

Robert Wood Johnson Foundation Payment Reform Evaluation Project
High Value Patient Centered Care Initiative
Oregon Health Leadership Council

Autumn 2012 Site Report

Context

The development, implementation, and future of the High Value Patient Centered Care Initiative (HVPCC) have been and will continue to be shaped by larger health system reforms in Oregon. In addition to HVPCC, five other health system and payment reform initiatives are running simultaneously in Oregon: Aligning Forces for Quality (AF4Q); Coordinated Care Organizations (CCOs) and global budgets; Comprehensive Primary Care Initiative (CPCI); Patient-Centered Primary Care Institute (PCPCI); and Patient-Centered Primary Care Home Program (PCPCH Program).

The not-for-profit Oregon Health Care Quality Corporation (Quality Corp), a contractor and partner in the HVPCC, is involved in several of these reforms.¹ Quality Corp is an independent, nonprofit organization dedicated to improving the quality and affordability of healthcare in Oregon by leading community collaborations and producing unbiased information. They work with the members of their community – including consumers, providers, employers, policymakers and health insurers – to improve the health of Oregonians.

With funding from the Robert Wood Johnson Foundation in 2007, Quality Corp launched the AF4Q Initiative to improve the quality of care in Oregon. In partnership with its network of stakeholders, Quality Corp has developed a comprehensive system for measuring primary care quality in Oregon. Since 2007, Quality Corp has been aggregating claims data from multiple payers to produce quality reports for consumers, providers, health plans, policymakers and employers. In 2011 Quality Corp received data from Oregon's largest health plans, managed care organizations, and the Oregon Health Authority Division of Medical Assistance Programs. Each data supplier received a custom report to identify areas of quality improvement. Quality Corp's most recent round of reports also were sent to over 3,300 primary care providers, representing nearly 81 percent of all practicing primary care providers in the state.² Quality Corp continues to produce and post online statewide reports of medical group performance scores and how those scores compare with other groups at the local and national levels, which also is part of its AF4Q efforts.

¹ Sources: <http://www.rwjf.org/qualityequality/af4q/> and <http://q-corp.org/>

² Public reports for consumers and employers, and Quality Corp's annual report for policymakers and health care professionals, are available on the website: www.partnerforqualitycare.org.

The other health system and payment reforms were largely consequences of the national economic recession,³ which substantially reduced the revenues of state governments, with the State of Oregon budget facing a \$3.5 billion shortfall.⁴ One approach to balancing the State's budget was to cut the number of Medicaid enrollees by 20-30 percent, but this action would increase the number of Oregonians without health insurance and potentially reduce future state revenues from the federal Medicaid expansion authorized by Congress' Affordable Care Act (ACA). In contrast, Oregon's governor, John Kitzhaber, favored an alternative approach: that better coordination and a more efficient health care system for Oregonians with publicly funded health insurance would reduce costs sufficiently to address the budget deficit.⁵

Favoring the second approach, in 2011 the Oregon Legislative Assembly authorized House Bill (HB) 3650, Health Systems Transformation, which was built on the State's existing infrastructure for public health insurance. In 2009, the Oregon Legislative Assembly passed HB 2009, which created two new state entities, the Health Care Authority (HCA) and the Oregon Health Policy Board (OHPB).⁶ The HCA oversees the public health insurance plans for Medicaid enrollees, public employees, school district employees, and the state's high risk pool and premium subsidy programs, all of which comprise a total of 800,000–900,000 covered lives. Governed by the nine-member OHPB, the HCA gives Oregon greater purchasing and market power to achieve its mission of improving the health of Oregonians by reducing costs and improving quality, delivering preventive care, and providing health care access.⁷ The passage of HB 3650 has been attributed to the State's urgent need to solve its substantial budget deficit, the governor's leadership, and a state history of cooperation and collaboration in health care and other policy sectors, as well as an innovative and pioneering culture.

Two key elements of the HB 3650 system transformation are as follows:

- Coordinated Care Organizations (CCOs): Oregonians covered by HCA insurance receive care through CCOs that replace managed care systems.⁸ Key principles of CCOs are the following:
 - Preventive care is delivered through patient-centered primary care medical homes (PCMHs), which will contribute to quality care at lower cost.
 - The PCMH is geared toward treating the whole patient, where patients receive the right care at the right time.
 - All patient services and records occur in a single organization, improving care coordination and reducing fragmentation, redundant services, and medical errors.

³ Source: <http://www.nber.org/cycles/sept2010.html>

⁴ Source: <http://health.oregon.gov/OHA/docs/fed-hlth-ref-or.pdf>

⁵ John Kitzhaber was elected Governor of Oregon for two terms from 1995 to 2003 and was re-elected for a third term in 2010.

⁶ Source: <http://www.leg.state.or.us/09reg/measpdf/hb2000.dir/hb2009.en.pdf>

⁷ Source: http://www.oregon.gov/OHA/about_us.shtml

⁸ Source: <http://gov.oregonlive.com/bill/2011/HB3650/>

- Prevention, catching problems earlier, and avoiding duplication contribute to cost savings.⁹
- Global Health Budgets: The State of Oregon’s current system of funding health care in silos (that is, separate budgets for hospital, ambulatory, mental health, and other care categories) is replaced by a new system that pools all money into a global budget dispersed by the HCA to CCOs.

In February 2012 the Oregon legislature passed Senate Bill 1580 authorizing the HCA to create CCOs to replace the State’s Medicaid contracts with managed care systems.¹⁰ Federal aid also was needed for the plan to work. Under the agreement with the Centers for Medicare & Medicaid Services (CMS) in May 2012, Oregon will receive \$1.9 billion to launch the Medicaid reforms, contingent on reducing Medicaid cost growth per capita by two percent and improving health outcomes by the end of two years.¹¹ Over the past five years, Medicaid costs have increased annually about six percent, which implies the growth rate must be lowered to four percent. In July 2012 thirteen CCO contracts were approved for the Oregon Health Plan (Medicaid children and adults) in 33 counties, and CCOs began operating by September 1, 2012. By the end of 2012, fifteen CCOs were serving about 90 percent of Oregon Health Plan members.¹² CCOs are expected to offer physical, mental and dental care. The reform is significant because the Oregon and Medicaid reforms are the only ones with global budgets in the U.S.

Two other primary care reforms followed on heels of the CCOs. As part of the Affordable Care Act, in spring 2012 the CMS’ Center for Medicare and Medicaid Innovation (CMMI) launched the Comprehensive Primary Care Initiative (CPCI) in Oregon.¹³ The CPCI is a collaboration between public and private payers and medical groups to strengthen primary care for Medicare enrollees. The CPCI offers bonus payments to medical groups that better coordinate primary care for their Medicare fee for service patients. About 70 medical groups are participating in Oregon’s CPCI, with patient care expected to begin by the end of 2012.

The other primary care reform is the Patient-Centered Primary Care Institute (PCPCI), which began in August 2012.¹⁴ Initiated by the Oregon Health Authority and Northwest Health Foundation, PCPCI’s

⁹ Source: <http://www.wvphealthauthority.org/images/pdf/2011-health-care-transformation.pdf>

¹⁰ Source: <http://gov.oregonlive.com/bill/2012/SB1580/>

¹¹ Washington Post: <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/09/19/interview-gov-john-kitzhaber-on-oregons-1-9-billion-medicaid-experiment/>

The Commonwealth Fund: <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2012/May/May-7-2012/Oregon-Gets-Nod-for-Medicaid-Global-Budget.aspx>

¹² Source: <https://cco.health.oregon.gov/Pages/Home.aspx>

¹³ Sources: <http://www.innovations.cms.gov/>; and <http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Oregon.html>

¹⁴ Source: <http://www.pcpci.org/>

mission is to connect qualifying medical groups with a wide variety of technical assistance to support the medical groups' transformation to primary care medical homes – and to assist groups to meet the requirements for the Oregon Health Authority's Patient-Centered Primary Care Home recognition. Oregon's Health Care Authority has contracted with Quality Corp, the neutral convener, facilitator, and project manager for PCPCI. The PCPCI has selected 25 medical groups in Oregon to participate in a Learning Collaborative to support practice transformation, and also will host webinars, create a train-the-trainer program, and offer other support for practice transformation.

Finally, when the Oregon legislature passed HB 2009 in 2009, the legislation created the Oregon Health Authority's Patient-Centered Primary Care Home Program (PCPCH Program).¹⁵ Under the law, primary care homes recognized by Medicaid receive supplemental payments to support enhanced care provided to Medicaid patients with selected chronic conditions to help patients manage their conditions. The Program is scheduled to end in September 2013.

In summary, since 2007 an accelerating pace of health care and payment reforms has been occurring in Oregon. Six reforms have been running simultaneously: the High Value Patient Centered Care Initiative, AF4Q, CCOs and global budgets, CPCI, PCPCI, and PCPCHP. Health plans and medical groups, many participating in more than one project, are overwhelmed by the volume, pace, and fragmented nature of reform. This creates challenges for medical groups trying to plan their financial futures. Oregon is also developing a health insurance exchange in response to the Affordable Care Act. A deeper look into the HVPCC is presented next.

Objective

Within this historical and legislative context, the Robert Wood Johnson Foundation (RWJF) funded a portion of the payment reform project known locally as the Oregon Health Leadership Council's High Value Patient Centered Care Initiative (HVPCC). The Oregon Health Leadership Council (OHLC) consists of 30 members from health care organizations, including eight major medical groups, eight major hospitals/health systems and the Oregon Association of Hospitals and Health Systems; twelve health plans; and the director of the HCA.¹⁶ The OHLC, formerly known as the Health Leadership Task Force, was formed in 2008 at the request of the Oregon business community. Its main mission is to control health care costs.

In its payment reform proposal to the RWJF, Quality Corp was not specific about its project goals because there was much uncertainty in Oregon about the future direction of the health care system. OHLC's strategy was to implement a multi-payer, statewide medical home initiative that would focus on commercial members with complex medical conditions. OHLC partnered with Renaissance Health, which

¹⁵ Source: <http://www.oregon.gov/oha/ohpr/Pages/healthreform/pcpch/index.aspx>

¹⁶ Source: <http://www.orhealthleadershipcouncil.org/>

has experience with similar initiatives, to manage the project and with Quality Corp to provide the data to support the effort.

OHLC launched the HVPCC in the fall of 2010 with five health plans, four of the State's purchasing groups, and fourteen medical groups.¹⁷ A key role of the HVPCC was building collaboration among stakeholders, which also would be essential for implementing the HB 3650 reforms. The Initiative's formal completion date was February 28, 2013; however, almost all of the participants are continuing on during a "bridge period" through the end of 2013 when the evaluation of the project is scheduled to be completed.

The main objectives of the program are to improve quality of care, increase efficiency of care likely resulting in lower cost, and provide a high level of patient experience in care through the use of primary care integrated nurse care managers for high-risk patients.

Approach

A challenge shared by the OHLC members is the effective, efficient care provision for complex, high-risk patients with multiple co-morbid conditions and high costs of care. To address the needs of these patients, 23 registered nurse care managers were recruited and trained to serve up to 3,600 commercially insured patients with chronic and complex conditions, including diabetes, coronary artery disease, depression, pain, HIV/AIDS, cancer, and others. Each health plan used an algorithm to identify high-risk patients – those predicted to have significant healthcare utilization in the future 12 months. To support a nurse at each medical group, each medical group set an enrollment target of 150-200 patients. Enrollment occurred two times, at the start of the Initiative and in early 2012 to backfill for patient attrition that had occurred over the year. Although no one health plan had sufficient volume of high risk patients to support this care model, collectively, the plans and payers had a sufficient eligible patients to launch the Initiative.

The nurses are employees of the medical groups and receive training from Renaissance Health in complex care management, including motivational interviewing, care transition skills, medication reconciliation strategies, shared decision making techniques, behavior modification, socio-behavioral risk assessment, and support for mental health conditions. As a whole, the training elements support the care managers to act as 'navigators,' customizing care to fit the needs of each patient and coordinating care with other members of the patient's health care team, which may include the primary

¹⁷ OHLC chose to implement the HVPCC after consideration of other alternatives. The HVPCC model was ultimately chosen based on findings from a similar project conducted at Boeing that increased quality, improved employee productivity, and reduced costs in a 12-24 month period. Two other factors supported this choice: 1) the HVPCC goals are aligned with the goals of Oregon's system reforms; and 2) when the PCMH is rolled out in CCOs, medical groups must manage high-risk (sicker) patients, which is a focus of the HVPCC. Two of the payers and some of the medical groups also are participating in Oregon's Comprehensive Primary Care Initiative.

care physician, specialists, other providers, hospitals, and health plans. Teams perform comprehensive multi-domain intake assessments with the patient, the care manager and the primary care physician; develop specific, custom shared action plans; and work proactively to support patients in reaching their goals. To facilitate this proactive planning, care teams conduct pre-visit planning and have regular team ‘huddles’ to discuss and coordinate care. Another goal is providing appropriate and greater access to care (such as same day access, urgent care and phone support 24 hours each day and seven days a week, email communication, and links to community services). Other care components include patient registries to track patients; electronic health records shared by the care team; management of care transitions following emergency room visits and hospital admission; the offer of advance directives and end-of-life care; and quarterly team performance reviews. To support the nurses on an ongoing basis, Renaissance Health provides regularly scheduled “Office Hour” calls to discuss challenges and to problem solve. In addition, over the two-year period, additional day long advanced training sessions have occurred with the nurses and additional joint sessions with the health plans.

To recruit the project’s medical groups, OHLC sent a request for proposals to 25 groups, 15 of which submitted proposals; OHLC interviewed and made site visits to assess the medical groups and subsequently contracted with 14 groups. The medical group not selected lacked sufficient volume of patients to support the nurse care manager. Program management is being performed by Renaissance Health.¹⁸

Health plans pay medical groups per-member-per-month (PMPM) payments to cover the personnel costs of the nurse care managers, and share any cost savings. Due to legal anti-trust concerns, each health plan contracts directly with each medical group; consequently, the PMPM and gain sharing arrangements vary by medical group and generally range from \$40-45 PMPM. Therefore, assuming an average of 200 enrolled patients per medical group and \$42 PMPM, a medical group would receive \$8,400 per month ($200 \times \$42 = \$8,400$). There are two salient features of the payment arrangements. One is that HVPCC is being implemented through the existing contractual relationships that health plans have with each medical group, which simplifies implementation of the enhanced care management payments. Medical groups have received contractual PMPM payments from the health plans after patients were enrolled, beginning in September 2010, and ending in February 2013 when the contracts ended. Second, medical groups are accountable contractually to provide health care coordinated by nurse care managers to a defined population of high risk patients with expected outcomes for two years, which enables standardization of the care management model.

Cost savings will be computed based on the difference in costs between the intervention group versus a tightly matched control group of patients from different practices that is identified by the evaluators (see Evaluation and Sustainability section below). Threshold targets are also in place for quality of care

¹⁸ Source: <http://www.pcpcc.net/profile/pranav-kothari>

and patient satisfaction.¹⁹ Shared savings will be paid at the end of the project based on the evaluation results, contingent on achieving both the savings and quality metrics. Although the HVPCC ended in February 2013, the health plans and most of the medical groups agreed to continue the project through the end of 2013 when the evaluation results will be known, and then make decisions about the project's future based on the evaluation results. During the 10-month (March-December) "bridge period," the health plans agreed, for simplicity, to increase the PMPM payment to all medical groups by five percent.

The OHLC contracted with Quality Corp for data reporting and submission of the claims data to the evaluator for the final evaluation. Quality Corp provides quarterly utilization reports for the medical groups and health plans and also provides periodic overall utilization reports to the full Council. In addition, Quality Corp will provide the final claims data set to the Evaluator for the formal evaluation. The data formats were developed in coordination with Quality Corp, Milliman (Quality Corp's data vendor), OHLC, and Renaissance Health.

To support these reports, Quality Corp assisted with tracking patient enrollment in HVPCC. Originally, each month, each medical group completed Excel spreadsheets – one for each health plan – that listed the HVPCC patients who received care from the medical group. For example, if a health plan covers HVPCC patients in all 14 medical groups, 14 spreadsheets are produced, creating a substantial administrative burden for the medical groups and health plans. The next step is to combine the spreadsheets for each health plan into a single roster. A well-defined list of HVPCC patients also is required for the quarterly reports and the final evaluation, which eventually determines the amount of shared savings.

At the start of HVPCC, this patient reporting process was cumbersome and a large amount of time was devoted to roster reconciliation – or resolving discrepancies between who the medical groups and health plans defined as HVPCC patients. Although there were several causes of this administrative burden, two important sources were confusion about the initial enrollment process and "patient churning." That is, patients may move in-and-out of the Initiative due to loss of insurance, loss of employment, switching health plans, or switching medical groups. Lack of access to patient identifiers due to HIPAA regulations and incorrect or missing data in the medical group spreadsheets or health plan records also contributed to the problem. Resolving the discrepancies was difficult because a common patient identifier existed neither between the medical groups and health plans, nor between the health plans. Through a joint effort among Quality Corp, Milliman, Renaissance Health, the medical groups and health plans, the reconciliation of patient enrollment is close to being resolved.

¹⁹ For quality, the goal is to maintain or improve Quality Compass at the 50th percentile threshold for diabetes, hypertension, and cholesterol metrics.

Working with Milliman, Quality Corp supplied quarterly reports that profile the utilization of its participating patients in each medical group (another entity is collecting patient satisfaction data using the Ambulatory Care Experiences Survey [ACES]).²⁰ Quality Corp has developed interactive, graphically based utilization reports for use by clinic staff at participating medical groups, which can be accessed through a Web Portal that allows comparisons with other medical groups. To produce the reports, the health plans submitted quarterly data to Milliman 30 days after the end of the quarter, and reports were developed and released within four weeks of obtaining claims data. The reports included information on Emergency Department (ED) use, hospitalizations, use of imaging services, pharmacy fill rates by therapeutic class, generic fill rates, visits over time to primary care, and visits over time to specialists. Each utilization topic area contains multiple reports. For example, ED use includes the following reports: ED visit rates by quarter compared to benchmarks over time, avoidable ED visits, ED visits by day of week, ED visits by weekend versus weekday, and drill down of ED visits by patient. Medical groups use the ED visit rates by quarter to track their enrolled patient panel's progress in avoiding ED use over time. The patient-level reports of ED use are used by nurse care managers to follow up on patient care since real time notification of ED visits does not happen routinely. All reports are accessed through the existing Quality Corp secure portal. Quality Corp has conducted webinars and multiple calls to train medical group personnel in the use of the reports and to obtain feedback on how to make them more actionable and to increase usability. It also has developed health plan summary reports composed of aggregated data from the utilization reports for the OHLC.

In addition, Quality Corp is also supplying claims data for the project's evaluation (see Evaluation and Sustainability section below). The final file containing claims through February 2013 will be delivered to the evaluators in the summer of 2013.

Logic Model

The HVPCC is expected to demonstrate cost savings and better quality and patient satisfaction for the following reasons:

- *Care Management Development.* Success in achieving project outcomes depends partly on the success of nurse care managers in changing patient behaviors. The nurse care managers initially completed 4.5 days of training before the Initiative was launched. The training included a mix of didactic skills needed to implement the high-risk care model such as engagement and recruitment, shared action planning, and motivational interviewing. These skills are aimed at building positive, enduring patient relationships and ultimately changing patient behavior. Nurse training continued throughout the Initiative with four-one day advanced collaborative training sessions and regular learning community phone calls ("Office Hours"). The advanced training

²⁰ In the AF4Q Project, Quality Corps was producing customized reports for medical groups every six months. Quality Corps reduced the amount of time between data arrival and report production to three months for this project.

sessions included training in areas such as the State of Oregon’s Living Well Program,²¹ improving patient management of chronic conditions and local physician experts lecturing in nutrition. The “Office Hours” enabled a strong development of community, collaboration and also a platform for further didactic topics. In addition, the learning community was supported by an online Private Learning Network – where the care managers could collaborate and continue dialogue online, asynchronously and longitudinally.

- *Multi-stakeholder Collaboration.* The OHLC also held three day-long meetings with health plans and medical groups to foster open dialogue and create a collaborative platform to learn and troubleshoot issues. This led to greater understanding and joint problem solving on specific issues including increasing patient engagement, integrating care managers into primary care, data transparency, and the development of the bridge period.
- *Targeted Focus.* Greater opportunity for return on investment (cost savings) may occur because the program is focused on high cost, complex patients who need more support and coordination with their care.
- *Focus on Care Coordination and Transitions.* The project emphasizes aligned and coordinated transitions in care, which is aimed at reducing emergency room visits and hospital admissions, and smoothing the transitions between care settings. The underlying assumption is that investing money in infrastructure (i.e., integrated nurse care managers, strong PCP participation, important data transparency) will ultimately save money by proactively addressing patients’ needs in a timely manner and reducing expensive, redundant and reactive care due to urgent, unmet needs.
- *Payment Model.* Funding the nurse care managers and rewarding physicians for value and outcomes are components that may lead to better quality of care at lower cost.
- *Leadership Buy-in.* Physician and administrative leadership buy-in in the medical groups is essential for successful implementation of the project. A key component of the physician leadership role is being a project champion in the medical group. One of the primary goals of the high-risk model is to shift the medical group from a culture of physician-oriented primary care to a team and population based care approach where physicians are working in tandem with the entire care team. Any intervention that supports and improves primary care and reduces fragmentation will have an opportunity to improve quality and patient satisfaction and reduce costs.

Facilitators and Barriers

The facilitators and barriers are presented in no particular order of importance.

Facilitators

- Oregon’s history of collaboration and innovation.

²¹ Source: <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Pages/Index.aspx>

- Oregon health plans and medical groups willingness to agree to a unified care model, payment approach and contract.
- Oregon’s health plans and the OHLC agreeing to fund the program including the funding for the nurses, project management, training, data reporting and evaluation.
- Robert Wood Johnson Foundation support to Quality Corp.
- Physician leadership was instrumental in medical groups switching to an alternate model of care where physicians work collaboratively with a nurse care manager and a care team.
- Well-qualified nurse care managers in all medical groups.
- A trusted and skilled team to help support the project including a four-member group of experienced health care leaders to implement the program, Renaissance Health with experience in these types of initiatives, and Quality Corp as a credible and respected data provider of information about health system performance.²²

Barriers

- Competition for time and attention: when HVPCC began, there were few health reform initiatives operating, but as the Initiative continued, larger-scale health reforms have competed for time and attention of health plans and medical groups.
- Payment environment: health plans and medical groups operate in a fee for service environment, which is not well-suited to making and receiving capitated payments.
- Risk identification methodology: HVPCC used health plan records and predictive risk modeling to identify high-risk patients. Medical group also identified patients who were high-risk from their clinical histories and might benefit from the Initiative, but who were not deemed eligible based on the modeling algorithm.²³ Defining the “best” method of identifying “high risk” is a subject of on-going discussion among stakeholders.
- Attribution and ongoing enrollment: identifying high-risk patients through health plan attribution models was challenging because patients changed employers and health plans, which in turn may make them ineligible for participation and may change their medical group and provider attribution.
- Data timeliness and accuracy: utilization data are reported quarterly to medical groups, but reporting data in real time would be more helpful, especially for emergency visits and inpatient hospitalizations.
- Data literacy: medical group staff may lack spreadsheet skills and require assistance in understanding and applying information in quarterly reports.

²² A four-member leadership group, composed of respected, local health leaders who collectively have over 100 years of health care experience, nurtured collaboration through informal facilitation, problem solving, negotiation, and conflict resolution.

²³ Another dimension of the barrier occurs when medical groups identify high risk patients who qualify for HVPCC but are ineligible because they patients are not covered by a participating health plan.

- Nurse retention: as more medical groups understand the value of nurse care managers to manage high risk patients, the new clinical experience and skills the nurses have made them strong candidates for other positions. This has led to some turnover amongst the original 23 care managers, which may undermine continuity of care with patients.
- Patient preferences: not all high-risk patients want to be in a medical home or participate in the project. In addition, some patients who are defined as being high-risk by their health plans and medical groups believe they are healthy.

Evaluation and Sustainability

Quality Corp and Milliman are supplying data for the project's evaluation, which is being led by faculty at the Oregon Health and Science University. The evaluation will determine the impact of the HVPCC Initiative, which ultimately may decide whether the HVPCC model continues or not. Shared savings will be determined by comparing the HVPCC patient costs with patient costs in a control group. OHSU will construct a control group composed of patients from other practices, matching control patients based on age, gender, health risk score from Milliman, geography (rural/urban), and other factors. Although descriptive analyses of HVPCC patient claims suggest the project is changing utilization in the expected direction, whether the HVPCC has reduced costs more in HVPCC than the control group will not be known until the evaluation is completed.

Beyond the creation of the control group, the evaluation may face two challenges. One is that health plans measure costs in different ways. Another challenge is that HVPCC patients have start and end dates of enrollment of varying duration, which may increase the complexity of patient matching and the analyses. This portion of the evaluation will address the whether this type of care management is better done within the medical groups or health plans. Anecdotal evidence suggests that while physicians initially had ambivalence towards integrating the nurse care managers and perceived them as interfering with their patient care sometimes, the physicians presently view the nurses as an additional resource and are very positive about the project. Most patients appear to like the program; they appreciate the additional care through the program, and they like having access to the nurse. At one extreme, one highly satisfied patient made a large monetary donation to the medical group. At the other extreme, some dissatisfied patients comment about receiving too much attention from the nurses, who are required to do monthly patient follow-ups, and ask nurses to stop contacting them.

After the HVPCC's clinical intervention ends in February 2013, the evaluation becomes the focus of the project. Whether the project is sustained in the future will depend on the evaluation results and their implications for the larger course of health care reform in Oregon.

Lessons Learned

At this point in the HVPCC's history, attention has now shifted from putting the program into place to identifying ways to improve its features and performance and completing the evaluation. The HVPCC implementation offers several preliminary insights about payment and health system reform.

A critical lesson learned is that implementing nurse care managers and team care requires a shift in the culture of the clinic. The medical groups' willingness and readiness to make the shift, along with physician leadership, contribute to medical group success in implementing the project.

Another insight is that HVPCC has achieved its implementation goals because the health plans and medical groups have open communication and collaboration to design and manage the program, identify changes, fix problems, and share perspectives. This insight suggests a broader health policy question of whether competitive markets, by their nature, may undermine collaboration between payers and providers and may become barriers to implementing payment and system reforms.

A third, related, insight is that collaboration does not happen by chance but must be nurtured by local, well-known leaders who are respected by most interest groups. When health plans and medical groups do not have a history of collaboration, either within or between these two groups, local leaders may play pivotal roles in keeping communication channels open and facilitating negotiations.

A fourth insight is that medical groups may be more willing to participate in payment reform when the prospective payment amounts offset their direct costs of implementing the project. In HVPCC the PMPM amounts were calculated explicitly to offset the medical groups' costs of the nurse care managers. In contrast, if the PMPM amount is viewed as a financial incentive to change medical practices and does not cover their costs, medical groups may be less likely to participate and change their practices, which may dilute the effect of the payment reform.

A fifth insight is that the relationships between health plans and medical groups are defined partly by legal contracts, and payment reforms may be more successful when structured around those relationships. In the HVPCC payment reform was implemented through legal contracts between health plans and medical groups, and medical groups were accountable legally for offering nurse case management to high risk patients defined by the health plans. These arrangements may be more likely to work when the PMPM amounts offset the medical group's costs. In contrast, in population-based PMPM where medical groups receive more dollars but much less per patient, medical groups may not be obligated by contract to provide care to specific patients.

Final lessons to be learned will emerge from the evaluation findings near the end of 2013 – a time when the HVPCC may be overshadowed by larger, new and on-going reforms of Oregon's health system. By

participating in HVPCC, health plans and medical groups have developed experience in high risk care management along several dimensions: planning, reimbursement, collaboration, integration into clinical practice, and new advanced skills. This experience may benefit health plans and medical groups when addressing future health system reforms – whether HVPCC or other Oregon efforts.