ENGAGING HOSPITALS IN VALUE-BASED PAYMENT: CCO SUCCESS CASES

Two collaborative arrangements leverage payment models with the aim of improving care.

CCOs counter concerns about risk and engage hospitals by aligning goals with community providers

While national Medicare payment reforms have drawn more attention, hospital care drives costs for Medicaid too, making up 32.9% of national expenditures in 2020.[1] As states increasingly look for cost savings and increased value from their Medicaid programs, some are targeting hospital care for value-based payment innovations along with areas like primary care and behavioral health that were earlier adopters of payment change. A recent analysis of state Medicaid managed-care contracts showed that 10 states — Oregon included — now have requirements or guidance for value-based contracting with hospitals.[2]

Oregon's coordinated care organizations (CCOs) describe varying experiences creating hospital VBP models. In some cases, CCOs have faced challenges attributed, for example, to limited Medicaid market share or resistance from a key hospital partner in their regions. Further, hospitals in communities with fewer financial relationships between hospitals and primary care have been more reluctant to accept CCO VBP models with financial risk, given that quality outcomes are less within their control. However, other CCOs have worked to nurture relationships and align goals to try new arrangements that better serve members. Here, we highlight two of these models.

Counties share accountability and rewards on the north coast

How it began

In 2014, providers in Columbia Pacific CCO's (CPCCO) three rural counties wanted to explore ways to better coordinate care for the CCO's membership while generating savings to address community needs. "When you get into rural areas, there's just not as many resources, so you tend to need to work with the other people there," noted Mae Pfeil, director of clinical integration with the CCO.

KEY TAKEAWAYS

- **Aligning with other provider quality or VBP efforts** reduces burden and can produce a win-win that may open the door to additional VBP development.
- **Shared accountability and savings mechanisms** can address concerns about financial risk for VBP arrangements in rural regions or where hospitals are newer to risk-sharing.
- **Enabling early success** through careful timing and target selection can create a foundation for future VBP expansion.

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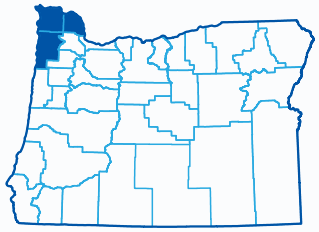
AT A GLANCE

CPCCO COUNTY RISK SHARE MODEL



Who's involved: Three major hospitals in the CCO's region, plus a majority of primary care and behavioral health providers

LAN Category: 3A (shared savings)*

Members included: 27,672

Annual dollar value: $86M (January-March 2022)

Financial risk: 1% risk corridor around target with 3% upside cap and providers sharing 50% of any upside earnings; 2.5% downside cap with providers assuming 25% of risk

Quality component: During the COVID-19 PHE, the model includes seven primary-care focused measures, plus reporting on improvement in language access. Additional measures are under discussion.

Social determinants of health and equity component: Shared savings are reinvested to address social determinants of health.

The region's provider networks were anchored by three critical-access hospitals, one in each county, which owned all specialty services and most primary care in the region.

Months of discussions about a shared-savings, shared-risk model led CareOregon, CPCCO's partner, to establish county-level VBP contracts between the CCO, hospitals, and other community providers in 2015.

How it works

Hospitals and virtually all contracted providers (hospital systems, federally qualified health centers, and community mental health providers) take part in shared risk pools, one for each county. The agreements cover the total cost of care for all hospital, specialty and primary care services. Savings come back to the county provider pools, which can retain them or invest in community projects.

How they did it

Several factors made the highly collaborative arrangements feasible. The financial relationships between hospital, specialty, and primary care gave hospitals more control over risk. "The hospitals serve kind of that three-part function in our risk share where they really have a lot of ownership, if you will, of the total cost of care," said Mimi Haley, CPCCO chief executive officer. "The vast majority of the dollars … are for acute inpatient and outpatient facility services."

Leveraging local champions. For the two hospitals owned by entities outside the region, CPCCO relied on local leaders to sell the model to decision-makers at their parent organizations. Adventist Health Tillamook briefly left the agreement, but leaders there were able to articulate the benefits of participation to their out-of-state owners after seeing how the pools pulled providers and communities together during the COVID-19 public health emergency. The hospital rejoined in 2021.

Buffering risk. The CCO also structured risk provisions carefully, setting a 1% corridor with 50% shared savings but only 25% downside risk, capped at 2.5%.* The shared nature of the risk made the arrangement more palatable for the region's hospitals.

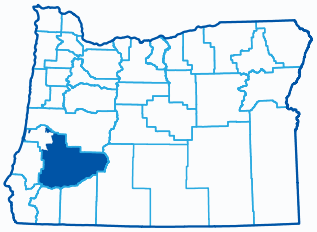
Pam Cooper, director of finance with Providence Seaside, noted that conventional wisdom goes against a hospital in a small, rural area taking on risk. "By focusing on upside savings, the CCO model works for Medicaid members in a community where Medicare members are not as lucky," she said. "Medicare Advantage plans are noticeably absent because large national insurers don't see a favorable actuarial analysis of our elderly population."

"But the way they [the CCO] have designed the risk model, we're not taking all of the risk. We are incentivized to collaborate with our trusted community partners."

** Downside risk must be 3% or greater to qualify as meaningful in Oregon's CCO VBP Roadmap specifications; hence, this agreement would be classified in category 3A of the HCP-LAN framework by Oregon Health Authority (OHA).*

AT A GLANCE

UHA PERINATAL HYPERTENSION BUNDLE



Who's involved: Three major hospitals in the CCO's region, plus the majority of primary care and behavioral health providers

LAN Category: 4A

Members included: 103 (January - April 2022)

Annual dollar value: $2M (projected for 2022)

Financial risk: Hospital receives case rate for pre- and postnatal services addressing perinatal hypertension.

Quality component: Three measures specific to perinatal hypertension

Social determinants of health and equity component: Model targets pregnancy risks experienced disproportionately by Black women.

The hospital-community provider collaboratives banked early savings against the potential for future spending overages and the need to pay back money, which also reduced concerns about risk.

Starting strong. CPCCO purposefully introduced the model midway through a year in which utilization was low and projected to remain low. This allowed hospitals and their provider partners to take a "baby step" into risk with a lower-than-average chance of overspending that initial year.

Streamlining measures. While the model previously included measures related to substance use disorder that were relevant to all participating providers, the CCO revised measurement to its core set of primary-care related measures during the pandemic. The CCO aspires to reinsert measures specific to hospital care, but so far these remain under discussion.[§] Cooper noted that Providence is accountable elsewhere for numerous hospital-specific quality benchmarks, making it appropriate for the model to focus on preventative care.

Payoffs for participants

The model has broken even or generated savings in all years except 2016, when providers in one county had to reimburse the CCO. To date, the county collaboratives have voted to invest nearly $5 million of shared savings from the model into community supports, including capital housing initiatives.

Benefits beyond shared savings. Hospital staff, community mental health, and the CCO meet regularly to coordinate efforts to address social determinants of health and compare notes on provider recruitment and other shared issues. Members of the risk pools collaborate with community-based social service organizations, such as the local community action agency, as well. The COVID-19 PHE heightened recognition among hospitals and the CCO of their shared role in the community's social safety net, Haley said, bringing them closer.

To Pam Cooper at Providence, priorities of the risk model match what her organization is doing anyway. "Our mission at Providence is to help our population be healthier. We are proud to participate."

CCO and hospital find common ground in Southern Oregon

How it began

Umpqua Health Alliance (UHA) reached out to its local hospital, Mercy Medical Center, to assess options for a payment bundle as the 2022 CCO VBP Roadmap care delivery area requirement approached.

§ CPCCO was one of several CCOs reporting hospital models for the 2022 CCO VBP Roadmap care delivery area requirement that did not include hospital-specific metrics. While these models do not currently meet OHA Roadmap requirements, CPCCO hopes to add a hospital metric back into the model in the future.

How it works

The new model bundles services for women experiencing perinatal hypertension into a case-rate payment with three related quality measures.

How they did it

As in the Columbia Pacific region, alignment of priorities made the agreement work. Dr. Douglas Carr, chief medical officer at UHA, said the CCO finds alignment a key strategy in engaging new providers in VBP in general.

"They say, 'Oh, well, we're not comfortable with that model.' And then we say, 'Well, what are some of those quality metrics that you're working on right now? And why don't we utilize those and not come up with something new?'"

In this case, after eliminating several candidate groups of services, the CCO asked the hospital about value-related initiatives it was already pursuing. It turned out the hospital had a payment bundle for services related to perinatal hypertension with its parent organization, CommonSpirit. The arrangement met the CCO requirement for both hospital and maternity care VBP arrangements.

Payoffs for participants

UHA reports that the model, now in its first year, is producing stronger performance on its perinatal quality measures.

TAKEAWAYS FOR HOSPITAL VBP

Aligning with other provider quality or VBP efforts reduces burden and can produce a win-win that may open the door to additional VBP development.

Building trust facilitates cooperation. "Hospitals can feel like they're islands a little bit," said Haley. "But if they feel like their health plan is not trying to drive them to their financial knees, it makes a difference in their willingness to participate." Shared accountability and mechanisms for savings to offset risk can ease concerns.

For new downside risk agreements, timing counts. "Pick a year when you're likely to generate some gains," advises Haley. "I mean, seriously, don't look at a year when you're in that part of the underwriting cycle where you're going to be struggling to make your targets." New partnerships and collaborations established during COVID-19 also offer openings for new arrangements.

References

1 Centers for Medicare and Medicaid Services (2022). National Health Expenditures Accounts. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical

2 Catalyst for Payment Reform (no date). Medicaid Managed Care Contracts as Instruments of Payment Reform: A Compendium of Contracting Strategies. Available at: https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2019/12/Medicaid-MCOs-as-Agents-of-Payment-Reform-1.pdf

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