

**Local Government Advisory Committee
to the Department of Human Services
Room 473, Human Services Building, Salem
October 8, 2004
Minutes**

Attending

Cindy Becker	DHS – Deputy Director
Cathy Cooper	DHS – Deputy Assistant Director, Seniors and People with Disabilities
Jean Cowan	Lincoln County Board of Commissioners
Angela Kimball (for Gina Firman)	Association of Oregon Community Mental Health Programs
Irene Fischer-Davidson	Clackamas County Human Services
Ramona Foley	DHS – Assistant Director, Children Adults and Families
David Foster	Oregon Housing and Community Services
Robert Furlow	Douglas County Health & Social Services
Sharon Guidera	Association of Mental Health Program Directors
Kelly Harms	DHS – Legislative Coordinator, Director’s Office
John Hartner	Oregon Association of Community Corrections Directors
Chris Johnson	Yamhill County Health and Human Services
Linda Modrell	Benton County Board of Commissioners
Ann Peltier	Conference of Local Health Officials
Lynn Read	DHS – Health Services
Clyde Saiki	DHS – Chief Administrative Officer
Erinn Kelley-Siel	Governor’s Health Policy Advisor
Mary Shortall	Area Agencies on Aging and Disability
Vic Todd	DHS – Assistant Director, Finance and Policy Analysis
James Toews	DHS – Assistant Director, Seniors and People with Disabilities
Wendy VanElverdinghe	Community Action Directors of Oregon
Bill Wagner	Cascade West Council of Governments
Gary Weeks	DHS - Director
Gillian Wesenberg	Douglas County Commission on Children and Families

Minutes: Colleen Snarski, DHS – Director’s Office Administration and staff to LGAC

WELCOME & INTRODUCTIONS/APPROVAL OF MINUTES

Linda Modrell called the meeting to order and roundtable introductions were made. The August 13, 2004, minutes were approved.

DIRECTOR'S REPORT

Flu vaccine shortage

Gary Weeks updated the committee on the steps the State is taking to deal with the national shortage of flu vaccine. This shortage was caused when one of only two manufacturers of flu vaccine for the U.S. was shut down because of contaminated products. The flu kills about 500 people each year in the state. Oregon will have about one-third of the vaccine needed to cover people in the highest risk populations. Oregon has a statute that governs who should receive vaccinations during shortages, outlines financial penalties that can be assessed for violations, and authorizes re-distribution. Those people include pregnant women, people over 65, and children. The State plans to invoke that statute shortly, though it doesn't expect to have to have a mandatory redistribution.

DHS has been working with hospitals, doctors and public health officials to determine the amount of vaccine available and protocols for distribution. Most of the providers contacted so far have received only about 25 percent of their shipments. Over the next few months, the department will keep the media informed as to the latest developments. The department suggests that people use common sense measures to help prevent the flu, like washing hands, getting plenty of rest, and staying home if you do get sick so others don't become infected.

Public Health Director

Interviews are scheduled with six finalists for the Public Health Director. The candidates have a wide variety of experiences, some are bilingual and many of the candidates have worked in public health in this country, as well as other countries. After the initial interviews, 2 or 3 candidates will be asked to stay overnight for finalist interviews. Weeks said the interview panel has broad representation, and the department will provide the committee with a list of their names (see page 8). This position is a part of the Health Services cluster and will be a part of the DHS Cabinet.

Rebalance

What we can report now is that the OMAP caseload is larger than projected, and the tobacco tax collections are \$20 million less than anticipated. It is going to be a difficult rebalance.

IGA/Local Medicaid Match (Cathy Cooper-SPD)

Cathy Cooper reported that we have had two meetings with the Centers for Medicare and Medicaid Services (CMS) with our regional administrator and deputy on the issue of Local Medicaid Match. We had one meeting last April and one just about three weeks ago (September 2004). This is all about a shift and a change that CMS is experiencing based on very strong accountability measures that Congress is imposing on CMS.

The "100 Accountants"

This came out in a CMS bulletin in January of 2004 that announced that CMS was initiating a nationwide accountability and review process that would move outside of Baltimore into every state. In actuality, there are only 90 accountants nationwide. Almost all of them have been hired and they are best described as Business Analysts or Business Auditors. The 90 positions are distributed as follows: Ten of them will be housed in Baltimore, with the rest of the 80 across the nation. In our region, we will have six auditors assigned. Two will be housed in the state of Washington. One will be housed in Oregon and the other states in a federal building, though that location has not been identified.

Cooper reported that they asked CMS if they could provide a clear description of what this new person will be doing in Oregon and what we can expect. She said they were told the auditors will be doing a financial analysis, starting with a review of our whole budget process-how we build our budget, how we identify when there is federal participation, and where we attach a Medicaid dollar to a state dollar. Cooper said our regional office stressed that this review is not about fraud, or finding abuse within state government. CMS does not anticipate that if the dollars were accurately spent and allocated, as we believe CFR has allowed us to do, there would be any disallowances. Efforts will be focused on a review of the activities in which the state uses administrative and local Medicaid Match.

This will entail a drill down into budgets to identify if it is supported by regulation, is that dollar a “clean” dollar that comes up from local government/county government. Cooper reported that CMS, just like the State, is really concerned about the reduction and loss in services and or programs at the local level. CMS assured us that they would try to prevent in any way an unraveling of local delivery, but ultimately we are all accountable for the use of the federal Medicaid dollar. If CMS finds things outside of the scope of regulations, they will work with us as we transition.

CMS stressed that they really want to work with the states, as partners and want us to agree upon transition and will work with us to have as much flexibility as allowable within regulations. However, they also want the State to be held accountable. Cooper said they talked to states about starting our own local reviews and understanding and documenting in our budgets, where those local dollars are coming from when we use local Medicaid match.

CMS has encouraged DHS to own any issues or concerns that we found, work on our own plan to fix the issues, then CMS would come behind and okay those. Our regional office really wants our region to be the first region that has finished this process and to get on with the real work that we have to do.

What we have done

Since April, the department has done a collaborative cross cluster look at how we accept, use and budget Medicaid dollars. Representatives from FPA, budget administrators, internal audits and clusters, and have started with the largest Medicaid users in the department, SPD and OMAP. SPD is the first one that has started to work on some reviews at the local level both in

our field offices and our AAA offices will be moving to developmental disability offices at the county level in the future. We will be looking at things like the Board of Nursing, the TLC Ombudsman office, and other places where we have local dollars that are matched by Medicaid dollars in our budget.

Cooper reported that DHS will be looking at all the administrative dollars that we accept. For that process, we developed a review tool based on the CRF and based on the best information we could get from CMS at the time. We have started some of those reviews right now in the field and we will continue doing those reviews. We really want to stress at the local level our commitment to meet with them and work with them on any opportunity to maximize the local dollars in other ways, if the ways they are using them now don't meet the requirements from CMS. We want to make sure we're not causing any long-term issues for them in this process, if at all possible. The department has a contract with PCG, a national firm, to look at expanding opportunities around Medicaid. We will be working with local areas to maximize these ideas.

Cooper said the message from our regional coordinator is that now the Administration on Aging wants to make sure that the local dollar in the Older American's Act program is a clean dollar. There are differences in how we use Medicaid dollars.

The two areas that would not be allowable through CMS are guardianship/conservatorship. The other sensitive issue is around the Veteran's Services Officer and the Veteran's Program. It is not an allowable Medicaid expense. As we find areas that won't be allowable, this will be communicated with local areas. Certain hours or activities that a Veterans Service Officer performs, such as outreach, may be allowable.

Cooper said we were doing what we thought was Oregon's way to be the most creative, the most flexible, to allow clients to receive services. This will now have to be within the context of the CFR's. We will do an extensive review and be very clear about we believe is allowable in this new environment.

Cooper said Senator Grassley's Committee investigated the home and community based waiver program nationwide and really gave CMS very low marks for their ability to review, control and understand what was going on all the waived services nationwide. We are glad to get the group a report on this. CMS is now responding to this concern with improved efforts around reviewing and holding states more accountable.

Drug and Alcohol Program (Ramona Foley)

Making progress on helping child welfare clients become successful in getting treatment.

The former CSD took just over a million dollars, set aside from child welfare dollars, and in '93-'95 implemented support teams in the largest counties (Multnomah, Lane, etc). The teams were subsequently abolished and the dollars were spread across the state, so that every county would have access to at least a portion of the dollars in order to connect child welfare clients with treatment. During the reorganization, we did not do a good job of marketing this change

and the connection we were trying to maintain for child welfare clients. We also were faced with the elimination of some treatment resources and this further confused providers regarding the purpose of the child welfare dollars and how they were being used.

We have encouraged SDA managers to discuss this with the provider community and let them know what we are doing with the child welfare funds. CAF does not have the authority to take these designated funds and reallocate the funds to purchase substance abuse treatment.

Chris Johnson pointed out that the Yamhill model was the pilot for the state in this effort. He also expressed concern regarding the current program in Yamhill when compared to the original model.

Ramona Foley agreed that child welfare should have a better connection with alcohol and drug treatment providers in achieving the goals of the project.

OREGON HEALTH PLAN (OHP) Erinn Kelley-Siel (Governor's Office)

Kelley-Siel reported that there is a 3-part process going on to look at the future of OHP. After the close of last session and defeat of Measure 30, the Governor pulled a small group together to talk about the future of the OHP in an environment where the program must be sustainable within current revenue, as well as provide value to clients. The Governor, a former insurance commissioner, realizes that the OHP can't be the vehicle for universal insurance. We need to think about how get access to basic health care for all Oregonians, and use this program differently in terms of access and insurance. He selected a small group of experts to head up this effort to create a model to get the conversation going. Kelley-Siel provided copies of the preliminary first draft of the report.

She stated we need to align growth of the program with current revenue. There are three recommendations in the preliminary draft around sustainability. The idea is that the State would expressly make a commitment that, for predictability and sustainability, we would work toward bringing the programs cost increases in line with our available revenue. In the last several years our revenue has grown about 5-6 percent per year. The cost of health care under the Oregon Health Plan has grown from 10-12 percent a year. The group felt limiting OHP expenditures to 7 percent per year was appropriate. Managed care capitation rates have increased an average of 7-8 percent a year, so the group felt their starting point was attainable, and that ceiling must be maintained in both managed care and fee-for-service. The State would also be held to the same standards as its partners.

The second idea was that any program this large should constantly be seeking out any kind of administrative efficiencies. Two noted are claims and contract management and better coordination of non-emergency medical transportation for OHP clients. There are opportunities for savings in both of these places. In the long term, the department is committed to continue

evaluating what it does in terms of overall administration of the program and how it can provide better value and save resources in that area.

The third area is enhanced management of pharmaceutical expenses. Oregon has some room to go, compared to other states, in term of more effective pharmaceutical management for Oregon and for clients. There are a series of steps to be taken to ensure better management of pharmaceutical benefits, which can save dollars without adversely effecting quality. This may be complicated because starting in 2006, the Medicare Part-D benefit will kick in for those dually eligible and the State effectively loses control over all of those prescription benefits.

Kelley-Siel gave a brief update on the budget process to provide context for the OHP discussion. In 2003-05, Oregon's legislatively approved budget, after Measure 30, is \$10.2 billion. In addition, the state spent about \$600 million from one-time revenue sources. Those one-time revenues will not be available next biennium, so in effect we need to add them to the \$10.2 billion, which gives us a total of \$10.8 billion. Right now, the September revenue forecast said Oregon will have \$11 billion to spend in 05-07. All the agency request budgets, which are for current service levels (includes inflation, cost of living increases) add up to a total \$12.8 billion dollars. The request from agencies to just maintain what they do today is \$1.8 billion over what the State will have available to us to spend in '05-'07. Kelley-Siel said no budget number has been determined yet for the Governor's OHP budget, nor has Legislature set a budget yet.

In this context, the group looked at what they would do if they had to cut, and where they would invest more resources if they had them. Because of various state and federal regulations, we are left with optional benefits and optional populations as ways to managed costs.

As a note: the group didn't feel it was appropriate to talk about "standard population" since that population is funded through provider revenue. The group focused just on what to do with General Funds, since this is what the State is most concerned about right now.

Optional benefits for the OHP Plus population include: pharmaceuticals, mental health, chemical dependency, dental and vision. Kelley-Siel said there was a discussion about which benefits the group would cut? Would it cut people first or benefits first? The group quickly concluded that reducing or eliminating pharmaceutical benefits, mental health benefits, and chemical dependency benefits for the Plus population is penny-wise and pound-foolish, since the State would pay more down the road for the loss of those benefits for that population. However, only dental and vision was recommended as an elimination for optional services available for reduction.

The only optional populations left to eliminate or reduce are 25,000 children and pregnant women that cost the state \$30 million in General Funds and 25,000 SPD clients, who when you add their health benefits and their long term services together, cost the State about \$400 million

a biennium. Standard is also an optional population, but the providers need to be part of the discussion if it was considered since their tax dollars are paying for the benefits.

Kelley-Siel said there was a conversation about future investment, and the group developed some clear themes. It would not recommend new investment in the program, as it exists today, unless the system first went under some major changes, such as better integration of physical and mental health care. The sustainability of long-term health care services here in Oregon, given the demographic data we have about the future of the SPD population would also need to be addressed. The group felt the first thing we should do if we have any money is to invest in some pilot projects and things that would focus on improving access.

Kelley-Siel said it was important to remember that the OHP is not the problem in Oregon. OHP is part of a larger, complicated and broken health care system across the state and nation. It is struggling with the same issues that employers are struggling with. The tools that employers have, like shifting costs to the beneficiaries or just eliminating care for folks, are not available to the State. We tried some cost shifting, but the courts have limited our ability to do that with this population. The State's tools are limited to better management, benefits, populations and provider reimbursement. The group believes if you're going to invest or try to expand, you need to make sure that you look at access, not just providing insurance coverage.

Phase #2 of this effort is getting comments on the initial draft. The group would like you to take a look at this document and tell them what you think. Do you have recommendations around sustainability; reductions if they're necessary; around program investment, if it is possible? Are there specific ideas that you have about the recommendations that we have here? Please send your comments directly to Kelley-Siel. There will be a series of meetings in October with a variety of stakeholders to present the report and to gather feedback. In early November, the group will reconvene to develop their next draft. The third phase will be to fully vet the draft, probably at the November Oregon Health Policy Commission meeting.

SMART Budget

Erinn Kelley-Siel reported that the League of Oregon Cities and the Association of County Governments are having further discussions around the budget. With this new process, the Governor wants to show the public what the State is legally required to do, and how it is mandated (for example, a federal requirement, a state law, etc.) He also wants a process that shows which programs provide the best values and outcomes. There is a website up now that explains the principles this budget was built around, as well as links to spreadsheets with enormous amounts of information about the programs. The website can be accessed at <http://governor.oregon.gov> or at <http://www.oregon.gov>. At either site, click on the "Oregon Principles" budget link.

The Governor is asking for feedback over the next month, which will be read and used as he prepares his Recommended Budget for the Legislature. You can give that input on line, or you can contact Kelley-Siel directly with your comments. At this point, the Governor's Office is looking for input on the content not the process of the "Oregon Principles" Budget. She is happy to come back to discuss ways to improve the process at a later date.

There are concerns around "optional" programs, since many "optional" programs help prevent costs in other areas (mental health avoids costs in corrections, etc). Kelly-Siel said that the ROI portion of the spreadsheets should address these types of issues.

As a side note, the mental health task force report will be released by Wednesday, October 13, 2004.

Public Health

The following is a list of individuals who participated on the two interview panels:

Mel Kohn, Paul Cieslak, LeAnn Mederios, Nancy Clarke, Lorraine Duncan, Lisa Angus, Ruth Helsley, Sarah Rosenberg, Tom Engle, Gail Shibley, Mary DeFerrari, Liz Morgan, Bill Coulombe, James Mason, Rob Vega, Chris Biggs, Mellony Bernal, Joel Young, Joe Finkbonner, and Rick Acevedo.

Cheri Tebeau-Harrell, Mike Skeels, Gloria English, Kathleen O'Leary, Dan Peddycord, Lillian Shirley, Marilyn Sutherland, Leda Garside, Duane Francis, and Joni Hammond.

FUTURE AGENDA ITEMS

The group provided items for future meetings, as follows:

- 2005 LGAC Meeting Schedule
- AOC legislative agenda
- Report on Mental Health Task Force
- Rebalance Plan
- Contract Update (Clyde Saiki)
- Children's Initiative (impact on counties)

Linda Modrell adjourned the meeting at 11:55 am.

NEXT MEETING

Date: November 12, 2004 – **CANCELED**
DECEMBER, 10, 2004
Time: 9:00 AM – Noon
Location: Room 473, Human Services Building

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