NIH Public Access
Author Manuscript
Healthc (Amst). Author manuscript; available in PMC 2014 December 22.

Published in final edited form as:
Healthc (Amst). 2014 September ; 2(3): 163–167. doi:10.1016/j.hjdsi.2013.11.002.

Oregon's Medicaid Transformation: An Innovative Approach To Holding A Health System Accountable For Spending Growth

K. John McConnell, PhD,
Center for Health Systems Effectiveness, Department of Emergency Medicine, Oregon Health & Science University

Anna Marie Chang, MD, MSCE,
Department of Emergency Medicine, Oregon Health & Science University

Deborah J. Cohen, PhD,
Department of Family Medicine, Oregon Health & Science University

Neal Wallace, PhD,
Hatfield School of Government, Portland State University

Michael E. Chernew, PhD,
Department of Health Care Policy, Harvard University

Glenn Kautz, MPH,
Center for Health Systems Effectiveness, Oregon Health & Science University

Dennis McCarty, PhD,
Department of Public Health and Preventive Medicine, Oregon Health & Science University

Bentson McFarland, MD, PhD,
Department of Psychiatry, Oregon Health & Science University

Bill Wright, PhD, and
Providence Center for Outcomes Research and Education

Jeanene Smith, MD
Office of Health Policy and Research, Oregon Health Authority

Abstract

In 2012, Oregon initiated a significant transformation of its Medicaid program, catalyzed in part through an innovative arrangement with the Centers for Medicare and Medicaid Services (CMS), which provided an upfront investment of $1.9 billion to the state. In exchange, Oregon agreed to reduce the rate of Medicaid spending by 2 percentage points without degrading quality. A failure to meet these targets triggers penalties on the order of hundreds of millions of dollars from CMS. We describe the novel arrangement with CMS and how the CCO structure compares to Accountable Care Organizations (ACOs) and managed care organizations (MCOs).

*Corresponding author information: K. John McConnell, Oregon Health & Science University, 3181 Sam Jackson Park Rd., Mail Code CR-114, *Portland, OR 97239*, Tel: 503.494.1989, mcconnjo@ohsu.edu.

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

State Medicaid programs are striving to change their payment models and slow the growth of health spending. In August 2012, Oregon launched a new approach to Medicaid coverage, dubbed Coordinated Care Organizations, or CCOs. These changes represent one of the most ambitious efforts of any health system to slow health spending and transform the delivery system.

The stakes have been raised considerably through an agreement with the federal government, which is providing $1.9 billion to Oregon to assist in the transition to CCOs. In exchange, Oregon agreed to reduce its rate of spending growth by 2 percentage points without diminishing the quality of care. If Oregon cannot meet these benchmarks, the State stands to lose hundreds of millions of dollars in payments from the federal government. Thus, Oregon has become the first state to agree to explicit spending growth targets with substantial consequences if these targets are not met. The arrangement between Oregon and the Centers for Medicare and Medicaid Services (CMS) is noteworthy because it allows the state flexibility in the management of its Medicaid program, while providing CMS a mechanism to achieve savings by holding Oregon accountable to cost and quality benchmarks.

Five principles are fundamental to CCOs:

1. CCOs are locally governed to address community needs.
2. CCO governing boards include health care providers, community members, and stakeholders in the local health systems.
3. Benefits for clients are integrated, coordinated, and include physical, behavioral and dental health care.
4. There will be one global budget that grows at a fixed rate. CCO budgets will allow for local flexibility, including services and supports that may not meet the definition of “medically necessary.”
5. CCOs will be held accountable for quality and access.

Oregon now has 16 CCOs, which are geographically defined organizations, with many emerging from previous Medicaid Managed Care Organizations (MCOs) that added new functionality (e.g., partnerships with local mental health and public health authorities) in order to become approved by the State as a CCO.

CCOs have characteristics of both health plans and provider groups, but generally can be considered closer to MCOs than Accountable Care Organizations (ACOs). Table 1 compares aspects of these three distinct models. Like ACOs, CCOs are accountable for the quality of care they provide. Unlike ACOs and MCOs, CCOs are required to be accountable for the health of the region, through Community Health Assessments, designed to assess the population of the region – not just the Medicaid members – and to provide an understanding and incentive for CCOs to focus on delivery system changes that improve overall population health. All three models require skillsets that cut across health plan and provider functions,[1-4] including, ideally, the ability to manage budgets prospectively, incorporate care coordination, and drive physician-hospital alignment. Unlike MCOs or ACOs, CCOs have

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

an explicit aim to move to a model where the majority of the budget is based on payment for outcomes. CCOs integrate financial streams for physical health, mental health, substance abuse, and eventually dental health, which typically have been carved out in MCO arrangements. Finally, the fixed increase in the global budget differs from arrangements established by most states that use managed care for their Medicaid populations and allow spending to increase according to the historical trend.

CCOs vary widely in the size of the population covered (from fewer than 11,000 enrollees to more than 150,000 enrollees) and in their geography. CCOs have been encouraged to reflect the local context, tailoring approaches to variations in numbers of clients served and geographic areas covered. CCOs are mutually exclusive, to the extent that a beneficiary is assigned to and can belong to one CCO that is responsible for paying for all of beneficiary's care. CCOs have been given substantial flexibility in how they set priorities and organize care, leading the governor to note that there are 16 "experiments" taking place in the State.[5]

By the end of 2012, CCOs enrolled approximately 600,000 Oregon Medicaid members (almost 90% of the Medicaid population). Prior to CCO implementation, approximately 78% of Oregon Medicaid members were enrolled in physical health managed care, and 88% were enrolled in capitated mental health organizations. Thus, for many, the transition did not result in immediate or apparent changes in care or in the ways members interacted with the enrollment system. Additional details about the CCO arrangement, including information on enrollment exclusions, CCO quality metrics and accountability, and community health assessments, are available as an e-Appendix.

STRUCTURE OF THE GLOBAL BUDGET

Cost savings for CCOs are predicated on the use of global budgets. The global budget is a risk-adjusted, per capita payment that is paid by the State to each CCO. CCOs with more or sicker enrollees receive larger payments. Oregon's CCO funding captures the majority of available funding streams for Medicaid populations, including approximately 20% of funds assigned to mental health "carve-outs" and 10% assigned to other services (e.g., non-emergency medical transport). The global budget is a mechanism for giving CCOs flexibility in how they pay for the care of their population. Furthermore, whereas Medicaid budgets are typically adjusted upwards according to the previous year's trend, Oregon's global budgets are set to be increased at a fixed annual rate of 3.4%.

The fixed increase of 3.4% was determined as part of an agreement with the Centers for Medicare and Medicaid Services (CMS), who awarded Oregon $1.9 billion dollars over five years (beginning on July 5, 2012) to support the transformation. Without this investment, the total funds available to CCOs would have been $650 million less in the second year, making the program virtually unsustainable (K. Ballas, personal communication, December 18, 2012). In return, Oregon agreed to reduce per capita spending growth by one percentage point from baseline in the second year, and two percentage points from baseline in 2015 and beyond. CMS and Oregon state actuaries agreed on a baseline growth rate of 5.4%, setting the 2015 target growth rate at 3.4%. Cost savings over ten years are estimated to be more than $11 billion, with $6 billion being returned to CMS. If growth reduction targets are not

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

achieved, Oregon faces substantial penalties, ranging from $145 million for not achieving the second year goal to $183 million in Years 4 and 5.

From the perspectives of the State and CMS, global budgets largely “solve” the cost issue, since the State can simply pay CCOs according to its pre-defined schedule, placing the CCOs entirely at risk. CCOs have been required to demonstrate substantial solvency requirements before certification. For example, CCOs must have the capacity for managing financial risk and maintaining restricted reserves of a minimum of $250,000 plus an amount equal to 50% of the CCO’s actual or projected liabilities. These requirements allow the State a mechanism for monitoring financial performance as an early warning system. Reinsurance is also required, and comes into play on a continuing basis as a risk mitigation strategy.

HOW WILL CARE CHANGE?

The wide variation in CCO organizational structure and strategy will create variations in the ways care delivery is changed. However, the State identified six levers to improve outcomes and slow healthcare spending:

Improving care coordination

CCOs emphasize the medical home model developed in Oregon, known as Patient-Centered Primary Care Homes. Oregon’s initiative changes care by incentivizing clinics to improve in-person access to care, as well as telephone access, after-hours access, preventive service reminders. Care coordination is not restricted to the primary care site. For example, one CCO pays for social workers to be staffed in emergency departments and identify frequent visitors, connecting them with a primary care provider. Another CCO has expanded nurse coordination with post-partum women and complex pediatric patients.

Implementing alternative payment methodologies

CCOs are required to identify alternative payment mechanisms with milestones and benchmarks established in contract amendments with the State. New arrangements, such as capitation or episode-based payments, are expected to de-emphasize high volume, high intensity care (more tests or procedures) in favor of care that improves patient outcomes (better coordination between providers, or patient education and self-management).

Integrating physical, behavioral, and oral health

Integration of physical and behavioral health care – widely seen as a promising cost-effective approach to improving care for individuals with co-existing mental health and physical health conditions[6-12] – is underway. Primary care clinics (particularly safety net clinics and those seeing a high percentage of Medicaid enrollees) are employing social workers or other staff with training in mental health care, allowing primary care physicians to engage a larger team and to address patients mental health needs on site. Clinics have established formal “warm hand-offs” with psychiatrists, increasing the likelihood that patients with severe mental illness can be seen quickly and that the primary care team can be kept informed of the patient’s status. Dental care is required to be integrated in a similar manner beginning in 2014.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Increased efficiency through administrative simplification

CCOs are encouraged to reduce the amount of provider resources devoted to administrative transactions, primarily by standardizing and automating processes that can be conducted electronically.

Use of flexible services to improve care

One departure from traditional healthcare budgets is the flexibility for CCOs to spend dollars in ways more likely to control costs while improving outcomes for members, although, as part of the waiver, CMS indicated that the State may not reduce eligibility or covered benefits. To illustrate the potential for these low cost innovations, Governor Kitzhaber has described how CCOs would have the ability to purchase a $200 air conditioner to improve outcomes and reduce hospital utilization for patients whose chronic illnesses might be exacerbated by heat, noting that this purchase would not have been possible in the old fee-for-service Medicaid program (since it is not a "medically necessary" service.)[13] The global budget is also intended to create an incentive for CCOs to use a portion of their funding on "upstream" public health initiatives to reduce costs and improve population health. As an example, the Trillium Community Health Plan offers cash incentives to pregnant women who stop smoking.

Spreading effective innovations and best practices

The Oregon Transformation Center acts as the State's integrator for innovation, improvement, and implementation of the coordinated care model throughout the state. The Transformation Center provides access to data and analytic tools, as well as focused learning and collaboration opportunities on a range of topics, including health equity. The Transformation Center also assigns each CCO an "Innovator Agent." Innovator Agents are analogous to the "extension agents" who provide technical assistance to farmers and have their origins in programs supported by the United States Department of Agriculture in the early 1900s.[14] Innovator Agents, employed by the State but embedded in the CCO, are designed to be a single, constant point of contact between the CCO and the State to identify promising innovations worthy of spread to other CCOs. Best practices are also reinforced through Oregon's Health Evidence Review Commission, which has developed "coverage guidances." With "coverage guidances", evidence-based reviews and evaluations form the basis of approved coverage and practices for specific conditions, promoting evidence-based care and reducing unnecessary utilization. The guidances include, for example, a recommendation that CCOs not pay for imaging (e.g., MRI), thermogrpahy or surface electromyography for patients presenting with non-specific low back pain and an absence of "red flag" conditions.

ADDRESSING ACCESS AND QUALITY

The CCO experiment places heavy emphasis on quality, which is assessed at two levels. First, CCOs are accountable to the State through 17 quality measures. Performance on these measures determines how much CCOs may be paid out of an "incentive pool." Second, the State is accountable to CMS through 33 Accountability Measures.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

CCO Accountability to the State

Seventeen "Incentive Measures" track the quality of CCO care and encompass preventive care, access and patient satisfaction, chronic illness management, behavioral health, maternal care, overuse, and electronic health record (EHR) adoption and use. The CCO Incentive Measures are part of the incentive pool, which establishes a bonus of approximately 2% of the CCO budget for attaining performance targets or improving performance. The percent of the global budget assigned to the quality pool is intended to increase gradually over time, continuing to reward CCOs for value and outcomes, rather than utilization of services.

State Accountability to CMS

The Oregon Quality and Access Test Measure metrics include 33 measures: 16 of the 17 CCO Incentive Measures, as well as an additional 17 drawn from three previously identified metric groups. The additional measures include assessment of ambulatory care sensitive admissions (e.g., preventable hospital admissions for asthma for adults), appropriate screening, clinical quality, and access. Details are provided in the e-Appendix. These components will be measured for each CCO and aggregated across all CCOs to construct a single composite score, similar to the composite score used for the Alternative Quality Contract of Massachusetts Blue Cross Blue Shield.[15] Oregon will pass the CMS quality and access test if the aggregate measure of quality does not decline from the baseline year. A failure to pass this test triggers a second test that is more complex, but likely to be more robust in adjusting for external or secular effects unrelated to Oregon's policy. A failure to pass the second test triggers significant financial penalties, as described above.

KEY CHALLENGES FACING CCOS

As Oregon embarks on an ambitious transformation, it faces at least four major challenges:

Achieving cost targets while improving quality

Oregon can hit its spending targets simply by paying global budgets according to the pre-defined rate of increase. Within the CCOs, the hope is that savings will be accomplished by reducing unnecessary and inefficient care. However, if utilization is not reduced, CCOs may resort to rate reductions in order to control costs – paying providers less on a per-visit or per-patient basis. Large rate reductions would be likely to reduce access to providers, and presumably would make it harder for the State to meet the quality benchmarks for which it is being held accountable.

Provider engagement

Will providers "buy-in" to the CCO concept? Some providers – particularly hospitals and some specialists – stand to be paid less with the CCO transformation, either through reduced payment rates or reductions in volume. There already have been several disputes. In the Willamette Valley region, Salem Hospital has filed a lawsuit against the local CCO to prevent decreased reimbursement from the CCO.[16] Other CCOs are reporting stronger support within their communities. For example, the AllCare CCO reported that 84% of

primary care providers in their region were certified and ready to work under the new CCO.[17]

Medicaid expansion

The bulk of the provisions of the Affordable Care Act will take place in 2014, and are expected to extend benefits to some adults as well as allowing more than 200,000 additional Oregonians to qualify for Medicaid. This expansion will present a new challenge to the State. Monitoring the changes in 2014 will be large part of the evaluation efforts.

Managing Failures

What happens if a CCO finds it impossible to provide adequate access and quality within the global budget set by the State? The consequences for failure are not entirely clear. The State is required to monitor CCOs closely and to intervene if performance is declining, and CMS has indicated that technical assistance will be available in this case. Failing this corrective action, it is unclear exactly what types of remediation would occur. It may be that the failed CCO population is incorporated into a neighboring, successful CCO, or that the State moves the population into a more traditional managed care setting (without the accountability and coordination that are the hallmarks of CCOs), or, finally, that the State reverts to a fee-for-service program for beneficiaries in that area. The lack of a clear alternative underscores the high stakes involved in the Oregon experiment.

CONCLUSIONS

How do we slow health care spending? Despite its paramount importance, we know relatively little about the best ways to answer this question. Oregon's unique CCO approach, and the lessons CCOs and state leaders learn from this experiment, will provide insight as to what works and what does not when attempting to curb health care spending. Furthermore, the arrangement between Oregon and CMS provides an innovative approach that could be used with other states. This approach – an upfront investment with accountability built into quality and cost metrics – provides a mechanism for CMS to achieve savings while allowing states considerable flexibility in how they carry out their Medicaid program.

CCOs face significant challenges in achieving their goals. Nonetheless, promising changes are underway. Ultimately, success of the CCO model depends upon true transformation of care. Understanding this transformation as it translates to costs, quality, and access will provide critical information to policy-makers and purchasers seeking to slow health care spending growth while still providing high quality, patient-centered care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

Research funded by grants from the National Institute of Mental Health (1R01MH100000), The National Institute on Drug Abuse (1R21DA035640), The Silver Family Foundation, and the Robert Wood Johnson Foundation.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

REFERENCES

1. Accountable Care Organizations Learning Network. [Accessed April 26, 2013] Toolkit. 2011. Available at: https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf
2. Burns LR, Pauly MV. Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s. Health Aff. 2012; 31(11):2407–2416. doi:10.1377/hlthaff.2011.0675.
3. Lewis VA, Larson BK, McClurg AB, Boswell RG, Fisher ES. The promise and peril of accountable care for vulnerable populations: a framework for overcoming obstacles. Health Aff (Millwood). 2012; 31(8):1777–1785. doi:10.1377/hlthaff.2012.0490. [PubMed: 22869656]
4. Larson BK, Citters ADV, Kreindler SA, et al. Insights From Transformations Under Way At Four Brookings-Dartmouth Accountable Care Organization Pilot Sites. Health Aff. 2012; 31(11):2395–2406. doi:10.1377/hlthaff.2011.1219.
5. Johnson, K. [Accessed April 24, 2013] Oregon Experiments With Localized Medicaid. The New York Times. Apr 12. 2013 http://www.nytimes.com/2013/04/13/us/oregon-experiments-with-localized-medicaid.html
6. Institute of Medicine. Improving the Quality of Health Care for Mental and Substance-Use Conditions. National Aacademies Press; Washington, D.C.: 2005.
7. Pollack, DA.; Raney, LE.; Vanderlip, ER. Handbook of Community Psychiatry. Springer; 2012. Integrated Care and Psychiatrists; p. 163-175.
8. Unutzer J, Katon WJ, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. JAMA: The Journal of the American Medical Association. 2002; 288(22):2836–2845. doi:10.1001/jama.288.22.2836.
9. Katon WJ, Lin EHB, Von Korff M, et al. Collaborative Care for Patients with Depression and Chronic Illnesses. New England Journal of Medicine. 2010; 363(27):2611–2620. doi:10.1056/NEJMoa1003955. [PubMed: 21190455]
10. DeGruy F, Etz R. Attending to the whole person in the patient-centered medical home: the case for incorporating mental healthcare, substance abuse care, and health behavior change. Families, Systems, & Health. 2010; 28(4):298–307.
11. Druss BG, Zhao L, Cummings JR, Shim RS, Rust GS, Marcus SC. Mental comorbidity and quality of diabetes care under Medicaid: a 50-state analysis. Med Care. 2012; 50(5):428–433. doi: 10.1097/MLR.0b013e318245a528. [PubMed: 22228248]
12. Druss BG, von Esenwein SA, Compton MT, Zhao L, Leslie DL. Budget impact and sustainability of medical care management for persons with serious mental illnesses. Am J Psychiatry. 2011; 168(11):1171–1178. doi:10.1176/appi.ajp.2011.11010071. [PubMed: 21676993]
13. Pope, C. [Accessed April 29, 2013] Gov. Kitzhaber pitches Oregon's health care plan to influential DC audience. Sep 18. 2012 The Oregonian - OregonLive.com. http://www.oregonlive.com/politics/index.ssf/2012/09/gov_kitzhaber_pitches_oregons.html
14. Gawande, A. [Accessed January 21, 2013] Testing, Testing. The New Yorker. Dec 14. 2009 Available at: http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande?currentPage=2
15. Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-Payer Innovation In Massachusetts: The "Alternative Quality Contract.". Health Aff. 2011; 30(1):51–61. doi:10.1377/hlthaff.2010.0980.
16. Yoo, S. [Accessed January 14, 2013] Salem Hospital sues area coordinated-care organization. Statesman Journal. 2013. Available at: http://www.statesmanjournal.com/article/20130112/NEWS/301090121
17. [Accessed April 24, 2013] Oregon's effort to overhaul health care faces several tests in 2013. 2012. The Oregonian - OregonLive.comAvailable at: http://www.oregonlive.com/opinion/index.ssf/2012/12/oregons_effort_to_overhaul_hea.html

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Table 1

Comparison of Accountable Care Organization, Managed Care Organization, and Coordinated Care Organization Models

	Medicare ACO	**MCO**	**CCO**
Governance	Providers, Beneficiaries	Health Plan	Providers, Beneficiaries, Representatives of the local community, selected from a Community Advisory Council
Payment	Primarily Fee for Service	Capitation	Global budget – intent is to move away from capitation to "pay for outcomes" Alternative Payment Mechanisms (APM) within the CCO, such as episode-based-payments, are encouraged
Spending for care that is not deemed medically necessary	Typically not allowed	Typically not allowed	Explicitly allowed
Accountable for quality measures	Yes	Typically no	Yes
Shared savings	Yes, if quality metrics are achieved	Typically no	Yes, if quality metrics are achieved
Spending growth target	Nothing explicit	Nothing explicit	At or below 3.4% by 2015
Incorporation of behavioral health	Nothing explicit; typically carved out	Nothing explicit; typically carved out	Funding for behavioral health is part of the global budget and integration of physical health care and behavioral health care at the primary care level is encouraged
Incorporation of dental health	Not included	Generally not included	Funding for dental health is part of the global budget and integration of physical health care and dental health care is encouraged
Accountability for population health	Not explicit	Not explicit	CCO accountable through measure of a community health assessment
Participation in Learning Collaboratives	Not required	Not required	Required
Demonstrated efforts to reduce health disparities and inequities	Not required	Not required	Required