

OREGON HEALTH FUND BOARD – Federal Laws Committee

February 14, 2008
9:00am (Digitally Recorded)

Oregon Medical Association, Sommer / McLoughlin Room
11740 SW 68th Parkway, Suite 100, Portland, OR

MEMBERS PRESENT: Frank Baumeister, M.D., Chair
Ellen Gradison, Vice Chair (by phone)
Mike Bonetto
Chris Bouneff
Michael Huntington, M.D.
Julie James
Mallen Kear, R.N.
Cheryle Kennedy
Larry Mullins
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED: Sharon Morris

STAFF PRESENT: Susan Otter, Policy Analyst
Barney Speight, Executive Director, OHFB
Jeanene Smith, Administrator, OHP
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- Call to Order
- Approval of Agenda
- Medicaid Panel: OHP-Contractors
- Follow-Up Mental Health Panel
- Medicaid Panel: Providers
- Medicaid Panel: Safety Net Providers
- Public Testimony

(Digitally Recorded)

Chair Baumeister I. Call to Order
• There is a quorum.

Chair Baumeister II. Approval of Agenda
No questions on agenda. Minutes from Jan 23 meeting are not available – will be sent to members for approval at Feb 28 meeting.

Chair Baumeister III. Medicaid Panel: OHP-Contractors
Fully Capitated Health Plan: Pam Mariea-Nason, Legislative Liaison, CareOregon

- CMS is eroding opportunities for innovation – limiting funds and eligibility. CMS is enacting rules that are shortsighted and confused, and have a large impact, like the Deficit Reduction Act (DRA) of 2005.
- The current OHP system is too expensive considering the outcomes.

- CMS system of payments to providers is basis for even commercial payments to providers. System pays more for technical services and less for prevention/disease management. This needs to change.
- DMAP uses same system for OHP – health plans don't get reimbursed for services not valued by CMS.
- In 2009, CMS not allowing states to only tax Medicaid managed care health plans – this will remove the funding source for OHP-Standard.
- HIPAA impacts coordination of care. Barriers to coordinating care between OHP-contracted health plans, and dental care and mental health organizations. See work by Governor's Task Force on Health Information Security and Privacy (HISPC).
- Oregon needs to commit general funds to the Medicaid expansion population covered under OHP-Standard.

Fully Capitated Health Plan: Rhonda Busek, COO, Lane Individual Practice Association, Inc. (LIPA)

- *(See written testimony included under presentations.)*
- Medicaid system is complex, and difficult to streamline. Lack of timeliness of CMS approvals (on OHP waivers, etc.) put health plans in limbo.
- CMS should increase payments to Oregon providers (Medicare). Decreasing Medicare rates are problematic. OHSU is cutting slots.
- Concerned about CMS proposal to no longer use Medicaid funds for graduate medical education.
- All but one of the FCHPs are in Medicare too – there is a conflicting interpretation of rules between Medicaid and Medicare.
- New citizenship documentation requirements for enrolling in Medicaid (DRA 2005) mean that eligible citizens are denied enrollment and care. See DHS report on this (*NOTE: DHS report included in Feb 28 meeting materials*).
- OHP application process is tedious and long.

Fully Capitated Health Plans: Cindy Becker, Executive Director, Coalition for a Healthy Oregon

- No predictability for states, providers, clients under Medicaid. Clients must deal with eligibility changes, changes in services and covered benefits. Providers must deal with benefit coverage changes and payment changes.
- Medicaid fee structure limits access to care – doctors don't get paid enough, and there is no effort to recruit and retain doctors.
- Administrative burdens: FCHP contracts are 92 pages with 14 addenda.
- Treatment vs. prevention model: Get paid for treatment, not prevention or cognitive intervention. No incentive for doctors to do prevention especially with low rates.
- Cost-sharing/patient responsibility: Clients are inappropriately using the ER with no consequences. May be that they have no access to primary care, or they may just be used to going to the ER. EMTALA and Medicaid have limits on cost-sharing.
- Oregon's OHP rates of payments to health plans are actuarially set, then legislature cuts by some percentage (once 30%). These rates and cuts vary from year to year.
- Need to integrate health plans/MHOs/DCOs – currently have different structures. Need to remove barriers to coordination – real, perceived, territorial. Federal buckets of money set up this disjointedness.

- Long-term care: little integration with acute care. Medicaid spending on LTC will only increase as Oregon's older population increases – LTC will eat up Medicaid. Some go into LTC because they are not getting their acute care needs met.
- Can't change the delivery system without changing the payment system.

Discussion

- Question to panel: Are your provider networks stable? Rhonda Busek, LIPA – yes, because of a feeling of social responsibility. Pam Mariea-Nason, CareOregon – yes because they are part of the community, but often providers are not open to new members because they are looking at their payer mix. New members have a hard time finding providers. Cindy Becker, COHO – OHP-Standard population is now high needs, not appealing to doctors.
- Is it that prevention is not historically in the model, or are health plans prohibited from paying for prevention? If plans are fully integrated (own doctors) they could add it, but Oregon's FCHPs aren't structured this way. There are some CPT codes for prevention, but CMS won't pay for these.
- More efficiency in care means get paid less next year. Need a new system of accountability, not based on encounter data.
- Integrating public health approaches is paramount.
- Currently key word for providers is "production" – need to change from this way of thinking.

Dental Care Organizations (DCOs): Deborah Loy, OHP Services Director, Capitol Dental Care

- *(See written testimony included under presentations.)*
- In addition to representing Capitol Dental Care, Deborah is also representing two groups:
 - stakeholder group including all 7 DCOs, the Oregon Dental Association, public dental health, Hygiene Association, others;
 - A collaborative partnership between 4 of the DCOs.
- Importance of oral health as part of overall health.
- CMS has made adult dental services optional under Medicaid. Unpredictability of Medicaid coverage of adults has led to dentists dropping out of Medicaid.
- CMS prohibits dentists from dispensing "take home" products that reduce bacteria and remineralize the mouth.
- OHP-Standard only includes emergency extraction benefit – no other dental coverage.
- Medicaid case law prohibits billing for a service if also offered free to others at same time it is provided (e.g. onsite at school based health centers).
- Medicaid does not allow billing a no-show fee to the client. This is especially important for dentists who see patients for 60-90 minute appointments. Dentists cite OHP enrollees' high rate of no shows as a top reason for not wanting to participate in OHP.

Mental Health Organizations (MHOs): Jim Russell, Executive Manager, Mid-Valley Behavioral Care Network

- *(See written testimony and handouts included under presentations.)*

- Main federal challenges to mental health care in Oregon are regulatory CMS changes. (*Refers to DMAP report, pg. 26-27, 36 – see Exhibit Materials.*)
- CMS has been attempting to shift costs to states (*see APHSA/NASMD letter in his handout*) which will result in reduced access, lower quality of care, and fewer people with health coverage.
- CMS changes in the definition of case management - regulations are much more restrictive than intent of DRA. This regulation change was done by CMS as an Interim Final Rule (with no notice or comment period)
- New CMS requirements for cost reporting – no margin for working capital, risk reserves, carry-forward funds. All “unspent” dollars must be returned – resulting in increased admin costs and decreased services. (Congressional moratorium delays implementation until May 25, 2008)
- CMS changes in the definition of rehabilitation services - too restrictive (Congressional action has delayed implementation until June 30, 2008)
- CMS use of a capitation rate checklist - retrospective not prospective.

Discussion

- Suggestions for changing capitated rate measurements? Possibly change from encounter basis to some accountability measures, to reward innovation.

Chair Baumeister IV.

Follow-Up Mental Health Panel

Community Mental Health Coalition of Oregon:

- **Angela Kimball, Director of State Policy, National Alliance on Mental Illness**
- **Leslie Ford, CEO, Cascadia**
- (*See presentation.*)
- High rates of mental health disorders (1 in 4 adults, 1 in 17 with serious mental illness, 1 in 10 children), yet low rates of care (1 in 3 adults with mental disorder access care).
- Screening and early intervention for youths and young adults are key. However, OHP and other insurance cuts off once youth become young adults.
- Stigma around mental illness – need for outreach, education, primary care integration.
- Adverse childhood experiences study (*see Exhibit Material for copy of study*) – links childhood trauma to health outcomes as adults.
- Persons with mental illness die younger than their peers of largely treatable medical conditions, need integrated health and mental health care.
- Need to align incentives to promote health – eligibility policies that promote continuity of care, financial incentives for prevention, screening, outreach, integrating health and mental health care.
- CMS does not require States’ SCHIP programs to have mental health parity – requirement is coverage at 75% of medical care benefits, and need not cover evidence-based practices.
- Medicare has high copays for mental health care (50%) which are often uncollectible, leaving providers uncompensated. No parity around inpatient day limits. Case management, some evidence based treatments, some types of providers not covered.

- Medicare is hostile to mental health – many with mental illness are dual eligibles (in both Medicare/Medicaid). Medicare administrative costs are more than reimbursement covers.
- Medicare Part D issues. Medicare should restore coverage of Benzodiazepines, eliminate cost-sharing, raise income limits and asset tests to qualify for Low Income Subsidy, waive late enrollment penalty for subsidy, allow mid-year enrollment changes, and institute “intelligent assignment” for low-income beneficiaries into plans that more adequately cover their medications, provide 90-day enrollment periods for subsidy-eligible individuals.
- Medicaid issues: IMD exclusion means no Medicaid match for individuals aged 22-64 in institutes for mental disease with more than 16 beds.
- Medicaid limits billing to one service per day – restricts coordination of care.
- Medicaid proposed rules: Targeted Case Management, Treatment Foster Care, Rehab, and Case Management, threaten delivery of services to maintain health, coordination with other systems (e.g. education) and provide best practices
- Barriers related to Medicaid disability criteria, enrollment process, denial of benefits while incarcerated, moving from unemployed to employed.

(Digital recording stopped due to technical problem)

Chair Baumeister V.

Medicaid Panel: Providers

Jane-Ellen Weidanz, Director of Public Policy, Oregon Association of Hospitals and Health Systems

- *(See presentation.)*
- *(Commenting on previous presentation)* CMS recently revoked IMD exclusion waivers in three states.
- Medicare and Medicaid together cover more than 30% Oregonians and drive Oregon health care by setting policy, funding, payment level, populations covered.
- Mindful of tension between Congress and the Executive – CMS makes policies that are inconsistent with Congress
- Medicare 24 month waiting period for people with disabilities once they become eligible for SSDI.
- Medicare Payment rates do not cover hospital’s costs – on average, 81% of costs. Rate formula disadvantages cost effective states. Hospitals fare somewhat better under Medicare Advantage plans’ rates.
- Efficiency is not the issue – Oregon is one of the most efficient states – there is very little efficiency left to be gained under Medicare.
- Medicaid: CMS approval of waivers – 2 year wait.
- Taxes (on Medicaid managed care and hospitals) that fund OHP standard sunset 9/09 due to federal law — Puts all OHP Standard at risk
- Medicaid Managed Care plans base hospital reimbursement on 80% of Medicare reimbursement and Medicaid FFS pays even less. So for every \$1 in cost: Medicare = \$.81 Reimbursement, Medicaid managed care = less than \$.65 Reimbursement. Leads to huge uncompensated care costs (\$751 million in 2006) for hospitals.
- Recommend Congress raise Medicare rates for efficient states like Oregon to the national average.

- Recommend CMS encourage states' efforts to expand coverage to uninsured. Would see flexibility – in waiver approval, flexibility to use different revenue sources, States using SCHIP to fullest extent, and consistent policies across states in waiver allowances.

Scott Gallant, Associate Executive Director, Oregon Medical Association

- *(See written testimony and handout included under presentations.)*
- Reform requires state-federal collaboration
- OMA supports US Sen. Ron Wyden's Health Americans Act, S 334.
- Support for Bruce Goldberg's recommendation at Jan 23 Federal Laws Committee meeting to broaden conversation with CMS. Medicaid is not a rational system, is overly regulated, wastes money adjusting to new rules/processing claims/submitting reports when there are no real benefits to these administrative costs.
- Medicare geographic payment variations – Oregon providers are paid less, results in access issues. These Medicare rates are used to calculate Medicaid rates – so Medicaid rates are low too.
- Federal anti-trust laws and Stark laws inhibit effective care and encourage oligopolies – leading to increased cost pressures.
- Federal support for medical education should be increased - workforce shortage-losing some federal support.
- Encourage Oregon Delegation to US Congress to develop and propose a long term strategy to develop access to services outside of hospitals – ideally clinics should offer 24 hour access for routine care.
- Permanently establish a rational rural health policy
- Revise federal tax structure to encourage individuals and small employers to purchase health insurance.
- Propose and adopt uniform standards for payment, quality measures and reduce overhead
- Implement interoperability standards before requiring quality measures, electronic prescribing and/or electronic medical records.
- Federally, at least, require all Americans will be protected from catastrophic medical costs.
- Oregon has been penalized for its efficient delivery system compared to other areas of the country – impacts physician services since Medicaid and some commercial payers follow Medicare payment policies.
- *(Refers to handout: "Physician Payments under OHP: Trends and Concerns" Henery & Assoc., June 2007 – see copy with presentation)* Study demonstrates Medicare underpays physicians and payments are projected to decrease. OHP payments, which are tied to Medicare rates, to physicians are low even though total dollars paid to hospitals have increased. Many physicians may drop OHP in the future.

Discussion

- Does Medicare Advantage pay better? Scott: Medicare Advantage FFS plans do not pass on substantial subsidies in their payments to physicians. Medicare Advantage managed care plans have 10-15% differential, but overall find 40% administrative costs are not reimbursed. Medicare Advantage rates are still based on traditional Medicare rates.
- Is primary care under-reimbursed? Scott: yes, but not sure that means that specialists are overpaid.

**Chair Baumeister VI. Medicaid Panel: Safety Net Providers
Craig Hostetler, Executive Director, Oregon Primary Care
Association**

- *(See presentation.)*
- Federally Qualified Health Centers (FQHCs) background – will focus on Community Health Centers since Committee will discuss Indian Health at a separate meeting.
- Community Health Centers (CHCs) address more than just financial barriers (e.g. serving the uninsured) – they also address language barriers, transportation/geographic barriers, serve homeless, socially isolated, health literacy barriers, and persons with mental illness, substance abuse, cognitive impairment.
- Federal barrier: Medicare and Medicaid payment for primary care based on visits – this is flawed. Need to align payment for performance rather than cutting costs for effective performance.
- Community input should be expected into 1115 waiver development.
- Citizenship documentation barriers in Medicaid – requirements present financial/logistical barriers and raises uninsured level of CHC population
- Health Provider Shortage Area (HPSA) and Medically Underserved Areas/Populations (MUA & P) – federal definitions used to designate clinic as FQHC/Rural Health Clinic (RHCs) for federal funding. These definitions are outdated and don't favor the large counties of the west coast states. CMS proposed rules to roll definitions together which would result in far fewer areas designated as HPSA/MUA & P – reducing FQHC/RHC funds.

Discussion

- Would universal coverage adversely affect Safety Net Clinics? Would jeopardize grants based on % uninsured served, but Health Fund Board program to pay for these folks. However, Board should consider addressing other barriers/needs currently addressed by Safety Net Clinics – perhaps with enhanced reimbursement.

Scott Ekblad, Director, Office of Rural Health

- *(See presentation.)*
- Rural Health Clinics (RHCs) background – receive enhanced reimbursement from Medicare and Medicaid. Isolated Rural Health Clinics are sole source of primary care in their communities.
- RHC payment cap is based on baseline payment established in 1988 with annual increases based on Medicare Economic Index. Outdated.
- Mental health services only reimbursed by Medicare if provided by LCSW or clinical psychologists – should expand types of providers.
- Productivity guidelines for RHC staff determine payment for services but are outdated.

Discussion

- Comments on medical education/provider shortage? Area Health Education Centers Program at OHSU sends 3rd year medical students in a 5 week rotation in an Oregon rural clinic. National Health Services Corp scaled back its rural/underserved populations program.

Chair Baumeister VII. Public Testimony
No public testimony was offered.

Chair Baumeister VIII. Adjournment

Meeting adjourned by Chair Baumeister.

Submitted By:
Susan Otter

Reviewed By:
Chair Baumeister

EXHIBIT MATERIALS

1. Draft Agenda for Feb. 14 meeting
2. Summary of Jan. 23 Federal Laws Committee meeting presentations
3. DMAP Report to the Federal Laws Committee: "The impact of federal policy on Oregon's health care reform efforts: Opportunities and barriers within Medicaid and SCHIP"
 - a. Summary of DMAP report
4. Data on Oregon's Uninsured
5. Oregon Health Care and Medicaid Spending
 - a. Dollar amount spent determining eligibility for OHP
6. Background for presentations:
 - a. List of FCHPs, MHOs, DCOs with enrollment
 - b. "Safety Net Clinic/FQHC Overview" (OPCA 1/15 presentation to Board)
 - c. "The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead," Vincent J. Felitti, MD, Kaiser Permanente Medical Care Program.
7. Follow-up information to 1/23 meeting:
 - a. Formal definitions of "evidence based"
 - b. US Congress press release, Jan 15, 2008: "Congressional Leaders Warn Against HHS Efforts to Limit Health Care for Low-Income Children"
 - c. US Court of Appeals 9th Circuit Court decision on San Francisco ERISA case, Jan. 2008
8. Public comments/referrals from other Committees
 - a. John Mullin (Oregon Law Center) comments to Federal Laws Committee
 - b. Health Equities Committee recommendation referred to Federal Laws Committee
9. Other Committee business:
 - a. Approved Federal Laws Committee Charter
 - b. OHFB report to state legislature, "Health Insurance Exchanges and Market Reform," Feb. 2008
 - c. February OHFB newsletter

PRESENTATIONS

1. Pam Mariea-Nason's testimony, CareOregon
2. Rhonda Busek's testimony, Lane Individual Practice Association (LIPA)
3. Deborah Loy's testimony, Capitol Dental Care
4. Jim Russell's testimony and handout, Mid-Valley Behavioral Care Network
5. Angela Kimball's presentation, National Alliance for Mental Illness
6. Scott Gallant's testimony and handout, Oregon Medical Association
7. Jane-ellen Weidanz's presentation, Oregon Association of Hospitals and Health Systems
8. Craig Hostetler's presentation, Oregon Primary Care Association
9. Scott Ekblad's presentation, Office of Rural Health