

**February 2, 2011**

**Options for Year 1 of 2011-2013 budget**

**Small group break out summary**

**Ideas and options for year 1**

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- ***Address Medicaid population in all regions of the state by bringing together community partners, local plans and provider networks*** to explore rapid approaches to decrease ED utilization and unnecessary hospital admissions. Could be first step toward the type of collaboration necessary for Yr 2 and onward to sustainable costs within accountable communities. Initial focus should be on the high utilizers in the region.  
***Next Steps:*** OHA will call together stakeholders to discuss potential approaches to align efforts that can be rapidly deployed for Year 1. Host “regional opportunity conferences.”
- ***Relief from regulatory requirements that contribute to administrative costs for plans and providers.*** Many recommended looking especially at behavioral health contract requirements as a source of significant load for plans and providers.  
***Next steps:*** OHA staff will seek input from stakeholders to delineate statutory and regulatory that have the most potential to yield immediate savings while not reducing accountability, identify how savings are attained (reduced FTE, administrative costs, etc). A template for collecting this information is attached.

**Options included in Governor’s Balanced Budget**

- ***Eliminate payments for marginally effective treatments based on evidence:*** The last 30-40 items on the Prioritized List of Health Services are prioritized to the bottom of the list because they have been determined by evidence to be marginally effective. (*Estimated savings: \$29.1m GF, \$80.5m TF*).

***Next steps:*** OHA staff is examining other funded lines, as directed by the Oregon Health Policy Board’s Action Plan, in consultation with the Center for Evidence-Based Policy. Ten common clinical guidelines are being developed with stakeholders and will be applied to Year 2 savings. The intent of this option is to eliminate or severely limit marginally effective tests and treatments for conditions that will remain above the line, by the use of evidence based decisions. For example:

- back surgery for radiculopathy is covered and will likely remain above the line, but there are several treatments, some of which are marginally effective and some of which are quite effective.
- imaging for back pain is currently covered as a "line 0" expense and will continue to be covered, but has been shown (by OHSU) to be marginally or not effective
- treating high cholesterol will be above the line, but statin therapy for those without other risk factors is expensive and only marginally effective.
- Treatment of cancer is above the line, but some of the second and third tier therapies are very expensive and either not effective or only marginally effective.

- Some of the preventive care we do is not evidence based (e.g., PSA's)- we should only be doing that which is evidence based.
- **Eliminate payments for never-events and healthcare acquired conditions:** Following Medicare definitions. *(Estimated savings in FFS for health care acquired conditions: \$0.04m GF, \$0.21m TF).*

**Next steps:** OHA staff to estimate savings from eliminating payment for never events in nursing facilities and from reducing payment for hospital readmissions. Current pricing includes FFS only so staff will develop pricing for Medicaid managed care as well. Continue analysis of potentially avoidable complications (PAC) to develop payment approaches.

### **Options that rapidly implemented and may yield savings in Year 1:**

- **Further restrict allowable DME so that they equal the rate reductions being proposed –** This could be a means for plans and other providers to reduce their costs.  
**Next steps:** Staff review needed rules, statute or CMS changes and calculate potential savings. *(Estimated savings: equivalent to rate reductions being proposed?).*
- **Restructure of dental benefit more to align with commercial benefit design to include limits on expenditures.** This could be a means for dental plans to operate within their rate reductions. *(Estimated savings: equivalent to rate reductions being proposed?).*  
**Next steps:** Dental plans and provider experts to determine benefit redesign and bring back to the team.
- **Tighten restrictions on prescribing brand name drugs where good generic options are available.**
  - Increasing restrictions on brand name drugs is a benefit restriction that would allow plans to operate within their rate reductions. *(Estimated savings: TBD)*
  - Making the Medicaid preferred drug list (PDL) enforceable is included in the Governor's balanced budget. *(Estimated savings: \$6.4m GF, \$17.8 TF)*
  - HB 2009 directed the development of a statewide PDL; savings potential from adoption of that PDL is currently being estimated. *(Estimated savings: TBD)***Note:** Generic use within Medicaid is currently at 85%, so opportunity may be limited.
- **Change payment to incent primary care homes and enhanced care coordination.**
  - *Implement patient-centered primary care homes to enhance care coordination.* This would shift care from more expensive areas to less expensive areas, better integration of behavioral health with physical health, focus efforts for optimal prevention and chronic disease management and aligned with the Policy Board's *Action Plan for Health*. Community mental health clinics were highlighted as an important location to include as a primary care home for some populations.  
**Next steps:** Significant work is underway within OHA but stakeholders will need to be involved in implementation planning to ensure efficient and timely implementation. Concerns over rate reductions undermining primary care access

could be mitigated by holding primary care at current rates for providers implementing primary care home models. (*Estimated savings: TBD*).

- *Initiate broad use of DRG methodology for inpatient care, APCs for outpatient.* This is part of the Policy Board’s Action Plan, as recommended by its Health Incentives and Outcomes Committee. This shift would lead to standardization of payment and provide a uniform base upon which to build further payment reform focused on performance and payments such as bundled payments that can discourage fragmented care.

**Next Steps:** Work with stakeholders to implement and develop contracting language. (*Estimated savings for changing payment to DRG hospitals to Medicare methodology in both managed care and FFS: \$5.72m GF, \$20.72m TF*). *Estimated savings form changing to APCs for inpatient care: TBD.*

- **A new model of care for “open card”/FFS portion of OHP** – The most significant group of Medicaid beneficiaries not currently enrolled in managed care are the “dual eligibles.” There is real potential for improving population health (including access to appropriate services), enhancing patient experience, and reducing the cost of services for this population. Examine the top 20% of utilizers and move into primary care homes within 6 months. (*Estimated savings: TBD*)  
**Next Steps:** Apply for a waiver of Medicaid rules to move this population into a managed care setting.

#### **Options presented in small groups, but not identified as “Top Two”**

- **Continue to explore efforts to pay for enhanced care coordination and effective care:** Go beyond the primary care home to work with hospital, specialty, dental, behavioral and long-term care providers to focus on reducing ED visits and hospital readmissions. This could include:
  - *Increase co-location or virtual relationships of providers to partner with others*
  - *Focus efforts on the 20% of the population that is driving 80% of the costs*
  - *Increase efforts to pay for effective treatments, target services growing rapidly without a solid evidence base and tie to an “essential benefit package”*
  - *Work to lower barriers that prevent care providers from working together such as anti-trust, concerns with risk, and challenges in the negotiation processes.*
  - *Focus on restructuring care in LTC to provide resources on site to avoid need for expensive transfer to ED or hospital setting, especially evenings and weekends.*
- **Augment and build primary care workforce capacity:** Explore ways to use dentists and other non-physical health focused providers to partner with physical health providers to identify and assist monitoring of chronic diseases such as diabetes while also enhancing Oregon’s primary care workforce. Peer counseling as used in some mental health and

substance abuse settings, patient navigators and community health workers were highlighted as examples of effective community partners with clinically-focused health providers and facilities.

- ***Develop metrics needed to reach budget goals and hold plans and providers accountable.*** Each community may have different drivers, so metrics will need to allow for future accountable care organizations to target their combined resources to address their local cost drivers.
- Need to include PEBB and OEBC in these efforts to drive costs down and improve care coordination in state employee and school district populations.