Oregon Health Authority
CCO 2.0

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Oregon Health Authority

Goals of CCO 2.0

Cost Containment in CCO 2.0

Accountability

Status of the RFA

Lessons from CCO 1.0

- Having a sustainable rate of growth target helps
- Paying for outcomes improves quality and drives change
- More opportunity to advance value-based payments to providers
- New opportunity in 2017 waiver to spend on health-related services

Challenges

- National health care costs expected to grow at 4.7%
- CCOs likely focused on “low hanging fruit”
  - More innovative approaches will be required to reduce costs in CCO 2.0

Goals of CCO 2.0

Guided by Governor Brown's vision, CCO 2.0 policies build on Oregon's strong foundation of health care innovation and tackle our biggest health problems

- Improve the behavioral health system and address barriers to the integration of care
- Increase value and pay for performance
- Focus on the social determinants of health and health equity
- Maintain sustainable cost growth and ensure financial transparency

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Principles for Cost Containment

- OHA expects CCOs to manage within a global budget
- OHA's goal is to achieve the sustainable and fixed rate of growth at the CCO program level (established by the waiver and legislatively approved budget)
- OHA will reward CCOs that are delivering efficient and quality care to OHP members within the rate of growth targets
- OHA intends to distribute funds in an equitable and transparent manner

However...

- CMS Waiver
- Actuarial soundness

CCO 2.0 Policies to Address Costs

- Evolve rate development for global budgets
- Advance value-based payments
- Increase investments in social determinants of health and health equity
- Promote better integration of physical, behavioral, and oral health
- Reinsurance
- Pharmacy costs

Advance Global Budgets

Policy Goal: Evolve rate methodology to include additional financial incentives to promote quality, efficiency, and high value care

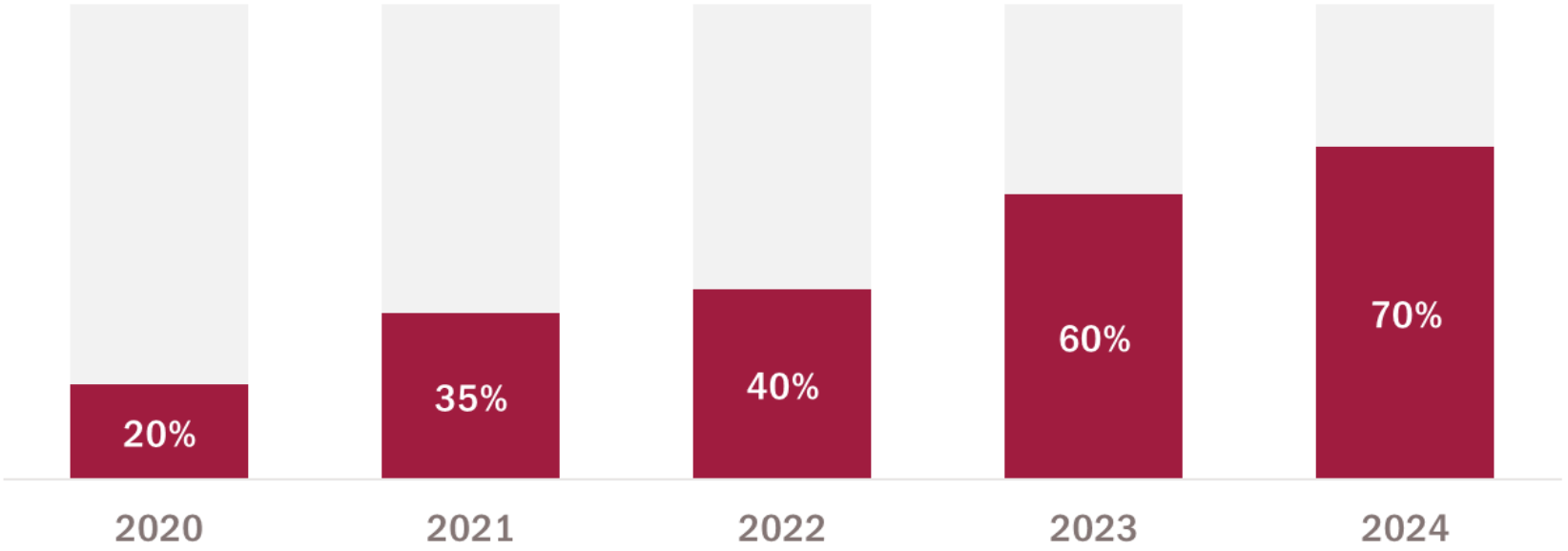
- Implement a performance based reward within CCOs rates for efficiency and quality care
- Build a financial system that encourages prevention and investments that reduce medical costs through spending on social determinants of health
- Continue holding CCOs accountable for quality outcomes with a financial incentive

CCO 2.0 Rate Methodology Changes

- Statewide basis for capitation rates with area factors to account for geographic differences and health-based risk factors
- Rebase rates every two years (instead of every year) to allow more stability in the CCO model, and free up resources to focus on CCO 2.0 goals of efficiency and quality
- Use tools that identify opportunities to reduce waste through more efficient and better care (e.g., avoidable hospitalizations)
- Encourage spending on social determinants of health by using a enhanced risk adjustment process 2022 forward in rates
- Implement a performance-based reward for CCOs that are operating efficiently and reducing waste in the system

Value-Based Payments

In 2.0, CCOs are required to **increase annually the level of payments that are value-based.**



CCO 2.0 Will Firmly Establish VBPs as the Primary Method of Payment

Value-Based Payments (VBP) link provider payments to **improved quality and performance** instead of to the volume of services

- By 2024, 70 percent of CCO provider payments must be in the form of a VBP
- In their work towards achieving VBP targets, CCOs must also develop new or expanded VBPs in five areas: hospital care, maternity health care, children's health care, behavioral health care, and oral health care
- CCOs will also be required to make monthly infrastructure and operations payments to all of their patient-centered primary care homes

Social Determinants of Health and Health Equity Policies

Social determinants of health and health equity policy strategies target improved health, bending the cost curve through:

- **Addressing the root causes of health issues** through HB 4018 implementation, an SDOH-HE Capacity Building Bonus Fund, and statewide housing priority
- **Aligning community priorities and streamlining efforts** through requiring CCOs, Local Public Health Authorities, and local hospitals to collaborate on shared Community Health Assessments/ Community Health Improvement Plans
- **Increasing smart workforce strategies,** including utilizing Traditional Health Workers, such as Community Health Workers

Additional Policy Changes

- Behavioral health
  - Advance integration of physical and behavioral health
  - Ensure timely access to the right level of care
- Establish a reinsurance program to better manage high cost patients and new, expensive therapies
- Strategic alignment of preferred drug lists to maximize federal rebates for prescription drugs
- Required changes in CCO pharmacy benefit manager contracts to increase transparency and maximize rebates

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New Accountability in CCO 2.0 contracts

In addition to the examples cited above, the CCO 2.0 contracts feature:

- Improved clarity and consistency that will strengthen the state's ability to enforce contract terms
- New contract enforcement measures, such as the ability for OHA to impose financial penalties for non-compliance
- New accountability provisions related to member care and access
- New requirements for monitoring Non-Emergency Medical Transportation providers
- Increased requirements for CCO monitoring of subcontractors
- Greater transparency on activities delegated or subcontracted to other entities

New Accountability in CCO 2.0 contracts

Continued...

- Changes to provider network reporting to help OHA identify and address network adequacy issues
- New provision to conduct validation studies of CCO encounter data to ensure accuracy
- Improved notification requirements when an OHP member has other insurance coverage (to reduce financial liability to OHP)
- New requirements for CCOs to monitor member wait-times for appointments

SB 1041, Financial Regulation of CCOs

Ensures that solvency and financial accountability standards are applied to CCOs, by granting OHA oversight authority for CCOs similar to how the insurance code grants DCBS oversight authority for commercial insurers

- Requires increased accountability and transparency regarding CCO finances
- Requires an examination of CCO solvency and financial resources at least every five years
- Establish a framework for Risk-based Capital (RBC) methodology to better assess financial risk and reserve levels of CCOs
- improves oversight tools for dealing with impaired CCOs

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CCO 2.0 Contracting Timeline

April 22	**Applications due**
April to July 2019	Evaluation, CCO selection, and service area negotiations
May 30	Required applicant conference on program integrity
July 9 (approximate)	**Award CCO contracts**
August 1	Readiness review documentation due
August	Technical assistance forum on contract, including changes from 2019 Legislature; revised contract published
September 15	Procurement Rates updated
September 27	Readiness review and corrective action plans completed
September 30	Contracts signed
October 1 to November 29	Member allocation
December	Member transition plans implemented
January 2020	New CCO contracts implemented

The Application Evaluation and Readiness Review Processes

- Built an evaluation plan that will look at each applicant's responses to key policy priorities and score their results
- Goal is to ensure that applicants can meet core requirements as laid out in the Request For Applications and CCO 2.0 goals
- Also evaluating for financial solvency of the applications, adequacy of member network, and community support
- After notice of intent to award in July, OHA will work with each applicant to assure they are ready to begin providing services in 2020 through a formal readiness review process
- Readiness review will look deeper at financial and operational status and ensure the CCO is viable for meeting policy goals and requirements

Member Transition: Member Choice and Auto-Assignment

- **Member Choice** is a period of time where members are able to select between available plans in their area
- **Auto-Assignment** is the automated process of enrolling members into a plan if they do not select an option during open enrollment

OHA Values and Priorities Guiding Member Transition

- There should be minimal disruption of **members' continuity of care**
- When possible, **members should be able to choose** their plan
- If members do not make a choice, OHA will auto-assign members into CCOs that allow them **to maintain existing primary care and behavioral health provider relationships**

Thank You

Oregon Health Authority