Oregon and the Future of Medicaid Managed Care

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Moderator:
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Outline of Today’s Webinar

- Environment and context
- Overview of the model
- Implementation
- Outcomes to date
- Spread of the model
- Key lessons learned
The Environment

• Health care costs were rising faster than any other economic indicator.

• Health programs were stealing precious dollars from other important services, e.g. education and public safety.

• We weren’t getting the healthcare outcomes we wanted.

• We wanted to make the case for Medicaid expansion and couldn’t just add more people to a system that wasn’t working.

• We believed 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
Health care spending has grown much faster than the rest of the economy in recent decades.

“It’s fine to discover cures, but, remember, chronic conditions are our bread and butter.”
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
• Achieve outcomes by paying for performance
• Attain fiscal sustainability
TRIPLE AIM

Improve Health

Lower Costs

Better Care
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
The Vision for the Coordinated Care Model

• Use the state as an active purchaser of health care to drive delivery system reform
• Start with Medicaid and spread the model to public employees and educators through contracting standards
• Then spread to Qualified Health Plans through certification
• At that point, the state will have enough market share to influence the market
First, Medicaid

• Up-front financing through 1115 Waiver
• Stood up 16 CCOs in 2012
• 95% of Medicaid members moved into CCOs
• Communities self-selected their regions
• CCOs formed out of existing MCOs
• Competition in only three regions
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
## Implementation Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>06/2009</td>
<td>HB 2009 (authorizing Oregon Health Authority) passed and signed by Gov. Kitzhaber</td>
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<tr>
<td>07/2011</td>
<td>HB 3650 (authorizing CCO business plan) passed and signed by Gov. Kitzhaber</td>
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<tr>
<td>02/2012</td>
<td>SB 1580 (enabling CCOs) passed and signed by Gov. Kitzhaber</td>
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<tr>
<td>07/2012</td>
<td>CMS approves Oregon’s Medicaid waiver application</td>
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<td>08/2012</td>
<td>First Medicaid-CCO contracts become effective</td>
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<tr>
<td>01/2013</td>
<td>Transformation Center established</td>
</tr>
<tr>
<td>06/2014</td>
<td>First quality payments made to CCOs</td>
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<tr>
<td>7/2014</td>
<td>PEBB contracting changes implemented for 2015</td>
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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
Stakeholder Engagement and Communication

• Foundation grant to conduct research to develop simple but aspirational messaging which was used consistently

• Agency Director and Executive Team spent significant amount of time communicating about health systems transformation (internally and externally)

• Many community and stakeholder meetings

• Outreach staff to travel around the state to explain the vision and gather feedback/concerns

• Extensive work with Legislature, Oregon Health Policy Board, Tribes, and Medicaid Advisory Committee and other key stakeholders
Help shape health reform in Oregon

The Oregon Health Authority is developing a plan to lower costs, increase access, and improve the quality of health care.

One of the key parts of the plan is the health insurance exchange, which will serve as a central marketplace to purchase health insurance available to all Oregonians.

Come learn more about the plan for health and health care improvements in Oregon and tell us how the health insurance exchange will work best for you.

The Oregon Health Authority is a leader in the effort to innovate for quality and affordable health care in Oregon, by putting the care back in health care, improving the health of Oregonians, and working to lower the cost of care so it is affordable and accessible to everyone.

If you’re unable to join us at a forum, visit us at www.Oregon.gov/CHOA to learn about other options for submitting your input.

Join the public forums:

MEDFORD
Wednesday, September 15th
From 6-8pm
Red Lion Inn
(Crater Lake Room)
200 N. Riverside Ave.
Work Streams

• Governor, agency director and executive team made clear this was a high-priority, urgent project that mattered for Oregon

• Created cross-functional “work streams” using existing staff with executives as leads

• Needed staff were asked to prioritize work stream work for limited period of time (and their managers were asked to backfill or place work on hold.)
OREGON IMPLEMENTATION WORKSTREAM STRUCTURE

Executive Sponsors

Executive Steering Team

Project Lead/Director: single point of accountability

Cross-Functional Work Streams:

1115 Waiver and DSHP Funds
Procurement/RFA Development
Finance/Global Budget
Member transition
Delivery System (MCO/CCO transition)
Community Development and Readiness
Internal support/Operations
Medicaid/Medicare alignment (Dually eligible)
Quality Pool, Outcomes and Metrics
Information systems
Communications

Each work stream has a charter, timeline and deliverables.
Transformation Center

- Recognized support beyond financial incentives necessary for transformation to really occur, so created a Transformation Center office within OHA

- Goal was to increase the rate and spread of transformation in Oregon’s health system
  - Transformation Center’s role is not to be the experts, but to help good ideas travel faster
  - Built a learning network that connects CCOs, providers and communities to each other

- Funded through Oregon’s 1115 waiver as well as its State Innovation Model (SIM) grant

- Also distributed $30 million in state grant funds to jump start innovation
Transformation Center Activities

- CCO Innovator Agents
- Learning Collaboratives
- Support for CACs
- Support Transformation Plans
  - Health System Transformation Fund Grants
- Support Community Health Improvement Plans
- Annual Summit and regional conferences
- Council of Clinical Innovators
- Technical Assistance Bank
Outcomes

- ED utilization: visits ↓ 21% costs ↓ 20%
- Primary care: visits ↑ 18% spending ↑ 20%
- Adult hospital admissions for:
  - adult asthma down 39%,
  - chronic lung disease down 48%,
  - heart failure down 34%,
  - short-term complications from diabetes down 9%
- Patient-centered primary care homes enrollment, up 55%
- Developmental screening of children up 68%

*Data as of June 2015*
AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION
CCO Incentive and State Performance Measures

Rate of patient visits to an emergency department in 2011 & 2013
(Lower scores are better)
Bolded names met benchmark or improvement target

Yamhill CCO
PrimaryHealth of Josephine County
Willamette Valley Community Health
All Care Health Plan
Health Share
Umpqua Health Alliance
PacificSource
Intercommunity Health Network
Western Oregon Advanced Health
Cascade Health Alliance
Jackson Care Connect
Columbia Pacific
FamilyCare
Eastern Oregon
Trillium

Benchmark 44.4

2013 Performance Report
June 24, 2014
Oregon Health Authority
Office of Health Analytics
AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

CCO Incentive and State Performance Measure

Ambulatory care: emergency department utilization

Measure description: Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

Purpose: Emergency departments are sometimes used for problems that could have been treated at a doctor’s office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients.

2013 data (n=6,476,701 member months)

This metric represents emergency department visits that occurred in 2013. Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. Financial data (starting on page 81) is consistent in showing reduced emergency department visits.

All 15 CCOs met their improvement target on this measure showing a strong trend toward fewer emergency department visits and more coordinated care.

Statewide
(Lower scores are better)
Data source: Administrative (billing) claims
Benchmark source: 2012 National Medicaid 90th percentile

2011: 61.0
2013: 50.5

Benchmark: 44.4

Race and ethnicity data between 2011 & 2013
(Lower scores are better)
Data missing for 7.4% of respondents
Each race category excludes Hispanic/Latino

- White: 54.9, 67.4
- American Indian/Alaskan Native: 62.0, 74.0
- African American/Black: 68.5, 80.2
- Hawaiian/Pacific Islander: 41.1, 52.7
- Hispanic/Latino: 36.6, 42.0
- Asian American: 22.3, 25.1

Benchmark: 44.4
### 2014 CCO Performance and Quality Pool Distribution

<table>
<thead>
<tr>
<th>Coordinated Care Organization</th>
<th>Number of measures met*</th>
<th>Percent of quality pool funds earned†</th>
<th>Total dollar amount earned</th>
<th>CCO enrollment*</th>
<th>Which challenge pools measures were met</th>
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</thead>
<tbody>
<tr>
<td>AllCare Health Plan</td>
<td>11.7</td>
<td>83 %</td>
<td>$ 6,170,421</td>
<td>47,178</td>
<td>Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>Cascade Health Alliance</td>
<td>11.7</td>
<td>84 %</td>
<td>$ 1,423,801</td>
<td>15,636</td>
<td>Depression, Diabetes, PCPCH</td>
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<tr>
<td>Columbia Pacific</td>
<td>13.9</td>
<td>104 %</td>
<td>$ 4,247,607</td>
<td>25,530</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>Eastern Oregon</td>
<td>12.6</td>
<td>103 %</td>
<td>$ 6,847,819</td>
<td>44,801</td>
<td>Diabetes, PCPCH, SBIRT</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>13.8</td>
<td>105 %</td>
<td>$ 17,157,018</td>
<td>110,324</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>Health Share of Oregon</td>
<td>16.8</td>
<td>105 %</td>
<td>$ 34,592,657</td>
<td>225,068</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>Intercommunity Health Network</td>
<td>9.9</td>
<td>62 %</td>
<td>$ 5,310,493</td>
<td>52,742</td>
<td>Diabetes, PCPCH</td>
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<tr>
<td>Jackson Care Connect</td>
<td>13.8</td>
<td>103 %</td>
<td>$ 4,704,838</td>
<td>27,828</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>PacificSource - Central Oregon</td>
<td>12.9</td>
<td>104 %</td>
<td>$ 8,177,907</td>
<td>50,875</td>
<td>Depression, Diabetes, PCPCH</td>
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<tr>
<td>PacificSource - Gorge</td>
<td>13.0</td>
<td>105 %</td>
<td>$ 1,872,161</td>
<td>12,244</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>PrimaryHealth of Josephine County</td>
<td>16.0</td>
<td>105 %</td>
<td>$ 1,601,588</td>
<td>10,565</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>Trillium</td>
<td>13.6</td>
<td>103 %</td>
<td>$ 12,658,814</td>
<td>72,187</td>
<td>Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>Umpqua Health Alliance</td>
<td>12.9</td>
<td>104 %</td>
<td>$ 4,491,875</td>
<td>25,195</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
</tr>
<tr>
<td>Western Oregon Advanced Health</td>
<td>12.8</td>
<td>103 %</td>
<td>$ 3,449,486</td>
<td>19,614</td>
<td>Diabetes, PCPCH, SBIRT</td>
</tr>
<tr>
<td>Willamette Valley Community Health</td>
<td>14.9</td>
<td>104 %</td>
<td>$ 12,802,864</td>
<td>93,357</td>
<td>Diabetes, PCPCH, SBIRT</td>
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<tr>
<td>Yamhill CCO</td>
<td>12.7</td>
<td>105 %</td>
<td>$ 2,981,967</td>
<td>20,753</td>
<td>Depression, Diabetes, PCPCH, SBIRT</td>
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</table>

*Out of 17 total CCO incentive measures.
† Includes both phase one distribution and challenge pool.
*CCO enrollment as of December 2014.

The 2014 quality pool distribution methodology is published online at: www.oregon.gov/oha/analytics/CCOData/2014 Reference Instructions.pdf
Aligning State Purchasing

• State vision is to implement the coordinated care model across health benefit purchasing programs to transform the delivery of care
  – ~40% of Oregonians coverage purchased by State

• Public employees purchasing
  – 130,000 lives with annual budget of $750m
  – Implemented the coordinated care model through a competitive procurement in 2014
  – Early results = 0-2% per capita growth trends

• Educators and school district purchasing
  – 160,000 lives with annual budget of $750m
  – Anticipated competitive procurement in 2016
Challenges

• Time, resources and expectations
• Change is hard; change fatigue
• 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
• Actuarial soundness and value-based payments
Key Takeaways

• The model creates a **sustainable path for Medicaid**.

• **There is no perfect, one-size fits all 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.

• There needs to be **leadership commitment** to the goals and deliverables of health reform and then discipline in the work and communication.

• **Agency work must be re-prioritized.** Agency staff need to see health reform as their work and where and how they fit in – they need a sense of both urgency and inspiration.

• There need to be **clear accountabilities and timelines** for outcomes.

• **Communicate early and often.**

• **Support for change and network for shared learning** is critical.
No child should have to go to the emergency department because of an asthma attack
Q & A

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