United States Senate
Special Committee on Aging
Washington, DC

September 13, 2006

Testimony of David Ford
President & CEO
CareOregon

CareOregon

CareOregon

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David Ford
President & CEO

Dave Ford has been in health insurance leadership roles for more than 20 years. Since 2003, Dave has served as CEO of CareOregon, the largest Medicaid Managed Care Organization in the state, serving Oregon Health Plan members, Dual Eligibles, and SSI recipients. Previously, he worked as an executive with Aetna, NYLCare, and Blue Cross of Washington and Alaska. As CEO, he completed a turnaround for an HMO serving SSI recipients in Washington, DC and Baltimore, MD. He has also worked with a Venture Capital firm in Palo Alto, CA. Dave is married to photographer/writer, Phi Ford, and has three grown children. He has a degree from the University of California, Davis.

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CareOregon

United States Senate Special Committee on Aging
CareOregon Written Testimony

David E. Ford, President & CEO
September 13, 2006

Accompanying Slides

Mr. Chairmen, Members of the Committee. Thank you for allowing me to testify today on the expansion of Medicaid Managed Care. **1**

My name is David Ford. I am President and CEO of CareOregon in Portland, Oregon.

I'm here to talk about Managed Medicaid, especially among aged, blind and disabled, often referred to as SSI, from the ground level. We have been managing all lines of Medicaid for 10 years. Since we are fully capitated for our member's health care, we are able to innovate, even ***required*** to innovate, with our delivery system partners for the benefit of our member for less cost than fee for service. I will be focusing tightly on one of many facets of care management for the complex member, in the context of Oregon.

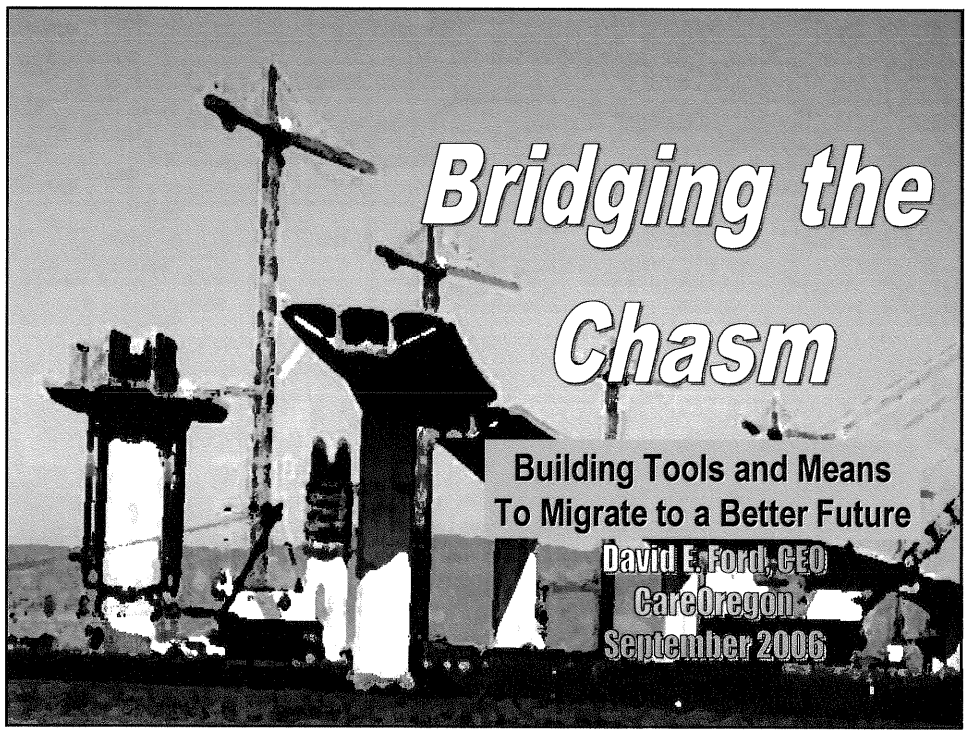
Complex care management is beyond Disease Management or Chronic Care Management. Complex care is for those people with 4 or more co-morbid conditions, i.e. diseases, [often complicated by depression or mental health issues], who are not well connected to social or medical support systems. We have received two grants from the Center for Health Care Strategies to develop the methodology and managed these complex members.

But first, CareOregon is a non-profit corporation founded in 1994 by Oregon Health Sciences University, Multnomah County Health Department and a number of Federally Qualified Health Centers to serve managed Medicaid Members. Thanks to Congressional action through MMA, CareOregon has grown to serve Dual Eligibles through our new Medicare Advantage Special Needs Plan. We are the largest of about twelve local managed care health plans. We serve 100,000 Medicaid and about 6000 Medicare Members. More than half of our members receive services through Safety Net Providers. The majority of our members are in the greater Portland area but we serve 16 counties throughout Oregon. **2** **3**

Personally, prior to coming to Oregon, I have been the CEO for two for-profit Health Plans which served Medicaid members; one in Washington State, and then one here in the Maryland/District of Columbia areas. In Maryland, we also served the SSI membership. One of my first observations, when I arrived 3 years ago in Oregon is how medically efficient Oregon is relative to Maryland for the same matched population. As the fourth illustration (slide 4) in the handout shows, for SSI recipients, the hospital days/1000 members in Maryland dropped from 2100 to 1900/1000 after 2 years of managed care. In Oregon, it dropped from 1300 to 1000/1000 days after two years of **4**

	Accompanying Slides
care management: *almost half the number of hospital days in Oregon vs. Maryland for a similar covered population.* The Dartmouth Atlas confirms this same efficient care pattern for Medicare compared to other national sites, as well.	5
This phenomenon drove us to look at how to further increase care efficiency and effectiveness in Oregon. First, we adopted the Institute of Medicine's Crossing the Quality Chasm as an operating framework for improving of the future for managed care. Second, we studied our members' data with a data tool from Johns Hopkins University called the *Adjusted Care Grouper Predictive Model* [ACG-PM]. This is a big word for being able to understand how sick and complex our members' are, where our care resources is being spent, and what we might do to help them. We found 12% of our members used 60% of the resources. 3% of our members used 30% of the resources. We also learned that the SSI members have many social, behavioral and mental health circumstances that influenced and complicated their medical conditions.	6,7,8,9 10 11
We learned from Dr. Barbara Starfield's research at Johns Hopkins, that people who have 4 or more co-morbid conditions (diseases), spike in resource use, so classic single disease management and managed care techniques were not enough. So we developed a full set of strategies and tools to improve the efficiency and effectiveness of care for our members.	12 13,14
The Center for Health Care Strategies provides us two, 3 year research grants, to pilot methods to prove the business case for managing complex members. With a nurse driven case management system, in year 1 the savings were $5,000 per member per year, in year two this increased to $6000 per member per year. Care is more integrated, effective and satisfying. That's the good news. The bad is that we can't find, hire or train nurses fast enough to reach all the members who can benefit from this. We are now experimenting with a changed care management model focusing on a team approach, which incorporates social workers, medical assistants and behaviorists.	15 16
We have learned several things. First, *it not the care people receive that drives the cost, it's the care they don't get that drives cost.* Lack of early preventive visits and too few monitoring visits and follow up calls are causing unneeded expensive emergency room visits, admissions and crisis complications. Second, much of the care received, actually and potentially, are in social systems, i.e. family, friends, neighbors, and church; **not** the medical systems. When integration, communication and collaboration among these systems are established, there are fewer costly acute and crisis interventions. More importantly, the patient remains more stable and connected to their 'normal' life' and safe from medical harm.	17
We are considering how we can electronically connect the full social and medical care community so they can collaborate on a single individual to improve timely, accurate and consistent communication for these complex members. We have been dialoging with Intel to see how we can use their 8,000 Portland employee base along with CareOregon as a "test bed" to rapidly develop this technology.	18
In closing, there are many things we could discuss. I've provided several ideas in the companion illustrations.	19, 20

Our capacity to innovate rapidly and effective has advanced profoundly in the last decade. Managed Care, which was once a barrier to care is now an enabler and facilitator of care. It is the right care, delivered at the right time, which drives down wasteful, unnessecary care and unsafe practices in our current system. Within our public expenditures of Medicare and Medicaid is where some of the most innovative, best advances in safe, efficient care are emerging. We would encourage your leadership to facilitate better care on a national scale by including more citizens in publicly sponsored managed care. I hope you will consider CareOregon a resource in helping this expansion move forward. Thank you for allowing me to participate in this discussion. I would be happy to answer any questions.



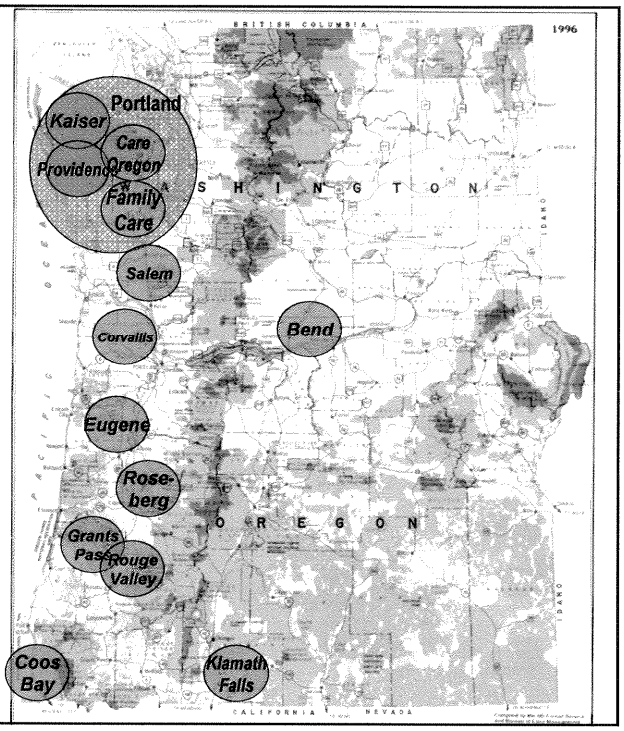
CareOregon Information

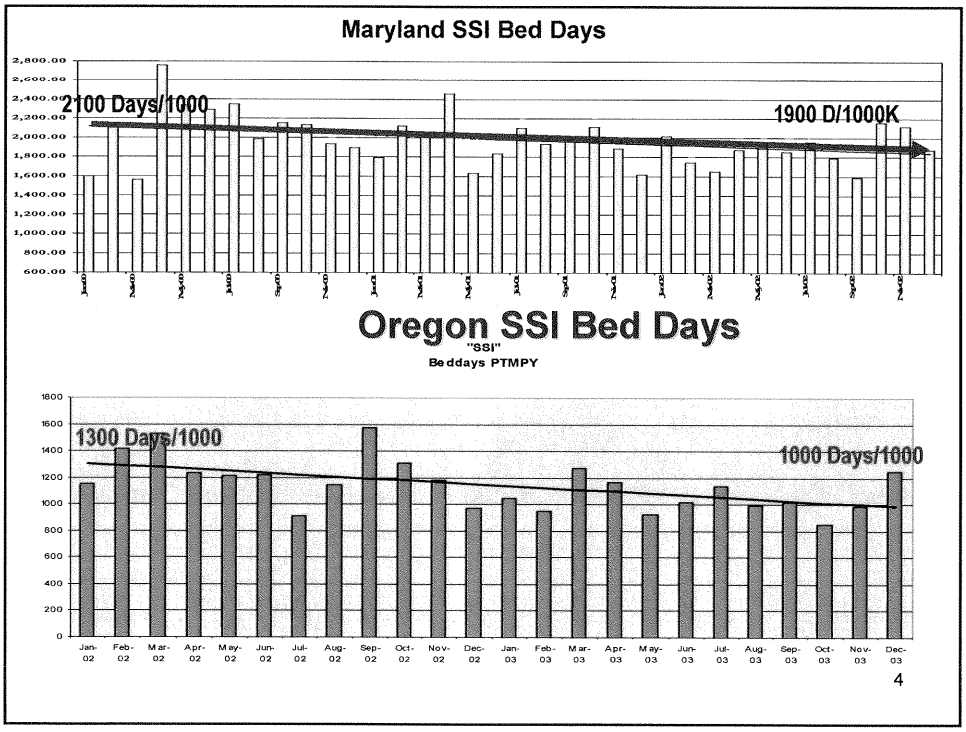
- Founded 1994 by Safety Net System
  - Oregon Health Sciences University
  - Multnomah Health Department
  - Federally Qualified Health Centers
- 100,000 Medicaid Members
  - Approximately 38% of State's MCO members
- 5600 Medicare Advantage Dual Eligible membes

2

Oregon's Local Integrated Systems

- Medicaid Delivery Systems
  - Coordinated Care
  - Physician Buy-in
  - Local Expertise
  - Local Data
  - Many:
    - Developing Community-wide EMR
    - Are Medicare Special Needs Plans

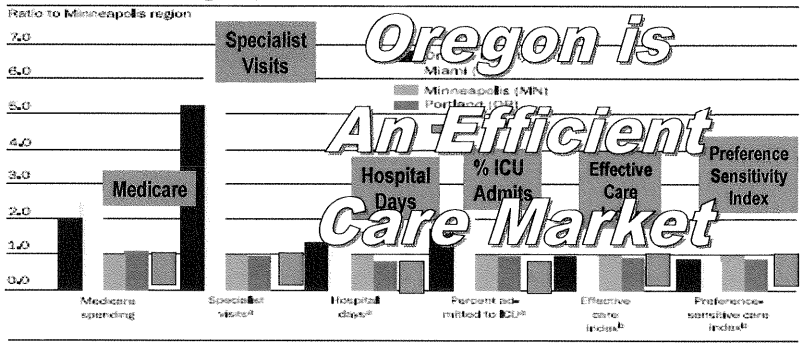




Dartmouth Study

MEDICARE REFORM

EXHIBIT 3
Comparison Of Medicare Spending, Supply-Sensitive Care, Preference-Sensitive Care, And Effective Care For Orange County, Miami, Minneapolis, And Portland Hospital Referral Regions, 1995–1996



SOURCE: *Dartmouth Atlas of Health Care*, 1995–96 database.
NOTE: Rates are given as ratio to Minneapolis hospital referral region (valued as 1.0).
[a] Care provided per decedent in the last six months of life.
[b] See Exhibit 2 for definitions.

Oregon is An Efficient Care Market

Source: Health Affairs

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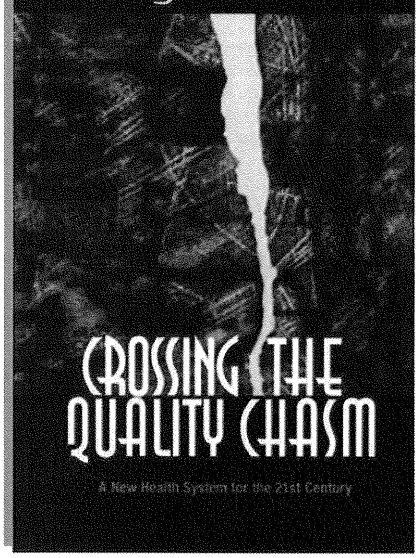
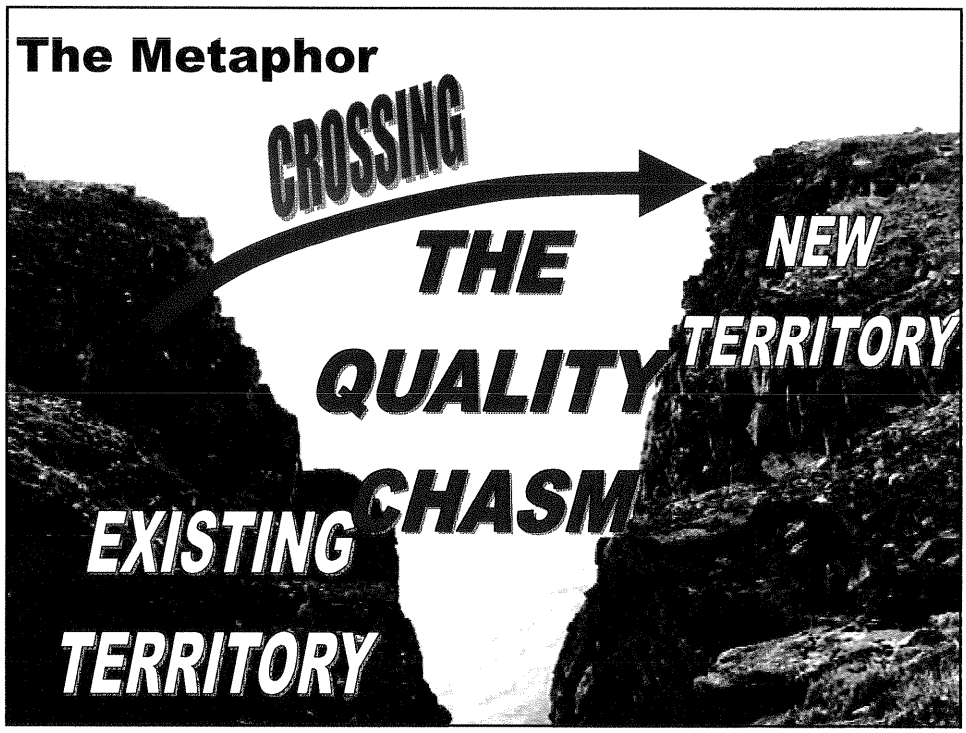
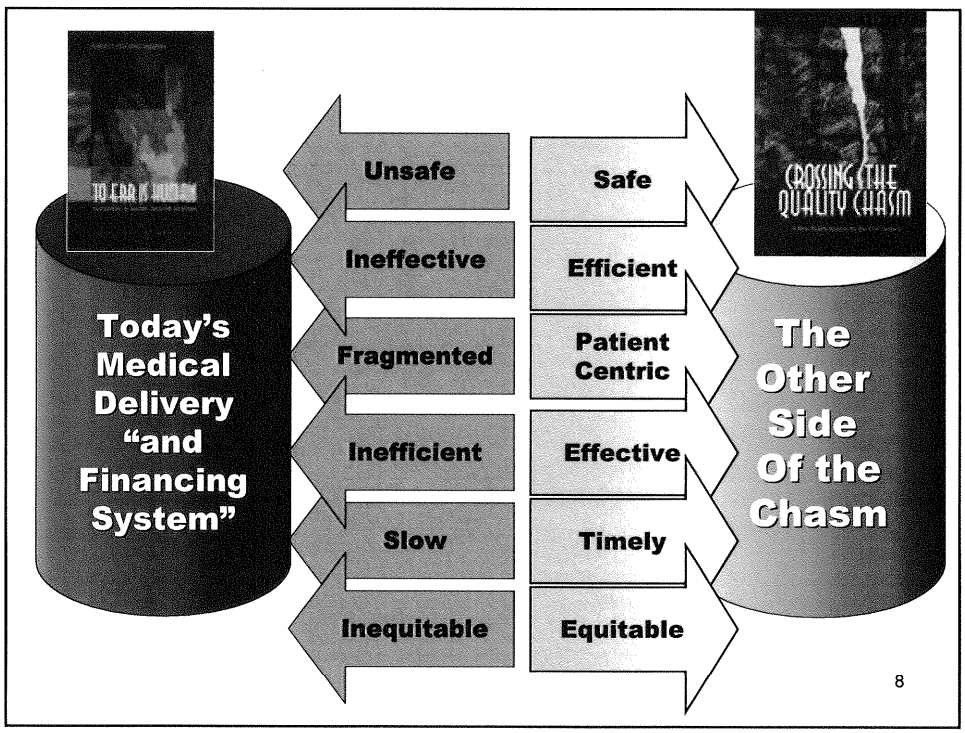
Major Call for Change



- **2000 Institute of Medicine Publication**
- **Critique of American Health System**
- **Blue Print for Change**

6


The Metaphor
CROSSING
THE
QUALITY
CHASM
NEW
TERRITORY
EXISTING
TERRITORY


Today's Medical Delivery "and Financing System"
Unsafe
Ineffective
Fragmented
Inefficient
Slow
Inequitable
Safe
Efficient
Patient Centric
Effective
Timely
Equitable
The Other Side Of the Chasm
CROSSING THE QUALITY CHASM
8

How?

IOM Blue Print for 21st Century Quality Bridge

Complex & Catastrophic

NICU Trauma

Chronically Ill

Acute Episode

General Acute and Misc. Trauma

IOM's Foundation

- Evidenced Based/ Aligned Treatments / Safety as Property
- Patient Centered / Ready Accessible
- Payment policies aligned with Improvement
- Supportive IT Platform: Transparent, shared information flow

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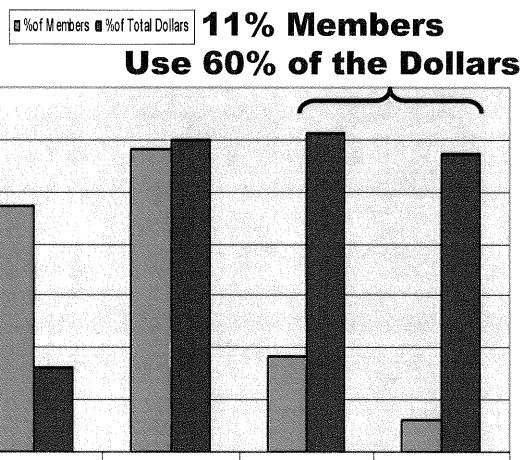
CareOregon

Distribution of ACG Comorbidity RUB

April 1, 2002 - March 31, 2003

Includes Members with >4 months Enrollment Only



	Nonusers	Healthy Users	Low	Moderate	High	Very High
%of Members	23%	12%	24%	29%	9%	3%
%of Total Dollars	1%	2%	8%	30%	31%	29%

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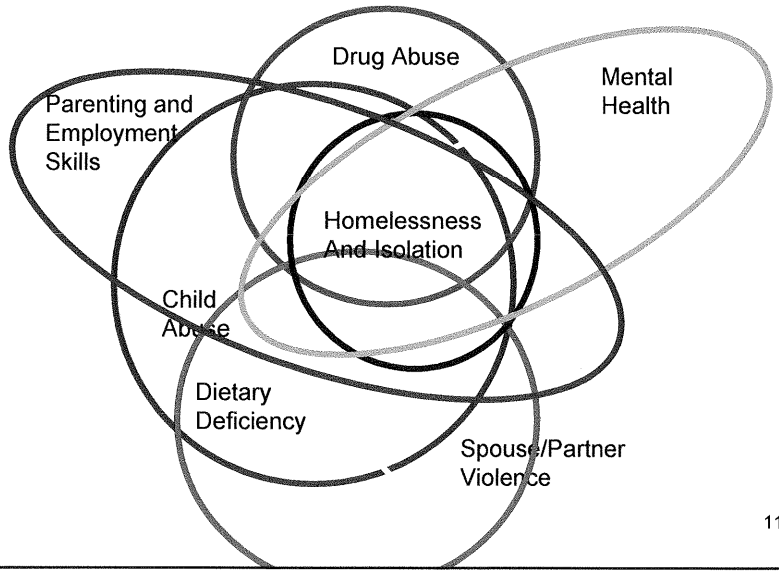
Complex Social Environment

Situational/Social Risk Factors



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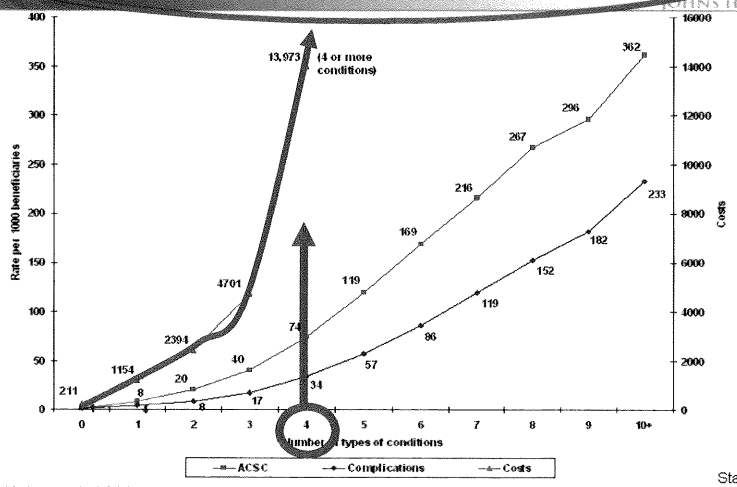
Co-morbidity, Inpatient Hospitalization, Avoidable Events, and Costs*



Source: Wolff et al, 2002

Starfield 10/03
03-252

*ages 65+, chronic conditions only

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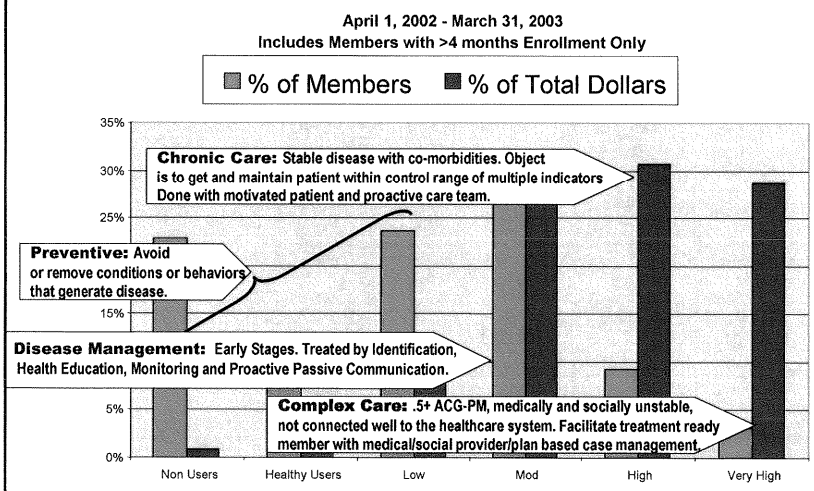
4

Source: Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. Arch Intern Med 2002; 162:2269-2276.

"Operationally Defining"
Disease, Chronic and Complex Care



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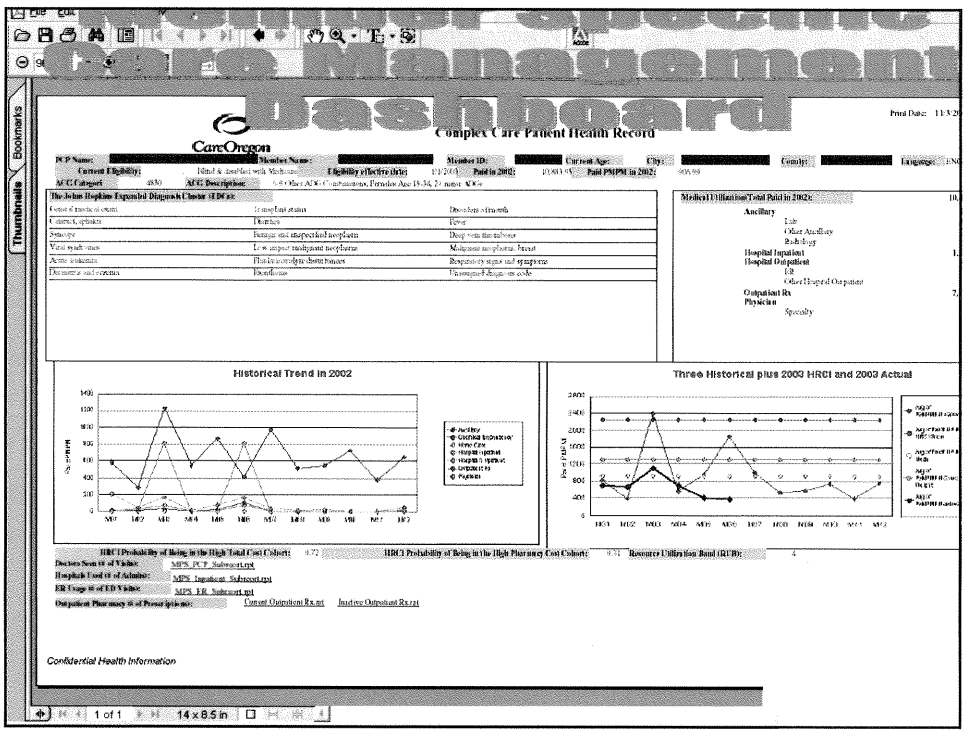

Program Dollar Savings

CM	Paid 2003	Paid 2004	Paid Change
Brief CM (n=1661)	$13,094,069.59 (pmpm $709)	$11,777,395.49 (pmpm $651)	-$1,316,674.10
No CM (n=59399)	$73,751,101.62 (pmpm $127)	$77,671,595.11 (pmpm $127)	$3,920,493.49
CM (n=326)	$5,272,876.82 (pmpm $1525	$3,765,855.28 (pmpm $1037)	-$1,507,021.54

~$5,000 Unadjusted Savings /case

But: Are the Savings from Case Management?

Did the sick members just get better?

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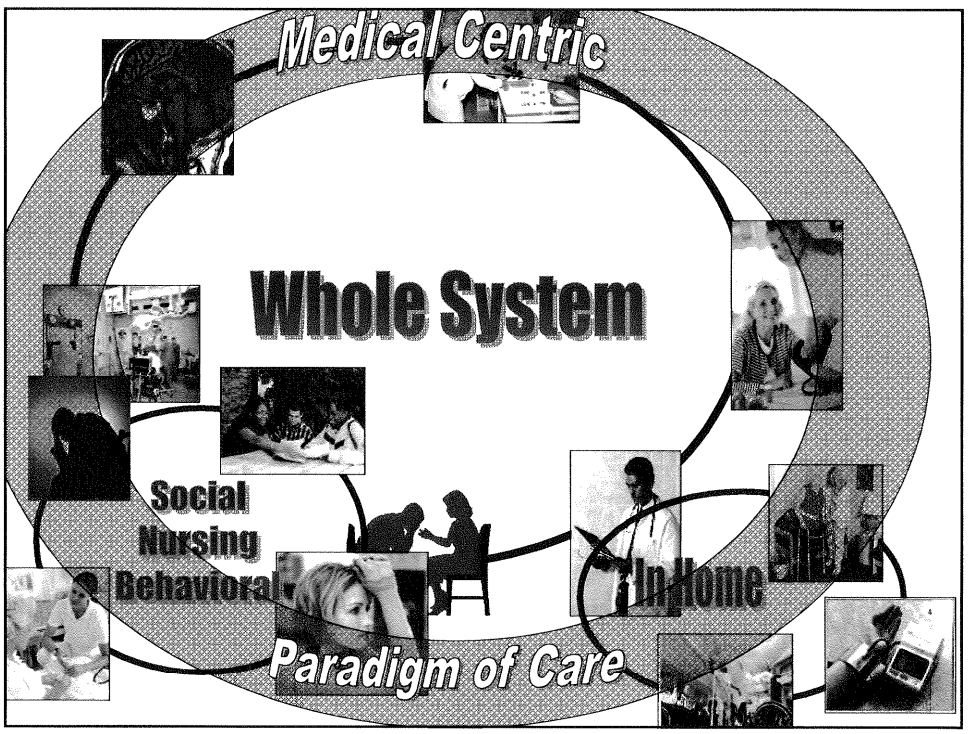

Where Most Care Is Delivered

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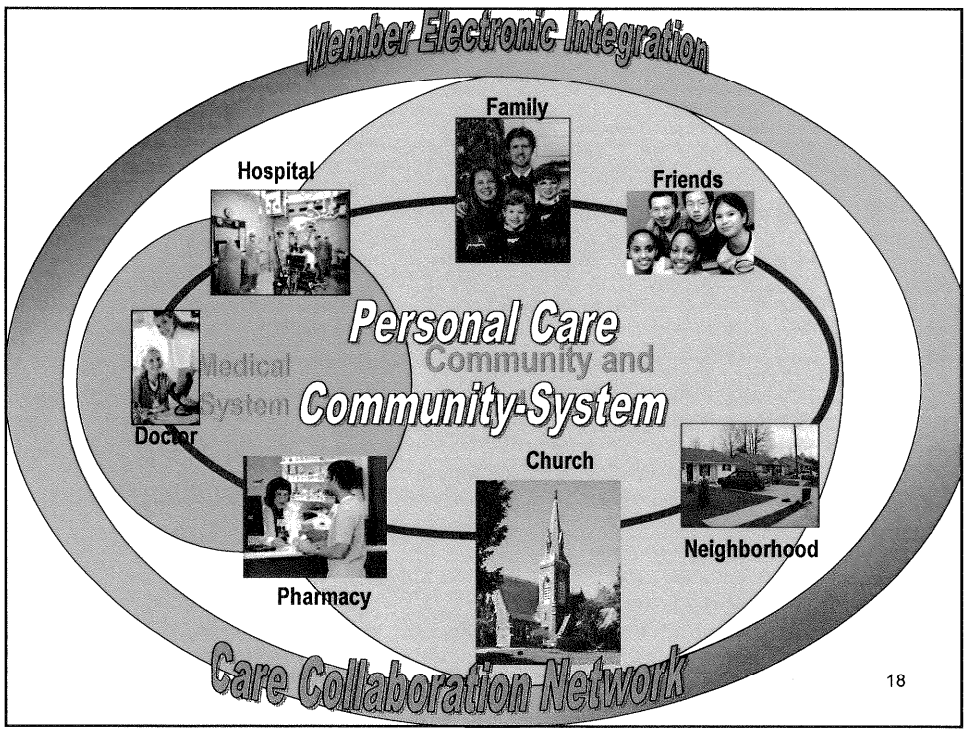

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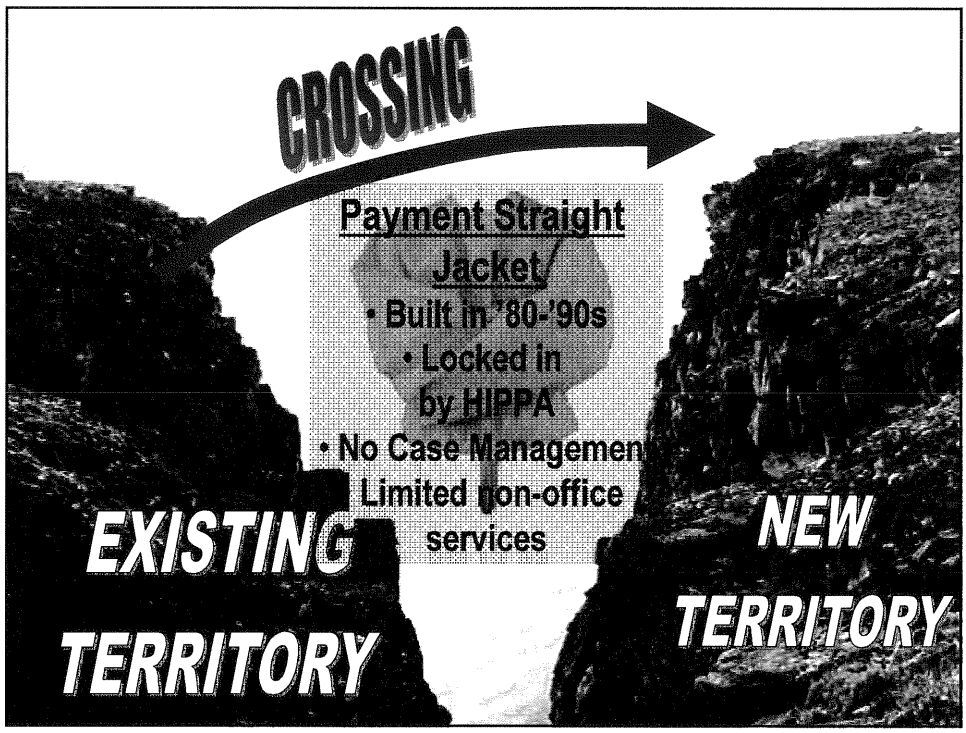

What More Can Be Done?

1. **With Confidence, expand Medicaid to included SSI**
   - Been widely done
   - Great success for members and cost
2. **Integrate, where possible, Mental and Behavioral Health Care with Physician Medicine**
3. **Acknowledge social care and physical care work to create synergy**
   - Need to have integrated collaborative technology
   - Need more patient control and choice in care processes
4. **Change what we pay for: Cannot get to tomorrow with yesterday's Piece-work payment Process**
   - Need to pay for case management, phone calls, email, out-of-office care management
5. **Take Actuarial Soundness seriously**
   - The State legislative practice on arbitrary "policy-adjustment" to rates undermines incentives for innovation
   - Give CMS teeth and process to rapidly enforce

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Better together

CareOregon

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CareOregon

CareOregon is the state's largest Medicaid health plan specializing in care for low income Oregonians under the Oregon Health Plan. CareOregon's mission is to create a model of care that emphasizes prevention and primary care case management. We incorporate a variety of health care providers in an effort to deliver high quality, culturally appropriate, cost-effective care. Our members receive health care services through a network of community and private medical providers throughout the state.

Founded in 1993 as a collaborative effort by public and private health care providers, CareOregon is a 501 [c] 3 private nonprofit Managed Care Organization with a 10 member Board of Directors. The current Board is comprised of private practitioners, several health care providers, and representatives of two of the founding partners; the Multnomah County Health Department and Oregon Health and Sciences University.

When the Oregon Health Plan began, it increased the number of people eligible for Medicaid benefits, changed the way health care providers are reimbursed for service, and changed the way providers are organized to receive payment for serving Medicaid clients. CareOregon was established so that the founding organizations could continue to serve the low-income, vulnerable populations through the Oregon Health Plan.

In order to provide continuous coverage to all of our almost 100,000 members, on January 1, 2006, CareOregon began offering a Medicare plan to members with both Medicare and Medicaid coverage (i.e., "dual eligibility") in seven Oregon counties. CareOregon Advantage, a Special Needs Plan, serves approximately 6,000 dual-eligible members, only a third of whom are senior citizens. The majority of CareOregon Advantage members are adults with multiple illnesses and many are fully disabled.

To further our mission, CareOregon develops partnerships with providers and provider organizations that serve low-income people to create a community-based model of care. We are focused on improving the health status of our members and the communities we serve. To accomplish this goal, we support the efforts of the clinicians and advocates who care for our members; educate members on appropriate utilization of health care resources; and provide case management and exceptional needs care coordination.

CareOregon Member Information

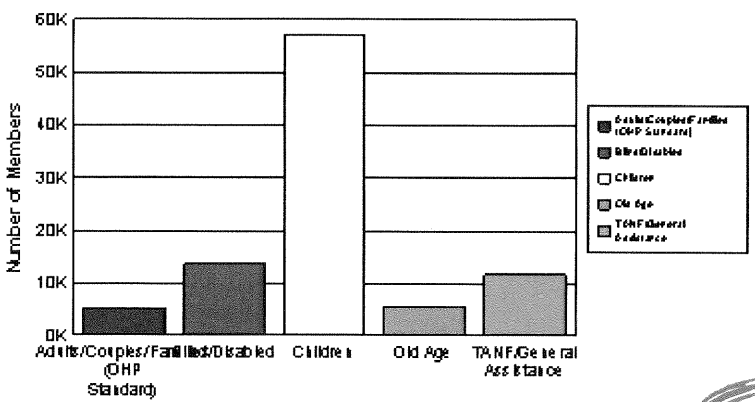
As of: August 31, 2006

Age Groups	Total
0-1	**6,503**
1-19	**53,659**
20-29	**8,140**
30-39	**6,525**
40-49	**6,187**
50-59	**4,980**
60+	**7,363**
Total	**93,357**

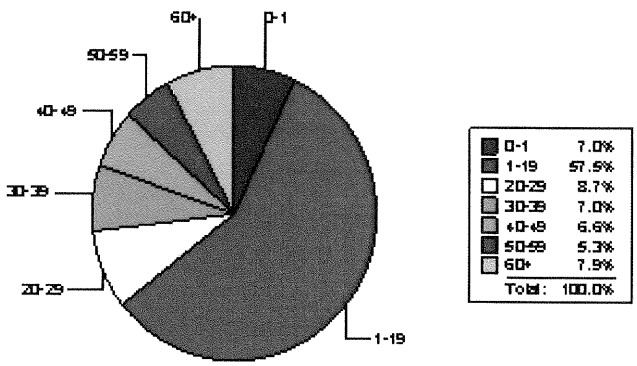
Gender	Total
Female	**51,943**
Male	**41,414**
Total	**93,357**

Eligibility Categories	Total
Blind & disabled with Medicare	**4,523**
Blind & disabled without Medicare	**9,147**
Childrens Health Insurance Program(CHIP) child < 1 year old	**156**
Childrens Health Insurance Program(CHIP) child between 1 and 5 yrs old	**1,931**
Childrens Health Insurance Program(CHIP) child between 6 and 18 yrs old	**6,589**
CSD children	**3,620**
OHP - adult < 100% poverty level	**1,306**
OHP - children < 1 year old	**6,372**
OHP - children between 1 and 5 years old	**17,104**
OHP adults and couples	**3,244**
OHP Families	**1,938**
OHP -l child between 6 and 18 years old	**21,410**
Old age with Medicare A and B	**3,094**
Old age with Medicare Part B only	**2,052**
Old age without Medicare	**405**
Poverty level medical - adult > 100% poverty level	**779**
Temporary Assistance for Needy Families - Adult	**9,426**
Temporary Assistance for Needy Families - Child 0-19	**261**
Total	**93,357**

Summary by Eligibility Category



Age Groups



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