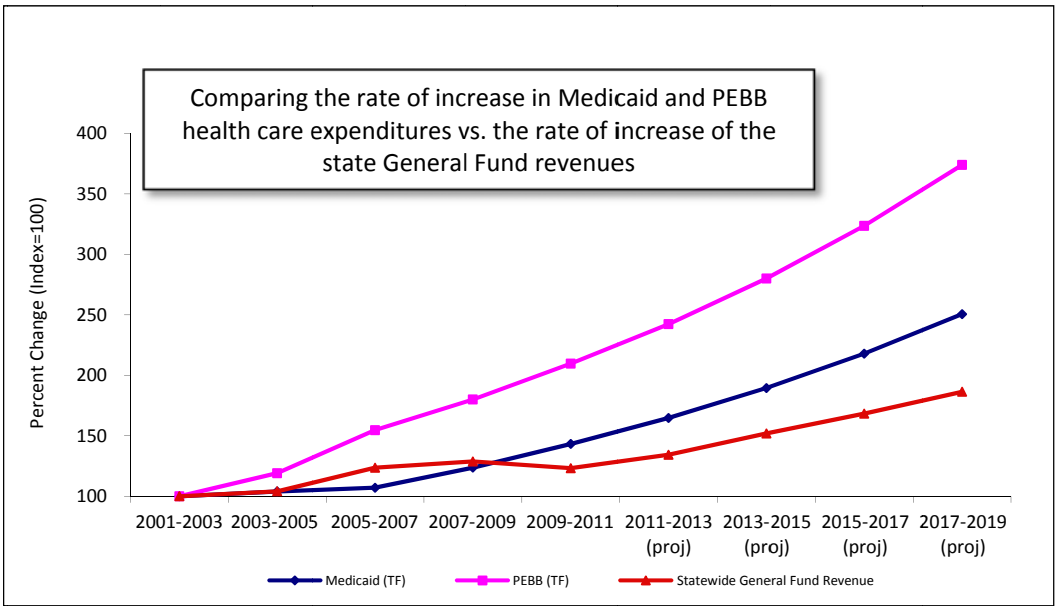
Health Share of Oregon

What is the reason for Coordinated Care Organizations (CCOs)?

The rationale for the development of Coordinated Care Organizations (CCOs) is to slow the rate of growth in Oregon health care expenditures. State General Fund revenues are expected to grow by 11 percent a biennium, meanwhile PEBB (Public Employees Benefit Board), which provides insurance for state employees and their dependents, is growing at a rate of 16 percent, and Oregon Medicaid is growing at 15% based on both programs' historical performance. These health care-related expenditures are increasing at a rate higher than state General Fund revenues, which is unsustainable.



If food had risen at the same rate as medical inflation since 1930:

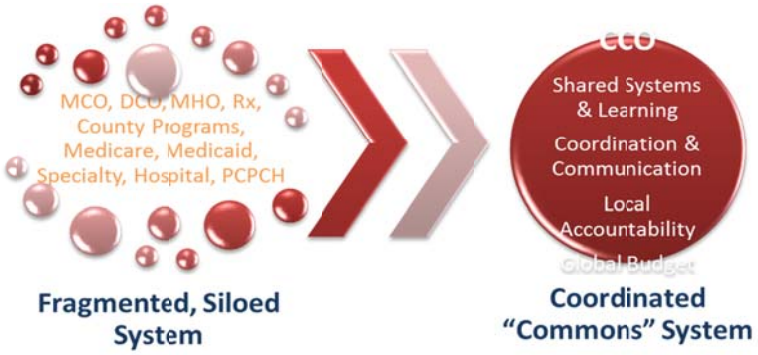
- 1 dozen eggs = $80.20
- 1 dozen oranges = $107.90
- 1 pound of bananas = $16.04
- 1 pound of coffee = $64.17

The traditional method for reducing health care costs has been to reduce how much the state pays through provider rate cuts, the number of people covered through changes in enrollment standards, and/or the benefits covered by moving the "line" on the prioritized list of services

The role of Coordinated Care Organizations is to instead provide an innovative, long-game method through changing the way the care is organized and delivered. In recognition of these reform efforts, the federal government provided Oregon with a federal investment of approximately $1.9 billion over five years. In exchange for this, Oregon has committed to meet key quality measurements for improved health for OHP clients while reducing the growth in spending by 2 percentage points per member by the end of the second year of the investment.

What are CCOs?

A CCO is a single organization that accepts responsibility for the cost of health care within a global budget and for delivery, management and quality of care delivered to the specific population of patients enrolled with the organization. CCOs have a global (single) budget that includes payment for mental health, physical health and, beginning in 2014, dental health services.



As the picture above illustrates, today, OHP members may have one plan for their doctor or nurse, another plan for their dentist, and if they have one, another plan for their counselor or therapist. That's confusing for the member and can lead to misunderstandings and mistakes in care. Under CCOs, a single organization will manage all care.

This system will make it easier for the member and their health care providers. It will be easier for providers to work together to avoid unnecessary tests or duplicate services. CCOs are also incented to focus on prevention and helping people better manage their chronic conditions. This helps reduce unnecessary emergency room visits or hospital admissions and gives people support to be healthy.

The benefit of a global budget system is that CCOs are accountable for the health outcomes of its members through the achievement of metrics. CCOs have a local, community-oriented vision with shared accountability and shared savings as well as the flexibility to pay for things that will keep people healthy and not just services needed once someone is already sick.

What is Health Share of Oregon?

Health Share of Oregon, formerly known as the Tri-County Medicaid Collaborative, is the largest CCO in Oregon, serving more than 165,000 members. Health Share is a community partnership that includes almost all Medicaid health plans, hospitals, county health departments and provider groups in the region. The member organizations include Adventist, CareOregon, Central City Concern, Kaiser, Legacy Health, OHSU, Providence, Tuality, and Clackamas, Multnomah and Washington counties.

Health Share was certified to operate as a CCO in Clackamas, Multnomah and Washington Counties and began serving Oregon Health Plan members in these counties on Sept. 1, 2012. In June 2012, Health Share received a $17.3 million Health Care Innovation Awards grant from the Centers for Medicare and Medicaid Services. This Health Commons Grant is designed to support innovative health care delivery and transformation efforts to improve population health in the tri-county region.

The broad scope of Health Share's participants and members provides an incredible opportunity to create a unified, regional system of care. The mission of Health Share is to develop an integrated health system that achieves better care, better health and lower costs for the Medicaid population and the tri-county community.

What is the Health Commons Grant?

The Health Commons Grant, an award of $17.3 million over three years from the CMS Innovation Center, is a springboard for Health Share of Oregon to create a regional system to better serve the Medicaid population in the Portland metro area. Through the implementation and/or expansion across the community of five complementary care model interventions, including the hiring and training of new community health outreach workers, we will achieve improved care coordination, develop enhanced systems for learning and collaboration, and create a sustainable system of care across our community.

Primary goals of the grant:

1. Implement key integrative care processes linking partner organizations and community resources for OHP enrollees
2. Implement targeted high-intensity, community-based programs that efficiently and effectively address the complex needs of high-acuity, high-utilizing patients
3. Create a learning system to promote continuous workforce development and quality improvement

The Health Commons Grant is a catalyst for the transformation plan being created by Health Share of Oregon. The grant-funded care model interventions serve as a foundation for additional transformation priorities that are collectively being developed by leaders from each of the Health Share partner organizations.

Why is Health Share different?

There are currently 13 CCOs operating in Oregon and, while each organization looks different, Health Share is unique. The other CCOs in Oregon are entities that merged two health plans into a single organization — a managed care organization (MCO) that previously managed the physical health benefit for Medicaid members and a mental health organization (MHO). Health Share has merged seven health plans — four MCOs and three MHOs, which makes it the largest CCO in the state, caring for approximately 40% of all Medicaid members.

Additionally, Health Share consists of all the major health systems in the community, which have and continue to be fierce competitors. Each member organization has a single representative on the Board of Directors, and while they are sitting on the board, they represent the interests of the community. There is also a Member Board that is made up of the founding members, which have financial risk in ensuring the success of the organization.

Another unique aspect is that there are two CCOs in the tri-county area (Multnomah, Clackamas and Washington), whereas there is only one CCO in every other region in the state. Family Care previously operated the fifth MCO in the region and had its own mental health organization. During the formation of Health Share, Family Care opted out and decided to form its own CCO. This means that Health Share and Family Care are the only two CCOs in the state that have to compete for members. Legacy is both a founding member of Health Share and one of its largest providers, but also we maintain a contractual provider relationship with the Family Care CCO. Legacy must maintain this contract so that we are not paid at a lower

rate since their members, due to our facility locations, would show up in our clinics and emergency departments regardless of contract relationships.

What are the major issues facing Health Share of Oregon?

The biggest strength of Health Share — the comprehensive community partnership of payers, providers and counties — is also its greatest challenge.

The first major issue relates to a variance in opinion on the amount of transformation needed particularly regarding risk transformation. As stated, Health Share is made up of four MCOs (CareOregon, Kaiser, Tuality and Providence). These managed care plans have, for the most part, made money off the Medicaid line of business and consequently would prefer for very little to change. These organizations would like Health Share to interfere as little as possible in their operations, which allows them the latitude to determine how to spend the capitated budget that they receive for each member. Meanwhile, the provider members of Health Share, including Legacy, OHSU and Adventist, receive very poor reimbursement and thus are most supportive of risk transformation. The providers would like to set a fixed percentage that the MCOs can retain for administrative services, which would ensure that the rest of the money is spent on care transformation initiatives and direct care expenses.

This ultimately boils down to a divergence in opinions over the mutualization of risk. The providers and counties that comprise Health Share ultimately believe that true transformation will only be achieved if there is shared risk and accountability for the entire membership. The purpose of transformation is to develop a new system that integrates care and not one that supports the continuation of the existing redundant administrative structures. Ultimately Health Share will have to decide if it is an "operating" organization or just a "convener/holding" company with seven separate entities operating underneath it — each with its own substantial infrastructure.

As with any collaborative, a significant challenge is to ensure that all the moving parts are working in a single direction. This second issue is essential, as Health Share must act cohesively in order to participate in a pay-for-performance program with the state. This pay-for-performance (P4P) program puts 2 percent of the global budget in a quality pool that will be distributed based on the performance of each CCO on 17 quality measures. The percent of the global budget assigned to the quality pool will gradually increase over time, continuing to reward CCOs for value and outcomes, rather than utilization of services. The pool will be distributed in two stages. In the first stage, the maximum amount of dollars that a CCO is eligible for will be allocated depending on performance on the 17 CCO incentive measures and benchmarks. In the second stage, remaining quality pool funds will be distributed to CCOs that meet benchmarks on four "challenge" measures — a subset of the incentive measures. Each CCO will be eligible for a maximum amount of quality pool funds based on its size, which will be determined by its aggregate member months. Due to Health Share's size, the amount that is at stake for Health Share is at least $14 million. As such, it is necessary for Health Share to perform as well as possible in meeting these measures. Due to its current structure as an umbrella organization, Health Share has very little control over the direct provision of services. As such, it is necessary for the member organizations within Health Share and the other providers within the networks to work collaboratively to identify and implement best practices that will allow for the strongest performance possible on these measures to ensure that Health Share earns back the amount withheld from the quality pool.

How will Health Share transform?

Health Share's transformation plan is focused on the following areas:

- Community health integration
- Delivery system transformation
- Accountability – including risk transformation
- Regional health information technology (HIT)

The goals of community health integration are to improve equity and population health by reducing health disparities and improving the life of all members of Health Share and the tri-county community. The second goal is focused on chronic disease prevention by ensuring that prevention-focused health care and community prevention efforts and services are available, integrated and mutually enforcing. Additionally, Health Share hopes to stimulate innovation and integration and engage and empower the community to impact health outcomes for OHP members in our region.

The initial focus of Health Share's Delivery System Transformation is to leverage the Health Commons grant through the five interventions funded by CMMI. Additionally, Health Share will identify additional opportunities for partner organizations. At this time, the provider partners within Health Share are focusing on meeting the pay-for-performance measures outlined above. Additionally, they will focus on developing specific initiatives and supports for the care management system, patient-centered primary care homes and maternal-child family health, as these are the primary areas related to the P4P program. Lastly, in order to affect the delivery system and achieve the aim of integration there is considerable work being done to integrate behavioral health with physical health, specifically around primary care and the acute care system.

The third major transformation area refers to accountability, and this diverse area encompasses reporting and informatics, risk transformation and administrative simplification. As efficiently as possible, Health Share must collect and accumulate data in order to effectively measure, analyze and report performance at multiple levels across the system to inform action and transformation. This will be especially important as Health Share works to monitor the P4P program and capitalize on opportunities to deal with the highest utilizing members in order to bend the cost curve. As mentioned, the idea of risk transformation is one of the most contentious albeit most important areas of transformation. The goal is to ultimately create a global risk system and alternate payment methodologies that will enable Health Share to reward the transition from volume to value in order to achieve the Triple Aim (what is triple aim? reporting and informatics, risk transformation and administrative simplification). And lastly, due to the complicated current structure that preserves seven separate health plans, it is important for Health Share to minimize duplication and cost of administrative services while improving performance and enhancing services to our members and providers.

Finally, as with nearly any initiative in health care, health information technology is a necessity to enable transformation. Each component of the transformation plan has technology requirements that must be developed and supported to enable long-term success.

What are the risks and opportunities of Health Share?

For the community, as a whole, Health Share is an exciting opportunity to envision how health care, and more importantly, community/population health, can be done differently. The rewards of this transformation can truly provide a long-term fix to the projected cost curve while simultaneously improving the health and outcomes of our population as well as increasing the satisfaction and engagement of those members being served. As such, the opportunity is substantial in both quantitative and qualitative terms. Conversely, the state as well as the Governor has a lot at stake due to the deal made with the federal government for the waiver and investment fund set-up to support the Coordinated Care Organizations. Further, while attention is focused on monitoring the performance of the entire state, acute attention is placed on Health Share due to its scale and unique organizational structure.

What is Legacy's role in Health Share?

Legacy Health has significant stake in Health Share as well. Legacy is one of the largest providers of Medicaid services both in the clinic, ED and inpatient settings. As such, Legacy stands to benefit tremendously if we are able to develop a system that better cares for these individuals and reduces cost and improves health.

Beginning with the role Legacy CEO George Brown, M.D., is playing as chair of the Health Share of Oregon Board, Legacy plays an active position in supporting the advancement of Health Share. As a member organization on Health Share's Board of Directors, Legacy was required to pay an upfront capital investment. Legacy has also devoted significant human resources to support Health Share — both in dedicated employees who worked at Health Share through the start-up of the organization as well as many other staff and clinicians who participate in workgroups focused on clinical models, care management redesign, finance and risk, IT, and governance.

Legacy believes in the purpose of Coordinated Care Organizations and specifically in the model and mission of Health Share to be an integrated community delivery system that achieves better care, better health, and lower costs for the Medicaid population and the tri-county community.