Transforming Health Care
In Oregon

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Utah Better Care Conference
Salt Lake City – December 14, 2012

NEWS RELEASE
MAY 3, 2012

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Oregon Governor John Kitzhaber and
Obama Administration announce agreement to improve care for
Oregonians on Medicaid

CARE coordination will improve health, achieve $11 billion in savings.
Innovations mirror national reforms made possible by Affordable Care Act.

(Washington, D.C.) — Governor Kitzhaber and the Obama Administration today announced an agreement in principle to coordinate care for Medicaid beneficiaries in Oregon, through a new model of care that will reduce the cost trend in Oregon’s Medicaid program by at least two percentage points within two years while improving health outcomes.

The U.S. Department of Health and Human Services (HHS) has given preliminary approval of a five-year, $1.9 billion demonstration of a Federal-State partnership to transform the way that care is delivered in Oregon’s Medicaid program. The initial investment of $620 million in the second year of the State’s current biennium will allow Oregon’s new care organizations to better deliver higher-quality, coordinated care for Medicaid patients while reducing preventable errors. Oregon estimates that this will achieve $11 billion in savings over the next decade.
Health Transformation in Oregon

Coordinated Care Organization” Vision (HB3650)

- Community based organizations with strong consumer involvement in governance that bring together the various providers of services
- Responsible for full integration of physical, behavioral and oral health, elimination of fragmentation
- Global budget
  - Revenue flexibility to allow innovative approaches
  - Opportunities for shared savings
  - Manage to agreed upon rate of growth
- Accountability through measures of health outcomes, patient experience and resource use
“Health Share of Oregon”

- September 1, 2012: 11 organizations around Portland, Oregon become a newly formed non-profit (501c3) Medicaid “Coordinated Care Organization” (CCO)
  - Partners include 3 County Mental Health Organizations, 4 Health Plans, 3 Hospital Systems, Public Health, and Community Clinics
  - They agree to collectively manage 265,000 enrollees in FFS and previously managed Medicaid under a single global budget for all physical and behavioral health services and be held jointly accountable for “Triple Aim” outcomes metrics
  - Everyone agrees that the CCO should fundamentally change organizational relationships

- Many had thought it unlikely that these historically competitive and disparate organizations would get this far...

What is happening in Oregon?

Why are people in health care working together, creating partnerships, building “shared service” systems … and being looked to as a potential model for national health reform?
State Level Answers...

• **Answer:** Medicaid Budget cuts of -26%
  – Recession driven State Budget deficit: $1.7 Billion (-24%)
  – Projected Medicaid cuts over 5 years $4.1 Billion (-29%)
  – 40% cuts will come from **Tri County region** = -$2.5 Billion / 5 yrs

• **Answer:** 20 year State dialog on health care reform
  – 1990s: Oregon Health Plan with “prioritized list;” 100k expansion
  – Continuing series of legislative initiatives looking to expand coverage
  – 2011 creation of Oregon Health Authority (OHA) to manage all State financed health purchasing: Medicaid, Public Employees, and State Educators

• **Answer:** “System Transformation” chosen over cuts in enrollees or benefits

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**The Oregonian**

**Health care: Innovation is key, governor says**

Oregon faces in 2011-13 an $860 million gap between funding and costs for nearly 600,000 people on the Oregon Health Plan, a 39 percent cut.

Kitzhaber has proposed to cut $570 million with traditional tactics -- reductions in administrative cost and health plan benefits and a 19 percent cut in Medicaid payments to doctors and other providers. But he doesn’t want to kick people off the plan as other states have. Instead, he wants to close the remaining $290 million gap by saving through reform.

"The only way out of this is to innovate or die," said the governor, also a physician.
Origins Of The Tri County CCO

• Historically competitive market: little integration after collapse of managed care in 1990s

• 2008: Oregon Health Leadership Council formed at request of Oregon business community to take on quality and cost
  – 30 State health leaders from major medical groups, hospitals/health systems, medical and hospital associations, local and national health plans, and director of Oregon Health Authority
  – 4 years working on payment reform, benefit design, best clinical practice, administrative simplification

• Recent history of delivery system change efforts
  – Oregon “Medical Home” initiatives from health plans, systems and State starting 2007; New state PCPCH Medicaid payment model 2012

• 2011 OHLC State wide CCO initiative
  – After 6 month consulting process decides CCO formation should be community based

“Tri County Medicaid Collaborative”

• Tri County leaders meet 1 week after OHLC decision to start TCMC.
  – Executive Steering Committee created; Chair appointed

• First question: whose in?
  – Initially: 3 health plans, 2 Hospital Systems, 1 county.
  – Quickly expanded to 2 more counties, community health clinics; ultimately last hospital and health plan
  – Should Medical and Nursing “Associations” be allowed in?
  – What about network providers? Mandated Board (TBA)...

• What is relationship to community service providers?
  – Legislatively mandated “Community Advisory Council” (TBA)
“The Money is the Money”

- Agreement that budget cuts mean limited State funding should be used in most cost effective manner and divided equitably
  - Agreement that those with “skin in the game” have more rights
  - Agreement on “Play or Pay” principle

- Little agreement beyond participation in global budget. What about:
  - Medicaid health plan reserves?
  - Reserves of those who have had a competitive advantage by not participating in Medicaid?

- Level of financial risk keeps everyone at the table

- Weekly Executive Steering Committee 2 hr meetings; long discussion, slow progress: “Storming, forming, norming”

“Provider Accountability / Control?”

- Agreement on increasing provider accountability
  - CCO legislation requires new “accountable” payment models
  - Paying for “value” vs “volume” / “outcomes” vs “services”

- Acknowledgement of wide variation in capacity of “providers” to take risk
  - Some integrated health systems managing risk with own health plans and providers
  - Majority of providers have no risk bearing capacity
    - Largest health plan (CareOregon) a diverse network of Safety Net FQHCs, hospital systems, Academic Medical Center, large and small community primary care and specialty practices
    - 1990s Managed Care experience reinforces provider risk aversion

- How do we move toward increased provider organizational risk capacity, especially as funding decreases?
What Is The Role of Consumers / Community?
Community Advisory Council

51% consumers: oversees Community Health Assessment and resulting Community Health Improvement Plan (CHIP)

Steve Weiss, Chair (Consumer Member – Multnomah County)
Amy Anderson (Consumer Member – Multnomah County)
Gary Cobb (Consumer Member – Multnomah County)
Glendora Claybrooks (Consumer Member – Washington County)
Joseph Lowe (Consumer Member – Clackamas County)
Lyla Swafford (Consumer Member – Washington County)
Ronda Harrison (Consumer Member – Washington County)
Tab Dansby (Consumer Member – Multnomah County)
OPEN (Consumer Member – Clackamas County)

Dalila Sarabia, Vice Chair (Community Member - Hillsboro Family Resource Center)
Dan Peccia (Community Member – Self Determination Resources)
Faith Gilstrap (Community Member – Oregon Family Support Network)
Kate O’Leary (Community Member – Washington County Health & Human Services)
Sam Chase (Community Member – Coalition of Community Health Clinics)
Sonja Ervin (Community Member – Alliance of Culturally Specific Behavioral Health Providers)
Susan Myers (Community Member – Multnomah County DHS)
Trell Anderson (Community Member – Housing Authority of Clackamas County)

State Required Transformation Plans

Risk & Payment
Aligning incentives to provider-driven care and provider accountability

Administrative Transformation
Simplification of administrative services for providers and members

Health System Transformation
Aligned Efforts With Clinical and Service Partners

Health Share of Oregon
• 3 key elements of Transformation Plan to be presented to the State of Oregon
Risk Transformation

• Exactly how will risk be “Transformed?”

• Those who manage risk well already hesitant to be at risk with those who do not manage risk at all -- those who don’t manage risk hesitant to assume it...

• Initial “Pass Through” compromise:
  – CCO initially delegates full risk to existing Physical Health and Behavioral Health Plans; reserves will be held by the plans.

• Strong State pressure to move from “shell” CCO

• “Neutral” outside consultants hired to develop risk model
  – “Gradualist” approach proposed: step wise transition from “shared savings” (with health plan) to “partial capitation” to “full capitation”

• What is decided by the CCO?
  – Setting of administrative expenses percentage by all full risk partners
  – Setting of floor for medical spend before funds revert to CCO

Administrative Transformation

• Exactly what does administrative simplification mean?
  – Centralization vs Standardization vs Alignment
  – Does centralization really save money?

• Resistance by plans and integrated systems to centralize functions, but general agreement for “standardization”
  – Common formulary but not common Pharmacy Benefit Management
  – Common utilization management standards but not centralized UM
  – Centralized ID cards, handbooks, CCO customer service...

• Common reporting to State of encounter and quality data drives initial data standardization
  – State requires unified encounter reporting
  – State CCO quality metrics require standardization
  – Need for common metrics for performance for “transparency,” systems to gather and report data for regular monitoring
**“We Can Do This!!!”**

**Delivery System Transformation**

- Responsible for full integration of physical, behavioral and oral health
- Global budget
  - Revenue flexibility to allow innovative approaches
- Must reduce cost trend by (at least) 2 percentage points over 3 years (CMS requirement for $1.9B 5 yr Investment; must meet quality targets.
- Must be prepared for “Fiscal Cliff” in 5 years...

- ... *but exactly HOW?????*

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**Meanwhile... back in the delivery system**

- Multi system collaborative application for CMS “Innovations Challenge Grant” (Nov-Dec 2011)

- Alignment with Tri County Assets and Challenge
  - History of multi party collaboration
  - Projects must take cost out of system rapidly
  - Existing projects that can be taken to scale
  - *? Springboard to CCO delivery system transformation?*
Whose Health? What Do They Need?
Health Share Membership

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<td>High</td>
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<td>Old age with Medicare A &amp; B</td>
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<td>18+</td>
<td>TANF</td>
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<tr>
<td>&gt;18</td>
<td>Low</td>
<td>CHP - Child &lt; 1 Year old</td>
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27% of our enrollees are high acuity

Very High Prevalence of Mental Health and Addictions
(State of Oregon DMAP Data)

CareOregon Tri County Claims Data: 21% Adults have 1+ chronic condition PLUS substance abuse or schizophrenia + bipolar disorder, 3%, both. Based on HSO 160,000 members (40% Adult). 21% Adults = 13,440; 3% Adults = 1920 (no FFS)
Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations
Cynthia Boyd, Bruce Leff, Carlos Weiss, Jennifer Wolff, Allison Hamblin, and Lorie Martin CHCS DECEMBER

Where is the $$$ going?
% of Total Billed Charges by Service
(State of Oregon Medicaid Data)

2009 Total Billed Charges = $1,630,851,673

Hospitalizations and ER admits amount to 43% of Billed Charges

* Outpatient Behavioral includes mental health services and ER and non-ER chemical dependency services
Obvious conclusion

• “Usual medical care” – even really really good usual medical care – will not be enough for the high acuity population.
  – Care Management / Case Management will be critical
  – Access to mental health and addictions resources will be critical
  – Socially determined risks cannot be ignored or assumed outside of “health care”
  – New (and less costly) approaches will be critical

Matching Services to Patient Need

- Complex and Costly Population
  - Need = Excellent Primary Care and Preventive Services

- Moderately Sick Population (1 or 2 chronic diseases)
  - Need = Plus Disease Management/Care Management and Integration with Specialists

- Relatively Healthy Population
  - Need = Plus Integrated Behavioral Health and Connections to Social Services

Driving change from patient need...
Serving Our Clients on Their Turf

Community outreach workers are paired with primary health homes and specialty practices to enhance the practices’ ability to provide individualized ‘high touch’ support to patients with exceptional utilization

- Staff are hired for engagement skills, compassion, non-judgmental attitude, outreach experience
- Focus is on the social determinants that drive high-cost medical utilization
- Voluntary program
- High PCP/Specialist involvement
- Outreach worker is incorporated as part of the practice team, but also has identity with a larger community of practice
- Documentation occurs in the practice’s EMR; population view and process metrics stored in a community care registry

What Are We Learning?

- High prevalence of childhood and life trauma (relevance of the ACE study); often translates into distrust of health care providers
- Prevalence of substance abuse, mental health conditions, and cognitive impairment
- Challenges with problem solving, system navigation, advocating for needs, self-management and relational skills
- Lack of timely access to psychiatric assessment and mental health respite services
- Care coordination needs extensive (particularly between sites of care)
- Many cant afford or do not have access to very basic non-medical items or services (ie transportation, stable housing, healthy food, medications, place to exercise, etc)
William

- Chronic Heart Failure
- History of Addition to IV Drugs and Alcohol
- COPD
- Schizoaffective Disorder
- Intermittent Homelessness
- Developmental Disorder
- Hepatitis C
- Type 2 Diabetes

October 2011:
Admitted to the hospital for almost a month for acute complications of his Chronic Heart Failure. Had a previous 25 day admission 5 months earlier.

October 2011:
Admitted to the hospital for Acute on Chronic Systolic Heart Failure and hospital pays for a month of Adult Foster Care instead of further admission.

Mid November 2011:
Met Community Outreach Worker and identified need for change, including higher level of care, housing and dealing with addiction.

Late November 2011:
Support for DD screening in conjunction with loss of Adult Foster Care – motivates desire to change behavior and addictions.

November 2011:
Medication management by PCP and psych due to stable housing arrangement.

December 2011:
Feeling better, renewed interest in volunteer work.

Early February 2012:
Approved for Hospital Bed needed for sleeping upright.

Mid March 2012:
Strong connection with DD case manager, planning for ICCT Program graduation.

Late April 2012:
Emergency Room visit due to high glucose, but not admitted. Engaged with AFC to monitor glucose and food intake.

Current:
- No Hospitalizations since 11/3/11
- No ER visits since 4/25/12
- No known relapses on drugs or alcohol

Early January 2012:
DD referral, screening, and support established.
Where Do We Start?

- **Strategy #1: Leverage CMMI Health Commons Grant as springboard for broad delivery system change**
  - Creates new 50+ FTE new direct service HSO workforce to focus on reducing high utilization driven by unmet socio behavioral needs
  - Target group approx one third of all high acuity/ cost members

- **Strategy #2: Align clinical efforts of partner organizations around CMMI Health Commons effort**
  - Convene Clinical Leaders to align Medicaid strategic planning efforts: large scale change means large systems change
  - Coordinate Care Management efforts of all partner organizations to create “virtual care management system”
  - Drive practice change efforts from needs of managing high acuity members: embedded care management and behavioral health, integration with mental health and addictions

- **Strategy #3: Build community partnerships with services that effect HSO outcomes and cost**
  - EMS, supportive housing, social services, family support programs, schools etc
  - Help align local community assets to support those at risk
Risk & Payment
Aligning incentives to provider-driven care and provider accountability

Administrative Transformation
Simplification of administrative services for providers and members

Mental Health Housing
Health System Transformation Community Services
Crisis Response Addictions

Health Share Clinical Workgroup Structure
CMO Workgroup and Grant Oversight Team Accountable to HSO Board

Outreach (ICTC Steering Committee)
Hospital-to-Home (C-Train Oversight Team)
Mental Health (ITT Workgroup / Oversight Committee)
ED Navigation (ED Guide Steering Committee)
Discharge (Standard Transition Advisory Group)
Intersections Group Project Leads and Project Managers

CMO Workgroup

Old Town / China Town WG
Supported Housing WG
Care Mgmt. WG
Addictions WG
Pharmacy WG
Grant Oversight Team

Quality Care: Mgmt. Mgmt.
Utilization Mgmt.
Care Role Project
Behavioral Health System Steering Committee
Acute Care System Mgmt.
Crisis Response
CMMI Health Commons Grant
Other Clinical Opportunities

Learning System (led by Learning System Workgroup TBD) (2013: Learning Collaboratives: April 26; Aug 23; Dec 13)
Reporting and Evaluation (led by Evaluation Workgroup)

IT Platform (Led by IT Oversight Team)
Parallel conversations:

Putting It All Together...

• Major focus of all CCOs has been control of global budget – how to divide up the money
  – Given the budget gap and potential deficits, who will be “on the hook?”
    • Am I paying more than my share? How do I keep what I have?
    • How come they aren’t doing their share?

• Delivery System Change has been a separate conversation
  – How can the needs of the population drive system change?
  – What is the role of the community / members?

• Emerging P4P: linking outcomes to budget
  – $1.9 B agreement with CMS includes increasing P4P withhold
  – CMS requires State to establish metrics to demonstrate that ALL goals of Triple Aim are being met

State P4P CCO Metrics

1. CAHPs Composite (7Qs)
2. Rate of PCPCH enrollment
3. ED Utilization (HEDIS)
4. Initiation and Engagement of Alcohol and Drug Treatment
5. Follow-up after hospitalization for mental illness
6. Mental health and physical health assessment for children in DHS custody
7. Screening for clinical depression and follow-up plan
8. Reducing elective delivery before 39 weeks
9. Prenatal care initiated in the first trimester
10. Developmental screening by 36 months (hybrid)
11. Colorectal Cancer Screening (hybrid)
12. Substance misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)
13. Optimal Diabetes Care (D3)
14. Controlling Hypertension
15. Adolescent Well-Care visits
“Transforming Health Together”

There’s no other way...

Health Share of Oregon