December 2016 Legislative Update

Quote of the Week

“It’s the most wonderful time of the year - and not just because it’s the holiday season, but because it’s also open enrollment season over at HealthCare.gov. That was a dad joke, I know.”

President Barack Obama promotes the Affordable Care Act as Donald Trump, the President-Elect, vows to repeal it.

The spotlight issue: The Governor’s Office and Oregon Health Authority have submitted a request to the federal Department of Health and Human Services Centers for Medicare and Medicaid Services to renew Oregon's Medicaid Demonstration waiver. Oregon’s initial waiver was approved to establish the Oregon Health Plan in 1994. The most recent waiver, approved in 2012, was for the Coordinated Care Organizations and is set to expire in June of 2017. Given the change in administration, officials are working to get the request fast-tracked. For more information: [http://www.opb.org/news/article/kate-brown-donald-trump-slimmed-down-medicaid-waiver/](http://www.opb.org/news/article/kate-brown-donald-trump-slimmed-down-medicaid-waiver/)

Oregon’s Newest State Senator

The Lane County Board of Commissioners appointed James Manning, of Eugene, to the Oregon Senate, filling the seat to be vacated when Sen. Chris Edwards (D-Eugene) resigns at the end of the year. Sen. Edwards is leaving to take a position with the University of Oregon.

Legislative Deadlines

**Wednesday, December 21**: Deadline to submit legislative concept drafts to Chief Clerk of the House or Secretary of the Senate for pre-session filing.


**Wednesday, February 1**: 2017 Legislative Session begins.

Governor Brown releases her recommended budget for 2017-19 on December 1

Here are the highlights:

- New taxes are needed to cover the $1.7 billion budget shortfall
- The General Fund (GF budget) is $20.8 billion for the 2017-2019 biennium.

The defeat of Measure 97, the minimum corporate tax increase, means new revenue is needed to balance the budget. (Note: the Better Oregon coalition wants to pass a two percent tax on
gross receipts for companies with more than $100 million in Oregon sales. They also want to increase the state’s tax on health care companies.)

- Her budget includes proposed increases on tobacco, liquor and a hospital assessment and insurer taxes. These increases would generate $897 million. The hospital assessment and insurer taxes are designed to provide health care coverage for every child (Cover All Kids) in Oregon.
- Implementation of Behavioral Health Investments -- fully implements the 2015-17 OHA budget state fund investments of $22 million for Oregon's mental health system and $6 million for addiction services.
- Reductions include a proposal to close the Junction City state psychiatric hospital which opened in 2015, and the elimination of a program that provides health care information to families with children who have special medical needs.

The transportation funding package (one of the big issues for next session) is not included in this bill. A separate bill will be introduced during session.

The co-chairs of the Legislature’s Joint Ways and Means Committee will counter with their own budget early in 2017.

December Legislative Days
House and Senate Health Care Committee hearings
Oregon legislators convened this week for interim legislative days. The Health Care Committees held informational hearings on the Behavioral Health Collaborative, OHP Enrollments and Renewals, Opioid Prescribing Guidelines, the Health Insurance Marketplace, Patient-Centered Primary Care Homes, Coordinated Care Organizations and rate-setting. They also offered a preview of committee bills (see bill summaries). The deadline for legislators to file bills in advance of the legislative session is December 21.

Behavioral Health Collaborative
Draft recommendations for Oregon’s Mental Health System
OHA Director Lynne Saxton introduced Royce Bowlin, the new Behavioral Health Director for the department, and Dwight Hilton, Executive Director of Lines for Life, and a member of the 50-member behavioral health collaborative. The collaborative has met nine times since last summer to develop a framework for mental health services in Oregon. A copy of its draft recommendations can be found here: https://olis.leg.state.or.us/liz/201511/Downloads/CommitteeMeetingDocument/94659

Sen. Elizabeth Steiner Hayward, a physician, talked about the importance of full integration of mental health and expressed concerns (shared by committee members) over having jurisdiction over mental health issues moved to the Senate Committee on Human Services, chaired by Sen. Sara Gelser. Sen. Steiner Hayward remarked there is “no separation between mind and body. We need to think holistically.”

Oregon Health Plan Enrollments and Renewals
Declining enrollment as the December 15 deadline approaches
The OHA reported a short-term decline in enrollment as the state approaches a stabilization post-Cover Oregon. They forecast a range of 1 million enrollees in early 2017, or about a fourth of Oregon’s population. House Health Committee Chair Mitch Greenlick challenged the fore-
cast, saying: “I believe you’re in trouble. I don’t believe your numbers are right.” He’s concerned about a precipitous drop. Director Saxton said they aren’t seeing those trends in their forecasts but the data won’t be tight until the end of February or March.

Opioid Prescribing Guidelines

_CDC Guidelines for opioid prescribing are used as the foundation for Oregon._ Oregon is now tied for second in the nation with non-medical use of prescription opioids. There were 154 deaths for pharmaceutical opioid overdose in 2014. Dr. Katrina Hedberg, the State Health Officer and Dr. Jim Rickards, the Chief Medical Officer for OHA, walked the committee through Oregon’s strategies. They include: limiting prescriptions of opioids, offering alternative pain therapies, increasing the availability of naloxone rescue and ensuring availability of treatment for opioid misuse disorder. They also reviewed the CDC guidelines, which have been endorsed as the foundation for opioid prescribing in Oregon. The guidelines are specific to chronic pain, not acute or end-of-life care. **Dr. Hedberg said they are reviewing possible changes to the state’s Prescription Drug Monitoring Program, including required provider enrollment, (which may be challenged by providers concerned with a clunky system) automated notification and allowing the use for public health practices. The PDMP is governed by statute and the changes described must be approved by the Legislature.**

Update on the Health Insurance Marketplace

_DCBS committee declines to endorse a Basic Health Plan option at this time._ Pat Allen, the Director of the Department of Business and Consumer Services noted concerns about increased costs for health insurance plans which are 10-15 percent over last year’s costs. They were also charged with convening a Marketplace Advisory Committee to review recommendations for a Basic Health Plan (BHP). The committee acknowledged and set aside uncertainty of ACA and state budget considerations (concerned about repeal and replace); agreed that pursuing a BHP now is not in the state’s interest and strongly agreed to continue conversations about how to help Oregonians with modest incomes (1332/BHP alternatives work group). They are concerned about a possible state requirement to develop new IT system to implement BHP § BHP effect on individual risk pool, affordability for population below 200% of Federal Poverty Level (FPL) and the complexity of adding a third program such as the BHP.

Implementation of Oregon’s PCPCH Program: Exemplary Practice and Program Findings

_Oregon’s Patient Centered Primary Care Home Program has saved an estimated $240 million over its first three years. However, current payment models don’t incentivize clinics to participate._

OHA contacted with Portland State University to evaluated the implementation of Oregon’s PCPCH program. The findings from the report show that the program has been “very successful” in meeting health transformational goals for Oregon’s primary care system. The program has:

- Encouraged clinics to embrace team-based care and continuous improvement, and to adopt a “patient centered lens.” This shift in organizational culture supports new clinic processes such as care coordination, shared decision-making and using data to drive actions, resulting in care teams that are more aware of patients’ goals.
- Helped clinics to shift towards population-based strategies that will improve the health of groups of patients who share a diagnosis or demographic characteristics.

In terms of costs and utilization, the PCPCH program has:
· Reduced total service expenditures per person by 4.2% or approximately $41 per person per quarter (~$13.50/month). Effects increased significantly the longer clinics were designated as a PCPCH, generally doubling from the first to third year of recognition.
· Resulted in $13 in savings in other services — such as specialty care, emergency department and inpatient care — for every $1 increase in primary care expenditures related to the PCPCH program.
· Saved an estimated $240M over its first three years. This amount should increase as more clinics become recognized and then continue to develop and mature in the program.

The program has challenges and a chief one is that, “payment models and other financial arrangements do not currently incentivize clinics to operate in alignment with PCPCH program aims. Clinic leaders struggle to financially support the changes necessary for both general and top-tier recognition.”

Sen. Steiner Hayward noted the study should be the backbone of everything the state does to control costs. Every $1 increase in primary care results in $13 in savings. She said these investments are critically important.

**CCOs and Rate Setting Process**

Family Care CEO Jeff Heatherington testified on their concerns with the Coordinated Care Organization rate-setting process. He said the OHA rates have forced Family Care to operate at a deficit for the last three years. They project a $55 million dollar operating deficit for 2017, which he noted was the same figure as the “clawback” OHA tried to recover as an overpayment in 2015. Family Care sued and the dispute was settled out of court with the OHA.

Family Care receives a rate of $375 per-member-per-month, compared to an average of $446 for other CCOs in the region. Health Share CEO Janet Meyer testified about the “high rates of disability” for their members and said Family Care has the lowest. She said, “it's the member mix. Once data (on members for the region) are combined, it’s risk-adjusted and rates are set.” Family Care countered that the process is not transparent and they’re concerned about limiting investments in primary care. Rates for the program are set by the Oregon Health Authority. The Legislature is expected to work on CCO reform bills next session.

Meeting materials for the health care committees can be found here:
**Senate Health Care:** [https://olis.leg.state.or.us/liz/2015I1/Committees/SHC/2016-12-12-08-00/MeetingMaterials](https://olis.leg.state.or.us/liz/2015I1/Committees/SHC/2016-12-12-08-00/MeetingMaterials)

**House Health Care:** [https://olis.leg.state.or.us/liz/2015I1/Committees/HHC/2016-12-13-08-00/MeetingMaterials](https://olis.leg.state.or.us/liz/2015I1/Committees/HHC/2016-12-13-08-00/MeetingMaterials)

**Senate Interim Committee on Human Services**

*Sen. President Peter Courtney advocates for increased coordination for local and regional systems that serve children.*

Sen. Courtney was joined by Sen. Jackie Winters, Marion County Commissioner Janet Carlson, and county experts on mental health and public health, to discuss systems of care for children in Oregon. Bill Baney from Multnomah County testified that the idea behind “System of Care” is to create a plan of care that’s community-based, guided by the family, and informed by their cultural experience.
Baneys says when a child or adolescent is involved with multiple child-serving agencies, they bring them to the table as partners in the family’s treatment. They use a governance framework to ensure they’re serving families as effectively as possible. The framework includes key partners and stakeholders, such as: juvenile justice, mental health, educators, early childhood, youth and family representatives, culturally specific providers, child welfare, developmental disabilities, primary care providers, community based providers.

Governor Kate Brown has highlighted a Children’s Cabinet in her latest proposed budget. The cabinet would reflect core elements of the system of care model.

Note: Senate President Peter Courtney submitted a copy of the 2016 Juvenile Justice Mental Health Task Force from the Oregon Judicial Department. One of the recommendations: The Judicial, Executive and Legislative branches should work together to create a Children’s Cabinet to centralize and better coordinate the work of governmental agencies, task forces, committees and work groups that address systems reform issues.

See the report here: https://olis.leg.state.or.us/liz/2015I1/Downloads/CommitteeMeeting-Document/94598

The report also includes the Children’s Mental Health Increased Emergency Department Visits Crisis Workgroup Recommendations from November 2014.

**House and Senate Judiciary Committee**

**Distracted Driving**

Sen. Courtney and Rep. Andy Olson have been working with the Oregon Department of Transportation’s Task Force on Distracted Driving to clarify the existing statute which bans cell phone use with certain exceptions. Sen. Courtney testified that the number of drunken driving fatalities has decreased by 28 percent while the number of fatalities has increased by the same amount. He’s the chief sponsor of LC 1105, which makes penalties for using a mobile communications device while driving the same as penalties for driving under the influence:

- One year in prison or $6,250 fine, or both
- Increases to 5 years in prison and $125,000 fine for multiple violations within 10 year.

ODOT Director Matt Garrett and Oregon State Police Superintendent Travis Hampton testified about the need to work together to determine behaviors that cause crashes. OSP’s Fatal Five include: speed, occupant safety, lane using, departure and distracted driving. One of the biggest hurdles of the current law is that officers must see a person talking or texting — it’s not enough to see them holding a cell phone to their ear. Driver education is critical as well. An ODOT task force on distracted driving will issue a report with recommendations at the end of the year.

For more information about the legislative process, please contact Katy King: KatyKing01@gmail.com