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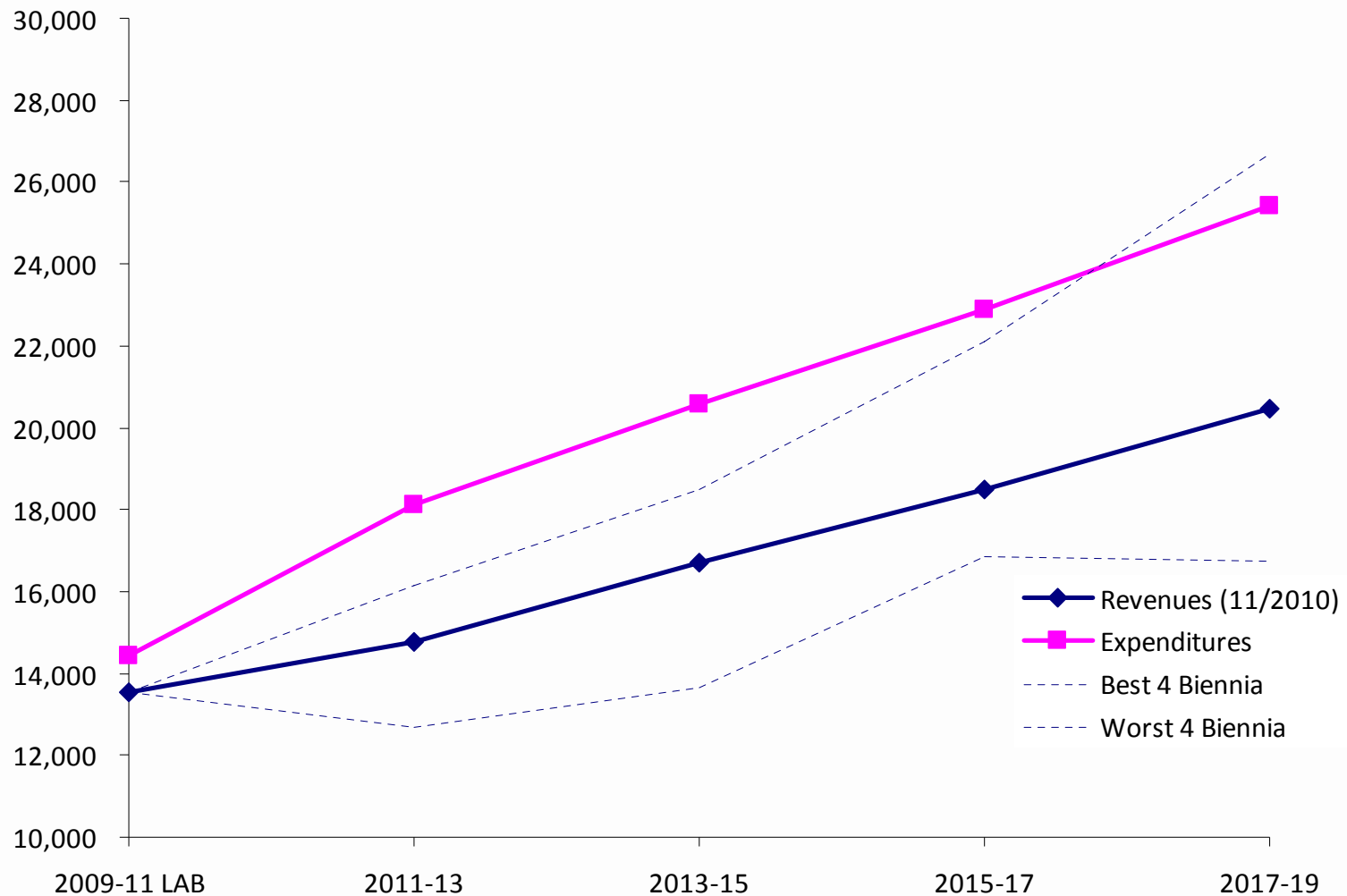
**Better health, better care, lower costs**  
**House Bill 3650**  
**Coordinated Care Organizations**



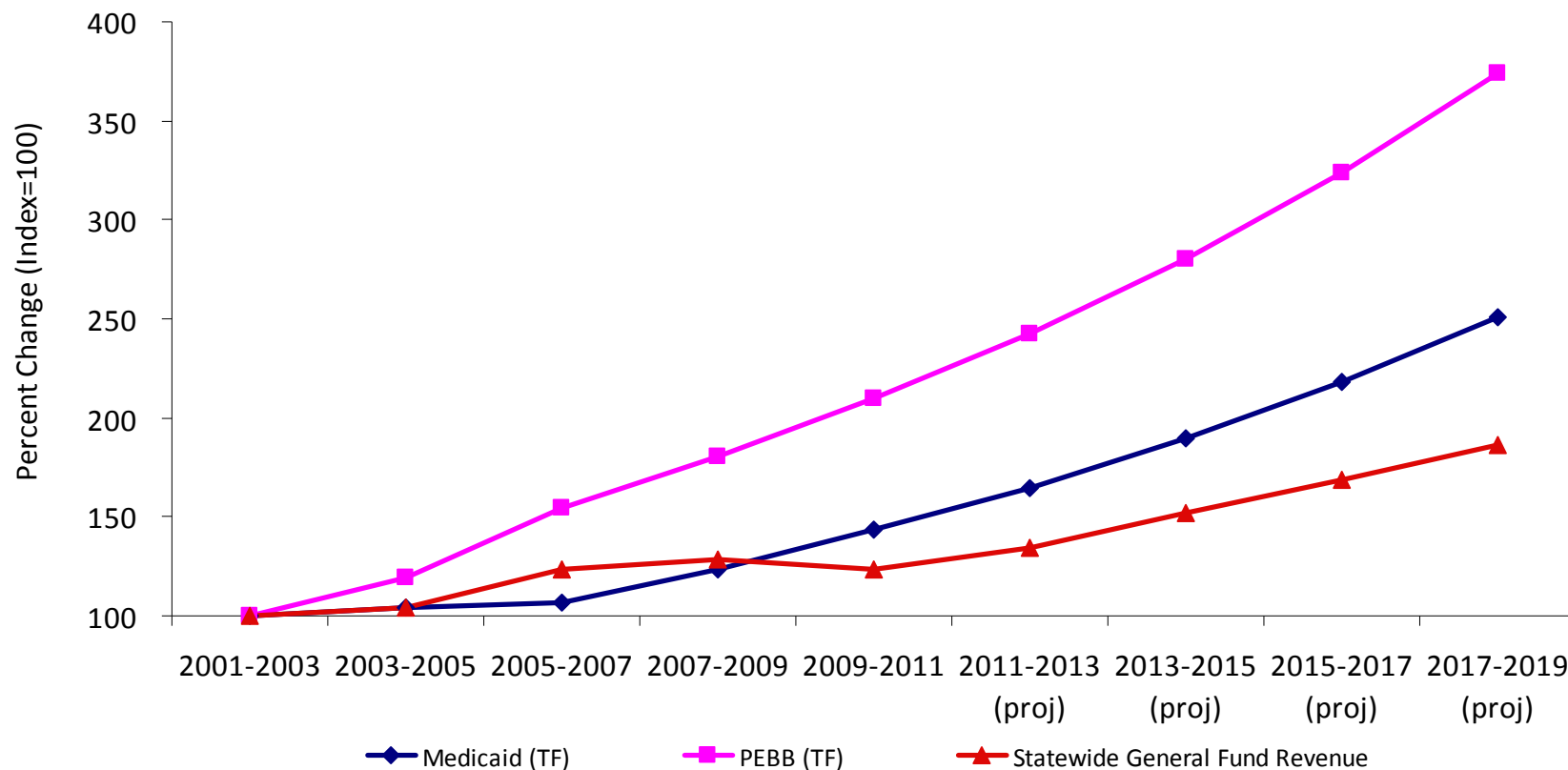
# Why transform and why now?

- 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.

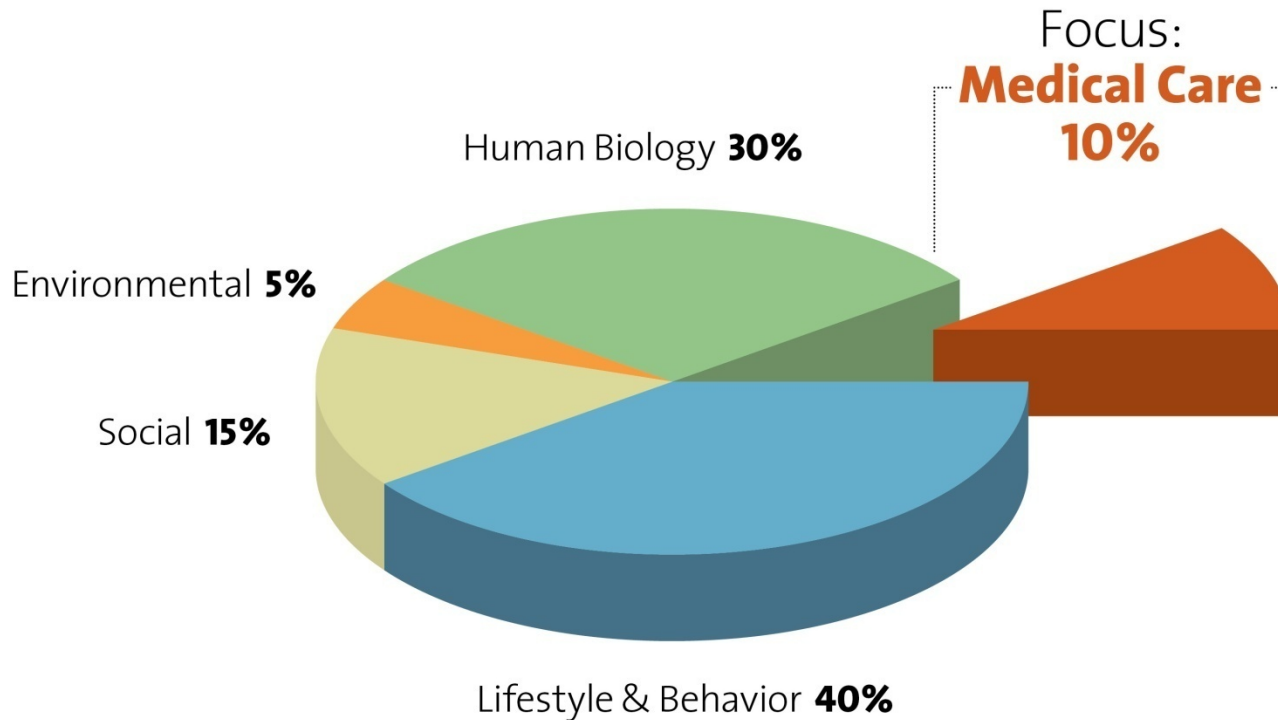
## Oregon's Health Community



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

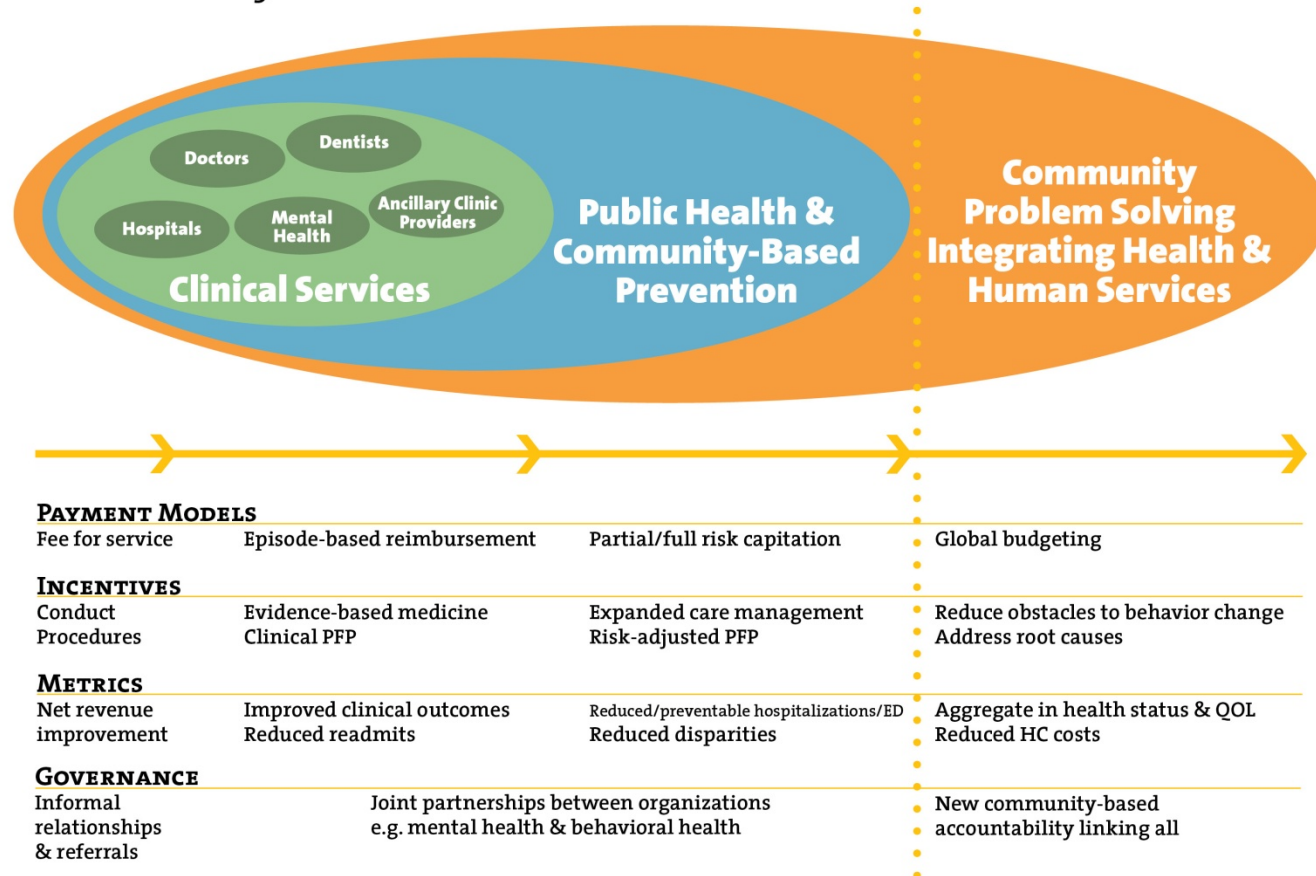
# Challenge:

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



# Solution:

Community health benefit and health reform



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

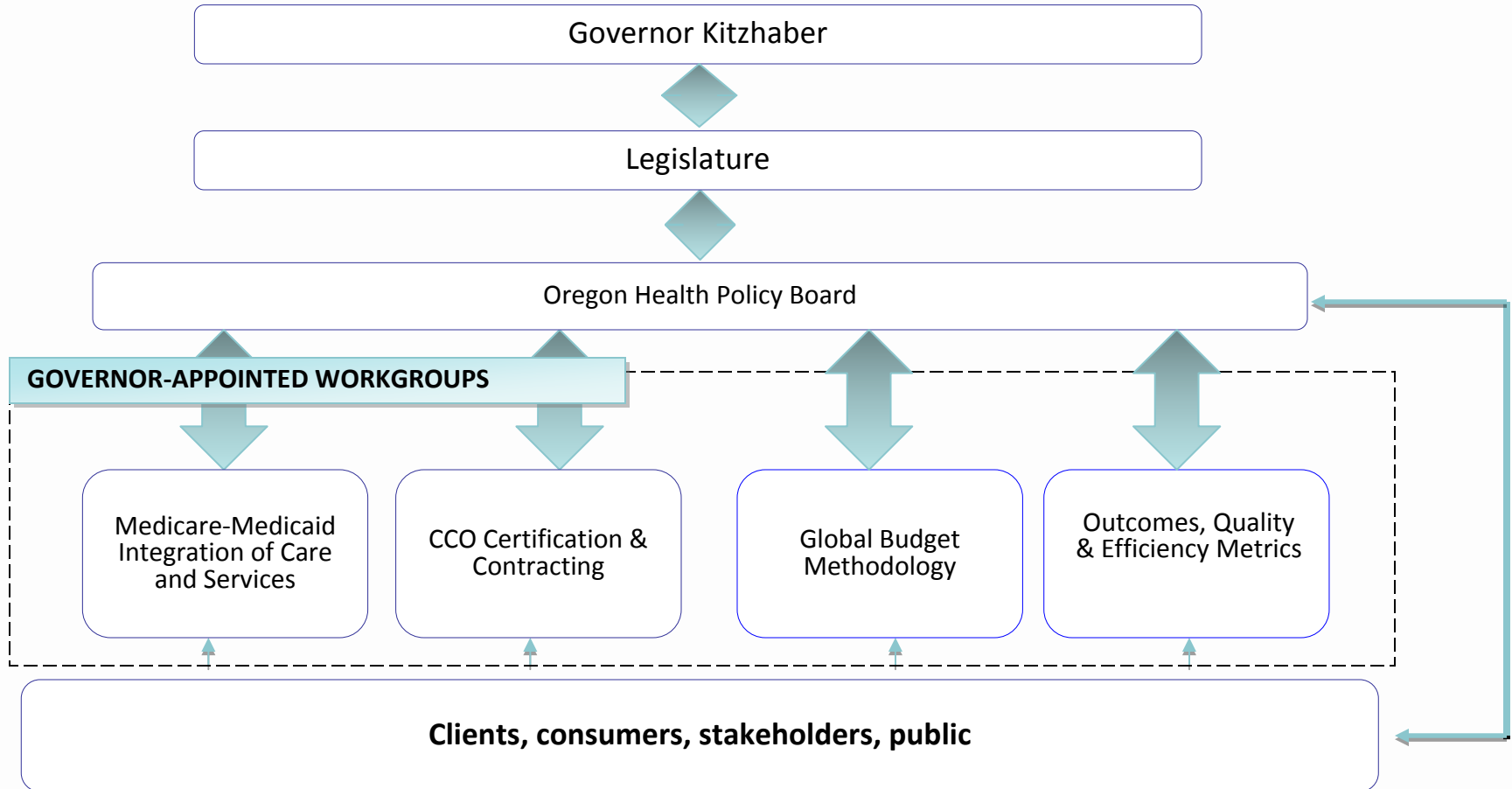


Nita Werner

# 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](http://www.health.oregon.gov)**