Oregon’s Medicaid Transformation – Early Observations on Variations in Organizational Structure and Strategy

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Stecker (this issue) and Howard et al (this issue) outline the nature of Oregon’s latest reform in health care delivery and debate the potential for success and failure of Oregon’s Medicaid transformation to Coordinated Care Organizations (CCOs) for Oregon Health Plan (OHP) members. The essays laud the potential for success and raise concerns about feasibility. Our research teams have been tracking CCO implementation and development. In what follows, we add preliminary details to the conversation related to the arguments within the articles.

Viability of the CMS-OHA timeline

The Oregon Health Authority (OHA) and the Centers for Medicare and Medicaid Services (CMS) have an aggressive timeline for cost savings (Howard et al). Stecker questions whether this is achievable and some CCO leaders do echo his concerns. Yet, one recent multi-provider demonstration project in Massachusetts achieved cost savings within a 2 year timeline (Song et al., 2011, 2012). Many CCOs have previous demonstration projects for cost savings, such as for complex patients or high utilizers of the emergency department and will rely on their experiences and ability to expand these projects to further cost savings. Furthermore, the state and the CCOs acknowledge the time constraints and recognize the difference between meeting goals and metrics and changing the delivery system. Thus, current ideas for cost savings are based on metrics that are more easily achievable. For example, many of the first year metrics are process measurements, such as colorectal screening, decrease in emergency department utilization, or follow up after mental health hospitalization; in contrast to long-term patient-
centered outcomes that may be a better measurement of delivery system change. Thus, these intermediate process goals may be able to be met in the given timeline.

**Is there any evidence that central CCO tenets actually save money?**

CCOs are built on the premise that the integration and coordination of mental and physical health in patient-centered medical homes will lead to better patient care and cost reductions. Central Oregon pilot programs decreased emergency utilization and costs (Waldroupe, 2011). CareOregon, a nonprofit Medicaid managed care plan, used centralized case management, service coordination, and behavioral health professionals in safety-net clinics to improve care and decrease costs (Klein & McCarthy, 2010). CareOregon partners with 5 of the 16 CCOs and these CCOs will benefit from CareOregon’s experience. Howard et al (first article) discuss the pilot project led by Central Oregon that showed a significant cost savings and decreased emergency department utilization in the region. Thus, many of the CCOs will be relying on previous experience to continue on the trajectory of quality improvement.

**Are medical home approaches too inconsistent among CCOs to yield systematic benefits?**

The Patient-Centered Primary Care Home (PCPCH) model (Oregon’s version of the patient-centered medical home) is a CCO cornerstone. PCPCH guidelines developed through a rigorous stakeholder negotiation require 10 “must pass” services including access, accountability, quality metrics, language translation services, and health records with standardized elements. Additionally, there are services that are rated on a points system. CCOs vary, however, in the degree to which primary clinics meet the highest PCPCH standards. In Pacific Source Central Oregon, approximately 85% of Medicaid members are attributed to a clinic that has PCPCH status. In Eastern Oregon, less than 5% of their members are attributed to a PCPCH-certified clinic. Regional differences create the context in which the CCOs are
embedded. These are critical factors to consider when assessing the baseline or foundation that may influence future CCO efforts. To support continued PCPCH development, commercial health plans have agreed to support enhanced rates for clinics with PCPCH certification. The rates, however, are still under negotiation.

**Will competition between health systems prevent the clinical integration and innovation required for success?**

CCOs are designed to be local community organizations that are led by a Board of Directors, which include representatives from local physical, mental, behavioral, and dental health organizations. The Board of Pacific Source of Central Oregon includes representation from the counties, health system, independent practice association, dental organization, and community members. This governing body was operationalized prior to the commencement of the CCOs and has become a foundation for this CCO. Meanwhile, other boards have not been as comprehensive. For example, Wallowa Memorial Hospital, a critical access hospital in Eastern Oregon, has no ownership stake or board representation in the Eastern Oregon Coordinated Care Organization. Additionally, there has been tension during the formation of the CCOs. For example, Salem Hospital sued its local CCO over reimbursements. In southern Oregon, the Cascade Health Alliance was unable to come to terms with the county for behavioral health care. When Klamath Youth Development Center became the county mental health program, they joined the CCO. CCOs have also initiated new partnerships and opportunities for collaboration and cooperation. For example, early in the process of CCO formation, stakeholders in Health Share of Oregon, which contains competing health systems and insurance providers, collaborated and obtained support to implement and expand five complementary care model interventions.
Will reform tools be implemented effectively across the state?

The OHA gave CCOs latitude in how to approach transformation. While supporting local control and recognizing regional variation, there is potential for some regions to meet metrics and others to fail. The state understands that its role is not just to regulate but to also support this transformation. Earlier this year, the Oregon Transformation Center of the OHA opened to partner with CCOs and increase rate and spread of innovation. The Center formed learning collaboratives and hired Innovator Agents. The learning collaboratives enable CCOs to share best and emerging practices; the Innovator Agents serve as a single point of contact between the CCOs and OHA, and are focused on helping with quality improvement. As a result of these changes, CCO leaders report that OHA feels like a partner in healthcare transformation; regulatory concerns no longer dominate the conversation.

**Conclusion:** The Oregon experiment is barely a year old. The OHA and its providers are still waiting for decisions from CMS on metrics and codes. It is premature to predict success or failure. Our analyses suggest, however, that the CCO and their members anticipate success and embrace the possibilities.


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