Alternative Payment Methodologies

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EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Before EOCCO

- **Moda Health (ODS Community Health), Inc. (FCHP)**
  - Baker, Malheur, Union and Wallowa
  - Clatsop, Columbia Jackson and Yamhill

- **GOBHI (MHO)**
  - Baker, Clatsop, Columbia, Douglas, Grant, Harney, Hood River, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco and Wheeler

- **Eastern Oregon Coordinated Care Organization, LLC. (EOCCO)**
  - Developed and submitted application for CCO model in 12 Eastern Oregon counties starting 11/1/2012
  - Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler
  - 46,000 members as of 9/1/2014

EOCCO Service Area and Common Cities and Towns

CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
Portland
MULTNOMAH
Hood River
HOOD RIVER
The Dalles
Moro
SHERMAN
Condon
GILLIAM
Boardman
Heppner
MORROW
Irrigon
Hermiston
Milton-Freewater
Walla Walla
Pendleton
UMATILLA
WALLOWA
Enterprise
Joseph
Elgin
La Grande
UNION
YAMHILL
CLACKAMAS
WASCO
POLK
MARION
Fossil
Spray
WHEELER
Mitchell
GRANT
John Day
Canyon City
Baker City
BAKER
LINCOLN
BENTON
LINN
JEFFERSON
Prineville
CROOK
Payette
Ontario
Vale
Fruitland
Nyssa
Caldwell, Nampa, Meridian & Boise
LANE
Bend
DESCHUTES
Burns
MALHEUR
Christmas Valley
LAKE
HARNEY
COOS
DOUGLAS
CURRY
JOSEPHINE
JACKSON
KLAMATH
Lakeview

Quick facts about EOCCO

- **Land Area: 49,929.75 sq. miles**
  - 52% of land area of State of Oregon
  - Larger than land area of 19 states
    - **MS, PA, OH, VA, TN, KY, IN, ME, SC, WV, MD, HI, MA, VT, NH, NJ, CT, DE and RI**
- **Population: 194,592**
  - 5% of Oregon's population
  - 1/3 the population of WY (least populous State)
  - Equivalent to the combined populations of Salem, Lake Oswego and Lebanon

EOCCO today

- **Investors**
  - Moda Health
  - GOBHI
  - Good Shepherd Hospital
  - Grande Ronde Hospital
  - St. Alphonsus Hospitals
  - St. Anthony Hospital
  - Pendleton IPA
  - Mirasol Clinic (Yakima Valley Farm Workers)
  - Future-(reserved for Counties or other providers as approved by the EOCCO owners)

Considerations for developing an APM

- FFS has been the historical payment model in Eastern Oregon
- Significant portion of our providers are Type A, B or critical access hospitals, FQHC's or RHC's
  - 10 cost base hospitals
  - 52% of EOCCO primary care clinics are FQHC's or RHC's
- Out of area/tertiary hospitals
- Specialists
- GOBHI (Mental Health and A&D providers)
- 12 Local Community Advisory Council's

Principles for developing our first year APM

- Relationships are key
- Must have provider buy in and engagement
- Keep it simple
- Use existing payment methodologies as a starting point
- Provide data to show performance

EOCCO APM for 2014

- Risk Sharing Model
  - Agreement between an insurance company and providers to share risk and to put proper incentives in place for providers and patients to benefit

- Model was built for a win-win situation

- Models include the proper financial vehicles that enable health care transformation

- Goal is to share surpluses back with providers and the LCAC's

2014 risk model

- Risk period: **April 2014 through December 2014.**
- Participation was voluntary
- One Fund – All participants will share
- Fund consists of certain portions of our CCO budget
- Individual member stoploss was established
- Participants have a minimal withhold
  - The withhold is the maximum risk a provider would assume
- Quality bonuses available

What is next

- Monitor performance of 2014 model and share data with participating providers
- Modify risk model for 2015 to become more sophisticated and include other providers
- Modify the model as needed based on CMS or State policy changes
  - RHRI initiative
  - Any impacts on the CCO global budget
- Invest in technology
- Use the model beyond Medicaid

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