Oregon's Health Reform: Learnings from the Road to Comprehensive Health System Change

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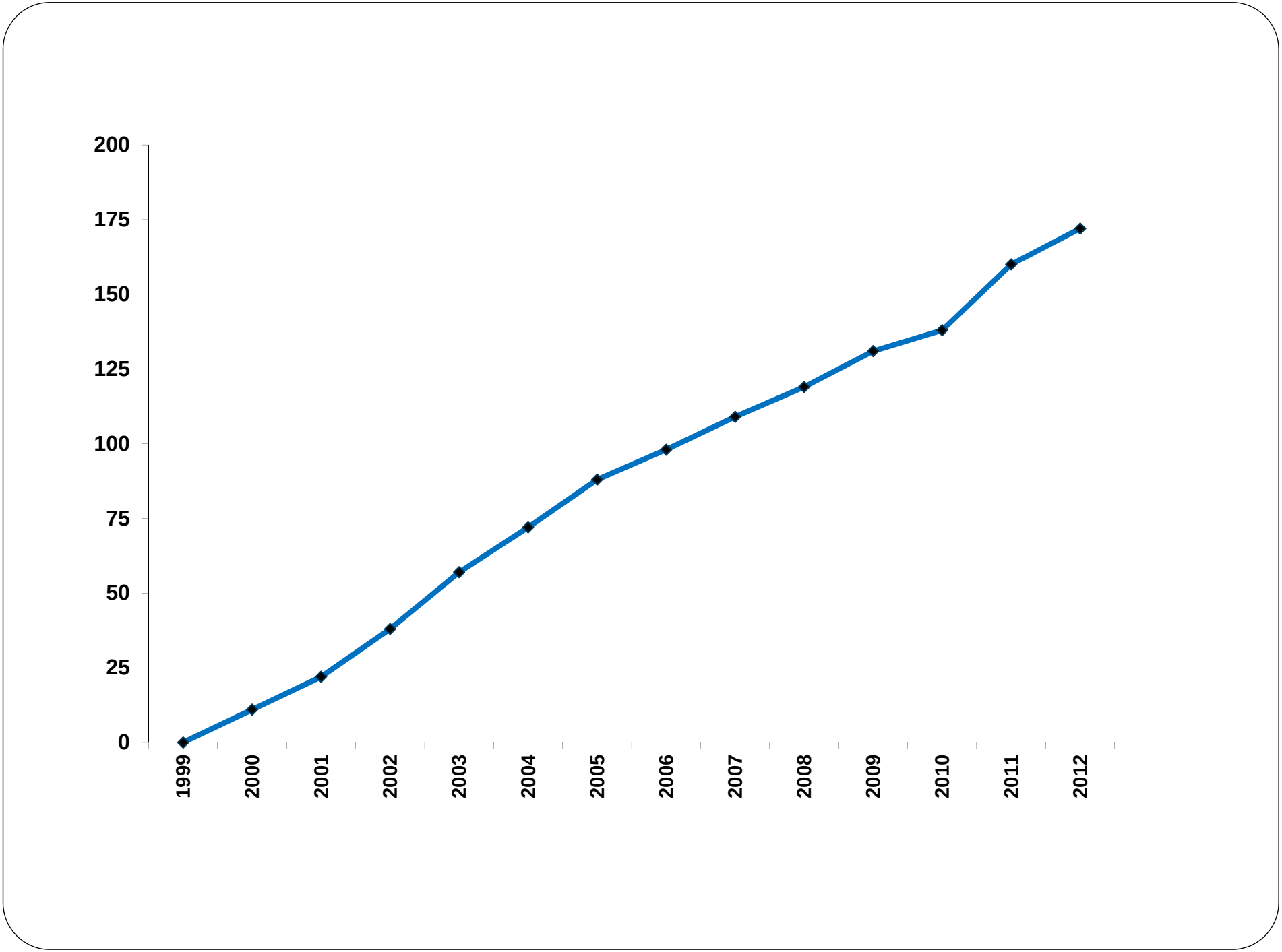
April 12, 2016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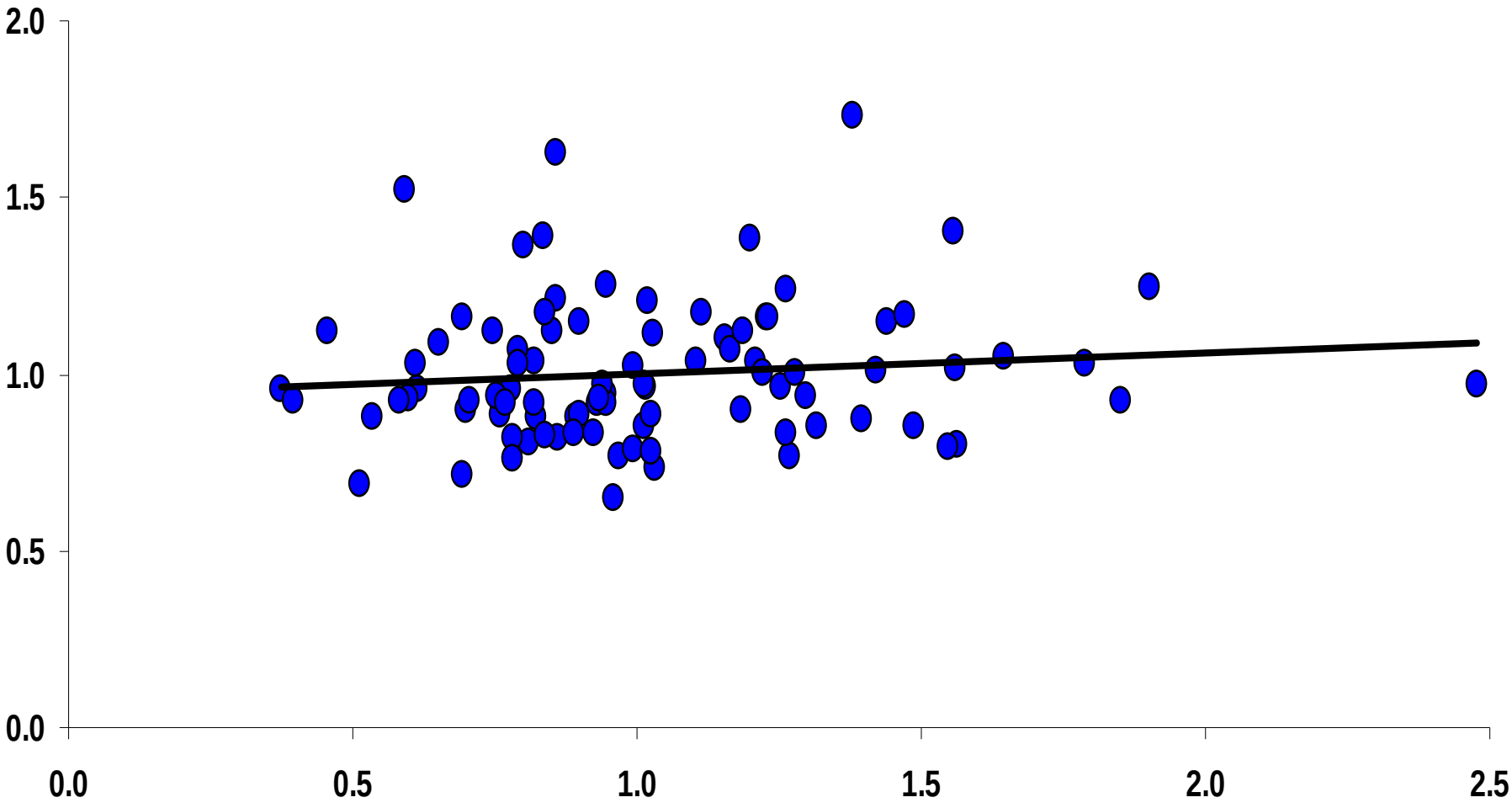
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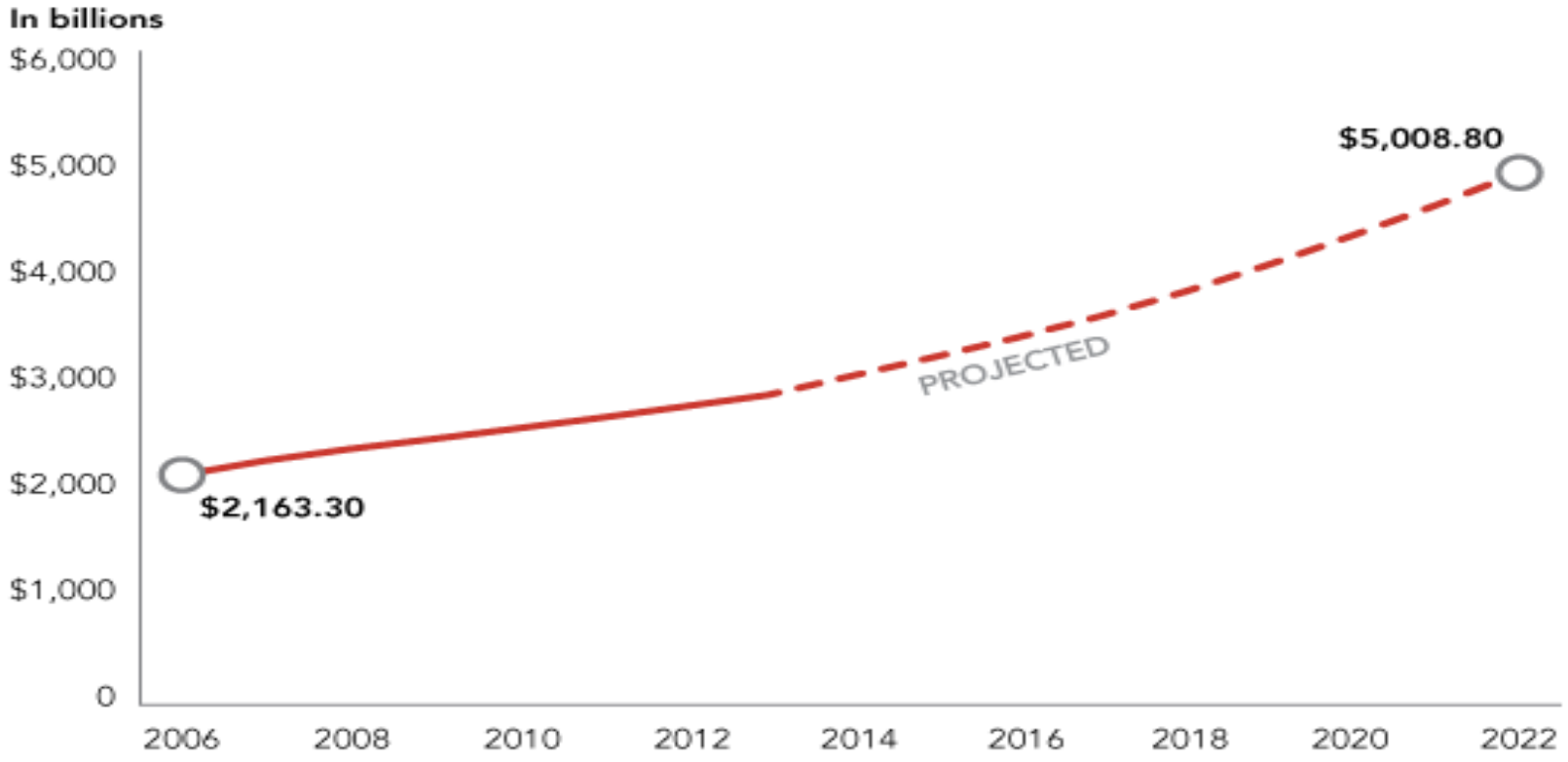
The Environment

- Health care costs rising faster than any other economic indicator
- Stealing precious $ from other important human endeavors e.g. education and public safety
- Healthcare outcomes not what we wanted
- A belief that we could do better!

Health care spending is projected to nearly double in the next decade.

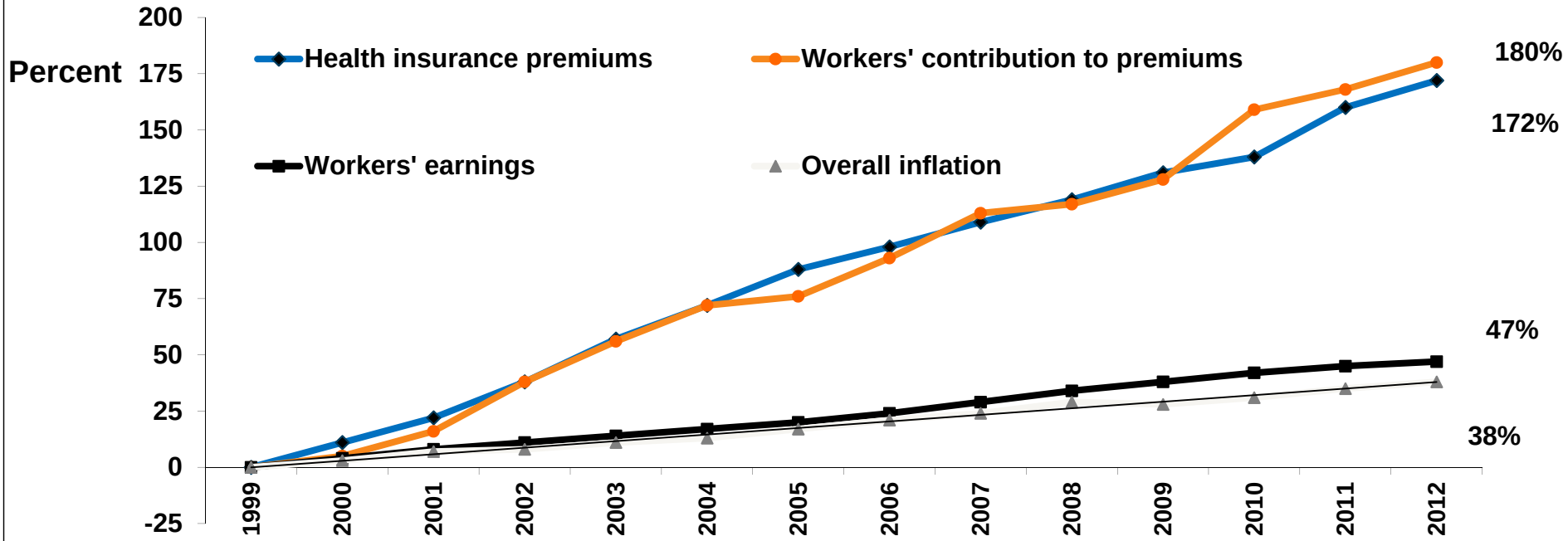


Notes: The health spending projections were based on the National Health Expenditures released in January 2013. The projections include impacts from the Affordable Care Act. Numbers may not add to totals because of rounding.
Source: Centers for Medicare & Medicaid Services, Office of the Actuary

THE HUFFINGTON POST

Premiums Rising Faster Than Inflation and Wages

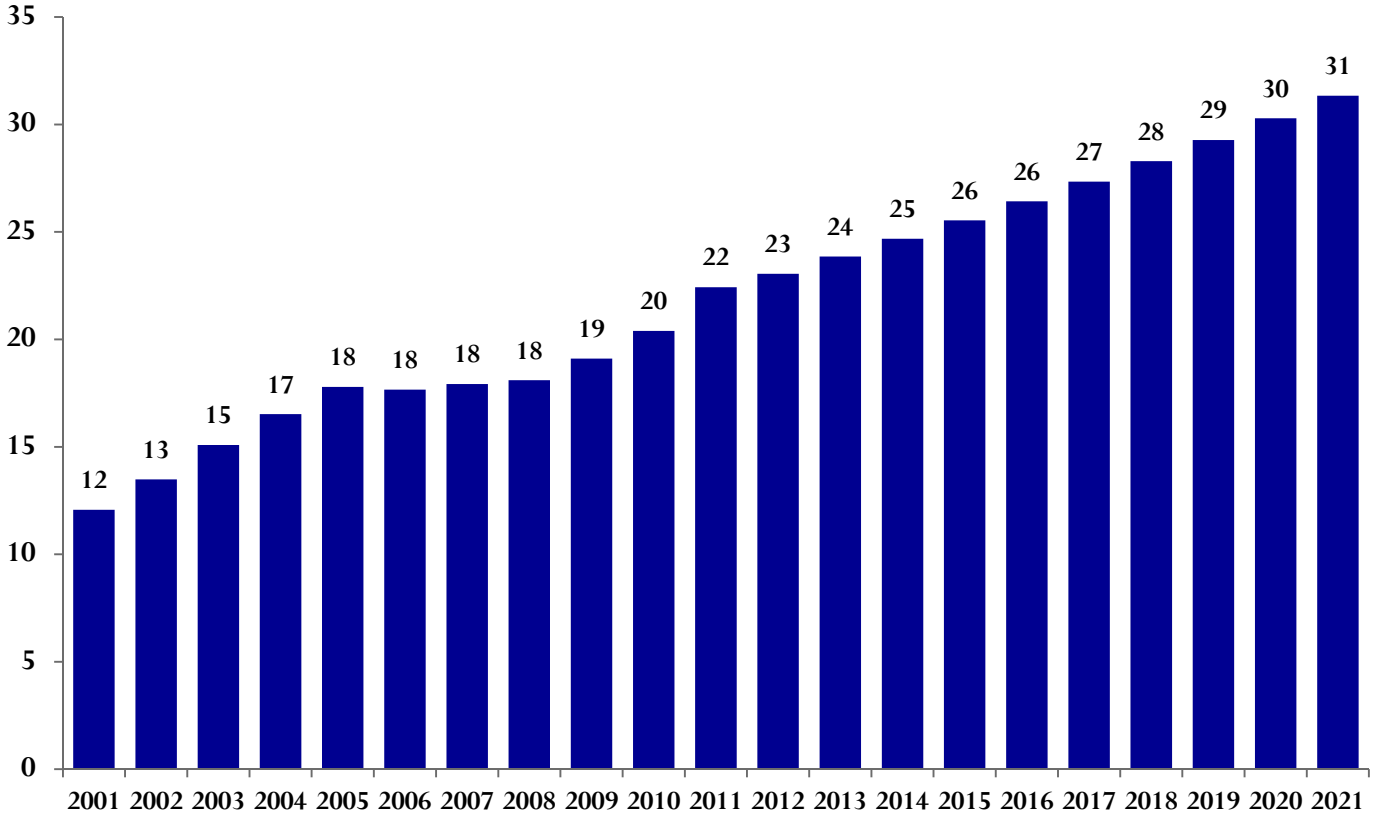
Cumulative changes in insurance premiums and workers' earnings, 1999–2012



Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 1999–2012*;

Premiums Rising Faster Than Family Income

Projected average family premium as a percentage of median family income, 2013–2021



Source: estimates based on CPS ASEC 2001–12, Kaiser/HRET 2001–12, CMS OACT 2012–21.

Waste Category Annual Dollar Estimates

Category	Cost to US Healthcare (2011 $B)
Overtreatment	$158 to $226
Failures to Coordinate Care	$25 to $45
Failures in Care Delivery	$102 to $154
Excess Administrative Costs	$107 to $389
Excessive Health Care Prices	$84 to $178
Fraud and Abuse	$82 to $272
2011 Total Waste	**$558 to $1263**
% of Total Spending	**21% to 47% (MED = 34%)**

Source: Don Berwick, MD


LATINO
diabetes
65%
more likely
to be
diabetic
AFRICAN
AMERICAN
stroke
40%
AMERICAN INDIAN
& ALASKA NATIVE
heart disease
15%
ASIAN AMERICAN &
PACIFIC ISLANDER
liver cancer
80%
more likely
to die from
liver cancer

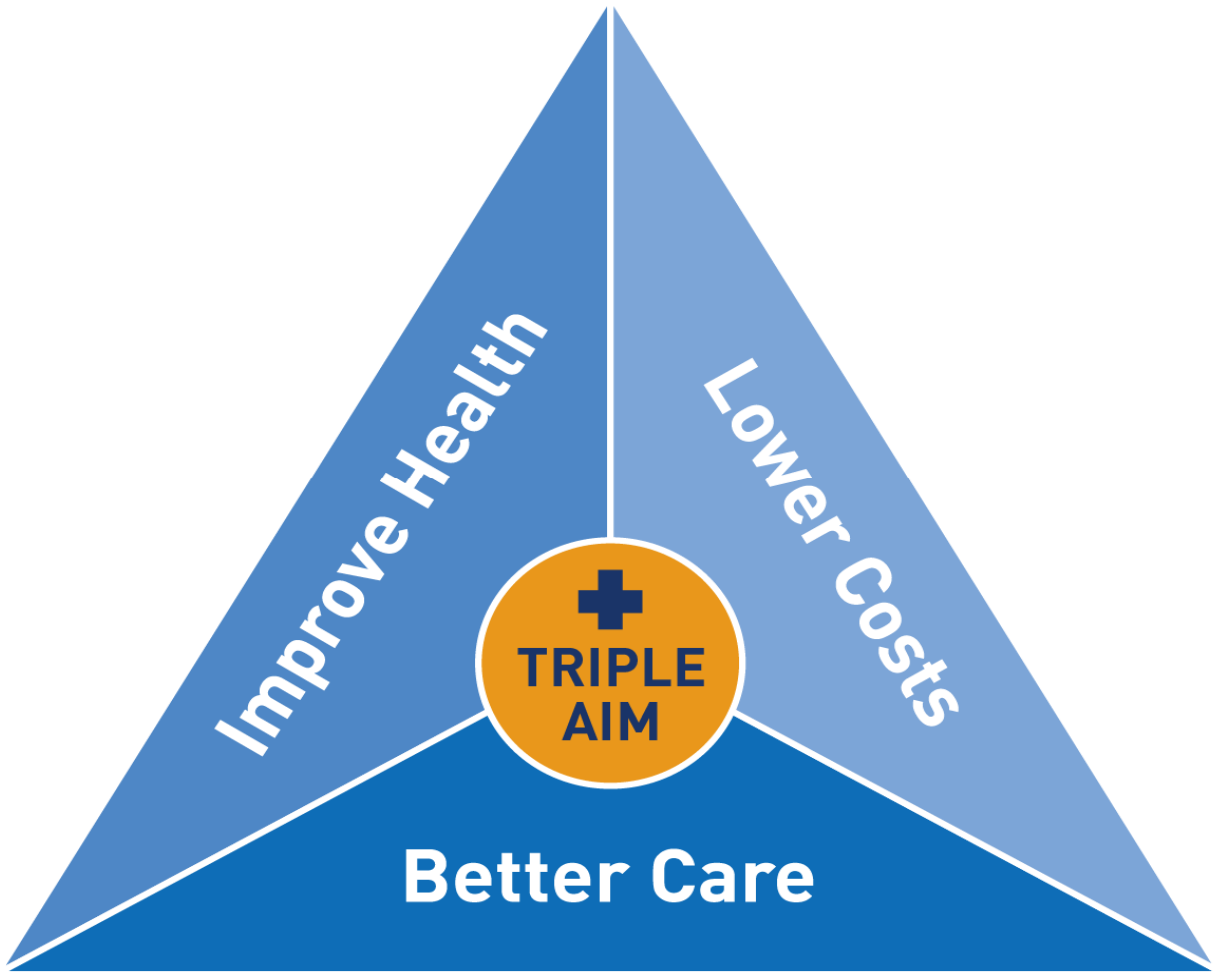
Traditional Budget Balancing

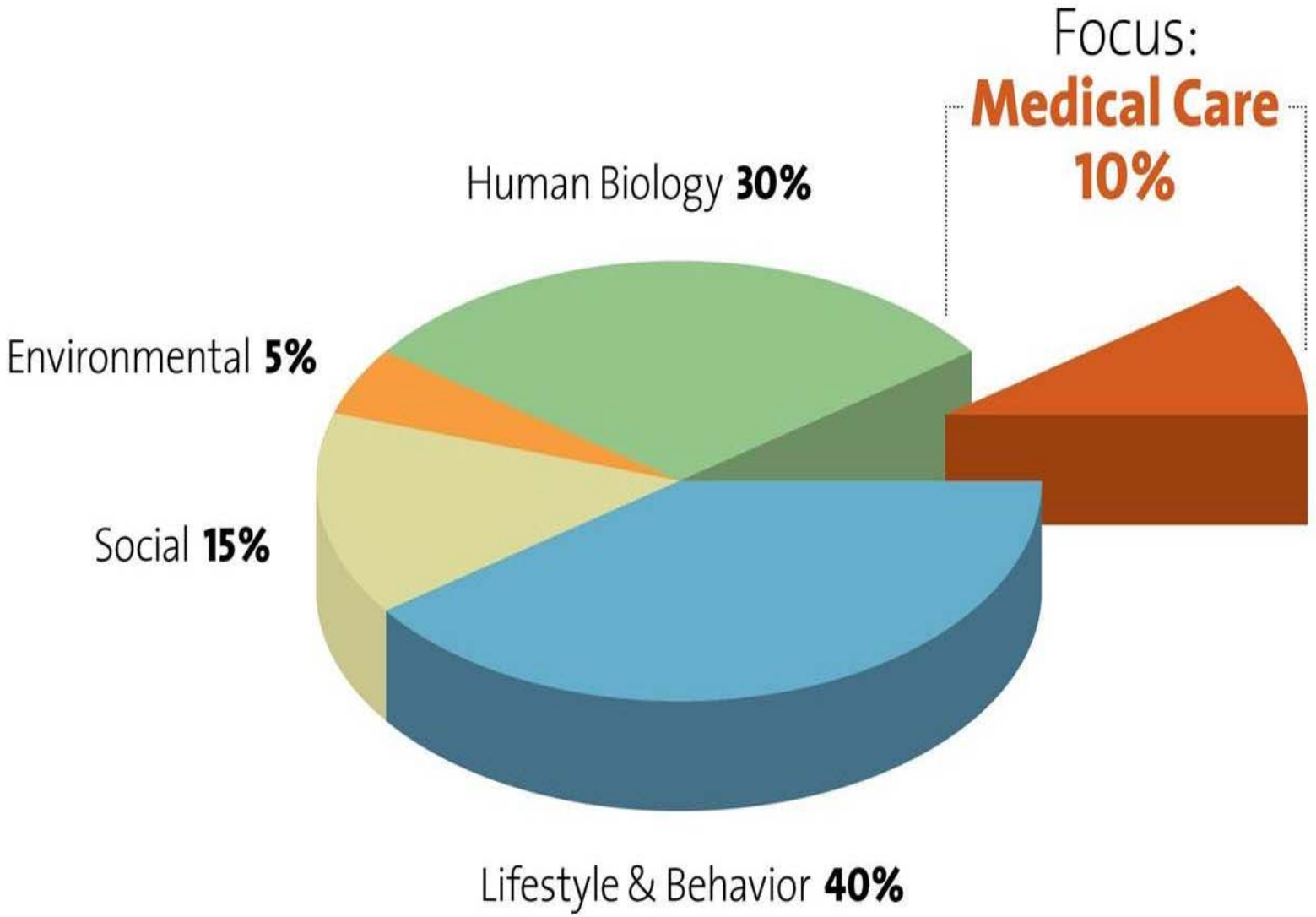
- Cut people from care
- Cut services
- Cut provider rates/shift costs

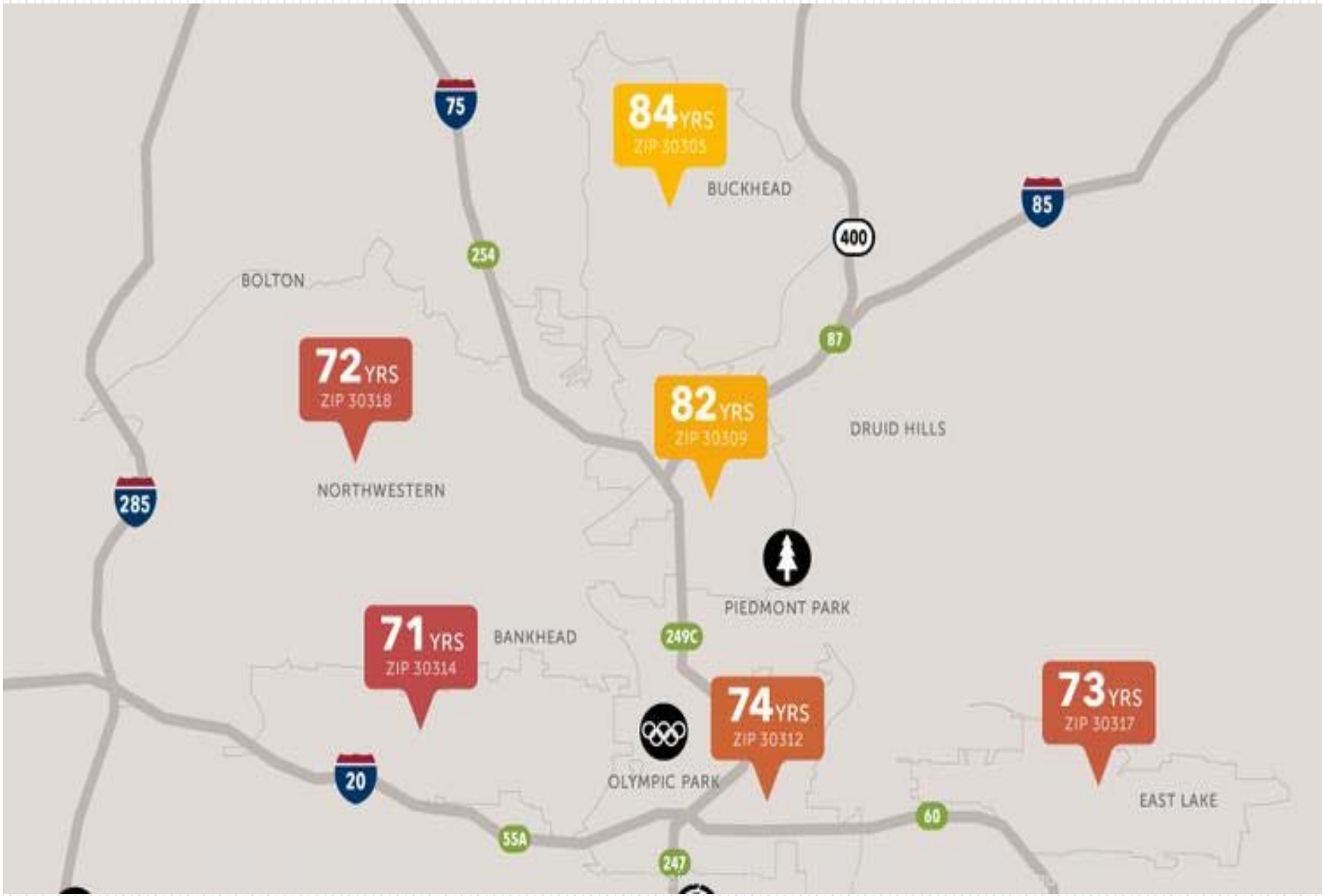
The Fourth Path

Change how care is delivered to:

- Reduce waste
- Improve health
- Create local accountability
- Align financial incentives
- Pay for performance and outcomes
- Create fiscal sustainability


Improve Health
Lower Costs
TRIPLE AIM
Better Care


Focus:
Medical Care
10%
Human Biology 30%
Environmental 5%
Social 15%
Lifestyle & Behavior 40%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NORTHWESTERN
PIEDMONT PARK
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BANKHEAD
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EAST LAKE
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No child should have to go to the Emergency Room because of an asthma attack

Oregon's Path to the Triple Aim: The Coordinated Care Model

Local Accountability & Governance

Global Budget with Fixed Rate of Per Capita Growth

Integrated and Coordinated Care

At Risk for Quality (Metrics)

Flexibility

The vision of the CCM ultimately extends beyond the clinic walls

Source: Public Health Institute

Coordinated Care Organizations

- Governance
  - Partnership between health care providers, consumers/community partners, and those taking financial risk
- Consumer advisory council requirement
- Working relationship with local public health authorities

Local Accountability & Governance

- Governance Board must include:
  - All entities within the CCO taking financial risk
  - At least two health care providers in active practice (representing primary care and mental health/chemical dependency)
  - At least two community members
  - At least one member of the CCO's Community Advisory Council (CAC)
- The CAC is required to:
  - Have more than 50% of members be consumers;
  - Must include representative from each county government in service area
  - Duties include Community Health Improvement Plan and reporting on progress.
- CCO also needs MOUs with local public health, tribes and area agency on aging.

Global Budget with a Fixed Rate of Growth

- Behavioral health, physical health and dental care integrated into a single budget
  - Long Term Supports & Services statutorily excluded.

- Global budgets that grow at no more than 3.4% per capita per year
  - Growth rate is statewide not per CCO

Integrated and Coordinated Care

- Global budget helps drive integration and coordination
- Emphasis on team-based patient-centered primary care
  - The right care at the right time
  - Special emphasis on patients with complex health care needs
- More care outside the clinic walls, including community health workers
- Increased adoption of HIE/HIT

At Risk for Quality (Metrics)

- Statutorily created Metrics & Scoring Committee establishes CCO incentive metrics, benchmarks & improvement goals.

- CCO Incentive Measures
  - Annual assessment of performance on 17 incentive measures.
  - Quality pool paid to CCOs for performance.
  - 3% of global budget held at risk for quality.
  - Currently, measures largely process-based and focused on quality primary care.

Flexibility

- Each CCO given room to transform delivery of care in whatever way makes most sense to that community as long as quality and financial goals are met.

- Increased ability to use funds for "flexible services"
  - Must offer Medicaid covered benefits, but have flexibility to create alternative solutions.
  - Governor Kitzhaber's air conditioner story

Oregon's 1115 Medicaid Waiver

- 1115 Medicaid demonstration waiver
  - Submitted March 1, 2012, Approved July 5, 2012
  - Establishes CCOs as Oregon's Medicaid delivery system
  - Flexibility to use federal funds for improving health
  - Federal investment of $1.9b over 5 years
  - Oregon's accountabilities
    - 2 percentage point reduction in per capita Medicaid trend
    - No reductions in benefits or eligibility
    - Financial penalties for not meeting cost savings or quality goals
    - Quality metrics

Coordinated Care Model

- The coordinated care model was first implemented in Oregon's Medicaid program: the Oregon Health Plan.

- There are 16 coordinated care organizations in every part of Oregon, serving 95% of Medicaid population; there are two CCOs also serving state employees (Public Employees Benefit Board members)

Before CCOs	With CCOs
Fragmented care	Coordinated, patient-centered care
Disconnected funding streams with unsustainable rates of growth	One global budget with a fixed rate of growth
No incentives for improving health (payment for volume, not value)	Metrics with incentives for quality and access
Limits on services	Flexible services
Health care delivery disconnected from population health	CCO community health assessments and improvement plans
Limited community voice and local partnerships	Local accountability and governance, including a community advisory council

Meeting the triple aim: what we are seeing so far…

- Every CCO is living within their global budget.
- The state is meeting its commitment to reduce Medicaid spending trend on a per person basis by 2 percentage points.
- State-level progress on measures of quality, utilization, and cost show promising signs of improvements in quality and cost and a shifting of resources to primary care.
- Race and ethnicity data shows broad disparities for most metrics – points to where efforts should be focused to achieve health equity
- Progress will not be linear but data are encouraging.

Progress to Date

- ED utilization - visits ⬇ 23 %
- Primary care - visits ⬆ 18%
- Adult hospital admissions for:
  - chronic lung disease down 68%,
  - short-term complications from diabetes down 32%
- Patient-centered primary care homes enrollment, up 61%

Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update

January 2016

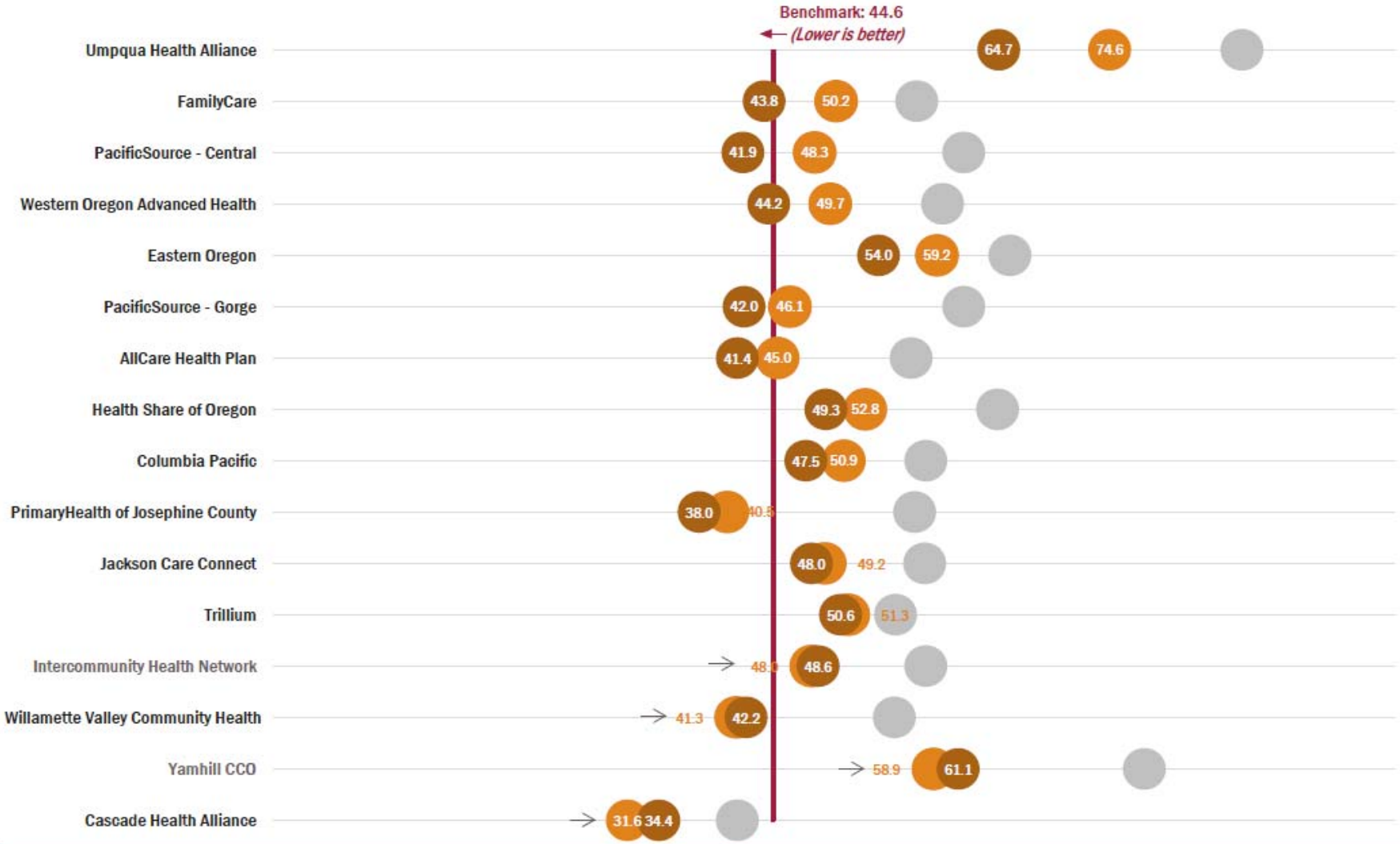
Oregon Health Authority

MEASUREMENT PERIOD:
July 2014–June 2015
Version 1.1
JANUARY 20, 2016

AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Twelve of 16 CCOs reduced emergency department utilization between 2013 and 2014.

Per 1,000 member months
Bolded names met benchmark or improvement target.
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Congestive heart failure admission rate

Measure description: Rate of adult members (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.
PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

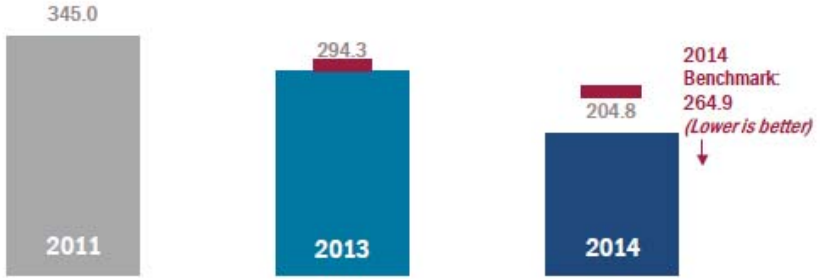
Purpose: Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

2014 data (n=5,495,358 member months)

Admission rates for congestive heart failure continued to improve and remained below the benchmark in 2014. Lower is better for this measure. Admission rates for all races and ethnicities improved in 2014, but African American/Black members had the highest admission rate, with 833.3 admissions per 100,000 member years. The second highest admission rate was for Asian American members with just 233.83 admissions per 100,000 member years. Fourteen CCOs improved their performance on this measure between 2013 and 2014.

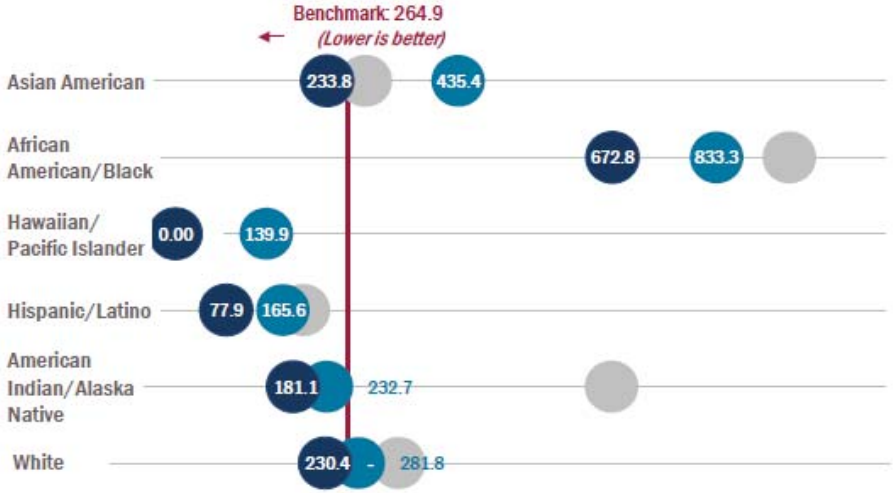
Statewide, the congestive heart failure admission rate improved again in 2014.

Data source: Administrative (billing) claims
Benchmark source: 10% reduction from previous year's statewide rate
2011 and 2013 data have been updated and may differ from earlier reports.



All races and ethnicities experienced improvement in congestive heart failure admission rates between 2013 and 2014.

Gray dots represent 2011. Data missing for 11.2% of respondents. Each race category excludes Hispanic/Latino.
2011 and 2013 data have been updated and may differ from earlier reports.




Health care
collaborators
not competitors

Supports for Transformation

- Transformation Center and Innovator Agents
- Learning collaboratives
- Peer-to-peer and rapid-cycle learning systems
- Community health assessments and community improvement plan
- Non-traditional healthcare workers
- Each CCO submitted a "Transformation plan"
- Primary care home support
- Technical assistance in addressing health equity

Better Health and Value Through

- Innovation
- Focus on chronic disease management
- Focus on comprehensive primary care and prevention
- Integration of physical, behavioral, oral health
- Alternative payment for quality and outcomes
- More home and community based care, community health workers/non-traditional health workers
- Electronic health records – information sharing
- Tele-health
- New care teams
- Use of best practices and centers of excellence

A Few of the Challenges

- Time, resources and expectations
- Change is hard….change is very hard
- Behavioral health / physical health integration
- Integrating dental care
- Ensuring robust provider networks to meet client needs
- Transforming care and paying for outcomes
- Accounting for "flexible" services
- Anti-trust
- Actuarial soundness

And Some More.....

- Penalties for failure to achieve cost, quality and access benchmarks
- Training and using new health care workers
- Increasing consumer engagement
- Personal responsibility for health
- Health information exchange
- Integrating with early learning and education systems

Lessons Learned/Key Takeaways

- Have a common vision
- Legislative, executive and stakeholder leadership commitment to the goals and deliverables of health reform
- Engaging stakeholders is critical – CEO's, consumers, advocates, federal policy makers
- Don't underestimate the investment needed in change management and technical support
- Our major health payment systems are are very much connected but seriously misaligned
- Need to recognize and help health care institutions transition and plan for new business models!!!
- Changing payment is critical – don't expect new methods of care with old methods of payment.
- Have reliable data and information. Good data and information is needed now, to chart your course, and later to monitor progress. Participants need to be involved with assuring validity.

Lessons Learned/Key Takeaways

- Statewide reform needs structure and leadership with clear accountabilities and timelines for outcomes
- There is no perfect structure - structure will be different depending on goals of reform, e.g., structure for Medicaid reform will look different than a broader health reform effort
- Government "agency" work must be prioritized to meet long-term goals. Agency staff need to see health reform as their work and where and how they fit in—it cannot be an add on.
- "It takes a village" – broad community support and involvement is critical.
- Communicate early, often and in multiple modalities and then communicate again
- This is hard work and it will take time, but…..don't slow down!
- Financial support helps the transition from old system to new.

Lessons Learned/Key Takeaways

- Be clear about goals – especially as it relates to improving health vs. improving the health system, access, quality, costs.
- On the journey to improve health, be careful not to "medicalize" social institutions.