Health Share of Oregon

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Legacy Health, Vice President Care Transformation

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What started all of this?

Comparing the rate of increase in Medicaid and PEBB health care expenditures vs. the rate of increase of the state General Fund revenues
## Funding gap

### Gap Analysis ($ in millions)

<table>
<thead>
<tr>
<th></th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oregon Medicaid Program:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current 7% spending trend</td>
<td>$3,178</td>
<td>$3,400</td>
<td>$3,638</td>
<td>$10,216</td>
</tr>
<tr>
<td>Reduced 4.6% spending target</td>
<td>$2,532</td>
<td>$2,986</td>
<td>$3,124</td>
<td>$8,642</td>
</tr>
<tr>
<td>Oregon spending reduction</td>
<td>($646)</td>
<td>($414)</td>
<td>($514)</td>
<td>($1,574)</td>
</tr>
<tr>
<td><strong>Portland Medicaid percent</strong></td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Portland spending reduction</td>
<td>($258)</td>
<td>($166)</td>
<td>($206)</td>
<td>($630)</td>
</tr>
</tbody>
</table>
How to reduce the cost of health care

Traditional Method: Cut, cut, cut

• Reduce how much we pay
  – E.g: cut provider rates

• Reduce the number of people covered
  – E.g: cut OHP Standard enrollment

• Reduce the benefits covered
  – E.g: move the “Line” on the Prioritized List

Innovative, Long-Game Method:

• Change the way care is organized and delivered
Health care: Innovation is key, governor says

Oregon faces in 2011-13 an $860 million gap between funding and costs for nearly 600,000 people on the Oregon Health Plan, a 39 percent cut.

Kitzhaber has proposed to cut $570 million with traditional tactics -- reductions in administrative cost and health plan benefits and a 19 percent cut in Medicaid payments to doctors and other providers. But he doesn't want to kick people off the plan as other states have. Instead, he wants to close the remaining $290 million gap by saving through reform.

"The only way out of this is to innovate or die," said the governor, also a physician.
Federal Support for CCOs -- $1.9 Billion!

- 5 year Investment... with strings attached
  - Cut cost growth by 1% pts after 2 years, then 2%
  - Measurably improve quality and access
    - 17 P4P metrics, 2% global budget bonus at risk
    - 1% timely reporting withhold for quarterly data

- Oregon’s case: Move 6 Key Transformation “Levers”
  - Focus on “those with multiple or complex conditions”
  - Alternative payment methods focused on outcomes
  - Integrated physical, behavioral, oral models of care
  - Administrative simplification / new models of care
  - “Flexible services”
  - Learning systems for accelerating innovation spread
The timeline of events

July ’11  HB 3650 signed into law
Jan ’12  OHPB’s Implementation Plan published
March ’12  SB 1580 signed into law
April ’12  CCO Letters of Intent submitted, RFA published
June’12  Application for CCO Certification due
July ’12  Readiness Review
August ’12  Execute CCO Contract with OHA
Sept ’12  Go Live
“Coordinated Care Organizations” (HB3650)

- 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, elimination of fragmentation
- Global budget
  - Revenue flexibility to allow innovative approaches
  - Opportunities for shared savings
  - Manage to agreed upon rate of growth
- Accountability through measures of health outcomes, patient experience and resource use
“Health Share of Oregon”

- 11 Tri County (Clackamas, Multnomah, Washington) organizations non profit (501c3) CCO
  - Partners include 3 County Mental Health Organizations, 4 Health Plans, 3 Hospital Systems, Public Health, and Community Clinics
  - Collectively manage 157,000 enrollees (current)
  - Diverse regional systems: urban to rural, multiple “communities”
  - Multiple “natural systems of care”
“Health Share of Oregon”

• 11 Tri County (Clackamas, Multnomah, Washington) organizations non profit (501c3) CCO
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Health Share of Oregon
Board of Directors

**Founding Members**

- Adventist Health: Tom Russell
- CareOregon: Patrick Curran
- Central City Concern: Ed Blackburn
- Clackamas County: Cindy Becker
- Kaiser Permanente: Andrew McCulloch
- Legacy Health: George Brown
- Multnomah County: Lillian Shirley
- OHSU: Joe Roberston
- Providence Health & Services: Greg Van Pelt
- Tuality Healthcare Alliance: Dick Stenson
- Washington County: Rod Branyan

**Elected Board Members**

- Primary Care Provider physician: Jill Ginsberg
- Specialist physician: W. Gary Hoffman
- Nurse Practitioner: Jean-Claude Provost
- Mental Health Treatment Provider: Mary Monnat
- Addiction Treatment Provider: Jackie Mercer
- Dentist: Michael Biermann
- Community-at-Large: Mel Rader
- Community-at-Large: Ramsey Weit
- Chair of Community Advisory Council: Steve Weiss
What is Health Share trying to accomplish?

• Health Share of Oregon’s mission is to develop an integrated health system that achieves better care, better health, and lower costs for the Medicaid population and the Tri-County community;

• In order to achieve this mission, we must do things differently in every aspect of the health care delivery system:
  • Clinical model of care
  • Finance model/Alternative payment methodology
  • Community involvement
  • Information technology
  • Collaboration and cooperation
What does Health Share look like today?

1% Reserves

3 Mental Health Plans
  - Admin
  - Claims

4 Physical Health Plans
  - Admin
  - Claims

1% Admin
The Work So Far

• Months of delicate and often difficult discussions among diverse and historically competitive organizations
• Awarded $17 million grant from the Centers for Medicare and Medicaid Innovation to fuel transformation of clinical care for high utilizing OHP enrollees
• Certified as Coordinated Care Organization Effective September 1; the largest CCO in the State
• Launched our Community Advisory Council and Seated Full 20 Member Board of Directors
• Recruited permanent leadership and staff
• Convening meetings with stakeholders, community members, and creating systems for transformation
• Preparing Three Transformation Plans
  • Model of Care (Includes Flexible Benefits, NTHW, Etc.)
  • Administrative Consolidation (Seven Health Plans)
  • Risk and Payment Methodology
• September 1 Launch
• Implementation of Transformation Plans
What has Health Share accomplished so far?

- Dec 2011 – Tri-County Medicaid Collaborative created
- Jan 2012 – Health Commons grant application
- Mar 2012 – Health Commons grant awarded
- Apr 2012 – CCO LOI submitted, Interim leadership team established
- May 2012 – CCO application submitted
- Jun 2012 – Board seated, Readiness review
- Jul 2012 – Bylaws, CareOregon MSA, Health Commons grant implementation
- Aug 2012 – CCO contract with OHA, Business plan approved, TCMC becomes Health Share of Oregon
- Sep 2012 – Go Live!
- Oct 2012 – Transformation planning
- Jan 2013 – DRAFT Transformation plan to OHA, Health Share offices established
- Feb 2013 – Janet Meyer named CEO
- Mar 2013 – Transformation plan to be finalized
- Apr 2013 – Transformation plan implementation
What does Health Share plan to do?

• Delivery system transformation
  • Health Commons grant, partner opportunities, P4P metrics, behavioral health integration, development of the provider network

• Accountability
  • Reporting and informatics, QAPI, risk transformation, admin simplification

• Community health integration
  • Equity and population health, chronic disease, engage community

• Regional HIT
  • Expanded membership and plan consolidation, HIE, delivery support
Total System Transformation

Risk & Payment
Align incentives to achieve the Triple Aim

Administrative Transformation
Simplify administrative services for providers and members

Clinical Transformation
Change the delivery system
Decrease overtreatment
Increase reliability
Improve patient-centeredness
Address social determinants
Where Do We Start?

• **Strategy #1: Leverage CMMI Health Commons Grant as springboard for broad delivery system change**
  – Creates new 50+ FTE new direct service HSO workforce to focus on reducing high utilization driven by unmet socio behavioral needs
  – Target group approx one third of all high acuity/cost members

• **Strategy #2: Align clinical efforts of partner organizations around CMMI Health Commons effort**
  – Convene Clinical Leaders to align Medicaid strategic planning efforts: large scale change means large systems change: CMO Work Group
  – Coordinate Care Management efforts of all partner organizations to create “virtual care management system;” Care Management Taskforce
  – Drive practice change efforts from needs of managing high acuity members: embedded care management and behavioral health, integration with mental health and addictions

• **Strategy #3: Build community partnerships with services that effect HSO outcomes and cost**
  – EMS, supportive housing, social services, family support programs, schools etc
  – Help align local community assets to support those at risk
CMMI Innovation Grant

AIM: Implement and spread new “transformative” models of care that will contribute to a reduction in the medical cost trend

Mechanisms of action (across all five interventions):

• Engage with high acuity patients around social determinants of health (housing, literacy, food security, effects of trauma, behavioral and cognitive drivers)

• Improve care coordination between systems and sites of care

• Improve timely access to needed services

• Invest in non traditional workforce, allowing others to work at the top of their license

• Implement “best practice” information sharing
## Health Commons interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Team</th>
<th>Year One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>Interdisciplinary Community Care Teams (ICCT)</td>
<td>CareOregon, MCHD, CCHD, Virginia Garcia, Central City Concern, Providence, Legacy IM clinics, OHSU Richmond, OHSU ED, EMS, Cascadia, Neighborhood Health Clinics, The Oregon Clinic</td>
</tr>
<tr>
<td>Hospital-to-home</td>
<td>Care Transition Innovation (C-Train)</td>
<td>OHSU, Legacy (Good Sam, Emanuel and Mt. Hood)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Intensive Transition Team</td>
<td>Multnomah, Clackamas and Washington Counties</td>
</tr>
<tr>
<td>ED Guide</td>
<td>ED Guide Leadership Team</td>
<td>Providence Milwaukie, Providence Portland, Providence St. Vincent</td>
</tr>
<tr>
<td>Discharge</td>
<td>Standardized Hospital Discharge and Transition</td>
<td>Legacy Emanuel Hospital with Legacy and MCHD clinics (Years 2 &amp; 3: Providence and OHSU)</td>
</tr>
</tbody>
</table>
Health Commons Grant

Improving lives for high-acuity/high-cost patients across the care continuum

**Primary Care**
Community Outreach Model

- Workforce: Community Outreach Worker, Outreach RNs, and Outreach SW and Recovery Mentors

**Specialty Care**
Community Outreach Model

- Workforce: Community Outreach RN and Respiratory Therapist

**Emergency Services**

- ED Navigation to Primary Care
- EMS Outreach

**Hospital Care**
Intensive Care Transition Support

- Workforce: Transitional Care RNS and Clinical Pharmacists, Transitional Care LCSWs

**Behavioral Health**
Community Outreach “Peer” Model

- Workforce: Peer Wellness Specialists
How do we leverage the CMMI Health Common Grant to springboard larger system change?

- Will only “touch” about 30% of high needs members
- Will not meet full need to decrease cost
- Will not address Pay for Performance metrics
Figure 3 | Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities

Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations
Cynthia Boyd, Bruce Leff, Carlos Weiss, Jennifer Wolff, Allison Hamblin, and Lorie Martin CHCS DECEMBER 2010
Where Are The Medicaid $$$ Going?

% of Total Billed Charges by Service

(State of Oregon Medicaid Data)

2009 Total Billed Charges = $1,630,851,673

Hospitalizations and ER admits amount to 43% of Billed Charges

* Outpatient Behavioral includes mental health services and ER and non-ER chemical dependency services
Top 5,000 High Cost Members

<table>
<thead>
<tr>
<th>Physical Health Assignment</th>
<th>Clackamas</th>
<th>Multnomah</th>
<th>Washington</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH SHARE/CAREOREGON</td>
<td>667</td>
<td>2785</td>
<td>619</td>
<td>4073</td>
</tr>
<tr>
<td>HEALTH SHARE/KAISER</td>
<td>20</td>
<td>128</td>
<td></td>
<td>148</td>
</tr>
<tr>
<td>HEALTH SHARE/PROVIDENCE</td>
<td>82</td>
<td>415</td>
<td>145</td>
<td>642</td>
</tr>
<tr>
<td>HEALTH SHARE/TUALITY</td>
<td>1</td>
<td>136</td>
<td>137</td>
<td>137</td>
</tr>
<tr>
<td>Grand Total</td>
<td>769</td>
<td>3329</td>
<td>900</td>
<td>5000</td>
</tr>
</tbody>
</table>

Physical Health Assignment

Mental Health Assignment
High Utilizer Members

CMMI Health Commons definition:
1. No inpatient admissions AND 6+ED visits
2. 1 non OB inpatient admission AND 0-5 ED visits
3. 2+ non OB inpatient admissions OR 1 non OB inpatient admission and 6+ED visits within the last 12 months.

<table>
<thead>
<tr>
<th>High Utilizers</th>
<th>1 Non OB Admit and 0-5 ER Visits</th>
<th>2+ Non OB Admits or 1+ Non OB Admits and 6+ ER Visits</th>
<th>No Non OB Admits/6+ ER Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>Members</td>
<td>Members</td>
<td>Members</td>
</tr>
<tr>
<td>CareOregon</td>
<td>1,917</td>
<td>1,186</td>
<td>1,214</td>
</tr>
<tr>
<td>Kaiser</td>
<td>101</td>
<td>55</td>
<td>66</td>
</tr>
<tr>
<td>Providence</td>
<td>391</td>
<td>159</td>
<td>195</td>
</tr>
<tr>
<td>Tuality</td>
<td>32</td>
<td>14</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>2,441</td>
<td>1,414</td>
<td>1,543</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Utilizers</th>
<th>1 Non OB Admit and 0-5 ER Visits</th>
<th>2+ Non OB Admits or 1+ Non OB Admits and 6+ ER Visits</th>
<th>No Non OB Admits/6+ ER Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>Members</td>
<td>Members</td>
<td>Members</td>
</tr>
<tr>
<td>Clackamas</td>
<td>563</td>
<td>302</td>
<td>328</td>
</tr>
<tr>
<td>Multnomah</td>
<td>2,051</td>
<td>1,226</td>
<td>1,003</td>
</tr>
<tr>
<td>Washington</td>
<td>490</td>
<td>253</td>
<td>332</td>
</tr>
<tr>
<td>Total</td>
<td>3,104</td>
<td>1,781</td>
<td>1,663</td>
</tr>
</tbody>
</table>

Analysis predicated on 24 months historical encounter data (9/2010-8/2012) provided by OHA/DMAP. Analysis period limited to latter 12 months: 9/1/2011-8/31/2012.
2013 P4P Programs

- 1% encounter data reporting withhold (~$6.7M)
- 2% provider quality performance bonus (~$13.4M)
1% encounter data reporting withhold

• Predicated on a single contractual performance measure: Pended claims resolved within 63 days
  – If one or more pended claims remain unresolved after 63 days in any month, 1% of CCO’s global budget will be withheld

• OHA intends to provide monthly performance scorecards inclusive of this and other contractual measures applicable to encounter data reporting
  – Health Share EDI Workgroup on point to ensure compliance

• Administrative Performance Policy and financial scenarios illustrating the administration of failure-to-perform penalties and 1% withholds have been developed by Health Share

• Analysis of Health Share’s RAEs’ performance Q1-Q3 2012:

<table>
<thead>
<tr>
<th>Claim Service Quarter</th>
<th>RAE</th>
<th>Number of pended claims lag over 63 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1-2012</td>
<td>Providence</td>
<td>1</td>
</tr>
<tr>
<td>Q2-2012</td>
<td>CareOregon</td>
<td>304</td>
</tr>
<tr>
<td>Q3-2012</td>
<td>CareOregon</td>
<td>65</td>
</tr>
</tbody>
</table>
2% Provider Quality Bonus

1. CAHPs Composite (7Qs)
2. Rate of PCPCH enrollment
3. ED Utilization (HEDIS)
4. Initiation and Engagement of Alcohol and Drug Treatment
5. Follow-up after hospitalization for mental illness
6. Mental health and physical health assessment for children in DHS custody
7. Screening for clinical depression and follow-up plan
8. Reducing elective delivery before 39 weeks
9. Prenatal care initiated in the first trimester
10. Developmental screening by 36 months (hybrid)
11. Colorectal Cancer Screening (hybrid)
12. Substance misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)
13. Optimal Diabetes Care (D3)
14. Controlling Hypertension
15. Adolescent Well-Care visits
<table>
<thead>
<tr>
<th>Incentive Measure</th>
<th>CCO Baseline Data</th>
<th>State Average</th>
<th>Improvement Target</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator</td>
<td>Denominator</td>
<td>Baseline</td>
<td>Initiation: 55.8%</td>
</tr>
<tr>
<td>Follow up care for children prescribed ADHD medications</td>
<td>Initiation: 405</td>
<td>C&amp;M: 184</td>
<td>Initiation: 726</td>
<td>C&amp;M: 269</td>
</tr>
<tr>
<td></td>
<td><strong>At Benchmark!!!</strong></td>
<td>58.6%</td>
<td>52.3%</td>
<td>Initiation: n/a</td>
</tr>
<tr>
<td>Prenatal and postpartum care: timeliness of prenatal care</td>
<td>2,758</td>
<td>4,084</td>
<td>67.5%</td>
<td>65.3%</td>
</tr>
<tr>
<td></td>
<td>+123</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory care: outpatient and emergency department utilization</td>
<td>ED Utilization: 112,198</td>
<td>-2782</td>
<td>ED Utilization: 1,879,992.4</td>
<td>-2782</td>
</tr>
<tr>
<td></td>
<td>Outpatient: 755,313</td>
<td>+7023</td>
<td>Outpatient: 1,879,992.4</td>
<td>+7023</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>1,825</td>
<td>6,003</td>
<td>30.4%</td>
<td>23.7%</td>
</tr>
<tr>
<td></td>
<td>+180</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental screening in the first 36 months of life</td>
<td>2,953</td>
<td>15,322</td>
<td>19.3%</td>
<td>20.9%</td>
</tr>
<tr>
<td></td>
<td>+460</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent well care visits</td>
<td>8,663</td>
<td>31,426</td>
<td>27.6%</td>
<td>21.0%</td>
</tr>
<tr>
<td></td>
<td>+943</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-Centered Primary Care Home (PCPCH) enrollment</td>
<td>Tier 1: 0</td>
<td><strong>+69,976</strong></td>
<td>Tier 2: 21,770</td>
<td>Tier 3: 63,756</td>
</tr>
<tr>
<td></td>
<td>50.3%</td>
<td>51.7%</td>
<td>n/a</td>
<td>100%</td>
</tr>
</tbody>
</table>
In Development, baselines due May:

- Screening for clinical depression and follow up plan
- Mental and physical health assessment within 60 days for children in DHS custody
- Elective delivery before 39 weeks
- Controlling high blood pressure
- Diabetes: HbA1c poor control
- Electronic Health Record (EHR) adoption

### Incentive Measure: Alcohol and drug misuse: screening, brief intervention, and referral for treatment (SBIRT)

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>State Average</th>
<th>Improvement Target</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>142,756</td>
<td>0.3/1,000</td>
<td>0.6/1,000</td>
<td>44.3/1,000</td>
<td>440/1,000</td>
</tr>
</tbody>
</table>

### Incentive Measure: Follow up after hospitalization for mental illness

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>State Average</th>
<th>Improvement Target</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>625</td>
<td>1,096</td>
<td>57.0%</td>
<td>57.6%</td>
<td>60.0%</td>
<td>68.0%</td>
</tr>
</tbody>
</table>

### Incentive Measure: Access to Care: Getting Care Quickly (CAHPS)

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>State Average</th>
<th>Improvement Target</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children: 74%</td>
<td>Adult: 77%</td>
<td>76%</td>
<td>74%</td>
<td>78%</td>
<td>87%</td>
</tr>
</tbody>
</table>

### Incentive Measure: Satisfaction with Care: Health Plan Information and Customer Service (CAHPS)

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Baseline</th>
<th>State Average</th>
<th>Improvement Target</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children: 83%</td>
<td>Adult: 77%</td>
<td>80%</td>
<td>78%</td>
<td>82%</td>
<td>84%</td>
</tr>
</tbody>
</table>
The challenges ahead

• Balancing stakeholder involvement with aggressive timelines/expectations

• Uncertainty around every corner

• Trying to change the tires while on a speeding car swerving down the highway

• Governance and politics

• Change is great as long as someone else goes first
Most importantly, how does all of this impact OHP members?

• Providers are able to and incentivized to provide the right care at the right place at the right time:
  • Primary Care Medical Home
  • Prevention
  • CMMI grant initiatives
  • Case management
  • Integration of physical, mental, and dental health
  • Sharing of best practices
Discussion questions

• Discuss and suggest 2-3 tactical strategies that Health Share should implement in order to meet the P4P metrics and address high utilizers?

• How would you incentivize private practice and alternative practitioners to collaborate with Health Share?

• How would you utilize technology to support delivery system transformation? What are the obstacles? How would you overcome them?

• How would you define success for Health Share? What does the organization look like in 2 years? In 5 years?