

Oregon's Implementation of Coordinated Care Organizations: An Examination of the
Changing Healthcare Structure

by

Timothy Ross Diestelkamp

A PROJECT

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Due to inefficiencies and unsustainable growth in health expenditures, a new approach needed to be taken in the realm of healthcare. There was a need to increase efficiency and value in order to achieve health outcomes. Hence, arose the concept of the Coordinated Care Organization (CCO). CCOs are seen as the next step in Oregon's health care reform, a process that began over twenty years ago with the introduction of the Oregon Health Plan. CCOs focus on the fundamental IHI Triple Aim of improving access to healthcare, improving quality of healthcare, while reducing the costs of healthcare. Additionally, CCOs also stress community interaction. CCOs are to be governed by provider organizations, community members and financial stakeholders. As CCOs will serve all OHP enrollees, the impacted population seems clear, but it is important to note that this population is not stagnant. The covered population is expected to grow to 24% of the state's population from the 17% that it currently covers. CCOs will be expected to not only provide these individuals with health coverage, while stressing efficiency and cost savings. This is a task that has seen many difficulties and problems but could result in huge rewards if accomplished correctly.

Keywords: coordinated care organizations, healthcare, reform, Triple Aim, efficiency

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I understand that my project will become part of the permanent collection of Oregon State University, University Honors College. My signature below authorizes release of my project to any reader upon request.

Timothy Ross Diestelkamp, Author

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LIST OF ACRONYMS

accountable care organization.....	(ACO)
Centers of Medicare & Medicaid Services.....	(CMS)
Central Oregon Health Council.....	(COHC)
Community Advisory Committee.....	(CAC)
Congressional Budget Office.....	(CBO)
Consumer Assessment of Healthcare Providers and Systems.....	(CAPHS)
coordinated care organization.....	(CCO)
electronic health records.....	(EHR)
US Department of Health and Human Services.....	(HHS)
health information exchange.....	(HIE)
health information organization.....	(HIO)
health information service provider.....	(HISP)
Health Insurance Portability and Accountability Act of 1996.....	(HIPAA)
Health Management Associates.....	(HMA)
health management organization.....	(HMO)
Healthcare Assessment Committee.....	(HAC)
Institute for Healthcare Improvement.....	(IHI)
InterCommunity Health Network.....	(IHN)
managed care organizations.....	(MCO)
National Quality Forums.....	(NQF)
Office of Management and Budget.....	(OMB)
Oregon Health Authority.....	(OHA)

Oregon Health Plan.....(OHP)

Oregon Health Policy Board.....(OHPB)

Oregon Society of Healthcare Executives....(OSHE)

Patient Centered Medical Home – Neighbor.....(PCMH – N)

Patient – Centered Primary Care Home.....(PCPCH)

Patient Protection and Affordable Care Act..(PPACA)

Quality Management Committee.....(QMC)

Regional Planning Council.....(RPC)

Samaritan Health Plan Operations.....(SHPO)

temporary assistance need families.....(TANF)

Dedication

This thesis is dedicated to my loving mother, Mary O'Blennis, my dedicated father, Scott Diestelkamp, and my three beautiful sisters, Amy, Audrey and Adrienne Diestelkamp. You all are my caring family, without whom I would not have the strength to accomplish all that I have. I love you.

Preface

This thesis is designed to be an inspection of public policy and an examination of the provided government documentation surrounding such policy. The majority of its length is to describe and help define coordinated care organizations and their purpose within Oregon's implementation project by reviewing and compiling literature from a number of sources. Additionally, the paper hopes to further document some of the findings of one of the first meetings following CCO implementation at the November 2012 OSHE meeting as well as note similarities and differences between CCOs. Finally, the thesis hopes to discuss the future of CCOs and understand potential roadblocks and possible solutions.

Oregon's Implementation of Coordinated Care Organizations: An Examination of the Changing Healthcare Structure

Introduction

Patient Protection and Affordable Care Act

In 2010, the Patient Protection and Affordable Care Act (PPACA) was passed into law by the Congress of the United States of America and signed into effect by President Barack Obama (Entitled The Patient Protection and Affordable Care Act, 2010). This legislation aimed to increase health care coverage for all Americans through a number of methods, including subsidies, tax credits, and mandates to both individuals and employers (Pear, 2012). In addition to increasing the scope of healthcare coverage, the PPACA also aimed to increase the quality of healthcare that was delivered to patients and improve the efficiency of the delivery. It also required private insurance companies to insure all applicants and eliminated discrimination practices based upon pre – existing conditions or sex (Week Magazine, 2012). From these changes, the Congressional Budget Office (CBO) projected that the enactment of the PPACA would result in a net decrease in the annual national deficit (Elmendorf, 2011). Also, the CBO commented that the PPACA would act to reduce Medicare expenditures which would help lower overall healthcare expenditures for the nation (Budget Office, 2011). So, one could sum up the goals of the PPACA to be congruent with The Institute for Healthcare Improvement's

(IHI) Triple Aim: 1) increase population health through increased access for individuals by providing its demonstrated tax credits, subsidies, and mandates, 2) improve quality through increasing metrics and emphasizing efficiency, and 3) reducing cost which has been projected by the Congressional Budget Office (Institute for Healthcare Improvement, 2013).

Accountable Care Organizations

Though these goals were the main focus of the PPACA, the legislation also acted to institute yet another change. The PPACA also discusses the concept of accountable care organizations (ACO) and their emergence in the healthcare arena (Gold, 2011). An ACO consists of many different providers (primary care physicians, hospitals, specialists, home health, etc.) who would agree to care for a group of patients. According to the details of the new law, these ACOs were expected to look after at least 5,000 Medicare enrollees for a period to be no less than three years. But the responsibility does not end here. The ACO is then tasked with collaboration and coordination of care for each patient. For the ACO to simply be the packaging of many services is not enough, but it must ensure that each component works to provide high quality care to the patient while emphasizing efficiency. Some estimates show that approximately 30% of the services provided to patients are either unnecessary or inappropriate (Reid, Compton, Grossman, and Fianjiang, 2005). Thus, arose the main goal of the ACOs; to provide high quality care to its patients, while working to increase efficiencies, reduce wastes and redundancies, and therefore reduce costs.

Though only mentioned on seven pages of the actual law, the ACOs seem to have set the healthcare industry into a frenzy (Gold). ACOs were scheduled to begin operation in 2012, though many organizations throughout the nation began working on them immediately upon the passage of the legislation. Some organizations even expanded their coverage past the required Medicare population to also include private insurance holders. As healthcare costs continue to rise, organizations are looking for anything to help reduce expenditures and many believe ACOs will answer the call, but why are ACOs emerging now? And why did Congress decide to highlight this strategy to healthcare improvement?

The key to ACOs is that they shift cost saving decisions to the providers. All providers within an ACO are held accountable as a group for the care of their patients and the coordination of their care between providers (Gold). The law included financial incentives for ACOs who could cooperate effectively and achieve high quality care while reducing wastes. Providers who could cooperate together, reduce costs, and still provide high quality care would receive a portion of the savings as a bonus. But as the name suggests, the ACOs do plan to keep providers accountable for the performance. Lack of coordination, ordering unnecessary or duplicate tests, and other redundancies will put providers at risk of losing money. From this approach, the US Department of Health and Human Services (HHS) estimates that up to \$960 million could be saved on Medicare expenditures over the first three years of the program's implementation (Gold). Though this number is small compared to the overall Medicare expenditures, it is a sign of improvement and could be used to help control other portions of healthcare expenditures in other public areas or private insurance.

With this implementation of ACO coverage for Medicare beneficiaries, many questions arose about payment. Medicare's traditional fee – for – service payment method does not seem to coincide with the goals of ACO implementation and has previously rewarded physicians and hospitals for ordering more tests or scheduling more procedures (Oregon Health Authority, 2012). Though ACOs wouldn't eliminate fee – for – service entirely, it would change some aspects of the program by adding the incentive bonuses to help keep costs down (Gold). These bonuses would be achievable by keeping costs down through coordination and waste reduction, while still meeting quality metrics. Additionally, bonuses would focus on preventative medicine and chronic disease management. By focusing on these primary care initiatives, tertiary care would ideally be avoided as much as possible and thus hopefully reduce costs. ACOs are not guaranteed to make money on each patient they treat and they are not guaranteed to recoup any losses they experience on investments to improve efficiency, such care coordination managers. It is important to note that the law does allow regulators to adopt new reimbursement methods if necessary for an ACO. This overall shared risk strategy makes reducing healthcare costs the priority of every provider and every ACO.

Each and every ACO could look different, and that is intentional and necessary (Gold). It is important for each ACO to utilize the resources already functioning well within a community as they are most familiar with the community. Also, each community functions differently, so there is no formulaic set of instructions to a successful ACO. Instead, the ACO should look to see what the needs of its community are, how they can best address these needs, and what methods would be most reasonable to accomplish the most good for their beneficiaries. Overall, it will take a coordinated

effort by hospitals, primary care physicians, and specialists to work together to provide the best care for their patients.

Some great concerns initially arose about ACOs as they sound an awful lot like health management organizations (HMO) which have a checkered reputation in the minds of many patients. ACOs may be similar in many ways to HMOs, however there are some key differences. For one, HMOs traditionally had an ‘in-network’ and ‘out-of-network’ designation for providers (Gold). By attending providers ‘in-network’, patients would bear less of the cost of their medical care. However, if a patient wanted to attend an ‘out-of-network’ provider, they needed to receive approval or they would be forced to bear a significant portion, if not the entirety, of the medical bill. With this key distinction, and other similar points, ACOs hope to imitate the cost control methods of HMOs while leaving the autonomy of patient choice in place.

It is necessary to note, that the ACOs do raise some concerns. Some officials fear ACOs will encourage the consolidation of health care facilities, especially hospitals (Gold). As these hospitals consolidate, larger capital investments will be possible and physician private practices could begin getting bought up as well. As these organizations continue to grow, their market share will increase and eventually health care costs could rise as well. This could undermine one of the paramount goals of ACO implementation, but it should additionally be noted that this is not a problem that exists only with ACOs. This problem of increasing market share exists industry – wide in healthcare currently, ACOs could contribute to this trend, but they are not the single, or even most significant, cause. The fear is that ACO implementation could serve as the proverbial,

‘straw that broke the camel’s back’ causing the consolidation trend in healthcare to escalate wildly.

As almost a response to the concerns about ACO market share, the US Justice Department’s antitrust division plans to work with new physician-hospital relationships to ensure that no antitrust legislation is being violated (Gold). If the US Justice Department can steer these new organizations clear of antitrust and anti-fraud violations, ideally, market share would not be too large of a worry, and projected cost reductions would remain as anticipated.

Oregon

Having worked on their own care model for some time, the Oregon legislature and Governor John Kitzhaber decided to ask for a waiver from the Centers for Medicare & Medicaid Services (CMS) in 2012. On July 5, 2012, CMS approved Oregon's request for this waiver, the 1115 Medicaid Waiver (Kitzhaber, 2012). This waiver asked that CMS allow Oregon to forego implementing ACOs and instead implement Coordinated Care Organizations (CCO). The CCOs are very similar to the ACOs discussed above; however they have some key differences to help them better deliver care to the Oregon population. One of the most key differences is the population that they cover. While the PPACA defined the population for ACOs to be the Medicare population, CCOs would serve the Medicaid population within the State of Oregon. Additionally, Oregon and CMS also agreed on the use of federal funds for flexible services. These flexible services must be for health related care, but the flexibility allows for a collection of services to be

developed that could be essential to improving care delivery. Additionally, the 1115 Medicaid Waiver established an agreement for a federal investment in the CCO program. Approximately \$1.9 billion will be allocated to the state over the next five years, at varying levels each year (Kitzhaber). This money does not come for free however. With this investment, the state is expected to demonstrate a reduction in the per capita medical trend. By the end of the second year, the trend is expected to be reduced by 2% (Kitzhaber). During these two years, no change is required for the first year, however, over the second year, an average reduction of 1% is required. These trend reductions are measured against a base trend of 5.4% as calculated by the Office of Management and Budget (OMB). Failure to meet these goals could result in extreme financial reductions in federal investment, possibly including the entirety of investment scheduled for years four and five. The 1115 Medicaid Waiver also has strict requirements for quality care. CMS decided it would work with the state to come up with quality criteria that would promote cost reduction while not sacrificing quality of care or limiting the volume of care. With these main aspects in the CMS waiver, the realm of CCOs and the Oregon Medicaid experiment were born.

The different populations that ACOs and CCOs cover is a key factor in the function of Oregon's Medicaid plan. It is not simply a change in the people they treat, but also the services they would be required to provide. Since the Medicare population primarily deals with the elderly and disabled, there is little need for an ACO to provide pediatric services for their population. In contrast, the Medicaid population consists mostly with low – income individuals, especially pregnant women and children. Thus, CCOs will be expected to provide pediatric care. With this simple example, it is easy to

understand how the structure of CCOs and ACOs will differ because of the different populations they serve and the different services they will be expected to provide.

While CCOs still focus on the fundamental IHI Triple Aim of improving access to healthcare, improving quality of healthcare, while reducing the costs of healthcare, they also emphasize integration and coordination of benefits and providers, accountability for use of resources, while expecting standards for quality care to be met. This aspect of integration is essential between the fields of physical and mental health for a CCO. Since the Medicaid population traditionally has a higher prevalence of mental health issues, coordination between mental health and physical health will be a paramount issue for CCOs to address.

Additionally, coordination is seen as a key strategy in reducing costs. Through a number of different strategies, it is plausible to see how coordination could reduce costs. For one, coordination would ideally reduce redundancies, thus reducing useless testing and eliminating the costs to perform such tests. Coordination could also reduce the excessive cost of ambulatory care sensitive conditions through proper patient management. Additionally, coordination could serve to reduce the healthcare spending of patients with multiple conditions. Instead of working independently and possibly with conflicting methods, multiple providers in a coordinated effort could treat a patient and help formulate the best treatment plan between them. In this way, cost of multiple provider visits or different treatment plans can be avoided. For these patients with multiple conditions, especially those that include physical, mental, behavioral and social health issues, coordination could serve as an impressive strategy to observe cost savings.

CCOs and ACOs also differ in enrollment methods, both Medicare and Medicaid are voluntary government services. An individual may be eligible and choose to decline such opportunities. However, if enrolled in the government program, each population differs in the freedom its patients enjoy when choosing providers. If an individual enrolls in Medicare and is accepted, they have freedom to choose their ACO, assuming multiple organizations exist within the patient's geographical area, they can choose which ACO to become a part of and which providers to see. This autonomy of patient choice is a key aspect of the ACOs (Gold). However, CCOs function much differently in enrollment methods. First, Medicaid enrollees are assigned a CCO. They don't necessarily get a choice. And once in a CCO, patients are bound to stay within that CCO if they choose to see a provider. In this way, CCOs do not focus on patient autonomy as the ACOs do.

A key difference between CCOs and ACOs exists in payment structure. CCOs receive a global payment from the state to cover Medicaid patients with a sustainable rate of growth instead of the utilizing the previous fee – for – service method to care for Medicare patients. In this way, CCOs are flexible to set up reimbursement methods within the CCO that work best for their structure, strategy and providers. The responsibility for financial success lies with the CCO, not the government. With ACOs getting reimbursed with fee – for – service methods, the government reimburses for quantity, not necessarily quality. In this way, the government is the responsible party for maintaining financial accountability.

CCOs also stress community interaction more than ACOs in some ways. CCOs are to be governed by provider organizations, community members and financial stakeholders (Oregon Health Policy Board). Conversely, ACOs did not necessarily stress

community involvement in the structure of the organization, but instead designed the structure to serve the community. The CCO will receive its fixed global Medicaid payment (which grows at a fixed rate annually). This payment will pay for the, “integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid or dually eligible for both Medicaid and Medicare.” (Oregon Health Policy Board) The CCO will be responsible for the quality of health of the Medicaid population it serves. By imparting the organization with this responsibility and the flexibility in its financial budgeting, the organization is able to customize its structure to be tailored to the community it serves. Hence, including community partners is not only prudent but extremely necessary for the organization to best serve its individuals with the money it is given.

CCOs are seen as the next step in Oregon’s health care reform that has been a process that began over twenty years ago with the introduction of the Oregon Health Plan (OHP) (Oregon Health Policy Board). Currently, managed care organizations (MCO), mental health organizations, and dental care organizations are caring for the Medicaid population while attempting to keep costs down. However, the state recognized the lack of efficiency in the system, and understood that through integration and coordination, this efficiency could be restored and further cost savings and quality improvements could be maximized. Additionally, and possibly most importantly, the old structure lacked a patient focused approach. Each provider existed separately, was paid separately, and managed its patient’s health separately. There was little incentive for providers to work together, coordinate care, or focus on preventative care for its patients. This led to a system of steeply increasing healthcare costs. While Medicaid costs were controlled in

the early 2000s, the costs of Medicaid continued to rise recently in Oregon (Health Management Associates, 2012). This growth has increased significantly and now exceeds the current and projected state General Fund revenue as shown in Figure 1 below. It is easy to see that this growth is unsustainable.

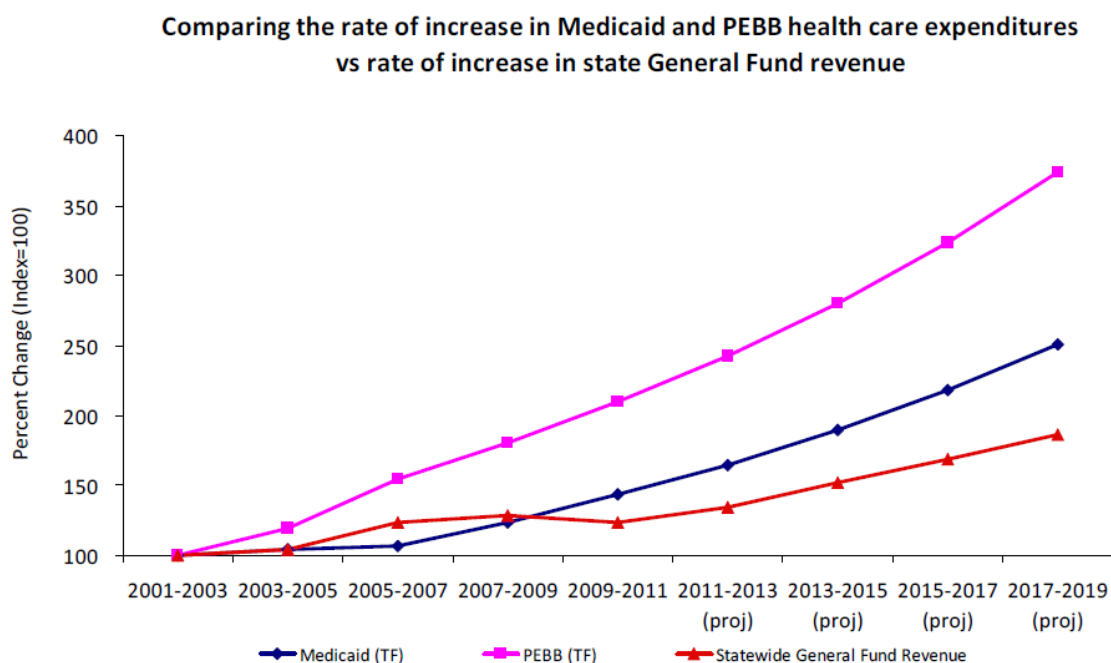


Figure 1 Health Management Associates. (2012, January 16). Financial Model and Analysis of Potential Statewide Savings from Statewide Adoption of the CCO Health Care Delivery System Redesign. *Health Management Associates*. Retrieved April 27, 2013, from www.oregon.gov/oha/OHPB/healthreform/docs/cco-fin-analysis-full.pdf

Thus from this daunting situation arose the idea of CCOs. Conventional wisdom would have recommended a number of other approaches such as reducing payments to providers, reducing covered individuals, or reducing benefits (Oregon Health Policy Board). Though conventional, these approaches did not seem wise to legislators as they have all proven unsuccessful. Thus, a new approach needed to be taken, an increase in

efficiency and value would be necessary to achieve health outcomes. Hence, arose the concept of the CCO.

Coordinated Care Organizations

Population Health

With population health being one of three goals of the Triple Aim, it is necessary to examine how the CCOs address this aspect. A major part of population health that the CCOs focus on is the access of individuals to sufficient health services. As CCOs will serve the majority of OHP enrollees, the impacted population seems clear, but there are a few key aspects of the population that are very necessary to point out. Between 2010 and 2011, the number of OHP enrollees grew rapidly and officials project a 3% growth in the coming years (Oregon Health Policy Board). This should be followed by a rapid growth during fiscal year 2014 when portions of the PPACA go into effect and expand Medicaid coverage. This is illustrated best in a graph published by the Oregon Health Policy Board (OHPB):

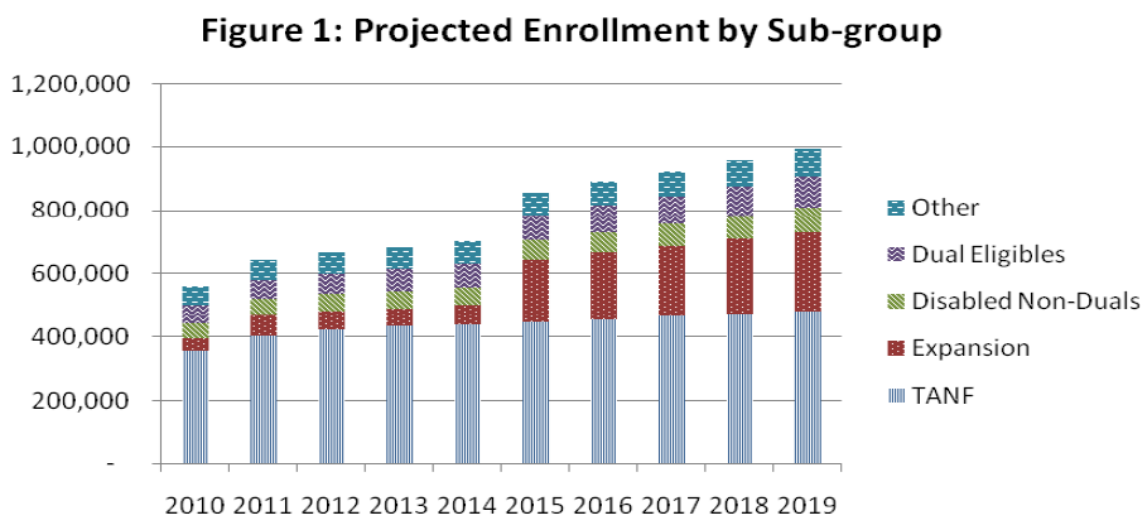


Figure 2 Oregon Health Policy Board. (2012, January 24). Coordinated Care Organizations. *Oregon Health Authority*. Retrieved April 27, 2013, from <https://cco.health.oregon.gov/Documents/cco-implementation-proposal.pdf>

These projections are extremely critical to understanding the access component of the CCOs. According to OHPB's graph, roughly 663,723 individuals were projected to be enrolled in the OHP in 2012 (Oregon Health Policy Board). According to the United State Census Bureau, Oregon's total state population was estimated to be 3,899,353 people (United States Census Bureau, 2013). Thus, a little more than 17% of the state of Oregon was to be covered by the OHP in 2012. But with the growth of the OHP population over the following seven years, this percentage will grow rapidly. The OHPB estimates that nearly 990,350 individuals will be enrolled in OHP in 2019 according to its above graph (Oregon Health Policy Board). The United States Census Bureau estimates that the Oregon population underwent a 1.8% change during the twenty-seven month period of April 1, 2010 to July 1, 2012 (United State Census Bureau). Assuming generally constant growth over this period which saw the 1.8% growth and applying that constant growth over a twelve month period instead of the observed 27 month period, it would be reasonable to expect an estimated annual population growth of 0.8%. Then, applying this annual population growth to account for the changing population from 2012 to 2019, we can extrapolate an estimated 2019 Oregon total population to be approximately 4,123,028 people. Thus, by comparing the estimated 990,350 OHP individuals in 2019 to the estimated population of the entire state in 2019, it is possible to see that almost 24% of the population will be expected to be covered by CCOs. This is a staggering figure considering only about 17% of the population used to be covered.

Also from this above graph, it is possible to see that non-disabled adults seem to constitute the majority of the projected growth, but the critical areas lie in the makeup of this non-disabled population. OHP projects that the annual growth rate of dual – eligible individuals and disabled individuals will be about 6% and the growth rate of temporary assistance need families (TANF), when excluding the Medicaid expansion period, will be closer to 2% (Oregon Health Policy Board). With a rate of growth about three times as great, these dual – eligible and disabled individuals are expected to constitute an even greater portion of the OHP population. This is noteworthy due to the extreme increase in average expense by the dual – eligible and disabled populations as compared to that of the TANF population. However, there does exist a silver lining to this situation. It is also believed that these more costly populations will present more opportunity for care integration, waste reduction, and cost savings for the entire health system. Though it may be a daunting task for CCOs to attempt to accomplish, if they can succeed in efficiently serving these high cost populations, huge savings could be observed.

But this potential growth in OHP population would go unnoticed by CCOs, unless it directly affects the number of people who will be enrolling in CCOs. Estimates suggest that in November, 2012, 90% of the OHP population would be enrolled in a CCO (Oregon Health Authority, 2012). With legislative exemptions only afforded to American Indians, Alaska natives, and related groups, all others are expected to be mandatorily enrolled in a CCO. Through this mandate, the percentage of OHP population served by CCOs is expected to remain the same, if not rise, as time continues.

With these projected increases in the population that will be served by CCOs, questions arose wondering how the state was currently doing in regards to access and

how they plan to improve. In September, 2012, the Oregon Health Authority published its Oregon Health Care Innovation Plan. Within this document they cited a number of statistics that would be key for CCOs to help improve with regards to access. It first cited a statistic from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that indicated that Oregon Medicaid member utilizing MCOs are 6% less likely to get the care they need than the national Medicaid MCO population (Oregon Health Authority, 2012). In some ways, CCOs can help address this problem. Since the CCO will have its members mandatorily assigned to its care, it will then be able to coordinate the needed care for its patients. Through this coordination and determination of needed care, ideally, patients will receive more required care as efforts can be coordinated for patients across all providers in the CCO.

An additional detriment to Oregon's previous Medicaid access was in the speed of care that was delivered. The Oregon Health Care Innovation Plan cited Oregon Medicaid MCO utilizers as being 5% less likely to get care quickly than national Medicaid MCO users (Oregon Health Authority, 2012). Though the Innovation Plan does not exactly interpret why the data suggests this, the data it reports does lead to a slightly obvious conclusion, there is room to improve efficiency and increase access. Again, this is a problem that hopes to be solved through CCO implementation. CCOs are designed around efficiency as payment methods and quality metrics force organizations to maximize productivity. Additionally, through the simple method of coordination and integration, and with many organizations adopting care managers to aid in this effort, care should be streamlined to help individuals receive the care they need in the quickest possible manner.

CCOs are also being designed to address a large population of patients who have often found access difficult due to the absence of a care coordinator or individual tasked with coordinating all aspects of care, from simpler tasks, such as transportation to and from providers, to more tedious work, such as interpreting insurance benefit policies for patients. CCOs are tasked with caring for the Medicaid population and a specific emphasis is being placed on high risk and vulnerable populations (Oregon Health Authority, 2012). CCOs are “expected by contract and accountability metrics to prioritize working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.” (Oregon Health Authority, 2012) In this way, access is being given to CCOs as a new responsibility. CCOs are not simply tasked with coordinating care, but they must assist their patients in accessing such services. By having a single-point of authority, the CCO who is responsible for the access of its patients to different services, care delivery can begin to improve.

Within this group of high-needs patients exists the dual-enrolled individuals. The Oregon Health Authority (OHA) is working on developing strategies for maximizing the effectiveness of CCOs for these individuals. By working with the CCO’s Medicare plan, the OHA hopes to take advantage of the coordination and integration aspects that are fundamental to CCOs to help provide better, more efficient, and more cost effective care to this population that is often extremely costly, per capita.

With this increase in patients, especially high risk patients, CCOs will continue to search for creative ways to address population needs in order to control costs while still

providing high quality care. This aspect can seem daunting, but it is a crucial portion of Oregon's health reform and achieving the Triple Aim.

Quality

For patients and providers alike, quality health care is always a top priority. Now with CCOs it is important to examine how they will continue to shift the quality continuum toward better health outcomes for each patient and how they plan to achieve these changes. One of the major goals of CCOs is to focus on health equity (Oregon Health Policy Board). Health equity is described by the OHPB to be, "the highest possible level of health for all people." Assuming that the OHP population is who they are discussing, the OHPB is hoping to raise health quality for its enrollees. But, it is important to note how they plan to do this, as many past attempts to improve health care quality have failed across the nation. Often economic and socio-political factors result in detrimental effects for at-risk populations. Consequently, these disadvantaged individuals result in raised health costs for all parties involved. But CCOs hope to break this chain of events and return health equity to Oregon.

To begin this process, CCOs are expected to develop and conduct a community needs assessment. Remember, CCOs are regionally based, and each CCO serves a different community, consisting of different people, different habits, different environmental factors, and overall different health needs. The community needs assessment is how the CCO can develop a plan to address the unmet needs of its community, aid any resources that currently exist but need assistance, and identify health

disparities that exist within the community. By identifying health disparities based on different races, ethnicities, languages, or a number of other factors, CCOs can begin planning to achieve this goal of health equity (Oregon Health Policy Board). The CCO will then be expected to maintain this information for its members over time to help provide data for metric identification and determination, temporal comparisons on progression or regression of the program, and further evaluation and restructuring of resources within the CCO which would greatly enhance its ability to serve its community.

To help acquire this data and measure outcomes over time, CCOs are expected to gain a minimum level of technological coordination between the many health providers that may exist within the organization (Oregon Health Policy Board). One such tool that can assist with this coordination is electronic health records (EHR) (Oregon Health Authority, 2013). To assist this implementation, CCOs are expected to determine adoption rates amongst providers within the organization. Additionally, CCOs must work to encourage their providers to adopt adequate EHRs in a timely manner and establish an adoption schedule for their organization. CCOs can also benefit greatly from health information exchange (HIE) services. HIE services allow providers to send patient information to other providers within the CCO. This service would help improve communication between providers, ideally improving quality of care, while also reducing duplicate testing. Two main HIE options will exist for CCOs. One is by direct communication. This will consist of a message from one provider being sent directly to the receiving provider. CCOs that choose this option will be required to register with a health information service provider (HISP). Also, OHPB specifies that, “Direct secure messaging will be available to all providers as a statewide service,” (Oregon Health

Policy Board) allowing all communities, even rural communities, to utilize such resources. Also, CCOs that implement an EHR will most likely find that their EHR provider also supplies HIE services as well. Registration with an HISP is required to ensure that messages are sent securely and that sending and receiving addresses are accurate. This appears to be a precaution to help CCOs avoid violating the Health Insurance Portability and Accountability Act of 1996 (HIPAA) while coordinating care amongst providers. The second option that is available to CCOs is health information organizations (HIOs) (Oregon Health Policy Board). A CCO's participation in an HIO must enable providers within the CCO to share medical information with other providers within the CCO.

Through the implementation of these technological tools, CCOs should be able to shift toward a value – based system of health service (Oregon Health Policy Board). The technology should be able to help CCOs identify a number of different factors that will assist it in transition. First, the technological tools should be able to help compile and record data for analysis. This can then be used to increase efficiency for the organization by monitoring physician performance or cost – effectiveness of treatment methods. It will also allow CCOs to easily and quickly report data for quality evaluations. Ideally, quality evaluations will not only be conducted by the OHA, but can be done internally within the CCO to help improve efficiency and outcomes. Lastly, technology can hopefully engage patient use to better their understanding of their health care system. By empowering the patients with knowledge of their own health and treatment methods they may be more likely to participate in the process. By allowing patients to access health portals online and provide them with their health records, doctor's treatment plans, and educational

material that is relevant to their health status, patients are able to actively participate in their health.

In addition to technological advancement, CCOs also hope to help increase quality of care through increased accountability. This aspect takes on a number of different forms. First, OHPB addressed the aspect of the OHA being accountable for supporting the success of the CCOs (Oregon Health Policy Board). In this way, the OHA is being held responsible for helping the CCOs succeed and providing them with the necessary tools for success. This support could take many forms and the OHPB specifically outlines timely feedback, establishing learning collaboratives, sharing and distributing best practice strategies to help CCOs succeed, resources to help establish new best practices for CCOs, and reducing administrative overhead as a few of the tasks of the OHA. These resources, along with fiscal progress reports to the state legislature and publishing data on each CCO, will be the main roles of the OHA in CCO implementation and success.

As one might expect, CCOs, individually, will also be held accountable for their success. Since the goal of CCO implementation is to achieve the Triple Aim, CCOs will be expected to show progress and achieve excellent performance on these three areas of health implementation (Oregon Health Policy Board). OHA will develop metrics in the three areas of the Triple Aim to help determine CCO success and difficulties (Oregon Health Authority, 2013). These metrics will also be published to inform the public of the performance of CCOs. In this way, the realm of accountability does not solely rest with OHA or the legislature, but instead communities can help hold their CCO accountable for its own performance and efficiency. By incorporating members – at – large from the

community to serve on a Community Advisory Council (CAC) the CCO understands what the community's wants and needs are, and thus where to focus resources and efforts.

Because CCOs will experience a transition period, not only in fundamental development and organization, but also in adapting to performance metrics, these measures will be phased in as time progresses (Oregon Health Policy Board). This will also allow OHA to build up data and use CCO data to fully develop performance standards. The first year, CCOs will only be expected to report the data, no minimum standards will be in place. It is necessary to give the CCOs a year to implement processes and plans and begin submitting reports for the OHA on a regular basis. After this, CCOs will be expected to meet standardized benchmarks as set by the OHA. All CCOs will count their first year of establishment as 'Year 1' and will only be accountable for correctly reporting. Though CCOs may have different establishment dates, they will all begin reporting their first year data upon their establishment. However, all CCOs will be expected to meet the minimum standards beginning January 2014. This deadline of January 2014 will effectively end all phase – in periods (periods of which only data reporting is necessary and minimum requirements are not required to be met, as in the first year of CCO implementation explained above) that are in effect and will prohibit any further phase – in periods from beginning. Thus, any CCO established less than a year before the January 2014 deadline will have a shortened phase – in period, and any established after January 2014 will receive no phase – in period and will be expected to meet performance benchmarks upon establishment.

Data for this reporting may flow either from CCOs to OHA or in the opposite direction, from OHA to CCOs (Oregon Health Policy Board). Depending on the measure being evaluated, either flow may be more or less advantageous. As an example from the OHPB illustrates, it may be easier, and more efficient, for OHA to collect patient satisfaction data, and then present their findings to the CCO. This is the current process for MCOs in the state and could function well for CCOs as well. Also, annual reports will be the evaluating basis for which the OHA will assess CCOs, however informal quarterly or semi – annual evaluations may provide more timely feedback for CCOs and may help CCOs make necessary improvements during the year.

CCO metrics are said to each fall into one of two categories, core measures or transformational metrics (Oregon Health Policy Board). Core measures will focus on the founding principles of CCOs, the Triple Aim, and will work to achieve the outcomes and quality that is expected through care coordination. These measures will be in effect universally for all CCOs and will include all services that CCOs offer within their global budget. Transformational metrics will assess an organizations progress toward achieving the coordination of care that is expected of CCOs. Transformational metrics will provide individual CCOs the necessary incentives and guidelines to help them integrate care and form these collaborative organizations. These two sets of metrics, working in conjunction with one another, will ideally stress improved quality and efficiency within CCOs as well as continued progress toward truly coordinated care for the entire system.

Performance standards for CCOs will also be divided into two categories, a minimum standard and an expectation for outstanding performance. Meeting, or failing to meet, these standards will be the basis for distributing financial and non – financial

rewards. Minimum standards will be under the evaluation of the OHA. Failing to meet minimum standards will result in penalties that are extremely similar to accountability measures for MCOs. OHA is responsible for supporting the CCOs and their success, but it also has an obligation to the public at large. Thus, the OHA is prepared to get involved with CCOs that fail to meet access, quality, or cost measures to help formulate a plan to institute corrective actions. This involvement can increase over time as marks continue to not be met. This information will be made public to the extent that is permitted (Oregon Health Authority, 2013).

OHA will focus on root causes as they attempt to correct poor performance. This will take the form of technical assistance early on in CCO implementation. However, as time continues, if no progress is observed, penalties should escalate progressively. Penalties can include, “technical assistance, corrective action plans, financial and non – financial sanctions, and, ultimately, non – renewal of contracts,” (Oregon Health Policy Board). Conversely, after Year 1, quality incentive payments are also available for CCOs who perform above and beyond the specified quality measures. This could take the form of a simplified recertification process or even financial rewards.

These performance standards will be reviewed over time. Again, the one year phase – in period is observed here in Figure 3 from the Oregon Health Policy Board:

Accountability standards, monitoring and oversight

- Year one — accountability for reporting only, reporting without budgetary or contractual consequences;
- Years two and three — CCOs expected to meet or exceed minimum performance expectations set for core measures and to improve on past performance for transformational measures.

Figure 3 Oregon Health Policy Board. (2012, January 24). Coordinated Care Organizations. *Oregon Health Authority*. Retrieved April 27, 2013, from <https://cco.health.oregon.gov/Documents/cco-implementation-proposal.pdf>

Data gathered from first year reports will be used to decide upon the minimum and outstanding benchmarks for which CCOs should strive. Also, measures and benchmarks may continually be moved, new measures may be adopted, old measures may be removed, or transformational measures reclassified as core measures as is seen fit. Currently, OHA is looking at National Quality Forum (NQF) measures to see if any additional measures should be included. This evolution of the metrics will ideally work to increase the effectiveness and appropriateness of the incentive system over time. An annual review process will be created which will utilize many different stakeholders, including CCOs, to better understand what is needed within the system and hopefully keep the system relevant and current for the CCOs universally (Oregon Health Authority, 2013).

These CCO metrics were developed by the Metrics and Scoring Committee in 2012 (Oregon Health Authority, 2013). In October of 2012, the committee identified 17 measures to be used in the incentive program. These 17 measures were also measures that were required by CMS, allowing CCO incentives to directly match CMS incentives. In this way, the committee was able to avoid any conflict between the incentive programs, allowing CCOs to focus on simply improving these 17 quality measures. Additionally, Oregon and CMS were able to identify 33 state measures for which CMS would evaluate Oregon. Of the 33 state measures, 16 of the 17 CCO measures were included as seen in Figure 4:

CCO Incentive and State Performance Measures

CCO Incentive Measures <i>CCOs are accountable to OHA</i>	State Performance Measures <i>OHA is accountable to CMS</i>
Alcohol or other substance misuse (SBIRT)	Alcohol or other substance misuse (SBIRT)
Follow-up after hospitalization for mental illness (NQF 0576)	Follow-up after hospitalization for mental illness (NQF 0576)
Screening for clinical depression and follow-up plan (NQF 0418)	Screening for clinical depression and follow-up plan (NQF 0418)
Follow-up care for children prescribed ADHD meds (NQF 0108) ³	Follow-up care for children prescribed ADHD meds (NQF 0108)
Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)
PC-01: Elective delivery (NQF 0469)	PC-01: Elective delivery (NQF 0469)
Ambulatory Care: Outpatient and ED utilization ⁴	Ambulatory Care: Outpatient and ED utilization
Colorectal cancer screening (HEDIS)	Colorectal cancer screening (HEDIS)
Patient-Centered Primary Care Home Enrollment	Patient-Centered Primary Care Home Enrollment
Developmental screening in the first 36 months of life (NQF 1448)	Developmental screening in the first 36 months of life (NQF 1448)
Adolescent well-care visits (NCQA)	Adolescent well-care visits (NCQA)
Controlling high blood pressure (NQF 0018)	Controlling high blood pressure (NQF 0018)
Diabetes: HbA1c Poor Control (NQF 0059) ⁵	Diabetes: HbA1c Poor Control (NQF 0059)
CAHPS adult and child composites: <ul style="list-style-type: none"> • Access to care • Satisfaction with care 	CAHPS adult and child composites: <ul style="list-style-type: none"> • Access to care • Satisfaction with care
EHR adoption (Meaningful Use 3 question composite)	EHR adoption (Meaningful Use 3 question composite)
Mental and physical health assessment within 60 days for children in DHS custody	

Figure 4 Oregon Health Authority. (2013, February). CCO Metrics. *Oregon Health Authority*. Retrieved April 27, 2013, from www.oregon.gov/oha/OHPB/docs/cco-metrics.pdf

OHA will compile all of the information for these 17 measures (Oregon Health Authority, 2013). CCOs will not need to provide additional data beyond their regular encounter data and Patient – Centered Primary Care Home (PCPCH) enrollment data. Some CCOs may find it beneficial to provide more information so their services are accurately reported.

To measure these metrics and determine financial incentives, the Scoring and Metrics Committee developed a Quality Pool concept (Oregon Metrics and Scoring Committee, 2013). The Quality Pool is a way to transfer payment incentives from capitation toward pay - for - performance. The pool is determined each year to be a certain amount of money. In year one it will be 2% of the per member per month costs (Oregon Metrics and Scoring Committee). This money in the pool will then be distribute to the CCOs that year. Each CCO has a potential amount of the pool that can be awarded to them. This potential is based upon the number of members covered by their CCO. CCOs can then access this money by meeting benchmarks. But this is just one phase of the pool distribution method. If a remainder of the pool goes unclaimed by CCOs that could not gather the entirety of their portion, that remaining amount is able to be claimed during the second phase called the challenge pool. The challenge pool is distributed to CCOs based on their demonstration of four metrics: primary care patient centered home enrollment; depression screening and follow - up plans; screening, brief intervention, and referral to treatment; and optimal diabetes care. This pool is distributed until all funds have been distributed and then the pool is again refilled the next year and the incentive plan continues. In this way, the Metrics and Scoring Committee has directly linked finances with incentive measures.

Finances

One of the most important questions that CCOs are expected to answer is, ‘Can health care costs be controlled?’ It was projected that Oregon Medicaid costs would reach

\$3.2 billion for the year ending June 30, 2013 (Oregon Health Policy Board). This is due to a number of factors. First, Oregon's Medicaid population has been increasing steadily and thus, expenditures are expected to increase as well. Though this in and of itself would raise costs, additionally, the base cost of healthcare has increased, thus compounding problems and leading to significantly greater rises in expenditures.

With these factors, it can be projected that Oregon will spend about \$11.7 billion between the two year period from 2017 – 2019 while serving almost one million beneficiaries (Oregon Health Policy Board). It is important to note that this estimation, provided by the OHPB, does include the extreme increases projected after the 2014 federal reform expansion. Thus, the OHA understood the necessity of fiscal planning in its CCO implementation and did contract with the organization Health Management Associates (HMA) to conduct this analysis.

The HMA report projects that CCOs will have five potential areas for savings (Health Management Associates). These are not necessarily expected to be observed as savings until the 2018 and 2019 fiscal years. The five areas are shown in Figure 5:

Estimates of Health Transformation Savings

- Improved Management of the Population
- Integration of Physical and Mental Health
- Implementation of the Mental Health Preferred Drug List
- Patient Centered Primary Care Homes
- Administrative Savings from managed care organization (MCO) Reductions

Figure 5 Health Management Associates. (2012, January 16). Financial Model and Analysis of Potential Statewide Savings from Statewide Adoption of the CCO Health Care Delivery System Redesign. *Health Management Associates*. Retrieved April 27, 2013, from www.oregon.gov/oha/OHPB/healthreform/docs/cco-fin-analysis-full.pdf

To begin, the HMA identified ‘Improved Management of the Population’ as a savings method (Health Management Associates). This arose by utilizing data from a report by Milliman of the Portland area for the Oregon Health Leadership Council. This report projected that managing the utilization of the TANF sub-population of Medicaid could save \$118 million to \$141 million statewide (Health Management Associates). In Milliman’s report, he defined this managed population to receive healthcare resources when necessary to meet optimum benchmarks. In this way, there was no overutilization of resources that would produce waste, but there was also no underutilization which would result in compounding illness and increased utilization later for the patient. Thus, savings would result from changing current practices and focusing on optimizing healthcare utilization.

The HMA made its own estimations by utilizing financial data and projections from the Milliman report, but also by expanding its effects to the population that CCOs would cover. These populations included the elderly, the disabled and individuals that would be included in the Medicaid expansion as defined by the federal government. The HMA report further included that it considered its findings to be conservative. It stated that these additional groups tend to have more complex condition, or compounding conditions, and their care is generally less managed and little integration commonly exists in their care strategies. Thus, these populations are thought to possess a very high potential for savings, which would be greater than that of the population used in the Milliman report. So, by introducing the aspects of care management and information integration to these populations, an even greater savings could be achieved, even above these conservative estimations of the HMA.

The HMA further clarified some of the savings that ‘Improved Management of the Population’ would entail. In particular, it specified that many savings experienced through efficient care of dual – eligible individuals would be experienced by Medicare rather than Medicaid (Health Management Associates). The HMA used reports from Milliman again and also estimates from The Lewin Group to approximate an 8.5% savings rate that could be applied to Medicaid expenditures. It did note that in order to achieve the 8.5% saving on Medicaid expenditures, a shared savings agreement between Medicare and the State would be necessary.

Secondly, the HMA introduces the concept of shared savings through integration of physical and mental health. The HMA recognizes other estimates that expect 20% - 40% savings experienced from the implementation of CCOs, however the HMA considered other saving strategies in Oregon and decided on a lower estimate of 10% - 20% (Health Management Associates). They included that their estimate assumed the integration of physical health concepts within mental health strategies and vice versa. Only through this ‘two – way’ integration would the savings be possible. Furthermore, the HMA made a specific point to show that these estimations do not include dental services, and if dental were included in the parameters, the estimated savings would have increased.

In its third concept, the HMA discussed the mental health preferred drug list. Instead of being analyzed by HMA, it was instead OHA who estimated these savings. OHA estimated a \$16 million savings to be experienced over two year periods which would only take affect for periods following July 1, 2013 (Health Management Associates). This portion was not analyzed or estimated by HMA as OHA stated that

legislative approval would dictate the implementation of the drug list and thus this simple savings model could suffice until the legislature finishes with the plan.

The HMA also estimated savings to be considered given an expansion in Medicaid resources. Such services such as claims auditing, reviewing coverage criteria, correcting incorrect coding, determining medical necessity, identifying liability and recouping overpayments are all explicitly stated by the HMA to help reduce costs if improved and expanded by Medicaid. However, the HMA does not know the extent to which these efforts will be employed within the state yet, thus it recognizes that any estimates made on such improvements should be considered preliminary and subject to change until such practices are observed.

The HMA also discusses the concept of patient – centered primary care homes. It suggests that by examining prior implementation of such techniques, these medical homes could result in 7% cost reduction (Health Management Associates). It adds that through the coordination and inclusion of specialty care that will be found in CCOs, care transitions will be improved and that it is possible to go beyond these previous observations to increase quality of patient care and experience while further reducing costs.

The last section that the HMA talks about individually is the likely reduction in administrative costs by utilizing CCOs. This is simply defined to be an effect of economies of scale which are likely to take effect as CCOs are projected to be much larger than previous health management organizations, such as MCOs (Health Management Associates). By utilizing economies of scale, CCOs could potentially lower administrative costs and thus lower expenditures overall.

The HMA model does utilize a phase-in of savings. It states that projections for year one fall between 10% and 20% of what could eventually be achieved once all programs and initiatives are underway (Health Management Associates). By mid – 2015, HMA estimates a savings rate of closer to 40% - 50% of fully achieved status. These projections are estimated to be approximately \$155 million - \$308 million within year one and approximately \$600 million by mid – 2015 (Health Management Associates). The HMA also recognizes these estimates to be reasonable, however they ensure to specify that it is likely for the estimates to be surpassed and experienced savings to be much higher.

The HMA also provides some information regarding savings from electronic implementation and reducing wastes. A study by Witter & Associates, LLC, estimated that a \$16 million reduction in costs could be observed through the use of an HIE (Health Management Associates). Though the state plans on implementing its own HIE, this is projected to take about five years. In the meantime, early adoption of an HIE could mean substantial savings for a number of CCOs. Though these estimates are not net costs that factor in implementation expenditures, there is federal support for these efforts and costs could be shared across payers which could make the implementation more feasible for many organizations and could result in considerable cost reduction.

Another key element in cost reduction is a shift in the reimbursement structure. By shifting reimbursement from the traditionally fee – for – service structure that was previously in place, CCOs will hope to find financial incentives that focus on quality and efficiency (Oregon Health Policy Board). This could be done by connecting payment to outcomes achieved, by promoting patient – centered care, or even compensating

providers for preventative care. By implementing reimbursement structures as such, ideally compensation would drive forward the goals of the Triple Aim by reinforcing population health coverage, quality healthcare, and cost efficient mechanisms of achieving these goals. To further this initiative, the OHPB Incentives and Outcomes Committee published some guidelines in 2010 seen as Figure 6:

Payment methodologies that support the Triple Aim

- *Equity* - Payment for health care should provide incentives for delivering evidence-based care (or emerging best practices) to all people.
- *Accountability* - Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals.
- *Simplicity* - Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse.
- *Transparency* - Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers.
- *Affordability* (cost containment) - Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency.

Figure 6 Oregon Health Policy Board. (2012, January 24). Coordinated Care Organizations. *Oregon Health Authority*. Retrieved April 27, 2013, from <https://cco.health.oregon.gov/Documents/cco-implementation-proposal.pdf>

While keeping these guidelines in mind, CCOs will be expected to determine which reimbursement method will work best for their organization and beneficiaries. The plan that the CCOs design could consist of only one methodology or it could be a combination of many different methodologies. Whatever the CCOs choose, they will be expected to show how they plan to utilize their reimbursement choice to achieve the Triple Aim. Of these methodologies, some examples provided by the OHPB include:

alternative payment methodologies

- Per-member per-month or other payments designed to support patient-centered primary care homes;
- Bundled payments (case rates, fee-for-service rates with risk sharing, or other) for acute episodes, or for episodes of chronic care defined by a calendar period;
- Incentives for service agreements between specialty and primary care physicians;
- Gain-sharing arrangements with providers, if volume is sufficient;
- Quality bonuses or other payment incentives for performance improvement on Triple Aim-focused quality, efficiency and outcomes metrics; and
- Incentives for the use of evidence-based and emerging best practices and health information technology.

Figure 7 Oregon Health Policy Board. (2012, January 24). Coordinated Care Organizations. *Oregon Health Authority*. Retrieved April 27, 2013, from <https://cco.health.oregon.gov/Documents/cco-implementation-proposal.pdf>

Though CCOs can choose from many different payment methodologies, including those above and many more, they are encouraged to utilize previously developed payment strategies so the experience with such systems already exists before implementation across CCOs (Health Management Associates). Also, incentives to promote best practices are also encouraged as this should help improve patient quality while ideally reducing costs. Whatever their choice though, CCOs will need to upgrade their networking and adaptability between providers so new payment structures can easily be implemented and can function effectively within the organization.

CCOs are reimbursed by the state government on the terms of global budgets. The global budget allocated to each CCO will be considered to cover the most Medicaid patients for the most possible services. The global budget is designed to cover all services that enrolled patients may utilize while under the care of the CCO. It is expected that the global budgets will include all services offered previously by Medicaid's managed care

programs as well as all of the services offered by Medicaid outside of its managed care programs according to the OHPB. This was decided upon as a means to further integration of services and achieve economies of scale in an attempt to increase efficiency and decrease costs. Furthermore, the global budget is able to give CCOs the flexibility to maximize efficiency for their organization and community specifically.

As CCOs continue to be phased in, the global budget will begin to incorporate quality incentives to reward CCOs for providing quality care to their patients. With this inclusion of quality measures, the global budgeting system hopes to shift from rewarding quantity of patient's served to rewarding quality of care for patients.

Implementation

In August 2012, the CCOs finally officially opened their doors. Thus far, there have been fifteen CCOs approved by the Oregon Health Plan. Figure 8 includes the fifteen organizations and the areas of Oregon they each cover.

Figure 8. 15 coordinated care organizations approved for Oregon Health Plan	
<u>CCO Name</u>	<u>Service Area</u>
AllCare Health Plan	Curry, Josephine, Jackson, and Douglas counties
Cascade Health Alliance	Klamath county
Colombia Pacific Coordinated Care Organization	Clatsop, Columbia, Tillamook, Coos, and Douglas counties
Eastern Oregon Coordinated Care Organization	Baker, Malheur, Sherman, Union, Wallowa, Grant, Harney, Lake, Morrow, Umatilla, Wheeler, and Gilliam counties
FamilyCare, Inc.	Clackamas, Multnomah, Washington, and Marion counties
Health Share of Oregon	Clackamas, Multnomah, and Washington counties
Intercommunity Health Network Coordinated Care Organization	Benton, Lincoln, and Linn counties
Jackson Care Connect	Jackson county

Pacific Source Community Solutions Coordinated Care Organization Central Oregon Region	Deschutes, Crook, Jefferson and Klamath county
Pacific Source Community Solutions Coordinated Care Organization, Columbia Gorge Region	Hood River and Wasco counties
PrimaryHealth of Josephine County, LLC	Josephine, Douglas and Jackson counties
Trillium Community Health Plan	Lane county
Umpqua Health Alliance	Douglas county
Western Oregon Advanced Health, LLC	Coos and Curry counties
Willamette Valley Community Health, LLC	Marion and Polk counties
Yamhill County Care Organization	Yamhill, Marion, Clackamas, and Polk counties

Figure 8 Oregon Health Policy Board. (n.d.). Coordinated Care Organizations. *Oregon.gov*. Retrieved April 27, 2013, from <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>

These fifteen organizations span the entire state of Oregon. Some cover massive regions that are sparsely populated, others cover little land area that is densely populated. Figure 9 shows this dispersion across the state.

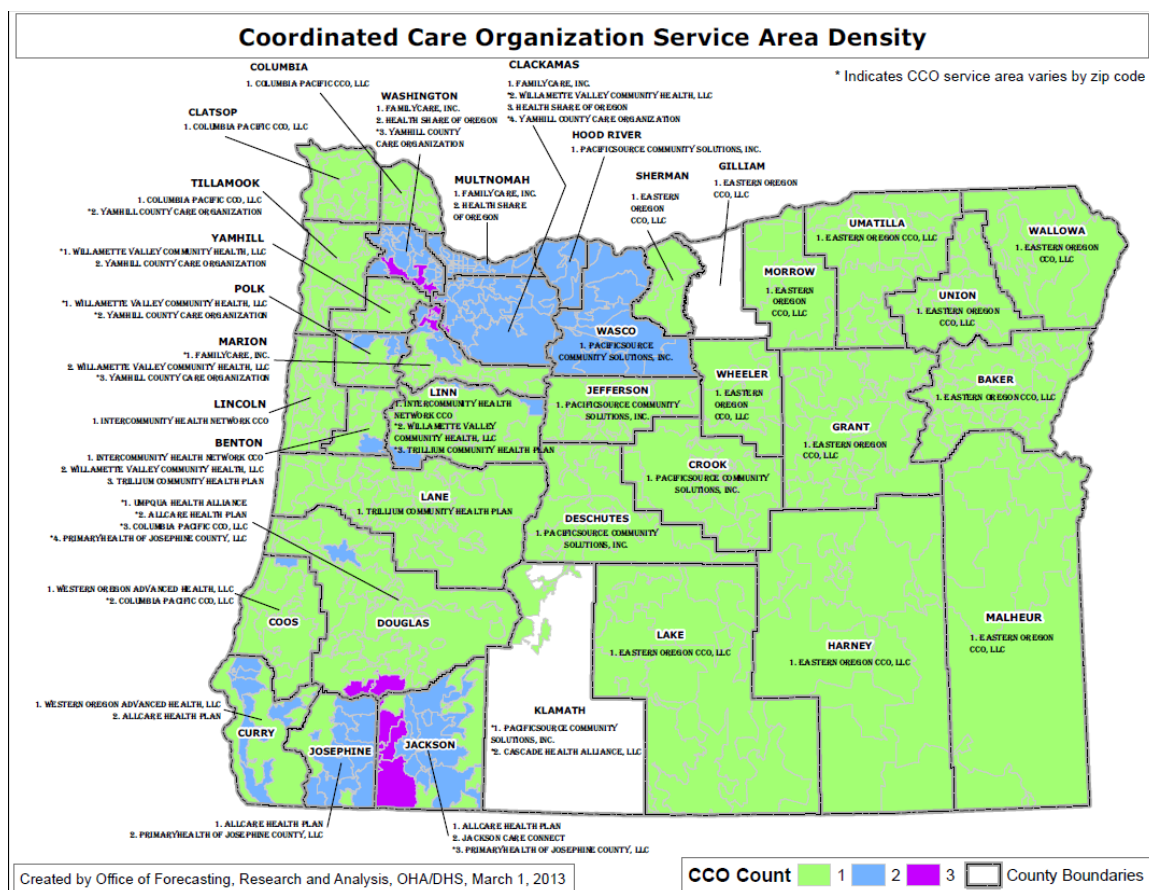


Figure 9 Office of Forecasting. (2013, March 1). Coordinated Care Organization Service Area Density. *Research and Analysis*. Retrieved April 27, 2013, from <http://www.oregon.gov/oha/OHPB/Documents/CCOs%20by%20county.pdf>

On November 14, 2012, the Oregon Society of Healthcare Executives hosted its event, Achieving the Triple Aim in Health Care through Coordinated Care Organizations with Dr. George Brown as Moderator (Oregon Society of Healthcare Executives, 2010). At this event three speakers, Kelley Kaiser of InterCommunity Health Network (IHN) Coordinated Care Organization, Dan Stevens of PacificSource Community Health Plans, and Terry Coplin of Trillium Community Health Plan, presented the plan they had drawn up for their CCO and its implementation in the first three months of live use. As one of

the first looks at CCO implementation, success and difficulties, this meeting was paramount in analyzing how CCOs were structured within the state of Oregon, what troubles or barriers existed for CCO development, and what strategies and future plans were being implemented or discussed to improve the success of CCOs statewide.

First to speak on her CCO, was Kelley Kaiser of IHN – CCO (Kaiser, 2012). Kaiser began discussing the reasoning and the plan that was adopted at IHN - CCO. She addressed three major components of their plan: 1) coordinating health care, 2) increasing efficiency through better coordination and communication, and 3) engaging all stakeholders to increase the effectiveness of care.

She then introduced the different sectors of IHN – CCO. First, the CCO has a Governing Board which works to oversee the other aspects of the care coordination and implementation (Kaiser). This board oversees Samaritan Health Plan Operations (SHPO), the IHN – CCO Regional Planning Council (RPC) and the SHPO Quality Management Committee (QMC). The SHPO works to coordinate and oversee efforts from many different aspects of clinical operations, including Mental Health Organizations, Dental Organizations, and Non – Emergent Transportation Brokerage to help improve the overall experience of the IHN – CCO member. The RPC works to coordinate and oversee efforts of the organization's Delivery System Transformation Steering Committee and the Finance Committee to work on improving care delivery while reducing costs. Additionally, the RPC coordinates with the SHPO QMC to help ensure that care quality does not suffer as decisions regarding care access and cost reductions are being made. In this way, the RPC seems to truly be the consolidated hub working to achieve the Triple Aim and improve the overall patient experience. The SHPO QMC oversees the SHPO

Healthcare Assessment Committee (HAC). This committee helps the SHPO QMC identify areas for improvement in the quality of healthcare that the patient is experiencing. Both the SHPO and the RPC work together to report information to and gain suggestions from the organization's Regional CAC. This council consists of representatives from each of three local CACs (Linn County Local CAC, Benton County Local CAC, and Lincoln County Local CAC). These three local CACs, along with the composite Regional CAC, work to inform the CCO of the needs of the community and provide feedback on the effectiveness and efficiency of the CCO.

These local CACs play a huge role in the governance of the CCO and have a highly integrated role. Each local CAC represents a specific county and it is up to the county to define these groups (Kaiser). These groups are responsible for coming to decisions and structuring themselves, as well as forming task forces as necessary. From each local CAC, 6 – 10 members are recommended to serve on the regional CAC. Of these recommendations, 3 – 5 are expected to be on the OHP, 1 from the county government, and 2 – 4 other individuals that the local CAC can recommend at – large. From these recommendations, a group of commissioners from the region then select the 19 appointments to serve on the Regional CAC. The goal of this process is to obtain the best representation of each group involved, especially across each of the counties. These 19 members constitute the IHN – CCO CAC, along with a coordinator and support staff. From these 19 members, one is elected to serve as the Chair of the IHN – CCO CAC and will serve as their representative to the Governing Board. In this way, the IHN – CCO attempts to stress community involvement as much as possible, ranging from involvement with the Governing Board and all the way to the local CAC. By doing this

the organization hopes to identify the needs of the community so it may adequately address these needs and increase its own efficiency and effectiveness. This, in turn, could hopefully reduce waste, and hence reduce overall expenditures. Additionally, the ability of CACs to return feedback and evaluations to the CCO will hopefully improve quality of care as well for the specific community that is being served by the CCO.

From Mrs. Kaiser's discussion and the evident integration of community partners in the decision making process of IHN – CCO, community involvement seems to be playing a huge role in improving the effectiveness of care and stressing local accountability. With this focus, the goals of the Triple Aim seem achievable, integration seems not only beneficial but extremely necessary and accountability will be present at the local level for the quality of care and proper resource distribution. Also, by gaining community involvement and support, the system remains community focused, thus allowing the new CCOs to not only effectively manage care, but also improve upon the patient centered approach that can result in positive results (Kaiser).

Next to speak was Dan Stevens, the Chief Operating Officer for PacificSource Community Health Plans. This CCO was structured extremely differently than the IHN – CCO. PacificSource Community Health Plans has formed a joint management contract with the Central Oregon Health Council (COHC) in order to co-manage the CCO (Stevens, 2012). The COHC will be comprised of three subcommittees, the CAC, the Operations Council, and the Clinical Advisory Council. Through these separate committees, the COHC will govern the CCO, establish guidelines and protocols for global budget allocation, coordinate the community needs assessment, and develop standards and metrics to ensure quality care delivery, amongst other responsibilities. The

COHC is also responsible for developing the strategic plan of the CCO. In a draft presented by Stevens, the COHC plans to focus on Care Coordination, Prevention and Population Health through taking a partnered look at utilizing public health initiatives along with primary care resources, Optimizing the Global Budget, and Person – Centered Integration. These areas will ideally be linked to interact and support each other through a set of ‘Synergy and Systems’. These are organizational tools that will help improve the overall efficiency of the business and help promote a stronger more cohesive organization. These ‘systems,’ as they are termed include Data Utilization & Integration, Workforce Development, Leadership & Collaboration, and Global Payment Restructure. By connecting together the four areas of the strategic plan through these systems, the ‘synergy’ is hopefully experienced to increase the overall productivity and efficiency of the organization. If this is accomplished, the Triple Aim will naturally follow suit as it is built upon these same principles.

PacificSource Community Health Plans will serve as the CCOs official contract holder from the OHA and will also contract with the providers for the CCO (Stevens). PacificSource will bear the fiscal burden and risk of the CCO. It will also manage care for its patients and will act as the administrator. Additionally, PacificSource will act as the integrating and operating body for the organization. In this way, PacificSource will specifically be able to address project management, extrapolate future trends and results, perform analysis on efficiency measures and quality outcomes, and evaluate effective and ineffective processes within the organization.

Also, providers will exist within the organizational structure of the CCO (Stevens). These providers will contract through PacificSource Community Health Plans

to provide care for the beneficiaries and will also work with COHC on the oversight of the health care provision. By utilizing the many dimensions and strengths of each of these groups, PacificSource hopes to fully develop a strategy that will allow it to improve the delivery of healthcare to its patients while reducing costs and prioritizing high quality care.

One of the most interesting components of PacificSource's plan for its CCO was its introduction of a HealthBridge (Stevens). By utilizing its Mosaic Medical space, PacificSource plans to not only integrate care, but also collocate care in one space. In this facility, many different healthcare needs could be offered under one roof. This facility would be an optimal way of improving access to individuals as many different health care services could be accessed in only one trip to the doctor. This would help eliminate many of the difficulties of care coordination with respect to transportation. This unique characteristic of an integrated health campus at PacificSource's CCO will hopefully allow it to excel in the areas of integration and communication.

The last person to present their CCO at the conference was Terry Coplin who serves as CEO of Trillium Community Health Plan. One of the most interesting aspects of this CCO was their focus on population management (Coplin, 2012). The idea is to keep the organization patient focused so the quality of care is increased, the cost of care is reduced and the overall health of the population will increase as well. Hence, Trillium was extremely influenced by principles of the Patient Centered Medical Home – Neighbor (PCMH – N). Some of the principles include items such as, “Ensure effective communication, coordination and integration. Ensure appropriate and timely consultations and referrals. Ensure efficient, appropriate, and effective flow of patient and

care information.” Within each of these statements, the Triple Aim seems to be at the core. Thus, it becomes obvious why Trillium would focus on such an approach. But with so many different statements and guidelines, many of which were excluded from the short excerpt provided, the message can be whittled down to three philosophies that Coplin mentioned. The focus is on the right care, the right tools and the right workforce. By providing patients with the right care, inherently, the wrong care is eliminated. By eliminating the wrong care, quality of care improves, costs reduce as waste lessens, and with more money to spend on other services and programming, community health can improve. By utilizing the right tools, efficiency is increased, allowing for all aspects of the Triple Aim to be achieved once again. And to have the right workforce interact with, diagnose and treat patients, health conditions can be addressed, treatment plans can be built and the patient can begin to get healthier sooner rather than later. And again, all aspects of the Triple Aim can be achieved. Coplin explained that through focusing on the patient and implementing this PCMH – N model properly, the CCO can begin population management and can achieve the Triple Aim efficiently and effectively.

A Look Ahead

Though we all wish we had a crystal ball in which to stare and see the future, unfortunately that luxury does not yet exist. Thus, conjecture is the most common tool to predict what will happen next. In an article by Dr. Eric Stecker published in The New England Journal of Medicine, he discusses many possible failures for the Oregon CCO ‘experiment’ as he appropriately terms it. He begins by addressing the cost saving methods that CCOs project will lower expenditures (Stecker, 2013). He states that many of these cost lowering strategies have been shown to not do such. He does admit that the patient centered care can lower costs and improve care quality; however he argues that those findings were in large well established settings. These cost savings he does not feel will translate to Oregon’s newly formulated CCOs.

He continues to question the integration between different providers that exist within a CCO. Yes, it may be easy to think that all of the children can play well in the sandbox, but what actually happens? He quickly points to maybe the biggest bullies on the Oregon healthcare playground, the Portland Health Share CCO, a group that provides care for approximately 40% of the OHP members (Stecker). With four units who traditionally compete with each other, the CCO has seen little to no integration or cooperation. He points out the lack of power held by the CCO to force coordination and how this severely limits the effectiveness of the CCO.

Even with these concerns, Dr. Stecker admits that he too cannot predict the future. He raises excellent issues that will need to be addressed in the near future in order for the Oregon CCO ‘experiment’ to succeed. He alludes to a possible expansion of the CCO

system into employer-insurance and admits that such action could carry CCOs over these current hurdles and on to a successful future (Stecker). However, without such expansion or drastic action, Dr. Stecker finds it unlikely for CCOs to overcome these organizational and financial roadblocks.

Conclusion

As Dr. Stecker aptly ends his article, regardless of the outcome, lessons will be learned. With each of these speakers at the OSHE meeting, one thing became apparent. There is no one single way to build a CCO. There is no cookie cutter mold, no secret instruction manual, and no recipe book for the single best CCO. Instead, each model will be different as each community that it serves is also different. IHN – CCO focused heavily on community buy – in and having every stakeholder involved. Whereas, PacificSource had a partnered agreement with COHC and its providers and worked on aspects such as its HealthBridge as an integrative health campus. And Trillium Community Health Plan focused on a patient centered medical home model and on population management. Each of these strategies is slightly different, yet they can all learn from each other. Just because IHN – CCO may not currently be in the process of constructing its own integrative health campus, doesn't mean they can't learn how PacificSource accomplished the tasks, learn from successes and failures along the way, and then implement a similar idea formulated to work best for their own community. And that statement goes for all CCOs across Oregon and the United States. With a project as new as Coordinated Care Organizations, or even Accountable Care Organizations, emerging in the healthcare industry, it will be necessary for everyone to learn together to improve health for each community one step at a time.

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