2014

Drive and tension - Coordinated Care Organization (CCO) case studie

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DRIVE AND TENSION:

CCO CASE STUDIES

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Support for this case study project was provided by a grant from the Robert Wood Johnson Foundation.

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INTRODUCTION

In an era of rising costs, the ACO model has been heralded as a keystone of health reform. Rather than compensating providers for services regardless of effectiveness or necessity, the ACO model uses global payments to incentivize providers to provide comprehensive services that keep populations healthy while relying on strict accountability standards. This structure encourages ACOs to generate innovative methods for improving population health.

At least, that's the idea. If ACOs *don't* work, the state of the economy will likely require reductions in payments, which will lead to significant and immediate reductions in quality and access. To avoid those consequences, policymakers need evidence that identifies what drives the success of ACOs. Evidence has surfaced from pilots such as the Medicare Shared Savings Program and the Pioneer ACO model, but the small scale of these programs builds in risk protection that limits the generalizability of results. In order to catalyze change, ACOs need to be tested at full scale.

OREGON: A TESTING GROUND FOR ACOs

Oregon is a perfect test site for evaluating ACOs at scale. On September 1, 2012 Oregon's first five Medicaid ACOs—called Coordinated Care Organizations (CCOs) – initiated operations. Nearly all of Oregon's Medicaid population is now covered under a CCO, making Oregon an invaluable *natural experiment* for several reasons. First, Oregon's CCOs will test the model's viability because they have accepted real risk -- their financial future is staked on reducing cost and improving care. Second, this policy change in Oregon reveals the interplay between government regulation, market context and local innovation to transform care in a way pilot programs cannot replicate. Third, Oregon's CCOs serve the *Medicaid* population—a group that is sicker, more vulnerable, and more expensive than the general population. And finally, because the legislation behind Oregon's CCOs provides flexibility in terms of how CCOs organize themselves, Oregon is also a perfect place to study *variation* among ACOs and identify the factors that facilitate or hinder their success.

KEY FEATURES OF CCOs

- Public-private collaboratives that contract with the state
- PMPM global budget for behavioral, physical and dental health care— upside and downside risk for costs
- Global budget is capped to ensure 2% reduction in Medicaid spending trend
- Withhold tied to 17 performance metrics—downside risk for quality
- Accountable for a Transformation Plan outlining key strategies, milestones and targets
- Each CCO must have a Community Advisory Council, made up of 51% consumers
- Each CCO must have representation from county government and the provider community

WHY READ THESE CASE STUDIES?

We conducted case studies of two of Oregon's CCOs: Health Share of Oregon and PacificSource Community Solutions in Central Oregon. Our case studies detail the governance, financial and organizational structures that make up each CCO; we also give an overview of each CCOs strategies for quality improvement, cost reduction, and consumer engagement. In addition, we describe the market, policy and environmental forces that shaped CCO structures and strategies.

Researchers interested in new payment models will learn about the factors and forces that drive outcomes associated with accountable care payment reform in Oregon. They will learn what aided Oregon's CCOs in meeting cost and quality goals; they'll also learn what kinds of system-level transformation *didn't* happen and why.

State leaders will learn how statewide Medicaid payment reform played out on the ground in Oregon. They will learn how state policies and regulations facilitated innovation and progress in some ways, and how they hindered innovation and progress in other ways. State leaders may find they can apply these lessons to policies in development at home.

APPROACH

We conducted detailed case studies of two of Oregon's most promising new CCOs: *Health Share of Oregon (HSO),* which serves an urban population centered in the Portland Metropolitan Area, and *PacificSource Community Solutions (PSCS)*, which serves a more rural population in central Oregon. We collected detailed data on the environmental context from which each CCO emerged, outlined the development of their structures, and processes, and explored how those distinct elements contribute to the ability of each CCO to achieve its transformation goals. We leveraged data from previously-funded studies of Oregon's CCOs, then supplemented it with new data we collected using a mixed-methods approach designed to provide a richly detailed account of the factors that facilitate or hinder the success of an ACO model in a Medicaid population.

MEASUREMENT DOMAINS

ENVIRONMENTAL CONTEXT	Policy context, local market conditions, and community ecology.
GOVERNANCE	Board makeup, leadership, decision-making structures, and organizational affiliations.
PAYMENT AND FINANCE	Flow of funds, contracting, alternative payment methodologies, allocation of risk and resources.
ORGANIZATIONAL CULTURE	Mission, goals, and values; cultural messaging and communications; processes and routines; systems change
STRATEGIES/ MODELS OF CARE	Population health management strategies, organization of clinical service delivery, integration and innovation.
CONSUMER ENGAGEMENT	Consumer awareness, consumer representation, customer service, and equity
PROGRESS AND OUTCOMES	Are CCOs leading to better care, better health, and lower costs?

Our report is divided into two main sections:

POLICY CONTEXT. We begin by introducing the history of Oregon's CCO policy, including how it was funded and what requirements it entails.

CASE STUDIES. We discuss each CCO's structure in light of the above measurement domains. Case Studies include a section devoted to each of the above domains, as well as a section outlining the forces that **drive** CCO partners together and a section on the **tensions** that pull them apart.

METHODS

Key Informant Interviews. We conducted over 200 interviews with key informants including state policymakers, CCO leaders, CCO community partners, providers, and patients. Interviews were conducted in-person or over the phone, and most lasted about 60 minutes. Interviews were recorded, transcribed, and entered into Atlas.ti for analysis. A coding dictionary was developed collaboratively among the research team; this coding guide was modified using an iterative feedback process to account for emerging patterns and themes.

Document Analysis. We coded and analyzed CCO applications, transformation plans, regulatory and compliance paperwork and financial filings to document planned activities, organizational and financial structures, and progress in meeting strategic objectives. In addition, we reviewed state policy, regulatory guidance, and reporting.

Meeting Observation. We attended Board meetings, Community Advisory Council meetings, state conferences, and state workgroups to gather information about CCO implementation and to analyze the relational dynamics among CCO partners.

CCO POLICY: ORIGIN

WHAT IS A CCO?

In March 2012 Oregon passed SB 1580, which laid the groundwork for the creation of Coordinated Care Organizations. CCOs are networks of health care providers, payers, and other stakeholders that accept a single global budget to provide integrated physical, mental, and dental health care to enrollees in the state's Medicaid program, called the Oregon Health Plan (OHP). In the ideal version, a CCO includes every organization in a single region that provides care to OHP members; this coordinated local engagement under a single global budget enables innovative local solutions to the challenges of providing quality care while reducing health care costs. In reality, geographies are not so distinct; CCOs are varied, complicated and complex.

STATE FUNDING

Financing for Oregon's CCOs was achieved via a 1115 Waiver, a State Innovation Model grant, and a $1.9 billion investment from the Department of Health and Human Services. The 1115 Waiver created the mechanism to integrate payments for physical, mental and dental health care services within a global budget. The State Innovation Model grant funded the creation of the Transformation Center, which provides technical assistance, communications support and learning opportunities for CCO leadership. The State Innovation Model grant also funded local health care transformation initiatives at CCOs through Transformation Grants. The $1.9 billion investment was made to cover the cost of transition to the new coordinated care model; in return, Oregon promised to reduce the per capita medical spending trend by 2 percentage points. If Oregon can't deliver the savings, it will have to pay steep financial penalties.

PAYMENT MODEL

The global budget included payment for physical and mental health care beginning in September of 2012; dental premiums were integrated January 2014. Additional payments for non-emergency medical transportation were integrated in 2014, followed by targeted case management payments in 2015. Thus from 2012-2015 the state of Oregon has folded most of the health care funding for the Medicaid population into the global budgets for CCOs. CCOs accept upside and downside risk for *costs* for enrolled members; they are entitled to savings captured (while taking acceptable medical loss ratios into consideration), but they are also accountable for any overages. Importantly, the global budget is capped at an amount that ensures that Oregon will meet the promised savings targets. Federal predictions had estimated that Oregon's Medicaid costs would rise 5.4%; Oregon promised to reduce that to 3.4%. Payments to CCOs were structured to ensure that Oregon met its targets.

In addition to the capitated global budget, the CCO payment model also holds CCOs accountable for *quality.* A percentage of the global budget (2% in 2013) is shaved off of the global budget and held by OHA until the following year, when CCOs can earn the money back based on their performance along 17 performance metrics.

CCO PERFORMANCE METRICS—2014

- Alcohol or other substance misuse (SBIRT)
- Follow-up after hospitalization for mental illness (NQF 0576)
- Screening for clinical depression and follow-up (NQF 0418)
- Follow-up care for children prescribed ADHD meds (NQF 010)
- Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)
- PC-01: Elective delivery before 39 weeks (NQF 0469)
- Ambulatory Care: Outpatient and Emergency Department utilization
- Colorectal cancer screening (HEDIS)
- Patient-Centered Primary Care Home Enrollment
- Developmental screening in the first 36 months of life (NQF 1448)
- Adolescent well-care visits (NCQA)
- Controlling high blood pressure (NQF 0059)
- Diabetes: HbA1c Poor Control (NQF 0059)
- CAHPS adult and child composites: Access to care and Satisfaction with care
- EHR Adoption
- Mental and physical health assessment within 60 days for children in DHS custody

CCO POLICY: REQUIREMENTS

TRANSFORMATION PLANS

In late 2012, CCOs were required to submit Transformation Plans, also known as *Exhibit K.* They outlined milestones, deliverables and targets to help CCOs develop into "fully-integrated community care systems" over the next two years. The transformation plan development process began in November 2012 and was an iterative process between the state and CCOs that ran through August 2013. CCOs were required to submit plans for improving in 8 key ways:

- Integrating mental health, physical health care and addictions
- Continued implementation of Patient-Centered Primary Care Homes
- Implementing alternative payment methodologies aligning payment with outcomes
- Preparing Needs Assessments and Improvement Plans
- Developing electronic health records, health information exchange, and meaningful use
- Ensuring members have access to culturally-specific communication
- Ensuring provider network is able to meet diverse cultural needs of community
- Eliminating racial , ethnic and linguistic disparities

GOVERNANCE REQUIREMENTS

CCOs can and do look different. Existing entities or new organizations can apply. They can be payers, provider networks, public health entities, or other organizations. They can be non-profit or for-profit.

The governing body of a CCO must include the "major components" of the health care delivery system. The governing body must include at least one primary care provider and one behavioral health care provider. Two members must be community members—at least one from the community advisory council (CAC).

Each CCO is required to have a community advisory council made up of 51% OHP consumers. Every CAC must include representation from county government, and the CAC is responsible for the community health needs assessment and the CCO's community health improvement plan.

TRANSFORMATION FUNDS

In January 2014 the state of Oregon used funding from its State Innovation Model grant to award $27 million in "Transformation Funds." These funds were intended to be used to enhance CCO progress toward population health management, medical home implementation, and investments in information technology. At many CCOs, these dollars were the only funds readily available to pay for innovative pilot projects; rates had already been squeezed by the cap on the global budget, and administrative dollars were scarce. CCOs invested Transformation Funds in the kinds of initiatives that they thought might create savings and improve outcomes, but that weren't ordinarily reimbursable through the old fee-for-service model. The hope was that if Transformation Fund projects could provide evidence for return on investment, it would be easier to obtain buy-in from providers to alter their payments in order to fund those innovations.

MEDICAID EXPANSION

As January 2014 approached, CCOs and OHA officials expressed concern about the influx of new enrollees. A recent study had found that OHA's limited lottery expansion in 2008 had led to a 40% increase in emergency department visits. Considering the access problems for OHP members that had already been documented, would CCOs have capacity to serve these new enrollees well?

Enrollment in 2012 was 560,000; 380,000 new beneficiaries were added in the 2014 expansion, an increase of 68%. In the first six months of the expansion, emergency department visit rates were *lower* than the 2013 rate, despite the addition of new Medicaid members. Outpatient utilization rates also fell, suggesting that the expansion population was healthier overall and brought less need for care than the pre-2014 population.

CCO POLICY: OUTCOMES

COSTS AND PROFITABILITY

The Oregon Health Authority reports that CCOs are indeed holding down costs, and that Oregon is on target to meet its commitment to the Centers for Medicare and Medicaid Services to reduce medical inflation by two percentage points per member per year. This is not surprising, considering that the CCO budgets were capped in such a way as to virtually ensure that the targets would be met. The question is: are those *actual* cost savings due to improved efficiency and improved quality? Or have costs shifted elsewhere?

On the surface, it appears that costs are not being borne by the CCOs. Nearly all CCOs reported an increase in net assets for the period from September 1, 2012-December 31, 2013 (usually referred to as Year 1). By 2014 (Year 2) there were 16 CCOs, all of which reported profits, although net income varied from $616,928 for Cascade Health Alliance to $69,895,385 for FamilyCare.

It is difficult to track costs further than the CCO level because CCOs are free to contract in many different ways with payers and providers—and they are encouraged to explore alternative payment methodologies that pass risk on to providers. Capitation or bundled payments may conceal costs borne by providers; these costs are difficult to trace, but one indicator of success may be the overall stability (or growth) of the provider network willing to serve the OHP population. While we did not trace this stability for our study, we also did not hear many stories of clinics or provider groups that had previously served Medicaid patients and had since refused to accept them. If providers are paying the price for the reduced cost trend, we have not heard about it yet.

The primary check built in to the CCO model to ensure that *patients* do not bear the cost of reduced spending is a set of quality metrics, discussed in the next section.

PERFORMANCE METRICS

CCOs accept downside risk for 17 quality incentive metrics; the Oregon Health Authority (OHA) is accountable to CMS for 33 state performance metrics. There is overlap between the two groups of metrics; in general, they are designed to measure access to preventive services, coordination across providers, and progress along certain paths toward a transformed health care system. CCO performance along these metrics is improving toward the benchmarks. 11 of 15 CCOs received 100% of the quality pool funds for which they were eligible in Year 1.

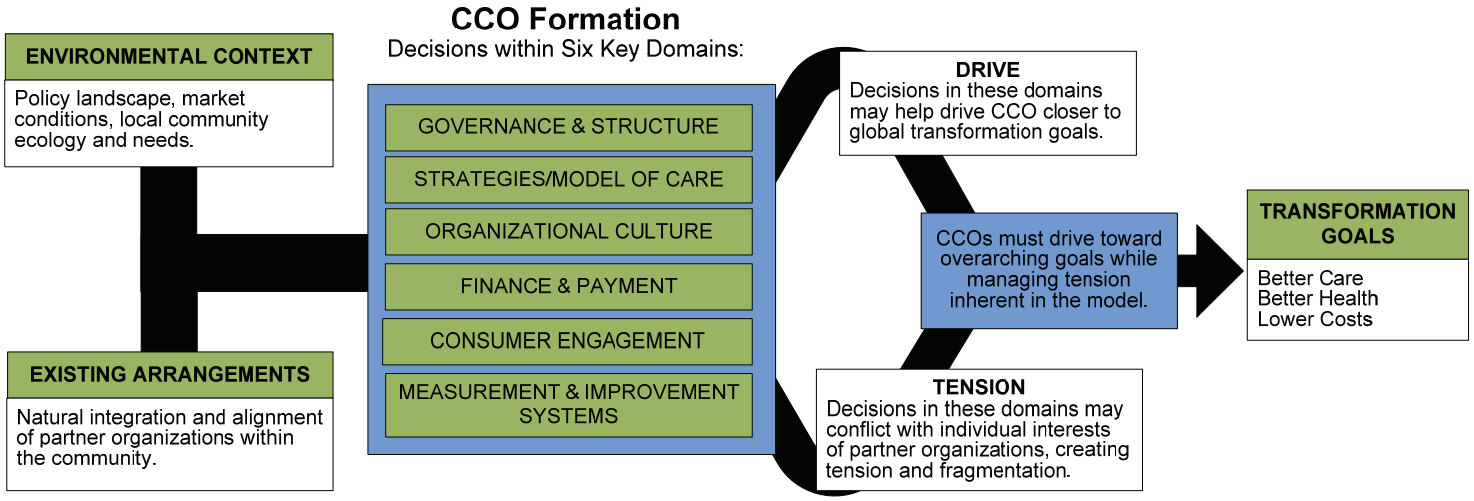
OHA reported positive outcomes for CY 2013. In comparison to baseline data from CY 2011, hospital admissions for congestive heart failure were reduced by 27%, and hospitalizations for adult asthma were reduced by 18%. The percentage of children receiving recommended developmental screenings increased by 58%. Spending for primary care and preventive services was up over 20%. In 2013, enrollment in patient-centered primary care homes increased by 52% over CY 2012, the baseline year for that measure. However, many CCOs had difficulty meeting certain targets, including access to care (as measured by CAHPS survey results). One of the most challenging metrics was the mental and physical health assessment within 60 days for children in DHS custody; this metric was deemed more transformational because of the inter-agency relationships required for success. Another challenging metric was the percentage of adult patients who received screening, brief intervention and referral for treatment for alcohol or other substance abuse. The baseline rate for this metric was 0%; it rose to 2% in 2013, but the benchmark is set at 13%.

A 2014 Mid-Year Report was published in January 2015 and covers data for the twelve-month period between July 2013 and June 2014. Results looked promising. The report found a 21% decrease in emergency department visits since the 2011 baseline, and decreased hospital admissions tied to management of certain chronic diseases. The rate of patients who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 48 percent since 2011 baseline data. OHA also reports that primary care costs are increasing, which indicates movement towards “the right care, in the right place, at the right time” among the Medicaid populations.

CASE STUDIES

CONCEPTUAL MODEL

In the next section, we report the factors that facilitate or impede a CCO's success in achieving better care, better health, and lower costs. To accomplish this, we will organize our findings within the bounds of the following conceptual model:

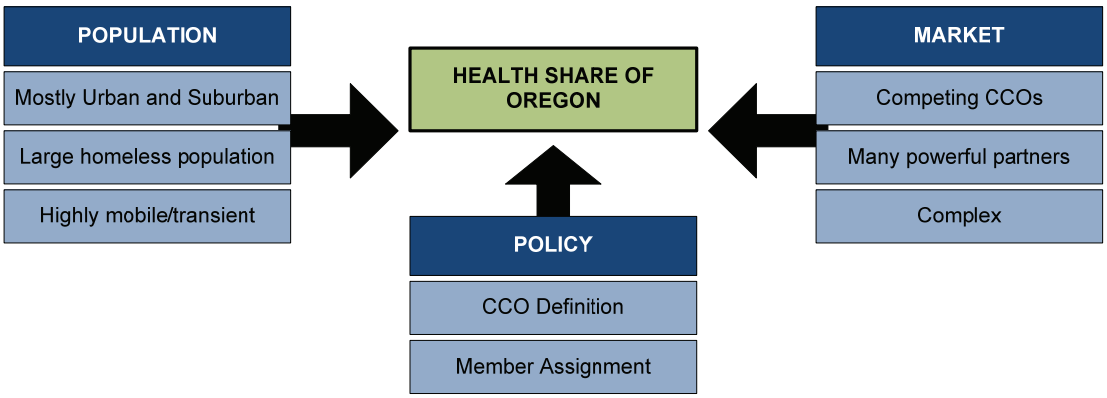


In our conceptual model, CCOs are an organizational mechanism to achieve Oregon's health care transformation goals. The structure and shape a CCO takes may be informed by environmental contexts, but may also be a function of the pre-existing interconnections between the partner organizations. Informed by each of those parameters, CCOs design operational models in pursuit of global transformation goals. But CCOs are partnerships of distinct organizations with distinct identities, so each decision is fraught with a potential duality: it may help ***drive*** the entire CCO toward larger transformation goals, but may also create ***tension*** if it runs counter to the partner's business, organizational, or cultural interests and values.

Almost every decision a CCO makes may reveal inherent tensions between global transformation goals and the interests of individual members. Optimizing care across a community may mean less money flowing to some partner organizations. Standardizing workflows to allow for better management of patients across different care settings may conflict with existing workflows in which partner organizations have already invested. Changing processes to accommodate the CCO may affect the way member organizations care for non-Medicaid patients who fall outside the CCO's purview, but remain within theirs. For CCOs to succeed, they must move toward global goals by making decisions, but every decision might also run counter to the needs and interests of some partner organizations. To achieve success, CCOs must overcome those barriers on a global level while balancing the disparate interests and needs of their coalition members.

We discuss each CCO's structure in light of the above domains. The following case studies include a section devoted to each of the above measurement domains, as well as a section outlining the forces that **drive** CCO partners together and a section on the **tensions** that pull them apart.

HEALTH SHARE OF OREGON: ENVIRONMENTAL CONTEXT



SNAPSHOT

POPULATION

Health Share of Oregon serves the Portland Metropolitan Area, Oregon's largest urban region. At the start of CCO implementation, Health Share's target population included 211,950 Medicaid enrollees and 251,160 uninsured patients (many of whom would likely be eligible for Medicaid under the ACA). This target group made up 29% of the 1.6 million total population in the Portland area. By February 2015, Health Share had 236,177 enrolled members and is Oregon's largest CCO.

MARKET

One of the reasons that Health Share did not come close to covering all of its target population is that it has competition. A second CCO, FamilyCare, operates in the same service area. While some CCO service areas do overlap, FamilyCare and Health Share are the only two that serve almost the exact same population.

POLICY

In the context of a competitive relationship between two CCOs, two details are important. The first is that the two CCOs appear to have different interpretations of what makes a CCO. FamilyCare's CEO has criticized Health Share for being an umbrella organization that is hiding business-as-usual by splitting its global budget among four health plans. On the other hand, some interviewees wondered whether the legislation was intended to make it possible for two CCOs to serve the same region, and questioned whether FamilyCare could operate as a CCO solely as a health plan.

CONTEXT

The competition in Portland's CCO market has an interesting history. Health Share's earliest genesis is likely related to a convening which brought the five Tri-County MCOs (CareOregon, Providence, Kaiser, Tuality, and FamilyCare) together to discuss a "regional system of care" for Medicaid. In December 2011, these groups established the Tri-County Medicaid Collaborative (TCMC) with the intention of exploring a response to CCO legislation

At some point prior to July 2012, FamilyCare left this collaborative. At that time, TCMC nearly disbanded. CareOregon covered the majority of Medicaid members in the region, and Providence, Kaiser and Tuality considered sending all Medicaid business to CareOregon. The decision had to be made quickly, and at one point Providence, Kaiser and Tuality agreed that to collapse all their Medicaid enrollees into a single managed care organization within a few months would cause an immense disruption in care. So the MCOs stayed at the table.

For a time, the relationship between the two CCOs was acrimonious. Specifically, there was strong disagreement about default member assignment methodology that, from Health Share's perspective, granted FamilyCare an unfair advantage. But in the past year the relationship between Health Share and FamilyCare has become more collaborative. Recognizing that many providers must contract with both CCOs, the two CCOs have collaborated to align contracting—even releasing a joint RFP for non-emergency medical services. They have also contributed to jointly support a community health needs assessment process.

HEALTH SHARE OF OREGON: GOVERNANCE

HEALTH SHARE OF OREGON: LEADERSHIP AND GOVERNANCE

BOARD OF DIRECTORS		LEADERSHIP TEAM
FOUNDING MEMBERS	**MANDATED MEMBERS**	
4 Physical RAEs - CareOregon - Providence - Kaiser - Tuality 3 Behavioral RAEs - Washington County - Clackamas County - Multnomah County 4 Provider Groups - Legacy - OHSU - Adventist - Central City Concern	Dental Clinic Owner FQHC Provider Specialty Provider Addictions Provider Mental Health Provider Housecall Provider/Nurse Public Health CBO CAC Chair (Consumer) Housing Representative	Chief Executive Officer Chief Operating Officer Chief Medical Officer Senior Medical Director Chief Information Officer Director of Community Engagement

SNAPSHOT

BOARD OF DIRECTORS

Health Share is governed by a "Big Board" that includes 20 representatives from payers, providers, and community organizations. However, some decisions—especially financial decisions—are ultimately made by a smaller group of representatives. This smaller group, sometimes called the "Founding Members" or "Member Board," represent the 11 organizations that were at the table early: CareOregon, Providence, Tuality, Kaiser, Adventist, Central City Concern, Legacy, OHSU, Multnomah County, Clackamas County, and Washington County.

LEADERSHIP TEAM

Health Share has 45 employees, including six members of the leadership team: the chief executive officer, chief operations officer, chief medical officer, senior medical director (who comes from behavioral health), director of community engagement, and the chief information officer. This leadership team is charged with executing strategy as defined by the Board of Directors. Their work is supported by subcommittees, including a finance committee. Health Share employees include administrative and compliance staff, customer service, and project management.

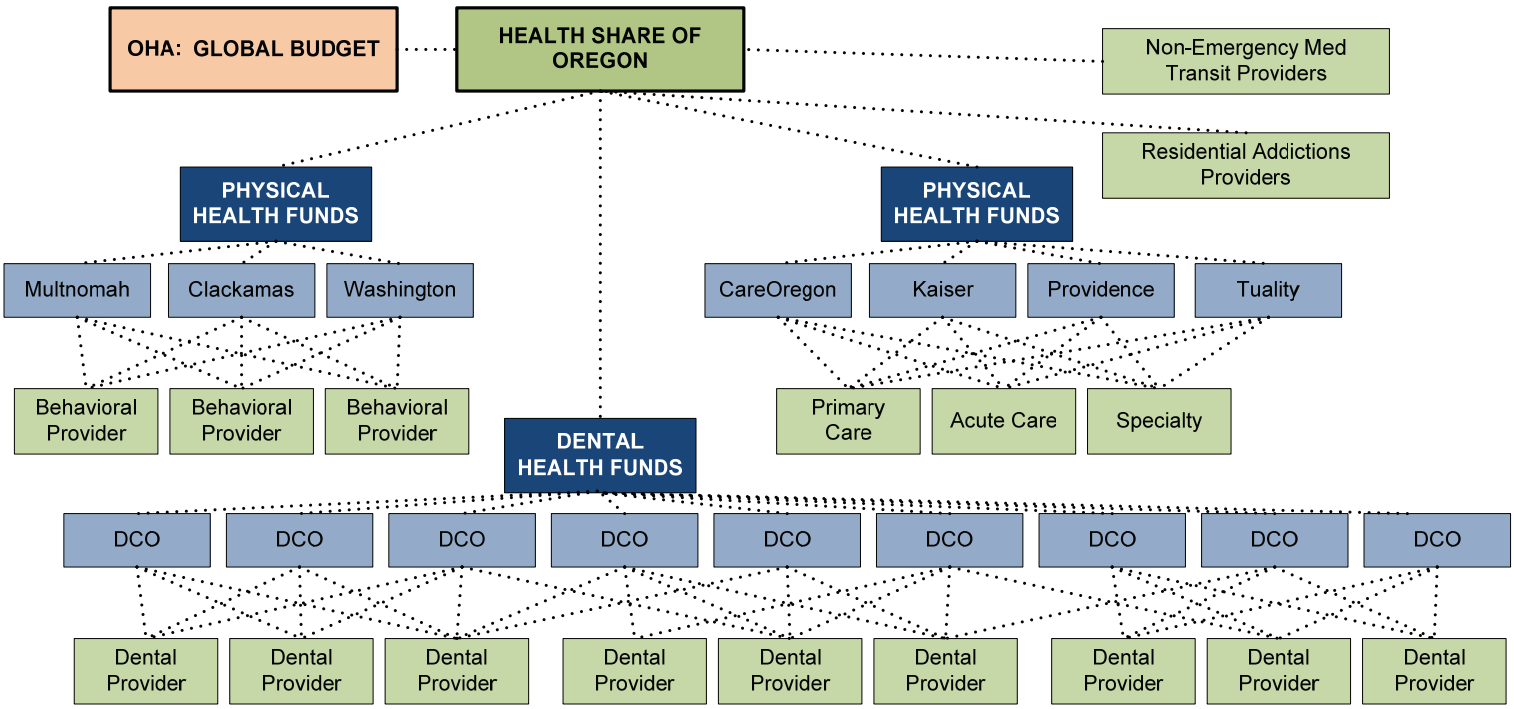
CONTEXT

The decision about who would be on the board was complicated and political. In the earliest days, the largest institutions had loaned staff and had loaned dollars. As one interviewee put it, "There was an assumption at that point that there might be future capital calls, and the folks putting up the money were uncomfortable with the idea that somebody else would be voting on their money." Payers worried that the board would vote for additional capital calls, and the large providers worried that the board would vote for reductions in reimbursements. They settled on a team of "Founders" nestled within a larger "Big Board."

Inevitably, some stakeholders were left out. Respondents told us that professional associations—such as the Oregon Nurses Association—wanted representation on the board but did not get it.

A final challenge emerged as the partners transitioned power from the board to the new Health Share leadership. In its earliest days, Health Share faced start-up challenges; one interviewee reported that "We didn't have HR. We couldn't run a credit card. No one knew how to get coffee. That's where I started."

HEALTH SHARE OF OREGON: FINANCE AND PAYMENT



SNAPSHOT

RISK-ACCEPTING ENTITIES

Health Share is currently made up of 16 Risk-Accepting Entities (RAEs): 4 physical managed care plans, 3 behavioral health managed care plans, and 9 dental managed care plans. Health Share negotiates with OHA for its rates and its global budget; 2% of the global budget was withheld for quality incentives in 2013. Roughly 1% of the global budget goes to reserves, and another 1% covers administrative expenses. Some portion goes to direct contracts with providers, such as residential addiction services, but the vast majority of the budget is funneled down to the 16 RAEs. Payments for physical and behavioral health services are risk-adjusted. The RAEs hold upside and downside risk for costs for their assigned populations.

ALTERNATIVE PAYMENT

Within each RAE, alternative payment is evolving. Many of the providers that care for the Health Share population are still reimbursed using fee-for-service methods. Some providers expressed an appetite for risk, but several interviewees told us that the provider community is "not ready" for risk. Nevertheless, at least one provider group within Health Share accepted capitation for Medicaid in 2014. Elsewhere at Health Share, pilot programs with FQHCs are exploring enhanced PMPM payment or wraparound payment to cover services not traditionally reimbursable under Medicaid. The behavioral health RAEs adopted a standard case rate structure.

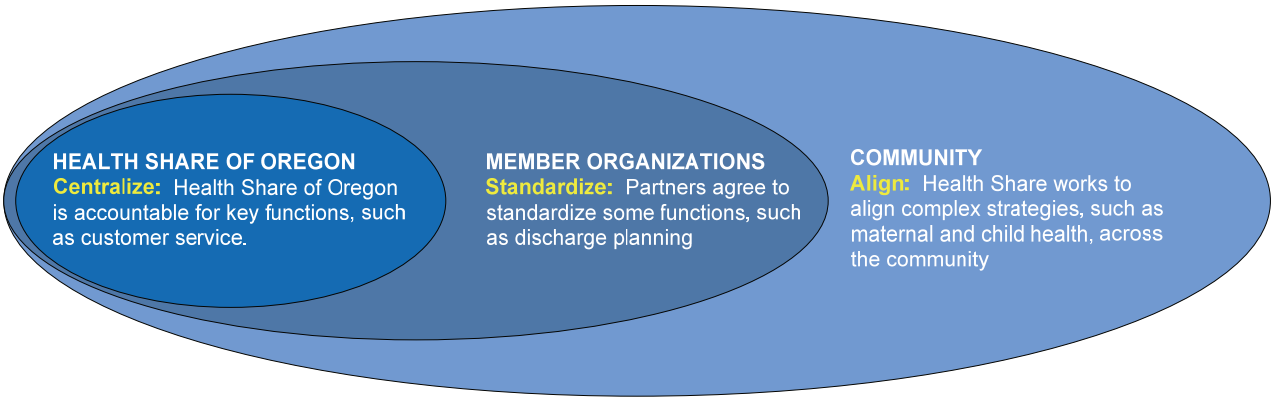
CONTEXT

Health Share has received criticism for doing "business-as-usual" by contracting with RAEs instead of with providers. From one perspective, Health Share has adopted what used to be the role of the state, and has implemented few structural changes to finance at the provider level. On the other hand, many of the respondents who had been part of negotiations during the early days of the CCO said that this was simply as far as Health Share could get; the individual RAEs will take payment reform from here.

Several respondents noted that the shift among the behavioral health care RAEs to a standard case rate structure was a "big win." Formerly, each county had its own system for treatment and reimbursement. While treatment models are not fully standardized, the standardized case rates are a step towards closer alignment.

Three years later, Health Share respondents have not shared any plans to alter the RAE structure significantly. Within each RAE, though, conversations about payment reform are progressing. Health Share has provided support to these conversations, most specifically by sponsoring the Advanced Primary Care model, which develops clinic-based multidisciplinary teams with staff skilled in treatment for complex patients. The project seeks to establish payment models that incentivize outcomes or business model changes.

HEALTH SHARE OF OREGON: ORGANIZATIONAL CULTURE



SNAPSHOT

HEALTH SHARE STAFF

Health Share is a *new entity*, which is important—many CCOs across the rest of the state are administered through existing managed care plans. Health Share's staff includes diverse members from different fields: one project manager came from urban planning, for instance, and another built emergency transport systems in developing countries. Many Health Share staff commented on the level of talent and said that it created a "think-tank" atmosphere.

CENTRALIZE, STANDARDIZE, ALIGN

As an umbrella organization, Health Share must decide what belongs in-house and what belongs in a contract. Operations that belonged in-house were "centralized"—that is, member organizations would allow those services to be administered by Health Share. This is the case with residential addictions services; Health Share manages that benefit and contracts with providers directly. In other cases, the partners "standardize." That is, each of the partners continues to provide the service, but they agree to provide it in the same way. And finally, Health Share determined that some services should simply be "aligned," which means: "We might do it a little differently, but we're all aligned around a core set of principles."

COMMUNITY PARTNERSHIPS

While Health Share's staff is made up of talented and committed team members, Health Share as an organization is still knit together by its board: representatives of the major health care payers and providers in the region. Each of these partners brings its own needs and interests to the table. While relations have been tenuous at times, member organizations are still committed.

CONTEXT

One of the most important early decisions was the decision to create a new "umbrella organization." Early on, the option to run the CCO through CareOregon had been considered; CareOregon does administer several other CCOs in other regions. Ultimately, founders decided to build a new organization. Health Share's founders wanted to make sure that the new CCO did not duplicate capacities that already existed in the community, so Health Share has management services agreements for human resources, finance, claims payment, and analytics.

Health Share relies on the commitment of its partners for success; in the early days of the CCO, that commitment was by no means certain. The organization was established through months of weekly meetings that brought together all the CEOs of the partner organizations. One participant in those meetings told us, "In the beginning it was this whole storming, norming, forming thing. I believe in retrospect there was no way the partners could even agree on who would get to vote, whether a simple majority would win. I think even those were beyond the capacity of the group." Ultimately, though, they found a way to collaborate.

Language used to describe the organization has shifted over the past two years. Early interviewees described Health Share as a "health commons." At times, some interviewees have stressed the importance of acting like a business—ensuring return on investment and making performance metrics. But once the first year's metrics were met, this language relaxed and a new identity emerged: many respondents in our most recent round of interviews referred to Health Share as a "collective impact backbone organization."

HEALTH SHARE OF OREGON: STRATEGIES AND MODELS OF CARE

HEALTH COMMONS GRANT	TRANSFORMATION PROJECTS	ASSESS WHAT WE KNOW	2015 STRATEGIC PLANNING
2012: CMMI grant funded five "quick wins"	2013: SIM grant funded new portfolio	2014: Research/Engagement to Refine Strategies	2015: Strategic Retreat scheduled for July
SHARE INFORMATION: Standardize discharge planning and introduce data systems for cross-partner collaboration FOCUS ON HIGH UTILIZERS: Coordinate care and provide intensive case management supports	SUPPORT PRIMARY CARE: Resources for expanding capacity, scope, and exploring new funding methodologies PUBLIC HEALTH AND PREVENTION: Healthy pregnancies, healthy families, and healthy homes	LIFE COURSE EVENTS STUDY: Learning what high-utilizers have in common: trauma COMMUNITY HEALTH IMPROVEMENT: A four-county collaboration to define community health priorities	Next priorities have not been determined, but respondents suggested that we may see a new commitment to prevention--especially prevention of adverse childhood experiences.

SNAPSHOT

INVEST IN THE COMMUNITY

Some stakeholders feared that a CCO in Portland would be made up solely of the big players—the large hospitals and health systems—who would build new Medicaid services from scratch. The community-based organizations that have long served this population advocated that Health Share leverage existing resources rather than building from scratch; in large part, this is the operational strategy that Health Share has adopted.

COORDINATE CARE FOR COMPLEX PATIENTS

Health Share's work initially focused on high-utilizers and aimed to answer the question: are there better ways to serve those who frequently end up in the hospital or emergency department? Tools for panel management and stratification were developed, and multidisciplinary teams were assembled to coordinate care for patients with complex challenges related to self-management of chronic conditions, severe or persistent mental illness, complex medication lists, or psychosocial barriers to health.

STRENGTHEN PRIMARY CARE

Two of Health Share's key initiatives focus on enhancing primary care. ProjectECHO was designed to support and mentor primary care clinicians in management of psychiatric medications. The Advanced Primary Care Initiative offered support for primary care homes as they sought to implement and refine a team-based model.

PREVENTION

Health Share's Transformation Projects included funding for maternal and child health, as well as funding for home visits for patients with asthma to tackle problems such as air pollution or mildew. Since then, the CCO has been turning its focus towards preventing trauma.

CONTEXT

Health Share started with the "Commons Five"- five innovative new programs funded by the Health Commons Grant—a CMMI project. These programs included:

The Standard Transitions Project, which implemented standardized discharge workflows across the region's hospitals and safety net primary care clinics.

The Health Resilience Program, which embeds licensed clinical social workers in primary care clinics to offer community-based intensive case management services to complex patients.

The Intensive Transitions Team, which assists inpatient psychiatric patients with their transition to outpatient services.

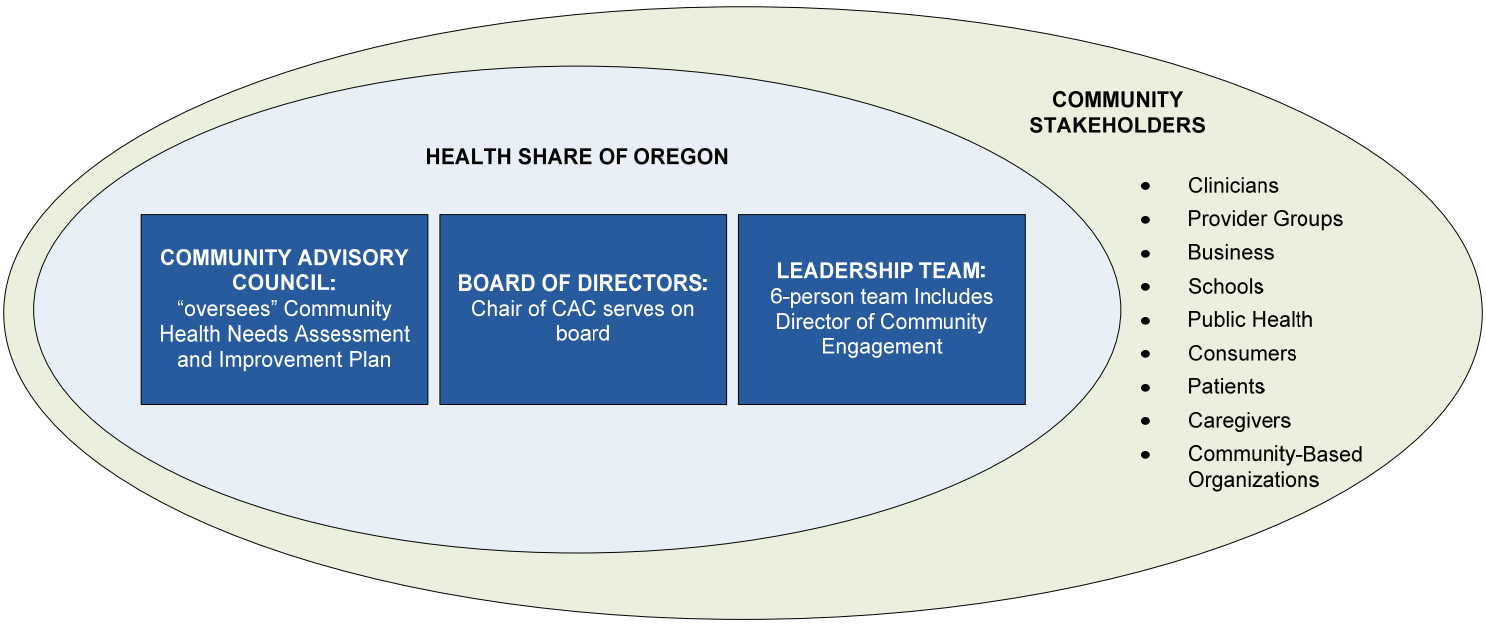
The C-Train Project, which provides nurse care coordinators and pharmacy medication management support for patients discharged with a high risk of readmission.

The ED Guide Program, which employs navigators who can help patients decide where best to receive services for non-emergency needs.

Nearly all of these early strategies were focused on providing intensive services to high-utilizers. As Health Share crafted these services, its leadership began to question: what makes a high-utilizer? After conducting an intensive research project that included in-depth qualitative interviews, a pattern emerged: Health Share partners learned that complex patients often had complex life histories that included traumatic experiences.

Health Share has since turned its strategic focus upstream, to early childhood and the first five years of life. New initiatives provide support to at-risk families, with the goal of preventing childhood trauma and building resources for resilience.

HEALTH SHARE OF OREGON: CONSUMER ENGAGEMENT



SNAPSHOT

COMMUNITY ADVISORY COUNCIL

CCOs are required to build a Community Advisory Council made up of 51% consumers. Health Share's CAC features strong community advocates as well as representatives from public health and community-based organizations. Respondents reported that the CAC is strong and committed, but has had difficulty understanding its role at the CCO. Some community participants said that their voices weren't heard; public health participants have been hesitant to disagree with consumers, even when the consumer's interest is at odds with population health strategies.

MOVING CUSTOMER SERVICE IN-HOUSE

Health Share has recently built an in-house customer support team. The team prides itself on one-touch resolution, and brings customer stories to the rest of the Health Share team on "Feel-Good Fridays."

CONVERSATIONS WITH HEALTH SHARE

Health Share hosts "community listening sessions" to enter into dialogue with consumers. Board members and other staff are available at these sessions to hear consumer frustrations and ideas.

CONTEXT

Health Share must compete with Family Care for members; Portland is full of billboards and buses advertising both companies. In this environment, attention to customer satisfaction has become critical. In keeping with its intention to avoid building duplicative services, Health Share initially contracted out its customer service operations. A member calling Health Share would reach a dispatcher at CareOregon, who would route the call based on the RAE that was serving the member. Since each RAE operates its own customer service, Health Share would have no need to build a new team from scratch. This approach proved problematic; customers were being routed three or four times before reaching the support agent that was needed. To solve the problem, customer service was brought in-house.

This move had important cultural implications. It added 10 team members, and for the first time it added a team that was production-based and paid hourly. Health Share staff report that the new team has added valuable insight into operations; customer service staff are encouraged to participate on workgroups and committees, and their stories of client experiences inform strategy and culture.

HEALTH SHARE OF OREGON: MEASUREMENT AND IMPROVEMENT

POPINTEL	CLAIMS-BASED DATA SYSTEM
Care coordination registry - Web-based and integrated across partners. - Allows teams at work on cross-site care coordination projects to manage their work, track care management for the target population, and measure process outcomes such as productivity. - Includes push notifications tied to utilization	**Monthly Dashboards** - Aggregates claims from all partners and applies OHA specifications so that Health Share can track performance on metrics - Dashboards are interactive; Health Share can slice or filter the data down to the member level, allowing the CCO to identify members in need of better service - New geographic lenses have been developed for a map-based view of population health

SNAPSHOT

IT FOR COORDINATION

Many of the Health Commons Grant pilots rely on PopIntel, a home-grown platform that allows multiple providers to communicate about things like discharges, upcoming appointments, and enrollment/participation in interventions. The system relies on push and pull notifications. Care managers and outreach workers rely on Popintel to track and monitor their work.

PERFORMANCE DASHBOARDS

Health Share's strategy is supported by a custom data system that aggregates claims data from each of the RAEs. Since most of the CCO pay-for-performance metrics are based on claims data, this system provides visibility into the CCO's progress on the metrics and helps them to identify populations or partners that could use additional support.

The data system produces monthly dashboards that track performance along each of the metrics, including information about how the performance of each of the RAEs contributes to Health Share's numbers. Dashboards include data broken down by race-ethnicity and are a useful tool for identifying and targeting health disparities.

IMPROVEMENT

To the extent that we were able to capture it, traditional quality improvement has not been an explicit function of the CCO. It may be that quality improvement is generally the purview of the RAEs and the provider organizations, which often have their own methods for spreading best practices or improving efficiency. However, at the time of this report CCOs have only lived through a single quality incentives disbursement, and Health Share may build quality improvement systems over time as they explore new methods for meeting their metrics.

CONTEXT

The data system was built out of the need for a third party to aggregate claims from the RAEs, who compete on the commercial market. Recent upgrades to the data system include geographic lenses, such as the ability to view outcomes by school district. These enhancements have been made with the explicit intention to drive conversations with non-health care community partners; the aim is to build a regional system of care that is not limited to the walls of the delivery system.

Interviewees at RAE organizations acknowledged that Health Share's data system has driven internal changes at their own organizations. None of the partners wants to be identified as "the one that isn't meeting the metric," so when their performance appears to be lagging they implement new policies or programs to boost numbers.

Health Share's data system has offered a sense of order and clarity within a system and an industry that is marked by complexity. While many interviewees acknowledged that there are many more numbers that they wish to see, as a whole they credited the data system for Health Share's success in meeting performance targets.

Building brand-new custom data solutions for accountable care management was not without its challenges. The process required an extensive network of data use agreements, which took time. Both PopIntel and the claims data system were built out at the same time that Health Share was launching, so the CCO was working "in the dark" at first. Both builds included iterative cycles of design and prototyping to ensure that the products would meet emerging needs.

HEALTH SHARE OF OREGON: PROGRESS

METRIC	2013	METRIC	2013
Adolescent Well-Child Visits	○	Developmental Screening First 36 Months	●
SBIRT*	○	Diabetes Control (HbA1c)	●
Outpatient and ED Utilization**	●	Early Elective Delivery	●
Access to Care	○	EHR adoption	●
Satisfaction with Care	○	Follow-up after Hospitalization for Mental Illness	●
Colorectal Screening	●	Assessments for Children in DHS Custody***	●
Controlling Hypertension	●	Primary Care Home Enrollment	●
Follow-up after ADHD Prescription	●	Timeliness of Prenatal Care	●
Depression Screening and Follow-up	●		

● = Met incentive metric ○ = Did not meet metric

SNAPSHOT

PERFORMANCE METRICS—YEAR ONE

Health Share met 13 of 17 performance metrics in Year One. It earned back all of the funds that had been withheld from the global budget, and it also earned additional funds because it outperformed other CCOs and was therefore eligible for additional incentive payments. Two of the metrics that it did not meet were the Access to Care and Satisfaction With Care targets, measured using the CAHPS survey. The other two unmet metrics were the percentage of adolescents receiving well-child visits and the percentage of adults receiving the SBIRT protocol.

HEALTH COMMONS GRANT

Health Share's Health Commons Grant ends in July 2015, and all 5 grant programs have been integrated into the operational budget at one or more RAE. That means that program data promised return on investment. Each program developed a sustainability model and was able to secure continued non-grant funding.

CONTINUED COLLABORATION

Nearly all of the interviewees at Health Share pointed to "the fact that we're all still together" as the single most important marker of progress.

CONTEXT

Health Share has leveraged "quick wins" into sustained progress. For example, many other CCOs would have loved to have started operations with a $17 million CMMI grant; Health Share was able to fund most of its touchstone programs with this initial investment, which created dozens of new jobs and dodged the challenges inherent in implementing non-traditional workforce members within a fee-for-service system.

Shifts in attitudes pre- and post-2013 quality incentive disbursements highlight the fact that success—winning 104% of the funds that had been withheld—has led to a collective sigh of relief and has increased commitment to working together.

The CCO still faces challenges. For instance, since the global budget is already lower than projected Medicaid spending, and since the CCO passes nearly all of its global budget on to the RAEs, there is virtually no "new money" on the table for Health Share to implement new transformation initiatives. That gives Health Share less muscle as it attempts to drive systems-level transformation; efforts to focus on culturally competent care or reduction in health disparities have ceded ground to efforts tied to quality performance metrics.

HEALTH SHARE OF OREGON: DRIVE V. TENSION

CCO implementation required partnerships among organizations that are traditional antagonists, and it required them to come together quickly. As we conducted these case studies, we wanted to analyze the extent to which internal and external forces or structures *drive* CCO partners together and the extent to which certain structures or attitudes might create *tension* that pulls them apart.

TENSION

The forces that put tension on Health Share as a collaborative are generally predictable. The primary force pushing partners apart is the fact that many compete in the commercial market. While they are incentivized—and pressured—by the state to come together as a CCO in service of the Medicaid population, these competitors fight fiercely for the next large employer contract or the next heart surgery.

The Challenges of Board Membership. Health Share's board includes CEOs or other senior executives at some of the biggest insurers or delivery systems in the region. These executives began as antagonists; respondents said it took time to get to know one another as a team responsible for a joint outcomes, and it took time to build trust.

Additionally, when board members attend Health Share meetings, they struggle to represent interests that are not always neatly aligned. The Chair of the Health Share board, for instance, is the CEO of one of the largest hospital systems in the area. There are times when a motion might be on the table and what is right for Health Share might not be the best move for his health system; it takes strength and leadership to navigate that tension.

Antagonism between payers and providers. While the large provider groups compete intensely in some areas, they join forces when they find themselves at odds with payers. One of the most intense challenges in the early days of Health Share emerged out of two fears: payers were concerned that they'd be asked to put up money, and providers were concerned that they'd be asked to slash rates. Other tensions grew out of disagreements about risk arrangements. Provider groups wanted to limit the administrative costs that could be withheld by the RAEs, in hopes that reimbursement rates would increase; RAEs wanted to retain the agency to use their capitated budgets as they saw fit.

"No one makes money on Medicaid."

None of the RAEs serve Medicaid alone, and this caused another challenge. A representative from another provider group said that she was surprised to learn that Medicaid wasn't profitable for payers at all: "I became acutely aware that in the large health systems Medicaid is a cost. It's a tiny part of what they do and largely if it ever came up in conversations it was about *how do you manage the loss*?" At times it was difficult for board members to return to their home organizations to ask for additional investments in the Medicaid program.

VOICES FROM THE FIELD:

Health Share leaders and partners testified to the tensions that challenge the organization.

"All the CEOs, they all have—this is a very competitive market, there's a lot of competitive tension, and the CEOs, while they know each other, they hadn't really sat down and worked things out together."

*

"[At first] there were many days I would come to work and think, "Today is the day the company's folding."

*

"Each of [the founders], in turn, almost drove the bus off the road. But when they saw it going off the road, they backed off, saying, 'Well, I really feel strongly about this but not strong enough to blow this whole thing up or for me to leave.'"

*

"I would have to say it was probably short of a miracle that we did get this pulled off, considering the complexity of the organization. […] I mean we were making this up as we were going. That is really a pretty herculean task."

HEALTH SHARE OF OREGON: DRIVE V. TENSION

Having assessed some of the ways in which the market and policy environment can create challenges or barriers to collaboration, we wanted to explore what kept partners at the table. The next section evaluates the factors that drive partners together, even when collaboration is difficult.

DRIVE

Health Share is a collaborative made up of competitors who have joined forces on behalf of the Medicaid population. What brought these traditional competitors to the table, and what made sure that they stayed?

Forced Adaptive Change. The biggest factor driving Health Share to became a CCO was the immense pressure from the state, driven by a budget gap. Before CCO reform, Oregon was facing a 30% reduction in reimbursement rates for providers; CCOs were the only way to avoid that slashing of rates. Oregon also hinted that CCOs would be given a preferred position in negotiations for insurance for state employees; at that point, everyone wanted to be at the table so that they did not risk losing out on lucrative state employee contracts.

Commitment to Service. Besides the strong financial and legislative incentives offered by the state, the partners in Health Share were driven to collaborate in the service of a very vulnerable population. On the one hand, this made good business sense: when low-income individuals find themselves in need of care, they often receive charity care. As one hospital executive put it, "we are already at risk for this population." On the other hand, many of the executives at the table in the early days of Health Share came together because they were truly driven to improve health and quality of life for the poor. One executive told us, "My reason for being there was I had realized that the whole sustainability of the Medicaid system was at stake."

Yoked Futures. Once these competing organizations had made a commitment to work with one another as Health Share, it became more difficult to act only in the service of the home organization's best interest. The partners began to realize that they would succeed or fail together: one early board member said, "I gotta trust everybody but I gotta take care of myself. And that's what keeps you together. Cause if one falls off, and you're roped up, you might all go down." This growing commitment led to hard compromises. "Everybody's ox is going to get gored," said one interviewee. "Let's just try not to make it fatal."

Hitting Performance Targets. Earning 104% of the funds that had been withheld for quality incentives was a huge win for Health Share, and many respondents spoke about how that success had cemented commitment to a partnership that can still be challenging at times. The pay-for-performance metrics are largely traditional delivery-system oriented metrics, but proving that they could meet those targets together helped Health Share partners develop confidence that they could tackle upstream drivers of health, such as ensuring that pregnancies are wanted and healthy or preventing childhood trauma.

VOICES FROM THE FIELD: Health Share leaders and partners testified to the forces that held them together, even when collaboration was challenging.

"I think there was a spirit generated out of, well, we're being kind of forced to do this and we do have this obligation to the population, and maybe we could do something different here, and maybe we can do the right thing. We have all been talking about this in our professional careers — It's a possibility' — but we really never had the ideal conditions to make something happen."

*

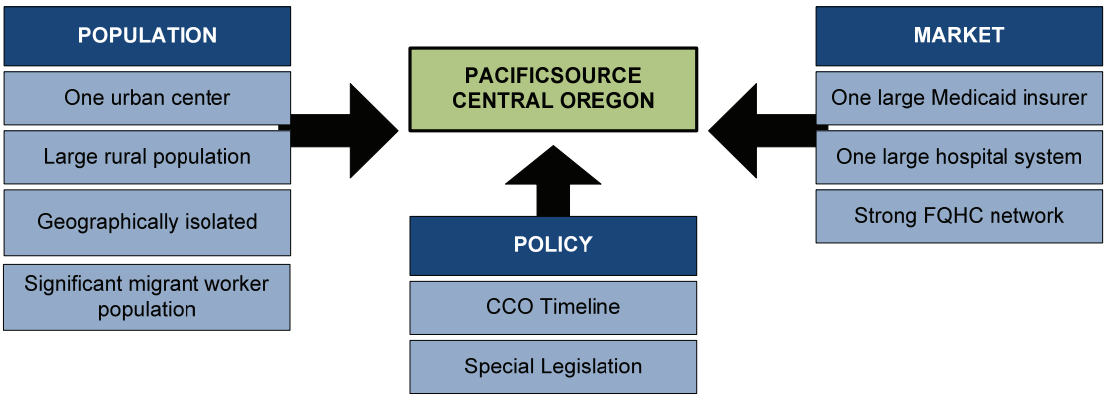
"Ultimately I thought that the right thing to do was the right thing by the population that we serve and I never hesitated to call that out to people whenever they were challenged by a lack of courage or trust."

*

On calls to new members that came in under the ACA:

"This part makes me cry. The people who were making the calls said it was the best two weeks of their life, because —almost without exception —the people they were calling said, 'I'm just so glad I have insurance! This is the best Christmas!' And we were just like, Oh this makes it all worth it. All the stuff federally, and the Cover Oregon stuff— you just think, 'You know, we did good.'

PACIFICSOURCE: ENVIRONMENTAL CONTEXT



SNAPSHOT

POPULATION

PacificSource Community Solutions (PSCS) has two CCOs. Our analysis is limited to the Central Oregon CCO, which covers Deschutes, Jefferson, and Crook counties. The region is largely rural, and just two cities have populations over 10,000. Many towns are built around ranching or agriculture. There is a significant population of migrant workers in the area, and the Warm Springs Indian Reservation is within the CCO's service area. Challenges facing the region include a growing homeless population in the Bend area.

MARKET

Many health care services are concentrated in a corridor between Bend and Redmond, requiring populations throughout the service area to travel long distances for care. The region's only hospital system is St. Charles Health System, and the only Medicaid insurer is PacificSource. Mosaic Medical, a network of FQHCs, provides safety net primary care services. One acknowledged challenge for the region is geographic: many specialty services in Oregon are found west of the Cascade Range, a mountain chain that creates a physical access barrier.

POLICY

Central Oregon began shifting towards regional planning early on, and a special legislation (SB 204) was passed empowering the region to collaborate in new ways prior to CCO legislation. The bill will sunset in 2016 and the region is currently advocating for updated legislation.

The state's transformation timeline has proved challenging for the CCO. PacificSource has committed to a community governance model that requires time for consensus building; some contracts have been rushed and harder questions put aside for later.

CONTEXT

The ACA Medicaid expansion was a significant challenge for PSCS. In December 2013 the CCO had 29,409 members; In January 2014 that number increased to 39,378. Enrollment as of April 2015 was 55,268; the CCO has nearly doubled in size.

Part of the reason for the immediate boost in Medicaid enrollment was the Fast Track option, which automatically enrolled individuals who were already enrolled in SNAP (food stamps) or CHIP (children's insurance). The Fast Track option was particularly disruptive for the Native American population. Many Native Americans were eligible for SNAP or CHIP, but did not wish to be enrolled in CCOs because they received most services through the Indian Health Service. While largely due to decisions made at the state level, this challenge still created tensions between the CCO and the Confederated Tribes of Warm Springs.

The population and geography of the area offer benefits and challenges to the CCO. Unlike in Portland, many health care stakeholders in Central Oregon know one another well, and a sense of interdependence has driven collaboration. On the other hand, the smaller population puts a significant burden on those whose job it is to execute on health care transformation; respondents noted that the same people tend to be at all the same meetings, and burnout, turnover and recruitment are a challenge.

The relative lack of competition in the market has caused some stakeholders to feel that others have too much power. The hospital system, in particular, can be perceived as a particular powerful player because the region simply couldn't do without it.

PACIFICSOURCE: GOVERNANCE

CENTRAL OREGON HEALTH COUNCIL (COHC): GOVERNS THROUGH JOINT MANAGEMENT AGREEMENT	
BOARD OF DIRECTORS	**SUPPORTING TEAMS**
Executive Director (hired for the COHC) Deschutes County Commissioner (CHAIR) President of Dental Care Organization (VICE-CHAIR) Crook County Commissioner Jefferson County Commissioner Health Plan President Specialty Clinic CEO Hospital CEO FQHC Network CEO IPA President Director of Behavioral Health (Deschutes County) Community Advisory Council Chair	**OPERATIONS COUNCIL** Includes many influential thought leaders Responsible for developing recommendations and proposals for board approval **FINANCE COMMITTEE** Responsible for developing recommendations for board approval **COHC STAFF** Executive Director, Operations Manager, and Analyst **PEP (Provider Engagement Panel)** Mechanism for Provider Involvement **CAC (Community Advisory Council)**

SNAPSHOT

COMMUNITY GOVERNANCE: COHC

The Central Oregon CCO is proud of its commitment to community governance. The health plan (PacificSource) is the sole entity that contracts with OHA as the CCO. PacificSource is not the governing body for the CCO, however. Through a joint management agreement, all decisions about the administration of the CCO are made by the Central Oregon Health Council (COHC).

The COHC has an executive director who was hired from out-of-state. The board of directors includes the executive director, one representative from the health plan, multiple provider representatives, county commissioners, and the chair of the community advisory council. This is important: while the health plan is the only COHC member to accept financial and legal responsibility for the contract with the state, the CCO is governed by the COHC— and the health plan has just one vote at that table.

A COMMITMENT TO PUBLIC PROCESS

Nearly all COHC meetings are open to the public. Respondents expressed pride in the CCO's commitment to community governance, but acknowledged that the structure has its challenges. The board of directors includes elected officials and CEOs, and they require briefing before engagement in public. Three committees— the finance committee, operations committee, and community advisory council— prepare recommendations and work to secure buy-in in advance.

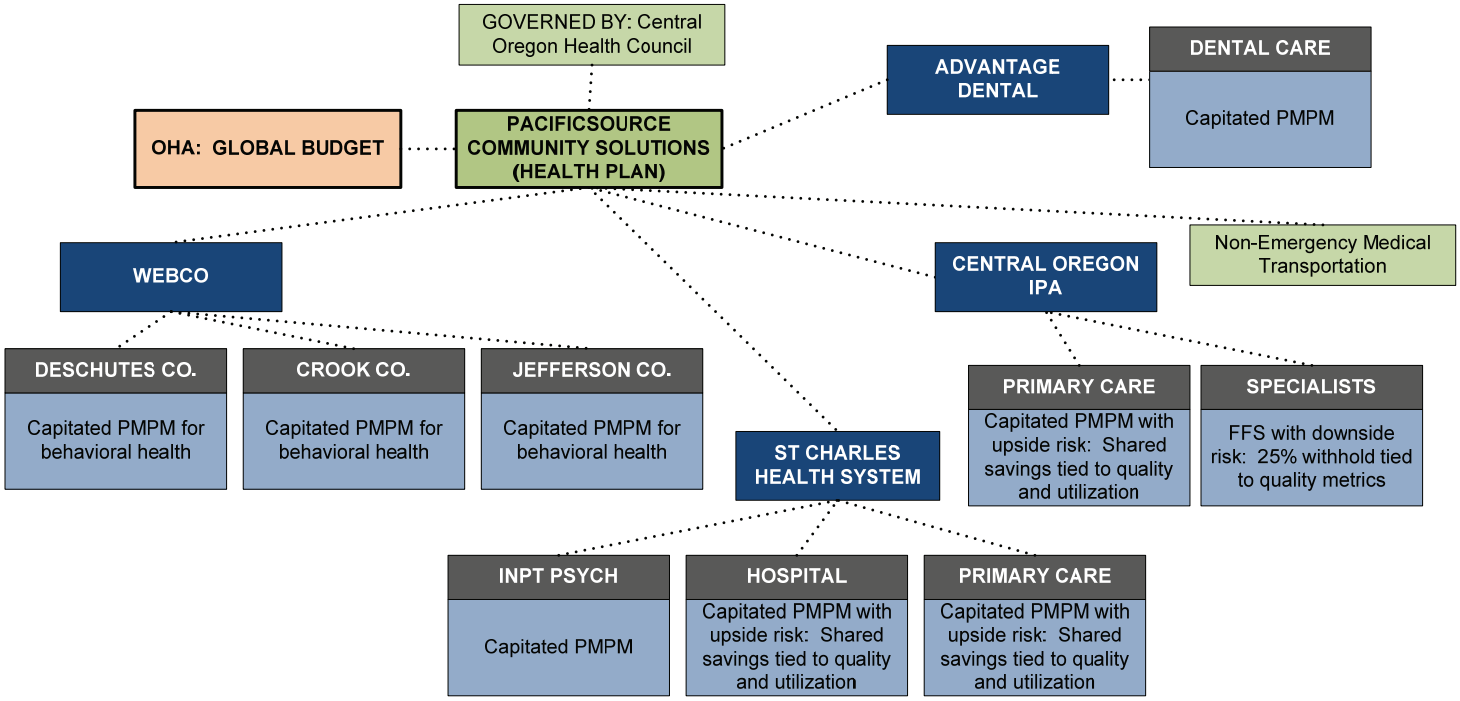
CONTEXT

The COHC was formed in advance of CCO legislation for two reasons. First, there was a desire to centralize regional planning for the area. One respondent told us that 144 plans had been created by public health and mental health across the three counties in a decade. "This was a hill to die on for us," the respondent said. "We wanted one four-year regional health improvement plan that would suffice for behavioral health, physical health, public health, alcohol and drug, and children and families."

As soon as regional planning conversations began to take place, however, the early partners realized that siloed budgets deterred collaboration and created inefficiencies. The COHC was first formed as a mechanism to enable partners to braid funding for joint initiatives that promised better care and lower costs through integrated care.

When CCO legislation was enacted, the COHC agreed that the collaborative represented the right partners to form a CCO. Its structure, however— volunteer membership and no reserves to speak of— prevented it from applying. The COHC issued a call for proposals from organizations that could serve as a contractor with the state on the council's behalf, and PacificSource was selected. The COHC retains control over the CCO through a joint management agreement.

PACIFICSOURCE: FINANCE AND PAYMENT



SNAPSHOT

CAPITATION

PSCS contracts using capitated payments for dental care, behavioral health care, primary care, acute care, and specialty care. In general, the providers receiving the capitated payment are the same partners that served the Medicaid population in the past, and payments for a single individual's care go to different partners depending on whether the care is dental, behavioral, primary care, or hospital care. This has led some to criticize PSCS for reverting to the status quo. One interviewee said, "money came in globally to the CCO, but it got processed right back out the old way. Nothing transformative about that."

ALTERNATIVE PAYMENT

A closer look reveals some exciting payment models. The biggest shift includes a new interdependency between primary care and the hospital system. PSCS withholds 25% of the hospital's budget; the funds are tied to quality and utilization targets. If those targets are met, the incentive dollars are *split* between the hospital and primary care. *That means that primary care providers in the region could earn 12.5% of the **hospital** budget*— millions of dollars.

WEBCO

PSCS had formerly contracted with each county separately. After CCO legislation passed, the three counties formed a collective called WEBCO (Wellness and Education Board of Central Oregon). WEBCO now contracts with the CCO.

CONTEXT

Respondents reported that PSCS has found contracting and implementation of alternative payment challenging, especially in light of the state's transformation timeline. The COHC's public process has meant that decisionmaking sometimes takes longer at PSCS than it might at other CCOs— yet PSCS has been held to the same integration timelines as the other CCOs. For instance, prior to CCO legislation the state had contracted directly with the counties for behavioral health services for Medicaid beneficiaries; CCO legislation required that CCOs— that is, PacificSource— now contract for those services. The CCO wanted to implement capitation and pay-for-performance, but the counties were wary of introducing new terms at the same time that they introduced a new contract partner.

As a fix, the CCO has relied on short-term contracts. One CCO representative said that integration conversations now sound roughly like this: "Okay, in the first year we'll just engage you the way the state engaged you. In the second year, we're going to introduce maybe a PMPM, but we'll guarantee you the revenue you got last year. And then in the third year, we need to really move to a more risk-oriented contract."

Despite what some see as slow progress, the shared savings model between the hospital and primary care is innovative— and Central Oregon is one of the few places in the US where the hospital receives a PMPM payment for Medicaid.

PACIFICSOURCE: ORGANIZATIONAL CULTURE

CHALLENGES

- Need to establish buy-in in advance leads to a slower process
- Requirement to manage public messaging leads to back-room deals
- Many contracts and service models are harder to translate beyond Medicaid

BENEFITS

- Health plan has emerged as a trustworthy partner
- Public nature of conversations encourages courage and commitment (can't back out without consequences)
- Recognition that "no one should make money off off Medicaid" opens up freedom to explore new financial models

SNAPSHOT

"THESE ARE PUBLIC DOLLARS"

PSCS's culture is defined by a commitment to community needs. One COHC board member said, "We ground ourselves at every meeting in the fact that our goal is to create an environment for healthy lives. We are not just trying to engage ourselves in medical payment reform. We are truly trying to look at the health of our community."

This commitment to community needs finds an extension in finance and governance. For instance, PacificSource (the health plan, which contracts with the state for the global budget) has determined the minimum percentage that it must retain for administrative sustainability. Any savings above that percentage are passed on to the community— the health council can decide how those funds are spent. When funds have become available— whether in the form of a state grant or a performance incentive disbursement— a community RFP process has been used to determine how to spend the money.

TRANSPARENCY AND PUBLIC PROCESS

COHC meetings are open to the public, which has created unique cultural norms. One consequence is that COHC meetings are especially conservative; as one respondent put it: "[Sometimes] we don't push the envelope quite far enough because folks aren't comfortable having some conversations in such a public forum." Additionally, board members want to feel prepared and informed before they weigh in on a new topic in public, which requires many *private* conversations— over beers or on a run— before the public conversation.

The COHC has recently established a private executive session that will allow its board members to "speak more candidly" and "get to the root issue versus dancing around it."

CONTEXT

The transparent and public nature of the COHC governance model has some important consequences. It's notable that at PSCS, three members of the board of directors are county commissioners. While county commissioners do serve on community advisory councils at other CCOs, it is rare for them to serve on a board that can ultimately rule on how health care dollars are spent. Most CCO boards are made up of payers and providers with extensive experience in health care financing and organization; many county commissioners come from business, but not necessarily from health care. The wider lens that the commissioners bring to the table may be in part responsible for PSCS's commitment to *community* health.

The role of the commissioners in CCO governance is also important since COHC proceedings are public. Commissioners are elected officials, so it's important that their public positions align with those of their electorate. Similarly, most other board members are CEOs of provider organizations; it's important to them that the public process depict their organizations as good community partners and as "doing enough" on behalf of the community.

In the past year, the COHC's identity has shifted. Difficult contract negotiations have exposed the fact that community governance only stretches so far. Members now see themselves as important partners and thought leaders in health care transformation, but they recognize the limits of the COHC's reach. One board member said, "We have to work hard to remember that it's not the community's job to tell someone how to run their own private business. We don't have any business doing that. What we can do is try and work together and find mutual wins."

PACIFICSOURCE: STRATEGIES AND MODELS OF CARE

	2011	2012-2013	2014-2015
Venue for Strategy Development	Hand-selected group of industry leaders	COHC Community RFP	COHC Strategic Planning
Primary Strategic Focus	ED Utilization Pediatric Care Management for Children with Complex Health Needs	Meeting Pay-for-Performance Metrics	Upstream Prevention and Health Equity

SNAPSHOT

COMMUNITY RFP FOR TRANSFORMATION PILOTS

The very first aligned effort of the COHC — which occurred prior to CCO legislation— required partners to "tax themselves" to fund joint integrated projects created to meet the Triple Aim. Since then, the COHC has used a community RFP process to identify new strategies or models of care for additional funding. Selected projects have included a pediatric complex care clinic, a community paramedicine pilot, and free toothbrushes.

COORDINATE CARE FOR COMPLEX PATIENTS

Early pilot projects focused on high-utilizers. An ED navigation pilot was counted as one of the CCO's first successes; it coupled community health workers with ED "frequent fliers" to tackle psychosocial drivers of utilization. Since then, the IPA has developed a community health worker program designed for complex patients, and an integrated clinic has been developed to provide intensive and fully-coordinated care for patients with severe and persistent mental illness.

SYSTEMS FOR COLLABORATION

A set of new initiatives has been oriented around a focus on improving systems for communications across service areas. These initiatives include standardized discharge planning, development of payment reform strategies, workforce development, and the creation of a health information exchange that can be leveraged for coordination. In large part, however, providers have been free to develop their own strategies for population health management.

EVALUATION

Having now conducted numerous pilots with limited capacity for evaluation and analysis, the CCO has recognized that it needs data to determine which pilots are really working.

CONTEXT

PSCS has gone through waves of community investment. The first wave occurred in 2011 when the COHC was in its infancy, and it required a shared financial commitment to three projects:

- Navigation for ED "Frequent Flyers"
- Early intervention for babies in NICU
- Multidisciplinary clinic for children with special health care needs

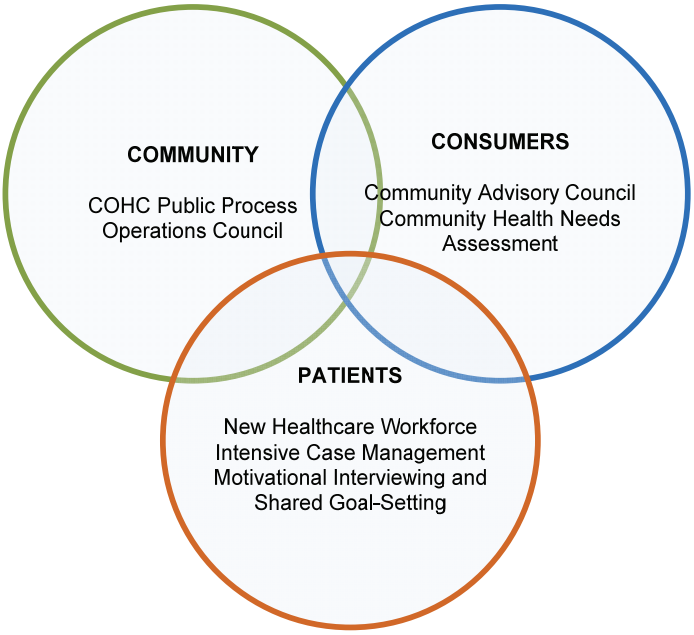
One early COHC partner said, "We walked out the door with a commitment from about fifteen people— public health, mental health, the hospital— who said, 'OK, we're going to shepherd this. We're going to make sure this happens.'"

As one of the first communities to explore these kinds of partnerships, Central Oregon became a "poster child" for what CCO legislation might do across the state. In 2012, the COHC decided to fund an additional round of collaborative projects, and engaged in a community RFP process to make the decision. "Let me tell you, it takes forever," said one respondent. "But we threw every idea at the wall and we ferreted it down and we came out with eight strategic initiatives."

In 2013, the state offered additional funding in the form of transformation dollars, and the COHC repeated the community RFP process. "Being the foolish marbles that we are," said one interviewee, "we said, 'Bring us your best and greatest ideas.' We had 36 proposals. Some of them are wackadoodle. But it was a fully open process. I doubt you'll find another CCO that embraced that in that way."

Having funded several rounds of small-scale projects, the COHC is exploring a long-term strategy focused on community prevention.

PACIFICSOURCE: CONSUMER ENGAGEMENT



SNAPSHOT

COMMUNITY ADVISORY COUNCIL

PSCS has a Community Advisory Council (CAC) that is chaired by a true consumer: a mother of several adopted children with special needs. The CAC is currently struggling to define its role, especially considering that the COHC is already supposed to represent the voice of the community. One CAC member said, "In my opinion one of the unfortunate consequences of the [COHC] model is that I don't' feel like there is as much authority in [the CAC] as was meant. We meet the requirements and all of that, but this group is still really trying to find their way."

CONTACT WITH MEMBERS: "OUR HANDS ARE TIED"

Federal regulations prevent CCOs from direct outreach to of members without the state as a mediator. The intention of the rule is to prevent health plans from influencing Medicaid beneficiaries in ways that might be financially advantageous to the plan but that would be against the member's best interest. Respondents shared their frustrations with this requirement. "It gets in the way of trying to actively engage them," said one respondent. "So the whole population health area— I think if you can't go and target subsets of the population with [interventions] that would end up with better outcomes, I mean you get kind of hamstrung."

PATIENT ENGAGEMENT

At the level of patient engagement, the CCO has had some success through its providers. Programs such as the IPA's community health worker pilot work intensively one-on-one to help patients set and achieve their own health goals.

CONTEXT

Like many other CCOs, PSCS has faced challenges in clarifying the role of the CAC.

One challenge is around recruitment. PSCS has had difficulty recruiting and retaining members of its CAC. While efforts have been made to recruit members from all across the CCO service area, in practice this has been challenging. The majority of the members of the CAC must be consumers, which means recruiting low-income adults who may have transportation barriers or health problems. Because such a small number of consumers could be found, the number of representatives from community-based organizations had to be limited.

Even with consumers representing a majority on the CAC, patient voices can still be drowned out. One respondent said, "Sometimes getting them to speak up and voice their concerns at a governance table is very hard. They're not as vocal asking questions and looking at data and poking holes. Some of that's just knowledge and experience and knowing what to ask. And some of it is just confidence, sitting at that table."

One CAC consumer member told us how frightened and intimidated she had been in the early days of the CCO. She told us that she had to ask a COHC board member to put together a list of acronyms to help her navigate board meetings, and she told us stories of how frightened she had been when asked to speak in front of county commissioners and CEOs.

PACIFICSOURCE: MEASUREMENT AND IMPROVEMENT

QUANTITATIVE METRICS 30% OF INCENTIVE DOLLARS	PROCESS METRICS 70% OF INCENTIVE DOLLARS
• Readmissions • Length of Stay • ED Utilization	• 8 total metrics - 4 relate to Emergency Department - 4 relate to readmissions • Process metrics require creation of steering committees, design of action plans, selection of future quantitative metrics

SNAPSHOT

PERFORMANCE AND PAYMENT

Capitated contracts to behavioral health and physical health care providers are tied to performance metrics. Metrics are negotiated each year. The 2014 contract included a 25% withhold from the hospital budget. If the metrics are met, the hospital and primary care will split the available dollars 50/50. Three quantitative metrics measure utilization; 30% of the total hospital withhold is tied to those three metrics. The rest of the incentive dollars can be won by meeting certain process metrics, valued at 8.75% each. Performance metrics tied to reductions in inappropriate utilization can encourage providers to "pay attention to Medicaid patients," for whom they often care at a cost.

EVALUATION PARTNERS FOR TRANSFORMATION PROJECTS

PSCS has been resourceful in making use of community resources, and recently partnered with Oregon Health and Science University to identify research partners and research funding for evaluation of several of their transformation pilot projects.

EMPHASIS ON ROI

Faced with the complexity of identifying, managing, and evaluating so many pilot projects funded with "community dollars," COHC leaders have emphasized the importance of developing ways to track return on investment. Respondents expressed a desire to be able to compare projects in terms of the investment needed and the benefits that might accrue to the community in the form of improved health, improved productivity, and reduced health care costs. However, as of yet the CCO does not have a system for this kind of measurement and tracking.

CONTEXT

Measurement at PSCS is happening in three key ways:

1. **CCO incentive metrics.** The community is motivated to meet CCO incentive metrics and bring incentive dollars to Central Oregon to be "reinvested in the community."
2. **P4P Contract Performance Metrics.** The CCO is developing contracts with behavioral health, dental health, and physical health care providers. These contracts will, over time, entail some withhold tied to performance to ensure that a capitated payment does not lead to declines in access or quality. At this time, most P4P metrics are either *process* metrics tied to capabilities that would have to be developed to engage in wider payment reform, or *quantitative metrics* tied to utilization.
3. **Pilot Program Metrics and Evaluation.** Some transformation projects and other community investments are being given evaluation resources designed to help tell the story of the program's impact.

Quality improvement programs have not, to our knowledge, been implemented at the CCO level. CCO partners do engage in quality improvement, and Mosaic Medical is far ahead of other FQHC networks in its ability to track outcomes. However, as of yet no systemic changes have been implemented with the goal of quality improvement.

PACIFICSOURCE: PROGRESS

METRIC	2013	METRIC	2013
Adolescent Well-Child Visits	●	Developmental Screening First 36 Months	●
SBIRT*	●	Diabetes Control (HbA1c)	●
Outpatient and ED Utilization**	●	Early Elective Delivery	●
Access to Care	○	EHR adoption	●
Satisfaction with Care	●	Follow-up after Hospitalization for Mental Illness	○
Colorectal Screening	○	Assessments for Children in DHS Custody***	○
Controlling Hypertension	●	Primary Care Home Enrollment	●
Follow-up after ADHD Prescription	●	Timeliness of Prenatal Care	●
Depression Screening and Follow-up	●		

● = Met incentive metric ○ = Did not meet metric

SNAPSHOT

PERFORMANCE METRICS—YEAR ONE

PSCS met 13 of 17 performance metrics in Year One. It earned back all of the funds that had been withheld from the global budget, and it also earned additional funds because it outperformed other CCOs and was therefore eligible for additional incentive payments. Two of the metrics that it did not meet were metrics that rely on systems change and integration: 1) follow-up after hospitalization for mental illness, and 2) assessments for children in DHS custody. These metrics have been identified by the state as "more transformational" because of the cross-system efforts require to meet them.

PSCS was the only CCO to meet the SBIRT metric in 2013. Several respondents credited Mosaic Medical with this accomplishment. A respondent at Mosaic acknowledged that the organization had redefined reports and workflows to better implement SBIRT at its clinics, without even knowing if Mosaic itself would earn the incentive dollars.

COMMUNITY ASSESSMENT OF PERFORMANCE

Participants tended to hesitate when asked about their success as a CCO so far. For many respondents, CCO implementation had felt rocky on the ground. Like Health Share, they were impressed that they were all still together.

CONTEXT

PSCS rallied community partners around incentive metrics without having a system for measuring performance across all partners and without clearly identifying how partners would benefit if the metrics were met.

Next, the CCO built reports to help providers understand how they were performing. For instance, area FQHCs receive updates every two weeks that illustrate which patients were counted as having received SBIRT screening. The FQHCs can then check their records to make sure that all SBIRTs were counted, and can identify places in the workflow where the SBIRT is being skipped.

It's likely that PSCS will invest in measurement and improvement systems during the next few years, in order to ensure that it can track performance on incentive metrics. Pay-for-performance can catalyze quality improvement systems in ways that the fee-for-service model simply can't. As one respondent put it,

"Quality folks used to bemoan how it was difficult to get attention before. Then pay-for-performance started kicking in, and we were like, 'Oh, all of a sudden I'm popular.'"

PACIFICSOURCE DRIVE V. TENSION

Partners in Central Oregon were drawn together prior to CCO implementation, and some respondents suggested that early work in Central Oregon might have laid the groundwork for statewide health care transformation. Yet despite their head start, many PSCS respondents felt they had lost ground. Below, we summarize some of the barriers and challenges that the CCO faced in its genesis.

TENSION

Competition was less of a cause for tension at PacificSource than it was at HealthShare, but the market in Central Oregon brought its own challenges.

Power Plays. The Central Oregon Health Council, the governing body for the CCO, is at its best when the group is aligned around community health. It is at its worst when distrust flares up between members. While many respondents praised St. Charles for visionary leadership in the earliest days of the CCO, others could not trust the hospital's motives. As accountable care spread across the nation, St. Charles began to purchase primary care practices. Some said that the providers asked to be bought out; others suspected that St. Charles was conducting a land grab. One respondents described this period as "An intense couple of years. There were a lot of people who were scared for their practices and ideals." Some interviewees suggested that distrust of the hospital system fed conflict at the Health Council years later. Another conflict surfaced when the three counties combined to form WEBCO. an intergovernmental agency with regional planning and contracting authority for behavioral heath, public health and education. One interviewee suggested that the impetus for the formation of WEBCO might have been to consolidate negotiating power in order to limit alteration of behavioral health care contracts.

Turnover and Burnout. The pace of change, which had been difficult in Portland, was even more challenging in Central Oregon because the same people had to serve on all the committees; the heavy lifting of transformation was falling on the same set of shoulders. Some key leaders were experiencing burnout; others were let go. One respondent from WEBCO acknowledged that "The CCO was probably frustrated with us when we had our crappy administrative staff. We had to hire [a replacement] and rebuild trust." Group dynamics at the COHC had also grown challenging, and the executive director resigned. It took months to hire a replacement, and another six months to bring her up to speed.

The Challenges of Community Process. In addition to the market challenges outlined above, the community governance model at PSCS was especially difficult to refine. Not all partners were ready for transparency at the same time, and the public process was slow and frustrating for some. In the context of burnout and distrust, early successes were quickly eclipsed by frustration with the state's ambitious transformation schedule and the immense lift of operationalizing new strategies and systems.

VOICES FROM THE FIELD:

PSCS leaders and partners testified to the tensions that challenge the organization.

*"Sometimes the CCO is considered to be PacificSource when the COHC wants PacificSource to do something or doesn't want to take responsibility for something. But then when the COHC wants to be making a decision or having authority it's 'No, **we** are the CCO.'"*

*

"[Quality incentives are] something you can get the provider community to—you just can't get them to it overnight, and you can't get them to it 17 times on different stuff."

*

"In general, no one— including the CCO or the Health Council, is really hitting it out of the park on analytics and savvy contracting skills because it's just not a strength that the region has been required to build. In this area, we don't tend to pay what's necessary to recruit some of those people, so you get what you pay for."

*

"It is easy conceptually to think about integrating various funding streams and then giving people flexibility and somehow being able then to do a whole lot more with the same dollars. The reality is much more complex than that, and if you don't acknowledge that complexity in advance and work to mitigate it, then you've set up your partners for a bumpy ride."

PACIFICSOURCE: DRIVE V. TENSION

Having assessed some of the barriers to collaboration, we wanted to explore what kept partners at the table. The next section evaluates the factors that drove partners at PSCS together, even when collaboration was difficult.

DRIVE

Partners in Central Oregon collaborated early and experienced early success. Over the past three years, however, the CCO has faced many challenges. How did PSCS overcome this adversity? What forces keep partners at the table, even when it gets hard?

A Public Trust. The community of leaders that makes up the COHC knows that it is unique. They are aware that most other CCOs did not adopt a community governance system, and yet the COHC is proud of its unusual model. The partners at the table agree that Medicaid dollars are public funds and should be used to enhance the health of the community. Many respondents told stories of disagreements among health council members that were defused or resolved through a reminder that the goal should not be to *collect* as much money as possible but to *use* Medicaid dollars as *wisely* as possible. Early commitments to transparency cemented a commitment to the public good.

Visionary Leadership. Many respondents credit PacificSource— that is, the health plan— with offering visionary leadership that inspired many partners to transcend conflict. While the IPA couldn't trust the hospital, for instance, both trusted the health plan. Leaders from PacificSource were particularly effective at demonstrating, through sacrifice, that they had skin in the game. One PacificSource representative said, "I learned that you have to give up power to empower. And I've been empowered to share everything. Everything. And what that allows us to do is to call for the same level of transparency from everybody else." This leadership by example proved a resilience factor that carried the COHC through adversity.

Personal Relationships. Respondents acknowledged that building trust over time made it easier to handle change and conflict. Several respondents pointed out that Central Oregon is a tight-knit community, and that negotiation is easier when "You know you're going to run into somebody at the store."

Deadlines and Incentive Metrics. Finally, while the state's aggressive transformation timeline made it difficult to get contracts executed, and while the incentive metrics did create a kind of "teaching to the test," respondents acknowledged that these policies were likely responsible for many of the activities of the Central Oregon CCO. For instance, while the CCO was unable to get the contract language that it wanted in the first year, it's uncertain that the CCO would have ever gotten those terms. In which case, it was better to start early than not to start at all. Similarly, while many respondents were frustrated with quality metric specifications, most acknowledged that the incentive metrics had provided a rallying point around which different layers of the health care system could align.

VOICES FROM THE FIELD: PSCS leaders and partners testified to the forces that held them together, even when collaboration was challenging.

"We were very clear: the guy who runs the billion dollar health system has a vote that carries the same weight as the mom from Madras with six children with special health care needs. We felt from the very beginning this was a public trust. We're dealing in other people's money. This is taxpayer money. And it's a sacred trust and we better be upfront with our financials and we better be upfront with our expectations that this isn't going to be owned by St. Charles and it certainly isn't going to be owned by Pacific Source.

*

"In fact, [PacificSource] didn't act like an insurance company at all. They acted like a community partner and I think their non-profit status and their behavior in their culture is just the right fit. A lot of things had happened because they had the right kind of ethic and the right people."

*

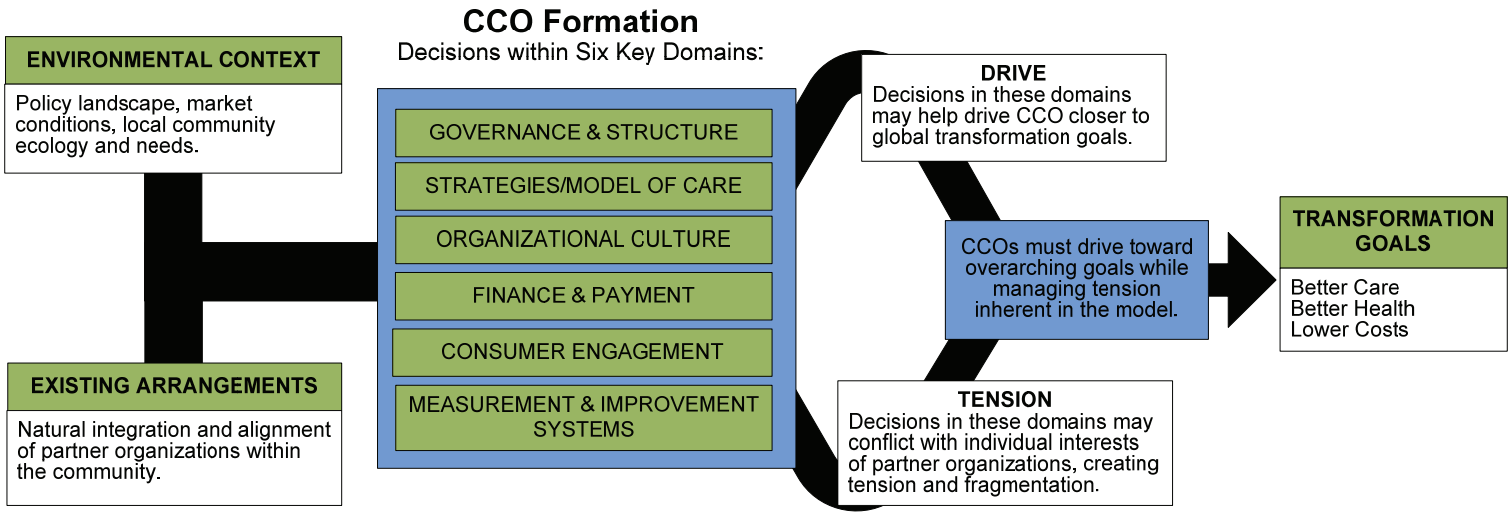
"Some community partners said, '[Teen well-child visits] are just not something that my docs are interested in doing.' And we said, 'Great, we can have all-day discussions about whether we agree or disagree. We are being graded on meeting that criteria. So, how can we help your docs get there?"

*

"Because we involve so much of the community, I don't think it allows us to be as nimble. But I think also, once we kind of get everyone around a certain thing, I think we really have the ability to push certain aspects quicker than if we were a little bit more nimble and didn't really have as many community partners involved."

CONCLUSIONS

Our case studies of CCOs in Oregon explored the contextual and organizational factors that facilitated or impeded progress towards transformation goals.



When we looked closely at the internal structures and the external contexts that defined each CCO under study, we found that PSCS and Health Share were very different. While the same policy applied in both CCOs, market forces had shaped entirely different structures. A fiercely competitive market in Portland had driven an exclusive governance structure that ensured that biggest players maintained decisionmaking authority, while a less competitive market in Central Oregon had facilitated broad collaboration in the form of a comprehensive but time-consuming public process. Additionally, the size and complexity of the market in Portland had delayed implementation of alternative payment models; PSCS was able to capitate providers and institute pay-for-performance mechanisms. On the other hand, well-stocked reserves, a larger enrolled population and access to large grants had enabled Health Share to make large community investments, while a limited budget and commitment to a community RFP process in Central Oregon had limited PSCS to smaller pilot projects.

Despite stark differences, respondents at both CCOs pointed to similar drivers of success.

1. State pressures acted as a catalyst for change. Pressure from the state in the form of quality incentive metrics, timelines for integrated budgets, and requirements for governance models can be said to have *worked*. Both CCOs cited these policies and regulations as driving conversations and planning activities that would not have taken place otherwise.

2. Collective narratives carried partners through adversity. Respondents at both CCOs referred to stories or statements of collective identity that inspired them to push through difficulty. At Health Share, respondents told us that part of their motivation to keep working at CCO implementation had to do with their desire to better serve an underserved population. At PacificSource, partners were motivated by their drive to carry out a commitment to community process in the service of community health.

Our goal for this case study was twofold. First, we wanted to understand what CCOs looked like on the ground. Second, we wanted to know if any lessons from the Oregon experiment might be offered to other states. The two drivers of success above give a clue: when policy pressures are combined with the opportunity to serve a moral purpose, the heavy lifting gets a little lighter.