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Fact Sheet

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The ABCs of CCOs

The Basics of How Oregon Aims to Transform Health Care

The success of Oregon's recent health reform legislation assumes that a "transformation" of the health care delivery system can improve health outcomes while significantly reducing costs. That transformation hinges on the creation of Coordinated Care Organizations (CCOs).

State officials aim to have newly-organized CCOs overseeing care for most Oregon Health Plan (OHP) enrollees by July 2012. CCOs could become the norm in the delivery of health care to all Oregonians if they succeed in improving efficiency and making OHP enrollees healthier.

This fact sheet answers basic questions about CCOs, their benefits and risks.

What is a Coordinated Care Organization (CCO)? A CCO is a new legal entity created by the state legislature to improve the delivery of health care and make Oregonians healthier. As envisioned, CCOs will coordinate care among a spectrum of providers, from primary care physicians and hospitals to dentists and behavioral health professionals.[1]

Is a CCO a for-profit entity? The 2011 law does not define the profit status of CCOs, so presumably they can be — but are not required to be — for-profit entities.

Can a CCO be an insurer? Yes. The 2011 law states that current managed care OHP contractors, which are insurers, can become CCOs.[2]

Who will be served by CCOs? Initially, CCOs will serve people covered by the Oregon Health Plan and other state Medicaid programs (except individuals receiving nursing and other long-term care),[3] as well as Medicare enrollees who are dually eligible for Medicaid.[4] CCOs will replace the managed care insurers that currently serve OHP enrollees. In the future, CCOs could serve teachers, other state employees and children who receive state assistance with their health insurance premiums.[5] Proponents of the transformation envision that CCOs could become a model for the health care industry and eventually serve all Oregonians.

How will the state select CCOs? The criteria for choosing CCOs are a work in progress. The state's health agency, the Oregon Health Authority (OHA), set up an advisory group to recommend criteria related to governance, health care quality, reducing health disparities, financial solvency and other issues.[6] Although OHA has the authority to set the selection criteria, it will present its initial plan to the state legislature for approval in February 2012.[7]

How many CCOs will there be? It is unknown how many CCOs there will be. The 2011 law establishing CCOs, however, requires the state to contract with more than just one CCO to serve the statewide population.[8]

How will CCOs improve Oregonians' health? Proponents of CCOs expect that CCOs will make Oregonians healthier by creating a more user-friendly health care system that emphasizes prevention and primary care. CCOs will be required to operate "patient-centered primary care

homes" that will coordinate care among a range of providers and make greater use of electronic health information to aid in coordination.[9] As set out in state law, CCOs must engage interpreters, community health workers and other personnel to reduce health disparities and help the most ill and isolated individuals get the care they need.[10]

How will CCOs save on medical costs? If CCOs succeed in keeping enrollees healthy, they will avoid having to spend more to treat serious conditions. Indeed, the law directs CCOs to focus on members with high health care needs to reduce the use of expensive hospital services.[11] The idea isn't to save by denying enrollees care.

How much does Oregon hope to save from the creation of CCOs? The legislature anticipated that CCOs would save the state $239 million in 2012-13.[12]

How will CCOs and their providers be paid? The state will pre-pay CCOs an amount, called a "global budget," for comprehensive care of each enrollee. The money will come from multiple federal and state funding sources. CCOs will, in turn, reimburse their providers based on the quality of the care they deliver — how healthy they keep their enrollees — rather than the volume of services they provide.[13]

Who will shoulder the financial risk? CCOs will shoulder financial risk in taking a state OHP contract, meaning they will be obligated to provide services while not being able to exactly predict the cost. CCOs will gain if they spend less than what they receive from the state and will lose if they spend more. Whether a CCO shares the risk with any of its providers or other entities such as insurers or reinsurers will depend on agreements with those entities. Whether the state will shoulder any of the risk is under discussion.[14]

Who will run the CCOs? By law, CCOs will be run by a governing body made up of (a) those who share in the financial risk of the organization, (b) the major components of the health care delivery system such as hospitals and outpatient offices and (c) members of the community. Those who bear financial risk will have majority representation.[15] The law does not specify that the major components of the health care delivery system must be those that serve the enrollees of the CCO. The law also neither defines "the community" and its representatives, nor requires inclusion of those experiencing common health issues or health disparities. In addition to a governing body, CCOs will have advisory councils primarily comprised of consumers and will include local government and community representatives.[16]

How much local control of CCOs will there be? By law, CCOs can be local, community-based organizations or statewide organizations with community-based participation in their governance, or a combination of the two.[17] The extent to which CCOs are locally controlled will depend on the prevalence of local representatives on their governing boards and the authority of advisory groups.

Are CCOs an experiment or do they exist elsewhere? CCOs are modeled after a handful of pilot projects set up in some Oregon communities and elsewhere that have improved patients' health and reduced costs. In the Affordable Care Act, Congress encouraged this coordinated approach in Medicare through a mandate to create "Accountable Care Organizations" (ACOs). Oregon's CCOs are similar to ACOs in coordinating care. Whether government payments to CCOs will include financial incentives to provide high quality care, as they will to Medicare ACOs, is under discussion by the Oregon Health Authority.[18]

Endnotes

[1] House Bill 3650 Section 20(8), 76th Oregon Legislature Assembly, 2011 Regular Session http://www.leg.state.or.us/11reg/measpdf/hb3600.dir/hb3650.en.pdf. Also, nursing homes and other long-term care providers will not be formally included but CCOs are required to coordinate with those facilities. See HB 3650 Section 1(3)b and Section 4(1)d.

[2] HB 3650 Section 14(3).

[3] HB 3650 Section 1(3)a.

[4] HB 3650 Section 1(3)a. See also Section 7. Oregon will need to obtain approval from the federal government to serve through CCOs individuals who are dually eligible for Medicare and Medicaid.

[5] HB 3650 Section 13(2)e. Oregonians covered through the state structures, Oregon Educators Benefit Board (OEBB), Pubic Employee Benefit Board (PEBB) and the state's premium subsidy program for children (known as KidsConnect) could be served in the future.

[6] Oregon Health Authority materials presented to the CCO Certification Work Group on October 18, 2011, http://health.oregon.gov/OHA/OHPB/health-reform/docs/2011-1018-materials-cco.pdf.

[7] HB 3650 Section 4(1) and Section 13(5).

[8] HB 3650 Section 4(1).

[9] HB 3650 Section 4(1)g and Section 12(3).

[10] HB 3650 Section 4(1)e.

[11] HB 3650 Section 4(j).

[12] *Analysis of the 2011-13 Legislatively Adopted Budget*, Legislative Fiscal Office, p. 33, http://www.leg.state.or.us/comm/lfo/2011-13%20LAB.pdf.

[13] HB 3650 Section 5(1).

[14] Oregon Health Authority Global Budget Methodology Work Group, Meeting Summary, September 20, 2011, http://health.oregon.gov/OHA/OHPB/health-reform/docs/workgroup-summary-criteria-global-sept.pdf.

[15] HB 3650 Section 4(1)o.

[16] HB 3650 Section 4(1)i.

[17] HB 3650 Section 4(1).

[18] Oregon Health Authority Global Budget Methodology Work Group, Meeting Summary, October 17, 2011, http://health.oregon.gov/OHA/OHPB/health-reform/docs/workgroup-summary-criteria-global-oct.pdf .

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