

# Oregon's Coordinated Care Organizations Show Promising Results

In 2012, Oregon established Coordinated Care Organizations (CCOs) to serve Medicaid members. In their first three years, CCOs were associated with reduced total spending and improvement on important quality measures.

**In 2012, Oregon established Coordinated Care Organizations (CCOs) to serve as the single point of accountability for the health care and outcomes of most Medicaid members.** CCOs were locally governed, with representation from Medicaid members, health care providers, and other local stakeholders. They received a global budget that covered physical, behavioral, and oral health care services, and they were responsible for coordinating and integrating these services. CCOs were required to work with health care providers on improving health care delivery and payment systems and could receive bonus payments for improving specific outcomes among their members.

**CCOs were established under a federal Medicaid demonstration waiver, with the goals of limiting increases in per capita spending and improving health care access and quality.** Many states are working to achieve these goals within their Medicaid programs. As a result, Oregon's experience is of interest.

**To understand the effects of CCOs, this evaluation analyzed changes in measures of health care spending, quality, and access from 2011 to 2015.** Where possible, the evaluation team compared changes among CCO members to changes among Medicaid members in Washington State, which did not make major changes to its Medicaid program during this time. Comparing changes in Oregon and Washington provides strong evidence about the effects of CCOs.

Kushner J, Tracy K, Lind B, et al. *Evaluation of Oregon's 2012-2017 Medicaid Waiver*. Center for Health Systems Effectiveness, Oregon Health & Science University; 2017.

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## KEY FINDINGS

- Oregon made major changes to its Medicaid program while controlling spending and maintaining overall quality.
- Total spending per member, per month decreased relative to Washington Medicaid members.
- Improvement on quality measures was mixed: some quality measures improved, while others did not improve as expected.
- Most access to care measures decreased slightly. Oregon's large Medicaid expansion likely contributed to this trend.



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## CCOs in context

CCOs were built on the foundations of Oregon's MCOs, but had multiple features that distinguished them from MCOs.

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## Oregon established Coordinated Care Organizations (CCOs)

In 2012, Oregon established Coordinated Care Organizations (CCOs)—a new type of Medicaid managed care organization (MCO). Before CCOs, different kinds of MCOs managed health care benefits for most of Oregon's Medicaid members. Each MCO received per capita payments from the state to cover a group of Medicaid members. Different MCOs managed physical, behavioral, and dental benefits, and county governments also managed some mental health services.

### Accountability for access and quality

Oregon established CCOs to serve as the single point of accountability for the health care access and quality of Medicaid members. CCOs were built on the foundation of Oregon's MCOs, but had multiple features that distinguished them from MCOs:

- CCOs were locally governed, with representation from Medicaid members, health care providers, and other local stakeholders.
- CCOs received a global budget that covered physical, behavioral, and oral health care services, and they were responsible for coordinating and integrating these services.
- CCOs had flexibility to pay for services that addressed members' social needs using their global budgets. Specifically, they were directed to use health related "flexible services" to replace or reduce the need for medical services.
- CCOs were required to work with health care providers on improving health care delivery and payment—including care coordination, information technology, and new payment models.
- CCOs could receive bonus payments for improving specific outcomes, called incentive measures, among their members.

## Federal support

Oregon established CCOs through a Medicaid demonstration waiver from the federal Centers for Medicare and Medicaid Services (CMS). Medicaid waivers allow states to test new approaches to health care delivery and payment, with the goal of learning lessons to improve Medicaid. CMS provided \$1.9 billion to support CCOs; in return, Oregon committed to achieving two primary goals through CCOs:

- Limit increases in per capita spending
- Improve health care access and quality

If Oregon failed to achieve these goals, CMS could impose substantial financial penalties on its Medicaid program.

### CCO evaluation

Oregon's Medicaid waiver required Oregon to evaluate CCOs' effects on health care spending, quality, and access. In 2016, the Oregon Health Authority, Oregon's Medicaid agency, selected the Center for Health Systems Effectiveness (CHSE) to carry out the final evaluation of CCOs.

To evaluate the effects of CCOs, the evaluation team selected a variety of measures reflecting health care spending, quality, and access. They analyzed changes in these measures among CCO members from 2011, the year before CCOs were established, to 2015. Where possible, they compared changes among CCO members to changes among Medicaid members in Washington State, which did not make major changes to its Medicaid program during this time. In addition, they used statistical techniques to account for observable differences between these populations. Comparing changes in Oregon and Washington provides strong evidence about the effects of CCOs.

## CCOs were associated with reduced total spending

Total spending per member, per month (PMPM) decreased among CCO members relative to Washington Medicaid members. This measure decreased moderately among both groups from 2011 to 2014 and 2015, but decreased more among CCO members. Inpatient facility spending, which reflects hospital visits where the patient stays overnight, decreased among both groups, but decreased much more among CCO members, driving the decrease in total spending among CCO members (Figure 1).

In contrast to total spending PMPM and inpatient facility spending PMPM, prescription drug spending PMPM increased substantially among CCO members and

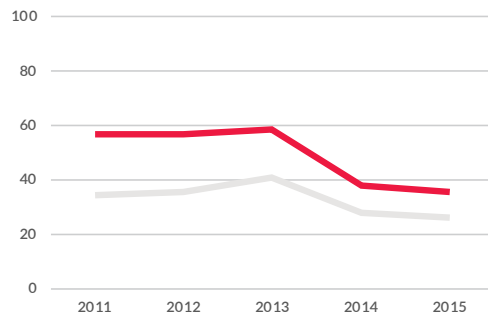
Washington Medicaid members (Figure 2). Limiting prescription drug spending growth will be important for controlling the growth of Oregon's total spending in the future.

## Improvement on quality measures was mixed

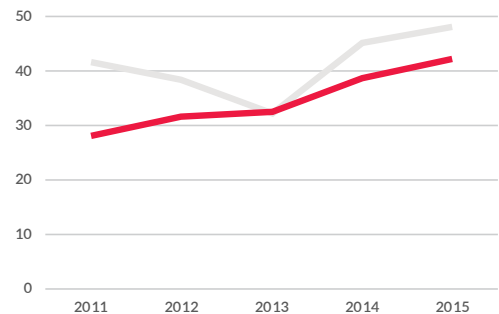
Important measures of health care quality improved among CCO members. For example:

- The rate of avoidable emergency department visits decreased relative to Washington Medicaid members (Figure 3).
- The percentage of adolescents with at least one well-care visit increased relative to Washington Medicaid members.
- Appropriate use of antibiotics for bronchitis, a measure of progress avoiding

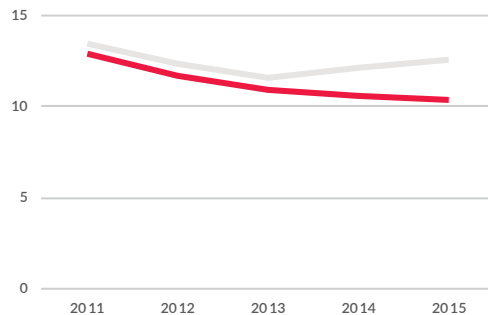
**Figure 1. Inpatient facility spending per member, per month among CCO members decreased more than among Washington Medicaid members.**



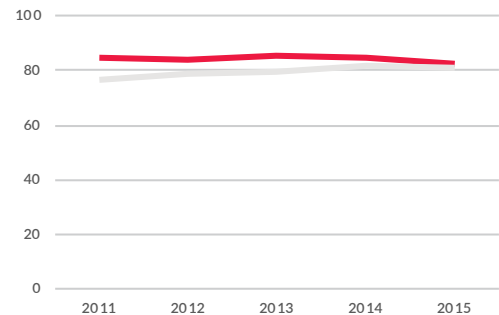
**Figure 2. Prescription drug spending per member, per month increased among CCO members and Washington Medicaid members.**



**Figure 3. The avoidable emergency department visit rate among CCO members decreased relative to Washington Medicaid members.**



**Figure 4. The rate of glucose testing for people with diabetes decreased among CCO members relative to Washington Medicaid members.**



Adjusted for differences between CCO and Washington Medicaid members.

the use of unnecessary health care services, increased relative to Washington Medicaid members.

Other quality measures did not improve in the first three years of CCOs. For example:

- Glucose testing for people with diabetes, a measure of preventive care for adults, decreased relative to Washington Medicaid members (Figure 4).
- The rate of 30-day follow-up after hospitalization for pneumonia, a measure of care coordination, decreased relative to Washington Medicaid members.
- The rate of 30-day follow-up after hospitalization for mental illness, a measure of behavioral health integration, decreased from 2011 to 2014 and 2015. (Due to data limitations, the evaluation team was unable to compare changes among CCO and Washington Medicaid members.)

### **Most access to care measures decreased slightly**

Most access to care measures decreased slightly among CCO members and Washington Medicaid members, but decreased more among CCO members. Medicaid expansion likely contributed to this trend. In 2014, Oregon expanded eligibility for Medicaid. New Medicaid members who used their benefits to access health care may have impacted the ability of existing CCO members to get appointments and services. While both Oregon and Washington expanded Medicaid eligibility in 2014, enrollment increased much less in Washington relative to mid-2011 levels.

### **Implications**

Within their first three years, CCOs were associated with a reduction in total spending per member, per month and improvement on important health care quality measures. While not all measures improved as expected, Oregon implemented a major shift in care

for Medicaid members without substantial reductions in quality or access. This shows that states can undertake substantial reforms to their Medicaid programs without catastrophic consequences.

Oregon's experience with CCOs offers multiple lessons for states working to control spending and improve quality in their Medicaid programs:

#### **Financial incentives**

Bonus payments were strongly associated with improvement in quality measures: While one-third of all analyzed measures improved, two-thirds of measures tied to bonus payments improved. States should consider targeted financial incentives for improving performance in specific areas.

#### **Behavioral health integration**

Within their first three years, CCOs initiated efforts to integrate physical and behavioral health care. However, contracting systems, billing restrictions, and regulations that existed before CCOs limited CCOs' ability to promote integration at the clinic level. States may need to address these factors in order to clear the way for physical and behavioral health care integration.

#### **Health information technology**

Health information technology, such as electronic health records (EHRs), can improve care coordination and quality. EHR adoption increased considerably among clinics in CCOs' networks from 2013 to 2015. However, a sample of Oregon's patient-centered medical homes experienced challenges using EHRs to their full potential. States may need to provide targeted requirements or incentives to improve EHR functionality and care coordination.

#### **Addressing social needs**

CCOs experimented with a variety of flexible services to address members' social needs. However, spending on flexible services was low relative to medical services. Interviews with CCOs indicated that lack of clarity

about the definition of flexible services and how they fit into the determination of CCOs' payment rates discouraged greater investment in flexible services. Other states that aim to address members' social needs should issue clear guidance on the kinds of services they expect Medicaid managed care organizations to provide and how these services fit into payment rates.

### **Oregon continues to refine the CCO model**

In 2017, Oregon extended its Medicaid waiver with CMS. The new waiver carried forward the key features of CCOs and included new provisions to help CCOs improve payment models and address members' social needs.

As of this writing, Oregon is in the process of executing new contracts with CCOs. Oregon intends to use these contracts to make progress in specific areas, an effort it calls "CCO 2.0." The new contracts will include more detailed requirements in the areas of payment models, behavioral health integration, health information technology, and addressing members' social needs.

Evaluation of Oregon's new Medicaid waiver and CCO 2.0 will continue to yield lessons for improving quality and controlling spending among state Medicaid programs.

## **CENTER FOR HEALTH SYSTEMS EFFECTIVENESS**

Written by Kyle Tracy of the Center for Health Systems Effectiveness

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