Alternative Payment Methodologies

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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, Hamey, 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, Hamey, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler
  - 46,000 members as of 9/1/2014
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 stop loss 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