October 2020 Data Brief – How Oregon's Insurance Carriers & Coordinated Care Organizations Paid for Health Care in 2018

Oregon is one of only a few states that collects data from health insurance carriers about how they pay health care providers outside of fee-for-service (FFS) arrangements, including value-based payments (VBP). This data brief summarizes carriers' and Coordinated Care Organizations' 2018 payment arrangements with providers such as doctors, clinics, hospitals, and more. The Oregon Health Authority (OHA) is publishing this data to meaningfully inform Oregon's continued effort to achieve the triple aim of better quality, lower costs and improved health.

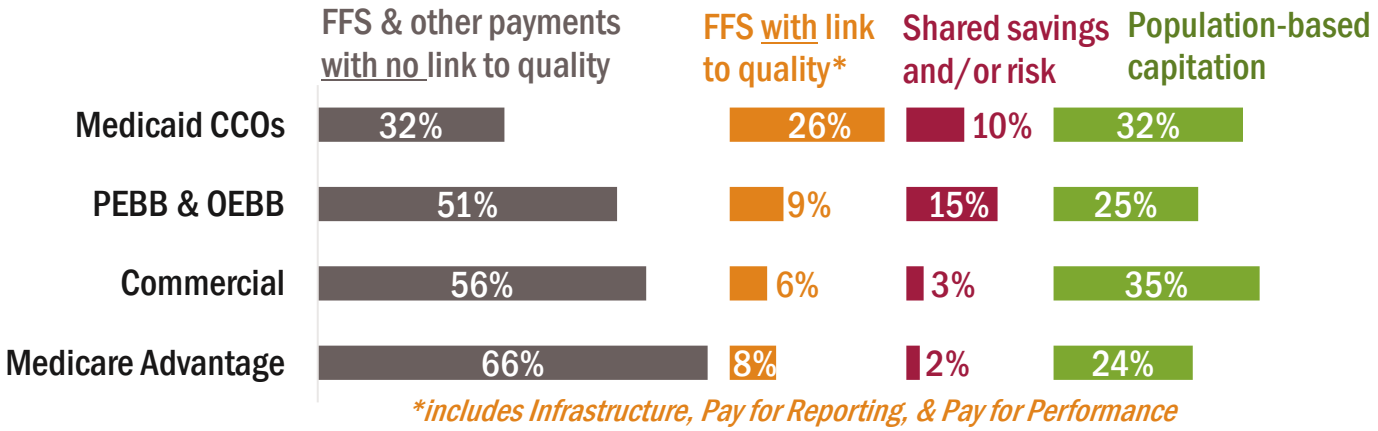
Historically the traditional method of payment in health care has been fee-for-service, which is a specific dollar amount paid for every medical procedure or service. Carriers and health care providers negotiate to find a mutually agreeable dollar amount for each medical procedure or service, resulting in substantial variation in reimbursement for the same service across various geographies and providers. Some carriers continue to use FFS, which can incentivize health care providers to do more procedures. Other carriers use alternative payment methodologies, a term that encompasses all non-FFS payments, which are better suited to incentivizing high-quality procedures that lead to improved health outcomes. In recent years policy makers and industry leaders have been highlighting the negative effects of paying for volume instead of paying for value, such as health care costs increasing without increases in quality. In response, many health insurance carriers pay providers with VBPs, which provide incentives to health care providers to focus on the quality of services and patients' health outcomes. VBPs are alternative payment methodologies, which means they are not FFS, and must include quality components in the payment arrangement. One example of a VBP is a quality bonus payment to a clinic if they increase the number of patients receiving a screening for depression and include a follow-up plan in the patients' medical charts.

The intended audience of this data brief is policy makers, industry leaders, advocates, and health care consumers. This data brief is the first report on VBPs in Oregon. Future reports will allow for time trend analysis to show if VBPs become more common. This brief also supports emerging interest in Oregon's Sustainable Health Care Cost Growth Target, and how VBPs can help carriers and health care providers achieve the cost growth target.

As depicted in Figure 1 below, in 2018 Oregon's Medicaid Coordinated Care Organizations (CCOs) led with the lowest amount (32%) of payments in FFS without a link to quality and highest amount of FFS with a link to quality or most sophisticated VBPs (68%). Public Employee (PEBB) and Oregon Educators

(OEBB) plans ranked second. Commercial plans ranked third and had the highest percent of dollars in capitation arrangements (35%), while Medicare Advantage plans ranked fourth with the largest percentage of dollars in FFS arrangements with no link to quality (66%).

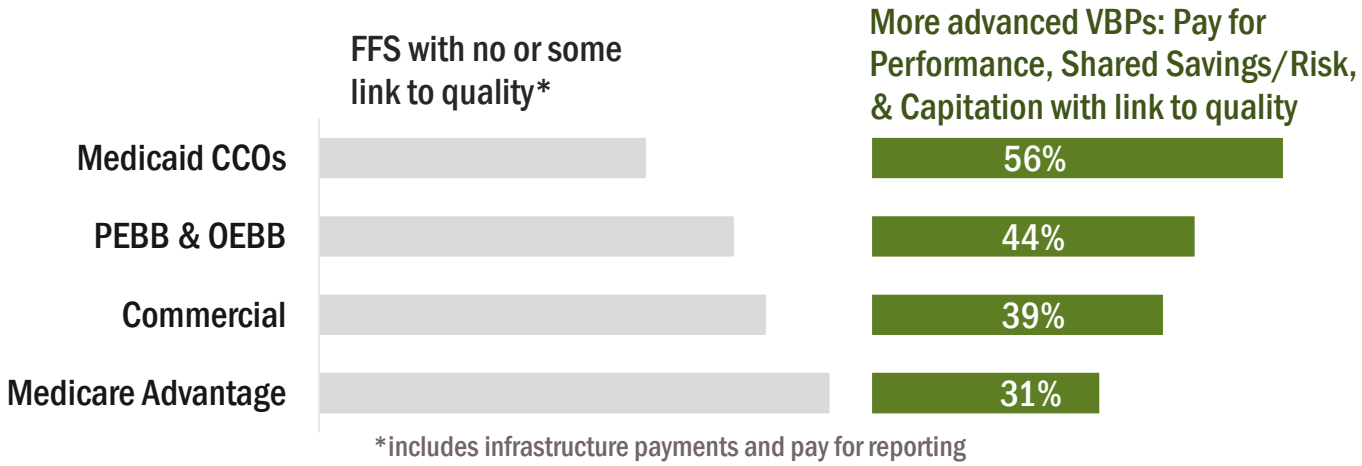
Figure 1 - 2018 Payment Arrangements in Oregon



There are different types of VBPs. Some VBPs do more to fundamentally change the way we pay for health care. The OHA is focused on increasing carriers' and CCOs' payments to providers that include VBP components such as quality incentive payments, shared savings or risk between the carrier and provider, or capitation payments that are linked to quality. CCOs, which serve individuals enrolled in the Oregon Health Plan, must allocate a growing percentage of spending to these types of VBPs beginning in 2020. The contract between CCOs and the state requires at least 70% of CCOs' payments have valued-based components by 2024.

Figure 2 below shows that in 2018 CCOs, collectively, had the highest proportion—at 56%— of payments that are categorized as more advanced VBPs; i.e., pay for performance, shared savings or risk, and capitation linked to quality. This aligns with the current requirement for CCOs to pay a growing percentage of payments in HCP-LAN Category 2C or higher (see Appendix). Medicare Advantage had the lowest percentage of VBPs at 31%.

Figure 2 - FFS with no link vs. VBP with link to quality



Data Source and Methodology:
The data used for this analysis is the All Payer All Claims (APAC) - Payment Arrangement File submitted in 2019, which reflects contracts in effect during 2018. Payment Arrangement File data are based on contracts between a carrier and a provider or entity. These are not claims data. Data from one CCO were removed due to errors.

Both Figure 1 and Figure 2 show the weighted average of all spending in each market (i.e. Medicaid CCOs, PEBB & OEBB, Commercial, and Medicare Advantage). Payers with larger shares of the market will have a larger influence on the weighted average. Payers vary significantly in terms of their VBP spending. For some payers nearly all their spending is in the form of a VBP, whereas other payers have relatively low amounts of VBP. Future reports will provide additional detail about this variation.

All data are processed for proration and absolute value.

> Proration example: A contract from July 2017-June 2018 totaling $100m would be prorated as $50m for 2018 because half of the contract was in the reporting year.
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> Absolute value example: a contract shows a negative payment (such as -$30,000), which means the provider paid the carrier this amount. OHA calculates the absolute value of this amount in order to not deflate the total dollar amount or percent associated with a VBP. If a CCO paid a provider $2m, and after reconciliation the provider pays back the CCO $30,000, OHA would interpret the total value of the contract to be $2,030,000 so that CCOs' and carriers' percent of payments with VBP components is not deflated.

Analyses also rely on a hierarchy of payment arrangement categories. OHA looks at all the components of a single contract, sums all payments, and attributes the sum to the highest category in that contract.

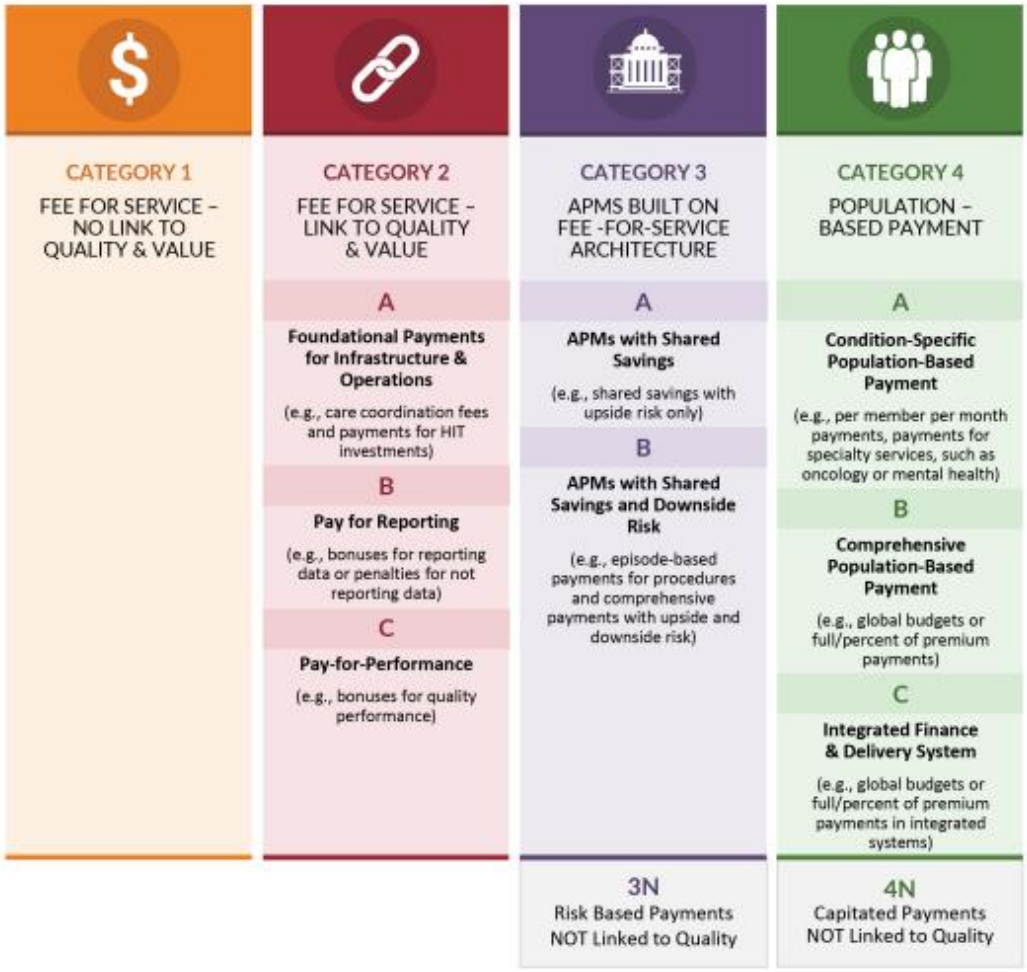
> Hierarchy example: a contract shows $75,000 in FFS (Category 1) and another row shows $5,000 quality incentive payment (Category 2C). The total amount is $80,000 and categorized as 2C.

The Payment Arrangement File uses the Health Care Payment Learning and Action Network's (HCP-LAN) Alternative Payment Methodology Framework, which can be found at https://hcp-lan.org/apm-refresh-white-paper.

More information about APAC and the Payment Arrangement File can be found at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx

Appendix

Health Care Payment Learning and Action Network's Framework[1]:



[1] Health Care Learning and Action Network, Alternative Payment Methodology Framework White Paper. Refreshed 2017. https://hcp-lan.org/apm-refresh-white-paper/