Updated ABCs of CCOs
The Basics of How Oregon Aims to Transform Health Care

The success of Oregon’s 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 Oregon Health Plan (OHP) enrollees as soon as August 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, updated to include changes since the February 2012 legislative session, sets out basic information 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.

How will CCOs be structured? The law leaves open the matter of how CCOs are organized. Some might be consortiums of providers such as hospitals, physicians, dentists and community clinics. Others might be insurance companies that work with a network of providers. They can be — but are not required to be — for-profit entities.

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), as well as Medicare enrollees who are dually eligible for Medicaid. 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. 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 state’s health agency, Oregon Health Authority (OHA), has established criteria that applicants must meet to be eligible for a CCO contract. The criteria address the coordination of care, governance and financial management. The state will also consider the capacity of prospective CCOs to provide patient-centered primary care, reward providers for good outcomes, reduce health disparities and employ electronic medical records and other health information technology.

How many CCOs will there be? The law requires the state to contract with more than just one CCO to serve the statewide population. The law also requires the state to consider approving more than one CCO for a single geographical area if that opportunity arises, to enhance access to care and choice of providers. Based on letters of interest recently submitted to the state, it’s possible that multiple regional CCOs will emerge.
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, (c) at least two health care providers, including a physician and a behavioral health provider, and (d) at least two members of the community. Those who bear financial risk will have majority representation. In addition to a governing body, CCOs will have advisory councils primarily comprised of consumers and will include local government and community representatives. At least one person participating on the community advisory council will serve on the governing board.

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. No matter the structure, only two board members must be community representatives. Ultimately, 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.

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 are required to operate “patient-centered primary care homes” or similar models that coordinate care among a range of providers and make greater use of electronic health information to aid in coordination. CCOs must engage interpreters, community health workers, mental health “peer wellness specialists” and other personnel to reduce health disparities and help the most ill and isolated individuals get needed care.

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.

Will benefits for OHP enrollees change? Benefits for OHP members will not shrink. CCOs must offer the same services members have been getting. Since CCOs will have new spending flexibility, they will have the authority to offer supplemental services to keep people healthier.

How much does Oregon hope to save from the creation of CCOs? The 2011 legislature anticipated that CCOs would save the state $239 million over a 12-month period during 2012-13. Independent experts, however, estimate that the savings will be between $57 million and $114 million, with increased savings in subsequent years.

How will CCOs and their providers be paid? The state will pre-pay CCOs a set 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, pay 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. The state plans to offer “quality incentives” to CCOs that excel in improving enrollee health.

Who will shoulder the financial risk? CCOs will shoulder primary 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.
How will CCOs be held accountable? The state is obligated to regularly measure CCO performance in how well they keep people healthy. An OHA committee, whose meetings are open to the public, is setting the standards for measuring CCO performance.\textsuperscript{24}

How transparent will CCOs be? CCOs are required to be “transparent in reporting progress and outcomes.”\textsuperscript{25} Under temporary OHA rules, CCO applicants must agree to post performance information on the internet and describe how they will be transparent in governance. The rules do not require governance meetings to be open to the public.\textsuperscript{26} OHA itself is required to regularly disclose information on CCO performance.\textsuperscript{27} Its data and documents on CCO performance will be made public “to the extent permissible.”\textsuperscript{28}

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.
Endnotes


2 House Bill 3650 (2011) Section 20(8), 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 (2011) Section 1(3)(b) and Section 4(1)(d).

3 HB 3650 (2011) Section 4(1). See also Section 4(3).

4 Local governments and other non-profits may comprise CCOs. HB 3650 (2011) Section 4(1) and(2).

5 HB 3650 (2011) Section 1(3)(a). See also Section 7. Oregon will need to obtain approval from the federal government to serve individuals who are dually eligible for Medicare and Medicaid through CCOs.

6 HB 3650 (2011) Section 13(2)(e). Oregonians covered through the state structures, Oregon Educators Benefit Board (OEBB), Public Employee Benefit Board (PEBB) and the state’s premium subsidy program for children (known as KidsConnect) could be served in the future.

7 HB 3650 Section 4; SB 1580 Section 20; Coordinated Care Organizations Implementation Proposal, Appendix D.

8 HB 3650 (2011) Section 4(1).


10 Letters of Intent To Apply at https://cco.health.oregon.gov/Pages/Letters-of-Intent-to-Apply.aspx. The entities proposing to serve the entire state are both multi-state insurers. Centene Corporation indicated interest in serving 33 Oregon counties. UnitedHealthcare indicated interest in serving 30 Oregon counties.


14 HB 3650 (2011) Section 4(1).

15 HB 3650 (2011) Section 4(1)(g) and Section 12(3). Also SB 1580 Section 20(2)(c).

16 HB 3650 (2011) Section 4(1)(e) and Section 8(c).


18 HB 3650 (2011) Section 20 (8). OHP benefits are determined by the Oregon legislature according to the Oregon Prioritized List of Health Services.


21 HB 3650 (2011) Section 5(1) and (2). Also Coordinated Care Organization Implementation Proposal, p. 28.

22 Rewards will be offered after the first year of CCO operations. Coordinated Care Organization Implementation Proposal, p. 28. Also, Request for Applications for Coordinated Care Organizations (CCOs), Appendix C.

23 Coordinated Care Organizations Implementation Proposal, Chapter 6. The state will continue to shoulder risk due to fee-for-service payment arrangements that will persist for a while. These payment arrangements will be converted to pre-paid payments per member per month to CCO contractors. When the state has no fee for service arrangements it will have divested itself of most risk.


25 ORS 414.018.

26 Temporary Oregon Administrative Rules 410-141-3015(28).

27 HB3650 (2011) Section 2(3). OHA is required to regularly report to the Oregon Health Policy Board, Governor and legislature.

28 Coordinated Care Organizations Implementation Plan, pp. 35, 41.