Medicaid Advisory Committee

July 23, 2014

General Services Building
Salem, Oregon

Oregon Health Authority

Time	Item	Presenter
9:00	Opening Remarks	Co-Chairs
9:05	Approval of Minutes – June 2014	Committee
9:10	Oregon Health Authority – Update on the Oregon Health Plan (OHP) and Coordinated Care Organizations (CCOs)	Rhonda Busek, OHA
9:20	Integrative Medicine Advisory Group (IMAG) – Overview of advisory group	Dr. Shaffer & Jeannette Nguyen-Johnson, OHA
10:00	Oregon's Health System Transformation – Overview of the 2013 Performance Report	Sarah Bartelmann, OHA
10:45	**BREAK**	
11:00	Committee Churn Mitigation Report – Review revisions and draft letter to Oregon Health Policy Board	Co-chairs; staff
11:45	Public Comment or Testimony	Co-Chairs
11:55	Closing comments	Co-Chairs
12:00	Adjourn	Co-Chairs

OHA Update on Coordinated Care Organizations (CCOs) and Oregon Health Plan (OHP)

Rhonda Busek
Interim Director, Medical Assistance Programs

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Integrative Medicine Advisory Group to the OHA

Dr. Wally Shaffer, Medical Director
Division of Medical Assistance Programs

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Background

Purpose: Advise the Director of OHA on ways to promote the use of integrative medicine disciplines into Oregon's health care delivery system.

- Convened in fall of 2013; meets monthly/bimonthly
- The IMAG discusses key topics such as access, consumer choice and quality of care, in support of the Triple Aim.

What is Integrative Medicine?

Integrative Medicine is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing.

- *Developed and adopted by The Consortium of Academic Health Centers for Integrative Medicine, May 2004; edited May 2005, May 2009 and November 2009*

IMAG Membership

- Five integrative medicine professions in Oregon that have a federally-recognized accrediting agency and a state health care regulatory board
  - Acupuncture and Oriental medicine
  - Chiropractic
  - Direct-entry midwifery
  - Massage therapy
  - Naturopathic medicine
- CCO medical directors and a commercial health plan medical director
- OHA staff
  - Dr. Jeanene Smith, OHA's Chief Medical Officer
  - Dr. Wally Shaffer, Medical Director of OHA's Division of Medical Assistance Programs

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Integrative Medicine Accrediting and Licensing Organizations

National Accrediting Entities*

- **Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM)**
  http://www.acaom.org/
- **Council on Naturopathic Medical (CNME)**
  http://www.cnme.org/
- **Council on Chiropractic Education (CCE)**
  http://www.cce-usa.org/
- **Commission on Massage Therapy Accreditation (COMTA)**
  http://www.comta.org/
- **Midwifery Education Accreditation Council (MEAC)**
  http://meacschools.org/

*Recognized by the U.S. Department of Education

State Health Care Regulatory Boards

- **Oregon Board of Chiropractic Examiners**
  www.oregon.gov/OBCE
- **Board of Direct Entry Midwifery**
  www.oregon.gov/OHLA/DEM
- **Oregon Board of Massage Therapists**
  www.oregon.gov/OBMT
- **Oregon Board of Naturopathic Medicine**
  www.oregon.gov/obnm
- **Oregon Medical Board (Acupuncture)**
  http://www.oregon.gov/omb/licensing/Pages/Acupuncturist.aspx

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Current IMAG Topics

1. Credentialing of Integrative Medicine providers
   - *IM Credentialing Information Tool (almost complete)*
2. Integrative Medicine and Oregon's achievement of the triple aim
   - *Resource guide identifies IM best practices (still in development)*
3. Exploring opportunities for participation/recognition in the Patient Centered Primary Care Home Program
   - *Communication plan (still in development)*

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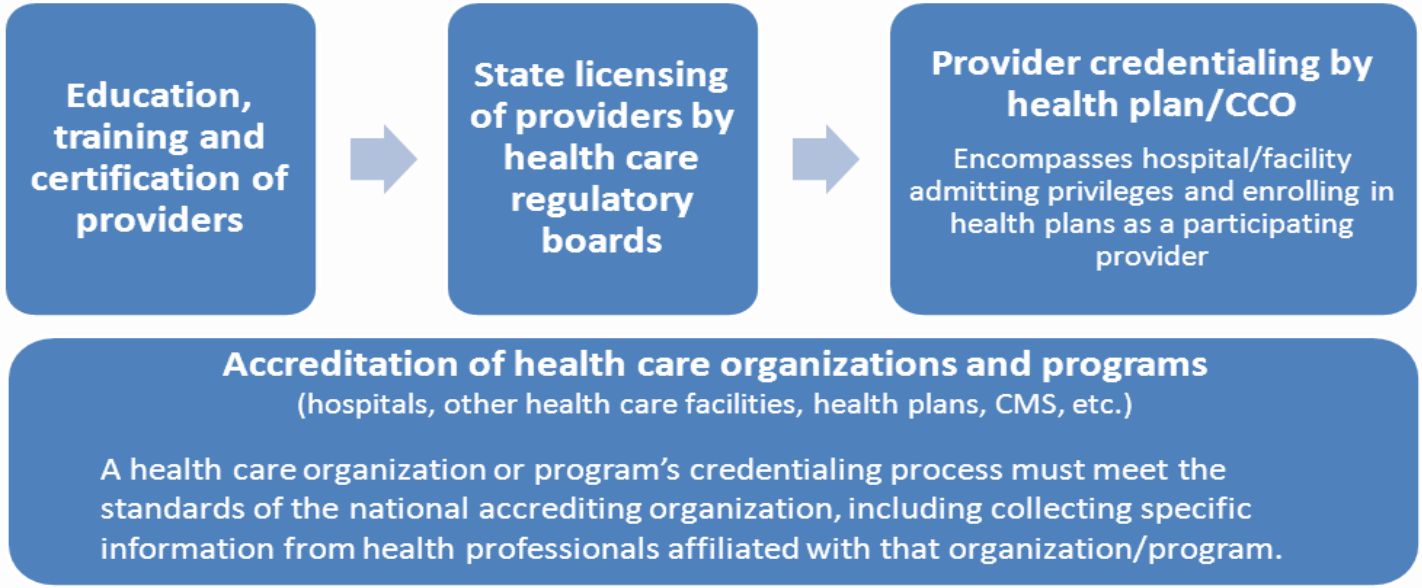
IM Credentialing Information Tool

- Identifies common credentialing elements required/collected by key health care accrediting entities and the state health care regulatory boards.
- To facilitate information sharing and education by integrative medicine professionals to their health system partners on key credentialing issues.

Pathway to Provider Credentialing



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Questions?

Health System Transformation 2013 Performance Report

Medicaid Advisory Committee
July 23, 2014

Sarah Bartelmann
Office of Health Analytics

Oregon Health Authority

Oregon Health Authority accountability

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 2013 performance to 2011 baseline.

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Quality Pool: distribution

To earn their full quality pool payment, CCOs had to:

- ✓ 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 went to the challenge pool.
To earn challenge pool payments, CCOs had to:

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

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Meeting goals and what they mean

The Metrics and Scoring Committee established a benchmark and/or improvement target for each incentive measure. Metrics and Scoring Committee reviews measures and targets each year for adjustment.

Benchmarks: These are national level benchmarks, set for exceptionally high achieving Medicaid programs. We would expect these to be reached in the long-term, rather than short term (5 to 10 years.) They may shift slightly year to year or be increased as needed.

Improvement targets: Each CCO has improvement targets for each incentive measure. Each target is based on the CCOs baseline. The baseline year moves forward requiring continued improvement.

2013 Performance Report: what's new?

- ✓ Final 2013 performance data on the CCO incentive metrics.
- ✓ Final 2013 performance data on the state performance metrics.
- ✓ 2013 Quality Pool (and challenge pool) distribution to CCOs.
- ✓ 2011 and 2013 data broken out by race and ethnicity.
- ✓ New grouper for cost and utilization data.

www.oregon.gov/oha/metrics/

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How did CCOs do?

Incentive metrics

- 11 out of 15 CCOs earned 100% of the quality pool
  - One CCO earned 70% and three earned 80%

- Incentive metrics: we saw statewide improvement on all 14 of the incentive measures included in the report

Statewide metrics – for reporting to CMS

- Of the 17 other metrics, we saw statewide improvement on 9 measures.
- There were just two measures where we didn't see any improvement statewide or at the CCO level.

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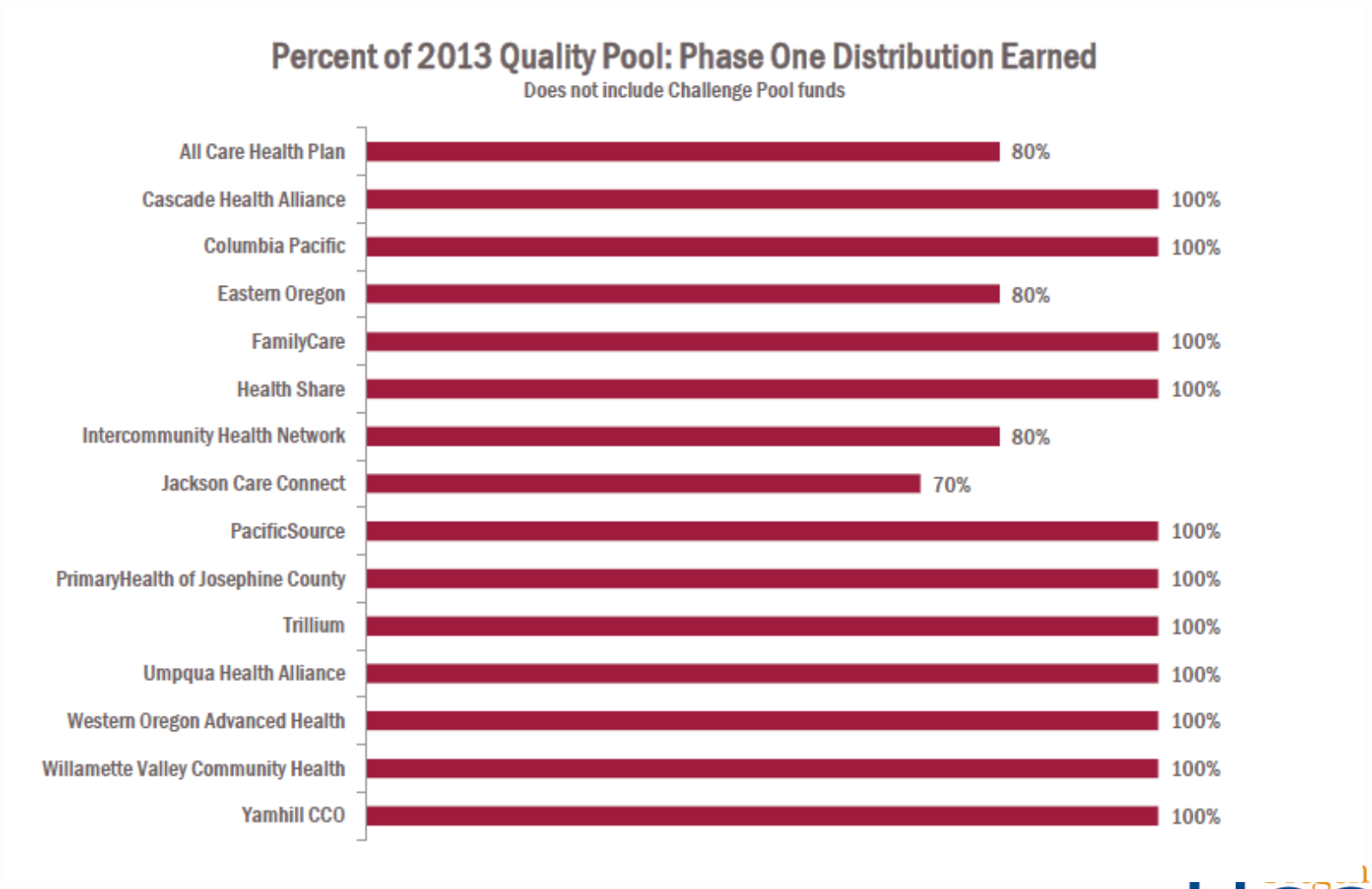
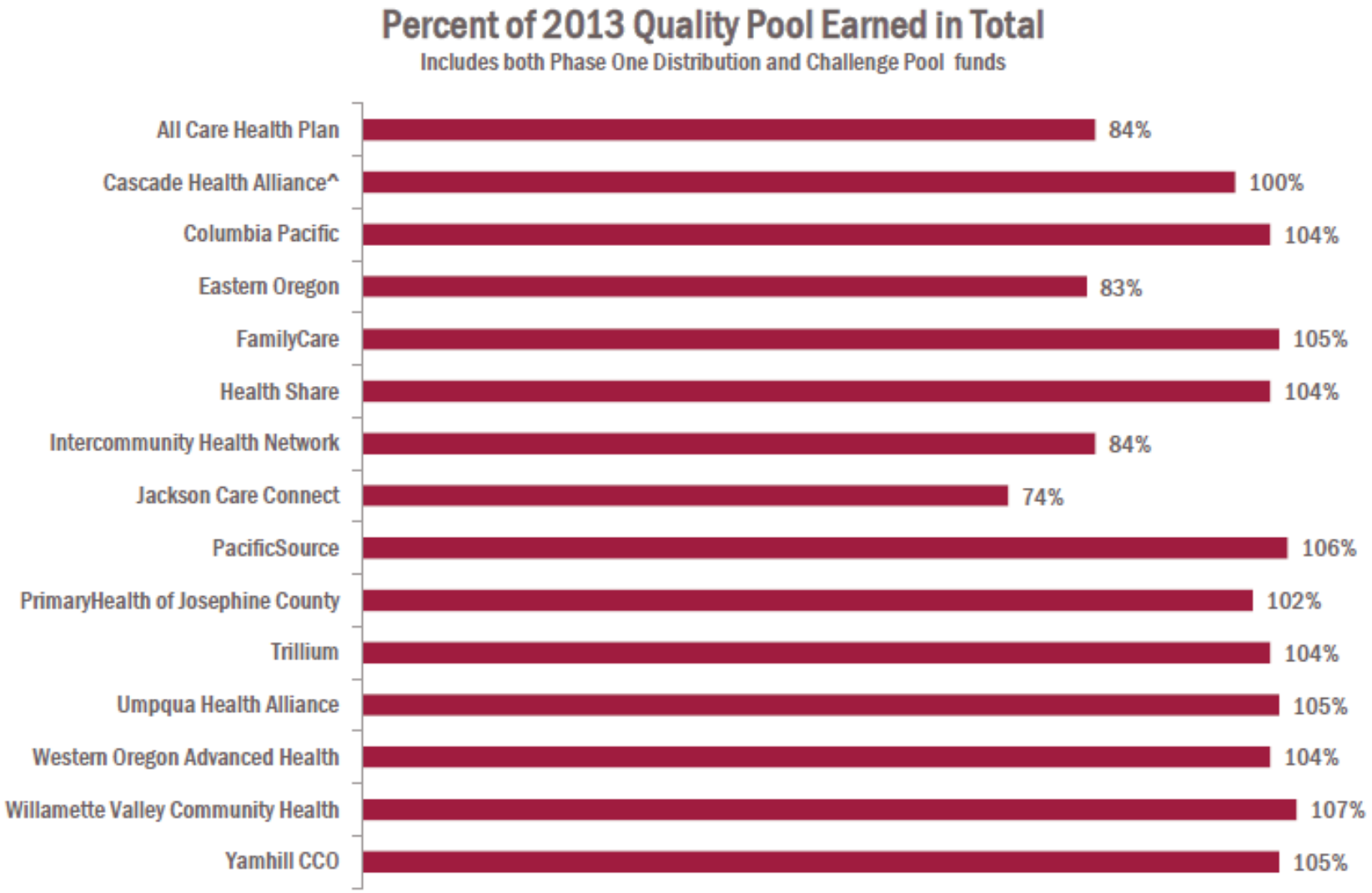
How did CCOs do?





^ Reflects prorated quality pool for partial year as CCO.

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Coordinated Care Organization	Number of measures met*	Percent of total quality pool funds earned†	Total dollar amount earned	CCO Enrollment•	Which challenge pool measures were met
All Care Health Plan	11.6	84%	$2,239,160	27,878	Diabetes, Depression
Cascade Health Alliance^	13.7	100%	$748,517	10,153	Diabetes, Depression, PCPCH
Columbia Pacific	13.8	104%	$1,461,310	14,413	Diabetes, Depression, PCPCH
Eastern Oregon	11.6	83%	$1,961,432	29,234	Diabetes, PCPCH
FamilyCare	13.7	105%	$4,354,150	50,064	Diabetes, Depression, PCPCH
Health Share	12.8	104%	$13,720,133	148,201	Diabetes, Depression, PCPCH
Intercommunity Health Network	11.9	84%	$2,669,122	32,728	Diabetes, Depression, PCPCH
Jackson Care Connect	11.4	74%	$1,286,078	18,539	Diabetes, Depression
PacificSource	12.9	106%	$3,452,010	36,667	Diabetes, Depression, PCPCH, SBIRT
PrimaryHealth of Josephine County	13.0	102%	$1,024,938	5,957	Diabetes, Depression, PCPCH
Trillium	12.9	104%	$4,949,647	49,677	Diabetes, Depression, PCPCH
Umpqua Health Alliance	13.7	105%	$1,716,647	16,102	Diabetes, Depression, PCPCH, SBIRT
Western Oregon Advanced Health	14.7	104%	$1,282,648	11,664	Diabetes, Depression, PCPCH
Willamette Valley Community Health	14.9	107%	$4,987,244	64,044	Diabetes, Depression, PCPCH, SBIRT
Yamhill CCO	14.8	105%	$1,137,005	13,368	Diabetes, Depression, PCPCH

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Overall, 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.

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Mixed results / progress on…

- **Adolescent well – care visits**
  (7 CCOs met improvement targets; 6 declined from 2011 baseline)
- **Colorectal cancer screening**
  (6 CCOs met improvement targets; 8 declined from 2011 baseline)
- **Follow up after hospitalization for mental illness**
  (10 CCOs met benchmark or improvement target; 6 declined from 2011 baseline)
- **Follow up care for children prescribed ADHD meds**
  (13 CCOs met benchmark or improvement target; 5 declined from 2011 baseline)
- **Assessments for children in DHS custody**
  (12 CCOs met benchmark or improvement target; 2 declined from 2011 baseline)
- **Prenatal and postpartum care**
  (12 CCOs met benchmark or improvement target; 4 declined from 2011 baseline)
- **Satisfaction with care**
  (12 CCOs met benchmark or improvement target; 2 declined)

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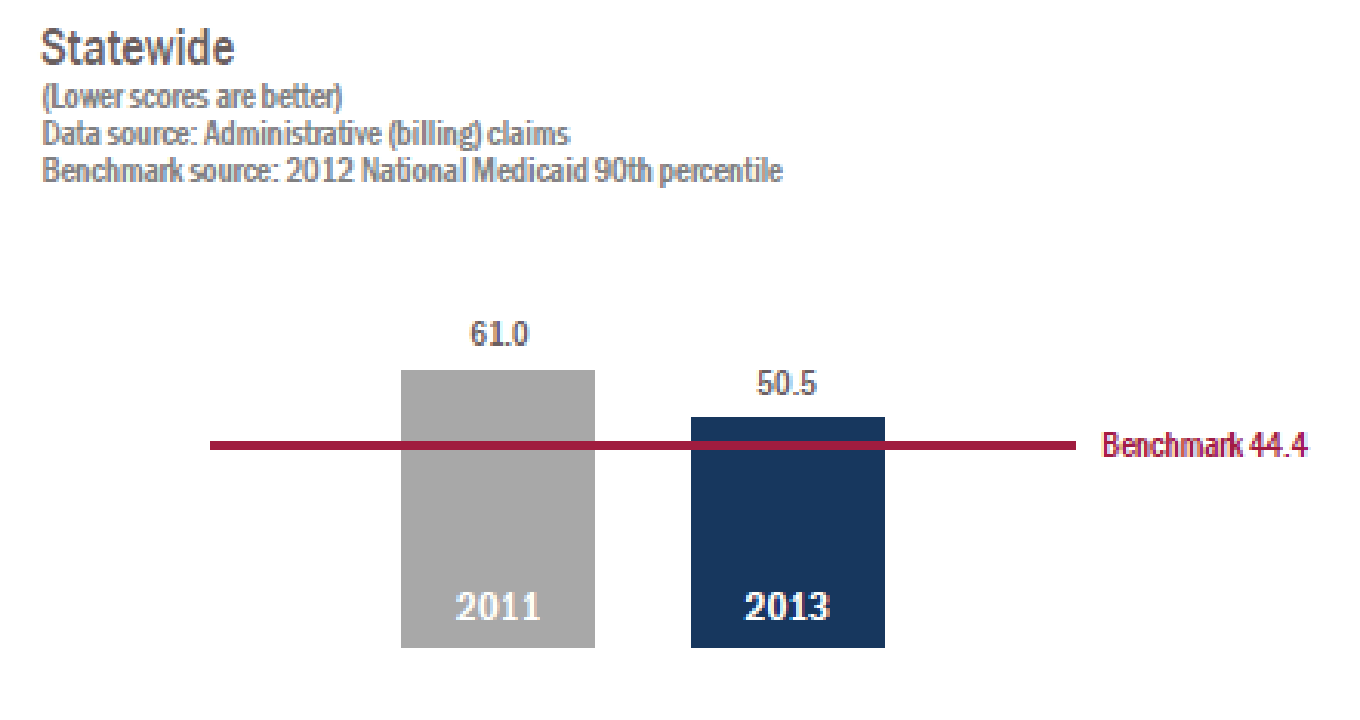
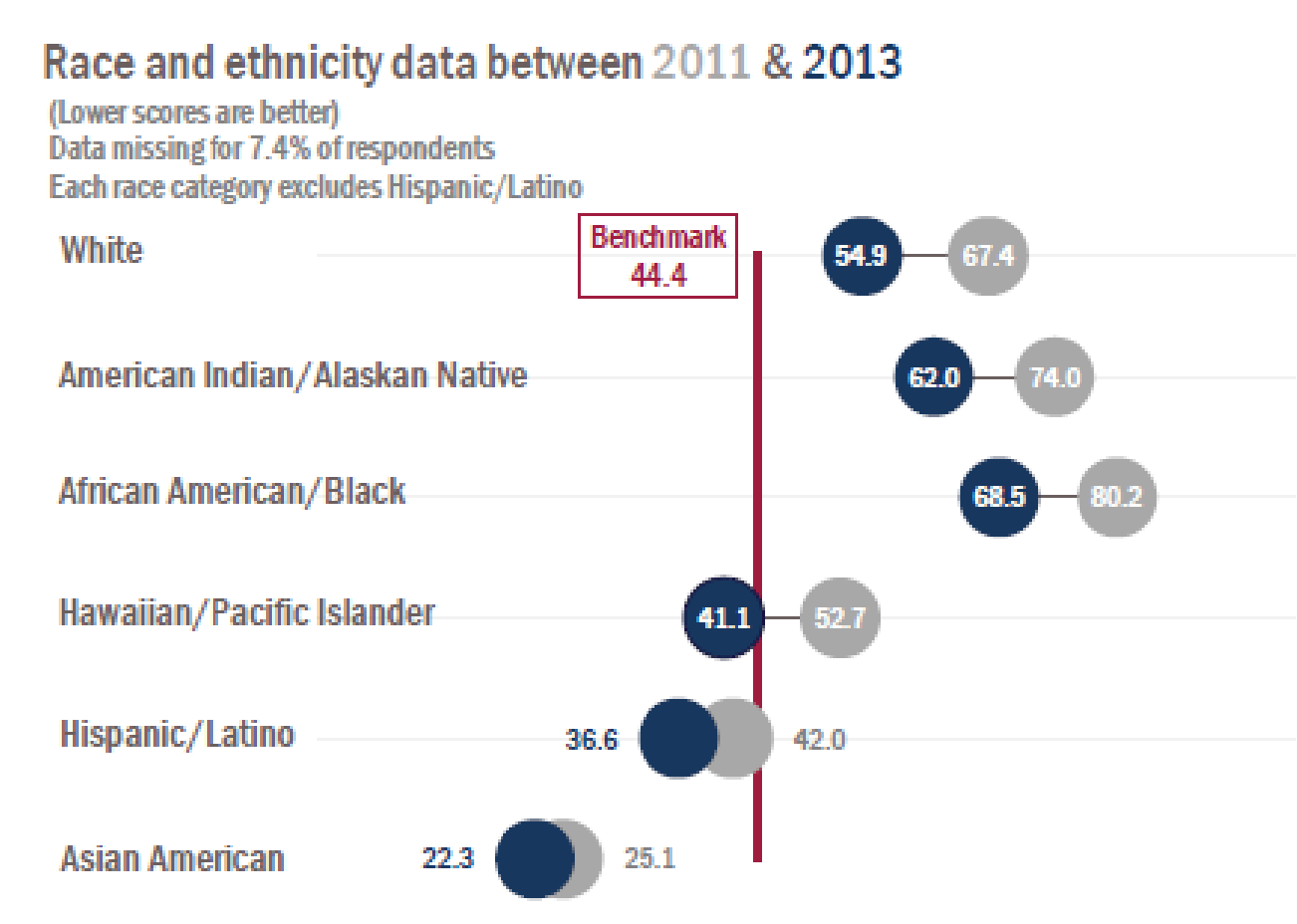
Decreased ED utilization

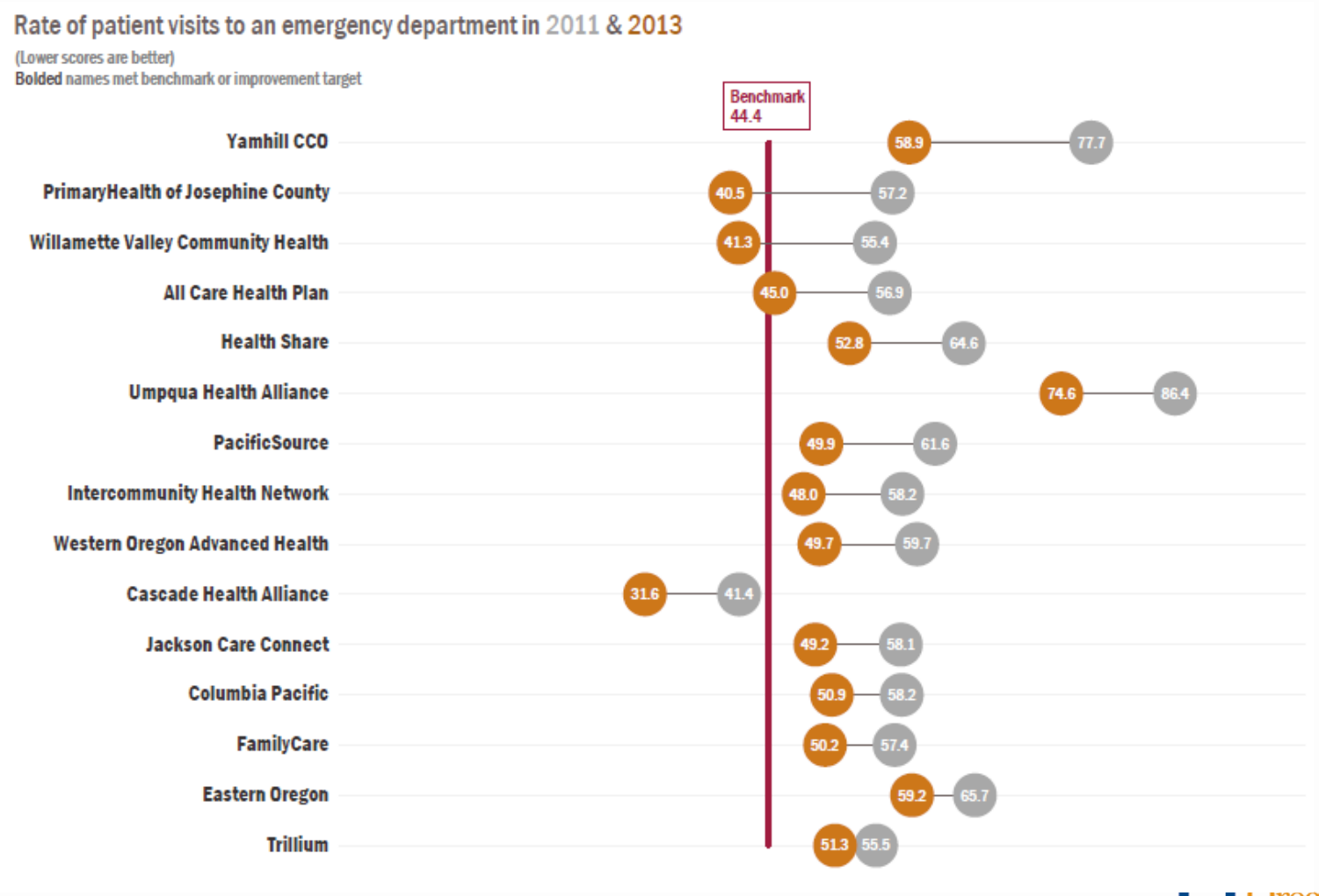
- ED visits decreased 17 percent since 2011.
- The cost of providing services in EDs decreased by 19 percent.



ED utilization by race & ethnicity



ED utilization by CCO



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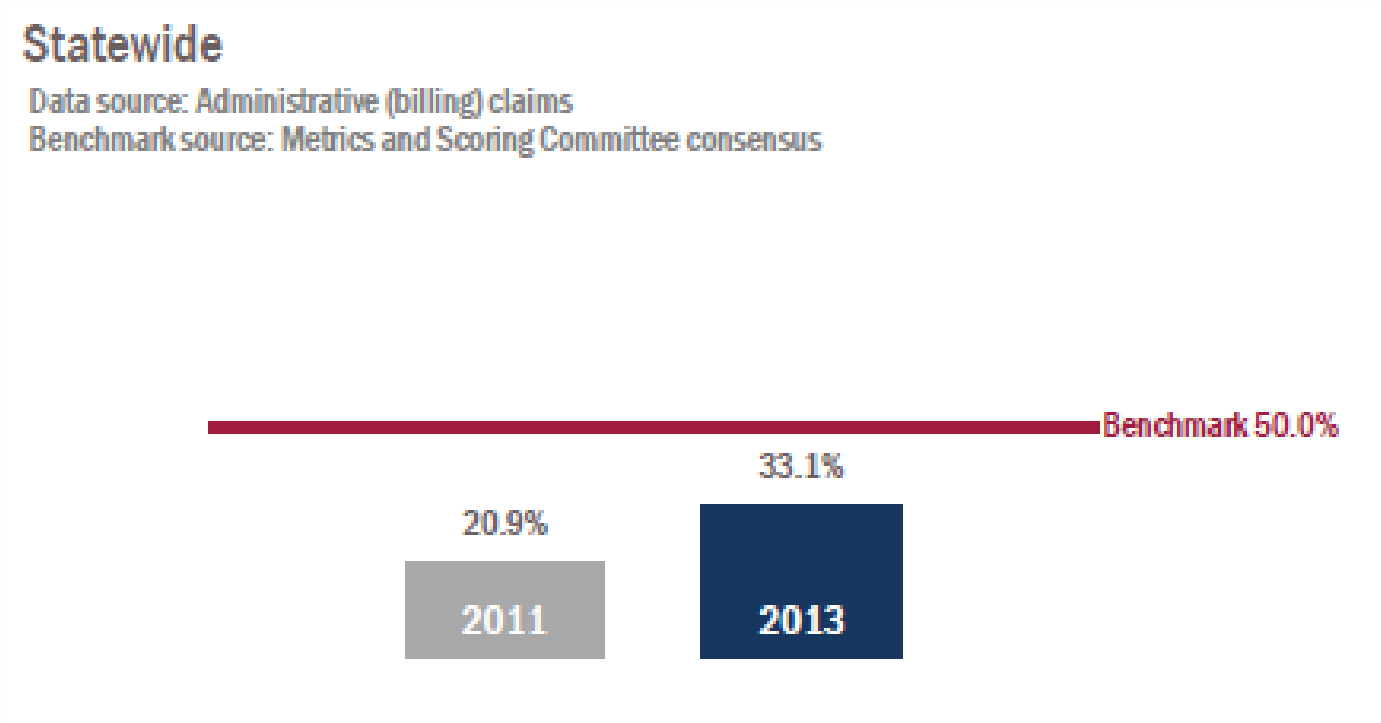
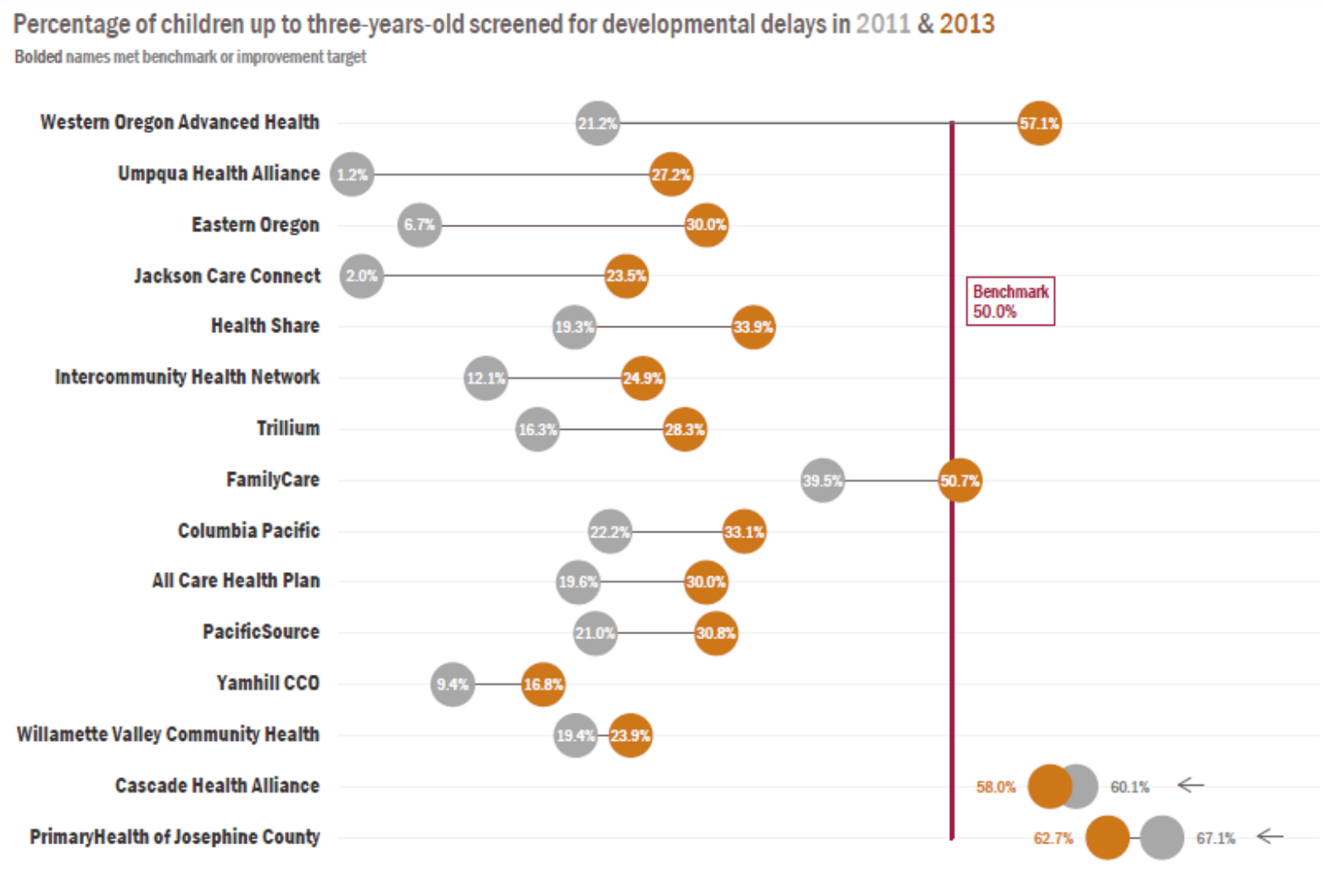
Increased developmental screening

- Developmental screening increased by 58 percent since 2011.



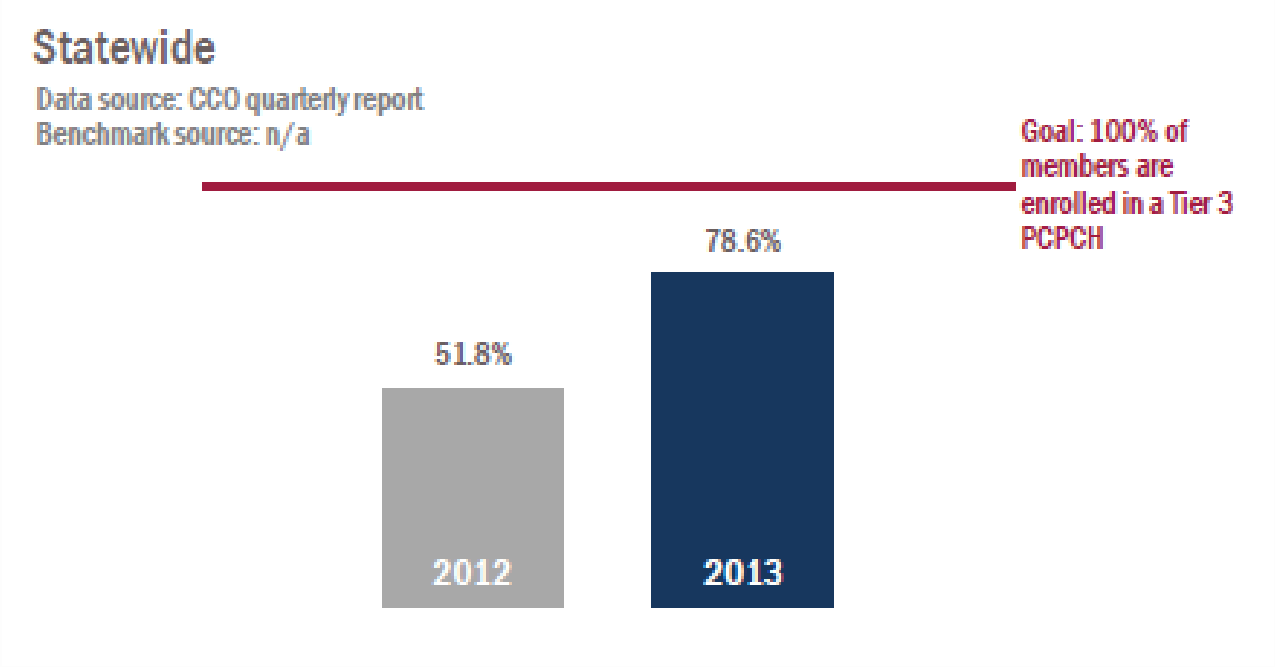
Developmental screening by race & ethnicity

Developmental screening by CCO

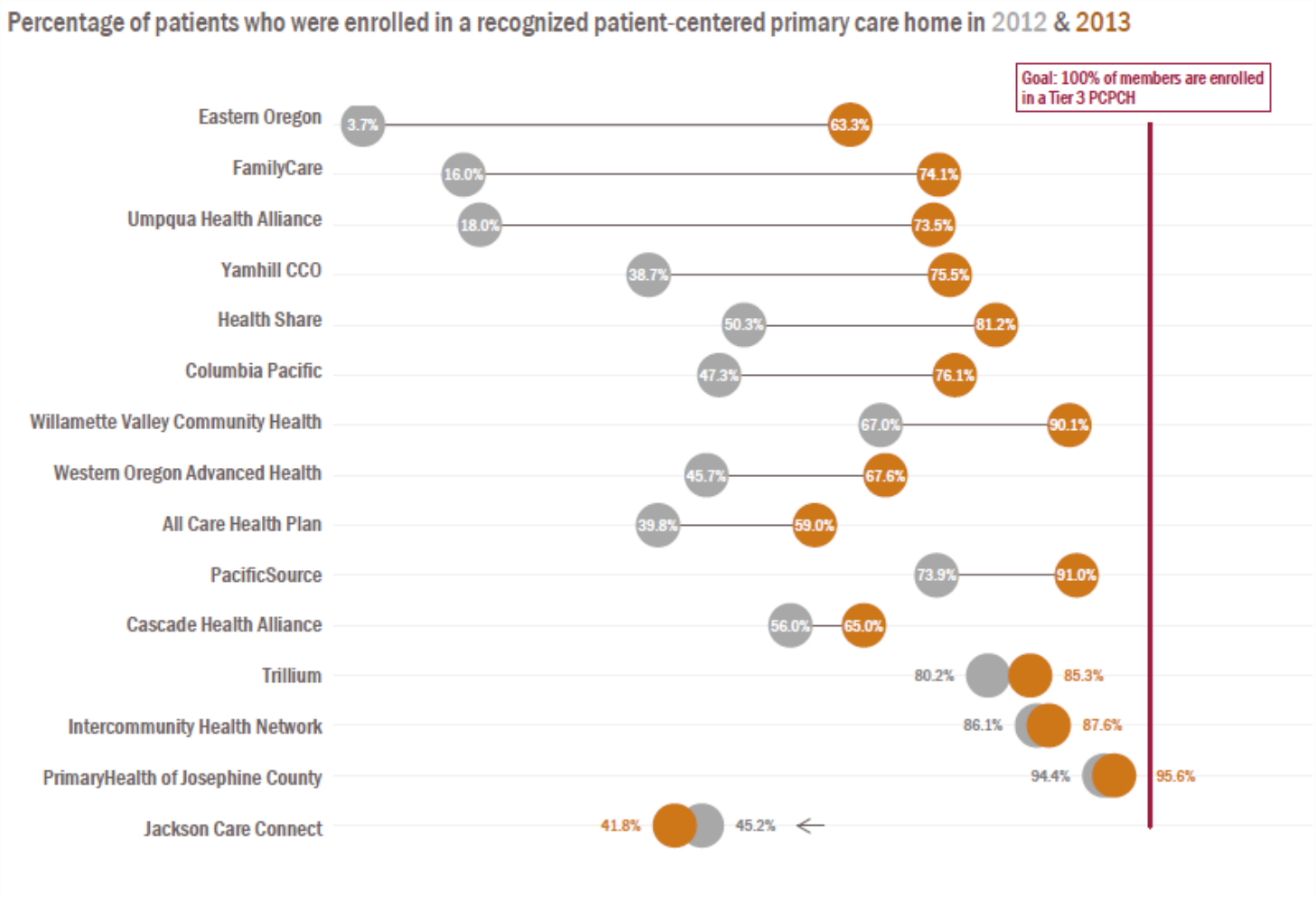


Increased primary care

- Outpatient primary care visits for CCO members' increased by 11%
- Spending for primary care and preventive services are up 20%
- Enrollment in PCPCH has increased by 52% since baseline.



PCPCH enrollment by CCO



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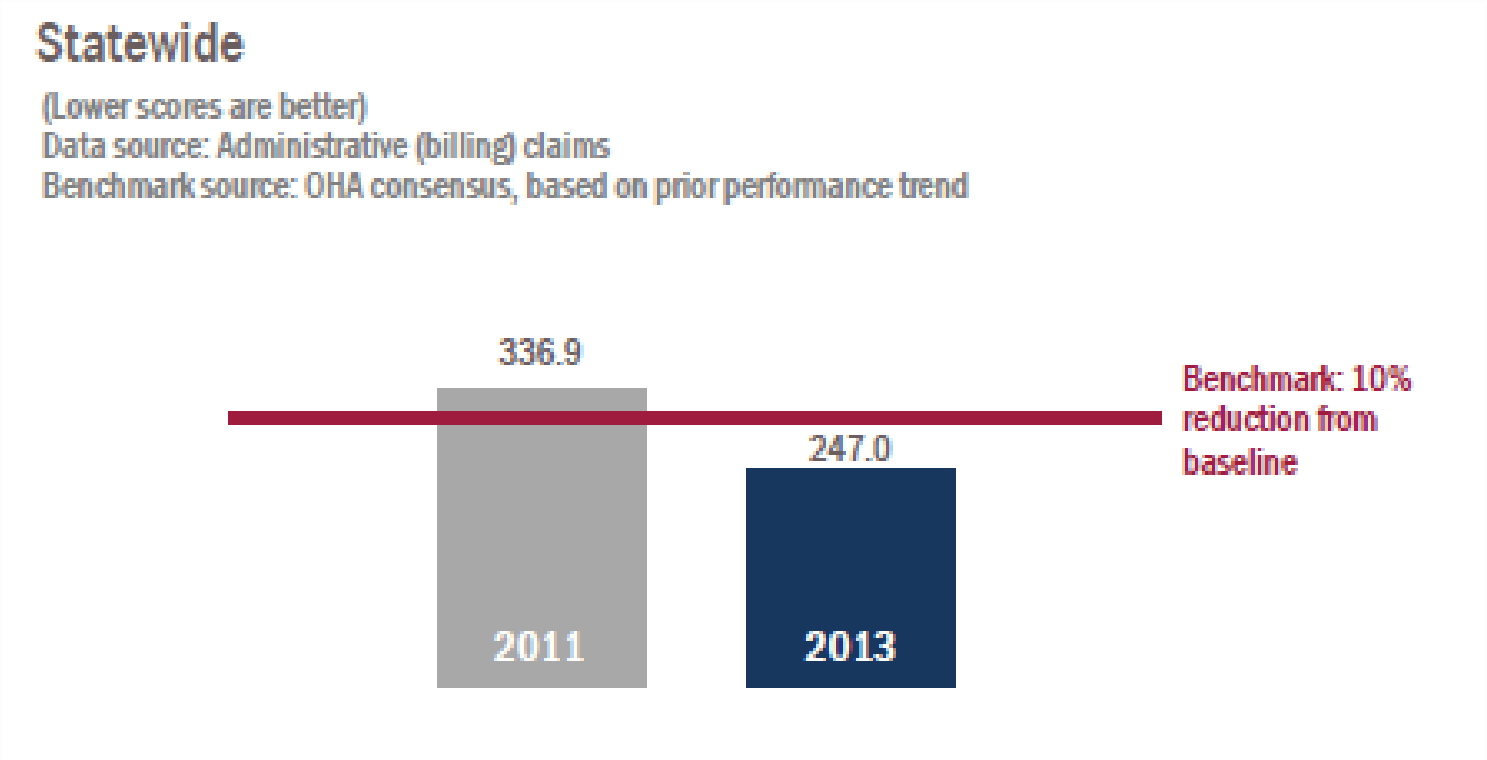
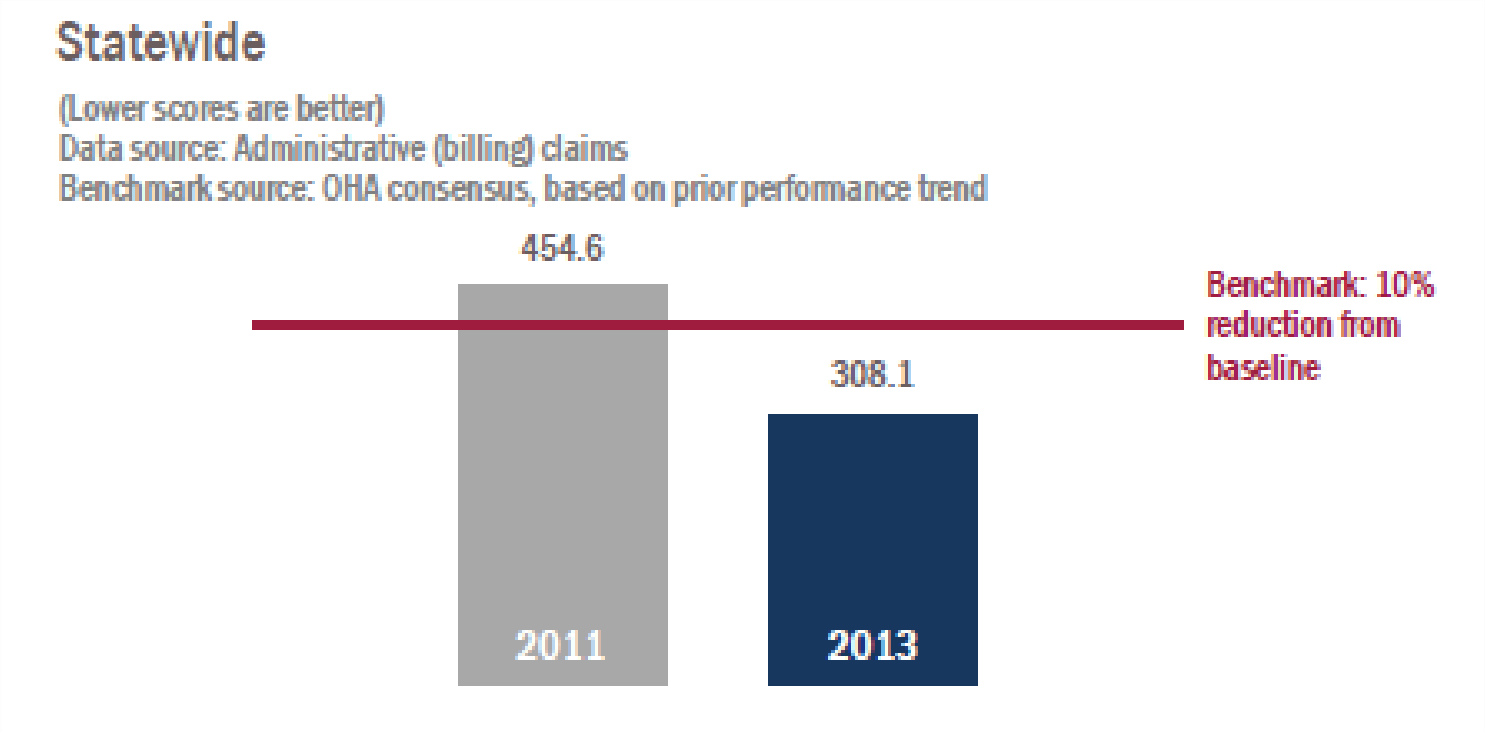
Decreased hospitalizations for chronic conditions: congestive heart failure

- Admission rate decreased by 27 percent.



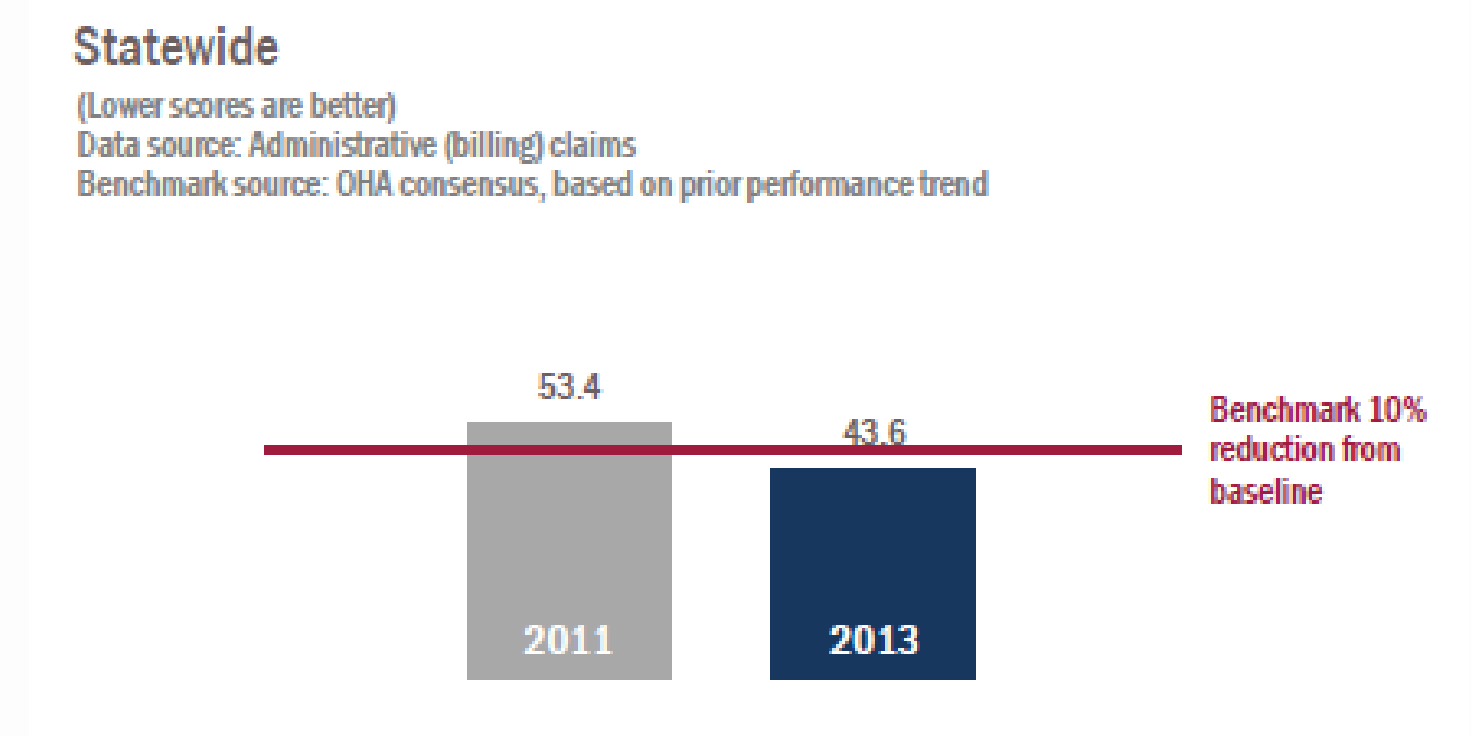
Decreased hospitalizations for chronic conditions: COPD

- Admission rate decreased by 32%



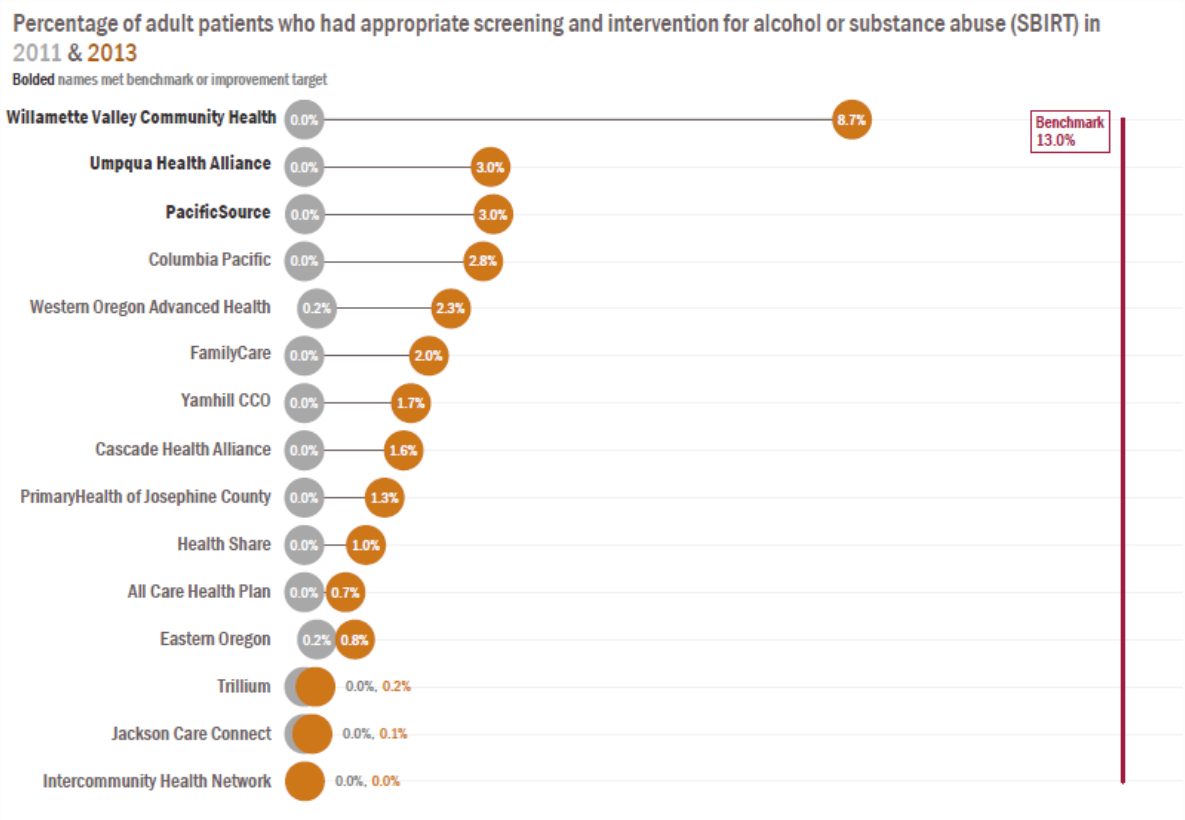
Decreased hospitalizations for chronic conditions: adult asthma

- Admission rate decreased by 18%



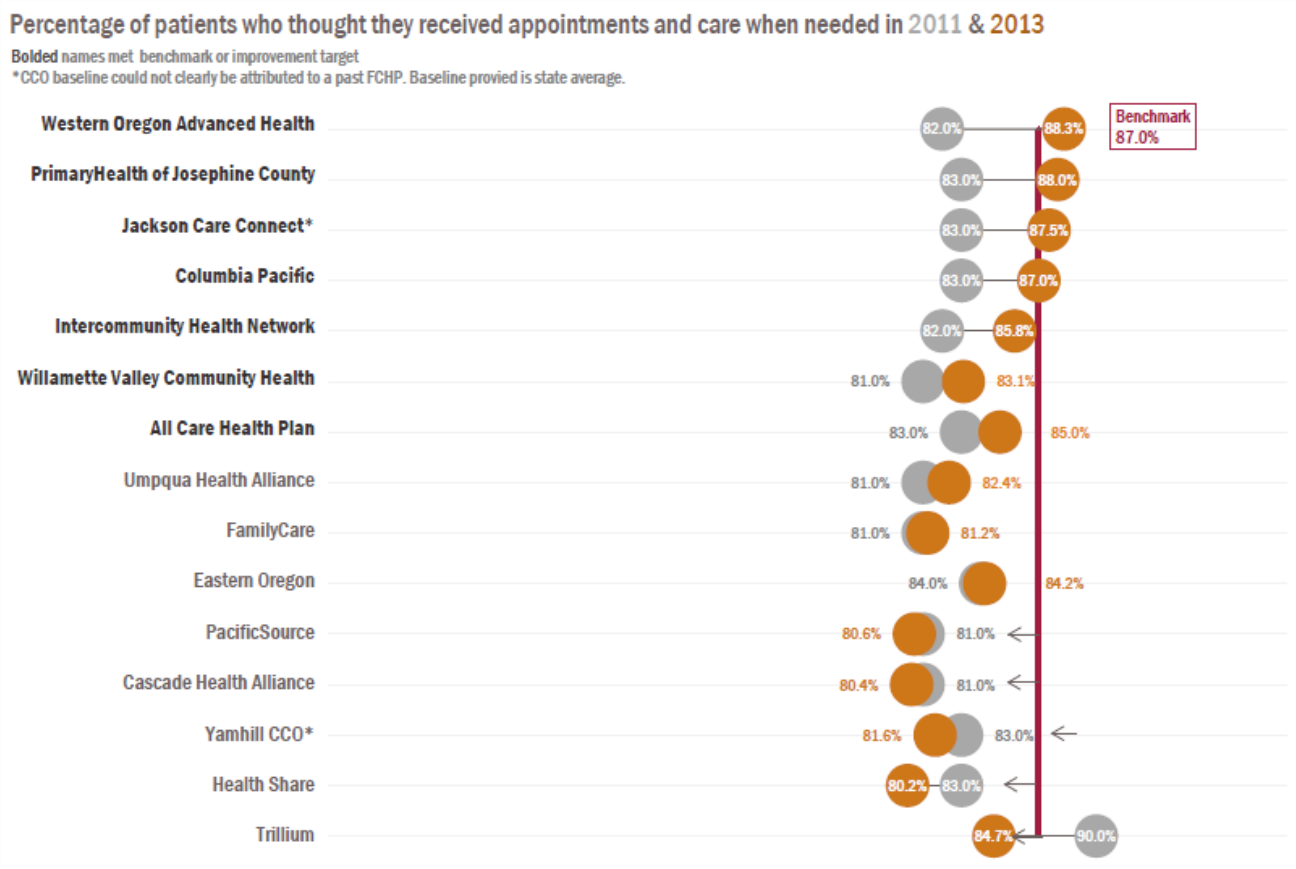
Areas for improvement: SBIRT

- Statewide improvement (0.0% → 2.0%)
- Nearly all CCOs made some improvement, but work still needed.



Areas for improvement: Access to care

- Statewide improvement (83% → 84%)
- Seven CCOs met the benchmark or improvement target



The Big Picture: Cost and Utilization

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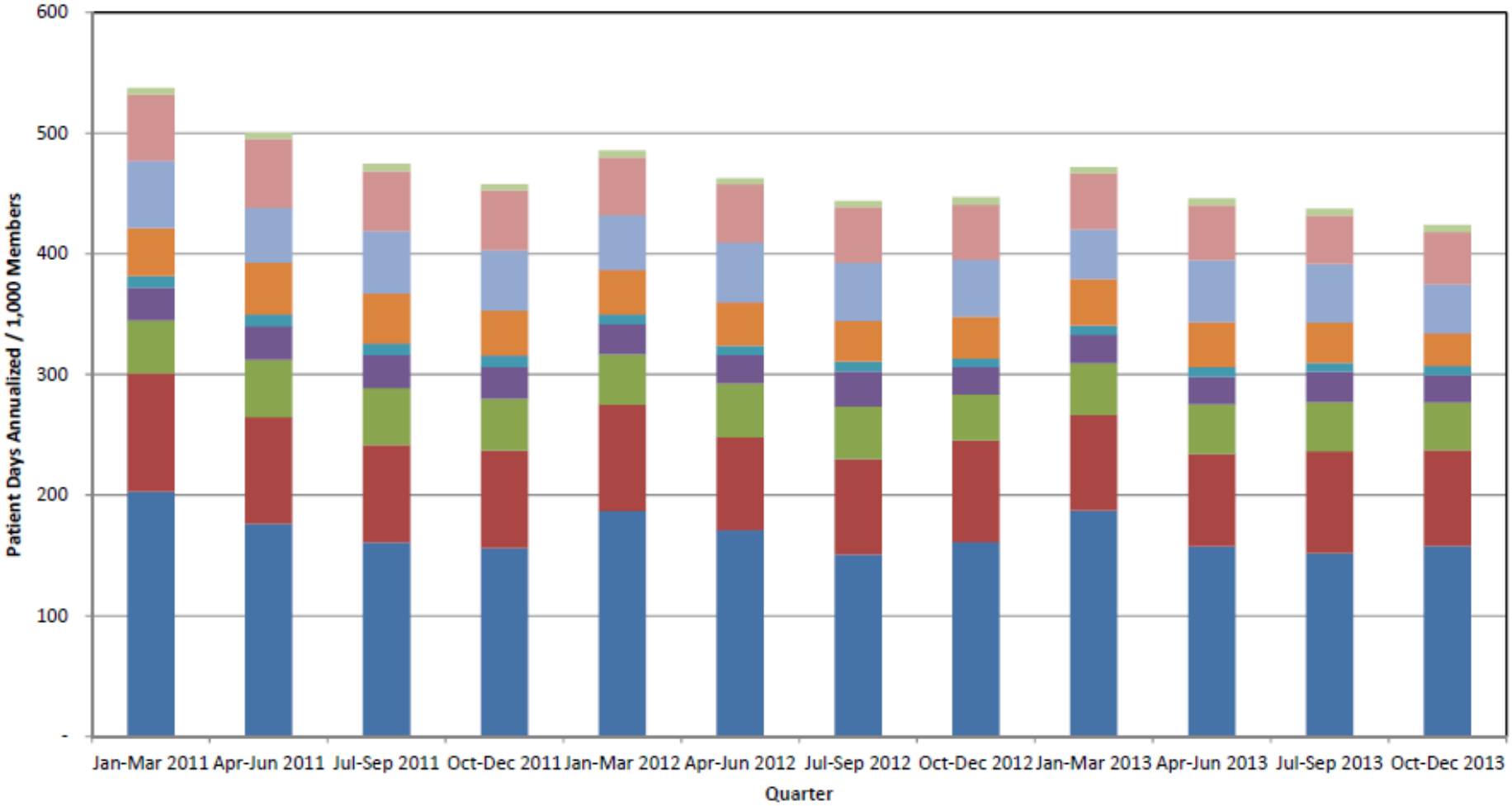
Inpatient Services -- Patient Days



- Inpatient -- Medical / General -- Patient Days
- Inpatient -- Surgical -- Patient Days
- Inpatient -- Maternity / Normal Delivery -- Patient Days
- Inpatient -- Maternity / C-Section Delivery -- Patient Days
- Inpatient -- Maternity / Non-Delivery -- Patient Days
- Inpatient -- Newborn / Well -- Patient Days
- Inpatient -- Newborn / With Complications -- Patient Days
- Inpatient -- Mental Health / Psychiatric -- Patient Days
- Inpatient -- Mental Health / Alcohol and Drug Abuse -- Patient Days

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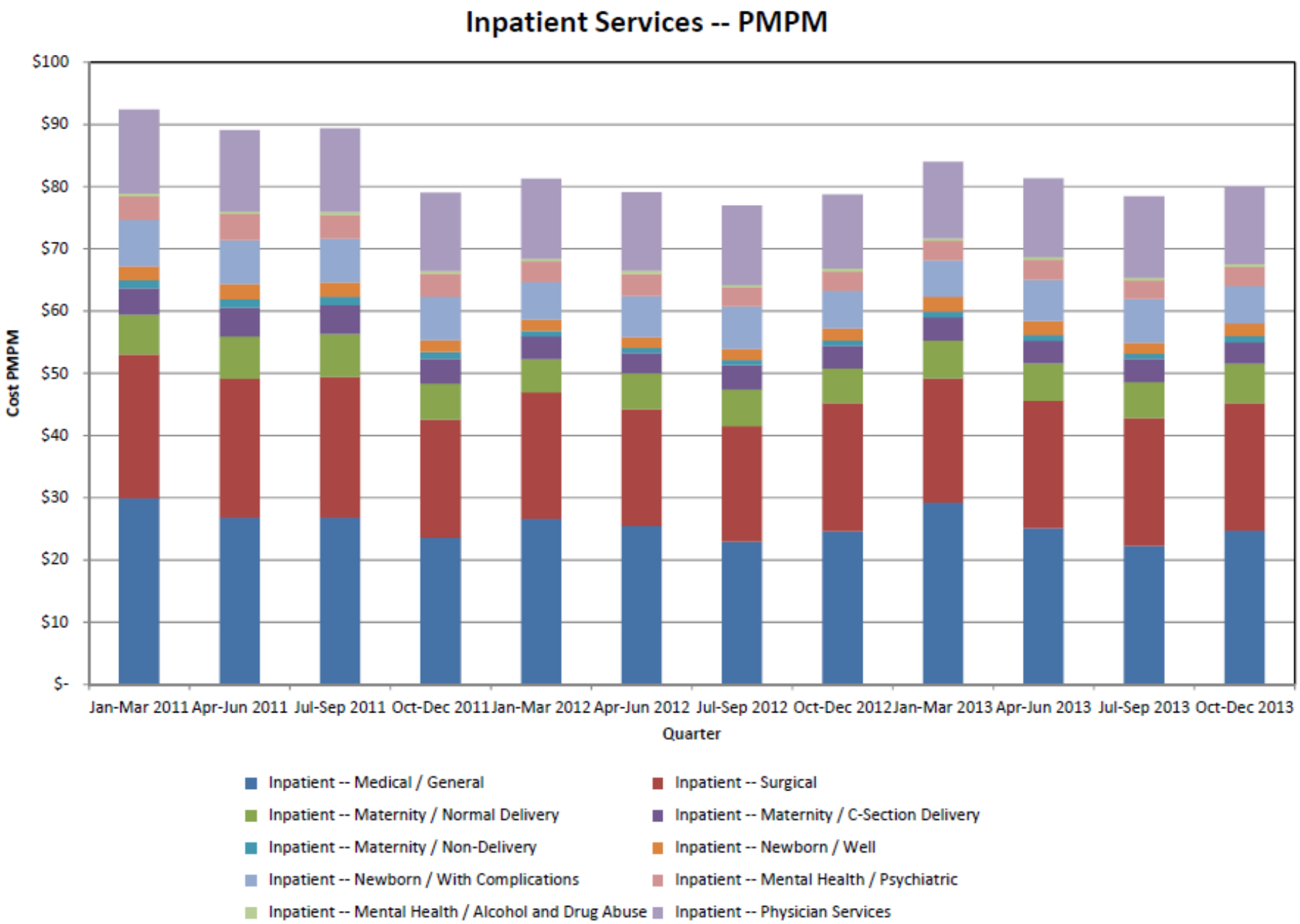
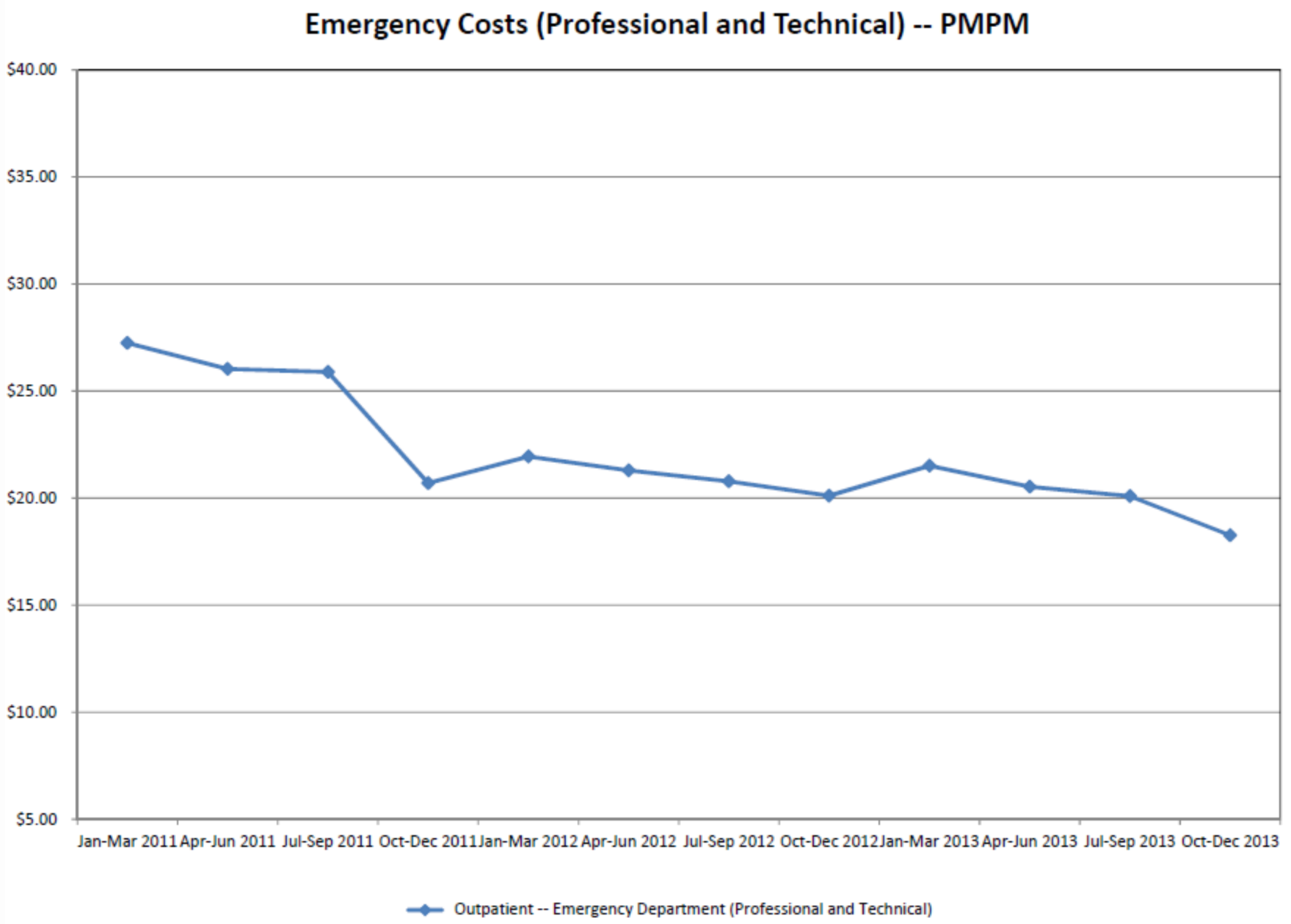

Inpatient Services -- PMPM
$100
$90
$80
$70
$60
$50
$40
$30
$20
$10
$-
Cost PMPM
Jan-Mar 2011
Apr-Jun 2011
Jul-Sep 2011
Oct-Dec 2011
Jan-Mar 2012
Apr-Jun 2012
Jul-Sep 2012
Oct-Dec 2012
Jan-Mar 2013
Apr-Jun 2013
Jul-Sep 2013
Oct-Dec 2013
Quarter
Inpatient -- Medical / General
Inpatient -- Surgical
Inpatient -- Maternity / Normal Delivery
Inpatient -- Maternity / C-Section Delivery
Inpatient -- Maternity / Non-Delivery
Inpatient -- Newborn / Well
Inpatient -- Newborn / With Complications
Inpatient -- Mental Health / Psychiatric
Inpatient -- Mental Health / Alcohol and Drug Abuse
Inpatient -- Physician Services


Emergency Costs (Professional and Technical) -- PMPM
$40.00
$35.00
$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
Jan-Mar 2011
Apr-Jun 2011
Jul-Sep 2011
Oct-Dec 2011
Jan-Mar 2012
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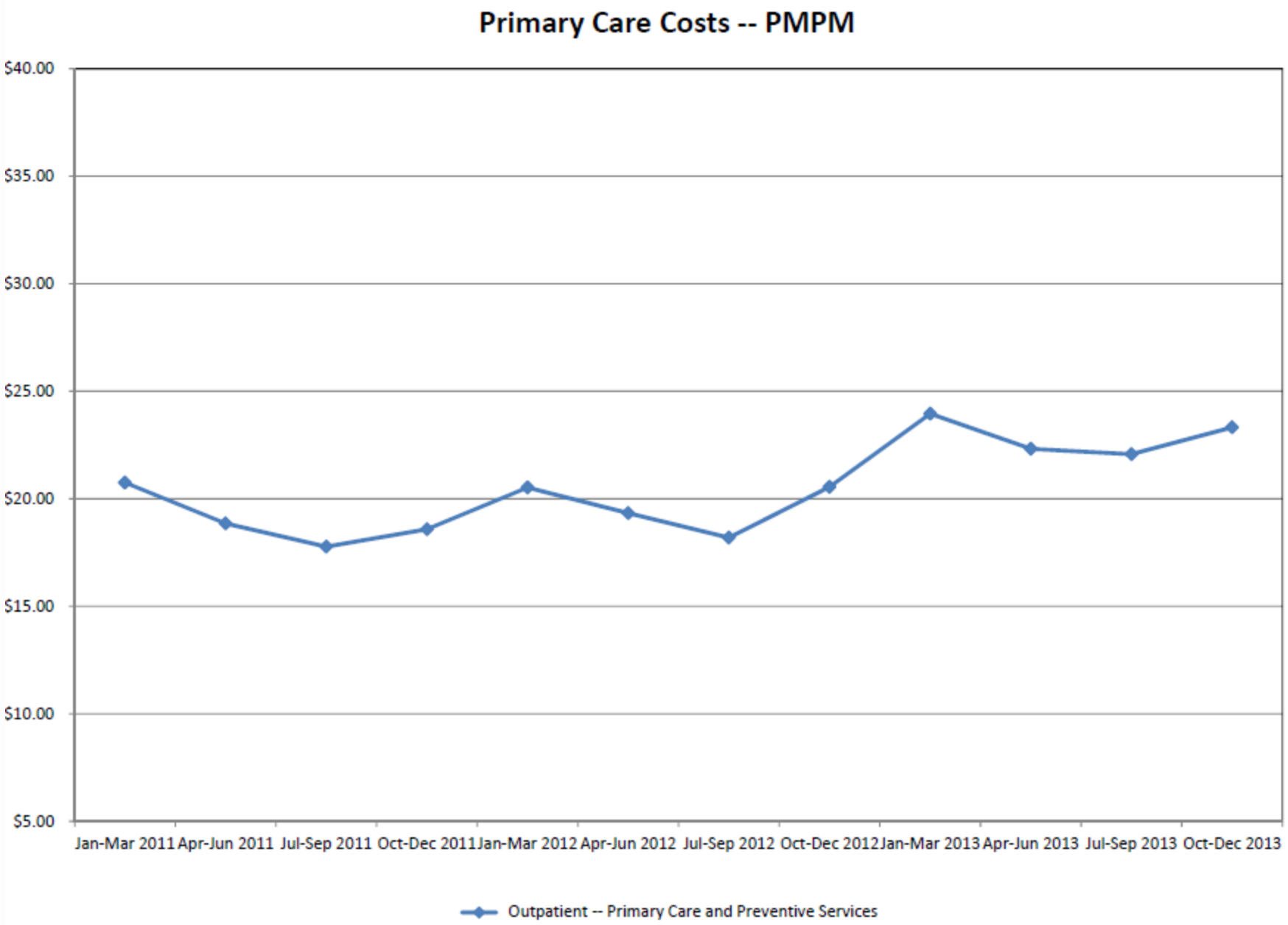
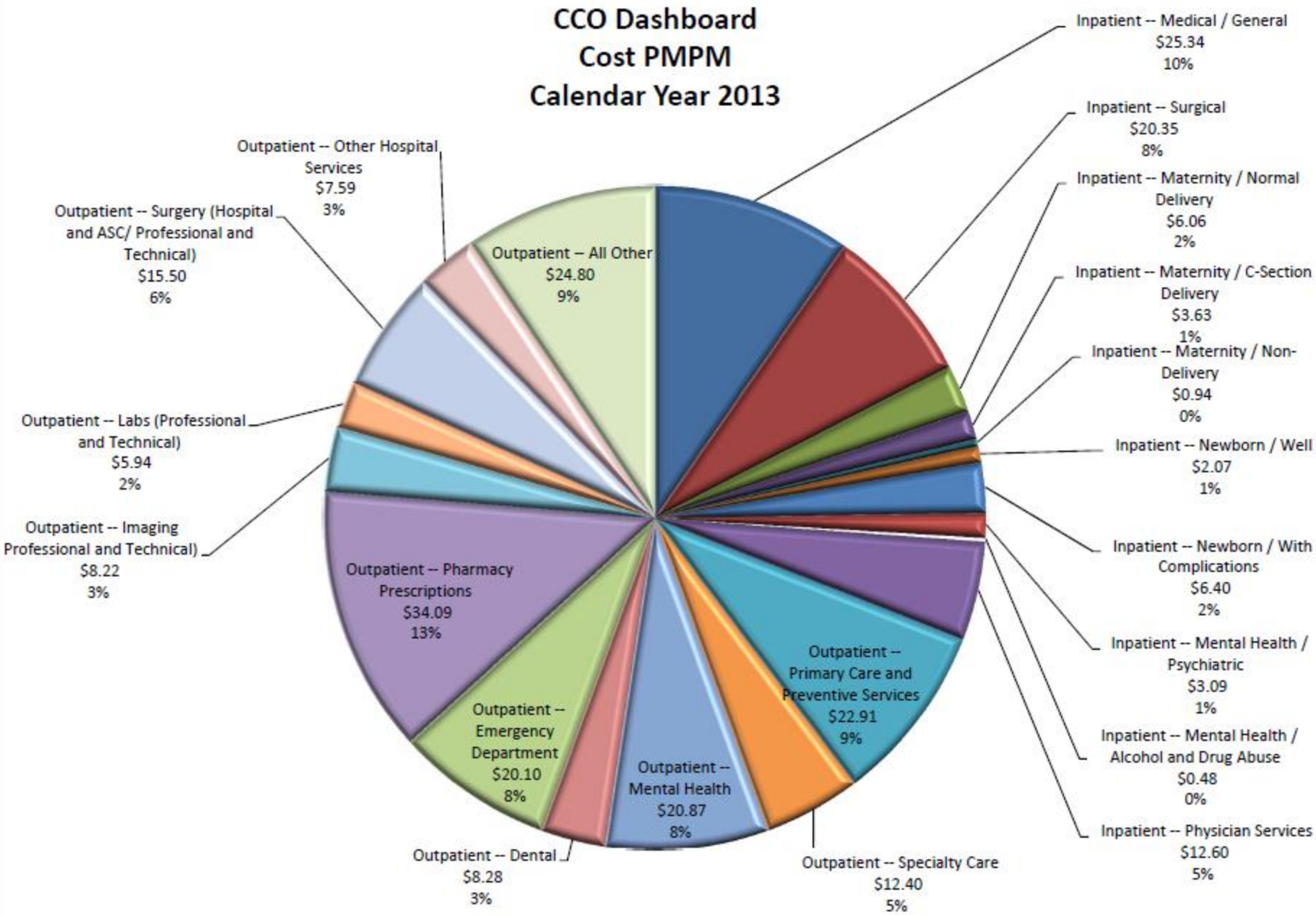
Jul-Sep 2012
Oct-Dec 2012
Jan-Mar 2013
Apr-Jun 2013
Jul-Sep 2013
Oct-Dec 2013
Outpatient -- Emergency Department (Professional and Technical)


Primary Care Costs -- PMPM
$40.00
$35.00
$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
Jan-Mar 2011
Apr-Jun 2011
Jul-Sep 2011
Oct-Dec 2011
Jan-Mar 2012
Apr-Jun 2012
Jul-Sep 2012
Oct-Dec 2012
Jan-Mar 2013
Apr-Jun 2013
Jul-Sep 2013
Oct-Dec 2013
Outpatient -- Primary Care and Preventive Services

CCO Dashboard
Cost PMPM
Calendar Year 2013



Next steps

- Continue to report at state and CCO level.
- Roll in 2014 data to monitor expansion population.
- Provide CCOs with CY 2013 data by race and ethnicity at CCO level (August learning collaborative).
- Continue subpopulation analysis of 2013 data (measures by language, by disability, etc)

For more information

The 2013 performance report and all technical specifications are posted online at http://health.oregon.gov/

Contact

Sarah Bartelmann

sarah.e.bartelmann@state.or.us

BREAK

Addressing Churn: Coverage Dynamics in Oregon's Insurance Affordability Programs

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Recap of Committee Process

- Introduced the issue of “churn” in new ACA environment in Oregon
- Learned about potential estimates of “churn”
- Oregon Health Study and Oregon churn assessment
- Environmental scan of state options to mitigate churn
- State of Washington churn assessment and coverage context
- Strategies to mitigate churn disruptions
  - Basic Health Plan, Bridge Plan, and Wraparound program
  - Advantages and disadvantages including financial implications
- Strategies to reduce or avoid churn
  - Income alignment, continuous 12 month eligibility, contractual mechanisms
  - Advantages and disadvantages
- Additional considerations including administrative issues, benefit differences, and consumer affordability

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Recap: June MAC meeting

- Reviewed draft report and recommendations
- The committee requested a list of changes—see cover letter summarizing changes

Today and Next Steps

- Make final revisions (if any); adopt report and recommendations
- Presentation to the Oregon Health Policy Board on August 5th

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Committee Principles for Evaluation of Churn Mitigation Strategies
Maximize affordability, benefit coverage, and continuity of care for individuals and families.
Consider and support the health needs of diverse racial and ethnic communities, parents, pregnant women, children, persons with disabilities, and residents in rural and frontier areas, among others served by OHP.
Balance consumer needs with the need for financial viability and operational self-sufficiency in the state Medicaid program, the health insurance Marketplace, and the health care delivery system.
Promote coverage options that ensure access and continuity to comprehensive health services and result in the lowest net level of churn.

Committee
Churn Recommendations

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Draft Recommendations to Reduce and Avoid Churn in 2015:

- Simplify and streamline OHP eligibility, enrollment and redetermination processes.
- Align OHP income eligibility and QHP tax credits' income budget periods.
- Conduct a cost-benefit analysis of adopting 12-month continuous eligibility for OHP income-eligible adults.
- Adopt transparent eligibility and enrollment performance indicator(s) to monitor churn in OHP.

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Alternative Coverage Options: Key Considerations

Basic Health Plan (BHP)

- Eligible enrollees ineligible for QHP subsidies
- New transition point and affordability cliff created at 200% FPL
- Federal funding may not cover cost of plans; State has financial exposure
- State fiscal responsibility for start-up and ongoing administrative costs
- Fewer covered lives in the Marketplace may affect risk pool, increase QHP premiums
- Providers may receive lower reimbursement rates than in a QHP

Medicaid Bridge Plan

- Equity issue for individuals never enrolled in Medicaid; not eligible to enroll (139-200% FPL)
- Administrative complexity; eligibility and enrollment systems will have cost implications
- To reduce consumer costs, providers paid at a lower rate than what they would be paid in a QHP

Draft Recommendations to Mitigate Disruptions from Churn in 2016

- Implement contractual mechanisms to support and streamline care transitions between relinquishing and receiving Medicaid CCOs and QHPs.
- Develop a plan to ensure insurance and delivery system alignment between Medicaid CCOs and Oregon's commercial market.
- Offer wraparound of targeted consumer out-of-pocket costs and /or benefits.
- BHP and Medicaid Bridge not viable options for 2014 or 2015 due to implementation costs and administrative complexity.

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Conclusion

- Committee extensively reviewed a set of comprehensive and practical strategies for policymakers and state officials to address churn
- Recommendations align with the Oregon's existing policies, and may enhance the Medicaid and Marketplace delivery system
- Several strategies could be implemented simultaneously and are complementary
- If adopted, recommendations will help Oregon achieve multiple, overlapping goals

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Public Comment or Testimony

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