WHITE PAPER
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Healthcare IT

ACOs on Steroids: Why the Oregon Experiment Matters

The state of Oregon is attempting a dramatic transformation of Medicaid to control costs while improving the quality of care

"We...showed that if every state did this, over the next 10 years it would return about USD 1.5 trillion to the federal coffers."

– Bruce Goldberg, MD, Director of the Oregon Health Authority

Executive Overview

Not many clinicians or healthcare IT professionals typically think of Medicaid as a hotbed of innovation. Yet the federal-state health program for lower-income people in the United States is attempting a dramatic transformation, and the State of Oregon has thrust itself to the forefront of it.

The Oregon Experiment, as it is called, carries high stakes—not only for the state of 3.9 million people in the Pacific Northwest but also for the movement toward accountable care organizations (ACOs) nationally.[1] Spurred by new federal regulations and reimbursement models, many healthcare provider groups are re-organizing themselves into ACOs.

The aim of the ACO model is to control healthcare cost inflation while improving health outcomes and the care experience—the "Triple Aim" embraced by the U.S. Centers for Medicare & Medicaid Services (CMS). The key mechanism is to shift from fee-for-service payments, i.e., reimbursing for each medical service provided, to a value-based structure, e.g., giving hospitals and medical practices a share of the cost savings they achieve and/or bonuses when they attain cost, quality, and access metrics for their patient populations.

Recently created by Oregon law, coordinated care organizations (CCOs) are patterned after the ACO model. CCOs feature different budgeting mechanisms and operate with greater flexibility across a broader array of services than the federal ACO model. The state's largest CCO is Health Share of Oregon, covering roughly 40 percent of the state's Medicaid population in the three-county Portland metropolitan region. Health Share of Oregon's broad ambitions, as well as its birthing pains, demonstrate the opportunities and barriers to healthcare transformation efforts that go beyond tinkering at the edges.

Josh Lemieux
Director of Communications
Health and Life Sciences
Intel Corporation

Prashant Shah
Health IT Software Architect
Health and Life Sciences
Intel Corporation

Stephanie Wilson
IT Project Manager
Intel Corporation

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Why the stakes are high

One-sixth of healthcare spending in the United States is through Medicaid, the third-largest domestic program in the federal budget. When the economy tumbles, as it did in 2007, Medicaid enrollment swells while taxpayer receipts drop. On average, states pay 43 percent of Medicaid costs. Because they must balance their budgets annually, states are under heavy pressure to control Medicaid spending, typically the second-largest item of their general fund budgets behind education.[2]

Under the Affordable Care Act, designed to decrease the number of uninsured people, states now have the option of expanding eligibility for Medicaid. The federal government will cover an estimated 93 percent of the USD 1 trillion to expand Medicaid through 2023.[3] The expansion of Medicaid during a time of tight budgets has invigorated scrutiny of the concentrated nature of its costs; nationally, 5 percent of Medicaid beneficiaries account for 54 percent of the program's spending.[4]

In Oregon, the expansion of Medicaid is projected to nearly double the number of beneficiaries over the next decade, adding 400,000 people to the rolls. Yet, even before this expansion, the state is trying to pull itself out of a deep budget hole. Gov. John Kitzhaber, a former emergency room physician, struck a deal with the Obama administration. He pledged to transform the way care is delivered to Medicaid patients (and those eligible for both Medicaid and Medicare)—especially those with higher needs and costs—while at the same time significantly reducing the growth of healthcare costs.

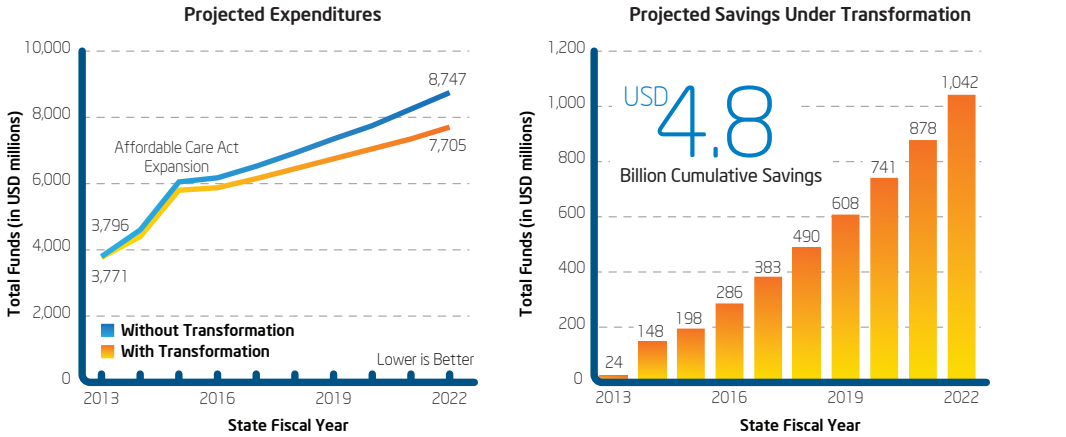
To keep the program financially sound while the Oregon Experiment gets started, the federal government has offered USD 1.9 billion to Oregon over five years. However, if the state fails in its part of the bargain—to keep its growth rate of per capita Medicaid spending at 2 percent slower than the rest of the country—the state will pay heavy penalties back to the federal government.[5]

Two percent slower growth may not sound like much. However, the graph shown in Figure 1 suggests otherwise.

Figure 1. Oregon Health Authority's analysis of savings over the next nine years.

Oregon's Trend Expenditure Agreement with Centers for Medicare and Medicaid Services (CMS)

As part of Oregon's Medicaid demonstration, the state agreed to reduce the Oregon Health Plan's per capita medical expenditure trend (i.e., the increase in capitation) by 2 percentage points over the final three years of the demonstration, while maintaining standards of access and quality. [Source: Oregon Health Authority]



Without Transformation baseline trend = 5.4 percent PMPM growth annually (President's Budget trend, OMB). With Transformation savings targets = PMPM expenditure increases cannot exceed 4.4 percent in year 2 of the demonstration (July 2013-June 2014) and 3.4 percent in year 3 (July 2014-July 2015) and beyond.

If the state is successful, in 10 years there will be as much as USD 3 in savings for every USD 1 that the federal government fronted for USD 1.9 billion in start-up costs, according to Bruce Goldberg, MD, director of the Oregon Health Authority. "We actually took it one step further and showed that if every state did this, over the next 10 years it would return about USD 1.5 trillion to the federal coffers," which would have a significant positive impact on the federal deficit, Goldberg said.[6]

The most ambitious part of the state's pledge is that it will achieve the cost growth reduction without cutting quality or access to care even as the size of the program nearly doubles. As Goldberg notes, "When costs have always been a problem, states and businesses have done three things: they've cut people from coverage, they cut benefits, or they've reduced payments. Each of those strategies, in the end, only shifts costs or eliminates people from organized care and has them end up in emergency rooms getting high-cost care."

A key element of Oregon's new strategy is **fixed global budgets**. In the past, the state has budgeted separately for physical, behavioral, and dental health. Medicaid patients experienced these services as unconnected siloes that failed to prevent expensive and unnecessary emergency room visits such as a Medicaid patient showing up in the ER because of an untreated toothache or underlying behavioral health issue.

The global budget has three key mechanisms. First, it begins to pay providers organized as CCOs to coordinate physical, dental, and behavioral health services. Second, it allows more flexibility for healthcare teams to help patients who have the highest risks and costs. For example, if a patient's lack of housing is the root cause of ER visits and hospital admissions, the care team can assign an outreach worker to help the patient find a better living situation. Third, the global budget dollars will grow each year at a slower than historic rate, which is critical to the state's pledge to ease the slope of its cost curve (Figure 1). "Putting a clear and sustainable limit on the growth, we believe, will help spur innovation in new care models to deliver higher-quality care at a lower cost," Goldberg said.

CCOs, nicknamed "ACOs on steroids," are community-based organizations that use a patient-centered primary home model with interdisciplinary care teams to coordinate physical, mental, chemical dependency, and oral care for the state's Medicaid and dual-eligible (Medicaid and Medicare) patients. "Care is coordinated at every point—from where services are delivered to how the bills are paid,"[8] envisions the Oregon Health Authority, which administers Medicaid in the state. As of January 2013, Oregon has certified 16 CCOs.

Health Share of Oregon – The grand experiment within the Oregon Experiment

Health Share of Oregon, the state's largest CCO, serves approximately 160,000 patients across three counties in the Portland metro area, nearly 40 percent of the state's Medicaid population. Faced with bigger demands yet tighter budgets to care for the Medicaid population, the eleven founding Health Share members and partner organizations (see sidebar) sought common ground beyond their traditional roles as competitors.

FOUNDING MEMBERS OF HEALTH SHARE OF OREGON

- Adventist Health
- CareOregon
- Central City Concern
- Clackamas County
- Kaiser Permanente
- Legacy Health
- Multnomah County
- Oregon Health & Science University
- Providence Health & Services
- Tuality Healthcare
- Washington County

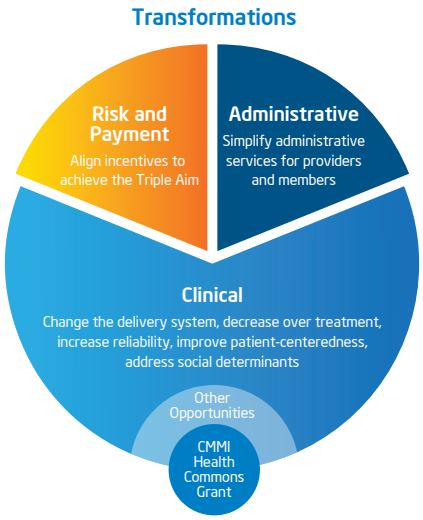


Figure 2. Health Share of Oregon's strategic plan to transform care focuses on three areas: Risk and Payment, Administrative Transformation, Clinical Transformation. [Source: Health Share of Oregon, 2012]

Collaboration among health and hospital systems, counties, insurers, medical practices, and community services is a requirement for success. "With our members, communities, and other stakeholders, we all share a role in making this the healthiest place in which to live," said Janet Meyer, CEO of Health Share of Oregon. "People and their providers will be asked to share responsibility for developing a path to health, which will be guided by the individual's needs.[9]"

Health Share is essentially a lean, start-up organization. Now employing about 25 people, its job is to coordinate the much larger and traditionally competitive systems.

Building blocks for a new model of care

In a prelude to forming Health Share of Oregon, several of the member organizations received a USD 17.3 million grant from the U.S. Centers for Medicare & Medicaid Services (CMS) Innovation Center. The community is moving quickly to pilot five promising interventions (outlined in Table 1) as part of what's called the CMMI Health Commons grant.

Consistent goals across all efforts include the avoidance of unnecessary or preventable emergency room admissions and readmissions, improved patient experience, and a deeper connection to a primary medical home and community services. This work requires a new way of thinking about who engages with the patient and when and how services are coordinated. A new role of outreach worker is being defined to provide assistance to the patient at points of crisis and transition.

Beyond initial formation and work in the first year on the CMMI Health Commons Grant projects, Health Share of Oregon has developed a strategic plan to transform care focused on three areas, as shown in Figure 2.

Table 1. The CMMI Health Commons Grant Interventions

INTERVENTION	DESCRIPTION
Interdisciplinary Community Care Teams	The deployment of non-traditional healthcare workers to focus on reducing the frequency of avoidable emergency department visits. These healthcare workers assist a population of at-risk members by facilitating the connection to a primary health home (physical and/or behavioral), engagement with community resources, and motivational coaching for self-management of health issues.
Care Transitions Innovation (Hospital-to-Home)	The goal of this work is to improve the transition experience from inpatient to outpatient care, thereby improving health while reducing the likeliness of hospital readmission. This intervention focuses on risk identification with the help of a transitional care nurse, pharmacy consultations, and support following discharge, and multidisciplinary team meetings to coordinate post-discharge care.[10]
Intensive Transitions Team (Mental Health)	A short-term solution that provides intensive case management and mental health services to individuals being discharged from a hospital inpatient unit or emergency department for psychiatric crisis. The intensive follow-up work ensures the engagement of high-risk individuals into appropriate services, with the goal of avoiding readmissions.
Emergency Department Navigator	It's estimated that as much as 60 percent of Oregon's Medicaid patient visits to the emergency department could be handled with non-emergency care.[11] This program places staff at the emergency department to help guide appropriate cases to other non-emergency services. As appropriate, patients are connected to primary care homes and support services.
Standardized Hospital Discharge	Based on a community-wide effort across systems and medical roles, this effort seeks to instantiate a standardized hospital discharge process and workflows, improving the patient discharge experience and increasing the likelihood of attendance at follow-up appointments.

For more on information on the standardization of discharge workflow, visit **www.intel.com/discharge-summary-white-paper**

Healthcare IT is viewed as a key ingredient

The Portland metro area enjoys a wealth of advantages beneficial to the goals of transformed healthcare. Nearly all healthcare systems have been early adopters of electronic health record (EHR) systems. The region boasts a highly educated pool of healthcare information technology (IT) experts, thanks to Oregon Health & Science University's Department of Medical Informatics and Clinical Epidemiology and several healthcare IT companies located in the Silicon Forest. Intel Corporation, which employs nearly 16,000 people in Oregon, supported the project by lending an IT project manager and architect to help in early-stage implementation. And perhaps most importantly, the region prides itself for progressivity and has a group of health system leaders willing to put aside traditional competitive roles to work collaboratively for a better path forward for the region's Medicaid population.

Daniel Dean, Health Share of Oregon's chief information officer, leads an oversight team made up of member system CIOs and others to define requirements and make strategic decisions on healthcare IT to support the effort. According to Dean: "Effective use of appropriate health information technology will enable desired transformation within the clinical delivery system, the introduction of new risk and payment models, and the completion of administrative simplification activities thereby supporting Health Share in its pursuit of achieving the Triple Aim objectives: better care, better health, and lower costs."

These leaders recognize the criticality of IT solutions to smooth transitions, identify risks and trends, track services and outcomes, and continuously learn and improve. IT touches most facets of the work in flight, including:

- **Electronic health records (EHR).** Systems to capture clinical data.
- **Health information exchange (HIE).** The sharing of electronic health information within the home organization and with partner or regional organizations, to provide improved care and population analysis.
- **Encounters and payment.** Timely and accurate submission of electronic claims and the receipt and distribution of corresponding payment.
- **Reporting.** The assimilation, trending, and meaningful display of important data from operations, financial, and clinical perspectives, to assist with making educated decisions.
- **Security.** Device security and information security.
- **Privacy.** Appropriate protection of health information.
- **Storage.** Informed strategies related to on-premise vs. cloud storage.
- **Hardware.** Selection of services, laptops, tablets, and other electronic devices provided to healthcare workers.

> "Effective use of appropriate health information technology will enable desired transformation within the clinical delivery system..."

Despite these advantages and cooperative spirit of the region, Health Share of Oregon faces significant challenges. Historical investments by member organizations in EHR and HIE systems have resulted in disparate implementations and configurations that make it difficult to share across organizational boundaries, even when they use the same EHR vendor. Each member organization has its own culture and workflows, and what works well at one may not be acceptable to another. Providers often document information inconsistently or redundantly across the various systems. There is no community repository of patient summary information. Nor is there consistent, community-wide documentation of a patient's care team. In addition to this diversity of member systems is the complexity of incorporating independent physicians and mental health providers, community clinics, mental health, and social services into the Health Share efforts. Yet another significant limitation is that Health Share of Oregon does not have a large IT budget of its own. Its success is dependent upon persuading and coordinating IT tasks among organizations that have their own IT budgets and priorities.

Under a tight budget and challenging timelines, the IT oversight team of CIOs settled on the following guiding principles to manage these complexities in a practical way:

- Technology changes should impact down-stream recipients (e.g., clinicians, patients) as little as possible.
- Technology changes should leverage the investments of founding members as much as possible.
- New solutions should be developed or purchased only when the existing investments made by the member organizations are insufficient to meet the goals.

This approach has lead the team initially to scope optimizations of the record-sharing and event-notification capabilities of Care Everywhere from Epic, which is the predominant, but not exclusive, EHR vendor in the metropolitan area. For parts of the CMMI grant work, the team is exploring population analysis, case management, and event-notification capabilities installed by Care Oregon, an insurer and founding member of Health Share, focusing on emergency room visits and hospital admissions and discharges. For the longer term, the IT oversight team is evaluating health information exchange (HIE) gateways and data warehouse services.

Conclusion: The Oregon Experiment will likely be watched for years to come

Although the Oregon Experiment is sweeping and ambitious, it remains only a portion of healthcare in the state and therefore is unlikely, by itself, to create a team-based care revolution across organizational boundaries.

It's logistically difficult for doctors, nurses and health IT teams to sustain different models of care for different patient populations. Health Share of Oregon is a melded model of cooperation in the treatment of Medicaid patients among healthcare organizations that vigorously compete to treat other populations with more lucrative fee-for-service payment contracts. However, the Oregon Health Authority controls contracting with providers to care for a large pool of public employees in addition to Medicare, and this ultimately may give the state more leverage in seeking systematic reform.[12] With Intel leading the way, large private employers also are showing interest in coordinated models of care.

Ultimately, the question is whether—or perhaps how soon—the balance shifts far enough away from standard fee-for-service models so that a critical mass of the state's population is covered in newer, team-based care models. The hope is that if good results are achieved through Medicaid-initiated activities such as a standardization of hospital discharge process, the improved workflows will be used for all patients in the community.

Much in keeping with its history of pioneers on the Oregon Trail, the Medicaid experiment is driving Oregon into unchartered territory. In a country with healthcare costs that are generally double what other industrialized countries pay—and one that wastes an estimated USD 750 billion dollars on healthcare each year according to the Institute of Medicine[13]—this type of experimentation is critical. Whether the Oregon Experiment succeeds, fails, or winds up with mixed results, it will carry important lessons for the rest of the country.

For More Information

Third-Party

- Oregon CCOs: www.oregon.gov/oha/OHPB/pages/health-reform/news/index.aspx
- Health Share of Oregon: www.healthshareoregon.org
- Grant initiatives: www.healthcommonsgrant.org

Intel

- Top IT Considerations for Coordinated Care
- Global Imperative to Redesign the Nucleus of Care
- Employer-Led Innovation for Healthcare Delivery and Payment Reform
- Accountable Care Organizations and Beyond: IT Strategies for 21st Century Healthcare
- Reducing Readmissions at Presbyterian Healthcare Services

For more information on Intel Care Coordination in Healthcare, visit **www.intel.com/healthcare/coordination**

[1] Stecker, Eric C., M.D., M.P.H, "The Oregon ACO Experiment — Bold Design, Challenging Execution." N Engl J Med 368 (2013) 982-985. www.nejm.org/doi/full/10.1056/NEJMp1214141?query=TOC

[2] The Henry J. Kaiser Family Foundation, "Five Key Questions ABout Medicaid and its Role in Sate/Federal Budgets and Health Reform." (2012). www.kff.org/medicaid/upload/8139-03.pdf

[3] Holahan, J. et al. National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid. Analysis completed by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, October 2012. www.kff.org/medicaid/8185.cfm.

[4] The Henry J. Kaiser Family Foundation, "Five Key Questions ABout Medicaid and its Role in Sate/Federal Budgets and Health Reform." (2012). www.kff.org/medicaid/upload/8139-03.pdf

[5] Kliff, Sarah. "Can Oregon Save American Health Care?" The Washington Post, (2013). www.washingtonpost.com/blogs/wonkblog/wp/2013/01/18/can-oregon-save-american-health-care/

[6] Intel Podcast with Dr. Bruce Goldberg. "Inside Oregon's Coordinated Care Model." (2012). http://communities.intel.com/community/healthcare/blog/2012/10/15/podcast-inside-oregon-s-health-it-coordinated-care-model

[7] Oregon Health Authority, "Coordinated Care Organizations – Next Steps." (2012). www.oregon.gov/oha/OHPB/meetings/2012/2012-0710-cco.pdf

[8] Oregon Health Authority, "Fact Sheet: Coordinated Care Organizations."(2013). www.oregon.gov/oha/OHPB/docs/cco-factsheet.pdf

[9] Health Share of Oregon, "Health Share of Oregon is Collaborative's New Name." (2012). www.healthshareoregon.org/health-share-of-oregon-is-collaboratives-new-name

[10] Health Commons Grant. www.healthcommonsgrant.org/intervention/hospital-to-home

[11] Health Commons Grant. www.healthcommonsgrant.org/intervention/ed-navigator

[12] Stecker, Eric C., M.D., M.P.H, "The Oregon ACO Experiment — Bold Design, Challenging Execution." N Engl J Med 368 (2013) 982-985. www.nejm.org/doi/full/10.1056/NEJMp1214141?query=TOC

[13] Institute of Medicine of the National Academies. "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America." (2012). www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx

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