Value-based Payment Provider survey

Oregon Health Authority

May 30, 2018

OVERVIEW

Background: Oregon Health Authority surveyed health care providers to fulfill a current 1115 waiver requirement and inform the CCO 2.0 value-based payments (VBP) policy development process.

Scope: Paying for value is a primary strategy for achieving OHA's triple aim of better health, better care and lower costs for all Oregonians. OHA is working to develop a strategy to increase the use of VBPs in Coordinated Care Organizations' (CCOs) contracts with network providers. The goal of increased use of value-based payments is to incentivize delivery system reform that focuses on value instead of volume of service and rewards providers for a combination of positive member health outcomes and cost savings.

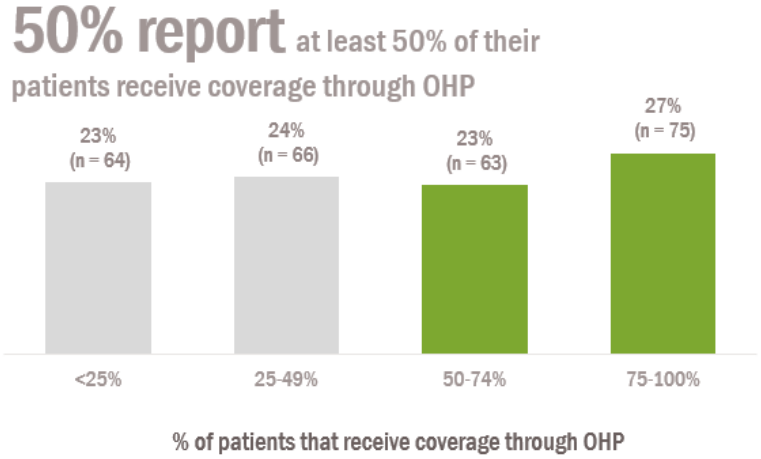
The goal of the survey was to assess provider readiness and experience with VBP models in Oregon.

Survey Period: 4/9/2018 – 4/25/2018

Surveys Completed: 274

Survey Results:

Approximately what percentage of your group's or practice's patients receive coverage through the Oregon Health Plan (OHP)/Medicaid?



Approximately how many Medicaid patients are served in your practice? (OHP)/Medicaid?

# OHP	n	%
<250	83	30%
250-500	32	12%
500-1,000	30	11%
1,000-2,500	46	17%
2,501-5,000	35	13%
5,001-10,000	29	11%
> 10,000	15	5%
No response	5	2%

CCO AFFILIATION & ORGANIZATION

81.1% of all respondents report contracting with at least one CCO.

Among those providers who report contracting with at least one CCO:

CCO*	n	%	Ratio of CCO Enrollees to Survey Takers
Advanced Health	8	3.6%	2,347:1
All Care CCO	32	14.3%	1,472:1
Cascade Health Alliance	10	4.5%	1,635:1
Columbia Pacific	31	13.9%	738:1
Eastern Oregon	42	18.8%	1,107:1
Health Share of Oregon	87	39.0%	2,371:1
Intercommunity Health Network	28	12.6%	1,836:1
Jackson Care Connect	28	12.6%	1,023:1
PacificSource - Central	27	12.1%	1,752:1
PacificSource - Gorge	22	9.9%	536:1
PrimaryHealth of Josephine County	17	7.6%	556:1
Trillium Community Health Plan	41	18.4%	2,060:1
Umpqua Health Alliance	16	7.2%	1,606:1
Willamette Valley Community Health	40	17.9%	2,332:1
Yamhill Community Care	31	13.9%	735:1

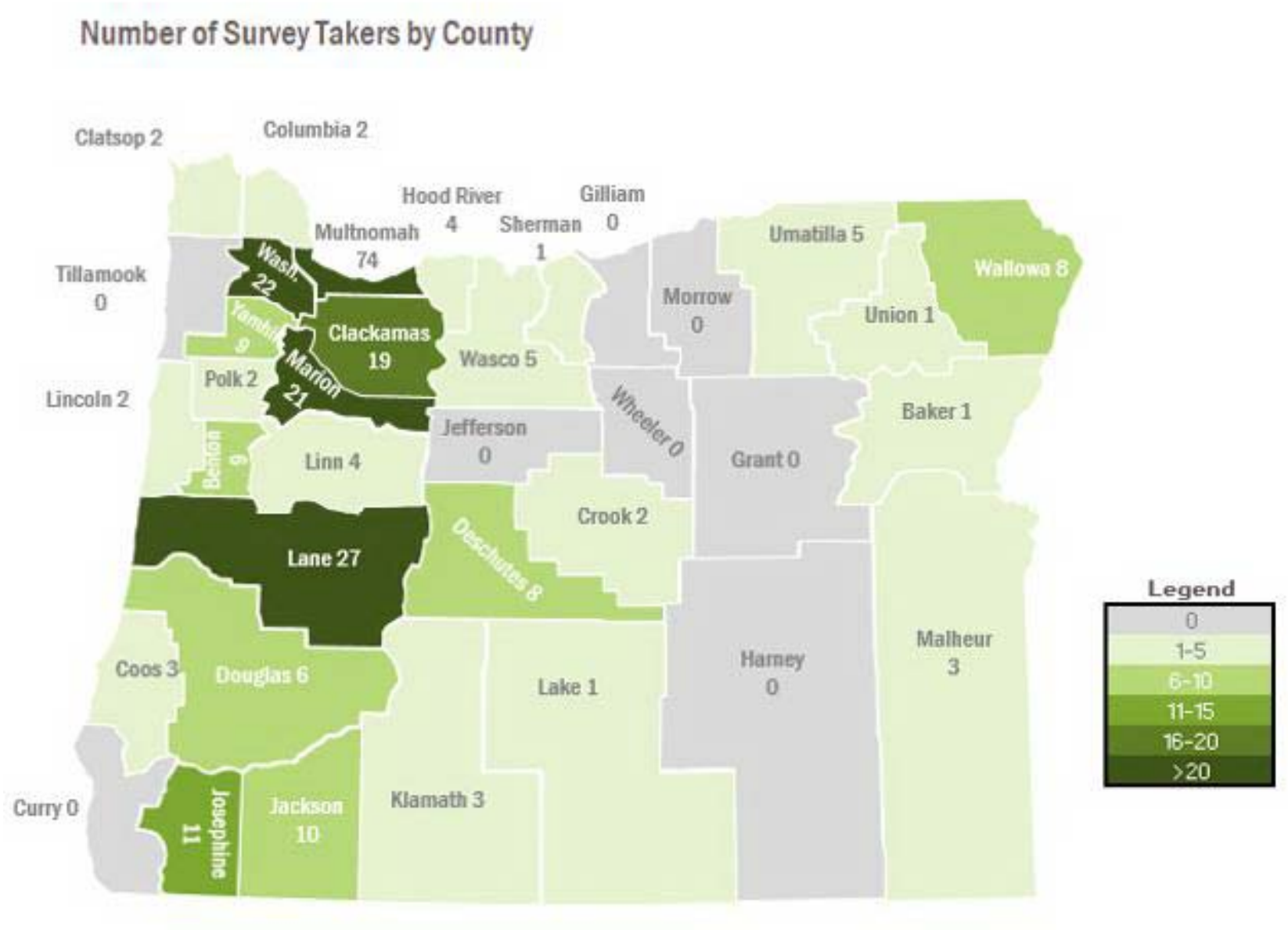
*Note: Respondent may fall into more than one CCO group.

Most responders represent **primary care organizations** and/or **behavioral health providers.**

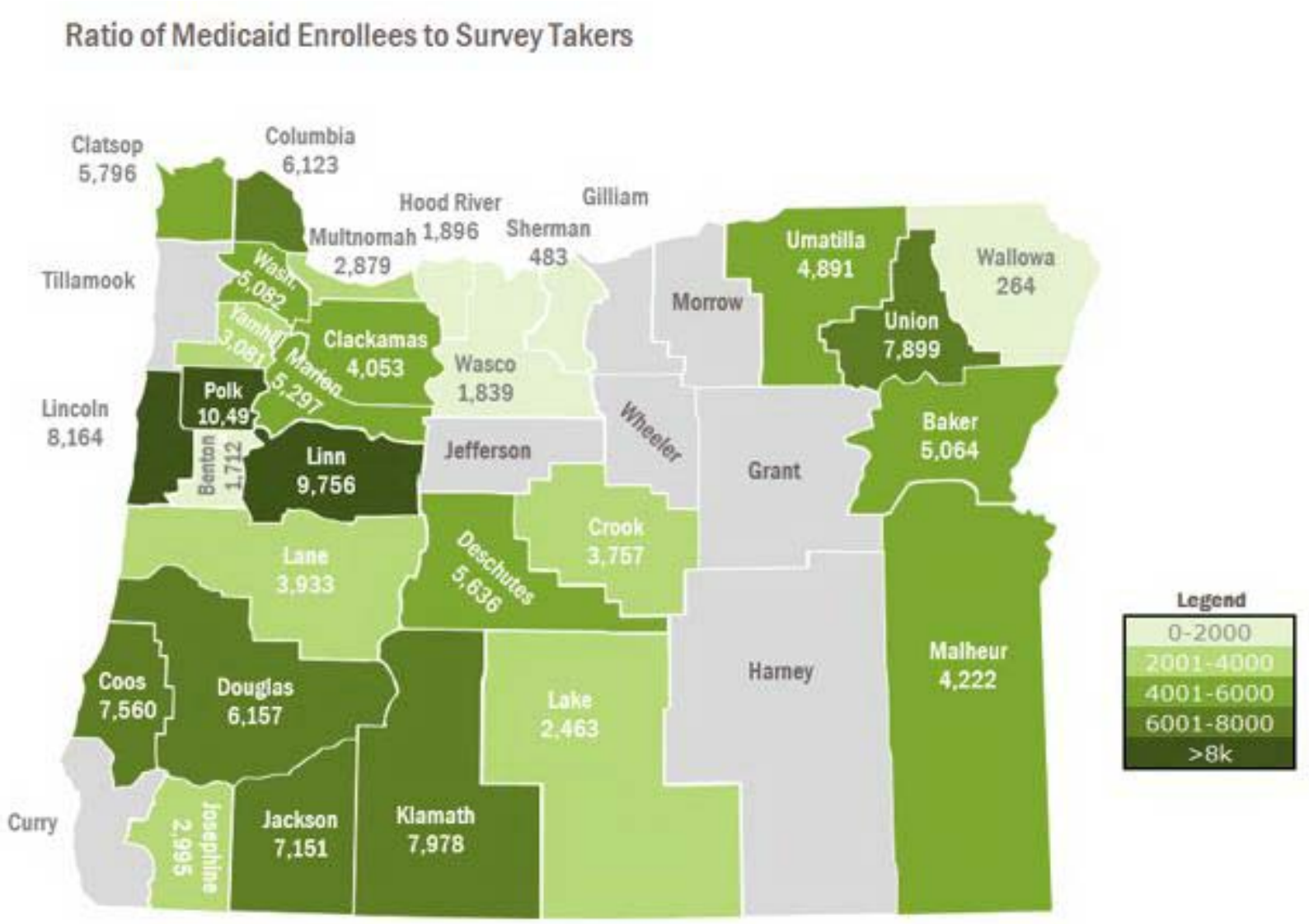
Organization*	n	%
Primary care organization	125	45.8%
Behavioral health provider	119	43.6%
Other (please specify)	49	17.9%
Health system	28	10.3%
Specialty care organization	22	8.1%
Dental provider	13	4.8%
Hospital	8	2.9%
Long-term services and supports (LTSS) provider	5	1.8%

*Note: Respondent may fall into more than one stakeholder group.

GEOGRAPHIC DISTRIBUTION (1)



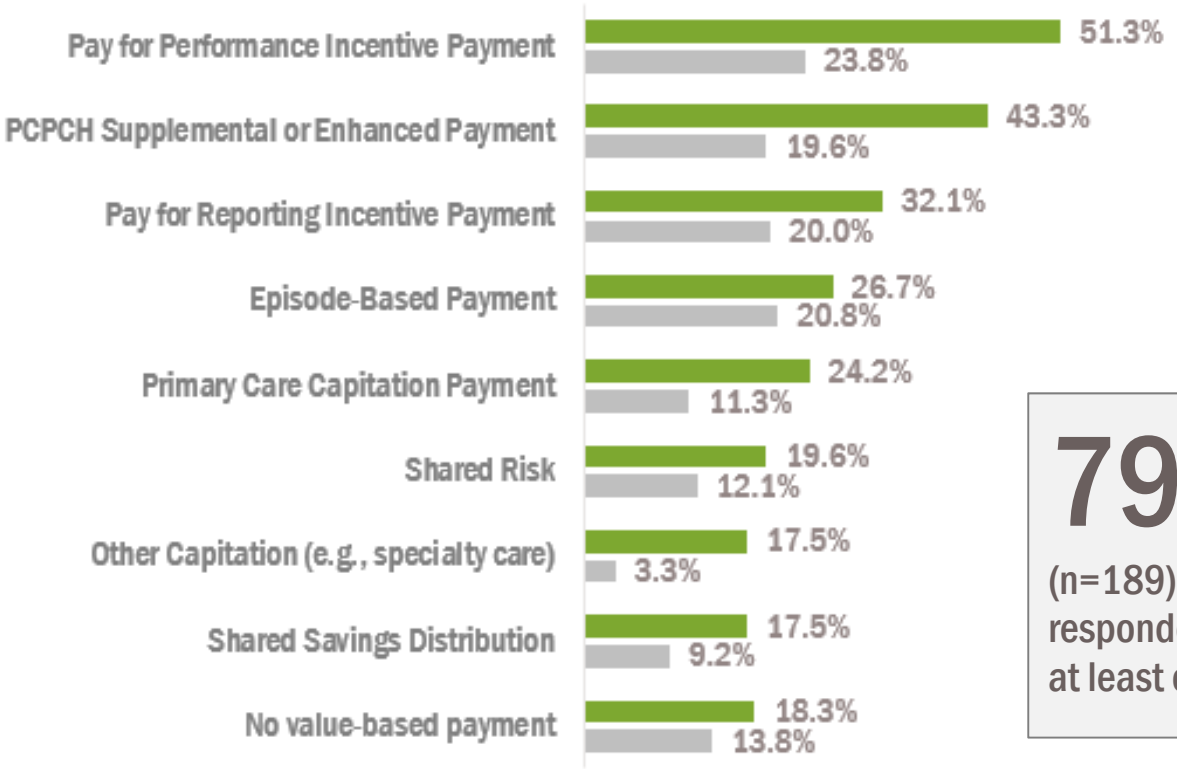
GEOGRAPHIC DISTRIBUTION (2)



VALUE-BASED PAYMENT USE

Which value-based payment models do payers use with you today?

Pay for Performance is the most frequently used VBP Model for OHP/CCO/MEDICAID and MEDICARE/COMMERCIAL.



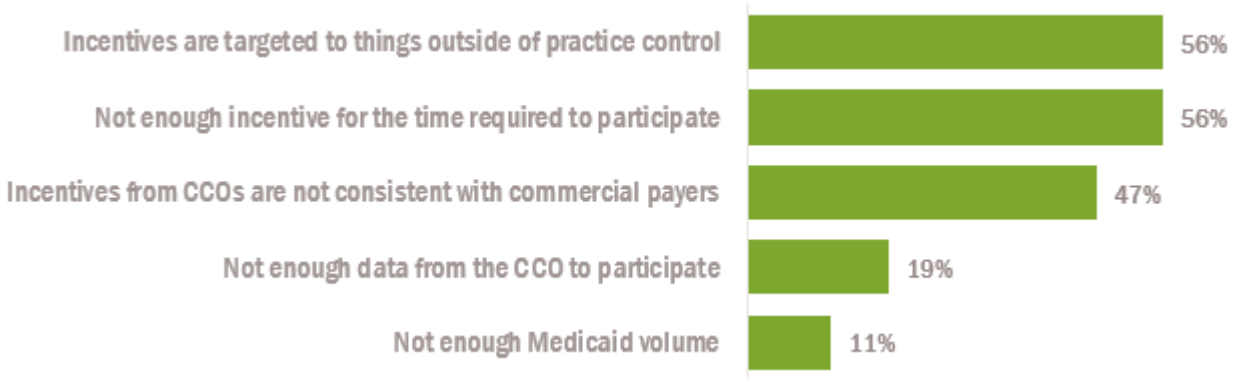
79%

(n=189) of those who responded, report using at least one form of VBP.

VALUE-BASED PAYMENT CHALLENGES

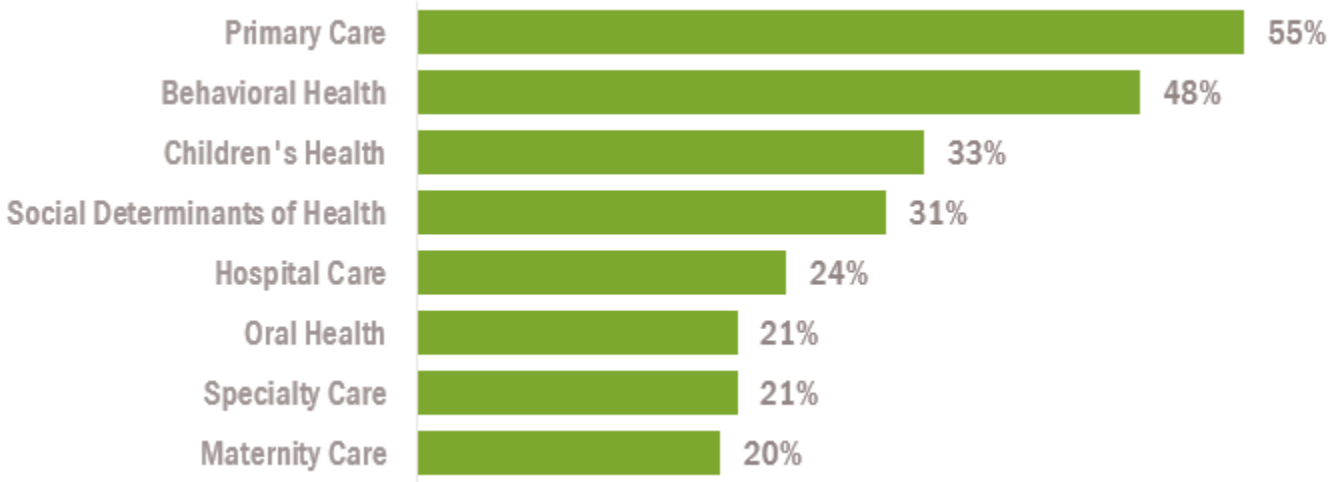
What are the challenges created for you by the CCO value-based payment models in which you participate?

168 respondents experienced at least one of the challenges presented. Of those...



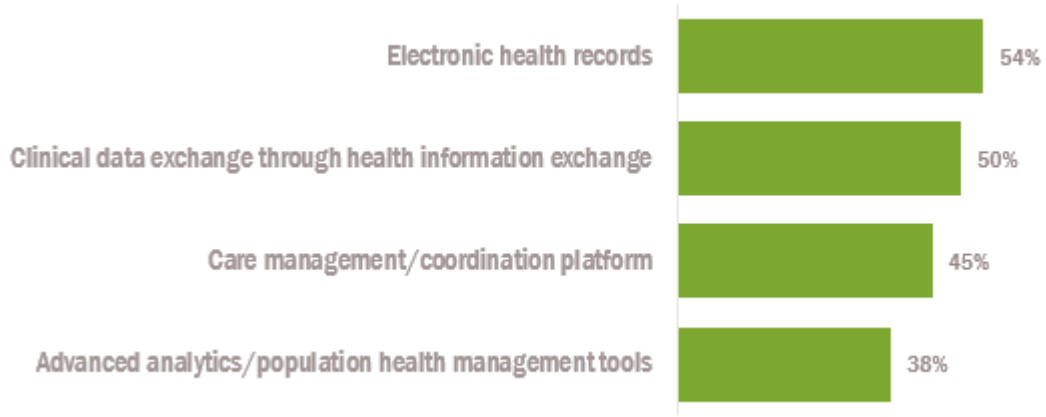
How are your current value-based payments tied to meeting specific quality standards, if at all? Select all that apply:

Would you suggest that OHA encourage CCOs to pay providers using value-based payment models aimed at any of the following? (Select as many as apply)



What information do you need from the CCO to manage your value-based payment contract(s)? Select all that apply:

What health information technology does your practice lack but need in order to succeed with value-based payment contracts? Select all that apply:



Open Ended / Other Responses

#	Please describe any of the payment models in which you are participating
1	TIP - Trillium Integration Program: We integrated behavioral health with our primary care clinic - true integration, we share an EMR and BHPs are employees. We also receive incentive dollars for the CCO Incentive Metrics
2	make sure your reform does not disincentivize the utilization of primary care. maybe more value-based payments for speciality care while retaining significant fee-for-service for primary care.
3	CPC+ Track 2
4	CPC+ Medicare program Health Share / Providence RAE Providence Medicare Advantage
5	MIPS, CCO, CPC+, PCPCH, Commerical
6	We are participating in the CPC+ program. Our local CCO has not offered us a contract. They said at this time they only have contracts with their two larger health groups.
7	Participating in CPC+ "Specialty care" capitation is paid for integrated behavioral health
8	Case rate payment methodology is used with our Pain management program. We have three levels of care and the clients are assessed into a level and we get a monthly payment for each client.
9	I understand these are changing within the BCN right now and most past incentives or value based payments are currently on hold, so I am going to refrain from answering because I'm not certain.
10	CCBHC PPS-1 Rate
11	I don't know the answer to this question.
12	We are developing a compilation measure that will move us to a high level of performance based payment system. It will ultimately include an outcome measure, but until that is fully implemented it is not being put into the calculations.
13	Fee for service
14	Level System for MH care via HealthShare Cost + contracts Capacity payments
15	Adult Foster Home - we get paid a basic amount which does not reflect the difference between the amount of care for different individuals, although it is supposed to.
16	Our membership experiences across the state experience about one of these incentives per their primary CCO.
17	We use the following: 1. sub-capitation for primary SUD/MH services 2. capacity payments for local network providers based on level of care, medical neccesity 3. pay for performance (P4P) in CCO pool, distributed to BH risk contract above (1.) and then also shared out to local providers based on services rendered 4. fee for service for other local, regional care based on medical necessity The only APM we aren't using at this point is case rate or bundled payment based on an episode of care. Thanks, Silas
18	PC3
19	Providing Culturally specific care through Capacity payment via the Multnomah, Washington and Clackamas County RAEs.

#	Please describe any of the payment models in which you are participating
20	Patients don't pay us. We have supervisory responsibility for them.
21	I don't know I work with clackamas county I have 3 adult foster homes
22	FEE FOR SERVICE
23	I cannot answer this question
24	Per member per month payments for Behavior Health Integration into primary project
25	As a behavioral health services provider for adults with serious mental illness we are paid through a per member per month reimbursement.
26	APCM - through OPCA.
27	case rate with varying level of care. associated with this is a risk corridor. not submitting shadow claim that is 80% of the case rate in aggregate will result in pay back.
28	MIPS, CPC+
29	unknown
30	Fee for Service
31	We are doing reporting for one payor on performance based measures. We are not yet receiving funds that way.
32	Certified Community Behavioral Health Clinic certification allows our agency to bill 'fee for service' from the Oregon Health Authority
33	Direct Primary Care Clinic, no insurance payments.
34	We feel in primary care that a mixed/blended payment methodology works best. There needs to remain a component of the fee for service to maintain accessibility for patients.
35	I don't participate in any of these.
36	I was a provider with FamilyCare. I'm am disappointed that they are no longer in business.
37	There are a variety of payment systems. Most programs receive case rate payment model with incentives/fines for not reaching certain standards. Example: documentation of follow up within 7 days of hospitalization. "risk corridor". My perspective is that any cost savings is only benefiting the insurance system. The case rates appear to be an incentive to enroll more people, vs. provision of quality services or providing services at the intensity and frequency needed by the people we are here to support. The funding structure is not aligned with the service/engagement needs or the true costs to provide quality care to people who struggle to access mainstream health systems. Ultimately, this runs a high risk of creating even greater barriers to healthcare for people with significant disabilities, people for whom English is a second language, people who are experiencing homelessness or financial insecurity, and people of color or from outside the Oregon Caucasian mainstream demographic. Even if the primary goal is serving more people, that goal is not being reasonably attained. There continues to be problematic wait times to secure appointments. Providers need to be supported to expand capacity to the community need. This includes standard evening and weekend hours, and adding new clinic locations. We need to have the capacity to provide timely behavioral health services.

#	Please describe any of the payment models in which you are participating
38	Fee-for-Service
39	Care Management Fee through CPC+ Behavioral Health pmpm at selected clinics with BHC and selected quality measure to report
40	N/A
41	Our arrangements with the CCOs are full risk capitation. CCO have shared incentive payments via pay for performance.
42	I believe the clinic in which I work receives a larger payment for services due to having me, a Psychologist on staff.
43	Our clinic gets an annual payment from Trillium CCO, and I think that payment is considered a "Pay for Performance Incentive Payment." However, I don't think the payment uses those words. The PCPCH supplemental payments are minor, and so far not significant for the Clinic's income.
44	I am a Licensed Professional Counselor in private practice. I was contracted with FamilyCare, and currently those clients are extended on a temporary non-contract authorization through May 2018 with Health Share and Willamette Valley CH. I was declined a contract with Health Share, and told there is no likelihood of getting it with WVCH. I billed FamilyCare directly. This question #7 presumes I know about the "value-based payment" system options listed, but I bill directly, so I can only assume I am either episode only, or none.
45	Fee for Service model
46	Fee-for-service with commercial insurance providers
47	Cash pay or scholarship clients.
48	Track 1 clinical metric improvement model with Care Oregon, part of HealthShare
49	Cash pay or private insurance
50	We have a capitated, per member, per month rate as well as fee for service for supported employment.
51	As per an operating budget review approved by OHA / DMAP November 2014.
52	CPC+ for medicare
53	The primary payment method is fee-for-service. We also receive pay for performance incentive payments based on the OHA metrics via Trillium. We share risk with Trillium via a 8% withhold of our contracted rates.
54	APM's for both of our CCO's and also incentive payments for meeting benchmarks
55	We have a risk based youth residential treatment contract with one CCO only (Pacific Source Community Solutions). All other CCO's are fee for service payment models for youth residential treatment.
56	We used to receive performance savings payments from FamilyCare. This is now gone and a huge loss to our practice. We still participate with LHP and PHP, who both use some of the payment models above.
57	CCO QIM COIPA Primary Care Matrix Medicaid Capitation Moda Synergy Product Trilateral CCO Shared Savings contract (Hospital, PacificSource, COIPA)

#	Please describe any of the payment models in which you are participating
58	We get a percentage of the incentive based measures for our participation as a provider of CANS assessments
59	Fee for service
60	medical withdrawal management case rate
61	We participate in the CareOregon PC3 pay-for-performance program. We receive episode-based payment for a number of services: specialty mental health, subacute detox, and medical respite.
62	We are a CPC+ tier 2 clinic
63	Not sure
64	Healthshare Detox Case Rates. Results in immense administrative burden in claim processing , payment application and cash flow management. This component must be included in evaluation of value based payment models. SUD/MH facilities operate on 5-6 days cash on hand so we need to be able to forecast and rely on payment timing.
65	I don't know.
66	Shared risk with the local hospital system for PacificSource OHP contract.
67	Not Familiar with some of the terms you are asking for here, but I believe these are the types we are involved with.
68	At this time, I only accept fee-for-service (is that the same as "Episode-Based payment?)
69	Receive contracted amount per type of client seen with a processed claim for behavioral health service.
70	I am not a provider. Please take me off you list. Only send e-mails like this to providers and not to patients who are signed up for the Oregon Health Plan.
71	Autonomous from and unrelated to external payers, WDG operates a value-based payment model for all markets served. Note, aside from OHP, WDG is the plan and provider in virtually all market we operate in. Willamette Dental Group (WDG) is a vertically integrated system - both plan and provider - that consist of a closed panel, staff model delivery system with clinicians leveraging an enterprise electronic record system equipped with clinical decision support. Our captive network, WDG P.C., is the largest multi-specialty group dental practice in the Pacific Northwest region with over 50+ offices in Washington, Oregon and Idaho. Moreover, we manage different lines of business including all commercial markets (individual, small, large and self) and Medicaid. As a staff model, closed panel, delivery system, WDG employs all providers who serve in our network. As a condition of employment, providers (regardless of specialty) are required to serve all lines of business including Medicaid. Importantly, we are not a claims paying entity; WDG providers do not submit claims, rather all services are entered into our electronic health record and captured in encounter data. Lastly, WDG providers' compensation consists of the following value-based payment model elements: 1. WDG does capitation for all lines of business - no FFS. 2. Compensation package consists of base salary and performance compensation. 3. Base salary is designed to be market competitive and meaningful as portion of overall compensation while being equitable and reasonably proportional. 4. Performance salary is meaningful, but not majority share, component of overall provider compensation. The measures that providers are accountable for include quality of care, following evidence-based practices, e-chart completion, appointment access goals, and Press Ganey survey results.

#	Please describe any of the payment models in which you are participating
72	Receive a based service rate calculated from the Level of Service Inventory.
73	We have found that a blended model of FFS and capitation has been an effective mechanism to shift from FFS to Value-based contracting. Appropriate and reasonable levers can be used to determine the level of PMPM payment. This enables the CCO and provider group to work together on shared objectives, while also delivering real time recognition of shifts in performance (rather than waiting 6 months after the performance period ended). For one CCO, the PMPM payment to the practice varies based upon: PCPCH status, access (i.e. open to Medicaid), and engagement (has the patient been seen in the last 365 days). These criteria demonstrate the level of commitment the practice has to serving the whole assigned OHP population. One challenge tthat we have encountered with engagement is the inability to contact the patient and/or family to ensure a patient visit and the high no-show rate for this population, even if a visit was scheduled. For another CCO, the PMPM rate is tied to performance on 12 performance metrics. While this helps align with the CCO incentive metrics, we have found that operationally, it is very challenging to ask a physician practice to monitor and perform on 12 metrics for one CCO population. Each metric requires a different workflow and level of support to effectively operationalize and manage to this population. We are beginning to look at a shared risk arrangement, which includes downside risk. This is very risk for a primary care provider group. Given the investment in medical home, we feel non-reimbursement for medical home capabilities is more than enough investment; downside risk should not be placed on primary care practices. We also believe that it is important to separately recognize medical homes that also have integrated behavioral health and/or employed psychologists, therapists or social workers on site. We have struggled with different roles these psychologists might play in a practice, and rarely does reimbursement from CCOs match the level of service provided to this population. CCOs have not been able to identify or recognize a blend of integrated behavioral health services, preventive services, and ongoing therapy services by one clinician. The buckets that have been created have not allowed for the diversity in services offered, especially for the pediatric population. Commercial lags significantly behind the CCOs in value-based payments. While they may offer capitated rates to larger health systems, independent practices generally don't have the volume necessary to change practice necessary to succeed in primary care capitation. Until the majority of commercial payers can align incentives, practices with a variety of commercial and CCO payers will struggle to move fully into a VBC environment. At best, our practices have been offered minor incentives for quality metrics, and the recognition for PCPCH is insignificant, at best.
74	Performance based pay with "bonus pay" for meeting metrics, patient satisfaction scores above 90%, meaningful use.
75	Quality metrics reporting with Care Oregon.

#	What are the challenges created for you by the CCO value-based payment models in which you participate? Other (please describe)
1	It would be nice to have up to date quarterly data
2	The ED Disparity Measure: WE still do not have a list of our patients with these diagnosis codes (Who is in our denominator?) If they were diagnosed in the ED, Inpatient, or with an outside BHP, we would not know they meet the criteria. Our CCO or OHA needs to supply us with this information.
3	We have challenges interfacing with our EMR
4	payment occurs up to 18 months after performance:-(
5	reporting methodology is not clear on how to report
6	To meet reporting requirments, the providers become data entry clerks rather than healthcare providers.
7	Inconsistent expectations between HRSA, OHA, and CCO
8	Multiple payment models create excess provider burden and practice administrative expense
9	claims are often missed by the CCO, requiring re-submission. Performance data reports are extremely slow to be reported, and leave us little time to find errors and correct them. Errors also abound in the case of patients who have medicare as primary, as those claims were submitted to medicare and not the CCO. Also, the quality measure have no data to support their use - they have not been proven to improve patients' health and in some cases seem completely arbitrary. More time is spend meeting the measure that could have been spent improving the patient's health in more meaningful ways.
10	data given late in the year, measure specifications change, measures specifications come out late
11	We do not have a contract with our CCO
12	N/A
13	It requires time and effort to meet the measures, which is very expensive and not currently reimbursing our costs
14	We struggle with not having timely, accurate data from the CCO
15	I think the reporting is not scrubbed very well for our patient base. Other than that for the most part we are doing what we can in our control to hit the incentive measures. Being accountable for patients that put our name down but have never been seen by us is a little tricky.
16	Actually, works quite well
17	Primary care not participating/coordinating with specialty care when incentives require both to work together.
18	Lack of recognition by CCO of the staff time needed to manage expectations
19	It takes a long time to align measures across many providers.
20	Need to include physical health savings into cost/benefit ratios for BH care

#	What are the challenges created for you by the CCO value-based payment models in which you participate? Other (please describe)
21	Our EMR makes it difficult to get the data needed
22	We are working with numbers on a page not reality.
23	Travel time in Rural/Eastern Oregon, which is not encounterable, greatly hinders productivity thus hindering capatation rates. This MUST be considered as we attempt to meet families where they are at..... which is not in the local mental health offices
24	Our providers report minimal incentives are not generally targeted to behavorial health activities, though there are a few CCO's that have made investment in their BH network as part of the process
25	The budget cut we took I closed one home could not find staff to pay a good salary. More paperwork. Now billing with incompetent Kepro There is more put onto the provides with less county support
26	Bad data. Poor reporting system. The numbers they present do not accurately represent what that are sayin they do.
27	I cannot answer this question
28	It can be time consuming to gather the data for the measures.
29	3 different payment models from the 3 different CCO's in my service area make coordination and alignment nearly impossible.
30	n/a
31	Member lists are not always accurate and affect clinic performance on metrics
32	All provided services are below funding line and thus not covered; OHP guidelines only allow consultation visits
33	Work required to participate does not align with provider compensation plans, so there is little to no incentive for provider participation in quality efforts
34	CCO's are often not aligned and are "chasing" different metrics. I think this will change in 2018, but it has been troublesome in the past. Additionally, each CCO handles incentives differently-- some are generous and transparent about the process (kudos to JCC) and others are not (AllCare).
35	the case rate for the serve mentally ill is not enought.
36	Not enough incentive for adolescent/young adult services. Not enough incentive for high acuity clients.
37	Data we receive from CCO is not timely enough to make real time improvements, OHA metrics that are not consistent with CMS/HEDIS metrics are increadily resourse heavy to build and track.
38	Metric targets come out 6 months into the year. Results have a 3 month lag time, mostly due to waiting for claims processing. New data analytics system, Arcadia, interface is not providing accurate data yet. We are having to do lots of validation, very time consuming.
39	Devalues medical necessity and standard of care
40	Because of the small size of our Medicaid population we are not eligible for some of the incentive payments

#	What are the challenges created for you by the CCO value-based payment models in which you participate? Other (please describe)
41	For the payor we are submitting data it is time consuming. It has added an administrative layer.
42	challenges with incentivizing providers in a governmental agency
43	incentives may cause loss of focus in other key priority area - ie chasing incentives
44	Even the best reporting software, Arcadia, has difficulty getting me accurate info that I can use to improve metrics.
45	Not enough input to OHA regarding measure specifics, would recommend more clinical input in drafting measure definations
46	The payment model for outpatient programs does not consider the needs of clients/programs needing specialty or more intensive supports. There appears to be a fundamental philsophy that "less is more". the system is under severe stress and is focusing more on agency financial stability and excessive documentation requirements vs. excellence in care.
47	I have participated in the past with CCO's and now only work with private insurance due to payment issues
48	CCOs are requesting info which is in addition to CPC+ reporting requirements.
49	feedback from colleagues that participate - too much administrative work
50	chasing the incentive money becomes the focus and distracts from other worthwhile efforts.
51	Unclear if we are in a CCO or not. More clarity for patients
52	I dont partctpate because of reasons selected above
53	CCO data is old by the time it gets to us from pulling from claims. Milliman does not always pull correctly for data extracts.
54	I do not receive any personal incentive. The system does not share incentive money with providers
55	Our annual payment from Trillium CCO dropped considerably last year, and we know from news coverage that Trillium increased its own cash reserves by millions of dollars in that same time period. Thus taxpayer money intended for health care and incentive payments to providers went into corporate bank accounts. (Trillium is owned by a for-profit, out-of-state corporation.) Meanwhile, our Clinic struggles to survive.
56	Again, this question doesn't get at my situation as a sole provider. I can say that my main challenge now seems to be getting accepted onto a CCO, as I was denied based on: location, low volume compared to clinics, higher cost to manage the follow up required to meet their administration of the CCO system. NONE of this speaks to the need of the client and the effectiveness of using counselors in private practice.
57	"Track 2" option has benchmark values, some of which are unobtainable within our practice and make the model almost impossible to use. (example, cigarette smoking prevalence benchmark, for my practice that is an FQHC with focus on homeless, alcohol and drug affected clients - it is not achievable , certainly not in short term, that we would get to a 30% prevalence rate.)
58	our clinic previously accepted trilium and they reassigned out patients without warning due to contract discpute

#	What are the challenges created for you by the CCO value-based payment models in which you participate? Other (please describe)
59	It is working.
60	Lacking knowledge around what specific CPT codes and credential levels count toward metrics.
61	I will not participate in these programs and that limits good services for clients on ohp
62	Lack of patient compliance, both showing up to appointments and following guidance recommended by provider
63	The rates provided by the CCO to us for the pmpm risk based contract are not sufficient. We received a slight increase this year but still not sufficient and we received a cut to the rates the prior year. However, it is still much better than DMAP fee for service rates which is what most other CCO's pay for residential treatment.
64	Payment model is not consistent with advanced PCPCH that includes integrated physical and behavioral health.
65	Number and timing of CANS referrals is not in our control
66	Payment model is not sufficient to cover the cost of the visit
67	some incentives are too prescriptive for our practice and infringe on provider discretion/judgement
68	The episode-based payment for specialty mental health in our region does not include quality-based performance incentives or performance standards; the only quantitative measure considered as part of episode-based payment is visit volume within an established risk corridor. The absence of quality metrics means that there is little formal incentive for providers to prioritize patient outcomes over patient volume, since they are only financially rewarded for bringing on as many patients as possible and providing just enough service to keep them within the risk corridor. That doesn't mean that providers have bad intentions, but in an environment in which they have historically been underfunded, they need financial support to work in other ways. Raising the case rate payments will not solve this problem: moving toward quality incentives for performance, based not on visit volume but on patient outcomes and true value of care, will.
69	Y'all suck
70	Claims based data is unreliable
71	Rationing of care through preauth w pscs
72	COIPA focus on large multi-specialty clinics and hospital. Small independent providers unsupported.
73	Metrics are often selected specific to Oregon, rather than aligning with CMS metric specifications.
74	Incentive dollars for PCPCH did not exist via the CCO until a few months ago and those too were put in as a grant based system
75	Trying to figure out wha tthe CCO will pay for and what they will not. It seems to change month to month sometimes, or rules are unclear.
76	specialty practice so limited to applicable care for reporting
77	I choose not to participate in a value-based payment model because I don't see enough clients for this to balance out. Also, I have worked in settings that operate on a value-based model in the past and it places

#	What are the challenges created for you by the CCO value-based payment models in which you participate? Other (please describe)
	emphasis on only seeing the clients who are the most acute as opposed to doing the really meaningful work of processing with clients who are in different stages of change.
78	I don't know what it is? Our clinic sees maybe 20 out 250 clients
79	Unable to get payments in a timely manner and contract for 2018 in a collaborative way.
80	I have lost track of what is measured and whether we are getting extra payments.
81	Because I am not a provider, I am a patient signed up for the Oregon Health Plan.
82	Commercial payers have not been paying via value-based payments, only fee-for-service in our area
83	SBHCs are required to serve anyone that comes to their door. Sometimes they are the PCP, and sometimes they see patients only for specific services (e.g. mental health, reproductive health, sports physicals, etc). Most VBPs are based on the patient being assigned to the clinic. This means SBHCs are not able to maximize the potential of the VBP and sometimes are unable to receive any payment for services for non-assigned patients. When attribution is utilized, SBHCs are, at least in some areas, excluded from the attribution model. Additionally, while statewide SBHCs see kids p-12, the majority of services are provided for adolescents, which are frequently not a population prioritized in development of VBPs, or Community Benefits for that matter.
84	Not eligible for incentives for all relveant measures. ie decreased ED use was not something Behavioral Health providers would receive a portion of the incentive payment for meeting the metric previously.
85	Lack of flexibility/willingness to move away from a one size fits all solution; creates reggression to the mean dynamics for some plans and impedes more transformational approaches.
86	examples contracts of pay for outcomes
87	Decreased Medicaid Service Payments
88	Not all of the CCO incentive metrics are directly attributed to metrics that are highest priority to a pediatric practice, in particular, adult measures for which the age was lowered to 15 or 16. Metrics or benchmarks for the adolescent population are rarely adjusted for the age band. In addition, consistency with the commercial population is imperative in order to effectively operationalize change within a practie.
89	Interface problems sharing data with CCO
90	Small rural clinic makes it difficult to meet productivity requirements for incentive pay.
91	Don’t know
92	No programs for specialty practices

#	Would you suggest that OHA encourage CCOs to pay providers using value-based payment models aimed at any of the following? Other (please describe)
1	An actual PCPCH reimbursement model rather than just a few dollar PMPM
2	Particularly residential behavioral health (Substance Abuse Disorder) reimbursements
3	why should the health care system have to pick up for business and gov failures re social determinants?
4	only if CCO can communicate clearly what is required for this type of payment
5	I think that patient/provider attribution needs to be straightened out before it goes any further
6	paying the patient to actually come to their visits and actively participate in their own health would do much further than value based pay for providers that cannot control the compliance of the patient.
7	Traditional Health Workers
8	Room for value-based and/or hybrid payment models in all areas of care.
9	Unsure
10	I am not sure
11	No help from OHA needed. Focus on your regulatory stuff. CCOs and Providers can figure it out for themselves
12	Degree of difficulty of care & time spent including both medical and behavioral.
13	The Alternative Payment Model was fine, I worked to get the numbers. Decreasing my cap check because I didn't see the healthy 22-year old does not make sence. Forcing me to see this patient yearly runs the risk of unecessary test.
14	Not sure, since my business doesn't involve paying for care
15	particularly children's behavioral health, both mental health and SUD; i don't know how the social determinants can be under this category since they are very dependent on other entities to fulfill
16	Pay reasonable amount for services rendered
17	I think value based payments help create focus, and have significantly increased our organization's ability to perform on improving the outcomes for our patients.
18	Value-based payment is not something I am in favor of.
19	none
20	if 'value' is based on treatment outcomes, I would assume having this at the PCP level would support doctors providing accurate and adequate referrals to specialty care. however, value based payment in the mental health field often dictate how frequent treatment can occur, while then holding an irresponsible and inadequate standard to meet within this rigid framework. the medical model appears to be more appropriate, where a member can access care based upon the level of medical need (which is built into mental health intake assessments)
21	cannot be 100% value based

#	Would you suggest that OHA encourage CCOs to pay providers using value-based payment models aimed at any of the following? Other (please describe)
22	Don't know enough about this to answer
23	Does Value Based, mean cost savings only? Or does it mean that we value these services and cover the costs of the care? There is a need for Medicaid waivers to cover the real costs of services, and ramp up the availability of in home services, short term specialty care, and permanent supportive housing. With social security incomes being hundreds of dollars lower each month than the cost to rent a tiny studio apartment, we will only see large increases in housing and health instability, and higher costs on the emergency health system. I would encourage OHA to lobby nationally for significant increases in social security disability and TANF model income benefits.
24	Not sure- don't know enough about value based models
25	the OHA continues to evaluate and fund based upon actuary encounters - this conflict must be resolved before adopting value-based payment models
26	addictions tx
27	OHA must first establish a standard rate for Licensed Residential Care & transfer those funds to the applicable CCOs prior to implementation.
28	No. Commercial companies tried this year's ago and most of those models are now gone. They don't work
29	None!
30	ED Utilization
31	Integrated physical and behavioral health in a single payment methodology across every system of care.
32	Enhanced Primary care payments to lower overall healthcare costs
33	No; fee for service has been effective and efficient.
34	Kill yourselves, you do terrible work.
35	No
36	Through transparant , simple public contracts
37	If funded at rates that compensate for portion of risk.
38	Would not encourage this for all customers we prefer the capitation model. Value based seems to require a lot more paperwork, which takes money away from providing services.
39	Unsure - would need to see plan & reporting requirements
40	if one is required all should be required
41	No - I do not suggest this model as I have found it to be the opposite of client-centered.
42	Case management
43	None---Does not apply to me.

#	Would you suggest that OHA encourage CCOs to pay providers using value-based payment models aimed at any of the following? Other (please describe)
44	Please include adolescents in "children's health" or call out services for youth. Adolescence is a time when mental illness becomes apparent, and risky behaviors begin that can impact long-term health. This is an important, and often forgotten population.
45	Community Paramedic Programs
46	Much of the work we do; education and counseling, helping patients navigate their insurance, working with case managers from the CCO, helping patients access transportation and social servies, are not reimbursable. These patient touches should count towards productivity.
47	i dont understand the question

#	What information do you need from the CCO to manage your value-based payment contract(s)? Other (please describe)
1	list of our patients that fit all denominators - so we know who to specifically target.
2	i already receive monthly patient lists with gaps and measure performance
3	clear communication on how to report this information for payment
4	Alignment around a single set of performance measures and feedback on all of our clinics patients, not just some payers, to make this possible.
5	We could use help with personnel to manage the contracts.
6	Benchmarks needed much sooner
7	Shared best practices for reporting in small FQHC.
8	We need more up-to-date/real time data.
9	Receiving all of the above along with Arcadia hared data warehouse information
10	N/A
11	Unsure
12	n/a
13	Costs of doing business overall; transparency in all of their income and expenses so we can figure out best financial incentives for best clinical outcomes and everybody can pay their bills
14	Creating a reporting system that is cost effective and supports ongoing data collection needs, ie consolidating work load not adding additional adminstrative burden through cost and operations but exploring opportunities for effeciencies with contracted network.
15	Transparency on their payments per member and targeted profit in their budget.
16	N/A
17	More support from the placing the correct folks for AFH
18	N/A
19	I cannot answer this question
20	NEED TO BE ALLOWED TO SEE, EVALUATE AND TREAT THESE PATIENTS AS MEDICALLY DEEMED NECESSARY WITH GUARANTEED REIMBURSEMENT
21	All of these items are helpful, though we have our own internal lists for ALL patients, not specific to a payer. Again, JCC provides this information and acts as a strong partner in this work. They really show up as partners in assisting us reach our goals together in a pro-active type of a way.
22	real time reports in order to make process improvements
23	I do feel like we have a great relationship with our CCO and do receive info when possible.

#	What information do you need from the CCO to manage your value-based payment contract(s)? Other (please describe)
24	Advocate with health plan for giving members information and option to be assigned to culturally specific primary care home
25	n/a
26	clear standards/procedures for accessing care if these predetermined standards made at the administrative level are not met on the clinical level
27	Not currently applicable -- provide a means for small group practices and solo practitioners to participate
28	N/A
29	more definition of what this means, and a focus on provision of quality care. If we know from research what services have the greatest impact on overall health and the health of the community, do we need to add more paperwork for clients and direct services providers.
30	training/education on v-b models
31	We need all of that information from Trillium. In fact, question 9, above, should have included a choice of "don't know," because we have very little information from Trillium CCO about what goes into deciding the incentive payment.
32	That OHA establish a standardized rate for licensed residential care & transfer the funds to the CCO to contract w/ providers accordingly.
33	Very specific details on how performance is measured. Currently very vague on what counts and what doesn't.
34	Current and accurate list of patients who are attributed members/ Also expanded gaps in care reports.
35	N/A as not currently receiving value-based payment
36	Alignment on measure requirements with commercial and Medicare payors. Alignment to practice beneficiary lists
37	recommendations for evidence-based strategies to meet these goals based on success of other agencies in meeting similar goals
38	Thanks for closing FamilyCare, [expletive removed].
39	Need accurate lists of attributed patients
40	having truly accurate, up to date data
41	What do all the contracts say- am I getting a fair deal
42	Practice by practice assessment for value-based payment opportunities.
43	Payments made on timely basis
44	Performance that doesn't require an extra level of documentation which seems burdensome to employees.

#	What information do you need from the CCO to manage your value-based payment contract(s)? Other (please describe)
45	accurate data
46	None--Does not apply to me.
47	Data connected to community paramedic utilization and cost savings
48	CCO provides referals for the level of care provided
49	As we become more advanced in system level data on social determinants of health, it will be important to share information from CCOs to provider practices to identify the best level of supports.
50	We need to be able to correct list of attributed patients- if their visits are happening at another clinic, it should change. We need to be able to submit our quality and data electronically and have IT support for the interface to do that.
51	i have no idea, we are just FFS
52	Anything else requested
53	i dont think we do value based payments

#	What health information technology does your practice lack but need in order to succeed with value-based payment contracts? Other (please describe)
1	PreManage and Hospital Connect
2	behavioral health services
3	We can use help with more care management personnel.
4	More accurate patient attribution and timely care gap lists
5	No onsite IT support. No data analyst staffed.
6	Arcadia, EDIE Preamange providing bulk of what is listed above.
7	N/A
8	Ability to use CCO as private practitioner.
9	We are currently getting care mgmt platforms, population health mgmt tools and HIE all in place, we are just not quite there yet.
10	Don't know
11	Less record keeping and more time for actual care.
12	The BH system could utilize support in all of these areas, particulary supported at a group offering or implementation.
13	None, since we don’t engage in these activities.
14	A form that is for mental health Most of the questions do not regard mental health it’s either medical or other things and it’s very small section deals with mental health it is not a good tool for payment
15	NOT SURE
16	Need funding for up to date EHR and maintenance. Need to coordinate/make compatible all systems-ease of sharing info.
17	It will be much better when the data going (Interface) to Arcadia (analytics tool) is found to be accurate.
18	n/a
19	need HiE but this becomes complex esp with high IT demands to implement
20	We use Arcadia, and have spent hours developing this platform. However, it still is not accurate
21	N/A
22	Clear and limited outcome measures which are easily to track, assess and report on. The more complex, the less effective and the more time we take away from client care.
23	unknown
24	Functional EMR

#	What health information technology does your practice lack but need in order to succeed with value-based payment contracts? Other (please describe)
25	none
26	A good way to identify crossover in all the quality measures across payors so practices can take a more strategic and proactive approach
27	Care Management is missing in two of our facilities.
28	I'm not sure that technology is really the key need here.
29	The option of a value-based payment contract
30	OCHIN- However being a "mom & pop RTF" I'm not staffed w/ an Internet Technology Department to manage all the compliance requirements.
31	I'm unsure what IT would improve success
32	It is too complicated. Just let us provide care!
33	updated reports from our CCO's on members with accurate phone numbers and addresses.
34	N/A as not currently receiving value-based payment
35	this doesn't apply to me
36	improved patient registry function that is not laborous to manage
37	[expletive removed]
38	a much better telehealth network (i.e. multilateral rather than unilateral connections) with specialists.
39	Many of these questions are too complicated to answer or even know what is needed to comply. Which seems to indicate we need more technical assistance to be able to move forward.
40	Claims data files.
41	Ability to track revenue at net rate not gross rate. Causes immense revenue swings
42	Ways to objectively measure performance that are not burdensome and therefore add extra stress on to employees as just one more thing added to their plate. When things are kept being added to plates, bloating occurs, which is no good for anyone.
43	All of the above to work consistently and accurately
44	A system that can calculate all the measures for all insurances.
45	Need extra staff to utilize PreManage--very time consuming
46	None---Does not apply to me.
47	Z
48	HIT is variable among SBHCs. They all have EHRs but analytical and data sharing capabilities vary.

#	What health information technology does your practice lack but need in order to succeed with value-based payment contracts? Other (please describe)
49	HIE is the most critical component to make this work, understanding it must go hand in hand with a care management platform. Premanage does not appear to be a perfect or even practical solution to this at this point in its development.
50	Unknown
51	Our practices have invested in a population health management tool that allows for a care management platform and advanced analytics. In order to see the entire spectrum of care for our shared members, claims data and/or shared clinical data is imperative to more effectively coordinate care and share care plans. This investment in a population health management tool, however, has not been recognized in terms of investment or support by the CCOs to better manage the shared population.
52	I don't even know
53	Internet connectivity and cellular access are challenging in rural areas.