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The Leading Edge

Oregon's Medicaid transformation: An innovative approach to holding a health system accountable for spending growth

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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).

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.

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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

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 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 the 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 in Appendix A.

1. 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 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