VIEWPOINT

Oregon's Medicaid Coordinated Care Organizations

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In 2012, the state of Oregon transformed its Medicaid program by establishing 16 "coordinated care organizations," or CCOs, to provide comprehensive care for its Medicaid population. Coordinated care organizations can be considered a type of accountable care organization (ACO): they are locally governed; are accountable for access, quality, and health spending; and emphasize primary care medical homes. However, CCOs differ from most Medicare and commercial ACOs in their acceptance of full financial risk in the form of a global budget. Coordinated care organizations are also required to integrate financing and delivery systems for a broad scope of services, including mental health, addiction, and dental services. Approximately 90% of the state's 1.1 million Medicaid enrollees now receive care through CCOs that take a variety of forms that reflect the local context. These CCOs include a mix of for-profit and not-for-profit organizations and vary in the size of the population covered (from fewer than 11 000 enrollees to more than 200 000 enrollees). Some CCOs were formed out of previous Medicaid managed care organizations, whereas others were created out of new alliances and partnerships.

Oregon's transformation was made possible through a remarkable arrangement with the Centers for Medicare & Medicaid Services (CMS), which, beginning in 2012, would provide a total of $1.9 billion over 5 years to support transformation.[1] In exchange, the state agreed to reduce the rate of per capita Medicaid spending growth from a historical average of 5.4% to 3.4% within 3 years. Expenditures on Oregon's Medicaid acute care program totaled $3.6 billion in fiscal year 2013; the 2% reduction was forecast to generate $8.6 billion in total savings over 10 years.[2] Approximately 76% ($6.5 billion) of these savings would accrue to CMS, resulting in a substantial positive return on the initial federal investment. The prespecified growth rate represented a departure from arrangements that set Medicaid managed care rates through negotiations or according to a historical trend.

The Oregon-CMS agreement also required that the quality of care, as defined by 33 measures, would not diminish over time. Accountability was applied in the form of financial penalties triggered by a failure to meet the prespecified spending or quality targets, ranging from $150 million in the second year to $185 million in years 3 and 4. While the investment from CMS exceeded the maximum penalties by close to $1 billion, much of the funding was used to fill a budget gap that would otherwise necessitate sizeable reductions in reimbursement rates. Thus, the state and its CCOs had strong incentives to meet their targets and avoid any penalties.

Oregon is now 3 years into this experiment, providing an opportunity to assess the performance midway through this ambitious Medicaid ACO reform. To date, the CCO model appears robust, despite initial concerns that the rapid transformation and constraints of the global budget could restrict access to care or create an infeasible business model.[3] The state has met its spending targets each year, avoiding potential financial penalties. Compared with a 2011 baseline, the Oregon Health Authority reported that per-member per-month spending for inpatient care had decreased in 2014 by 14.8%.[4] Per-member per-month spending on outpatient care was also lower, by 2.4%. However, outpatient spending trends masked a 19.2% increase in spending on primary care services—a change some observers might find encouraging, given the historical access challenges for the Medicaid population. Of note, reductions in spending were also observed in 2013, suggesting that these decreases were not primarily attributable to an influx of healthier Medicaid enrollees who joined CCOs in 2014. Together, the reductions in inpatient and outpatient spending suggest that Oregon is on track to meet its 5-year 3.4% spending growth target.

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Coordinated care organizations also improved quality on measures that were relevant to pay-for-performance bonuses. The 2014 CCO bonus pool was based on 3% of the global budget and determined by performance on 17 incentive measures. Thirteen CCOs received 100% of their bonus payments, and the remaining 3 CCOs received at least 60% of their bonus payments. In total, the state paid out more than $128 million to CCOs in 2014—approximately $150 for every Medicaid enrollee managed by the CCOs. Overall, statewide improvement was observed for all of the incentive measures for which 2011 data were available.

One of the most substantial improvements occurred in the rate of screening, brief intervention, and referral to treatment for alcohol and substance use, which moved from a statewide average of 0.1% in 2011 to 7.3% in 2014.[4] The change in this measure is noteworthy because it demonstrates the effect of incentive payments and because this quality measure, focused on alcohol and substance use, is a departure from the typi-

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cal quality measures used by Medicare and commercial ACO models.[5] In earning these bonus payments, CCOs also demonstrated large increases in the percentage of their patients enrolled in a recognized patient-centered primary care home (PCPCH), moving from a statewide average of 51.8% in 2012 to 81.0% in 2014.[4]

However, CCOs demonstrated mixed performance across a range of measures that were not connected to incentive payments. Immunizations for children and adolescents and tobacco cessation efforts improved over the 2011-2014 time period. But rates of chlamydia screening, cervical cancer screening, and well-child visits in the first 15 months declined.

Although these results are promising, they are preliminary. A rigorous National Institutes of Health–and foundation-funded evaluation is under way. Even if Oregon and the CCOs meet their obligations to CMS, a formal analysis is necessary to determine the extent to which observed changes can be attributed to the CCO model, as opposed to larger, secular trends in health care.

Coordinated care organizations will face a number of important challenges in the upcoming years. The observed early successes may be largely attributable to an overall slowdown in health care spending and the ability of CCOs to identify easily achievable goals, such as improving the management of selected high-cost patients or reducing readmissions through care transition programs. Longer-term efforts to keep the growth rate of health care expenditures at 3.4% and improve quality may require more substantial changes in the delivery system. Furthermore, as part of the Affordable Care Act, Oregon expanded its Medicaid coverage, adding more than 400 000 people in 2014, a 69% increase over 2013 levels. Although 2014 data suggest CCOs were able to enroll these new members in PCPCH clinics and provide access, coordinating care for this new population may require new tools and additional efforts.

The CCO transformation and the survival of the global budget mechanism will also require flexibility in the regulatory and actuarial requirements imposed by CMS. Whereas the state of Oregon and CCOs originally envisioned a model that moved away from the fee-for-service payment model to a global budget focused on outcomes, CMS has increased its scrutiny of the budgeting mechanism and its requirements for detailed claims and encounter data as the basis for rate setting.[6] This development challenges the ability for CCOs to invest in quality or upstream public health initiatives and limits the transformative potential of the original CCO model.

Oregon's experience provides a number of lessons that are applicable to other states, regardless of whether they are expanding coverage. The Oregon-CMS exchange, if successful, could serve as a template for Medicaid reform. By providing an up-front investment to states but holding them accountable for the increase in spending, CMS has an opportunity to test reform models that have built in incentives to achieve savings. The CCO model also offers an important test of the potential to contain the cost of the Medicaid program through policies that focus on reforming the delivery system, as opposed to reforms that engage patients through greater cost-sharing or premiums. Furthermore, as part of the ACO model, the lessons from Oregon will provide yet another indication of what types of ACO models have the best chance of improving the value of care.[7] Overall, lessons from Oregon will provide important evidence about the extent to which new models can provide adequate access, improve population health, and slow the growth of health care spending.

ARTICLE INFORMATION

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