Abstract

To control Medicaid costs, improve quality, and drive community engagement, the Oregon Health Plan introduced a new system of Coordinated Care Organizations (CCOs). While CCOs bear resemblance to traditional Medicaid managed care, there are differences deliberately designed to improve care coordination, increase accountability, and incorporate greater community governance. Reforms include: global budgets integrating medical, dental, behavioral health, and public health functions; risk-adjusted payments rewarding outcomes and evidence-based practice; increased transparency; and greater community engagement. The CCO model does face challenges, but on balance we are decidedly optimistic about the opportunities for improved health care delivery, better health outcomes, and overall savings.

Keywords: Medicaid, state health reform, managed care, Oregon, global budget
Introduction

Oregon has always been an innovator when it comes to its Medicaid program, known as the Oregon Health Plan (OHP). OHP has attracted nationwide and international attention since its start in 1994. Oregon’s method of explicit health care rationing through a prioritized list of medical conditions and interventions is particularly controversial. The intent behind this approach is to cover more people by reimbursing providers only for certain cost-effective services and thereby limiting costs (Bodenheimer 1997: 651-6; Oberlander 2007: w96-w105).

The state has moved forward once again with a plan to improve the financial sustainability of OHP, by transforming the way that health care is delivered in Oregon. Covered services still remain ranked based on the prioritized list of conditions and treatments. What is unique this time is the creation of Coordinated Care Organizations (CCOs), which receive global budgets for the integrated provision of medical, behavioral, and oral health services.

The paper discusses ways in which the CCO model is uniquely different from traditional capitated managed care. The CCO model does face challenges, but on balance we are decidedly optimistic about the opportunities for improved health care delivery, better health outcomes, and overall savings.

The Evolution of the CCO Model

In June 2009, the Oregon legislature passed and the governor signed House Bill (HB) 2009, the Health Authority Law. This legislation established the Oregon Health Authority (OHA). The law established a Patient-Centered Primary Care Home (PCPCH) program, which developed
strategies to promote widespread adoption of PCPCHs as a new delivery model for populations covered by the OHA. The PCPCH team-based medical home model focuses on prevention and on continuity of accessible, comprehensive primary care that emphasizes communication and collaboration among all levels of providers. Care teams are led by physicians and heavily utilize midlevel providers, including physician assistants and nurse practitioners, as well as other nursing, health educator and health navigator personnel (H.R. Res. 3650, 76th Leg., Reg. Sess. (Or. 2011); S. Res. 1580, 76th Leg., Reg. Sess. (Or. 2012); Nutting, Crabtree, and McDaniel 2012: 2417-22; Takach 2012: 2432-40; H.R. Res. 2009, 75th Leg., Reg. Sess. (Or. 2009)).

The PCPCH differs from the historical primary care model in that the PCPCH is paid and incentivized to coordinate care, works proactively with patients to manage chronic diseases, facilitates patient self-management, and promotes healthier lifestyles. When Oregon HB 3650 of 2011 established the Oregon Integrated and Coordinated Health Care Delivery System, which called for the Coordinated Care Organization (CCO) model, the CCOs were required to have PCPCHs in place for their enrollees (H.R. 3650, 2011).

In July 2012, the Centers for Medicare and Medicaid Services (CMS) approved the Medicaid waiver application and the state began implementing the Oregon Integrated and Coordinated Health Care Delivery System. By the end of the year, 15 new CCOs had been approved by the OHA, and are currently operating in 16 service areas.

From the federal perspective, CMS has committed $1.9 billion over 5 years to aid Oregon in implementing the new CCO reform initiative. Over the next 10 years, forecasters predict that the
state and the federal government will save $11 billion compared to the status quo (Cooper 2012; Raphael 2012).

How the CCO works

A Coordinated Care Organization is a network of physical, mental, and dental health care providers that is linked to publicly funded health programs including the local mental health authority (H.R. 3650, 2011; Oregon Health Authority 2011). Statewide specialist services are available to patients within CCOs, and CCOs are required to have contracts with all dental care organizations within their service areas no later than July 1, 2014 (H.R. 3650, 2011; Health System Transformation Team 2011).

CCOs vary in their organizational structures. Some are substantially the same as their OHP managed care organization (MCO) predecessors, with the MCO at the core and contractual relationships with providers. Others, like Health Share of Oregon, are formed as alliances between previously competing MCOs, health systems, dental health organizations, behavioral health groups, and county health departments (Oregon Health Policy Board 2012). This flexible organizational model has enabled the state to ensure 90% of Medicaid-enrollees have coverage availability from at least one CCO (Oregon.gov 2013). Figure A in the Appendices presents a map approximating the service areas of the CCOs approved in 2012.

Since the early years of the OHP, the state has placed nearly all Medicaid enrollees in locally owned managed care plans. That experience has been a formative influence in the development of the CCO model. The state is required to continue contracting with those prepaid Medicaid
MCOs in locations throughout the state that are not covered by a CCO. Moreover, the OHA is allowed to amend its existing contracts with those managed care organizations to enable them to become CCOs (Health System Transformation Team 2011). By July 1, 2017, managed care plans must transition to the CCO model in order to retain their contracts with the state.

Figure B in the Appendices presents a side by side comparison of the new CCO model and the previous Medicaid MCO model, discussed here.

**Global Payment**

Each CCO receives a capitated global budget to deliver comprehensive health care services to a defined population within their service areas. The overarching goal of the global payment method is to decrease overall costs of care by maintaining good health through primary and preventive care, using best practices, and discouraging defensive medicine, overutilization, and preventable emergency room care (H.R. 3650, 2011; Oregon Health Authority 2011). Providers participating in a CCO share financial risk, and their incomes reflect how well they manage the global budgets and population health (Oregon Health Authority 2012).

CCOs have financial incentives to prioritize health care to members with high health care needs, mental illness, chemical dependency, and multiple chronic illnesses (H.R. 3650, 2011). At the time of this writing, a number of CCOs had plans in place to identify high-utilizer patients and to better coordinate their care. This includes the use of health navigators to work more closely and proactively with these patients, the improvement of electronic data interchange among the
partners in the CCO, and the co-location of behavioral health professionals in the CCOs’ largest primary care clinics (CCO Oregon 2013).

The state will determine the new global budgets prospectively for the upcoming biennium no later than February 1 of every odd-numbered year (H.R. 3650, 2011). This is similar to how the state has budgeted OHP MCO capitation in the past. However, in addition to the benefit-related changes, CCOs must reduce administrative costs below what was historically permitted. CCO global budgets will allow 9% administrative costs and 3% profit margin (H.R. 3650, 2011). This means that CCOs must either reduce administrative costs to stay within the limits, or the organizations’ administrative costs will have to be shifted to other insurance customers.

Under the waiver approved by CMS, Oregon has committed to reduce OHP’s per capita growth in medical expenditure by 2 percentage points (measured from projected 5.4 percent annual growth) by the 3rd year of CCO implementation in 2015. This budget limit will severely restrict increases in global budgets, and therefore require CCOs to achieve savings by enhancing care delivery.

In future years, the OHA will adjust CCO global budgets based on populations served and individual CCOs’ performance on health outcomes. This adjustment considers the risk of the population based on available public health data, as well as utilization and cost data collected by the OHA (Health System Transformation Team 2011). Similar approaches to risk adjustment have been implemented in others states’ Medicaid payment structures, including in Minnesota (Minnesota Department of Human Services 2010).
Within the global budget, the Oregon Health Authority encourages CCOs to utilize alternative payment methods that reimburse providers based on health outcomes and quality measures (H.R. 3650, 2011). This differs somewhat from the existing OHP MCO model in which the MCOs are capitated by the state, but most physicians are paid fee-for-service (FFS) by the MCOs.

The accountability for health outcomes is an important change in the transition from the old OHP MCO model. Providers may be terminated from CCOs based on a performance matrix (including failure to report on quality of care, outcome or financial metrics) (H.R. 3650, 2011).

**CCO Impact on Providers**

In the CCO model, PCPCHs are the entity at which patients visit primary care providers and receive a majority of care. PCPCHs will function as health care teams that work together with the aim of keeping members at their healthiest by focusing on primary and preventive care, and by more efficiently managing chronic health conditions (Oregon Health Authority 2011).

PCPCH teams may be comprised of family practice physicians, medical assistants, registered and/or licensed nurses, dietitians, cardiologists, community health workers, personal health navigators, administrative assistants, behavioral health professionals, and a multitude of other health care providers depending upon the specific needs of the patient. Recognizing the importance of well-coordinated behavioral health services in maximizing overall health, a number of CCOs are improving their coordination protocols, and in some cases are co-locating behavioral health professionals in the PCPCH clinics (CCO Oregon, 2013).
Primary care providers in Oregon are allowed to participate in multiple CCOs. By law, CCOs and providers must cooperate to provide comprehensive services to enrollees. The intent is to be inclusive, offering membership to all providers interested in participating in the CCO. At the same time, providers are not permitted to unreasonably refuse to participate if their services are needed to adequately care for the CCO enrollees. However, providers may refuse to contract with a CCO if the amount of reimbursement offered is unreasonable (H.R. 3650, 2011; CCO Oregon 2011).

The PCPCH care team model will be a challenge for some primary care physicians, who now need to interact with new types of non-physician health care providers. In coordination with the OHA, these providers, including community health workers and personal health navigators, will soon be certified by their associated state regulatory agencies (H.R. 3650, 2011).

In the original OHP MCO model, physicians maintained control of patient care and were the central source of medical opinions. Within the new CCO system, patients may also rely on other health care provider opinions, such as personal health navigators. This shift forces primary care physicians to function in a more team-oriented environment where decision-making power is shared and consumers are more empowered (H.R. 3650, 2011).

CCOs are also responsible for the health care management of individuals receiving long-term care (but not payment for custodial care). That responsibility falls to the primary care physician and care team. There is potential for long-term care operators to shift more medical management
tasks to the PCPCH team (Health System Transformation Team 2011). Possible unintended consequences may include primary care physicians refusing to accept Medicaid patients, difficulty in recruiting and retaining primary care physicians in Oregon, increased rates of burnout due to increased physician workload, and a potential threat to quality of care as care teams may become overworked.

**CCOs and Compensation to Providers**

One of the biggest changes under the CCO model is the requirement to follow evidence based practice guidelines. Providers will be compensated based on new alternate payment methodologies that are designed to reward quality and good health outcomes in addition to case load or patient volume (H.R. 3650, 2011).

CCOs are allowed to reimburse only for those services outlined in the Prioritized List of Health Services. This means that while CCOs and physicians must follow evidence-based guidelines and are held financially accountable for the outcomes of their patients, what they believe to be the best care options might not be included in the Prioritized List of Health Services. This restriction is not dissimilar from the traditional OHP MCO model, which only paid for services covered under the Prioritized List.

**Safeguards and Administration**

On March 2, 2012, SB1580 was drafted by the OHA, and signed into law. This law provides additional information on the design and regulation of CCOs; establishes the requirement for the
OHA to report quarterly to the legislature on the implementation status and performance of the new CCO system; and grants the necessary official legislative approval for implementation.

Beyond authorization to implement the new system, the law also includes additional safeguards regarding patients’ rights and protection against unreasonable denials of care; specifies that CCOs’ Community Advisory Councils have input on preventive care provided by the CCO; and establishes the Work Group on Patient Safety and Defensive Medicine.

**Governance**

Another fundamental shift from the historical OHP MCO model to the new CCO model is in governance. A CCO’s board of directors must include individual provider organizations and at least one member of a mandated Community Advisory Council made up of local government officials, community members, and consumers (CCO Oregon 2011). CCO organizational decision-making processes must include community input from seniors, people with disabilities, individuals using behavioral health services, racially and ethnically diverse populations reflective of the service area, and providers within the CCO (Health System Transformation Team 2011). In general, the CCO model will reduce the power of health insurance companies in Oregon and increase the power of other stakeholders, who now have a greater voice in matters such as covered services and reimbursement rates.

**Reporting, Transparency, & Accountability**

Reporting and accountability are improved under the CCO model. Both CCOs and the OHA must ensure accountability and transparency of financial data including payer costs, provider
costs, and provider payments along with outcomes and quality measurements (Health System Transformation Team 2011). In the OHP MCO model, there was little transparency below the level of an MCO’s capitation. The increased level of scrutiny may help the state lessen waste and abuse in the system.

CCOs must track and submit data to the OHA. (Health Transformation Team 2011). Along with the CCO quality measures, the OHA is required to report progress on eliminating health disparities, adherence to evidence based clinical guidelines, adoption of administrative rules, customer satisfaction, costs and savings (CCO Oregon 2011). Quarterly reports of these quality measures (for the previous 12 months) are posted on the OHA website and submitted to CMS.

Accountability is an important new element in the CCO model. CCOs, in partnership with communities and patients, now have accountability for costs, quality, and the overall health of the members in their areas (H.R. 3650, 2011). CCOs will encourage greater patient accountability using incentive-based systems, patient education, increased access through PCPCHs, and improving patient-provider communication via phone and internet (Health System Transformation Team 2011). If Oregon’s health reform is to succeed, CCOs must communicate effectively with patients, who in turn must understand their role in producing health and controlling costs.

**Opportunities and Challenges**

Oregon’s CCOs provide a unique opportunity to improve care and control Medicaid cost growth, by integrating physical, mental, and oral health services within a framework that aligns payment
mechanisms with outcomes for a defined member population. At the state level, global budgets and shared savings provide incentives for efficiency, while quality requirements discourage cost reduction approaches that might sacrifice patient outcomes.

Individual CCOs have clear incentives to emphasize prevention, develop coordinated care models, and provide evidence-based care. Participating providers will have increased accountability for the overall cost and quality of care they provide.

On paper, the transformation from the traditional Medicaid MCO model to the CCO model is substantial; and from a population perspective the total change to the system will be greater than the sum of the parts. Still, there are significant implementation challenges.

First: Information systems that have the ability to share patient data across providers are essential to achieve full care coordination. The challenges of health information exchange—data exchange standards, infrastructure costs, and the reluctance of provider organizations to share data—must be dealt with head on. PCPCHs bear the responsibility for delivering most services as well as coordinating care, but supporting multidisciplinary care teams and electronic medical records will continue to be a challenge for small practices and in rural areas with low population density.

Second: As part of its waiver, CMS has required a pay-for-performance system. The volume of performance data collected, based on encounter data as well as some medical record review, is increasing. Rapid design and implementation of this system are challenges for the state and also
for CCOs, and performance measurement and improvement strategies will need to be refined based on the experience of the early years of measurement and payments. OHA has established a Metrics and Scoring Committee to guide development and refinement of CCO performance measurement. It has also established a Transformation Center to accelerate performance improvement by fostering the spread of effective practices across CCOs (Oregon Health Authority 2013).

Third: Perhaps the greatest challenges relate to organization and governance. The collaborative nature of CCOs and the stringent global budgets make this task more difficult than in earlier capitated MCOs, especially where funds must be spent for care coordination or other non-clinical interventions that yield savings to the CCO, but may lead to lower utilization and/or fees for some providers.

Fourth: Historically, the OHP MCOs were capitated by the state and in turn contracted with providers on a capitated or fee-for-service basis. Given the size and scope of CCOs, billing and reimbursement will be a complex process requiring a workforce that can track provider performance measures and adjust provider payments.

Fifth: Although the PCPCHs have the most regular patient contact and the greatest impact on health, most are small practices, and generally unable to support the burden of CCO financial administration. With a large, capable workforce already in place and the ability to communicate with many health care entities, insurance companies (like the existing OHP MCOs) are the likely choice to manage and disburse global payments.
Sixth: Preserving continuity of care for OHP members with mental illness is an important quality goal, and because these members often use a large volume of physical and oral health services, coordinating their care is crucial for meeting budget targets. Each CCO must decide how to contract with health departments or with other local providers. Some health departments fear they may face funding reductions as a result.

Finally, community stakeholders now play a larger role in CCO operations than they did in the historical OHP MCO model. Each CCO must collaborate with its Community Advisory Council, which must be primarily comprised of consumers, to prepare a Community Health Assessment and Community Health Improvement Plan. CCOs therefore need to develop ways to balance openness to community input against challenging quality and cost performance requirements.

**Final Thoughts**

The CCO concept is not new in Oregon. The Central Oregon Health Council (COHC) piloted a similar model in 2009. The COHC is a partnership of sixteen organizations, both public and private, including local governments, PacificSource (an insurer), and the Oregon Health Authority (Waldroup 2011). The initial group of enrollees in the COHC consisted of 144 Oregon Health Plan members. During the first half of 2011 the group experienced 541 fewer emergency department visits, a 49% decline, equating to approximately $750,000 of savings (Waldroup 2011). The results of this study, along with the fundamental tenants of the CCO model give us optimism for the success of the CCO model in Oregon.
Under the Affordable Care Act, states that partially expand Medicaid will not receive the enhanced funding that comes with a full expansion. Given the fiscal pressures state Medicaid programs will face even if they fully expand eligibility, there is a clear need for states to promptly find ways to work with providers in order to meet population health goals in a cost-effective manner. Oregon has taken bold steps in this direction. The results of this Oregon experiment will be beneficial for states that have not taken the necessary steps to thoughtfully guide Medicaid expansion.
Notes


Oregon Health Authority. “OHA Transformation Center.” http://transformationcenter.org/


Appendices

Figure A: Service Areas of 2012 CCOs
### Figure B: Comparison of CCOs and OHP MCOs

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