**OHA Stakeholder Meeting Synopsis**

**Sept. 15th, 2016**

**Budget**

The proposed OHA budget will grow by 1 percent, or $228 million, from the previous biennium to account for inflation (as set by the state), phase-ins from previous legislative sessions, a reduction in federal funds for the expanded Medicaid program, changes in the Medicaid caseload, and changes in revenue streams.

The General Fund is expected to see a 48 percent growth, or about $1 billion, due to a reduction in federal match funds for the ACA (down to 95 percent in 2017 and continuing down every January until it reaches 90 percent in 2020), decline in Title 19 non-ACA match rate due to economic improvement, a decrease in tobacco tax revenue, phase-ins and phase-outs, inflation and other cost increases, caseload changes, the expiration of one time funds, and technical adjustments.

This is a moment-in-time budget, based on current law, which reflects exactly what we know today.

Q: Does the expected change in caseload mean people who were on Medicaid are no longer going to be on Medicaid, or does it mean we’ll have a more accurate number?

A: It represents a more accurate forecast. The forecasts are done by trend lines, and due to data issues, the original forecasts were too high.

Q: How far will the federal match in ACA funds go down in total?

A: It will ultimately go down to a 90 percent federal match rate.

Q: Does the caseload number reflect people moving from under 100 percent of the federal poverty level (FPL) line up to the 138 percent FPL line where we have a federal match that’s higher than traditional Medicaid? If so, do the people moving up and people moving down cancel each other out?

A: It’s reflective of things going both ways; we are seeing some ACA folks shifting into a lower FPL as well as people moving up. We can get back to you with more specific numbers.

Q: Will the traditional Medicaid population reimbursement rate drop? What are we being reimbursed for now for the expanded Medicaid population?

A: The traditional Medicaid reimbursement rate will stay at 65 percent. Right now, we’re being reimbursed at 100 percent for the expanded Medicaid population, which will decrease to 90 percent by 2020. It is important to note, since these are trends we’re watching, that the traditional Medicaid population is growing.

Q: Now that we kind of have a snapshot of what the Medicaid population, do you have an idea of where it should be? How many people would ideally be on Medicaid?

A: We’re doing some research on that, both in-house and through monthly meetings with DCBS. Although we don’t have a hard number of where our state should be, we’re looking at other states’ experiences (like Washington, where 30 percent of the population is on Medicaid) as well as contributing factors. We keep thinking, and hoping, that it should be just under a million. We will be implementing fraud systems in 2017 to help with this.

Q: If Measure 97 fails, have you prepared cuts to the budget to make up the deficit? It would help the stakeholders to know so we can all be on the same page.

A: We will absolutely provide you with that information via our website as soon as we’re able.

**1115 Waiver**

OHA is very enthusiastic about our waiver and we’ve proposed some innovative things that the federal government is very excited about. Our proposal includes tactics to address transitioning people out of prison into the community successfully, getting the federal government to invest in more initiatives in Oregon, and innovative ways to address social determinants. Our waiver review is currently in progress, and more information is available on our website.

Q: We’ve heard some members of Congress are challenging CMS. Is there anything we can do to communicate to members of Congress that we support Oregon’s waiver and work with CMS?

A: Our general experiences tells us that CMS will go through a major transition with the presidential election. That being said, the success that Oregon has demonstrated to date, like staying within the 3.4 percent annual growth trend, puts us in good stead for attracting CMS investment. There probably will be some opportunities to communicate with the Oregon delegation, but if you’re already working with members of Congress and you why to say why you support our waiver, that’s appreciated.

Q: How does the waiver address the incarcerated population, particularly in terms of coverage, Hep C, and housing?

A: We are operating in a controlled expense model, and we’ll be looking at the data in December that will give us the best look we’ve had at the population to prioritize effectively. Thank you for the reminder to consider the incarcerated population.

**USDOJ and Oregon Performance Plan/behavioral health update**

The Oregon Performance Plan, which went into effect July 1, is a very useful tool for addressing the challenges of severe and persistent mental illness in Oregon. There is a team of people within the agency that are accountable for that work, and a behavioral health specialist has been assigned to meet with OHA on a bimonthly basis to track our progress. Part of the work we’ve been doing with the state hospital and .370 commitments has been in preparation for this plan. The reason we’ve convened the Behavioral Health Collaborative is to address the challenge of building the community infrastructure to address the needs of those with severe and persistent mental illness in their communities. The collaborative will be producing a report in November with recommendations to the Legislature that will help us have conversations with hospitals, CCOs, and county mental health programs about what we can do in Oregon to improve mental health outcomes.

Q: There are very specific targets in the USDOJ agreement. Should we expect a package that goes to Ways and Means? What will that package look like?

A: There may be a package in the future, but right now we’re looking at current spend and current allocation.

Q: Has a county baseline been created?

A: The mapping tool, which is online, has county baseline data. If that’s not sufficient, let us know and we can get you additional data.

Q: Senate Bill 1515 is having a drastic impact on the foster system that could ultimately blow back on the state hospital and health care system. Does OHA have a crisis response in place should that happen?

A: We’re allocating staff to DHS and working closely with them to help with the crisis. For the last six months we’ve been compiling data for the residential care of children over a five-year period that shows places where there are gaps and challenges that will help us address the situation.

Q: Last year you convened behavioral health town hall meetings. What did you glean from those that has gone into the waiver or that you plan to use in the future?

A: Four things grew out of that: 1) It informed the structure of the Behavioral Health Collaborative and the way it’s addressing issues. 2) It brought attention to the members of the system’s needs for natural supports, housing, and jobs. 3) It highlighted the way in which people cycle in and out of the system because we’re not meeting all their needs. 4) It raised the voices of the users to participate in the changing of the system.

Q: With the coordination of care benefit for OSH patients in the waiver, where does this leave the KEPRO contract? Is there going to be a carve-out for the care coordination of OSH patients or will CCOs be expected to manage that?

A: I don’t know, but we’ll get back to you with more information.

**Public Health Modernization**

One of the great opportunities Oregon has is this integration between public health modernization and health system transformation. It was Dr. Goldberg’s vision to get public health, Medicaid health, and the state hospital in one place, to leverage outcomes, use money more effectively, and get more people the care they need. I applaud that vision and we’re about to give it a test drive. In Oregon, it’s our plan to integrate the work that’s done by the CCOs with the Medicaid population, the state hospital, and the public health departments across the state.

Q: The county public health department is an equity partner with CCOs. The problem with the public health model is that it’s divided in two where one side is focused on regulation and the other on prevention. Is it time to separate them?

A: That discussion is going on right now, but the challenge in Oregon is that we’re a small state and to the effect that we’re savvy and use our resources wisely, what it means is we get more done.

**Access to coverage**

There’s going to be a report released today (Sept. 15, 2016) on Oregon’s ranking for access to coverage. I’d like to put that on the agenda for our next meeting once you and I have had a chance to see the numbers. What I will say is that Oregon is in the top quartile of getting people enrolled in services. We’ve made significant progress, we’ve exceeded other states, and we regularly consult with other states on how they can improve enrollment. However, we have access challenges yet to be conquered so the work’s not done. We’re three years into this massive social transformation, and what we look at every day at OHA is not if it’s done and perfect, but if reasonable progress is being made.

**Oral health**

It’s really impressive in the three years of health transformation in Oregon how our dental community has become not just advocates for good dentistry, but how they really get the connection between oral, physical and behavioral health. All of us in this room fully understand the implications of dental health for physical health, and so we have some challenges going forward. We have the challenge of access and getting people into the office, of scientifically evaluating the services offered and their impacts on the communities we serve, and making sure rural communities have the access they need. We have lots of work to do there, but many states don’t provide dental benefits, at all, to their Medicaid population so again, Oregon is at the forefront of trying to get this done and done well.

Q: What’s the comparison with the commercial numbers?

A: I don’t know, but we’re looking at that right now, and we’re specifically looking at the exchange. Part of our collective challenge is that the premise of the ACA is, in part, that the exchange works and right now there are some challenges across the country with the exchange. Our partners at DCBS are telling us that one of the challenges we’re seeing in that space is that young people who go on the exchange as their first insurance experience are not excited about what they’re seeing.

Q: Do you have any data regarding EDs and dental care?

A: I don’t know but we can look. I know from my conversations with ER doctors that it’s a problem, and I know from my behavioral health work that it’s a huge problem for children in the behavioral health system. It’s a huge cost and we have people who have very serious dental needs that keep them from getting jobs.

Q: Will this be folded into CCO metrics?

A: Yes. The COFA community intends to study adding dental care this session.

**Additional questions**

Q: Are the LCs (legislative concepts) online?

A: The POPs are online in the big budget document. The LCs are not yet online because many of them have not gone through legislative counsel.

Q: On the priorities handout, it’s really hard to have a meaningful discussion about aligning value based payments with rate structure without more details.

A: One of the things the agency has done is set priorities so that we’re not only responsive to the requirements of the federal government, state government, and Legislature, but also so that we hold ourselves accountable as an agency to getting things done on a biennial basis. The value-based payment work is housed in several areas and there’s layers of details in different settings on the website and in our work plans. There’s an aggressive amount of work going on in HP&A; Mannat has been working with the CCOs in that space. There’s also work going on that will be housed in the Behavioral Health Collaborative, work with CMS and the waiver, and work in the rate discussion as well. We don’t have that all figured out, we just have people working intensely on it.

**Future topics and promises for additional information**

* Alternative payment methodology
	+ Both CCO and health clinic APMs
* EMS in rural communities
* Data regarding EDs and dental care
* Access to coverage
* Care coordination for OSH patients under the new waiver
* Data sharing from a state level (potentially looping in other agencies to talk about this as well)
* Pharmaceutical costs and legislation related to it
* The work OHA is doing on Senate Bill 440 & 231
* The work OHA is doing to provide health care to all children (related to legislation aimed at expanding health care to undocumented immigrants)