
Medicaid Advisory Committee

May 25th, 2016

Oregon State Library

Salem, Oregon

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font above the word "Health" in a large, blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, serif font. A thin blue horizontal line is positioned between "Health" and "Authority".

Oregon
Health
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Time	Item	Presenter
9:30	Opening Remarks	Co-Chairs
9:40	2014-2015 Section 1115 Annual Report	Janna Starr, OHA
9:50	Oregon 1115 Waiver Renewal <ul style="list-style-type: none"> • Waiver Renewal Update • Housing and health proposal • Committee Q&A • Letter of support from MAC 	Oliver Droppers and Veronica Guerra, OHA
10:20	Oregon 1115 Waiver Renewal – Public Comment	
10:40	Break	
10:30	MAC End of Year Report 2015 and OHA Response	Co-chairs
11:10	Oral Health Access Framework <ul style="list-style-type: none"> • OHA Oral Health Strategic Planning & Initiatives • The Opportunity: Framework on Oral Health Access in Oregon Health Plan • Oral Health Access and Oregon’s Dental Care Delivery System • Committee Q&A and Discussion 	Dr. Bruce Austin and Amanda Peden, OHA
11:50	Public Comment	
12:10	Committee Planning Session <ul style="list-style-type: none"> • Review proposed topical agenda for 2016 • Committee input 	Co-chairs
12:20	Closing comments	Co-chairs

2014-2015 Section 1115 Annual Report

Janna Starr
Oregon Health Authority

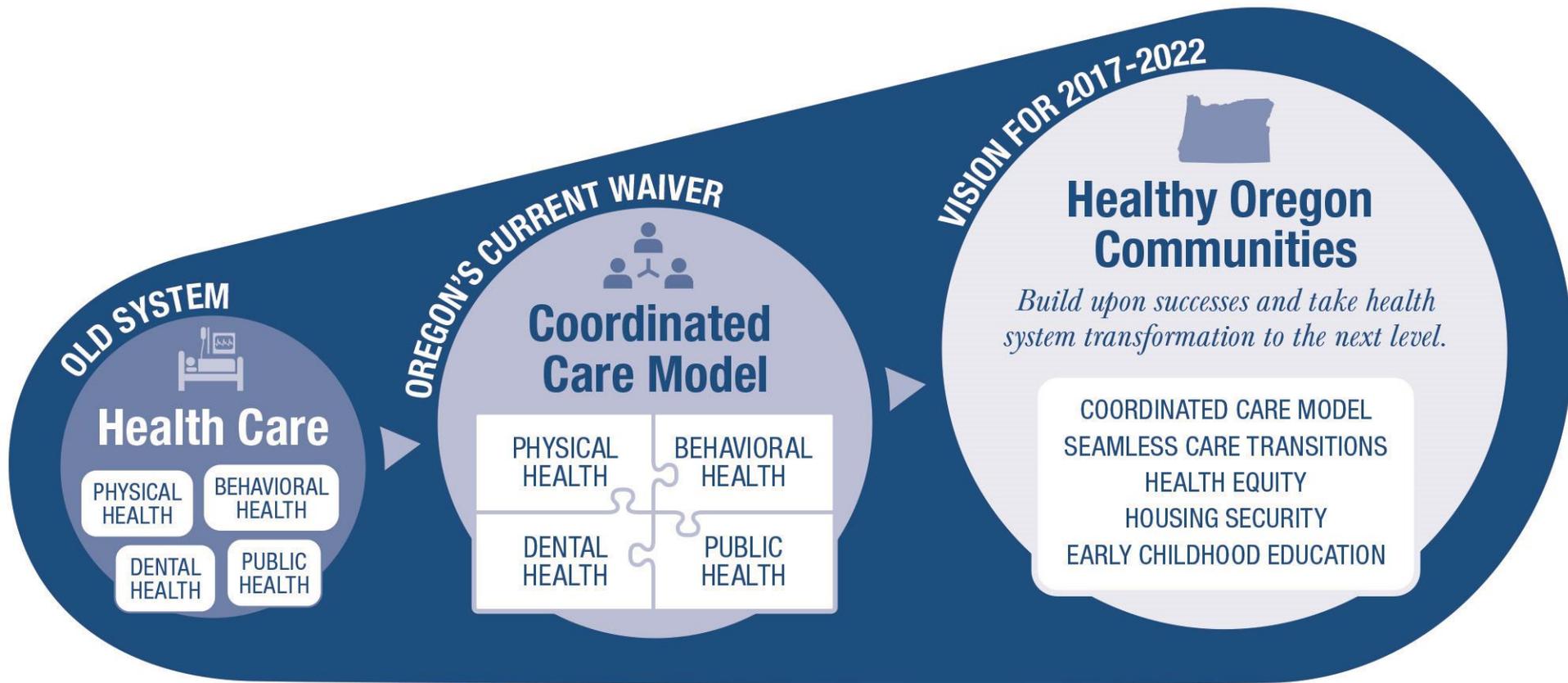
**Oregon's Waiver:
Proposed renewal to Oregon's 1115
Demonstration Waiver with the
Centers for Medicare and Medicaid Services**



Opportunity in Oregon

- A significant number of Oregon's chronically homeless and individuals at-risk of homelessness are now eligible and enrolled in Medicaid
- Leverage Oregon's successful health system transformation and our 16 coordinated care organizations (CCOs)
- Oregon's Legislature and local municipalities have invested millions in expanding affordable housing (2015 and 2016)
- Existing US Department of Justice Agreement with Oregon and the Oregon State Hospital to improve community mental health treatment and programs

Opportunity in Oregon



The Next Level of Reform

1. Build on transformation with focus on integration of physical, behavioral, and oral health care through a performance driven system.
2. More deeply address social determinants of health and health equity with the goal of improving population health and health outcomes.
3. Commit to continuing to hold down costs through an integrated budget that grows at a sustainable rate.
4. Continue to expand the coordinated care model.



Coordinated Health Partnerships (CHPs)

Proposal to CMS: five-year grants to local pilots to increase supportive housing integration among targeted populations and develop infrastructure to ensure ongoing collaboration among the participating entities, including:

- CCOs
- County agencies
- Corrections
- Tribes
- Health providers
- Housing entities
- Local hospitals
- Other entities serving or advocating for the targeted population



Supportive Housing Strategies

Form local collaborations – With five-year grants, support a statewide pilot program of community-based Coordinated Health Partnerships (CHPs) to enhance local coordination and integration of health and housing-related services and transitions of care.

Support and enhance flexible services - Create and enhance access to flexible housing supportive services delivered both by Coordinated Care Organizations (CCOs) for CCO enrollees, and by other providers and community resources for fee-for service beneficiaries in the target population(s)

Develop a menu of supportive services for targeted populations - Create a list of supportive services that focus on domains of homelessness prevention and care coordination, transitional supports, and tenancy sustainability

CHP Target Populations

- High-risk, high needs individuals
 - ✓ With repeated incidents of avoidable emergency use or hospital admissions;
 - ✓ With two or more chronic conditions;
 - ✓ With mental health and/or substance use disorders;
 - ✓ Who are currently experiencing homelessness; and/or
 - ✓ Individuals who are at risk of homelessness, including dual eligibles, and IHS, Tribal, and Urban Indian program constituents, and individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail).
- CHPs may choose to limit the population served within their pilot application
- OHA will work with CHPs to determine the number and focus of target population

CHP Objectives

Pilots will seek to address local supportive housing needs and develop solutions that fit local communities in Oregon. Pilot objectives include:

- Increasing awareness of and access to housing supportive services
- Increasing coordination of housing supportive services for a targeted at-risk population.
 - Local CHPs may identify specific sub-populations to include in pilot program based on community needs
- Reducing inappropriate emergency, inpatient and residential treatment facility utilization
- Increasing access to and use of primary care
- Improving data collection and sharing among local entities to support ongoing case management, monitoring, and improvements

CHP Pilot Design

- Required to provide services across three domains: homelessness prevention/transitions of care, housing transition services, and tenancy sustaining services
 - At a minimum, CHP pilots will be expected to implement one program per domain area
- Individuals eligible for Medicaid coverage in Oregon can decide to participate in a pilot project and opt in and opt out at any time
- Each grantee will be required to develop their own payment methodology and strategies for financing services that are consistent with federal guidelines
- Payments to grantees will be based on meeting process measure targets in the first three year and by the fifth year payments will be made based on member outcomes

CHP Pilot Domains

CHP Pilot Domains	Example: Potential Types of Services
<p>Homelessness Prevention/ Transitions of Care</p> <p>Support to ensure care coordination among non-medical settings; fund services to support an individual's ability to move from institutional settings to less costly community-based care settings</p>	<ul style="list-style-type: none">• Care coordination services for pre-adjudicated criminally justice involved and Oregon State Hospital patients• Acute care transitions to less costly community-based settings• Ensuring that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health• Ongoing assessment of medical, mental health, substance use disorder or dental needs• Case management and coordinating the access to and provision of services from multiple agencies• Establishing service linkages with community providers

CHP Pilot Domains

CHP Pilot Domains	Example: Potential Types of Services
<p data-bbox="102 335 595 454">Housing Transition Services</p> <p data-bbox="102 539 641 845">Invest in pre-tenancy services to decrease health care costs and reduce use of high-cost health care services</p>	<ul data-bbox="685 335 1819 1049" style="list-style-type: none"><li data-bbox="685 335 1535 385">• Tenant screening and assessment<li data-bbox="685 392 1758 621">• Assistance with housing searches and applications, move-in assistance, short-term expenses such as security deposits, other landlord-required rental or lease costs<li data-bbox="685 635 1690 749">• Moving costs, basic furnishings, food and grocery supports<li data-bbox="685 756 1819 806">• Adaptive aids and environmental modifications<li data-bbox="685 813 1748 921">• Housing support crisis plan and intervention services<li data-bbox="685 935 1777 1049">• Care coordination services with medical homes, behavioral health and SUD providers

CHP Pilot Domains

CHP Pilot Domains	Example: Potential Types of Services
<p>Tenancy Sustaining Services</p> <p>Invest in services that support the individual in being a successful tenant in his/her housing arrangement</p>	<ul style="list-style-type: none">• Tenancy rights/responsibilities education; coaching and maintaining relationships with landlords• Eviction prevention (paying rent on time, conflict resolution, lease behavior requirements)• Utilities assistance/management (energy/gas)• Landlord relationship/maintenance• Crisis interventions and linkages with community resources to prevent eviction when housing is jeopardized• Linkages to education/job training, employment• Care coordination services with medical homes, behavioral health and SUD providers

Preliminary Evaluation Considerations

- Reductions in ED use and psychiatric acute care hospitalizations or boarding
- Increases in primary care and behavioral health care use, including medication adherence
- Decreased discharges to secure residential treatment facilities
- Increase in transitions from recovery to permanent housing settings
- Increase in access to care and quality of care after moving into housing
- Retention in housing unit for 12 months or longer
- Increase in percentage of adults accessing employment and benefits services
- Increase in the percentage of individuals that transition to affordable housing (market rate housing/community housing placement)
- Increase in self-sufficiency among those served

Community Engagement

As part of our waiver renewal process, Oregon is engaging key communities of interest for input:

- Tribal Leaders in consultation
- Consumer and member advocacy groups
- Hospital and health system leaders
- Coordinated care organization leaders
- Local governments
- Health and health care committees, advisory groups, and workgroups
- Local organizations and non-profits with a stake in key components of the waiver

OHA has participated in more than 75 meetings with stakeholders, community partners, and the public

Process Going Forward

- Public input and tribal consultation through June 1
 - [Draft waiver application posted for public review](#)
 - Community Survey on waiver priorities
www.surveymonkey.com/r/QPW23N
 - Community, stakeholder, and policy presentations and meetings
- Draft application submitted to CMS mid-June
- Reach a high level agreement with CMS on renewal by fall
- Quickly work through issues and concerns raised by CMS
- Finalize the waiver renewal in early 2017 with implementation beginning July 1, 2017

Questions?



For more information, visit:

<https://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>

Photos: Oregon State Archives

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Public Comment: Oregon 1115 Waiver Renewal

BREAK

MAC End of Year Report 2015 and OHA Response

OHA Oral Health Initiatives

Dr. Bruce Austin, Dental Director
Oregon Health Authority

Oral Health in Oregon: Children

- Up to 3,800 first and third graders suffer from oral pain or infections on any given day
- More than 1 in 2 Oregon kids had cavities
- About 1 in 7 had rampant decay (7 or more cavities)
- Disparities: regional, income, race/ethnicity



Oral Health in Oregon: Adults

- 40% of adults 18 and over have lost one or more teeth¹
- More than 1 in 8 seniors have lost all teeth (are edentulous)¹
- In 2010, ED visits for non-traumatic dental problems in Oregon cost \$8 million²
 - OHP enrollees were four times more likely than commercially-insured Oregonians to visit ED for dental problems

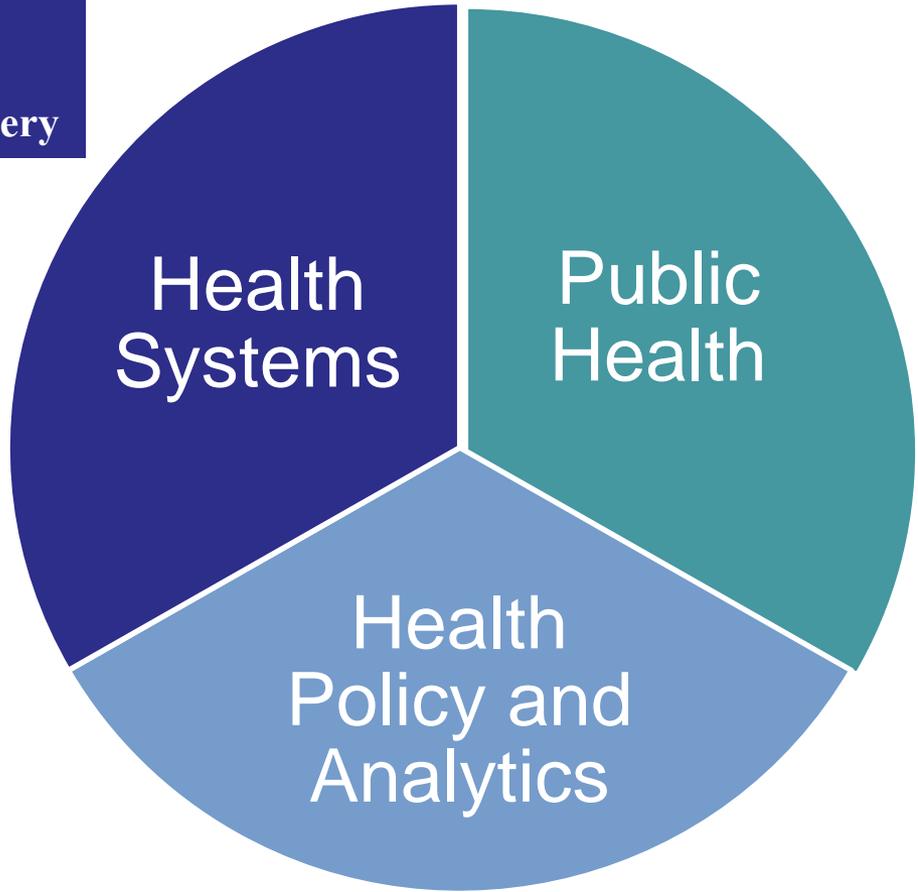
1. 2014 Behavioral Risk Factor Surveillance System (BRFSS) data from the Oregon Oral Health Surveillance System
<https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/surveillance.aspx>

2. Sun, B. & Chi, D. Emergency Department Visits for Non-Traumatic Dental Problems in Oregon State (2014). http://www.oregoncf.org/Templates/media/files/oral_health_funders_collaborative/dental-report-final.pdf

Oral Health in OHA

- Medicaid Policy Analysis
- OHP oral health benefits and delivery

- State Dental Director (works across agency)
- Dental data hub and dental metrics
- Oral health policy development/health system transformation policy
- Coordination/strategic planning



- Oral health surveillance
- School-based programs
- Dental pilot projects
- Public health interventions local & statewide (e.g. Title V)
- Health education (e.g. tooth brushing, benefits of fluoridation)

Oral health in a changing landscape

2013

Medicaid expansion

Affordable Care Act Insurance Marketplaces launch

- Pediatric dental of one 10 Essential Health Benefits



2015

State Health Improvement Plan (2015-2019)

- OHA Public Health Division created plan for statewide use
- Oral health one of 7 priorities

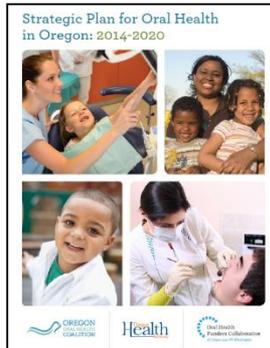
OHA Dental Director hired

Dental sealant metric adopted as of 2016

2013

2015

2017



2014

Strategic Plan for Oral Health in Oregon (2014-2020)

- Statewide multi-stakeholder plan for oral health improvement

Dental integrated into CCO model (July)

2016

Oral Health in Oregon: OHA Dental Director report to the legislature (March)

Restored certain dental benefits

Where are we now?

OHA Oral Health Strategic Plan

Develop a coordination and alignment roadmap for oral health work across the agency

1. Integrate OHA-specific priorities and strategies from existing statewide oral health plans
 - [Strategic Plan for Oral Health in Oregon: 2014-2020](#) (Oregon Oral Health Coalition/Oregon Health Authority/Oral Health Funders Collaborative)
 - [State Health Improvement Plan: 2015-2019](#) (OHA Public Health Division)
2. Gap analysis to identify emerging oral health priorities and strategies in the context of:
 - Health System Transformation 2.0
 - OHA Priorities 2016-2017
 - Pending 1115 Waiver Renewal
 - OHPB priority area: system integration (February 2016)

Timeline: Summer/Fall 2016

The case for considering access in Oregon

- Historically, OHP members show lower utilization rates than the general population
 - In 2014, 23% of OHP adults had dental visit in 2014¹; while 67% of all adults reported having a dental visit²
- Recent developments call for agency exploration of oral health access
 1. **Influx of new enrollees:** over 440,000 Oregonians newly enrolled in OHP since Medicaid expansion
 2. **Oral health integration:** Integration of oral health into CCO model occurred in July 2014.
 3. **State responsibility re: network adequacy:** Recent CMS rules require network adequacy standards for pediatric dental providers

1. OHA administrative data

2. 2014 Behavioral Risk Factor Surveillance System (BRFSS) data from the Oregon Oral Health Surveillance System
<https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/surveillance.aspx>

Access to Oral Health Services in Medicaid

Amanda Peden, Policy Analyst
Oregon Health Authority

Five As of Access

- **Affordability** is determined by how the provider's charges relate to the client's ability and willingness to pay for services.
- **Availability** measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client.
- **Accessibility** refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location.

*Wyszewianski, L., McLaughlin, G. (2002). Access to Care: Remembering Old Lessons. [Health Services Research](#), 37(6), 1441-1443

Five As of Access (cont.)*

- **Accommodation** reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client. Of greatest concern are hours of operation, how telephone communications are handled, and the client's ability to receive care without prior appointments.
- **Acceptability** captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and vice versa. These characteristics include the age, sex, social class, and ethnicity of the provider (and of the client), as well as the diagnosis and type of coverage of the client.

*Wyszewianski, L., McLaughlin, G. (2002). Access to Care: Remembering Old Lessons. [Health Services Research](#), 37(6), 1441-1443

Medicaid's Purchasing Power



Medicaid serves 68 million Americans

With expansion, may serve up to 79 million



48% newborns

33% children

Many people with chronic illnesses and disabilities

Many frail elderly



Poor health care quality is an issue for all Americans; however, the gap is substantially greater for Medicaid beneficiaries



As the largest purchaser of health insurance, Medicaid can leverage its purchasing power to:

Access performance data

Identify and address gaps in quality

The Severity of the Problem

- Low-income adults are 40% less likely to have **visited the dentist** in the past 12 months than those with higher incomes.
- 42% of non-elderly, low-income adults have **untreated tooth decay**.
- More than one-third of elderly, low-income adults have **lost all their teeth**.
- Poor oral health **elevates risks for chronic disease** such as diabetes and heart disease.
- Poor oral health can lead to **lost workdays and reduced employability**.

Populations at Greater Risk for Oral Health Problems*

- Chronically Ill
- People with special health care needs
- Elderly
- Institutional/homebound
- Racial/ethnic minorities
- Residents of rural or underserved areas
- Homeless
- Pregnant women and mothers



*The Institute of Medicine (2011). "Improving Access to Oral Health Care for Vulnerable and Underserved Populations." Available at: <http://www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf>

Key Barriers to Oral Health among Low-Income Adults

- **Inadequate Coverage**
 - ▶ Many states have eliminated or cut Medicaid adult dental benefits
 - ▶ Scope and frequency of adult dental benefit coverage varies by state
- **Insufficient Provider Availability**
 - ▶ Low dentist participation in Medicaid driven by low reimbursement rates, administrative requirements, patient behaviors
- **Individual Barriers**
 - ▶ Inability to make work/childcare arrangements or to obtain transportation
 - ▶ Low oral health literacy
 - ▶ Perception that oral health is secondary to overall health
 - ▶ Knowledge of dental coverage and how to utilize benefits

Current Definitions of Medicaid Adult Dental Benefit Categories

Medicaid Dental Benefits	Emergency Only	Relief of pain under defined emergency situations (e.g., uncontrolled bleeding, traumatic injury, etc.).
	Limited	Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per-person annual expenditure cap is \$1,000 or less.
	Extensive	A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA; per-person annual expenditure cap is at least \$1,000.

Dental Benefits Offerings for States' Adult Medicaid Base and Expansion Populations

Dental Benefits Category	Offered to Medicaid Base Population	Offered to Medicaid Expansion Population
No dental benefits	5 states: AL, AZ, DE, MD, TN	4 states: DE, AZ, MD, ND
Emergency-Only	14 states: FL, GA, HI, ME, MS, MO, MT, NV, NH, OK, TX, UT, WV, ID	4 states: HI, NV, NH, WV
Limited	17 states: AR, CO, DC, IL, IN, KS, KY, LA, MI, MN, NE, PA, SC, SD, VT, VA, WY	10 states: AR, CO, DC, IL, IN, KY, MI, MN, PA, VT
Extensive	15 states: AK, CA, CT, IA, MA, NJ, NM, NY, NC, ND, OH, OR , RI, WA, WI	11 states: CA, CT, IA, MA, NJ, NM, NY, OH, OR, RI, WA

Why Address Adult Oral Health Now?

Improve Oral Health Across the Lifespan

- Surgeon General Landmark Report: Oral health is integral to overall health and well-being.
- Adult dental service utilization lags behind children's.
- Major barriers: coverage, access, personal/financial.

Leverage Momentum From the ACA

- Twenty-eight states plus DC expanded Medicaid eligibility for adults under Affordable Care Act (ACA).
- All states have the opportunity to include or enhance dental benefits for base and expansion beneficiaries.

Effectively Manage Costs

- Increasing use of emergency department (ED) for dental needs.¹
- 70% of dental-related visits to the ED from 2008-2010 were by residents of low-income geographic areas.²

1. Health Policy Institute, American Dental Association (2013). "Dental-related emergency department visits on the increase in the United States." Available at: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0513_1.pdf

2. V. Allareddy, S. Rampa, M. Lee, V. Allareddy, and R. Nalliah. "Hospital-based Emergency Department Visits Involving Dental Conditions: Profile and Predictors of Poor Outcomes and Resource Utilization." *Journal of the American Dental Association*, 145, .4 (2014): 331-337.

State Strategies to Promote Oral Health Access

- Outreach targeted to newly eligible and hard-to-reach populations (e.g., homeless).
- Building connections and support through stakeholder engagement and collaboration.
- Financial and non-financial incentives to improve the number of and access to oral health providers.
- Expand the dental workforce through use of alternative practice and mid-level providers.

Oral Health Access Framework

Dr. Bruce Austin, Dental Director and
Oliver Droppers, Policy Analyst
Oregon Health Authority

The Opportunity: Oral Health Access Framework

OHA ask to Medicaid Advisory Committee:

Develop a framework for defining and assessing access to oral health for OHP members.

The Opportunity: Oral Health Access Framework

Two questions to direct committee's work:

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should we define access)?
2. What key measures should OHA use to assess access to oral health services for OHP members (i.e. how should we monitor and identify access problems)?

Proposed Committee Work Plan

Date (2016)	Task Description
<p>May 25 (MAC Mtg.)</p>	<p>Introduce OHA request to develop the framework for assessing oral health access in OHP and committee work plan; present background on oral health for adults in Medicaid, summary of oral health delivery system in Medicaid, and summary of OHA strategic priorities and initiatives. Committee to consider creating a Dental Work Group to advise the committee on dental access framework.</p>
<p>June</p>	<p>Dental Access Work Group meeting: consider factors that help/hinder oral health access. Develop a working definition of access.</p>
<p>June 22 (MAC Mtg.)</p>	<ul style="list-style-type: none"> • Dental Access Work Group present list of key factors influencing access for OHP members and working definition of access. • Present national/state model definitions and factors; presentations on model metrics/measures from active dental work groups.
<p>July</p>	<p>Dental Access Work Group meeting: Develop and prioritize list of key measures influencing access for OHP members.</p>
<p>July 27 (MAC Mtg.)</p>	<p>Dental Access Work Group present prioritized list of key measures for committee consideration.</p>
<p>August</p>	<p>Dental Access Work Group meeting: Review draft memo on framework for oral health access in OHP</p>
<p>September 28 (MAC Mtg.)</p>	<p>Review and finalize draft committee memo on framework for oral health access in OHP for OHA</p>

Questions?

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Public Comment: Oral Health Access Framework

Committee Planning Session