Health Reform In Oregon: An Opera Grand/Buffa? (in Four Acts)

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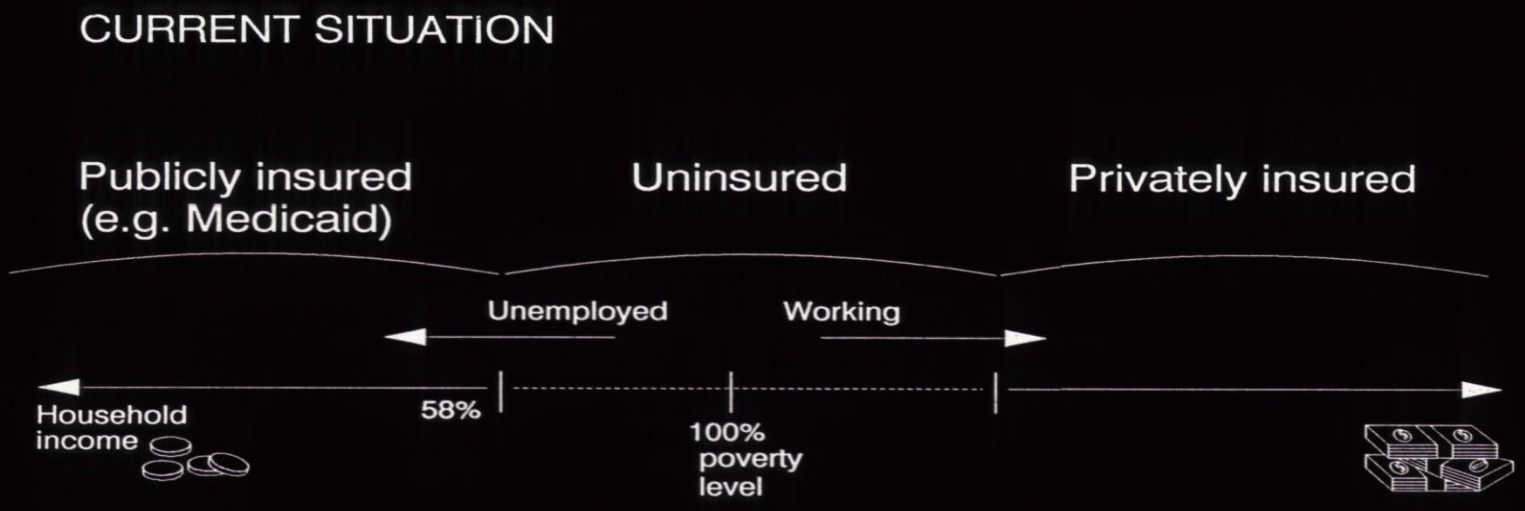
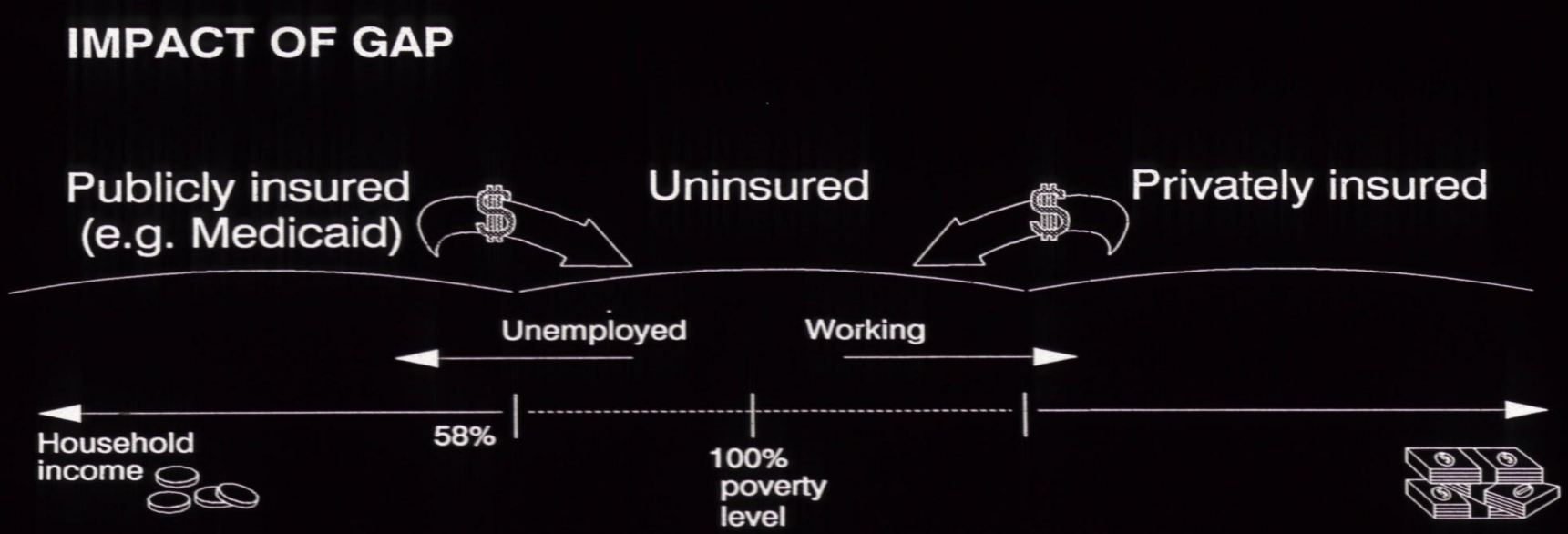
With supporting materials from OHA and
Apologies to Tchaikovsky, Mozart, Chopin, Verdi, Sondheim, and Simon

1989 Overture: Pre-OHP Situation

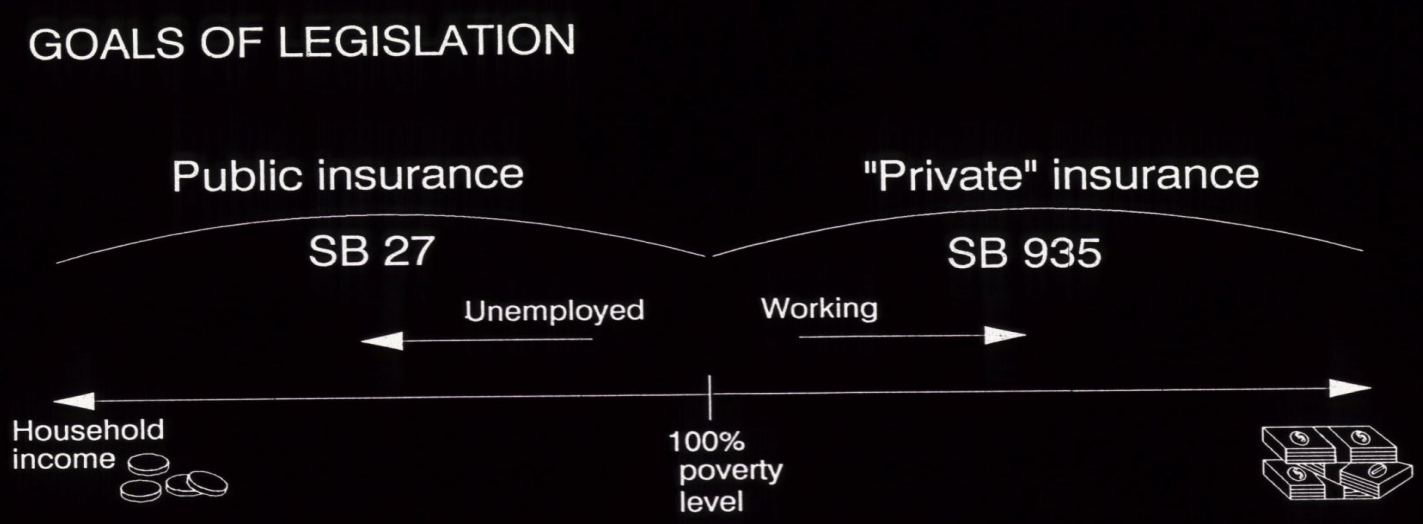


Cost Shifting, Pre-1989



Private and public insurance subsidizes health care costs of uninsured.

Act I: OHP Legislation: Universal Coverage



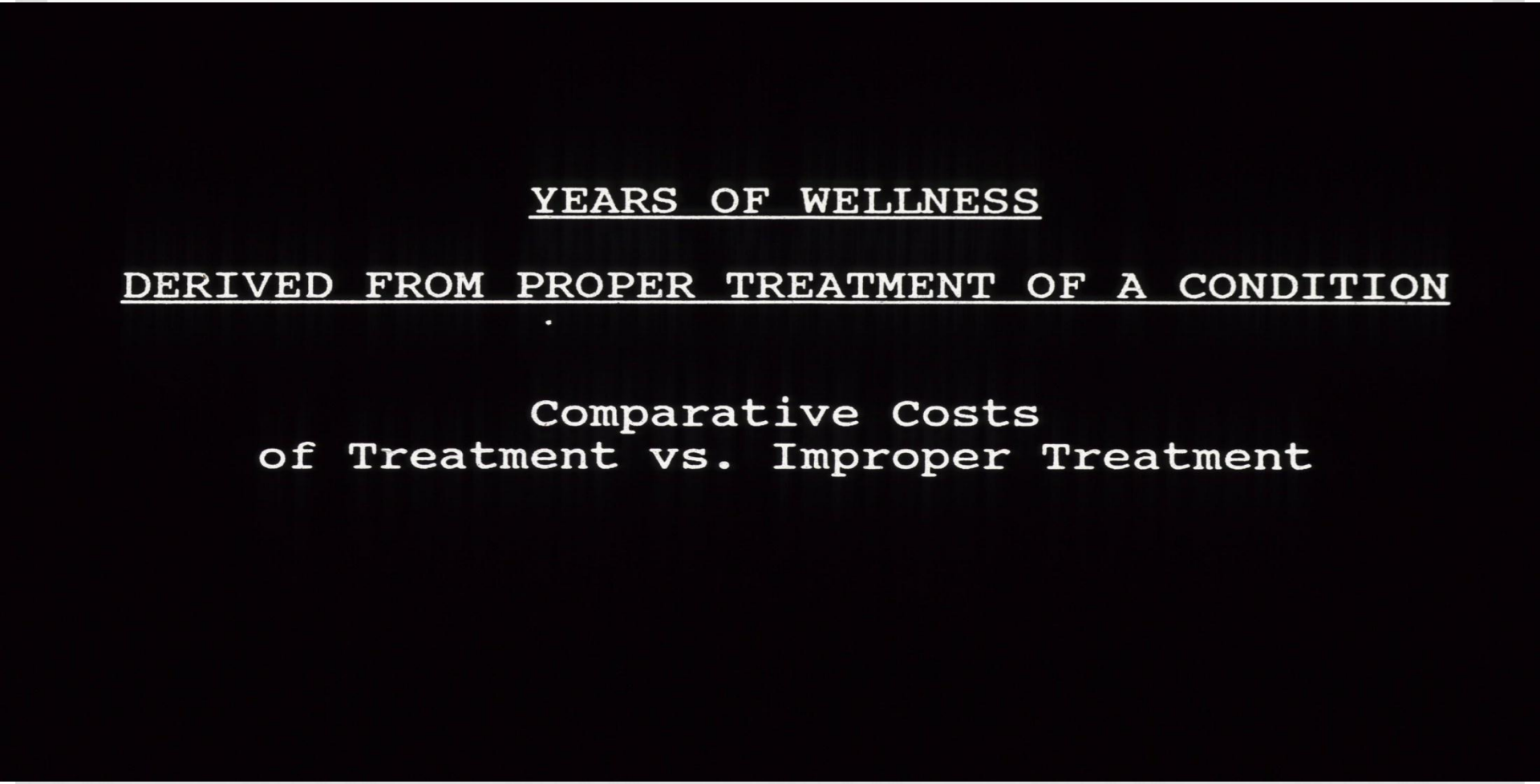
1. Extend coverage to all citizens.
2. Reimburse providers adequately.
3. Prioritize services to be covered in a rational way.

Health Services Commission Embarks On Noble Mission: Create Prioritized List

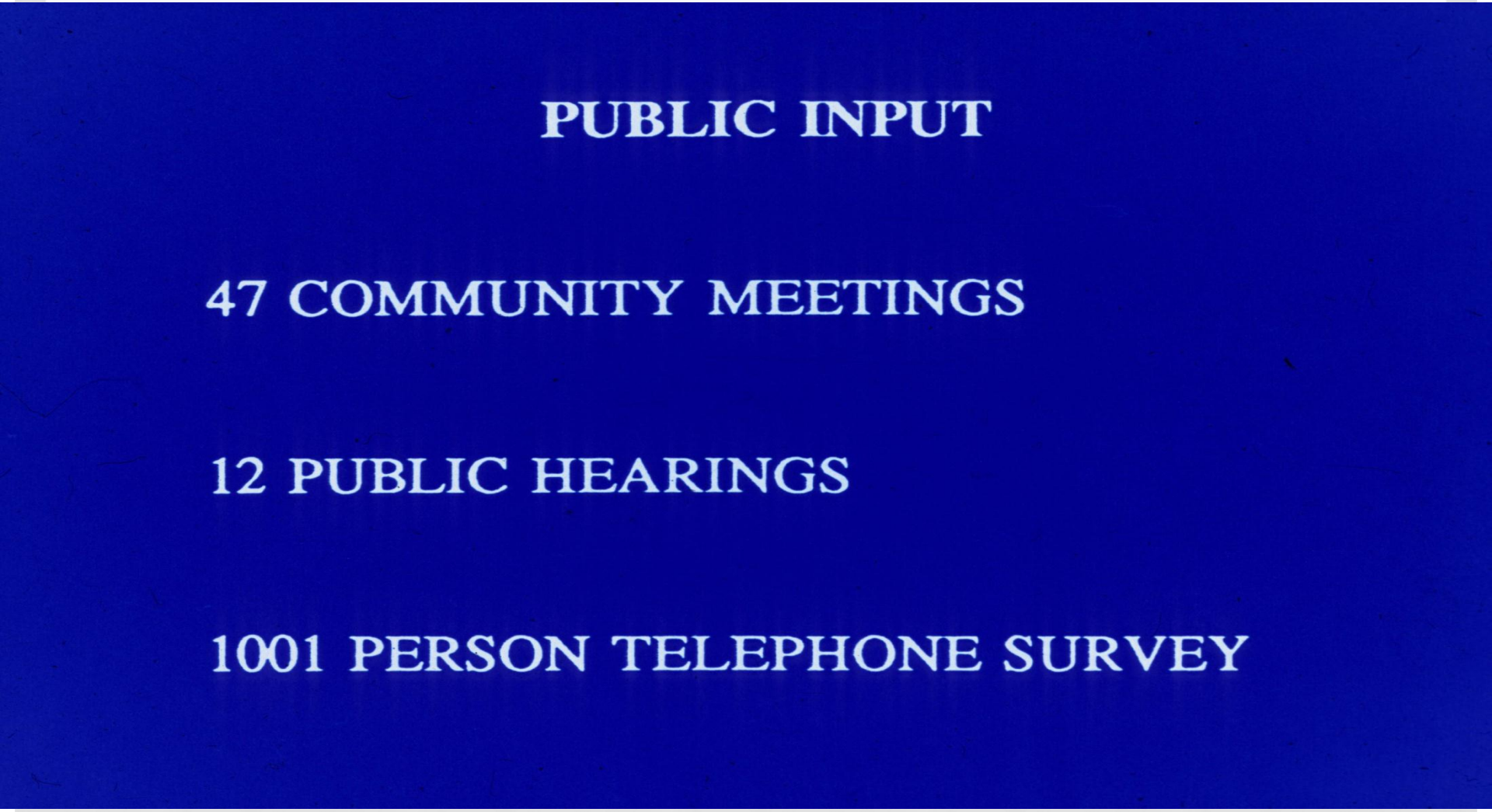
Simple Task: Collect Data On Conditions & Plug Into Formula?

$$B_n = \sum_{k=1}^{y_n} \frac{\sum_{i=1}^{5} \left[\left(P_{i1} * \left(1 + \sum_{j=1}^{30} d_{ij1} w_j \right) \right) - \left(P_{i2} * \left(1 + \sum_{j=1}^{30} d_{ij2} w_j \right) \right) \right] / (1 + D)^k}{(c_{k1} - c_{k2}) / (1 + R - MI)^k}$$

Okay, What The Formula Really Means

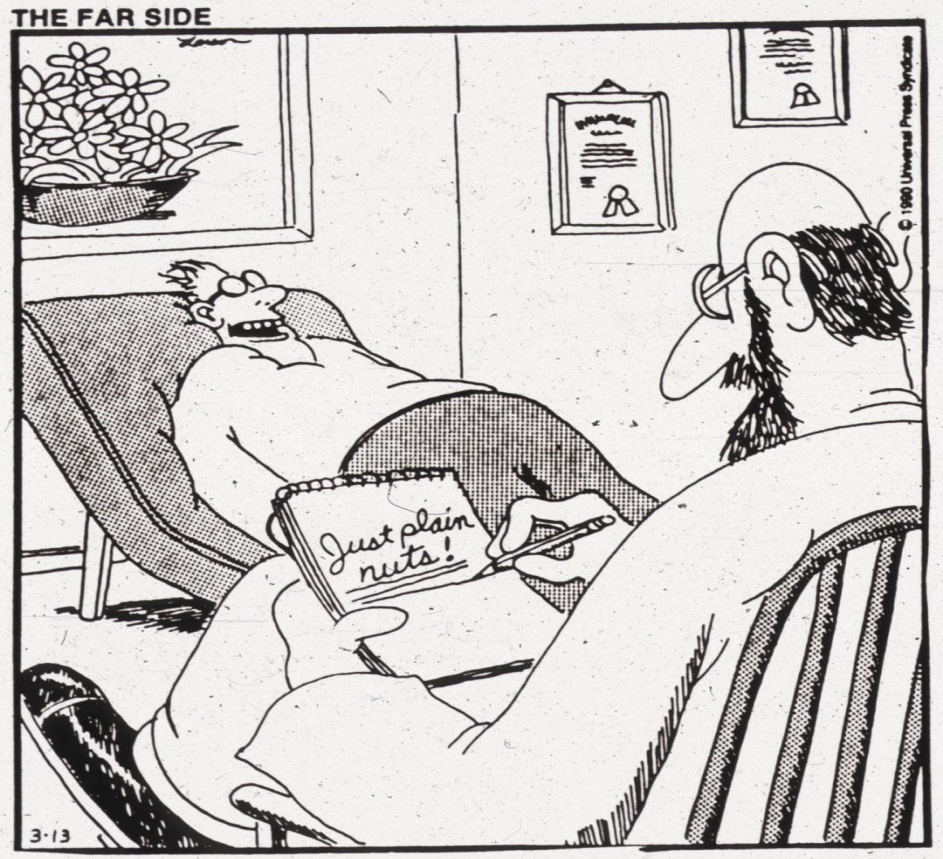


An Oregon Tradition: Solicit Public Involvement



A Funny Thing Happened On the Way to the Legislature: Someone Fiddled With The Formula

Psychiatrists Diagnose List's Flaws



List Gets Revised/Improved: Lump, Sort, Rearrange Method

RANKED CATEGORIZATION OF SERVICES

1. **Acute Fatal:** Treatment prevents death with full recovery.
2. **Maternity Care**
3. **Acute Fatal:** Treatment prevents death without full recovery
4. **Preventive Care for children**
5. **Chronic Fatal:** Treatment improves life span and quality of life
6. **Reproductive Services:** (Excludes maternity and infertility services)

RANKED CATEGORIZATION OF SERVICES

7. **Comfort Care:** Palliative therapy for conditions in which death is imminent

8. **Preventive Dental Care**

9. **Proven Effective Preventive Care for Adults**

10. **Acute Nonfatal:** Treatment causes return to previous health state

11. **Chronic Nonfatal:** One-time treatment improves quality of life

12. **Acute Nonfatal:** Treatment without return to previous health state

RANKED CATEGORIZATION OF SERVICES

13. **Chronic Nonfatal:** Repetitive treatment improves quality of life

14. **Acute Nonfatal:** Treatment expedites recovery of self-limiting conditions

15. **Infertility Services**

16. **Less Effective Preventive Care for Adults**

17. **Fatal or Nonfatal:** Treatment causes minimal or no improvement in quality of life

Where To Draw The Priority Line?

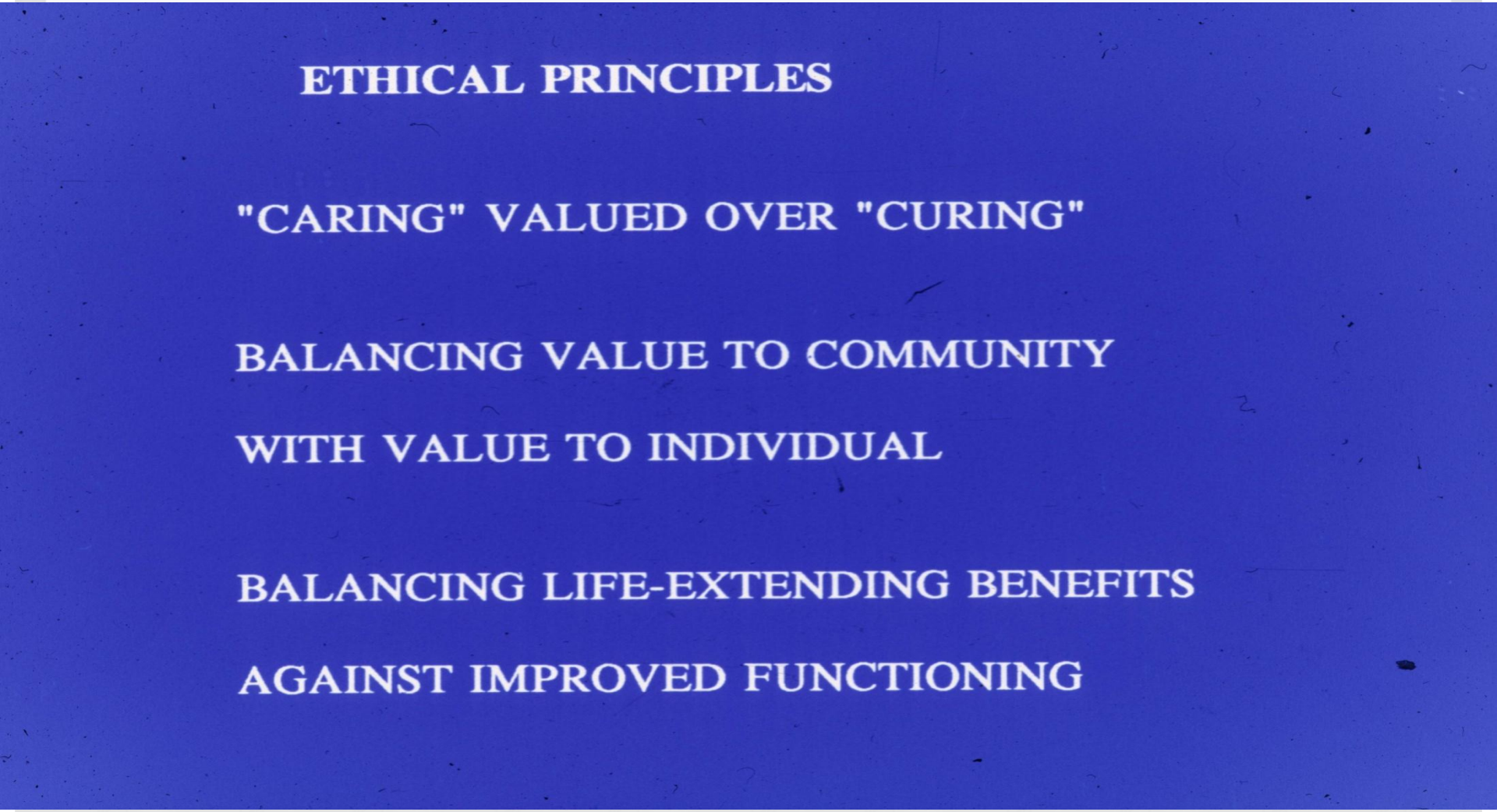
CATEGORIES

1 TO 9 – ESSENTIAL SERVICES

10 TO 13 – IMPORTANT

14 TO 17 – VALUABLE TO SOME INDIVIDUALS

Values Guide Prioritization



Intermission: What Happened Between Early 1990s & 2007?

- Feds approve Medicaid waiver allowing OHP to proceed.
- Employer mandate dropped →OHP now Medicaid only.
- Separate managed care health, mental, and dental health organizations formed to manage funds/care for OHP enrollees in each county/region of state.
- Dramatic increase in number of persons enrolled in Medicaid, from 300K to 450K.
- Gradual improvement in system functioning: more people getting care, decreased inappropriate utilization of ED, OHP helping many → employment and insurance through work.
- 2002-3: Major economic downturn, dramatic reductions in OHP benefits for expansion population, >100K persons lose coverage.

Act II: Return To The Legislature

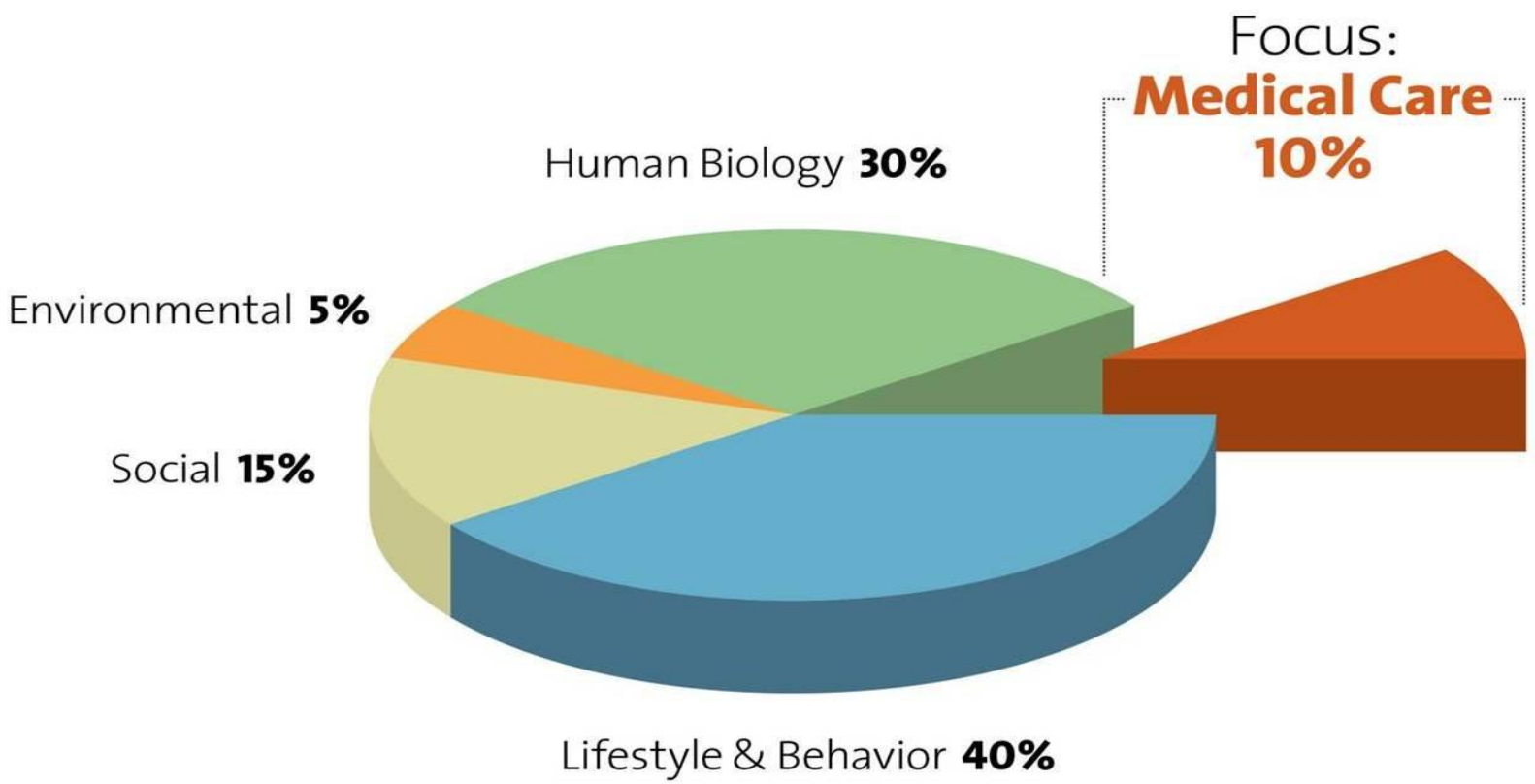
- Concerns grow regarding health system's increasing costs, return to higher numbers of uninsured and underinsured, and poor outcomes.
- 2007: "Try again, but do it right this time!"
- SB 329 creates Oregon Health Fund Board to initiate planning process, guided by the Triple Aim.

Goal: Triple Aim

A New Vision For A Healthy Oregon

1 **Better health.**

Can We Shift Focus To Population Health?

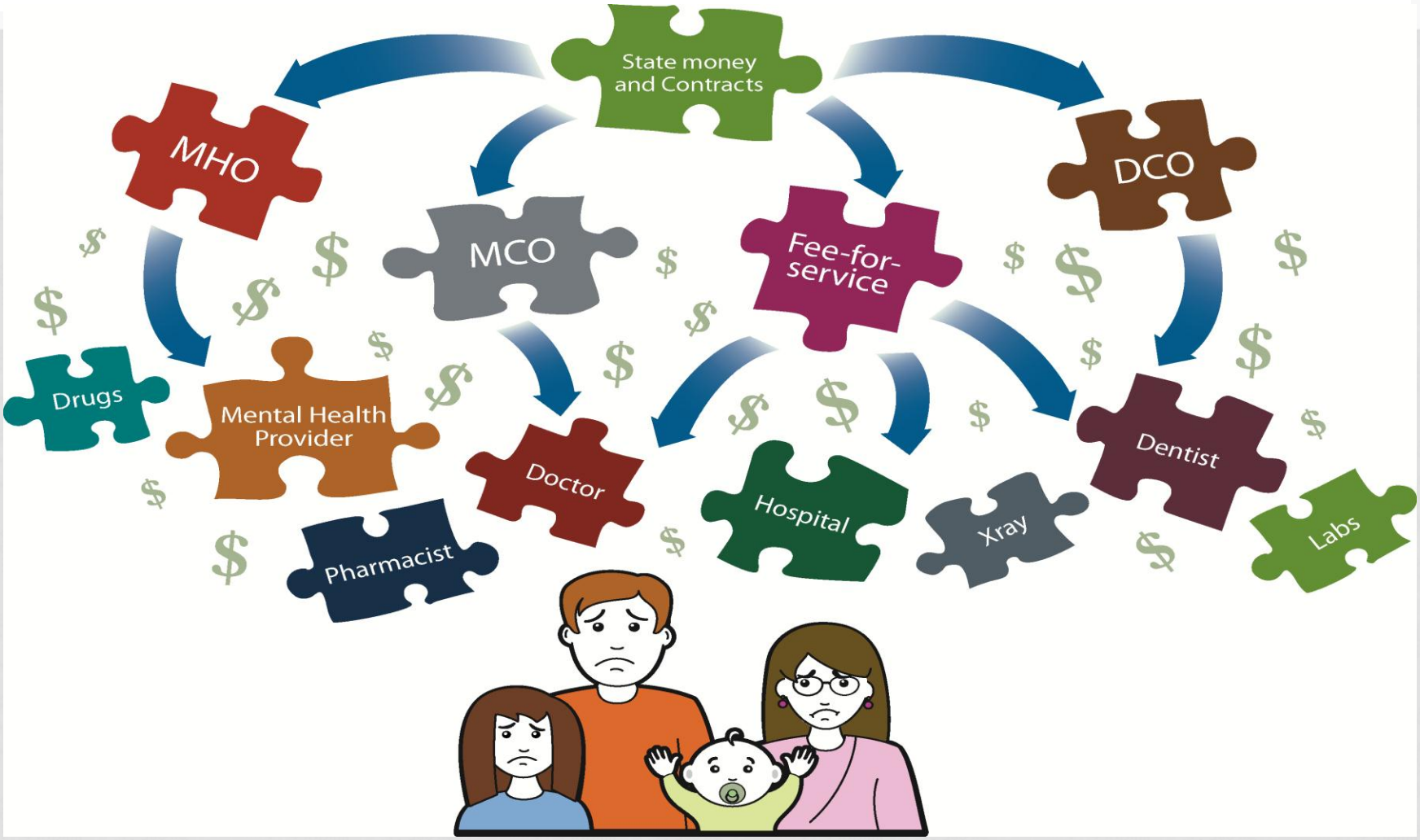


Goal: Triple Aim

A New Vision For A Healthy Oregon

1. Better health.
2. Better care.

Better Care Elusive: Can We Get It Together?

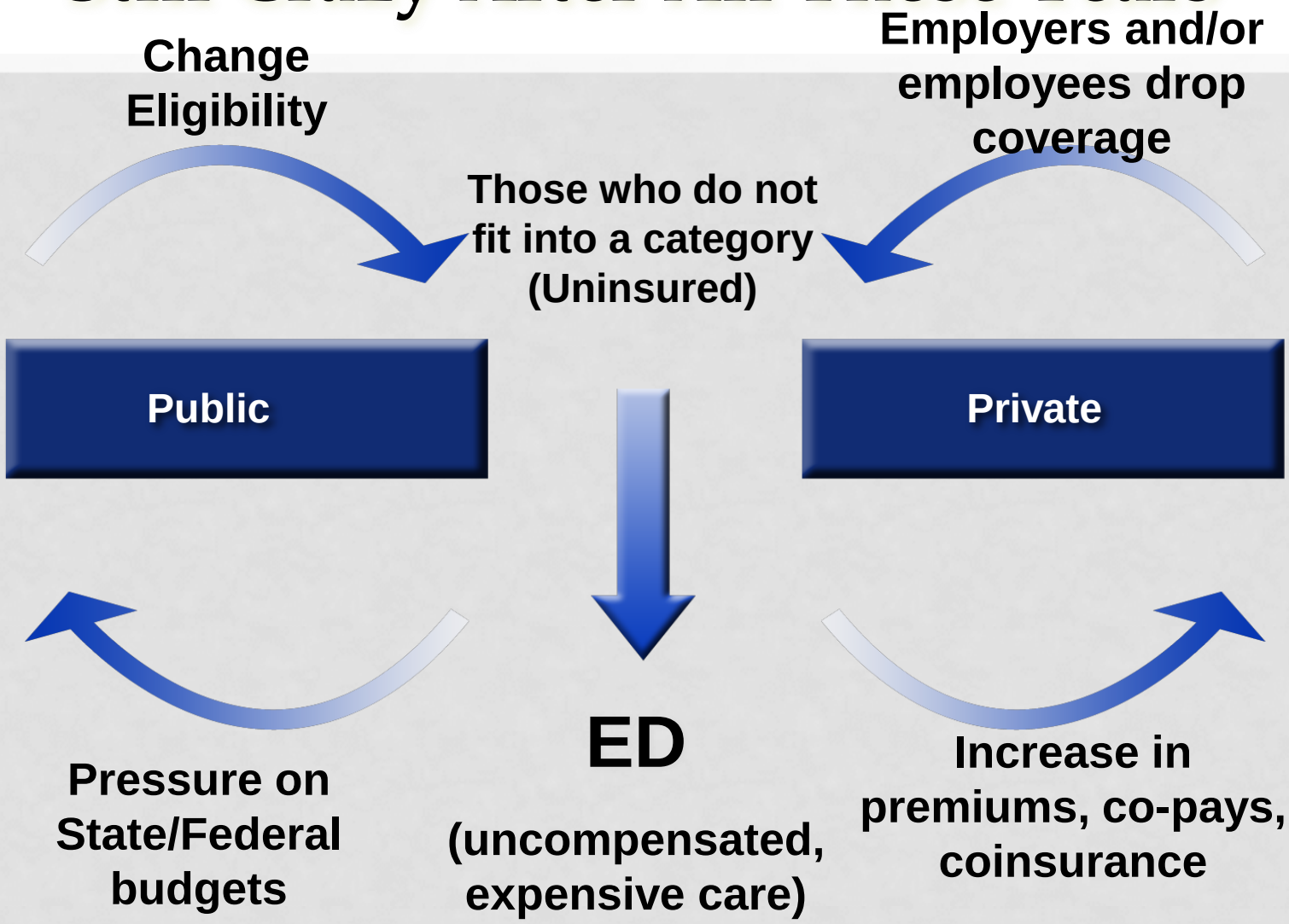


Goal: Triple Aim

A New Vision For A Healthy Oregon

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

Costs Shifting:
Still Crazy After All These Years



Oregon Health Fund Board

- Goal: to determine if universal coverage system is feasible and how to structure it.
- 11 member diverse group, supported by several key committees to review financing, delivery system design, federal laws, etc.
- Report to legislature, Aim High: Building a Healthy Oregon
- Recommendations → 2 key bills in 2009 legislative session

House Bill 2009

- Created Oregon Health Authority (OHA), consolidating most state offices dealing with health services: public health, addictions and mental health, Medicaid, public employee and school district employee health benefits, high risk pool, etc.
- Created Oregon Health Policy Board to oversee OHA and continue the planning of the reformed system.

House Bill 2116

- In spite of down economy in 2008, leaders desired to add and restore health coverage to children and low income adults (OHP Standard had dropped from 125K to ~ 25K enrollees since 2003).
- Passed revenue tax on all hospitals and health plans, which could then be used to leverage federal Medicaid match → adding 80-130K new enrollees to OHP & Healthy Kids and allowing hospitals and health plans to break even.

Oregon Health Policy Board

- Created key committees to plan:
  - Primary care home definition and standards
  - Health information technology
  - Quality and outcomes & payment reform
  - Workforce development
  - Public employer health purchasing
  - Medical liability
  - Health insurance exchange
- Oregon's Action Plan for Health, 2010 report to legislature with goals for near and longer term, most of which to be implemented by 2014

March Triumphal: Oregon's Action Plan Strategies

1. **Use purchasing power** to change how we deliver and pay for health care: Align public purchasing, reduce administrative costs, change how we pay, establish value-based benefits, and set budgets
2. **Shift focus to prevention**: Improve health, lower costs, and allow smarter allocation of resources
3. **Improve health equity**: Better health and lower costs for everyone
4. **Establish a health insurance exchange** to make it easier for Oregonians to get affordable health insurance

March Triumphal: Oregon's Action Plan Strategies

5. **Reduce barriers to health care**: Adequate insurance, providers with the right training for the right places, and easy access to care
6. **Set standards for safe and effective care**: Primary care homes, electronic health information, evidence-based care, and addressing medical liability
7. **Involve everyone in health system improvements**: Consumers, patients, health partners and regional health care organizations
8. **Measure progress**: Timely data and meaningful information

March, 2010: Congress Enacts PPACA

- Looks a lot like Oregon's plan.
- Comparable to the German, French, or Japanese national systems.
- Oregon positions itself to be on the cutting edge of reform efforts once again: doesn't join other states in opposing ACA, pursues various demonstration grants, pilot projects, modeling for other states.
- How do these approaches compare with Fuchs concept of the 4 Cs: coverage, cost control, coordinated care, choice?*

*Fuchs V, 2009. Health Reform: Getting The Essentials Right. Health Affairs 28:2 180-183

Act III: Transformation Aria

After 2010 election and dismal revenue and deficit forecasts, Governor-elect Kitzhaber proposes swifter implementation of reforms.

Suggests transforming system by integrating funding and redesigning delivery system.

Contends that this could lead to sufficient savings to reduce the need for budget cuts.

Why Transform?

- Health care costs increasingly unaffordable to individuals, businesses, state and local governments
- Inefficient health care systems → unnecessary costs to taxpayers
- Dollars diverted from education, children's services, public safety
- Spending a lot for questionable outcomes – 80% of health care dollars go to 20% of patients, mostly for chronic care
- Lack of coordination between general medical, mental, dental and other care and public health → worse outcomes and higher costs

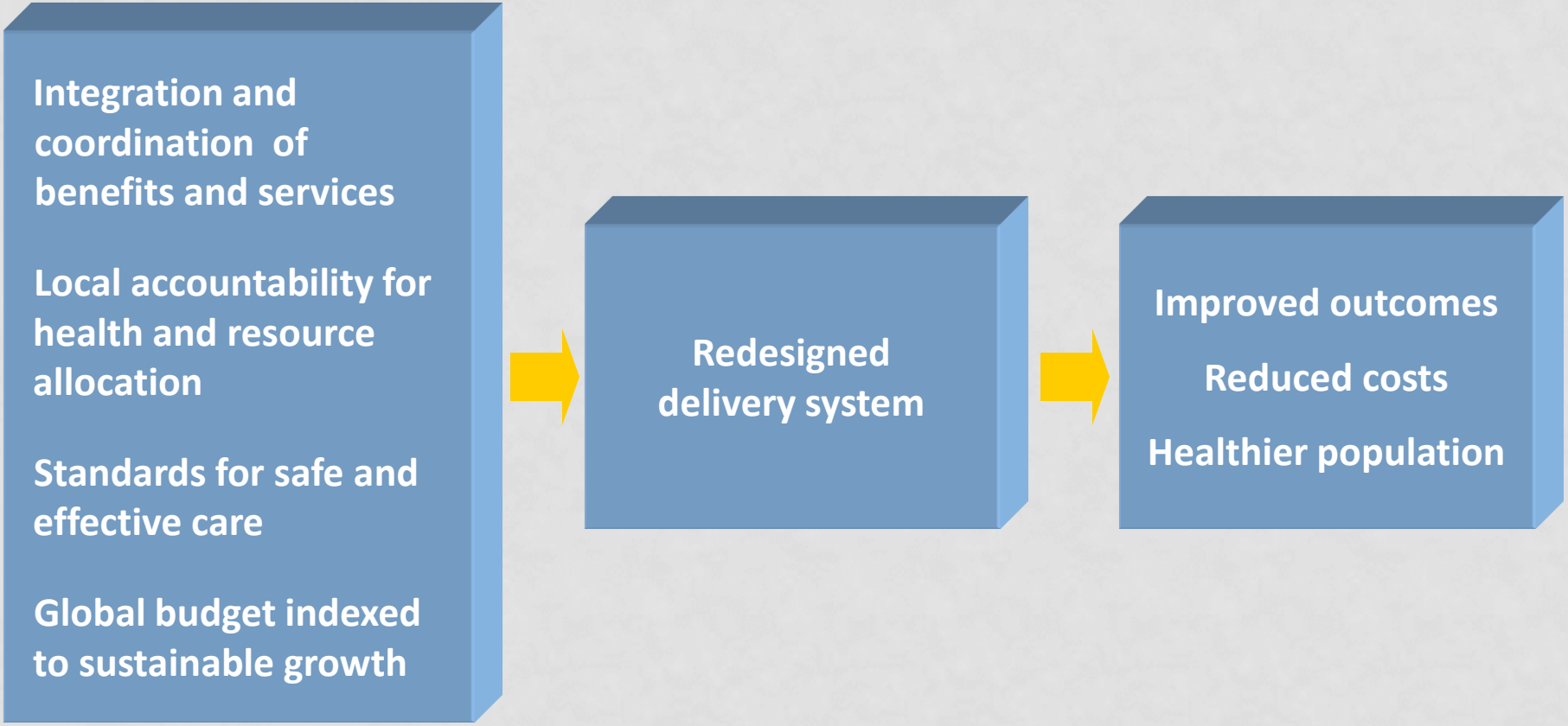
Why Now?

- High costs are unsustainable.
- A better way to deal with budget shortfall than cutting people from OHP.
- Cost shifts to Oregon businesses and families.
- The budget reality calls for real system change for the long term.

House Bill 3650

- Creates a new vision for the Oregon Health Plan.
- Passed in 2011 session with broad bipartisan support.
- Emphasizes better health – recognizes if we deal with budgets alone, we won't succeed.
- Transforms the system to meet the outcomes we need.

Vision Of HB 3650: CCOs and PCPCHs



CCOs: Coordinated Care Organizations

- Community-based, strong consumer involvement in governance that bring together the various providers of services
- Responsible for full integration of physical, behavioral and oral health
- Global budget
  - Revenue flexibility to allow innovative approaches to prevention, team-based care
  - Opportunities for shared savings
- Accountability through measures of health outcomes

CCO Key Element: Global Budget

- Global budgets based on initial revenue/expenditure targets, then increased at agreed-upon rate rather than historical trend
- Management of costs – clear incentives to operate efficiently
- More flexibility allowed within global budgets, so providers can meet the needs of patients and their communities
- Accountability is paramount
- Opportunities for shared savings when patients remain healthy and avoid high-cost care

CCO Key Element: Accountability And Metrics

Incentives & measurements for: right care, right time, right place by the right person

- **Activities geared towards health improvement**
- **Hospital quality and safety**
- **Patient experience of care**
- **Health outcomes**
- **Clinical, encounter, and administrative databases**

Patient-Centered Primary Care Home (PCPCH) Attributes

ACCESS TO CARE

"Be there when we need you."

ACCOUNTABILITY

"Take responsibility for making sure we receive the best possible health care."

COMPREHENSIVE WHOLE PERSON CARE

"Provide or help us get the health care, information, and services we need."

CONTINUITY

"Be our partner over time in caring for us."

COORDINATION AND INTEGRATION

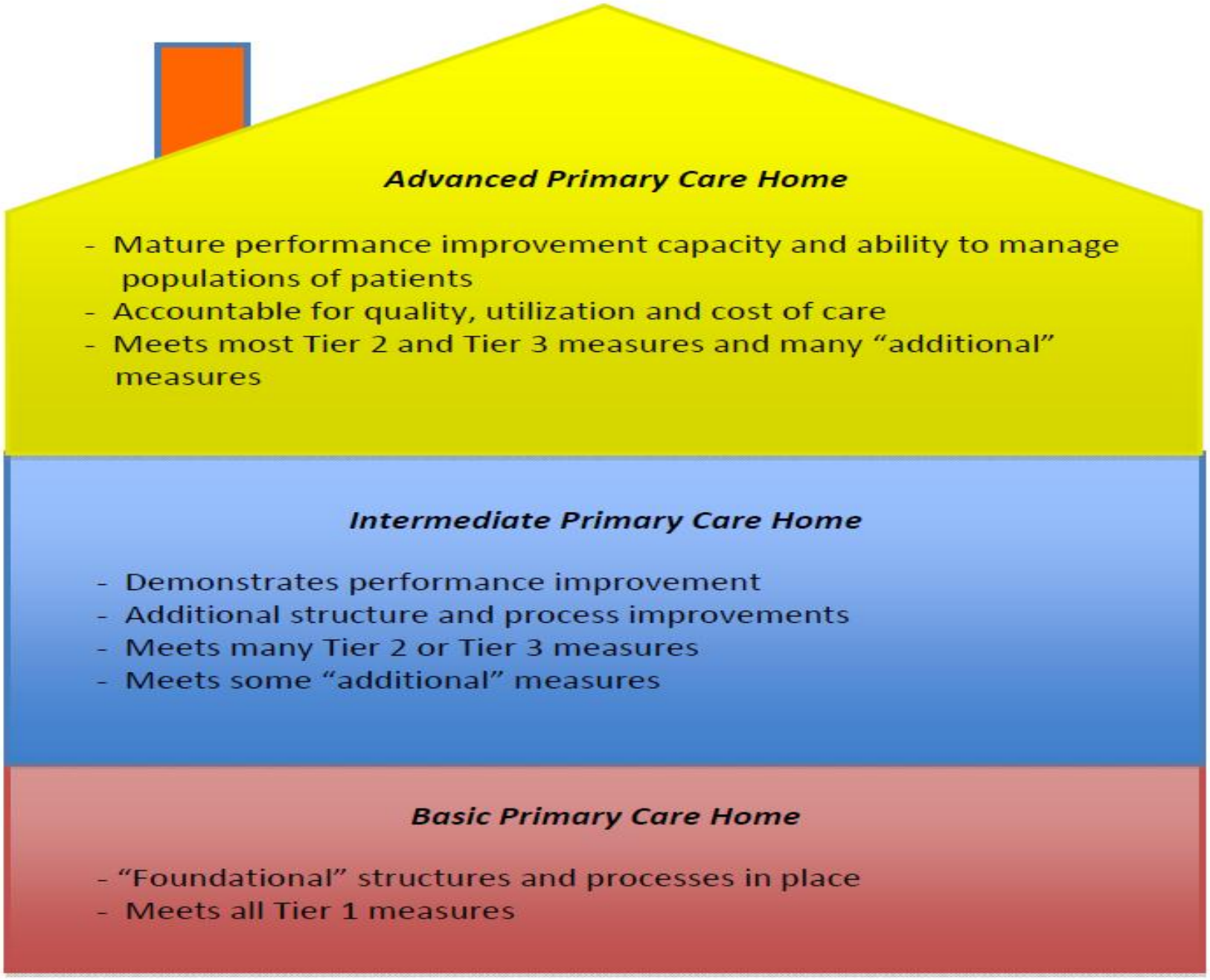
"Help us navigate the health care system to get the care we need in a safe and timely way."

PERSON AND FAMILY CENTERED CARE

"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."

PCPCH Measures

Access To Care In-Person Access Telephone and Electronic Access Administrative Access **Accountability** Performance Improvement Cost and Utilization **Comprehensive Whole Person Care** Scope of Services	**Continuity** Provider Continuity Information Continuity Geographic Continuity **Coordination And Integration** Data Management Care Coordination Care Planning **Person And Family Centered Care** Communication Education and Self-Management Support Experience of Care


Advanced Primary Care Home
- Mature performance improvement capacity and ability to manage populations of patients
- Accountable for quality, utilization and cost of care
- Meets most Tier 2 and Tier 3 measures and many "additional" measures
Intermediate Primary Care Home
- Demonstrates performance improvement
- Additional structure and process improvements
- Meets many Tier 2 or Tier 3 measures
- Meets some "additional" measures
Basic Primary Care Home
- "Foundational" structures and processes in place
- Meets all Tier 1 measures

Psychiatric Providers in Integrated Care

- Integrated care will be an increasingly more prominent component of the care system.
- Roles for psychiatric providers in integrated care:
  - Complex case assessment
  - Limited direct patient care
  - Curbside and case-specific consultation with PCPs, BH providers, and care teams
  - Clinical supervision and training
  - Team and systems level administrative, policy, and service coordination functions
- **Workforce training implications: We must train psychiatrists to be competent, creative, collaborative, and adaptive members of integrated care systems!**

Addictions & MH System Transformation

- Parallel to Transformation Initiative & its emphasis on integration of BH & Primary Care
- Emphasis on early intervention to promote independence, resilience, recovery and health
- Flexibility provided to local communities
- Improved accountability in community-based system
- Consumer and family involvement in planning and ongoing governance
- Reduced reliance on institutional care
- Increased availability of high quality community-based services

Act IV: Implementation
How We Get There

Today			Tomorrow
PAYMENT MODELS			
Fee for service	Episode-based reimbursement	Partial/full risk capitation	Global budgeting
INCENTIVES			
Conduct Procedures	Evidence-based medicine Clinical PFP	Expanded care management Risk-adjusted PFP	Reduce obstacles to behavior change Address root causes
METRICS			
Net revenue improvement	Improved clinical outcomes Reduced readmits	Reduced/preventable hospitalizations/ED Reduced disparities	Aggregate in health status & QOL Reduced HC costs
GOVERNANCE			
Informal relationships & referrals	Joint partnerships between organizations e.g. mental health & behavioral health		New community-based accountability linking all

Information from Public Health Institute

Path To Better Health & Value

- Increase ability to reduce preventable conditions
- Widespread use of PCPCHs
- Improved outcomes from enhanced care coordination and care delivered in most appropriate setting
- Continually reducing errors and waste
- Innovative payment strategies
- Use of best practices and centers of excellence
- Single point of accountability for achieving results

Phased-in Expansion

- Begin with Medicaid (OHP and Healthy Kids)
- Obtain federal waiver to manage Medicare funds for Dual Eligible enrollees
- If successful, use redesigned delivery system platform for public employee contracts:
  - PEBB: State employees
  - OEBB: School district employees
- If successful, redesigned delivery system could be core component/connector of health insurance exchange (HIX) & stimulus for commercial sector to participate.

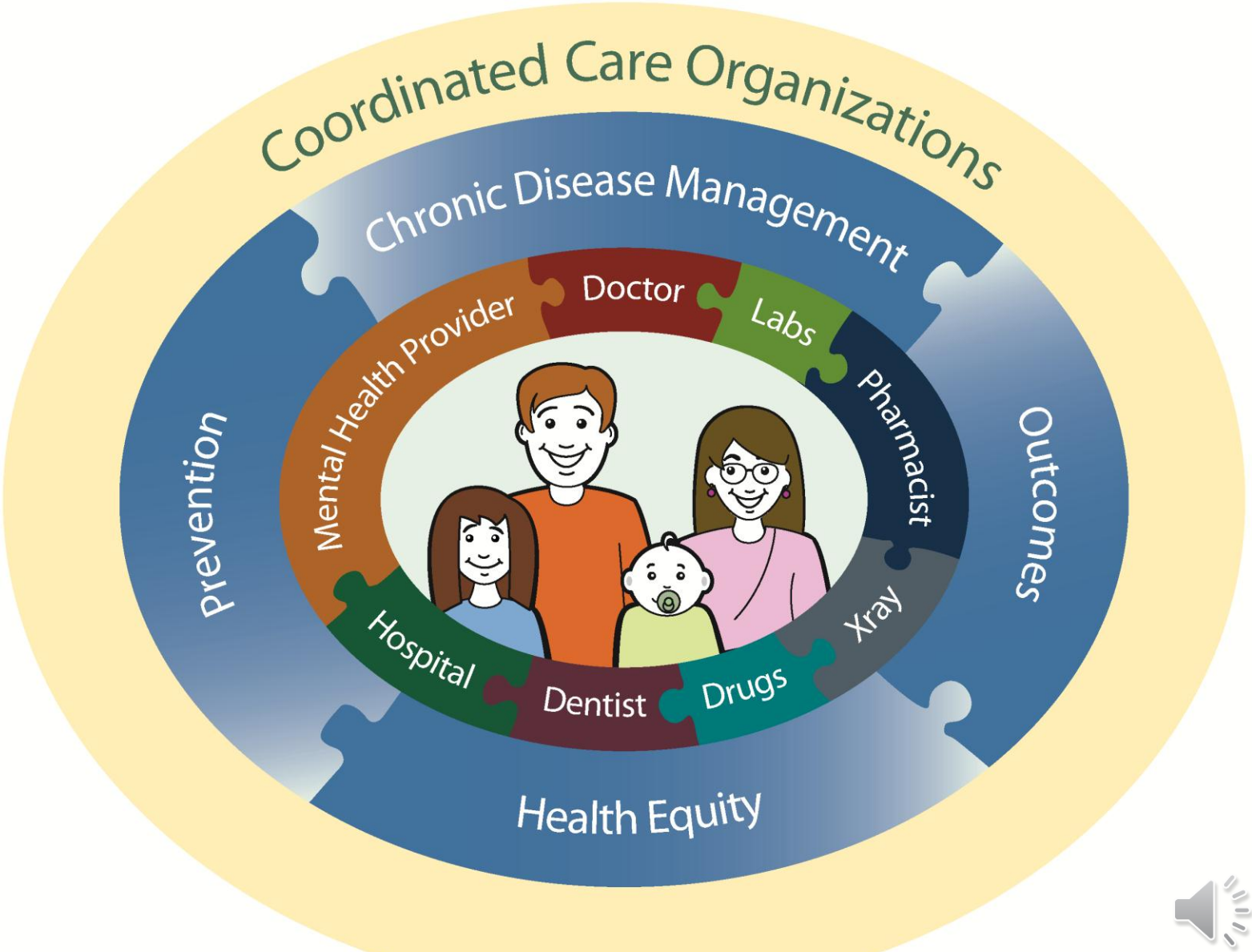
Challenges

- Change is difficult
- Time is short
- Federal approvals are necessary
- Transitioning from current models while maintaining access to care and community infrastructure
- Projected savings and stable revenues may not materialize

Timeline & Public Process

- **Feb, 2012: Feds promise $2.5 Billion over next 5 years to help Oregon's implementation**
- **March, 2012: SB 1580 passes (CCO implementation bill)**
- **March, 2012: CCO plan to CMS for approval**
- **Late Spring/Summer 2012: First wave of CCOs launch, more CCOs begin to emerge**
- **2012-13: Expansion of CCOs ⟹ PEBB/OEBB?**
- **2012-14: HIX Essential Benefit Package refined**
- **2013: HIX begins enrollment**
- **2014: HIX coverage begins**

The Grand Finale:
Better Health, Better Care, Lower Cost



Curtain?

- Harmonious ending?
- Is there an Act V (Victory)?
- Applause?
- Rather than wait nervously for the reviews, we should be tuning our instruments and exercising our voices.