formance measurement and use of the other types of incentives.

Badly designed incentive schemes that do not include the dimension of shared purpose can be perceived as manipulative, as disrespectful of physicians' professional identity, and as statements of power, with economics taking precedence over clinical concerns. An incentive scheme that is based on a robust sense of shared purpose, by contrast, protects and promotes physicians' sense of moral responsibility and ethical standards in a way that enables physicians to take ownership of it rather than feel it is imposed on them. Thus, instead of being passively graded or rewarded, physicians engage in the development, ongoing evaluation, and critical review of the incentive scheme, reporting any negative effects on the quality, efficiency, and equity of patient care.

We believe that shared-purpose orientations are not only a precondition for an ethical use of incentives but also essential for organizational effectiveness. When teams feel ownership of the shared goal, they can display creativity and flexibility that go beyond what's possible with incentives based on tradition, self-interest, or affective responses alone, while maintaining health professionals' sense of moral agency and responsibility. Practically speaking, however, a shared-purpose orientation alone is frequently not sufficient. Other types of incentives must be used to enhance organizations' effectiveness so that they may pursue the shared purpose.

It is not easy to design and implement such an array of incentives, with each element aimed thoughtfully at protecting or improving the institution's progress toward its aims. Again, examining Weber's motives of social actions can help us understand what would be suitable framework conditions: an institution whose tradition, culture, and mission health care professionals can identify with; a climate of respectful social interactions that allows physicians to uphold their professional standards and their sense of moral responsibility; transparency about institutional aims and the way they are promoted; a proactive attitude toward monitoring effects of incentives on the quality and fairness of patient care and incentive-related conflicts of interests perceived by physicians; and processes that encourage physicians and other stakeholders to engage in the development of a shared purpose and the continuous evaluation and revision of incentive schemes.

Under such conditions, incentives — in the sense of financial or nonfinancial drivers of action — need not be antithetical to a morally acceptable practice of medicine. In fact, they may prove to be valuable instruments in the attempt to realize both the economic and the ethical visions of high-performing health care delivery organizations.

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The Oregon ACO Experiment — Bold Design, Challenging Execution

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The Affordable Care Act (ACA) and the Center for Medicare and Medicaid Innovation emphasize accountable care organizations (ACOs) as mechanisms for achieving cost savings while ensuring high-quality care. ACOs are expected to contain costs through improvements in health care delivery and realignment of financial incentives, but their effectiveness remains unproved, and there are reasons for concern that they may fail.[1] Oregon has embarked on an ambitious

program centered on the ACO model, which aims to change Medicaid financing and health care delivery. The Oregon experiment highlights both the bold vision of ACO-based health care reform and the potential challenges to executing that vision. Failure of the Oregon experiment would not only jeopardize health care for vulnerable Oregonians but also call into question the viability of central tenets of the ACA.

In 2011, Oregon Governor John Kitzhaber, a physician, worked with the state legislature to create coordinated care organizations (CCOs; see table), which have been described as ACOs on steroids.[2] On the basis of the CCO structure, the state received a modification to its federal Medicaid waiver on July 5, 2012, for the Oregon Health Plan, allowing it to change its program design and receive additional financial support.[3] The Oregon Health Plan includes Medicaid and the Children's Health Insurance Program (CHIP) and is overseen by the Oregon Health Authority.

The Kitzhaber administration made a daring commitment that the Oregon Health Plan will contain escalating Medicaid and CHIP health care costs on a short timeline. Under the federal waiver, the Health Authority provides CCOs with stable funding to serve patients enrolled in the Oregon Health Plan for the first year of the program and requires these organizations to achieve a 2% reduction in the rate of growth in per capita Medicaid spending (from an assumed trend of 5.4%, using 2011 as the baseline) by the end of the program's second year.[4] In exchange, the federal government will provide approximately $1.9 billion over 5 years to support the program, but large penalties will be imposed if the required savings aren't achieved.

A central strength of this reform plan is that the Health Authority is statutorily responsible for overseeing the provision of health insurance for both public employees and Oregon Health Plan enrollees (see table). The possibility that the Health Authority could, in the future, exclude providers from lucrative contracts for public employees' insurance has motivated most major health systems to participate in CCOs serving Oregon Health Plan enrollees. The state's ability to link these two programs through a single agency gives it the leverage to effect systemwide reform.

However, as committed as many Oregon stakeholders are to this experiment,[2] there is a distinct possibility that it will fail. The state's proposal for the Oregon Health Plan to achieve savings and quality improvement without diminution of eligibility or benefits depends on a combination of improved administrative efficiencies and effective health care delivery reforms.[3] The reform principles emphasized in the Oregon plan include expansion of disease-management programs; more flexible care, including expanded behavioral health services that are more integrated with physical health services; improved care coordination; and expansion of patient-centered medical homes.

Elements of the Oregon Health Care Reform Plan.

Coordinated care organizations
Oregon health care organizations modeled after accountable care organizations (ACOs) and intended to yield faster cost savings without compromising quality or coverage
Defined by Oregon statute and certified by the Oregon Health Authority (without federal ACO designation required)
Have greater flexibility to use federal funds to create an array of services that may include nontraditional methods of improving care delivery
Use global payments that incorporate a strong capitation component; by 2014, payments for physical, behavioral, and dental health to be combined into a single global payment
Differ from Medicaid managed care organizations in requiring a broader array of services, quality measurement, and incentives for high-quality care
Oregon Health Authority
State agency overseeing any health-related programs
Responsible for overseeing Medicaid, Children's Health Insurance Program (CHIP), and public employees' health insurance
Oversees health insurance for 875,000 Oregonians (22% of population)
Oregon Health Plan
State-administered health insurance for Medicaid and CHIP enrollees
Overseen by Oregon Health Authority
Includes 600,000 Oregonians (15% of population)
Public employees' health insurance
State-administered health insurance for employed public-sector workers (state employees and local teachers)
Overseen by Oregon Health Authority
Includes 275,000 Oregonians (7% of population)

Many of these approaches have not been shown to reduce costs.[1] Although studies have consistently shown that patient-centered medical homes (often incorporating disease-management programs) can achieve cost savings while improving quality of care, the evidence comes from large, highly integrated care networks with years of experience and a history of iterative improvements. These conditions are not realistic for many Oregon CCOs. Studies have also shown cost savings from individual behavioral health programs, but it is not clear that the overall effect of expanded behavioral health care will be cost saving.

Beyond the debate about the importance of scholarly evidence for delivery reform, notable challenges to implementation and execution remain. In many CCOs, there is no integration among the contracted health systems. For example, the Portland-based Health Share CCO — the state's largest CCO, responsible for nearly 40% of Oregon Health Plan enrollees — comprises four units, with little or no integration among them. The Portland hospital marketplace is very competitive,[2] and the organizations within the Health Share units continue to engage in vigorous rivalries. Perhaps for this reason, the CCO leadership has been described as a "convener" of constituents. This unusual management approach, in which the CCO lacks executive or operational oversight of member organizations, coupled with potentially competing internal priorities may well limit the CCO's success.

Another major challenge is that CCO-contracted organizations have mixed models of reimbursement that may undermine the efforts of the Oregon Health Plan to improve efficiency. Most contracted providers receive payments primarily on a fee-for-service basis, and hospitals on a per-admission or per-diem basis. The health care delivery changes required to achieve savings under the capitation components of the Oregon Health Plan could erode provider revenues for care provided under employer-sponsored, fee-for-service health insurance contracts, which are generally more lucrative than public safety-net plans and cover four times as many Oregonians. Thus, to achieve cost savings under the Oregon Health Plan without eroding revenue from traditional payment models, CCO-contracted organizations may be required to develop different systems of care for patients with various types of insurance, which could prove unacceptable to many providers and patients. Alternatively, organizations could incorporate population-management strategies into their work without regard to their effect on fee-for-service revenues. That approach, however, would require both exceptional institutional commitment to reform and strong balance sheets.

State policymakers probably anticipate that Oregon Health Plan reforms will ultimately be incorporated more widely into employer-based insurance. If such a transition occurs rapidly, it could create self-sustaining momentum for the Oregon ACO experiment. If not, insurmountable fiscal and operational challenges for participating organizations could overwhelm reform efforts.

There are no easy fixes. Sophisticated health policy experts in Oregon have designed the current system on the basis of 20 years of experience with payment and delivery experiments. Nonetheless, strong plans for implementation and execution are recognized as critical to the success of any ACO program,[1,5] and improvements are necessary and possible for the Oregon Health Plan. For the same reasons that most major Oregon health care organizations initially agreed to participate in CCOs serving the Oregon Health Plan, a sufficient number may be motivated to address the flaws of CCOs if effectively pushed by state or federal policymakers.

Overall, the Oregon experience highlights several important considerations regarding formation, implementation, and performance characteristics that policymakers and payers should consider when contracting with ACOs.[5] In terms of formation, it is very important to determine whether the ACO structure directs patients toward maximally efficient care and continuously identifies and operationalizes delivery-system improvements. Also critical is determining whether a large enough proportion of providers' revenue is generated by ACO contracts to ensure adequate commitment to desired structural reforms.

Important considerations for implementation include whether the ACO has plans for meaningful delivery-system improvements that are actionable early in the contract period, whether the ACO exerts appropriate management responsibility over member organizations, whether ACO information-technology systems are mature, and whether health care providers are sufficiently engaged to support the ACO's performance goals.

On the performance front, policymakers and payers should ask whether provider-productivity

metrics effectively account for population-management efforts (versus individual episodes of care), whether providers are offered incentives related to prespecified quality and value metrics, and whether patients are given incentives to seek high-value care.

Some of these considerations have been well addressed in the Oregon experiment, whereas others have not. Failure of the Oregon Health Plan would be consequential, not only for the patients, doctors, and hospitals in Oregon but also for the future of the ACO as a model for health care reform. Regardless of outcome, this experiment will hold crucial lessons for ACO-based reform.

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