



Health Care Stewardship

Oregon Case Study

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In 2015, Urban conducted case studies examining health care stewardship in five states: Colorado, Minnesota, Ohio, Oregon, and Vermont. Stewardship demands active pursuit by governments of systemwide improvements, beyond typical public health and purchasing roles. This means developing a strategic framework for a health policy that reaches all citizens, building support among stakeholders, regulating and monitoring health care systems, and using data to improve. Through a series of on-the-ground interviews, we examined the unique ways states have leveraged their authority to improve the quality and efficiency of health care systems. To learn more or read the other case studies, visit <http://www.urban.org/policy-centers/health-policy-center/projects/health-care-stewardship-case-studies>.

Overview

Oregon has long tried to manage its Medicaid program with approaches other than reducing provider payments, the number or people covered, or covered benefits (such as the controversial Prioritized List of Health Care Services in the late 1980s). Similarly, for nearly three decades Oregon has sought health care reform for all, starting with an initial focus on assuring universal health insurance coverage with a concurrent interest in delivery system reform and cost-effective health care spending. In the words of one long-term observer, Oregon wanted “to produce a more rational health care system.” In 1989, Oregon enacted a series of health reforms, including an employer mandate, with the goal of achieving universal coverage in the state. The mandate never went into effect, however, and the state’s health reform efforts instead focused primarily on the Medicaid expansion component of the broadly conceived Oregon Health Plan (Oregon Health Authority 2012; Oberlander 2007).

Twenty years of frustrating attempts to transform health care ensued until 2009 when, under the leadership of Governor Kulongoski, Oregon again committed to broad reform by passing legislation that consolidated the purchasing power of all public programs that purchase health insurance (e.g., Medicaid, the Public Employees' Benefit Board [PEBB], the Oregon Educators' Benefit Board [OEBB], and the Office of Private Health Partnerships) and incorporated the departments of Public Health and Addiction and Mental Health into a new agency called the Oregon Health Authority (OHA). That legislation also created the Oregon Health Policy Board (OHPB) as a policymaking and oversight body for the OHA, established a medical home initiative called the Patient-Centered Primary Care Home (PCPCH) program, and created an all-payer all-claims database (APACD).

In 2010, John Kitzhaber, who had been an active leader in state health policy since his days serving in the state senate in the 1980s and early 1990s, was elected as governor for a third term (he served two terms from 1995 to 2003), partly out of a desire finally to accomplish health care delivery system restructuring. Kitzhaber immediately enacted a public participatory process some refer to as the "Oregon way." Over a few months, broad consensus developed around a major restructuring of Medicaid, grounded in Oregon's cultural embrace of locally driven options and reliant on collaboration among state-based payers and providers. Such consensus initially developed with the goal of more directly improving the health of communities as a whole rather than just providing health care services to Medicaid beneficiaries (i.e., the integration of public health and personal health care services at the community level).

In March 2012, relying on consensus, the state legislature passed bipartisan legislation by overwhelming margins in both houses to create coordinated care organizations (CCOs), local entities responsible for providing and hopefully integrating physical, behavioral, and dental health care to Medicaid beneficiaries. These community-based organizations, envisioned as a partnership among those sharing financial risk, providers, and community members, have largely replaced Medicaid managed-care plans as the organizer and point of accountability for health care quality and outcomes for their members within the constraints of a single global budget for the geographic area, initially for Medicaid beneficiaries (Oregon Health Authority 2012). The global budget combines previously fragmented funding for medical, dental, and behavioral health care into one stream, and CCOs are responsible for holding their spending to targeted growth rates. CCOs organize and pay providers to deliver care using a patient-centered, team-based approach, and they are held accountable for quality and cost against benchmarks established by the state government. CCOs retain flexibility to institute their own payment and delivery reforms and to work out the details within the social and delivery system cultures and constraints of their particular geographic areas, which vary significantly across the urban and rural areas of Oregon.

To support this major structural reform, the Centers for Medicare and Medicaid Services approved the state government's 1115 demonstration waiver application in July 2012, enabling the state to move forward with the CCO approach; the first CCOs launched in August 2012. In the following year, the state government applied for and was awarded a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) testing grant to extend the coordinated care model (CCM) to Oregon

residents who receive publicly funded health insurance through OHA. The model was to be extended initially to state employees and teachers and subsequently to individuals and businesses purchasing qualified health plans on Cover Oregon, the health insurance marketplace, and perhaps then to those eligible for both Medicare and Medicaid, known as dual eligibles (Oregon Health Authority 2012). Designers of CCO-based reforms had an explicit goal that all Oregon residents would eventually receive health care through the Medicaid-based CCOs or, alternatively, through similarly constituted organizations developed in parallel by other payers in alignment with the CCM. As one respondent told us, “The model is what we want—and the concepts—more than that the CCO is [the entity which] does it.”

Rather than use the threat of diminished funding or termination of CCO contracts in the event of poor performance, the state government has chosen to work with CCOs through learning collaboratives to improve their performance. Additionally, the state government is not using competition among CCOs as a tool for cost control and quality assurance. As one interviewee responded, “The idea wasn’t competition at the community level, but rather the idea was to create a regional incubator of innovation to work together to solve problems in their community. It was the spirit of overcoming fragmentation not creating competition.” With the exception of two metropolitan areas, each CCO has a geographic monopoly on its patient population. And the CCOs with overlapping patient populations do not engage much competitively. Rather, the state government’s approach relies on CCO’s global budgets, spending trend targets, regulatory structure, and performance-based metric benchmarks—rather than competition among CCOs—to hold CCOs accountable for cost reduction and quality improvement. CCOs in turn are supposed to hold providers accountable for their performance on cost and quality.

To date, the state government has successfully built and incorporated Medicaid beneficiaries into locally diverse and decentralized CCOs, but it has fallen short of its goal of significantly involving local community representatives in the development and governance of CCOs. Although each CCO is required to have a community advisory council and to include a member of this council in governance, some observers believe this structure provides too little say to the community.

Political and Policy Context

Throughout its most recent round of reforms, Oregon was under the administration of Governor John Kitzhaber, a Democrat who resigned in early February 2015, at which time Oregon Secretary of State Kate Brown took office. Kitzhaber served in the Oregon legislature beginning in 1979, and from 1985 to 1993 was president of the state senate, where his notable achievement was the creation of the OHP. In 1994, Kitzhaber was elected to his first term as governor, which he followed with a second term from 1998 to 2002 and a third term from 2011 to 2015.¹ The state elected to establish its own insurance exchange in 2011² and faced significant technological hurdles that led to its transformation to a federally facilitated state exchange. In 2015, Cover Oregon, the independent corporation operating the exchange, was dissolved and administrative control was transferred to the state’s Department of Commerce and Business Services.³

Oregon expanded Medicaid under the Affordable Care Act (ACA).⁴ Enrollment in Oregon's Medicaid and the Children's Health Insurance Program has grown 65 percent since the passage of the ACA and now includes over one-quarter of the state's population.⁵ From 2010 to 2013, growth of Medicaid spending slowed to 8.4 percent, down 3 percentage points from 11.4 percent from 2007 to 2010. Oregon spends only \$100 per enrollee more than the national average, and ranks 25th out of 50 states and the District of Columbia for per-enrollee spending.⁶

Oregon has one of the most competitive insurance markets in the country. The largest commercial insurer in the state has a market share of 31 percent, and seven insurers have at least 5 percent market share.⁷

State Goals

Debate over the goals for and direction of health care reform occurred throughout the 2000s. That debate produced the previously discussed 2009 legislation, which articulated the state government's reform goals: to improve the lifelong health of all Oregonians; increase the quality, reliability, and availability of care for all Oregonians; and lower or contain the cost of care so it is affordable to everyone. This set of aims, commonly known as the Triple Aim, continues to be the driving force behind Oregon's efforts (Oregon Health Authority 2012).

The state government has identified four key features of CCOs. They must (1) be locally governed to address community needs; (2) operate within a global budget with a fixed rate of growth; (3) be accountable for the health outcomes of the population they serve; and (4) be governed by a partnership of health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.⁸

The state government has had a long-standing interest in delivery reform to pursue the Triple Aim for all citizens. From an initially narrow focus, such broad reform arose from a funding crisis in the state's health care purchasing. With dismal projections and a slow recovery from the Great Recession, designers of the CCO-based Medicaid reforms saw the opportunity to leverage this immediate need to address Medicaid fiscal problems into the broader goal of overall delivery system reform. Respondents agreed that many saw an opportunity "not to let a good crisis go to waste."

View of State's Role

In responding to the immediate need to address Medicaid shortfalls, involved stakeholders generally credit state government, and Governor Kitzhaber in particular, as the main driver for delivery system reform and as a convener of stakeholders interested in participating in health care reform. Although the legislature subsequently passed the enabling legislation in 2012, it was the process of achieving consensus on restructuring Medicaid, initiated by the governor and by OHA director Bruce Goldberg that paved the way for bipartisan endorsement in the state legislature.

Simultaneously, because the legislation directly affects only public payers, many in the private sector remained “on the sidelines to watch how it works out.” Still, there seems to be a consensus that providers increasingly understand the need to change and could be strongly influenced by the success or failure of the CCO model. “You have a sentinel event—and the state is the sentinel event,” said one respondent. One way in which OHA hoped to reach this tipping point was through practice-level transformation that affected the care of all patients, not just those whose care is paid for by CCOs. More explicitly, through its receipt of the SIM grant from CMMI, the state proposed to test and accelerate the spread of its CCO model: It would first extend to beneficiaries of state-funded insurance plans and subsequently to Medicare and private plans, ultimately reaching a tipping point at which delivery system transformation could spread across the entire state (Oregon Health Authority 2012).

Leadership

Fiscal pressures from increasingly costly public programs to purchase health insurance for Medicaid beneficiaries, teachers, and state employees, combined with a budget shortfall in fiscal year 2011 (Medicaid alone had a \$2 billion hole)⁹ became a catalyst for broader delivery system reform supported across party lines. Republicans and Democrats both believed that the state government needed to solve the immediate budget crisis and produce a long-term fix to address the unsustainable growth of Oregon’s health insurance costs.

The state government’s budgetary woes, often referred to as a “burning budget platform,” provided an opening for a newly elected governor already interested in pursuing reform. Governor Kitzhaber framed the solution to the budget crisis as a “choice” between two options: cut Medicaid benefits and payments to providers with resulting reduction in access to the Oregon Health Plan (the usual way), or overhaul the Medicaid delivery system and prudently control costs in the process. The threat of budget cuts, including a 15 percent cut to provider payment rates, boosted stakeholder and legislator interest in exploring the latter. Rather than engage in particular payment level and benefit reductions, the core of the new approach involved putting the CCOs on global budgets tied to pre-established growth rates, effectively placing a budget limit on Medicaid spending, with safeguards to hold providers accountable for quality.

Authority

State government has focused on direct action where it has clear authority: Medicaid and publicly funded employees. As noted, anticipating the thrust for broad delivery reform, the state passed legislation in 2009 to consolidate the purchasing power of all public health benefits in a newly created OHA, establishing the PCPCH program, and creating the APACD.

The state lacks authority over commercial insurers and self-funded insurers to produce comparable delivery system reform. Lacking a regulatory hook, the adopted approach was to interest the business community in supporting Medicaid and other public employee efforts with CCOs because of employers’

concerns about cost shifting. To some extent, the state's ability to use its convening authority as a shield against antitrust enforcement provided an opportunity for collaborative engagement that might have spillover effect on private sector purchasing and delivery. More fundamentally, architects of the CCO concept hoped that the model's success would interest the private sector in either replicating it for their own insured, or parallelly adopting the concepts but using organizational structures other than established CCOs.

Leverage

Although its authority over Medicaid is clear, the state sought broad stakeholder buy-in to major reform and was able to use Medicaid's fiscal crisis to get attention and drive the process. Central to building its leverage to achieve legislative action, Governor Kitzhaber was able to use the prospect of substantial fiscal help in the form of the 1115 waiver to gain broad support. According to the terms of the deal, the federal government agreed to invest \$1.9 billion over five years to finance Medicaid's delivery system transformation into CCOs and plug the hole in the state's Medicaid budget.

In addition, as envisioned in 2009 with the formation of the OHA as the purchaser for all public employees and Medicaid, the state purchases for about 34 percent of Oregon's 3.9 million citizens.¹⁰ As the CCO-based reorganization was being accomplished, the state expressed interest in being selected as one of the demonstration sites for the Financial Alignment Initiative, (the "duals demonstration"), allowing states to integrate primary, acute, and behavioral health and long-term services and supports for dual eligibles. In the end, the state and the provider and insurer community chose not to apply given the terms of the demonstration. Despite the state's withdrawal from pursuit of the duals demonstration, 54 percent of dually eligible residents are covered under a CCO, and the state continues streamline Medicaid and Medicare enrollment to improve uptake of dual eligibles into CCOs.

The 1115 waiver continues to serve as a source of leverage by giving OHA considerable power over CCOs. In addition to providing an infusion of federal funds, the waiver establishes CCOs in the Medicaid delivery system; requires that the state government reduce its per capita medical trend by two percentage points (from 5.4 percent to 3.4 percent) by the end of the waiver's second year; requires that CCOs meet quality benchmarks; and requires a financial incentive for achieving performance benchmarks. The state government's failure to achieve the mandatory Medicaid savings would lead to significant financial penalties.¹¹

These federal waiver requirements have given the state government leverage to push CCOs to meet quality metric benchmarks and achieve savings. At the start of the delivery system transformation, the state government laid out basic requirements for Medicaid CCOs and established strict control over their global budgets, including annual growth rates, forcing CCOs to operate under a financial ceiling. The state government also began producing a public semiannual report describing each CCO's performance on quality, utilization, and cost measures.

Federal Role

Oregon's health care reform objectives have long been both health insurance reform with universal coverage of Oregonians and delivery system reform. In the years immediately preceding the passage of the ACA in 2010, Oregon's reform process waivered somewhat as policy makers weighed which to address first—health insurance access gaps or delivery system reform. The choice was somewhat moot, however, because the state government simply could not finance a major health insurance access expansion on its own. Thus, the ACA, specifically its funding of the Medicaid expansion and subsidies for many in the health insurance exchanges, which the state fully embraced, permitted the state government, stakeholders, and the public to focus on delivery reform. Unfortunately, major problems with implementation of Cover Oregon distracted from and delayed progress on the CCM's expansion and led to the resignation of Bruce Goldberg, a key leader of the reform process and the head of OHA.

As discussed, the infusion of new federal Medicaid dollars in 2012 with the 1115 waiver for delivery reform, on top of existing federal funding for the Medicaid expansion and health insurance exchange, gave the state government the resources to implement the CCO concept and related delivery system reforms. Additional federal funding opportunities have further boosted the state government's delivery system reform activities. The following year, in 2013, the state government applied for and was selected as a CMMI SIM testing state.¹²

Role of Medicaid

The state government is using its Medicaid program to drive statewide delivery system transformation. Because hospitals and many physicians and other health professionals care for Oregonians regardless of their payment source, some hope that CCOs might become accountable care organizations, which they hope would serve the state's entire population more successfully because of their reduced conflicting program requirements and payment incentives.

The articulated concept was to expand the CCO model beyond Medicaid through incremental steps. Once the CCOs are well developed and proven successful with the Medicaid program, state government would next expand CCOs to include the remaining public programs for which the OHA purchases health insurance (including teachers and state employees), then dual eligibles through CMMI's Financial Alignment Initiative, and ultimately to all Medicare beneficiaries through a full waiver or demonstration.

Spillover into the PEBB and the OEGB purchasing has begun, although it has not occurred to the degree originally desired by OHA. In 2013 the governing board of PEBB designed its 2015 health plan request for proposals to prioritize CCOs and similarly structured products, and its 2015 offerings include plans that offer the CCM through two CCOs and two commercial payers. OEGB has also added a CCM option for its members through a contract with Moda Health, one of the main OEGB plan carriers.

These expansions would ideally create an inexorable momentum to affect the rest of the health care system. The state's strategy for completing this expansion is to collaborate with the other affected stakeholders (e.g., commercial plans, self-insured employers, the Centers for Medicare and Medicaid Services,¹³ and consumers) and lead by example. The state government hopes to demonstrate to the remaining nonparticipating stakeholders that CCOs are successfully providing high-quality health care within a sustainable growth rate to all residents who receive public health benefits and that CCOs are a viable path forward for the rest of Oregon's residents.

Structure and Processes for Accomplishing Change

Legislation passed in 2009 consolidated responsibility for the purchase of health insurance for all public programs into one government agency, OHA. This reorganization instigated a shift in the state government's attitude toward health insurance purchasing. Observers generally agree that the state government culture has shifted from a primarily regulatory role (e.g., detecting health insurance fraud), to a mindset of getting everyone on board with health care reform as a partner while carrying out its duties as a regulator.

As noted, to shore up support in both parties, across a range of stakeholders, and within local communities, Governor Kitzhaber relied on Oregon's culture and history of collaborative and consensus-driven policy development through a year-long series of stakeholder and community meetings. First, the governor invited a group of stakeholders to weekly open meetings that became known as the "Wednesday meetings." Bruce Goldberg, the director of the OHA, and Mike Bonetto, the governor's health care policy advisor, facilitated these open meetings, which included Republican and Democratic state legislators, representatives of insurers, hospitals, doctors, long-term care providers, community health agencies, and advocacy groups. Second, in what were later referred to as the "Monday meetings," the governor met privately with key political stakeholders who were important to achieving legislative support for the ideas coming from the Wednesday meetings. Reportedly, this group included representatives of the Medicare MCOs, the hospital association, AARP, and the Service Employees International Union. Third, OHA held local meetings around the state to explain to the public that the state government's health care costs were growing at an unsustainable rate and that the governor's vision for delivery system reform would restrain that growth. This consensus-building process led to the passage of HB 3650 in 2011, which outlined the CCO concept and required subsequent legislation to operationalize CCOs. Between the 2009 and 2011 legislation, the OHA orchestrated broadly inclusive work groups to create detailed plans for the launch of CCOs. Following these meetings, the previously discussed 2012 legislation passed in both chambers of the legislature with overwhelming support.

Some stakeholders were skeptical that this process truly produced a consensus-driven outcome, viewing the Wednesday meetings and the local meetings held around the state as "political theatrics." Those critical felt that the real decisions were made behind closed doors in conversations with more powerful stakeholders during the Monday meetings. Further, some felt that the Monday meetings contributed to the state government's compromise on the goal to have strong community involvement

and control over the delivery reforms. According to one participant in the process, the Monday meeting participants had an initial goal of achieving “Medicaid MCOs on steroids,” whereas the Wednesday meeting participants were fully supportive of the concept of community-based and controlled delivery systems that had less deference to established insurer and provider organizations.

Participants and observers agree the end result was a CCO model that blended the two concepts, although some expressed disappointment that most of the CCOs’ governance did not provide a significant role for either public officials or community members unaffiliated with health care organizations. Within state and federal guidelines, the governor planned to grant the governing bodies of CCOs the latitude to develop their own CCO model. Discussion with stakeholders about the composition of the governing bodies was somewhat contentious. The resulting agreement was that three types of stakeholders would be represented on the governing boards: those giving care (i.e., providers), those taking financial risk (i.e., insurers and risk-bearing providers), and those representing members of the communities (although in some cases community members’ involvement in governance was less formal, consisting of participation on advisory workgroups).

The agreement to carve out Medicaid’s long-term care component from CCOs is an example of the state government’s compromise on its vision for greater community involvement. Advocates for long-term care and seniors felt that the state’s long-term care system already effectively balanced and addressed long-term care patients’ medical and social needs. Advocates “were concerned about the medicalization of the long term care system. It’s set up on a social model and [advocates] were concerned it would be run by medical management organizations.” Advocates also expressed concern that CCOs would focus too much on medical care and thus shortchange social supports for long-term care patients. The agreement allowing Medicaid’s long-term care system to operate outside of CCOs created political momentum in support of the CCO approach for acute care services. However, some believe the compromise on governance also continues the over “medicalization” of physical and behavioral health delivery, with inadequate attention paid to social determinants of health and the opportunity to reorient care toward a public health model.

The agreement on the structure and governance of CCOs as the replacement for managed care as the organizer of health care delivery for Medicaid did not initially address changes to the process of health delivery at the patient-clinician level. The actual changes to how care is delivered and paid for were to be developed later, with CCOs free to use different approaches to payment reform and related innovation.

Progress to Date

Stakeholders generally agree that the state government has made considerable progress in building CCOs in place of Medicaid MCOs. The 1115 waiver was approved in July 2012, and the first set of CCOs came on in August. The rest were operational by November and covered the entire state, exceeding initial expectations of CCO adoption. In just three months, about 600,000 Medicaid beneficiaries were transferred from Medicaid managed care plans to CCOs. It is well appreciated that

to date the important changes in the locus of control over the global budgets being provided under the new model have not yet translated into true delivery system transformation.

In the words of one stakeholder, “they [MCOs] took down their sign that said ‘managed care’ and put up a sign with ‘CCO.’” Subsequently, however, there seems to be agreement that parties that either had been competitors or were previously unconnected have begun to collaborate. One respondent said that “what has been accomplished is that we are all at the table talking and working together. We are having different conversations in the community than I could ever have hoped for.”

Although the reform process is still beginning, the state government is on track with its goals for cost and quality. The global budgets, apparently, have been effective at controlling Medicaid spending, and the CCOs have largely been able to meet the Medicaid waiver’s goals. A natural next step in the evolution of those metrics requires shifting from being process-oriented to gauging progress on outcomes and raising expectations for change. Some stakeholders believe that the benchmarks for improvement from baseline measures were set too low (perhaps to avoid jeopardizing the 1115 waiver) and did not require significant change or improvement in CCO care.

Sustainability

Impending fiscal pressures may force the state government to engage in difficult conversations with stakeholders about the sustainability of CCOs in Medicaid; the state government’s Medicaid budget will face increased pressure over the next few years as the additional federal funding from the 1115 waiver runs out and other supplemental revenue streams (e.g., the hospital provider tax) are maxed out. That said, CCOs have quickly become an integral part of the state’s Medicaid program and have proven their ability to achieve initial cost containment and improvement benchmarks. As one designer summarizes, “Part 1 was start with Medicaid, then [the state government would] change that model into the PEBB and show the commercial side that it was possible to take it beyond Medicaid and show delivery systems could live in a sustainable rate of growth and adjust what you pay for. We showed you could do that.” Interviewees agree CCOs will likely remain a part of Oregon’s Medicaid program for the foreseeable future.

But sustaining momentum and working together to expand the CCO concept and model outside of Medicaid will likely be much harder to accomplish. The state government’s original vision to spread delivery system reforms past state-purchased care and onto the entire health system remains a work in process, and some are skeptical about whether it can or should be achieved. For some, the goal of a single delivery structure based around a single community-based CCO receiving global payments and accountable for quality misses the reality that patient populations across the state have very different needs and thus might need different delivery approaches. As one stakeholder said, “The conversations are about the most vulnerable, not the employed or commercial populations. And the geriatric population [also] is very different.”

Further, the collaborative model that is the basis for CCOs' organization may not be useful for patient populations covered by other payers. The consensus to move from managed care to CCOs in Medicaid was based around a desire to overcome fragmentation for a vulnerable population that is also in need of social and community services, not to create competition for that population. But as summarized by one observer of Oregon health reform efforts, "I think people are willing to cooperate on Medicaid because no one was making money on it. But everyone is still thinking about making money on the commercial side."

From an antitrust perspective, for competing health care providers serving people whose care is paid for by the state, the state government could be a neutral convener to permit discussion and collaboration. Among competing health care providers serving people whose care is paid for by nonstate parties, however, the state's ability to be a neutral convener would likely not apply to a process of supplanting collaboration for competition unless the state was willing to meet the Supreme Court test for state action immunity. This test requires the state to have a "clearly articulated" policy alternative to competition being "actively supervised" by the state (Havighurst 2006). We did not detect broad interest in having the state take on that role for the broader population. More likely, if the CCO model were successful, employers and insurers caring for the commercial and Medicare populations would try to adopt similar concepts in a competitive market, removed from the community-based orientation underlying the CCO concept.

The recent resignation of Governor Kitzhaber may further slow progress. As mentioned, his leadership was one of the most important driving forces behind the creation of CCOs. His absence, as well as the departure of key OHA staff in recent months, may sap energy and enthusiasm for expanding the CCM outside of Medicaid. It remains to be seen how Kate Brown and her administration will pursue the reforms begun under Kitzhaber.

Conclusion

Oregon's state government has the statutory authority and leverage to advance delivery reforms in its Medicaid program. The health care reform legislation passed in 2011 and 2012 granted the state government the authority to pursue CCO formation, contingent on the receipt of federal approval of an 1115 waiver. The state government is using that waiver's federal requirements to push CCOs to achieve quality and cost benchmarks.

There is broad agreement that proponents of the Medicaid reforms envisioned ultimate expansion of the CCO concept to all citizens in the state, initially by spreading the CCM to other populations for whom the state is responsible as a purchaser. The consolidation of the state government's health insurance purchasing authority into the OHA and the state government's receipt of a SIM grant have created an opportunity for the state government to act, but the state government lacks the authority to compel the adoption of the CCM for all citizens.

The lack of a regulatory hook to influence commercial insurers and self-insured employers makes the path to statewide delivery system reform even more difficult. It could well be that the state will be successful in demonstrating that the concepts embedded in the CCO approach, including using global payments as form of budgeting, requiring accountability using performance metrics on quality, and decentralizing decisionmaking to local organizations, work well, but it is too early to know. However, it seems the CCO model has not yet accomplished one of the major tenets that stimulated CCO activity: a large community role in governance to join public health and personal health services at the community level.

If CCOs can continue demonstrating that high-quality health care can be provided within a sustainable rate of growth to all residents who receive public health benefits, commercial insurers and self-insured employers may start to consider some variants of the CCO model—perhaps accountable care organizations—as a viable path forward for privately insured and Medicare patients, but likely relying on competition rather than collaboration. The idea of collaborating actively with competitors has raised antitrust concerns among private payers and providers. Because of these concerns, and because of concerns that the needs of Medicaid beneficiaries differ from those of commercial and Medicare beneficiaries, private payers are likely to be more open to adopting similar (but not identical) payment and organizational structures to those found in the Medicaid CCOs.

Notes

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10. OEBC covers 150,000 lives; see “About Us,” Oregon Educators Benefit Board, accessed November 23, 2015, <http://www.oregon.gov/oha/OEBC/Pages/About-Us.aspx>. PEBB covers 133,000 lives; see “About Us,” Public

Employees Benefit Board, accessed November 23, 2015.

http://www.oregon.gov/DAS/PEBB/Pages/about_us.aspx. OHP covers 1,064,000 lives as of April 2015; see “About the Oregon Health Plan,” Oregon Health Plan, accessed April 22, 2015, http://www.oregon.gov/oha/healthplan/Pages/about_us.aspx. In total, this amounts to 1,347,000 lives covered. See also “Oregon QuickFacts from the US Census Bureau,” US Census Bureau, accessed November 23, 2015. <http://quickfacts.census.gov/qfd/states/41000.html>.

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13. Expansion to Medicare beneficiaries would require a waiver from the Centers for Medicare & Medicaid Services.

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About the Authors



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