CHI SNAC LABS 2016

Food for Thought

Updates from the Safety Net Advisory Committee (SNAC)

Study Compares Oregon's Medicaid Reforms with Colorado's

SNAC Lab Also Examines Specialty Care Access

MARCH 17, 2016

Introduction

Oregon and Colorado have a lot in common.

Both are Western states with a mostly urban population, as well as geographically large rural and frontier counties. The people share a love of the mountains and craft beer. And their Medicaid programs are implementing reforms built around the concept of making regional organizations accountable for cost and care.

But the Oregon and Colorado Medicaid programs differ in structure and the incentives they offer, providing the opportunity for researchers to compare and contrast the two approaches.

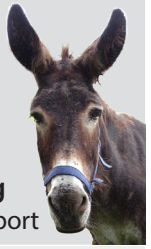
The research by a team that includes Coloradans Rich Lindrooth and Jeanette Waxmonsky is not yet finished, but the two gave an update on their progress at the March 17 meeting of the Safety Net Advisory Committee Learning Lab (SNAC Lab).

The March SNAC Lab also featured a discussion about access to specialty care. See Page 2 for the report.

Primary Themes

- Colorado and Oregon have embarked on accountable care reforms in their Medicaid programs, but they differ in their governance and payments.
- Oregon has a stronger set of incentives to encourage its regional organizations to be accountable for health care costs.
- In Colorado, local coalitions are examining ways to increase access to specialty care.

A Tale of Two States: Oregon vs. Colorado

	Oregon	Colorado
Population July 2015	4,028,977	5,456,574
Unusual State Symbol	 Dungeness Crab State crustacean	Pack Burro Racing State sport 
Tallest Mountain	Mount Hood 11,239 feet	Mount Elbert 14,440 feet
Iconic Television Comedy	Portlandia 	South Park 
Recreational Marijuana Legalized	2014	2012

Special Project

Examining Access to Specialty Care in Colorado

Access to specialty care is becoming a hot topic. The Colorado Health Institute has been researching the problem from multiple angles over the past year.

CHI plans to explore the topic at SNAC Labs in 2016. Discussions will be guided by three questions:

- Is access to specialty care a growing problem in Colorado?
- Who is most affected?
- Are communities rising to the challenge?

The objective is to explore what different organizations are doing to address specialty care access and identify opportunities to collaborate.

Attendees of the March 17 SNAC Lab heard from three regional health organizations in the metro area — Aurora Health Access, Boulder County Health Improvement Collaborative and the Mile High Health Alliance. Here's a look at the work all three of these groups are doing:

Aurora Health Access

Heather Dolan is a board member of Aurora Health Access, a collaboration of health care providers, businesses and residents. The group studied multiple health needs in the city, and access to specialty care rose to the top, especially for Medicaid clients. The greatest needs are for orthopedics, dermatology, neurology, urology and rheumatology. Aurora Health Access plans to focus on one specialty where it can make the most difference.

Group members will ask themselves:

- Do we have local champions who can advance access to this type of care?
- Is the problem a statewide workforce issue that Aurora could not solve on its own?
- Is there an influx of patients in specialty care who would be better served in primary care?
- If we could make an improvement, what would it mean for the quality and length of life of people in Aurora?

Boulder County Health Improvement Collaborative

Dawn Joyce of *Boulder* County Housing and Human Services discussed the Boulder County Health Improvement Collaborative, which has been operating for nine years. The group includes the county commissioners' office, the county Health and Human Services agency and area providers.

Members of the group asked themselves where they could make the biggest impact in improving health for county residents. They zeroed in on access to specialty care. Boulder County has an especially large need for ophthalmology.

The best access improvements have come from cultivating personal relationships with providers, Joyce said. The group also is looking for local "champions" and meeting with hospitals and medical societies. In the long term, members of the collaborative want to address access problems not just for the uninsured and Medicaid clients but for the underinsured as well.

Mile High Health Alliance

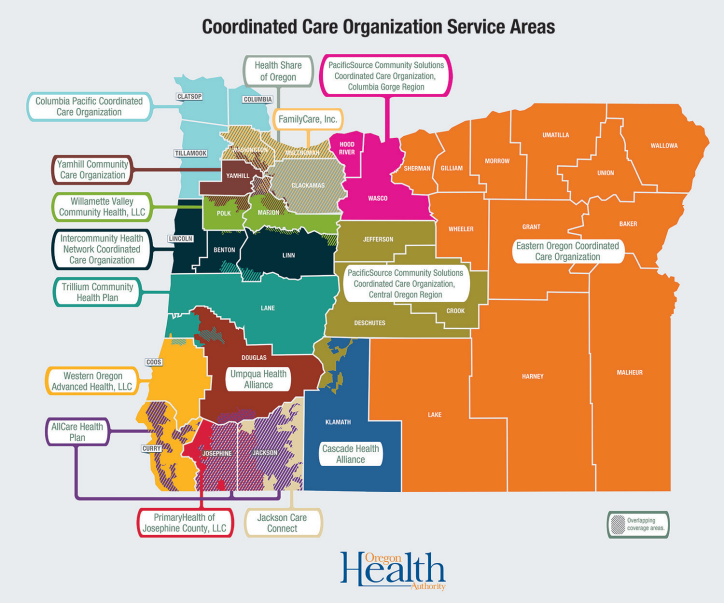
Lisa McCann of Denver Health discussed the work of the Mile High Health Alliance, which was formed a year ago to fill the need for an organization to work on access to care issues.

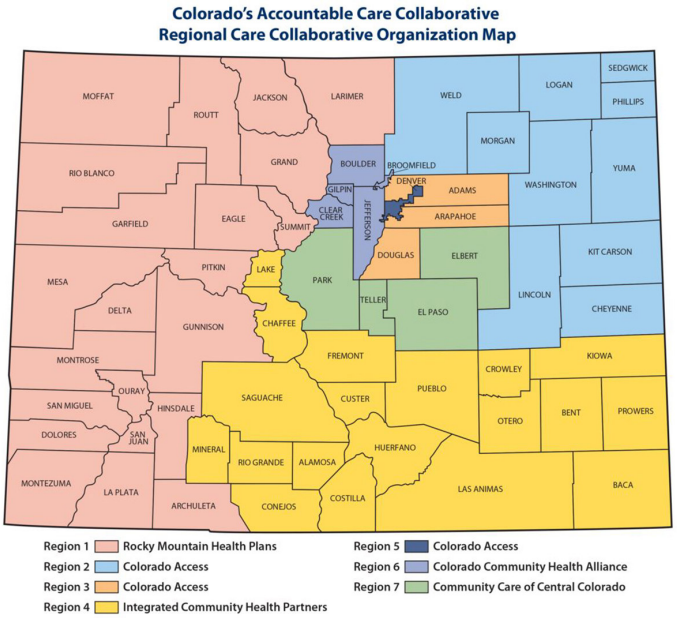
The group's top four issues are access to specialty care; super-utilizers; integrated physical and behavioral health care; and first access to care, which includes coverage, health literacy and entry into care. The aim right now is to improve specialty care access for Medicaid users, McCann said.

The Alliance is working to form a referral hub to connect patients in need with willing specialty care providers.

A grant from the Caring for Colorado Foundation paid for an implementation plan, developed by the Colorado Health Institute, for the referral hub. The Alliance is seeking funding to start a pilot in early 2017.

Maps 1 and 2. Service Area Boundaries for Oregon's Coordinated Care Organizations and Colorado's Regional Care Collaborative Organizations.





Background

Colorado's Medicaid reform, launched in 2011, shares several similarities with Oregon's efforts. Colorado administers its system through seven Regional Care Collaborative Organizations (RCCOs). Oregon uses 16 Coordinated Care Organizations (CCOs). Both RCCOs and CCOs are responsible for arranging care for enrollees in their respective regions.

The differences between the two programs are the focus of an in-progress study by an interstate team that includes Rich Lindrooth of the Colorado School of Public Health and Jeanette Waxmonsky of Jefferson Center's Office of Healthcare Transformation and the University of Colorado School of Medicine. They shared some of the research with SNAC Lab attendees.

Oregon launched its CCOs in 2012, a year after Colorado began the Accountable Care Collaborative, which is operated through the RCCOs. Oregon was facing a budget shortfall in its Medicaid program of nearly $2 billion. The Centers for Medicare & Medicaid Services made a deal with Oregon to reduce the debt if Oregon would promise to lower the growth rate of Medicaid spending by two percentage points. This arrangement represents the most ambitious attempt within Medicaid to hold a state accountable for health care spending, Lindrooth said.

The governance of Oregon's CCOs is broader than Colorado's RCCOs. In Oregon, representatives from the health care delivery system and the community at large are included on boards that govern CCOs. A majority of seats on each CCO board must be held by people who share financial risk, including providers and hospitals.

In Colorado, the leadership of RCCOs is determined by whether the RCCO is led by health plans or payers, providers or community stakeholders. In payer-led RCCOs, the RCCO reports to upper health plan management. In provider-led and community-led RCCOs, a board of key stakeholders is in charge. Additionally, RCCOs must convene advisory committees for members and key stakeholders, but those committees may not represent upper management.

Oregon vs. Colorado

Key Differences

Oregon: Global payments

Colorado: Fee for service model, with PMPM payments for case management

Oregon also pays its providers differently. Colorado uses a fee-for-service model, with some per-member-per-month (PMPM) payments added to support case management.

In Oregon, the CCOs are given global capitated payments to provide care to the members in their regions. The CCOs bear the financial risk for exceeding

Oregon Results: Oregon CCOs vs. Commercial Insurance

Per member per month spending by Oregon CCOs compared with Oregon commercially insured population, 2011 to 2013

Inpatient:	**$6.82 more**
Emergency Department:	**$0.99 less**
Primary Care:	**$0.23 more**
Other Outpatient:	**$3.67 less**
Total:	**No difference** *(However, both were declining)*

the budget, and they have a strong set of incentives to reduce unnecessary health care utilization and improve quality.

Colorado tracks RCCO performance on three performance indicators — reduction in emergency department use, increase in postpartum follow-up visits and increase in well-child visits. Oregon uses 17 incentive measures.

Oregon vs. Colorado

Key Differences

Oregon: 17 incentive measure to track performance

Colorado: Three key performance indicators

The study compares Oregon's CCOs with two control groups — Colorado's RCCOs and Oregon's privately insured population — to measure the effects on health spending.

The different structures most likely have led to different outcomes in the two states, although Lindrooth said the research is not yet complete.

However, the researchers were able to compare progress in Oregon's Medicaid system to the state's private insurance plans from 2011 to 2013. They repriced and weighted the private data in order to make an apples-to-apples comparison to Medicaid.

Emergency department spending in Medicaid was nearly $1 PMPM lower than in commercial coverage. And Medicaid's costs for other outpatient procedures were $3.67 PMPM lower. However, Medicaid's primary care spending was 23 cents higher PMPM, and inpatient care was $6.82 PMPM higher. The increase in inpatient spending outweighed savings elsewhere in Medicaid. Lindrooth said the large increase was puzzling.

Both Oregon and Colorado showed improvements on their respective performance indicators. For example, Colorado targeted high-cost imaging, and spending on that item declined more in Colorado than in Oregon.

Waxmonsky discussed the qualitative side of the study, which consisted of in-depth interviews with three Oregon CCOs and three Colorado RCCOs as well as a review of publically available documents such as contracts and work plans for all seven RCCOs and sixteen CCOs.

Both Oregon and Colorado organizations have focused on reducing costly and avoidable care. Here are some of the efforts in Oregon, some of which are also being tried in Colorado:

- Emergency department (ED) navigators to direct people who often visit EDs to a more appropriate setting for care.
- A 911 diversion program for frequent users of emergency medical services.
- A program to focus on care transitions after hospital discharge.
- A complex care clinic for patients with multiple medical and social needs.
- Community health workers to address culturally specific needs of patients.
- Enhanced coordination for complex pediatric care.

CCOs are responsible for both physical and mental health care and have global budgets to cover both. One CCO in the study built its integration efforts off a community-wide conversation in 2009. That CCO now has about 15 psychologists embedded in different care settings across its region.

Other behavioral health integration efforts by CCOs include:

- Health resilience workers for patients with mental health needs.
- Pilot projects to place primary care doctors in behavioral health homes.
- Pilot projects to place addiction specialists in primary care settings.

- A communications campaign to increase awareness and literacy of mental wellness.

All in all, CCOs tended to devote more effort to behavioral health integration than RCCOs. Efforts similar to Oregon's initiatives are underway in Colorado, but they are not necessarily led by the RCCOs, Waxmonsky said.

The SNAC Lab Discussion

SNAC Lab participants posed some detailed questions about Oregon's system to the researchers.

One person wanted to know whether the researchers would look at differences in patient experience between the two states, and whether there are different outcomes for specific conditions.

Lindrooth said his team is looking at outcomes, but they do not yet have data to report.

Donna Mills, a former Colorado RCCO head, is now CEO of the Central Oregon Health Council CCO in Oregon. She called in to talk about her experiences in both states.

Audience members asked Mills how Oregon assigns patients to CCOs, which in some cases overlap. Mills said patients are assigned to the CCO closest to their home, but they can change if they already have a relationship with a provider in a different region.

SNAC Lab participants also said they were intrigued by Oregon's use of community health workers. The research team will publish a paper on this topic, Waxmonsky said. Every CCO is doing something different with community health workers. For example, one region is focusing its outreach on its large Russian-speaking population.

Conclusion

Oregon and Colorado have embarked on a similar path to improve care and manage costs through regionally based organizations. Oregon has embraced a global payment model to hold its regional organizations accountable for results. A forthcoming study will point out the similarities and differences in the two states' approaches.

Organizations Represented at the March 17, 2016, SNAC Lab

- Aurora Health Access
- Boulder Community Health Improvement Coalition
- Caring for Colorado Foundation
- Central Oregon Health Council
- ClinicNET
- Colorado Access
- Colorado Association of Local Public Health Officials
- Colorado Association for School-Based Health Care
- Colorado Coalition for the Medically Underserved
- Colorado Community Health Alliance
- Colorado Community Health Network
- Colorado Consumer Health Initiative
- Colorado Department of Health Care Policy and Financing
- Colorado Department of Public Health and Environment
- Colorado Health Foundation
- Colorado Hospital Association
- Colorado School of Public Health
- The Commonwealth Fund
- Denver Regional Council of Governments
- Jefferson Center for Mental Health
- Mile High Health Alliance
- Oral Health Colorado
- Noridian Healthcare Solutions
- North Colorado Health Alliance
- Rocky Mountain Youth Clinics
- SET Family Medical Clinic
- Telligen
- University of Colorado-Denver

Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

303 E. 17th Ave., Suite 930, Denver, CO 80203 • 303.831.4200 • coloradohealthinstitute.org