Health Policy and Reform: A Federal and State Perspective

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“Health care is broken. The delivery system isn’t working. ... We set up a delivery system which is fragmented, unsafe, not sufficiently patient-centered, full of waste, unreliable, despite the great efforts of the workforce. ... It isn’t built for modern times. Medicare doesn’t need fixing. Health care needs fixing.”

--Don Berwick, December 12, 2011

Prior Administrator of the Centers for Medicare and Medicaid Services. Prior to his work in the administration, he was President and Chief Executive Officer of the Institute for Healthcare Improvement.
Focus of Health Care Reform:

- **Change Insurance practices** to a patient centered outcome focus
- **Address Administrative costs** above 10%
- **FFS** medicine and misaligned incentives
- **Wide practice variation**
- Health care “profit”
- Continued double-digit **premium inflation**
- 50 million **uninsured** Americans
- Health care distributed **ONLY** at the **workplace**
Expectations for Industry change

• Hospitals and health systems create systems of care
• Standardization in approach
• Payment by accountable lives; not by services or episodes
• New mantra: “Most good for most people at least amount of cost”
• Focus on outcomes and quality
Expectation for Industry change

- Focus on the Medical Home
- Payment Reform including bundled payments, P4P, episode of care, capitation, global medical budget
- Connecting PCPs and Specialists
- Connecting clinical IT and financial systems
- Enhancing care management — enterprise-wide
- Understand and work within value-based plan design
Challenges for health care and health reform

Cost

Quality

Access
Health and Healthcare

Factors Influencing Health Status

- Lifestyle: 51%
- Environment: 19%
- Health care: 10%
- Human biology: 20%
- Smoking
  - Obesity
  - Stress
  - Nutrition
  - Blood pressure
  - Alcohol
  - Drug Use

Institute of Healthcare Improvement
Triple Aim Project

Triple Aim
• (Quality) Improve the health of the population;
• (Access) Enhance the patient experience of care (including quality, access, and reliability); and
• (Cost) Reduce, or at least control, the per capita cost of care.

By organizing regionally to:
• Provide care for a defined patient population
• Create “macro-integrators” that can
  • organize and provide the “entire range of services”
• Accountable Care Organization (ACO) Federal
• Coordinated Care Organization (CCO) State
• Connect with “micro-integrators” – primary care providers
• Measure and report on the indicators
Accountable Care Organizations (ACOs)

• The term “Accountable Care Organization (ACO) is a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients and was included in the Patient Protection and Affordable Care Act.

• Federal Term and approach
Coordinated Care Organizations (CCOs)

• Coordinated Care Organization (CCO) is a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid).

• State Term and approach
Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. (3,4) These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group. The health outcomes of such groups are of relevance to policy makers in both the public and private sectors.
Accountable Care Organization’s (ACOs)

• An ACO is a local health care organization and a related set of providers that can be held accountable for the cost and quality of care delivered to a defined population.

• The goal of an ACO is to deliver coordinated, and efficient care therefore qualifying for a bonus, and if they fail possibly a penalty.
Most States are working on ACO legislation

Credit for state highlight slides: http://www.nashp.org/publication/better-value-state-roles-promoting-aco
Why transform and why now?

- **Health care costs** are increasingly unaffordable to individuals, the state, and business.

- **Current fiscal climate** creates imperative and unique opportunity to redesign Oregon’s health care delivery system to get better value for all.

- **Outcomes** are not what they should be – estimated 80% of health care dollars go to 20% of patients, mostly for chronic care.

- **Lack of coordination** between physical, mental, dental and other care and public health means worse outcomes and higher costs.
Vision of HB 3650

Integration and coordination of benefits and services

Local accountability for health and resource allocation

Standards for safe and effective care

Global budget indexed to sustainable growth

Redesigned Delivery System

Improved outcomes

Reduced costs

Healthier population
Goal: Triple Aim
A new vision for a healthy Oregon.

Oregon’s Health Community

1. **Enhance the patient experience**
   through clinical outcomes, patient safety and satisfaction
2. **Improve the health of Oregonians**
3. **Reduce per capita cost**
Coordinated Care Organizations

• The 2011 Oregon Legislature approved HB 3650 to transform how health care is delivered
• The bill was specific to those members covered under Medicaid or in our state, the Oregon Health Plan (OHP) and those dually covered by Medicare and Medicaid (OHP).
• State employees and state educators were called out as the next population to be included.
Coordinated Care Organizations

- **Community-based management** of the following services:
  - Physical health
  - Mental Health
  - Dental Health

- **Coordination with Long Term Care** is mandated
Coordinated Care Organization (CCO)

Definition:
• CCO means an organization that serves as a single-point of accountability for the cost of health care within a global budget and for access to and quality of a coordinated system of physical health, behavioral health and oral health care services delivered to the specific population of patients enrolled with the organization.
“Coordinated Care Organization (CCO)"

Key Elements:
• Population based care focused on all 5 determinants of health
• Requires use of Medical Homes
• Requires participating physicians to utilize Health Information Technology
• Emphasizes mental health parity
• Requires use of Non-traditional Health workers
• Requires coverage of flexible services and supports
• Requires community participation and oversight of plan
Non-Traditional Health Workers

- House Bill 3650 defines and requires use of community health workers, peer wellness specialists and personal health navigators.

- These “non-traditional health workers” are defined as:
  - Community Health Worker - an individual who promotes health or nutrition within the community in which the individual resides.
  - Peer Support Specialists - are those who provide peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor.
  - **Personal Health Navigator** - An individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the person’s particular circumstances and in light of the patient’s needs, lifestyle, combination of conditions and desired outcomes.
What does this mean for Women’s Healthcare?

• Fewer Uninsured. Up to 15 million currently uninsured women gain coverage by 2014.
• National Direct Access to Women’s care services
• Continued Ob-Gyn Use of Ultrasound.
• Mandated Maternity and Women's Preventive Health Coverage.
• Insurance Reforms: No gender-rated premiums; no pre-existing condition exclusions; no waiting periods over 90 days; no annual lifetime limits; no coverage rescissions unless for fraud. By 2014, reforms improve coverage for 14.5 million women.
• Participation in Medical Homes for Women.
• Easier Medicaid Coverage of Family Planning. States can cover women with incomes over the Medicaid eligibility level without federal waivers.
• Medicaid Payment for Smoking Cessation Counseling.
• More Research into Postpartum Depression.
• Standardized Health Information Technology (HIT).
• Potential usage of doulas and lay midwives
DRAFT - HEALTH SYSTEM TRANSFORMATION TIMELINE

Legislature
- 2011 Session (Transformation Bill)
- Legislative Oversight: Periodic Reports to Legislature, Interim Committees, and E-Board

Health Policy Board
- Periodic Status Reports; Opportunities for Stakeholder and Public Input

Tribal and Local Governments
- Quarterly Status Reports and Input

Consumer Outreach and Education
- Consumer Input
- Communications Plan Development
- Outreach and Education
- Consumer Enrollment and Transition Assistance

Coordinated Care Organizations
- Stakeholder Input
- RFP Development and Drafting; Equity Review
- Applications Submitted
- Review & Selection
- Finalize Contracts
- Statewide Implementation

Early Adopters
- Applications Submitted
- Early Adopter Implementation

Federal Waiver or Other Permission
- Technical Assistance Solicited from CMS
- Request for Federal Permission Submitted
- Request for Federal Permission Reviewed by CMS

1 Request for Proposals for Coordinated Care Organizations.
2 Early adopters must meet the same criteria as the regular RFP applications.
3 Federal permission would be sought for global budgeting, combining Medicare funding for dual-eligibles beneficiaries with Medicaid, and payment reform.
QUESTIONS?

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