



CASE STUDY

Mosaic Medical's Participation in the Central Oregon CCO and Three-Layer Payment Reform

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Mosaic Medical is a prominent example of a health center pursuing accountable care through the Central Oregon Coordinated Care Organization (CCO) and is one of the most advanced health center alternative payment models in the country. The Central Oregon CCO serves a largely rural population in the tri-county area of Deschutes, Crook, and Jefferson counties, which includes Bend, Oregon. In addition to the advanced nature of its payment reform model, the Central Oregon CCO community also has a unique governance structure that includes a wide array of community partnerships, including health centers like Mosaic, a major hospital system, a health plan, the community board, and others.

This case study will examine the origins of the CCO in Bend as well as the participation of the major community health center within its network, Mosaic Medical. We will examine the CCO's financial model and key components of its clinical care model. Finally, we will summarize the benefits and challenges Mosaic faces as a result of the collaboration and examine the implications of this model for other health centers seeking to pursue accountable care strategies.

Motivation for Organizational Innovation

In September 2012, the Oregon Health Authority established its first five Medicaid accountable care organizations (ACOs), called CCOs, as part of Senate Bill 1580, in a move that aimed to reduce state and federal Medicaid spending by \$11 billion over 10 years.¹ A CCO is a public-private organization that

Mosaic Medical Health Center

Locations: 13 sites and two mobile clinics

Patients served: over 19,000 in 12 months, over 23,000 in 18 months

Number of primary care providers: 32

Number of other providers (behavioral health, pharmacy, nutrition, substance abuse, psychiatric prescribers): 21

2017 Revenue: over \$30 million

contracts with the state, serves a geographically defined service area, and operates under a per-member-per-month (PMPM) global budget for behavioral, physical, and dental health care. CCOs aim to integrate care for the entire Medicaid population in a particular region.² In the Central Oregon CCO, the partners include the health plan, the single hospital system, the health center network, the County Health Department and other community-based organizations. The Central Oregon CCO, like other CCOs in the state, has significant freedom to decide how best to engage patients, manage care, improve outcomes and reduce costs in their home communities³ while being held accountable for quality outcomes, which include seventeen metrics spanning preventive care, system capacity, and patient satisfaction.⁴

CCOs are successors to the Medicaid managed care plans in Oregon, and are subject to Centers for Medicare and Medicaid Services (CMS) spending targets for the state Medicaid program. Oregon's 1115 waiver that established CCOs committed to reducing the Medicaid cost curve by two percentage points below the rate of projected global spending growth.⁵ The waiver also provided a \$1.9 billion investment to underwrite and catalyze the state transformation project.⁶ Supported by this significant federal investment, the state expanded the reform and moved 90% of its Medicaid beneficiaries into sixteen CCOs.⁷

Before its CCO was formed, the Central Oregon partners had already established a multi-county

regional planning effort, and local healthcare stakeholders had taxed themselves to fund a series of pilot projects exploring behavioral health integration and population health management.⁸ This body, the Central Oregon Health Council (COHC), formed the basis for the CCO partners to establish trust and foster strong working relationships. Mosaic, as the largest Medicaid primary care provider in the tri-county area, was involved from the beginning in the COHC, as was the Central Oregon Independent Practice Association (COIPA), which represented Mosaic, independent primary care providers, and specialty care providers.⁹ When the state issued a request for proposal for the CCOs, PacificSource (the county's nonprofit health plan) and other community partners began discussions about an appropriate governance structure. They decided that COHC could serve as the governing body and that a joint management agreement would define the responsibilities of the differing stakeholders.

“Mosaic has been at the table from the beginning, our CEO is one of the board members of the COHC. I am also a board member representing primary care and other independent providers from the IPA side on the board.”

-Divya Sharma, Medical Director of COIPA, Medical Director of Clinical Quality and Value for Mosaic Medical

Building trust among the CCO partners was essential within the COHC. While the hospital system and independent primary care practices had historically related in more of a competitive framework, the different entities recognized the need to partner in new ways in order for the CCO to be successful. Over time, Mosaic has worked intentionally to build trust with the health system as well as other partners, viewing these trusting relationships as essential to care for the region's vulnerable populations.

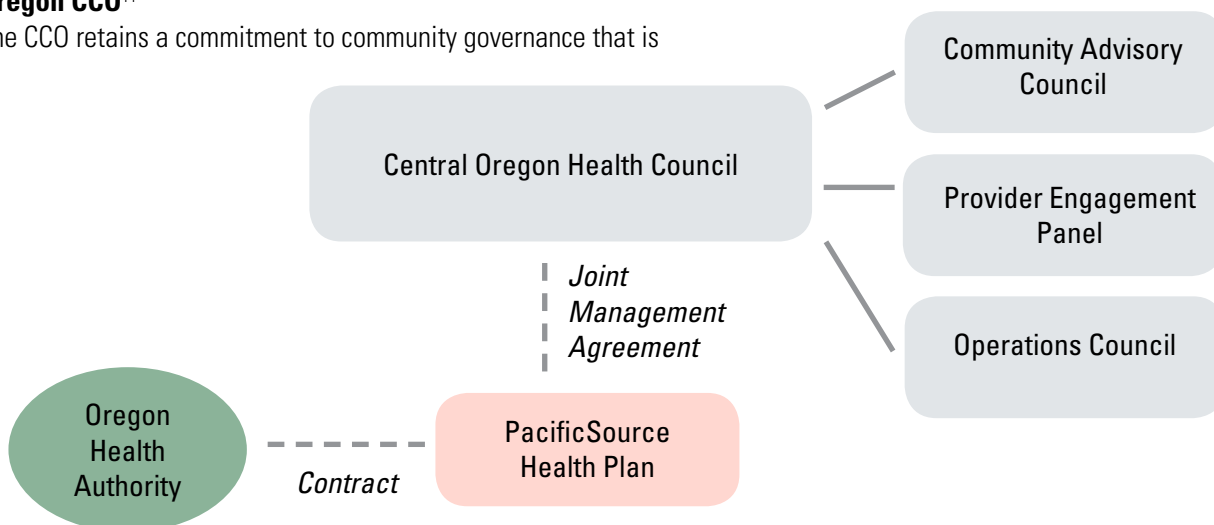
Governance and Management Structure

Exhibit 1 describes the governance structure of the Central Oregon CCO. The COHC is composed of an executive director, one representative from the health plan, multiple provider representatives, three county commissioners, the independent practice association medical director, the hospital representative and CEO, and the chair of the community advisory council. Though the health plan, PacificSource, is the only COHC member to accept financial and legal responsibility for the contract with the state, the CCO is governed by the COHC, and the health plan has just one vote on the decision-making council.¹⁰ PacificSource is ultimately at risk for the dollars but has capped its profits at 2%; any other surpluses go back to the community through individual contracts or through the COHC.

Exhibit 1. Governance Structure of the Central

Oregon CCO¹¹

The CCO retains a commitment to community governance that is



exemplified through the workings of the COHC. Each CCO must have a Community Advisory Council (CAC), made up of Medicaid consumers and members of the county government. The Central Oregon CCO's CAC is integrated into the COHC.¹² The COHC also encompasses a Provider Engagement Panel, which is comprised of representatives from various healthcare organizations within COHC and provides the clinical perspective necessary to its success. The Operations Council chartered by the COHC Board of Directors is charged with providing strategic, operational, and regional guidance, to operationalize and implement key initiatives to meet the goals of the COHC.

The Central Oregon CCO is the only CCO with the COHC structure, with the exception of Columbia Gorge. This CCO is also unique in that the COHC board includes public commissioners from each of the counties represented in the region. On other CCO boards throughout Oregon, public commissioners were relegated to the CAC.¹³ Having public officials involved in the proceedings and decision-making of the COHC brought extra emphasis to the coalition's commitment to community health.

Leading the healthcare transformation can be a significant burden on CCO stakeholders. The CCO partners noted that the same people tend to be at all the same meetings, and burnout, turnover, and recruitment present challenges. The relative lack of competition in the market has caused some stakeholders to feel that others have too much power. The hospital system, in particular, is the only one in the area and therefore has the potential to exert significant influence.¹⁴ However, many health care stakeholders in Central Oregon know one another well, and a sense of interdependence has driven collaboration.

The most important benefit of this governance structure for Mosaic is that primary care has the opportunity to advance specific initiatives in accountable care within a shared power structure. Not only is Mosaic represented on the COHC but so too is the Central Oregon Independent Practice Association, bringing together health centers and small independent provider offices to form a more unified primary care voice in the COHC. COIPA's role is to serve as an advocate for primary care and independent providers on the COHC, help the small independent practices manage their patients better under the new systems, and serve as the chief

contracting entity for negotiating CCO payments with PacificSource.¹⁵ COIPA also helped implement payment and clinical system redesign, with Mosaic playing a major role because they represent 40% of all Medicaid patients in the service area.¹⁶

Payment Model

When the CCO was implemented, Mosaic's payments included three distinct arrangements: 1) shared savings linked to quality and utilization metrics; 2) per member per month care coordination payments through the CCO; and 3) an alternative payment and care model (APCM), which replaced the Prospective Payment System (PPS) as the base payment for primary care services in Oregon community health centers. In the literature, this has been referred to as a "three-layered" payment model.¹⁷ Movement to alternative payment arrangements was facilitated by the fact that COIPA was already involved in risk-based contracting prior to the formation of the CCO and brought experience helping their organizational members manage risk.¹⁸

CCO Payment

Oregon's Medicaid pays the Central Oregon CCO under a global budget in which they receive a fixed PMPM for every Medicaid recipient. Primary care clinics and hospital-based primary care receive capitated PMPM payments per established patient, with upside risk and shared savings tied to quality and utilization. The PMPM payment is based on historical costs, with the state requiring that costs only increase by about 3% a year. Under this shared savings arrangement, PacificSource withholds a portion of the hospital's budget. If quality and utilization targets are met, the withheld dollars are paid out as incentive dollars which are split between the hospital and providers. This is a substantial benefit, as primary care has the potential to earn a portion of the hospital withhold, which is a significant dollar amount that can be invested in delivery system transformations and other projects. One factor enabling this arrangement is that St. Charles Hospital System has primary care providers who are also entitled to the primary care portion of the withheld dollars, thereby making the hospital's portion of incentive payments larger than the portion received by other primary care providers.¹⁹

“Another great benefit of health reform is getting paid prospectively and having a steady, predictable income as well as a slightly larger one, which has allowed us to enhance our care.”

-Steve Strang, Chief Financial Officer,
Mosaic Medical

The move toward payment reform required initial investment to develop needed systems. In the joint management agreement, it was specified that PacificSource would pay the health council 0.325% of every PMPM dollar they received for the benefit of Medicaid members. The state supplemented these funds, using State Innovation Model (SIM) dollars to create a Transformation Fund for each CCO to finance innovative projects. These projects offered the chance to solidify relationships and build momentum as partners witnessed successes by pooling resources to achieve better quality care with cost savings. For instance, COHC received \$6.6M in shared savings from 2014 which was able to be invested in managing the pent up demand of an additional 20,000 Medicaid lives from Medicaid expansion.²⁰

Oregon's Medicaid expansion dramatically increased Mosaic's Medicaid covered population and, with this change, its revenues increased. In order to receive its per capita Medicaid PMPM payment, patients are expected to re-enroll in Medicaid on an annual basis. Members can re-enroll on their own; however, many require assistance in doing so. To meet this need, Mosaic has had to hire additional outreach and enrollment assistants to engage patients in the community and ensure that they are covered under Medicaid.²¹

Alternative Payment and Care Model

Oregon is the first in the nation to implement a PMPM-based payment alternative to the prevailing PPS payment method for Medicaid patients receiving care in health centers. Mosaic Medical has been involved in the implementation of a primary care capitated

payment system under a federally approved Alternative Payment and Care Model (APCM) demonstration project since 2013, meaning they no longer earn revenue based on the number of individual visits patients receive but instead through PMPM payments (which are budget neutral to the state but no less than PPS payments).²² The APCM is based on the historical utilization for an assigned population and converted to a clinic-specific monthly PMPM. This new APCM pilot dovetailed well with the work of the CCOs, as Oregon's Medicaid agency found that collaboration with the Oregon Primary Care Association (OPCA) and health centers on the new APCM enabled them to comply with a legislative mandate to adopt non-fee-for-service payment methodologies.²³

Restructuring payment to PMPM allows providers the freedom to more effectively manage population health for their patients. Patient-centered payment incentivizes providers to optimize, rather than maximize face-to-face visits and utilize enabling services, thereby facilitating better care delivery that focuses on the patient's needs in a more holistic manner. Reconciliation occurs at the end of the year, so if the new APCM payments total less than what the health center would have received in total payments under the PPS, Medicaid pays the difference.²⁴ Consistent and predictable flow of PMPM payments can support financial stability, however, cash flow may not always be predictable given the state's implementation of the APCM. The state's "meaningful touches" requirement presents a challenge by requiring health centers to document visits and/or engagement touches with 100% of established patients on a two-year basis (Exhibit 2).²⁵ Mosaic would like to deliver care in the most efficient manner but must reach out to make sure all of their assigned members are engaged in care, which often proves difficult in the safety-net population.²⁶

According to Craig Hostetler, the former executive director of OPCA, Mosaic and other early participants in the APCM demonstration sought a payment system more consistent with medical home approaches.²⁷ For example, Mosaic aspired to improve the workplace environment to more easily recruit and retain staff and to deliver expanded care coordination, team-based care, and electronic communication. Participation from COIPA and health centers in the Safety Net Medical Home Initiative helped spur conversations with health

Exhibit 2. Examples of “Meaningful Touch” Categories

- Accessing Community Resource/ Service
- Case Management
- Coordinating Care: Clinical Follow-up and Transitions
- Coordinating Care: Dental
- Coordinating Care: Information Management Education Provided in Group Setting
- Exercise Class Participant
- Use of Flowsheet
- Health Education Supportive Counseling
- Home Care Visit Encounter
- Home Visit (non-billable)
- MyChart Encounter
- Panel Management Outreach Support Group Participant
- Telemedicine Encounter

centers about the need for a payment model that was more aligned with achieving goals to improve health outcomes while also addressing caregiver satisfaction, recruitment, and retention.²⁸ Ultimately, implementing the APCM and CCOs concurrently provided key flexibility to deliver care in innovative ways, while also providing financial incentives for achieving outcomes.

Delivery System Improvements

Care redesign and payment reform were closely intertwined in the development of the Central Oregon CCO. Payment reform drove a new mentality to continually improve and meet the seventeen quality metrics established by the Oregon Health Authority (Exhibit 3). To make these clinical improvements and earn incentive dollars, the COHC has an Operations Council with Mosaic and other clinics that tracks progress on data metrics and shares best practices in clinical care (i.e. workflows for hypertension screening).²⁹ COHC applications for funds to implement Quality Incentive Metric (QIM) bonus payments average \$10-12 million per year.³⁰

Care redesign and quality improvement were facilitated by the movement of all of the key Central Oregon providers to a common EMR system. Mosaic, a multispecialty group, and the County's major behavioral health provider have already moved to Epic and the St. Charles Health System is in the process of adopting it. Epic's "Care Everywhere" interoperability platform allows all the region's providers to exchange patient records across the care continuum. COIPA provides EMR analytic support to help clinics build dashboards to extract clinical quality measures and track performance. COIPA and COHC have invested QIM dollars into hiring QIM Coordinators, especially to help smaller clinics meet certain metrics. Clinics that reach quality targets receive bonus payments at the end of each quarter even if the region does not. This process builds provider engagement in quality improvement efforts.³¹

Exhibit 3. CCO Quality Metrics

- Satisfaction with Care
- Colorectal Screening
- Controlling Hypertension
- Follow-Up after ADHD Prescription
- Adolescent Well-Child Visits
- SBIRT
- Outpatient and ED Utilization
- Access to Care
- Depression Screening and Follow-Up
- Developmental Screening First 36 Months
- Early Elective Delivery
- Diabetes Control (HbA1c)
- EHR Adoption
- Follow-up after Hospitalization of Mental Illness
- Assessments for Children in DHS Custody
- Primary Care Home Enrollment
- Timeliness of Prenatal Care

In response to the CCO payments, Mosaic expanded their care coordination capabilities and hiring of care coordinators. Flexible funds are used to support enabling services that address the social determinants of health (i.e. air conditioners for asthma treatment, wheel chair ramps, etc.).³² Flexible funds also enable whole person care by involving new members of the care team like community health workers, RN care managers, and behavioral health specialists.

The implementation of the APCM allowed Mosaic to enhance their patient-centered medical home model. Most importantly, the APCM facilitated the delivery of care by robust teams, which involved creating interdisciplinary teams (e.g. behavioral health, pharmacy, nutrition, and primary care) and structuring each member's role with the goal of ensuring that they are working at the top of their license. According to Dr. Christine Pierson, CMO of Mosaic Medical, however, this has been a slow and iterative process, "It has taken three years and we are still refining how to use every provider at the top of their license."³³

Beyond encouraging team-based care, the APCM also allowed the clinic to pay for enabling services such as case management, exercise class participation, telephone and home visits, warm hand-offs, transportation assistance, and telemedicine. Team members use an "Engagement Touches" tool that is integrated with the health center's EHR to document and track these enabling services that support patient-centered care.³⁴

The results of the simultaneous payment reforms and care redesign led to significant reductions in total utilization in Central Oregon. An independent evaluator's first year preliminary quantitative analysis of the three pilot health centers, including Mosaic, showed decreases in emergency room and inpatient utilization, as well as increases in preventative screening rates.³⁵

Conclusion and Implications for Other Health Centers

Mosaic is participating in one of the most advanced, primary-care based payment reform models for Medicaid in the country, both because of its three distinct payment arrangements and because of the significant reallocation of revenues from the hospital to primary care. Through the CCO, Mosaic and other primary care providers have received significant payments for quality improvement as well as a PMPM amount for care coordination. The APCM allowed Mosaic to provide more flexible care in a robust, team-based model in which the incentives were shifted from volume-based services delivery to improving population health.

The COHC governance structure, though cumbersome at times because of the large number of voices at the table, is beneficial in ensuring that larger players do not dominate decision making. The shared governance model was also reflected in the unique distribution of shared savings which shifts hospital dollars to primary care and the Central Oregon Health Council. Mosaic was able to work collaboratively across a diverse group of providers and public officials to implement the CCO and the payment reform pilot. Facilitated by strong leadership at the COHC and the development of a strong, unified IPA, Mosaic was able to build a foundation of trust with its IPA partners, including small, independent primary care practices as well as its CCO partners.

"Because we involve so much of the community, I don't think it allows us to be as nimble. But once we can get everyone around a certain thing, I think we have the ability to push certain aspects quicker than if we didn't have as many community partners involved."

-Donna Mills, Executive Director of the COHC

Mosaic's experience in the Central Oregon CCO offers important implications for other health centers interested in pursuing accountable care strategies:

1. Successfully participating in payment and delivery system reform requires leadership that "thinks outside the box" to design new care systems, is willing to try novel approaches, and has an ability to build trust among community partners. These leadership characteristics help promote trust among partners that have not traditionally worked together, which is essential when performing collectively under payment reform.
2. Participating in a community coalition to pursue accountable care is a valuable strategy for health centers, particularly in rural areas. Mosaic was able to collaborate with multiple partners (including a hospital system, an IPA, behavioral health providers, a health plan, and county social service departments) which would have been difficult, if not impossible, in more competitive urban markets. The broad participation in the COHC facilitated partnerships and strategies for care redesign and payment reform.
3. Working with hospitals that are committed to population health can yield tangible benefits for health centers and other partners. In the case of the Oregon CCO, the enlightened leadership of the St. Charles Health System and its commitment to partnerships with CCO participants ensured the reallocation of revenue from the hospital to primary care to improve the overall care system.
4. Health plans can be valuable partners in accessing useful data for managing care and implementing payment reform. The COHC, which includes multiple stakeholders, successfully partnered with PacificSource Health Plan to improve the health information technology and care coordination infrastructure in primary care, which, in turn, helped facilitate reductions in utilization and total cost of care.
5. The "three-layered" payment model of participating in shared savings, PMPM for care coordination, and alternative payment agreements can offer health centers greater ability to align their services with population health efforts. Mosaic was able to obtain substantial new revenues and to capitalize on the financial flexibility and predictable cash flow through this multi-layered model.

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