

MEDICAID FINANCIAL STRATEGIES – INFORMATION REQUEST

INSTRUCTIONS

OHA is working closely with CCOs to react to the health emergency and economic crisis occurring in Oregon due to the COVID-19 pandemic. At an April 14 CEO meeting, OHA agreed to request information of CCOs to facilitate collaboration on provider payment and other financial strategies.

Please fill out this form and return it to actuarial.services@dhsoha.state.or.us by **4/27/2020**. All the information provided in this questionnaire will be shared publicly.

CCO Name: Eastern Oregon CCO

Primary Contact Person at CCO: Sean Jessup

Primary Contact Person's email: sean.jessup@modahealth.com

Describe your CCO's efforts to evaluate the financial need of *providers who have experienced or are expected to experience a sharp decline in revenue ("Affected Providers")* from your CCO since public orders limiting non-urgent care were adopted. What approaches have you taken, and what have you learned? (limit to 2 pages)

EOCCO has spoken with each of the 10 hospital CEOs within our 12-county service area, several independent primary care practices, the CEO of Eastern Oregon IPA, DCO partners and our behavioral health partner, GOBHI, to evaluate what support EOCCO can provide and timing for that support. As part of these individual conversations EOCCO asked what CARES act support providers were applying for and/or had received. Generally speaking, most providers that are eligible for CARES act funding have applied for or have received funding. This funding is a critical backstop to support providers in the short term.

For providers that are already receiving capitation from EOCCO they are grateful to see the steady stream of funding for Medicaid continue regardless of the declines in volumes.

The most significant impact is on the hospitals, residential behavioral health providers and small independent providers who have traditionally been paid FFS.

What we learned early on during our initial discussions is that one of the primary keys to ongoing sustainability for Eastern Oregon providers was to get back to work. As a result, EOCCO facilitated discussions between OHA and each of the 10 hospital CEOs within our geography to discuss a potential pilot within the EOCCO geography. Under the pilot, at an appropriate time, hospitals and providers would be allowed to resume providing elective procedures while keeping the health and safety of members, healthcare workers and the constituents within the communities safe. We are very happy to see that providers can get back to work beginning May 1st.

EOCCO has also disseminated a survey to all contracted providers and partner organizations to assess the impact of COVID-19 on daily operations. The survey included components of the ramifications to revenue streams as

well as staffing modifications. The results of this survey will help drive EOCCO's further decision-making regarding allocation of resources and assistance.

Describe your CCO's payment strategies to Affected Providers. Select all that apply. Have you:

- Offered advance payments based on average historical monthly payments (per member per month (PMPM) with required quality metrics
- Offered advance payments based on average historical monthly payments PMPM without required quality metrics
- Pre-paid incentive dollars that were originally associated with quality metrics performance
- Relaxed quality metrics performance requirements
- Modified existing risk-sharing payment arrangements
- Eliminated risk-sharing (while maintaining the shared-savings)
- Implemented other payment approaches, please describe:
EOCCO has offered primary care practices that are currently paid on a FFS payment methodology the option to move to capitation.

EOCCO is currently exploring a capitated or prepayment options to the 10 hospitals that operate in our service area. This option may be short term or permanent and may or may not be reconciled back to FFS payments.

The EOCCO board approved temporarily holding back a portion of the early release of quality funding should a provider within our service area require additional financial support that is in serious financial jeopardy. Any of the temporary held funding that is not needed in the near term will be distributed back into the programs we have traditionally funded.

Provide details regarding the terms and timing of your CCO's proposed alternative payment methods to Affected Providers, such as advance or capitated payments, risk-sharing, reconciliations, and quality or other bonuses:

PCPs wanting to move to a capitation model can do so the first of the month following their decision to change from FFS to capitation.

Our hospital capitation or prepayment proposal/option will be fully vetted in the near term and offered as an option for hospitals in the month of May.

EOCCO will pay out a portion of 2019 quality funding by the end of April. Prepayment of 2020 quality withhold funding will be paid out in May.

Describe how any new payment arrangements to Affected Providers vary by provider type or other circumstances (e.g. behavioral health provider or regional differences).

PCPs have the option to move to capitation, based on an existing structure EOCCO already has in place.

We are actively working through a capitation or prepayment proposal for hospitals.

We are actively working through a capitation or prepayment proposal for residential behavioral health providers.

Describe your CCO's strategies to engage Affected Providers about moving to value-based payments. Are the proposed moves for a limited time (e.g. 2020 only in direct response to the COVID-19 emergency), or are these efforts linked to your ongoing efforts to meet VBP targets per CCO contractual requirements?

EOCCO is actively working with PCP's to offer Capitation for primary care services. We are providing financial data as needed to support these discussions. Capitation agreements are for 12 months and the model/contract is renewed annually. This effort is aligned with our ongoing VBP efforts.

EOCCO has convened a group of EOCCO Hospital CEO's to evaluate Capitation/prepayment options for hospitals. EOCCO is providing data analytics and looking at historical data to support these discussions. GOBHI is working directly with residential behavioral health providers to discuss capitation/prepayment models. These models may be short term or for up to a year and then renewed annually. While these efforts were not necessarily part of our near term VBP strategy, the transition would be a positive evolution to our strategies.

OHA is seeking to provide advance payment to open card Affected Providers in 2020, subject to some extent of reconciliation that depends on policy decisions, logistics, and CMS guidance. How do you think your CCO's provider engagement and payment strategies could integrate with OHA's open card efforts?

OHA may want to consider a consistent strategy by provider type, PCP's, Hospitals, Behavioral Health, etc. For providers that may have a large amount of FFS and CCO dollars paid or for providers that work with multiple CCO's there may be the ability to align payment strategies.

It likely does not make sense to align strategies when a provider has very low FFS dollars. OHA may want to consider whether the impact of an advance payment on a small volume FFS provider is meaningful help. Additionally, OHA may want to prioritize support for the largest volume FFS providers first.

If your organization has a commercial line of business, are you making similar changes identified above in your commercial plans? What differences in strategies do you expect? What barriers to you anticipate?

N/A

What suggestions do you have to engage and encourage commercial health plans to play a part in providing financial support to providers affected by steep declines in FFS revenue?

EOCCO believes that some commercial health plans are playing a part in providing financial support to providers. One of EOCCO's partners Moda Health is providing the following support:

Advancing payment of \$3.86M in Shared Savings model funds to hospital systems participating in Moda's value-based payment models.

Offering primary care practices currently participating in Moda's value-based payment models the opportunity to increase the percentage of capitation for primary care services, so that they can continue to receive a

sustainable revenue stream regardless of utilization. This is in addition to the monthly Care Management Fee pmpm payments, that Moda already provides to these practices for each member attributed to the practice.

Working to operationalize an accelerated shift away from FFS payments to full capitation agreements for qualifying Moda providers.

OHA may want to ask commercial health plans a similar set of questions as those you are asking from CCOs. Again, we believe getting providers back to work is the key to long term financial sustainability regardless of the payer.

What other actions would you suggest OHA consider to address Affected Providers payment and financial strategies?

Throughout our conversations with providers they quickly identified that Medicaid generally represents just a portion (about 1/3rd) of provider revenues for medical providers in Eastern Oregon. The funding mix does vary for Dental and Behavioral Health providers, but again Medicaid is typically not the only funding source. While the distribution of quality funding and offering options of capitation or prepayment models were acknowledged as helpful, Medicaid alone cannot solve the financial strain being felt by providers. In our view getting providers back to work is the best option to ensure the long-term financial sustainability of providers. The ability to begin elective procedures effective May 1st is a great step forward. We would also recommend that OHA understand what CARES act funding providers have applied for or received. This funding offers critical support for providers in the short term beyond what OHA and CCO's are already doing.

As a result of the Rural Health Reform Initiative (RHRI) and pursuant to ORS 414.653(5), EOCCO recommends that Good Shepherd Medical Center, Grande Ronde Hospital, and St Anthony Hospital be transitioned from their current designation back to Cost Based Reimbursement for Medicaid. As these hospitals are investing heavily in COVID-19 preparations, while their volumes are significantly reduced, a move back to Cost Based Reimbursement could help rebuild adequate reserves to ensure longer term sustainability.

What financial or operational actions is your CCO taking to prepare for a potential increase in Medicaid enrollment? What areas present the greatest vulnerability to access to care and network adequacy as a result of increasing member enrollment? To the extent possible provide reference to geographic, technical, and provider type.

Our belief is that many of the new members expected to come onto the Medicaid program as a result of the crisis previously had coverage through the exchange or through their employer. As a result, we believe that many of the new members that were previously accessing "medical care" already have established care with a current EOCCO provider. As it relates to medical providers, we don't believe there will be a significant "access issue" for EOCCO. We do acknowledge that the dental and behavioral health deliveries systems do look different for Medicaid and these areas within the delivery systems will need to be vetted to ensure adequate access for the new enrollees. It would be helpful to know if OHA agrees with this general belief as it relates to the new membership. Clearly the loss of any provider in our geography will have an impact on access so we are focused on supporting providers to ensure this does not occur.

Our primary financial concern is the need to further increase capital to meet the 200% RBC requirement. The increased membership will result in increased premium, coupled with the uncertainty in utilization experience could put stress on the capital levels of the EOCCO to meet the 200% RBC requirements. This could result in

capital call from each of EOCCO's eight partners, seven of which are hospitals or providers from Eastern Oregon who are currently being severely impacted financially by the COVID -19 crisis. The last thing we want to do right now is ask financially strapped organizations for additional capital in order to meet the 200% RBC requirement. We would like the OHA to consider reducing the 200% RBC requirement.

From an operational standpoint, Moda on behalf of EOCCO is cross training additional staff to support EOCCO operations in anticipation of enrollment growth.

What requests do you have for OHA regarding modeling of potential enrollment and budgetary impacts resulting from COVID-19?

As mentioned above, increased enrollment and premium, results in the need for increased capital to meet the 200% RBC requirement. Our request is for OHA to consider adopting an RBC level of less than 200%, so that CCOs can focus on providing care to the new and existing members during this crisis versus focusing on how raising additional capital.

Additionally, we are concerned about the decline in general fund revenues that could result in future cuts in CCO premiums and/or reductions in member benefits and eligibility. As a system it would be good to start discussing mitigation strategies.

Please summarize your strategies for Affected Providers to 1-2 paragraph that could be broadcasted to the public and help providers understand how to engage with your CCO. (This answer will be added to a summary by CCO and posted to a website quickly)

EOCCO's efforts can be categorized into four main workstreams; advocacy on behalf of the provider community, direct provider financial support, promoting and maintaining member access to providers and easing administrative burden for providers. Following are the many efforts that have been put in place to support our provider community;

Advocacy on behalf of the Provider Community:

- EOCCO has facilitated discussions between OHA and each of the 10 hospital CEOs within our geography to discuss a potential pilot within the EOCCO geography. Under the pilot, at an appropriate time, hospitals and providers would be allowed to resume providing elective procedures while keeping the health and safety of members, healthcare workers and the constituents within the communities safe. One of the primary keys to ongoing sustainability of the hospitals in Eastern Oregon is to get back to work. We are very happy to see that providers can get back to work beginning May 1st.
- Working at a federal level on advocacy to revise any future Paycheck Protection Program (PPP) funding to allow EOCCO's five health district hospitals to qualify for PPP funding. Although the original legislation waived the non-profit status, these hospitals are technically considered government entities, which are not covered under PPP. We are happy to hear that health districts are now qualified for PPP funding as part of the second round of CARES act funding for this program.

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- As a result of the Rural Health Reform Initiative (RHRI) and pursuant to ORS 414.653(5), EOCCO is requesting that the Oregon Health Authority consider transitioning Good Shepherd Medical Center, Grande Ronde Hospital, and St Anthony Hospital from their current designation back to Cost Based Reimbursement for Medicaid. As these hospitals are investing heavily in COVID-19 preparations, while their volumes are significantly reduced, a move back to Cost Based Reimbursement could help rebuild adequate reserves to ensure longer term sustainability.

Direct Provider Financial Support:

- Distributing \$4.5 Million in 2019 quality funds in April to key sectors within the delivery system, (Hospitals, PCP's, Dental and Behavioral Health). Funds are intended to provide financial support.
- Distributing \$2 Million in 2020 quality funds this May to hospitals and primary care practices. Funds are intended to provide financial support.
- Establishing an emergency fund intended to support providers in our service area that require additional financial support that are in serious financial jeopardy. The intent of this fund is to ensure access and provider capacity.
- Offering primary care practices, the option to take capitation for primary care services so that they can receive a sustainable Medicaid revenue stream regardless of volumes. This is in addition to the monthly PCPCH payments EOCCO already provides State certified primary care practices for each EOCCO member attributed to the practice.
- EOCCO is currently exploring capitation models for hospitals and residential behavioral health programs on an interim or permanent basis to provide a sustainable Medicaid revenue stream regardless of volumes. Hospitals have indicated interest in exploring this option.

Promoting and Maintaining Member Access to Providers

Expanded access to telehealth care:

- Providers can provide services through telephone, video, text and other options to help members get the care they need during the COVID-19 state of emergency. Encounters for tele-behavioral health have significantly increased since the beginning of March.
- Provider reimbursement for telehealth services is at the same level as in-person care.
- EOCCO is outreaching to providers to help them understand their options related to providing telehealth.

Easing access to medications and equipment:

- "Refill too soon" policies for medications and medical equipment were adjusted to ensure members have needed medications and supplies on hand.
- Implemented mail order pharmacy benefit to increase member access.
- Monitoring for critical prescription supply shortages.

Proactive outreach to high-risk members:

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- EOCCO's Care Management team is actively reaching out to high-risk members to ensure they have the support and care that they need, and is connecting members to providers for follow-up services, as needed.
- Behavioral health intensive care coordinators are also actively reaching out to the most vulnerable populations with Serious and Persistent Mental Illness.
- CCO staff is presenting COVID-19 benefits and resources to all 12 Local Community Advisory Councils.

Easing Provider Administrative Burden:

Helping providers care for patients:

Provider administrative burdens have been eased by:

- Extending approved date range on prior authorizations.
- Temporarily offering provisional credentialing and waiving verification of certain elements.
- Extending claim submission and utilization management deadlines.

EOCCO will continue to outreach to our provider community to understand the impacts that providers may be facing and to participate in efforts to support access and quality care for members. Questions about these strategies can be directed to eoccometrics@modahealth.com.