Oregon's Primary Care Transformation Initiative

2023 Progress Report

Primary Care Payment Reform Collaborative

April 2024

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Acknowledgments

This publication was prepared by the Oregon Health Authority's Transformation Center.

For questions about this report, please contact:

Oregon Health Authority
Delivery System Innovation Office, Transformation Center
Chris DeMars, Director, Delivery System Innovation Office, Acting Director, Health Policy Office
chris.demars@oha.oregon.gov

Executive summary

The Primary Care Payment Reform Collaborative (Collaborative) is legislatively charged with developing and sharing best practices in technical assistance and reimbursement methods that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Specifically, the Collaborative is required to focus on:

- Increasing investment in primary care (without increasing costs to consumers or increasing the total cost of health care).
- Improving reimbursement methods, including by investing in the social determinants of health.
- Aligning primary care reimbursement by purchasers of care.

This annual report reviews the Collaborative's work in 2023 and outlines next steps for making progress in 2024.

The focus of the Collaborative's work in 2023 was to continue the work launched in 2022 by the Value-Based Payment (VBP) Model Development Workgroup to build upon the Collaborative's recommendations to the VBP Compact Workgroup. This work involved developing a primary care payment model with a focus on health equity and sufficient specificity to achieve alignment across payers.

The VBP Model Development Workgroup completed the VBP payment model in May 2023 and the Collaborative endorsed the primary care VBP payment model in June. The Collaborative convened two subgroups in September 2023 to further develop the model, one to select quality measures to incorporate in the model and the other to develop at least one pilot integrating risk adjustment to account for social factors that influence patients' health outcomes (i.e., social risk adjustment). Social risk adjustment can help advance health equity by better allocating resources between under-resourced populations and populations with more secure socioeconomic standing to avoid health disparities.

Primary care VBP model design

The all-payer primary care payment model includes the following four components:

1. **Prospective capitated payments** for a defined set of primary care services that are widely performed by primary care practices, represent a preponderance of primary care spending, and could potentially be overutilized in the traditional model of fee-for-service
2. **Fee-for-service payments for all other covered services** such as prenatal visits, end-of-life and advanced care planning, home visits and after-hours care
3. **Infrastructure per-member-per-month payments** that include: 1) a base payment tied to Patient-Centered Primary Care Home tier, and 2) additional payments for specific high-value services

4. **Performance-based incentive payments** based on an aligned set of quality measures

The primary care VBP model includes components to promote health equity, such as:

- Support for practices to stratify quality metrics by demographic factors, including race and ethnicity.
- Infrastructure payments to address health-related social needs and promote health equity.
- Inclusion of health equity-focused measures.
- Strategies to protect against unintended adverse consequences of VBP, including identifying and responding when practices are withholding or limiting care or making too many specialty, urgent care and emergency department referrals.

In coordination with the Collaborative, the VBP Compact Workgroup developed an online VBP toolkit to help clinicians, provider entities, and their payer partners increase VBP implementation. The toolkit includes guidance for implementing the primary care VBP model.

Collaborative retreat

In October, the Collaborative met in person for a strategic planning retreat to: 1) learn about primary care investment initiatives across the country, 2) discuss the primary care spend report and how to use it and 3) determine future work for the Collaborative.

In 2024, the Collaborative will pursue four areas of work identified at the October strategic planning retreat: 1) policy and legislative work, 2) education and outreach to promote the implementation of the primary care VBP model, 3) data work, and 4) continue development of one or more pilots of social risk adjustment.

Introduction

The Primary Care Payment Reform Collaborative (Collaborative) is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA). Senate Bill 934 (2017) directs the Collaborative to advise and assist OHA in implementing a Primary Care Transformation Initiative (Initiative) to:

- Use value-based payment (VBP) methods that are not paid on a per-claim basis to:
  - Increase the investment in primary care
  - Align primary care reimbursement by all purchasers of care
  - Continue to improve reimbursement methods, including by investing in the social determinants of health
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care
- Facilitate the integration of primary care behavioral and physical health care

The legislation directs the Collaborative to develop strategies that support implementing the Initiative, including providing technical assistance; aggregating data and aligning metrics; and evaluating the Initiative. The charge, deliverables and composition of the Collaborative are outlined in its charter (Appendix A). The Collaborative currently includes 31 members (Appendix B) representing a range of providers, payers and other primary care partners. The full Collaborative – which has met regularly since 2016 – convened four times in 2023. The VBP Model Development Workgroup (Appendix C), convened in 2022, continued its work in 2023 over the course of 12 meetings, including subgroup meetings focused on metrics and social risk adjustment.

The Collaborative Steering Committee, chartered in 2022, met seven times in 2023 to provide leadership to the Collaborative and OHA, help guide and plan the work of the group, and assist in meeting the Collaborative's legislatively prescribed goals. Steering Committee members are noted in the Collaborative roster (Appendix B).

In 2023, the Collaborative continued to prioritize health equity in alignment with OHA's goal to eliminate health inequities in Oregon by 2030. Specifically, the Collaborative focused on integrating health equity within the primary care VBP model.

This annual report reviews the Collaborative's work in 2023 and outlines its next steps for making progress in 2024.

Alignment and collaboration with the Value-Based Payment Compact Workgroup

As part of Oregon's legislatively mandated initiative to contain growth in health care costs, the Health Care Cost Growth Target Implementation Committee identified advancing VBPs

across Oregon as its first strategy to achieve its cost-growth target. The Oregon VBP Compact, jointly sponsored by OHA and the Oregon Health Leadership Council, is a voluntary commitment by payers and providers to participate in and spread VBPs. The Compact has 63 signatories, covering 73 percent of the people in Oregon.

The Collaborative has a keen interest in Oregon's VBP Compact and worked in partnership with the VBP Compact Workgroup in 2023 to promote the spread of primary care VBPs across the state. Two Collaborative members also sit on the VBP Compact Workgroup. To initiate a partnership with the VBP Compact Workgroup, in 2022 the Collaborative presented a memo (Appendix D) to the VBP Compact Workgroup outlining overarching recommendations for primary care VBP and recommendations specific to the continuum of VBP models, attribution, complex care, behavioral health integration and care for children and youth.

The recommendations related to:

- Alignment to minimize administrative burden
- VBPs to address health equity
- Inclusion of enhanced fee-for-service (FFS) and per-member-per-month (PMPM) payments
- Exclusion of high-cost health care, such as certain specialist procedures and inpatient stays that are largely outside the control of primary care
- Analysis of quality, access and utilization data by race, ethnicity, language and disability (REALD)
- Limited metrics that address care across the lifespan
- Improvement targets
- Risk and mitigation strategies

The VBP Compact Workgroup requested the Collaborative develop a primary care payment model incorporating these recommendations. The payment model will be included in a menu of VBP models, the first strategy identified by the VBP Compact Workgroup in its VBP Roadmap to increase the use of VBP. During 2022 and 2023, the Collaborative has built upon the contents of the memo and its 2018 recommended payment model to draft a primary care VBP model for adoption across payers.

VBP toolkit

This year, the VBP Compact Workgroup, with the assistance of the Collaborative, developed an online VBP toolkit to help clinicians, provider entities, and their payer partners prepare for VBP arrangements, implement these arrangements, and overcome specific challenges to operating successfully within increasingly advanced VBP models. The toolkit also includes guidance for implementing the primary care VBP model.

Development of the primary care VBP model

The development of a payment model with enough specificity to achieve aligned implementation requires consideration and decisions on many design elements. The Peterson-Milbank Program for Sustainable Health Care Costs supported technical assistance for OHA from Bailit Health, a consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and employer purchasers. Consultants from Bailit Health facilitated the VBP Model Development Workgroup, which was comprised of both payers and providers, through the model design process.

Principles and process

The VBP Model Development Workgroup started the primary care VBP model development process by agreeing on the following principles to guide the payment model design.

- Support the unique needs of adult and pediatric populations to ensure equitable access to, and delivery of, care.
- Support practices to provide the full scope of care patients need to address medical and social complexity, while not disincentivizing them from serving complex patients.
- Align models and metrics across payers to ease administrative burden on practices and maximize healthcare teams' impact on health outcomes, while allowing for flexibility in implementation by diverse types of practices.
- Support interdisciplinary teams to provide team-based care.
- Support the ability of practices to build and invest in partnerships with communitybased organizations to increase patient access to services that address health-related social needs and social determinants of health.
- Include metrics that are evidence-informed and parsimonious; address all populations served by Patient-Centered Primary Care Homes; have reasonable benchmarks and improvement targets; and incorporate total cost of care and financial sustainability.

With the principles established, Bailit Health guided the VBP Model Development Workgroup through a series of questions on specific design decisions to enable development of the VBP model. The VBP Model Development Workgroup updated the Collaborative throughout the process and presented the final draft model to the Collaborative at the June 2023 meeting. The Collaborative endorsed the model in June and presented it to the VBP Compact Workgroup in September.

The development process consisted of addressing the following ten primary design decision topics:

1. Base payment model options
2. Defining primary care practices and services for the VBP model
3. Primary care provider selection and attribution

4. Rate development methodology
5. Risk adjustment
6. Accounting for cost-sharing in capitated payments
7. Value incentives and rewards
8. Aligned quality metrics
9. Ensuring equity
10. Protecting against negative consequences

Primary care VBP model

The all-payer primary care payment model includes the following four components:

1. **Prospective capitated payments** for a defined set of primary care services that are widely performed by primary care practices, represent a preponderance of primary care spending, and could potentially be overutilized in the traditional model of fee-for-service
2. **FFS payments for all other covered services** such as prenatal visits, end of life and advanced care planning, home visits and after-hours care
3. **Infrastructure per-member-per-month payments** that include: 1) a base payment tied to Patient-Centered Primary Care Home (PCPCH) tier, and 2) additional payments for specific high-value services
4. **Performance-based incentive payments** based on an aligned set of quality measures

The payment model includes support for integrated behavioral health services provided by any provider type. While total cost of care (TCOC) is not part of the primary care VBP model, it could be added as a complement if payers and providers choose to do so.

Defining primary care practices and prerequisites for the VBP model

The first step to implementing the payment model is to define primary care practices eligible to participate.

- The payment model strongly recommends and incentivizes Oregon PCPCH recognition, but recognition is not a prerequisite for practice participation. Recognition can be incentivized and rewarded through supplemental payments (such as infrastructure payments).
- There are no other practice participation prerequisites, such as minimum practice size or performance pre-qualifications.
- The model will phase in organically with the goal of all practices adopting the model within three years, in a manner to be decided between individual payers and their contracted practices.

Defining primary care services to include in capitated payments for the VBP model

The model focuses on services provided, not on specific provider types, allowing for the inclusion of services provided by a diverse array of care team members. The following guiding principles inform whether services are included in or excluded from the capitated service payments:

- Include services that are:
  - Widely performed by primary care practices
  - Represent a preponderance of primary care spending
  - Prone to overuse when paid fee-for-service
- Exclude services that are:
  - Performed at widely varying rates among providers and/or offered inconsistently
  - Subject to potential underutilization and where there is interest in incentivizing increased volume

To help inform which services to include, OHA surveyed all of the payers that signed onto the VBP Compact to better understand whether payers include specific types of primary care team members (such as traditional health workers) and service categories (pharmacist services and integrated behavioral health services) in current primary care prospective payment VBP contracts, and which services/codes are included in or carved out from current primary care prospective payment contracts.

Based on this survey and input from the VBP Model Development Workgroup members, the workgroup developed a common code list of all services that should be included in the primary care capitation payments (Appendix E). In addition to the principles outlined above, the decision was informed by an analysis of which codes the health plans identified as being included in current primary care capitation contracts, and which codes/services comprise the largest amount of total primary care spending.

The codes included in the primary care capitation payments account for the following percentage of total primary care spending:

Commercial		Medicaid	
% of total PC spending (age 0-18)	% of total PC spending (age 19+)	% of total PC spending (age 0-18)	% of total PC spending (age 19+)
92.62%	86.46%	92.94%	83.06%

Workgroup members acknowledged the need to avoid "moral hazards" when including these and other codes in capitated payments, such as incentives to refer out more medically complex patients. The model includes a list of strategies to protect against unintended adverse consequences, including incorporating strategies to identify and respond when practices are withholding or limiting care, or making too many specialty, urgent care and emergency department referrals.

Attribution and primary care provider (PCP) selection

The VBP Model Development Workgroup revisited the attribution principles from the 2018 PCPRC report (Appendix E), which were developed to foster alignment and transparency on methodology, and to ensure outcome metrics associated with VBPs accurately reflect a clinic's patient population. The workgroup adopted the 2018 Attribution Principles and added the following hierarchal order to guide attribution.

1. Prioritize patient choice – always ask the patient for primary care provider (PCP) in enrollment information (even if not required by the health plan).
2. If the patient does not choose a PCP, attribute the patient to a provider based on utilization/attribution process (as defined in Attachment B).
3. If the patient chooses a PCP, but then has predominant utilization with another primary care provider, assign the patient to that provider and communicate to the patient the opportunity to re-select their preferred PCP.
4. If the patient does not choose and there is no prior utilization, assign these patients to primary care providers to enable the best opportunity to serve the entire insured population.

The model also includes the requirement that insurers establish a primary care provider assignment correction process that works in partnership with providers to address inaccurately assigned enrollees.

The attribution in the model aligns with Oregon Administrative Rule 836-053-0028 developed in response to SB 1529 (2022) requiring insurers to assign enrollees who are Oregon residents to an individual or group of individuals who are primary care providers in a specified hierarchal order.

Prospective payment rate development methodology

The prospective payment rate is set based on an analysis of historic per member per month (PMPM) with spending according to the following guidelines:

- For larger providers, payers and providers may agree to develop practice-specific rates on a case-by-case basis or utilize a standard PMPM capitation rate based on a market-wide calculation.
- For smaller providers, payers may offer a standard PMPM capitation rate based on a market-wide or small practice-only calculation.

- Payers may also offer PMPM capitation rates specific to practices with special patient profiles, such as children with high medical complexity.
- Additional considerations:
  - The model acknowledges the challenge that certain services performed inconsistently across practices may fall under a broader billing code and including the broader billing code in the capitated payment may not guarantee adequate revenue for all services that fall under that broader code. Therefore, looking at historic PMPM spending on a *practice-specific* basis may be the preferred approach to ensure adequate revenue for all services that fall under that broader code.
  - The model description also acknowledges the limitations of developing payment rates based on historical spending, as such rates will reflect only the specific services that payers have traditionally covered and previous patterns of utilization.
- Rate development will account for primary care services delivered by providers outside of the capitation according to the following guidelines:
  - Payers apply monthly re-attribution to shift the prospective payment to a new primary care site as quickly as possible.
  - Payers monitor the percentage of primary care services delivered to attributed members outside the primary care practice and develop an improvement plan with practices with a high percentage.
- Rates will be updated annually.
- Payers will provide a general description of the rate methodology to providers using a common template to be developed by OHA.

Accounting for patient cost-sharing in rate development

Capitated payments will be adjusted to remove the patient cost-sharing obligation, rather than paid using the full allowed amount, with a subsequent retrospective deduction of the patient cost-sharing obligation. This approach anticipates the practice will receive additional revenue directly from the patient regarding services provided.

Risk adjustment

The VBP Model Development Workgroup decided that, at a minimum, payers should risk adjust based on age and sex. The Collaborative discussed clinical risk adjustment and decided on the following considerations:

1. For any application of clinical risk adjustment, separate methodologies should be used for adults and pediatric populations using a validated methodology specific to that population, as available.

2. Clinical risk adjustment will be used when measuring a practice on total cost of care as an addition to the primary care VBP model and mutually agreeable to payers and providers.
3. Clinical risk adjustment is optional for prospective primary care capitation payments.
   - Considerations in favor of applying clinical risk adjustment:
     - Adjusting payments based on a clinical risk score can help ensure a more accurate estimate of how much it will cost to care for a patient population based on the patients' conditions.
     - Risk-adjusted capitation payments that reflect the relative clinical risk of the patient panel could result in higher capitated payments to providers who treat patients with greater health care needs.
   - Limitations of clinical risk adjustment:
     - A commonly accepted methodology to estimate how much primary care someone needs based on their medical condition(s) does not yet exist.
   - Prospective payment rates can instead be calculated based on historical utilization with an additional payment increase to compensate for capitated procedure codes not historically reimbursed by a given payer, as described in the section on "rate development methodology."
4. Clinical risk adjustment will be used for infrastructure payments that entail care management and other services involving support for patients with higher medical complexity. Payers may use clinical risk adjustment for other infrastructure payments.

OHA convened a subgroup to discuss methods to risk adjust for social factors, such as income, employment and housing status, and develop one or more pilots. The social risk adjustment subgroup met three times in 2023 and established the following principles to guide the work:

- Support primary care to meet the needs of patients with socially complex needs.
- Be good stewards of the data used for social risk adjustment, including selecting appropriate data and being transparent about data sources.
- Consider both community and individual data sources to inform social risk adjustment.
- Involve people who experience health inequities and historical and contemporary injustices in model development for a better outcome.
- Identify and mitigate against possible unintended consequences of social risk adjustment.
- Design a social risk adjustment approach that supports people already seeking care and those that are attributed to a primary care provider but have not been seen.
- Take a first step and do not let perfect be the enemy of good.

The subgroup will continue to meet in 2024 to explore possible data sources, including claims data and geographic indices available using census data, learn about approaches implemented in Massachusetts and Minnesota, and develop one or more pilots.

Value incentives and rewards

The model includes incentives to reward practices for high performance relative to external benchmarks and improvement over time.

- External benchmarks can be national benchmarks, statewide coordinated care organization (CCO) benchmarks (for Medicaid), or statewide insurer-specific network benchmarks.
- Improvement rewards should be equivalent to high-performance rewards to provide a strong incentive for practices with lower performance scores to improve.
- Improvement targets should represent meaningful improvement and be reasonably attainable.
- Practices identified by payers as serving patient populations with unusually high medical and/or social risk may be held accountable only for improvement if the payer and practice agree that external benchmarks are not applicable.
- Measures for which there have been substantial specification changes should be temporarily removed from the incentive methodology until new practice-specific and external benchmark data are available.

The total eligible incentive payments will be equal to at least 10% of the value of annual projected practice service payments (capitated + fee-for-service) for the practice's attributed patients.

- This does not mean the practice will earn the full 10%, but that it would do so if it meets all incentive metrics.
- Payers for which eligible incentive payments equal less than 10% may transition to 10% over three years.
- Incentive payments should be made as proximate to the practice's actions to achieve rewards as possible.
    - One recommended technique is to make reward payments tied to the delivery of specific services, such as a bonus payment for each claim related to a prescribed screening.
    - Payers should make certain reward payments during the performance period if feasible, rather than at the end of the performance period, to ensure sufficient and sustainable resources for performance improvement investments.

    - Different methods can be used for different metrics. For example, some metrics might still be assessed for the calendar year after the year is complete if that is the most appropriate method.

Incentives will be tied to a common set of performance measures used by commercial and Medicaid payers, with flexibility for limited use of common Medicaid-specific measures by CCOs.

Aligned quality metrics

The aligned primary care measure set (Appendix F) balances minimizing the reporting burden for primary care providers while sufficiently demonstrating quality, and:

- Includes separate sets for adults and children
- Does not exceed eight measures for adults or children
- Contains at least one behavioral health measure for each population
- Contains at least one equity-focused measure
- Aligns with measure sets currently used by commercial and public payers

The VBP Model Development Workgroup considered various options to integrate equity into the metrics and decided on three parallel approaches:

1. Include National Quality Forum (NQF) identified disparity sensitive measures, applying the following identification process: 1) prevalence of the condition in minority population; 2) disparity in the quality gap between the disadvantaged population and the group with the highest quality; and 3) impact financially, publicly, and on the community at large. The following measures are included in the measure set and on the NQF list of identified measures:
    - Cervical cancer screening
    - HbA1c poor control
    - Depression screening – youth
    - Controlling high blood pressure
2. Consider adopting the CCO incentive metric “Social determinants of health: Social needs screening and referral“ in 2025
3. Evaluate each quality measure through an equity lens. Whenever feasible, payers will identify disparities by aggregating data on each quality measure across contracted providers and stratifying measures by race, ethnicity, geography and possibly other demographic factors. Payers will communicate the findings with providers to inform strategies to reduce disparities.

Infrastructure payments

The VBP Model Development Workgroup decided that infrastructure payments to all practices participating in the VBP model should include the following components:

1. A base payment tied to PCPCH tier, which includes payments to non-PCPCH practices that are actively seeking to obtain PCPCH recognition; and
2. Additional payments, as agreed upon by the payer and practice, for specific high-value services. These additional infrastructure payments should be for: a) services that are not already paid for via the PCPCH program, or b) services that are included in the PCPCH program where the practice has identified a need for additional financial support for implementation or sustainability. Examples of such services include, but are not limited to:
    - Additional case management and care coordination for patients with higher levels of medical and social risk.
    - Integrated behavioral health services not typically paid for by fee-for-service.
    - Traditional health worker services.
    - Integrated pharmacist services, such as medication consultations.
    - Addressing health-related social needs (HRSN).
    - Infrastructure (technology and staff) to collect and use data on race, ethnicity, language or disability (REALD) and sexual orientation or gender identity (SOGI).

To receive an infrastructure payment to support behavioral health integration, a primary care practice must meet at least one of the following sets of behavioral health integration standards, which should include a minimum threshold for behavioral health clinician staffing ratio or population reach percentage:

1. PCPCH Measure 3.C.3: PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.
2. Integrated Behavioral Health Alliance (IBHA) Recommended Minimum Standards for PCPCHs Providing Integrated Health Care (https://cobhc.org/wp-content/uploads/2023/02/IBHA-Minimum-Standards-2.0-02062023.pdf).

Equity in the primary care VBP model

The primary care VBP model includes the following components to promote health equity:

- Inclusion of equity-focused quality measures in the aligned measure set as described above.
- Financial incentives for practices to stratify quality measure performance by REALD and SOGI to identify any potential disparities and develop targeted interventions.
- Support for services such as health-related social needs (HRSN) screening and/or traditional health worker (THW) services in the prospective payment or via fee-for-service or supplemental payments.
- Infrastructure payments to support collaboration and data sharing between primary care practices and social service organizations to address identified HRSNs.

- Exploration of risk adjustment methodologies that account for social risk factors.

Implementation of VBP can sometimes result in unintended adverse consequences when practices make decisions based on the desire to keep capitated payments, such as withholding or limiting care or making too many specialty, urgent care and emergency department (ED) referrals. To minimize this risk, payers can incorporate strategies to identify and respond, including:

- Monitoring practice behavior to identify cases where access is decreasing or there are other signs of limiting care, such as through using patient experience survey questions regarding access or tracking trends in visit volume.
- Monitoring practices' data-stratified quality measure performance by REALD and SOGI to identify any potential disparities and develop targeted interventions.
- Creating incentives and/or disincentives for practices to minimize inappropriate use of specialists, urgent care and EDs, such as including quality measures that measure access and other patient-reported measures of satisfaction, and/or that evaluate patterns of specialist referrals and identify excessive use.
- Making additional payments to practices that treat patients with higher medical complexity.
- Excluding from prospective payment and enhancing payment for care delivered outside of normal care delivery hours to incentivize expanded access.

Strategic planning retreat

On October 11, 2023, the Collaborative met in person for a strategic planning retreat to: 1) learn about primary care investment initiatives across the country, 2) discuss the primary care spend report and how to use it and 3) determine future work for the Collaborative.

Staff provided an overview of the Collaborative from the legislative requirements that established the group to accomplishments and challenges thus far. A summary of primary care investment around the country was presented by staff from the Primary Care Development Corporation, a nonprofit that provides capital financing, expertise, and advocacy to expand primary care access and advance health equity. State legislatures across the country are focused on primary care measurement with some considering primary care spending targets, like Oregon's target of 12%. States are also looking at how primary care spending relates to health care cost growth benchmarking and health equity.

Following the presentations, Collaborative members identified four areas for short- and longer-term impact.

- Policy and legislative work, which could include identifying one or more primary care payment legislative champions to increase focus on primary care and revisiting the definition of primary care.

- Education and outreach to promote the implementation of the primary care VBP model, which could include coordinating with partner organizations to educate providers and payers and collaborating with the VBP Compact Workgroup to promote the VBP toolkit and the model.
- Data work, which could include improving data standardization and identification of data sources in addition to the All Payer All Claims data to measure and report the implementation of VBP.
- Continue work to develop one or more pilots of social risk adjustment that can help advance health equity by better-allocating resources between under-resourced populations and populations with more secure socioeconomic standing to avoid unjust differences that lead to health disparities.

Collaborative work in 2024

In 2024, the Collaborative will pursue the four areas identified at the strategic planning retreat detailed above. The Collaborative looks forward to its ongoing partnership with the VBP Compact Workgroup to continue to align payment and increase investment in primary care in 2024.

Appendix A: Primary Care Payment Reform Collaborative charter

I. Authority

Oregon is required by statute (Chapter 575 Oregon Laws) to convene a Primary Care Payment Reform Collaborative to advise and assist in the implementation of a Primary Care Transformation Initiative. The purpose of the initiative is to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Senate Bill 934 (2017) states that the initiative should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care).
- Improve reimbursement methods, including by investing in the social determinants of health.
- Align primary care reimbursement by purchasers of care.

To achieve the implementation of this initiative, the Collaborative will support:

- Using value-based payment methods.
- Incorporating health equity into primary care payment reform.
- Providing technical assistance to clinics and payers in implementing the initiative.
- Aggregating data across payers and providers.
- Aligning metrics, in concert with work of the Health Plan Quality Metrics Committee established in ORS 413.017.
- Facilitating the integration of primary care behavioral and physical health care.

II. Deliverables

Senate Bill 934 (2017) requires the Collaborative to report annually to the Oregon Health Policy Board (OHBP) and the Oregon Legislature on the implementation of the Primary Care Transformation Initiative and progress toward meeting primary care spending targets. The third progress report was delivered by April 1, 2020. The goals of the initiative will be met by 2027.

The Collaborative has combined the Implementation and Technical Assistance work groups, convened in 2019, into one workgroup to move the initiative forward in 2021. This group will meet regularly in between Collaborative meetings to identify:

1. Strategies to support implementation of payment models in the initiative including attribution, data aggregation and reporting.

2. Technical assistance (TA) resources to support the implementation of the initiative payment models, including leveraging existing TA resources.

The Collaborative is focused on primary care transformation and reimbursement. Specialty care and inpatient hospital services are not within the scope, except to the extent to which that these topics impact the goals of the Initiative.

The Collaborative is committed to coordinating and aligning with related initiatives including, but not limited to, Comprehensive Primary Care Plus (CPC+), Health Plan Quality Metrics Committee, the Patient-Centered Primary Care Home Program and the Sustainable Health Care Cost Growth Target Program.

III. Dependencies

To the extent directed and supported by OHA, the Committee will coordinate its recommendations to align with national and state health policy initiatives in formal reports submitted to:

- OHA Leadership
- Oregon Health Policy Board
- Oregon Legislature

The ability of the Committee to fulfill its statutory duties as outlined in sections I and III is contingent upon support of and direction by OHA, as well as coordination with other health policy advisory bodies.

IV. Membership

In accordance with Chapter 575 Oregon Law, Collaborative membership includes representatives from the following entities:

- Primary care providers
- Health care consumers
- Experts in primary care contracting and reimbursement
- Independent practice associations
- Behavioral health treatment providers
- Third party administrators
- Employers that offer self-insured health benefit plans
- The Department of Consumer and Business Services
- Carriers
- A statewide organization for mental health professionals who provide primary care
- A statewide organization representing federally qualified health centers
- A statewide organization representing hospitals and health systems

- A statewide professional association for family physicians
- A statewide professional association for physicians
- A statewide professional association for nurses
- The Centers for Medicare and Medicaid Services

Additional members may be invited to participate based on their experience and knowledge of primary care. Collaborative member terms are for a minimum of two years, with up to six meetings per year.

V. Resources

Internal staff resources include the following:

- Executive Sponsors: OHA Health Policy & Analytics Division Director; OHA Chief Medical Officer
- Staff support:
  - Health Policy and Analytics Division, Transformation Center (lead)
  - Health Systems Division
- External Relations Division

Appendix B: Primary Care Payment Reform Collaborative members

- Carolyn Anderson, Clinical Quality Director, Mountain View Medical Center
- Joy Conklin, Vice President of Practice Advocacy, Oregon Medical Association
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Lisa Emerson, Senior Health Insurance Programs Analyst, Oregon Department of Consumer and Business Services
- Scott Fields, Chief Medical Officer/Chief Informatics Officer, OCHIN
- Brian Frank, Physician, Oregon Academy of Family Physicians
- Carlos Gomez, Manager, Provider Network Operations, Umpqua Health Alliance
- Tim Hachfeld, Program Manager, Primary Care APMs, Regence BlueCross BlueShield & Cambia Health Solutions*
- Ruben Halperin, Medical Director, Providence Health Plans**
- Amy Hill, Vice President, Provider and Network Management, Health Net Health Plan of Oregon Inc. and Trillium Community Health Plan
- Kristan Jeannis, Quality Improvement Coordinator, Tuality Health Alliance
- Lisa Ladd, Director of Contracting & Provider Network, WVP Health Authority
- Cat Livingston, Medical Director, Health Share of Oregon
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics
- Lynnea Lindsey, Director of Behavioral Health Service Line, Oregon Network, PeaceHealth
- Barbara Martin, Director of Primary Care, Central City Concern
- Miranda Miller, Director of Value-Based Performance, Samaritan Medical Group**
- Angela Mitchell, Vice President, VBP and Contracting, CareOregon
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Health Services Officer and Chief Medical Officer, Winding Waters Community Health Center**
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Deborah Rumsey, Executive Director, Children's Health Alliance**
- Ben Sachdeva, Senior Financial Analyst, Advanced Health
- Divya Sharma, Medical Director, Central Oregon Independent Practice Association
- Christi Siedlecki, Chief Executive Officer, Grants Pass Clinic**
- Danielle Sobel, Policy Director, Oregon Primary Care Association**
- Larry Soderberg, Chief Financial Officer, Yamhill Community Care
- Rebecca Tiel, Senior Vice President of Operations and Membership, Oregon Association of Hospitals and Health Systems
- C.J. Wilson, General Counsel, ATRIO Health Plans

- Rebel Wilson, Assistant Vice President, Network Strategy & Contracting, Samaritan Health Plans, InterCommunity Health Network CCO *, **

Oregon Health Authority staff and consultants

- Diana Bianco, Collaborative Facilitator, Artemis Consulting
- Summer Boslaugh, Transformation Analyst, Oregon Health Authority Transformation Center
- Chris DeMars, Director, Delivery Systems Innovation Office and Acting Director, Health Policy Office
- Amy Harris, Manager, Oregon Health Authority Patient-Centered Primary Care Home Program

* New member in 2023

**Member of Steering Committee

Appendix C: VBP Model Development Workgroup members

- Hayes Bakken, Physician Improvement Specialist, Oregon Pediatric Improvement Partnership*
- Trent Began, Director, Financial Operations, Samaritan Health Plans*
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Stephanie Dreyfuss, Vice President, Provider Services, Providence Health Plans*
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Eleanor Escafi, Assistant Director of Strategy and Execution, Network Management/Provider Partnership Innovation, Regence BlueCross BlueShield of Oregon & Cambia Health Solutions
- Brian Frank, Physician, Oregon Academy of Family Physicians
- Ruben Halperin, Medical Director, Providence Health Plans
- Lisa Ladd, Director of Contracting & Provider Network, WVP Health Authority
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics
- Lynnea Lindsey, Director of Behavioral Health Services, Legacy Health
- Peter McGarry, Chief Financial Officer, PacificSource Health Plans*
- Laura McMahon, Providence Health Services*
- Miranda Miller, Director of Value-Based Performance, Samaritan Medical Group**
- Angela Mitchell, Vice President, Value-based Payment and Contracting, CareOregon
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Health Services Officer and Chief Medical Officer, Winding Waters Community Health Center
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Deborah Rumsey, Executive Director, Children's Health Alliance
- Divya Sharma, Medical Director, Central Oregon Independent Practice Association
- Brandie Thielman, Director, Provider Network, Health Net*

* Not a Collaborative member

Appendix D: Memorandum to Value-based Payment Compact Workgroup

To: Oregon Value-based Payment Compact Workgroup

From: Primary Care Payment Reform Collaborative

Date: December 6, 2021

Subject: Value-based Payment and Primary Care

The Primary Care Payment Reform Collaborative (Collaborative) is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA). The Collaborative advises and assists OHA in increasing investment in primary care and using value-based payment (VBP) to align primary care reimbursement and improve reimbursement methods, including by investing in the social determinants of health. The Collaborative also seeks to facilitate the integration of behavioral and physical health in primary care through VBPs.

The legislation that created the Collaborative also directs it to develop strategies that support the use of VBPs in primary care, including the provision of technical assistance, the aggregation of data and alignment of metrics, and evaluation. The Collaborative includes 39 members with expertise in primary care payment representing a range of providers, payers and other primary care stakeholders. Two Collaborative members — Eleanor Escafi from Cambia Health Solutions and Dr. Elizabeth Powers from Winding Waters Community Health Center — also sit on the VBP Compact Workgroup.

The Collaborative has a keen interest in Oregon's VBP Compact and wants to work in partnership with the VBP Compact Workgroup to promote the spread of VBPs across the state. The purpose of this memo is to share recommendations for your consideration regarding primary care and VBPs.

Before presenting the recommendations, it is important to acknowledge the continued impact of the coronavirus on the healthcare system — including primary care. Early in the pandemic, primary care practices experienced an abrupt decrease in patient visits, which led many to struggle financially to keep the doors open. VBP arrangements, particularly population-based payments, allowed some practices the flexibility to meet the changing demands of the pandemic while minimizing the stress of a decreasing cash flow. Even as patient volume has stabilized, the workforce is still impacted by trauma, stress and burnout.

Overarching recommendations

The 2018 Collaborative recommendations called for an aligned VBP structure to support primary care practices to improve quality and reduce health care costs. The Collaborative is pleased with the creation of the VBP Compact Workgroup and strongly urges the following be adopted by the VBP Compact Workgroup:

1. Create alignment of VBP models and metrics across lines of business to eliminate fragmentation, duplication and administrative burden and costs.
2. Design VBPs to address health equity by setting care delivery expectations for provision of person-centered, culturally appropriate care (e.g., community health workers [CHWs] and translation services); and pay incentives to reduce health disparities in quality of care, outcomes, and patient experience.
3. Implement, at a minimum, a blended model of enhanced fee-for-service (FFS) and per-member-per-month (PMPM) payments to support Patient-Centered Primary Care Homes (PCPCHs) and providers delivering high-quality care.
4. Exclude expensive health care costs for children and adults such as certain specialist procedures and inpatient stays that are largely outside the control of primary care.
5. Collect and analyze quality, access and utilization data by race, ethnicity, language and disability (REALD) to understand health disparities and develop outreach and other mitigation strategies to improve health equity.
6. Incorporate a limited number of metrics from the Health Plan Quality Metrics Committee Aligned Measure Menu Set[1] that measure both short- and long-term outcomes, such as primary care engagement of patients who have not previously established with a PCP, and address care across the lifespan.
7. Set improvement targets for metrics when there is a significant gap in performance from established benchmarks. For example, a clinic with a tobacco use rate of 65% could reasonably reduce the rate to 62% while achieving a benchmark of 25% would be very difficult.
8. If using a total cost of care VBP model, outline risks and mitigation strategies in contract such as stop-loss insurance, exclusion of high-cost patients, available networks, and associated rates and pharmacy costs.
9. Recommend primary care practices participating in VBP models be an OHA recognized PCPCH.

Below are additional recommendations specific to the following topics: the continuum of VBP models, attribution, complex care, behavioral health integration and care for children and youth.

[1]Health Plan Quality Metrics Committee Aligned Measure Menu Set Reflecting HPQMC decisions through May 25, 2021 https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/Aligned-Measures-Menu.pdf

Considerations	Recommendations
Continuum of VBP models There is a continuum of VBP models and many primary care practices are not equipped to take on full financial risk for patients.	• Implement aligned shared savings models that are more attractive for clinics to participate in and could provide a stepping stone toward more advanced VBP arrangements. • When developing shared risk agreements, ensure they will not negatively impact clinics that are working with the highest risk clients by including representatives from some of these clinics in the development of the agreements. • Implement appropriate risk adjustment for addressing high-cost patients. Leverage the experience of Massachusetts. Risk-adjust for youth separately from adults to adequately address the complexities of children's health conditions and risk factors.
Attribution Better attribution alignment and transparency will improve practice understanding of and success in VBP models.	• Payers, providers and patients need to work collaboratively to ensure accuracy and agreement about patient attribution. • Clearly communicate at the beginning of the VBP performance period—in advance of care delivery—which providers can take on accountability for patients, prioritizing primary care providers. Regularly communicate member assignment to primary care providers with opportunities for providers to make corrections. • Allow and facilitate member selection of a primary care provider within the applicable network at the time of enrollment across lines of business. If patient input cannot be obtained, attribute patients to providers based on claims evaluation and management visits for a minimum of 24 months, prioritizing primary care and preventive care visits.
Complex care Providers who deliver care to patients with complex health and social needs require support to maintain services.	• Implement appropriate risk adjustment for addressing high-cost patients. Risk-adjust for youth separately from adults to adequately address the complexities of children's health conditions and risk factors. Work towards development and adoption of a risk adjustment model that incorporates the impact of social determinants of health

Considerations	Recommendations
	and health related social needs on outcomes for any VBP model. Leverage the experience of Massachusetts. • Implement an enhanced PMPM based on comprehensive risk stratification for health and social needs that fully captures the cost of providing complex care.
Behavioral health integration VBPs can sustainably support integrated team-based behavioral health care in primary care.	• Pay primary care providers and behavioral health clinicians working in a clinic with integrated health care for an agreed-upon set of FFS codes with no pre-authorization requirements. • Include population-based payments, based on meeting standards of integration or quality benchmarks, that sustainably support key elements of behavioral health integration in primary care that are not typically paid for under FFS mechanisms, such as same-day brief consultations; preventive behavioral health; warm hand-offs between the primary care provider and the behavioral health clinician; behavioral health clinician participation in pre-visit planning and team huddles; consultations between primary care and behavioral health clinicians; and care coordination and communication, especially outside the primary care clinic, including with specialists, schools, teachers, community services, etc. Payment models include risk adjusted PMPM based on meeting standards of integration or benchmarks. • For VBPs, use both child and adult measures such as behavioral health screening and intervention, population reach, access to care, patient experience or other outcomes and physical health measures that are impacted by behavioral health integration such as HbA1c, blood pressure, and nicotine use, asthma medication adherence and ADHD medication adherence. • Contract with integrated clinics for all services delivered at the clinic in a single contract that does not require prior authorization for behavioral health services and double co-payments for patients who see a primary care provider and behavioral health clinician on the same day.

Considerations	Recommendations
	• Remove policies that reject two payments for services provided on the same day by a primary care provider and behavioral health clinician.
Children and youth VBPs are appropriate for health care for children and youth if they take into account the unique aspects of pediatric care.	• Risk-adjust for youth separately from adults to adequately address the complexities of children's health conditions and risk factors. • Structure VBP models to incentivize increased screening, preventive care and effective management of chronic health conditions, recognizing that investment in children's health and well-being may support lifelong wellness and result in a long-term return on investment for society. • Recognize that there are limited opportunities for short-term, direct health care cost savings among pediatric populations compared to adult populations. VBP models that incentivize short-term cost savings may not optimally serve most pediatric patients.

Next steps

Thank you for the opportunity to share these recommendations for consideration. The Collaborative requests a response describing how the recommendations will be integrated into the VBP Compact Workgroup activities. The Collaborative looks forward to further engagement with the workgroup and is available to speak to the workgroup on specific topics and answer questions.

The following members of the Collaborative endorsed these recommendations

Advanced Health
Atrio Health Plans
CareOregon
Central City Concern
Central Oregon Independent Practice Association
Children's Health Alliance
Columbia Pacific CCO
Creach Consulting, LLC
Grants Pass Clinic, LLP
Hagan Hamilton Insurance Solutions
Health Net Health Plan of Oregon, Inc.
Oregon Rural Practice-based Research Network
OSPIRG
PacificSource Health Plans
Providence Health Plans
Providence Medical Group – Oregon
Public Employees' Benefit Board
Regence & Cambia Health Solutions
Samaritan Health Plans
Trillium Community Health Plan
Tuality Health Alliance
Umpqua Health Alliance

Health Share of Oregon
InterCommunity Health Network CCO
Legacy Health
Metropolitan Pediatrics
Mountain View Medical Center
OCHIN
OHSU Family Medicine at Richmond
Oregon Academy of Family Physicians
Oregon Association of Hospitals & Health Systems
Oregon Department of Consumer and Business Services
Oregon Educator's Benefit Board
Oregon Medical Association
Oregon Pediatric Improvement Partnership
Oregon Primary Care Association
Willamette Family, Inc.
Winding Waters Clinic
WVP Health Authority
Yamhill Community Care Organization

Appendix E: Common code list for primary care capitation payments

1. Office or outpatient visit for an established patient (99211-99215)
2. Office or outpatient visit for a new patient (99202-99205)
3. Telephone calls for patient management (99441-99443)
4. Prolonged physician services (99354, 99355, 99358- 99360)
5. Preventive medicine counseling or risk reduction intervention (99401-99404)
6. Preventive medicine initial evaluation (99381-99387)
7. Preventive medicine periodic re-evaluation (99391-99397, 99429)
8. Administration of immunizations (90460, 90461, 90471-90474)
9. Transitional care management services (99495, 99496)
10. Medical team conference (99366-99368)
11. Therapeutic, prophylactic or diagnostic injection (96372)
12. Group preventive medicine counseling or risk reduction intervention (99411, 99412)
13. Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes, 11-20 minutes, 21 or more minutes (99421, 99422, 99423)
14. Non-face-to-face online medical evaluation (99444)
15. Non-physician telephone services (98966, 98967)
16. Online assessment, management services by non-physician (98969)
17. Annual wellness visit, personalized prevention plan of service (G0438, G0439)
18. Comprehensive geriatric assessment and treatment planning performed by assessment team (S0250)
19. Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month (S0320)

All other codes are excluded from the primary care capitated payments.

Appendix F: Matching patients and providers: definitions and framework

Prepared by the CPC+ Payer Group and the Primary Care Payment Reform Collaborative

The processes used to identify a patient-provider health care relationship are fundamental to population health and value-based payment (VBP) models. Patient attribution both designates the population for whom a provider will accept accountability under the model and forms the basis for performance measurement, reporting and payment.[2]

Lack of clarity and variation of attribution methodologies is a challenge for practices and payers. Benefits of more transparency and alignment include improved cost and quality benchmarking, increased understanding across the health system, building trust between practices and payers, enhancing the ability of practices to focus their efforts and better engage patients, and maximizing the benefits of data aggregation.

The CPC+ Payer Group and the Primary Care Payment Reform Collaborative have prepared this document to clarify definitions and provide a framework outlining the components and principles that drive processes that “match” patients and providers. The definitions and framework will be used by members of the CPC+ Payer Group and the Collaborative to communicate the methods used in primary care VBP models. Described below are four distinct methods commonly used to identify a patient-provider relationship: member selection, health plan assignment, enrollment, and use of claims or encounter data.

Purposes of shared definitions and framework are to:

- Agree to shared definitions of terms, enabling consistent use and intention
- Provide a framework for describing attribution methodologies to stakeholders, particularly providers
- Provide educational materials about attribution for practices
- Reduce complexity and confusion for payers and practices
- Build trust and transparency around attribution methodologies
- Facilitate the reliable identification of a provider-patient relationship

Attribution principles

Payers, purchasers, providers and patients will adopt the following principles for patient attribution to ensure more effective VBP-based investment in primary care. The intent of these

[2] Health Care Payment Learning & Action Network. Accelerating and Aligning Population-Based Payment: Patient Attribution. June 30, 2016.

principles is to foster alignment and transparency on methodology, and to ensure outcome metrics associated with VBPs accurately reflect a clinic's patient population.

1. Payers will adopt policies such as lower patient cost sharing, transformation in benefit design, and educational efforts to encourage patient choice of a primary care provider.
2. Payers, providers and patients will work together to develop and implement strategies to ensure that patients who want to identify their primary care providers can, and this patient choice will be prioritized for attribution, regardless of business line of coverage for those patients.
3. Payers, providers and patients should work collaboratively to ensure accuracy and agreement about patient attribution. Payers will ensure providers have clear and actionable information about patients assigned to them and providers will ensure the accuracy of the claims data they submit that support the attribution process. This information should be shared by payers at least quarterly.
4. Payers will use the same approach for attribution for performance measurement and financial accountability.
5. Payers will prioritize primary care providers and preventive care visits when analyzing claims or encounter data for attribution, and may consider other factors such as geographic location, family selection of primary care provider, and past claims.
6. Payers will use other claims-based evaluation and management visits if patient input cannot be obtained, and preventive care visits cannot be used and link those visits with primary care provider types. At least 24 months of claims-based data should be used, if available.
7. Payers will define which providers would be eligible to take on accountability for patients at the beginning of the performance period and share this information with providers in advance. Identify clearly who can serve as primary care providers (for example, could recommend all providers in recognized PCPCHs).
8. To support payer alignment and ensure accurate attribution — which allows for proper VBPs being made to a provider or clinic — providers agree to work in good faith with payers to ensure billing practices allow for the submission of complete claims data to payers.[3]
9. The Collaborative will consider alignment across payers at level of attribution (clinic vs. individual provider).

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[3]Billing practices should consistently utilize the CMS claim form fields and definitions to ensure accurate attribution of members at the participating clinic level. For example, CMS 1500 box 32 should properly reflect the Service Facility Location information to include name, address and National Provider Identifier of the site the services were delivered.

Shared definitions

Member selection

According to the Health Care Payment Learning & Action Network, patient choice is the ideal way to connect a patient and a provider.[4] Member selection is a prospective process in which a payer solicits from a health plan member the selection of a primary care provider or clinic. Often this is part of the health plan enrollment process. In CMS payment models like CPC+ and Primary Care First, this process of using the patient identification of the PCP/clinic is called "voluntary alignment." In some health plan products, the selected PCP is tied to the plan benefit structure.

Assignment

Assignment is a prospective process in which a payer matches a health plan member with a primary care provider based on specific criteria such as zip code, availability, age or other considerations. Some payers encourage member selection of a PCP before using the assignment process and members have the option to change their assigned PCP. Outreach to patients may be conducted as part of the health plan enrollment process, particularly if an assigned PCP is tied to the health plan benefit structure. Some payers share rosters with providers that combine member selections and health plan assignments since both are prospective and do not rely on claims history of prior visits. Primary care clinics are often encouraged by payers to contact patients on the roster to establish a relationship so patients may choose a provider or team (empanelment).

Enrollment

The enrollment method is similar to member selection and is sometimes used to prospectively recruit members to a specific program that has selection criteria, for example, the Primary Care First Seriously Ill Population (SIP) released by CMS in 2019. According to CMS, patients lacking a primary care practitioner will have an opportunity to enroll in care with a Primary Care First practice that opts in to participate in the SIP payment model. To identify the SIP-eligible population, CMS will run claims attribution and identify un-attributable Medicare beneficiaries to use as a roster for potential enrollment. In enrollment models, members sometimes enroll in the program in the primary care office (for example, chronic care management) or with the payer/health plan (for example, SIP). Enrollment is important in cases where the services will result in member cost share because it enables the member to make an active choice.

[4] Id. p. 8. "The ideal method for patient attribution is active, intentional identification or self-reporting by patients."

Attribution by analyzing claims- or encounter-based data

This attribution method is a retrospective process in which a health plan uses a member's prior claims experience or encounter data to infer a patient-provider health care relationship. Each payer's attribution algorithms have a defined look-back period, a claims code set, criteria for eligible providers, and rules regarding most recent visits and plurality of visits in cases where a patient saw multiple PCPs during the lookback period. The strategy and frequency of running attribution may vary by payer. Although all attribution methods are inherently retrospective (relying on prior visits to infer a patient-provider relationship) the application of attributed populations can be used either retrospectively or prospectively:

- An example of a retrospective application could be a pay-for-performance program: attribution reports completed at the end of the performance period determine the patient population of the pay-for-performance program.
- An example of a prospective application could be care management fees paid prospectively: attribution reports completed at the beginning of a payment period would prospectively determine the population of patients for a care management fee. Another example is a total cost of care, risk-based payment made prospectively to a large clinic system, using claims-based attribution reports completed at the beginning of a payment period to determine the population of patients and estimated costs.

Appendix G: Primary care VBP model quality measure sets

Adult Primary Care Measure Set			
Measure	**Steward**	**Reporting entity**	**Data Source**
Controlling High Blood Pressure	NQF#0018/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Diabetes Care: HbA1c Poor Control	NQF#0059/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Breast Cancer Screening	NQF#2372/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Cervical Cancer Screening	NQF#0032/NCQA	Clinic	Administrative, hybrid, or EHR
Colorectal Cancer Screening	NQF#0034/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Medicare Annual Wellness Visit	N/A	Clinic	Claims
Depression Screening and Follow-up	NQF#0418/CMS	Clinic	Claims/Clinical Data (eCQM measure)
Initiation and Engagement of Substance Use Disorder Treatment	NQF#0004/NCQA	Clinic	Administrative or EHR

Pediatric Primary Care Measure Set			
Measure	**Steward**	**Reporting entity**	**Data Source**
Childhood immunization status by 2 (Combo 3*)	NQF#0038	Plan	Claims
Immunizations for adolescents by 13 (Combo 2)	NQF#0038	Plan	Claims
Well visits: Six within 15 months**	NQF#1392	Plan	Claims
Well visits: Two within 15-30 months**	NQF#1392	Plan	Claims
Well visits: 3-6 years***	NQF#1516	Plan	Claims
Well visits: 7-11 years***	NQF#1516	Plan	Claims
Well visits: 12-21 years***	NQF#1516	Plan	Claims
Depression Screening and Follow-up	NQF#0418	Clinic	Clinical Data (eCQM measure)

*Commercial only payers may use Combo 10

**If the denominators are too small, replace with Well Child Visits in First 30 months (W30) – eight visits in zero-30 months

***If the denominators are too small, replace with Child & Adolescent Well Visits (WCV) – well visits 3-21 years