

MEDICAID ADVISORY COMMITTEE

January 27th, 2016

9:00 a.m. – 12:00 p.m.

Oregon State Library, Room 102/103

250 Winter St. NE, Salem OR 97301

Webinar registration: <https://attendee.gotowebinar.com/register/2587787845832917761>

AGENDA

Time	Item	Presenter
9:00	Opening Remarks	Co-Chairs
9:10	Oregon Health Plan (OHP) and Coordinated Care Organizations – OHA update <ul style="list-style-type: none"> Enrollment and redetermination dashboard 	Rhonda Busek, OHA
9:20	Oregon 1115 Waiver Renewal <ul style="list-style-type: none"> Overview of Oregon’s 1115 Demonstration 	Janna Starr, DHS
9:50	Basic Health Program <ul style="list-style-type: none"> HB 4109 (2014) and HB 2934 (2015) MAC’s 2014 recommendation 	Staff, OHA
10:20	Break	
10:30	Health Equity Policy Committee <ul style="list-style-type: none"> Informational session 	Emily Wang, HEPC
11:00	Oregon Department of Human Services <ul style="list-style-type: none"> Overview of Medicaid funding services and programs 	Mike McCormick and Don Erickson, DHS
11:30	Medicaid Advisory Committee <ul style="list-style-type: none"> Review draft inaugural 2015 report Proposed work plan 	Co-chairs
11:55	Closing comments	

Materials:

1. Agenda
2. Draft Minutes, December 2015
3. MAC Inaugural annual report
4. BHP backgrounder (**Draft Jan 2016*)
5. Framework for Basic Health in Oregon DHS
6. OHP Dashboard Jan. 2016 (**forthcoming*)
7. Health Equality Policy Committee Charter and Roster

Next Meeting:

Wednesday, February 24th: 9:00 a.m. – 12:00 p.m.

Oregon State Library bldg. -Room #103- 250

Winter St. NE, Salem, OR 97301

OREGON MEDICAID ADVISORY COMMITTEE (MAC)
December 9th 2015, 9:30am – 12:30pm
Oregon State Library
250 Winter Street, NE, Salem OR. 97301

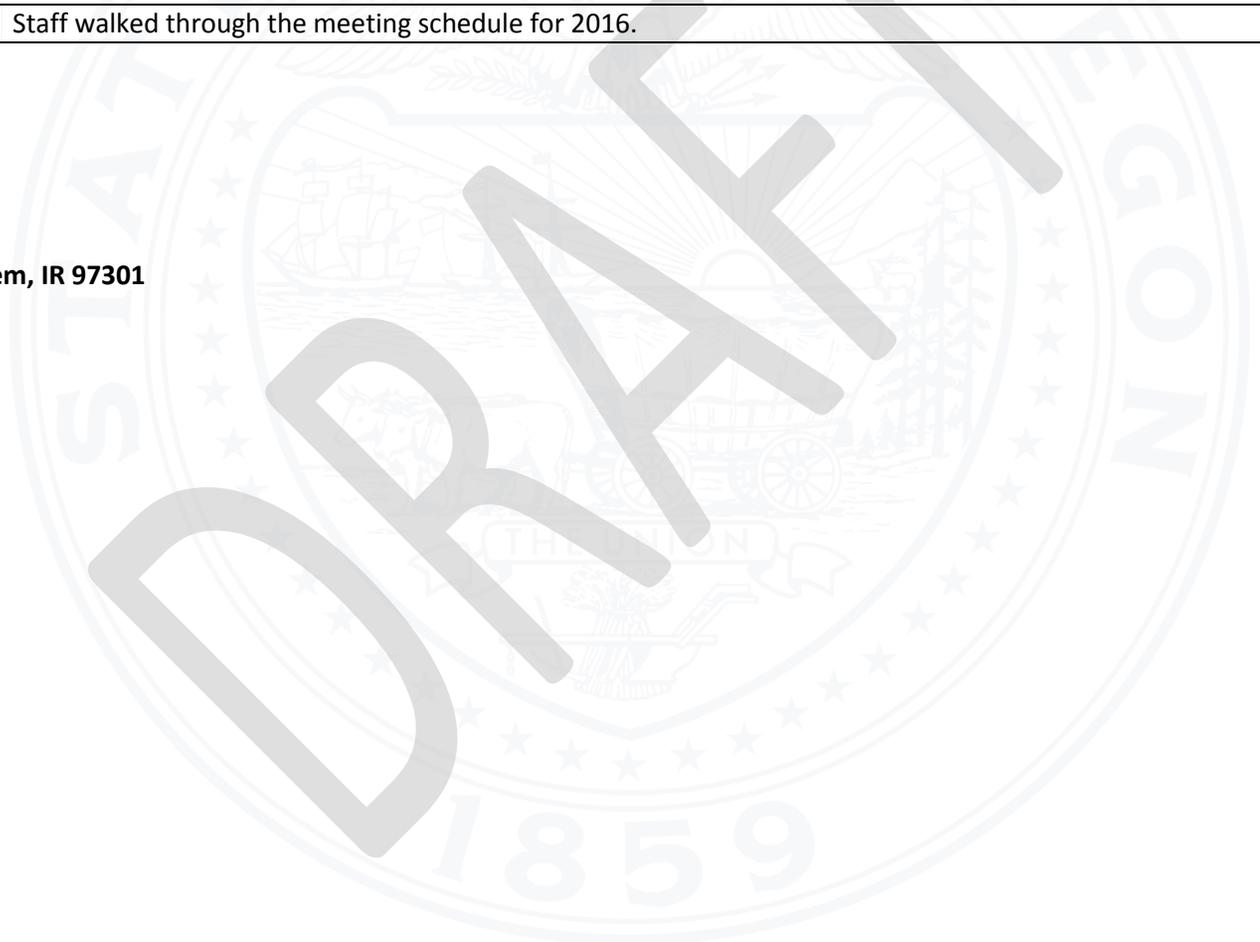
MEMBERS IN ATTENDANCE: Janet Patin, Karen Gaffney, Rhonda Busek, Glendora Claybrooks, Bob Diprete, Ross Ryan, Alyssa Franzen and Don Erickson
MEMBERS ABSENT:
PHONE PARTICIPANTS: Laura Etherton, Marcia Hill, Carol Criswell
PRESENTERS: Rhonda Busek, OHA; Cara Biddlecom, OHA; Sarah Miller, OHA/DHS
STAFF: Oliver Droppers

TOPIC	<i>Key Discussion Points</i>
Opening Remarks and Staff Update	<p>Introduction and roll call. Staff reviewed the agenda and the list of topics to cover. (*Due to inclement weather a number of members called in to the meeting. Unfortunately, the conference line at the State Library did not work).</p> <ul style="list-style-type: none"> Committee members reviewed draft minutes from their October meeting. Committee approved minutes.
OHA OmbudsAdvisory Council	<p>Ellen Pinney, OHA OmbudsAdvisory Council</p> <ul style="list-style-type: none"> Ellen discussed her observations from attending several of the Behavioral Health town hall meetings that were facilitated in the winter of 2015. Ellen reviewed the OHP Determination and Enrollment Project dashboard (see meeting materials). She highlighted the number of individuals enrolled in OHP since Feb. 2015 despite the number of unexpected challenges encountered in 2014 and 2015. Ellen also walked through the OHP Section 1115 Quarterly Report from the 3rd quarter of 2015. She highlighted the top complaints, grievances, appeals and hearings (see pg.5-10). Metropolitan Group is preparing a report about how OHA can improve client communication. The information was collected through focus groups facilitated by the Metropolitan Group. Question: wonder about the issues related to lack of access to health records. Is this an issue around patient engagement and care teams, or something else? Response: this is probably connected with clients that are being deemed as non-compliant, prescription of opioids, and drug seeking behavior.
OHP and CCO – OHA Update	<p>Rhonda Busek and Janna Starr, Oregon Health Authority (OHA)</p> <ul style="list-style-type: none"> Rhonda walked through recent activities and priorities of the OHA including eligibility determinations, processing, OHP call center and OHP dashboard. Rhonda walked through the new OHA organizational chart and briefly summarized the seven divisions including the new directors of each division. She also walked through the Division of Health Systems and the various units within the division.
2015 Legislative Update	<p>Brian Nieuburt, Legislative Coordinator, OHA</p> <ul style="list-style-type: none"> Brian reviewed a number of bills that passed during the 2015 legislative session. The focus of Brian’s remarks were on bills that impact Medicaid, coordinated care organizations (CCOs,) and benefits and services for OHP members. Brian also discussed several budget notes including the Medicaid Managed Care Information System (MMIS) Workgroup. Brian commented that there’s a fair amount of work already underway for the 2017 session. Also, in relationship with the legislature is work already happening with renewing Oregon’s Section 1115 waiver and CCO contracts renewal.

TOPIC	<i>Key Discussion Points</i>
OregonONEligibility	<p>Sarah Miller - OHA OregonONEligibility System (see slides 7-18)</p> <ul style="list-style-type: none"> • Sarah provided a comprehensive overview of the new OregONEligibility system. The new “ONE” system is Oregon’s new Medicaid/CHIP eligibility determination system for determining modified adjusted gross income (MAGI). • In partnership with Deloitte, OHA’s single system integrator, the project has completed design, development, and system integration test for application components, and expects to begin user acceptance test on September 15, 2015. • Starting in 2016, Medicaid eligibility will be competed in the ONE system and the Medicaid enrollment system of record is Oregon’s MMIS. • Sarah highlighted the new system’s functionality and go-live dates in 2015 and 2016. • Question: have you anticipated the most challenging barriers in successfully standing up the system. Response: yes, it will not be pain free for everyone served by OHP. We continue to work to improve the rollout of the new system. • Question: will this system be used for individuals with intellectual and developmental disabilities (IDD)? Response: yes, eventually. Initially, the system is targeted to support a subset of OHP populations including MAGI, Citizen Alien Waived Emergent Medical (CAWEM), CAWEM Plus, and former foster care children. The system will eventually be used for all Medicaid populations. Integrated eligibility would be ideal for Oregon.
Basic Health Program (BHP)	<p>Basic Health Program, Committee Staff – Oliver Droppers (see slides 20-34)</p> <ul style="list-style-type: none"> • Dr. Patin summarized the concept of the Basic Health Program (BHP). She also highlighted the committee’s work in 2014 with respect to the BHP and identifying potential policies to mitigate and reduce churn. • Staff provided a timeline of various efforts in Oregon that have explored the feasibility with respect to the BHP. • Committee expressed interest in wanting to revisit their 2014 recommendation regarding the BHP. Co-chairs and members agreed that the committee would like to prepare a formal statement on the BHP in lieu of new work and analysis completed in the last 24 months (HB 4109 and HB 2934). • Several committee members commented on what’s changed in Oregon since the committee’s report was released in August 2014. The committee will review a revised statement at its January 2016 meeting.
Public Health Modernization	<p>Cara Biddlecom, Public Health Modernization, OHA (see slides 35-46)</p> <ul style="list-style-type: none"> • Cara summarized the work completed by the Task Force on the Future of Public Health Services (HB 2348). • Cara highlighted the recommendations of the task force and house bill 3100 (2015), which operationalized many of the recommendations over the period of 2015-17. • Cara concluded her presentation by walking through the next steps with respect to public health modernization in Oregon.
Committee Planning for 2016	<p>Co-chairs and staff led a planning discussion for 2016 (see slides 47-49)</p> <ul style="list-style-type: none"> • The committee reviewed their April 2015 charter and was asked by staff to provide input on potential priority policy areas for 2016. In response, members of the committee shared the following: <ul style="list-style-type: none"> ○ Members would like an opportunity to be kept abreast and advise OHA on Oregon’s 1115 waiver renewal process including any major policy work going on at OHA related to OHP/Medicaid and the 2016 waiver renewal initiative. ○ Provide input on potential policy proposals that touch upon CCOs and collaboration with public health, community health improvement plans (CHIPs) and community health assessments (CHAs), and track outcome data with respect to health systems transformation and modernization of public health in Oregon.

TOPIC	<i>Key Discussion Points</i>
	<ul style="list-style-type: none"> ○ Access and quality metrics: engage in a process for assessing issues around quality and access to comprehensive health services, including oral health services in OHP. ○ Engage the Department of Human Services (DHS) to explore and assess key issues that agency is planning to address in 2016. The committee is in a unique position to provide input on pertinent issues related to the Oregon Health Plan (OHP). ○ Members would like an update from OHA's Transformation Center as federal funding through the State Innovation Model (SIM) grant ends in 2016. ○ Committee would like a formal response to their Sept. 2015 committee recommendations on 12 month continuous enrollment.
Closing Comments	Staff walked through the meeting schedule for 2016.

Next MAC meeting:
February 24th, 2016
9:00 a.m. – 12:00 p.m.
Oregon State Library
250 Winter Street NE., Salem, OR 97301





MEMORANDUM

DATE: January 27th, 2016
TO: Lynne Saxton, Director, Oregon Health Authority
FROM: Medicaid Advisory Committee
RE: End of Year Report, 2015

For almost three decades, Oregon's Medicaid Advisory Committee (MAC), a federally-mandated body,¹ has participated in policy development, advising, and assessment of Oregon's administration of its Medicaid program, the Oregon Health Plan (OHP). The Committee has a successful history of Medicaid policy development that spans:

- Policy framework for the original OHP 1115 waiver and subsequent waiver renewals
- Expansion of health insurance coverage for children through [HealthyKids](#) (2006)
- Integration of behavioral and physical health care in OHP ([2009](#))
- Provision of [comprehensive benefits](#) for Oregon's ACA expansion population (2012)
- Reducing and mitigating [churn](#) in a post-ACA coverage landscape (2014)

Notable accomplishments by the committee in 2015:

- Submitted memo to OHA regarding renewal and reenrollment in OHP (January)
- Comprehensive [report](#) on CHIP premium assistance submitted to the Oregon Legislature in February 2015 per Senate Bill [1526](#) (February)
- Adopted inaugural [charter](#) (April)
- Met with OHA's Director, Lynne Saxton (July, see committee [memo](#))
- Received presentations from five CCO Community Advisory Councils (CACs) ([March-Sept.](#))
- Prepared a comprehensive financial [analysis](#) of 12-month continuous eligible for adults in OHP in the 2017-19 biennium (October)

In accordance with the committee's 2015 [charter](#), the annual letter is intended to highlight key issues that affect OHP enrollees and their families, as well as provide a list of pertinent reports developed by the committee in 2015. In general, throughout the year and as reflected in the committee's work, the MAC continues to serve a unique role by assembling a multi-faceted, publicly-convened group of stakeholders, including coordinated care organizations (CCOs), providers and clients, to advise the state Medicaid agency on the administration of OHP. The Committee is guided by a set of long-standing principles (see charter) designed to promote consumer engagement, health equity, coverage affordability, care continuity, and financial sustainability for Oregon's Medicaid program. In sum, the Committee strives to ensure the best, objective, and credible research is provided to Oregon policy makers as reflected in its 2015 [charter](#) and its reports.

¹ In accordance with [42 CFR 431.12](#) and ORS [414.221-225](#).

2015 Committee Highlights

CHIP Premium Assistance: Building on the committee's previous work in 2014, at the start of the year the committee concluded its work examining the feasibility of offering premium assistance insurance for children enrolled in Oregon's existing Children's Health Insurance Program (CHIP). The committee reviewed federal and state regulations pertaining to CHIP and premium assistance, and assessed the potential impact to individual CHIP members and their families in terms of access, continuity of care, benefits, affordability, and whole family coverage. Based on the committee's work it recommended:

- A premium assistance program for Oregon's CHIP population was not feasible in 2015 and that the state reassess opportunities to improve Oregon's CHIP program in the future.

The committee's report and full recommendations were included in OHA's [report](#) submitted to the Oregon Legislature in February 2015.

12-month Continuous Eligibility for OHP Adults: As directed by OHA, for eight months (February through September), the committee explored 12-month continuous eligibility for income-eligible adults in Medicaid, similar to the policy already in place for children. This work included conducting a financial analysis of adopting this policy for the 2017-19 biennium. Results of the analysis indicated that the continuity of Medicaid coverage would increase during the 17-19 biennium by approximately 15 percent, thus, reducing churning on and off of OHP. Adoption of this policy, however, would require a state investment of \$223 million in order to draw down \$1.01 billion in additional federal revenue. Approximately \$58 million of the state's portion is due to a decrease of 2.6 percent in the enhanced federal participation rate for the Medicaid expansion population.²

Unfortunately, due to insufficient data and limited research on this topic, potential administrative savings and lower per-member per-month costs were not included in the committee's analysis as the information was not available.³ Based on the committee's careful examination and financial analysis, the committee ultimately [recommended](#):

- OHA request this policy as part of Oregon's 1115 waiver renewal with CMS in 2017.
- OHA adopt transparent OHP eligibility, enrollment and redetermination performance indicators.
- Complete annual assessments of administrative costs that result from churn and potential savings to the Medicaid program, CCOs and health providers by reducing churn.

OHA's New Director: In July, OHA's Director, Lynne Saxton, visited with the committee. During Lynne's visit, she outlined OHA's priority areas, current initiatives and engaged the committee to identify ways for the committee to further partner with OHA in 2016. Members shared with Lynne the committee's four priority areas: (1) improving access to care for OHP members including

² ACA provides states with a FMAP of 100% for the period of 2014-2016, and then phases down to 90 percent in 2020 and beyond.

³ Individuals enrolled in Medicaid for longer periods of time may experience lower monthly costs as these individuals are more likely to receive primary and preventive care as a direct result of enhanced coverage continuity. See Medicaid Advisory Committee April 2015 [brief](#) on 12-month continuous eligibility.

working toward seamless coverage and care continuity, (2) creating and using a transparent system-wide accountability framework, (3) support administrative simplification in OHP, and (4) examining person and family-centered policies. Two important outcomes of this meeting were:

- Recognizing the need for ongoing dialogue with OHA leadership with a focus on the shared goals to meet the Triple Aim in Oregon for those served by OHP.
- Proactively advising OHA on ways to make the eligibility and enrollment process a cleaner and easier process; and ultimately, reduce the complexities and challenges individuals and families face with Oregon’s Medicaid eligibility systems.

CCO Community Advisory Councils: Anchoring the Committee’s work is the recognition that in order to think about health and health care differently is the need to broaden support for community-based models of care. Oregon’s 30+ CCO Community Advisory Councils (CACs) are leading this charge, with innovative and exciting initiatives across Oregon based on community values, preferences and health priorities identified in their community health assessments (CHAs) and community health improvement plans (CHIPs). Stemming from the MAC’s commitment to person- and family-centered Medicaid policies, the committee opted to hear directly from CACs to learn about the:

- Role of the individual CACs including membership and community engagement activities;
- Current focus and priority areas as highlighted in the CAC’s community health improvement plan;
- Challenges and barriers from the perspective of the CAC, from staff and OHP members; and
- Future focus related to implementation activities as outlined in the CHIPs.

Throughout the year, the committee had the opportunity to hear directly from a number of CACs:

- Health Share Community Advisory Council
- Trillium Community Advisory Council
- Columbia Pacific CCO CAC
- Family Care CCO CAC
- InterCommunity Health Network CCO CAC

Based on the information shared by the CACs, the committee learned that:

- Wide range of priority areas identified among the CACs with varying implementation strategies;
- Successes and challenges experienced by individual CACs are often shared and not unique to a particular community;
- Sustained engagement of CAC members is challenging;
- Need for authentic consumer voice vs. tokenism, and recognition of community engagement.

Periodic Updates: An informed and effective public advisory entity must also do its due diligence with staying up-to-date on a vast array of emerging federal and state policy and the performance of a variety of state programs, many of which directly affect those served by OHP. In 2015, the committee received a series of informational updates:

- Oregon’s health system transformation performance reports
- Legislative updates during and post 2015 legislative session
- OHA Transformation Center
- OHP Section 1115 Waiver Quarter Reports to CMS
- Oregon’s Health IT initiatives
- OHA Ombuds Advisory Council
- OHA’s New Dental Director, Dr. Austin and OHA’s oral health priorities.
- OHA’s new Medicaid eligibility system, OregonONEligibility

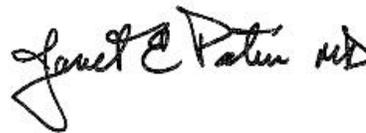
The committee reached an important milestone in 2015. In the spring, the Director of the Department of Human Services (DHS) appointed, Don Erickson, as the ex-officio member for DHS. This was an important development as the committee hadn’t had direct representation from DHS since the creation of OHA in 2009.

In closing, we are excited about our inaugural annual report. We hope this report provides insight into the committee’s work, its policy priorities, and will help to inform state and community partners on a range of issues for the more than 1 million Oregonians now enrolled in OHP.

Sincerely,



Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee



Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

Medicaid Advisory Committee Members

Karen Gaffney, MS – Co-Chair, Lane County health care executive, Trillium CCO Board Member

Janet Patin, MD, FAAFP – Co-Chair, physician, Providence Health Systems

Rhonda Busek, MBA –Director, Provider Services, Health Systems, OHA Ex Officio member

Glendora Claybrooks, NCMA, MHA, GCPM – OHP member; CAC Member, Health Share

Carol Criswell, BA – family health navigator

Robert Diprete – former MAC Director, retired Deputy Administrator, Office for Health Policy and Research

Don Erickson – COO, Aging and People with Disabilities, DHS Ex Officio member

Laura Etherton – Policy Director, Oregon Primary Care Association

Alyssa Franzen, DMD – dental provider; Dental Director, Care Oregon

Marcia Hille – Executive Director, Sequoia Mental Health Services

Ross Ryan – OHP member, consumer advocate

Leslie Sutton, JD – children & disability advocate, Oregon Council on Developmental Disabilities

What is the Basic Health Program?

The Basic Health Program ([BHP](#)) is an insurance affordability program (IAP) established by section 2331 of the Affordable Care Act (ACA) that offers coverage in lieu of Marketplace coverage for individuals with incomes between 138-200 percent of the federal poverty level (FPL). It also offers coverage for individuals lawfully present up to 200 FPL - and that do not qualify for Medicaid due to their immigration status.

Who would be eligible for a BHP?

Citizens or lawfully present non-citizens between 138% and 200% of the federal poverty level (FPL) and lawfully present non-citizens below 138% FPL not yet eligible for Medicaid because they have not resided in the U.S. for 5 years. If a state establishes a BHP, eligible individuals are prohibited from receiving federal subsidies to enroll in qualified health plans (QHPs) through the Exchange/Marketplace.

What services would be covered?

BHP plans must offer at least the ten essential health benefits specified in the Affordable Care Act; states do have the option of adding benefits.

What would consumers pay?

Consumers would pay no more than the allowable premiums and cost sharing an individual would have paid if he or she enrolled in QHP coverage through the Exchange, possibly less, if a state chooses to reduce premiums and other out of pocket costs.

Who would provide services to BHP members?

States would be required to ensure at least two different insurers offer BHP plans and provide services through a managed care or similar system.

How would the state pay for a BHP?

States would use federal tax credits and costs sharing reductions to subsidize coverage for individuals with incomes below 200% of FPL who would otherwise be eligible to purchase coverage through the Marketplace. No federal funds are available for start-up or ongoing program administration.

Medicaid Advisory Committee's 2014 churn report

In 2013, OHA tasked Oregon's Medicaid Advisory Committee (MAC) with developing recommendations to reduce and mitigate Medicaid "churn" and its effects in Oregon. For seven months, the committee reviewed a range of churn mitigation options that included the Basic Health Plan, a Medicaid Bridge Plan, and a Wraparound program. In August 2014, the Committee presented its [churn report](#) to the Oregon Health Policy Board. The report offered a comprehensive set of policy strategies to reduce and mitigate future churn in the new ACA coverage environment. Specifically, the committee concluded that:

Basic Health Program (BHP)

- *Any recommendation regarding BHP from the standpoint of churn should wait until the feasibility study required by House Bill 4109 is completed (pg. 16).*

The committee also identified several issues for future BHP discussions that included: determining reasonable provider reimbursement rates, scope of benefit coverage (OHP vs. QHP), the feasibility of operating BHP through existing CCOs, consumer choice, and administrative complexity in establishing an entirely new program.

Oregon House Bill 4109 (2014)

In March 2014, the Oregon Legislature passed House Bill [4109](#), directing the Oregon Health Authority (OHA) to commission an independent study of the costs and impacts of operating the federal Basic Health Program (BHP) in Oregon. Through a competitive RFP process, OHA worked with national experts, Wakely Consulting Group (Wakely) and the Urban Institute (Urban), to analyze the Basic Health Program's potential effects on consumers, the Oregon Marketplace, and state-supported health care programs. Throughout the process, OHA also engaged a group of stakeholders to identify and solicit input on key assumptions, and review preliminary findings.

States exploring the BHP as a potential alternative coverage program for low- and moderate-income consumers need to consider a number of program design elements ranging from benefit design, out-of-pocket costs, plan and provider networks, reimbursement rates, and program administration and financing. Per the requirements of House Bill 4109, the study estimated:

- Eligible BHP population including individuals likely to enroll;
- Consumer affordability and continuity of coverage;
- Impact to Oregon's Marketplace;
- Potential federal funding for BHP; and
- State implementation and administrative costs.

Key Conclusions of HB 4109 BHP [Study](#) (2014)

- An estimated 87,600 people would qualify for BHP in 2016; 61,400-66,300 individuals would enroll.
 - 55,000 individuals would transition from Marketplace to BHP
 - Slight decline in overall uninsured (approx. 5,400-9,900)
 - Consumer savings of approx. \$800 - \$1,590 per year
- A BHP program would only marginally impact the individual market risk pool, carrier interest in the exchange Marketplace, and Marketplace stability.
- Two different BHP scenarios were modeled (see table 1). Neither scenario yielded a financial "break even" point for Oregon. Projections result in *deficits* ranging from \$1.6-\$119.1 million in 2016.
- No modeled scenario yielded a financial "break even" point for Oregon.
 - Projected deficits in 2016 of \$1.6 - \$119 million.

Findings from the commissioned report offer a comprehensive assessment of the BHP in Oregon for consideration by Oregon policy makers and stakeholders.

House Bill 2934 (2015)

The 2015 Legislature passed [House Bill 2934](#) creating the Basic Health Program (BHP) Stakeholder Group. The Legislative Assembly directed the BHP Stakeholder Group to provide recommendations regarding the policy, operational and financial preferences of the group in the design and operation of a BHP, in order to further the goals of reducing the cost of health care and ensuring all residents of this state equal access to health care. This work was to build on previous work of [House Bill 4109](#) (2014 Legislative Session) that resulted in an [independent study of the costs and impacts of the BHP in Oregon](#). The group submitted its [recommendations](#) to the appropriate interim committees of the Legislative Assembly on November 13, 2015.

Based on a set of principles, the stakeholder group decided upon the following framework and program design for a BHP.

Hybrid Marketplace	
Delivery System	CCOs and commercial QHPs plans compete for BHP enrollees using principles of Oregon’s coordinated care model (CCM)
Benefit Coverage	Full Medicaid benefit level without adult dental
Provider Reimbursement	Average of Medicaid and Commercial (~81% of Oregon’s commercial reimbursement rate)
Premiums & Cost-sharing	<138% FPL, \$0; 138-200% FPL graduated premium structure; no cost-sharing
Eligibility & Enrollment	Marketplace standards; 12-month continuous eligibility; FFM eligibility system (federal hub)*
Consumer Choice	Standard Health Plan (SHP) offerings via Marketplace
Administrative Functions	Marketplace and carriers (client services, grievances, premium billing)
Sustainable Growth Rate	Annualized sustainable fixed rate of growth; methodology and rate to be determined by Legislature

*Please see paragraph on page II regarding use of federal hub as the FFM cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations.

The group also recommended that the Legislature consider updating the 2014 BHP financial feasibility model and to develop financial projections for future years beyond 2017 based on the design preferences outlined above. It is important to note that as of October 2015, the Federally-Facilitated Marketplace (FFM) cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations for states such as Oregon, which rely on a federally-supported State-based Marketplace (SBM).

A Framework for Basic Health in Oregon

A framework for a Basic Health Program — potentially the next big step in health reform in Oregon — has taken shape. A group of health industry officials and consumer advocates has issued recommendations for how to structure a Basic Health Program in Oregon.¹ This fact sheet summarizes its recommendations.

What is Basic Health?

Basic Health is an option under the Affordable Care Act for states to provide health insurance for low-income people currently eligible for marketplace coverage — mainly those with incomes between 138 and 200 percent of the federal poverty level. Basic Health could be nearly fully paid for with the federal dollars that would otherwise subsidize marketplace coverage for the group.²

Recommended Basic Health Framework

Plans offered in the marketplace. Eligible individuals would choose among plans offered in the health insurance marketplace by both coordinated care organizations (CCOs) and traditional insurers.

Adopts the coordinated care model. Plans would conform to Oregon's innovative coordinated care model.³ As such, insurers would employ patient-centered medical homes, measure provider performance and pay for desired outcomes, with funding subject to a sustainable rate of growth.

Benefits mirror Oregon Health Plan. Basic Health would use the Oregon Health Plan (OHP) package, without adult dental. If the federal funding were sufficient, adult dental services would be included. Even without adult dental, OHP offers a more comprehensive package than plans in the marketplace.

Plans more affordable. Plans would be offered at less than half of the cost of marketplace plans.⁴ Prices would be set on a sliding scale: a lower price for those with lower incomes. People otherwise eligible for Medicaid but barred due to immigration status would have no charge for coverage, just as in OHP. No one would face deductibles, copayments or coinsurance when getting care.

Reimbursement above Medicaid and Medicare. Provider reimbursements would be set halfway between Medicaid and commercial insurance, somewhat above Medicare reimbursement levels.

Same enrollment and administration as in the marketplace. Basic Health would conform to the enrollment standards of the marketplace, such as its open enrollment period and 12-month eligibility structure. The marketplace and insurers would have the same responsibilities they do now for client services, grievances and premium billing.⁵

Who Would Benefit from Basic Health?

Some 88,000 Oregonians would be eligible for Basic Health.⁶ Among those who would benefit:

Uninsured Oregonians. An estimated 15,000 uninsured Oregonians would stand to gain more affordable health insurance.⁷

Cash-strapped households. Tens of thousands of low-income Oregonians now purchasing marketplace plans would see premiums cut at least in half, leaving more money to meet basic needs.⁸ They would also no longer face out-of-pocket costs when seeing a doctor and filling prescriptions.

Legal permanent residents. An estimated 3,500 – 6,500 immigrants eligible for OHP but barred by a five-year residency requirement would benefit.⁹

COFA residents. People from Pacific island nations residing in the country under the Compact of Free Association (COFA) and barred by federal law from Medicaid could gain comprehensive, affordable coverage. An estimated 3,000 COFA immigrants live in Oregon.

People with chronic conditions. Individuals with chronic diseases would be better able to manage their conditions without the out-of-pocket costs they currently must pay.

People with income fluctuations. Individuals who now must change providers when their income fluctuates — causing them to switch between private and public insurance — could potentially keep their providers with the choice of CCO and commercial plans.

People with special needs. Individuals needing medical transportation and other OHP services not covered by commercial insurance would receive Basic Health's more comprehensive package.

Endnotes

¹ Recommendations for a Basic Health Program are described in *HB 2934 — Oregon Basic Health Program (BHP) Stakeholder Advisory Group: Recommendations*, Oregon Health Authority, November 2015, <http://www.ocpp.org/media/uploads/pdf/2015/11/OHA-HB2934-BHP-Report-20151116FNL.pdf>.

² More information about Basic Health is available at: <http://www.medicaid.gov/basic-health-program/basic-health--program.html>.

³ *Oregon's coordinated care model: Better health, better care, lower costs: The Oregon Way*, Oregon Health Authority, <http://www.ocpp.org/media/uploads/pdf/2015/11/OHA-Coordinated-Care-Model.pdf>.

⁴ The pricing structure the stakeholder group recommended would have premiums costing 31 percent to 38 percent of marketplace plans, depending on a person's income.

⁵ The stakeholder group did not recommend procedures for disenrollment for non-payment of premiums, concluding that further study on the impact of various options was needed.

⁶ *Oregon Basic Health Program Study*, Wakely Consulting Group and The Urban Institute, October 29, 2014, http://www.ocpp.org/media/uploads/pdf/2014/11/Oregon_BHP_Report20141029.pdf.

⁷ Ibid. Depending on the premiums charged, an estimated 5,400 to 9,900 of the eligible 15,000 uninsured would enroll in the program.

⁸ Ibid. The Wakely study estimated up to 56,400 previously insured Oregonians would enroll in Basic Health, depending on premiums. An Oregon Health Authority presentation showed 46,116 Oregonians below 200 percent of the federal poverty level were enrolled in marketplace plans in 2015. All would be eligible for Basic Health. <http://www.ocpp.org/media/uploads/pdf/2015/11/OHA-BHP-Presentation-20151008.pdf>.

⁹ *Mend the Gap: Why Full Coverage Makes Sense for Oregon*, Oregon Health Equity Alliance, November 2015, <http://www.ocpp.org/media/uploads/documents/2015/rpt20151117-oregon-mend-the-gap-health.pdf>.

This work is made possible in part by the support of Community Catalyst, Northwest Health Foundation, the Ford Foundation, the Stoneman Family Foundation, Meyer Memorial Trust, the Redtail Fund of the Oregon Community Foundation, AFT Oregon, the Oregon Education Association, the Oregon School Employees Association, SEIU Local 503, United Food and Commercial Workers Local 555, and by the generous support of organizations and individuals.

Background/History

In 2009, the Oregon Legislative Assembly created the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB), the policy-making and oversight body for OHA, to address the issues of cost, quality and access to health care. In 2010, OHPB created an *Action Plan for Health* that involves actions by all stakeholders — the legislature, consumers, businesses, health care providers and others — in a plan to "provide and fund access to affordable, quality care for all Oregonians by 2015." Within the *Action Plan*, **improving health equity is a foundational strategy** for achieving the triple aim objectives of:

- Improve the lifelong health of all Oregonians
- Increase the quality, reliability and availability of care for all Oregonians
- Lower or contain the cost of care so it is affordable for everyone

In September 2010, OHPB established the Health Equity Policy Review Committee (HEPRC) to proactively evaluate all recommended policy improvements to assure optimal promotion of the elimination of inequities and health equity. The 24-person committee representative of Oregon's professional, cultural and geographic diversity sought to ensure the avoidance of creating or maintaining health policies that perpetuate or increase avoidable and unjust health inequities. Over a 3 month period, HEPRC reviewed the policy plans for several of the OHPB subcommittees before submitting final recommendations to OHPB.

Committees included:

- The Health Care Workforce Committee
- The Health Incentives and Outcomes Committee
- Oregon Health Improvement Plan Committee
- Public Employers Health Purchasing Committee
- The Health Improvement Plan
- Health Insurance Exchange Consumer Advisory Group
- Health Information Technology Oversight Council (HITOC)

Three of HEPRC's policy priorities were included in the policy board's *Action Plan for Health* and advanced through legislation and OHA administrative changes. These policies are:

- Assuring Culturally Competent Health Care through continuing education
- Assuring Granular Race and Ethnicity Data Collection
- Diversifying the health care workforce and assuring culturally competent health care through the use of Community Health Workers

The group was chartered by the OHPB through February 2011.

While OHPB chose not to reinstate the committee given their belief that health equity needed to be integrated throughout all OHPB committees and policy initiatives, the Office of Equity and Inclusion (OEI) continued to convene the committee, and expanded membership to include the general public.

OHPB and OHA recognize specific strategies must be explored, recommended, and implemented to ensure all populations enjoy health equitably within the context of Health Systems Transformation, development of

the Health Insurance Exchange, and other health-related opportunities for policy and programmatic development.

Authority

In 2011, the Office of Equity and Inclusion (OEI) established the Health Equity Policy Committee (HEPC) to serve as the office’s policy advisory committee, with a focus on health equity.

Government and Community Stakeholder Engagement

Through HEPC, OEI facilitates diverse stakeholder engagement (both internal and external to OHA), to proactively explore, develop, evaluate and recommend policies, which can advance interdisciplinary, inter-sectoral, cross-government, health equity policy improvements and programmatic actions.

The Health Equity Policy Committee will seek information from and collaborate with a wide range of state and national partners including:

- The Oregon Health Policy Board
- Divisions and committees of the Oregon Health Authority (i.e. Public Health Division-PHD, Transformation Center-TC, Oregon Health Policy and Research-OHPR, Oregon Healthcare Workforce Committee, Addictions and Mental Health-AMH, Patient-centered Primary Care Home Program-PCPCH, Division of Medicaid Assistance Programs-DMAP, Traditional Health Worker Commission-THW, Health Care Interpreter Program-HCI, etc.)
 - a. OHA representatives to HEPC can expect to:
 - i. Present policy concepts, policy drafts, or other items for HEPC input
 - ii. Note HEPC input
 - iii. Respond at meeting or plan to follow up with HEPC to report on how their input was used, either through the Health Equity Policy Analyst or a future meeting
- Health care employers and providers

The Health Equity Policy Committee will draw from national and local knowledge/expertise of individuals and organizations working with and/or among communities experiencing health disparities. The committee will review related publications and reports produced by:

- Academia, foundations, and national experts on health equity and health disparities
- Community and faith-based organizations
- Oregon Health Authority and Office of Equity and Inclusion
- National Partnership for Action to Eliminate Health Disparities

Advisory Committee Purpose and Scope

Purpose

The purpose of the Health Equity Policy Committee (HEPC) is to advise Office of Equity and Inclusion (OEI) and raise issues to assure that policy making and program improvement processes proactively promote the elimination of health disparities and the achievement of health equity for all Oregonians. HEPC facilitates linkages among elements within health and health care systems and the diverse communities they serve. The committee operates as a bi-directional mechanism for receiving community input and increasing understanding among community stakeholders of how to effectively engage with OEI and influence its policy actions and decisions.

Executive Sponsor: Leann Johnson, OEI Director

Meeting Frequency: Bi-monthly (every other month)

Leadership Roles, Responsibilities & Membership

HEPC Co-Chairs

The role of the co-chairs is to:

- 1) Work with OEI staff to create meeting agendas
- 2) Facilitate HEPC meetings
- 3) Help facilitate decision making between HEPC meetings, as needed

Executive Committee

The role of the Executive Committee members is to:

- 1) Help HEPC accomplish its work in the most efficient way
- 2) Inform and support meeting agenda development
- 3) Complete tasks between meetings, as needed
- 4) Liaise with relevant groups, committees, and individuals as appropriate.

Membership

4) Committee Membership:

Committee membership is open to the public. The committee will welcome individuals who have varying levels of expertise and life experience in health equity policy advocacy and policy making processes.

5) Committee Decision Process:

Committee decisions will be made by consensus among attendees

6) Ensuring Committee Diversity:

Special attention will be paid to ensure the committee is representative of communities experiencing health disparities, including, but not limited to racially and ethnically diverse populations, linguistically diverse populations, LGBTQ populations, seniors, people with disabilities, rural communities, and economically disadvantaged.

OHA Staff

Leann Johnson, OEI

Carol Cheney, OEI

Emily Wang, OEI

Requests for membership can be sent Emily Wang: Emily.L.Wang@state.or.us

Strategic Activities

Develop 1 year plan with a minimum of 1 deliverable per year in the areas below.

Check-in at least quarterly with Executive Sponsor

Engagement

- Consult with Oregon’s health leaders to develop policies and programs that promote health equity and eliminate health disparities
- Identify opportunities for aligning and/or coordinating community health equity efforts, including strategies and messaging
- Increase and facilitate leadership and participation of socially and culturally diverse organizations by:
 - Conducting trainings in the policy-making process
 - Facilitating relationship-building and information exchange between the State’s health leaders and community organizations
 - Other identified opportunities

Policy Development and Implementation

- Identify and recommend strategic health equity policy and quality improvement priorities to track over the **2014-2016** biennium, inclusive of social determinants of health or “root causes” of health inequities. Priorities responsive to *criteria for health equity policy priority setting* and timely opportunities identified by OHA, OEI, and their community stakeholders via community engagement and assessment efforts (i.e. community forums, storytelling sessions, key informant interviews, focus groups, electronic surveys, environmental scan, etc.) will receive top priority review and recommend policy priorities for subsequent biennia.
 - **Policy Delphi Survey Results-** Top General Policy Areas, Top 10 Policy Items (overall), Top 17 Policy Items (for OEI)
 - **2016- Focus on top 5 priorities in ranked order:**
 - Ensure access to health, dental and mental health services for all individuals (#1)
 - Ensure more granular data on communities of color & other disadvantaged/underrepresented communities (#2)
 - Ensure CCO community health assessments track disparities & work w/ community to identify policies for eliminating them (#2)
 - Update school curriculum to incorporate racial, social & economic justice, meaning students develop skills & attitudes to build an inclusive society & end damaging biases & stereotypes of “others,” and support cultural identity development (#2)
 - Evaluate health providers’ skills in cultural competence, as well as organizations’ cultural competence (#3)
 - Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics & school-based health centers (#3)
 - **Environmental Scan-** Housing/Neighborhoods, Employment and Education
 - **2016-Focus on Education**
 - Update school curriculum (within top 5 priorities above)
 - Identify, promote and monitor opportunities and activities to ensure there is sufficient focus to eliminate health disparities and promote health equity in the development and implementation of

Health Systems Transformation, Public Health Accreditation, Mental Health Transformation & Public Health Modernization.

- Identify opportunities to collaborate with CCOs, CCO Community Advisory Committees, state and local mental health and public health agencies, and other stakeholders within and outside OHA, including communities of color, LGBTQ communities, and people with disabilities, to improve the effectiveness of **community health assessments (CHAs) and community health improvement plans (CHPs)** in identifying, prioritizing, and effectively addressing health disparities impacting CCO members and the general population in all CCO service areas.
- Identify and explore health equity opportunities that may be pursued through other policy and program efforts in OHA and the legislature.

Quality Improvement and Cost Reduction

- Develop health equity business case demonstrating cost savings and return on investments
- Participate in the analysis, and dissemination of granular racial and ethnic health data
- Identify and promote policy opportunities which support:
 - data initiatives that lead directly to health equity policy change,
 - access to health care for undocumented Oregonians
 - cultural competence and trauma-informed care
 - implementation of Culturally and Linguistically Appropriate Standards (CLAS) and link CLAS standards to clinical quality measures
 - full implementation of Health Care Interpreter (HCI) Program
 - increased health literacy through program and service delivery
 - efforts to diversify Oregon’s health care and public health workforce

Meeting Schedule

2016 Bi-Monthly Meetings (every 2 months, on Fridays at OEI Conference Room)

Jan 8, 9:30-11:30 a.m.

Mar 11, 9:30-11:30 a.m.

May 13, 9:30-11:30 a.m.

July 8, 9:30-11:30 a.m.

Sept 9, 9:30-11:30 a.m.

Nov 14, 9:30-11:30 a.m.

2016 Health Equity Policy Committee Roster

FIRST	LAST	ORGANIZATION/COALITION, IF ANY
Sandra	Clark	Health Share
Alberto	Moreno	Oregon Latino Health Coalition
		The Center for Intercultural Organizing
Bob	Diprete	Medicare Beneficiary, Retired from OHP
Beth	Englander	Oregon Law Center
Brandy	Ethridge	Researcher
Chris	Coughlin	
Dayna	Morrison	Oregon AIDS Education and Training Center
Denise	Johnson	Care Oregon
		211 Info
John	Mullin	Oregon Law Center
Joseph	Santos-Lyons	Asian Pacific American Network of Oregon/Oregon Health Equity Alliance
Victoria	Demchak	Oregon Primary Care Association
Lisa	Ladendorff	Northeast Oregon Network
Liz	Baxter	Oregon Public Health Institute
		Oregon Community Health Worker Association (ORCHWA)
Lucy	Baker	Oregon Advocacy Commissions
Maura	Roche	Strategy Works NW
		Urban League of Portland
Patricia	Cortez	Juventud FACETA
Sandra	Hernandes	Spect-Actors Collective
Shafia	Monroe	International Center for Traditional Childbearing
Fabiana	Wallis	Psychologist
		Native American Youth and Family Center (NAYA) & Future Generations
Lindsay	Goes Behind	Collaborative
Nancy	Kramer	Oregon Advocacy Commissions
Suzanne	Hansche	Allies for a Healthier Oregon (AHO)
Samantha	Naliboff	Volunteers of America
Michelle	Glass	Oregon Action
Jennifer	Ware	Southern Oregon Health Equity Coalition (Jackson County)
Yesenia	Castro	Mid-Columbia Health Equity Advocates (Hood River & Wasco Counties)
Karen	Levy Keon	Linn Benton Health Equity Alliance
Jessica	Hiddleston	Let's Talk Diversity Coalition (Jefferson County & Conf. Tribes of Warm Springs)
Valere	Lane	Klamath Regional Health Equity Coalition
Zena	Rockowitz	Oregon Health Equity Alliance