
Health System Transformation



What we'll cover

- ACA and insurance enrollment in 2014
- Coordinated care: why it began and what it is
- Measuring the success: CCO metrics
- Spreading the coordinated care model

ACA AND ENROLLMENT

Affordable Care Act: Overview

- **Largest changes in health care in 50 years**
- **Coverage and Access**
 - Medicaid Expansion
 - Health Insurance Exchanges
 - Health Insurance Market Reforms

Oregon Health Plan Enrollment

Oregonians on the Oregon Health Plan

- As of January 5, 2014
 - 990,00 Oregonians are on the Oregon Health Plan
 - 380,600 Received coverage since Jan. 1, 2014
 - About 90% of the OHP members are in a coordinated care organization, receiving care designed to bring better health, better care, lower costs.

Extensive outreach efforts

- Fast-track
- OHA's outreach team:
 - Trained over 2,300 individuals statewide, resulting in over 1,350 active assisters within 330 organizations
 - Managed 49 grants, 41 volunteer agreements, and hundreds of OHA contracted providers certified for application assistance

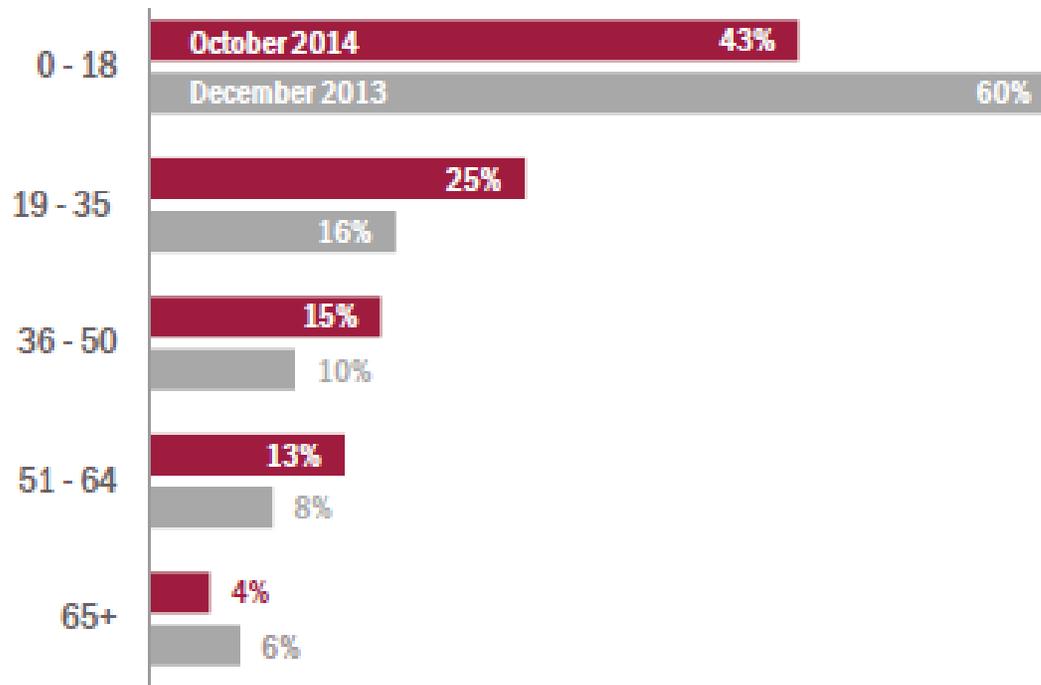
Oregon Health Plan: Changing Demographics

As of October 2014:

- The proportion of members ages 19-35 enrolled in Medicaid increased more than any other age group.
- Despite the influx of new members, the racial / ethnic make up of Medicaid enrollees has remained consistent.
- The proportion of men enrolled in Medicaid increased.

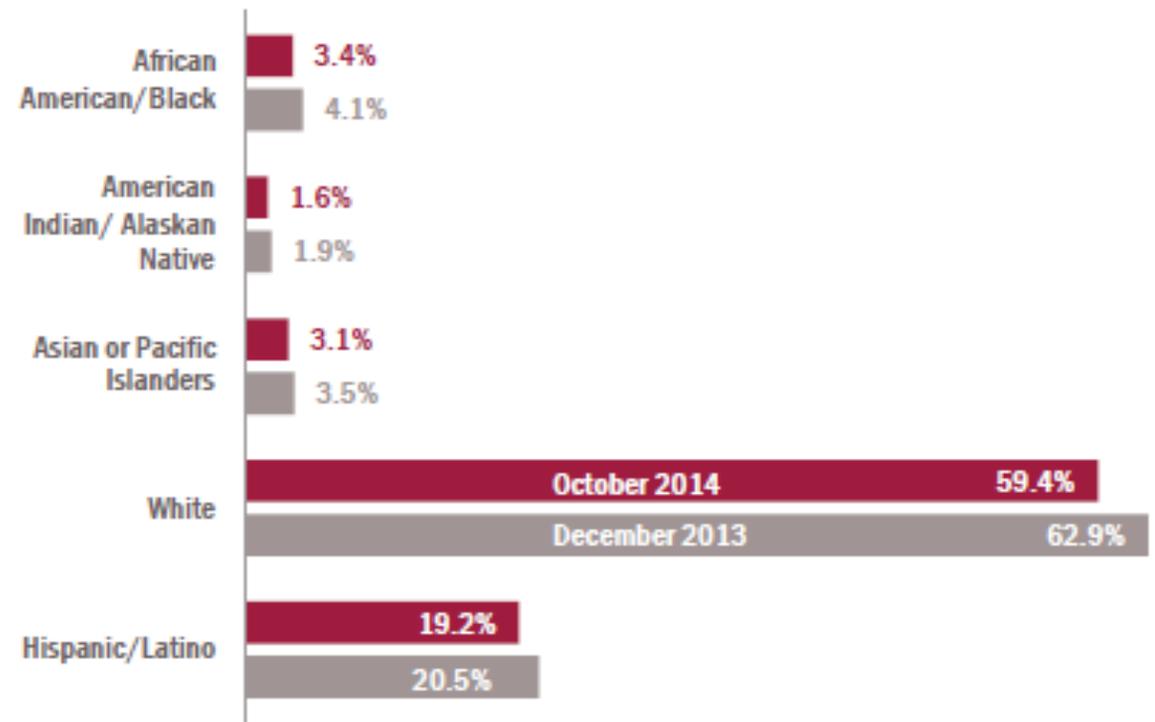
Oregon Health Plan: Changing Demographics

The proportion of members ages 19-35 enrolled in Medicaid has increased more than other age groups between December 2013 and October 2014



Oregon Health Plan: Changing Demographics

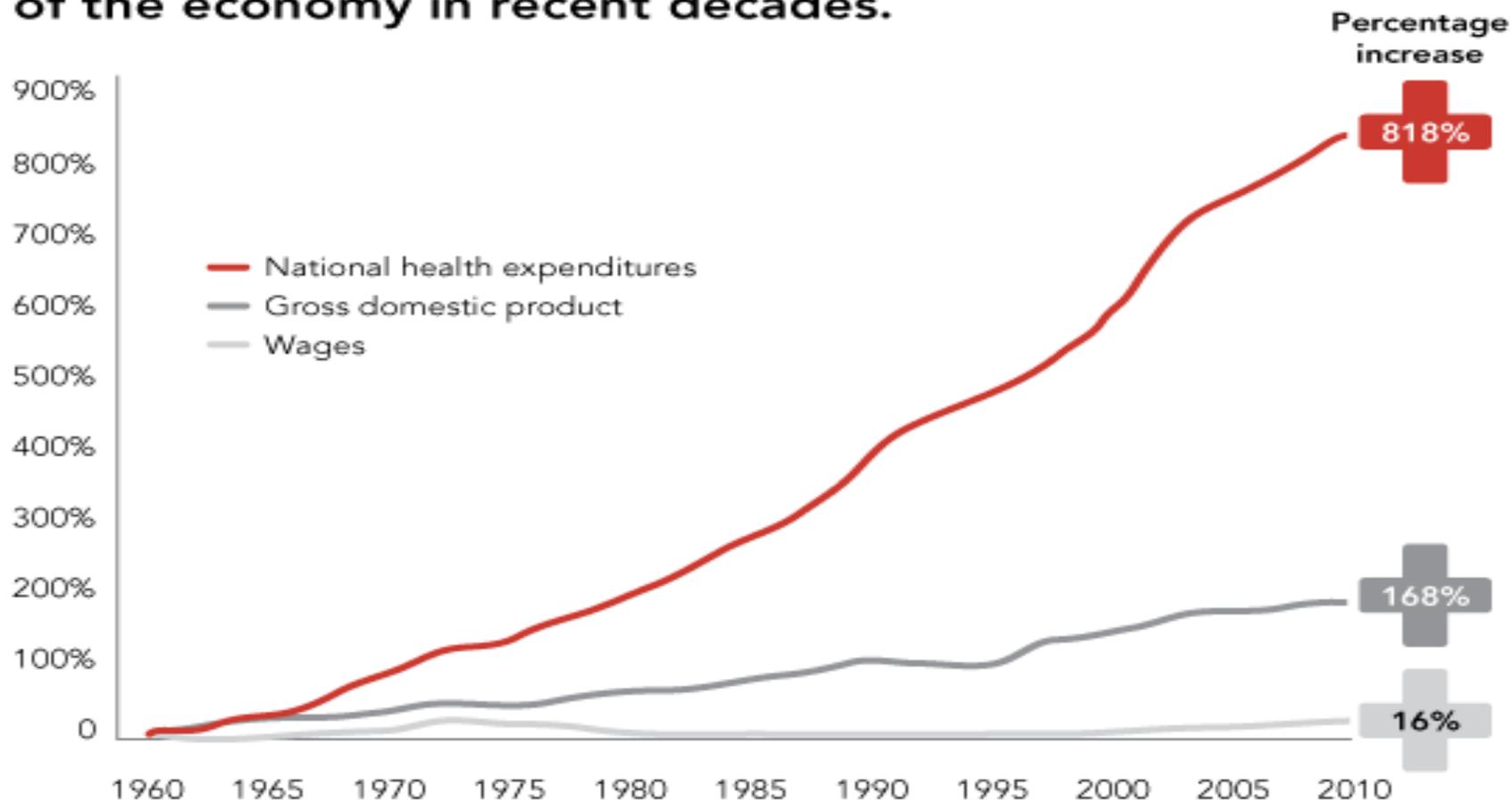
Despite the influx of new member, the racial/ethnic makeup of Medicaid enrollees has not changed much between December 2013 and **October 2014**.



(Data missing for 7% of respondents in 2014)

COORDINATED CARE

Health care spending has grown much faster than the rest of the economy in recent decades.



Sources: McKinsey, "Accounting for the Cost of U.S. Health Care" (2011), Center for American Progress

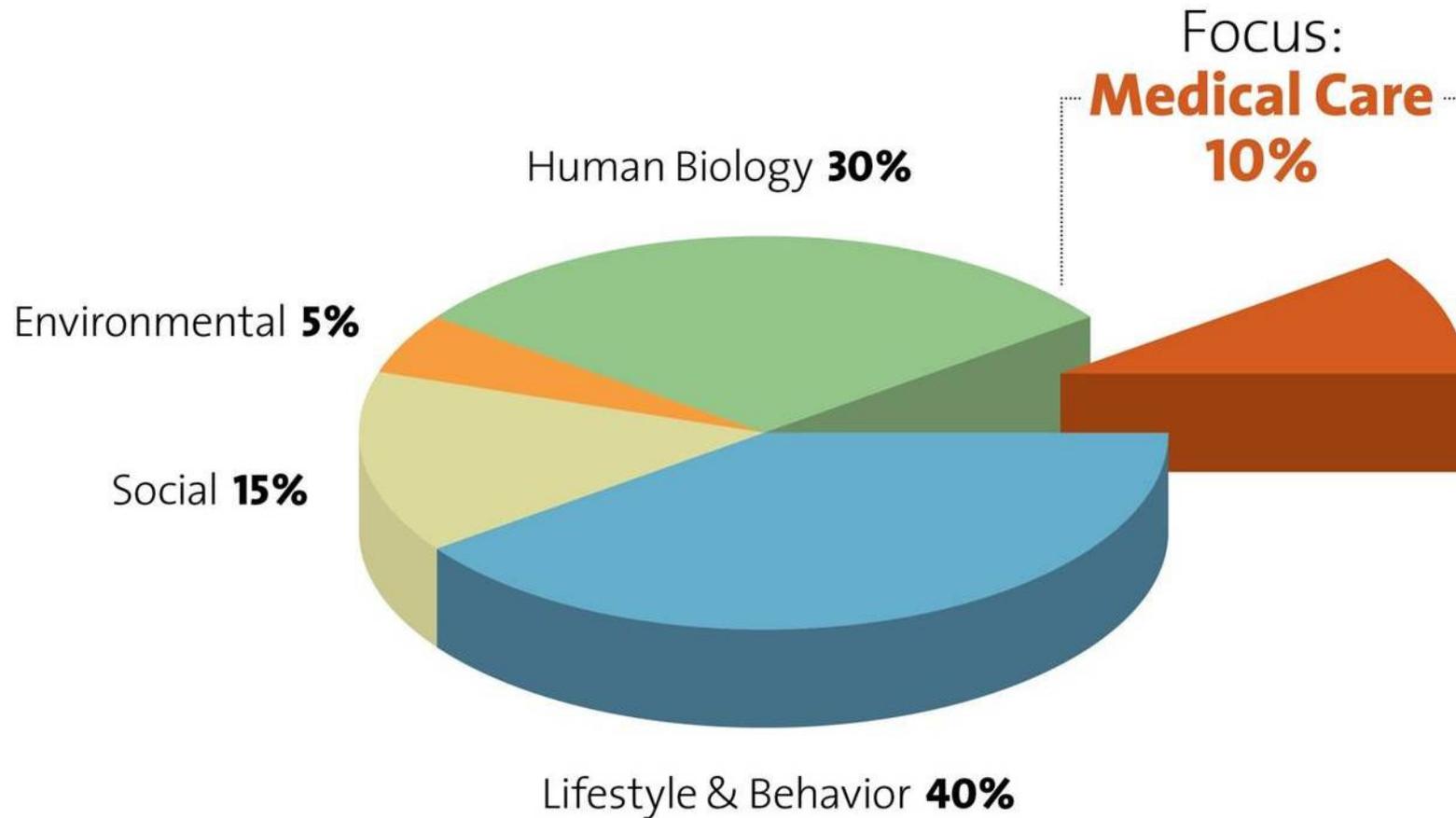
THE HUFFINGTON POST

Health
Authority

Traditional budget balancing

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

Wrong focus = wrong results



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



Oregon's Coordinated Care Model



Best practices to manage and coordinate care



- Value-based benefit design that create incentives for consumers to use evidence-based services.
- These systems improve data accuracy, allowing for better patient care, while reducing costs associated with duplicate or unnecessary services.
- Primary care clinician as the individual's regular source of care.
- Patient-centered primary care homes provides team-based care.
- Behavioral, physical and dental health care integrated through evidence-based best practices.
- Electronic health records and information exchange across care settings.
- Culturally and linguistically appropriate care.

Shared responsibility for health



- Shared decision-making.
- Benefits that provide incentives for preventive care and healthy behavior, and support the use of evidence-based services.
- Consumer and community engagement and collaboration.

Performance is measured



- An aligned, consistent measure set. Measures are consistent across major public and private payers, including commonly defined measures in each of the following areas: access, quality, patient satisfaction, patient activation, service utilization, and cost.
- Regular analysis of information.
- Provider-level and administrator-level measurement.

Paying for outcomes and health



- Pay according to performance.
- Design payment and coverage approaches that cut waste while not diminishing quality.
- Reward primary care.
- Increasing the proportion of total payments based on performance over time.

Transparency in price and quality



- Transparency in prices to allow for comparisons of providers.
- Clear information about the price of services. This includes information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans.
- Information available on provider performance. Information on quality, patient experience, and volume is clearly available to plan participants when the nationally recognized or endorsed measures of hospital and physician performance are used.

Maintain costs at a sustainable rate of growth



- Population-based contracts that include risk-adjusted annual increases in the total cost of care for services reimbursed.
- Provider contracts that include provisions that agree on rates and quality incentive payments for each contract year.

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 more than OHP members
- Locally governed by a partnership between health care providers, community partners, consumers, and those taking financial risk.
- Consumer advisory council requirement
- Behavioral health, physical, dental care held to one budget.
- Responsible for health outcomes and receive incentives for quality

Accountability: Oregon's 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

CCO's Early Work...

- Reducing unnecessary Emergency Department visits.
- Working to better integrate mental and physical health care.
- Developing a complex care model for patients with chronic and complex conditions.
- Hiring community health workers to help people manage the most acute and chronic conditions.
- Developing processes that enable families to address all of their child's health needs at a single clinic.

Better Health and Value Through

- Innovation
- Focus on chronic disease management
- Focus on comprehensive primary care and prevention
- Coordination: physical, behavioral and dental 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 for health system transformation

- The coordinated care model has been implemented in the state's public employees benefits program, PEBB
- Aligning care models in Oregon Health Plan, PEBB, OEBC and private market
- Leverage work to reduce costs, increase transparency in commercial market

MEASURING SUCCESS

CCO Performance

OHA Accountability & CCO Incentives

State Performance Measures

- Annual assessment of statewide performance on 33 measures.
- Financial penalties to the state if quality goals are not achieved.

CCO Incentive Measures

- Annual assessment of CCO performance on 17 measures.
- Quality pool paid to CCOs for performance.
- Compare current performance against prior baseline year.



CCO Performance

Quality Pool: Metrics and Scoring Committee

- 2012 Senate Bill 1580 establishes committee
- Nine members serve two-year terms. Must include:
 - 3 members at large;
 - 3 members with expertise in health outcome measures
 - 3 representatives of CCOs
- Committee uses public process to identify objective outcome and quality measures and benchmarks

CCO Performance

Quality Pool: distribution

To earn their full quality pool payment, CCOs must:

- ✓ Meet the benchmark or improvement target on at least 12 of the 17 measures; and
- ✓ Have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from quality pool goes to the challenge pool.

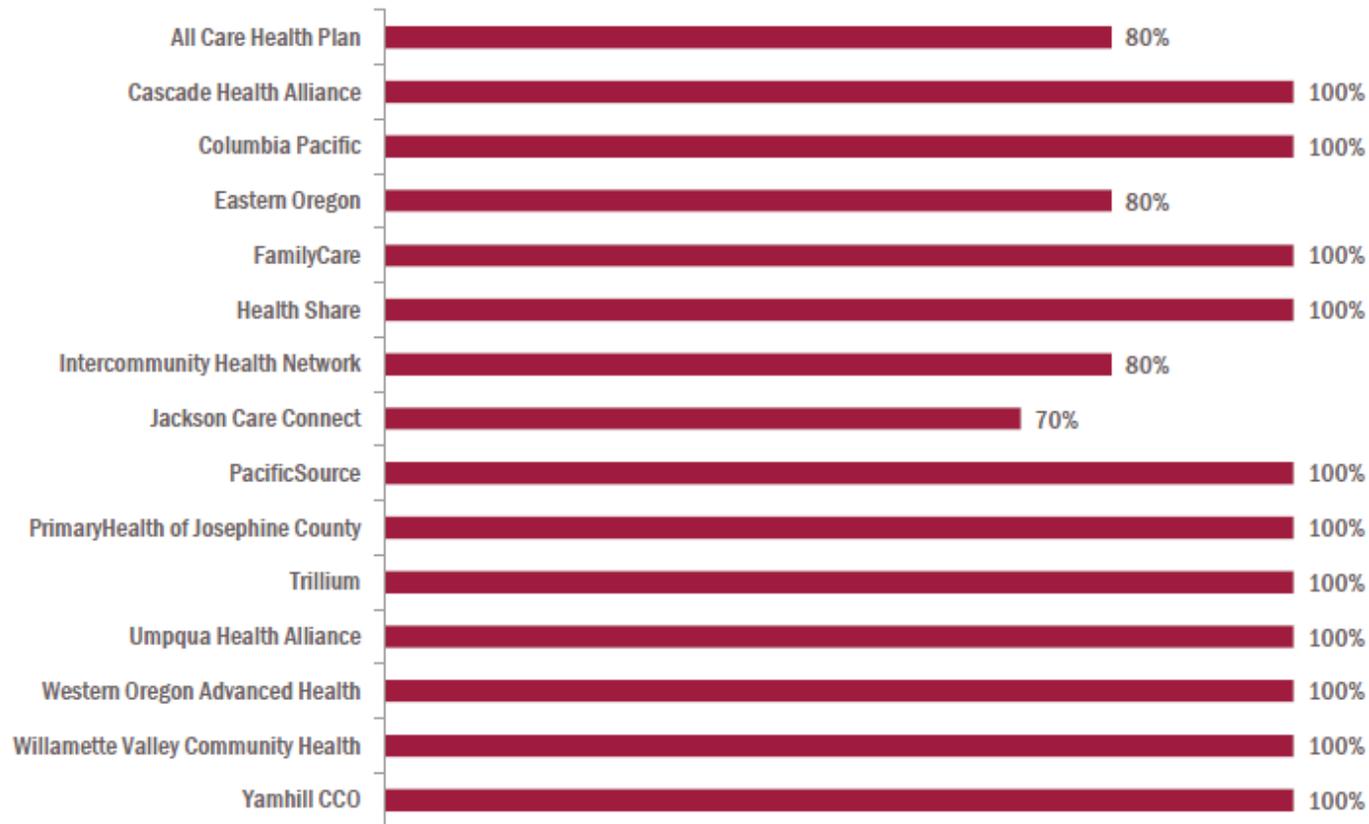
To earn challenge pool payments, CCOs must:

- ✓ Meet the benchmark or improvement target on the four challenge pool measures: depression screening, diabetes HbA1c control, SBIRT, and PCPCH enrollment.

CCO Performance in 2013

Percent of 2013 Quality Pool: Phase One Distribution Earned

Does not include Challenge Pool funds



CCO Performance in 2013

Percent of 2013 Quality Pool Earned in Total

Includes both Phase One Distribution and Challenge Pool funds



^ Reflects prorated quality pool for partial year as CCO.

CCO Performance in 2013

All CCOs improved on...

Ambulatory care: emergency department utilization

✓ All CCOs met their improvement targets.

Developmental screening

✓ All CCOs met their improvement targets and four met benchmark.

Early elective delivery

✓ All CCOs were below the benchmark (lower is better).

Electronic Health Record (EHR) adoption

✓ All CCOs met their improvement target or surpassed benchmark.

Mixed Results on

- **Adolescent well – care visits** (7 CCOs met targets)
- **Colorectal cancer screening** (6 CCOs met targets)
- **Follow up after hospitalization for mental illness** (10 CCOs)
- **Follow up care for children prescribed ADHD meds** (13 CCOs)
- **Assessments for children in DHS custody** (12 CCOs)
- **Prenatal and postpartum care** (11 CCOs made improvements)
- **Satisfaction with care** (12 CCOs made improvements)

CCO Performance: Raising the bar

- Raising the bar
 - For 2014: CCOs must show improvement from their 2013 data to receive incentive payments
 - The bar continues to be raised and the transparent process of selecting measures – or dropping as there is widespread success on a measure – will continue.
 - For 2015, two measures were dropped and three new measures were added. The new measures are more outcome-based.
 - For 2014: The incentive pool increased from 2% to 3% -- increasing the rewards for improving.

2014 Mid-Year Progress

- New performance report documents state and CCO progress from July 1, 2013 through June 30, 2014.
- Report includes data on key measures for the 380,000+ Oregonians who enrolled in the Oregon Health Plan since the ACA took effect January 1, 2014.
- Report includes core performance measures, focusing on population health issues, e.g., prevalence of obesity and tobacco.

Coordinated care model continues to show improvements for Medicaid members

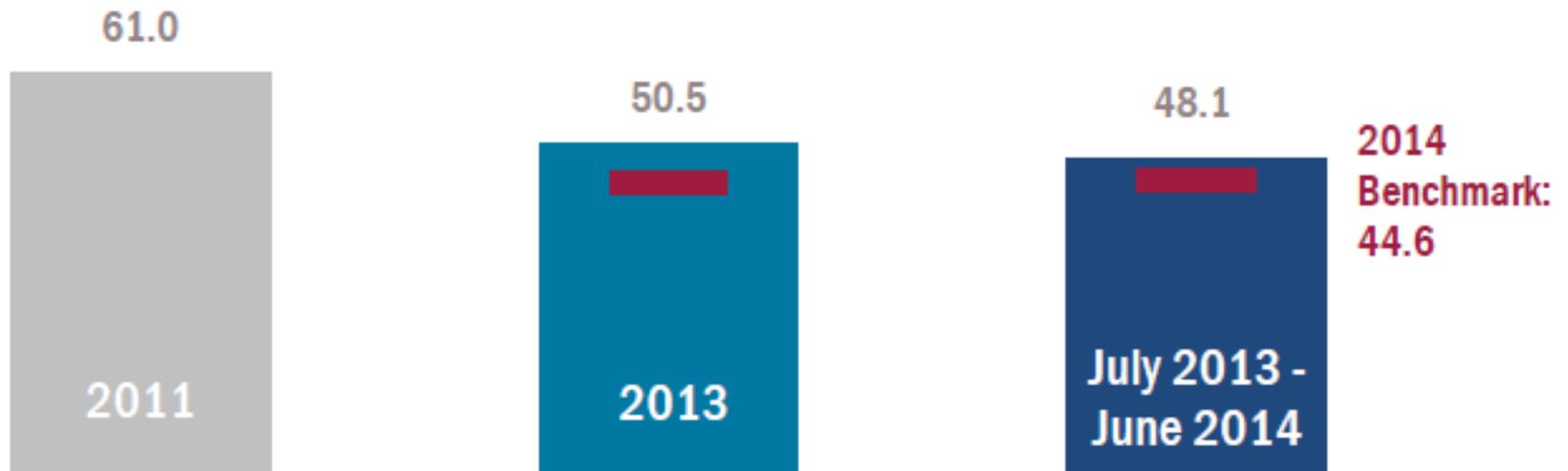
- Decreased emergency department visits.
- Decreased hospital admissions for short-term complications from diabetes.
- Decreased hospital admissions for chronic obstructive pulmonary disease.
- Increased enrollment in Patient-Centered Primary Care Homes.

Statewide, emergency department utilization has continued to decline.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: 2013 National Medicaid 90th percentile

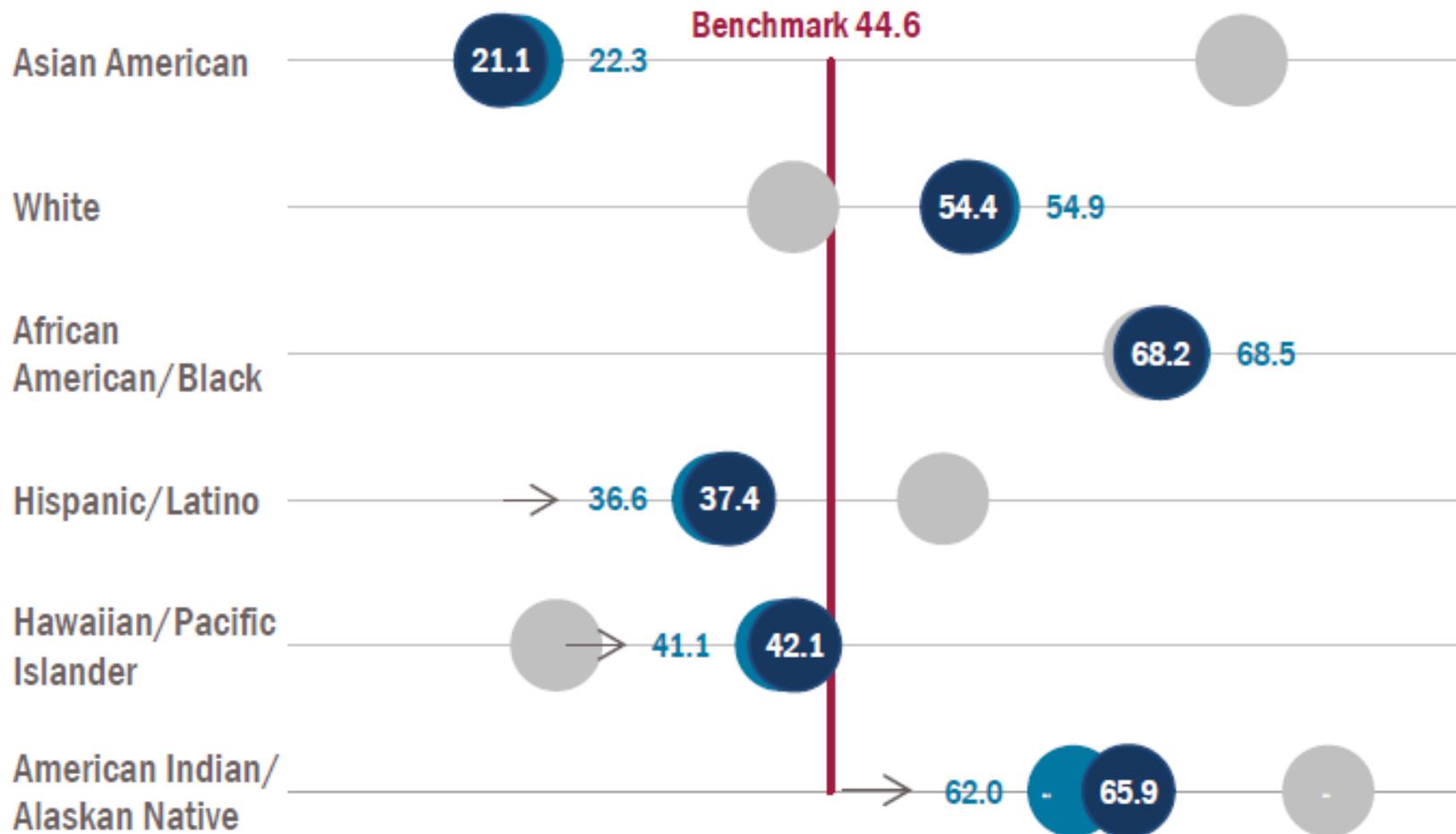


Asian Americans used the emergency department least frequently in **June 2014** and experienced the greatest improvement since **2013**.

(Lower scores are better)

Gray dots represent 2011.

Data missing for 8.9% of respondents. Each race category excludes Hispanic/Latino

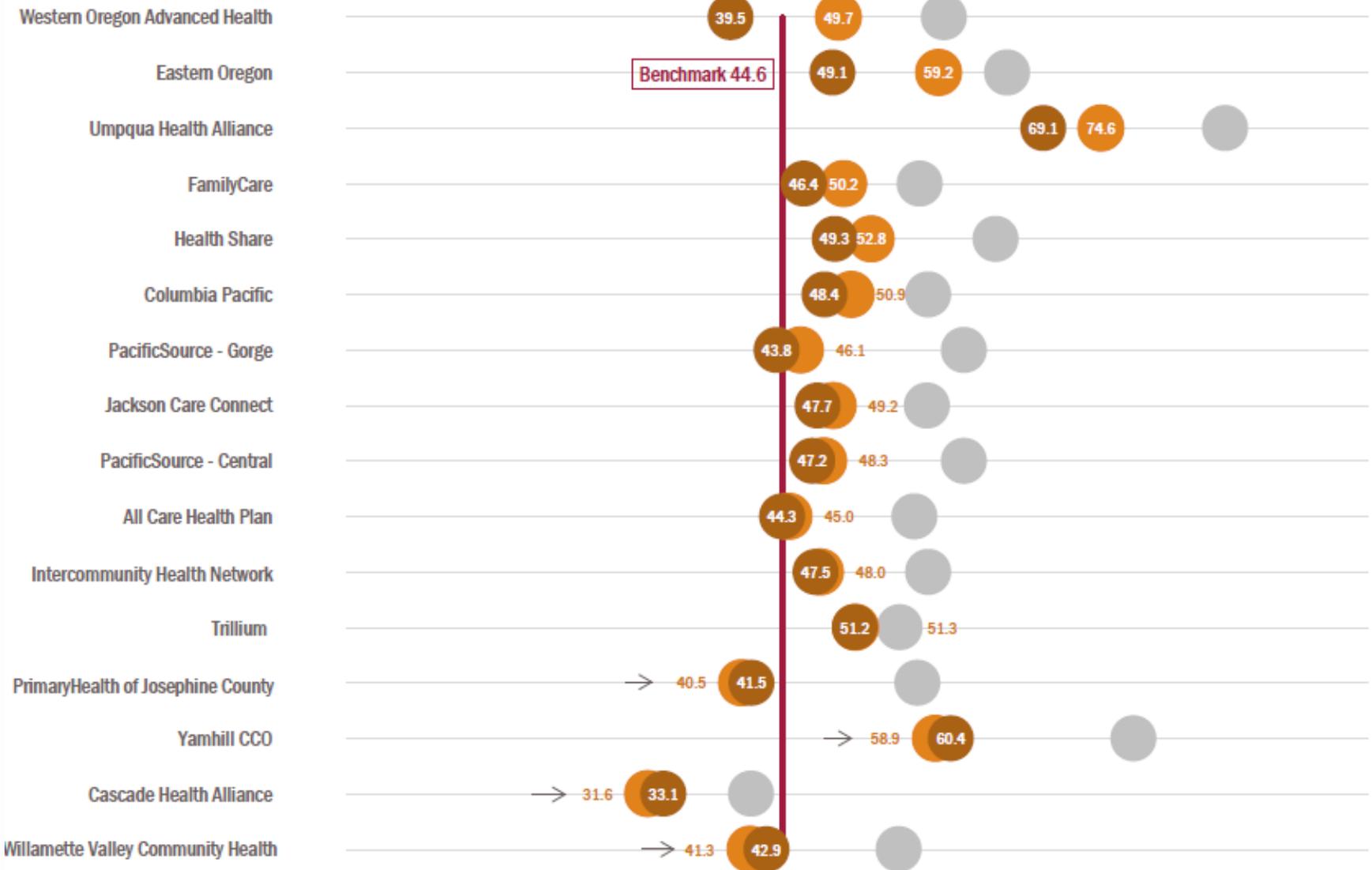


Emergency department utilization continued to decline for many CCOs between 2013 & June 2014.

(Lower scores are better)

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.



ED Utilization since January 1, 2014

Statewide, new ACA members use emergency rooms less frequently than other members.

Lower is better.

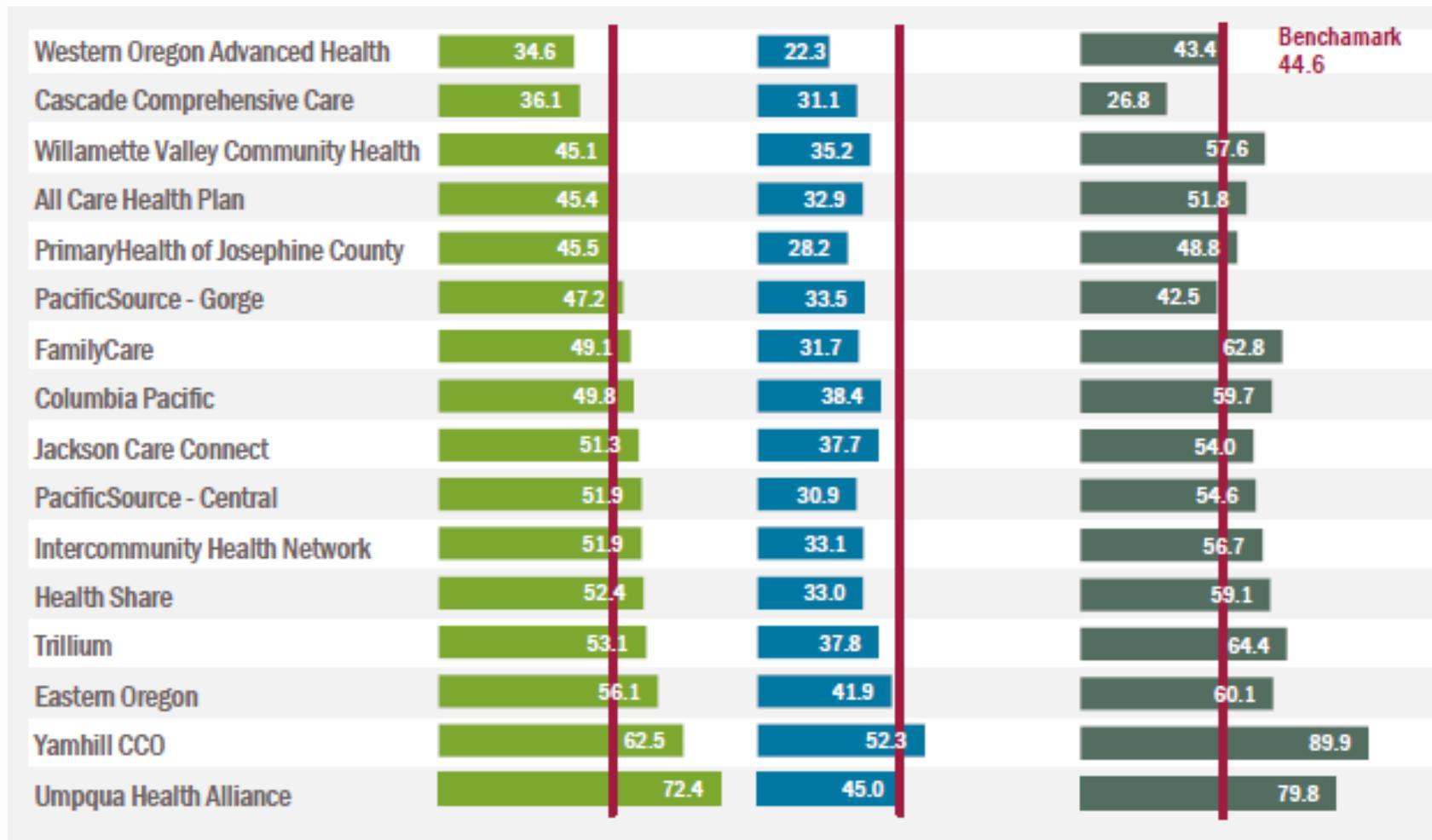
Rates are reported per 1,000 member months

Data source: Administrative (billing) claims

2014 benchmark source: 2013 National Medicaid 90th percentile



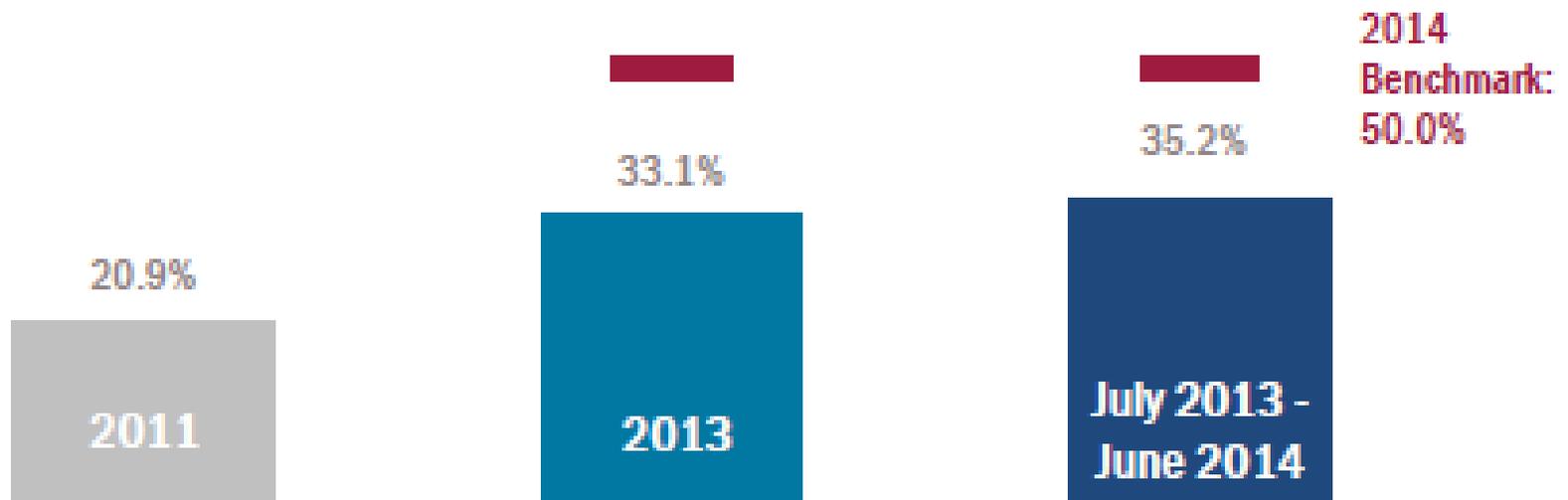
ED Utilization since January 1, 2014



Statewide, developmental screening continues to increase.

Data source: Administrative (billing) claims

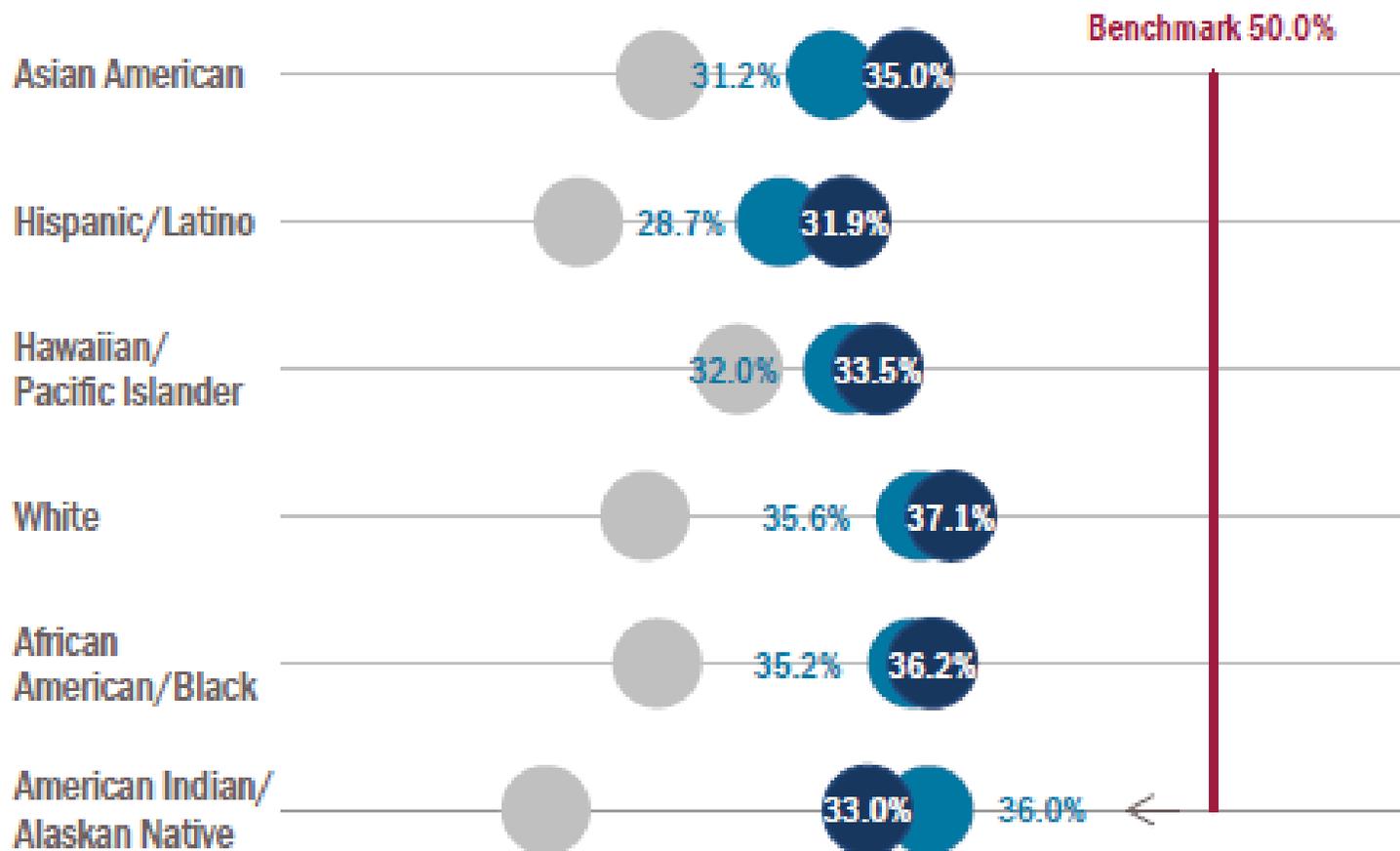
2014 benchmark source: Metrics and Scoring Committee consensus



All racial and ethnic groups except American Indian/Alaskan Natives show increased developmental screenings between 2013 & June 2014.

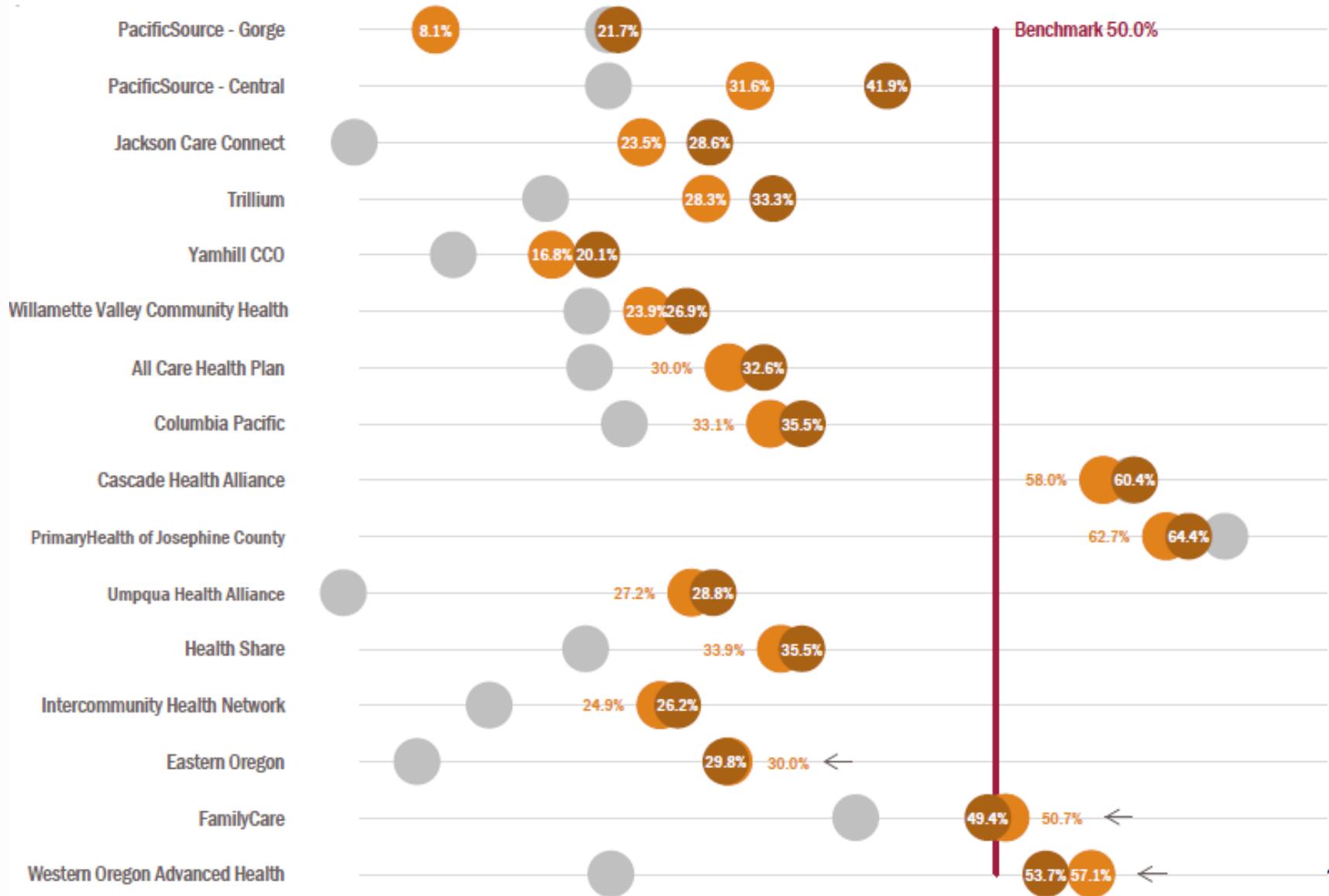
Gray dots represent 2011.

Data missing for 9.7% of respondents. Each race category excludes Hispanic/Latino.



Developmental screenings increased in nearly all CCOs between 2013 & June 2014.

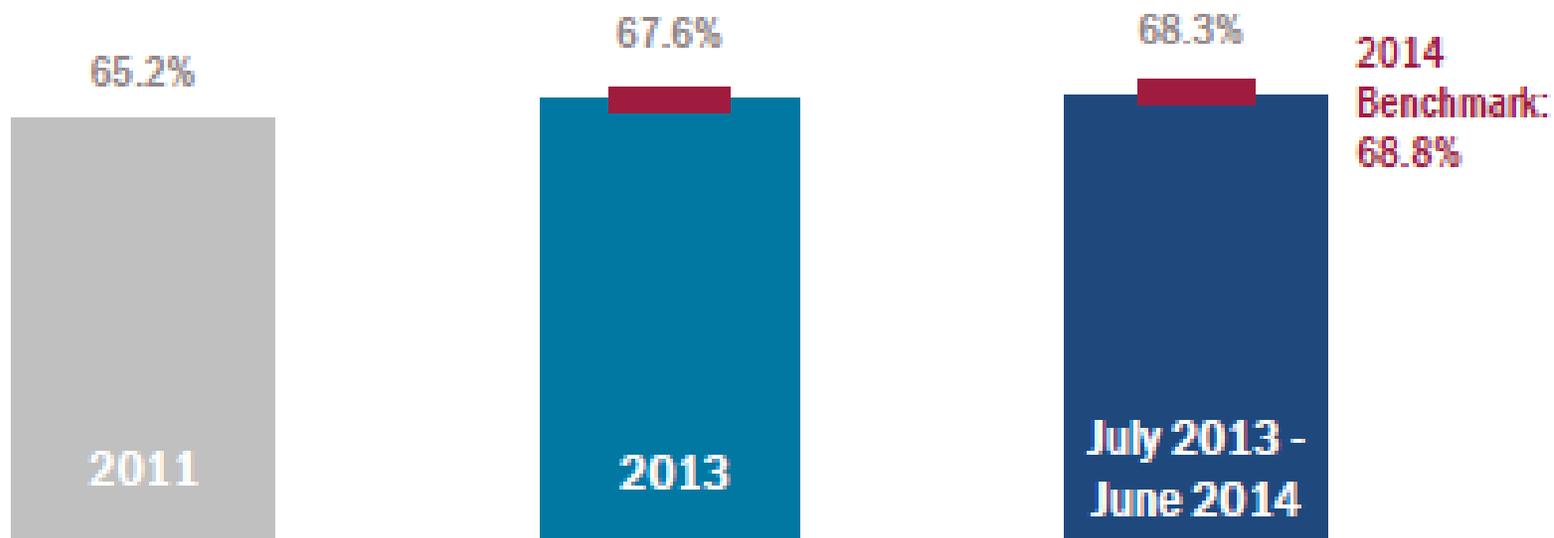
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization.
 Baseline data for PacificSource Central and Gorge are combined.



Statewide, follow-up care after hospitalization for mental illness has improved.

Data source: Administrative (billing) claims

2014 benchmark source: 2013 National Medicaid 90th percentile



Follow-up care after hospitalization for mental illness decreased for all racial/ethnic groups between 2013 and June 2014.

Gray dots represent 2011.

Data missing for 6.5% of respondents. Each race category excludes Hispanic/Latino.

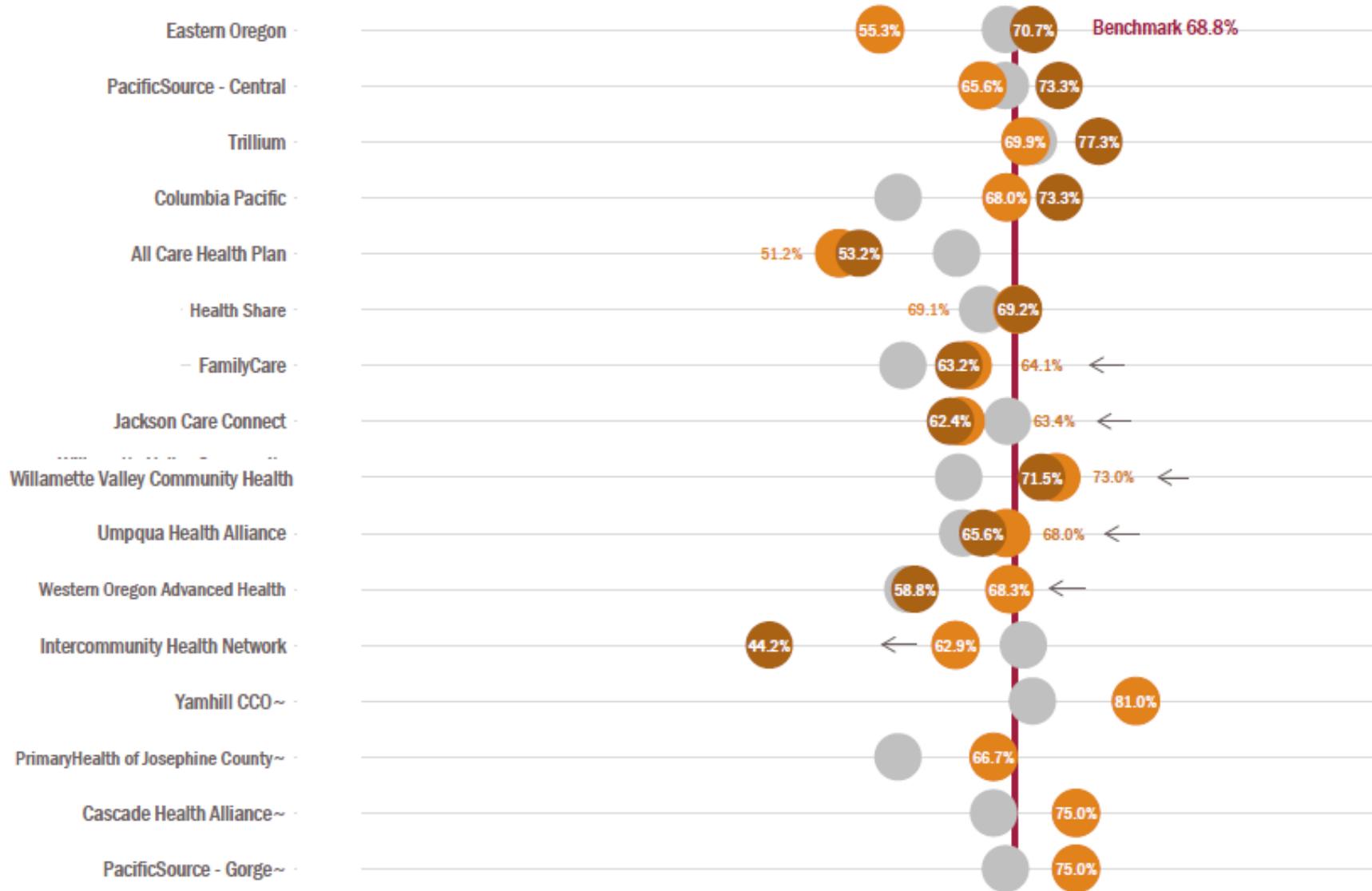


CCOs have mixed results between 2013 & June 2014 in providing timely follow-up after hospitalization for mental illness.

Gray dots represent 2011 baselines, which are pre-CCO & based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.

~ Data suppressed (n<30)

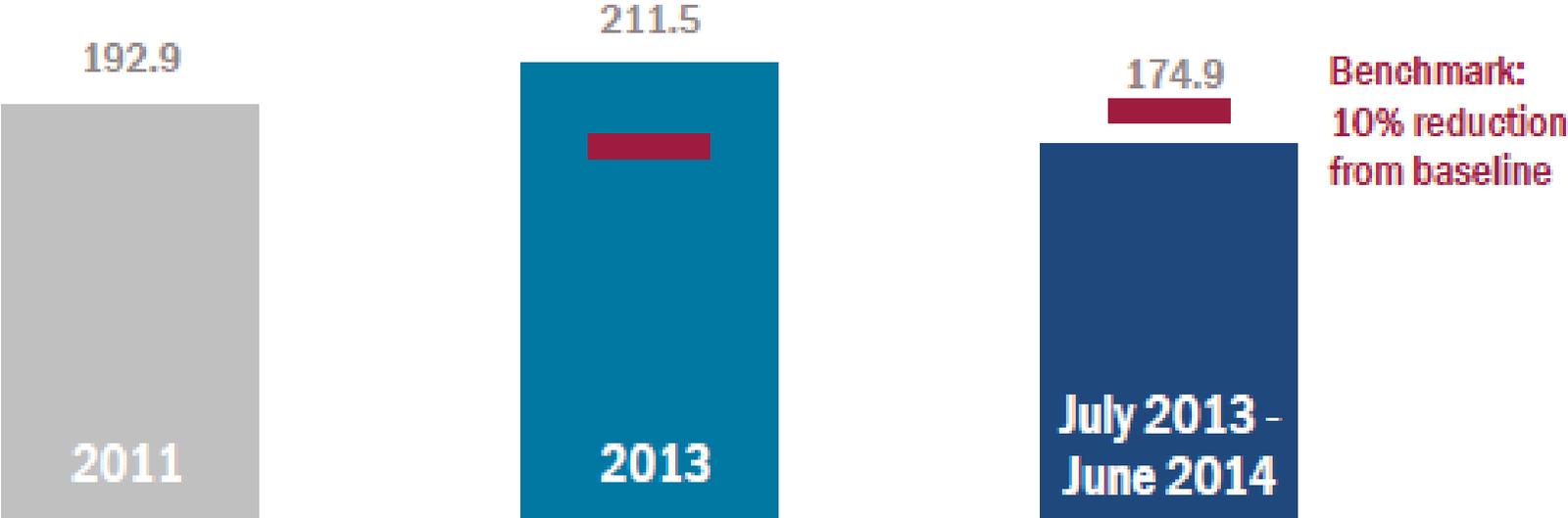


Statewide, hospital admission rates due to diabetes complications have declined.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: OHA consensus, based on prior performance trend

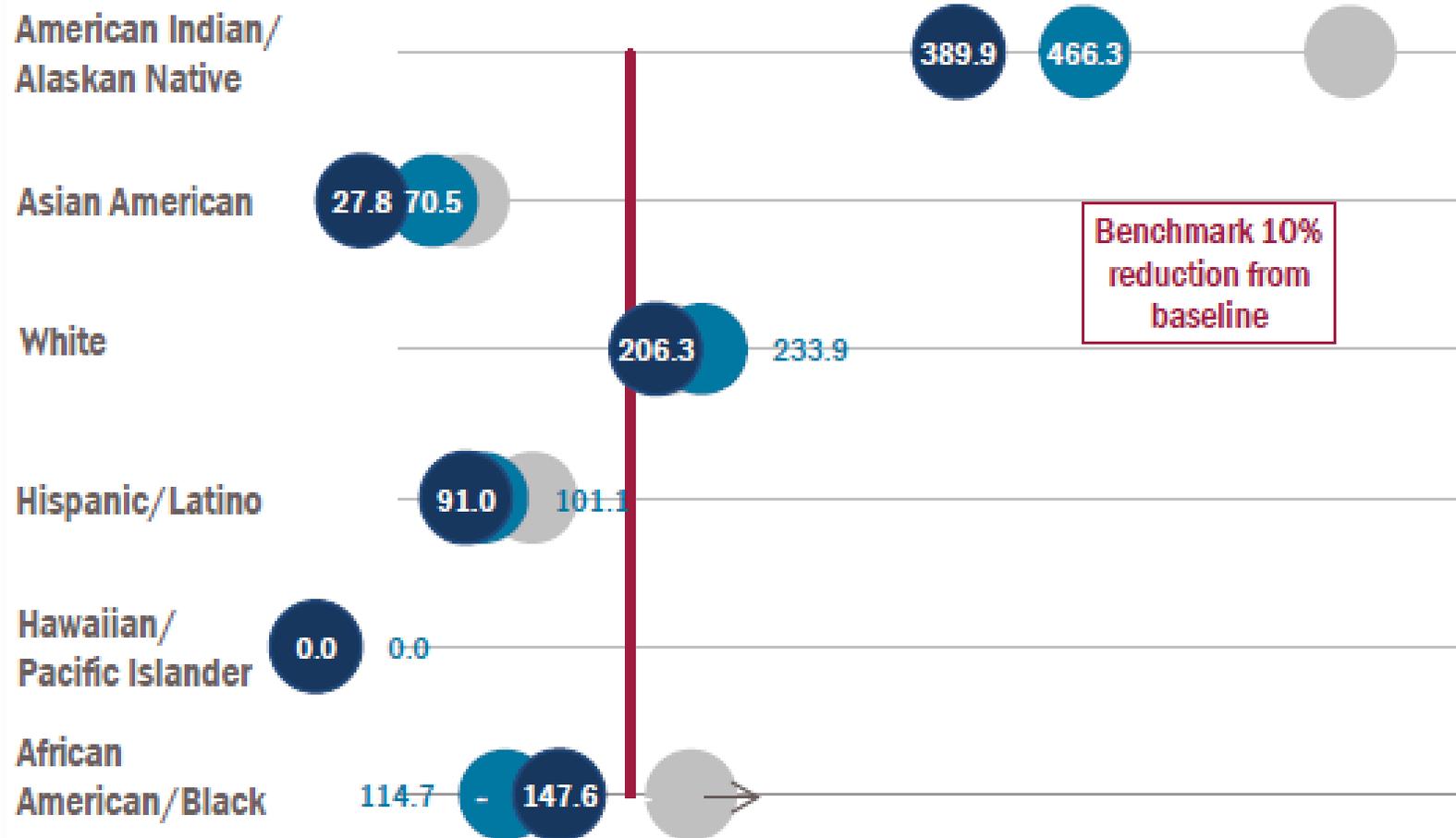


American Indian/Alaskan Natives experienced the most improvement between 2013 and June 2014, yet hospital admission rates remain higher than other groups.

(Lower scores are better.)

Gray dots represent 2011. Data missing for 8.7% of respondents.

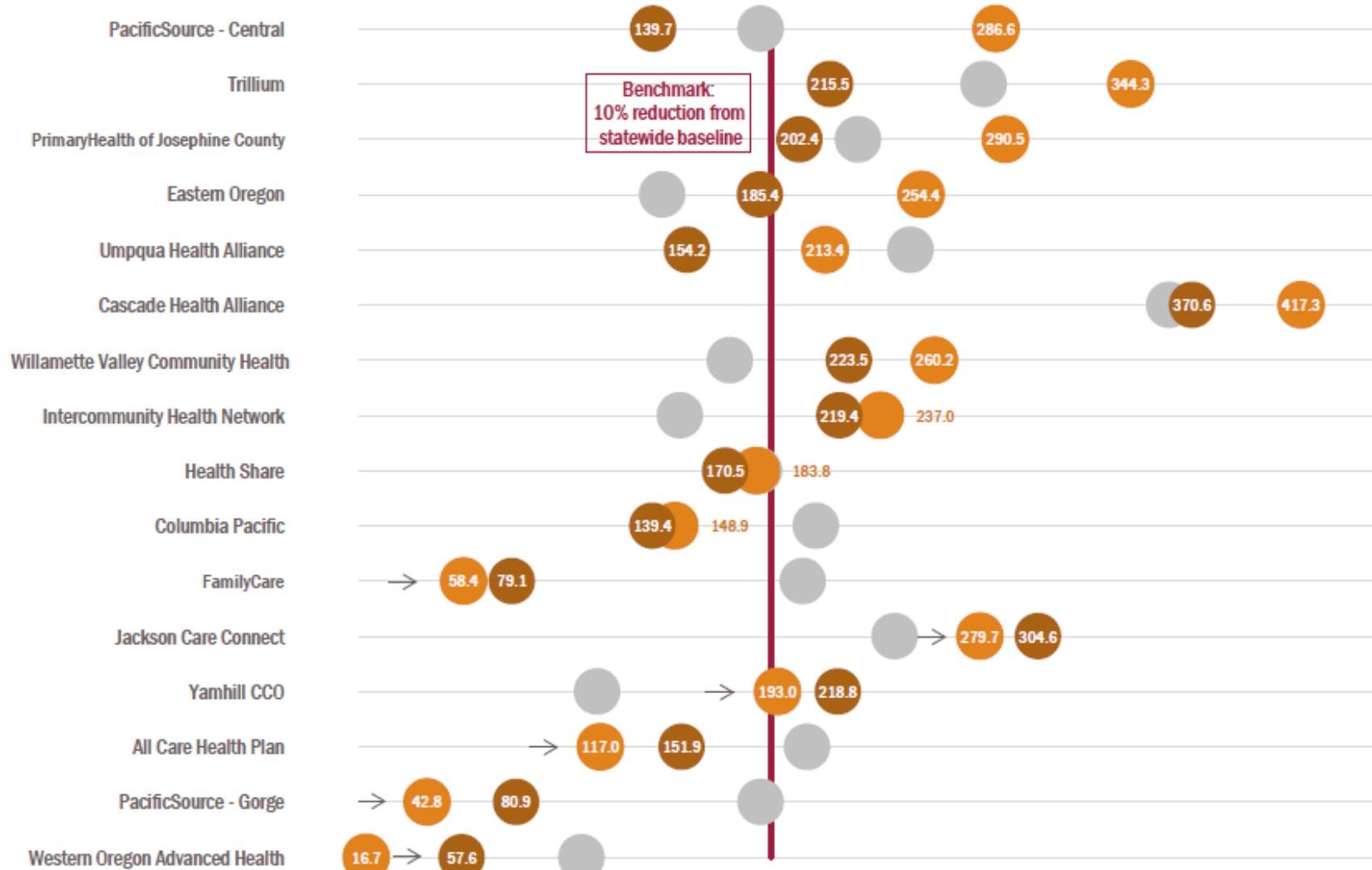
Each race category excludes Hispanic/Latino.



The number of CCOs that have met the benchmark increased between 2013 & June 2014.

(Lower scores are better). Rates are per 100,000 member years

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. PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators.

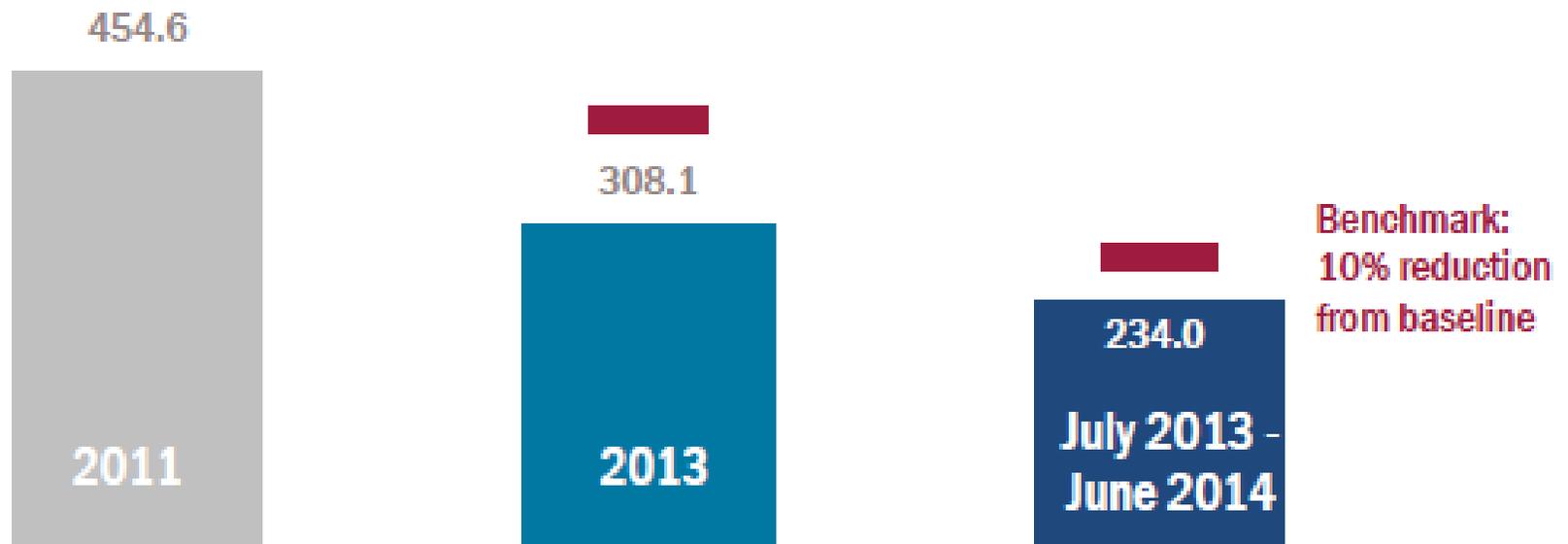


Statewide, hospital admission rates for adults with COPD or asthma continue to fall.

(Lower scores are better)

Data source: Administrative (billing) claims

2014 benchmark source: OHA consensus, based on prior performance trend

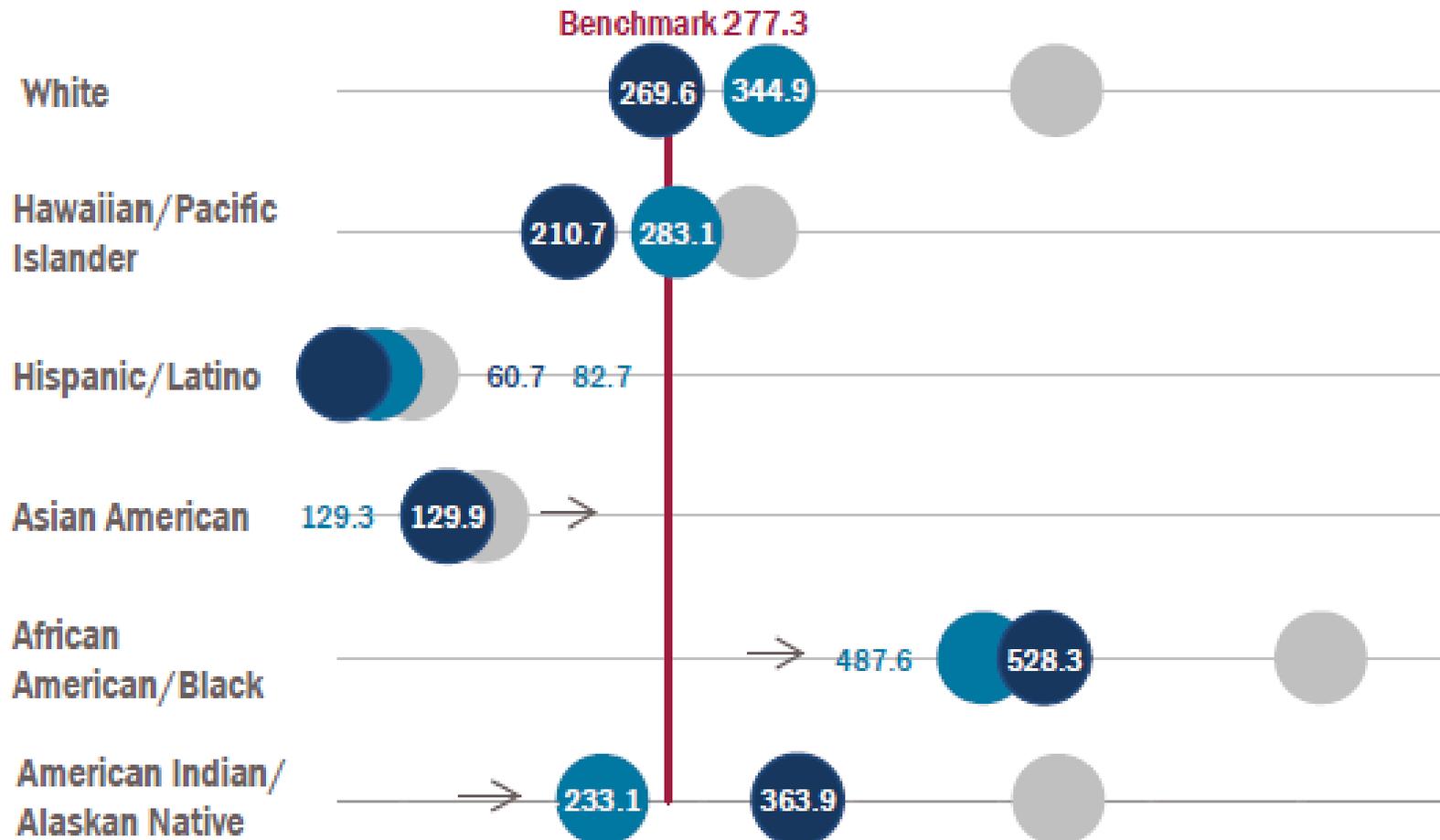


Admission rates for adults with COPD were mixed across racial/ethnic groups between 2013 and June 2014.

(Lower scores are better)

Gray dots represent 2011.

Data missing for 8.7% of respondents. Each race category excludes Hispanic/Latino.

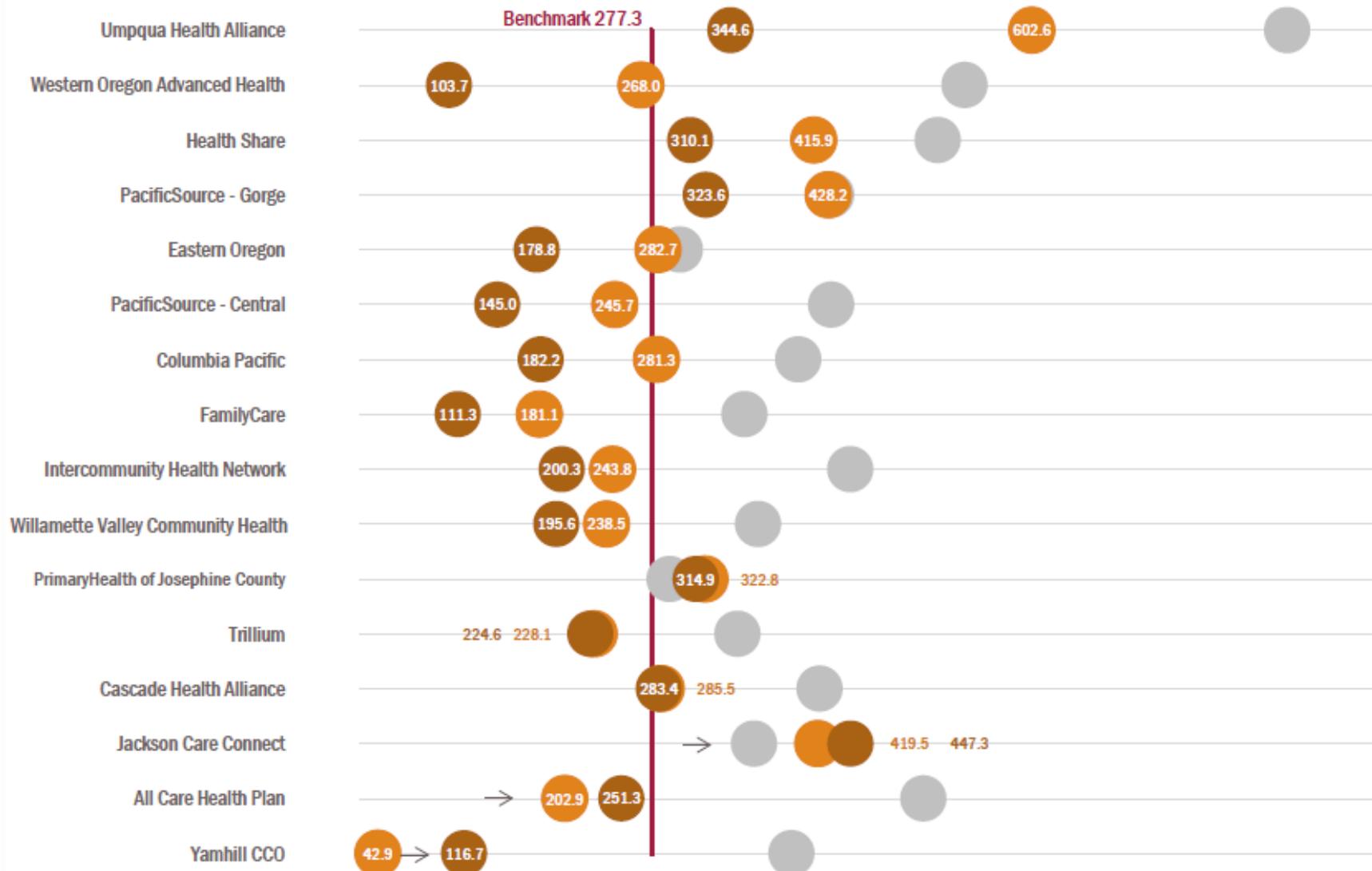


Overall, CCOs continued to show improvement between 2013 & June 2014.

(Lower scores are better). Rates are per 100,000 member years

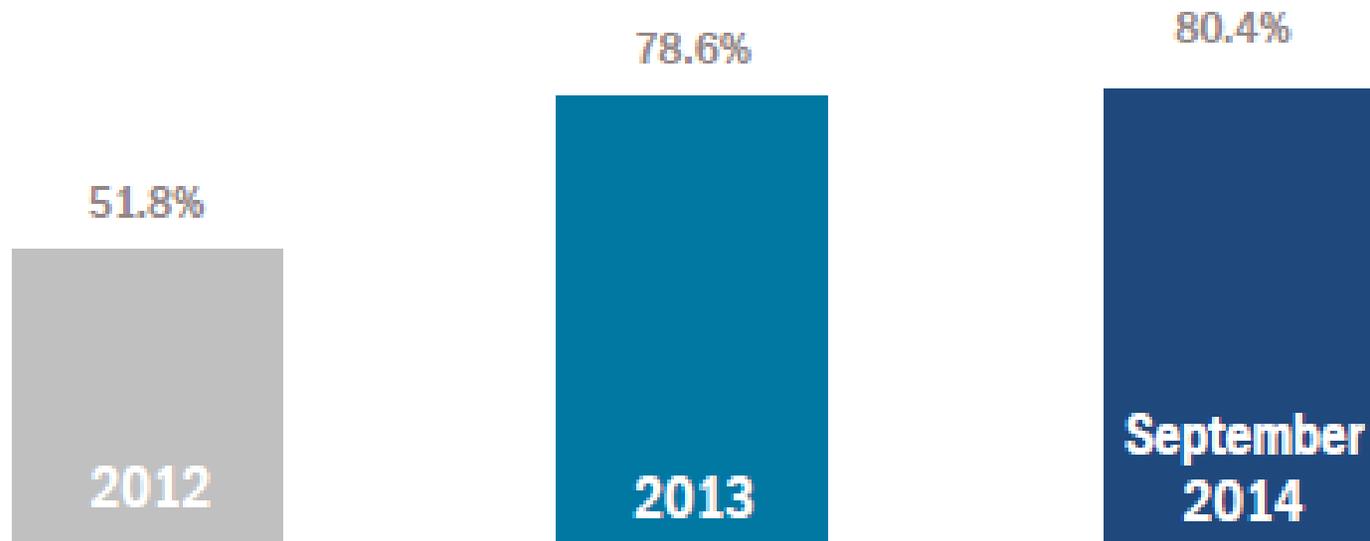
Gray dots represent 2011 baselines, which are pre-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.

PQIs come from the Agency for Healthcare Research and Quality, Prevention Quality Indicators



Statewide, patient-centered primary care home enrollment continues to increase.

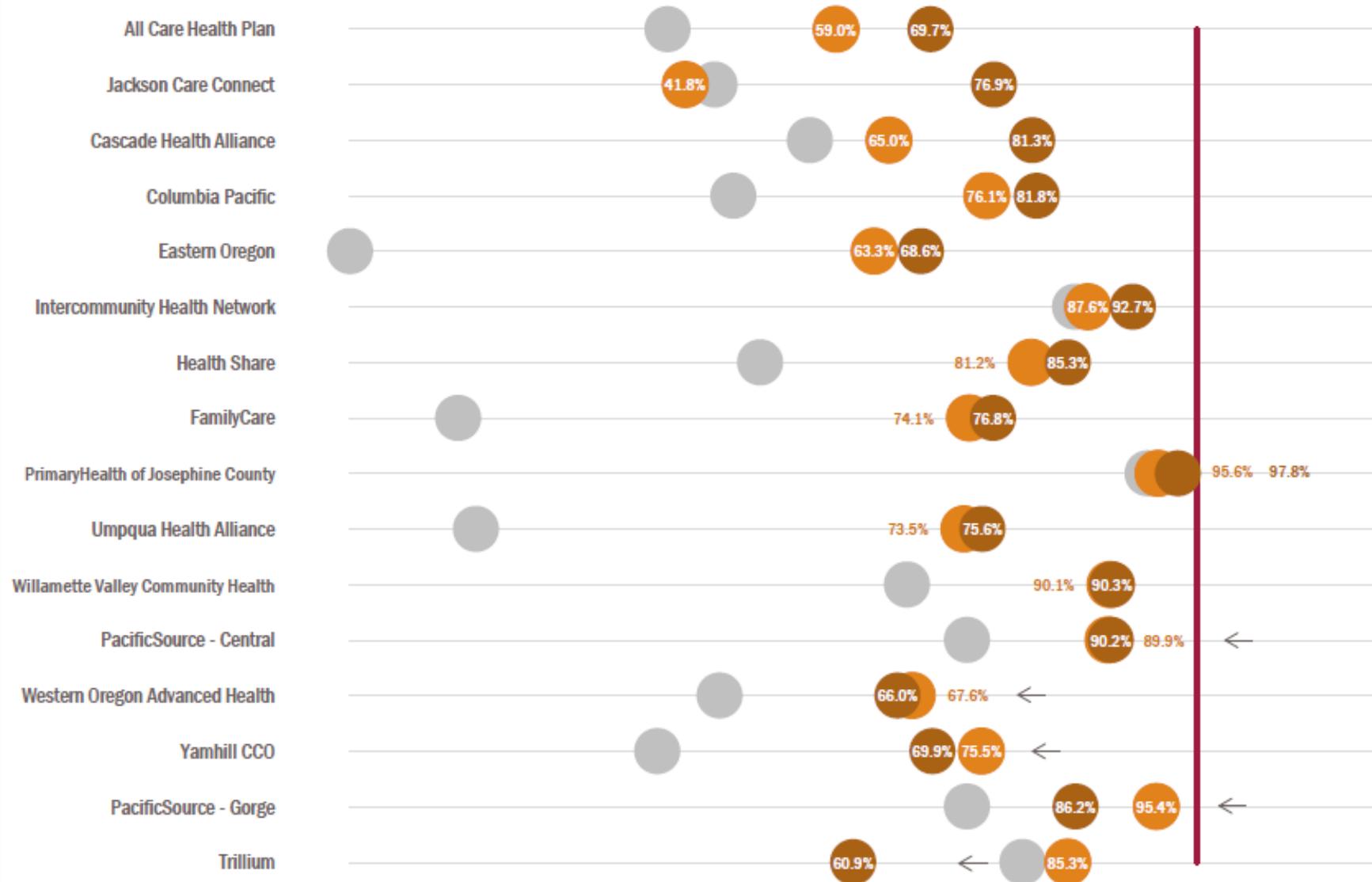
Data source: CCO quarterly report
2014 benchmark source: n/a



Overall, PCPCH enrollment continues to increase between 2013 & September 2014.

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.

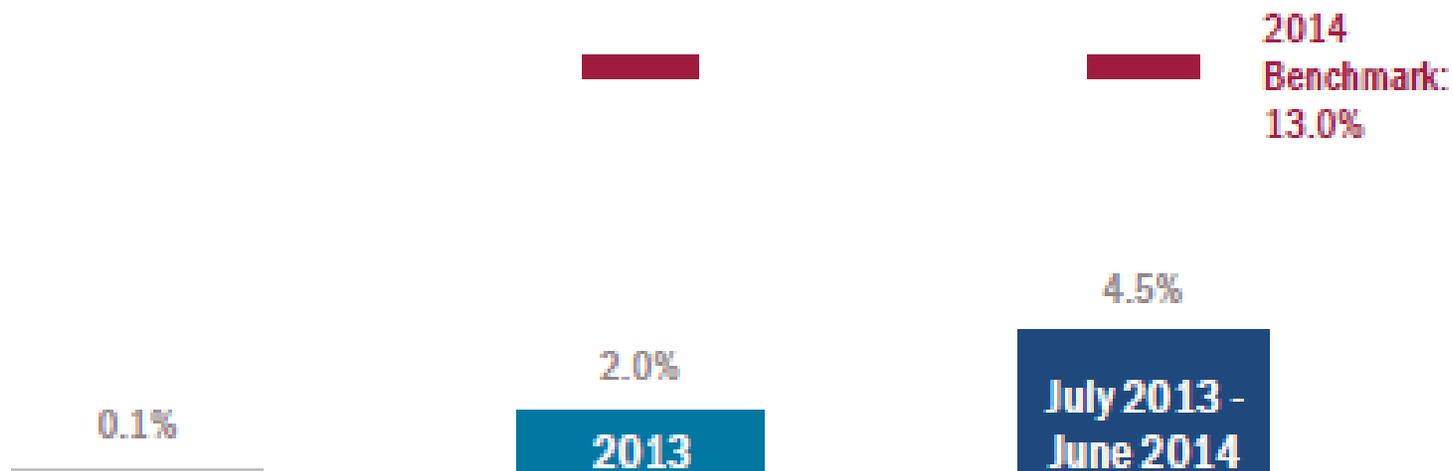


Room for Improvement: SBIRT

Statewide, appropriate screening and intervention for alcohol or substance abuse has increased steadily each year.

Data source: Administrative (billing) claims

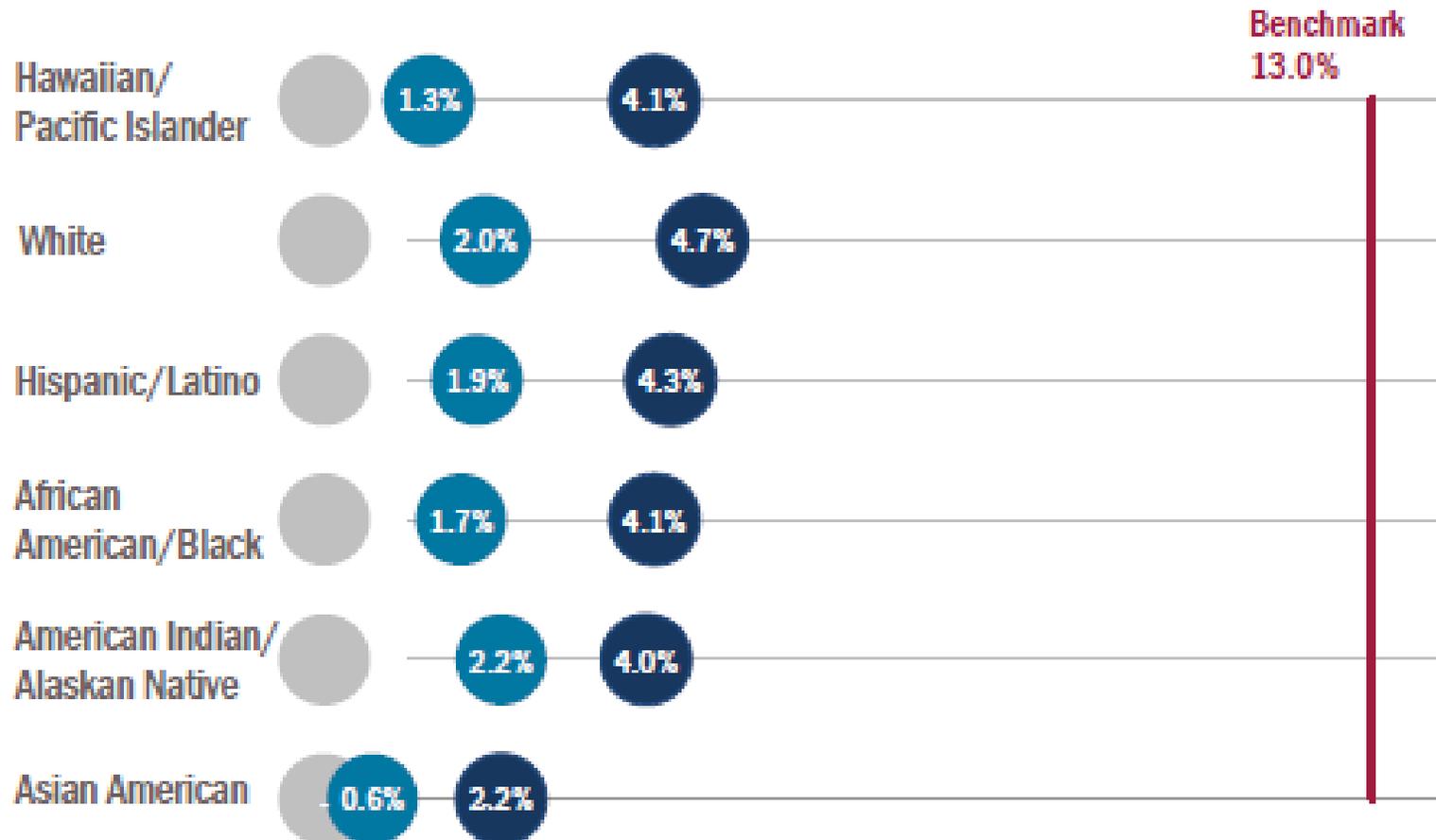
2014 benchmark source: Metrics and Scoring Committee consensus



SBIRT rates improved for all racial/ethnic groups between 2013 & June 2014.

Gray dots represent 2011.

Data missing for 8.5% of respondents. Each race category excludes Hispanic/Latino.



CCOs continued to improve SBIRT between 2013 & June 2014.

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.



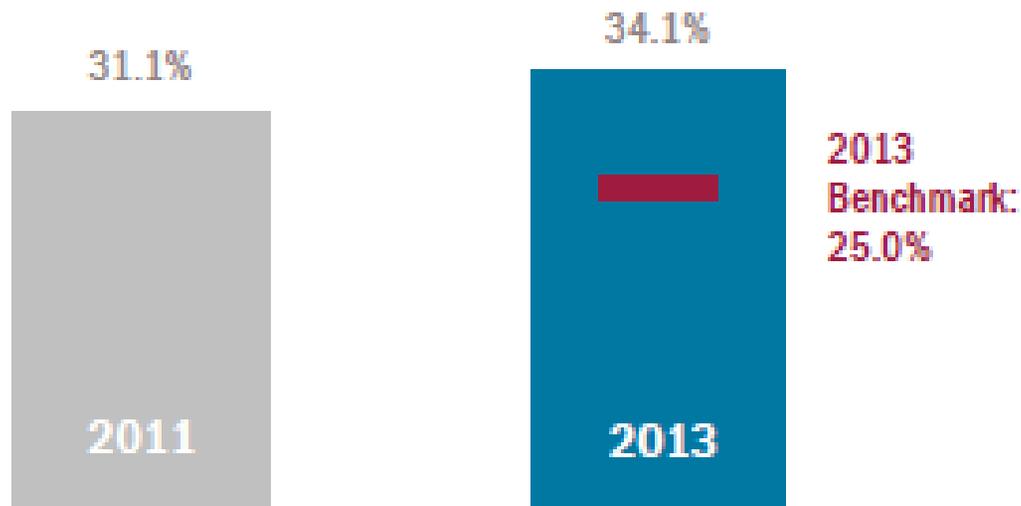
Core Performance: Tobacco Prevalence

Statewide, tobacco use increased in the Medicaid population since 2011.

(Lower scores are better)

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

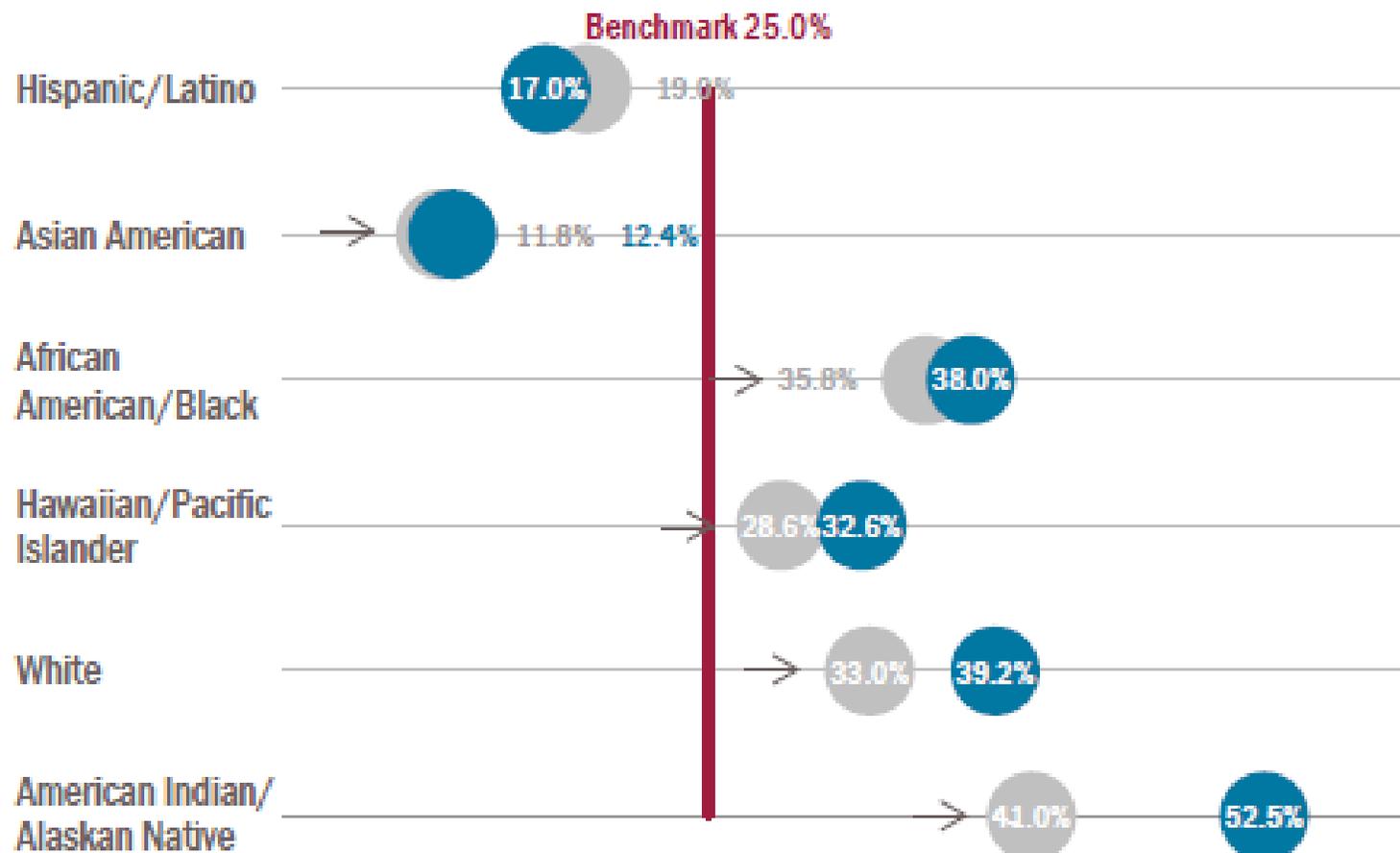
2014 benchmark source: Oregon's 1115 demonstration waiver goals



Tobacco use increased for all racial/ethnic groups except Hispanic/Latino between 2011 and 2013.

(Lower scores are better).

Each race category excludes Hispanic/Latino.

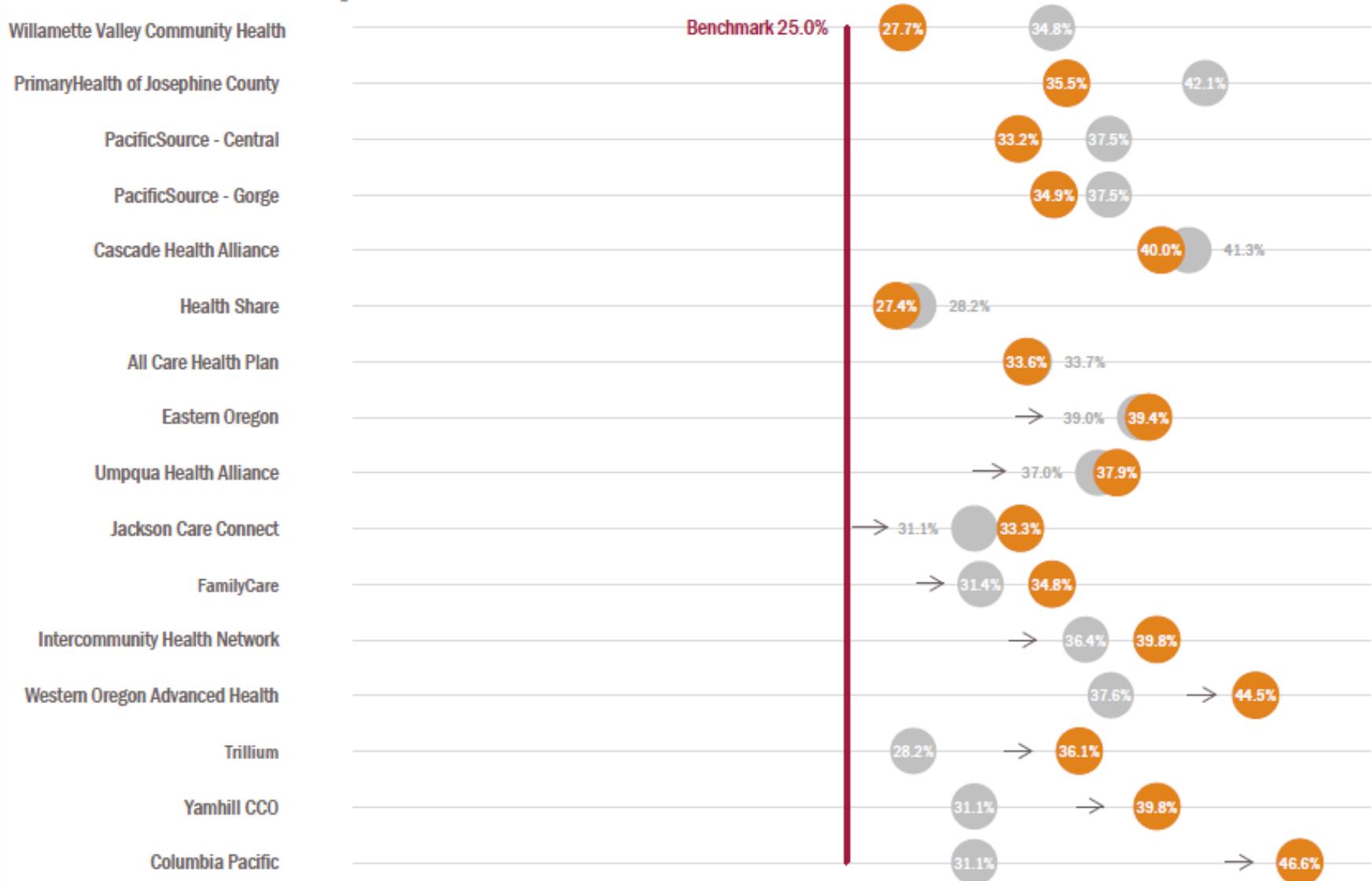


While tobacco use decreased in seven CCOs between 2011 and 2013, tobacco use increased in nine CCOs.

(Lower scores are better)

2011 baselines are pre-CCO and based on data from the predecessor care organization.

Baseline data for PacificSource Central and Gorge are combined.



SPREADING THE COORDINATED CARE MODEL

The OHA Transformation Center

- To support Health System Transformation, OHA needs to transform itself, too.
 - Move beyond just regulating CCOs. Be a supportive partner in transformation and the spread of innovation.
 - Transformation Center will operate as OHA's hub for innovation and improvement.
 - Will also help the agency see where it needs to transform internally.
- Goal: Partner with CCOs, providers and communities to increase the rate and spread of innovation needed to achieve triple aim.
 - Our role is to help good ideas travel faster.
 - Will work collaboratively with partners.
- Spread elements of the coordinated care model to other payers

Transformation Center's Work

- CCO Innovator Agents
- Council of Clinical Innovators
- Learning Collaboratives
- Support for Transformation Plans
- Health System Transformation Fund Grants
- CCO Summit
- Good Ideas Bank

CCO Innovator Agents

- High-level OHA positions embedded in the CCO community
- Serve as a single point of contact for the CCOs with the agency and help bust bureaucracy within OHA
- Support the CCO as it implements its transformation plan
 - Act as champions of change, not regulators
- Connect regularly with other Innovator Agents to share best and emerging practices and for shared problem solving

Learning Collaboratives

- Transformation Center learning collaboratives allow CCOs to:
 - Share best and emerging practices
 - Engage in shared problem solving
- Participation in one statewide learning collaborative is required in contract and our waiver – others are voluntary
- Current Transformation Center learning collaboratives:
 - Medical Directors and Quality Improvement Coordinators (focused on Incentive Metrics)
 - Community Advisory Council members (includes CAC Summit)
 - Providers serving patients with complex care needs
- CCO CEOs meet regularly to share and learn from each other

Learning Collaboratives

- Participants drive topics and agendas
- Heavy emphasis on sharing and learning from each other, but outside experts are brought in when requested
- Web-based collaboration tool (Groupsie) allows for connection and conversation between meetings

Transformation Center: What's Next?

- CCO Summit 2015
- Supporting connections between CCOs and:
 - Early Learning Hubs
 - Local Public Health Departments
- Fostering work within CCOs:
 - Behavioral health integration
 - Dental integration
 - Health equity
 - Patient engagement
 - Community Health Improvement Plan implementation

To learn more....

www.health.oregon.gov