

# **Health Reform Implementation: What the Heck Do We Do Now?**

**Len M. Nichols, Ph.D.**

**Professor of Health Policy**

**Director, Center for Health Policy Research and Ethics**

**State Network Annual Meeting**

**Portland, OR**

**July 11, 2012**



**Where Innovation Is Tradition**





# What Did our Supreme Court Do?

- Upheld the constitutionality, not the wisdom, of promising access for all
  - Wisdom, if, and how, is for politics to decide
- Struck down federal power to “coerce” states to expand Medicaid as much as PPACA does
- Left the rest of PPACA implementation to us

# And How Do We Feel About It?



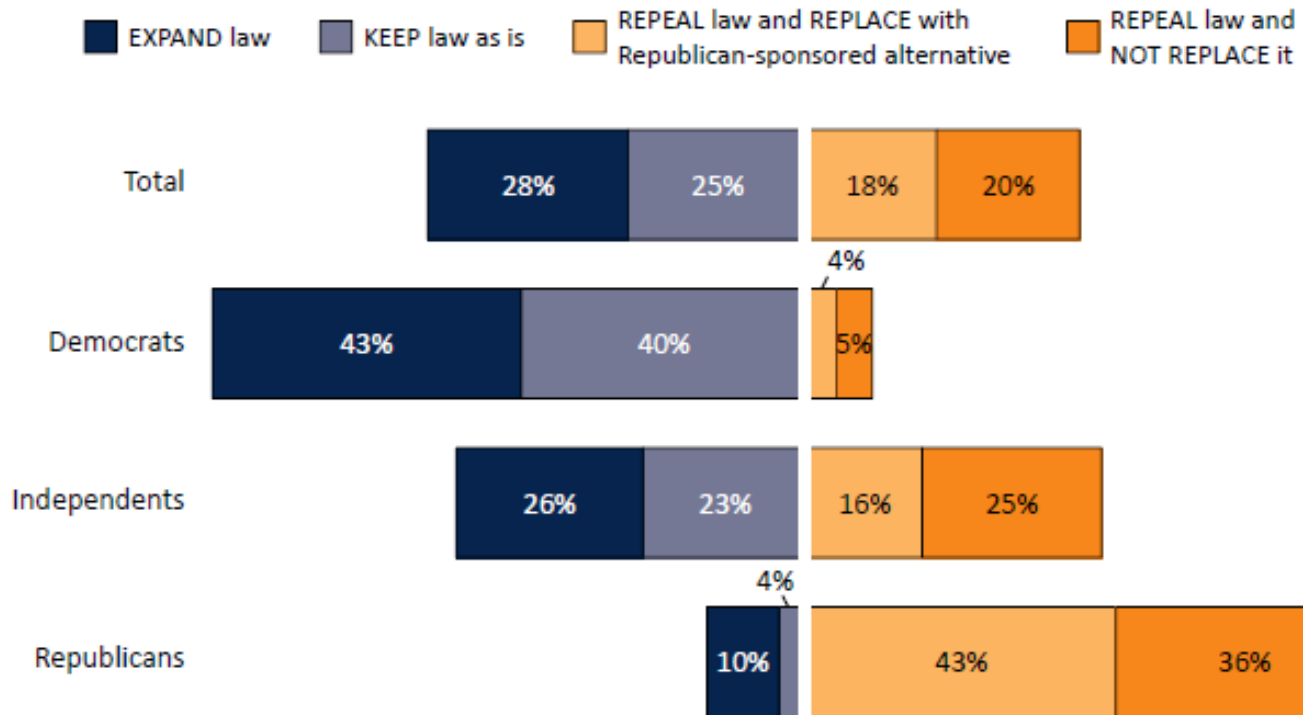


“Chief Justice Roberts squandered the opportunity to restore judicial, financial and legislative sanity to a government that by any sane person’s standards is insane and addicted to centralized federal control of our lives. Because our legislative, judicial and executive branches of government hold the 10th Amendment in contempt, I’m beginning to wonder if it would have been best had the South won the Civil War. *Our Founding Fathers’ concept of limited government is dead.*”

<http://exchangegoldforcash.com/money/u-s-government/president/2012-election/breitbart/rocker-nugent-blasts-justice-roberts-wonders-if-south-should-have-won-civil-war/>

## Partisans Disagree On Next Steps For Health Reform Law

What would you like to see Congress do when it comes to the health care law?



Note: Don't know/Refused answers not shown.

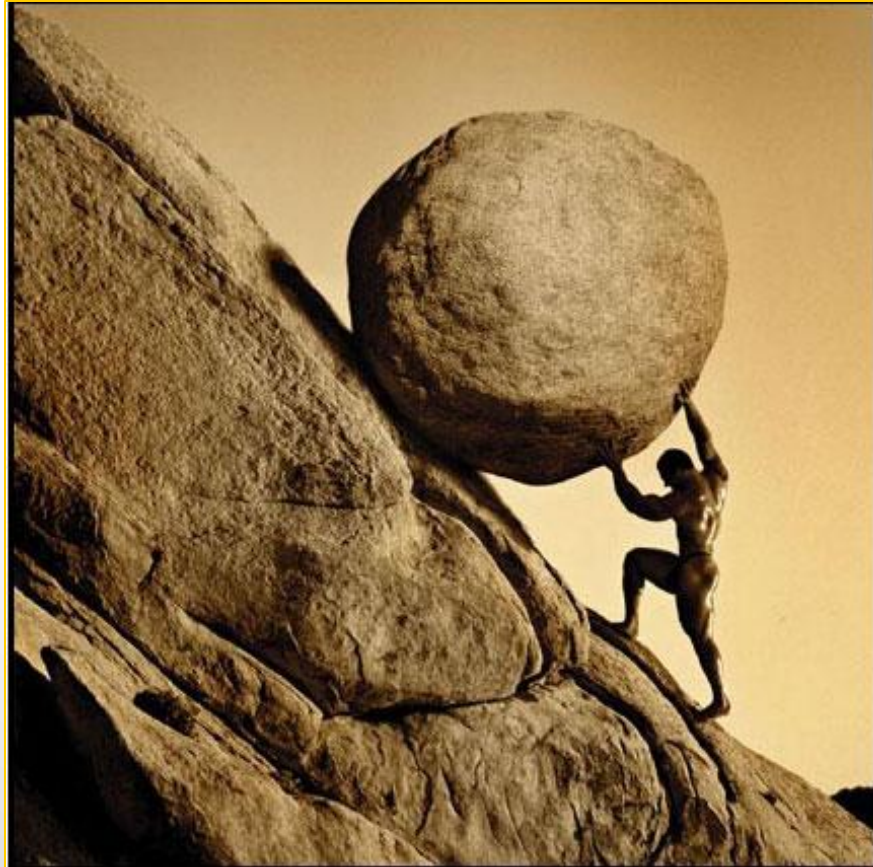
Source: Kaiser Family Foundation Health Tracking Poll: Early Reaction to Supreme Court Decision on the ACA (conducted June 28-30, 2012)

# Big Picture Options

- Hope for R election sweep → repeal + replace?
- Federal exchange, no Medicaid expansion
- State exchange, Medicaid expansion
- Something in the middle

# So What *SHOULD* WE Do?

# Reform would be hard enough...



# Why Can't We All Agree On Goals?

- Different world views
- Redistribution is necessary to ensure access
- Hard to forge agreements without requisite trust
- Hard to build trust in 24/7 attack news cycle

# What Do We NEED To Do?

- Re-learn how to listen to and hear each other
- Remember our own History

# Appomattox Court House, April 1865



# Constitutional Convention, 1787



Internet photo of work by Junius Brutus Stearns, 1856

# Remember the Constitutional Convention

- Philadelphia actions “behind closed doors”
- THEN Debated state by state, with game film
  - Much distrust of “the betters”
  - Opponents were accused of self-interest
  - Basic liberties (bill of rights) not attached
  - Was “Congress” trying to become a king?

# (Re-Building) Trust

- Acknowledge it's been lost
  - Washington agreed to be President and he chose to retire after 2 terms
  - Bill of Rights drafted and approved right away
- Listen to opponents and debate *fairly*
  - Federal power cannot be unlimited
  - Malpractice reform
  - Budget failsafe
  - More state flexibility

# So My Free Advice

- Start preparing your “state innovation waiver” memo (Section 1332) now, if you are so inclined
- Explain how you would rather meet goals and metrics of PPACA, (coverage, affordability, scope)
  - Put folks above poverty into Exchange, not Medicaid
  - Expand Medicaid in steps, not all at once
  - Allow phase-ins to Bronze
  - Lay out pathway to full state operation of Exchange
- Articulate your own goals and propose metrics

# Transforming the Oregon Health Plan: Coordinated Care Organizations

July 2012

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



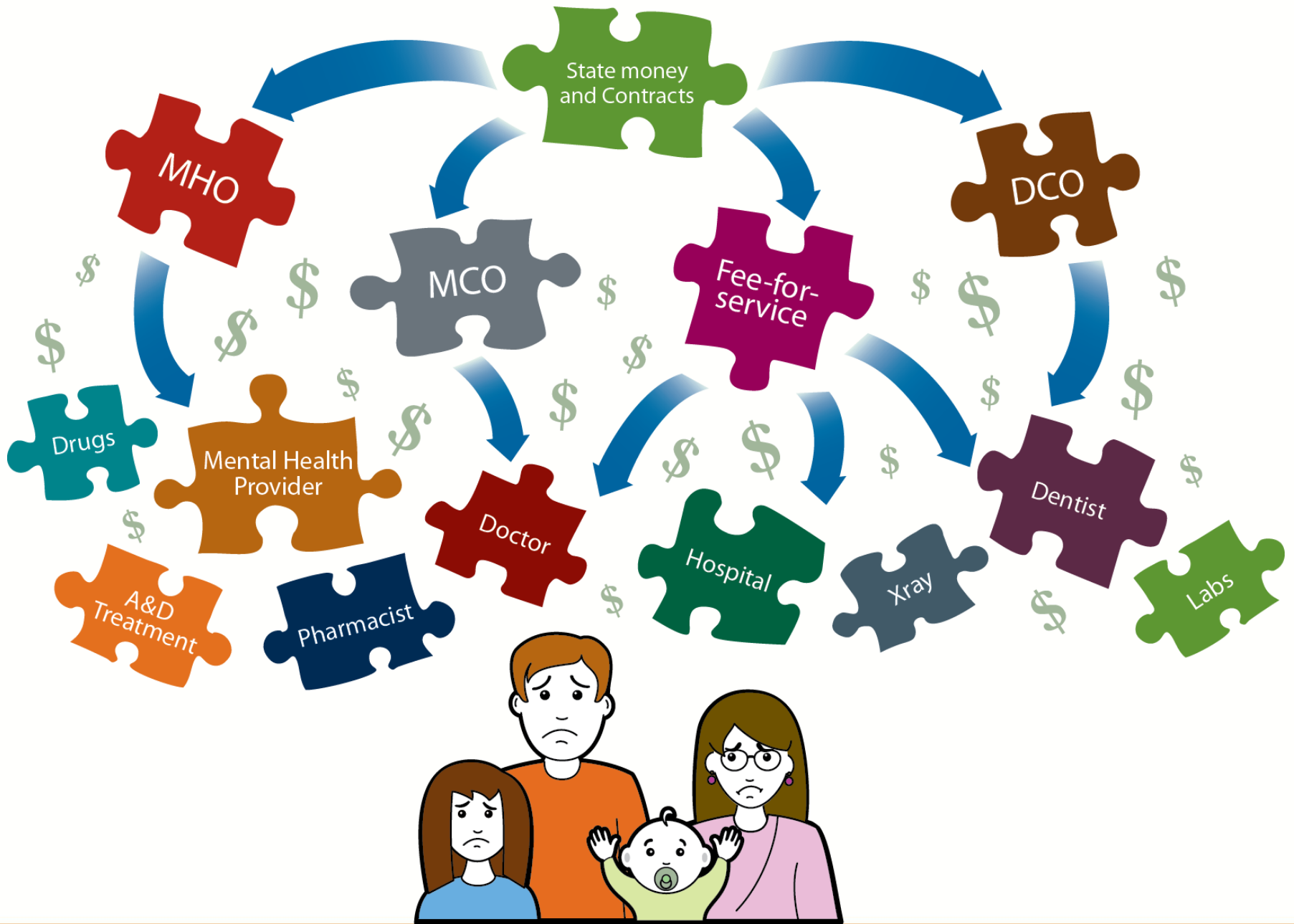
# State Healthcare Costs Unsustainable:

- 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

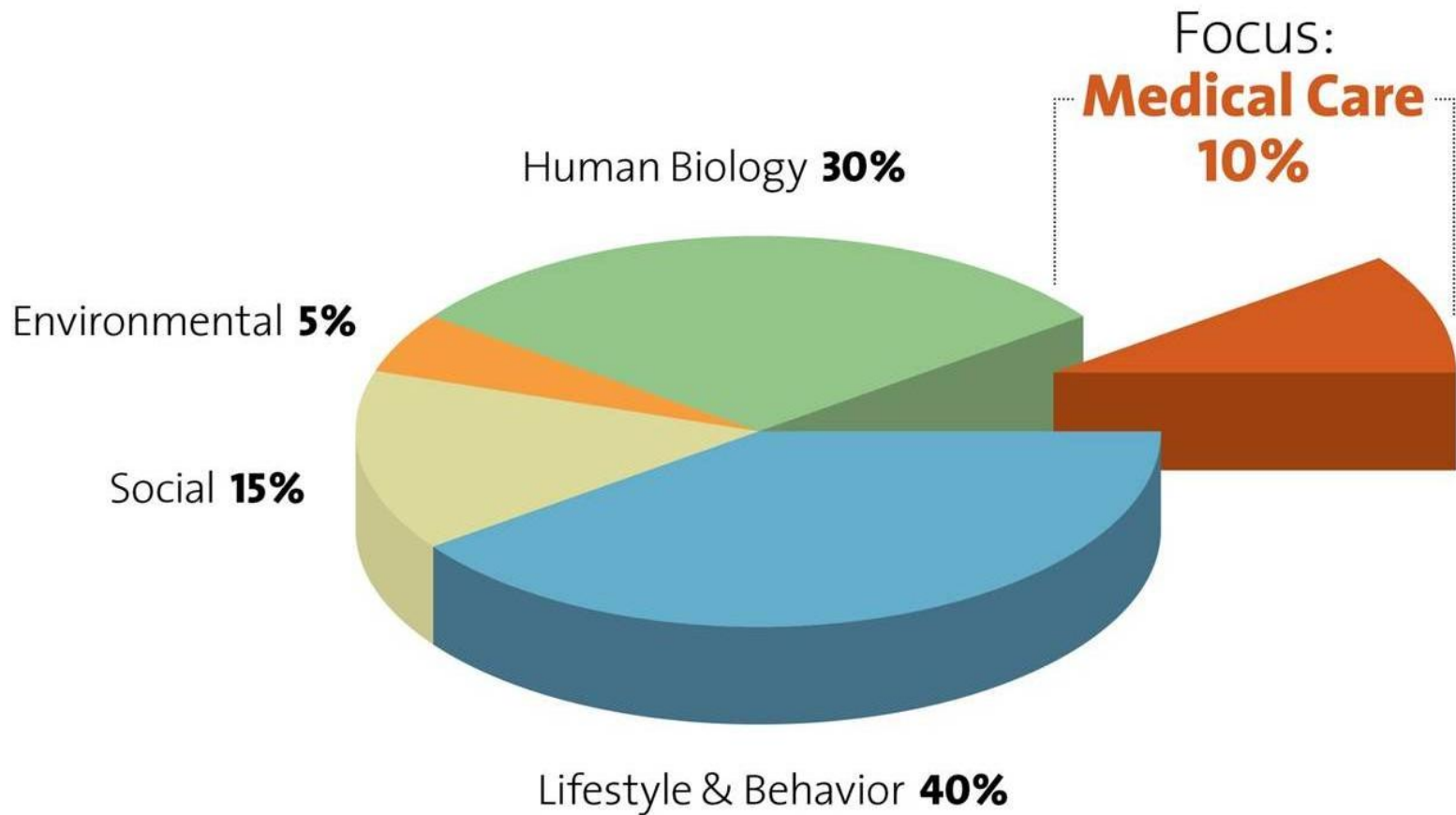
- Cut people from care
- Cut provider rates
- Cut services

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

# Triple Aim: A new vision for Oregon

-  **1 Better health.**
-  **2 Better care.**
-  **3 Lower costs.**

# 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

# 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

# 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.

# 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**

# 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



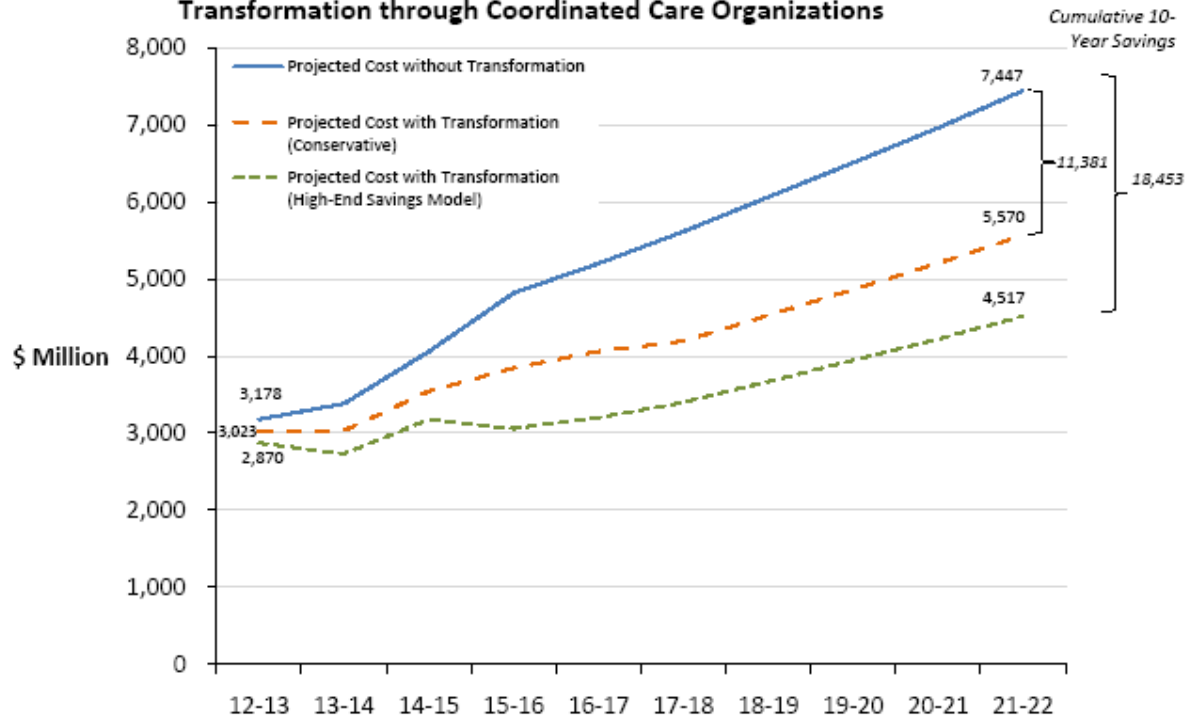
# OHA Coordinating and Streamlining

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



# If we do nothing....

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



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.



# 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

# 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**

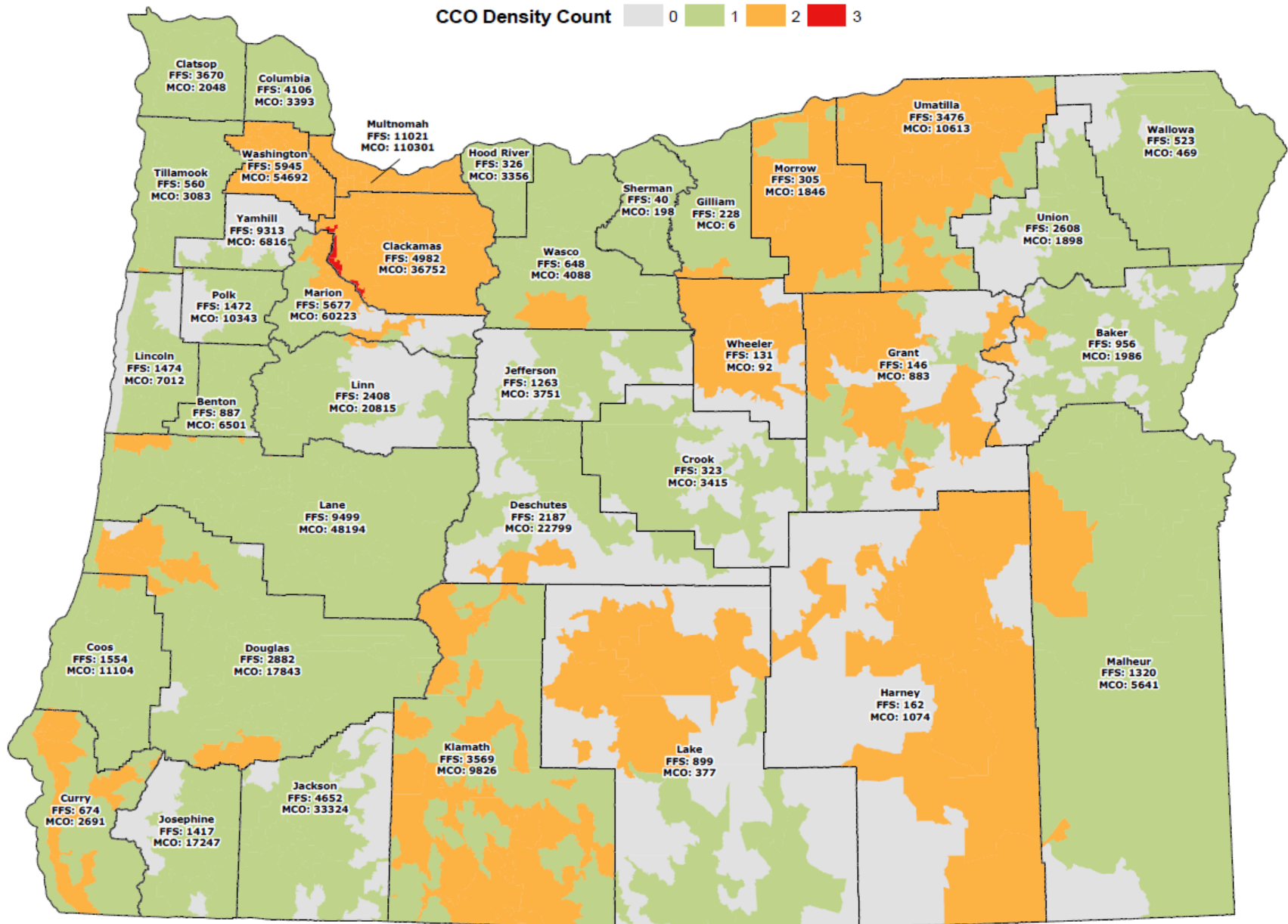
# Timeline and Status Today:

---

- 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

# Coordinated Care Organization Applicants Service Area Density with OHP Total Client Counts by County

CCO Density Count    0    1    2    3



# 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

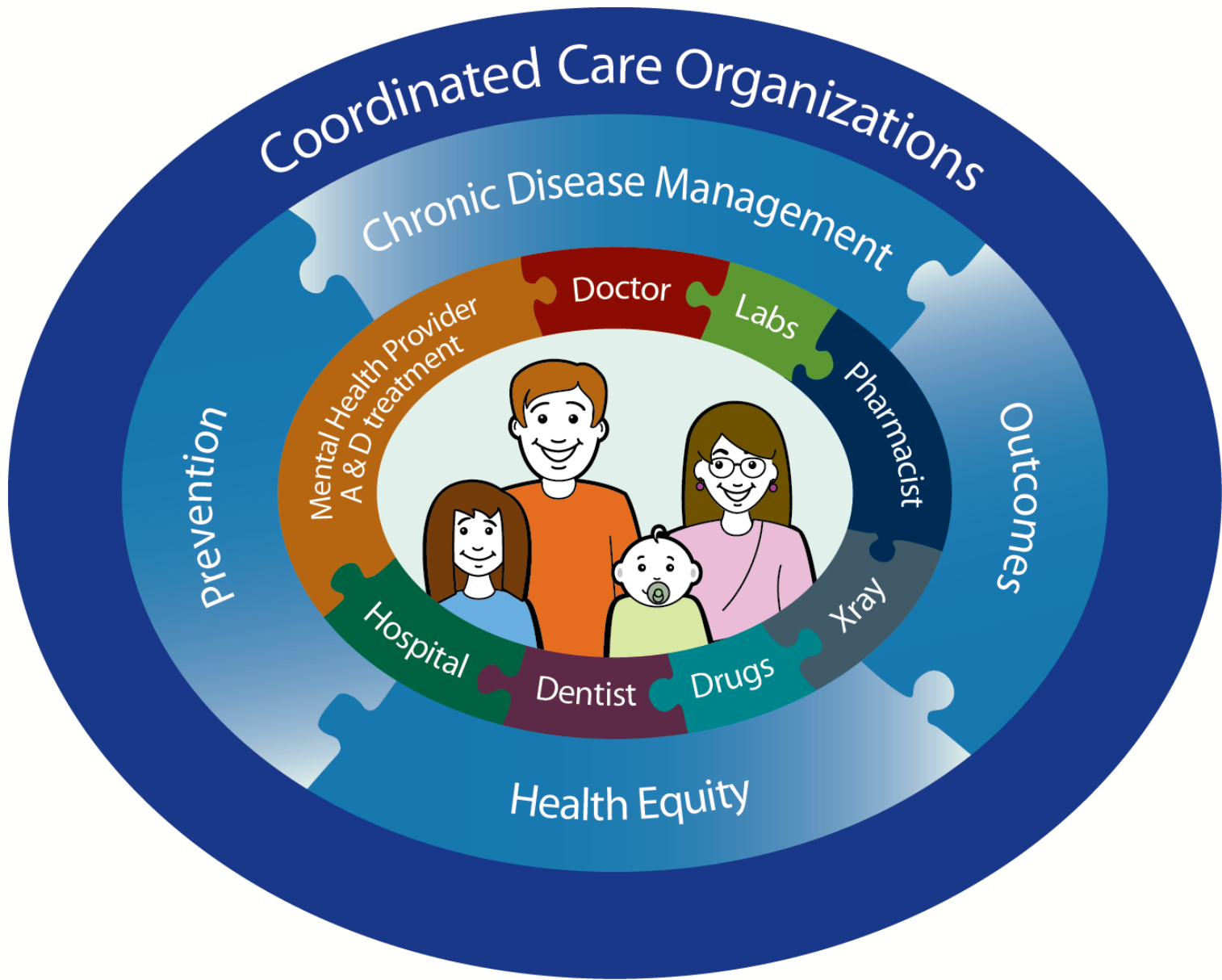
**Exception:** better  
managed care for  
chronic illness

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

# 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





# Questions?

**For more information:**

<http://health.oregon.gov>

[jeanene.smith@state.or.us](mailto:jeanene.smith@state.or.us)