

Oregon Health Authority

2011-13 Agency Request Budget Reduction Options

ARB – 25% General Fund Reduction Options Requirement:

As the state of Oregon grapples with an ongoing budget crisis, the Governor has asked all agencies to submit a list of budget reductions equivalent to 25% of the General Fund (GF) dollars in the Current Service Level (CSL) budget for the 2011-2013 biennium. (The Current Service Level budget is the projected costs to continue the current Oregon Health Authority (OHA) programs and services in 2011-13, including program caseload growth costs, inflationary cost increases, and the discontinuation of the Federal ARRA stimulus funding received during the 2009-11 biennium.) This reduction list will be submitted with the Agency Request Budget, but is not included in the budget. Rather, they are options the Governor can consider when crafting the 2011-13 Recommended Budget.

Background – from where OHA is starting:

In its 2009-11 budget, OHA identified 99 Policy Packages that totaled \$897.4 million GF and \$3.2 Billion Total Funds (TF) of additional funding needed to begin to meet the true need for Health/Human Service programs and services for Oregon's citizens. Of this, 12 Packages were included in the 2009-11 Legislatively Adopted Budget, totaling \$42.5 million GF and \$1.5 Billion TF. This leaves \$855.2 million GF and \$1.7 Billion TF in unmet Human Service needs that the 2011-13 Current Service Level budget does not consider. Since the 2009 Legislative Session ended and the LAB was completed, OHA has had to make additional budget reductions due to declining state revenues.

It is from this position that the OHA list of reduction options would be applied to achieve a 25% reduction of General Fund.

Approach:

There are principally five types of budget reduction options available to the department:

- Program support/administrative reductions
- Program eligibility restrictions
- Program services/benefits reductions
- Service provider payment rate reductions
- Elimination of programs or services/benefits

In addition, OHA will continue and expand its Continuous Improvement efforts to improve efficiency and reduce costs as part of this list of budget reduction options.

In crafting the list of OHA 2011-13 CSL budget reduction options, OHA leadership identified the following guidelines/guiding principles when prioritizing the reduction list with the understanding that deep reductions will have adverse effects to the Oregonians we serve:

1. Do least the harm to the fewest people.
2. Apply the OHA goals when looking at which services to preserve: improve the lifelong health of all Oregonians, increase the quality, reliability and availability of care for all Oregonians, lower or contain the cost of care so it is affordable to everyone.
3. Continue all administrative reductions, cost controls, and efficiency measures implemented in 2009-11 and prior.
4. Maximize efficiencies and cost reductions available through the federal Affordable Care Act.
5. Consider alternative funding sources and alternative sources for programs that people can access as a stop gap to lost OHA programs.
6. Remove controllable Current Service Level increases first – COLAs, etc.

7. Avoid reductions that will shift people to more costly programs in OHA & DHS.
8. If the choice is between cutting an entire program or reducing it to the degree it is ineffective (“thinning the soup”), reduce the entire program.
9. When programs are reduced or eliminated, make commensurate reductions to support and administrative functions.
10. Recognize that heavy constraints for maintenance of eligibility for Medicaid programs will shift reductions to deeper provider rate cuts and services/benefits.

Coordination of OHA with the Department of Human Services (DHS):

OHA has coordinated with DHS as each department has crafted their respective reduction options around the guideline of “avoiding reductions that will shift people to more costly programs in OHA & DHS”. Each OHA and DHS reduction has been examined in regards to the effect it may have on other DHS and/or OHA programs. These types of reductions have been priced such that any cost shifts to other OHA or DHS programs have been deducted from the reduction option.

OHA budget distribution:

The OHA Current Service Level budget is comprised of:

	<u>General Fund</u> (Billions)	<u>Total Fund</u> (Billions)
Funding that is paid to OHA service providers:	\$ 2.16 (79%)	\$11.97 (93%)
Funding of direct support/services (OSH, BMRC):	\$ 0.39 (14%)	\$ 0.45 (4%)
Funding for direct program support and admin:	\$ 0.18 (7%)	\$ 0.38 (3%)
Total OHA CSL budget	\$ 2.73	*\$12.80
*(Total Fund excluding non-limited funding = \$9.6 Billion)		

Overview of the OHA budget reduction options list:

Since 93% of the OHA budget funds payments to the various providers of OHA services to Oregonians while 4% goes to direct support/care of Oregonians in OHA programs (such as the Oregon State Hospital), the majority of the budget reductions will come in these areas – that’s where the money is.

Reduction options that reduce program services and benefits total \$300 million GF (43.9%) of the total GF reduction list and those options that affect rates paid to providers of OHA program services total \$184.6 million (27%) of the total GF reduction options. These types of reductions are a large portion of the options list because they represent the largest portion of the OHA budget. And, because the agency is constrained in the types of reductions that affect program eligibility and services due to Maintenance of Eligibility requirements of the federal Affordable Care Act, reduction in provider rates is the only viable option for some programs. Violation of this Maintenance of Eligibility requirement will put the entire Federal Medicaid Program funding in jeopardy.

Effects of the OHA budget reduction options:

Oregon Health Plan

Early in the list are reduction options that result from continuous improvement efforts. Some of these include:

- Program integrity initiatives to reduce the amount of waste, fraud and abuse in the program.
- Capturing federal drug rebates for drugs paid for by Medicaid managed care plans.
- Increasing identification and collection of payments from third parties with primary responsibility for payment of medical claims.
- Increasing the use of evidence-based practice guidelines to improve health outcomes for patients.

Some provider payment methodologies would be restructured. Examples include pharmacy reimbursement and outpatient hospital reimbursement. With reductions in the amount paid to providers, clients would begin to see access to services erode.

As we go deeper in the list, the payment reductions would become more significant—keeping managed care capitation rates at the lowest end of the actuarially sound range, reducing payments to managed care plans below hospitals' cost, actually decreasing payments to providers in our fee-for-service delivery system from today's low rates by 5 percent. These types of reductions would require approval by the federal government and would only be approved if they continue to allow reasonable access for clients; however, we know access would continue to erode.

Payment to hospitals for graduate medical education would be eliminated; at the very time we need more trained medical professionals to serve our growing population.

The managed care delivery system would be restructured, potentially disrupting clients' usual source of care, and limiting client choice of providers.

Enhanced reimbursement to hospitals would be eliminated, moving away from the agreement hospitals had with the State when they signed up to pay a tax to support the OHP Standard (expansion adults) program.

Many services would be eliminated for all populations (adults, children, pregnant women, persons with disabilities). These include treatment for gall bladder cancer, fractures that won't mend, acute bronchitis, menopause, osteoarthritis, urinary incontinence, hearing loss, chronic depression, and many more. Elimination of coverage for these services will impact the health and well-being of individuals and their families.

Services that are considered optional by the federal government would be eliminated in their entirety for adults. These include dental, mental health, addiction, and prescription drug services. Obviously, some individuals would not survive without these services; others would see their health deteriorate. There would be increased pressures put on hospital emergency rooms, with costs shifted thereby raising insurance premiums for all, and public safety issues would emerge as individuals lose coverage for addiction and mental health services.

Public Health (PH)

Early in the list are reduction options that result from continuation of administrative reductions used to achieve budget shortfalls in the 2009-2011 budget cycle. Some of these include:

- Implementing a hiring freeze on all General Fund positions that become vacant.
- Targeting reductions in service and supplies such as educational and media campaigns which promote information on certain public health programs.
- Eliminating cost of living adjustments for those contractual areas of which PH has discretion over the contracted amounts in program service delivery.

As we go deeper into the targeted reductions, program support for the Mobile Training Unit (also a reduction in meeting the 09-11 cuts) would be discontinued. PH expects this may diminish EMT capacity in rural and frontier counties that rely greatly upon volunteer EMTs, unless an alternative funding source can be identified to provide this needed training.

Payments to Local Health Departments (LHD) are reduced incrementally through a series of reductions which remove the departments' ability to implement additional clinical services, and reduce income eligibility guidelines removing as many as 39% of clients served.

The Oregon Trauma System would have all funding eliminated. This program implements standards of practice and safety for care and equipment and assures compliance with national standards. Eliminating the Trauma System may also reduce the number of hospitals participating in Oregon's Trauma System, thereby reducing or limiting access to quality trauma care.

The base state support to LHDs and communities operating School Based Health Centers (SBHC) is reduced by 39%. This may result in some Centers closing. Loss of service to an estimated 24,000 clients aged 5-19, which generally use SBHC for preventative treatment services, diagnosis and treating chronic conditions, screenings and education, immunizations, and reproductive health services. Forty-seven percent of SBHC clients were un-insured in the 2008-2009 school year.

State support to LHDs for HIV/STD/TB outbreak investigations is reduced. Additionally, cuts are made to TB drug purchases and other medications that LHDs use to treat sexually transmitted disease. The State Communicable Disease program directly purchases these and distributes to counties during an outbreak. It would also reduce the support in the AIDS Drug Assistance Program (ADAP) CareAssist which could mean implementation of a waiting list for persons needing to be on the program, increase co-payments for those enrolled who may be at risk of

interrupting their drug therapy. Most of these clients are enrolled in ADAP's Care Assist as their safety net, because CareAssist has become their payer of last resort. The collective reductions would cut state support by as much as 69%, and would jeopardize meeting the match and maintenance of effort requirements for the Ryan White Federal Funding.

State support to LHDs for communicable disease monitoring, surveillance and reporting as required under ORS 431,432, 433 and 437 is reduced. Combined with other PH reductions, this further erodes a LHD's ability to maintain a core system.

Addictions and Mental Health (AMH)

In the first 5% cuts:

- Continuation of AMH central office program support staff reductions in the staff vacancy freeze.
- Continuation of no cost of living to contracts for this biennium.
- Oregon State Hospital (OSH) and Blue Mountain Recovery Center (BMRC) freeze positions and cut transitional programs and reduce the Portland-OSH campus by 20 beds.
- Reductions to community services non-Medicaid indigent alcohol and drug and mental health, families and children, crisis services and outpatient.

As cuts go deeper, 5-10%, the community system of care and the institutions continue to reduce capacity and services. Those cuts include:

- Reductions to acute care, children and adult outpatient crisis services.
- Reductions to AMH program management staff.
- The 8-9% reduction level will result in closure of the Portland-OSH campus; the loss of 92 beds.
- Reduction of up to 50 percent of the remaining AMH direct contract programs and elimination of future development of community mental health facilities.

Above 10% reductions, the closure of programs and services continue in increments. Those reductions include:

- Additional community mental health reductions in outpatient crisis services for adults and children.
- Reductions in addictions that reduce outpatient, residential services and elimination of the ITRS affecting families served by CAF.
- OSH closing transitional cottages and three Geropsych non-Medicaid wards.
- BMRC closing a unit resulting in capacity of 40 beds.

Above 20% reductions include:

- Further reductions in AMH staff.
- Continuation of community services reductions in mental health and addictions resulting in a loss of up to 50 percent of capacity.
- The hospitals continue to cut wards, including forensic and Gero Medicaid community facilities.

Above 10% the reductions will result in loss of community and residential capacity that will be difficult to replace until more resources are available. As community staffs are laid off and facilities are closed the ability to reestablish facilities and programs may not be possible. Another problem is that above 5% cuts the federal alcohol and drug and mental health block grants maintenance of effort requirements will not be met further jeopardizing federal funding.