Case Studies of Accountable Care Systems

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Health Share of Oregon: A Community-Oriented Approach to Accountable Care for Medicaid Beneficiaries

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Abstract Health Share of Oregon is a nonprofit founded in 2012 to coordinate the provision of medical, dental, and behavioral health care for Medicaid beneficiaries in a tricounty region encompassing Portland. As one of 16 coordinated care organizations designated by the state to oversee and improve the delivery of these services for a geographically defined population, it receives a global budget. It distributes per-capita payments to health plans—some of which are integrated delivery systems—and county-run mental health agencies that have agreed to accept risk for providing or ensuring access to defined services. These risk-bearing entities—all founders of Health Share—serve on its governing board, along with representatives of community-based organizations and social service agencies committed to this population. Health Share brings these stakeholders together to improve care for high-need, high-cost patients; achieve efficiencies by centralizing certain administrative and enrollment functions; and create accountability for performance.

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A Note on This Series

This case study series, which follows up on previous Commonwealth Fund research examining the attributes of high-performing organized delivery systems,[1] describes how three diverse organizations are creating accountable care systems. It focuses on how each organization is building on experience to develop a system for population health management.

IMPETUS FOR ACO FORMATION AND DEVELOPMENT

In 2012, the Centers for Medicare and Medicaid Services (CMS) agreed to provide Oregon $1.9 billion over five years to avert a budget shortfall in its Medicaid program, with the stipulation that the state reduce the rate of growth in per-capita Medicaid spending by 2 percent by the second year.[2] To achieve this goal, Oregon implemented a Medicaid reform plan envisioned by its governor, John Kitzhaber,[3] that required any health plan or provider participating in the Medicaid program to join or form a regional coordinated care organization (CCO) that would be responsible for meeting state-designated quality improvement and cost containment goals.

Health Share of Oregon, the largest of 16 CCOs that formed across the state, was founded by four competing health plans, three county-run mental health agencies, and several health care provider organizations in the greater Portland area (Exhibit 1). The participating health plans and mental health agencies are designated risk-accepting entities (RAEs), which take financial responsibility for providing defined benefits to Medicaid beneficiaries. The health plan CareOregon, the subject of a previous Commonwealth Fund case study,[4] is one of these RAEs. The Portland area also is served by a competing CCO known as FamilyCare.

To meet the strict financial and quality targets set by the state, Health Share has instituted a wide range of initiatives to help member organizations improve the quality and coordination of care for high-need, high-cost patients. These efforts focus on improving care transitions, increasing care management, and addressing the socioeconomic barriers to health, including homelessness. This work is supported by a $3.4 million state transformation grant to redesign care in accordance with local priorities and a $17.3 million Health Commons grant from the Center for Medicare and Medicaid Innovation.[5]

Exhibit 1. At-A-Glance: Health Share of Oregon Coordinated Care Organization

Entity type	Nonprofit coordinated care organization that brings community partners together to improve health outcomes and reduce costs for a geographically defined population of Medicaid beneficiaries
Service area	Three counties (Clackamas, Multnomah, and Washington) encompassing greater Portland, the state's largest metropolitan area
ACO program	Medicaid accountable care organization
ACO partners	Seven risk-accepting entities (RAEs) that take financial responsibility for providing defined medical or behavioral health services, nine dental health plans, and several community-based organizations and social service agencies. Four RAEs focus on physical health care; three of these–Kaiser Permanente, Providence Health and Services, and Tuality Healthcare–are integrated delivery systems with affiliated health plans. The fourth, CareOregon, is a network model health plan founded by safety-net providers, which include federally qualified health centers, urban hospital systems, and an academic medical center. Three RAEs are county mental health agencies that focus on behavioral health care.
Patients served	Approximately 227,000 Medicaid beneficiaries were enrolled in Health Share as of June 2014. For physical health care, approximately two-thirds are served by the CareOregon RAE, while the remaining third are served by the other three RAEs.
Providers	Health Share's combined network includes 17,000 providers of all types, including nearly all hospitals in the tricounty region (excluding the VA and Shriner Hospital for Children)
EHR systems	Health Share is promoting links between providers' electronic health record (EHR) systems and has created a care coordination registry to aid those working with its members who have exceptional needs
Financial arrangement	Health Share receives a global per-capita budget from the Oregon Health Authority (the state's Medicaid agency), which it apportions to its RAEs. These, in turn, pay contracted providers on a capitated or fee-for-service basis. The state withholds 2 percent of the CCO's overall capitation budget, contingent on the CCO and its RAEs meeting cost and quality targets. Health Share retains 2 percent of its global budget to cover administrative expenses and reserves. Future increases in per-capita payments to the CCO (and its RAEs) will be reduced by 1 percentage point in the first year and a cumulative 2 percentage points the second year.
Governance	The CCO's governing board includes representatives of the entities bearing financial risk, which have authority to make decisions about payment. By state mandate, the board also includes representatives of safety-net hospitals, dental clinics, and substance abuse treatment centers, as well as other stakeholders with expertise treating Medicaid beneficiaries.

BUILDING A SYSTEM FOR POPULATION HEALTH MANAGEMENT

Care redesign. Because many of Health Share's provider organizations and payers had previously invested in the infrastructure needed to establish patient-centered medical homes (PCMHs), more than 90 percent of Health Share members are cared for in a state-certified PCMH. Health Share is now working to develop an advanced primary care model for patients with complex medical, behavioral, and social needs, using an approach similar to one used by Legacy Medical Group, part of an urban health system that contracts with CareOregon. This approach relies on nurse case managers, pharmacists, and social workers to support primary care physicians in medical homes that care for a large number of high-needs patients. Early data from Legacy show that this intensification of care reduced use of the hospital: admissions declined from 6.5 percent to 5.7 percent of patients in one year, while emergency department (ED) visits declined from 12.6 percent to 11.6 percent of patients.

Because mental health problems are common among Health Share members, the CCO is also working to identify and spread best practices for addressing these needs. Part of this involves helping the three county-based mental health agencies integrate their efforts through colocation of services and improved care transitions between inpatient psychiatric units and community mental health programs. For the latter, Health Share established an intensive transition team, funded by the Health Commons grant, which provides short-term intensive case management and mental health services to individuals who have had a psychiatric hospital admission. The team deploys mobile crisis support specialists who can meet patients at the hospital and then follow them throughout their transition to outpatient care. Local mental health crisis programs in each county help connect these patients to community-based services and supports.

> *"To produce transformation, health systems have to make an intentional decision to shift resources into primary care and have conversations about standardizing discharge programs, as well as care plans and protocols. That is where you're going to see the greatest payoff."*
>
> Janet L. Meyer, CEO,
> Health Share of Oregon

The three county mental health agencies also are working to increase efficiency by standardizing administrative processes, which has the added benefit of improving Health Share's ability to monitor performance across its network as all three providers define and measure services in the same way. The administrative simplification has led to a reduction in the number of ways that services are authorized from several hundred to a few dozen, as well as agreement on standards for the length and intensity of services and the creation of a single contracting mechanism for residential treatment services. Discussions are under way to create and fund specialized high-cost substance abuse treatment services on a regional basis, which would be difficult for individual RAEs to sustain alone given the small numbers of patients who will benefit.

Care management of patients with complex, costly needs. Health Share is using funds from the Health Commons grant to wrap additional care management services around those already provided by its RAEs, with a focus on improving care transitions, increasing patient activation, and ensuring appropriate and cost-effective use of health care resources. One such program assigns "health resilience specialists" to engage and mentor patients who have had six or more ED visits or one nonobstetric hospital admission in a year. Home and community visits are common, allowing the health resilience specialists to observe firsthand the challenges patients face, including lack of transportation, safe housing, and refrigeration to store medications.

The Health Commons grant also funds several other interventions aimed at improving care and reducing costs for high-risk Medicaid beneficiaries (Exhibit 2). Evaluation is integral to the grant program, allowing rapid learning as findings reveal ways in which the interventions can be recalibrated to achieve aims. For example, an evaluation of the ED Guides program, which places nontraditional health care workers in emergency departments to help patients with nonacute needs find the most appropriate place to get care, found the intervention reduced costs only among a subgroup of newly enrolled individuals and those with four or more ED visits in the past year.[6] This discovery led the project team to refine the target population to increase the program's effectiveness.[7]

Patient and family engagement and activation. Policy leaders in Oregon believe consumers play a critical role in improving health outcomes and redesigning the health care system around their needs. As such, the CCO program requires the establishment of a community advisory council, with consumers making up half of the membership. The council is tasked with performing a community health assessment and health improvement plan. In addition, one of Health Share's largest RAEs uses outreach workers to support patients in navigating the health care system, improving their health literacy, and advocating for their needs and treatment preferences.

Integrated data and analytics. Health Share is working to build an integrated data system that will enable hospitals—the majority of which use the same electronic health record (EHR) system—to share information with clinics and outreach workers serving the same population of patients. Health Share also plans to leverage the state's investment in health information exchange and quality reporting systems to identify patients in need of care management and enable better care coordination. The CCO also has created a performance dashboard to help providers track their individual and joint progress in meeting performance targets set by the state to improve quality for Medicaid beneficiaries.[8]

Supportive payment models and financial incentives. The Oregon Health Authority—the state's Medicaid agency—pays CCOs a fixed amount per Medicaid member. The state is reducing the rate of increase in these per-capita payments by 1 percentage point in the first year and a cumulative 2 percentage points the second year. Health Share apportions per-capita payments to its RAEs after retaining 2 percent to cover administrative expenses and reserves. RAEs have the flexibility to use per-capita payments for care redesign activities in partnership with their contracted providers, which are paid on a capitated or fee-for-service basis. The RAEs also have the opportunity to earn performance incentives worth up to 2 percent of their capitation payments, contingent on the CCO meeting performance targets on 17 metrics collected by the Oregon Health Authority.

The state's payment model also provides flexibility for CCOs to use their funding to address nonmedical needs that impact health, like housing. For instance, funds could be used to buy an air conditioner for a homebound patient to help prevent exacerbations of chronic conditions leading to hospitalization. Health Share is working with community-based organizations and social services agencies to use these resources in an effective and prudent way, given the limited pool of funding.

Exhibit 2. Health Share Interventions Supported by the Health Commons Grant

1. **ED Guides:** A program that places nontraditional health care workers in emergency departments to help patients with nonacute needs find the most appropriate place to get care.
2. **Standard Transitions:** A program focused on building standard discharge summaries into electronic health record systems of hospitals affiliated with the CCO and creating standardized workflows to ensure that the primary care and inpatient care teams know exactly who is responsible for each step in the care process.
3. **C-Train:** A care transitions intervention that provides high-intensity support to high-use patients who are discharged from the hospital. This program helps patients transition from inpatient to outpatient care, provides pharmacist support to increase medication adherence, and links patients to resources to meet psychosocial needs.
4. **Intensive Transitions Teams:** A program that provides transitions support for patients who have had a psychiatric hospital admission. It relies on mobile crisis support specialists to meet patients at the hospital and then follow them throughout their transition to outpatient care.
5. **Interdisciplinary Community Care Teams (ICCTs):** Teams provide multidisciplinary support to high-use patients to help them build health literacy, address psychosocial needs, and overcome barriers to health. Within the ICCT program, there are four subprograms that have each hired outreach workers with specialized skill sets to meet the needs of the unique populations served.
    a. **Health Resilience Program:** A program run centrally by CareOregon that embeds 16 health resilience specialists in primary care clinics across the community. Two are embedded in specialty clinics that serve patients with complex pulmonary and liver conditions. One is paired with a physician assistant in a community setting.
    b. **Central City Concern Health Improvement Project:** This program employs five outreach workers, including a recovery specialist, a registered nurse, and a mental health professional who are embedded in a primary care clinic and serve patients experiencing homelessness.
    c. **New Directions:** This program employs three social workers embedded in a hospital emergency department (ED) who work with frequent ED utilizers with mental health challenges.
    d. **Tri-County 911 Service Coordination Program:** This program employs four social workers who work in the three counties with frequent 911 callers.

Source: Adapted from Health Commons Grant Narrative Progress Report, June 30, 2014, http://www.healthcommonsgrant.org/wp-content/uploads/Grant-Update.pdf.

RESULTS

The Oregon Health Authority reported performance results for 2013, the first full year that CCOs were operating statewide. Health Share earned 100 percent of its performance incentive pool for meeting benchmark or improvement targets set by the state on 12 of 16 measures, such as an 18 percent reduction in ED visits, and for enrolling more than 80 percent of its members in primary care medical homes (see Appendix).[9] Through initiatives funded by its Health Commons grant, Health Share seeks to produce savings of $32.5 million through a reduction in avoidable hospitalizations of 17 percent and emergency department use of 20 percent for the target high-use population of 19,000 patients in the first three years. These estimated savings were based partly on early results of pilot programs.

LESSONS LEARNED

Enabling factors. Oregon is unique among U.S. states in terms of the sophistication of its Medicaid agency and its willingness to experiment with managed care techniques that are fundamental to the design of CCOs.

Challenges and insights. While Health Share enjoys both state and federal support, its ultimate success depends on the willingness and capacity of its stakeholders to invest in new approaches to care. The Medicaid financial crisis that led to the creation of Health Share and other CCOs offered a powerful incentive for provider organizations to cooperate to avoid disrupting the flow of Medicaid payments that help cover their fixed costs. With a bailout from the federal government, that sense of urgency lessened, reducing the momentum for immediate change.

Like other CCOs in the state, Health Share faces the challenge of accommodating a large number of newly enrolled Medicaid beneficiaries who joined the program when the state expanded eligibility under the Affordable Care Act. The rapid influx of new members has strained the capacity of existing primary care sites, leading to a spike in ED visits in the Portland area and elsewhere in the state.[10]

Although the three mental health RAEs have made progress in integrating behavioral health services across the three counties, there has not yet been meaningful integration among physical and mental health RAEs. A related challenge is the desire of staff in competing physical health RAEs to retain autonomy in executing programs designed to achieve shared cost and quality goals. To help address this, Health Share established a chief medical officer workgroup to encourage collaboration and increase accountability for joint approaches to clinical transformation and has more recently created joint operating committees for its physical, behavioral health, and dental partners.

Health Share also must find a way to ensure that the administrative costs of its efforts to centralize processes and procedures yield benefits that are greater than its member organizations could realize from alternative use of the funds. Determining the best use of funds and the strategic focus for the organization has not been easy given the diversity of opinion regarding the strongest levers for achieving transformation, according to the organizations' leaders. Some believe the greatest benefit will come from engaging hospital systems, which control the means of health care production, while others see opportunity in engaging community organizations and social service agencies that can influence the socioeconomic determinants of health.

Next steps. Health Share leaders say fostering greater transparency of quality and cost data will be one of the organization's next steps. It also must find ways of sustaining care management programs now supported by grant funding, by demonstrating that the programs are worth direct investment by RAEs as a mechanism for reducing hospital use and costs.

Health Share also will continue to encourage provider organizations to assume risk as a means of accelerating practice transformation. This may mean some safety-net hospital systems that now contract with CareOregon will become separate risk-bearing entities—a shift that may be accelerated as commercial payers seek to enter risk-sharing agreements with these providers. Although it will likely continue to serve as a RAE for safety-net clinics, CareOregon is supportive of this change in its network as part of its transition toward a company that offers management services for health system improvement.

Notes

[1] D. McCarthy and K. Mueller, *Organizing for Higher Performance: Case Studies of Organized Delivery Systems* (New York: The Commonwealth Fund, July 2009); and D. McCarthy and S. Klein, *The Triple Aim Journey: Improving Population Health and Patients' Experience of Care, While Reducing Costs* (New York: The Commonwealth Fund, July 2010).

[2] The financing arrangement was made through a modification of the state's existing Section 1115 waiver for the Oregon Health Plan. See: E. C. Stecker, "The Oregon ACO Experiment—Bold Design, Challenging Execution," *New England Journal of Medicine,* March 14, 2013 368(11):982–85.

[3] K. Foden-Vencil, "Oregon's $2 Billion Medicaid Bet," *Kaiser Health News*, May 30, 2012; and S. Abramsky, "John Kitzhaber's Oregon Dream," *The Nation*, May 21, 2013.

[4] S. Klein and D. McCarthy, *CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner* (New York: The Commonwealth Fund, July 2010).

[5] The Health Commons project is supported by Grant Number 1C1CMS330985 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

[6] Providence Health and Services, CORE (Center for Outcomes Research and Education), *Providence ED Guide Program: Analysis of Program Impacts and Sustainability* (Portland, Ore.: Providence Health & Services, March 21, 2014), http://www.healthcommonsgrant.org/wp-content/uploads/2014-3-21-ED-Guide-Report-FINAL.pdf.

[7] Health Share of Oregon, Health Commons Grant, *Narrative Progress Report for the Reporting Period Ending June 30, 2014,* http://www.healthcommonsgrant.org/wp-content/uploads/Grant-Update.pdf.

[8] *Health Share of Oregon 1.0—Building the Foundation,* http://www.healthcommonsgrant.org/wp-content/uploads/Health-Share-Building-the-Foundation-2014-2.pdf.

[9] Oregon Health Authority, Office of Health Analytics, *Coordinated Care Organization Performance Measures 2013 Final Report, June 24, 2014,* http://www.oregon.gov/oha/Metrics/Documents/cco-healthshare-2014-06.pdf; and Oregon Health Authority, *Oregon's Health System Transformation 2013 Performance Report,* June 24, 2014, http://www.oregon.gov/oha/Metrics/Documents/2013%20Performance%20Report.pdf.

[10] D. Thompson, "Oregon's CCOs Get a Flood of New Enrollees: Can They Handle It?" *Portland Business Journal*, Jan. 16, 2014.

Appendix. Oregon Coordinated Care Organization Performance Results

	Statewide			Health Share			Benchmark
PERCENTAGE MEASURES (higher is better unless indicated)	2011	2013	Change	2011	2013	Change	
Access to care	83.0	84.3	1.6%	83.0	80.2	–3.4%	87.0
Adolescent well care	27.1	29.2	7.7%	31.2	33.5	7.4%	53.2
SBIRT for alcohol or other substance misuse	0.0	2.0		0.0	1.0		13.0
Appropriate testing for children with pharyngitis	73.7	72.8	–1.2%	72.1	73.8	2.4%	76.0
Cervical cancer screening	56.1	53.3	–5.0%	56.9	55.3	–2.8%	74.0
Childhood immunization status	66.0	65.3	–1.1%	68.0	69.4	2.1%	82.0
Chlamydia screening in women ages 16–24	59.9	54.4	–9.2%	65.8	62.3	–5.3%	63.0
Comprehensive diabetes care: HbA1c testing	78.5	79.3	1.0%	80.3	80.7	0.5%	86.0
Comprehensive diabetes care: LDL-C screening	67.2	70.1	4.3%	68.2	72.0	5.6%	80.0
Developmental screening in the first 36 months of life	20.9	33.1	58.4%	19.3	33.9	75.6%	50.0
Early elective delivery (lower is better)	10.1	2.6	–74.3%	11.8	3.5	–70.3%	5.0
Electronic health record (EHR) adoption	28.0	59.0	110.7%	32.3	59.2	83.3%	49.2
Follow-up after hospitalization for mental illness	65.2	67.6	3.7%	65.6	69.1	5.3%	68.0
Follow-up care for children prescribed ADHD medication (initiation phase)	52.2	53.3	2.1%	55.8	58.7	5.2%	51.0
Immunization for adolescents	49.2	52.9	7.5%	57.2	59.9	4.7%	70.8
Medical assistance with smoking and tobacco use cessation: advice to quit	50.0	55.0	10.0%	58.0	58.1	0.2%	84.4
Medical assistance with smoking and tobacco use cessation: medication recommendation	24.0	28.9	20.4%	28.0	41.9	49.6%	50.7
Medical assistance with smoking and tobacco use cessation: strategies to quit	22.0	23.6	7.3%	27.0	30.1	11.5%	56.6
Mental and physical health assessment within 60 days for children in DHS custody	53.6	63.5	18.5%	51.4	60.9	18.5%	90.0
Patient-centered primary care home enrollment**	51.8	78.6	51.7%	50.3	81.2	61.4%	100.0
Timeliness of prenatal care	65.3	67.3	3.1%	67.5	68.5	1.5%	69.4
Satisfaction with care (CAHPS)	78.0	84.0	7.7%	80.0	79.5	–0.6%	84.0
Well-child visits in the first 15 months of life	68.3	60.9	–10.8%	70.5	61.3	–13.0%	77.3
RATE MEASURES (lower is better unless indicated)							
All-cause readmission (per 1,000 member months)	12.3	11.7	–4.9%	14.2	13.4	–5.6%	10.5
Emergency department use (per 1,000 member months)	61.0	50.5	–17.2%	64.6	52.8	–18.3%	44.4
Outpatient use (per 1,000 member months; higher is better)	364.2	323.5	–11.2%	363.0	337.4	–7.1%	439.0
Colorectal cancer screening (per 1,000 member months; higher is better)	10.7	11.4	6.5%	12.5	14.0	12.0%	12.9
Diabetes short-term complications in adults admission rate (per 100,000 member years)	192.9	211.5	9.6%	185.1	183.8	–0.7%	173.6
COPD or asthma in older adults (age 40+) admission rate (per 100,000 member years)	454.6	308.1	–32.2%	522.0	415.9	–20.3%	409.1
Asthma admission rate among adults ages 18–39 (per 100,000 member years)	53.4	43.6	–18.4%	75.8	57.3	–24.4%	48.1
Congestive heart failure admission rate among adults (per 100,000 member years)	336.9	247.0	–26.7%	457.8	411.4	–10.1%	303.2

Notes: Bolded measures represent performance incentive pool measures; three additional measures (not shown) were tested in the first year (Health Share met all three testing measures). SBIRT = Screening, Brief Intervention and Referral to Treatment.
* For the patient-centered primary care home enrollment measure, plans have to achieve a rate of at least 60% to receive 100% of their incentive pool dollars.
Source: Oregon Health Authority, Oregon's Health System Transformation 2013 Performance Report, June 24, 2014, http://www.oregon.gov/oha/Metrics/Documents/2013%20Performance%20Report.pdf.

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The aim of Commonwealth Fund–sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.

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