
Oregon's Safety Net

Incorporating Value-based payment into system reform

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Oregon chose a new way

- Better Health, Better Care and Lower Costs
 - Transform the delivery system
 - Robust public process
 - Bipartisan support
 - Federal waiver approved - \$1.9B investment tied to quality and reduction in costs
- Coordinated care model
 - Starting with coordinated care organizations in Medicaid
 - Aiming to spread to other state-purchased coverage, Oregon's Health Insurance Exchange, private payers

Health System Transformation

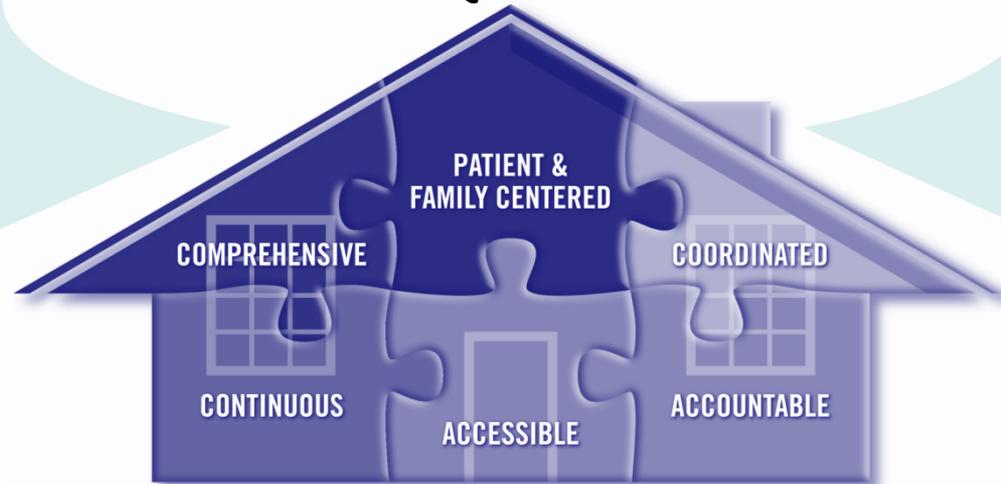
COORDINATED CARE ORGANIZATION

Local accountability
for health and
resource allocation

Standards for safe
and effective care

Integration
and
coordination
of benefits
and services

Global budget
indexed to
sustainable
growth



PATIENT-CENTERED PRIMARY CARE HOME

Coordinated care organizations (CCOs)

- 16 CCOs serve 90% of Oregon Medicaid members (> 1.2 million lives)
 - Since ACA expansion, Medicaid now serves about 1 in 4 Oregonians
- Governed by a partnership of health providers, community partners, consumers and those taking financial risk
- Consumer advisory councils
- Physical, mental and dental health care combined into one budget/capitation rate
- Responsible for health outcomes
 - Paid for performance on 18 quality measures
 - State reports to CMS on additional measures

FQHCs and value-based payment

- State Plan Amendment (SPA12-08) submitted to CMS for FQHC and RHC Alternative Payment Methodology
- CMS approval of SPA on August 13, 2012
- FQHC and RHCs can choose to participate in APM under section 1902(bb)(6) of the Act – State must pay at least what the clinic would receive under PPS
- APM purpose is to allow clinics to innovate the model of care/engage patients in ways not billable under PPS

CCO Incentive measures

- PCPCH enrollment percentage
- Adolescent well-care visits
- Developmental screenings in the first 36 months of life
- Depression screenings and follow up plan
- Childhood immunization status
- Mental, physical, and dental health assessments within 60 days for children in custody of state child welfare

FQHC and RHC innovations

- Team-based model of care, including licensed and non-licensed medical staff, Clinical Pharmacists, CHWs, Nutritionists, Behavioral Health practitioners, and Case Managers
- Addressing social determinants of health
 - One clinic provides free legal help to those with criminal backgrounds to help obtain housing
 - Another clinic has test kitchen for cooking classes for diabetics taught by Nutritionist
 - Clinics meet quarterly to share in collaborative learning

Transformation and Value-based payment

- Health Centers in Oregon are positioning themselves to benefit from CCO requirements by helping the state develop an APM that is aligned with Transformation goals to move away from increased billing of office visits and to integrate and coordinate services to manage patient needs
 - Without suffering reduced practice revenue
 - With increased patient and provider satisfaction
 - While increasing access and quality of outcomes
 - While assisting CCOs in achieving incentive targets securing shared savings contracts

What Health Centers are saying...

- *“Since beginning (APM), Virginia Garcia has seen high-impact changes that have allowed our organization to better pursue our core mission in Washington and Yamhill Counties. By utilizing APM, we now have the time to do the work of being a Patient Centered Primary Care Home and optimize the core practices of our patient teams.”*
 - Virginia Garcia Memorial Health Center
- *“REaCH Team (Richmond Engagement and Community Health) is a multi-disciplinary team focused on high-utilizer patients. Activities include linking patients to Outreach Workers who help connect to community resources, navigate healthcare system, support self-management, etc. A Care Coordinator tracks Richmond patients when admitted and using Emergency Room to ensure coordinated follow-up care or touch is made.”*
 - OHSU Richmond Family Medicine

What Health Centers are saying...

- *“APM model of care helps support a “hotspotting team” we’ve assembled, referred to as the Community Care Coordination Team (comprised of a Family Nurse Practitioner, Mental Health Specialist, and Community Health Worker), to target complex patients with high emergency department and in-patient utilization. This work has resulted in a **76% reduction in ED visits and an 82% reduction in hospital admissions.** These drops in utilization have resulted in **74% reductions in hospital charges for over 190 patients.**”*
 - Virginia Garcia Memorial Health Center (self reported data)
- *“Social Workers began **Dialectical Behavioral Therapy group visits** focusing on REaCH patients and others with depression, anxiety, anger issues and usually history of some sort of trauma which interferes with treatment of chronic or other conditions. The groups meet for 6 week courses and are well attended.”*
 - OHSU Richmond

Performance Measurement

- ER utilization 12% below previous trend in 2013, and 34% below trend in 2014
- Inpatient hospital utilization 9% lower than trend in 2013, and 42% lower in 2014
- Patients accessed services at their medical home 58% above trend in 2013, and 27% in 2014 (ACA expansion was 375,000 new lives in Oregon)
- Prescription drug utilization was 47% higher than trend in 2013, and 32% higher in 2014
- Patients accessing outpatient clinic care outside the medical home dropped 17% below the trend in 2013, and 43% below in 2014

Rural Health Reform Initiative

- HB 3650, 2011 session directed OHA to reform the cost-based methodology previously used for reimbursement by managed care
- Hospitals determined to be at financial risk exempted, based on actuarial determination of risk facing hospitals transitioning to Prospective Payment System such as MS-DRG
- Work group convened by OHA with Hospital Association, CCOs, and Actuarial consultants
- Participation of delivery system and agency officials was collaborative

Results of Rural Health Reform Initiative

- 15 of Oregon's 32 rural hospitals transitioned off cost-based reimbursement (CBR) in 2015
- CCOs amended contracts with hospitals coming off CBR and began managing discharges and transitions of care together
- Capitation rates to CCOs were developed with assumptions on the changing costs CCOs would experience

What have we learned?

- Transformation is hard and it takes time and funding
- System transformation includes cultural transformation at the agency, and contractors/delivery system
- Flexibility spawns a variety of models and innovation
- Timing is important – what else is on your plate right now?
- Communicate, communicate, communicate
- Make adjustments – what we did yesterday may not be our process tomorrow
- There appears to be correlation between non-billable interventions and declining utilization in other service categories

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