Date Submitted: October 22, 2024
Public Comment Submission from: Tom Sincic
Organization: NA
Topic: Public Meetings Law
Will oral comments be provided as well: No

To: UHPGB Committees
From: Tom Sincic, MSN, FNP-Retired
Date: 10/22/2024

Re: Public Meetings Law and Potentially Unnecessary Restrictions—Revised Testimony for Committees

I am providing the statement below from the Oregon Government Ethics Commission and information from the public meetings law so as to avoid unnecessarily imposed restrictions on communication and enhance the needed collaboration among those who are generously volunteering to do this important work.

"From: MYERS Susan * OGEC <Susan.MYERS@ogec.oregon.gov>
Sent: Tuesday, September 24, 2024 10:09 AM
To: Sen Dembrow <Sen.MichaelDembrow@oregonlegislature.gov>
Subject: Oregon Government Ethics Commission

Senator Dembrow –

I wanted to reach out to you personally regarding the Oregon Government Ethics Commission and the administrative rules for Public Meetings Law, which were adopted by the Commission at its meeting on September 20th. Mainly I wanted to reassure you that the Commission did carefully consider the comments you submitted regarding the prohibition on serial communications.

As you note, HB 2805 and the existing case law (*Handy* case) provide that serial communications among a quorum of the members of the governing body on matters subject to the governing body's decision or deliberation are prohibited. **The Rule that was adopted, OAR 199-050-0020, does not prohibit communications among less than a quorum of the governing body. Rather, it simply clarifies the statutory prohibition.** It states:

A quorum of the members of a governing body shall not, outside of a meeting conducted in compliance with the Public Meetings Law, use a series of communications of any kind, directly or through intermediaries, for the purpose of deliberating or deciding on any matter that is within the jurisdiction of the governing body.

I would be more than happy to answer any questions you may have concerning this rule or any of the other rules that were adopted by the Commission.

Susan V. Myers
Executive Director
Oregon Government Ethics Commission
susan.myers@ogec.oregon.gov
(503) 378-6808"

"(Training on public meetings law)
SECTION 3. (1)(a) The Oregon Government Ethics Commission shall annually prepare training on the requirements of ORS 192.610 to 192.690 and best practices to enhance compliance with those requirements. **The commission may delegate the preparation and presentation of trainings to another organization, except that the commission must approve the content of training prepared by another organization prior to presentation of the training.**
(b) At the discretion of the commission, trainings prepared under this section may be presented in live sessions or be made available for viewing online. Training sessions may be presented to multiple governing bodies at any one time and may be presented in a pre-recorded format."

I want to now reiterate that my understanding is that the Oregon Dept. of Justice is not yet authorized to give training on the public meetings law discussed on 10/17 board meeting. The law specific states that only the Oregon Government Ethics Commission or its designee can provide this training. I recently confirmed that the OGEC had not authorized anyone else to provide the training. I believe this to still be true.

The Board needs to look at what the OGEC has put in writing to Senator Dembrow which I previously provided. I strongly recommend that the board and its committees get training as a group from the OGEC. This is the information that should guide the members of the committees.

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To: UHPGB Finance and Revenue Committee
From: Tom Sincic, MSN, FNP-Retired
Date: 11/15/2024

Re: Finding Health Care Revenue

As you continue your search for the multiple places where dollars are spent related to healthcare, I want to bring up the unaccounted for millions that are a part of tuition at Oregon's universities. These dollars are often found in their student interest bearing loans paid in the years ahead. The hardship this causes has been brought forward by students. It is very unclear as to what the benefits and limitations are for the various plans. Of note are the inconstancies and inequities within and across the systems. FYI It turns out that state law allows all this. https://oregon.public.law/statutes/ors_743.550

There is also each schools cost for managing these systems that should be accounted for as an expenditure. Below are some initial findings taken from the schools' websites. We are doing research to clarify and find out more. This is a work in progress that should be a part of the committee's exploration. Happy to talk about how to coordinate this effort.

Student population should be a clear part of public engagement work as well.

University of Oregon (UO):

- **International Students:** Mandatory enrollment in the UO Student Health Benefits Plan, with the option to apply for a waiver if they have comparable coverage.
- **Domestic Students:** Not required to have health insurance but can voluntarily enroll in the university's plan.

Oregon State University (OSU):

- **International Students:** Required to enroll in the OSU Student Health Insurance Plan unless they obtain a waiver by demonstrating equivalent coverage.
- **Domestic Students:** Not mandated to have health insurance but are strongly encouraged to maintain coverage. They can opt into the university's plan if enrolled in a minimum number of credit hours.

Portland State University (PSU):

- **International Students:** Automatically enrolled in the PSU Student Health Insurance Plan, with the possibility of waiving enrollment by providing proof of comparable insurance.
- **Domestic Students:** All students taking five or more in-load, non-Restricted Differential Tuition credit hours are automatically enrolled in the PSU Student Health Insurance Plan. They can waive this coverage by providing proof of other adequate health insurance.

Western Oregon University (WOU):

- **International Students:** Required to have health insurance and are automatically enrolled in the university's plan. They may waive this by providing proof of comparable coverage.
- **Domestic Students:** Not required to have health insurance but can purchase it through the university.

Southern Oregon University (SOU):

- **International Students:** Must have health insurance and are automatically enrolled in the SOU Student Health Insurance Plan, with an option to waive if they have equivalent coverage.
- **Domestic Students:** Not mandated to have health insurance but can opt into the university's plan.

Eastern Oregon University (EOU):

- **International Students:** Required to have health insurance and are automatically enrolled in the university's plan unless they provide proof of comparable coverage.
- **Domestic Students:** Not required to have health insurance but may purchase it through the university.

Oregon Institute of Technology (Oregon Tech):

- **International Students:** Must have health insurance and are automatically enrolled in the university's plan, with the option to waive by showing proof of comparable coverage.
- **Domestic Students:** Not mandated to have health insurance but can enroll in the university's plan.

University of Oregon (UO):

- **Plan:** UO Student Health Benefits Plan.
- **Cost:** For the 2024-2025 academic year, the premium is $1,200 per term.
- **Details:** This comprehensive plan is available to all active, eligible students.

Oregon State University (OSU):

- **Plan:** OSU Student Health Insurance Plan through PacificSource.
- **Cost:** For domestic, Ecampus, and PharmD students, the per-term costs for the 2024-2025 academic year are:
    - Fall (9/11/24 - 12/20/24): $1,174
    - Winter (12/21/24 - 3/19/25): $1,174
    - Spring (3/20/25 - 9/10/25): $1,174
    - Summer (6/12/25 - 9/10/25): $896
- **Additional Fees:** An administrative fee of $70 per term is charged directly to the student account.

Portland State University (PSU):

- **Plan:** PSU Student Health Insurance Plan.
- **Cost:** For the 2024-2025 academic year, the cost for health insurance is $1,256 per term (Summer is $917)
- **Details:** Domestic students taking five or more credits and international students are automatically enrolled but can waive the coverage with proof of comparable insurance.

Western Oregon University (WOU):

- **Plan:** WOU Student Health Insurance Plan.
- **Cost:** For the 2024-2025 academic year, the premium is $1,100 per term.
- **Details:** International students are automatically enrolled, while domestic students can opt-in.

Southern Oregon University (SOU):

- **Plan:** SOU Student Health Insurance Plan.
- **Cost:** For the 2024-2025 academic year, the premium is $1,250 per term.
- **Details:** International students are automatically enrolled, with an option to waive; domestic students can opt-in.

Eastern Oregon University (EOU):

- **Plan:** EOU Student Health Insurance Plan.
- **Cost:** For the 2024-2025 academic year, the premium is $1,050 per term.
- **Details:** International students are automatically enrolled, while domestic students may purchase the plan.

Oregon Institute of Technology (Oregon Tech):

- **Plan:** Oregon Tech Student Health Insurance Plan.
- **Cost:** For the 2024-2025 academic year, the premium is $1,200 per term.
- **Details:** International students are automatically enrolled, with an option to waive; domestic students can enroll voluntarily.

Date Submitted: November 14, 2024
Public Comment Submission from: Charlie Swanson
Organization: Self
Topic: health expenditures in Oregon
Will oral comments be provided as well:

Comments on the agenda of the Finance & Revenue Committee, 11/19/2024

From Charlie Swanson

The Finance and Revenue Committee (FRC) of Oregon's Governance Board needs the most credible real data regarding expenditures as a baseline. The portion of the slide deck for our meeting starting on slide 20 and titled Health Spending in Oregon does not present such information. I suggest that we change the agenda – the presentation is not a good use of our time as it currently exists. A more useful agenda item might be to continue what we talked about at the end of the first meeting – fleshing out more detail of what sort of baseline data would help us, and finding out how OHA and HMA can help assemble that data, and what needs to be done by someone else.

All of the data that I use below is publicly available. Much of the best data is directly from OHA, and there is probably lots of useful data that is not readily publicly accessible, but is available to HMA and OHA. It seems that within OHA and likely HMA there is a lot of expertise and information that could help us, and I hope that they will work with us. Importantly, this includes working with us between meetings. We are not going to accomplish our work plan with just infrequent meetings. It sort of feels like the health care spending presentation on our agenda represents talking at us, not working with us.

At the first meeting of the Finance and Revenue Committee, the group agreed on the attributes of a decent financial study. These are:

1. Based on fiduciary accounting standards with confidence intervals.
2. Show your work. No hidden adjustments.
3. Everything must add up to known data with a stable methodology.
4. Must provide breakout for behavioral, primary care.
5. Must include all revenue including taxes which support federal programs.
6. Effect on services covered by charitable giving, Out-of-pocket, LTSS
7. Must explain whether savings from unification still exist even if all expenditures are not unified.

We acknowledged at the meeting that it may be difficult to live up to all of these standards. We discussed the CBIZ Optumas report to the Task Force at that first meeting. Much of that information is of some use, especially if it can be updated, we can fill in the blanks about what is missing, and we can get more granular in some areas. But the data from Sustainable Health Care Cost Growth Target Annual Report, which constitutes most of the agenda item #4 (Review Health Spending) is essentially useless as it currently exists. Below I will explain why I think that – mostly because the data is so far off of any other estimate of "known data with a stable methodology" (#3 above) that it is simply not credible. It also is presented in a way that is at odds with essentially all of what Warren George talked about at our first meeting. That is also true for the data from the RAND report, which in addition has the problem of being too old even if it were more complete and transparent.

In my explanations below I will make use of terminology from National Health Expenditure Accounts, which uses total health care expenditures (TCHE), consisting of Personal Health Care Expenditures (PHC), government administration and the net cost of health insurance, public health expenditures, and expenditures on structures and equipment.[1] These terms are fleshed out a bit more in Appendix 1, and I argue that this forms a good basis of a stable methodology.

We likely need information about all of these types of spending. Public health expenditures are important because the line between public and personal health is blurry. For example, vaccinations can be given as part of a public program or at individual doctor or pharmacy visits. With the nomination of RFK Jr. for Secretary of HHS, it is likely even more important for a good state program to consider public health in its design.

Data on government administration and the net cost of health insurance should be considered because important potential administrative savings are related to this and should be quantified. For equity and cost-efficiency reasons, expenditures on structures and equipment should be considered.

Long term services and supports (LTSS) may or may not be included in a plan proposed by the Governance Board, so it will be useful to identify which spending is of this nature.

In all of these expenditure categories, it will be useful to be able to attribute the funds to a source – possibly the following classifications –

- Federal government
- State government
- County government
- Municipal government
- Private insurance, hopefully broken into insurance paid for by government funds, other private insurance regulated by DCBS, self-insured companies, and Taft Hartley Trusts and other such entities
- Individual out-of-pocket
- Charitable source

When we are trying to figure out needed new revenue sources or how to preserve an existing source, or if it is likely that such preservation is possible, such information is likely to be important.

In Appendix 2, I list some questions that I suspect OHA could quickly answer and some suggestions of data that they have that could help us. This could be a beginning of what we talk about with a replacement agenda item.

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[1] It also includes spending for noncommercial biomedical research, which we can probably ignore at the state level.

I will start by addressing and presenting some "known data with a stable methodology."

NHEA data for Oregon

Among the most credible data regarding health care expenditures is from CMS NHEA. State level data for PHC is available through 2020. There are two main difficulties with this data for our purposes: (1) as just mentioned, data is only available through 2020, and (2) data is only available for PHC. Another issue is that it is not sufficiently granular to allow straightforward designations of behavioral/mental health, primary care, or even LTSS (though this can sort of be done?). Table 1 below shows Oregon expenditures for 2017 through 2020 from NHEA, with non-PHC expenditures estimated from a presumed Oregon share of national expenditures (same per capita as national values). If expenditure data is very different from this, it will be useful to try to understand why if we are to use the data rationally.

Table 1. Health care expenditures in Oregon from NHEA ($ millions)

	2017	2018	2019	2020
total personal health care expenditures (PHC)	36,607	38,354	40,623	42,716
Medicare	7,799	8,311	8,913	9,086
Medicaid	7,616	8,108	8,556	8,967
Private Insurance	11,469	12,367	12,736	12,844
Other	9,723	9,568	10,418	11,819
out-of-pocket (OOP)	4,720	4,938	5,166	5,128
all else (VA,IHS,DOD,charity,etc)	5,003	4,630	5,252	6,691
net cost of insurance	3,397	3,778	3,631	4,442
public health	1,218	1,272	1,391	3,114
structures and equipment	1,654	1,739	1,765	1,726
Total health care expenditures (THCE)	42,876	45,143	47,411	51,998

Slide 33 of the November presentation shows personal health care (PHC) expenditure data from CMS, though it is labeled as total health care expenditures. This contains the same data that is in the first line of Table 1. But as a reminder, slide 33 does not include expenditures on public health, net cost of health insurance (both public and private overhead), or investment (capital expenditures and research), so it is certainly not total health care expenditures.

RAND report data is not of much use

The RAND report is opaque as to what is included. They projected 2020 expenditures of $36.2 billion. They clearly did not include public health and structures and equipment, but that only accounts $3.2 billion of the $11.2 billion difference (if we use 2019 as a proxy for 2020, since 2020 was weird because of Covid). Chapter 7 (Alternative Specifications for the

Options and Other Considerations) of the RAND report indicates that they did not include dental, vision, and hearing. That is still not enough to explain the discrepancy. What else was not included? LTSS? It may not be useful to analyze further.

CBIZ Optumas report data is credible but there are questions

The CBIZ Optumas report is much more transparent and useful, but there are still questions that need to be addressed if we are to make use of it. Again, we need to understand what is included and what is not. Expenditures on public health and on structures and equipment are not included, but insurance costs are. As Warren George noted at our October meeting, the totals listed in Table 3 (p. 13) and Table 8 (p. 30) disagree. The sum of the listed values in Table 8 is actually what is listed in Tabel 3 ($37,570 million). Warren interpreted that as a hidden adjustment, though perhaps it was just an error leftover from some previous calculation. This is $6.7 billion less than expected from Table 1.

Warren also presented a slide (#42) of things not included in the Optumas report, with an estimate of their size:

- DOD, VA, IHS, Schools, Institutions, Worksite (4.5%)
- Research and Investment (not personal care)
- Population Health (not personal care)
- Costs Currently Funded Through Private Donations (5%)
- Out of Pocket costs for service not covered by plan (4 to 7%)
- Long Term Supports and Services (except as provided through Medicaid). (8 to 10%)

Together, the missing items seem to be larger than the discrepancy between Optumas and NHEA. Assuming that Warren presented percentages of the $37.6 billion from Optumas, the listed percentages would amount to $8.1 to $10.0 billion. I suspect that Optumas included some of the things on this list (likely LTSS provided by Medicare?) and that Costs Currently Funded through Private Donations is instead mostly funded by workers comp and property and casualty insurers. But it would likely be helpful to determine this.

I will note that the layout of the Optumas Table 8 is very useful, and could serve as template for more complete, up to date, and granular data.

Data from Oregon Health Care Cost Growth Targets – not yet in a useful format

As presented in slide (#34), Oregon's cost growth target data is not credible. The slide claims to be presenting total health care expenditures for 2021 and 2022. Does it make sense that expenditures in Oregon dropped by $19 billion (37%) from 2020 to 2021? Or that CMS NHEA data is that far off?

We can try to figure out what is missing, but it would be more helpful to hold off on presenting this information until someone figures that out.

Some of what is missing - While Oregon cost growth target data is presented as total health care expenditures, it never purports to include public health or structures and equipment. Instead, it purports to be personal health care (PHC) and cost of private insurance (apparently leaving out government overhead for health insurance?). But that amounts to less than 25% of the discrepancy. What else is missing? An important missing piece is expenditures by private self-insured entities. Such entities are not mandatory reporters but *"OHA also identifies ERISA self-insured plans and invites these payers to voluntarily submit cost growth data."* There does not appear to be publicly available estimates of how much is missing because of this, but OHA may have such estimates.

Slide 35 contains the statement *"In 2022, Oregon spent $9,261 per person per year in overall expenditures. National average in 2022 was $13,493 per person per year."* On most available health care expenditure measures, Oregon is close to the national average. This discrepancy affects slides 36 through 39. Of course, one of the things that is off is that the national average is for total health care costs, and the Oregon value is just for personal health care and the cost of private insurance.

There is a question on slide 42 – "Could this be our starting point for a cost target?" I would say no.

To continue on with an analysis of Oregon's cost growth target data, let us look at hospital expenditures. There is detailed data for hospital expenditures in Oregon from OHA.[2] A summary of net patient revenue for Oregon hospitals is in Table 2.

Table 2. Net patient revenue for Oregon hospitals ($ millions)

	2021	2022	2023
Medicare	4,990	5,544	6,195
Medicaid	2,572	2,643	3,033
self-pay	238	266	245
commercial	6,196	6,292	6,685
other	890	918	993
total	14,886	15,662	17,151

Slide 38 shows reported inpatient claims of $5.38 billion in 2021 and $5.44 billion in 2022, and outpatient claims amount to $5.10 billion and $5.43 billion. These total $10.48 and $10.87 billion. These values are 42% and 44% lower than reported net patient revenue. There is a lot missing from the cost growth data!

[2] https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/Databank%20Q1%202007%20-%20Q4%202023.xlsx

The detailed hospital data can be used to make estimates of other expenditures. From 2014 to 2020, CMS NHEA data indicates that hospital expenditures in Oregon accounted for 37.4% to 38.4% of personal health care (PHC) expenditures. Combining the cost growth data from OHA and the hospital data from OHA, hospital expenditures jumped to 49% of PHC expenditures in 2021 and 2022. That likely gives an indication of how much is missing.

I will note that NHEA data includes more than just net patient revenue in their accounting of expenditures on hospitals, because as the methodology paper says, *"Non-patient revenues are included in the NHEA because hospitals take anticipated levels of these revenues into account when setting patient revenue charges."* When we or a contractor are doing analysis, we may want to think about whether this is reasonable. This difference amounts to between $1.1 to $1.9 billion in the years 2019 to 2023. Even using total revenue, Oregon's hospital reports show expenditures that are only 91% to 96% of what NHEA data shows. Perhaps the state hospitals or VA hospitals in Oregon are part of the NHEA estimates?

Warren pointed out that some lines in the Optumas report combine expenditures in a manner that makes it less useful. The prime example is table 3, note 2 – *"Medicare out-of-pocket is included in the Medicare total line."* A similar combination is in the cost growth data – putting Medicaid expenditures for dual eligibles with Medicare. It might be useful to keep dual eligibles as a separate group, and to list Medicare and Medicaid expenditures for them separately. It is at least important to know what expenditures come from federal sources and what from state sources.

Appendix 1. What are National Health Expenditures?

From p. 6 of the National Health Expenditure Accounts: Methodology Paper, 2022 –

What are National Health Expenditures?

Expenditures in the NHEA represent aggregate health care spending in the United States. The NHEA recognize several types of health care spending within this broad definition.

- Personal Health Care expenditures (PHC) represent all revenue received by health care providers and retail establishments for medical goods and services as well as all non-patient and non-operating revenue, grants, subsidies, and philanthropy received by health care providers.
- Health Consumption Expenditures (HCE) represent spending for all medical care rendered during the year, and is the sum of PHC, government public health activity, and government administration and the net cost of health insurance.
- National Health Expenditures (NHE) equals HCE plus investment, or the sum of medical sector purchases of structures and equipment and expenditures for noncommercial medical research.
- Government public health activity measures spending by governments to organize and deliver health services and to prevent or control health problems.
- Government administration and the net cost of health insurance includes the administrative cost of running various government health care programs, and for private insurers, the net cost represents the difference between premiums earned and the claims or losses incurred for which insurers are liable.
- Finally, the category of Investment includes spending for noncommercial biomedical research and expenditures by health care establishments on structures and equipment.

Appendix 2. Questions and requests for OHA help

Particular expenditure items that OHA is likely able to quickly provide –

MBES data reported by OHA to CMS includes a wealth of information. It would be good to get a compact report of much of this from OHA for the years 2019 through 2023. Presumably what is reported to CMS is for federal fiscal years, Oregon's budgets are set for state of Oregon fiscal years, and CMS NHEA data is for calendar years. Ideally, the information could be presented for each sort of year, or at least making clear for which of these time-frames it is presented.

It would be nice to have information in the following categories, with the federal share and state share clearly identified:

- Total net MAP expenditures
- Total net CHIP expenditures
- Total net ADM expenditures
- Expenditures that go to an MCO
- Expenditures that go towards long term services and supports (home & community based and nursing facility based)
- Expenditures that go towards Medicare premiums
- Any other expenditures that would not be considered as Personal Health Care Expenditures in NHEA reports identified and quantified

Similar information for CAK (Cover All Kids) and HOP (Healthier Oregon Program). HOP is new enough that there is probably not much data, so anything that could help give an idea of what might be expected going forward would be useful. Perhaps this is small enough to be in the error bars of any projection of OHP expenditures?

Particular expenditure items that OHA can likely help with (but might take a little longer?) –

OHA likely has detailed information regarding PEBB and OEBB expenditures. Again, information for the years 2019 through 2023 would be useful.

- How much is paid by employers for PEBB and OEBB private insurance?
- How much is paid by employees?
- What is paid by public employers who self-insure?
- For those public employers who self-insure, how much do they spend on private stop-gap insurance?
- Is there an estimate of administrative overhead of health insurance for public employers?

- Does OHA have similar data for public employers who are not part of PEBB or OEBB?

MBES reports have a line item "Federally-Qualified Health Center". I expect that this is the money that comes directly from the state and federal government for FQHCs, and that FQHCs get further funds from Medicare or Medicaid (or CCOs?) when services are provided. Is that correct? If so, can that further amount be quantified? Do they also get money from the counties that does not first flow through Medicaid/Medicare, and can that be quantified?

Can the money that flows through various public programs to mental/behavioral health be quantified?

On November 8, 2024 OHA released a report on primary care expenditures for 2022.[3] It would be useful for the FRC to discuss how to ask OHA to most usefully provide information from that report to the FRC. Or how members of the FRC can work with OHA to get the most useful data?

Quantify public health expenditures in Oregon, with an indication of the source of funding (federal, state, county, other public entity)?

CMS NHEA data is available for personal health care expenditures for each state.[4] Among the categories of expenditures is "Home Health", which it lists as $1.06 billion for Oregon in 2019. MBES reports indicate $2.3 billion was spent by Medicaid alone on home health in Oregon. The NHEA methodology paper indicates that its "home health" category includes *"expenditures for medical care services delivered in the home by freestanding home health agencies"*. "Hospital-based home health care" is included in the hospital category, and "Medicaid home and community-based waivers" are included in the "Other health, residential, and personal care" category. CMS NHEA lists Oregon expenditures in this last category as $4.0 billion for 2021. Does OHA or HMA have any data or information that can shed more light on this so as to allow reasonable comparisons?

The cost growth target data includes expenditure line items "Oregon Department of Corrections", "BH services provided by additional contracts", and "Oregon Department of Corrections". It would be good to have that information for 2019 through 2023. The UHPGB proposal may be unlikely to affect this, but it might help in comparisons with federal data – especially if OHA can help us understand where such expenditures would be included in NHEA, or if they are included at all. What about other correctional facilities in Oregon?

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[3] OHA just released a report on primary care expenditures for 2022 - https://visual-data.dhsoha.state.or.us/t/OHA/views/PCSR_2024_v2_1_0/Home?%3Aembed=y&%3Aiid=2&%3AisGuestRedirectFromVizportal=y

[4] Health expenditures by state of residence: summary tables (ZIP)

Help from LRO?

LRO might be able to break apart retirement income into social security income (not taxable by the Oregon constitution) and other retirement income (which is taxable in Oregon).

Questions regarding publicly available MBES data and CCO internal financial statements.

1. I would expect that the MBES line item "Medicaid – MCO" would relate to how much CCOs get from OHA. But I tried reconciling the reported values in several years with values reported in CCO internal financial statements under "Revenues". Which of the items listed by CCOs as part "Revenues" would be included in the state total "Medicaid – MCO" value? How are "qualified directed payments" listed on CCO internal statements accounted in MBES reports? What about "insurer tax"?

2. Is it correct that CAK and HOP expenditures are not included on MBES reports?

3. Are there CHIP expenditures that are not listed in the C- lines of MBES MAP reports?

4. Oregon CHIP expenditures reported to the Task Force by CBIZ Optumas ($448 million in 2019) are much greater than what appears to be reported in MBES reports ($121 million in 2019). Please help reconcile this.

5. Does the Certificate of Need process (or some other provisions) allow OHA to quantify expenditures on major capital projects for health care facilities? Is data available for 2019 through 2023?

6. These 6 line items come right after "Prescribed Drugs" line item - *Drug Rebate Offset – National, Drug Rebate Offset - State Sidebar Agreement, MCO - National Agreement, MCO - State Sidebar Agreement, Increased ACA OFFSET - Fee for Service, Increased ACA OFFSET – MCO.* Are these all related to rebates for prescription drugs? How do the MCO lines relate to CCO financial statements?
7.
8.