VALUE-BASED PAYMENT ROADMAP

FOR COORDINATED CARE ORGANIZATIONS

Oregon Health Authority

Acknowledgments

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Value-Based Payment Roadmap for Coordinated Care Organizations
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TABLE OF CONTENTS

DEFINITIONS

This section provides definitions of key terms for value-based payment policies, as defined by the Oregon Health Authority, to provide a common level of understanding for all audiences.

Behavioral health care: Services to treat mental health and addictive disorders, including problem gambling and substance use disorders.

Children's health care: Services provided to individuals age 0–18, including primary care, behavioral and oral health care, and any other health care needs.

Health equity: Reaching the highest possible level of health for all people. Historically, health inequities have resulted from health, economic, and social policies that have disadvantaged communities.

Hospital services: Services provided within a hospital inpatient or outpatient setting.

Maternity care: Services provided to a pregnant woman during her pregnancy and within the six-month postnatal period.

Meaningful risk: A payment arrangement in which the amount of dollars at risk for a provider is significant enough to incentivize change because of the potential financial impact.

Member: An Oregon Health Plan (OHP) client enrolled with a pre-paid health plan or CCO.

Oral health care: Services delivered to provide preventive care and to treat dental disease.

Patient: An individual who receives health care services through a coordinated care organization's (CCO's) network provider.

Payer: The entity that is responsible for contracting with a network of providers to deliver health care services to a set of members.

Primary care: Family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

DEFINITIONS CONTINUED

Priority populations: Racial, ethnic and culturally based communities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees; and people at the intersections of these populations

Provider: The entity with which the CCO holds a contract for the delivery of direct care and services to a CCO member. A contracted managed care vendor to which a CCO may delegate provision of services (for example, a designated organization, behavioral health or dental) is not a provider.

Risk adjustment: A modification of payment amounts or of contractual budgets to reflect the relative health status of the population, and/or a change in population health status over time.

Value: The delivery of evidence-based, person-centered, efficient care that contributes to improved quality and positive health outcomes at an appropriate cost.

Value-based payment: Payment to a provider that explicitly rewards the value that can be produced through the provision of health care services to CCO members.

INTRODUCTION

Oregon has a long history of health system transformation, including substantial efforts to move away from traditional volume-based health care payments to payments based on value that support positive member health outcomes and cost savings. Movement toward value-based payment (VBP) is supported nationally, as it is broadly accepted that the status quo fee-for-service payment model promotes a fragmented health system unable to provide patient-centered, whole-person care.

Oregon's Medicaid coordinated care organizations (CCOs), implemented in 2011, were an important delivery system advancement along the path toward VBP, and significant support continues for expanding the use of payments based on value within CCOs. Oregon's 1115 Medicaid waiver, renewed in January 2017, included requirements of the Oregon Health Authority (OHA) to develop a plan describing how the state, CCOs and network providers would achieve established VBP targets by June 30, 2022. Further, Governor Brown's September 2017 letter to the Oregon Health Policy Board requested that the amount of payments tied to performance increase over time in the next iteration of CCOs, or CCO 2.0, occurring from 2020 to 2024.

As a part of the CCO 2.0 process, OHA conducted a maturity assessment of the first five years of CCOs' VBP experience and identified the following four insights: the use of VBPs varied by CCO; while payment models beyond fee-for-service existed, CCOs had less experience linking payment to quality; differences in geography, plan size and provider market power meant a "one-size-fits-all" VBP approach would not work; and existing reporting did not adequately capture CCO VBP activities. OHA then began a period of significant public engagement including statewide, multilingual public meetings and surveys, VBP-focused work groups with existing CCOs, and a survey of providers. The public engagement and stakeholder feedback gathered though this process, the Evaluation of Oregon's 2012-2017 Medicaid Waiver, and the environmental scan of other states' VBP policies informed this VBP Roadmap for CCOs.

VALUE-BASED PAYMENT ROADMAP FOR CCOS

Objectives

Oregon's VBP Roadmap for CCOs aims to:

- Reward providers' delivery of patient-centered, high-quality care
- Reward health plan and system performance
- Align payment reforms with other state and federal efforts
- Ensure consideration of health disparities and members with complex needs
- Support the triple aim of better care, better health and lower health care costs

CCO VBP Roadmap Overview

The Health Care Payment Learning and Action Network (LAN), a national effort supported by the Centers for Medicare and Medicaid Services (CMS) to accelerate VBP across markets, developed a framework for categorizing VBPs that has become the nationally accepted method to measure progress on VBP adoption. OHA will use the LAN Alternative Payment Model Framework (2017) to categorize and track CCOs' use of VBPs[1] during CCO 2.0 (see Figure 1).

OHA's CCO 2.0 VBP requirements are designed as a complementary package of strategies that collectively support the triple aim. CCOs' VBP requirements between 2020-2024 include the following:

Patient-Centered Primary Care Home VBP

CCOs are required to provide per-member-per-month (PMPM) payments to their Patient-Centered Primary Care Home (PCPCH) clinics. A Category 2A VBP (Foundational Payments for Infrastructure & Operations) is required as defined by the LAN Framework. CCOs are required to also vary their PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPMs must increase each year over the five-year contract and be meaningful amounts. Although OHA is not defining a specific minimum dollar amount, the payments should meaningfully support clinics' work to deliver patient-centered care.

Note: Unless combined with a LAN Category 2C or higher, this requirement does not count toward the annual CCO VBP minimum threshold or CCO annual target, described below, which requires a LAN Category 2C (Pay-for-Performance) or higher

Annual CCO VBP targets

CCOs will be required to annually increase the level of payments that are in the form of a VBP and fall within LAN Category 2C (Pay-for-Performance) or higher, through the duration of the CCO 2.0 period, according to the following schedule:

- 2020: no less than **20%** of the CCO's payments to providers;
- 2021: no less than **35%** of the CCO's payments to providers;
- 2022: no less than **50%** of the CCO's payments to providers;
- 2023: no less than **60%** of the CCO's payments to providers; and
- 2024: no less than **70%** of the CCO's payments to providers.

[1] OHA has intentionally transitioned from the term "alternative payment models" (APMs) toward value-based payment (VBP) to signify the importance of payments to reflect quality and outcomes.

Annual CCO risk-based VBP targets

Beginning 2023, CCOs will be required to increase the amount of VBPs, as a percent of total payments to providers, that fall within LAN Category 3B (Shared Savings and Downside Risk) or higher to no less than 20% (in 2023) and 25% (in 2024).

Care delivery area VBPs

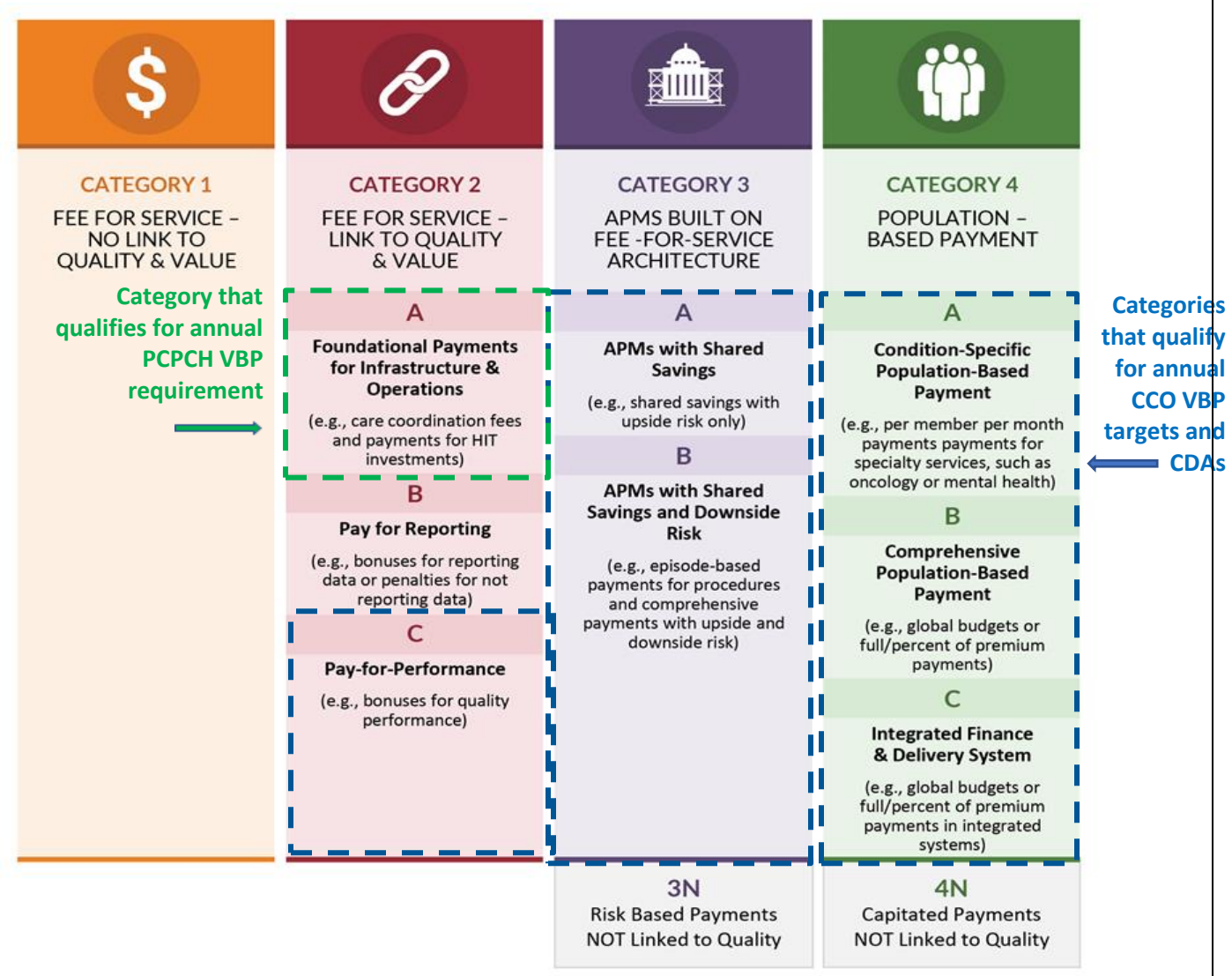
CCOs are required to develop VBPs in the following care delivery areas (CDAs): hospital care, maternity care, behavioral health care, children's health care and oral health care. Required VBPs in CDAs must fall within LAN Category 2C (Pay-for-Performance) or higher through the duration of the CCO 2.0 period, according to the following schedule:

- **2020:** CCO shall develop three new, or expanded from an existing contract, CDA VBPs. The three new or expanded VBPs must be in hospital care, maternity care and behavioral health care. A VBP may encompass two CDAs concurrently (for example, a hospital maternity care VBP that meets specifications for both hospital care and maternity care CDAs could count for both).
- **2021:** CCO shall implement the three new or expanded CDA VBPs developed in 2020.
- **2022 and 2023:** CCO shall implement a new or expanded VBP each year, in each of the remaining CDAs. VBPs in all five CDAs must be in place by the end of 2023.

LAN VBP categories

Today, many provider arrangements remain in LAN Category 1 — a traditional fee-for-service payment with no financial link to quality or value. These arrangements pay providers to deliver a service without providing any incentive to improve quality or reduce costs. Payments in this category include Diagnosis-Related Group (DRG) hospital payments, payments by payers to providers based on percentage of charges, and the traditional fee-schedule method. Figure 1 depicts the four LAN categories and indicates what OHA will count toward required PCPCH VBPs, annual CCO VBP targets and care delivery area VBPs. OHA intends to encourage and incentivize a move toward more advanced VBP models.

Figure 1: LAN Payment Categories



Measuring VBP Progress

The following comprehensive reporting will ensure OHA can track and report CCOs' VBP development and implementation progress (additional detail can be found in the *OHA VBP Technical Guide for CCOs*).

1. Each June, beginning 2020, each CCO's executive leadership team will engage in interviews with OHA to discuss VBP development and implementation;
2. February of 2021, each CCO must report preliminary 2020 VBP data using the VBP Targets and PCPCH Data Template;
3. Each September, beginning 2021, each CCO must submit their previous year's VBP data using the All Payers All Claims (APAC)s Payment Arrangement File; and

4. Beginning 2022, each CCO must submit the Care Delivery Area and PCPCH VBP Data Template.

Support and Considerations for VBP Adoption

OHA recognizes the importance of supporting both CCOs and providers as they move to increase the use of VBP. To that end, OHA will strive to align its policies across OHA initiatives and to provide technical assistance to both CCOs and providers to support their adoption of VBP models.

Metrics Alignment

To ensure quality metrics are aligned, CCOs will be required, to the extent applicable, to use the quality measures identified by the Health Plan Quality Metrics Committee (HPQMC) in their VBP arrangements. The HPQMC was established by Senate Bill 440 (2015) to identify health outcome and quality measures that may be applied to services provided by CCOs or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board. CCOs should select appropriate quality metrics from the HPQMC Aligned Measures Menu to link to VBP contracts.

If the HPQMC measures menu does not include measures that are appropriate for a planned VBP model, CCOs may use other metrics defined by the National Quality Forum or similar national measure steward. If a CCO proposes an original metric, additional information and approval will be required.

In the event OHA contracts with multiple CCOs serving Oregon Health Plan members in the same service area, OHA requires the CCOs to participate in OHA-facilitated discussions to select performance measures, and any other areas of alignment identified by OHA, to be incorporated into each CCO's VBP provider contracts for common provider types and specialties. Each CCO will incorporate all selected measures, and any other areas of alignment, into applicable provider contracts.

Technical Assistance

OHA will continue to provide technical assistance (TA) to CCOs and providers to assist in the development, implementation and adoption of VBPs across provider types, including but not limited to hospitals, specialists, behavioral health providers, and oral health providers. In addition, TA in emerging areas such as risk adjustment on payments to include health complexity, the combination of medical and social complexity, and the development of VBP models that promote health equity is planned for future years.

Monitoring Priority Populations and Members with Complex Health Care Needs

By allowing providers the flexibility to deliver needed care, VBP strategies should, on the whole, benefit members with complex health care needs and priority populations such as racial, ethnic and culturally based communities; lesbian, gay, bisexual, transgender and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees and members with complex health care needs, as well as populations at the intersections of these groups.

It is essential to ensure there are no negative unintended consequences of VBPs on these and other populations. Consequently, as part of the CCO's annual VBP interview, CCOs must share the steps they are taking to address potential adverse consequences, including the CCOs' monitoring process, findings to date, and recommended model changes to address any identified issues.

In addition, OHA will continue to identify opportunities to incorporate social determinants of health and members' social needs —which are the social and economic barriers to an individual's health, such as housing instability and food insecurity — and health equity into VBP models, including adjusting payment based on social risk factors.

SUMMARY

As part of Oregon's Value-Based Payment Roadmap, CCOs will be required to meet specific VBP targets beginning in 2020, as summarized in Figure 2 below. OHA will closely monitor and oversee the use of VBP models through review of required reporting and annual interviews and will support CCOs in identifying trends and making corrections to VBP models as needed.

OHA may publish each CCO's data, such as the actual VBP percentage of spending that is LAN Category 2C or higher and LAN Category 3B or higher, as well as data pertaining to the CCO's care delivery area VBPs, PCPCH VBPs, and other details.

Figure 2: VBP Roadmap: CCO Targets and Timeline

	2020	2021	2022	2023	2024
% of Payments in Category 2C and higher	20%	35%	50%	60%	70%
% of Payments in Category 3B and higher	n/a	n/a	n/a	20%	25%
# of New/Expanded CDA VBPs	Develop **3 CDAs**	Implement **3 CDAs**	Implement **1 CDA**	Implement **1 CDA**	**n/a**
	• New/expanded VBPs in hospital care, maternity care and behavioral health care by 2021 • New/expanded VBPs in children's healthcare and oral health by 2023				

OHA's VBP Roadmap for CCOs is a pathway toward ensuring partners are able to develop payment systems with the flexibility to ensure care focuses on the whole person and supports the development of healthier and better integrated communities.

In addition, realizing the vision of a transformed health system will require significant multi-sector, system-wide collaboration and individual commitments to improve how services are collectively paid. Ultimately, expansion of VBP needs to include payers beyond Medicaid to successfully transform the delivery system. OHA recognizes that adoption of VBP will be accelerated through alignment of payment approaches across the public and private sectors, which will ensure broader dissemination of meaningful financial incentives that reward providers who deliver higher-quality and more affordable care.