

**DHS – APD Stakeholder Listening Session March 23, 2016 regarding Budget Note HB 5026**

**Best Case Scenario**

**Alternate Case Scenario**

Program is fully funded - Caseloads grow as forecasted - Need to slowly bend the cost curve

Program is not fully funded - Reductions below current service level - Need to rapidly bend the cost curve

Best Case Scenario			Alternate Case Scenario		
CORE VALUE	POTENTIAL OPPORTUNITY	GREATEST ANGST	CORE VALUE	POTENTIAL OPPORTUNITY	GREATEST ANGST
Believe in the APD Mission, Vision, and Goals	Greater collaboration between healthcare and long term services and supports	Services for high needs consumers could be reduced so much – compromising independence	Family values (you do it yourself)	Tax population	Consumer impact on those who may lose services
Keep families strong through support			Technology assisted devices	People become sicker > increasing cost	
ORS 410 Older citizens are entitled to enjoy their later years in health, honor and dignity, and citizens with disabilities are entitled to live lives of maximum freedom and independence	Ombudsman for Durable Medical Equipment who could break down brick walls	Maintaining caseload – given attrition (specifically individuals with moderate to late stage dementia)	Choice	Forces innovation and new practices	Greater case management and caseload need, less focus on matching services to individuals and their need, reducing person centered care
Mentioned numerous times: Choice, Dignity, Independence	Navigators to help consumers through the system	Lack of proper planning	People first is no longer a priority	PARIS –related to using Federal programs in lieu of State program when appropriate	
Person first– least restrictive – centered on needs	Get Congress to permit competition amongst Rx providers for Part D drug costs	Budget forecast for 17-19	Shared sacrifice	Look for creative ways to make services more affordable, or more accessible	Mental Health first to be cut – costs more in long-term
Evaluate and measure accountability	Innovations – especially use of better technology	Transportation as a barrier to using services	Unemployment for homecare workers	Forces greater focus on evaluation and assessment	Risk of being out of compliance with state regulations
Continued innovation – taking the lead	Dual eligible, pre-duals, and persons most at risk – care and cost (triple aim)	People will not get needed services and suffer as a result	No longer set example (as a leader in long term supports)	Puts greater focus upon private pay or family caregivers	Inability to use real data measures to evaluate and adjust for unintended consequences
Person centered services and programs	Shift focus to non-Medicaid (private pay or care) family caregivers	ALFs rising costs providing least acuity/frailty compared to AFH, RCF, in-home	Financial stability	Force Employers to see impact and help	More costs on state budget for services
Move Medicaid residents from high priced nursing, assisted living and residential care facilities into adult foster homes	Programs and services to more people across the State	Lack of funding for Adult Day Care Centers	Remind Legislature and Governor of promise to provide 50% savings with single medical deduction to long term services and supports	Focus on prevention as a cost containment strategy	Long term services and supports is forced into medical model
Choice; respecting choice, maximizing choice and promoting individual choice	To serve the growing number of people diagnosed with Alzheimer’s and other related dementias across the disease process, not when in crisis or in as a reaction to a dangerous situation (i.e. APS)	DHS leadership changes, lack of stability		Service and assessment tools qualifications	Snowball effect of cuts could lead to a recession – fewer tax revenues – more unemployment and other demands on system
Providing equitable access		Due to the growing population, the current funding of services can’t be funded or sustained given the current delivery system		State lottery that funds APD, sales tax or soda and candy tax	Loss of services
Preventive services/focus on prevention		Demographics – different impact for different populations (age based)		Keep track of those cut from services (discussion on the value of knowing what happens to those who are cut from services and if, as an example, they come back to a higher level of service or become sustaining with something different)	Penny wise – pound foolish
Risk tolerant	To support care partners (givers and recipients)	Multnomah Co implementing “rules” before approved	Zero changes to the values, can see changes when the values are driven by a stricter bottom line	Partnering – volunteers – interns	Pitting kids, schools, public safety and others vs older adults and persons with disabilities
Do no harm		Wait list for Services		State funded senior companion program	Forced in-home cuts
Interdependence	New minimum wage – more \$ into State	Minimum wage changes		Better demonstration project versus K state plan	Can’t carry over
Engagement of consumers	General assistance expansion	Developing outcomes around data – data needs to show we are making a difference		Try to find more money	More homeless
Access and well trained caregivers	Create a state with no boundaries – work together to focus on consumer	More housing – especially for bariatric & mental health consumers		Family contribute to Medicaid care plan	Loss of community based services
	Better waiver	Oversight of new care		Natural supports	Potential for reduced quality of care and services
	PACE program expansion	Department of Labor impact, home care services program			Staff turnover - field strain
	Expand OPI to all people with disabilities	Lack of resources for prevention and early intervention			Lack of preventative services
					Cut to overall programming and staff who deliver the services
					Individuals moving to higher care needs if cut from services at a lower case level

Foreign competition with pharmaceutical companies	Staying in home is seen as too expensive – reduce choice			
Better coordination of services	Kids vs services (pitting service streams)			
Add a 6th resident to adult foster homes	Never plan appropriately			
Universal Provider number	Lack of workforce			
PACE Pilot Act – serving dual eligible	Funding			
Better intact forms and standards	Population expansion			
Expand workforce	Oversight of new providers			
Support and education around special populations (dementia, mental health)	Looking for a silver bullet – there is no such thing			
Consider how to heighten or strengthen role of natural supports	Quality of care with dissemination of system			
Ability to offer enhanced services to individuals diagnosed with intellectual, cognitive and physical disabilities	Long term services & supports may be forced more into a medical model			
Preventative services and programs	Unfettered housing w/services			
Innovation bring better services and more federal money	Not innovating or addressing pre-long term services and supports and ways to help families care			
Quality housing with services program	Legislative intent & budget note			
HCBS seen as a cost saver – changing the dialogue around Salem on that	Lewin Group, recommendations too severe			
Focus on pre-Medicaid population, delay or defer	Lack of funding to support community resources			
Stronger emphasis on prevention and early intervention	Increasing workload or field staff – unmanageable			
Wraparound services to keep folks in-home longer; including technology supports	Federal labor rules adding non-productive costs, requiring reductions in the # of persons who can be served			
Commitment to workforce development	Lack of community understanding aging needs			
More, robust training and cross agency coordination	Jumping from one plan to another, no fidelity			
Could find enhanced Medicaid Federal money through creative approaches	Quality of care will get worse instead of better			
Better coordination of services	Sustainable funding			
More support for family caregivers would delay entrances into higher levels of care or into Medicaid system	17-19 cuts so low requiring significant cuts to programs			
Service assessment – tweaks around # of hours & type (services for IDL's and IADL's)	Not driven by evidence based outcomes			
	Legislators lack of knowledge of situation			
	Not enough guardian's for individuals who are cognitively impaired: Who decides risks, decides programs to enroll in, and makes Medicaid decisions?			