

Coordinated Care Organizations How Are They Doing?

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OPHA October 13, 2015, afternoon breakout session.

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In 30 years working with cancer patients I saw many patients with advanced and neglected cancers. Some of these patients had avoided doctors for months or even years in spite of worrisome symptoms because they felt they could not afford care. Seeing this happen repeatedly was a very saddening experience for me. I learned that it didn't need to happen. I began to realize that illness can be as much a result of politics as biology. The political question is, "By law, who will be allowed a good chance for a healthy life and good health care?" This talk is about how well CCOs are answering that question.

*What is a coordinated care organization (CCO)?

Unified care. The care-delivery component of each CCO is the patient-centered primary medical home in which primary care practitioners collaborate with a standardized array of other caregivers under a capitated budget to deliver better care at lower cost.

*Sixteen CCOs have formed since August 2012, each run by a board composed of local healthcare providers and community members. These boards advised by a local community advisory council through the chair of the advisory council who sits on the board. However, board meetings are closed to the public. More later about that as a frailty of CCOs.

*So how are we doing?

*95% of Oregonians now have some form of health insurance compared to 84%--in 2012.

The 2015 Robert Wood Johnson report says 83% but is using 2012 data

*CCO cards say they're insured but 1/12 CCO patients still can't find a doctor.

* *Access Measure description: Percentage of members (adults and children) who thought they received appointments and care when they needed them.* A home health nurse in Lincoln County I know sees quite a few of this 16%. She worries about these people and spends far too much of her valuable nursing time on the phone begging and battling for them.

*Each June the Oregon Health Authority publishes its assessment of performance by Oregon CCOs. ^ Performance is measured based on 17 key healthcare metrics. *Benchmarks: unless stated otherwise are averages of the 2013 national Medicaid 75th percentiles for adults and children*

**Satisfaction level is the percentage of members (adults and children) who received needed information or help and thought they were treated with courtesy and respect by provider staff.* Satisfaction level among those who actually gained access to care has not changed since 2011. I've spoken with several patients enrolled in CCOs and have been impressed with their level of satisfaction.

*Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting. This trend of avoidable patient visits to emergency departments suggests more appropriate use of the ER by CCO patients.

* Things are improving in prenatal care. More than 40 percent of all babies born in Oregon are covered by Medicaid. Timeliness of prenatal care leads to significantly better health outcomes and cost savings.

*But before and since CCOs only 2/3 of children received recommended vaccines before their second birthday.

Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools which help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats. 2.

*Control of congestive heart failure is better (the rate of adult members (ages 18 and older) requiring a hospital stay because of congestive heart failure. Benchmark source: 10% reduction from previous year's statewide rate 2011 and 2013 data have been updated and may differ from earlier reports.

* A CCO and a patient centered medical home helped this man control his congestive heart failure. He had been in and out of the hospital many times before the CCO was available to him.

*If you work with low-income patients you are likely to meet or learn of someone who has had a devastating stroke because he or she couldn't afford insurance, didn't qualify for Medicaid, and therefore had undetected and uncontrolled hypertension. I know of two such individuals.

But CCOs haven't been able to help much yet. Having 35% of the enrolled hypertensive CCO patients with uncontrolled BP is not good. > 75% of Americans who have strokes have high BP.

There are no earlier CCO data. The US Medicaid 75th percentile in 2013 was 64%.

*CCOs may be helping diabetics. Better glycemic control seen here (HbA1c > 9.0%) decreases the likelihood of complications, including poor circulation leading to impaired mobility, amputations, kidney failure and blindness. Benchmark: There are no earlier CCO data. The US Medicaid 75th percentile in 2013 was 66%.

*Transformation is slow difficult work - meaningful systems change takes time, like turning ocean liner around when many of the crew members don't know how to and a few don't want to turn it around. And of course powerful special interest tugboats keep pulling this healthcare ship toward their harbors.

* 27% of patients who are initially eligible churn in and out of Medicaid eligibility because of varying incomes year to year. This leads to disruptions in continuity therefore poor quality healthcare. We need a single risk pool.

<http://www.oregon.gov/oha/OHPR/MAC/Documents/2014%20MAC%20Churn%20Report.pdf>

*Yearly reapplication is required because of changes in eligibility. People forget, can't find required documents, don't understand. They unintentionally let coverage lapse and are surprised to discover they aren't covered by Medicaid anymore. More churning.

* Even if Oregon limits Medicaid spending growth to 3.5%/yr as we are obligated to do to keep all of our federal subsidy, the subsidy for the expanded Medicaid population drops from 100% to 94 percent in 2017 and to 90 percent in 2020. Oregon will have to come up with an extra \$369 million per year from 2017 to 2020 and then \$500 million/yr after that. Oregon's annual Medicaid budget is \$6.8 billion.

Four options have been tried during Medicaid revenue short-falls in the past.

#1: raise taxes without changing benefits

#2: cut other state programs: police, fire and safety, schools, elderly, infrastructure, transportation

#3: reduce Medicaid eligibility. This immediately reduces state spending — until neglected patients again fill our emergency rooms.

#4: cut benefits. same as above

*Other problems

*Opacity of CCO management. CCO board decisions about the use of our Medicaid money need to be transparent to the public.

One of the 11 privately owned CCOs, tripled its profits in 2013 because of a rapid absorption of Medicaid patients. During the time this CCO was taking in its \$300-\$400 pmpm Medicaid payments, thousands of its patients ended up depending on safety net clinics because the CCO had too few primary care providers. Safety net clinic workers I spoke with said that the CCO could have hired more providers but had turned down applications from many qualified nurse practitioners and physician assistants.

This CCO was scheduled to be purchased last month by a Fortune 500 company, Centene, of Louisville Kentucky. This is not what most of us had in mind when CCOs were conceived.

*I encourage you to investigate. Find out who sits on your CCO board by going online to Oregon.gov/CCO governing boards and ask them for a clear accounting of where the money goes. Is it going for convincingly documented care of patients? If your CCO doesn't freely provide information you need, local journalists and your legislators may be willing to help.

*I think we can say that Oregon's coordinated care organization experiment is starting to succeed and is based on sound principles of providing better care for more people at less cost. But we need major improvements in transparency, oversight, and incentives and we need a single risk pool and unified payer system if the ideals of the CCOs are to survive.

Tell legislators, media, Oregon Health Authority we must:

1. Keep working on the CCO model of care *delivery* and capitated *payments*. This work is vital to success
2. Stop determining who "deserves" care and who doesn't with our complex eligibility schemes. The process is too costly and disruptive. We must include everyone.
3. Fight for more public surveillance and power over how all public money, including Medicaid money, is used.
- *4. Make sure insurance is not just a card or promissory note but in fact allows health and access to health care.
5. Make CCOs serve needs of the public rather than stockholders and the medical industry.
6. Create a unified coding and payment system with a single risk pool (everyone in).

*These web sites listed on your handout will help you gather and confirm the data you need if you want to help CCOs succeed and achieve better health care for more Oregonians at lower cost.

As we talk with others about health care reform I hope we can listen carefully, honor their fears, and then pivot back to a mutually agreeable goal such as better care. Help the other person see how achieving better care for more people at less cost will benefit them, their family, and their neighbors. It is pretty likely that the person wants all of those people have access to good healthcare.

*We have indeed come a long way in a very short time, but we have a long way to go. Please investigate these organizations and websites, learn what you can about what's going on, and rev up your activism for the public good and public health. Here are two organizations that you can look in on and join to put your thoughts into action.

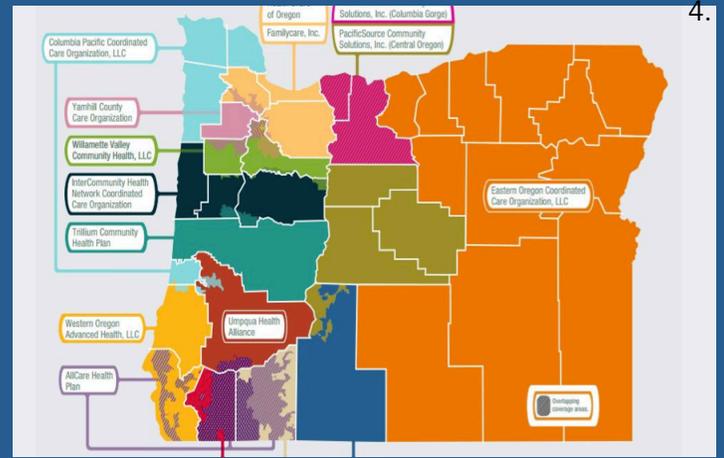
“All diseases have two causes:
one is pathological
the other — political.”



Rudolf Virchow

German Pathologist University of Berlin, 1848

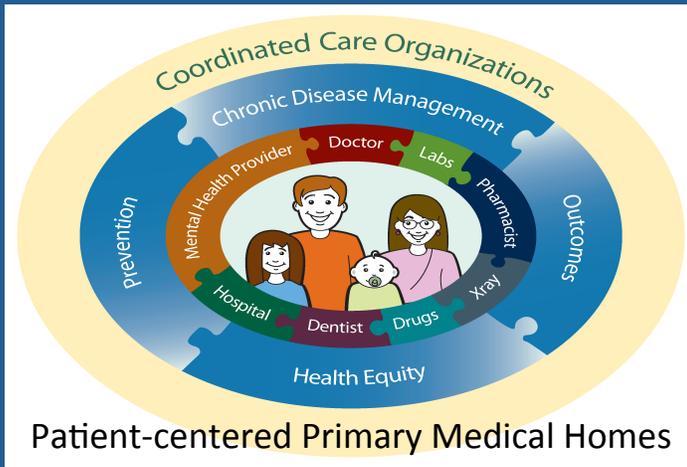
Political decisions determine who has access to healthy life conditions and care. How political are we willing to be?



Sixteen Coordinated Care Organizations

CCO boards advised by leader of each community advisory council. However, board meetings are closed to the public.

Unified Care



Churning



Oregon.gov/ Addressing Churn... August 2014

People churn in and out of Medicaid eligibilities because of varying incomes year to year. Discontinuity of care.

Oregon's Health System Transformation
2014 Final Report oregon.gov

Kaiser Family Foundation kff.org

Physicians for a National Health Program

Robert Wood Johnson Foundation
countyhealthrankings.org/oregon

Why the Oregon CCO Experiment Could Fail
HSS Public Access, 2014

Health Care For All Oregon
www.hcao.org

Mid Valley Health Care Advocates
www.mvhca.org

Physicians for a National Health Program-Oregon
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