CCO 2.0:
Increasing Value-based Payment

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Transformation Center
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Agenda

• CCO 2.0 Background
• CCO 2.0: VBP Policy Overview

• Full report:
  – *CCO 2.0 Recommendations of the Oregon Health Policy Board*
    • Report: [https://apps.state.or.us/Forms/Served/le9830.pdf](https://apps.state.or.us/Forms/Served/le9830.pdf)
What is CCO 2.0 and Why is It Important?

• Coordinated Care Organizations (CCOs) started in 2012 with the promise to improve health, provide better care, and lower health care costs for Oregon Health Plan members.
  – We now have over five years of data about what is working and what needs more work.

• CCO 2.0: The next five-year CCO contracts; start in 2020

• CCO 2.0 is important because of large amount of people and dollars
  – One in four Oregonians—nearly one million people—receive health coverage through the Oregon Health Plan; most are CCO members
  – Oregon’s Medicaid budget is about $14 billion, accounting for 19% of the state’s budget
CCO 2.0: Continued Health System Transformation

- Maintain cost growth
- Increase value and pay for performance
- Focus on social determinants of health and equity
- Improve behavioral health system
CCOs will be selected through a Request for Application (RFA) process

Only current CCOs and companies with an existing Oregon “footprint” can apply.

- October - December 2018: RFA development begins. Formal question-and-answer process will be launched. OHA will amend rules, develop rates, and finalize technical details.
- November 19: OHA will hold an additional technical forum on open enrollment/member transition and rates and member attribution.
- January 2019: RFA released.
- February 2019: Letters of intent due.
- April to June 2019: Evaluation, CCO selection, and negotiations.
- June 2019: Award CCO contracts.
- September to December 2019: Readiness review.
- January 2020: New CCO contracts implemented.
Value-based Payments (VBP)

- Most health care in the U.S. is paid for using a fee-for-service (FFS) model, which pays for each health care service, visit, or test. This system incentivizes the delivery of more health care, instead of better health care.

- The goal of increased use of VBPs is to incentivize delivery system reform that focuses on value instead of volume of care delivered, rewarding providers for a combination of high-quality care, positive member health outcomes and cost savings.
OHA VBP Opportunities

Enhancement of VBP in the Oregon Health Plan
- Oregon Health Authority payments to CCOs
- CCO payments to their providers

Opportunities for VBP alignment

• Within OHA:
  - Public Employees’ Benefit Board
  - Oregon Educators Benefit Board

• Between OHA and other payers
  - Comprehensive Primary Care Plus
  - Primary Care Payment Reform Collaborative
VBP and the Triple Aim

**Triple Aim**
- Improve Patient Experience
- Improve Health of Population
- Reduce Costs

**Payment Reform**

- **Fee-for-service**
  - Volume-driven care
  - Focused on acute singular event
  - Payer and provider incentives not aligned

- **Value-Based**
  - Value (not volume) of care
  - Prevention and care coordination for improved quality and health outcomes
  - Aligned incentives between payers and providers
CCO 2.0 VBP Public Engagement

- CCO 2.0 survey and public forums

- CCO Value-based Payment Work Group
  • Three facilitated meetings with all CCOs represented

- VBP Provider Survey

- Presented at standing committees, including:
  • Quality and Health Outcomes Committee, Primary Care Payment Reform Collaborative, Medicaid Advisory Committee, Healthcare Workforce Committee, Health Information Technology Oversight Committee

- Written comments submitted by external partners (and many more, all posted at https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-recommendations.aspx)
  • Oregon Academy of Family Physicians, Oregon Medical Association, CareOregon, Oregon Primary Care Association, OCHIN, Coalition of Local Health Officials, Trillium Community Health Plan, OHPB Health Equity Committee
Public Engagement – Key Themes

– Written comments by stakeholders
  • Largely supportive of increased use of VBPs; requests for meaningful incentives and metric alignment for providers; concerns around data-sharing; consideration of VBPs within rate-setting.

– CCO 2.0 VBP Survey Themes
  • Comments mixed between VBP being the right direction and VBP challenges in implementation and practice.

– VBP Provider Survey Themes
  • Experience with VBPs; blended model of FFS and capitation has been effective to shift from FFS to VBP; concerns regarding meaningful incentives and metric alignment, sufficient/timely data, and behavioral health integration.
CCO 2.0: VBP Policy Summary

VBP: CCO’s payments to providers

- 2020: 20%
- 2021: Care delivery area VBPs: 2021-2024
- 2022
- 2023
- 2024: 70%

Patient-Centered Primary Care Home VBPs: 2020-2024

+
VBP for PCPCH clinics

Require per-member, per month “infrastructure” payments (i.e., payments based on PCPCH tier level):
• Provide financial support for PCPCHs to implement and sustain a robust PCPCH model of care
  – Supports staff and activities not reimbursed through FFS
• Enhance PCPCHs’ ability to adopt more advanced VBPs

PCPCH program evaluation* findings:
• PCPCH Program encouraged clinics to embrace team-based care.
• Every $1 increase in primary care expenditures related to the PCPCH Program led to $13 average health care system savings.
CCO 2.0 VBP Targets & Timeline

- 20% VBP
  - CCO's payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher

- 2020
  - 20% VBP target

- 2021
  - Launch care delivery area VBPs

- 2022
  - 35% VBP target
  - Increase VBPs with shared savings and downside risk

- 2023
  - 50% VBP target

- 2024
  - 60% VBP target
  - 70% VBP Target

- LAN Category 2C (Pay for Performance) or higher
CCO 2.0 VBP Targets

- VBP Framework from the Health Care Payment Learning and Action Network
Beginning January 2021, CCOs are required to implement VBPs in key care delivery focus areas:

- Flexibility of VBP models, design and size (i.e., no spend or population size requirement) but must be LAN category 2C or higher
- Uses VBP as a lever to advance OHA goals
- VBP models may include more than one care delivery area
- Hospital and maternity care VBP required to be in place by 2022

### Care Delivery Area

<table>
<thead>
<tr>
<th>Care Delivery Area</th>
<th>Rational for focus</th>
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<tbody>
<tr>
<td>Hospital care</td>
<td>High-cost; minimal CCO VBP experience</td>
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<tr>
<td>Maternity care</td>
<td>Governor’s priority; major area of spending; upstream</td>
</tr>
<tr>
<td>Children’s health care</td>
<td>Governor’s priority; widespread public support</td>
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<tr>
<td>Behavioral health care</td>
<td>CCO 2.0 priority; VBP can promote integration</td>
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<tr>
<td>Oral health care</td>
<td>Foundational to CCO model; VBP can promote integration</td>
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VBP Reporting

• Require CCO applicants to demonstrate necessary information technology (IT) infrastructure for VBP reporting

• Streamline reporting by using All Payer All Claims (APAC) database for VBP reporting

• Collect supplemental data and annual interviews
VBP Implementation Support

Planned OHA Transformation Center VBP technical assistance for CCOs includes:

• Developing equitable VBPs, including risk adjustment on medical and social complexity

• Developing VBP models in care delivery areas

• Developing more advanced, risk-based VBPs
Thank you!
Questions?