranc asked if there has been discussion on reimbursement for physicians. Adding more children and not increasing reimbursement for physicians will create an access problem. Erinn Kelley-Siel responded that her office is including a proposal for funding for more school-based health centers as well as an increase of funding for existing centers. Her office is also looking be whether at there is an ability to build on the school-based health center model to expand access to dental care for kids. Provider reimbursement currently is a big issue being discussed. With respect to the pooled product, her office believes it's important to maintain the model that exists with FHIAP, where low-income families would be able to opt into the private coverage that provides better reimbursement for providers. Families, with incomes under 200% of poverty, would also have the option of enrolling in OHP, without any cost sharing.

Erinn Kelley-Siel has heard that targeting revenue to safety net clinics, as opposed to a broader network, creates a two-tier level of care where low-income folks would be driven toward a certain group of providers as opposed to having a broader provider network available to them. Many of Oregon's safety net clinics have achieved FQHC status and receive full-cost reimbursement.

Dr. Jeanene Smith explained the handout, a draft chart of Healthy Kids Coverage Options/Subsidy Levels, for clients with incomes of 0% to 350% of federal poverty. Families with incomes above 350% would receive no subsidy toward coverage. Kids, currently receiving FHIAP due to the parents' employer not providing dependent coverage in the workplace, would be transitioned over to the state "pooled product" with subsidized premiums. The state will send out Request for Proposals (RFP's) for bid, and there may be more than one insurance plan in the state that would offer the "pooled product". The plan would be required to provide a basic benefit package modeled after the comprehensive OHP Plus benefit but with cost sharing.

Erinn Kelley-Siel said as white papers are developed around some of the issues, that the Governor's Office would like to receive feedback from the MAC.

Health Services Commission

Darren Coffman, Health Services Commission (HSC), presented an update on the reordering of the Prioritized List. The reordering would provide more emphasis around preventive care and chronic disease management. HSC held 5 different focus group meetings with specialty providers, family physicians, the Expanded Access Coalition, consumer groups. Positive comments were received, and everyone supported the re-emphasis on prevention and chronic disease management.

The HSC is focusing on the preliminary reprioritization of services within the nine medical specialties resulting from the new methodology being developed. Congenital newborn disorders have been taken out of the first category, Maternity and Newborn Care, and were prioritized to other categories they would better fit into.

The HSC has begun to assign relative weights to the categories to come up with an overall score to help define where it is they ultimately fall on the list. Decision was made to take 'commonness' of an illness out as a grading category. It was pointed out that it was more important to put money towards treating rare conditions where treatment was just as effective.

Allison Little, Medical Director, met with different physicians and came up with ratings for each of the measures on all 710 line items on the List based on the new mathematical methodology for these criteria. The final List will have a blending across the lines of the categories.

Dr. Wopat asked about the cost of Line Zero (diagnostic testing or unspecified conditions) and how that might be reduced. Darren Coffman responded that the Commission agrees that the percentage of the costs of the OHP Standard benefits taken up by Line Zero are a bit alarming. It's estimated to be about $136 per member per month out of a $550 per member per month package as it exists right now. The HSC believes that something needs to be addressed in that area and will continue to look at that.

Dr. Douma commented the state would have to seek federal approval for Medicaid matching funds and will have to justify the methodology used to come up with the lines. The one that is the most critical is "effectiveness" since it is a multiplier, and a small change in the effectiveness rating has a huge change in the number. That will probably be the hardest to use evidence-based medicine to justify. Dr. Douma recommended the need to have really good talking points about that particular one. He asked when the List is re-priced, do we have any sense of what line we are talking about. He suggested a 50% reduction in overall cost as a place to start.

Darren Coffman recalled looking at old numbers a couple of years ago but couldn't recall where the 50% mark shook out. He believes it may be within the line 200-300 range. That pricing was done 2-3 years ago when the program was different.

Two-phase CMS approval process:

1. Approval of the new biennial re-prioritized List assuming the current rules. HSC will work with the actuary to assess where an equivalent funding line would be on the new List and then what services would potentially move up or down on that basis. Only about 20 lines on the draft List are moving one way or the other. Darren doesn't believe that part of the approval process will be appreciably different from what was previously done.
2. A second approval process with CMS would involve the drawing of that second line. Services that historically fell below the funding line would remain the same. There will be major changes in the prioritization of services higher on the List. Those services that have a prevention or chronic disease management focus would be moved higher on the list and would be in a safer area if a second funding line is drawn.

The HSC has not ever made any recommendations on where the funding line would be drawn. The Commission provides a tool by delivering the List that the Legislature may or may not choose to use.

Citizenship Identification Requirements
Karen House, DHS Children, Adult and Families, presented an update on the new federal Medicaid citizenship documentation and identification requirements. A passport is sufficient verification for both citizenship and identification. A birth certificate would also require another form of identification.

The new federal requirements, which take effect on July 1st, apply to citizens, of all ages, who are either new applicants or current recipients at the time they re-certify. Previously, applicants were able to self declare citizenship. There will be a 45-day grace period for states to obtain the documentation in order to claim federal matching funds.

13 different documents other than a passport and birth certificate will be allowed for verification of citizenship. DHS will access the Oregon Vital Statistics records to help those people born in Oregon. Concern is for people not born in Oregon. Requirements are more lenient for children under 16 years of age.

State Medicaid Directors along with the American Public Human Services Association have submitted a letter to the federal government documenting a variety of concerns with the new requirements and requesting that certain populations be excluded, i.e., foster care children, the elderly and developmentally disabled. The National Governor's Association has requested delay of implementation by at least 3 months.

The verification documents are tiered in four categories. The first category, passport/naturalization papers, prove both citizenship and identity. The other 13 documents are tiered in three additional groups to verify documentation of citizenship only and have to be matched with another document to verify identity. School records or records from a doctor could be used to verify identity. Vital Statistics will be able to match about 50% of our clients.

DHS has two goals:
- Comply with the federal regulations
- Work with clients to meet the eligibility requirements. DHS will try to be as flexible as possible in order to give people reasonable time to be informed of what the requirements are and work with them to obtain the documents. There will be instances when the documentation would not be obtained during the required time period. The state would then have to use General funds to pay for some clients who were unable to obtain their documents.

DHS is in the process of checking with Oregon's neighboring states to see if an electronic data exchange for birth certificates is possible.

At this time, DHS is not set up to track those who have lost coverage. DHS will be tracking and verifying what documents are used for verification. Workers have been instructed to contact Central office on anyone he/she believes might be denied due to lack of documentation, and Central Office will work closely with the clients to make sure they've looked into any and all possibilities.

Concern was expressed that those people who were denied Title XIX coverage would fall to the safety net clinics creating a huge financial burden for the clinics.

OHP Waiver Planning
Dr. Douma talked about what brought him here as State Medical Director and what he believes are important global issues to be addressed in his role as State Medicaid Director.

1. Look at the state health plans as part of the overall statewide health plan delivery system and become part of that dialogue in the delivery of services to all Oregonians. The state can learn from each other and also from the private sector which has some good efficiency methodologies.

2. Evaluate the OHP after 10-15 years of operation to see what we are doing and what may or may not be as innovative as it was 15 years ago. Lynn Read will stay on as Deputy which will allow Dr. Douma to work more at the policy level; explore how we can work more proactively in making changes; learn about other states' Medicaid programs; and do some benchmarking to collect more information in order to allow us to solidify what we're doing well and expand on those things that we can do better.

3. Promote a good understanding of the real value of Medicaid and the OHP to the public:

    - Demonstrate that the medical program is providing services to those who couldn't find services if they didn't have OHP/Medicaid.
    - Present the savings of costs and the savings in the criminal justice system as the result of what we do.
    - Document and market the value of DHS as the biggest JOBS program in Oregon, bringing in millions of federal dollars that otherwise would be sitting out there in Washington or distributed somewhere else. This is a huge economic value which translates into increased taxes with families' incomes going up and fewer people needing services.

Action item
Dr. Douma requested feedback from the MAC in order to begin an open dialogue with the legislators.

The next meeting will be held on Wednesday, July 26, from 10:00 am to 1:00 pm, in room 103, Oregon State Library, 250 Winter Street, NE in Salem.

Medicaid Advisory Committee
July 26, 2006
10:00 am – 1:00 pm
Room 103, State Library
Draft Minutes

Present:	Elizabeth Byers; Michael Garland; Kelley Kaiser; Tina Kotek; Carole Romm; Jim Russell; Thomas Turek, MD; Michael Volpe
Absent:	Bruce Bliatout; Donna Crawford; Yves Lefranc, MD; Michael Shirtcliff; DMD, Dick Stenson; Carmen Urbina; Rick Wopat, MD
OHPR:	Jeanene Smith, MD, MPH; Darren Coffman, Nora Leibowitz, Bob DiPrete
OMAP:	Lynn Read, Mary Reitan
FHIAP:	Kelly Harms

Tina Kotek, Chair, called the meeting to order and asked presenters to give a brief presentation with time for questions afterward.

The June 28th minutes were approved with a change on page 1, Minutes, second agenda item for next meeting:
- the MAC needs to be receiving regular reports from the Expanded Access Coalition

MAC Work Plan Issues
Tina Kotek asked the Medicaid Advisory Committee (MAC) for agreement and any additions to the priorities the MAC would be working on through the end of the year.

The Committee will have continued involvement working on:
- Healthy Kids Plan in a policy advisory capacity
- Chronic Care Management with the Health Services Commission (HSC)
- Overall health reform with the Health Policy Commission (HPC)

New items suggested:
- Economics of Medicaid
- Revenue streams and revenue generation – Should the MAC be a source of information in conversation about revenue, in terms of some of the health care proposals?

Long term care expenditures are 30-40% of the Medicaid budget and would be an item for discussion at future meetings.

Elizabeth Byers suggested adding: access to Medicaid services. She would like the MAC to receive more information on how many people who are enrolled in the Oregon Health Plan (OHP) ever receive services. Many people who are enrolled in a managed care plan still get their care at the emergency room.

Michael Garland commented that the MAC should focus on the impact of policy and management decisions on Medicaid clients. Creation of a suitable model would allow the MAC to see the result of decisions under the control or outside of the control of OMAP on clients, i.e., access impacts, quality impacts.

Lynn Read mentioned there are two departmental performance measures that DHS reports every biennium to the Legislature.

- Percentage of OHP clients who've accessed primary care
- Break out of the percentage of clients into racial/ethnic groups who've accessed primary care

The MAC will consider recommending a performance measure around access.

Michael Garland suggested either a pie or a bar chart that shows how many of the potentially eligible Medicaid population are actually being served. The MAC needs to see if the impact of policies are making it more difficult or easier for people to get enrolled.

Michael Garland also suggested an outline to bring MAC members up to date on Medicaid issues, then invite others in to give clarity on issues the MAC would want to hear about. Invited presenters would be asked to send a copy of their presentation to members ahead of time so members could formulate their questions.

Action Item:
Data would be provided to the MAC on a monthly basis. Someone from Budget and Management would be asked to present to the MAC what the revenue situation looks like.

Healthy Kids and Legislative Proposals

Jeanene Smith, OHPR, commented that the Healthy Kids Plan is proceeding. OMAP and the Office of Private Health Partnerships (OPHP) have been working with OHPR on pricing assumptions to be able to give a number for the Governor's Budget by August 1st.

The Governor's Office will be holding stakeholder conversations over the next few weeks to continue to solicit more input. Stakeholders would include:

- Medical Association
- Hospital Association
- Oregon Primary Care Association
- Health care providers
- Safety net clinic
- Expanded Access Coalition

OHPR is working closely with Senator Monnes Anderson about her LC 175. The framework is essentially the same as the Governor's Healthy Kids Plan placeholder.

The multicultural stakeholder group will be reconvened to work with OHPR and the Office of Private Health Partnerships OPHP) to further craft the outreach component, working the communities of color and rural communities.

More work is needed around the pooled insurance product to make it equally comprehensive to OHP Plus. OHPR and OPHP will work with the insurance community, develop an RFP, and ask for bids in order to implement in January 2008.

The Governor is committed to kids having a comprehensive benefit package in the pooled product that would include dental, vision, and mental health services.

At this time, the only change in the Legislative Concept from what the MAC recommended is the two-month uninsurance requirement. There are certain exceptions to the uninsurance requirement.

The pooled insurance product, by the nature of it being in the private market, will require some cost sharing from children with family incomes above 200% federal poverty.

Carole Romm recommended that the MAC send a letter to Senator Monnes Anderson expressing concern about cost sharing in LC 175.

Action Item:
Bob DiPrete, Tina Kotek and Carole Romm will draft a letter to Senator Monnes Anderson expressing the Committee's concern on certain provisions in her Legislative Concept that differs from the recommendations of the MAC that were based on feedback from community meetings.

The employer-sponsored insurance benefit may not be as comprehensive which may cause some tension. Family Health Insurance Assistance Program (FHIAP) does not require that parents sign their children up for employer-sponsored health insurance rather than OHP Plus. The requirement applies only to adults. Parents will have the choice of enrolling their children in the new Healthy Kids pooled product or OHP Plus.

A child with a life-threatening medical condition would have the two-month uninsurance period waived.

Health Services Commission Update
Darren Coffman, Health Services Commission, indicated the new re-prioritized list was submitted to PriceWaterHouseCoopers on July 17 for pricing. The final Per capita Cost Report is projected to be completed on September 1st. The number of line items that were hand adjusted was under 5% of the total lines. The top 12 lines place an emphasis on chronic disease management and prevention.

1. Pregnancy
2. Birth of Infant

3. Preventive Services, birth to 10 years
4. Preventive Services with Proven Effectiveness, over age 10
5. Abuse or Dependence of Psychoactive Substance
6. Tobacco Dependence
7. Reproductive Services
8. Obesity-Intensive Nutritional/Physical Activity Counseling and Behavioral Interventions
9. Major Depression, Recurrent
10. Type I Diabetes Mellitus
11. Asthma
12. Hypertension and Hypertensive Disease

Lines at the bottom of the Prioritized List were those services that either had no effective treatment or no treatment was necessary.

The Commission will be reconvening a task force to review whether it is appropriate to limit line 0 (diagnostic services) for a reduced OHP Standard benefit package. The cost to provide these services is 20-25% of the total OHP Standard budget. Line 0 also includes emergency department costs, medical transportation and durable medical equipment in terms of how it's priced by the actuary. All new diagnostic services are currently reviewed for effectiveness.

The task force will need to weigh all the different options:

- guidelines
- exclusions
- tailor what services are available based on what the new OHP Standard benefit package might look like

The task force will focus on OHP Standard but may also look at some OHP Plus services.

The OHP Standard Benefit Design Workgroup will examine the principles that should be looked at in using the new List to expand OHP Standard coverage and what the trade-offs could be in terms of benefit coverage if no additional funds are made available. The workgroup will raise some of the issues needing to be discussed and researched going into the Legislative Session.

Darren Coffman indicated that he doesn't foresee any issue from Centers for Medicare and Medicaid Services (CMS) using the hand adjustment process for the re-prioritization of the List since this has been a part of every previous methodology.

Action item
Darren Coffman will provide the list of members on the Health Services Commission Task Force and the OHP Standard Benefit Redesign Workgroup to the Committee.

Oregon Health Policy Commission Update

Nora Leibowitz presented the Health Policy Commission's update on health reform proposals. The goal is to have a meaningful, realistic and implementable health reform plan over the next five years that would build on both the private market and public insurance structures as well run parallel to and support some of the other system reform efforts.

Guiding principles established by the Commission last year are being used to build a 'straw' plan. Essentials of the 'straw plan' are to:

- support the current employer market
- require everyone in Oregon to be insured
- expand subsidies for low-income individuals
- maximize the state's federal reimbursement
- individual mandate – employer contributions

Other emphases the Commission has agreed upon:

- quality
- transparency
- cost controls
- incentives for using preventive care and chronic case management

The Commission is discussing what to base employer contributions:

- require employers to provide health insurance for their employees, or
- pay a fee to the state (the fee would not be the equivalent of providing health insurance but a smaller amount.)

The Commission is watching the Massachusetts program and is interested in the health insurance broker option.
employers pay a fee of $295 per employee per year

- use a connector (health insurance broker) for individuals and small businesses to find coverage and for low-income people to access subsidies
- ability for individuals to use pre-tax dollars
- offer multiple insurance packages for small businesses to buy into

The Commission will have some initial price scoping completed by mid to end of September in order to have a general sense of how much money will be involved to cover the uninsured, what that means, and will there be any savings.

Stakeholder input will be held solicited during September and October. The final report will be produced for the 2007 Legislative Session.

There has been no decision about whether the Health Insurance Exchange would be private, public or a combination of both.

Action items:

Nora Leibowitz will provide the guiding principles to the MAC.

Health Policy Commission (HPC) meeting notices will be forwarded to the MAC.

Citizenship Status and Legislative Proposals
Karen House, Children, Adults and Families, presented an update on the new changes in the federal rules concerning citizenship and identification. CMS published the rules on July 12. One of the changes in the rules is that persons receiving Medicare or SSI benefits can use their Social Security card to prove citizenship.

CMS has given states a 30-day comment period in their July 12th letter. DHS will compare the new rules with the letter on June 21 from National Association of State Medicaid Directors and American Public Human Services Association to CMS expressing concern with the new regulations.

Birth certificates have been moved up to the second level of reliability in proving identity which is good news for Oregon. Concern is that DHS may have to hire more staff to make copies of the original documents. DHS is working to find a way to implement an automatic system match of the DHS records with Vital Statistics for those born in Oregon which will save a lot of work for the eligibility workers.

DHS plans to implement the new citizenship requirements starting on September 1st. A notice will be included in the application and re-determination packets. Messages will be put on the Medical ID cards. Information flyers will be sent out to stakeholders and advocates. A press release will be sent out to the public. System changes have been made to track how the process is moving forward.

Citizenship must be verified only once unless there is a three-year break in Medicaid enrollment. Children are also required to prove identity. The following can be used for children under 16 years of age to prove identity:

- nursery school/elementary school records
- physician records
- notarized parent affadavit

Oregon is also looking at some interstate agreements with neighboring states to obtain vital records.

OHP Standard Reopening
Karen House explained that DHS has been monitoring OHP Standard very closely since enrollment closed in July 2004. Currently, there are approximately 21,000 clients enrolled in OHP Standard. The monthly average caseload that could be sustained, based on the Legislatively Adopted Budget is around 24,000.

DHS has looked at options to reopen OHP Standard and has recommended the creation of a reservation list. The reservation list would be available to clients for a limited time period, be based on a first-come, first-served basis and would allow DHS to monitor

how many people are added to the program. The reservation would require federal approval.

If DHS accepts the reservation list proposal:
- The waiver amendment request would be submitted to CMS in September 2006.
- DHS would begin accepting names in December 2006.
- Upon CMS approval, DHS would begin enrollment in February 2007.

The proposal has been shared with stakeholder/advocate groups.

Michael Garland recommended that the MAC make a statement in support of the reservation list in order to open OHP Standard to bring back the maximum number of clients allowed.

The MAC supports the option of using a reservation list to reopen OHP Standard.

Expanded Access Coalition
Elizabeth Byers explained the Expanded Access Coalition (EAC) started five years ago and meets the fourth Tuesday of every month. The Coalition consists of activists at the agency level, the community level, faith-based level, people who are working with clients who use the Oregon Health Plan.

Elizabeth Byers indicated the EAC is a really good resource to find out what's happening with people who use the program and the impacts of policy on those people. Elizabeth said she would:

1. forward more information to the MAC on the activities of the Coalition
2. asked the MAC to support a time of actual public comment at Committee meetings by inviting client(s) to talk about their experiences while receiving OHP services
3. requested that someone really knowledgeable about what's happening with medical care for undocumented children and adults speak to the MAC

Michael Garland suggested that Elizabeth Byers or the Coalition organize the speaker to come to the MAC when they see an issue they believe would be important for the MAC to hear.

Action item:
Mary Reitan will forward the Expanded Access Coalition meeting notice, agenda and minutes to the MAC.

OMAP Update
Lynn Read, Senior Assistant Administrator, Office of Medical Assistance Programs, highlighted some of the budget reduction items coming out of the last Legislative Session; 12-month continuous enrollment for SCHIP; premium changes that went into effect in June; waiver renewal; and discussion about provider taxes.

Budget Reductions:

1. Elimination of Graduate Medical Education (GME) – CMS approved this reduction by default, to be effective 7/1/06. Payment for graduate medical education will be eliminated with the exception of Oregon Health Sciences University (OHSU). OHSU may see some increase in their program as a result of the elimination of the basic GME program.

2. Benefit reductions – DHS has not heard anything about approval from CMS yet. Reductions include:
   - 18-day hospital limit
   - elimination of over-the counter drugs
   - elimination of routine vision for OHP Plus adults
   - reduction in dental services for OHP Plus adults

3. Implementation of Emergency Department (ED) triage fee for fee-for-service clients. The proposed rule will be out formally for comment on August 1st with a target date for implementation on September 1st. DHS has not received CMS approval as yet.

4. Nurse Advice Line for fee-for-service clients was implemented in December 2005. Clients with an actual or perceived medical need can call and talk to someone who is knowledgeable about health care issues. Lynn Read is hoping to receive information on the usage and outcomes during the early months of that program later this week.

5. Expansion of the Disease Management Program was implemented in November 2005 providing services for:
   - asthma
   - diabetes
   - congestive heart disease
   - chronic obstructive pulmonary disease
   - coronary artery disease

CMS approval has only been received on the elimination of Graduate Medical Education. A waiver amendment was not required, and Oregon received approval by default on the State Plan Amendment as no action was taken by CMS in the 90-day period.

DHS has not been able to implement the benefit reductions that were built into 2005-07 Legislatively Adopted Budget. DHS will have to show at the Legislative Emergency Board November Rebalance a reduced number of months of anticipated savings from these reductions and will not be able to ask the Emergency Board for additional funding. The reduced savings will have to be dealt with within the context of the Department's budget.

If DHS cannot rebalance across the department, the agency would be require to present potential management actions which would allow them to operate within their budget.

12-Month Continuous Enrollment
This is a change to the SCHIP program that would allow 12 months of continuous enrollment and was implemented on June 1st. The impact of the change is unknown at this time. The 12-month continuous enrollment is assumed to be a continuing program and does have a roll-up cost of $7
million which has been built into the 2007-09 Legislative budget.

Premium Change
As of June 1, premiums will no longer be assessed on clients with incomes at 10% or below of federal poverty. Clients with incomes above 10% of federal poverty now will not be denied because they haven't been timely with their premium payment, but clients will have to have the premiums caught up when they apply at their next re-certification period.

Waiver Renewal
DHS will submit their waiver renewal request to CMS by October 31st requesting continuation of the current OHP program with some additional flexibility.

The state is seeking flexibility to:
- extend eligibility to 12 months for the Poverty Level Medical kids
- reduce the period of uninsurance requirement for children in the SCHIP and for families in the Family Health Insurance Assistance Program(FHIAP) from the current 6 months to something less
- increase or eliminate the asset limit for children receiving benefits under SCHIP or for families receiving assistance under FHIAP

Oregon will reapply to CMS to amend the waiver for the more substantive work following the 2007 Legislative Session.

Oregon currently has authority to use Title XXI funding for childless adults in FHIAP and also has statutory support at the federal level for doing that.
DHS would not be looking at changing that in the waiver renewal.

Oregon will no longer be turning back any Tile XXI funds. The hierarchy for drawing down Title XXI funds:
- Children with family incomes up to 200% of federal poverty
- Parents of children
- Childless adults in FHIAP

Provider Taxes
Medicaid managed care and hospital provider taxes currently support the OHP Standard program and are due to sunset on January 2, 2008.

When the existing provider taxes were initiated, it was a collaborative process and brought along the needed political support. Lynn Read expects a similar type of collaborative approach during the next Legislative Session should those taxes be renewed.

Assuming the provider taxes are renewed, there are some federal issues. The Deficit Reduction Act will let states tax Medicaid managed care organizations until October 2009. After that, states will no longer be allowed to tax Medicaid managed care plans alone but must tax the private market plans as well.

In the President's Proposed Budget he has proposed that he has administrative authority to lower the ceiling that providers can be taxed at from 6% to 3%. There would be a financial impact to Oregon. The 5.8% Medicaid managed care tax and the 6% nursing home tax would be impacted if the ceiling is lowered to 3%.

Currently, provider taxes support the 24,000 OHP Standard client population. There are many questions for future discussion. Some believe the state should move away from provider taxes to cover OHP Standard.

The cost to cover 10,000 OHP Standard clients with the benefit they have today would be around $44 million General Fund ($450 per person per month) for 24 months.

Action item
Provider taxes and revenue discussion will be added to the agenda for the September meeting.

Other
There will not be a MAC meeting during August. The next meeting is scheduled to be held on Wednesday, September 27, 2006, from 9:00 am to 12:30 pm, in Hearing Room C, State Capitol, 900 Court Street, NE in Salem.

Medicaid Advisory Committee
September 27, 2006
10:00 am – 12:30 pm
Hearing Room C, State Capitol

Present:
Michael Garland; Tina Kotek; Yves Lefranc, MD; Carole Romm, Jim Russell; Michael Shirtcliff, DMD; Dick Stenson; Thomas Turek, MD; Carmen Urbina

Absent:
Bruce Bliatout, Elizabeth Byers; Donna Crawford; Kelley Kaiser; Michael Volpe; Rick Wopat, MD

OHPR:
Jeanene Smith, MD, MPH; Ree Sailors; Bob DiPrete; Darren Coffman, Nora Leibowitz

DMAP:
Allen Douma, MD; Jim Edge; Charles Gallia; Mary Reitan

Call to Order
Opening remarks, Tina Kotek, Chair. July 26 minutes approved as written.

DMAP/DHS Information Sharing
Charles Gallia, Acting Research Manager, Division of Medical Assistance Programs (DMAP), presented examples of data reports DMAP could provide to the MAC and asked what types of information they would like to see in the future.

- Total Clients by Eligibility Group (produced on a monthly basis)
- Eligibles/Enrollment charts by:
  - program
  - expenditures for OHP services
  - enrollment by program/delivery system/benefit/race/ethnicity
  - gender breakdown by major program
  - age groups
  - Medicaid non-OHP eligibility groups (QMB, CAWEM, breast and cervical cancer)
  - Medicaid enrollable eligibles by race/ethnicity
  - Non-enrollables by race/ethnicity (exceptions to mandatory enrollment in a managed care plan)
  - Federal poverty levels for medical assistance eligibility groups

- Total OHP population over time by eligibility group (CHIP/OHP Plus and Standard): table of quality of care measures-example: number and percentage of enrollees with 3 diabetes-related services broken down by gender, race and ethnicity, age, geographic location, benefit package

- Health Employer Data and Information Set measures. The reports are presented in a few forums such as:

- Managed Care Quality Improvement Workgroup (composed of managed care plans that contract with the state to provide services)
- medical directors of the health care plans

Many of the reports are also available on the DHS website:
www.oregon.gov.DHS/healthplan/data_pubs/main.shtml

Carole Romm would like to see the percentage of enrollees that had a primary care visit.

Dr. Turek suggested that the charts represent all OHP clients, both enrolled in fee-for-service and managed care.

Michael Shirtcliff asked if the same type of data could be obtained for other diagnoses. Charles Gallia responded CPT, ICD-9 and CDT codes could be used to produce the data.

Dr. Lefranc asked if immunizations could be tracked. Charles Gallia responded yes for children. Older people are more challenging as some receive immunizations from free services and safety net clinics.

Michael Garland would like to see five-year trend data on a quarterly basis to measure how we are doing against the parameters:

- enrolling people – How many OHP eligibles did we actually reach?
- providing encounter services – How many encounters really occurred in the population enrolled? The MAC would be able to see service intensity that the health needs are not distributed evenly across the entire population.

Charles Gallia suggested that there are indirect indicators of access such as emergency department utilization for non-emergent or ambulatory care sensitive conditions. DMAP would be able to work with the Office of Health Policy and Research to pull hospital discharge data and match with the Medicaid Management Information System (MMIS) to see the gaps in services.

Carole Romm would see to see all the HEDIS (Health Employer Data Information Set) measures DMAP is collecting.

Michael Garland reminded members that the MAC needs to be attentive to policy advising and not policy management.

Tina Kotek recommended the MAC choose 10 types of reports they would like to see on a regular basis.

Action Item
Charles Gallia will work with Bob DiPrete and the MAC subcommittee (Michael Garland, Carole Romm, Carmen Urbina) on types of data reports the MAC could use.

Michael Garland felt it would important for the MAC to see a both service-intensity snapshot and trends over time. What percent of the population most utilizes the services. Another would be for the MAC to see service delivery modalities in a comparative mode (fee-for-service and managed care). There should also be 3 or 4 sentinel quality measures. These would bring policy awareness to the MAC.

Tina Kotek would like to see the information from FHIAP a little more closely aligned with the OHP for maximum comparability.

Health Services Commission (HSC)

Darren Coffman, Director, Health Services Commission, presented an update on the HSC and the Line Zero Task Force.

One HSC meeting has been held since the last MAC meeting to determine placement of ICD-9 codes on the prioritized list of health services. There has not been a meeting of the OHP Standard Benefit Design Workgroup since July. The next meeting is scheduled for October 13, when information from the actuary should be available in order to look at how many people OHP Standard could potentially be expanded to if different benefit levels were used.

The Line Zero Task Force met in August and September to review what services are falling out in line zero (diagnostic services, ancillary services and other services that are not attributable to specific line items on the prioritized list). One of the broad areas that line zero services broke out into was imaging services which are ranked second to emergency department visits in terms of cost.

Three years ago the Task Force also looked at imaging and recommended to DMAP that they consider contracting with a third party to help in the management of those services by prior authorizing the different imaging services. The Task Force felt that it might be too onerous of a burden to put on the providers at that time because it wasn't being required of them from any of the other payers. Today, that is not the case. It was felt that because providers are required to prior authorize imaging services by all the other payers, it would be reasonable for Oregon Medicaid to ask them to do the same for OHP clients. Three years ago, the study showed that inappropriate utilization could be reduced by as much as 75%. The Task Force will reaffirm its recommendation to DMAP in that area.

The Task Force also reviewed emergency department visits. They reviewed information from CareOregon who reimburses at a triage-level reimbursement fee for non-emergent conditions presenting in the emergency room. DMAP will be implementing that type of system for OHP. The HSC believes that costs will be lowered.

Another line on line zero services is signs and symptoms. These are services when a client presents at the emergency room with headache, abdominal pain or another symptom that isn't clear in a diagnosis and requires testing to determine what the client has. These diagnostic services actually make up a third of the costs of line zero. The

Task Force couldn't really come to a conclusion on how to contain those costs. They discussed some level of caps on the number of diagnostic visits or specific types of diagnostic services for cost containment but did not reach consensus that caps were the best approach in this area. The Task Force asked that staff look at other states who had implemented such caps to see what their experience has been.

Michael Garland asked if the Health Services Commission defines what is included in line zero. Darren Coffman, responded that line zero is actually defined as what is not on the prioritized list. The actuary decides what services are included in line zero.

The Task Force will report to the full HSC and will make a recommendation to DMAP on imaging.

Jeanene Smith, MD, MPH introduced the new administrator for the Office of Oregon Health Policy and Research, Ree Sailors, who came from Washington State.

The Governor made an announcement at a press event releasing details on the funding plan for the Healthy Kids program on Monday, the highlight being an $.84 increase in the tobacco tax. Future stakeholder meetings will be held to solicit more input.

LC 175, Senator Monnes Anderson's plan for a Healthy Kids Plan is being revised. The senator will present the revised legislative concept to the Senate Committee on Children's Health for feedback. The Committee will meet in October.

The Governor's Healthy Kids Plan and LC 175 are similar.

Tina Kotek presented the draft letter from the MAC to Senator Monnes Anderson recommending some changes to LC 175:

- Carriers participating in the program: The MAC strongly suggests that the fully capitated health plans participate in the program because they have the experience and knowledge of the population.
- Subsidy levels – The MAC asks that the subsidy levels the MAC recommended be considered.
- Benefits – The language in the bill should indicate that the Healthy Kids benefits should actually match the OHP.
- CHIP – The section that breaks out CHIP from OHP may need to be changed. The SCHIP and the Medicaid money stream are all part of the Healthy Kids money stream.
- Enrollment and Retention – The MAC wants to emphasize enrollment and retention.
- Coinsurance versus copayments and premium sharing – The MAC stressed that coinsurance could have a negative impact on a poor family. It could mean bankruptcy or lack of participation in the program. The MAC suggests premium sharing, and if, necessary, reasonable copayments.

Michael Garland recommended the MAC assert that having competing kids programs is not desirable from the point of view of policy or administration and that the programs should complement each other instead.

The letter will be revised with two wording changes and sent to Senator Monnes Anderson immediately. Stakeholder meetings will be held in late October to communicate the progress on Healthy Kids and solicit input. A letter will be sent out notifying stakeholders who attended previous meetings of the meeting date.

Benefit Reductions

Jim Edge, Assistant Administrator, DMAP outlined the four benefit reductions that Centers for Medicare and Medicaid Services (CMS) approved on September 13. These reductions were in a bill at the end of the last legislative session. There was a directive in the DHS budget bill instructing DMAP to request approval of waiver amendments to implement four type of benefit reductions in order to achieve savings:

- Implement a limited dental benefit for the OHP Plus adult population
- Eliminate routine vision care for the OHP Plus population
- Implement a limited over-the counter non-prescription drug benefit for both OHP Plus and Standard
- Implement a limited number of hospital days that would be covered for the OHP Plus population

The reductions were presented to the MAC early on. The MAC opposed the reduction in hospital days. DMAP has been mandated by statute to implement the reductions.

CMS responded to Oregon's request on September 13 and approved all four benefit reductions. DMAP will begin implementing the reductions probably in February or March 2007 in order to give enough time so that the managed care plans, DHS systems, the actuarial work needed to calculate rates for the managed care plans, and contracts can be ready.

These reductions will sunset at the end of the biennium because they were in the DHS budget bill. There will be only a short time to achieve any savings unless the full legislature in the 2007 session gives a directive to extend the reductions. Savings would be about $2 million in General Fund.

Another directive from the 2005 legislative session was $4 million in miscellaneous reductions in DMAP's budget. To achieve this, DMAP has implemented:

- adding some diseases to the disease management contract
- nurse triage line (implemented through subcontract with McKesson)
- limit on non-emergency use of the emergency department – paying a triage fee rather than a full payment for non emergency use of emergency rooms. This will be implemented soon.

When limits are put on benefits, there is a federal mandate to exempt pregnant women and children from these limits.

Jim Edge explained that these cuts came from the agencies' requirement to submit budget reductions in the building of the biennial budget. For the OHP, we often have to identify all services that are not federally required.

Dr. Shirtcliff indicated that the dental community did not receive additional funds during the last legislative session. They came up with a compromise to reduce some procedures and offer a basic dental package in order to cover more OHP clients. The package the dental community came up with was similar to the basic benefit package that CMS approved. The remaining issue is crowns.

Dr. Lefranc asked if anything is being done to reduce the administrative overhead a physician needs to cover in order to see more patients. Maybe the MAC could look at ways to reduce the administrative burden so that physicians would be able to see more patients.

Jim Edge added that physicians haven't had cost-of-living increases since 2000 due to budget constraints. That has caused the reimbursement rate to remain stagnant while medical inflation has increased.

Jim Edge indicated that the managed care and hospital provider taxes are the only source of revenue to fund what's left of the OHP Standard population. Two issues:

The statute for the provider tax is due to sunset. The legislature will need to address the issue.
There is a federal proposal that provider taxes be limited to 3% of their gross revenues. Currently, the upper limit is 6%. Our managed care provider tax is set at 5.8%. Federal action could cause a significant cut in provider tax collections.

Clients currently receiving OHP Standard benefits tend to be sicker clients with higher costs.

Action item
Jim Edge will provide the MAC with pricing for clients on OHP Standard.

Oregon Health Policy Commission (OHPC)
Nora Leibowitz, OHPC, presented an overview of the OHPC's Health Reform Straw Plan. The overall goal is that all Oregonians will receive affordable, accessible and efficient health care that will ensure positive outcomes and promote healthy lives. The intent is to talk about insurance and also to talk about health, recognizing that health care is not the only element.

OHPC has been working on a series of reforms that can be implemented over the next 5 years where everyone contributes, individuals and businesses. It would build on private and public insurance structures. A successful plan must integrate cost, quality, transparency and public health and complement other reform efforts in the state.

- Individual Coverage Mandate – Everyone would be required to obtain insurance. Oregon would encourage participation similar to how Massachusetts has done that in terms of having some kind of financial penalty for individuals who do not purchase or get subsidized insurance. One penalty a non participant might face is the loss of the individual exemption on state taxes. Other incentives are also being discussed. Oregon does not plan to mandate what is acceptable insurance recognizing that some people currently receive employer-sponsored insurance and prefer to keep that insurance.
- Employer Contribution - Employers will pay a fee based on their workers, and the fee would be pro-rated for part-time employees. Employers who do provide insurance to their employees would be exempt from the fee. The fee is not intended to be equivalent to the cost of health insurance, possibly a fee in the range of $300 per person per year. It is believed that employers who currently pay for employee insurance would be likely to continue as they are in competitive fields and want to retain quality employees. There will not be a requirement on what is acceptable insurance in order to waive the fee because putting a requirement on what the insurance has to look like makes Oregon susceptible to a very likely ERISA challenge.
- Health Insurance Exchange – This is similar to the Massachusetts "connector". This is a sustainable, voluntary, basically central marketplace for individuals and small employers to purchase health insurance. It will be attractive for employers because it provides a mechanism for pre-tax purchase, and it is envisioned as a way to allow employers who currently are only able to offer one insurance package for all their employees to give them a choice of packages. The exchange would act to pool employees from various small employers and provide some of the administrative functions that are often a burden to small employers such as researching and administering contracts.
- Public Coverage, Subsidies and Incentives -The Plan would maximize Medicaid funding for insurance premium subsidies and direct coverage to ensure affordable insurance for lower income individuals. For subsidized clients, it will be an opportunity for the state to use its money to encourage individuals to choose coverage that provides needed services including primary care, prevention and chronic care. Oregon would try to maximize federal reimbursement as much as possible and would ask CMS for federal match up to 300% of federal poverty.

Individuals who already had employer sponsored coverage would that coverage rather than enrolling in the OHP.

The Health Policy Commission is working with several work groups within the Commission, including the Delivery Systems workgroup to talk about delivery system improvements, quality and transparency. Those groups will be providing information over the next couple of months to form those portions of the report.

Dr. Lefranc suggested an information exchange be formed to help consumers find affordable, convenient, appropriate medical insurance.

Dick Stenson mentioned a recent article that 90% of people who had sought an individual health insurance policy had been unsuccessful in finding an affordable one. He suggested:

- eliminate the pre-existing condition clause for any health plan who participates in this program
- require any health plan that sells insurance in the State of Oregon be required to participate in this program

Nora Leibowitz said her office is working with someone at OHSU on estimating what the costs will be. New money would be needed to finance the program. Nora asked the MAC for their ideas on financing the system.

The OHPC will present the report at the beginning of the 2007 Legislative Session with the idea that the health reform plan would be implemented as soon as the legislature approved the plan.

Nora Leibowitz said the next meeting of the Health Policy Commission is scheduled for October 5th , at the McCoy Building, 426 SW Stark Street, room 10A, in Portland. She asked invited MAC members to attend the meeting.

Public Comment #1

Craig Hostetler, Oregon Primary Care Association (OPCA), provided testimony and indicated he was impressed with the recommendations from the MAC to the governor in designing the Healthy Kids program to cover all uninsured children in Oregon. The OPCA represents Community Health Centers, including Homeless, Migrant and some School Based Health Centers across the state. OPCA serves 230,000 low-income and vulnerable populations, with over 40 percent that are uninsured and another 40 percent who are receiving Medicaid. Approximately 83,000 of their patients are children. He emphasized issues the OPCA felt were critical for the MAC to consider further in developing the Healthy Kids Program:

- The Healthy Kid Programs is a great program but it needs to be part of a broader health policy package that expands coverage for adults as well.
- The OPCA supports the MAC's recommendation that families with incomes below 200% of federal poverty be covered through OHP Plus or employer-sponsored coverage through FHIAP. These programs should be fully aligned with each other, including the MAC's recommendation to eliminate FHIAP's cost-sharing components for children below 200% of poverty.
- The OPCA had questions about adding a third package, a new state-sponsored insurance plan for children. They asked what is the state trying to fix. Right now, there is confusion between FHIAP and OHP. OPCA would need more information on this. He urged that if a third tier is added, that aggressive outreach and marketing be undertaken to help families evaluate the differences between coverage benefits and costs.

Public Comment #2
Pam Mariea-Nason, from CareOregon, came to this meeting representing the Coalition for a Healthy Oregon (COHO) which is made up of most of the fully-capitated health plans. COHO would like to raise awareness of a concern on the issue of actuarial soundness and where it intersects with the budget. Senator Grassley, Senate Finance Committee, has sent a letter to all State Medicaid Directors asking a series of questions on this issue. The intent is to ensure that managed care plans are receiving actuarially sound rates for the care necessary. The managed care plans should not be required to backfill due to state budget fluctuations.

COHO has provided the letter from Senator Grassley and a study from ACAP on Rate Setting and Actuarial Soundness in Medicaid Managed Care to the state and is awaiting a response. They have also hired Mercer to act as an actuary to look at the rates and the rate-setting process that the state goes through. They will be looking at what kinds of things go into those rates, e.g. trend lines for hospital and physician utilization. It is very important to have as much transparency as possible in looking at those rates.

Carole Romm said that we need to be sure we're not cutting back on services, and the health plans really need to be accountable on this.

Action item
DMAP will provide discussion on the actuarial program at a future MAC meeting.

Next Meeting
The next MAC meeting will be held on Wednesday, October 25, 2006, from 10:00 am to 12:30 pm in Hearing Room C, State Capitol, 900 Court Street, NE, in Salem. There will not be a meeting in December.

Meeting adjourned.

Medicaid Advisory Committee
October 25, 2006
10:00 am – 12:30 pm
Hearing Room C, State Capitol

Present: Tina Kotek; Yves Lefranc, MD; Carole Romm; Jim Russell; Michael Shirtcliff, DMD; Dick Stenson; Thomas Turek, MD

Absent: Bruce Bliatout; Donna Crawford; Kelly Kaiser;
Carmen Urbina, Michael Volpe, Rick Wopat, MD

OHPR: Jeanene Smith; Bob DiPrete, Heidi Allen

OMAP: Jim Edge, Mary Reitan

FHIAP: Craig Kuhn, Kelly Harms

Opening Remarks
Tina Kotek, Chair, opened the meeting and asked those in the audience who would like to present public comment to let Mary Reitan know.

September 27th minutes approved as written.

Update on Healthy Kids
Jeanene Smith, MD, MPH, Assistant Administrator, Office of Oregon Health Policy and Research (OHPR) presented an update on Healthy Kids, Legislative Concept 175 and the recent Governor's office stakeholder meetings.

Senator Monnes Anderson's Committee on Children's Health Care reviewed another version of Legislative Concept (L.C.) 175 this week which closely mirrors the Governor's intention around Healthy Kids. The committee unanimously voted it to become an L.C. for the 2007 Legislative Session. The draft that came out of Committee did address some of the recommendations from the MAC.

- Mentioning managed care plans as being potential partners in the private health option
- There was not specifically a designation of what type of cost sharing the MAC is recommending although there is some reference in regard to cost sharing in the bill.
- The draft L.C. mentions the benefits offered in the private health option will be equal to the OHP Plus package or "comparable". The legislative intent from the members of the Committee is that it is to be equivalent to OHP Plus. "Comparable" is still in the bill language.
- Additional language was added in regards to enrollment and retention and the role of the state in doing outreach.

The biggest issue is how cost sharing is referenced in the draft. It still talks about copayments and coinsurance. There was commitment at the stakeholder meetings that there should be no coinsurance for families with incomes below 350 percent of federal poverty.

Erinn Kelley-Siel presented an overview of the Healthy Kids proposal at three forums last week to solicit feedback from providers, advocates, and insurance carriers/health plans.

Action item
OHPR will provide MAC members with a copy of the power-point overview and the summary document on Healthy Kids.

The Office of Private Health Partnerships (OPHP) and the Medicaid agencies are working collaboratively on the planning process now even before the bill has been signed. The intent is to keep stakeholders involved during this process.

Kelly Harms, OPHP, presented an update on the meeting with the insurance carriers and health plans. There were will be two RFP processes, one to help select the carriers and define the benefit packages offered through OPHP The other RFP will focus around outreach.

Kelly Harms explained why it is important from OPHP's perspective to keep the word "comparable" in the language on the Healthy Kids bill. An example would be that the commercial health products would not include non-emergent transportation.

OPHP will put out a Request for Information (RFI) to solicit information that addresses all questions and concerns prior to developing Request for Proposal (RFP). The RFI process will begin prior to the bill being approved and signed and should be out by the end of the year in order to have all feedback back by early 2007. The RFP will be developed during the spring of 2007.

Carole Romm asked how the benefit package was being designed. Kelly Harms responded that OPHP staff is taking a hard look at what the OHP Plus benefit package is and will then translate that package into commercial terms. The intent is to keep stakeholders informed as they move forward through the process.

Action item
Kelly Harms asked MAC members to send any concerns to Bob DiPrete by e-mail, and he will forward to Kelly and Craig Kuhn.

Tina Kotek said consistency across the insurance carriers is needed in order to make the implementation of the plan work.

Kelly Harms noted that all plans FHIAP subsidizes must meet certain minimum standards. Benefits must be actuarially equivalent to federally mandated Medicaid benefits. There is also some State statutory language that defines that. In order to obtain federal match, plans must provide the required services to meet that benchmark. Plans do have comprehensive benefits but also have some cost sharing factored in.

Dr. Lefranc asked when the OPHP is seeking managed care partners, have they looked at the plans' overhead costs in order to take on the increased numbers of children. Can some of the administrative paperwork burden be reduced?

Kelly Harms responded that the product, as envisioned now, would be paid at commercial reimbursement rates for children with incomes over 200% of federal poverty. OPHP will continue to explore ways to streamline the administrative work wherever possible.

Carole Romm asked Dr. Smith for an update on seamlessness of enrollment.
Dr. Smith indicated that Department of Human Services (DHS) would be the central eligibility mecca for eligibility determination in the Healthy Kids program. Children with family incomes below 200% of federal poverty would have the option of enrolling in Medicaid or employer-sponsored health insurance. Children with family incomes above 200% of federal poverty have the choice of using their employer-sponsored health insurance with a subsidy through FHIAP or enrolling in the private insurance plan.

Kelly Harms added the OPHP is looking at sharing information electronically between agencies to assist in the enrollment process and not add the burden on to the families as to which agency to enroll at.

Healthy Kids Outreach Update
Heidi Allen, OPHR, described the power-point document which will be presented on October 31 at the Multicultural Stakeholders meeting in Portland to solicit more feedback on outreach and enrollment strategies.

The Multicultural stakeholders group recommended:
- Community-Based approaches rather than state agencies
- Cooperative rather than competitive processes
- Process to be an on-going relationship between the State of Oregon with leaders in communities of color
- Develop trust by consistently providing accurate information that takes into consideration cultural issues.

Heidi Allen researched successful approaches used by other states to improve outreach in minority communities. Grants is one way to help communities. The multicultural stakeholders believe that it is important to have people of color working in state agencies to be able to provide outreach in their communities.
- Texas
  - Contracts with 50 community-based organizations to provide outreach within communities
  - Partnerships with faith communities to provide outreach (pulpit messages, bulletins)
- New York: Facilitated enrollment. Face-to-face, multi-lingual enrollment (Oregon doesn't have face-to-face enrollment); evening and weekend hours.

- California: Certified application assistants $50 per completed application. More than 12,000 application assistants are out based out of a variety of community-based organizations
- Ohio: Local community college training program to help people certify as enrollment specialists; beauty shop visits
- Massachusetts: Creativity within the Latino Community. Boston pilot project - a random comparison of Hispanic case managers versus a control group of traditional outreach and enrollment methods. The comparison found that racial disparities between Latino and white in insurance status were mostly eliminated.

Oregon's Healthy Kids Outreach Strategies:

- Marketing approach-creates a "brand name" for Healthy Kids – will bring in more kids who are eligible but not enrolled
    - Community-based coalition grants-targets "hard to reach" populations
    - Application assistance awards
        - Doesn't require agency or significant infrastructure
        - Training will be the big issue
        - Can be used for many groups
- OHPR will be seeking feedback from community groups to assist in developing areas for community grants:
    - What type of outreach will they provide?
    - How would the grantee evaluate the effectiveness of their outreach efforts?
    - How do we evaluate success?

Kelly Harms noted that OPHP is looking at all spectrums of the population and what are the barriers for kids not being enrolled. Strategies are needed to reach families of all income levels in order reach the children. Kelly said the MAC and others will be asked for names to contact for ideas.

The Office of Private Health Partnerships (OPHP) and DHS plan to hold 60 training sessions statewide on outreach and education.

Tina Kotek added that community grants will need to be targeted to the populations and geographies who have the most uninsured kids.

The goal of Healthy Kids is to enroll 95 percent of the total population of children during a three-year period.

The RFP process to bring on more health plans will be a competitive process which allow groups to be creative and pool resources in order to provide services to more people.

OHP Standard Benefits Workgroup Update

Darren Coffman updated the Committee on the discussions of the OHP Standard Benefit Design Workgroup. He distributed a draft document discussed at their last meeting on October 13, 2006. It shows the number of individuals who could be covered under OHP

Standard in 2007-09 if a second funding line were drawn on the Health Services Commission's new Prioritized List of Health Services. The document, titled "Potential OHP Standard Benefit Designs Based on the 2007-09 Prioritized List and Funding Reflect by the DHS Agency Requested Budget" assumes approval of a budget that would allow the coverage of 24,000 people at current service levels. Current service levels would include coverage of lines 1-503 on the new list (which best equates to the benefits on lines 1-530 on the current list) and the additional exclusions now in place for OHP Standard (e.g., limited hospital benefit package, emergency only dental care, no vision services). The chart shows that approximately the same number of people could be covered if the OHP Standard benefit package were instead defined solely by the services included on lines 1-400 of the new list. He explained that additional people could be served if the funding level were drawn higher on the list (e.g., at line 300, about 4,000 more people could be served for a total of 28,000). Alternatively, fewer people would be served at a funding level farther down the list (e.g., at line 503, there would be no additional exclusions and the package would equate that provided to OHP Plus, resulting in approximately 22,000 on OHP Standard). It is estimated that only 20,000 individuals could be covered by OHP Standard if the Prioritized List were not in place.

Mr. Coffman then explained that the columns to the right of the first two show the types of services covered at five different levels of funding on the new list. For example, a funding line drawn at line 300 would include all maternity & newborn care (which is very small in OHP Standard), preventive services, and comfort care that is provided now. Additionally, nearly all of the costs associated with chronic disease management and reproductive services currently provided would continue to be funded at this level. For Category 6, Fatal Conditions where Treatment is Aimed at Disease Modification or Cure, 207 of the 267 lines currently funded (out of 270 on the entire list) would continue to be covered, representing 82% of the current expenditures for these services. Finally, only 12 lines in Category 7, Nonfatal Conditions where Treatment is aimed at Disease Modification or Cure, representing 3% of current costs, would be covered at this funding level. No services for self-limited conditions or categorized as inconsequential care are currently funded by OHP, nor would they be using the new list unless additional lines were funded beyond those covered now.

He noted that OHPR staff are to return to the next meeting of the OHP Standard Benefit Design Workgroup with examples of services, described in layman's terms, that would be added under the various categories as the funding line is moved further down the list (e.g., what are examples of services included in the 54 lines added in Category 6 if the funding line were drawn at line 400 instead of 300).

Provider Tax Update

Jim Edge, Division of Medical Assistance Programs (DMAP) explained that a legislative bill was approved during the 2003 Legislative session to tax managed care organizations and hospitals in order to provide funding for 24,000 clients to be enrolled in the OHP Standard benefit package.

The hospital provider tax began in July 2004 and applies only to Diagnosis-Related Groups (DRG) hospitals and does not apply to Type A and B hospitals. The tax rate is currently set at 0.82% of the hospital's net revenue.
The tax revenue is sent to DHS to obtain federal matching funds. Money is then returned to the hospitals by reimbursing higher fee-for-service inpatient DRG rates at 100% of the Medicare allowable. The tax will sunset on January 2, 2008. DHS has proposed a Policy Option package to extend the hospital provider tax to January 2, 2010.

The managed care tax began in May 2004 and applies to managed care organizations (MCOs) in Oregon with a Medicaid line of business. The tax rate is 5.8% of capitation payments. Money is returned to the managed care organizations in an increased administrative fee from 8% to 13.34%.
This tax also sunsets on January 2, 2008.

Federal requirements will eliminate this tax as it applies to only MCO's with a public line of business and not to all plans. Senator Gordon Smith was able to get an extension passed for states that had the MCO tax in place, before the bill was signed, that would allow them to continue this tax until October 1, 2009.

DHS has proposed a Policy Option package to extend the managed care provider tax to October 1, 2009.

DHS is collecting approximately $25 million per quarter from the two tax groups:
- $15 million from managed care organizations
- $10 million from hospitals

The Department receives 60-40 federal match from the tax.
The federal government has expressed its intent to lower the maximum tax on MCO's from 6% to 3%. Oregon would be impacted first by losing its ability to tax MCO's because the tax is not broad-based. If Oregon loses its ability to tax MCOs, it will create a huge problem as the funding for OHP Standard is through the managed care tax.

DHS proposes to extend the two taxes out as far as possible and then they would have to find new/additional revenue to fund OHP Standard.

Cost/Quality/Access/Leadership: Role of the Medicaid Advisory Committee
Tina Kotek asked that this agenda item be moved to November MAC meeting. The MAC would form a work group at the next meeting to look at what is their charge/role for the next year and what do they plan to accomplish. The MAC would categorize their work around cost, quality and access so that nothing would be left out.

Tina announced that she will be leaving the MAC this month and asked members to send nominations for a new co-chair to either Bob DiPrete or Carole Romm.

Public Comment
Cedric Hayden, DMD, representing Hayden Family Dental Group, a dental care organization, and low-income dental patients, presented public comment. Dr. Hayden gave some background on his profession and his work serving Medicaid clients. He added that the first day he opened his office in Eugene, there were 200 OHP clients lined up at his door. Dr. Hayden offered the following suggestions:

Emphasize prevention. Applied prevention is very effective, more effective in dentistry than in the other health professions.

Oral health care is extremely cost effective. A PERS employee will pay about $45 per month, plus co-payments and deductibles. There is a capitation payment of $17.77 for a client on OHP Plus. The OHP Standard Plan is capitated at $5.00 per member per month.

Use the Prioritized List without carve-out as you decide what services will be delivered to Oregonians. Return to the original premise that the Prioritized List be used and prevention be emphasized.

The dental community supports Policy Option Package #103-103A related to adding 10,000 clients to OHP Standard but suggests making the dental benefits comparable to OHP Plus dental benefits. The cost would be approximately $840,000 a year to fully fund those 10,000 clients to the same level as the OHP Plus clients.

The dental community supports Policy Option Package #101, which expands statewide dental sealants, and suggests also providing other prevention services and basic fillings for children.

Policy Option Package #106 – Efficiency – The dental community recommends assigning people to dental care organizations based on utilization. Auto-enrollment actually reduces access based on the process of assigning that is used today. Utilization should be between 25 and 30%.

Carole Romm asked if there is any outcome data to show the effectiveness of care provided by the DCOs. Dr. Hayden responded that the state uses two types of data to track the effectiveness of care provided by the DCOs:

- Utilization data – how many members who are seen by the DCO per year. The national average is 25% for plans like this.
- Quality Improvement – DMAP tracks the delivery of preventive services. The results are posted quarterly, broken down by age groups.

Dr. Shirtcliff added that the dental community will be meeting today. One of the debates they will have is what the dental community should be recommending for a basic dental benefit package in order to give the most appropriate services for the most people.

Dr. Lefranc added that patients coming to the emergency department with dental pain is common.

Dr. Hayden indicated the OHP has two forms of delivery:

Managed care access rate – 25%
Fee-for-service access rate – 0.6%

Next Meeting

The next meeting will be held on Wednesday, November 15, 2006, from 10:00 am to 12:30 pm in Hearing Room D, State Capitol, 900 Court Street, NE, in Salem.

Meeting adjourned.

Medicaid Advisory Committee
November 15, 2006
10:00 am– 12:30 pm
Hearing Room C, State Capitol

Present: Bruce Bliatout; Ella Booth (by phone); Donna Crawford; Kelley Kaiser (by phone); Yves Lefranc, MD; Carole Romm; Jim Russell; Thomas Turek, MD (by phone); Rick Wopat, MD

Absent: Michael Shirtcliff, DMD; Dick Stenson; Carmen Urbina; Michael Volpe

OHPR: Jeanene Smith, MD, MPH; Bob DiPrete
FHIAP: Kelly Harms, Craig Kuhn
DMAP: Jim Edge, Mary Reitan

Opening Remarks
Carole Romm announced that Jim Russell will serve as Co-chair of the Medicaid Advisory Committee (MAC). Ella Booth, from the Center for Health Care Ethics at Oregon Health and Sciences University, will serve as a new member, replacing Michael Garland.

Dr. Lefranc indicated he would like to participate in the leadership around the issue of ensuring outreach and access for racial and ethnic populations. The MAC unanimously approved of this suggestion.

Minutes
October 25th minutes approved as written.

Senate Committee
Rick Berkobien, Administrator for the Senate Health Care Access and Affordability Commission, presented an update of the draft report on Comprehensive Health Care Reform that was reviewed by the Commission on August 27. Primary elements of the plan:

- Health care funding pool – State-funding pool that would bring in moneys from various entities.
- Broad-base of funding – funding pool of moneys collected from the private sector, employer/employee health care contributions, public employees' health care contributions; funds from employers and individuals who currently are not paying for health insurance; and federal matching Medicaid dollars. The funding pool would distribute a universal health care card to eligible enrollees.
- Universal Oregon Health Card – would allow each eligible Oregonian to have access to health care services for one year through an Accountable Health Plan.
- Accountable Health Plans (AHPs) – Current providers (fully capitated health plans, private sector carriers, health care contractors) would compete for and must accept any Oregonian with an Oregon Health Care card. Providers would have to adhere to requirements set by the state on quality and transparency. A plan would have to offer a stipulated essential health care benefit package based on a minimum package of services currently used for OHP Plus. OHP Plus currently has a robust package of services.

Dr. Wopat added that Senators Bates, Westlund, Representative Richardson and others really bring in a broad base of input to the Commission.

Some questions have not been answered as yet. One is that
Medicare has not been addressed in the Comprehensive Health Reform proposal, and there is concern that it may not be rolled in.
Another issue the Commission is looking at is how to create equitable funding from employers. There is strong support around creating a pooling of funds to create that sense of shared responsibility.

Rick Berkobien indicated there will probably be a revenue-generating House bill that will stipulate how funds will come from employers.

Dr. Wopat said the only strong concern he's heard to date is around Advance Directives. The initial proposal was that individuals of legal age with an Oregon Health Care card would be required to execute some type of Advance Directive. More discussion needs to be held on this.

Dr. Lefranc raised concern of pharmacies charging too much for prescription drugs and that there needs to be control of this pricing. He asked if there would be a plan to increase payment to providers as a way to increase access for new patients.

Rick Berkobien responded that in the new Legislative Concept the system would make payments to providers equitable in order to avoid cost shifting. The State would require transparency, accountability and efficiency from pharmacies.

Dr. Wopat added that the work of the Health Services Commission (HSC) around re-prioritization of the List has led to a higher prioritization of prevention and chronic disease management which creates an opportunity to put the money where it is most effective.

Cardholders and employers would receive a basic health care benefit package, and some would be able to "buy up" additional services on top of the essential services. Rick Berkobien did not believe crowd-out would be an issue with this model.

Oregon Health Policy Commission

Nora Leibowitz, Oregon Health Policy Commission (OHPC), presented an update on the Commission's Health Reform. The key components of the reform proposals include:

- Individual mandate for coverage
- Employer participation
- Health Insurance Exchange – marketplace for buying insurance
- Maximizing Medicaid dollars and utilizing public coverage both through Medicaid and through subsidies for individuals to be able to purchase insurance in the private market or accept insurance offered by employers.

Structure of the OHPC Report:

- An introduction that talks about why reform is needed and what's wrong with the current system that needs reform.
- The HPCs Guiding Principles and their desire to focus on persons' health care and also public health and prevention.
- Reform recommendations: What Oregon can do to create a high value, affordable health care system and how they can support community efforts for health care access and delivery.
- How the HPC can support community efforts to improve health care access and delivery.
- Evaluating the Reform: What would be considered success and how would that success be measured?
- Constructing the 5-year plan. The HPC will work on reforms that could be enacted over the next five years, recognizing that there are other organizations working on reforms that may take a longer time.

Over the next couple of months, the draft report will be made public for comment.

Dr. Lefranc asked if the Commission had looked at providing a tax break for providers. A tax break would make it more attractive for providers to take on more patients. Nora Leibowitz responded it hasn't been part of the discussion but it is an interesting idea, and she would bring it up to the HPC.

John McConnell, OHSU, was asked to research what would be the increase or decrease for state and the federal match if more people were enrolled. There would be an increase for the state of about $500 million in state investment, not including employer fees or federal match. Employer costs would see a slight increase due to some employers who pay nothing now. Currently, cost shifting is equal to about 10% of insurance premiums.

During the last HPC discussion there was agreement that by bringing on 15-20% new enrollees, there would probably be some front-end costs. A short-term investment would be returned over time by reduced cost shift and reduced avoidable costs for people without insurance. The program would cost about $500 million a year.

Nora Leibowitz added that another part of the HPC's recommendations is to utilize other attempts to control costs and make the system more efficient, recognizing that we have this opportunity to make change that has a financial impact in the initial years.

Dr. Wopat indicated the difference between the Senate Commission and Health Policy Commission's recommendations is really around individual ownership. One is more of a private business model and the other is a utility model.

Healthy Kids
Jeanene Smith, MD, MPH, Office of Health Policy and Research (OPHR) provided an brief update on Healthy Kids.

Three stakeholders' meetings were held by the Governor's Office for providers (hospitals, health plans, physicians), advocates, and insurance carriers.

OHPR is collecting input from the series of meetings to do some implementation planning on how the private health insurance product would be structured. The Office of Private Health Partnerships (OPHP) is developing a Request for Information (RFI) to send out to insurance carriers during the next couple of months for input. OPHR is continuing to work with the Division of Medical Assistance Programs (DMAP) and the OPHP in shaping community grants for facilitated outreach efforts. The Governor's intent is to raise the tobacco tax and maximize Medicaid dollars as much as possible to provide funding the Healthy Kids Plan.

Bob DiPrete and others from OHPR and DHS have been working with the Office of Multicultural Health and others to ensure that the outreach efforts are tailored appropriately.

Carole Romm indicated Dr. Lefranc would be interested in working with OHPR on the outreach component. Bruce Bliatout also volunteered to assist in the outreach efforts.

Bob DiPrete asked if there was any way to predict what the MAC should anticipate in terms of how the four different health care proposals will interact, combine or the timing of when they are debated. Dr. Smith said it would depend on political decisions.

DRA Citizenship Status

Michelle Mack, Department of Human Services (DHS), presented an overview of the Deficit Reduction Act (DRA) requirements for clients who are citizens and who are now required to show proof of that citizenship. In the past, people were allowed to self-declare citizenship. The DRA passed in 2005 and was to be implemented in July 2006, requiring people to document their citizenship status. DHS implemented the process on September 1, 2006. Staff in DHS statewide were trained to assist clients in every way possible to obtain the documents required for citizenship verification and have been working with clients one-on-one. DHS has worked closely with advocate groups, contractors and providers to send the information out about the new requirements. In some circumstances, DHS paid for the required documents when clients were unable to afford it. There are four tiers of acceptable documents to prove citizenship and identity. The first tier is the only one that does not require two pieces of ID. First tier documents include passport, naturalization papers, certificate of citizenship (persons born overseas because their parents were in the military or mission field)

New applicants will not receive medical coverage until they've provided proof of citizenship. The feds allow a "reasonable opportunity period", 45-90 days to produce the required documents, but states are allowed extensions. Clients currently receiving benefits, will not lose them while they are obtaining documentation. New applicants applying for Medicaid benefits would not be eligible until the documents have been received.

Assumed eligible pregnant women and their Assumed Eligible Newborns do not have to show citizenship documentation until the end of their protected eligibility period.

Non citizens would see no change. Undocumented non-citizens are only eligible for emergent care per federal regulations.

Carole Romm heard that only 31 states have implemented the citizenship rule. Oregon may have an opportunity to re-look at this.

Bruce Bliatout asked if persons here due to political asylum or refugees who have the required documents are eligible for services. Michelle Mack responded they are eligible for the same services they had before and do not have to show proof of citizenship.

There is a level of risk from the feds if Oregon doesn't follow through with the citizenship requirements. The feds plan to conduct audits in the future and, if Oregon is not in compliance, we would lose federal financial participation or be put into a corrective action plan.

Dr. Lefranc asked if there was data on how many persons were unable to prove citizenship. Michelle Mack responded that, to date, no one has lost benefits due to not being able to prove citizenship. DHS has worked really hard to help people. When re-certifications are sent out to clients, a certain percentage are never responded to. This may be due to increased income, child support or other reasons.

Clyde Saiki, DHS Deputy Director, chairs the DHS steering committee working on citizenship verification.

MAC Leadership on Medicaid Cost/Quality/Access

Carole Romm asked for discussion on a work plan for the MAC during 2007. The MAC discussed taking a more proactive stance and formulating their questions, testimony and data around three areas: cost, quality (measures of provider and health plan quality), and access.

Jim Russell asked the MAC to look at what kinds of information might be available to inform them around health care. The MAC could then digest the information into areas they wanted to influence.

Dr. Wopat indicated the majority of work the MAC has done has been around access. Discussions around cost and quality are universal regardless of what the coverage is. Many groups are looking at the total population in terms of cost and quality. The MAC will need to focus on special issues for the population they represent.

Carole Romm said the MAC will need to look at data to be sure services are appropriate for the population.

Dr. Lefranc said the patient population using Medicaid is much different from private patients. More work is required for the safety net clinic than that of a private clinic. The need for quality control cannot be applied the same, as many are immigrants, mono-lingual Spanish speaking patients, requiring a whole different kind of medicine.

Donna Crawford added that if a person who has a disability falls and breaks a shoulder that injury would have more implications than the same injury in a non-disabled person. The client may need attendant care or transportation if he/she can no longer drive.

Dr. Wopat indicated that any plan wanting to contract for care needs to be accountable for the care they deliver and requirements should be set up for that. Medicaid requirements address those issues, i.e., exceptional needs coordination, literacy issues, ADA modifications. A plan can be held accountable on a contractual basis to meet those requirements.

Over the next five years, reporting systems will be improved on cost and quality by the health care plans.

Dr. Lefranc believes it is important to keep an eye on access and that the patients are receiving the services they need. **He suggested that someone be invited to present a report on access and services provided at a future MAC meeting.**

Carole Romm shared the MAC Policy Framework for Medicaid Data.

- Focus on three population groups
  - those already enrolled in a Medicaid program
  - those evidently eligible but not enrolled
  - the uninsured and underinsured who may become Medicaid eligible
- Structure and analyze data within three general categories, and according to key policy questions:
  - Access – How can outreach be maximized?
  - Costs – If Federal Financial Participation (FFP) is maximized, what would be the costs and impact to programs? If employers are not continuing to pay for most of the cost of family health coverage, that cost that's being passed on to workers is increasing a lot faster than their income is and middle class families are finding themselves unable to pay to cover their children. If we look to the people who might be eligible, if we maximize Medicaid by getting Federal match, it would cover a lot of people who are potentially going to be on one Medicaid program or another.
- Economic effects of increasing health coverage
  - brings in federal matching funds
  - ability to leverage other state funds
  - increased productivity of workforce and other human capital improvements
  - "velocity of money" effect on state and local economies

Dr. Wopat asked for an explanation of "velocity of money". Bob DiPrete responded that if you introduce new money into an economy, the impact of it is multiplied because that

same money will be used more than once. Bringing in more money for health care will change the amount of real estate needed in that community, i.e., gas stations, stores, etc. It is the ripple effect of bringing new money into a community and has an impact across the economy.

Data for the Medicaid Advisory Committee
Kelly Harms, Office of Private Health Partnerships (OPHP) which administers Family Health Insurance Assistance Program (FHIAP), provided a FHIAP 101 to members. Ballot Measure 44 passed 10 years ago which put a tobacco tax into the health care system in Oregon. The money was to be used to expand health care to the lower-income uninsured population.

House Bill 2894 passed during the 1997 Legislative session, creating FHIAP. The program was implemented in 9 months, and the first subsidy was paid in July 1998.

In November 2002, FHIAP received federal funding when the OHP 2 waivers were approved. Clients were then able to choose which program they wanted to receive coverage in. FHIAP was able to use Title XXI funding to cover adults, and subsidize insurance plans that met the benefit benchmark.

The program targets low-income, uninsured Oregonians with incomes under 185% of federal poverty. Approximately 50% of FHIAP enrollees earn less than 100% of federal poverty.

FHIAP's initial marketing and outreach efforts focused on people living in rural areas before going into the I-5 corridor and metro area.

FHIAP requires persons to be uninsured 6 months, except those who had being receiving Medicaid, preventing people from dropping their coverage to enroll in this program.

FHIAP is not a direct coverage program and offers a subsidy toward the premium costs of regular health insurance based a family's monthly gross income. FHIAP doesn't pay for co-pays, deductibles or co-insurance but does set subsidy levels for premiums high. All eligible children must have health insurance before adults can use the subsidy.

FHIAP leverages employer dollars wherever possible and requires employees who have coverage available through their employer to take that coverage, provided the employer makes a contribution toward payment of the premium. Employees that do not have health coverage offered through their employers, or when their employer offers insurance but does not contribute toward the premium, may enroll in the individual or the group market. Premiums are more expensive in the individual market.

FHIAP will be moving to subsidize dental in the individual market if the carriers offer it. A mental health benefit is covered.

FHIAP staff encourage people to apply for the OHP or other programs they could be eligible for. Clients move back and forth between programs and FHIAP staff work with DHS staff to make the process a smooth one.

FHIAP's program is open to 15,000 enrollees. Persons are placed on a reservation list and when the program opens, they will be notified to apply.

Employers, in order to qualify for FHIAP, must offer a health benefit that meets the benchmark, a minimum set of standards and cost sharing, the actuarial equivalent of Medicaid mandated benefits.

In the group market, the employers will have to contribute at least 50% of the costs for the employee-only coverage. Most employers pay 100% of premium costs for their employees. Employers are not required to pay for dependents care. FHIAP helps with dependent coverage.

Kelly Harms explained the application process for individuals applying to enroll in both the individual and group market.

Kelly Harms provided the MAC with a summarized FHIAP Snapshot of Program Activity that includes enrollment data and proposed that it was a document her office could provide to the MAC on a monthly basis.

Action item
Kelly Harms will pass both Dr. Lefranc and Bruce Bliatout's names and contact information to FHIAP's Education, Information and Outreach manager to assist in outreach planning efforts.

Dr. Wopat expressed concern about expanding outreach in the FHIAP program when it only can cover up to 15,000 enrollees. Kelly Harms responded that FHIAP's administrative costs are 9% and does include the outreach and training component. FHIAP provides outreach and training not only to FHIAP but also the Oregon Health Plan (OHP). FHIAP is a solution for some people but not for everyone.

Dr. Wopat believes the state should be required to provide financial incentives to health care plans that go out and seek patients, get them enrolled and make sure they are receiving the benefits provided in their coverage.

Carole Romm would like to see data on administrative costs per person per month in both the OHP and FHIAP systems.

Bob DiPrete added that FHIAP is an expansion program and not mandated by the federal government. The federal government doesn't require the state to keep the program open all the time as it does with mandated programs. FHIAP is limited in funding to a level that doesn't allow it to remain open to enroll a lot more people.

Next Meeting
The next Medicaid Advisory Committee (MAC) meeting is scheduled for Wednesday, January 24, 2007, from 10:00 am to 12:30 pm in Room 167A, State Capitol, 900 Court Street, NE, in Salem. There will not be a meeting in December.

Action item
The MAC will discuss their draft Mission Statement at the next meeting.