Oregon Health Authority

TRANSFORMATION CENTER

Coordinated Care Organizations 101

2014 Coordinated Care Model Summit

Oregon Convention Center

December 4, 2014

Coordinated Care Organizations 101

Oregon's Coordinated Care Model: Inspiring Health System Innovation

December 3-4, 2014

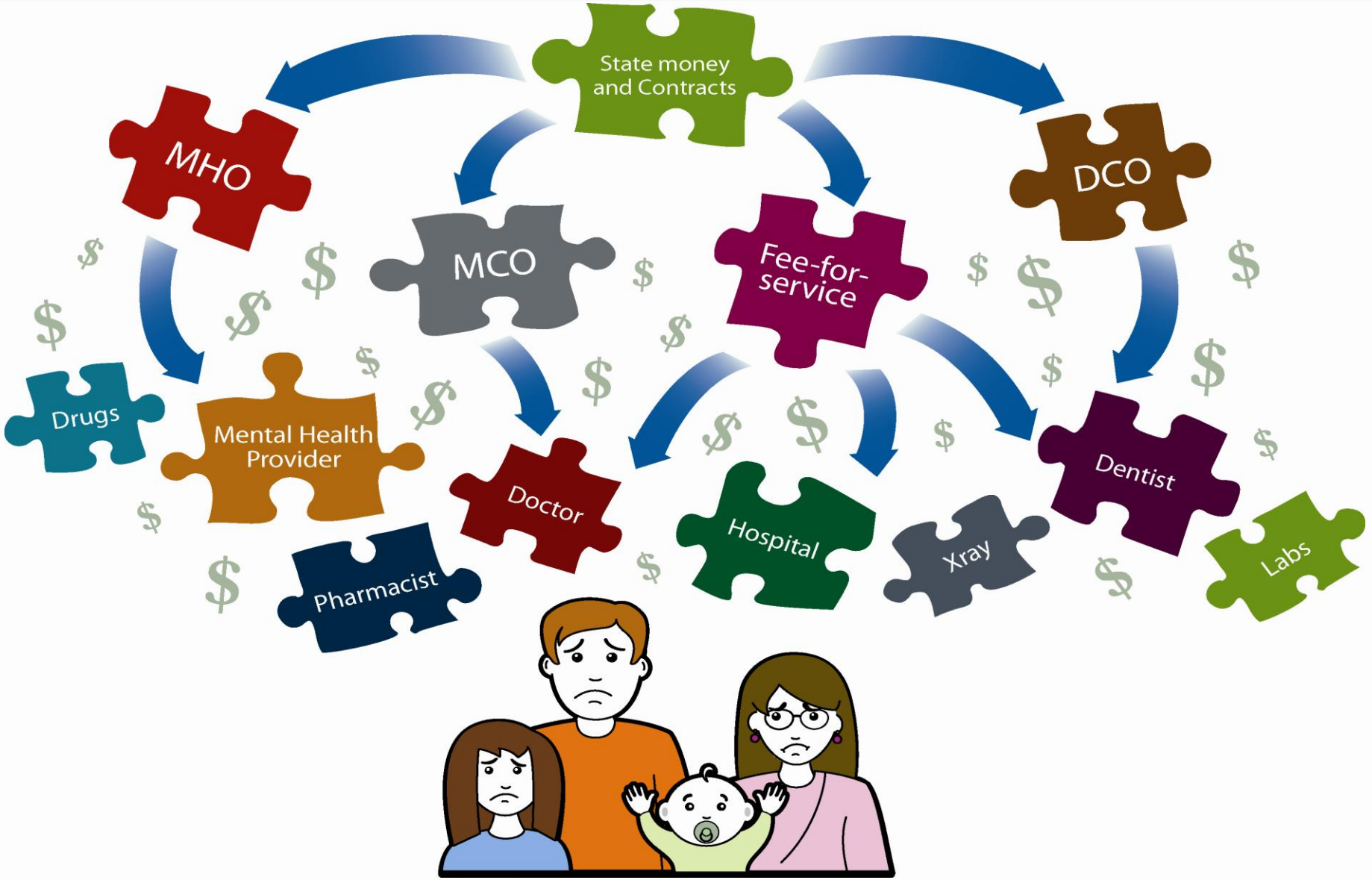
Judy Mohr Peterson

Oregon State Medicaid Director

Oregon Health Authority

Why Health System Transformation?

- Health care costs are increasingly unaffordable
- Even for all we spend, health outcomes are not what they should be
- Lack of coordination between physical, mental, dental and other care to public health means worse outcomes and higher costs


State money and Contracts
MHO
MCO
Fee-for-service
DCO
Drugs
Mental Health Provider
Pharmacist
Doctor
Hospital
Xray
Dentist
Labs

State Budget Crisis

Traditional Medicaid methods for budget balancing:

1. **Cut People**
2. **Cut Benefits**
3. **Cut Rates**

GOAL: Triple Aim

A new vision for a healthy Oregon.

1. **Better health.**
2. **Better care.**
3. **Lower costs.**

Oregon's Strategic Approach: Triple Aim

- A new fourth way for improved Medicaid program
- Changing how care is delivered to:
  - Reduce waste
  - Improve health
  - Create local accountability
  - Align financial incentives
  - Pay for performance and outcomes
  - Create fiscal sustainability

What is a Coordinated Care Organization?

- A local network of all types of health care providers working together to deliver care for Oregon Health Plan members
- Risk-bearing entities with prescribed governance & community advisory councils
- Care is coordinated at every point – from where services are delivered to how the bills are paid

Coordinated Care Organizations

- There are 16 CCOs in every part of Oregon serving ~95% of our ~ 1,00,000 OHP members
- Mental, physical, dental care held to one budget
- Responsible for health outcomes
- Receive incentives for quality
- Budgets grow at 3.4% per capita per year

2013-2015 CCO budget is 2 percentage points per capita below national growth trends

Coordinated Care Organizations
Key Health System Transformation Components

- **Community level accountability and flexibility**
- **Governance** by a partnership of providers of care, community members and stakeholders in the health system who have financial responsibility and risk
- **Global budget that grows at a sustainable, fixed rate** with **payment alternatives** that incent positive health outcomes
- **New models of integrated care**: **patient centered** and team-focused; i**ntegrated** physical, behavioral and oral health; use of **"flexible**" or health-related services
- Use of **"traditional" health care workers** (peer wellness specialists; community health workers; patient navigators) to expand workforce and address social determinants of health

CCOs: Governed locally

CCO Governance Boards

- Major components of health care delivery system
- Entities or organizations that share in financial risk
- At least two health care providers in active practice
  - **Primary care** physician or nurse practitioner
  - **Mental health or chemical dependency** treatment provider
- At least two community members
- At least one member of **Community Advisory Council**
  - Majority of members must be consumers
  - Must include representative from each county government in service area
  - Duties include Community Health Improvement Plan and reporting on progress

CCO: Innovation & Transformation Supports

- Transformation Center and Innovator Agents
  - Learning Collaboratives
  - Peer-to-peer and rapid-cycle learning systems
- Community Advisory Councils: Community health assessments and improvement plan
- CCO-specific Transformation Plans with milestones and deliverables
- Delivery system reforms:
  - Non-traditional health care workers
  - Primary care home adoption

Accountability and Transparency

State Performance Measures

- Annual assessment of statewide performance on 33 measures
- Financial penalties to the state if quality goals are not achieved

CCO Incentive Measures

- Annual assessment of CCO performance on 17 measures
- Quality pool paid to CCOs for performance
- Compare 2013 performance to 2011 baseline

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Key metrics tied to Quality Pool

Incentive payments tied to 17 metrics in seven areas critical to reducing costs and improving quality:

- Addressing chronic conditions
- Reducing preventable and costly utilization
- Integrating physical and behavioral health care
- Improving access to effective and timely care
- Improving perinatal and maternity care
- Reducing preventable rehospitalizations
- Spread of patient-centered primary care homes for all populations

Quality Pool: distribution

To earn their full quality pool payment, CCOs had to:

- ✓ Meet the benchmark or improvement target on at least 12 of the 17 measures; and
- ✓ Have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from quality pool went to the challenge pool.

To earn challenge pool payments, CCOs had to:

- ✓ Meet the benchmark or improvement target on the four challenge pool measures: depression screening, diabetes HbA1c control, SBIRT, and PCPCH enrollment.

How did CCOs do?

Incentive metrics

- ✓ 11 out of 15 CCOs earned 100% of the quality pool
  - One CCO earned 70% and three earned 80%

- ✓ Statewide improvement on all 14 of the incentive measures included in the report

Our vision: no child in Oregon should ever be hospitalized with asthma

Malik, 8, used to go to the ER with asthma attacks as much as twice a month. Thanks to a coordinated care pilot project and a community health worker, he is avoiding the hospital.

More stories at: www.health.oregon.gov

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Better health, better care, lower cost