ACO

An organization of providers that is accountable for the care of the Medicare Beneficiaries assigned to it. ACO's will have a strong emphasis on Primary Care and reducing overall costs of medical care.

Governance

ACO Governing Bodies consist of:

- Providers of Service
- Suppliers of Service
- Medicare Beneficiaries

Reporting

Analyzing

- Claims
- Financial Data
- Quality Data
- Quarterly and Annual Reports
- Site Visits
- Beneficiary Surveys

Payments

Shared Savings and Shared Losses

- A benchmark is established based on the estimate of what the total Expenditures for the group of beneficiaries would have been without an ACO.
- When the total per capita cost is below the estimated benchmark, the ACO receives their part of the shared savings.
- If the total per capita cost is above the estimated benchmark, the ACO pays their part of the shared losses.
- Quality criteria must be reached to be eligible for shared savings.

Two Risk models

- One sided model: The ACO only shared in savings for the first two years. In the third year the ACO shares in savings and losses.
- Two Sided model: The ACO shares in savings and losses in the first three years, and gets a greater percentage of the shared savings than the one sided model.

Beneficiaries

- The ACO must serve at least 5,000 beneficiaries
- Beneficiaries are assigned based on the use of a primary care physician within an ACO.
- Beneficiaries are not restricted to services from providers within the ACO.

Providers

- Removed if they fail to meet quality standards.
- Primary Care providers may only participate in one ACO, hospitals and other providers may participate in more than one.

CCO

Community based organizations using patient centered primary care homes, fixed global budgets and efficiency and quality improvements to reduce costs for Oregon Medicaid patients. CCOs align and integrate the care of Oregonians eligible for both Medicare and Medicaid to reduce administrative costs, waste and duplication.

Governance

CCO Governance:

- A majority interest of persons that share financial risk
- Major components of the health care delivery system
- The community at large

A community advisory council:

- Local Governments
- Community
- Consumers

Reporting

OHA will report:

- Benchmarks and Quality Measures
- Progress eliminating health disparities
- Rules adopted
- Customer satisfaction
- Costs
- Financial Data

Payments

Global budgets

- Calculation methods of global budgets to be determined by the Global Budget Work Group.
- CCOs are encouraged to use alternative payment methodologies.
- Reimbursements based on outcomes, not volume of care.

Work Groups

A meaningful process to establish:

- Qualification Criteria
- Global Budget Process
- Process for resolving providers refusal to contract with CCOs
- Processes for reporting financial information
- Plan for adding PEBB and OEBB

Providers

- May participate in more than one CCO
- Emphasize prevention
- Removed if they fail to meet quality standards.
- May not unreasonably refuse to contract with a CCO
- Work together to develop best practices for culturally appropriate care.