Americans have experienced runaway increases in healthcare costs. While wages for American workers grew 16% from 1960 to 2010, national health expenditures during that half-century grew by 818%. This reality has left too many Americans – including too many Oregonians – without affordable health coverage. Additionally, as states and the federal government have sought to address this healthcare cost crisis, the traditional approach has been the “Three Cuts” path: cut people from care, cut provider rates and cut service levels.

**Oregon’s Coordinated Care Model**

- **Best practices to manage and coordinate care**
- **Paying for outcomes and health**
- **Transparency in price and quality**
- **Sustainable rate of growth**
- **Shared responsibility for health**
- **Measuring performance**

**BETTER HEALTH, BETTER CARE, LOWER COSTS**

Giving providers more flexibility

Flexible services are often illustrated by the example of an air conditioner for a patient with congestive heart failure. These nonmedical services result in better health for the patient at a lower cost. For example, if a senior was repeatedly hospitalized during the summer months due to extremely hot conditions, it would be much more affordable for her health plan to pay for a $200 air conditioner than for a $20,000 hospital stay.

| Hospital stay: $20,000 | Air conditioner: $200 |

Supporting and spreading innovation

Supporting innovative practices and spreading lessons learned advances transformation of the healthcare system. One pilot project in Oregon is testing the rapidly advancing mobile and cloud-based telemedicine solutions to address issues of access to specialty care, especially in rural areas. Lack of specialty care can result in extended wait times and primary care providers often push their professional limits managing dermatological issues. Using telemedicine, images of dermatologic problems can be quickly acquired and uploaded to a secure platform for dermatologists to make a diagnosis and develop treatment. While this project is starting in one clinic, it can be rapidly spread through the coordinated care organization (CCO) and beyond.

INNOVATION

Innovation is the key to health system transformation. Innovation can include:

- Flexible services and use of funds;
- A more flexible workforce, such as the use of community health workers, who can provide the right level of care at the right time;
- Focusing on primary care and managing chronic conditions;
- Supporting and spreading innovative projects;
- Reducing waste while improving health;
- Engaging patients and creating local accountability;
- Paying for performance and outcomes;
- Creating fiscal sustainability; and
- Using best practices and centers of excellence;

Pay for outcomes and health

Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. Innovative payment methods such as population and episode-based payments, and offering incentives for quality outcomes instead of volume-based fees support better care and lower costs.

Oregon’s CCOs receive incentive payments for the quality of care they provide through a “Quality Pool”. Of the 33 quality and access metrics, CCOs receive incentive payments from this pool for making targeted improvements or meeting benchmarks on 17 of these metrics. The leftover money from those that don’t receive 100% of their funds goes to a “challenge pool”, where the funds are available for CCOs that are high achieving in key metrics areas.

Sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model – and one that strengthens all other principles. Preventing a cost shift to employers, individuals and families, and reducing inappropriate use and costs through a fixed-rate-of-growth approach is the foundation to health care transformation.

Best practices to manage and coordinate care

The model is built on the use of evidence-based best practices to manage and coordinate care. This produces better care and improved outcomes, including a positive patient experience and lower costs.

Value-based benefit design creates incentives for consumers to use evidence-based services. These services are the most effective for cost and quality, so they cost less for consumers, their employers or purchasers, and health plans.

Shared Responsibility

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and consumers can share responsibility and decision making for care, while coming to joint agreements on how the individual wants to improve or maintain positive health behaviors.

Measuring performance

Measuring performance consistently across health systems improves opportunities, performance and accountability, while easing providers’ reporting burden. It may also help improve the quality of care in the health system as a whole.

Oregon’s CCOs are held accountable for 33 quality metrics, which are publicly available and updated regularly. By sharing this information, we can see where we started, where we are and where we need to go next.

Transparency

Clear information about the price of services, including information about the benefit design, is publicly available. Information available on plan performance including quality, patient experience and access is publicly posted and easy to access.
The takeaway is clear: Two years into health system transformation, the coordinated care model is working. CCOs are delivering on their goals of reducing waste, improving health outcomes, creating local accountability and flexibility, aligning financial incentives and creating long-term fiscal sustainability. Additionally:

- **Emergency room use is declining**, even when accounting for an expanded population of patients, thanks to the Affordable Care Act;
- **More than a million Oregonians are now enrolled in a coordinated care model health plan** – one in four Oregonians – when state employees covered through the Public Employees Benefit Board joined Medicaid recipients in coverage through this model;
- **Member-patients are entering a transformed health system** focused on seamless coordination and preventive care;
- **CCOs are continuing to reduce costs** and live within their global budgets; all 16 CCOs met or surpassed their benchmarks for Electronic Health Record adoption;
- **All 16 CCOs met developmental screening benchmarks**;
- **All 16 CCOs received at least 74% of quality pool payments**, with the majority – 11 of 16 – receiving the full 100% of payments;
- **For 2015, two performance measures have been dropped, and three new measures have been added**; measures that are more clearly outcomes-based.

By putting the patient first and center; focusing on health outcomes; requiring and rewarding performance measures and transparency; and giving local Oregonians both flexibility and responsibility, CCOs are making significant progress in meeting their shared mission of better health and better care for all Oregonians.

At the heart of this transformation is Oregon’s new business model for health care, which prioritizes preventive care and reduces costly hospital admissions and emergency room visits. With set standards for improved health services and reduced waste and inefficiency, Oregon is on a path to save billions while improving health over the next decade.

Thanks to our coordinated care model and other reforms established over the last three years, Oregon is now on track to have a structural budget surplus in seven years. The result: Every dollar saved on unnecessary health expenses is a dollar that can be reinvested in children and families, education, creating good jobs and building statewide prosperity.