Challenges and Opportunities of State Health Reform

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CLINTON'S HEALTH PLAN

How it will work
What it will cover
What it will cost you

EXCLUSIVE

The inside story of the most sweeping reform since the New Deal
Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver will be effective January 1, 2016. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

African American Health Disparities Compared to Non-Hispanic Whites

Racial and ethnic health disparities are undermining our communities and our health system. African Americans are more likely to suffer from certain health conditions, and they are more likely to get sicker, have serious complications, and even die from them. These are some of the more common health disparities that affect African Americans in the United States compared to non-Hispanic whites.

**AFRICAN AMERICAN HEALTH DISPARITIES: ADULTS**

- **Asthma**: 2.1 times more likely to die from asthma
- **Depression**: 20% less likely to receive treatment for depression
- **Stroke**: 40% more likely to die from stroke
- **Heart Disease**: 30% more likely to die of heart disease
- **Breast Cancer**: 40% more likely to die from breast cancer
- **Cervical Cancer**: 2 times more likely to die from cervical cancer
- **Prostate Cancer**: 2 times more likely to die from prostate cancer
- **HIV**: 3 times more likely to be diagnosed with HIV
- **Diabetes**: 3 times more likely to be diabetic
- **Obesity**: 40% more likely to be obese
- **Maternal Mortality**: 2.5 times more likely to die during pregnancy

**AFRICAN AMERICAN HEALTH DISPARITIES: CHILDREN**

Compared to non-Hispanic white children, African American children are more likely to suffer from the following:

- **Infant Mortality**: 30% more likely to die as an infant
- **SIDS**: 2 times more likely to die of SIDS
- **Asthma**: 6 times more likely to have asthma
- **Obesity**: 60% more likely to be obese
- **Depression**: 30% more likely to attempt suicide as a high-schooler

How do we reduce racial and ethnic health disparities? We must work together to improve our health care system to make it high-quality, comprehensive, affordable, and accessible for everyone.
The Environment

- Health care costs rising faster than any other economic indicator

- Stealing precious $ from other important human endeavors e.g. education and public safety

- Healthcare outcomes not what we wanted

- A belief 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
Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 1999–2012*;
Premiums Rising Faster Than Family Income

Projected average family premium as a percentage of median family income, 2013–2021

## Waste Category Annual Dollar Estimates

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost to US Healthcare (2011 $B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overtreatment</td>
<td>$158 to $226</td>
</tr>
<tr>
<td>Failures to Coordinate Care</td>
<td>$25 to $45</td>
</tr>
<tr>
<td>Failures in Care Delivery</td>
<td>$102 to $154</td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>$107 to $389</td>
</tr>
<tr>
<td>Excessive Health Care Prices</td>
<td>$84 to $178</td>
</tr>
<tr>
<td>Fraud and Abuse</td>
<td>$82 to $272</td>
</tr>
<tr>
<td><strong>2011 Total Waste</strong></td>
<td><strong>$558 to $1263</strong></td>
</tr>
<tr>
<td>% of Total Spending</td>
<td><strong>21% to 47% (MED = 34%)</strong></td>
</tr>
</tbody>
</table>

Source: Don Berwick, MD
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
- Pay for performance and outcomes
- Create fiscal sustainability
No child should have to go to the Emergency Room because of an asthma attack
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.

Join the public forums:

MEDFORD
Wednesday, September 15th
From 6-8pm

Red Lion Inn
(Crater Lake Room)
200 N. Riverside Ave.

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/OMA to learn about other options for submitting your input.
Building Support

- Define the problem
- Use data
- Communicate early and often, internally and externally
  - Joint Legislative Committee
  - Oregon Health Policy Board
  - Medicaid Advisory Committee
  - Tribal meetings
  - 76 public meetings
  - Story bank
- Resulted in bipartisan support and legislation
Oregon’s Coordinated Care Model

- Best Practices to manage and coordinate care
- Paying for outcomes and health
- Transparency in price and quality
- Sustainable rate of growth
- Shared responsibility for health
- Measuring Performance

Better Health
Better Care
Lower Costs
Coordinated Care Organizations

- GOVERNANCE
  - Partnership between health care providers, consumers/community partners, and those taking financial risk
  - Consumer advisory council requirement
  - Working relationship with local public health authorities
Coordinated Care Organizations

- Behavioral health, physical, dental care held to one budget
- Ability to use Medicaid dollars flexibly to better meet consumer needs
- Global budgets that grow at no more than 3.4% per capita per year.
- Responsible for health outcomes and for quality
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.
Coordinated Care Organizations

- The coordinated care model was first implemented in Oregon’s Medicaid program: the Oregon Health Plan.

- There are 16 coordinated care organizations in every part of Oregon, serving 95% of Medicaid population; there are two CCOs also serving state employees (Public Employees Benefit Board members)
1115 Medicaid demonstration waiver

- Establishes CCOs as Oregon’s Medicaid delivery system
- Flexibility to use federal funds for improving health
- Federal investment of $1.9b over 5 years with ROI of $4.9b
- Oregon’s accountabilities
  - 2 percentage point reduction in per capita Medicaid trend
  - No reductions in benefits or eligibility
  - Quality metrics
  - Financial penalties for not meeting cost savings or quality goals
  - Workforce investments
Accountability for CCOs

- CCOs are accountable for 33 measures of health and performance
- Results are reported regularly and posted on Oregon Health Authority website
- CCO financial data posted regularly
<table>
<thead>
<tr>
<th>Before CCOs</th>
<th>With CCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fragmented care</td>
<td>Coordinated, patient-centered care</td>
</tr>
<tr>
<td>Disconnected funding streams with unsustainable rates of</td>
<td>One global budget with a fixed rate of growth</td>
</tr>
<tr>
<td>growth</td>
<td></td>
</tr>
<tr>
<td>No incentives for improving health (payment for volume,</td>
<td>Metrics with incentives for quality and access</td>
</tr>
<tr>
<td>not value)</td>
<td></td>
</tr>
<tr>
<td>Limits on services</td>
<td>Flexible services</td>
</tr>
<tr>
<td>Health care delivery disconnected from population health</td>
<td>CCO community health assessments and improvement plans</td>
</tr>
<tr>
<td>Limited community voice and local partnerships</td>
<td>Local accountability and governance,</td>
</tr>
<tr>
<td></td>
<td>including a community advisory council</td>
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</table>
Meeting the triple aim: what we are seeing so far...

• Every CCO is living within their global budget.
• The state is meeting its commitment to reduce Medicaid spending trend on a per person basis by 2 percentage points.
• State-level progress on measures of quality, utilization, and cost show promising signs of improvements in quality and cost and a shifting of resources to primary care.
• Race and ethnicity data shows broad disparities for most metrics – points to where efforts should be focused to achieve health equity.
• Progress will not be linear but data are encouraging.
Progress to Date

- 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*
Oregon's Health System Transformation

2014 Final Report
Twelve of 16 CCOs reduced emergency department utilization between 2013 and 2014.

Per 1,000 member months

**Bolded** names met benchmark or improvement target.

Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

**Benchmark: 44.6** (Lower is better)

- **Umpqua Health Alliance**
  - 2013: 64.7
  - 2014: 74.5

- **FamilyCare**
  - 2013: 60.2
  - 2014: 50.2

- **PacificSource - Central**
  - 2013: 48.3
  - 2014: 41.9

- **Western Oregon Advanced Health**
  - 2013: 49.7
  - 2014: 44.2

- **Eastern Oregon**
  - 2013: 59.2
  - 2014: 54.0

- **PacificSource - Gorge**
  - 2013: 52.8
  - 2014: 49.3

- **AllCare Health Plan**
  - 2013: 47.5
  - 2014: 47.5

- **Health Share of Oregon**
  - 2013: 50.9
  - 2014: 49.3

- **Columbia Pacific**
  - 2013: 50.6
  - 2014: 50.6

- **PrimaryHealth of Josephine County**
  - 2013: 40.8
  - 2014: 38.0

- **Jackson Care Connect**
  - 2013: 49.2
  - 2014: 48.0

- **Trillium**
  - 2013: 51.3
  - 2014: 50.6

- **Intercommunity Health Network**
  - 2013: 48.6
  - 2014: 48.6

- **Willamette Valley Community Health**
  - 2013: 42.2
  - 2014: 41.3

- **Yamhill CCD**
  - 2013: 61.1
  - 2014: 58.9

- **Cascade Health Alliance**
  - 2013: 34.4
  - 2014: 31.6

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2014 Performance Report
June 24, 2015

Oregon Health Authority
Office of Health Analytics
PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Congestive heart failure admission rate

**Measure description:** Rate of adult members (ages 18 and older) who had a hospital stay because of congestive heart failure. Rates are reported per 100,000 member years. A lower score is better.

PQI stands for Prevention Quality Indicators, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

**Purpose:** Good disease management with a health care provider can help people with chronic diseases avoid complications that could lead to a hospital stay. Improving the quality of care for people with chronic disease to help them avoid hospital stays improves the patient experience of health care and improves overall health outcomes. Decreasing hospital stays also helps to reduce health care costs.

**2014 data** (n=5,495,358 member months)

Admission rates for congestive heart failure continued to improve and remained below the benchmark in 2014. Lower is better for this measure. Admission rates for all races and ethnicities improved in 2014, but African American/Black members had the highest admission rate, with 833.3 admissions per 100,000 member years. The second highest admission rate was for Asian American members with just 233.83 admissions per 100,000 member years. Fourteen CCOs improved their performance on this measure between 2013 and 2014.

Statewide, the congestive heart failure admission rate improved again in 2014.

Data source: Administrative (billing) claims
Benchmark source: 10% reduction from previous year’s statewide rate
2011 and 2013 data have been updated and may differ from earlier reports.

**All races and ethnicities experienced improvement in congestive heart failure admission rates between 2013 and 2014.**

Gray dots represent 2011. Data missing for 11.2% of respondents. Each race category excludes Hispanic/Latino. 2011 and 2013 data have been updated and may differ from earlier reports.

2014 Benchmark: 264.9 (Lower is better)
Health care collaborators not competitors
Supports for Transformation

- Transformation Center and Innovator Agents
- Learning collaboratives
- Peer-to-peer and rapid-cycle learning systems
- Community health assessments and community improvement plan
- Non-traditional healthcare workers
- Each CCO submitted a “Transformation plan”
- Primary care home support
- Technical assistance in addressing health equity
Better Health and Value Through

- Innovation
- Focus on chronic disease management
- Focus on comprehensive primary care and prevention
- Integration of physical, behavioral, oral health
- Alternative payment for quality and outcomes
- More home and community based care, community health workers/non-traditional health workers
- Electronic health records – information sharing
- Tele-health
- New care teams
- Use of best practices and centers of excellence
Next Steps

- Aligning care models, standards and reporting in Medicaid, Public Employee purchasing and insurance exchange.

- Leverage work to reduce costs, increase transparency in commercial market
A Few of the Challenges

- Time, resources and expectations
- Change is hard….change is very hard
- 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
- Anti-trust
- Actuarial soundness
And Some More…..

- Penalties for failure to achieve cost, quality and access benchmarks
- Training and using new health care workers
- Increasing consumer engagement
- Personal responsibility for health
- Health information exchange
- Integrating with early learning and education systems
Lessons Learned/Key Takeaways

- Have a common vision

- Legislative, executive and stakeholder leadership commitment to the goals and deliverables of health reform

- Engaging stakeholders is critical – CEO’s, consumers, CMS

- Don’t underestimate the investment needed in change management and technical support

- Changing payment is critical – don’t expect new methods of care with old methods of payment.

- Have reliable data and information. Good data and information is needed now, to chart your course, and later to monitor progress. Participants need to be involved with assuring validity.

- Need structure and leadership with clear accountabilities and timelines for outcomes
Lessons Learned/Key Takeaways

- There is no perfect 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.

- Government “agency” work must be prioritized to meet long-term goals. Agency staff need to see health reform as their work and where and how they fit in—it cannot be an add on.

- “It takes a village” – broad community support and involvement is critical.

- Communicate early, often and in multiple modalities and then communicate again.

- This is hard work and it will take time, but…..don’t slow down!

- Financial support helps the transition from old system to new.
Opportunities for State Policy

- National health reform
- Health care costs continue to rise faster than other economic indicators
- Health care is an ever increasing budget item for states
- Many models around the country to learn from
- All health care is local
- We value health
Challenges

- Politics are particularly divisive right now
- Arc of change is long
- It's complicated and it's personal
- Medicare
- Lots of money in status quo
- We need more leaders
The future belongs to those who create it.