

July 6, 2012

On July 5, 2012 the Centers for Medicaid and Medicare (CMS) approved Oregon's 1115 Medicaid Waiver that was necessary to implement health system transformation. Waivers of this size and scope usually take years to negotiate. The ability to finish so rapidly is a testament to both the importance of this waiver and to an effective federal and state partnership. A very brief summary of the key issues follow:

- **Establishment of Coordinated Care Organizations (CCOs):** Establishes CCOs as the delivery system for Medicaid. Language in the waiver that describes CCOs mirrors that in our legislation.
- **Flexibility in use of federal funds:** State has ability to use Medicaid dollars for flexible services e.g. non-traditional health care workers. All flexible services will have to be used for health related care; however, the CCO will have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health. Flexible services will be accounted for in what is paid to CCOs and utilization assumptions for use of these services will be applied. The state and CMS have 120 days to develop the appropriate methodology for accounting for flexible services and their utilization.
- **Federal Investment:** Calls for federal investment of ~\$1.9 billion over 5 years (Year 1: \$620 million, Year 2: \$620M, Year 3 \$290M, Year 4: \$183M, Year 5: \$183M). This funding comes through the Designated State Health Programs (DSHP). Penalties apply as noted below.
- **Savings:** State agrees to reduce per capita medical trend by 2 percentage points by the end of the second year of the waiver. There is a ramp up to achieve this. During this year, there is no reduction. Second year must average a 1 percentage point reduction, but again the state must be at a 2 percentage point reduction by the end of the second year. The reduction is from an assumed trend of 5.4% as calculated by OMB and based on the President's budget. Base expenditure is calendar year 2011. Penalties for not achieving this are significant. Ranging from \$145 million for not achieving the second year goal, to \$183 million in Years 4 and 5.
- **Quality:** There are strong criteria around quality. CMS want to assure that cost savings are not realized by either withholding needed care, degrading quality or by cutting payment rates. As such there is a requirement that CCOs meet a number of quality metrics and that there is a financial incentive for achieving performance benchmarks. The state and CMS have 120 days to work with national experts on creating the appropriate metrics and incentives. There is a requirement by CMS for a 1% withhold

beginning in Year 2 for timely and accurate data submission. A bonus incentive pool is also required in Years 2 and beyond.

- **Transparency:** CMS requires assurance that in the interest of advancing transparency and providing Oregon Health Plan enrollees with the information necessary to make informed choices, the state shall make public information about the quality of care provided by a CCO.
- **Workforce:** To support the new model of care within CCOs will require changes in the health care workforce. As such Oregon will establish a loan repayment program for primary care physicians who agree to work in rural or underserved communities in Oregon and training for 300 community health workers by 2015.
- **OHP Medical Benefits:** Current OHP medical benefits will be maintained (there will be no reduction to lines covered on the prioritized list).