Medicaid Advisory Committee

April 22, 2015

General Services Building
Salem, Oregon
<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td><strong>Opening Remarks</strong>&lt;br&gt;- Approval of minutes – March 2015&lt;br&gt;- Revised charter, work plan – adopt&lt;br&gt;- OHA Update</td>
<td>Co-Chairs; Rhonda Busek, OHA; staff</td>
</tr>
<tr>
<td>9:10</td>
<td>2015 Legislative Update</td>
<td>Staff</td>
</tr>
<tr>
<td>9:15</td>
<td><strong>Oregon Health Authority - Oregon Health Plan (OHP)</strong>&lt;br&gt;- Background: Community Partner Outreach Program&lt;br&gt;- Regional Learning Collaborative, Community Engagement and Provider Outreach</td>
<td>Regional Outreach Coordinators, OHA</td>
</tr>
<tr>
<td>9:45</td>
<td><strong>OHA Metrics and Scoring Committee</strong>&lt;br&gt;- Oregon’s Health Systems Transformation 2014 Mid-Year Performance Report</td>
<td>Sarah Bartelmann, OHA</td>
</tr>
<tr>
<td>10:15</td>
<td><strong>Trillium Community Advisory Council</strong>&lt;br&gt;- Trillium’s CAC membership and community engagement activities&lt;br&gt;- Council priority areas and implementation activities outlined in the CHIP</td>
<td>Leah Edelman, Trillium CAC;</td>
</tr>
<tr>
<td>10:45</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>11:00</td>
<td><strong>Medicaid 12 Month Continuous Eligibility</strong>&lt;br&gt;- Overview of federal policy, work plan and key considerations</td>
<td>Co-Chairs; OHA staff</td>
</tr>
<tr>
<td>11:50</td>
<td><strong>Public Comment or Testimony</strong></td>
<td>Co-Chairs</td>
</tr>
<tr>
<td>12pm</td>
<td>Adjourn</td>
<td>Co-Chairs; staff</td>
</tr>
</tbody>
</table>
Update: OHP Enrollment & Redeterminations

Rhonda Busek, Interim Director, Medical Assistance Programs, OHA
2015 Legislative Update

Brian Nieubuurt
Legislative Coordinator for Health Care Programs, OHA
Medicaid Advisory Committee Presentation

Oliver Vera, Manager, OHA Community Partner Outreach Program
Overview of the Community Partner Outreach Program

Goal: To ensure all eligible Oregonians are able to sign up for health coverage

- 8 Regional Outreach Coordinators
- 1 Provider Campaign Coordinator
- 1 Community Engagement Coordinator
- 1 Grants and Agreements Coordinator
- 1 Operations Manager
- 1 Program Manager
Overview of the Community Partner Outreach Program

Our Community Partners

• Over 230 contracted partner organizations statewide
  – Network of over 800 certified Application Assisters (staff/volunteer)

• Health care providers, community-based organizations, faith-based organizations, Tribes, health advocacy groups, health care systems, safety-net clinics, county health departments and more

• Provide culturally and linguistically appropriate assistance at no-cost
Overview of the Community Partner Outreach Program

What do we do?

- Training and Certification
- Collaborative Meetings
- Technical Support and Outreach Strategies
- Community Level Support
- Materials
Q&A
Health System Transformation
2014 Mid-Year Performance Report

Medicaid Advisory Council
April 22, 2015

Sarah Bartelmann
Health Analytics
Today:

1. What have we learned about the ACA population?

2. What are we learning about the Coordinated Care Model?

3. What can we learn about areas within Behavioral Health and Public Health?

4. Summary and Updates
Oregon Health Authority accountability

Core Performance Measures
- Included in Oregon's 1115 demonstration waiver - some focus on population health
- There are no financial incentives or penalties associated with them

State Performance Measures
- Annual assessment of statewide performance on 33 measures.
- Financial penalties to the state if quality goals are not achieved.

CCO Incentive Measures
- Annual assessment of CCO performance on 17 measures.
- Quality pool paid to CCOs for performance.
- Compare 2013 performance to 2011 baseline.
2014 Mid-Year Performance Report

- State and CCO progress is reported for July 1, 2013 through June 30, 2014; compared with calendar 2013 and baseline year 2011.

- No quality pool payments were made based on this data, or included in this report.

www.oregon.gov/oha/metrics/
2014 Mid-Year Performance Report: What’s New?

 ✓ **Core Performance Measures:** Population health measures reported to CMS each year as part of Oregon’s 1115 waiver.

 ✓ **Expansion Population:** Data on key measures for the 380,000+ Oregonians who enrolled in the Oregon Health Plan since the ACA took effect January 1, 2014.

 ✓ **Enhanced Financial Data:** New visualizations and drill-downs for cost and utilization.
The ACA Medicaid Expansion Fills Current Gaps in Coverage

Medicaid Eligibility Today
Limited to Specific Low-Income Groups

Medicaid Eligibility in 2014
Extends to Adults ≤138% FPL*

Elderly & Persons with Disabilities

Children

Pregnant Women

Parents

Adults

NOTE: The June 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius maintained the Medicaid expansion, but limited the Secretary’s authority to enforce it, effectively making the expansion optional for states. 138% FPL = $15,856 for an individual and $26,951 for a family of three in 2013.

ACA EXPANSION IN OREGON
Oregon Health Plan: Changing Demographics

The proportion of members ages 19-35 enrolled in Medicaid has increased more than other age groups between December 2013 and October 2014.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>October 2014</th>
<th>December 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 18</td>
<td>43%</td>
<td>60%</td>
</tr>
<tr>
<td>19 - 35</td>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>36 - 50</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>51 - 64</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>65+</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Oregon Health Plan: Changing Demographics

Despite the influx of new members, the racial/ethnic makeup of Medicaid enrollees has not changed much between December 2013 and October 2014.

- African American/Black: 3.4% (2013: 4.1%)
- American Indian/Alaskan Native: 1.6% (2013: 1.9%)
- Asian or Pacific Islanders: 3.1% (2013: 3.5%)
- White: 59.4% (2013: 62.9%)
- Hispanic/Latino: 19.2% (2013: 20.5%)

(Data missing for 7% of respondents in 2014)
ED Utilization since January 1, 2014

Statewide, new ACA members use emergency rooms less frequently than other members.
Lower is better.
Rates are reported per 1,000 member months
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile

- Pre-2014: 51.0
- New: 34.4
- Returning: 59.7
## ED Utilization since Jan 1, 2014 by CCO

<table>
<thead>
<tr>
<th>CCO Name</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Oregon Advanced Health</td>
<td>34.6</td>
<td>22.3</td>
<td>43.4</td>
</tr>
<tr>
<td>Cascade Comprehensive Care</td>
<td>36.1</td>
<td>31.1</td>
<td>26.8</td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>45.1</td>
<td>35.2</td>
<td>57.6</td>
</tr>
<tr>
<td>All Care Health Plan</td>
<td>45.4</td>
<td>32.9</td>
<td>51.8</td>
</tr>
<tr>
<td>Primary Health of Josephine County</td>
<td>45.5</td>
<td>28.2</td>
<td>48.8</td>
</tr>
<tr>
<td>PacificSource - Gorge</td>
<td>47.2</td>
<td>33.5</td>
<td>42.5</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>49.1</td>
<td>31.7</td>
<td>62.8</td>
</tr>
<tr>
<td>Columbia Pacific</td>
<td>49.8</td>
<td>38.4</td>
<td>59.7</td>
</tr>
<tr>
<td>Jackson Care Connect</td>
<td>51.3</td>
<td>37.7</td>
<td>54.0</td>
</tr>
<tr>
<td>PacificSource - Central</td>
<td>51.9</td>
<td>30.9</td>
<td>54.6</td>
</tr>
<tr>
<td>Intercommunity Health Network</td>
<td>51.9</td>
<td>33.1</td>
<td>56.7</td>
</tr>
<tr>
<td>Health Share</td>
<td>52.4</td>
<td>33.0</td>
<td>59.1</td>
</tr>
<tr>
<td>Trillium</td>
<td>53.1</td>
<td>37.8</td>
<td>64.4</td>
</tr>
<tr>
<td>Eastern Oregon</td>
<td>56.1</td>
<td>41.9</td>
<td>60.1</td>
</tr>
<tr>
<td>Yamhill CCO</td>
<td>62.5</td>
<td>52.3</td>
<td>89.9</td>
</tr>
<tr>
<td>Umpqua Health Alliance</td>
<td>72.4</td>
<td>45.0</td>
<td>79.8</td>
</tr>
</tbody>
</table>
Avoidable ED Utilization since Jan 1, 2014

Statewide, new ACA members have lower rates of avoidable emergency department utilization than other members.

Lower is better.
Rates are reported per 1,000 member months
Data source: Administrative (billing) claims

9.0
pre-2014

4.7
new

8.3
returning
What next?

- Monitor ED visit use and outpatient visits with a full year of data.

- Work to understand more about the new members – are they relatively healthy or is the decrease in ED use the result of a change in health care delivery?

- Deeper dive into CCOs efforts to reduce ED utilization for additional context.

- Examine access to care over time.
COORDINATED CARE MODEL
Statewide, emergency department utilization has continued to decline.

(Lower scores are better)
Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile

- ED visits decreased 21 percent since 2011, despite an influx of 20 percent new enrollment from ACA expansion.
Emergency Department Costs Decreased by 20%

Meanwhile, Emergency Department costs have declined, with no noticable increase due to the ACA expansion population.

Figures in U.S. dollars, per member per month
PCPCH Enrollment Increased by 55% since 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment Rate</th>
<th>Number of CCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>51.8%</td>
<td>528,689</td>
</tr>
<tr>
<td>2013</td>
<td>78.6%</td>
<td>739,023</td>
</tr>
<tr>
<td>2014 Q1</td>
<td>79.6%</td>
<td>827,939</td>
</tr>
<tr>
<td>2014 Q2</td>
<td>76.9%</td>
<td></td>
</tr>
<tr>
<td>2014 Q3</td>
<td>80.4%</td>
<td>868,392</td>
</tr>
</tbody>
</table>
Outpatient Costs

- Overall PMPM outpatient costs have decreased.
- Primary care spending has increased
What are we learning about the Coordinated Care Model?

- Primary care visits per 1,000 member months increased by 8% among Medicaid members.
- Emergency department visits per 1,000 member months decreased by 5% among:
  - Medicare Advantage
  - Medicaid CCO
  - OEBB and PEBB
  - Commercial
"What gets measured, gets managed."
Peter Drucker

Incentives promote change
How Are We Doing?

- **Incentive Metrics**: Statewide improvement on all nine of the incentive metrics (compare 2011 to mid-year 2014)

- **State Performance Metrics**: statewide improvements on 10 of the 14 state performance metrics (compare 2011 to mid-year 2014)

- **Core Performance Metrics**: Statewide progress was mixed – first time reporting
More work is needed…

Child and adolescent access to primary care providers
✓ Access declined for all age groups at the statewide level (results were not reported at the CCO level).

Initiation and engagement of alcohol or other drug treatment (engagement phase)
✓ Nine of 16 CCOs declined on this measure.

Tobacco use prevalence
✓ Nine of 16 CCOs declined on this measure, and none have reached the benchmark.
BEHAVIORAL HEALTH – WHAT CAN WE LEARN
Statewide, follow-up care after hospitalization for mental illness has improved.

Data source: Administrative (billing) claims
2014 benchmark source: 2013 National Medicaid 90th percentile

- Modified measure specifications allow community providers to complete follow-up, promoting behavioral and physical health care integration.
Progress on SBIRT

Statewide, appropriate screening and intervention for alcohol or substance abuse has increased steadily each year.

Data source: Administrative (billing) claims
2014 benchmark source: Metrics and Scoring Committee consensus

- 2014 Benchmark: 13.0%
- July 2013 - June 2014: 4.5%
- 2013: 2.0%
- 2012: 0.1%
SBIRT rates improved for all racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011. Data missing for 8.5% of respondents. Each race category excludes Hispanic/Latino.

- Hawaiian/Pacific Islander: 1.3% (2013), 4.1% (2014)
- White: 2.0% (2013), 4.7% (2014)
- Hispanic/Latino: 1.9% (2013), 4.3% (2014)
- African American/Black: 1.7% (2013), 4.1% (2014)
- American Indian/Alaskan Native: 2.2% (2013), 4.0% (2014)
- Asian American: 0.6% (2013), 2.2% (2014)
Inpatient Costs

- Inpatient PMPM costs have declined 5.7 percent since 2011.
- Greatest declines were in mental health and maternity.
Outpatient Costs

- Overall PMPM outpatient costs have decreased.

- Spending for mental health has remained roughly the same.
"I have five dollars that says you won’t give me a shot and we’ll sweep this little matter under the rug."
Statewide, childhood immunizations shows a slight increase.
Data source: Administrative (billing) claims and ALERT Immunization Information System
2014 benchmark source: 2013 National Medicaid 75th percentile

Children on OHP have about the same proportion of completed immunizations as all children in Oregon.
Statewide, adolescent immunizations continue to increase in June 2014.

Data source: Administrative (billing) claims and ALERT Immunization Information System
2014 benchmark source: 2013 National Medicaid 75th percentile

Adolescents are lagging behind the benchmark
Core Performance: Tobacco Prevalence

Statewide, tobacco use increased in the Medicaid population since 2011.
(Lower scores are better)
Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)
2014 benchmark source: Oregon's 1115 demonstration waiver goals

Tobacco use among all Oregonians is ~18%
Tobacco use increased for all racial/ethnic groups except Hispanic/Latino between 2011 and 2013. (Lower scores are better). Each race category excludes Hispanic/Latino.

- **Hispanic/Latino**: 17.0% ( Benchmark 25.0% ) / 19.0%
- **Asian American**: 11.8% / 12.4%
- **African American/Black**: 35.8% / 38.0%
- **Hawaiian/Pacific Islander**: 28.6% / 32.6%
- **White**: 33.0% / 39.2%
- **American Indian/Alaskan Native**: 41.0% / 52.5%
While tobacco use decreased in seven CCOs between 2011 and 2013, tobacco use increased in nine CCOs.

(Lower scores are better)

2011 baselines are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.
Main messages

• Incentive measures get the attention -- $$ drives improvements.

• Progress in some areas appears to be accelerated for Medicaid when compared to other payers.

• Measures show progress and some challenges for improving behavioral health and population health.
Next Progress Report

✓ Will be published late June 2015.

✓ Metrics calculated for calendar year 2014.

✓ Will include CY 2014 quality pool distribution.

✓ Will have expanded cost and utilization information.
CCO Incentive Metrics for 2015

Retired:  
- Early elective delivery  
- Follow-after medication for ADHD

Added:  
- Dental sealants for children  
- Effective contraceptive use among women at risk of unintended pregnancy

Modified:  
- SBIRT for adolescents  
- Dental health assessments for children in foster care

Challenge pool metrics:  
- SBIRT  
- Depression screening and follow-up  
- Diabetes HbA1c poor control  
- Developmental screening
Workgroup and Committee Updates

Child and Family Wellbeing Measures Workgroup
- Identifying measures for comprehensive library.
- Developing bundled Kindergarten Readiness measure.
- Will present recommendation to Metrics & Scoring.

Metrics & Scoring Committee
- Charge: select 2016 measures and benchmarks.
- Considering tobacco prevalence measure options for ’16.
- Unlikely to be major changes in measure set.
- New Committee members to be appointed soon.
For More Information

The 2014 Mid Year Performance Report and all technical specifications are posted online at health.oregon.gov

Contact
Sarah Bartelmann
sarah.e.bartelmann@state.or.us
503.490.5689
Community Advisory Council & Rural Advisory Council
Our Purpose

Engage Trillium Community Health Plan Members and the community as a whole to:

- Advise and make recommendations to the governing Board on the strategic direction of the organization,
- Ensure that Trillium remains responsive to consumer and community health needs, and
- Advise on the design and priorities of Trillium in achieving the Triple Aim.

Provide a link back to community members to aid in:

- Achieving the goals of the Triple Aim
- Ensuring Trillium’s effectiveness in providing quality services that are accessible to all members.
Our Structure

- Community Advisory Council
  - 20 members
  - 51% Consumer members

- Rural Advisory Council
  - Up to 20 members
  - 51% consumer members
  - Provides an authentic voice for non-urban Trillium members

- Two members of the RAC sit on the CAC
- Two members of the CAC sit on the Governing Board of Trillium
CAC Committees

• Prevention
  - Identify prevention opportunities and develop recommendations.

• Health Equity
  - Identifying disparities and recommend solutions.

• Member Engagement
  - Gather feedback from members and recommend communication strategies to Trillium.

• Combination of CAC members, community members and content experts.
CHIP Highlights

Tobacco Use Reduction

QTIP (Quit Tobacco Incentive Program)

For pregnant women
Collaboration with WIC
76 Women enrolled
CHIP Highlights

Reduce Childhood Obesity

NAP-SAC

*(Nutrition & Physical Activity Self – Assessment for Child Care)*

- Collaboration with Family Development Center of Lane and Douglas Counties
- Trained 225 Child Care workers
- Affecting 920 children
- Showing increases in nutrition and physical activity scores
- System change
CHIP Highlights

Mental Health and Substance Abuse

Family Check Up

Collaboration with Lane County Family Mediation
Served 142 families (as of March)
Trillium CAC Advantage

• Large and active CAC, reflective of region

• Partnership with Public Health

• Organizational commitment to the CAC

• Active participation by Trillium staff

• CAC granted authentic decision making power
• Policy changes vs. programs
• Getting everyone up to speed
• Defining CAC/Trillium relationship
  • Growing pains
Medicaid 12 Month Continuous Eligibility for Adults
Background

• In 2014, the Oregon Health Plan (OHP) opened up to more low-income adults
  – Eligibility to 133% of Federal Poverty Level (effectively 138% w/5% income disregard)
  – New eligibility method called MAGI – modified adjusted gross income that follows federal tax rules for identifying income and family size.
  – Individuals can now qualify for OHP coverage without being in a special category. This opens coverage up to childless adults.

• Federal Government funds new eligible individuals at enhanced match rate: 100% through 2016, gradually decreasing to 90% in 2020 and beyond

• Oregon’s regular FMAP in 2015 and 2016 is ≈64%
Approximate Federal Poverty Levels (FPL) for Medical Eligibility Groups in 2015

<table>
<thead>
<tr>
<th>Group</th>
<th>Medicaid</th>
<th>Modified Adjusted Gross Income (MAGI)</th>
<th>Medicaid/Children’s Health Insurance Program (CHIP) population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women and infants (age 0–1)</td>
<td>185%</td>
<td>133%</td>
<td>133%</td>
</tr>
<tr>
<td>Children (age 0–18)</td>
<td>185%</td>
<td>133%</td>
<td>133%</td>
</tr>
<tr>
<td>Parent and other caretaker relatives</td>
<td>38%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Aged, blind and disabled</td>
<td>250%</td>
<td>133%</td>
<td>133%</td>
</tr>
<tr>
<td>ACA adults</td>
<td>250%</td>
<td>133%</td>
<td>133%</td>
</tr>
<tr>
<td>Breast and Cervical Cancer Treatment Program</td>
<td>250%</td>
<td>133%</td>
<td>133%</td>
</tr>
<tr>
<td>Qualified Medicare beneficiaries (QMB) and specified low-income Medicare beneficiaries (SLMB)</td>
<td>135%</td>
<td>135%</td>
<td>100% 100% Basic</td>
</tr>
</tbody>
</table>

**Caseloads**
- Women: 18,656
- CHIP: 68,295
- Medicaid: 320,356
- Infants: 28,581
- Medicaid: 53,097
- ACA adults: 121,267
- Breast and Cervical Cancer Treatment Program: 388,674
- 623
- QMB: 22,673
- SLMB: 22,751

* MAGI is the means-tested Medicaid/CHIP eligibility criteria.
** Non-MAGI has other eligibility criteria in addition to the means test.
What is Churn?

• Churn occurs when individuals involuntarily move on and off coverage and must transition from one coverage vehicle to another or become uninsured

• Causes for churn include:
  – Income changes (e.g. gain or loss of employment)
  – Changes in family circumstances (e.g. marriage)
  – Administrative churn

• Churn results in adverse consequences:
  – Discontinuity in coverage; barriers to accessing care for consumers
  – Unnecessary duplication of tests and treatment plan revisions
  – Increased administrative expense for health plans and the state
  – Decreased incentive for health plans/providers to invest in longer-term care management and coordination activities
  – Administrative difficulty in managing benefits /measuring quality when enrollees switch health plans frequently
MAC Churn Work in 2014

In 2014 the MAC examined the issue of churn and recommended two buckets of strategies to address churn:

1) **Strategies to mitigate disruptions as a result of churn**
   
   **Goals:**
   
   – Maintain access to the same plans and providers as family circumstances change; enroll families in the same plan
   – Reduce the affordability cliff as a result of a transition off Medicaid

2) **Strategies to reduce and avoid churn**

   **Goals:**
   
   – Reduce the number of times an individual moves from one coverage vehicle to another
   – Minimize insurance gaps as individuals transition

**Recommendation:** OHA study the cost-benefit and financial feasibility of 12-months continuous eligibility
12-Months Continuous Eligibility

**Policy:** Allows individuals to maintain coverage in Medicaid or CHIP for a full year, regardless of fluctuations in family income
- Option has been available for children since 1997
- As of January 2013, 32 states provided it for children in Medicaid or CHIP; 23 provided it in both programs, including Oregon

**Authority:**
- In May 2013 CMS suggested the option as a strategy for states’ adult Medicaid populations
- State must seek approval of a new 1115 waiver or amend existing 1115 to make option available for adults
12-Months Continuous Eligibility, cont.

Financing:

• Based on research George Washington University, CMS determined that:
  – 97.4% of the cost should be financed at the enhanced matching rate available for newly eligible adults and
  – the remaining 2.6% at a state’s regular Medicaid matching rate

• Estimated that states would likely receive a matching rate between 98.7% and 99.3% percent for their ACA expansion populations in 2014.

• While continuous eligibility will likely increase enrollment continuity and coverage in Medicaid, it also creates additional costs for a state.

• To date, only New York state had has implemented the policy for their adult populations, likely due to financing barriers.
Source: Adapted from Families USA Fact Sheet, August 2013
Rationale for 12-month continuous eligibility

Consumers:

• Promotes coverage continuity for eligible individuals, despite fluctuations in family income or other eligibility criteria.
• Increases access to timely and necessary preventive and ongoing health care, ensuring continuity in services, including medications, that Medicaid eligible individuals need.
• Reduces hospitalizations for chronic health conditions that occur as a result of the lack of consistent care.
• Helps states to serve the greatest number of eligible individuals possible and to keep them enrolled for appropriate eligibility periods.
• Promotes the triple aim by supporting consistent, comprehensive coverage for low-income families.

State: Could reduce administrative costs and see potential savings.
Oregon Medicaid Policy

- Oregon’s 2012 Section 1115 Waiver allows the state to enroll all OHP populations for 12-months.
- Individuals determined eligible are enrolled in OHP for a 12-month certification period, but must report changes in circumstances affecting eligibility within 30 days of occurrence.
- Changes that affect income eligibility and that must be reported are:
  - A change in source of income
  - Change in employment status (e.g. new job or job loss)
  - Change in earned income of more than $100 or unearned income of more than $50
- Circumstances affecting eligibility not related to income include but are not limited to:
  - Receipt or loss of health coverage
  - Change in pregnancy status of a household member
  - Change in household group membership (e.g. marriage)
Oregon Feasibility Study

- Consider feasibility of 12 months continuous eligibility beginning in the 2017-19 biennium
- Examine policy and implementation considerations
- Financial analysis will provide:
  - Estimates for additional member months for adults in OHP temporarily ineligible
  - Forecasts of federal funds/revenues that reflect reduced FMAP for the ACA expansion population, and required matching funds in Oregon
  - Potential cost savings
- A preliminary analysis will be available by mid-June for the committee’s review.
Looking Ahead: Summer Schedule

- **May** – no meeting
- **June 3 & 4th** CAC Summit
- **June 24th** meeting (Salem)
  - Judy Mohr-Peterson will present on OHA’s MAGI Transfer Project
  - Columbia Pacific CCO CAC
  - FamilyCare CCO CAC

- **July 22nd** meeting (Salem)
  - Lynne Saxton, OHA Director
  - Confirming 2 CACs
  - Finalize/adopt rec. on 12 month continuous eligibility
Public Comment or Testimony