[00:00:01.290] Announcer:

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[00:00:36.420] Don Crane:

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[00:01:15.810] Don Crane:

Good morning, APG podcast listeners. We know that one of the Biden administration's ambitions is the expansion of coverage headed towards their goal, I think, of universal coverage and strengthening the Affordable Care Act. We know further that there's been a lot of talk about a public option that even though the Dems now have a quote-unquote majority in the House and the Senate with the addition of Vice President Harris's tie breaking vote, I think most of the betting money is that a public option looks like a very, very steep hill to climb. Tough thing to do through Congress, any Congress, maybe particularly this Congress, and involves issues we won't get into now about reconciliation, et cetera, et cetera. What does look, however much more conceivable and possible, is an expansion of coverage via Medicaid and more specifically affected by 1115 and 1332 waivers which the administration can do without the approval of a stalemate in Congress. And, so our gaze has shifted a lot lately to the whole waiver process and examples of Medicaid expansion in states that might serve as models.

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So, in light of this, I had the good fortune of sitting down yesterday with Oregon's former Governor, John Kitzhaber, who was the architect of Oregon's coordinated care organization initiative, which now covers about one out of every four Oregonians. It just may be a model to emulate. I'll let him describe the details, but it's capitated. It's population-based. It has quality measures. So, there is much to like about it. And it

may serve as a model for really where the value movement is going forward with the Biden administration.

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Governor Kitzhaber is an extraordinary person. It's a politician having the clinical experience and a clinician having the political experience issue here. So, he is a very important resource. And I think you'll find this podcast very interesting. So please take a listen. Thank you, Governor Kitzhaber, so good to have you with us today. If I may, John, I'll call you John, since we're pretty friendly these days. You know, you practiced medicine for a whole bunch of years as an E.R. doctor in Oregon.

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You were in the Oregon House of Representatives and then the Senate. You were the president of the Oregon Senate for, I think like eight years. You were Oregon's longest serving governor, I think four terms. So, you've certainly had your time in politics. But what brings us, I think, to this conversation today more than anything else, is your work as the chief architect of Oregon's coordinated care organization model. That's the label I put on it. They have a more formal one. But it was and is a really major effort in the country to bring capitated care to a Medicaid product, but with delivery model reform.

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So, with quality measurement capitation and a sustained growth rate, we'll get into that… to this day, though, one out of every four Oregonians and 60 percent of the children get quality care through one of the CCOs that you had the leading, I think, role in designing. And so that makes for, I think, an amazing background and gives you an enormous experience to shed some light on what we're trying to accomplish right now. So, having talked with you a bunch lately, John, and had you speak to my board and our members and so on.

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You know, I think this what I'm now about to ask is kind of a rhetorical question, but, so, what are you doing these days? And really what is driving you?

[00:05:16.830] John Kitzhaber, MD:

Yeah, well, thanks, thanks, Don, for inviting me on the podcast. And thank you for your friendship and for the support of your organization over the years. Well, I'm very involved in many of the things I was working on when I was in public office and engaged with the Biden administration, trying to offer some constructive proposals to build on and complement his non-COVID healthcare agenda that he laid out during the campaign here in Oregon.

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I'm working on the whole issue of creating a more effective way to actually deliver on the need to address the social determinants of health. You know, part of that's a funding issue, but even more importantly is being able to actually get the right services to the right people at the right time and for long enough to make a difference. Then I continue to do some work on natural resource issues and the climate.

[00:06:18.760] Don Crane:

Very, very good. So, Biden administration, here we are, first week still of February, almost the first week of February. We sit around here wondering what the Biden administration is going to do. We're reading tea leaves. Clearly, we're interested in the value movement and other things as well. But, so, what's your take and prediction? Where do you see the Biden administration and Congress? I think I should say, headed with respect to healthcare?

[00:06:53.050] John Kitzhaber, MD:

Well, I think we need to break it into two categories. One is COVID-related healthcare issues, which I think are going to completely consume the administration and Congress for the next several months. And I think that's as it should be. It's a public health crisis, obviously. And it has had these huge economic impacts on states in terms of their ability to maintain their own healthcare systems, particularly Medicaid. And then obviously the huge economic dislocation that has resulted from the shutdown.

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And then the other portion of it, which I think is perhaps more relevant to our conversation, is the policies he laid out, at least in his campaign, which involve a building on the Affordable Care Act to make care more affordable to consumers, primarily by increasing the subsidies in the ACA marketplace and then adopting a new public option.

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Just from a political standpoint, I think it's going to be very difficult to get to those issues for the next couple of months. There's a question regarding how much of that actually requires statutory change and that may well require action through reconciliation if they don't have a cooperative, you know, at least a minority of Republicans supporting him in the Senate. So, I think the future is kind of up in the air. The proposals that I've been suggesting are ways to build on his proposals, but in a way that can be done, I think largely through a CMS and CMMI, through the waiver process, looking specifically at 1115 and 1332 waivers.

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And I think that the biggest concern I have about the Biden proposal is that while increasing public subsidies will make care more affordable to individuals, it actually doesn't make the total cost of care more affordable. Or nor does it change the delivery model. And I think there are real problems with that, given the fact that our national debt is now approaching 28 trillion dollars and our budget deficit is over 3 trillion. So clearly a way to make care more affordable by certainly increasing subsidies, but also by reducing the total cost of care.

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But moving away from fee-for-service to value, I think needs to be a central component of the agenda.

[00:09:13.000] Don Crane:

So, I think we're in agreement. So, react, my perspective on this, John, if you will: Oregon has had enormous success with its CCO program, as I see it. I think it's fair to surmise that Biden will have trouble with really lofty goals in terms of expansion like public exchanges. But he does have this ability to control CMS and CMMI and the waiver process. And so, it seems like to my way of thinking, I think, yours perhaps, a perfect time for people to focus on the Oregon experience and a good opportunity to emulate that for other states and to encourage it federally through the waiver process, et cetera, et cetera.

[00:09:58.510]

So, I'm seeing this being is a pretty big opportunity for you and the kind of work you're doing. Do you agree with me?

[00:10:06.430] John Kitzhaber, MD:

Yeah, yeah, I do. And just for those who are not familiar with the coordinator organization model, I'm not suggesting we export, you know, the model, but I think the concepts, the principles on which it's built are exportable. And those basically involve moving Medicaid away from fee-for-service to a capitated model. That very important to understand that it's linked to a global resulting global budget is linked to a growth rate, sustainable growth rate.

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In our case, no more than 3.4 percent per member per year growth and tied to rigorous metrics around quality outcomes and access. And it's interesting, one of the things we learned was that the real cost savings are not in the fees, the fee schedule itself, but actually in bending down the trend. We, over the course of the first five years, we were able to add another 385,000 people under the ACA expansion.

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All CCOs met the quality and outcome metrics and we realized the cumulative total fund savings of over a billion, over a billion dollars. So, I think that states, both red states and blue states are going to be facing huge general fund budget shortfalls because of the increase in Medicaid enrollment and falling tax revenues and rural hospitals in particular, which are important community centers as well as medical centers. And often some of the largest employers in rural parts of America, I think can benefit enormously from a global budget that is a budget that's not dependent on volume.

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And our largest CCO geographically is called the Eastern Oregon CCO, which has about half the geography of our state. The eastern side of the state for rural hospitals want a frontier hospital in that coordinated care organization. And they've actually done quite well because they're on a predictable budget model. So, we know that we can get this done through 1115 waivers. And I think there'll be some real interest, I think, around the country and moving to something like this.

[00:12:20.090] Don Crane:

So did that improvement in trend in Oregon, did that result from, as you said, it wasn't the case really so much in reducing provider compensation, hospital and physician, I gather, but reduced utilization, I would assume. Is that correct? And did you get a sense that the health status of the population actually improved such that there was a lower demand and need for care?

[00:12:45.890] John Kitzhaber, MD:

Yes, I think that's exactly one of the success stories. We moved, I think one of the quality outcome metrics, these are metrics that actually are linked to reimbursement, was moving, was a percentage of your CCO population that was moved into patient centered primary care medical home. And we've got ninety-five plus percent in that kind of managed arrangement. And CCOs also have a local governance structure. So, they are well connected with other local social service agencies, et cetera.

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So, it's created a real change in culture that is moving away from strictly a clinical model to taking a broader view of community health and partnering with other non-clinical entities that also have a role in promoting health.

[00:13:37.460] Don Crane:

So, let me reveal my ignorance a little bit. So, Medicaid in Oregon, I'm more familiar with California where we've got large Medicaid health plans…kinda two-plan model.

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We have also the county sort of sponsored model. How in Oregon is Medicaid sort of governed and managed?

[00:13:56.840] John Kitzhaber, MD:

So, up until 2012, when we set up this model, it was essentially a group of autonomous, sort of disconnected MCOs, behavioral health organizations, dental care organizations that all provided care to this Medicaid population. And, you know, there were some IPAs that were formed twenty-five years ago to provide care to Medicaid under the Oregon Health Plan. So, when we moved away from that model, we put out a basically an RFP for people to apply to be coordinated care organizations.

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There were a series of requirements, a certain reserve requirements and financial requirements, but also this commitment to manage the health and the cost to the population against a quality and outcome metrics. So, what emerged were initially 16 different models. The one in Portland has four major mental health. It has three county medical mental health organizations. It's got a number of hospitals. They're all a little bit different. Right? They kind of reflect the communities from which they emerge.

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A couple of them are partnered with commercial insurance companies, PacificSource being one and Moda Health being another. And until 2015, there weren't any for profit MCOs in Oregon. Trillium, which was the coordinated care organization formed in Lane County, which is our second largest metropolitan area, was actually purchased by it was an IPA and it was purchased by Centene.

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So, we have this we do have one for profit MCO, but the rest of them are, it's just a variety of care entities. The counties themselves are not specific Medicaid providers as they are in California.

[00:15:50.030] Don Crane:

I see, I see. So, maybe a rhetorical question, but, you know, why not if the Biden administration simply wants to improve subsidies in the exchange and elsewhere and for Medicaid and non-expansion states to develop, maybe tax credits or other tax inducements to make Medicaid more attractive and thus improve the penetration of coverage in that fashion.

[00:16:18.210]

Why all the emphasis on delivery model reform? Why is that necessary?

[00:16:23.190] John Kitzhaber, MD:

Well, I mean, I think the story of the Great Recession 10 years ago is very instructive. So, as you recall, in 2009, Congress passed the American Recovery and Reinvestment Act, which was their version of the Corona stimulus package.

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Right? We didn't have the pandemic, but we had serious unemployment that contained eighty-six billion dollars to prop up state Medicaid programs. When the economy improved in 2011, those programs ended. In Oregon it was a 640-million-dollar overnight cut in the Medicaid budget. So, I think people need to recognize that if we're successful in getting most of the population vaccinated in this calendar year and the economy comes back in 2023, a whole lot of this money is propping up state Medicaid programs, that's propping up the ACA market and propping up our economy is going to go away because they're going to have to get very, very serious about deficit reduction.

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So, it's simply propping up the existing inefficient fee-for-service system with more money doesn't actually reduce the total cost of care, which is the, you know, the major reason we have coverage problems. It undermines the ability to invest in the social determinants of health. And we can talk about this more later. It undermines equity. So, I think it's imperative that if we're going to add more money to the ACA market and to Medicaid, that we also go hand-in-hand with efforts to move towards value.

[00:18:01.170] Don Crane:

So, we're seeing the value movement struggle in some cases in some areas of the country right now. I think, for example, of the many CMMI pilots and demos that didn't yield the savings for CMS. This is not to say that they didn't generate some success measured in different ways, but looking solely at savings for CMS, they didn't yield good results. So, say if Brad Smith in his recent article in *JAMA*, as he looked at, I think, the 55 different pilots, some five or so generated the savings.

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So, part of the reason, I think, is because of the sort of fee-for-service platform underlying so many of those demonstrations. And that platform fee-for-service kind of continues because it seems to be in some ways pretty intractable. It is hard to, you know, turn that tanker around and put people into some kind of prospective, budget-based model just isn't easy. So, how did you succeed in getting so much of Oregon to move into a kind of a budget-based capitated model? Did you twist arms?

[00:19:10.800]

Did you promise savings? I mean, did you just cajole? What is it that got you, how are you successful where others have not been?

[00:19:18.300] John Kitzhaber, MD:

Well, I think there are a couple of reasons. You know, we've had a history of sort of cutting-edge healthcare transformation going back 30 years to when we created the Oregon Health Plan and the central part of which was building a benefit package to the prioritized list of services that looked at health outcomes, as well as just the large categories that you see in the in the ACA mandated benefit package. But I think we took advantage of crisis, which I think we're in the same situation today.

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In 2011, we had a 3-billion-dollar budget deficit. That's not much in California terms, but it was one of the largest per capita budget deficits in the country. And 40 percent of that was in Medicaid. Part of that because of the loss of the funds and part of it because of falling tax revenues and increased Medicaid enrollment. And it was clear that in order to maintain all those people and get ready to absorb the potential increase under the Affordable Care Act, we would have to, you know, cut provider reimbursement rates around 40 percent or drop tens of thousands of people from coverage.

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So, we brought the providers and consumers together and said, why don't we try to get more value for each dollar spent by redesigning the delivery model? The business model was the coordinated care organizations. We went back to Washington, DC, and got waivers to allow us to use the CCO as the Medicaid delivery model. But in addition, that initial upfront investment of 1.9 billion dollars, a five-year, one-time investment, to give us a glide path to move from fee-for-service to this new delivery model.

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So, the CCOs were required to reduce the trend rate from 5.4 percent to 3.4 percent by the end of the second year of the waiver. So, we had a couple of years to set this up and then over the course of the five years that initial investment declined as the cost savings from the CCOs begin to accrue. So, I think in order to move the system, you do, I personally believe you have to cap the growth trend.

[00:21:34.480] John Kitzhaber, MD:

There's no other way to create the incentives. There are so many ways to game the current system under fee-for-service. And you have to have a period of time in which to get ready for that. And you may need an upfront investment. But the point is that we paid back that initial investment and still realized a billion dollars in total savings. So, I think we're in the same environment today. I think people once we get past this pandemic and realize that the healthcare system, at least the publicly subsidized portion of the healthcare system, is far more vulnerable and fragile than it was at the end of 2013.

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So, do you think that this pandemic creates the same kind of, or same whatever, amount of motivation from the crisis to which you just referred, and in Oregon such that we can make that move to value? Is it…are we going to be able to leverage off it as successfully?

[00:22:27.130] John Kitzhaber, MD:

I think, you know, it's obviously going to take some political will and it's going to take some strong leadership within the provider community. But I think there are three reasons that…three sort of…three levers that we didn't have in the past. The first, obviously, is the drop in utilization that resulted from the, you know, the social distancing measures disproportionately impacted those parts of the system that were most heavily dependent on fee-for-service, which really exposed in a fairly glaring way the irrationality and really instability of a business model depends on volume, regardless of the value of the service.

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And it also raises questions about to what degree do we have excess capacity and overutilization prior to COVID-19. So that's one data point. The second one is that we saw Black Americans and Indigenous Americans and Americans of color dying in disproportionate numbers from COVID. And I think there's growing recognition that those deaths are attributable to structural inequities in our society that make these populations much more likely to have diabetes or hypertension or poor housing, inadequate nutrition, fewer educational opportunities.

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So, these are issues that have been with us for years. But I think the pandemic highlighted the, you know, the shocking magnitude of this problem and the recognition that effectively addressing this is going to require a far greater investment in these chronically under-resourced communities. The only way you can do that is to find those resources, to bend down the cost curve and re-allocate some of that growth trend back onto the front end. So, the demand for equity, the higher awareness of the need to address these disparities, I think is another very powerful political factor that could push us towards a more rational, value-based system.

[00:24:29.520] Don Crane:

So, tell me more about how specifically you addressed these disparities. Let's take housing, for example. What did the CCO program do about insufficient housing for some of the beneficiaries of the program?

[00:24:42.640] John Kitzhaber, MD:

So, it would depend on this CCO. Obviously, as I said, they're all different. In Portland, the three hospital systems and organizational care Oregon raised contributed about 22 billion dollars for low-income housing in that region. In Eastern Oregon Coordinated Care Organization, which spans 12 rural counties, each county had a local advisory committee that helped decide how the coordinated care organization would reinvest some of those cost savings back into their communities. So, I would say that there were efforts to do that within individual CCOs.

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It was not a statewide systemic approach. And I think that's what we need. I think we need to recognize that I would say, if I had to pick two social determinants of health, that would probably have the biggest impact, I would probably address housing, which you just mentioned, and behavioral health, and particularly substance abuse disorder. We are going to have an enormous behavioral health, mental health crisis. We've already got one. It's going to manifest itself in kids who have been isolated and are struggling with online learning.

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And so, those two investments, I think, are the ones that I would elevate in terms of helping address both the health disparities, but also reducing the disease burden coming in the front end. And if you're on a capitated budget, you have a vested interest, obviously, in moving upstream to reduce the drivers of disability and disease.

[00:26:23.530] Don Crane:

So little interested to hear that you didn't mention nutrition because I kind of gaze across the land…

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when I look at efforts of private sector to address social determinants issues, it seems like nutrition floats to the top. Maybe it's just the easiest one to address; food banks and the like. Any thoughts on that?

[00:26:43.060] John Kitzhaber, MD:

Yeah, I think I didn't mean to exclude it. I mean, they are definitely interrelated, but I think food insecurity is also to some extent related to the housing crisis. So, they're all interrelated. And I think it's important. I think the important aspect in this conversation we're having right now is, you know, we act as though social determinants of health is this new discovered issue. Right? The issue du jour, and not many people actually bore down to what it really means.

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And I do think it has to do with housing, nutrition and a whole lot to do with mental health and behavioral health and investments in stable families, all of which, it's kind of complex.

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But I do think that you can identify those people who actually have the greatest need for those services. The coordinated care organizations, I think, can serve as a community convener to try to organize resources and make sure that they get to the right people.

[00:27:40.780] Don Crane:

So, I love hearing you mention having the providers sense a vested interest in housing and in the line of behavioral issues and so forth. Can you expand on that a little more? So, right now, a little more background for the most part, I think it's fair to generalize that APG members are not paid to address even behavioral issues, but not nutritional nor housing. In the main. I think that's generally true. I've long thought that would be a good thing.

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It hasn't happened yet until, tell me, has that happened in Oregon? Do the providers feel a vested interest in these social determinants under the program?

[00:28:23.650] John Kitzhaber, MD:

I think there's a growing awareness, particularly in primary care, about the impact of those social determinants in the world of medical practice.

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I think that in particular, the first five years of the CCO's were a journey of discovery in terms of realizing the huge extent to which behavioral health and particularly substance use disorder drives the physical side of the ledger. I mean, opioids are one of the biggest cost drivers in the CCO model. Right? And so, there's a growing interest in recognizing we just don't want to be, you know, treating this with Sublocade. And we actually want to go upstream and understand the, you know, sort of the conditions of injustice that have driven the opioid epidemic.

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And, you know, doctors are not housing authorities. They're not social service agencies. That's not their area of expertise.

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But I think having them understand that a lot of the problems they treat have their origins outside the clinical system and then having a care model that actually engages the local community in partnership to begin to address those upstream issues is a huge step in the right direction.

[00:29:42.250] Don Crane:

So, we've talked about the CCO program and a lot about Medicaid. What are your thoughts on Medicare commercial? That's a big swath of the population, certainly. So, what are your thoughts there?

[00:29:53.800] John Kitzhaber, MD:

Well, let's parse them out. I am a big believer in moving capitation into the ACA market. It is really the only heavily directly subsidized federal program that doesn't have a uniform fee schedule, for example.

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And I think that if you were to move or exploit whether you could use a 1332 to waiver to actually move capitation into the ACA market and then use that as the de facto public option. So, I think that is the place to begin to move the value design into the commercial market. I think the easiest place to do it. And there's a strong justification because it's a heavily subsidized federal program. The other end of the equation, which I think you're more familiar with, is Medicare.

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And, you know, I think it's just incredibly important that that program be moved towards value. You know, my focus has been more on the Medicare Advantage side of things, which certainly has its problems and the ability to gain reimbursement through creative use of risk scores, that would have to be addressed. But I do think it has some of the contours of the CCOs. I mean, it's a fixed amount of money and required to manage within that.

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So, I think that focusing on Medicare is going to be incredibly, incredibly important. If you look at the projections sort of there's a projected 60 percent increase in the size of the healthcare budget by healthcare economy by 2028. Much of that is in Medicare, and about 40 percent of it is price. And I think the only way you really get the leverage to address price is through moving away from fee-for-service into some kind of capitated model and again, linked to a sustainable growth rate.

[00:31:46.380] Don Crane:

Very, very good.

[00:31:47.260]

Well, let me end with a wrap-up question or two, John. Value movement, generally, we're all on tenterhooks here waiting for the appointment of the CMS Director, waiting for somebody in CMMI—that's Medicare. We've got health plans that seem, in some instances, to be moving into value and others I think not, frankly. What's your handicapping on the value movement generally across all these products and programs and nationally? Where are we going to be in 10 years? Are we really doing this or are we not?

[00:32:21.570] John Kitzhaber, MD:

Well, I think we're going to get there either with us or without us. I think this is going to be driven increasingly by two factors: the demand for equity and to really address health disparities and what is likely become a 30-trillion-dollar national debt. And just to put that into perspective, you know, our budget deficit was less than a billion dollars on January 1st of 2020. We tripled it in eight months. It took us 10 years to add nine billion dollars to the national debt

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and we are close to adding seven billion in a year. So, those two factors are going to drive change. And I'm actually optimistic because I got a call a couple of weeks ago from one of the specialty, multi-specialty clinics in Portland. Total fee-for-service. Their question was how do we move away from fee-for-service to value?

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So, I think…

[00:33:13.980] Don Crane:

What did you tell them?

[00:33:15.090] John Kitzhaber, MD:

Well, we are going to engage in a conversation about that with their board, because I think they recognize that's where the world is moving. And they also recognize that sort of, to a large extent, a lot of the social unrest that we're seeing today has to do with these gross disparities, economic health and educational disparities. And you can't hide from that just because you're in a fee-for-service clinic.

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So, I'm optimistic.

[00:33:40.260] Don Crane:

Very, very good. Well, John, this has been very enlightening. I appreciate it. I love your time. We'll do it again. I think that brings us to the end. Any final comments that you'd like to make?

[00:33:52.500] John Kitzhaber, MD:

Well, no, I just I appreciate being on the podcast. And I just want to compliment you and APG for the yeoman's work you've done over the years trying to move this system to one that makes more sense from a quality outcome basis.

[00:34:04.800] Don Crane:

Well, thank you for that. We intend to work closely with you as we move forward in this noble quest. So, anyway, so thank you very much, John. Stay healthy and we will talk to you soon.

[00:34:15.510] John Kitzhaber, MD:

All right, Don, thanks so much.

[00:34:17.910]

Thanks for listening to APG on American Healthcare with your host, APG President and CEO Don Crane. For more information about APG and transcripts of this show, visit the website at APG dot org.