These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks

report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

SENATE COMMITTEE ON HEALTH INSURANCE AND BIOETHICS

February 12, 1991Hearing Room C 3:00p.m.Tapes 14 -

MEMBERS PRESENT:Sen. Bob Shoemaker, Chair Sen. Joyce Cohen, Vice-Chair Sen. Jeannette Hamby Sen. Lenn Hannon Sen. Frank Roberts

MEMBER EXCUSED: Senator Cohen

STAFF PRESENT: Barbara Coombs, Committee Administrator Mark Sigel, Committee Assistant

MEASURES Briefing on Medicaid Program CONSIDERED:

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TAPE 14, SIDE A

000 CHAIR SHOEMAKER: Calls meeting to order at 3:15.

002 JEAN THORNE, OFFICE OF MEDICAL ASSISTANCE PROGRAM (MEDICAID) DIRECTOR: Presents (EXHIBIT A) which provides an overview of the Medicaid program in Oregon.... Medicaid has become more complex. The federal government has now mandated that..

- There is a proposal to end the Medically Needy program. Governor's budget calls for an end this program.

038 SENATOR ROBERTS:

045 CHAIR SHOEMAKER: Have the federal governemnt required us to cover ...

072 SENATOR ROBERTS: There is no federal funding for

077 SENATOR HAMBY:

096 CHAIR SHOEMAKER:

141 CHAIR SHOEMAKER: What is acute slash medical care?

145 horne:

JOEL YOUNG, MANAGER FOR mEDICAID'S MANAGED CARE PROGRAMNN ASSISTANCE: Also presents (EXHIBIT A) which includes a chapter on Medicaid's managed care program.We needed federal authorization in order toi start our program. We got that.

248 CS: Why do you expect this savings level?

250 fr: Are Medicaid providers required to participate?

332 CHAIR SHOEMAKER:

347 CS: So a client will select a provider and...

374 bc: Is rhere a disincentive for a physician to order certain services? What is the utilization restraint for inpatient service?

374 JY: Its basedf on whather its a ...

399 Thoprne: There is an incentive to control utiliation. They share in savings from reduced utilization.

Tape 15 Side A

011 BC: Do you discern a difference between

013 jy: We asren ot able to dtermine whether one ofr the other is

031 thorne:

040 CS: Is the HMO or the PCO patient less expensive to serve?

045 : Thorne: THe PCO patient is less expensive to serve for us because we get to share in the savings while for the HMO patient the provider gets to keep all the savibngs. Its easier from an administrative standpoint to serve the HMO covered patient.

091 cs: Let me back up to this requirement rthat you pay for a fee for service basis...

174 bc: Thd total savngs forthe PCO programs were $ ... were half returned to the Medicaid program? Were there similar savings for the HMO programs?

179 JY:

205 CAROLE FALLER,MANAGED CARE COORDINATOR FOR THE EUGENE CLINIC: Presents (EXHIBIT B) which summarizes program elements that PCOs share. One of our repsonibilities is to help ADC get primary care physicians.

276 fr: what asssurance is there that a primary care physician will be available?

311 cs: What is the breadth of care for mothers, prospective pmothers and their children?

324 cf: Obstetrical care is one service that fiyts in under our capitated services.

354 cs If you have a mother with several children and the mother is pregnant.. what kind of services does she receive?

Tape 14 Side B

002 Under the PCO program AADC clients get services and access and support that they traditionally lacked under other Medicvaid arrangements. They have guarenteed access, they feel they ahve aright to get acare and to ask questions.

051 cs: Are there any significant differences you have with the state and their PCo and the provider an their PCO....?

058 CF: Our state PCo actually works a ittle better.

076 CS: Whate kind of response are you getting from your providers?

080 cf: Sometimes the providers get upset when the patients don't adhere to treatments or show up for appointments but overall they are quite happy.

088 cs; Are all the providers registered through your clinic located in the actual building?

095 cs: How does the stop loss work?

097 cf: $5,000 can be paid out per patient.

100 Throne: We are actally the reinsurer.

119 cs: You cover the whole family if it is an ADC family.

123 cf: 66% of the population are children.

148 BOB DIPRETE: MANAGER, DELIVERY SYSTEM FOR SB 27 OF OMAP: Presents another portion of (EXHIBIT A) which summarizes how managed casre programs will operate under SB 27.

250 cs: Can you tell us a littlwe about the cost based....

255 bd:

306 cs: We are going to find that a cost based system is going to cost more?

313 Thorne:

322 Roberts: It has troubled me extensicvely how you can dtermine a dr's costs when they set their own income ;levels.

359 fr: What in the end is this gpoing to do to the averge physicams income?

366 bD: I don't know? Even under the new program doctors will get less for tasking medicaid patients than for takinf other pateints.

Tape 15 side B

000 BC: Why do you want to be moving people in to a full service HMO if you realixe more sdsavings ...

020 BC: It strikes me that you have a fascinating tool to study utilzation review and cap utilization. What is the chack on use in the case manager

040 BC: Is there no incentive

063 Senator Roberts: There is no benefit to the primary care physician to reduce utilization, correct?

070 bd:

Thjorne: We require our heavy users of care to sign onto a program

097 FR: Your program to reduce doctor shopping acyually reduces overall costs?

100 Thorne: Yes.

106 cs: Any reformas to reduce hospitaal expesnes?

120 JT: Cost reduction is in the hoptial's interest. Under our current hospital system we pay for services according the DRG system or Diagnostic Realted Group set rates.

164 CS: Do hospitals resist taking Medicaid patients?

168 jt: They are required by law to treeat Medicaid patients in emergency siturationsd.

188 fr:

235 cs; Adjourns mmetting at 455.