
Coordinated Care Organizations (CCOs):

Better health, better care, lower costs

House Bill 3650

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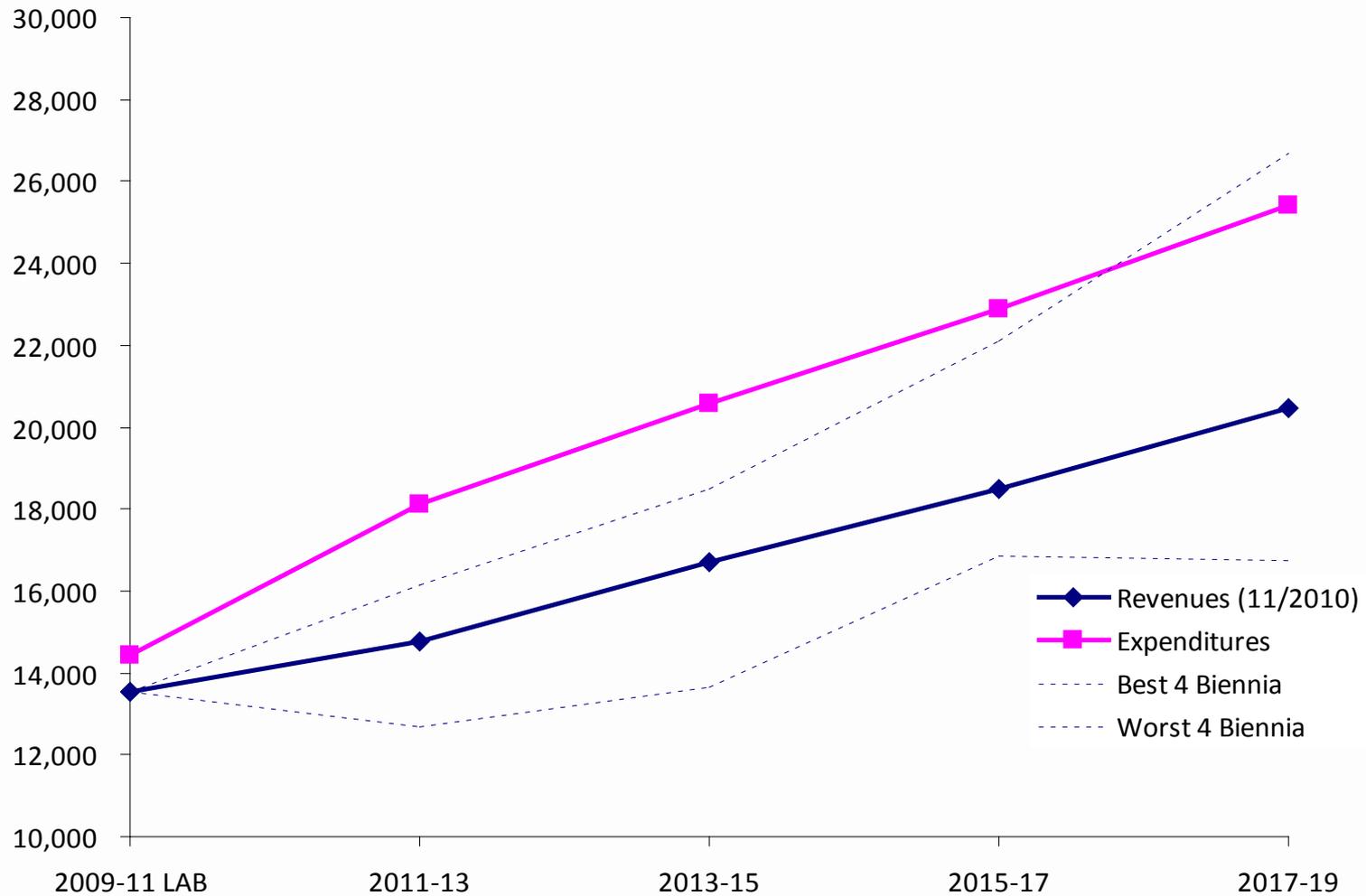
Administrator, Office for Oregon Health Policy and Research



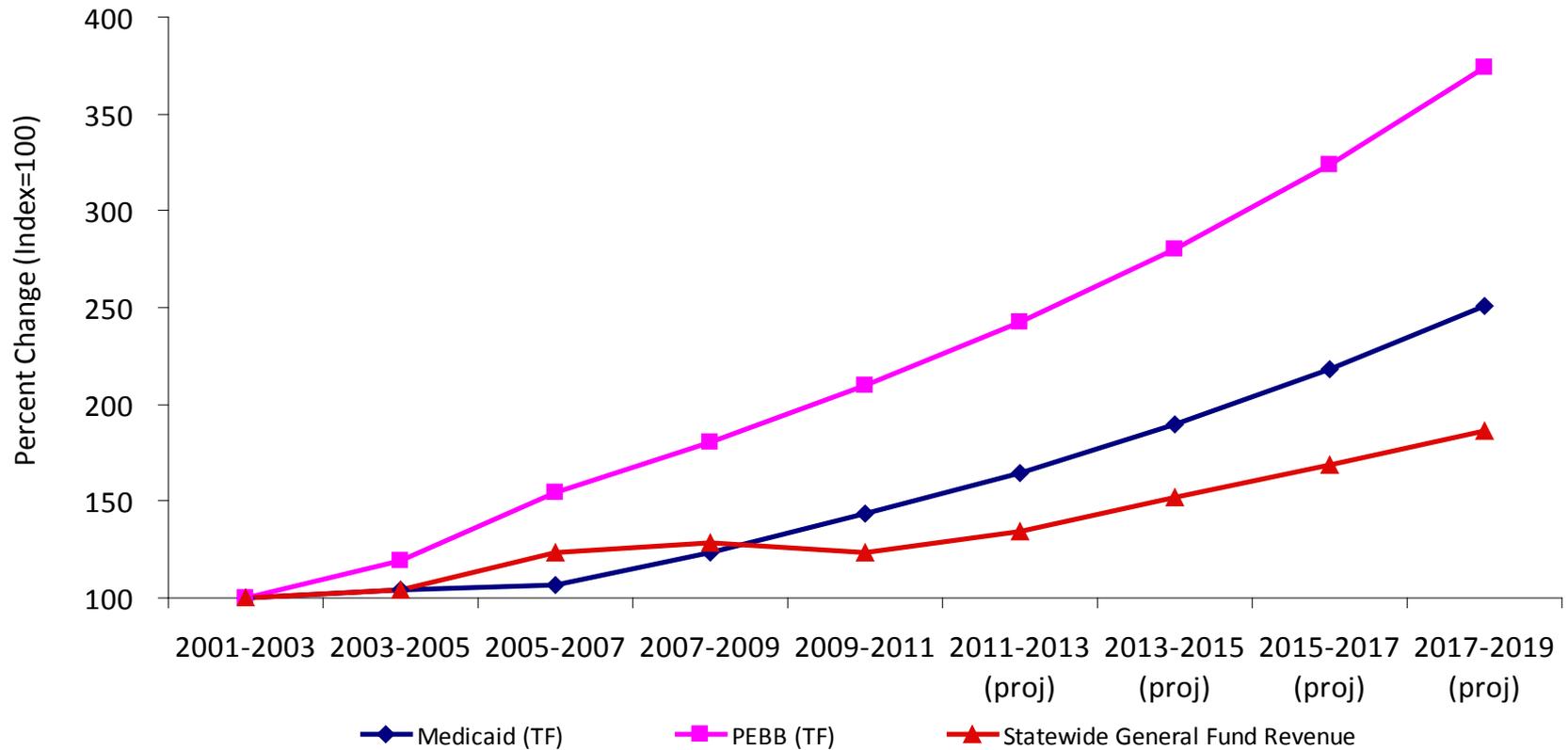
Why transform and why now?

- Health care costs are increasingly unaffordable to individuals, the state, and business
- Current fiscal climate creates imperative and unique opportunity to redesign Oregon's health care delivery system to get better value for all
- Outcomes are not what they should be – estimated 80% of health care dollars go to 20% of patients, mostly for chronic care
- Lack of coordination between physical, mental, dental and other care and public health means worse outcomes and higher costs

The budget realities



Comparing the rate of increase in Medicaid and PEBB health care expenditures vs rate of increase in state General Fund revenue



Goal: Triple Aim

A new vision for a healthy Oregon.

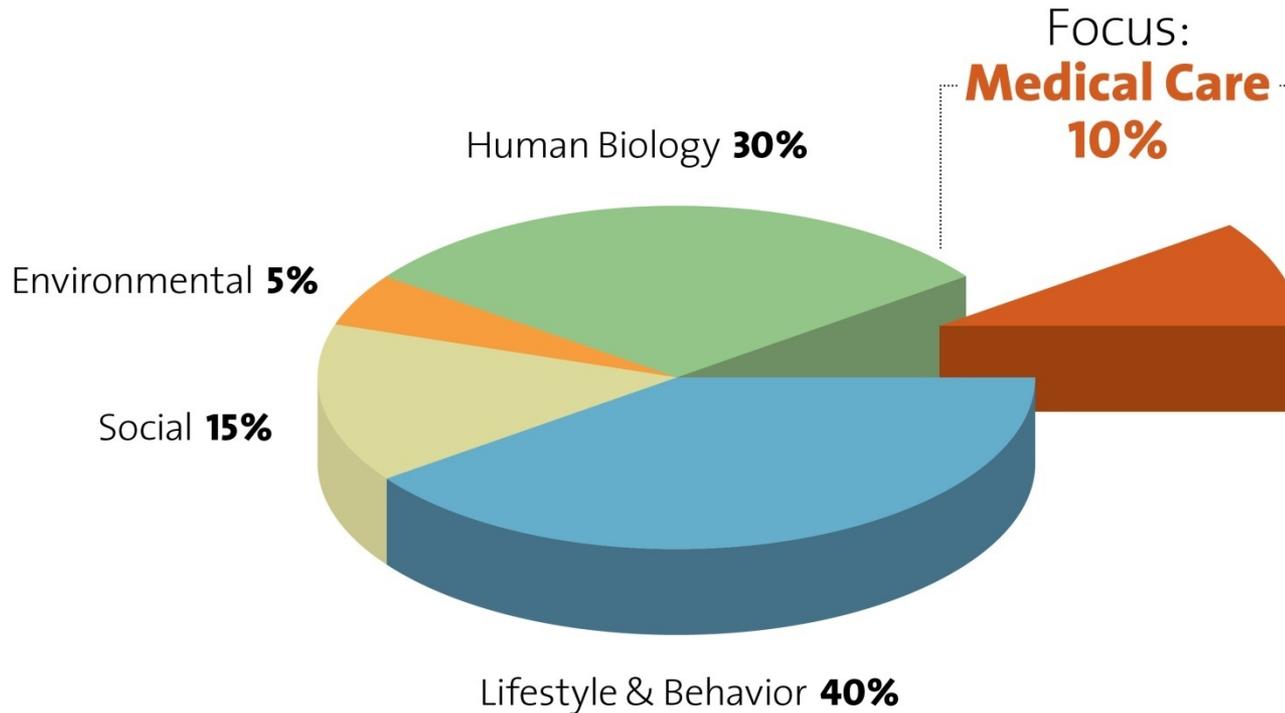
Oregon's Health Community



- 1 Enhance the patient experience**
through clinical outcomes, patient safety and satisfaction
- 2 Improve the health of Oregonians**
- 3 Reduce per capita cost**

Challenge:

Too much focus placed on medical care, while disregarding the larger sphere of contributing health factors.



Solution:

Community health benefit and health reform



PAYMENT MODELS

Fee for service	Episode-based reimbursement	Partial/full risk capitation	Global budgeting
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INCENTIVES

Conduct Procedures	Evidence-based medicine Clinical PFP	Expanded care management Risk-adjusted PFP	Reduce obstacles to behavior change Address root causes
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METRICS

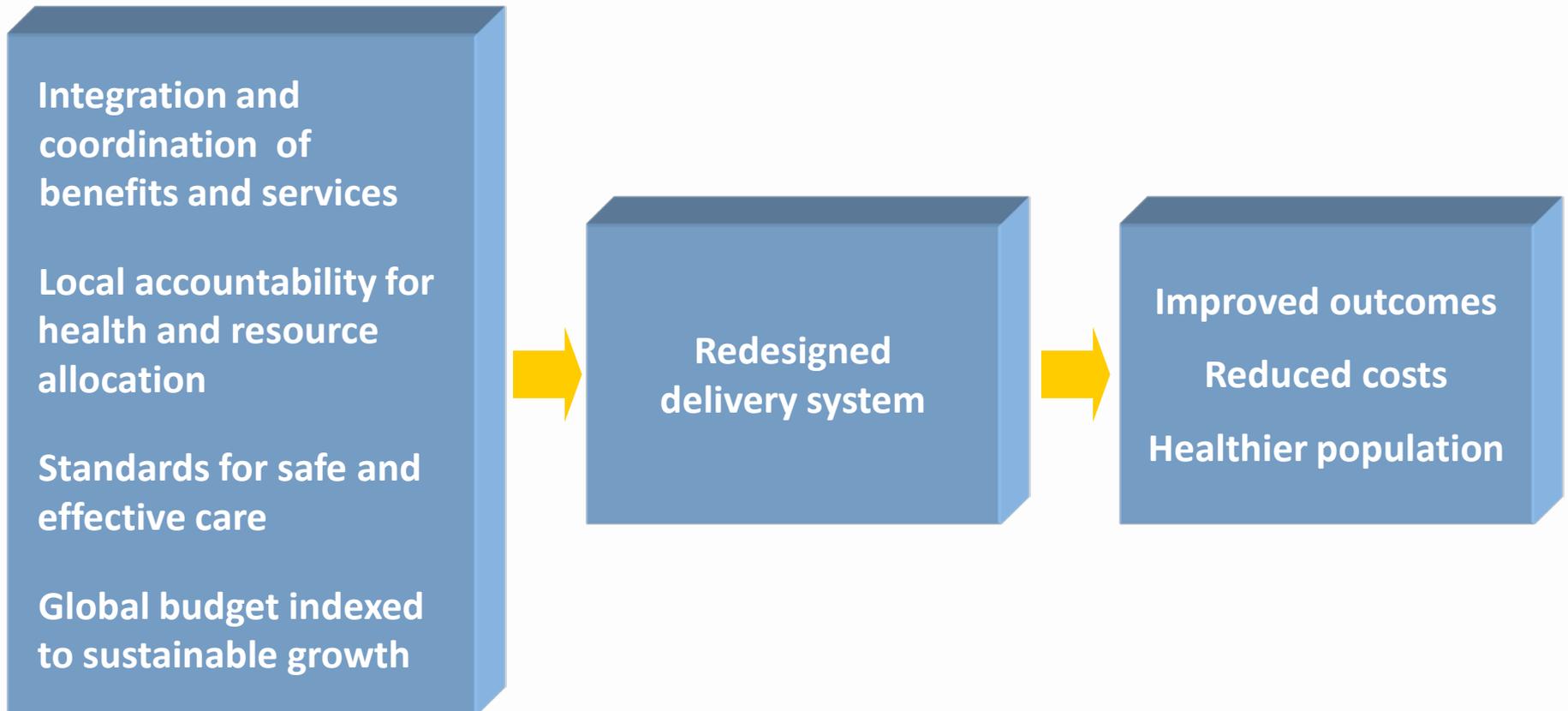
Net revenue improvement	Improved clinical outcomes Reduced readmits	Reduced/preventable hospitalizations/ED Reduced disparities	Aggregate in health status & QOL Reduced HC costs
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GOVERNANCE

Informal relationships & referrals	Joint partnerships between organizations e.g. mental health & behavioral health		New community-based accountability linking all
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Information from Public Health Institute

Vision of HB 3650



Vision of HB 3650

- Full integration of physical health, mental health, and oral health, elimination of fragmentation in system, initially with Medicaid population, but directs planning to include other publicly–supported health benefit purchasers, including PEBB and OEBC.
- Health care services that focus on improving health equity and reducing health disparities
- Federal approval to blend Medicare and Medicaid health care funds for those who have health care paid for by both (“dual”) brings Medicare dollars into an integrated system
- Organizations to manage to budgets fixed to agreed upon rate of growth, rather than historical trend
- Organizations will be accountable for and manage to metrics, outcomes and resource allocation

Examples of what we can build on

- **Mosaic Medical / Bend** - 2010. One year-long pilot program with 100 costliest Medicaid patients. Frequent ED visits up to 25 year. Team based care. Cost decreased: Mosaic's 6,400 Medicaid patients in 2010 decreased by more than \$621,000, thanks to just six months of reduced reliance on the emergency room for non-emergent care.
- **CareOregon Pilot Project** – 41% of their Medicaid clients. Highest risk. Reduced inpatient hospitalization between 16 – 18%. ED stabilized during a period when other ED increased. Costs decreasing to non-high risk patients.

And there are many more examples in your communities

Coordinated Care Organizations

- Community based organizations with strong consumer involvement in governance
- Not a “one size fits all” solution: emphasis on flexibility and governance at the community level
- Global budget
 - Revenue flexibility to allow innovative approaches to prevention, team-based care
 - Opportunities for shared savings
- Accountability through measures of health outcomes

What are Accountable Care Organizations (ACOs) versus CCOs ??

- Both aim to enhance care coordination, improve the quality of care and reduce inefficiencies through payment arrangements with entities that share in savings and losses.
- ACOs, as proposed in federal legislation and draft rules, are provider-focused arrangements with Medicare, for traditional Fee for Service (FFS) clients to deliver services. Savings and losses are proposed to be applied in a “look back” with payment remaining FFS
- HB 3650 doesn't restrict CCO eligibility to just provider groups. The state could contract with local, community-based organizations, networks of providers, health plans, alignments of plans and/or providers through contractual arrangements, etc if they meet the CCO criteria and responsibilities, and accept a global budget payment arrangement.

9/22/11

Global budgets

- Global budgets based on initial revenue/expenditure target and then increased at agreed-upon-rate
- Management of costs – clear incentives to operate efficiently
 - More flexibility allowed within global budgets, so providers can meet the needs of patients and their communities
 - Accountability is paramount
 - There are opportunities for shared savings when patients remain healthy and avoid high-cost care.

Accountability and Metrics

Incentives for right care, right time, right place by the right person

- **Measurements for activities geared towards health improvement**
 - Mental illness prevention and treatment
 - Preventive dental and physical health services
 - Tobacco cessation and treatment, obesity prevention and treatment
 - Member enrollment in primary care health homes
 - Home environment assessments – asthma
- **Measurements for hospital quality and safety**
 - Chronic heart failure care, pneumonia care, surgical care
 - Healthcare acquired infection, complications after surgery
- **Measurements for patient experience of care**
 - Communication, responsiveness, integration of care
 - Getting timely, needed care
- **Measurements for health outcomes**
 - Diabetes in control, blood pressure control, cholesterol control
 - Decreasing emergency room visits

Timeline

- Through Nov. 2011: Public input opportunities and information sharing
 - 4 Governor-appointed work groups
 - Monthly Oregon Health Policy Board meetings
 - Statewide community input
- Nov. 2011 – Update to legislature
- Dec/Jan 2011: Proposal to legislature specifying CCO criteria and global budget methodology draft
- Feb. 2012: Legislative session
- Mar. 2012: If approved by legislature, send CCO plan to federal government
- July 2012: First CCO launches

Oregon Health Policy Board

Health System Transformation Work groups

Through Nov. 2011

- **Coordinated Care Organization Criteria Workgroup**
 - Input on specific criteria and process expected for the CCOs, including governance and business requirements
- **Global Budget Methodology Workgroup**
 - Discussions on best risk-sharing arrangement between the state and the CCOs and other aspects of how to set the structure of the budget and financial arrangements
- **Outcomes, Quality and Efficiency Metrics Workgroup**
 - Input on how best to identify the key metrics of accountability for the CCOs
- **Medicare-Medicaid Integration of Care and Services Workgroup**
 - Focused discussions of key aspects of CCO structure needed for improving care coordination for those dually eligible for Medicaid and Medicare

What does this mean for rural communities?

- Rural areas have had to collaborate in order to meet needs, so many of the necessary relationships already exist.
- Will require
 - strong local leadership and a focus on improving the health of the population served
 - focus on partnerships between delivery system, county mental health, public health, and long-term care supports and services.
 - Building on primary care through patient-centered primary care health homes development
- Aims to ease the challenges of coordinating care for rural Oregonians

Coordinated care can meet rural communities health needs

- CCOs will be accountable for enhancing the coordination of care, especially for chronic disease through the efficient use of services and providers to address the local community needs.
- This is important as we know rural communities face
 - Higher rates of chronic disease
 - Healthcare workforce challenges
 - Limited access to specialty services for complex care
- CCOs will be expected to maximize the use of primary care and the relationships already in place in rural communities between providers and their community and their patients

CCOs and preparing for 2014

- Estimate is that there are about 220,000 adult (18-64) uninsured Oregonians at or below 138% of poverty who will be newly eligible for Medicaid starting in 2014.
- Some county level data available:
 - 17,000 in Deschutes county
 - 14,000 in Douglas county
 - 26,000 in Jackson county
 - 12,000 in Josephine county
 - 10,000 in Klamath county
- CCO development will be critical to serving these newly covered Oregonians.
- Also prepares for serving those who will get coverage via the Health Insurance Exchange that starts in 2014

Questions?

Learn more. Get involved.

www.health.oregon.gov