



---

## Coordinated Care Organizations (CCOs) in Oregon: How they Work and Future Opportunities

---

### Background on CCOs

In 2012, Oregon launched Coordinated Care Organizations (CCOs) through the state's [1115 Medicaid waiver](#) and an accompanying [state innovation model](#) (SIM) grant from the Center for Medicare and Medicaid Innovation. CCOs are community-governed organizations that deliver care to Medicaid and Oregon Health Plan (OHP) members through a coordinated care model of service delivery. CCOs are designed to address problems inherent in a fragmented health system. In particular, CCOs are responsible for physical, behavioral, and oral health care services for Medicaid members.

While similar to Medicaid managed care organizations ([MCOs](#)), the CCO model differs in several key ways:

- ★ CCOs work at the community level through [collaborative relationships](#) to provide care;
- ★ CCOs have a [global budget](#) to manage physical, mental, and dental health (in place of a set capitated rate for each type); and
- ★ CCOs have the [flexibility](#) to spend dollars on an array of health-related services.

In 2018, following the successful implementation of the CCO model, the Oregon Legislature worked with the Oregon Health Authority (OHA) and stakeholders to develop [CCO 2.0](#), which focused on [four](#) key areas of improvement: behavioral health and care integration, pay for performance, social determinants of health, and sustainable cost growth. Where CCO 1.0 allowed flexibility, CCO 2.0 is more rigorous and will hold CCOs more [accountable](#).

While the CCO model continues to [evolve](#), Oregon can boast that its CCO members experienced the [lowest cost and highest value services](#) compared to Commercial and Medicare insured members. These results suggest that the CCO model is a promising mechanism for improving the health of Oregonians.

---

## Cost Containment

Two primary benefits of the CCO model are its cost containment and effective use of state funds. A key feature of the CCO model is that it has a fixed annual cost growth rate of [3.4%](#), versus [6.4%](#) for non-CCOs. This low-cost growth requirement enables the state to more effectively budget for the CCO and ensures the CCOs are effectively managed.

The CCO fixed growth rate requirement is particularly important given the rapid [increase in health care costs](#) in Oregon. [Recent research](#) in Oregon has highlighted tremendous price disparities in provider rates. Commercially insured individuals pay more than double (247% of Medicare rates) what Medicare patients pay for outpatient services and nearly two times more (178% Medicare rates) for inpatient services. In contrast, CCOs are paid a [global capitated rate](#) that incentivizes them to ensure their members stay healthy, rather than a fee-for-service model. This [value-based payment model](#) encourages and holds providers more accountable for the health of the communities they serve. In addition, the global capitation model incentivizes providers to focus on preventive care and [curbing health expenditures](#).

---

## Health-Related Services (HRS) and Social Determinants of Health (SDOH)

Across the US, Medicaid programs are striving to improve health outcomes by leveraging funding to address social determinants of health (SDOH). In 2021, the Centers for Medicare and Medicaid Services sent a [letter](#) to state health officials encouraging these investments and clarifying the extent to which Medicaid funding can be used for addressing SDOH.

In 2018, the Oregon Legislature passed the [Supporting Health for All through Reinvestment \(SHARE\) initiative](#), which requires CCOs to spend a predetermined portion of their revenue on SDOH. The Oregon Health Authority (OHA) specifically directs CCOs to meet the SDOH needs of their communities through health-related services spending, also known as HRS. HRS are traditionally [non-covered](#) services under Oregon's Medicaid program. The CCO model allows for an expansion of the services Medicaid typically covers. HRS payments are intended to improve the quality of health care delivery and improve community health. To achieve these goals, HRS are divided into [two types](#): Flexible Services (supplementary services provided to an individual beyond standard OHP benefits) and Community Benefit Initiatives (supplementary services provided at a community level). In practice, that means that CCOs provide members with [HRS benefits](#) such as access to gym memberships, nutrition education, chronic care management, and housing services.

---

## Stakeholder Engagement and Community Involvement

There are several practices in place for coordinated care organizations to engage stakeholders.

CCOs are [required to submit](#) Community Health Plans (CHPs) and Community Health Assessments (CHAs) to various organizations in their communities to engage stakeholders and hold CCOs accountable. As part of this outreach, CCOs are required to share their [CHAs](#) with hospitals, tribes, public health agencies, other CCOs in their communities, and the Oregon health authority (OHA). In addition, each plan (CHP) must address a minimum of [two](#) of the state's health improvement plan priorities.

Another mechanism for communities to engage with and have oversight of CCOs operating in their communities is through [governance](#). Each CCO is advised by a Community Advisory Council (CAC) which is required to be at least 51% current or recent (within the past 6 months) Medicaid members. In addition to the guidance provided by the council (CAC), the Oregon statute requires that the governing body of each CCO reserve a minimum of [two seats](#) for members of the CAC as well as [two seats](#) for at-large community members. This helps ensure the needs of the community are addressed and that there is alignment and engagement between CCOs and their community partners.

---

## Leveraging CCOs During Oregon's Development of a Bridge Plan

Oregon's unique CCO model has been essential to increasing effective, community-oriented care to those who need it most in the state. Oregon has always been a pioneer in innovative health care policy, and they are continuing this trend with the 2022 passage of [HB 4035](#). That law creates a "Bridge Plan" to cover Oregonians just above the Medicaid eligibility threshold. This program will cover Oregonians with incomes between [138% and 200% of the Federal Poverty Level \(FPL\)](#), many of whom face affordability challenges that make them more likely to go without or "churn" between coverage options. This population faces an increased risk of losing coverage once Medicaid redeterminations begin again at the end of the federal Public Health Emergency (PHE).

[HB 4035](#) authorizes the creation of a [Bridge Plan task force](#), which is charged with developing a proposal for Bridge Plan implementation that meets certain statutory requirements, including that the Bridge Plan must be offered through existing Medicaid CCOs. As the task force develops its implementation plan, it will be important to consider how to best utilize the strength of CCOs. Currently, there are significant differences between the provider networks and benefits packages offered through Medicaid and on the Exchange. Designing a Bridge Plan

that leverages the existing CCO infrastructure allows the state to continue to leverage the strengths of this model while creating alignment between the Bridge Plan and Medicaid to ensure people can retain providers and benefits when they churn off Medicaid at the end of the PHE. These updates will also provide people with continuity in coverage so that Oregon residents have dependable health coverage that is there when they need it most.

In summary, the CCO model has succeeded in delivering cost-effective services, promoted comprehensive health investments, and garnered community engagement and support. There is an opportunity for more Oregonians to access these benefits through the development of the Bridge Plan.