Oregon banks on community health care
By Christine Vestal, Stateline Staff Writer

Long before the national health law was enacted last year, a handful of states started work on their own health care overhauls. Massachusetts became the first state to require health coverage for all; it was the model for President Obama’s Affordable Care Act. Vermont has enacted a unique, state-based method of financing health care.

Oregon may soon become the next national model — for seeking to control costs and improve the public’s health at the same time. Setting up so-called “coordinated care organizations” as the front door for patients, the state aims to abandon the impersonal and fragmented way most people receive health services today. In its place, the state hopes, will be community-based systems that resemble the way medicine was practiced a century ago, when local doctors visited families in their living rooms.

Governor John Kitzhaber, a Democrat and former emergency room physician, signed legislation in June to launch Oregon’s first-of-its-kind health plan. It was not the only time the governor had been involved in a health policy change that would be both groundbreaking and controversial. In the 1980s, while he was state Senate president, and then during a first stint as governor, Kitzhaber promoted a re-ordering of state health care spending that critics derided as “rationing.” But a version of that system is still intact.

Today, the 64-year-old Kitzhaber is in a hurry to get the state’s new health care practices up and running before the national health law’s scheduled Medicaid expansion in 2014. Though he supports the Obama administration’s law, Kitzhaber says it did not go far enough.

“Expanding coverage to give more people access (which is the main thrust of the Affordable Care Act) — without changing the system people have access to — will only serve to increase cost and expand the national debt,” he told a crowd of health policy experts in Washington earlier this month.

Coordinated care

Oregon’s new health care scheme aims to do what Massachusetts failed to do and the national health law seems unlikely to do — get a handle on costs. The coordinated care organizations
— which are scheduled to be in operation sometime next year — are charged with doing most of the work.

In broad terms, the new law calls for creating local health care teams that would provide something new in the field. Instead of providing only medical services, the new organizations would combine comprehensive medical and dental care with behavioral health and substance abuse services.

The organizations would also offer preventive care, help Medicaid beneficiaries navigate the system and ensure that patients have access to any other local support services they need — all under one fixed fee per customer.

The idea is to make sure every patient gets the care he or she needs to either stay healthy or minimize the complications of acute illnesses and chronic diseases. The services to be offered will be as varied as finding rides for a young woman who needs pre-natal care, translating medical instructions for a patient who speaks another language, and providing mental health counseling for an elder who suffers from depression. It also means developing protocols to ensure that patients who are discharged from hospitals receive follow-up treatment and consultation to avoid unnecessary readmissions.

Licensed and monitored by the state, the new groups will be governed in each community by a board representing health care providers, consumers and local government. It’s envisioned that counties, localities and many of the state’s existing managed care companies will apply for state certification.

It sounds expensive, but Kitzhaber and his allies are convinced it will actually save the state a considerable amount of money. For one thing, the governor believes it will keep people healthier and reduce the amount of medical treatment they need. For another, he says, it will be more efficient.

When Kitzhaber talks about how coordinated care organizations will change the way health care is delivered, he uses the hypothetical example of a 90-year-old woman who lives alone in southern Oregon, where the summers are hot. She suffers from congestive heart failure and has repeatedly been admitted to the local hospital for treatment.

"The system today will pay for an ambulance to take her to the hospital and $50,000 to cure her," Kitzhaber says. "It won’t pay $500 for a window air conditioner, which is really all she needs to stay in her home and out of the acute medical system."

Under the current system, Kitzhaber says, "we won’t know about her until she shows up in the emergency room. "Under a new system with a strong connection to the community, a health worker would be checking on her on a regular basis to make sure her medical and non-medical needs have been met," he says.

Over the next two months, Oregon officials will be detailing the requirements and specifications for the coordinated care groups through a statewide public hearing process. In February 2012, lawmakers are expected to give their final stamp of approval. This year’s vote on the concept for the new organizations was nearly unanimous.

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10/27/2011
At first, the new health groups will be sole providers for the state’s 600,000 Medicaid beneficiaries. Soon, however, Kitzhaber wants them to serve Oregon’s 300,000 state employees and teachers. Later, universities and possibly small businesses may become clients.

Eventually, the plan’s backers hope that coordinated care organizations would be available to anyone who wants to sign up. Before that happens, though, “they will have to demonstrate their value,” says Kitzhaber’s health policy adviser, Mike Benetto. That means improving health outcomes, saving money and getting a thumbs-up from consumers.

The concept for these new health groups was tested in central Oregon on a group of so-called “frequent flyers” who had a record of checking into local hospitals as many as 25 times a year. The result was a big drop in hospital admissions and significant Medicaid savings.

To simulate the proposed new organizations, teams from hospitals, mental health facilities and other health care and social service providers in the area managed a select group of Medicaid patients — the sickest and most costly. Nearly all had more than one chronic disease and suffered from mental disorders and substance abuse. In addition to supervising their medical care, the teams helped patients find transportation, alter unhealthy lifestyles and upgrade their living conditions.

“The results were dramatic,” Benetto says. “Once we corrected some misaligned financial incentives, everyone was able to do the right thing.”

Oregon will need federal waivers to fully implement its plan and provide its newly designed system of unorthodox care. If the waivers aren’t granted quickly, Kitzhaber says the plan may fall behind its ambitious schedule. The state has not formally asked Washington for flexibility in implementing the plan. But Kitzhaber says informal talks with the U.S. Department of Health and Human Services have been positive.

“We can’t file a waiver until the plan is complete,” says Benetto. “But we want to start taking applications for the new organizations as soon as the legislature approves it,” he adds. “We haven’t quite figured all that out yet.”

A priority list

Oregon has a history of avant garde health policies. In 1988, when Kitzhaber was Senate president, he came up with a unique way to shave millions off the state’s Medicaid bill. Instead of paying for every known medical treatment — whether it worked or not — he proposed eliminating certain costly and ineffective procedures. That was when the “rationing” criticism began to hit him. But Kitzhaber stuck to his “priority list” even when the federal government repeatedly refused to approve it.

He argued that it was better to ration medical services by deciding what procedures people could live without than to ration limited state revenues by deciding who got health insurance and who didn’t. Washington finally approved Kitzhaber’s priority list, allowing Oregon to use the savings it generated to become one of only a few states to expand Medicaid coverage to low-income adults.

This year, the list of state-accepted procedures included 502 medical treatments, starting with maternity care for pregnant women. Cut from the list were 177 therapies, including those for common ailments such as hemorrhoids, tension headaches, pink eye, diaper rash and the

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10/27/2011
common cold. In many cases, over-the-counter drugs were recommended instead. The list also rejected aggressive treatments for obesity and a variety of psychological disorders.

Budget constraints

As in 35 other states, severe revenue shortfalls this year forced Oregon to reduce the Medicaid fees it pays hospitals. Although hospital industry leaders complained the cuts left very little savings to be squeezed out of the medical community, state officials say it won’t slow progress toward creating the new health organizations.

In 2002, during Kitzhaber’s first stint as governor, an economic slowdown did force Oregon to curtail its health care ambitions. An expanded Medicaid plan that had been covering low-income adults since 1994 had to stop taking applications. Enrollment fell from 124,000 people to fewer than 24,000. In 2009, a new tax on health care providers gave the program a second chance; enrollment has since grown to 65,000.

Taking the setback in stride, Kitzhaber moved during his first and second terms as governor (1995 to 2003) to include more mental health services under the Medicaid umbrella, rein in prescription drug costs, create special disease management programs, and increase the use of managed care plans.

Today 80 percent of Oregon’s Medicaid beneficiaries are served by managed care organizations, which experts say will make it easier for the state to pivot to the new coordinated care system. In the governor’s view, current state budget crises represent opportunities for change. “The reality,” he insists, “is that we simply do not have the resources to maintain the current system.”

—Contact Christine Vestal at evestal@stateline.org

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