

Case Study: Medicaid and Public Health Collaboration in Oregon

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The Robert Wood Johnson Foundation awarded the Nemours Foundation a 1-year grant to explore and promote the use of existing Medicaid authority to support prevention. The initiatives described in the companion documents are intended to sustain approaches that link the clinic to community prevention efforts addressing chronic disease, including childhood obesity. This case study is part of a practical resource that will include two additional case studies, a roadmap and other tools for states, and a white paper. Together, these resources bring to light how states have successfully created sustainable financing through Medicaid and the Children's Health Insurance Program for preventing chronic diseases at both the individual and population levels. The toolkit can help states get started or continue their prevention efforts. These additional documents can be found at <http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention>.

Oregon is one of the leading states engaged in innovative health care delivery system reform that includes population health as a central component. Collaboration among key agencies and stakeholders is an important feature of Oregon's reform efforts, and it occurs at many levels. This case study will highlight the state's efforts to link the Medicaid delivery system and public health system to support prevention initiatives. Oregon's experience may be helpful to other states as they consider reforms under Medicaid to advance population health and other prevention strategies.

In Oregon, both the state Medicaid office and state Public Health Division are housed within the Oregon Health Authority (OHA). This agency encompasses all public health care purchasing programs along with health policy and public health. Under a single agency, Medicaid and public health have shared goals and many opportunities to collaborate as partners on a population health strategy designed to improve health outcomes for a geographically defined population. In the road map referenced above, we refer to this type of prevention strategy as population level 2 or PL-2. While other case studies have focused on how Oregon is aligning its health care and early learning systems (National Academy for State Health Policy, 2014a), this case study focuses on collaboration between Medicaid and public health in Oregon to improve health outcomes for a geographically defined population.

Overview of Oregon's Health System Transformation

Oregon's pathway to transformation began in 1989 with the creation of the Oregon Health Plan. In 1994, Oregon obtained approval from the Centers for Medicare and Medicaid Services (CMS) for their first section 1115 waiver, which established the prioritized list of services, the delivery of services through Medicaid managed care organizations, and the expansion of services to the working poor (CMS, 2016). The next step in Oregon's transformation, which was driven in part by a large shortfall in the Medicaid budget and also a desire to improve health outcomes, was the establishment of coordinated care organizations (CCOs) for its Medicaid population, approved through a section 1115 waiver in 2012. With the 2012 waiver amendment, Oregon sought to demonstrate the effectiveness of approaches to improving the delivery system for Oregon Medicaid beneficiaries by achieving the triple aim of "improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations through such improvements" (CMS, 2017).

Oregon's CCOs Are Focused on Addressing Specific Community Health Needs

The CCOs (similar to accountable care organizations as defined by CMS) are community-level entities that

finance health care and are governed through a partnership of providers, payers that assume risk for Medicaid enrollees, and community-based organizations. Each CCO is required to have a memorandum of understanding with its local public health authority and establish a community advisory council that brings together stakeholders to assess community needs (e.g., chronic diseases that are preventable through physical activity and nutrition) and develop plans to address those needs.

Currently, 16 CCOs provide services to more than 1 million Medicaid beneficiaries across the state. The CCOs' primary functions are to integrate and coordinate physical, behavioral, and oral health care; reward outcomes rather than volume in the payment system; align incentives across medical care and long-term care services and supports; and partner with community public health systems to improve health (OHA, 2012).

Oregon Created Incentives for CCOs to Address Social Determinants of Health

The CCOs are paid a flat amount—a “global budget”—based on a per member per month capitated amount that grows at a fixed rate to cover the physical, mental, and dental care needs of Medicaid patients in their region. The state withholds a specified percentage (e.g., 4 percent in 2016) of its CCO payments and places the funding in an incentive pool. The CCO's performance on specified metrics, such as developmental screening and enrolling patients in medical homes, developed by Oregon's Metrics and Scoring Committee, determines what the CCOs can earn back (National Academy for State Health Policy, 2014b). In 2016, the Metrics and Scoring Committee established a population health measure to reduce tobacco prevalence, and the committee is exploring additional population health measures for upcoming years. The CCOs are accountable for the outcomes of the populations they serve in their respective geographic regions, and there is a financial incentive to keep people healthy.

Models of Care That Connect the Clinical Experience to Community Social Services That Fully Address the Needs of Families

Oregon's coordinated care model encourages CCOs to focus on prevention, chronic illness management, and person-centered care (Oregon Health Policy Board, 2012). For example, the CCOs can use nontraditional

workers (e.g., community health workers) to better coordinate care by connecting Medicaid beneficiaries to such social services as the Supplemental Nutrition Assistance Program (SNAP), when appropriate (Milbank Memorial Fund, 2016). The CCOs also can provide certain nonmedical services (called “flexible” services in Oregon) such as housing supports to better meet the needs of their population. Through this flexibility, for example, CCOs are paying for air conditioners as a way to prevent unnecessary hospitalizations or emergency department (ED) visits. The coordinated care model has resulted in improvements in a number of areas such as reductions in ED visits and increased access to primary care for children and adolescents (OHA, 2015c).

Alternative Payment Methodologies Focus on Value Rather Than Volume

To improve the quality and efficiency in the delivery of services, the CCOs must demonstrate in their transformation plans how they are using alternative payment methods for health outcomes and quality measures. The CCOs have the flexibility to choose the type of alternative payment methods. The payment methods should support the following objectives:

- Reimburse providers on the basis of health outcomes and quality.
- Hold organizations and providers responsible for the efficient delivery of care.
- Reward good performance.
- Create incentives for the prevention, early identification, and early intervention of conditions that lead to chronic illnesses.
- Provide person-centered planning in the design and delivery of care and use of person-centered primary care homes.
- Incentivize coordination across provider type and levels of care (OHA, 2015c).

Oregon's CCOs Are Demonstrating Improvements in Quality of Care

The state's coordinated care model, including the financial incentives, appears to be having success in improving care for Medicaid enrollees. “Medicaid enrollment increased by approximately 400,000 individuals since the Affordable Care Act expansion took effect January 2014, bringing enrollment to approximately 1.1 million Oregonians.” This increase has changed the Oregon

Health Plan (OHP) population to include more adult members, with children ages 0–18 now representing 40 percent of the OHP population, in contrast to 60 percent in 2013. CCOs responded to the significant enrollment growth while also improving quality as indicated by the annual performance metrics (OHA, 2016, p. 4). Key findings from a June 2016 Oregon Health Authority report show significant improvements on several key health metrics including:

- The percentage of adult Medicaid beneficiaries who were readmitted to a hospital for any reason within 30 days has improved 33 percent since 2011.
- Adolescent well-care visits have increased 38 percent since 2011.
- Hospital admission for short-term complications from diabetes have decreased 29 percent since 2011 (OHA, 2015c).

Factors That Affect a Collaborative Approach

One of the conditions of success for significant transformation of a delivery system is collaboration between Medicaid and public health. The following section describes these “accelerators” that laid the groundwork for a strong collaboration in Oregon. Accelerators are specific state actions that drive a collaborative approach. Many of these accelerators are formal structures established by the state that ensure collaboration with continuous improvement and feedback.

Accelerators

Oregon Governor Championed Health Care Reform

Former Governor John Kitzhaber championed the state’s health care delivery system transformation. The legislature passed legislation in 2011, and implementation of the new delivery and payment system reforms began in 2012. He also convinced CMS in 2012 to make a \$1.9 billion investment in Oregon’s CCOs in exchange for a commitment to reduce the Medicaid cost trend from 5.4 percent to 3.4 percent with no reduction in benefits or eligibility and to meet rigorous quality and outcome measures. The former governor’s clear articulation of goals helped state agencies align their efforts and collaborate to accomplish these goals. One of his goals, for example, was “to transform Oregon’s Medicaid delivery system to focus on prevention, integration, and coordination of health care across the continuum

of care with the goal of improving outcomes and bending the cost curve” (Kitzhaber, 2012). Oregon’s current governor, Kate Brown, has continued to champion Oregon’s health system transformation.

Organizational Structure Facilitates Collaboration

Within the Oregon Health Authority (OHA), the clinical leads of the Public Health Division, Office of Health Policy and Analytics, Health Systems Division, and Office of Health Equity and Inclusion, as well as the Medicaid director, all sit on the OHA quality council, which reviews clinical quality metrics and initiatives and sets priorities and actions plans. In addition, OHA developed a clinical services improvement unit with cross-agency roles of the Medicaid medical director, oral health director, behavioral health director, and the quality improvement director. To further efforts to improve quality, an external committee, the CCO Quality Health Outcomes Committee (QHOC), which includes leadership from OHA and CCOs, meets monthly to discuss clinical and quality issues. QHOC membership is composed of CCO medical directors in physical health, behavioral health, oral health, and quality improvement coordinators. QHOC provides the medium for clinical leadership across organizations to bridge between Medicaid, public health, and health equity. The monthly meetings foster the sharing of best practices from the community and CCOs and further reinforce that the CCOs need to work with their community partners, including public health.

One specific example of an ongoing cross-agency team is the National Diabetes Prevention Program pilot demonstration with the National Association of Chronic Disease Directors. The goal of this partnership between CCOs, state-level public health, local public health, and community organizations is to develop the mechanisms for implementation, including Medicaid reimbursement for diabetes self-management programs. Other examples include the statewide approach to the opioid epidemic, the cross-agency work on early learning hubs and the Regional Social Determinants of Health Network.

CCO Contracts Require Collaboration with Community Stakeholders to Ensure Public Health Focus

Each CCO is required to establish a community advisory council to ensure that the health care needs of consumers and the community are being addressed.

The community advisory council must include representatives of the community and of each county government served by the CCO. One of the responsibilities of the community advisory council is to identify and advocate for preventive care practices to be used by the CCO. The council also must oversee a community health assessment and adopt a community health improvement plan. The Oregon Health Authority's Public Health Division and the Transformation Center provide support for the community health assessments and improvement plans. The Public Health Division makes population health data available for community health assessments and analyzes data at the CCO region level when possible through the state health indicators and Oregon Public Health Assessment Tool.

State-Funded Integrator and Innovator Agents Provide Linkages and Continuous Feedback

In 1997, Oregon voters passed ballot measure 44, a tobacco tax that in part funded and established the Tobacco Prevention and Education Program. At the beginning of the program, it funded a full-time equivalent employee who split time between public health and Medicaid to cultivate agency-to-agency relationships that aimed to help Oregon Health Plan members quit tobacco. This person identified ways Medicaid and public health could be working together more effectively. This person takes on the function of an integrator, someone who works intentionally and systematically across agencies or sectors to achieve improvements in health and well-being. The two agencies now have a strong working relationship and success in achieving results. They have leveraged positive results on tobacco control to continue to expand this collaboration to other performance improvement efforts that address asthma, breast and colorectal cancers, diabetes, high blood pressure, and increased access to evidence-based chronic disease self-management programs.

In addition, each CCO has an "innovator agent" assigned to them. Innovator agents are employees of the OHA. They help CCOs and OHA work together to achieve the goals of health system transformation. Innovator agents foster relationships between CCOs and local public health departments, and they help each CCO understand the innovative work going on at the other CCOs and how to implement new benefits.

Forum for Learning with Dedicated Resources that Encourage Collaboration and Help Spread and Scale Best Practices

Oregon has been quite intentional about fostering collaboration through its funding of the Sustainable Relationships for Community Health (SRCH) Institutes. The OHA Public Health Division uses public health funding to ensure that leadership from local public health authorities and CCOs work together to improve community health. The funding is targeted for local public health authorities to partner with their local CCO to align and delineate roles and responsibilities to improve health outcomes. They have created five SRCH Institutes or "learning collaboratives" where local members participate in facilitated discussions and receive technical assistance to learn about and adopt promising practices. Each SRCH Institute comprises a CCO, a public health agency, a community-based organization, and a clinic. They feature a series of three two-day meetings. The second round of SRCH Institutes launched in July 2016.

The SRCH Institutes help establish formal commitments, such as memorandum of understanding and data sharing agreements, "to reinforce collaboration and a long-term commitment to health system improvement and community-clinical linkages" (OHA, 2015b). The institutes have focused on addressing prevention, early detection, and self-management of chronic diseases such as tobacco, hypertension, diabetes, and colorectal cancer. At the conclusion of the SRCH Institutes, each of the five local groups cocreate a plan and agreements that enhance collaboration and promote linkages between the community and the clinic.

Data Sharing Agreement to Ensure Community and Clinic Partners Share Information Around Shared Goals

Some of the CCOs, local public health authorities, and community partners and clinics have established data sharing agreements and are using electronic health records to refer patients or consumers to evidence-based programs that help patients better manage their disease and take control of their health. CCOs are reimbursing for these programs, and community programs are electronically providing feedback to the clinic and CCO, closing the loop for care. In addition, in one region, there is a multisector approach to linking clinical needs related to the social determinants of health to the various community resources to address

these determinants with a goal of providing navigation, coordination, measurement, and evaluation of multiple strategies serving the same population.

Funding Collaborations on Local Health Priorities

Oregon also used a portion of its Federal State Innovation Model (SIM) award to fund four consortia of local public health authorities and CCOs to address a local health priority. These consortia addressed health topics including developmental screening, tobacco prevention and cessation, preconception health, and opioid overdose. Each consortium demonstrated health improvements in its focus area over the 3-year award period. In addition, each created a sustainable partnership and expanded the reach of these collaborations.

Designated Statewide Entity to Evaluate Evidence and Inform Decision Making Assures Best Interests of Beneficiaries

Oregon's unique approach to Medicaid benefits features a prioritized list of acute, primary, and specialist health services developed by the Health Evidence Review Commission (HERC). This list ranks "condition and treatment pairs by priority, from the most to least important" based on the clinical effectiveness and cost-effectiveness of the services (CMS, 2010). Based on state funds available, the Oregon state legislature determines the number of services on the list in numerical order that must be covered by Medicaid. All of the condition/treatment pairings above the cutoff line must be covered by CCOs. Oregon's CCOs may cover the condition/treatment pairings below the line, however, at their option. Recently, the HERC expanded the prioritized list to include "multisector interventions." Multisector interventions include evidence-based interventions that occur outside the clinic walls and typically do not have billing codes. For example, HERC recently provided a compilation of national recommendations (e.g., from the Institute of Medicine) on multisector approaches to community-based interventions to address obesity. Public health provides consultation and expertise upon request and can bring issues forward for HERC to consider.

Barriers

States can face many barriers that impede the development of a collaborative approach. Some of the following barriers are relevant in Oregon; other barriers are not an issue in Oregon but may present more of a challenge in other states.

Competing Priorities

One barrier is competing sets of priorities across agencies. In Oregon, Medicaid, public health, and the CCOs all understand the critical role of prevention in improving health and containing costs, but the health care system is often required to focus on immediate goals and needs ahead of prevention. The situation in Oregon is complicated by the incentive measures, which incentivize CCOs to focus on short-term goals. To address this barrier, states could include more of a balance between population health and clinical incentive metrics.

Current Medical Loss Ratio (MLR) Requirements Are a Barrier to Moving Outside the "Medicalized Silo" and Going Upstream

Addressing the social determinants of health requires venturing outside the medical setting and connecting to the social service system. This includes working with housing, transportation, schools, and other sectors. Oregon's "flexible services" covers some of these services such as housing supports and wellness. A barrier, however, is that these flexible services (health-related services) are required as part of Oregon's section 1115 waiver to be counted as administrative costs, which inflates the nonmedical (administrative) portion of the MLR. (The medical costs of the MLR must be at least 85 percent; the administrative costs are limited to 15 percent.) To address the MLR issue, Oregon obtained an amendment to its waiver from CMS. As of January 12, 2017, the waiver was clarified so that "health-related services that meet the requirements as specified at 45 C.F.R. 158.150 or 45 C.F.R. 158.151 will be included in the numerator of the medical loss ratio as required under 42 C.F.R. 438.8 and 42 C.F.R. 438.74" (CMS, 2017).

Unintended Consequences of Investment in Nonmedical Services

A related issue is that investment in cost-effective non-medical services can reduce use of state plan services on which the capitated rate is based. As a result, CCO rates may decline over time. This is known as "premium slide" (OHA, 2015a). To further incentivize CCOs to use nonmedical support services, Oregon has considered enhancing the rate-setting methods to prevent premium slide and compensate CCOs identified as high performing—that is, CCOs that show improved quality and reduced costs.

A Point Person is Needed to Keep Track of Cross-Agency Work

While collaboration is occurring across the Oregon Health Authority divisions, the ongoing connections are hard to keep track of without a point person. To address this barrier, states can create structures that facilitate collaboration, such as Oregon's clinical services improvement unit, which assigns dedicated point persons.

Establishing Relationships with New Agencies Can Be Challenging

Working across agencies will require forging new relationships. This can be challenging as the agencies may have different cultures, perspectives, and missions. Moreover, the state agencies may use different language, jargon, and acronyms, and they likely will have different funding and data sources. To address this barrier, states should take the time to gain an understanding of each agency's culture. Establishing a work group to identify overlapping goals and areas for collaboration also could be helpful.

Lessons Learned

A number of lessons can be drawn from Oregon's experience of prioritizing collaboration between Medicaid and public health in their health system transformation. The following is a set of strategies states should consider as they undergo efforts to reform their delivery systems.

State Officials Should Clearly Define Statewide Goals for Reform

Governors or other high-ranking officials should set statewide goals so all state employees have a shared understanding of what they are jointly working to accomplish. The leadership can send the message that they expect and will hold state agencies accountable for collaboration with one another to achieve these state goals. Developing shared goals or aligning goals is critical to improving collaboration across agencies. Working toward a shared goal on one issue can help build solid relationships for future joint efforts. After achieving success by working together on tobacco issues, the Oregon Medicaid and public health agencies have developed a strong working relationship that now extends to other efforts.

States Can Require Partnerships to Ensure Collaboration

Requiring collaboration through legislation or in contracts is one way to assure collaboration. As noted earlier, Oregon requires its CCOs to have a memorandum of understanding with the local public health authorities and establish a community advisory council. States also can set up cross-agency or cross-divisional committees (e.g., QHOC) to ensure that all voices are heard.

States Can Create or Identify and Fund Integrator Roles

An integrator is a person or entity that works intentionally and systematically across sectors (e.g., health, public health) to achieve improvements in health and well-being. Implementing population health strategies requires leaders who can forge partnerships between Medicaid and public health. It is essential to have an understanding of the various programmatic requirements, data challenges, and the big picture goals. Designating a staff person who performs some of the integrator roles can help ensure that concrete action occurs. Funding this position shows that the state truly values the collaboration. By colocating a staff person in two different agencies, it can help build trust and appreciation of different perspectives and responsibilities across agencies. Similarly, the innovator agents are an example of how innovation can be shared and spread around the state. Finally, the CCOs themselves play an integrator role by bringing together resources toward shared goals.

States Can Fund or Sponsor Learning Collaboratives

Learning collaboratives provide for an important exchange of information and can be a means to spread and scale best practices. States can provide funding for agencies or stakeholders to come together periodically to participate in facilitated discussions or obtain technical assistance on issues that might be hard to resolve on their own. The SRCH Institutes in Oregon, for example, helps the local CCO and Public Health Authority understand and learn from one another while also offering technical assistance on complex matters such as data sharing agreements.

States Can Play a Convening Function

A convening entity—one of the integrator roles—can provide the space for a diverse group of stakeholders to align goals, set priorities, and develop strategies and work plans, thus maximizing the ability to achieve success. States can convene broad groups of stakeholders, both public and private, to provide the opportunity for each group to define and clarify roles so expertise and responsibilities are not duplicated.

States Can Use an Evidence Base to Inform Decision Making

Using the evidence base to inform policy and decision making ensures that decisions are made in the best interests of beneficiaries. States can fund an entity—like HERC in Oregon—that uses evidence to inform policy decisions. Having a dedicated funding stream rather than a grant-funded program ensures that this function will be sustained over time.

States Can Break Down Silos and “Move Upstream”

According to Maggie Bennington-Davis of Health Share (one of Oregon’s CCOs), “The board of directors realized that it could identify and serve people forever, but it needed to go upstream to address the source of the problems. They devised strategic goals centered around practical approaches and opportunities for innovation.”

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