MEMO

DATE: December 11, 2012
TO: Oregon Health Policy Board

FROM: Oregon Medicaid Advisory Committee
RE: Oregon Medicaid Benchmark Plan: Final Recommendation

Dear Chairs Parsons and Shirley and members of the Board:

After several months of meetings that involved thoughtful and detailed discussions, the Oregon Medicaid Advisory Committee (MAC) is pleased to present their final recommendation for Oregon's Medicaid Benchmark benefit package. The recommended benefit package will fulfill the new Affordable Care Act (ACA) requirements that need to apply to any current or future Medicaid expansion population of non-pregnant adults, including individuals currently covered under the Oregon Health Plan (OHP) Standard program. The letter identifies the final recommendation, and describes the process and rationale for the recommendation. In addition, the MAC received public input, which is provided for your review. At the conclusion of this memo are several observations noted by the committee for future consideration.

Action Item	Request for endorsement of the committee's final recommendation
Recommendation	The committee recommends the **Oregon Health Plan *Plus*** (for non-pregnant adults) to be the state's Medicaid benchmark plan.
Key Decision Points	• Ensure alignment with Oregon's Triple Aim, Coordinated Care Organizations, and federal requirements in the ACA. • Simplify, align, and streamline benefit coverage across the Oregon Health Plan. • Aim to meet all health care needs of adult Oregonians eligible for OHP.
Additional * Recommendations	• Restore and strengthen services and benefits historically covered for all populations by the Oregon Health Plan. • Monitor impact and minimize disruption around coverage and benefits for individuals that transition between OHP and Qualified Health Plans (QHPs). • Leverage federal opportunities through the ACA that support improvements in health and well-being of diverse segments of Oregon's population, and promote fiscal sustainability of the Oregon Health Plan.

* Please see page 5 for more information about the additional recommendations.

Background

The federal Affordable Care Act requires states to select a benchmark benefit plan for any Medicaid expansion population of non-elderly, non-pregnant adults. The benchmark benefit plan refers to a comprehensive package of items and services known as "essential health benefits" (EHBs). Starting in January 2014, Medicaid benchmark or benchmark-equivalent plans must include all 10 categories of EHBs. Oregon will not be able to use the current set of benefits offered through OHP Standard for any of the state's Medicaid current or future adult expansion populations. The current benefit package for OHP Standard does not meet benchmark or benchmark-equivalent coverage criteria because of limitations and exclusions of certain services such as rehabilitative services, physical therapy, occupational therapy, and speech therapy, among others. At the time of the passage of the ACA in 2009, it also did not provide a full hospital benefit.

States, including Oregon, have the option to provide a Medicaid benefit package for current or future expansion population(s) from the following benchmark plans:

- Largest federal employees health plan (Blue Cross Blue Shield)
- State employee health plan (in Oregon, Providence Statewide)
- Largest non-Medicaid HMO plan (in Oregon, Kaiser HMO)
- Secretary- approved package, including Traditional Medicaid package (OHP Plus)

Compared to OHP Standard, the benefit package for adults in OHP Plus already provides full benchmark coverage (i.e. all 10 categories of EHBs). If Oregon elects to expand coverage to individuals that become newly eligible for Medicaid starting in 2014 (non-pregnant adults aged 19-65 with incomes up to 138 percent of the federal poverty level (FPL)[†]—a new benchmark plan is required.

States also are required to select a commercial EHB plan. In August 2012, the Essential Health Benefits Work group, established by Governor Kitzhaber for the purpose of putting forward an EHB benchmark plan for Oregon's individual and small group market, recommended the *PacificSource Preferred CoDeduct* small group plan. This plan will be used as the "base" for all plans offered inside and outside the Oregon Health Insurance Exchange in the *commercial individual and small group market*.

Committee Discussion

From July through October 2012, the committee worked to select a benefit package that will meet all federally required EHBs and fulfill the federal benchmark selection criteria. On October 24th, the committee made a preliminary recommendation to designate **OHP *Plus*** (for non-pregnant adults) as the basis for the state's Medicaid benchmark plan. Over the four-month period, members discussed a range of issues that ultimately influenced the committee's final recommendation. The committee received a series of briefs by Deborah Bachrach, a national expert and former Medicaid Director of New York on the federal ACA requirements.

[†] In 2012, 138% of FPL is $15,415 for an individual; $26,344 for a family of three in 2012. http://www.kff.org/medicaid/quicktake_aca_medicaid.cfm

The committee's overall deliberation process and key decisions are summarized as follows:

- Adopted a set of decision-making principles to guide committee's work in selecting a Medicaid benefit package (see appendix A). Principles encourage alignment with Oregon's Triple Aim and Coordinated Care Organizations (CCOs), and desire to account for all health care needs of adult Oregonians eligible for OHP.
- Assessed federal requirements for states that are considering expansion of their Medicaid program in terms of mandatory and optional benefits a state may cover.
- Compared a side-by-side comparison matrix of Oregon's potential Medicaid benchmark plans: largest federal plan, Blue Cross Blue Shield; largest private HMO plan, Kaiser; largest state employee plan, the Providence Statewide plan (originally used to design OHP Standard); OHP Plus (≥21 adults); and OHP Standard.
- Examined Oregon's EHB plan for the individual and small group market, the *PacificSource Preferred CoDeduct* small group plan, and discussed potential impact on individuals and families as they transition ("churn") between OHP and Qualified Health Plans.
- Eliminated the largest federal plan, largest private HMO plan, largest state employee plan, and commercial EHB plan. The reason for elimination was that the committee opted to start with OHP for adults in designing the state's Medicaid benchmark benefit package.
- Determined that a single Medicaid EHB plan is the preferred option in Oregon. Offering more than one plan will likely create confusion for OHP enrollees, and lead to administrative costs and complexities for providers, practices, CCOs, and Oregon Health Authority (OHA).
- Examined federal cost-sharing requirements of the ACA, which allow states to adopt a cost-sharing structure that can include deductibles or co-payments.[‡] The committee agreed that although cost-sharing among Oregon's Medicaid expansion population may potentially generate marginal revenue, it would also create administrative challenges and barriers to accessing care for OHP beneficiaries. Furthermore, taking into consideration the state's experience with OHP Standard and cost-sharing, fact of limited cost-sharing in OHP currently, and acknowledgement that co-pays and deductibles serve as disincentives and deterrents in accessing and receiving vital services—the committee opted for no-cost sharing for any Medicaid expansion population.
- Adopted the final recommendation as it likely will minimize disruption for individuals that move among different benefit packages within OHP based upon available options, and recommendation met all seven decision-making principles.

Public Comment

Committee meetings were open for the public to attend and provide public comment. The MAC website also provided opportunity for individuals or groups to submit public comment electronically. Public comment was formally requested November 5th through November 19th. Over one hundred public comments were received during the formal public comment period.

[‡] Premiums are not allowed under the ACA.

In sum, the public comment received expressed favorable support for the committee's recommendation. While not within the decision parameters of the committee in developing their final recommendation, a considerable amount of public comment focused on specific benefits and services to Oregon's pediatric population and chiropractic community. A summary of all public comment received is attached for your review and generalized below (see attachment A).

- Several advocate groups and health professionals expressed their desire to increase coverage of particular services that include mental health counseling, newborn circumcision, and comprehensive dental coverage.
- Several comments raised the potential issue around the long-term financial sustainability of a comprehensive Medicaid EHB benefit package as a general concern if Oregon chooses to expand its Medicaid program in 2014.
- A few comments emphasized the importance of screening for HIV and other sexually transmitted infections, specifically per guidelines set forth by the Centers for Disease Control and Prevention (CDC). In Oregon, for individuals diagnosed as HIV-positive, all HIV antiretrovirals are covered in OHP without exclusions or formulary restrictions.
- Representatives of Oregon's nutrition counseling community contend OHP's current lifetime limit of five visits per individual is insufficient. They propose an increase of two visits per year for five years or until the underlying health issue is resolved. Generally, their recommendation is for the Medicaid Benchmark plan to support more "intense and sustained" preventive and intervention related nutrition counseling sessions for OHP enrollees.
- Numerous comments expressed the importance of expanding coverage of chiropractic services in OHP, as well as extending the role of chiropractors within the profession's scope of training and licensure. Generally, comments emphasized the need to support chiropractors of being able to treat all parts of the body (e.g. beyond spine adjustments).
- Individuals, parents, families, caregivers, and health care professionals of children diagnosed with Phenylketonuria (PKU) submitted a number of comments [*PKU is a condition in which infants are born without the ability to properly break down an amino acid called phenylalanine]. Comments expressed the need for lifetime coverage of treatments and related services necessary for individuals dealing with this metabolic condition. The specific recommendation was to cover PKU treatments for adolescents as they transition into adulthood.

Public Comment for the Medicaid Benchmark regarding coverage of specific services will be forwarded to the Health Evidence Review Commission (HERC). The HERC is responsible to develop and maintain a list of health services ranked by priority (i.e. the Prioritized List), from the most important to the least important, representing the comparative benefits of each service to the population to be served.

Additional Recommendations

As the federally-mandated body charged with providing direction to OHA on operation of the Medicaid program, the committee would like to offer its expertise and perspective on several additional recommendations. As the committee worked through this process, several important observations emerged. Members agreed these observations, albeit outside the scope of this recommendation, nonetheless merit mention for future consideration by the Board, OHA, or the MAC.

The intent of offering these observations is to inform future Oregon health policy aimed at improving the health and well-being of Oregon's Medicaid population. The comments are important considerations if Oregon is to fully recognize the original intent of OHP as well as leverage federal opportunities outlined in the ACA:

- Coverage of current OHP enrollees and services are maintained or strengthened across all populations including restoration, preservation, and expansion of comprehensive oral and vision care services for adults covered in OHP.
- Identify and implement strategies that reduce the potential for any adverse affects among individuals that lose, or gain benefits as they "churn" between OHP and Qualified Health Plans (QHPs).
- Develop meaningful, evidence-based, and non-punitive strategies that address the issue of personal responsibility in lieu of cost-sharing that will support improvements in health and wellbeing, and promote fiscal sustainability of Oregon's Medicaid program.
- Gradually expand and support primary and preventive services in OHP beyond federal EHB requirements to take into account the health care needs of diverse segments of Oregon's population.

The committee understands the prioritization involved with the policy development process and that, often, important aspects of Oregon's health system transformation cannot be immediately addressed. As the Board moves forward with its oversight of CCOs, the committee suggests identifying important issues such as those listed above to be addressed in the future. Such a process and expressed commitment will allow communities, families, and individuals in OHP to be assured these issues will receive adequate attention in Oregon.

In Closing

The committee recommends selection of the **Oregon Health Plan *Plus*** (for non-pregnant adults) as the basis for the state's Medicaid benchmark plan stating 2014. Thank you for the opportunity to collaborate on this monumental reform of health care delivery for current and future Medicaid beneficiaries. We look forward in working with the Board in the future to ensure all Oregonians have access to comprehensive and integrated health care coverage.

Thank you for your consideration of this recommendation and the committee's additional observations. We would be happy to provide any clarification and look forward to future collaboration. In closing, members of the committee appreciate the opportunity to support the Oregon Health Authority and the Board on this and many other issues that are central to the delivery of high-quality health care by the Oregon Health Plan and CCOs.

Sincerely

Rhonda Busek
Co-Chair, Medicaid Advisory Committee

Jim Russell, MSW
Co-Chair, Medicaid Advisory Committee

Appendix A:
Oregon Medicaid Advisory Committee
Decision-making Principles for Medicaid Benchmark Coverage

Background

The federal Affordable Care Act established a new Medicaid eligibility group of non-pregnant adults between 19-65 with incomes up to 138% Federal Poverty Level (PFL). As directed by the Affordable Care Act, States are required to provide Benchmark or Benchmark-equivalent coverage to adults in the new adult eligibility group as described under §1937 of the Social Security Act (DRA). This means the Medicaid benchmark could be:

- State's full Medicaid package (e.g. Oregon Health Plan—Plus for adults)
- Largest federal employees plan
- Largest state employee plan (Providence Statewide)
- Largest private HMO plan (a Kaiser plan)

Oregon, as it considers the 2014 Medicaid expansion, will need to define its Medicaid Benchmark to the Centers for Medicare and Medicaid Services (CMS) for any of the state's current or future adult expansion populations. The Medicaid Advisory Committee is charged with advising the Oregon Health Authority (OHA) and the Oregon Health Policy Board on the operation of Oregon's Medicaid program, including the Oregon Health Plan (OHP). The committee is leading the effort to develop a recommendation for the Oregon Health Policy Board and the Governor's Office to consider for the state's Medicaid Benchmark plan. The committee will explore the federal requirements and available options in designing Oregon's Medicaid Benchmark plan.

Proposed Principles

As the MAC is composed of consumers, providers serving Medicaid clients, and advocates familiar with safety net services, the MAC assumes a special responsibility to speak on behalf of the Medicaid population and how they experience the health care system. The committee adopted a set of decision-making principles to guide their work in selecting essential health benefits (EHB) as part of the Medicaid benefit package; a package that is the least disruptive to the Oregon Health Plan.

On August 22, 2012 the MAC met to initiate its work to develop a recommendation for Oregon's Medicaid Benchmark plan. Members reviewed and considered an initial draft of decision-making criteria to guide the committee's work in selecting an essential benefit package. Below is a revised set of decision-making criteria, now referred to as "principles." The revised principles reflect the committee's discussion and agreed upon changes including integration of a set of principles adopted by the MAC in 2011 to advise the OHA in past efforts to improve the OHP.

Adopted Principles

The committee formally adopted the set of principles on September 26. Revisions reflect a desire to incorporate changes that support and encourage alignment with Coordinated Care

Organizations in Oregon. Committee members also believe the principles should ensure alignment with the Triple Aim. Upon formal adoption, at a minimum, any final recommendation to the OHPB should support the principles listed below.

Table 1: Decision-making Principles for Medicaid Benchmark Coverage

1. Alignment with Oregon's Triple Aim and Coordinated Care Organizations (CCOs)	✓
2. Ensure inclusion of all 10 statutory benefit categories and identify meaningful differences in coverage including wellness/prevention, behavioral, mental and dental services	✓
3. Acknowledge value-based benefits, potential cost-sharing relative to income, and flexible utilization of covered services to avoid future costs	✓
4. Appropriate balance of benefits among statutorily required categories so benefits are not unduly weighted toward any category	✓
5. Account for the health care needs of all adult Oregonians, focused on benefits that may address social determinants of health	✓
6. Consider impact on coverage and benefits for individuals that transition between OHP and Qualified Health Plans (QHPs)	✓
7. Consider administrative implications when selecting preferred benefit package including minimizing disruption to the Oregon Health Plan	✓

MEMO

DATE: January 8, 2013

TO: Oregon Health Policy Board

FROM: OHPR, Staff to the Medicaid Advisory Committee

RE: Selection of the Medicaid Benchmark and Health System Transformation

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At the December 2012 Board meeting, members requested an explanation of how the Medicaid Advisory Committee's (MAC) recommendation for the Oregon Health Plan (OHP) Plus (non-pregnant adults) benefit package to serve as Oregon's Medicaid benchmark aligns with overall Transformation efforts in Oregon. This memo is provided in response to that request.

As outlined in the recommendation letter to the Board and in the December presentation, states are required to determine the benefit package they will use for current Medicaid expansion populations such as Oregon's OHP Standard beneficiaries, as well as future expansion populations should the State elect to expand in 2014. Because current OHP Standard benefits do not align with the Affordable Care Act's Essential Benefit requirements, the MAC spent several months reviewing other options and ultimately recommended that OHP Plus (for non-pregnant adults) be the state's Medicaid benchmark plan. Current transformation efforts were a major consideration in the MAC's review and recommendation process; several MAC members are involved with CCOs or other aspects of transformation and could speak directly to changes to the delivery of care to Medicaid enrollees. Some of the ways in which the Medicaid EHB recommendation supports transformation are outlined below.

- ***Offers Administrative Simplification to OHP Benefits to aid CCOs' Transformation Efforts***
  With three separate packages in OHP (OHP Plus for children/pregnant women; OHP Plus for non-pregnant adults; and, current OHP Standard for expansion adults)—it can be administratively burdensome for the plans, providers, and members to manage benefits. Working to move all non-pregnant adults to a single package will help ensure that CCOs, providers, and members all understand the base benefits expected and can assure adequate access is available. This approach will also aid the CCOs by reducing time and resources spent on sorting out which OHP member is eligible for which set of benefits. This can reduce administrative overhead inside the CCOs, freeing them and their affiliated providers to focus on alignment across their new organizations, particularly for physical and behavioral health benefits, as well as work towards increased efficiency and quality of care.

  Ideally, the MAC would like the adult package enhanced to what is currently offered to children and pregnant women in OHP Plus but were cognitive of the potential increased cost to the state. Committee members felt that aligning all the non-pregnant adults' benefits into a single benefit

package would serve as an initial step in streamlining benefits across Oregon's Medicaid populations.

- ***Enhances funding inside the Global Budget to the CCOs and their communities***
  Providing a richer benefit to the OHP Standard population enhances the investment to CCOs and their communities by increasing the base payments to CCOs through enhanced benefit dollars for the OHP Standard population. This population will have fuller benefits in the essential benefit areas of rehabilitative and habilitative services, as well as durable medical equipment, anesthesia services, home health services, and dental services. This will support needed services to OHP members and the health of regional communities and will increase the CCOs' ability to enhance care coordination.

  Oregon is looking to move further towards value-based payments to the CCOs, with the global budget and quality incentive pool as first steps. Streamlining the benefits for non-pregnant adults starts to blend available funding streams and supports CCOs to work within the global budget to control costs and increase efficiency of delivering care across the adult OHP population. This uniformity of benefits will facilitate a population-wide assessment and determination of the needs of non-pregnant adults within CCOS and their communities.

- ***Supports Patient-centered Primary Care Home and CCOs to meet the needs of the OHP members***
  Transformed delivery systems will aim to provide much of the care needed by OHP members through Patient-centered Primary Care Homes (PCPCH). With the essential benefits obtained through the OHP Plus (non-pregnant adults) benefit package, there will be greater flexibility to get needed services that can return or maintain a member's health, such as occupational and speech therapy or physical/occupational therapy after specific surgeries. While there may be other individualized flexible benefits needed, primary care providers and their PCPCH teams, including community health workers and others will know that all non-pregnant adults in the CCO will be eligible for similar base levels of care needed to manage members' health care needs.

- ***Starts to restore OHP to its original design of a base set of benefits across a population***
  Governor Kitzhaber's original vision of the Oregon Health Plan was to "get all the noses under the tent" and to ensure a base set of benefits for members delivered in a coordinated way at the community level. The original OHP started with aligned benefits across the non-pregnant members and the separate package of OHP Standard was created in 2003 to allow the State to maintain some coverage for Oregon's expansion population. Now with the Affordable Care Act, states are expected to offer a more robust package. Oregon and the Governor are simultaneously aiming to enhance care and lower costs through a transformed delivery system. Streamlining the benefits compliments the vision of the Oregon Health Plan both historically and as we move into the future.

Medicaid Advisory Committee (MAC)
Summary of Public Comment/Testimony to Date December 31, 2012

Medicaid Advisory Committee (MAC) meetings were open for the public to attend.
Listed below: summary of public comment or testimony submitted the MAC (mac.info@state.or.us)

Individual	Organization	Summary of Public Comment received Nov 5th-19th and Dec. 13th-31st 2012	Date	Categories
Marilyn Durham	Individual	Ms. Durham has a son who is homeless, disabled by a traumatic head injury, and unable to work due to injury and illness. She hopes the new Medicaid EHB package will speed up the process for those who are disabled and need assistance.	12/26/2012	Disabled
Summary of Public Comment/Testimoney recieved Nov. 5th-19th 2012				
Matthew Sinnott, MHA	Willamette Dental Group (WDG)	WDG supports the proposed benchmark for "new eligibles" under the ACA. WDG believe OHP Plus benefits are consistent with their approach to oral health and dental services. Further that by "defining a meaningful benefit for all Medicaid populations" would mitigate churn issues for Medicaid populations who churn between OHP plan coverage.	11/8/2012	Endorsement
Ted Amann, Director of Health System Development	Central City Concern	Central City Concern fully supports and endorses the preliminary recommendation of the Medicaid Advisory Committee to designate the Oregon Health Plan Plus (for non-pregnant adults) as the state's Medicaid benchmark plan. They believe this plan will provide a robust benefit package for people who are newly eligible for Medicaid benefits under the Affordable Care Act expansion, and provide consistent coverage as people move between eligibility categories. They also believe this approach will minimize administrative burdens and expenses for the Oregon Health Authority by avoiding the need to administer a new benefit package and coordinate benefits as people move between eligibility categories.	11/13/2012	Endorsement
Cherryl L. Ramirez, Director, AOCMHP	Association of Oregon Community Mental Health Programs (AOCMHP)	The AOCMHP was in support of the MAC's recommendation to designate the Oregon Health Plan Plus as the basis for the state's Medicaid benchmark plan. They agreed with the intent to simplify, align, and streamline benefit coverage across the Oregon Health Plan and to minimize disruption for individuals who move among different benefit packages within OHP.	11/20/2012	Endorsement
Estelle Womack	Individual	Ms. Womack believes Medicaid should be expanded to those without health care as far as finances allow and suggests a minimal sliding scale for payment so more people would be covered.	11/9/2012	Endorsement
Deb Kero	Individual	Ms. Kero believes that Chiropractors should NOT BE LIMITED to any specific area of the body. Would like for chiropractors to individually decide what areas they are capable to help people with and not have anyone decide for them.	11/10/2012	Chiropractic
Tom Clunie D.C.	Individual	Dr. Clunie is under the impression that the Benchmark is trying to limit chiropractic solely to spinal manipulations and does not agree with this. He states that chiropractors such as himself have spent years studying and passing on to their patients what it takes to be healthy and has helped many people avoid expensive surgery and drugs.	11/10/2012	Chiropractic
Jennifer Hunking	Individual	Ms. Hunking believes that chiropractors are great doctors who treat a wide range of conditions and is "thankful to have full access to doctors who do not push pills at her."	11/10/2012	Chiropractic
Vern Saboe, Jr, DC., DACAN., FICC., DABFP., FACO.	Individual	Dr. Saboe states that "The preliminary recommended Medicaid Expansion Benchmark Plan erroneously lists "Chiropractic" and "Naturopath: as if these were "services" rather than health care professions which is blatantly inappropriate. This inapplicable listing appears under EHB category 1. Ambulatory patient services" paradoxically the first service listed under this first category is "a. Primary care to treat illness/injury." Many chiropractic physicians across the state act in the capacity of primary care physicians providing evidence-based non-pharmacological interventions for most of the 60 most common conditions presenting in primary care and of course these colleagues treat injuries as well all of which are within in our clinical training, scope and licensure. In conclusion, these preliminary recommendations for the Medicaid Expansion Benchmark plan must be amended to reflect this clinical reality."	11/10/2012	Chiropractic
Mrs. Ellie Dicker	Individual	Mrs. Dicker requests chiropractors be allowed to treat all parts of the body. Mrs. Dicker she has been helped by chiropractors for several different types of health issues. She states that chiropractors and naturopaths are health care professionals necessary to her well being and that they are her primary care physicians.	11/11/2012	Chiropractic
Kristin Piacitelli	Individual	Ms. Piacitelli requests that chiropractors continue to treat all parts of the body. Ms. Piacitelli claims has been helped by a chiropractor with a knee injury as well as shoulder pain, toe pain and hip pain at various points in time when no other health care professional helped her with those issues. States chiropractors are trained and experienced with helping people with much more than only the spine. Provided the same comment as Vern Saboe, Jr., on 11/10/2012.	11/12/2012	Chiropractic
Michael Sears, DC, IAYT	Individual	Dr. Sears states chiropractors are experts at evaluating, treating and relieving neuromusculoskeletal complaints, but this is just one aspect of chiropractic care. He states its underlying qualities are to shift the locus of control from external reliance on other to an internal control for one's self. Further that chiropractic care promotes wellness and asks to enable chiropractic care at the highest level of it's licensure to as many of our citizens as possible.	11/12/2012	Chiropractic
Dr. Rob Bodner, LMT, DC	Ridgeline Clinic	Dr. Rob is a chiropractor in Portland and sees a diverse clientele who come to him with an array of maladies. He believes he is a neighborhood doctor who treats various issues and conditions, and is most often seen for musculoskeletal conditions. He makes referrals when the condition is out of his scope of practice. He claims he is affordable compared to many MDs and DOs and that his care is patient centered. He says that the community would be the ones who suffered if the Benchmark plan severely limited the scope of practice for DCs.	11/12/2012	Chiropractic
Lynn Connors	Individual	Ms. Connors is a retired professional dancer who has been working in Oregon's public school system since 1999. Due to stressful work conditions and three accidents, she has been treated by a chiropractor. Due to the effectiveness of the chiropractic treatment, she is able to continue working. Would like to see that people have a choice when it comes to their healthcare.	11/12/2012	Chiropractic
Eric Grace	Individual	Mr. Grace requests that chiropractors continue to treat all parts of the body. He claims he has been helped by his chiropractor with a foot issue, hip issue, shoulder issue, and digestive issues when no other health care professional was able to help him. He states that chiropractors are trained and experienced with helping people with much more than only the spine. He provided the same comment as Vern Saboe, Jr., on 11/10/2012.	11/12/2012	Chiropractic
Penelope J. Levin	Individual	Ms. Levin requests that chiropractors continue to treat all parts of the body. She claims she has been helped by her chiropractor with a foot issue, hip issue, shoulder issue, and digestive issues when no other health care professional was able to help him. She states that chiropractors are trained and experienced with helping people with much more than only the spine. He provided the same comment as Vern Saboe, Jr., on 11/10/2012.	11/14/2012	Chiropractic
Cindy Holloway	Individual	Ms. Holloway has a chiropractor who uses gentle and highly skilled treatment of all muscle and tendon connections as well as cranial facial treatment. She claims she has had better progress with her than most. She does not want to see chiropractors limited to spinal treatment only.	11/14/2012	Chiropractic

Medicaid Advisory Committee (MAC)
Summary of Public Comment/Testimony to Date December 31, 2012

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Individual	Organization	Summary of Public Comment received Nov 5th-19th and Dec. 13th-31st 2012	Date	Categories
Jerit Fourman	Individual	Mr. Fourman provided the same comments as Dr. Sears on 11/12/2012.	11/14/2012	Chiropractic
JEFFREY LEVIN & PENELOPE LEVIN	Individuals	The Levins provided the same comments as Dr. Sears on 11/12/2012.	11/15/2012	Chiropractic
AJ & Margaret Flores	Individuals	AJ & Margaret Flores provided the same comments as Dr. Sears on 11/12/2012.	11/15/2012	Chiropractic
Sheila M. Walker	Individual	Ms. Walker has a host of musculoskeletal issues that are treated by her chiropractor, whose treatment has done more for her mobility than medication. She would like to see chiropractors be considered to treat beyond spine adjustments.	11/15/2012	Chiropractic
Joe Carroll	Individual	Mr. Carroll is an Oregon resident and patient who has seen a number of board-certified chiropractors in the state of Oregon, and is concerned that the state will be blocking them from any future role outside of neuromusculosketal issues. He has found great relief with issues that were not purely NMS and would like to see that chiropractic doctors are not limited from fully helping their patients.	11/15/2012	Chiropractic
Elise G. Hewitt, DC, CST, DICCP, FICC	Portland Chiropractic Group	Dr. Hewitt is a board-certified pediatric chiropractor who provides a comprehensive range of services for her young patients, including adjustments, additional imaging or laboratory testing as needed, other manual therapies, physiotherapies, nutritional supplements, dietary and lifestyle advice, exercise and postural rehab, as appropriate for each patient. In addition, provides wellness and preventative care for children. Her practice is 100% referral based from many health providers, including pediatricians, physical therapists, occupational therapists, lactation consultants, naturopaths and other chiropractors. She also refers to these and other providers as dictated by her patients' needs. She believes that rather than limiting chiropractors to a single service like manipulation, the DC's training and expertise should be used to fill the workforce gap and offer Oregonians an effective, cost effective option to meet their healthcare	11/15/2012	Chiropractic
Kate Adams LMT, LPTA #6704	Individual	Ms. Adams requests that chiropractors continue to treat all parts of the body. She has been helped by her chiropractor for arm, shoulders, feet, cranial bones, jaw, and leg bones, when no other health care professional helped her with those issues. She believed chiropractors are trained and experienced with helping people with much more than only the spine.	11/18/2012	Chiropractic
Joseph E. Pfeifer, D.C.	University of Western States	Dr. Pfeifer encourage the Committee to expand the role of chiropractic physicians in the Oregon Heath Plan Plus to include the range of services within the profession's scope of training and licensure.	11/19/2012	Chiropractic
Pamela A Jensen, EA	Individual	Ms. Jensen provided the same comments as Dr. Sears on 11/12/2012.	11/19/2012	Chiropractic
Timothy Hill	Individual	Mr. Hill proposes that coverage for "non traditional" therapies such as chiropractic, acupuncture and massage therapy, might be targeted as "Cadillac," given the "opposition to the Affordable Care Act."This might undermine the success of the project. He "would love to see this as the first steps toward a single-payer system, and understand that excellent coverage would be one of the major attractions to getting people enrolled."	11/3/2012	Coverage for non-Traditional Providers
Rosalie Czerwinski	Individual	Ms. Czerwinski would like for naturopaths, chiropractors and acupuncturists to be included in the plan. She states "they have been invaluable for many of us" and due to the care and instruction of these providers no longer takes any pharmaceuticals and as is in good health.	11/5/2012	Coverage for non-Traditional Providers
Joe Marrone	Individual	Mr. Marrone thinks the benefits package is reasonable and understands tradeoffs have to be made. He would like to see inclusions for dental benefits that would have large scale health benefits and some savings to general health down the road. He believes untreated dental problems are a major health problem that preventive case has a major impact on.	11/5/2012	Dental
Ruth McEwen	Individual	Ms. McEwen recommended that the durable medical equipment benefit needed to be re-examined for sufficient coverage as it cuts across all populatoins. She reinfored that appropriate DME can cause a person to be more independent and less dependent on other services in the system.	11/28/2012	Durable Medical Equipment
Anonymous	Individual	Individual is a dentist and claims the information provided does not specify who will qualify and for what plan and what the actual benefits may be. He would also like to see better reimbursement for providers serving OHP clients, because "without practitioners, there is no ACA, or OHP." He would like to for OHP clients to have "more skin in the game by	11/2/2012	Enhanced reimbursement
Julia Lager-Mesulam, LCSW, Director	Partnership Project	Mrs. Lager-Mesulam states that what is critical in decreasing the number of new HIV infections is to ensure that annual HIV screening or as needed is covered at 100%. To add to that list would also be STD and Viral Hepatitis screenings and treatments.	11/14/2012	HIV
Paul Denouden	Individual	Mr. Denouden would like to make sure routine HIV testing is covered and that a plan is put in place to proactively make sure it is done in patients per the recommended CDC guidelines, and for those who are HIV-positive that all HIV antiretrovirals are covered without exclusions or formulary restrictions.	11/16/2012	HIV
Kahreen Tebeau, Associate Director of Public Policy	Oregon Association of Hospitals and Health Systems	Ms. Tebeau on behalf of the OAHHS, believes that the selection of OHP Plus, and the Medicaid expansion itself, represents a huge opportunity to expand access and coverage for many of Oregon's most vulnerable people. Oregon hospitals are supportive of OHP Plus as the benchmark selection and believe that aligning benefits across the Medicaid program benefits patients, the State, and hospitals and other providers that deliver care to Medicaid clients. It promotes administrative simplification, and has the potential to lower costs downstream by providing more comprehensive coverage to the newly eligible– many of whom will have high health needs that have gone unattended due to lack of previous coverage. In the short term – should the Governor choose to opt-in to the Medicaid expansion– we all win. The federal government will pay 100% match for providing these benefits to the newly eligible for 3 years. However, in the longer term, as we wrestle with a potential state budget shortfall in funding the current Medicaid program, and as the federal match rate ratchets down to 95% by 2017 and 90% by 2020, Oregonians will have to find a way to fund this expansion	11/12/2012	Hospital Association
Rachel E. Seltzer, MD	Oregon Health & Science University	Ms. Seltzer provides recommendations to improve population health among Oregon's Medicaid population: 1) Access to information about health, and access to health services (including access to Medicaid programs) that is comprehendible. 2) Improved access to health services for Medicaid recipients. 3) Integration of behavioral health services is requisite for population health. 4) Inclusion of oral health services in the mainstream delivery system model. 5) Improve reimbursement for pediatricians and other providers treating children to help ensure that children have	11/6/2012	Population Health

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Anonymous	Medicaid recipient	This person believes that the increasing coverage of non-disabled recipients is taking away from Medicaid funding for Medicaid services for the disabled, this "resulting in Oregon's system being a failure at what it claims to be doing for the APD population." Individual He believes that "connecting" Medicaid to Medicare standards also results in less dollars and services, resulting in a failing system for the APD population. Would like to see OHP disconnected from Medicare standards. States that "Medicaid is meant to look at in-home and community needs, Medicare institutionalizes recipients by looking at "in-home use only." Respondent would like to see three areas discussed in more depth: 1) Durable Medical Equipment, 2) Physical & Occupational Therapy, and (3) Coverage for homecare workers to assist their consumer employers while in the hospital.Another option is to consider connecting OHP to Medicare with no changes and use it as the Benchmark Plan, but also create an "APD Medicaid". For dual eligibles they could have the option of continuing with OHP or switching to APD Medicaid as the CCOs are doing. This would result in fluctuating the enrollment numbers for each plan but it would stop limiting and institutionalizing the APD population due to the rapid growth of the Medicaid population.	11/15/2012	Medicaid recipient
Alison Goldstein, LCSW	Individual	Ms. Goldstein would like to see mental health counseling services covered in the Benchmark plan.	11/15/2012	Mental health counseling
Laura Culberson Farr	Oregon Association of Naturopathic Physicians	Ms. Farr indicated that the OANP is encouraged that the Committee's preliminary recommendations include integrating naturopathic physicians as a provider type. She states that by listing naturopathic doctors among the provider types eligible to provide primary care will bring the Medicaid system in its entirety into alignment with both state and federal regulations relating to non-discrimination against providers. (ORS 414, Section 4, Chapter 80; S.2706 Affordable Care	11/19/2012	Naturopath
David B Lashley, MD, FAAP	Randall Children's Hospital	Dr. Lashley inquired about the coverage for newborn circumcision, which he claims "is a procedure covered by all commercial plans in the state and by some of the current Medicaid managed care plans."	11/4/2012	Newborn circumcision
Leah Brandis, RD,LD	Individual	Ms. Brandis is a member of the Oregon Academy of Nutrition and Dietetics and a Registered Dietitian in Oregon. She believes the current limit of the Essential Health Benefits for nutrition counseling is only 5 visits per lifetime and believes this is too low to provide significant outcomes in patients' chronic disease management. She proposes that the limit be increased to 2 visits per year for 5 years or until the issue is resolved.	11/18/2012	Nutrition
Sonja L. Connor, MS, RD, LD	Endocrinology, Diabetes and Clinical Nutrition Oregon Health & Science University	Ms. Connor provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Nancy Becker MS RD LD	Individual	Ms. Becker provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Terese M. Scollard MBA RD LD	Individual	Ms. Scollard made the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition she writes for acute disease such as cancer of the head, neck and GI tract or other medical diagnoses that cause significant nutritional impairment and malnutrition, a minimum of 3 hours in the initial year of acute disease and 2 hrs/year thereafter until resolved is more reasonable for effective prevention and treatment and to better avoid rescue costs of malnutrition in hospital.	11/19/2012	Nutrition
Tracy Ryan-Borchers, PhD, RD, LD	Individual	Ms. Ryan-Borchers provided the same comment re nutrition counseling as Ms. Scollard on 11/19/12.	11/19/2012	Nutrition
Patty Case, MS, RD	Oregon State University Klamath Basin Research & Extension Center	Ms. Case provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Angela Mathison Treadwell, RD	Umatilla-Morrow Head Start, Inc.	Ms. Mathison Treadwell provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Nicole Hanks	Individual	Ms. Hanks provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Carol Walsh, MS, RD, LD, CDE	The Corvallis Clinic	Ms. Walsh provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Kristie M. Gorman, RD, CSG, LD	Providence St Vincent Medical Center	Ms. Gorman provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition she claims that fewer people would be hospitalized and those hospitalized would likely have better health outcomes if they were followed by a dietitian to help manage their chronic diseases. Also she states that Oregonians should lead the way in preventing/delaying complications of chronic disease and helping our senior citizens reduce obesity.	11/19/2012	Nutrition
Ingrid Skoog	Individual	Ms. Skoog made the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition she states that the research clearly shows that a support system for behavior change results in better outcomes than knowledge only and that the RD represents a very cost effective partner in helping high risk individuals and those with already diagnosed chronic diseases improve their health and reduce long term health care costs.	11/19/2012	Nutrition
Kati Thompson RD LD	Lambert House & Marie Smith Center	Ms. Thompson provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Kimra Hawk, RD, LD	Providence St Vincent Medical Center	Ms. Hawk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Joan Medlen	Individual	Ms. Medlen writes to encourage the availability of nutrition counseling and education for the Oregon Medicaid Benchmark Plan by increasing the number of visits for nutrition counseling as well as the number of dietitians available. She states that people with intellectual and developmental disabilities (IDD) are the types people she serves through the CCOs and that it is difficult to effectively counsel for any diagnosis for this population. She states that making nutrition counseling available through CCOs is in line with the Governor's vision for obesity reduction and prevention. She states that RDs are specialized in serving people with IDD to help and support them through these issues.	11/19/2012	Nutrition
Tina Gruner, M.S., R.D., C.D.E., L.D.	Individual	Ms. Gruner provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition

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Ginger Terry, MA, RD	VA Medical Center, Roseburg, Oregon	Ms. Terry provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Angela Hermes, RD, LD, CLT	Nourishing Transitions	Ms. Hermes provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Cary Fardal, RD	Oregon State Hospital	Ms. Fardal provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Amy Floreen RD, LD	Balance, Nutrition and Management Consulting	Ms. Floreen provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Kathy Schwab, MPH, RD	Providence Health & Services	Ms.Schwab provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Beth Schwenk, MS, RD, CDE	Providence Seaside Hospital	Ms. Schwenk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Erin Wicklund, RD, LD	Providence	Mr. Wicklund supports more nutrition counseling for improved outcomes and claims that 5 visits per lifetime is too low. He states that it takes time and access to follow up for patients to implement lifestyle changes.	11/19/2012	Nutrition
Joy Jordan RD	Avamere Living	Ms. Jordan provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Vicki L Duesterhoeft, MS, RD, LD	Oregon State Hospital	Ms. Duesterhoeft provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Marilyn Bacon RD LD CNSC	Individual	Ms. Bacon provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jacque DeVore, RD, MPH	Shriners Hospital for Children	Jacque Devore provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jennifer Lehman, RD,LD,CDE	Sky Lakes Diabetes Services	Ms. Lehman provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Karen Huntzinger MS,RD,CSO	Salem Hospital	Ms. Huntzinger provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Cheryl Kirk, R.D., L.D.	Individual	Ms. Kirk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christopher M Konczyk MS, RD, LD	Salem Health	Mr. Konczyk provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Shannon Agee	Individual	Ms. Agee provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christina Heiberg, RD, LD	Providence St. Vincent Medical Center	Ms. Heiberg provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jane Eyre Schuster, RD, CDE	Diabetes Program Coordinator I Legacy Meridian	Ms. Schuster provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Niki Strealy, RD, LD	Strategic Nutrition, LLC	Ms. Strealy provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Allison Forney, RD	Individual	Ms. Forney provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Katie M. Dodd, MS, RD, LD	VA Southern Oregon Rehabilitation Center and Clinics	Ms. Dodd provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012. In addition, she works with the Veterans Heath Administration in Southern Oregon coordinating a weight management program and providing medical nutrition therapy for patients in their homes for a variety of health reasons, including managing diabetes, heart disease, weight management, prevention of unintentional weight loss, dysphagia, among many other medical conditions. She claims that Initial education and counseling is important, but it is the follow-up that truly makes a difference. For her results in weight management patients, she provides “intense and sustained” counseling which means 8+ visits in a 4 month time period. For my patients in home care, follow-up varies from once per week to once per year, depending on their medical needs. She has also provided medical nutrition therapy to a patient with end stage liver disease for monthly visits and has seen the patient's quality of life improved and the cost to our health care system reduced.	11/19/2012	Nutrition
Joanna Helm	Oregon Health and Science University	Ms. Helm provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Michele Shrum Guerrero, RD, LD	Individual	Ms. Shrum Guerrero provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Natasha Luff RD, LD	Individual	Ms. Luff provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Ron George	Individual	Mr. George provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Melissa Pence RD LD	Individual	Ms. Pence provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christen L Wiley DTR	Individual	Ms. Wiley provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition

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Maureen McCarthy, MPH, RD, CSR, LD	Oregon Health & Science University	Ms. McCarthy provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Athena Nofziger RD,LD,CHC	Samaritan Lebanon Community Hospital	Ms. Nofziger provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
John Gobble, DrPH, RD, LD, MCHES	Medical Nutrition Therapy Northwest	Mr. Gobble provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Sareena Smith-Bucholz, BS	Oregon Health & Science University	Ms. Smith-Bucholz provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Jennifer Kennedy RD, LD	Providence St. Vincent Eating Disorder Program	Ms. Kennedy provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Angela Johnson, RD, LD	Samaritan Bariatric Program	Ms. Johnson provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Valerie Edwards, MS, RD, LD	Providence Portland Medical Center	Ms. Edwards provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Andrea Q Vintro, MS, RD, CSSD, LD	The KOR Physical Therapy and Athletic Wellness	Ms. Vintro provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Ann Fujii, MPH, RD, LD, CDE	Individual	Ms. Fujii provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Verdie Hicks, CDM, CFPP	Green Valley Rehab	Ms. Hicks provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Denise Cedar, RD, LD, CDE	Individual	Ms. Fujii provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Andrea Smith, RD LD	Individual	Ms. Smith provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Christine Poniewozik	Individual	Ms. Poniewozik provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Esther Teerman RDLD	Individual	Ms. Teerman provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Erin Dooher, Clinical Dietitian	Samaritan Pacific Communities Hospital	Erin Dooher states that the current Benchmark plan for nutrition counseling is below and standard she is familiar with. She references diabetes as the "upcoming biggest concern for our country's medical expenses in the next 30 years." She states the current benchmark severely undeserving the following patients: Type 2 diabetes mellitus, Adult weight management, Pediatric weight management. She says for diabetes visits, they do 13 hours in the first year of diagnosis, and 2-3 visits/year in each subsequent year. This is a minimum standard fully reimbursed by Medicare. For pediatric obesity, they so six visits over regular intervals, and this is covered by many insurance plans. She proposes the limit be increased to a minimum of 2 visits per year for 5 years or until the issue is resolved.	11/19/2012	Nutrition
Theresa Anderson RD LD	Samaritan Diabetes Education	Ms. Anderson would like for nutrition intervention to be covered. She states that it is cost-effective and that many physicians and nurses do not have time to do nutrition counseling and have also not likely been trained to do it.	11/19/2012	Nutrition
Kathleen Huntington MS, RD, LD		Ms. Huntington believes a restriction to five nutrition counseling sessions, per lifetime, does not address the clinical needs of patients diagnosed with inborn metabolic errors (IEM). This arbitrary restriction compromises the goal of implementing preventative care that is a major tenet of the Newborn Screening system. The Oregon Medical Foods law passed in 1997, 2003 (Senate Bill 74) and 2009 (Senate Bill 9) indicates that – "…Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment...."	11/19/2012	Nutrition
Sandy Jolley, RD, CDE	Silverton Health	Ms. Jolley provided the same comment re nutrition counseling as Ms. Brandis 11/18/2012.	11/19/2012	Nutrition
Sharon M. Fox, MHA	Children's Health Alliance	Children's Health Alliance believes it is important for the Medicaid Essential Health Benefit package to consider the following: 1) Habilitation services should be offered in parity with rehabilitation services for adults. We recommend that Oregon define "habilitation" based on the NAIC/HHS Uniform Glossary definition. 2) Coverage for drugs and biologics for use by children should consider children's' special needs and the stage in their life course. 3) Coverage for durable medical equipment should consider children's developmental course and implications for long term consequences. 4) Coverage which promotes physical, mental and behavioral health integration for children without requiring a defined diagnosis, e.g. mental illness. 5) Denial of certain services based on the Prioritized List and the current funding Line can have significantly different outcomes and life-long consequences for children when applied uniformly to children and adults.	11/19/2012	Pediatric coverage

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Charlie Pioli	Individual	Mr. Pioli believes he has done a good job combating his PKU, which is inborn metabolic error, but believes that he and his family couldn't have managed without a strong healthcare plan. He drinks a powdered milk that acts as a substitute for regular protein; a single can of it is very expensive. Mr. Piolo request that he and his sister who also has PKU, and his family, be considered when a decision is made regarding the Benchmark.	11/14/2012	PKU
Chris Baillie	Individual	Mrs. Ballie has 3 children with PKU and has been dealing with this metabolic condition their whole lives and knows firsthand how expensive it would be to treat it if they didn't have insurance that covered their required metabolic food. She hopes that her kids will never have to worry about how to get their food.	11/14/2012	PKU
Adray Dull	Individual	Adray Dull is the parent of a child who requires Phenylade formula to maintain a normal healthy life. Their family is only able to afford the formula due to the coverage provided by their health care plan. They encourage the coverage of this formula.	11/14/2012	PKU
Michael D. Mann	Individual	Mr. Mann has two family members born with PKU who need a food supplement, which is very expensive. He asks that the new health plan provide coverage for adults who need this type of food supplement.	11/14/2012	PKU
Diane C Williams M.D.	Individual	Dr. Williams would like to see that adults with inborn errors of metabolism (such of PKU) be included on the insurance coverage. She states that these disorders are inherited and do not go away and that the medical foods are expensive and prohibitive for many people. Inability of stay on dietary control can result in significant difficulties and should be considered a medical necessity. Dr. Williams is a pediatrician and grandmother of a 12 year old child with PKU and can attest to this important medical need.	11/14/2012	PKU
Mary Jo Mann	Individual	Mrs. Mann has two children with PKU. She states that her family has been fortunate to have access to insurance coverage for her children's treatment and formula. She says the cost of coverage for this essential treatment is beyond the reach of the average person. She would like to see the Metabolic formula and low protein benefits for PKU and other metabolic disorders be covered in the Essential Benefits.	11/14/2012	PKU
Evan Kruse	Individual	Mr. Kruse would like to see the coverage for Medical Formula and low-protein foods and include lifetime coverage for these items in the Essential Health Benefits package.	11/14/2012	PKU
Makenzie L. Wesner	Individual	Ms. Wesner writes to express concern about Benefit 10 in the Illustration of Total Essential Health Benefits. She would like to see coverage of “Metabolic formula and low protein food for inborn errors of metabolism” for children and adults.	11/17/2012	PKU
Laura Goode	Individual	Ms. Goode writes to express the importance for insurance coverage for children, as well as adults with an EIM.	11/17/2012	PKU
B. Nicole Dean	Individual	Ms. Dean would like to see coverage of PKU for adults as well as children.	11/18/2012	PKU
Neil R. M. BuistMD	Individual	Dr. Buist would like to see coverage for PKU treatments for adults as well as children.	11/18/2012	PKU
Sarah C. Pearson	Individual	Ms. Pearson would like to see coverage of medical formula and medical low protein foods insured by private or public insurance groups, once children are grown.	11/19/2012	PKU
Laura Terrill Patten, Executive Director	Planned Parenthood Advocates of Oregon	Planned Parenthood Advocates of Oregon has reviewed the preliminary recommendation for the Medicaid Benchmark Plan and generally supports the comprehensive approach to women’s health care coverage. However, there are a few items we would like to see addressed with greater specificity to better clarify and ensure consistent treatment of women who move between different benefits packages in Oregon: 1) Prescription birth control: We would like to see clarification in language regarding contraception and propose coverage of “All FDA-approved prescription contraceptive methods and devices” as outlined in ORS 743A.066. 2) Birth control services: in accordance with current law (743A.066), we would like to see clarifying language regarding related birth control services, “outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive.” 3) Women’s preventive health care screenings: mammography and pelvic exams/PAP tests are specifically listed in the preliminary recommendation, but “physical examination of the breast” as outlined in ORS 743A.108 is not. They would like to see that added.	11/16/2012	Reproductive Health
Wendy J. Edwards, MPA:HA	Samaritan Health Plans	SHP believes the proposed benchmark seems to go beyond the essential health benefit requirements and that OHP Standard better aligns with the ACA requirements. They identify three coverage areas where OHP Plus stands out from OHP Standard: 1) Chiropractic services, 2) Dental services, and 3) Stay limitations - there are no limitation on rehabilitative and habiliative services or devices in OHP Plus, specifically related to inpatient, massage, physical and occupational therapy and speech therapy. The Medicaid benchmark plan does not clearly explain the impact of funding limitations and the relationship to the prioritized list. They recommend that the MAC reconsider OHP Standard as the recommended EHB for Oregon.	11/8/2012	Recommend OH P Standard

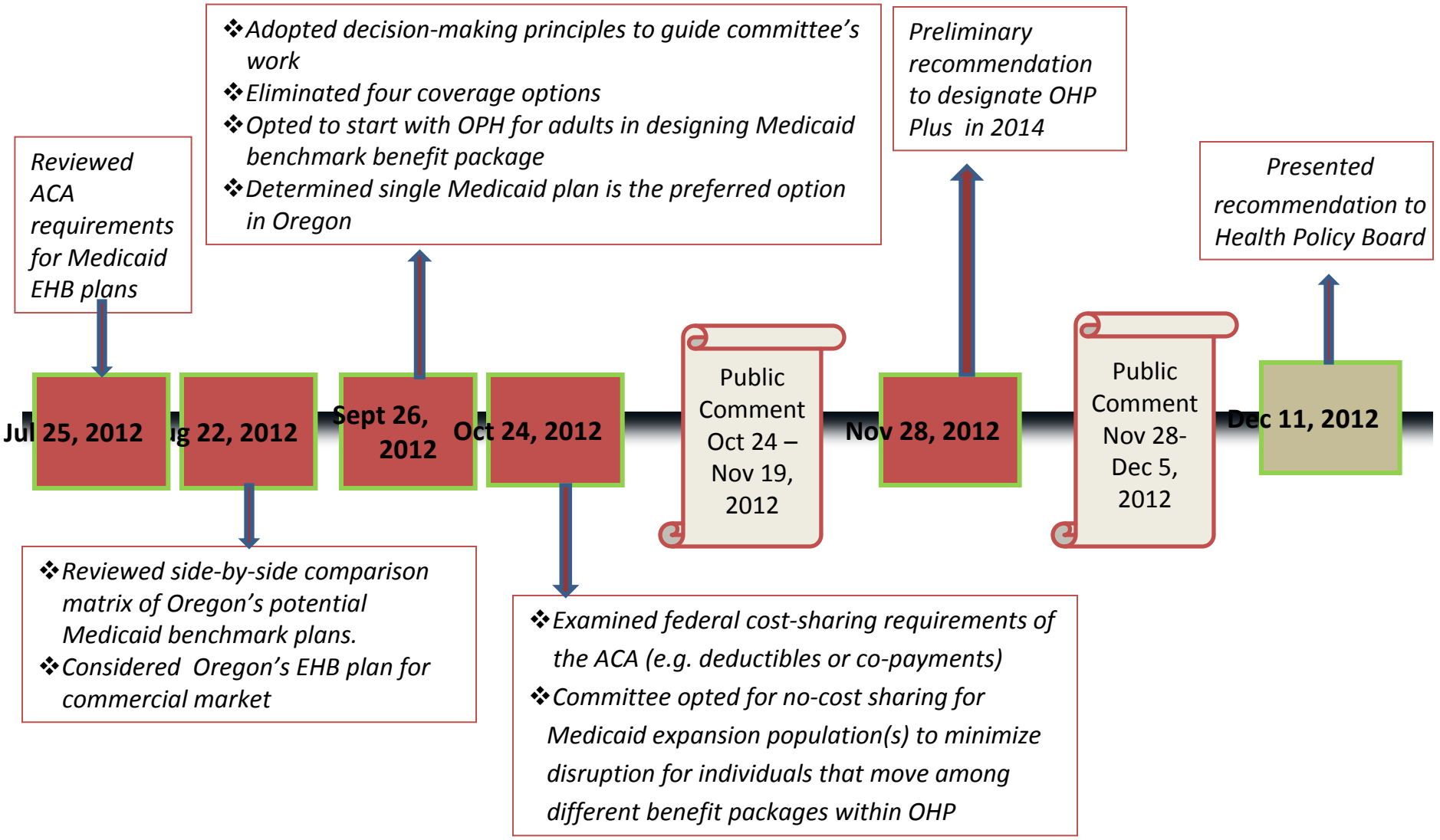
Oregon Medicaid Essential Health Benefits

Recommendation from the Medicaid Advisory Committee

Jim Russell, Committee Co-chair
Oliver Droppers, Committee staff, OHPR

Oregon Health Authority

OREGON MEDICAID BENCHMARK BENEFITS – DECISION TIMELINE



Public Input

- Public comment received via the email and submitted to staff
  - Initial comment period: November 5th thru 19th
  - Second comment period: December 13th thru 31st
- Received 100+ comments from interested parties
- Comments focused on increasing specific covered services and benefits
  - Appropriate comments forwarded to the Health Evidence Review Commission
- Comments generally supportive of recommendation

Oregon Health Authority

Medicaid Benchmark Decision-Making Principles

1. Alignment with Oregon's Triple Aim and CCOs
2. Ensure inclusion of all federal benefit categories and identify meaningful differences in coverage
3. Acknowledge value-based benefits, potential cost-sharing relative to income, and flexible utilization of covered services to avoid future costs
4. Appropriate balance of benefits among statutorily required categories so benefits are not unduly weighted toward any category
5. Account for the health care needs of all adult Oregonians, with a focus on benefits that may address social determinants of health
6. Consider impact on coverage and benefits for individuals that transition between OHP and the commercial market
7. Consider administrative implications when selecting preferred benefit package including minimizing disruption to OHP

Final Recommendation

Action Item	Request for endorsement of the committee's final recommendation
Recommendation	The committee recommends the **Oregon Health Plan *Plus*** (for non-pregnant adults) to be the state's Medicaid benchmark plan.
Key Decision Points	• Ensure alignment with Oregon's Triple Aim and Coordinated Care Organizations and federal requirements in the ACA. • Simplify, align, and streamline benefit coverage across the Oregon Health Plan. • Aim to meet all health care needs of adult Oregonians eligible for OHP.

Selection of Medicaid Benchmark &Transformation

- Offers Administrative Simplification to OHP Benefits to aid CCOs' Transformation Efforts
- Enhances funding inside the Global Budget to the CCOs and their communities
- Supports Patient-centered Primary Care Home and CCOs to meet the needs of the OHP members
- Starts to restore OHP to its original design of a base set of benefits across a population

Oregon Health Authority

Questions?

Medicaid Advisory Committee:
www.oregon.gov/OHA/OHPR/Pages/MAC/MACwelcomepage.aspx

Email: Mac.info@state.or.us

Oregon Health Authority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