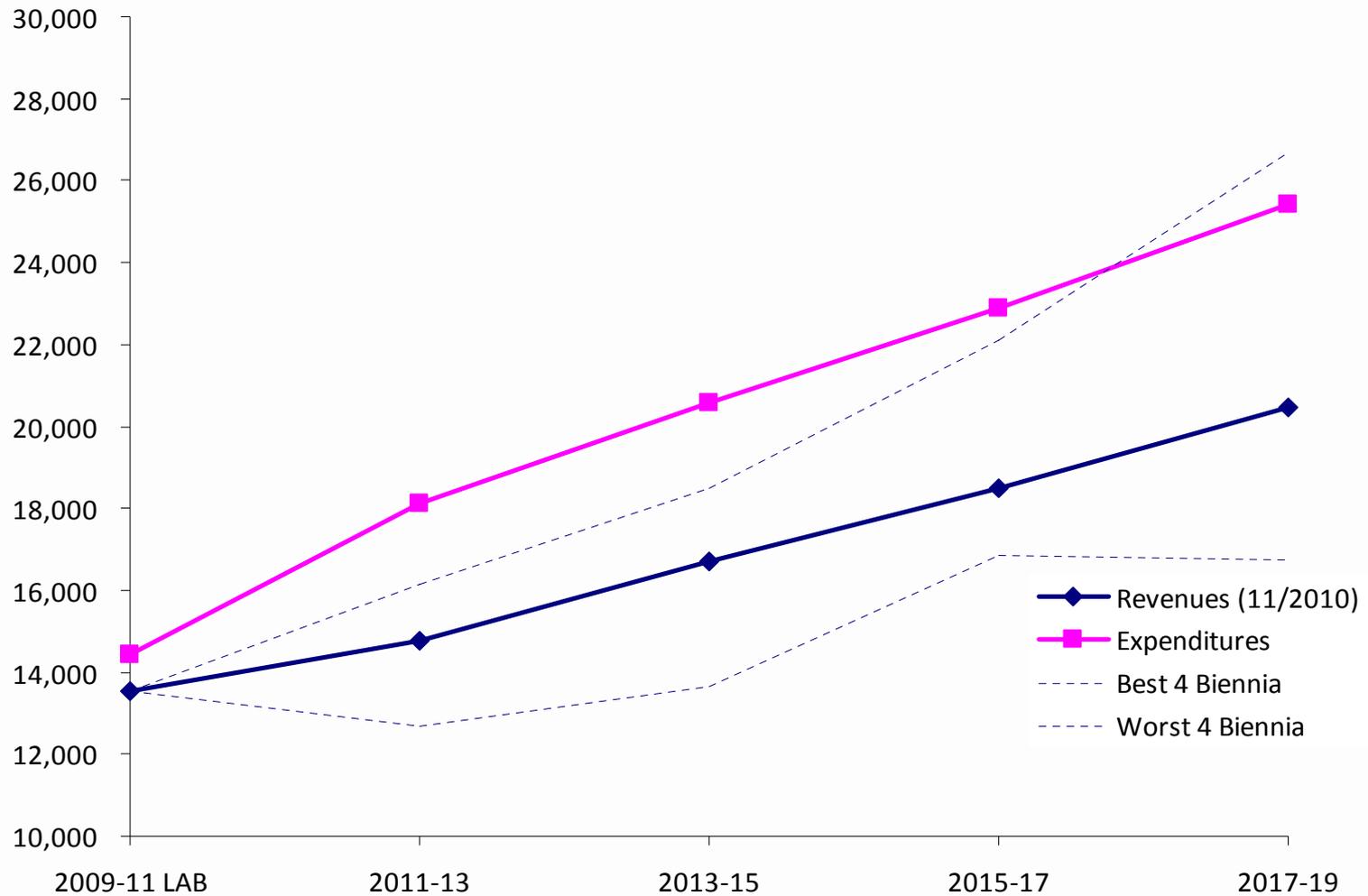

Better health, better care, lower costs
House Bill 3650
Coordinated Care Organizations



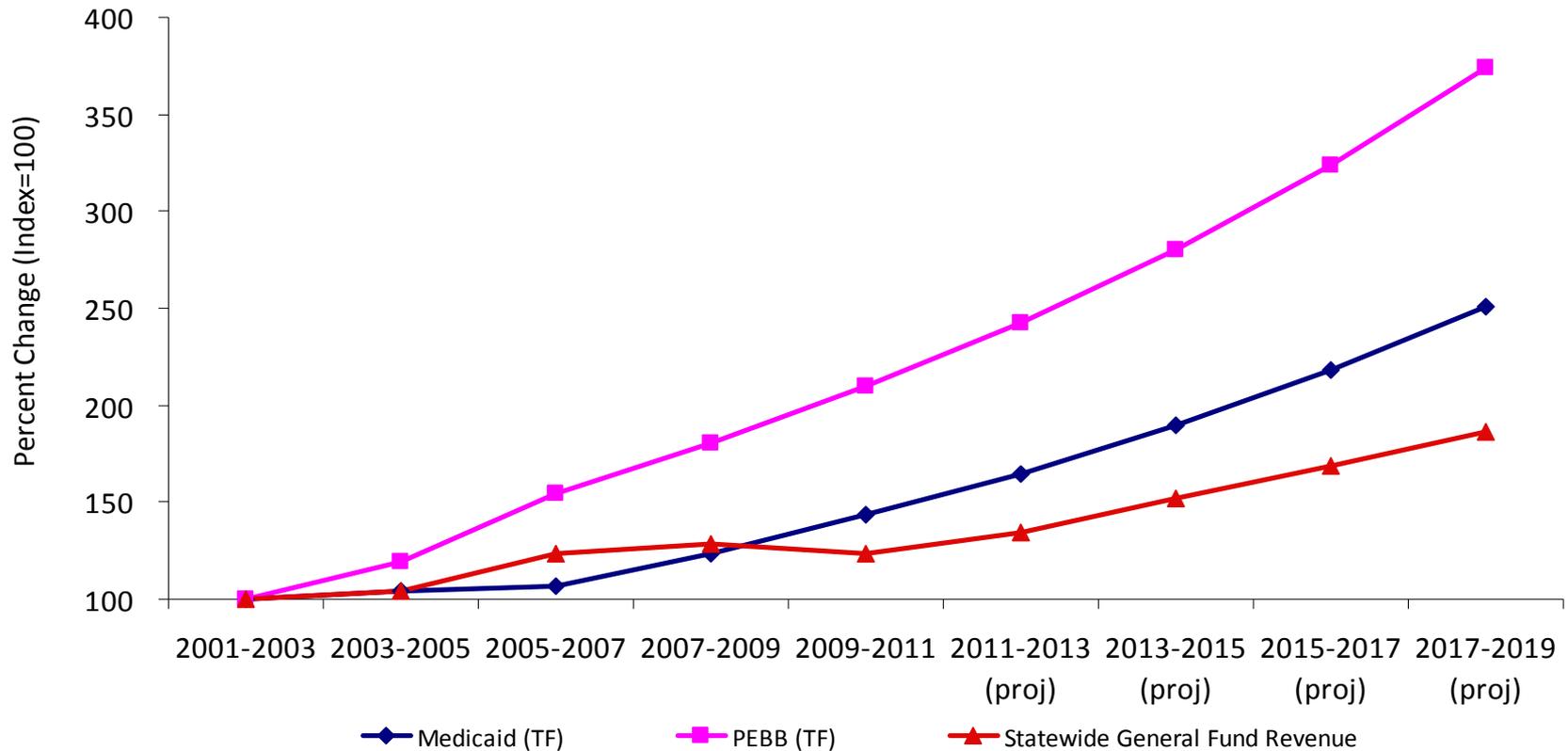
Why transform and why now?

- Health care costs are increasingly unaffordable to individuals, the state, and business
- Current fiscal climate creates imperative and unique opportunity to redesign Oregon's health care delivery system to get better value for all
- Outcomes are not what they should be – estimated 80% of health care dollars go to 20% of patients, mostly for chronic care
- Lack of coordination between physical, mental, dental and other care and public health means worse outcomes and higher costs

The budget realities



Comparing the rate of increase in Medicaid and PEBB health care expenditures vs rate of increase in state General Fund revenue



Goal: Triple Aim

A new vision for a healthy Oregon.

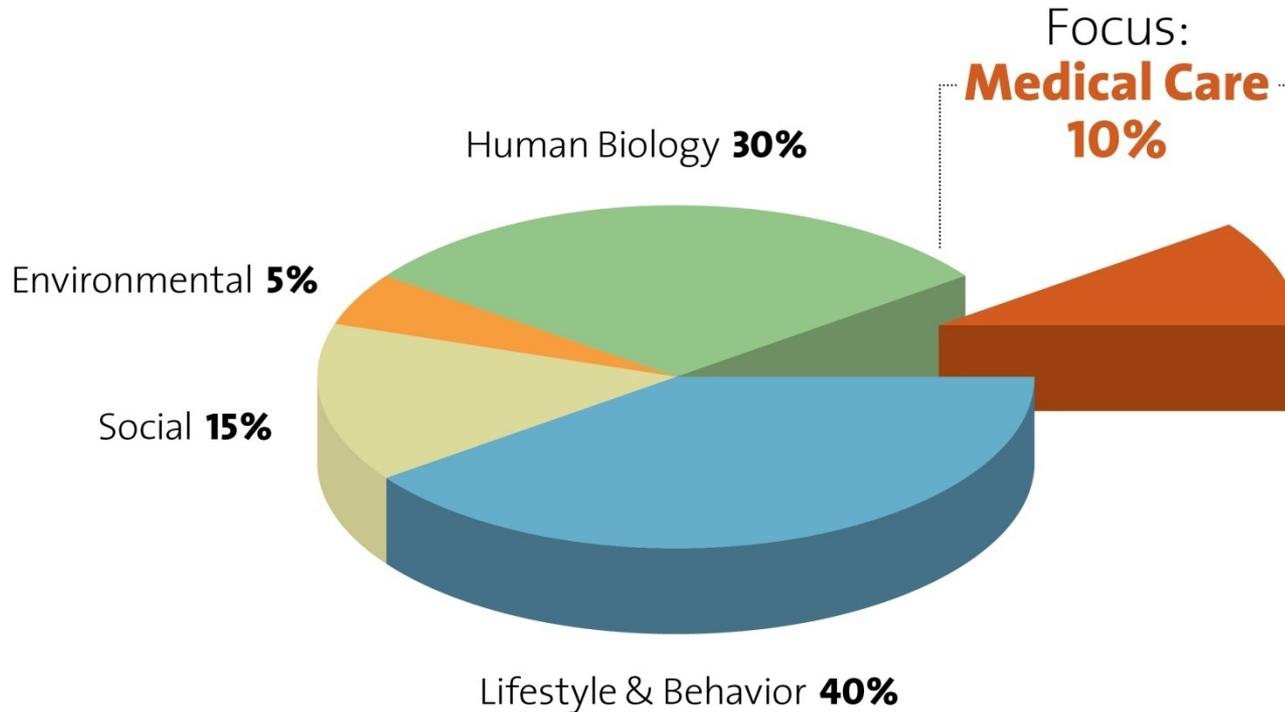
Oregon's Health Community



- 1 Enhance the patient experience**
through clinical outcomes, patient safety and satisfaction
- 2 Improve the health of Oregonians**
- 3 Reduce per capita cost**

Challenge:

Too much focus placed on medical care, while disregarding the larger sphere of contributing health factors.



Solution:

Community health benefit and health reform



PAYMENT MODELS

Fee for service	Episode-based reimbursement	Partial/full risk capitation	Global budgeting
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INCENTIVES

Conduct Procedures	Evidence-based medicine Clinical PFP	Expanded care management Risk-adjusted PFP	Reduce obstacles to behavior change Address root causes
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METRICS

Net revenue improvement	Improved clinical outcomes Reduced readmits	Reduced/preventable hospitalizations/ED Reduced disparities	Aggregate in health status & QOL Reduced HC costs
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GOVERNANCE

Informal relationships & referrals	Joint partnerships between organizations e.g. mental health & behavioral health		New community-based accountability linking all
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Information from Public Health Institute

Vision of HB 3650

- Full integration of physical health, mental health, and oral health, elimination of fragmentation in system
- Federal approval to blend Medicare and Medicaid health care funds for those who have health care paid for by both (“dual”) brings Medicare dollars into an integrated system
- Organizations to manage to budgets fixed to agreed upon rate of growth, rather than historical trend
- Organizations will be accountable for and manage to metrics, outcomes and resource allocation

Underlying assumptions

Increasing the quality, reliability, availability and continuity of care requires an integrated and coordinated health care system that focuses on:

- Prevention
- Improving health equity and reducing health disparities
- Maximizing the use of primary care health homes
- Using evidence-based practices and health information technology
- Collecting high quality data to measure health outcomes, quality, and cost
- Community-level accountability for improving health
- Services that are person-centered, provide choice, and emphasize independence

What we can build on

- **Mosaic Medical / Bend** - 2010. One year-long pilot program with 100 costliest Medicaid patients. Frequent ED visits up to 25 year. Team based care. Cost decreased: Mosaic's 6,400 Medicaid patients in 2010 decreased by more than \$621,000, thanks to just six months of reduced reliance on the emergency room for non-emergent care.
- **CareOregon 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.

Coordinated Care Organizations

- 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
- Global budget
 - Revenue flexibility to allow innovative approaches to prevention, team-based care
 - Opportunities for shared savings
- Accountability through measures of health outcomes

Global budgets

- Global budgets based on initial revenue/expenditure target and 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
- There are opportunities for shared savings when patients remain healthy and avoid high-cost care.

Accountability and Metrics

Incentives for right care, right time, right place by the right person

- **Measurements for activities geared towards health improvement**
 - Mental illness prevention and treatment
 - Preventive dental and physical health services
 - Tobacco cessation and treatment, obesity prevention and treatment
 - Member enrollment in primary care health homes
 - Home environment assessments – asthma
- **Measurements for hospital quality and safety**
 - Chronic heart failure care, pneumonia care, surgical care
 - Healthcare acquired infection, complications after surgery
- **Measurements for patient experience of care**
 - Communication, responsiveness, integration of care
 - Getting timely, needed care
- **Measurements for health outcomes**
 - Diabetes in control, blood pressure control, cholesterol control
 - Decreasing emergency room visits

Oregon Health Policy Board

Nine-member citizen-led, established to make policy and reform recommendations. Members appointed by the Governor and confirmed by the Senate.



Eric Parsons
Chair



Lillian Shirley
Vice-Chair



Mike Bonetto



Eileen Brady



Carlos Crespo



Felisa Hagins



Chuck Hofmann



Joe Robertson

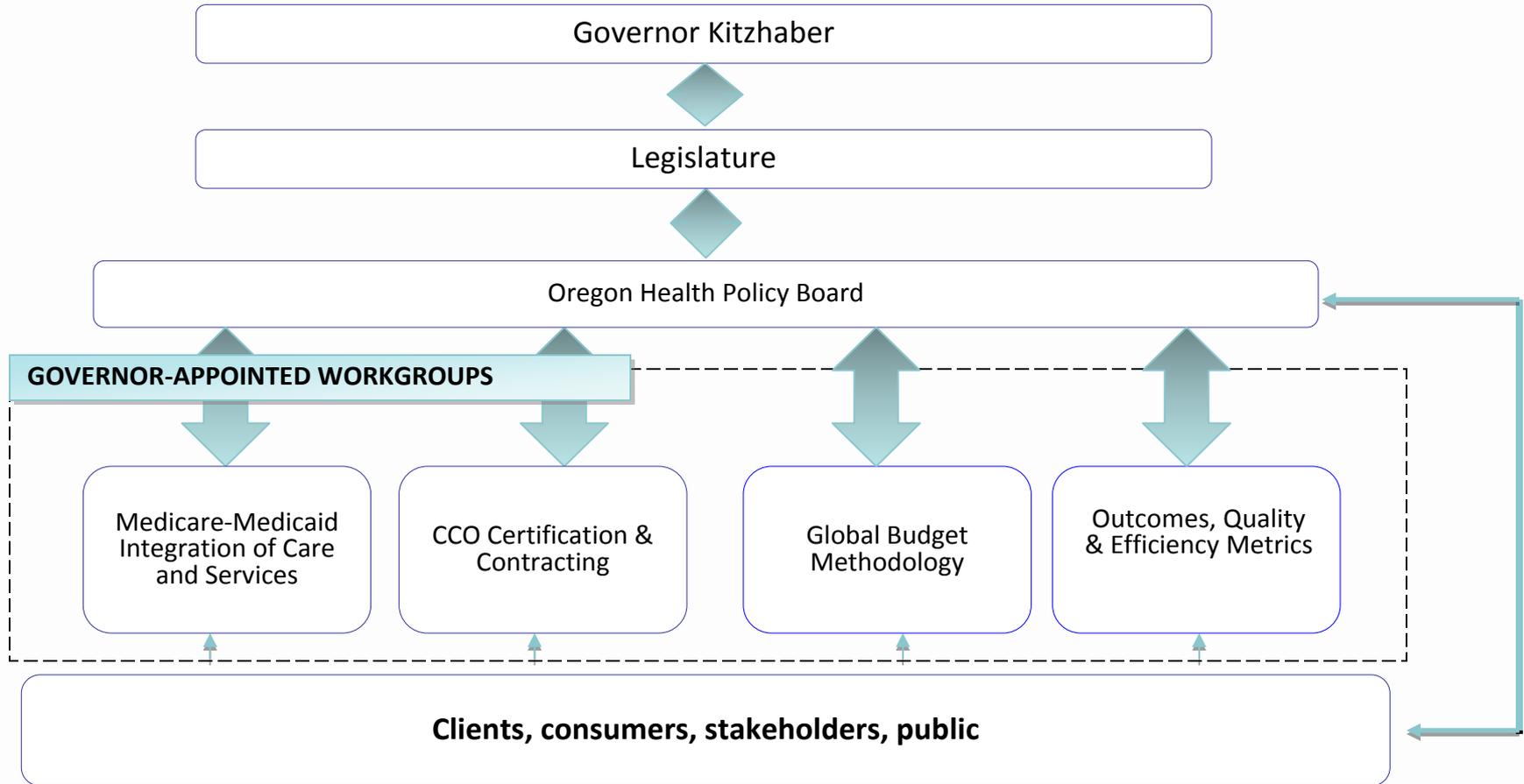


Nita Werner

Process

- Four work groups appointed by the Governor: Criteria, Global Budget, Outcomes/Metrics, and Medicare-Medicaid Integration for people who are eligible for both
- Over 400 people applied, 133 individuals representing diversity of interests are on the group
- Work groups have been chartered and are meeting regularly
- Reports come to the board, along with public comments
- Board synthesizes and reports back to groups

Health System Transformation Work Group Process



Oregon Health Policy Board

Health System Transformation Work groups

Through Nov. 2011

- **Coordinated Care Organization criteria**
 - Who, how, where. Core competencies in clinical, financial and operational areas defined.
- **Global Budget Methodology**
 - Consideration of criteria for determining global budget funds, shared savings arrangements, stop-loss, risk corridors and risk sharing arrangements
- **Outcomes, Quality and Efficiency Metrics**
 - Clinical, financial and operational metrics
- **Medicare-Medicaid Integration of Care and Services**
 - Proposals for integrating care for those who are dually eligible for Medicare and Medicaid into CCO framework and for creating virtual integration for long term care services.

Oregon Health Policy Board Products

OHPB will deliver the following products to the Legislature in February 2012:

- Draft legislative language for implementation of Coordinated Care Organizations (CCOs)
- A business plan for CCO development
- Medical liability/cost containment strategies
- Standards for specified health care workers: community health workers, peer wellness specialists, personal health navigators

Elements of a Business Plan for Oregon Health System Transformation

HB 3650 directly requires that OHA and OHPB address the following issues, which will be elements in the business plan:

- Coordinated Care Organization (CCO) qualification process and criteria
- Global budget methodology
- Savings models and financial reporting requirements
- Health equity and health disparity strategies
- Plans for contracting with PEBB/OEBB and other public health benefit purchasers
- Outcomes, quality and efficiency metrics
- Coordination of care for individuals who are dually eligible for Medicare and Medicaid
- Transition to CCOs
- Alternative dispute resolution

Timeline

- Through Nov. 2011: Public input opportunities and information sharing
 - 4 Governor work groups
 - Statewide community input
- Nov. 2011 – Update to Legislature
- Jan. 2012: OHPB products finalized and delivered to the Legislature
- Feb. 2012: Legislative Session
- Mar. 2012: If approved, send CCO plan to CMS
- Late Spring/Summer 2012: First CCO launches

Questions?

Learn more. Get involved.

www.health.oregon.gov