Transforming the Oregon Health Plan: Coordinated Care Organizations

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Jeanene Smith MD, MPH
Administrator, Office for Oregon Health Policy and Research
The Oregon Health Plan –
Our Medicaid/CHIP program

- 50% of babies born in Oregon
- 16% of Oregonians
- 85% of Oregon providers
- 11% percent of total state budget
- Fastest growing portion of state budget
We can’t afford this anymore

If food had risen at the same rates as medical inflation since the 1930s:

- 1 dozen eggs $80.20
- 1 dozen oranges $107.90
- 1 lb. of bananas $16.04
- 1 lb. of coffee $64.17

Source: American Institute for Preventive Medicine 2007
State Healthcare Costs Unsustainable:

- Health care costs are increasingly unaffordable to individuals, businesses, the state and local governments.
- Inefficient health care systems bring unnecessary costs to taxpayers.
- When budgets are cut, services are slashed.
- Dollars from education, children’s services, public safety.
- 2014: as many as 200,000 Oregonians will be added to the Oregon Health Plan.
- Costs for state employees and school district benefit pools also rising, requiring increased cost share to individuals.
Traditional budget balancing

- Cut people from care
- Cut provider rates
- Cut services

Meanwhile..................
The complicated puzzle we faced:

- 85 percent of OHP clients:
  - 16 managed physical health care organizations
  - 10 mental health organizations
  - 8 dental care organizations.
- Remainder: “fee-for-service” arrangements between the state and local providers.
- High electronic record adoption in practices, esp. large systems but only small pockets of regional connectivity
- Some payment reform efforts by some payers, only some pilot patient-centered primary care home efforts
Better Health = Lower Costs

Need to move towards a system that improves health, not just spends on healthcare.
High cost of today’s system

- **Cost to health**
  - Behavioral health: major driver of bad outcomes
  - Chronic conditions – uncoordinated care, inability to use incentives for prevention

- **Cost to state**
  - ER or acute care that could have been prevented
  - Unnecessary administrative costs in health care system and Oregon Health Authority

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Triple Aim: A new vision for Oregon

2. Better care.
3. Lower costs.

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Senate Bill 1580
Launched Coordinated Care Organizations

- Follow up to 2011’s HB 3650- Health Care Transformation
- Strong bi-partisan support
- A year of public input – more than 75 public meetings or tribal consultations
- Built on 1994’s Oregon Health Plan that covers 600,000 Oregonians today
- Also built on HB 2009 that set the stage in June 2009 for Oregon’s broad health care reform, including proceeding with a health insurance exchange and delivery system transformation
Examples already there to build on:

**Bend** (Central Oregon) - behavioral health pilot program
- 100 costliest Medicaid patients with each having up to 25 ED visits/year
- Team based care with community health workers
- Reduced ED visits by 49% and reduced net costs more than $600,000 in first six months

**CareOregon** (OHP plan)- Primary Care Renewal Pilot Project
- 41% of their Medicaid clients. Highest risk.
- Reduced inpatient hospitalization between 16 – 18%.
- ED stabilized during a period when other ED increased.
- Costs decreasing to non-high risk patients.

And there are many more examples in your states’ communities
Changing health care delivery

- Benefits and services are integrated and coordinated
- One global budget that grows at a fixed rate
- Metrics: standards for safe and effective care
- Local accountability for health and budget
- Local flexibility

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Coordinated Care Organizations

A local network of all types of health care providers working together to deliver care for Oregon Health Plan clients.

Care is coordinated at every point – from where services are delivered to how the bills are paid.
Benefits & services are integrated and coordinated

- Physical health, behavioral health, dental health
- Focus on chronic disease management
- Focus on primary care
- Get better outcomes:
  - Health equity
  - Prevention
- Community health workers/non-traditional health workers
- Electronic health records

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Global budget

• **Current system**
  - MCO/MHO/DCO/FFS
  - Payments based on actions
  - No incentives for health outcomes

• **CCO global budget**
  - One budget
  - Accountable to health outcomes/metrics
  - Local vision, shared accountability, shared savings
  - Flexibility to pay for the things that keep people healthy
Accountability: CCO Criteria

✓ Coordinate physical, mental health and chemical dependency services, oral health care.

✓ Encourage prevention and health through alternative payments to providers.

✓ Engage community members/health care providers in improving health of community.

✓ Address regional, cultural, socioeconomic and racial disparities in health care.

✓ Manage financial risk, establish financial reserves, meet minimum financial requirements.

✓ Operate within a global budget.

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CCOs: governed locally

State law says governance must include:

- Major components of health care delivery system
- Entities or organizations that share in financial risk
- At least two health care providers in active practice
  - Primary care physician or nurse practitioner
  - Mental health or chemical dependency treatment provider
- At least two community members
- At least one member of Community Advisory Council

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Each CCO required to have a Community Advisory Council

- Majority of members must be consumers.
- Must include representative from each county government in service area.
- Duties include Community Health Improvement Plan and reporting on progress.
- CCO Applications included local statements of support
OHA Coordinating and Streamlining

- Eliminating duplicative structures between physical and mental health divisions
- Eliminating duplicate review and approval processes
- Eliminating separate quality monitoring process and rules

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If we do nothing....

Health Management Associates’ Annual Projected Savings Attributable to Health System Transformation through Coordinated Care Organizations

Cumulative 10-Year Savings

$ Million

Source: Health Management Associates
Notes: Health Management Associates' projections end in 2019. The 2019-2021 biennium and 2021-2022 state fiscal year were extended forward by the Oregon Health Authority by applying the growth rates in HMA’s model.

1/12/2012
Better health = lower costs

Reducing costs while improving care
- A third-party analysis
- Savings would be more than $1 billion total fund within three years and more than $3.1 billion total fund expenditures over the next five years.

Federal partnership
- Approximately 60 percent of Oregon Medicaid dollars are paid by the federal government
  - Waiver
  - Financial investment

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Better health = lower costs

- Agreement with federal government to reduce projected state and federal Medicaid spending by $11 billion over 10 years. Oregon will lower the cost curve two percentage points in the next two years.

- Up-front investment of $1.9 billion from the U.S. Dept. of Health and Human Services over five years to support coordinated care model.
CMS Medicare/Medicaid Alignment Demonstration

- 3-year demonstration project in many states
- Oregon’s way will be through CCOs, potentially by 2014
- Key features:
  - Align Medicaid and Medicare requirements
  - Passive enrollment of dually eligible individuals in CCOs (with opt out option)
  - Blended Medicare/Medicaid funding and flexibility around spending
  - Integrated Medicare/Medicaid benefits
Across Oregon, unprecedented collaboration
Timeline and Status Today:

• RFA posted in March, 2012
• Letters of Intent submitted April, 2012
• Eight CCOs were certified to start on August 1, 2012
• Six more are under evaluation to potentially start on Sept. 1, 2012
• Final wave of applications due early next month for October start date
What CCOs mean for local providers

- Providers will contract directly with CCOs
- Fee-for-service will be phased into CCO
- OHP medical benefits are not changing
- Metrics will be staggered
“One of the problems we can solve is the tremendous fragmentation among the people who pay for the care and what they expect from us.”

Hood River family physician
Oregon’s Patient-Centered Primary Care Homes (PCPCH)

Create access to patient-centered, high quality care and reduce costs by supporting practice transformation

AIM:
- All OHA covered lives receive care through a PCPCH (Medicaid, State employees, High Risk pool, etc) & 75% of all Oregonians by 2015

Key steps to achieve:
- PCPCH Recognition based on Oregon statewide Standards
  - NCQA recognition counts but need to augment with outcome measures
- Refinement and evaluation of the PCPCH Standards over time
- Provider Outreach & Technical assistance via Learning Collaborative
- Coordination across OHA divisions, CCO development and health reform initiatives via contract language
- Align payment efforts around Standards – ACA Section 2703 SPA; CMMI’s CPCI, local private efforts to ease burden for providers
Early Success and Continued Partnership
Over 160 clinics recognized as primary care homes as of July 2012
What CCOs mean for OHP clients

Nothing is changing today

Oregon Health Plan medical benefits are not changing

Most clients won’t see much change

Exception: better managed care for chronic illness

Clients will receive at least 30 days notice prior to any changes

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What helped us get this far so fast?

- “Burning Platform”- only option was transformation
- Collaboration around a Strategic Vision through “Oregon-style” public discussion and dialogue
- Legislative and Executive branch leadership to build bipartisan support
- Help validating and verifying our approach with national expertise and experience through our RWJF State Network consultants and other states’ experts.
- Close contact and dialogue with HHS/CMS even before submitting our waiver.

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Questions?

For more information:

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jeanene.smith@state.or.us