Oregon's Value-Based Payment Roadmap for Coordinated Care Organizations

INTERIM PROGRESS REPORT

March 2022

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

Prepared for:
Oregon Health Authority

OHSU

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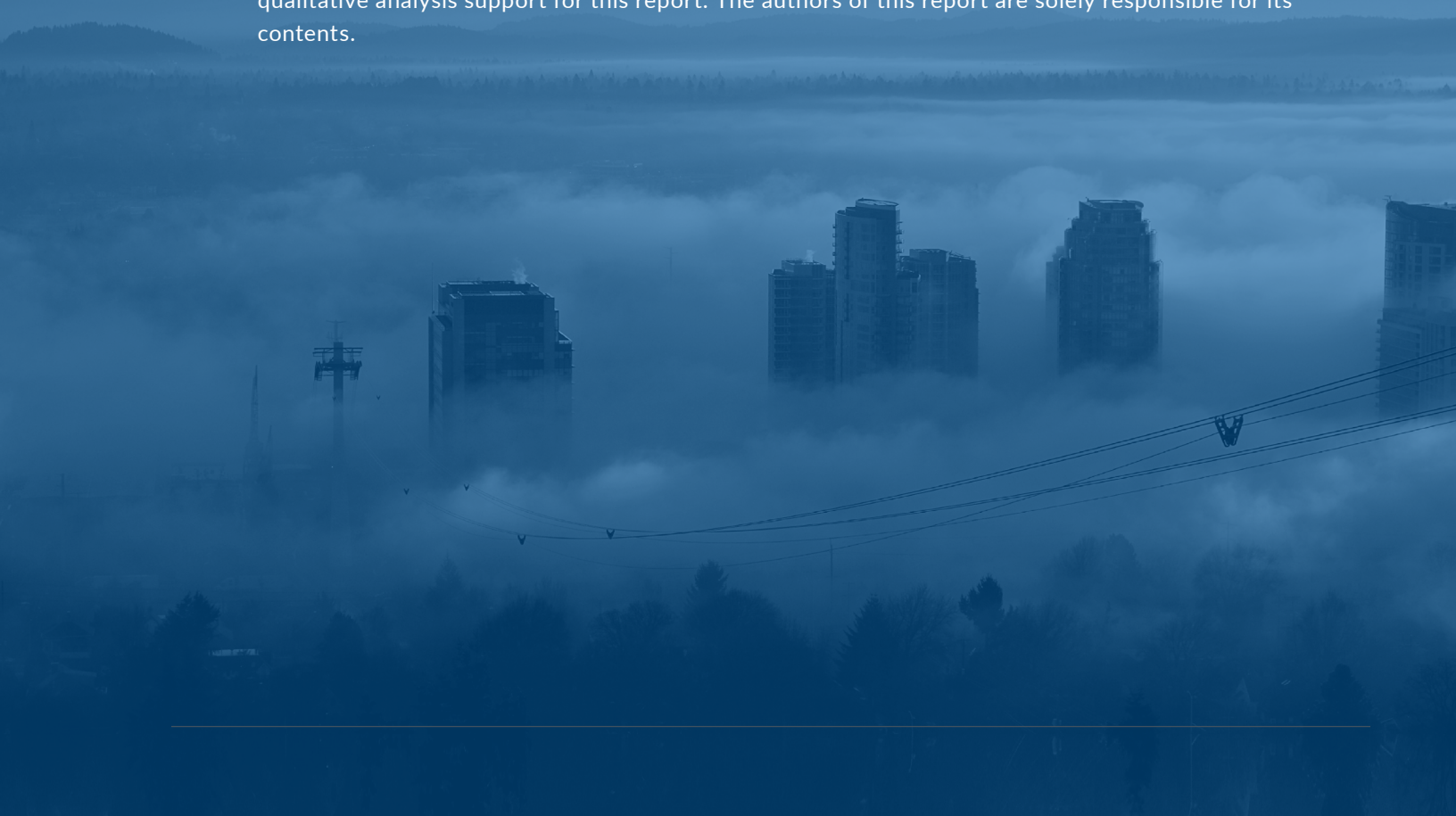
Acknowledgments

We thank Lisa Krois, Sarah Wetherson, Chris DeMars, Zachary Goldman, and other staff at Oregon Health Authority for their generosity with information about Oregon's Value-based Payment Roadmap for Coordinated Care Organizations, assistance with obtaining data for the evaluation, and time to answer questions and provide feedback. Jenny Grunditz and Ruth Rowland provided qualitative analysis support for this report. The authors of this report are solely responsible for its contents.



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SUGGESTED CITATION

Petchel, S., Simeon, E., Daly, A., Morrison, S. *Oregon's Value-Based Payment Roadmap for Coordinated Care Organizations: Interim Evaluation Annual Progress Report (March 2022).* Report to the Oregon Health Authority. OHSU Center for Health Systems Effectiveness, Portland, Oregon.

Acronyms

BHO	behavioral health organization
CBO	community-based organization
CCO	Coordinated Care Organization
CDA	care delivery area
CHSE	Center for Health Systems Effectiveness
CIE	community information exchange
CLAS	culturally and linguistically appropriate services
DRG	diagnosis related groups
FFS	fee-for-service
HCP-LAN/LAN	Health Care Payment Learning and Action Network
HIT	health information technology
OHA	Oregon Health Authority
PCPCH	Patient-Centered Primary Care Home
PMPM	per-member per-month
REALD	race, ethnicity, language and disability
THW	traditional health worker
VBP	value-based payment

Executive Summary

Transitioning to a health system that consistently delivers high-value care is a key policy goal for Oregon. To achieve this goal, the Oregon Health Authority is promoting the transition to value-based payments (VBPs) in Medicaid through the Value-based Payment Roadmap for Coordinated Care Organizations.

The Roadmap aligns Oregon's VBP goals for Medicaid with the Health Care Payment Learning and Action Network's Alternative Payment Model framework ("the LAN framework"), and requires Coordinated Care Organizations (CCOs) to create new VBP models in 2020-2024 as well as meeting annual goals for payments made to providers in qualifying VBP arrangements.

About the Evaluation

The Center for Health Systems Effectiveness is conducting a multi-year evaluation of CCOs' progress toward the VBP Roadmap requirements. This report includes findings as of June 2021.

The report relied on key informant interviews with CCO leaders in June 2021 focused on their VBP activities and progress. We also reviewed information about CCOs' VBP payment model characteristics from 2020 as reported to OHA in late 2021. This report is one in a series, beginning with a baseline evaluation in 2020. Findings will be reported on a rolling basis during the CCO 2.0 contract cycle.

Interim Evaluation Key Findings and Recommendations

Takeaway 1. The COVID-19 pandemic altered CCOs' VBP efforts through early 2021. CCOs reported increased provider interest in population-based payments for financial stability, and provider risk aversion to new quality requirements.

CCOs faced a challenging environment for promoting VBP adoption in 2021 due to the ongoing pandemic and workforce burnout. CCOs reported progress promoting population-based and shared savings VBP arrangements across a range of care areas. These arrangements are an important step toward Oregon's VBP Roadmap goals. However, the COVID-19 pandemic forced CCOs to take a more flexible stance on selection of providers' VBP performance measures, and a modest approach to setting performance goals. CCOs reported their providers' VBP quality strategies were somewhat fragmented given the enhanced flexibility they had offered providers during the pandemic.

Recommendation. CCOs should strive to retain population-based (category 4) arrangements and look for opportunities to align performance measures, as CCOs reintroduce VBP quality measures and goals that were relaxed or waived for providers during the pandemic.

Takeaway 2. CCOs have focused on promotion of health equity in their early VBP efforts, and reported success engaging providers in reviewing community and provider-level performance data. Challenges were noted with monitoring health inequities arising from VBP arrangements, and wide variation in providers' HIT capabilities required CCOs to be flexible in their approaches to sharing performance data.

Each CCO took a unique approach to promoting health equity through VBPs, though all focused broadly on four aspects of VBP model design: 1) measure selection and targets, 2) tiered or adjusted payments, 3) eligible providers, and 4) process or attestation-based requirements. CCOs may need additional guidance to narrow and implement health equity monitoring strategies going forward.

Recommendation. OHA may wish to develop recommendations for CCOs on best practices within these model elements. CCOs and OHA should monitor within-CCO changes in these model elements over time to assess whether CCOs are collectively increasing their efforts to promote health equity through VBPs.

CCOs' ability to monitor for health inequities arising under VBP arrangements depended on their capacity to collect and use race, ethnicity, language and disability (REALD) and social needs data. CCOs consistently reported challenges with REALD and social needs data collection, management, analysis and interpretation. Challenges were similar to those reported in 2020, and part of the difficulty arose from the wide range of options CCOs have for data sources or data collection tools. CCOs that succeeded in collecting REALD or social needs data reported struggling to translate findings into actionable next steps for themselves or providers.

Recommendation. Provide guidance on OHA's recommended approach(es) for collection of REALD and social needs data. CCOs would also benefit from technical assistance on analyzing and interpreting data for identification of health inequities.

Takeaway 3. CCOs would benefit from further information on the state's plans to promote multi-payer alignment of VBP models and quality strategies.

Alignment of quality strategies and measures across Medicaid, Medicare and commercial health plans can reduce reporting burdens on providers in VBP arrangements. Some CCOs were waiting to see whether OHA would implement new requirements for payment model alignment in the future before assessing how their existing quality measures or payment models aligned with other CCOs and non-Medicaid payers. A statewide strategy for hospital payments was identified by one CCO as "the state's biggest opportunity for multi-payer alignment," though diversity in hospital classifications *(see p. 27)* will require ongoing flexibility in CCOs' hospital payment modes.

Recommendation. The state may wish to guide CCOs on which care delivery areas or quality measures are most likely to be required within multi-payer strategies in the future. OHA should also explore whether a statewide hospital quality strategy could better align performance measures and goals across regions while retaining CCOs' ability to locally tailor reimbursement modes and risk-bearing elements.

Takeaway 4. All CCOs developed payment models for new Patient-Centered Primary Care Home (PCPCH) payments. Most took modest approaches to meet this requirement, which may not achieve the state's goal of supporting meaningful investments in primary care infrastructure.

CCOs developed infrastructure payments to PCPCHs in 2020 as required. These payment models included tiered per-member per-month (PMPM) amounts that increased by clinics' PCPCH recognition level, though there was substantial variation across CCOs in the PMPM amounts within each tier. These PMPM payments may not lead to meaningful new clinic-level infrastructure investments since, on average, payment amounts were relatively small at all PCPCH tiers. These payments may also provide little incentive for clinics to achieve higher PCPCH recognition levels since most clinics were already recognized at tiers 4 or 5.

Recommendation. OHA should explore options to increase the impact of tiered infrastructure payments, including promoting higher payment amounts and encouraging CCOs' expansion of these models to other providers such as behavioral health.

Takeaway 5. CCOs developed new payment models in priority care delivery areas (CDAs) including hospital, maternity and behavioral health care. However, lack of HIT capacity at the CCO and provider levels was emerging as an early challenge for most CCOs.

CCOs were generally on track to meet the requirement to implement new VBP models in maternity, hospital and behavioral health care by 2022. Several CCOs had implemented models ahead of schedule. Some were struggling to implement the quality elements of new CDA arrangements; challenges implementing HIT capabilities for bundled payments were common. CCOs' early VBP contracting efforts focused on provider organizations with previous VBP experience or with robust HIT infrastructure. Lack of provider HIT capabilities may become an increasing barrier to CCOs' achievement of annual VBP targets or expansion of CDA payment models, as CCOs engage a broader range of providers in new VBP arrangements. Convening discussions in these areas may help OHA and CCOs to collectively identify opportunities for future quality measure alignment across regions and providers.

Recommendation. Focus CCO convenings and technical assistance on HIT-related support in priority CDAs and for bundled payments in 2022. CCOs also requested advance guidance on health care claims codes or modifiers needed for future VBP reporting to OHA, as well as earlier publication of evaluation results, to inform their HIT capacity-building efforts.

Recommendation. OHA should consider providing technical assistance to CCOs focused on quality strategies for behavioral health VBPs. Priority topics may include member attribution strategies, development of HIT infrastructure for sub-capitated arrangements, clarification on what qualifies as a VBP at the behavioral health organization (BHO) level, options for non-claims-based provider performance monitoring, and strategies for collection of baseline data to establish VBP quality benchmarks.

Recommendation. OHA should closely monitor CCOs' progress implementing quality strategies in the maternity care delivery area. This area may be particularly impacted by challenges with bundled payment model implementation. OHA may also be able to support CCOs' adoption of bundled payment models through guidance on data integration strategies or through coordination with efforts such as the Connect Oregon initiative.

Key Takeaway 6. CCOs identified opportunities for OHA to provide additional guidance, technical assistance and material to help them meet current and future VBP Roadmap requirements.

CCOs identified certain situations where they were unsure how to interpret or apply the state's VBP requirements. These questions may be **opportunities for additional guidance from OHA:**

- **What options exist for VBP arrangements for prescription benefit managers?** Related, will CCOs be required to include pharmacy expenditures in their future calculation of VBP participation?
- **What "counts" as qualifying VBP expenditures?** For example, should CCOs include claims as qualifying VBP expenditures if these are reimbursed as FFS claims, but a primary care provider also bears risk for these costs under a total cost of care (category 4) arrangement?
- **Which VBP models qualify as shared risk arrangements?** CCOs will be required to meet annual targets for the proportion of payments made to providers in shared risk arrangements beginning in 2023, which OHA defines as HCP-LAN categories 3B or higher. CCOs did not appear to consistently know that the state has included HCP-LAN category 4 in qualifying downside risk arrangements; some limited their focus to 3B arrangements.
- **What is the rationale for downside risk arrangements?** One CCO leader questioned whether OHA's requirement for achievement of downside risk arrangements was necessary in light of the state's cost-growth targets and quality requirements.
- **Which VBP models could also meet other CCO 2.0 requirements?** CCOs were interested in payment models covering, for example, Traditional Health Workers or doula care. OHA may wish to work with CCOs to identify examples of VBP models that have been designed with other CCO 2.0 requirements in mind.

CCOs also requested VBP outreach or educational materials they could share with providers to help explain the state's VBP requirements and providers' options within these requirements.

Introduction

Medicaid is an important health care resource for nearly a third of Oregonians, covering more than 1.3 million people.[1] Oregon provides Medicaid insurance coverage primarily through Coordinated Care Organizations (CCOs) that are accountable for ensuring the quality and accessibility of care delivered to members in their region.[2]

Governor Kate Brown in 2017 identified "increasing value and paying for performance" as one of four key areas of focus for Oregon Health Authority's (OHA) design and implementation of Oregon's Medicaid program. The transition to value-based payment (VBP) models that tie health care providers' payments to quality goals and sustainable rates of growth is an important policy tool for achieving this goal.

The VBP Roadmap and CCO 2.0

The state worked with CCOs to develop OHA's Value-Based Payment Roadmap for Coordinated Care Organizations[3] ("the VBP Roadmap") in 2019. The VBP Roadmap is a foundational element of CCO requirements during the 2020-2024 contract cycle (CCO 2.0). The Roadmap aligned Oregon's Medicaid VBP definition with the Health Care Payment Learning and Action Network's Alternative Payment Model framework[4] ("the LAN framework"). The LAN framework supports the categorization of CCOs' qualifying VBP models and enables measurement of VBP adoption within these categories over time. See Exhibit B *(next page)* for a description of the HCP-LAN framework and its payment model categories.

The Roadmap requirements[3] include the achievement of annual targets *(see Exhibit A)* for qualifying VBP arrangements with provider organizations over time (defined as LAN category 2C or higher arrangements), the development of new VBP models in specific CDAs and for Patient-Centered Primary Care Homes (PCPCHs). See Exhibit C for a description of these requirements.

Exhibit A. CCOs are required to meet annual goals for the percent of member expenses paid in VBP arrangements

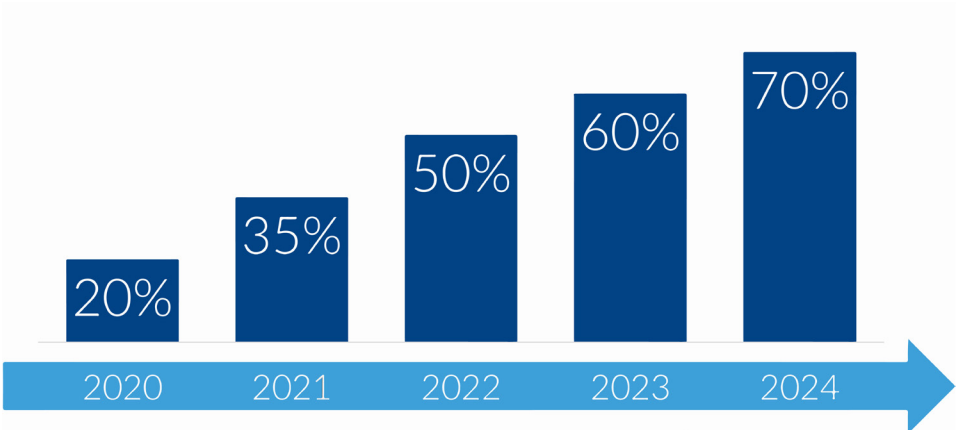


Exhibit B. The Health Care Payment Learning & Action Network's Alternative Payment Model Framework

In 2017, the Health Care Payment Learning & Action Network (HCP-LAN) published the Alternative Payment Model Framework (Refreshed) to help align alternative payment approaches across the U.S. health care system in an effort to support health care payment reform, promote quality and contain costs. The framework describes categories of health care payment models including fee-for-service (FFS) (category 1), models that reward quality and performance (category 2), models that incorporate shared financial savings and risk (category 3), and fully population-based arrangements (category 4) that depart from volume-based FFS payments.

Oregon's VBP Roadmap for CCOs uses the HCP-LAN framework as a common language for categorizing CCOs' contracts with providers.

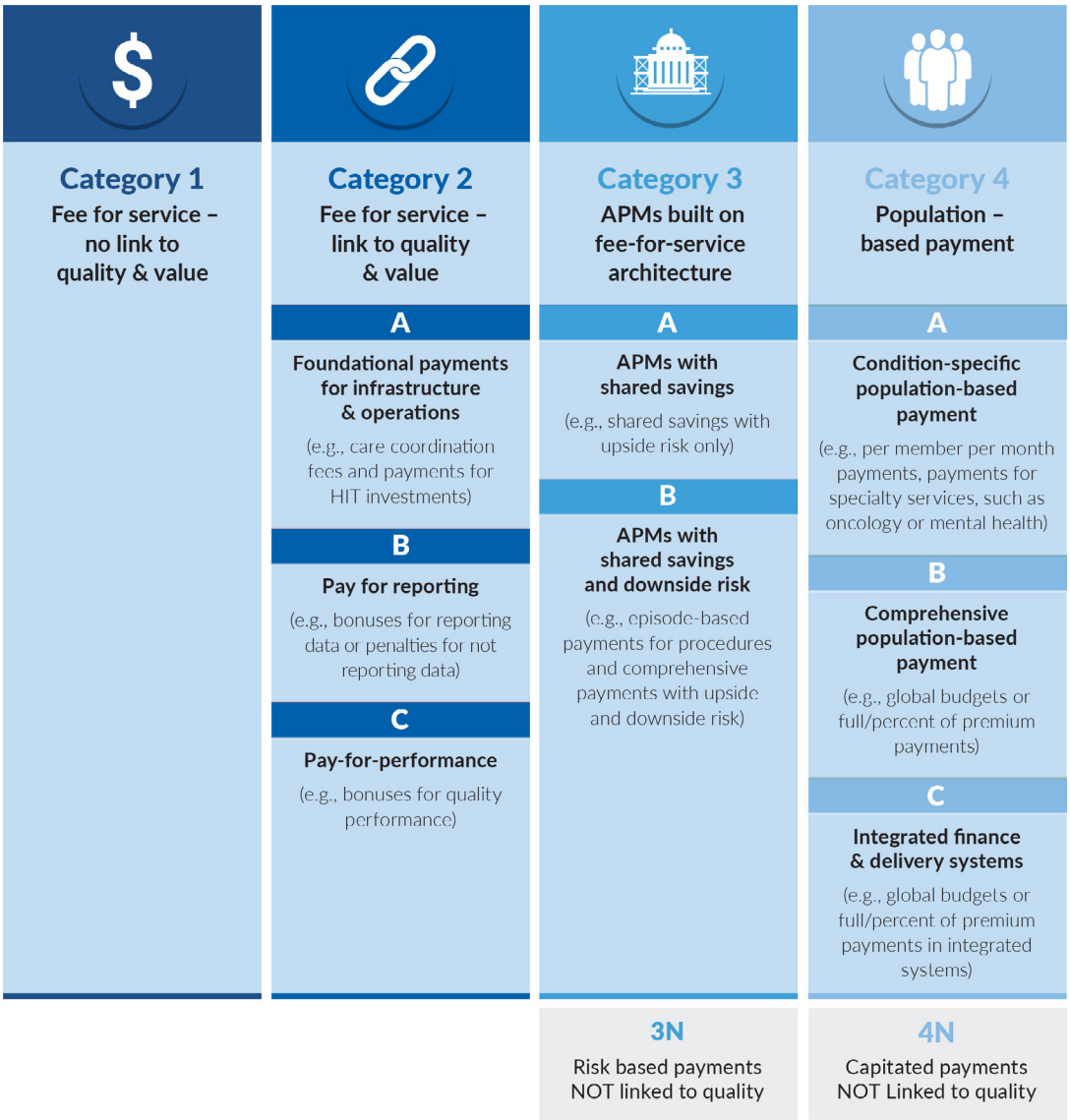


Image reproduced from the Health Care Payment Learning and Action Network's 2017 (refreshed) Alternative Payment Model APM Framework available at https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

VBP Roadmap goals in 2020 and 2021

In 2020 and 2021, CCOs were required to achieve the following VBP milestones:

Exhibit C. Requirements of CCOs in 2020 and 2021 from Oregon's VBP Roadmap

	2020 Requirement	2021 Requirement
Annual VBP targets 	CCOs were required to make at least 20% of payments to providers through qualifying VBP arrangements (HCP-LAN category 2C or higher). The state later granted CCOs flexibility to temporarily convert arrangements to pay-for-reporting (category 2B) without penalty due to COVID-19.	CCOs were required to make at least 35% of payments to providers within qualifying VBP arrangements (HCP-LAN category 2C or higher).
Patient-Centered Primary Care Homes 	CCOs were required to implement a new payment model for PCPCHs by 2020 that supported infrastructure investments and rewarded clinics for higher levels of PCPCH recognition. These payment models must include a LAN category 2A per-member per-month (PMPM) payment that increases by PCPCH tier.	CCOs are required to meaningfully increase PMPM payments within each PCPCH tier during each year of the five-year CCO contract cycle to continue promoting infrastructure investments that enhance care delivery.
Care delivery areas 	CCOs were originally charged with developing new or enhanced VBP models in three CDAs in 2020 for implementation by 2021: maternity care, hospital care, and behavioral health care. OHA delayed this requirement by one year due to COVID-19.	Following OHA's decision to delay this requirement by one year, CCOs were required to develop new or enhanced VBPs in hospital care, maternity, and behavioral health areas during 2021 to be implemented by 2022. CCOs have the option to meet CDA requirements in two areas with a single combined payment model.

Abbreviations. CCO: Coordinated Care Organization; CDA: Care Delivery Area; HCP-LAN: Health Care Payment Learning & Action Network; OHA: Oregon Health Authority; PCPCH: Patient-Centered Primary Care Home

About this report

The Center for Health Systems Effectiveness was engaged to evaluate CCOs' progress toward the VBP Roadmap goals and requirements. **This interim report includes:**

- CCOs' self-reported progress developing and implementing new payment models and engaging providers to meet VBP Roadmap requirements as of mid-2021 *(Section 2)*.
- CCOs' achievement of PCPCH infrastructure payment requirements that took effect in 2020 *(Section 3)*.
- CCOs' progress developing payment models in priority CDAs *(Section 4)*.
- CCOs' development of health information technology (HIT) capacity to monitor and report on VBP arrangements, including supporting providers to use VBP data for population health improvement *(Section 5)*.

- Recommendations for OHA to continue supporting CCO progress toward VBP Roadmap requirements *(Section 6)*.

Data sources and methods

This report draws from a variety of data. Evaluators collected written questionnaires from CCOs in May 2021 and conducted interviews with CCO leaders in June 2021. Questionnaires and interviews were analyzed to assess CCOs' implementation progress as well as assistance needed from the state.

We analyzed CCOs' achievement of the PCPCH infrastructure payment model requirement for 2020 using data submitted by CCOs to OHA in late 2021 for the calendar year 2020.

Detailed data on CCOs' payment arrangements with providers for the calendar year 2020 was not yet available at the time of publication. These results will be published in a future evaluation report.

A detailed description of data sources and methods used for this evaluation can be found in the appendix.

CCO Progress Promoting VBP Arrangements in 2021

KEY TAKEAWAYS

- **CCOs faced a challenging environment for promoting VBP adoption in 2021** due to the ongoing COVID-19 pandemic and several new requirements taking effect across CCO 2.0 initiatives. CCOs reported some progress building relationships and trust with providers, but were also challenged by workforce burnout and lack of provider familiarity with VBP.
- **CCOs encountered challenges implementing VBP quality strategies.** CCOs reported highly customized approaches to designing providers' VBP performance requirements. CCOs also reported widespread modifications or waiving of quality goals during the pandemic, especially for primary care, behavioral health and oral health providers. Aligning and standardizing providers' performance measures was an ongoing challenge. Some CCOs were waiting to see if OHA would require quality measure alignment in the future.
- **CCOs reported providers were more receptive to shared financial risk through population-based and shared savings arrangements.** These arrangements offered financial stability during the pandemic. In contrast, CCOs reported less provider interest in downside risk or pay-for-performance VBP models.
- **There was no universal approach to promoting health equity through VBP model design.** CCOs reported considerable variation in regional priorities and available partners. Despite this variation, CCOs focused on similar elements of VBP contracts when promoting health equity, including quality measures and goals, tiered reimbursement levels, provider networks, and process measures. OHA should monitor each CCO's progress in those areas relative to where they began the CCO 2.0 contract cycle.

CCO leaders were interviewed in June 2021. Interviews explored factors influencing CCOs' progress toward VBP Roadmap requirements *(see Section 1, Exhibit C)* at that time, as well as successes, challenges, and support needed. CCOs also provided mid-year descriptions of VBP activities through a pre-interview questionnaire. In this section, we present key findings from these interviews and questionnaires.

A challenging environment for provider engagement

As was the case in 2020, CCOs faced competing priorities in 2021 that challenged their efforts to promote VBP adoption. CCOs struggled to find sufficient time for planning, as one leader described:

"I think a lot of it has to do with timelines of the different deliverables being tight and not having enough time to synthesize across. When it comes to payment models, there's the [methamphetamine] work, our health equity plan, the VBP roadmap, the traditional health worker initiatives and all of that is interrelated. Oftentimes there's the rush to try to meet the deadlines … a lot of times we haven't had enough time to do the planning and do the work and get organized to do that."

The COVID-19 pandemic was also perceived to have slowed CCOs' progress toward VBP Roadmap goals, making providers reluctant to adopt changes in payment arrangements. Several CCOs reported provider organizations were declining VBP participation due to burnout or limited bandwidth from the ongoing effects of the pandemic. These issues ranged from general exhaustion and *"not wanting one more new thing to think about,"* to perceptions that providers were highly focused on vaccine outreach and did not have time to implement new workflows or processes related to VBPs.

One rural CCO described how the pandemic was particularly impacting VBP readiness in its primary care network which was serving as the primary mechanism for rural vaccine outreach:

"Our [vaccine outreach] was led exclusively by our primary care community and Federally Qualified Health Centers and the CCO. A lot of the challenge is just … dealing with the fatigue that the providers feel from this whole COVID-19 experience and trying to get everybody vaccinated. And then we're coming along behind and saying 'let's not forget about VBPs and quality that we have to still focus on."

CCOs reported progress developing the capacity to engage providers in VBP planning in 2021. Some CCO leaders reported that promoting new VBP adoption took persistence over time, often through multiple conversations or a lengthy process of identifying the key decision-maker at a hospital or clinic. Interest or enthusiasm for VBP from organizational leadership was described as a key factor:

"I've seen more dramatic change [from] leadership change than just about any other factor. If a leader comes in with a vision and a strategy and wanting to bring [VBP] capability to their team within the provider organization, if they want to do something in the value-based space, it will happen."

However, there was mixed evidence that CCOs were succeeding in reaching new provider organizations not already engaged in VBP arrangements. CCOs continued to be challenged by provider inexperience with VBPs or performance monitoring in 2021. Provider understanding of VBPs was still developing, with some providers needing orientation to concepts such as the HCP-LAN framework before proceeding with contracting discussions. CCOs also reported needing to increase provider awareness of and confidence in performance data used for VBP contracting and implementation.

"I think we've had to make some efforts to assure them that the data is good that they'll be getting in those reports, and that they can trust it."

Some CCOs offered **suggestions** to overcome providers' lack of familiarity with VBP. These included:

- **Developing trusting relationships.** One CCO noted the importance of sharing the VBP Roadmap with provider organizations to provide context for the new emphasis on VBPs.
- **Leveraging existing VBP-participating providers as champions or messengers.** One CCO noted that when providers and hospitals were reluctant to consider VBP arrangements, hearing

from peer organizations in VBP arrangements was beneficial. Organizations engaged on the CCOs' boards or governance councils were also important messengers.

- **Gathering provider input during VBP model design.** CCOs varied in how and when they engaged providers in designing new VBP models. Primary mechanisms included soliciting input from providers during contract negotiations, soliciting feedback from advisory panels or committees, or leveraging performance monitoring meetings as opportunities to discuss VBP planning.
- **Beginning negotiations with VBP arrangements as the default contracting option.** One CCO suggested structuring negotiations with providers so that FFS arrangements were considered only in situations where VBP was not feasible for a provider organization.
- **Development of outreach or educational materials** by OHA that CCOs could share with providers to help explain the state's VBP requirements and providers' options.

Quality incentives and benchmarks

CCOs took highly customized approaches to quality strategies in VBP arrangements with providers.

CCOs reported needing to work on a case-by-case basis with each provider organization when selecting quality measures as part of VBP contracts. One CCO reported they were attempting to internally standardize measure specifications across their VBP arrangements but it was "not going as well as they'd like."

More broadly, CCOs were aware of the importance of aligning measures across payers to reduce reporting burdens on providers, but were struggling to achieve this. When a provider organization already tracked quality or performance measures, CCOs reported needing to develop providers' Medicaid VBP arrangements with these quality measures and plan to transition to standardized measures over time. CCOs offered to work with providers to align measures across payers, but several noted that providers needed to lead these conversations and had not had time during the pandemic: "It's a bandwidth issue for everyone."

CCOs also identified certain **strategies** to overcome challenges developing the quality and performance elements of new VBP arrangements, including:

- **Collaborative selection of performance measures.** Some CCOs began VBP negotiations by providing reports to build understanding of community demographics or population health status that could contextualize a clinic's own performance goals. The selection of quality measures needed to be a dialogue with providers and groups of practices to foster collaboration and alignment across models.
- **Considering performance incentive bonus arrangements or measures aligned with providers' COVID response strategies.** One CCO reported focusing quality incentives specifically on services or care that were most negatively impacted by the pandemic in 2020, such as well-child visits. This strategy was taken in place of reducing providers' quality goals.
- **Starting with easier quality goals** that providers were highly likely to achieve reduced perceived risks of VBP arrangements. This approach allowed CCOs to gradually increase providers' risk exposure, giving providers time to build capacity and adapt to new payment models.

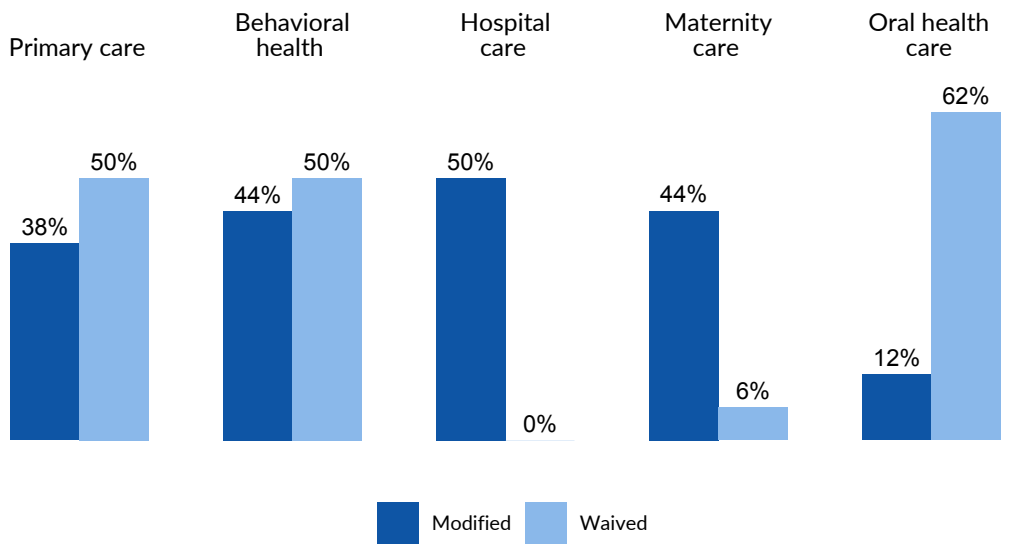
Changes to CCOs' VBP quality strategies and provider reporting requirements continued in 2021 due to the COVID-19 pandemic.

These changes were similar to those made in 2020 during the early months of the pandemic. **Changes in providers' quality strategies** made by CCOs during the pandemic generally included:

- Transitioning to pay-for-reporting arrangements and waiving providers' performance targets in 2021.
- Creating quality measures and incentives for equitable COVID-19 vaccine access.
- Using 2019 rather than 2020 as a baseline for setting providers' goals or quality measure targets going forward.

CCOs reported varied modifications to providers' VBP quality reporting requirements and targets across different care areas. Primary care, behavioral health and oral health sectors saw more substantial changes in CCOs' quality and reporting requirements during the pandemic than the hospital and maternity care sectors *(see Exhibit D)*. Half of CCOs also fully waived providers' quality goals for primary care, behavioral health and oral health.

Exhibit D. CCOs reporting changes to providers' VBP quality goals due to COVID-19, May 2021



Source: CCO questionnaires collected in May 2021. N=16 CCOs

Opportunities to support CCOs' quality strategies

The following opportunities were identified where OHA may be able to provide additional guidance or support to CCOs as they develop their VBP quality and performance strategies:

- **CCOs were seeking ongoing OHA feedback on VBP model design early in their planning efforts.** CCOs valued having OHA as "a sounding board" for whether certain VBP model designs were "good approaches" while CCOs were engaged in provider negotiations. CCOs are able to request this feedback from OHA and are encouraged to do so.

- **CCOs wanted VBP models and strategies that could also meet other CCO 2.0 requirements.** OHA may wish to convene a discussion among CCOs to identify examples of VBP models that have been designed with this in mind. For instance, one CCO reported they were trying to develop a VBP model covering traditional health worker (THW) services to complement case rates for doula care.
- **Some CCOs reported waiting to see whether OHA would require payment model alignment** in the future before assessing how their existing quality measures aligned with other CCOs or non-Medicaid payers. In several cases, CCOs reported they were modeling VBP arrangements on OHA's CCO performance measures. The state may wish to guide CCOs on which CDAs or quality measures are most likely to be required within multi-payer strategies in the future.

Promoting shared financial risk in VBP arrangements

CCOs reported varied enthusiasm from providers for shared risk arrangements in 2021, citing financial uncertainty stemming from the pandemic as an ongoing challenge. CCOs generally described providers as more receptive to shared savings and population-based arrangements (e.g. category 3A and 4), while pay-for-performance or downside risk models (category 2 and 3B) were more difficult to promote.

Providers were more amenable to shared risk arrangements if they had pre-pandemic experience with these payment models, but CCOs also reported varying provider preferences for the structure of these arrangements. One CCO reported that 3B arrangements (FFS with downside risk) were an "easier sell" to its providers because they had "softer edges" than population-based VBP arrangements, while another CCO stated its providers wanted to "skip over [3B arrangements]" and "jump to capitation" (e.g. category 4) VBPs.

When CCOs reported success promoting new shared risk arrangements with providers, they identified the following **strategies** as helpful:

- **Using COVID-19 stabilization payments as an entry point** to longer-term VBP arrangements. CCOs reported success engaging providers in VBPs by introducing category 4 payments (with or without quality requirements) during the pandemic that stabilized practice revenues. One CCO reported success using this approach to engage a hospital in a category 4N arrangement without quality requirements that was well-positioned to convert to a VBP arrangement by incorporating quality measures in the future.
- **Setting population-based payment rates carefully to reward desirable changes.** One CCO reported needing to set VBP rates slightly higher than what providers would have received under FFS to make VBPs attractive. Other strategies included incorporating clinical risk adjustment into PMPM rates or adjusting population-based payments to reward the addition or expansion of priority services. One CCO also noted the importance of planning for inclusion of THW services and other historically non-billable services when setting VBP rates.
- **Tying providers' target rate of growth to the state's 3.4% cost growth target.** For hospitals, one CCO reported success tying the hospital's budget target to the state's cost growth target when structuring a downside risk arrangement.

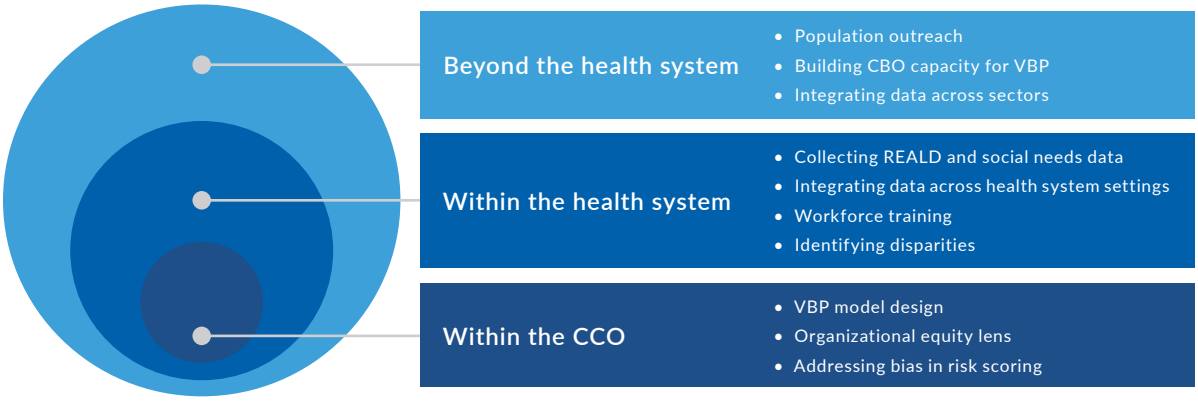
CCOs varied in how they used the term "downside risk" in interviews. Some CCOs using the term broadly to encompass HCP-LAN 3A, 3B, and category 4 arrangements (consistent with OHA's definition); other CCOs used "downside risk" to refer more narrowly to category 3B arrangements. OHA may wish to conduct additional outreach to CCOs to clarify key VBP terminology.

Promotion of Health Equity through VBP Model Design

Promoting health equity is a central goal of Oregon's health care transformation efforts.[5] OHA has strongly encouraged CCOs to develop VBP models that promote health equity, and required CCOs to consider how their VBP arrangements may create health disparities.

CCOs described a range of planning efforts to promote health equity through, or in conjunction with, their VBP promotion strategies in 2021. Developing the capacity to collect and use demographic data to identify disparities remained a central focus. To supplement these data-driven efforts, some CCOs were pursuing additional strategies within the CCO, with provider organizations, and with community-based organizations (CBOs) beyond the health system *(see Exhibit E)*.

Exhibit E. CCO Strategies to promote health equity through VBPs



CCOs varied substantially in the approaches they were taking to promote health equity through VBP model design, and there was no standard approach. This variation reflected that CCOs began the CCO 2.0 contract cycle with meaningfully different baseline experiences with VBP contracting as well as substantial variation in their preferred payment model designs and emphases. Priorities for new VBP quality strategies also varied across regions, reflecting different community needs and options for partnering with providers and CBOs.

While each CCO took a unique approach, their strategies for promoting health equity through VBP model design broadly focused on similar elements in providers' contracts *(see Exhibit F)*.

Exhibit F. VBP model elements that CCOs use to promote health equity

Measure selection and targets	CCOs commonly described the selection of quality measures and goals as a core element of promoting health equity through their VBP models by focusing on priority populations or holding providers accountable for closing gaps in care. Several CCOs focused on access to culturally and linguistically appropriate services (CLAS) in 2021.
Tiered or adjusted payments	Two CCOs were exploring payment adjustments designed to promote equity by rewarding providers for serving higher acuity members, either through a risk-adjusted reimbursement model or an additional primary care PMPM payment for members with behavioral health conditions. One CCO reported including a medical-loss ratio target in a downside risk arrangement to ensure downside risk did not lead to reductions in access to care. Another CCO had changed its member risk scoring approach to address racial bias in its algorithm.
Eligible providers	One CCO reported working with a staff equity specialist and a Tribal member liaison to increase engagement with providers of color and/or providers of CLAS. Other CCOs described developing new VBP arrangements that included services from THWs, CBOs, and school-based health centers to increase access to care in underserved communities.
Process measures and attestation-based requirements	Several CCOs reported incorporating new requirements into provider contracts including provider and staff participation in equity and trauma-informed care training, acceptance of non-discrimination policies, or required participation in surveys to assess the availability of CLAS.

OHA may wish to develop recommendations for CCOs on best practices within these model elements. Some CCOs appeared to be struggling to narrow their focus or assess the appropriateness of various options.

CCOs and OHA should monitor within-CCO changes in the above model elements over time to assess whether CCOs are collectively increasing their efforts to promote health equity through VBPs.

It may be difficult for OHA to broadly assess CCOs' progress in this area against a common standard or statewide indicator of change in the future, given variation in CCO approaches. As CCOs move from planning toward implementing new VBP models, it will be important to track each CCO's progress relative to where they began the CCO 2.0 contract cycle.

Some CCOs also reported progress on internal equity strategies not explicitly tied to provider contracts. These included the adoption of a racial equity lens to guide decision-making, equity training for analysts, and additional staff training to identify health disparities. These strategies were described as complementary to CCOs' efforts to promote health equity through VBP model design, though often did not relate directly to the VBP Roadmap requirements.

RURAL AREAS EXPERIENCE UNIQUE SUCCESSES AND CHALLENGES WITH VBP

Rural populations and health systems have different attributes and needs compared with urban areas; these differences can pose challenges for implementation of VBP models designed with urban populations in mind.[6] Prior research has found challenges with VBP implementation in rural areas including small population sizes that destabilize quality metrics, provider and practice profit margins that limit risk-taking abilities, a smaller workforce, and limited HIT infrastructure that increases reporting and administrative burden for practices.[7]

A sub-analysis of CCO key informant interviews was conducted by one member of the research team (Morrison) to assess VBP implementation experiences for rural CCOs. Interviews with seven CCOs serving primarily rural service areas were compared with interviews from three CCOs serving primarily urban or mixed service areas.

This research found rural CCOs face specific **challenges** with VBP adoption that mirror those seen in rural communities nationally. For example:

- Rural CCO leaders faced a dilemma balancing standard and customized quality measure specifications. Standard specifications posed challenges when rural populations differed demographically from urban areas (e.g., older ages) or when very small numbers of members were included in calculations. Multiple measure sets increased administrative burdens for rural provider organizations that operated with smaller staff and struggled with workforce retention.
- HIT and VBP reporting capabilities, such as dashboards for providers to monitor quality metric performance, were often cited as an area of accomplishment by CCOs with urban or mixed service areas. In primarily rural CCO regions, lack of HIT capacity and reporting capabilities were cited as challenges.

Despite challenges, **successes** reported by rural CCOs included:

- Achieving increases in the percent of VBPs.
- Providers and hospitals advancing to arrangements at higher HCP-LAN categories.
- A perceived increase in communication between the CCOs and providers, and an increase in providers engaging with quality data when available.
- VBP as a stabilizing factor for providers facing declining revenues during the pandemic.

Rural CCO leaders wanted **opportunities for dialogue** with other CCOs to learn how they are addressing challenges with VBPs. Rural CCOs also reported providers wanted opportunities to discuss VBPs with other rural providers. Specific priorities included the following:

- Hospitals and specialists were hesitant to adopt financial risk-sharing because of a perception that they lacked ability to influence performance outcomes.
- Rural CCOs lacked market share or leverage to negotiate with larger providers and hospitals. These power dynamics were perceived as greater challenges for rural areas.
- Limited buy-in by some rural providers who perceived that the emphasis of VBP was on a sustainable rate of cost growth, which did not align with community priorities or the perceived purpose of the CCO to disburse resources.

Although CCOs serving rural Oregon face many of the same challenges in implementing VBP that urban centers do, unique challenges and opportunities also exist in rural areas. This research highlights the need for VBP options to address specific needs of rural hospitals and specialists, increased support for HIT investment, and adaptable quality measures that work for rural areas.

Making VBP Work for Lower-Volume Providers

CCOs reported that there was insufficient volume to make VBP models attractive or viable for some providers. Some CCOs reported provider organizations were too small to administratively manage VBP arrangements or the number of providers' Medicaid-insured patients was insufficient to support the calculation of reliable quality measures. One CCO reported that pooling small providers together for performance measure calculations was not an appealing solution for clinics that operated as independent practices by choice: *"Some of these practices are small because they like it that way."*

CCOs identified two **strategies to overcome these challenges**:

- **Aligning to quality measures for non-Medicaid members, where appropriate.** In cases where a provider organization had capacity for performance monitoring but low Medicaid volume made calculating measures unreliable, three CCOs reported they were aligning to measures providers already calculated for patients insured by other payers, such as Medicare Advantage.
- **For small organizations, focusing on quality bonuses and shared savings potential** rather than downside risk allowed small provider organizations to participate in VBPs even when downside risk was not financially feasible.

Additional Guidance Needed

CCOs may need **additional guidance in these areas** as they work toward annual VBP targets:

- **What options exist for VBP arrangements for prescription benefit managers?** Related, will CCOs be required to include pharmacy expenditures in their future calculation of VBP participation? OHA's current methodology captures pharmacy expenditures in its calculation of the percent of CCO payments made in VBP arrangements in order that a global budget VBP arrangement (i.e., LAN category 3A, 3B, or 4 arrangement) could include providers' prescribing patterns.
- **What "counts" as qualifying VBP expenditures?** For example, should CCOs include claims (such as diagnostic claims) as qualifying VBP expenditures if these are reimbursed as FFS claims, but a primary care provider also bears risk for these costs under a total cost of care (category 4) arrangement?
- **Which VBP models qualify as shared risk arrangements?** CCOs will be required to meet annual targets for the proportion of payments made to providers in shared risk arrangements beginning in 2023, which OHA defines as HCP-LAN categories 3B or higher. CCOs did not appear to consistently know that the state has included HCP-LAN category 4 in qualifying downside risk arrangements; some limited their focus to 3B arrangements.
- **What is the rationale for downside risk arrangements?** One CCO leader questioned whether OHA's requirement for achievement of downside risk arrangements was necessary in light of the state's cost-growth targets and quality requirements: *"If we are meeting the quality measures, and we are meeting the rate of growth, and we are providing access, why is it important to have downside risk?"*

Implementation of Primary Care Infrastructure Payment Models

KEY TAKEAWAYS

- **All CCOs developed infrastructure payment models for PCPCHs in 2020.** These payment models included tiered PMPM amounts that increased by clinics' PCPCH recognition level. Two CCOs reported no PMPMs for tiers 1-2 and OHA subsequently clarified this requirement for CCOs.
- **There was substantial variation between CCOs in the PMPM amounts clinics earned in each PCPCH tier.** Overall, CCOs reported relatively small PMPM amounts in all tiers. It is unclear whether all CCOs have designed models that support meaningful investments in PCPCH infrastructure.

The PCPCH program is Oregon's primary care medical home initiative. Clinics across the state are eligible to be recognized as PCPCHs at one of five levels when they meet standards for recognition in areas including: access to care; accountability; whole-person care; continuity of care; coordination and integration; and patient- and family-centered care.[8]

The VBP Roadmap requires CCOs to implement new infrastructure payment models for PCPCHs in 2020. These payment models must include:

- **Tiered PMPM amounts** that increase by clinics' PCPCH recognition level so that clinics with higher recognition status received higher PMPM amounts;
- **Increasing PMPM amounts** in each tier during each year of the CCO contract cycle.

CCOs implemented payment models that rewarded clinics for higher PCPCH recognition levels in 2020.

CCOs reported to OHA the PMPM payments made to PCPCH clinics in 2020. All CCOs reported tiered payment models that increased by PCPCH recognition level (not shown); however, two CCOs reported models that did not include PMPM payments to clinics at tiers 1 or 2. The impact of this variance from OHA requirements in 2020 is likely small as only two PCPCHs were contracted under these arrangements. OHA has subsequently clarified this requirement for CCOs.

Average PMPM payments generally increased by tier but were small dollar amounts.

The average amount paid by CCOs to tier 1 clinics was $3.83 PMPM, increasing to $8.70 PMPM for tier 5 clinics, when payments were weighted by the number of Medicaid members attributed to each clinic *(see Exhibit G)*. Some CCOs reported a payment range rather than fixed PMPM amount clinics were paid within each PCPCH tier. These ranges reflected additional criteria CCOs used to establish clinics' PMPM payments. For example, some CCOs incorporated risk adjustments for member acuity or larger payments for rural clinics.

Exhibit G. CCO infrastructure payments to PCPCHs, 2020

	Tier 1 clinics	Tier 2 clinics	Tier 3 clinics	Tier 4 clinics	Tier 5 clinics
Number of contracted clinics, all CCOs (N)	1	5	83	482	126
Average PMPM payment (weighted)	$3.83	$2.82	$4.19	$7.45	$8.70

Note: Some CCOs reported a payment range rather than fixed amount per tier. The average PMPM payment (weighted) is the mean of all CCOs' reported payments in that tier after payments are weighted by clinics' attributed Medicaid members. Source: 'PCPCH+CDA Data Templates' submitted by CCOs to OHA for the 2020 calendar year.

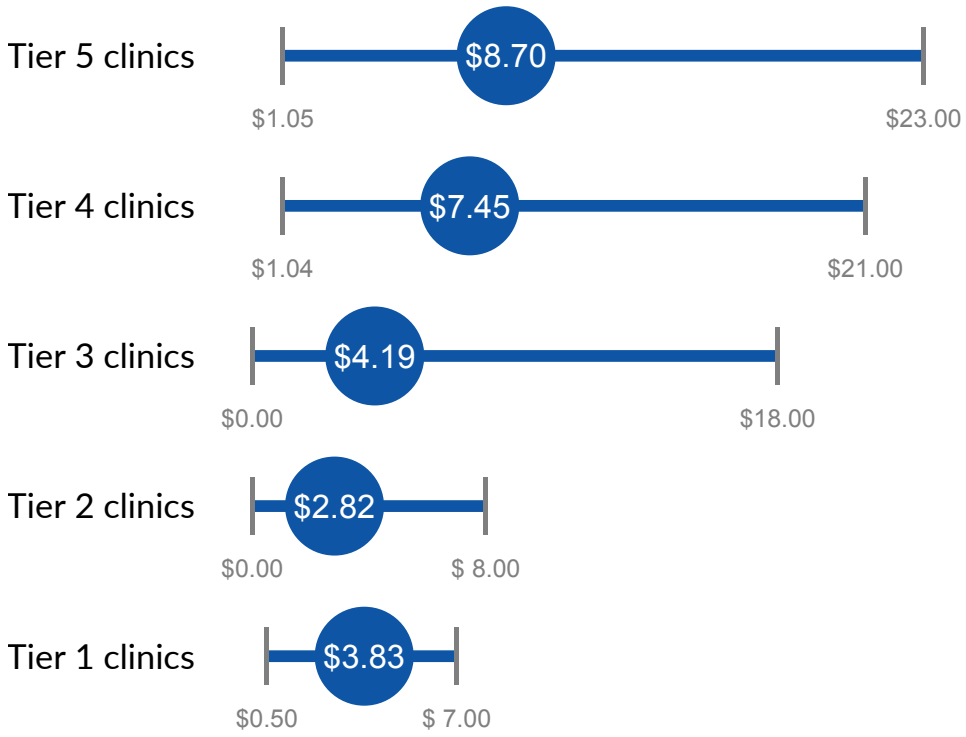
The PMPM amount clinics could earn within each tier varied across CCOs in 2020.

Exhibit H depicts the smallest and largest PMPM amounts paid by any single CCO within each tier for 2020, as well as the average PMPM paid by all CCOs, weighted by clinics' Medicaid member attribution.

The average PMPM payments were relatively small in all tiers across CCOs, despite some CCOs reporting larger PMPM amounts,

CCOs provided a mid-year narrative update on their PCPCH infrastructure payment models in May 2021. Reported PMPM amounts within tiers still varied substantially across CCOs at that time (not shown).

Exhibit H. CCOs' minimum, average, and maximum per member per month payments paid to Patient-Centered Primary Care Homes, by clinic recognition level, 2020

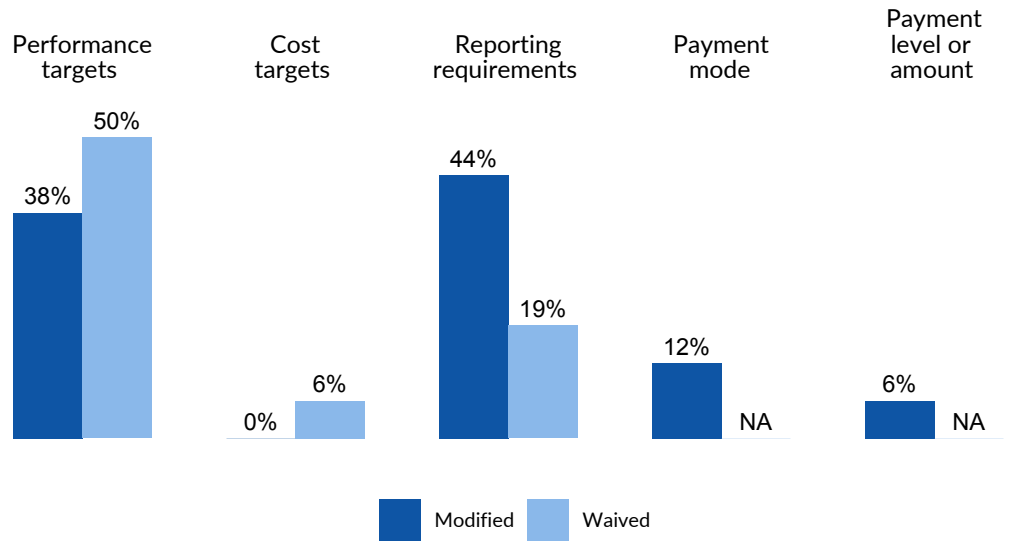


Note: Minimum and maximum values reflect the lowest and highest dollar PMPM payments by any CCO to a PCPCH in that tier. The average PMPM is the mean of all CCOs' reported average PMPM payments in that tier, weighted by their clinics' attributed Medicaid members. Source: 'PCPCH+CDA Data Templates' submitted by CCOs to OHA for the 2020 calendar year.

CCOs made other changes to primary care VBP arrangements during the COVID-19 pandemic.

Exhibit I shows reported modifications to CCOs' primary care payment arrangements as of mid-2021. These payment arrangements were not necessarily with recognized PCPCH clinics, but provide context for the shifting landscape of primary care payments during the pandemic. Half of CCOs reported waiving quality goals for primary care providers, while 38% made modifications to the goals. CCOs also commonly reported modifying reporting requirements (44%) though other changes such as modifications to cost targets, payment modes or levels were rare.

Exhibit I. CCOs reporting changes to primary care VBP arrangements due to COVID-19, May 2021



Source: CCO questionnaires collected in May 2021. N=16 CCOs.

Overall, CCOs developed infrastructure payment models consistent with the requirement in this area, but it is unclear whether these models will support further investments in PCPCH infrastructure.

The majority of PCPCH clinics were already recognized as tiers 4 or 5 (87%, n=608) in 2020. OHA should assess whether the tiered infrastructure payment requirement is likely to drive further advances in PCPCH recognition given the small number of clinics at lower recognition levels. OHA should also assess the extent to which PMPM arrangements have supported new HIT investments for monitoring population health and health inequities at the clinic level given the number of CCOs reporting these as challenges to provider VBP implementation.

One CCO reported leveraging its PCPCH arrangement to proactively encourage participation by behavioral health providers in 2021. OHA may wish to explore this variation of the infrastructure payment model more fully, given HIT-related capacity challenges CCOs described with behavioral health providers.

SECTION 4

Progress Developing Models in Priority Care Delivery Areas

KEY TAKEAWAYS

- **CCOs' progress toward CDA requirements for 2022 was mixed.** CCOs reported some success promoting acceptance of population-based (category 4) payments with hospitals and behavioral health providers, while they encountered challenges promoting adoption or implementation of bundled payment models across CDAs.
- **CCOs struggled to develop and implement the quality components of new CDA arrangements.** These challenges often related to CCO or provider HIT capacities. OHA may wish to provide more targeted technical assistance to address specific HIT challenges in each CDA.

The VBP Roadmap for CCOs identifies five CDAs in which CCOs must develop and implement new payment models. The areas are:

1. Hospital care
2. Maternity care
3. Behavioral health care
4. Oral health care
5. Children's health care

CCOs were required to develop new payment models in areas 1-3 for implementation in 2022. Requirements for areas 4-5 take effect in 2023 and 2024, with flexibility for CCOs to choose which model to implement each of those years. CCOs have the option to develop one payment model that combines two CDAs.

Hospital care	Maternity care	Behavioral health care
• By mid-2021, all CCOs had either implemented hospital VBPs or were actively engaged in these negotiations. • CCOs reported success promoting category 4 models for financial stabilization during the pandemic. • CCOs took a conservative approach to quality strategies because hospitals were less receptive to new performance measures. • CCOs reported challenges fostering collaboration between hospitals and primary care organizations on VBP implementation.	• These arrangements were typically in negotiation but not yet implemented by mid-2021. CCOs pursuing bundled payments were struggling with HIT-related challenges. • Roughly half of CCOs planned to meet this requirement with a combined maternity-hospital bundled payment arrangement. • CCOs pursuing hospital-only or outpatient-only maternity VBPs reported fewer HIT challenges. These negotiations were largely concluded by mid-2021.	• CCOs reported a highly unstable behavioral health sector facing many external pressures in 2021. CCOs focused on payment stabilization and relaxed or waived quality goals. • Providers were receptive to future quality incentives but there were substantial gaps in provider HIT capabilities that impeded progress. • CCOs reported better progress implementing VBPs for behavioral health integration with primary care organizations that had existing HIT infrastructure.

Hospital Care VBP Arrangements

Five CCOs reported existing hospital VBP arrangements already in place by mid-2021 to meet the CDA requirement. The remaining CCOs were negotiating new arrangements.

These models fell into categories 4C, 4A, 3B, or 2C. Other CCOs reported discussions underway regarding new hospital VBPs in 2021, including hospital maternity-care case rates (n=3 CCOs), the addition of new quality measures to an existing shared risk arrangement (n=1), and a new category 2C arrangement (n=1).

Oregon hospital types

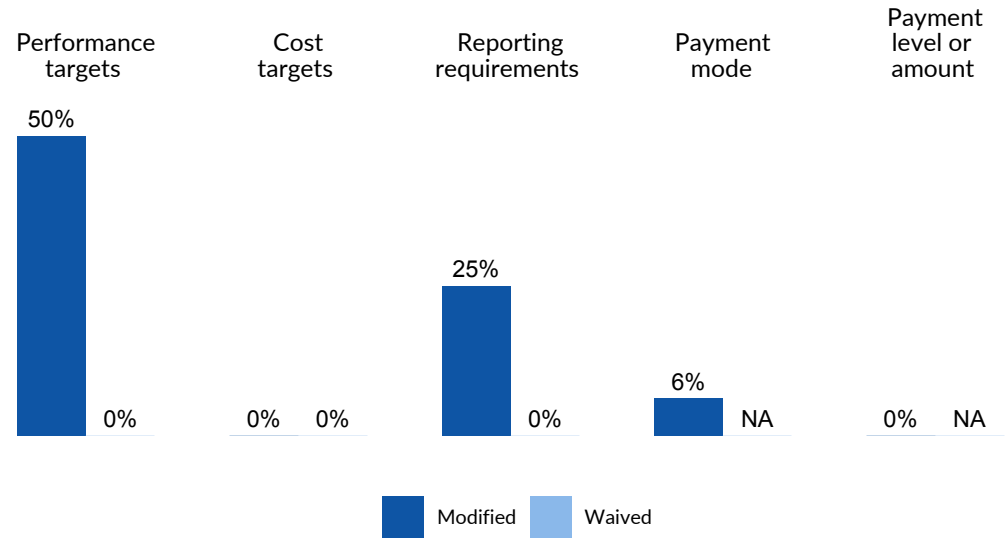
The Oregon Health Authority's Hospital Reporting Program classifies hospitals as follows:

- **DRG.** Reimbursed through standard Medicare diagnosis related groups (DRG); typically located in large urban areas.
- **Type C.** Subset of DRG hospitals with more than 50 beds; typically located in rural areas; do not serve as a referral center in their region.
- **Type A.** Smaller facilities (fewer than 51 beds); often rural; located more than 30 miles from another hospital.
- **Type B.** Smaller facilities (fewer than 51 beds); located less than 30 miles from another hospital.

The COVID-19 pandemic led CCOs to scale back existing quality strategies for hospitals.

As of May 2021, half of CCOs had modified hospitals' quality goals due to COVID-19, while one quarter had made changes to reporting requirements *(see Exhibit J)*. In contrast, CCOs reported little or no impact of the pandemic on hospital cost targets, payment modes (e.g. converting from retrospective to prospective payments) or payment levels.

Exhibit J: CCOs reporting changes to hospital VBP arrangements due to COVID-19, May 2021



Source: CCO questionnaires collected in May 2021. N=16 CCOs.

CCOs reported mixed progress negotiating new or enhanced hospital VBP arrangements in 2021.

There was interest from hospitals in population-based (category 4) arrangements as a means to stabilize revenues during the pandemic. However, CCOs also reported concerns from hospitals, including heightened risk aversion and a concern that population-based payment arrangements would undermine hospitals' ability to expand market share.

CCOs promoted hospital quality strategies by focusing initial VBP discussions on financial stabilization while gradually introducing and increasing quality components. Hospitals were often driving these conversations, with CCOs needing to align their payment models to a hospital's existing quality framework, or adopt quality measures the hospital had historically performed well on, to reduce perceived risk exposure.

Several CCO leaders noted the importance of aligned hospital and primary care VBP strategies, with different challenges emerging for health systems than standalone hospitals.

CCOs encountered different challenges promoting VBP for hospitals with affiliated primary care clinics operating under a single health system than for hospitals unaffiliated with primary care clinics. CCOs sometimes reported struggling to promote VBPs with standalone hospitals if the hospital did not perceive an ability to influence factors driving utilization of its services. One CCO leader described this tension:

> *"I think it differs whether a hospital [is affiliated with] primary care that [they] have attribution to or that can impact factors that may drive down hospital costs… The more standalone hospitals are hesitant to [take] any risk [or] to put any skin in the game in regards to VBPs. I think that's going to be a continued challenge for all of us as we go forward."*

In contrast, one CCO reported a hospital that was part of a larger health system was unable to adopt a global budget arrangement because the health system's primary care clinics lacked capacity to accept new members.

CCOs' efforts to promote hospital VBPs were challenged by limited options for state-endorsed hospital quality measures. Some CCOs see significant opportunity for a coordinated statewide strategy.

CCOs struggled with limited options for state-endorsed hospital quality measures, and existing state-approved measures did not work well at local levels due to small numbers of Medicaid members and regional "spillover" (members crossing CCO borders to seek care in hospitals or primary care clinics in other CCO regions).

While diversity in state and federal hospital classifications *(see below)* will require ongoing flexibility in CCOs' hospital payment modes, **OHA should explore whether a statewide hospital quality strategy could better align quality measures and goals across regions while retaining the ability to locally tailor reimbursement modes and risk-bearing elements.** A statewide strategy for hospitals was identified by one CCO as *"the state's biggest opportunity for multi-payer alignment."*

Maternity Care VBP Arrangements

Most CCOs reported multiple VBP efforts underway related to maternity care. As of mid-2021, these arrangements were in development or negotiation and not yet implemented.

Two approaches for maternity VBP arrangements have emerged, with some CCOs aiming to meet this CDA requirement through bundled hospital and outpatient maternity care payment arrangements covering multiple providers, while others pursued more narrowly designed hospital-only or outpatient-only maternity VBP models.

- **CCOs' bundled hospital and maternity care payments were typically not yet implemented by mid-2021.** Four CCOs reported negotiations with hospitals while three CCOs reported discussions with specialty obstetric providers. CCOs were developing the technical specifications for these models, noting difficulties selecting services or providers that would be covered. One CCO reported that maternity care providers were *"requesting a lot of scenario exclusions."*
- **CCOs pursuing hospital-only or outpatient-only maternity VBP models were further along.** These more narrowly designed approaches were pursued as an alternative to bundled payments because of uncertainty and delays caused by COVID-19. CCOs generally reported fewer challenges designing or promoting non-bundled arrangements, though one CCO noted it was too early to draw conclusions about the efficacy of these models.

Examples of these **non-bundled VBP models** included:

- **Category 2C maternal medical home models.** One CCO had implemented this model ahead of schedule in 2021 with no further planned changes; the other planned implementation by 2022.
- **New maternity care quality measures** incorporated into existing primary care (n=2 CCOs) and hospital VBP arrangements (n=1 CCO).
- **Integrated maternity and SUD care models.** One CCO already had this type of model in place in 2021, and another reported a model planned for implementation.
- **Doula care models.** Four CCOs reported existing VBP arrangements covering doula services.

Roughly half of CCOs scaled back existing maternity care VBP quality strategies in 2021 due to COVID-19.

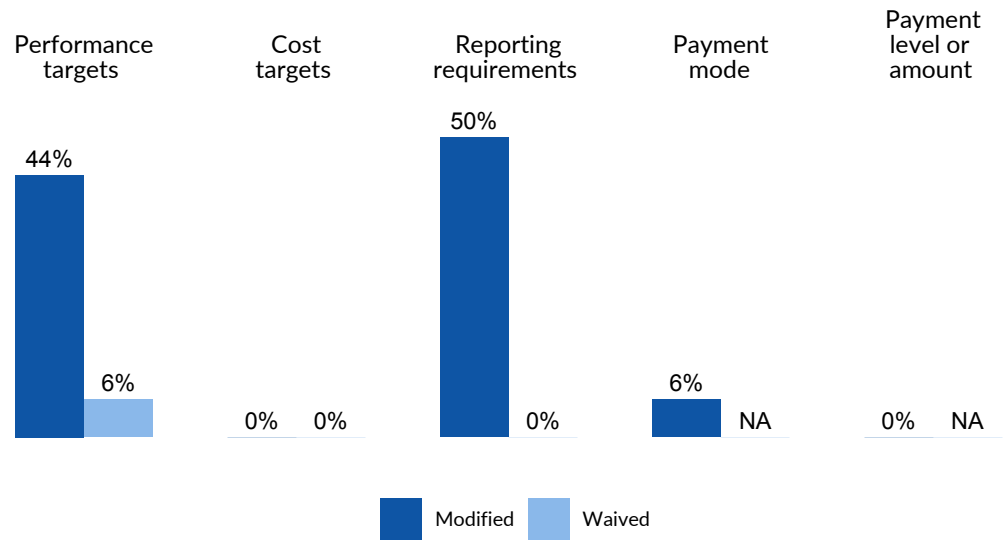
Exhibit K shows CCOs' pandemic-related changes to maternity care VBPs, as reported in May 2021. These changes were mostly limited to modifying providers' performance targets (reported by 44% of CCOs) and reporting requirements (50% of CCOs).

This was in contrast to primary care, behavioral health and oral health areas, where roughly half of CCOs reported fully waiving providers' quality goals.

Looking ahead, one CCO leader also described the importance of the VBP Roadmap and OHA's CDA requirement to help them promote maternity care provider adoption of quality measures in VBP arrangements:

> *"I think it'll be important when the [2022] contracts start getting negotiated [to say to providers]: "this is an OHA requirement that there be some [focus] in these domains. This is what we've identified as the best way we can achieve that objective…Not only have we committed to the OHA that we'd do it, we think it's an impactful thing within the aligned measure set."*

Exhibit K: CCOs reporting changes to maternity care VBP arrangements due to COVID-19, May 2021



Source: CCO questionnaires collected in May 2021. N=16 CCOs.

OHA should closely monitor CCOs' progress in the maternity care area. CCOs' overall progress in this area as of mid-2021 suggested they were particularly struggling to develop and implement quality strategies in the maternity care area. While some CCOs appear to have pursued blended hospital and maternity care models to streamline their VBP requirements, these CCOs encountered more substantial challenges with data collection, aggregation, analysis and reporting as they sought to implement these arrangements.

CCOs need focused technical assistance to develop and implement quality strategies in maternity care VBP arrangements. Technical assistance may be most beneficial if it includes targeted support for CCOs pursuing bundled hospital and maternity care payment arrangements, as CCOs reported struggling with HIT capabilities needed to implement these models.

Behavioral Health Care VBP Arrangements

CCOs were focused on the stabilization of existing behavioral health provider networks.

CCOs described a highly unstable environment in 2021 that challenged their efforts to promote VBP adoption among behavioral health providers, with pressures including the COVID-19 pandemic, widespread workforce and retention challenges, and hospital capacity shortfalls. One CCO described behavioral health workforce challenges in 2021 as "the worst we have ever seen."

Most CCOs reported existing behavioral health VBP arrangements and were laying a foundation for modest enhancements to quality strategies in mid-2021 despite sector-wide challenges.

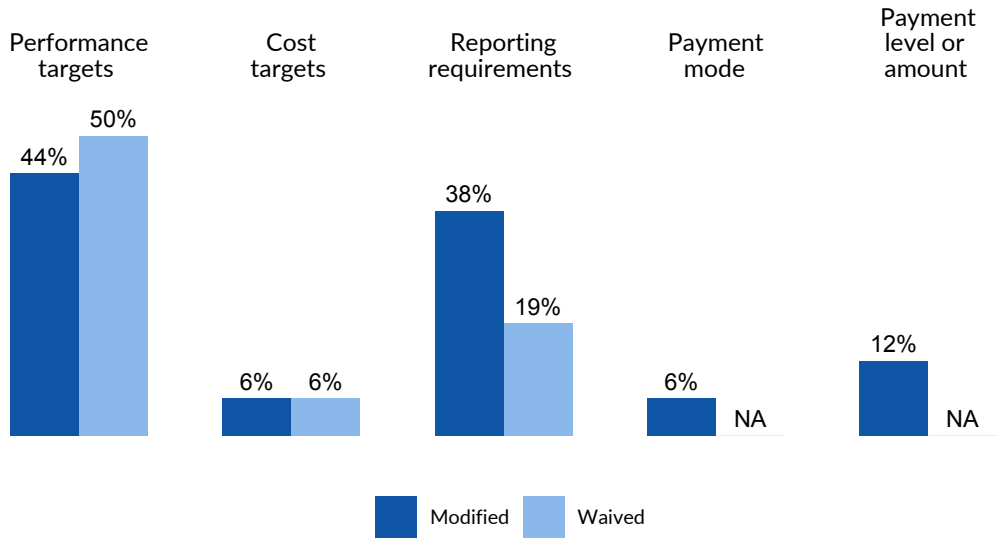
CCOs reported **two approache**s to their behavioral health payment arrangements:

- **VBP arrangements with behavioral health providers.** These were typically already implemented in mid-2021, though three CCOs were also expanding their provider networks. Most CCOs in this group planned enhanced quality strategies including new behavioral health measures (n=2 CCOs), a new incentive payment for collection of medical complexity data (n=1 CCO), and a new behavioral health "composite score" measure (n=2 CCOs). CCOs reported behavioral health providers were receptive to population-based VBPs with quality requirements. Some CCOs were soliciting input from providers to design these arrangements, hosting work sessions, or collecting input on regulatory and payment barriers to be addressed through VBP model design.
- **VBP arrangements to integrate behavioral health services in primary care settings.** Seven CCOs were planning to add behavioral health integration incentives to existing primary care contracts in 2021. CCOs were interested in bundled payments to promote the integration of behavioral health and substance use disorder services in primary care.

Many CCOs also reported changes to behavioral health VBP arrangements related to COVID-19.

Half of CCOs had waived providers' quality goals and 19% had waived provider reporting during the pandemic *(see Exhibit L)*.

Exhibit L: CCOs reporting changes to behavioral health VBP arrangements due to COVID-19, May 2021



Source: CCO questionnaires collected in May 2021. N=16 CCOs.

CCOs with existing or planned VBP arrangements in behavioral health also reported emerging **challenges with quality strategies tied specifically to PMPMs.** Issues included:

- Tension between prospectively attributing members to behavioral health providers in order to enable performance monitoring, and giving members flexibility to select their own providers.
- Lack of reporting infrastructure to monitor provider performance under sub-capitated behavioral health arrangements or in a bundled payment arrangement. One CCO was struggling to develop the HIT infrastructure to support this work and suggested a statewide centralized reporting option.
- Confusion about whether a population-based VBP arrangement with quality incentives at the behavioral health organization (BHO) level qualified as a VBP if it did not directly influence providers' compensation.
- Inability to tie providers' compensation to performance in VBP contracts taking effect in 2022 because of the need for baseline data providers had not historically tracked.
- Lack of infrastructure to collect data for non-claims-based behavioral health reporting.

These areas may be opportunities for focused training or technical assistance from OHA to CCOs who are pursuing category 4 behavioral health VBPs.

VBP Design and Implementation in Other Care Areas

CCOs were focused on VBP Roadmap requirements for behavioral, hospital, and maternity care in 2021 as these requirements took effect in 2022. CCO efforts to develop and implement arrangements for oral health, children's health, and other care areas were only briefly explored for this report, though CCOs did report efforts in other areas. These are summarized below.

Oral health

- One CCO had implemented and another was developing a new oral health VBP.
- CCOs were exploring options to convert existing sub-capitated arrangements with dental care organizations to VBP arrangements. These negotiations were challenging, with one CCO worrying they may face penalties in this area in the future.
- Eight CCOs had waived or modified quality requirements in oral health contracts in 2021 due to COVID-19, with two fully waiving reporting requirements

Children's health

- Two CCOs reported work on children's health care VBPs; one had implemented a category 4 VBP model for pediatric care, and another was developing a model for future implementation.
- Generally, CCOs provided very little detail regarding plans or activities in this area.

Other areas

- Three CCOs were developing and one CCO had implemented a traditional health worker VBP.
- One CCO reported a payment model pilot for a community health worker project focused on diabetes care at an FQHC.
- One CCO was exploring quality measures for an existing arrangement with a Pharmacy Benefit Manager. This was slated for implementation in 2023.
- One CCO reported a new VBP arrangement to integrate physical therapists into primary care settings for pain management.

SECTION 5

CCO and Provider Capabilities to Monitor and Report on VBP Performance

KEY TAKEAWAYS

- **CCOs reported success engaging providers in reviewing community and provider-level performance data.** Sharing and reviewing data with providers was a critical element of all CCOs' VBP implementation strategies. Providers varied meaningfully in their ability to use data. It is likely that CCOs will continue to need a range of options for sharing data with providers given that variation in provider analytic capabilities and support needs will persist over time.
- **CCOs were developing capacity to monitor providers' performance in VBP arrangements, but challenges were noted.** CCOs reported ongoing challenges using REALD and social needs data to monitor health inequities arising within VBP arrangements. They were also challenged integrating data from across platforms and care providers to support bundled payment models. CCOs sometimes struggled to translate data on health inequities into recommendations or next steps for providers. CCOs need technical assistance and guidance from OHA in these areas.
- **CCOs were able to meet OHA's new VBP reporting requirements through mid-2021.** CCOs relied on manual assembly of some VBP information and were seeking ways to streamline their reporting capabilities, though there were no consistent areas identified where OHA could streamline reporting requirements. OHA should monitor this area over time

CCOs need data management systems that support **monitoring of overall CCO progress** toward VBP Roadmap requirements and enable reporting to CCO leadership, OHA, and other community members. CCOs also need the ability to **monitor individual providers' performance** in VBP arrangements. Ideally, this would include disaggregating performance for subgroups of Medicaid members to assess variation across different social or demographic groups.

CCO Monitoring of Progress toward VBP Requirements

Beginning in 2020, CCOs were required to report on progress toward VBP Roadmap goals and milestones during the CCO 2.0 contract period. CCOs were able to meet these reporting requirements as of mid-2021, though CCO leaders spoke generally about their reliance on manual processes to compile information. Several CCOs were seeking ways to streamline this effort, as one leader described:

"It still has been a bit on the manual side of things, as far as tracking progress. But [we are] working towards ways that we can try to automate that as best as possible."

Some CCOs reported additional investments in analytic staffing and software to develop capacity for VBP reporting:

"It's complicated to figure out what to report in what [HCP-LAN category], and so we've had to consume a significant amount of analytical time to get [ourselves] organized so we could widely report on it…"

"…We've had to beef up [the analytics] team to make sure that they're capturing the right dollars … we're evaluating systems right now to see what is the next generation of value-based software accounting programs we need because what we have right now might not be good enough for the future…"

OHA should continue to solicit ongoing feedback on whether CCOs' VBP reporting capabilities to OHA continue to improve over time.

In 2021, **specific suggestions from CCOs** to improve VBP reporting requirements included:

- Ensuring OHA develops and provides advance guidance on any health care claims codes or modifiers CCOs will need to use to fulfill future reporting requirements.
- Publishing results or findings from prior-year CCO reporting before the next reporting deadline to allow time for CCOs to incorporate lessons learned.

CCO Monitoring and Reporting on Provider VBP Performance

CCOs reported mixed progress developing their internal capacity to monitor performance of and share data with VBP-contracted providers in 2021. **Two primary challenges** had emerged:

1. Collecting and using REALD and social needs data.
2. Developing infrastructure to support the integration of data across platforms and settings.

Both challenges were related to the overall complexity of CCOs' HIT expansion efforts and their limited ability to collect and analyze member-level data.

Collecting and Using REALD and Social Needs Data

CCOs reported progress developing capacity to use REALD data to disaggregate provider performance results for subgroups of Medicaid members. Specific examples included assessing disparities in primary care access by race, disaggregating CCO incentive measures by race, and stratifying provider data to assess culturally and linguistically appropriate care.

These efforts influenced some CCO leaders' awareness of health disparities and enhanced their understanding of members' needs. One CCO leader described the importance of acknowledging inequity in existing care delivery as a starting point for VBP planning, noting "we don't have equity at baseline" in quality measures such as access to interpreter services. Another CCO leader shared that internal analysis had revealed they were not adequately reaching their Spanish-speaking members, which had led to new outreach efforts.

The COVID-19 pandemic also heightened and focused CCOs' efforts to identify and respond to health inequities, with multiple CCO leaders describing that work as paving the way for additional equity efforts over time:

> *"That framework of narrowing in on where we're seeing [vaccination] disparities emerging real-time will inform how we think about that work in our larger VBP strategy when it's not quite so intensively focused on this one thing [e.g. COVID-19]."*

> *"There's a giant dashboard behind this that shows a map and can filter by race and ethnicity, and risk groups, that goes out every week to partners [and] that we huddle actively around. Then there's direct organizing around those groups with the community directly to figure out where vaccines should go. That's in combination with hospital partners as well. So it's just much more cleanly stratified by race, and ethnicity, and language than we've ever gotten before. Then the actions taken associated with it are much more specific than we've been before."*

However, CCOs' capabilities to collect and use REALD and social needs data were still developing. Specific challenges included:

- **Limited demographic data for monitoring disparities,** either because data were not collected at all or contained a large proportion of records with undisclosed information. One CCO had previously conducted a retrospective chart review to supplement missing demographic data and reported that this approach yielded mixed results and was not recommended. Another CCO requested that OHA provide additional training options and resources for providers on social needs screening tools such as PRAPARE.[9]
- **Ambiguity about who should collect REALD or social needs data.** CCOs reported not knowing whether it was more appropriate for providers or health plans to collect this information from members. One CCO requested that OHA provide guidance or recommendations in this area.
- **Small numbers when disaggregating quality measures by demographic category.** CCOs were unable to report some disaggregated quality measures due to very small numbers of members included in calculations. Two CCOs expressed concerns that providers or staff may draw faulty conclusions about the presence of health inequities due to random variation in these disaggregated measures.
- **Interpreting data and developing responses.** Several CCOs noted they were not confident in their ability to translate data on disparities into actionable recommendations for their providers.

Integrating Data Across Platforms

Some CCOs encountered a challenge that **VBP-relevant data were stored across multiple non-integrated platforms,** making it difficult for CCOs to see comprehensive information about members. This was particularly true for CCOs aiming to link clinical and social needs data.

> *"I think the overarching issue is just the lack of having any data pieces you might need in one consolidated space whether it be around social determinants or whether it just be clinical pieces of information that are in disparate sources."*

> *"...part of the equity plan is to do a lot of work augmenting that data by pulling data from disparate sources, whether that be intake surveys, or member assessments, or information from the [data system]. All of these sources are ... different opportunities for us to fill in some of those data gaps with the hope being that once we do have it all, we can at least do our best to hopefully get a credible result."*

Lack of data system interoperability was cited as a barrier to the adoption of bundled payment models. CCOs described difficulties with internal data management, as well as data sharing and integration challenges among multiple providers who may be participating in an episode-based or case-rate payment model.

> *"...bundles are a particular challenge. I've talked to at least six other CCOs about their infrastructure in that space. It challenges most of us. I mean, frankly, it's also mixed bag on the provider side..."*

> *"...the question becomes ... the mechanics of understanding the unit costs per each process that you bundle together, and having an outcome around that. For smaller CCOs like us, the question becomes the technology and the infrastructure to make that happen."*

Two CCOs were exploring community information exchange (CIE) platforms to support their VBP efforts. They raised concerns about investing in CIE systems without knowing whether providers would use them, and one CCO was holding work sessions with providers prior to platform selection.

OHA may be able to support CCOs' adoption of bundled payment models through guidance on data integration strategies. The Connect Oregon[10] CIE initiative in which several CCOs are participating may also present opportunities to support CCO implementation of bundled payments. Regions with multiple CCOs may especially need aligned CIE approaches, and may also stand to benefit from being able to share costs.

Sharing Data with Providers to Support Population Health Management

CCOs were engaged in proactive efforts to share VBP-relevant data with providers in 2021.

Approaches varied based on CCO and provider capabilities and preferences, but CCOs reported meaningful progress building capacity in this area, employing **complementary strategies** to share performance data.

- **One-on-one meetings** were used for sharing provider-specific data, discussing issues or needs, and encouraging specific follow-up actions such as member outreach to improve performance.
- **Community meetings** were used to share regional data, discuss trends, and provide context for individual providers' performance relative to their peers. CCOs also used these meetings to gather information about factors that may be driving changes in CCO-level measures over time.

Community meetings promoted dialogue among providers in addition to communication with the CCO.

One CCO leader noted how providers used these meetings to support one another's implementation of new HIT:

> *"It's been kind of fun to see the providers looking at that on a granular level and discussing amongst themselves how they're doing this through their new EMRs because we do have quite a few providers in our community that recently switched to new EMR. They're troubleshooting it amongst themselves, so it's been a great collaboration with the community."*

> *"The good news about this is that the providers are very engaged and asked tons of really meaningful questions, and so they have an interest in this."*

Wide variation in provider organizations' HIT capabilities required that CCOs be flexible in their approach to sharing performance data.

Larger organizations were sometimes able to implement two-way data sharing and conduct their own internal analysis and monitoring. For providers without this capability, CCOs offered access to online portals or paper-based reports. CCOs were generally able to meet providers' needs. However, this created an administrative burden for some:

> *"...we still find ourselves having to send out multiple different reports because we're gathering different data pieces to answer questions about individual measures within VBPs and so [...] we haven't been able to streamline that piece from an administrative perspective [...] we're getting there. It's just taking a lot longer than I would have hoped."*

Overall, CCOs appeared to be making progress in developing internal VBP reporting capabilities in 2021. They also reported positive responses and engagement from providers. This favorable reception may reflect that CCOs' early VBP activities have focused on providers with fewer barriers to VBP adoption, such as providers with prior experience in VBP arrangements or with robust quality improvement infrastructure.

OHA should monitor this area closely as CCOs face pressure to engage providers who are new to VBP arrangements to meet increasing annual targets in future years.

Recommended Next Steps

Below we present key takeaways from the VBP Roadmap evaluation as of mid-2021. We recommend the following next steps as Oregon Health Authority aims to support CCOs to meet VBP Roadmap requirements in 2022 and beyond.

Takeaway 1. The COVID-19 pandemic altered CCOs' VBP efforts through early 2021. CCOs reported increased provider interest in population-based payments for financial stability, and heightened provider risk aversion to new quality requirements.

Each CCO took a unique approach to promoting health equity through VBPs, though all focused broadly on four aspects of VBP model design: 1) measure selection and targets, 2) tiered or adjusted payments, 3) eligible providers, and 4) process or attestation-based requirements.

Recommendation. CCOs should strive to retain population-based (category 4) arrangements and look for oportunities to align performance measures, as CCOs reintroduce VBP quality measures and goals that were relaxed or waived for providers during the pandemic.

Takeaway 2. CCOs focused on promotion of health equity in their early VBP efforts and reported success engaging providers to review performance data. Wide variation in providers' HIT capabilities required CCOs to be flexible in their approaches to sharing performance data.

CCOs reported a wide range of strategies for promoting health equity through VBP model design. Each CCO took a unique approach to promoting health equity through VBPs, though all focused broadly on **four aspects of VBP model design:**

1. Measure selection and targets.
2. Tiered or adjusted payments.
3. Eligible providers.
4. Process or attestation-based requirements.

Recommendation. OHA may wish to develop recommendations for CCOs on best practices within these model elements. CCOs and OHA should monitor within-CCO changes in the above model elements over time to assess whether CCOs are collectively increasing their efforts to promote health equity through VBPs.

Despite variation in approaches, all CCOs needed reliable data on members' social needs and REALD status to implement these strategies. Capacity to collect and use REALD and social

needs data is also critical to CCOs' ability to monitor for health inequities arising under VBP arrangements.

CCOs consistently reported challenges with REALD and social needs data collection, management, and analysis. Part of the difficulty appears to be the wide range of options CCOs have for data collection tools and data sources. Some CCOs also reported confusion about whether it was more appropriate to collect data directly from members or rely on providers to do so.

Recommendation. OHA should provide guidance to CCOs on preferred approaches for collection of REALD and social needs data from members. While offering CCOs continued flexibility in this area is important, guidance on preferred approaches may help CCOs narrow options. CCOs may need to take the lead on these data collection activities due to wide variation in provider reporting capabilities.

Clarifying a preferred approach to data collection would also allow OHA to provide more focused training or resources to CCOs on best practices for analyzing and interpreting data on health inequities. Some CCOs reported that although they were able to identify health inequities, they struggled to translate these findings into actionable next steps for themselves or providers.

Recommendation. CCOs would benefit from technical assistance from OHA on analyzing and interpreting data for identification of health inequities.

Takeaway 3. CCOs would benefit from further information on the state's plans to promote multi-payer alignment of VBP models and quality strategies.

Value-based payment initiatives are not unique to Medicaid; health plans providing commercial and Medicare coverage are also engaged in promoting the adoption of value-based payment arrangements with their provider networks. This co-occurring shift to VBPs can create challenges for providers when they need to fulfill reporting requirements or meet quality goals that are not well aligned across contracts. Oregon Health Authority worked with partners to develop a VBP Compact to encourage Medicaid, Medicare, and commercial health plans to voluntarily adopt aligned VBP strategies.

At the time CCOs were interviewed for this report, some CCOs were waiting to see whether OHA would implement new requirements for payment model alignment in the future before assessing how their existing quality measures or payment models aligned with other CCOs and non-Medicaid payers.

A statewide strategy for hospital payments was identified by one CCO as "the state's biggest opportunity for multi-payer alignment," though diversity in hospital classifications *(see p. 27)* will require ongoing flexibility in CCOs' hospital payment modes.

Recommendation. The state may wish to guide CCOs on which care delivery areas or quality measures are most likely to be required within multi-payer strategies in the future. OHA should also explore whether a statewide hospital quality strategy could better align performance measures and goals across regions while retaining CCOs' ability to locally tailor reimbursement modes and risk-bearing elements

Takeaway 4. All CCOs developed payment models for new primary care infrastructure. Payments were generally small amounts at all PCPCH tiers, which may not achieve the state's goal of supporting meaningful investments in primary care infrastructure.

CCOs developed infrastructure payments to PCPCHs in 2020. These payment models included tiered PMPM amounts that increased by clinics' PCPCH recognition level. There was substantial variation across CCOs in the PMPM amounts within each tier.

These payment models may not meaningfully advance OHA's goals as intended. The majority of contracted PCPCH clinics were already recognized at tier 4 or 5, suggesting tiered payments may provide little incentive for clinics to achieve higher recognition levels.

The average per-member per-month payment amounts were also relatively small across all PCPCH tiers, suggesting these payment models may not lead to meaningful clinic-level infrastructure investments.

Recommendation. OHA should assess factors that are influencing how CCOs are setting these payment levels, and explore options to increase the impact of tiered infrastructure payments. OHA should also explore options to evaluate the impact of these payments at the clinic level to understand whether PMPM payments are supporting clinic-level infrastructure investments.

Takeaway 5. CCOs developed new payment models in priority CDAs including hospital, maternity and behavioral health care. However, lack of HIT capacity at the CCO and provider levels was emerging as an early challenge.

CCOs began the CCO 2.0 contract cycle with widely varying experience designing and implementing VBP arrangements. As of this report, CCOs were generally on track to implement VBP arrangements in maternity, hospital and behavioral health care areas by 2022. Several CCOs had implemented models ahead of schedule.

Meaningful differences in quality measurement capabilities persist among CCOs. Several CCOs were struggling to design and implement the quality elements of CDA arrangements and many were taking modest approaches to provider performance monitoring as a result. Implementing HIT capacity for bundled payments was a particular challenge.

Recommendation. OHA should consider technical assistance to CCOs on quality strategies for behavioral health VBPs. Priority topics may include: member attribution strategies, development of HIT infrastructure for sub-capitated arrangements, clarification on what qualifies as a VBP at the BHO level, options for non-claims-based provider performance monitoring, and strategies for collection of baseline data to establish VBP quality benchmarks.

Recommendation. OHA should closely monitor CCOs' progress implementing quality strategies in the maternity care delivery area. This area may be particularly impacted by challenges with bundled payment model implementation. OHA may also be able to support CCOs' adoption of bundled payment models through guidance on data integration strategies or through coordination with efforts such as the Connect Oregon initiative.

CCOs' early VBP contracting efforts focused on provider organizations with previous VBP experience or with robust HIT infrastructure. Lack of provider HIT capabilities may become an

increasing barrier to CCOs' achievement of annual VBP targets or expansion of CDA payment models, as CCOs engage a broader range of providers in new VBP arrangements.

OHA has planned CCO convenings in 2022 to support VBP capacity building. Focusing these discussions on HIT-related challenges emerging in the priority CDAs may be a necessary next step, particularly for CCOs adopting bundled payment models. This approach may also help OHA and CCOs to collectively identify opportunities for future quality measure alignment across regions and providers.

Recommendation. Focus CCO convenings and technical assistance on HIT-related support in priority CDAs and for bundled payments in 2022. CCOs also requested advance guidance on health care claims codes or modifiers needed for future VBP reporting to OHA, as well as earlier publication of evaluation results, to inform their HIT capacity-building efforts.

Takeaway 6. .CCOs identified opportunities for OHA to provide additional guidance, technical assistance and materials to help them meet current and future VBP Roadmap requirements

CCOs identified certain situations where they were unsure how to interpret or apply the state's VBP requirements. These questions may be **opportunities for additional guidance from OHA:**

- **What options exist for VBP arrangements for prescription benefit managers?** Related, will CCOs be required to include pharmacy expenditures in their future calculation of VBP participation?
- **What "counts" as qualifying VBP expenditures?** For example, should CCOs include claims as qualifying VBP expenditures if these are reimbursed as FFS claims, but a primary care provider also bears risk for these costs under a total cost of care (category 4) arrangement?
- **Which VBP models qualify as shared risk arrangements?** CCOs will be required to meet annual targets for the proportion of payments made to providers in shared risk arrangements beginning in 2023, which OHA defines as HCP-LAN categories 3B or higher. CCOs did not appear to consistently know that the state has included HCP-LAN category 4 in qualifying downside risk arrangements; some limited their focus to 3B arrangements.
- **What is the rationale for downside risk arrangements?** One CCO leader questioned whether OHA's requirement for achievement of downside risk arrangements was necessary in light of the state's cost-growth targets and quality requirements.
- **Which VBP models could also meet other CCO 2.0 requirements?** CCOs were interested in payment models covering, for example, Traditional Health Workers or doula care. OHA may wish to work with CCOs to identify examples of VBP models that have been designed with other CCO 2.0 requirements in mind.

CCOs also requested VBP outreach or educational materials they could share with providers to help explain the state's VBP requirements and providers' options within these requirements.

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Data Sources and Methods

This report presented a) results of a qualitative analysis of key informant interviews and written information provided by CCOs in 2021, and b) results of a quantitative analysis of CCO-reported payment models for PCPCHs. This appendix describes data sources and analytic methods for these analyses.

VBP Pre-Interview Questionnaires

CCOs are required to participate annually in interviews with the state to discuss progress toward VBP Roadmap requirements. The OHSU Institutional Review Board determined that this project did not meet the definition of human subjects research and waived oversight of data collection and consent procedures.

In May 2021, the state administered a pre-interview questionnaire to all CCOs to gather information about their VBP activities at that time. The questionnaire was developed in partnership with CHSE following identification of priority topics and questions for the evaluation. All CCOs responded to this request for information.

CHSE conducted a content analysis of CCOs' responses to the questionnaire. CCO responses to specific questions in these documents were indexed by question. This index was reviewed by members of the research team to summarize findings across CCOs and identify similarities and differences in approaches to VBP model design, progress toward VBP milestones and requirements, and challenges and successes encountered in developing and implementing new VBP models. Responses varied in length and detail.

Two financial entities, PacificSource Community Solutions and Trillium Community Health Plan, operated multiple CCOs in 2021. These entities each submitted a single combined questionnaire for their CCO regions. CCOs' responses to questions regarding COVID-19-related contract modifications were counted multiple times if the response represented multiple CCO regions.

VBP Key Informant Interviews

In June 2021, CHSE conducted 10 key informant interviews with leadership representatives from Oregon's CCOs. PacificSource Community Solutions and Trillium Community Health Plan each participated in a single interview for all regions they served. Jackson Care Connect and Columbia Pacific CCO are owned by CareOregon and representatives from these CCOs also completed a single interview. CHSE partnered with the state to develop an interview guide with standard questions for all CCOs. Interview questions for each CCO were then customized following review of each CCOs' responses to the written questionnaire. Staff from OHA's Transformation Center and OHA's Office of Health Information Technology also joined these calls. Interviews lasted approximately ninety minutes and were conducted and recorded using a video call platform. All interviews were professionally transcribed.

CCO interview transcripts were de-identified and entered into Atlas.ti[11] for data management and analysis. A subset of the data was a priori coded by two researchers with consideration for the

evaluation aims and specific areas of focus. The application of codes was then reviewed by two members of the research team to ensure consistency and alignment with code definitions. The remaining data were then coded. A series of code reports was produced and reviewed by three members of the research team, who met to review key impressions, reconcile differences and develop key findings. Findings from key informant interviews and written questionnaires were integrated at the interpretation and reporting stage to summarize overarching findings from the two analyses.

PCPCH Data Templates

This analysis utilized administrative data obtained from Oregon Health Authority's PCPCH-CDA Data Templates ("data templates") collected from CCOs in fall 2021. These data templates contained information from CCOs about payments made in 2020 to meet OHA's VBP Roadmap requirement for PCPCH infrastructure payment models. Information included the number of contracted clinics recognized at each of five PCPCH tiers, the PMPM dollar amount (or range) clinics could earn at each tier, and the average PMPM payment to clinics in each tier, weighted by clinics' Medicaid member attribution.

Data templates were received as individual files from each CCO, and contained a combination of quantitative and qualitative information. Quantitative information about CCOs' PCPCH payment models was extracted into a single analytic file. Data elements were assessed for missing and outlier values. Rows were excluded when CCOs reported a payment model with zero contracted clinics and a $0 PMPM amount. Rows with zero clinics and a non-zero PMPM amount, and rows with non-zero clinics and a $0 PMPM amount, were retained.

The minimum and maximum amounts paid by each CCO in each PCPCH tier were identified to calculate the minimum and maximum PMPM amount paid by any CCO in each PCPCH tier. Where CCOs reported a single PMPM payment amount for a PCPCH tier, this value was considered both the minimum and maximum PMPM amount for that CCO and tier. Where CCOs reported a PMPM payment range rather than a fixed amount, the highest and lowest values reported by that CCO for that PCPCH tier were used. The lowest and highest reported PMPM amount among all CCOs within each PCPCH tier was then identified.

To find the average PMPM amount paid by CCOs in each PCPCH tier, we calculated the mean of all CCOs' weighted average PMPM amounts reported in each PCPCH tier. These CCO-reported average PMPMs were already weighted by clinics' Medicaid member attribution and no further adjustments were made.