APAC Payment Arrangement File

Data Need Use-Case for Value-based Payments (VBP) or Alternative Payment Methodologies (APM)

Title of the use-case: Annual assessment of Oregon payers' percent of spending in a VBP for primary care.

Unit or Division needing data: Health Policy and Analytics

Timing and schedule of when data are needed: The Collaborative recommends "Year 1" begin in 2020, and "Year 4" be no later than 2024.

Table 1: Primary care VBP targets out of all primary care spending, by Payer, for HCP LAN Categories 2A and 2C or higher*

	Year 1	Year 2	Year 4
Primary care VBP targets out of all primary care spending, by Payer, for HCP LAN Categories 2A and 2C or higher**	40%	55%	75%

*Includes 3A VBPs with Shared Savings, 3B VBPs with Shared Savings and Downside Risk, and 4A Condition-Specific Population Based Payments. VPBs with downside risk are generally best suited for clinics that can take on more financial risk (that is, large, health system-based clinics). In addition, for the purposes of this table, VBP spending is calculated in accordance with the following guidance from the HCP LAN 2018 Alternative Payment Models Survey (http://hcp-lan.org/workproducts/APM-survey.pdf): "Plans should report the total dollars paid, which includes the base payment plus any incentive, such as fee-for-service with a bonus for performance, fee-for-service and savings that were shared with providers, etc."

Table 2: Primary care VBP targets out of all primary care spending, by payer, by primary care payment model component**

Primary Care Payment Model Component	Year 1	Year 2	Year 4
Fee-For-service (FFS) with no link to quality and value – not a VBP		TBD by payer	25% (max)
Advanced primary care infrastructure (ACPI) payments • Typically, this investment is through up-front PMPM payments, supporting non-billable team-based care • These payments to clinics will not be at risk	10%	TBD by payer	Target range: greater than 10%-40%

Performance-based incentive payments • Payments for performance on agreed-upon accountability measures, such as population-based quality metrics and utilization	5%	TBD by payer	Target range: greater than 5%-10%
Comprehensive primary care payments (CPCP) • Up-front payments (typically PMPM), based on historical spending in primary care • Accompanied by decreased FFS rates		TBD by payer	Target range: 10-25% or greater

**For the purposes of this table, VBP spending means the APCI payment, performance-based incentive payment, and/or CPCP only.

Description of why data are needed: All health care payers that provide coverage in Oregon will report on progress toward meeting targets (see tables 1 and 2) for primary care payments. For years two to four, payers will set and report individual annual targets for the three VBP components of the payment model.

Payers must develop and offer to clinics the components of the payment model that demonstrate their intent to meet the minimum targets in primary care payments and investments aligned with LAN categories "2A" and "2C or higher" (categories are outlined in Table 1). "Category 2C or higher" includes multiple HCP LAN categories to allow payers flexibility in how they meet the target.

Per Table 2, payers also will report payments aligned with each primary care payment model component separately, even if those dollars are included in a contract with other HCP LAN categories.

The intent of the targets in Table 2 is to capture and track over time the penetration of each of the payment model components (via the percent of dollars in each payment model component relative to total payer spending in primary care). Note that advanced primary care infrastructure (ACPI) payments, performance-based incentive payments, and comprehensive primary care payments generally align with LAN categories 2A, 2C, and 4B respectively.

Specific details and technical specifications:

- Inclusion and exclusion criteria:
  - Payers must develop and offer to clinics the components of the payment model that demonstrate their intent to meet the minimum targets in primary care payments and investments aligned with LAN categories "2A" and "2C or higher"
  - Payers also will report payments aligned with each primary care payment model component separately, even if those dollars are included in a contract with other HCP LAN categories.

Additional information (if necessary):

The Primary Care Payment Reform Collaborative ("Collaborative") is a legislatively mandated (Chapter 575 Oregon Laws; Senate Bill [SB] 934 [2017]) multi-stakeholder advisory body to the Oregon Health Authority (OHA). Per SB 934, the Collaborative is to advise and assist OHA in the implementation of a Primary Care Transformation Initiative ("Initiative") to:

- Use value-based payment methods that are not paid on a per-claim basis to:
  - Increase the investment in primary care
  - Align primary care reimbursement by all purchasers of care
  - Continue to improve reimbursement methods, including by investing in the social determinants of health

- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care

SB 934 also includes strategies for the Collaborative to consider that support the implementation of the Primary Care Transformation Initiative:

- Provide technical assistance to clinics and payers in implementing the Initiative
- Aggregate the data from and align the metrics used in the Initiative with the work of the Health Plan Quality Metrics Committee
- Facilitate the integration of primary care behavioral and physical health care.

Links and other resources:

Oregon's Primary Care Transformation Initiative 2018 Progress Report

APAC Payment Arrangement File

Data Need Use-Case for Value-based Payments (VBP) or Alternative Payment Methodologies (APM)

Title of the use-case: Annual assessment of CCOs' required spending for Patient Centered Primary Care Homes (PCPCHs)

Unit or Division needing data: Health Policy and Analytics, Value-Based Payment team

Timing and schedule of when data are needed:

- Beginning 2020, CCOs are required to provide per-member-per-month (PMPM) payments to their Patient-Centered Primary Care Home (PCPCH) clinics. A Category 2A VBP (Foundational Payments for Infrastructure & Operations) is required as defined by the LAN Framework.
- CCOs are required to also vary their PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs.
- The PMPMs must increase each year over the five-year contract and be meaningful amounts. Although OHA is not defining a specific minimum dollar amount, the payments should meaningfully support clinics' work to deliver patient-centered care.

Note, unless combined with a LAN category 2C or higher, this requirement does not count toward the annual CCO VBP minimum threshold or CCO annual target, described in another data need use case summary.

Description of why data are needed: The Patient-Centered Primary Care Home Program is a key part of Oregon's efforts to fulfill a vision for better health, better care and lower costs for all Oregonians.

Specific details and technical specifications:

- Inclusion and exclusion criteria:
  - For this specific calculation, spending in LAN's Pay for Performance category 2A counts towards this requirement.

- Numerator and Denominator: There is no numerator or denominator used for this requirement.

Links and other resources:
Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017"

OHA's Value-based Payment Roadmap for Coordinated Care Organizations

Value-based Payment Roadmap: Categorization Guidance for Coordinated Care Organizations

APAC Payment Arrangement File

Data Need Use-Case for Value-based Payments (VBP) or Alternative Payment Methodologies (APM)

Title of the use-case: Annual assessment of CCOs' required percent of spending in a VBP

Unit or Division needing data: Health Policy and Analytics, Value-Based Payment team

Timing and schedule of when data are needed: Beginning 2020, CCOs are expected to spend a percentage of their total spending in the form of VBPs, with annual variations on required Health Care Payment Learning and Action Network's (LAN's) VBP category and required minimum percentage.

The Payment Arrangement File that CCOs submit in September of each subsequent year, will reflect the spending from previous calendar year 2020.

Annual CCO VBP requirements, 2020-2024, detailed below.

- For services provided in 2020, no less than 20% of the CCO's payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
- For services provided in 2021, no less than 35% of the CCO's payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
- For services provided in 2022, no less than 50% of the CCO's payments to providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher;
- For services provided in 2023, no less than 60% of the CCO's payments to providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher; and it is expected that, beginning 2023, no less than 20% of the CCO's payments to providers must fall within LAN Category 3B (Shared Savings and Downside Risk) or higher; and
- For services provided in 2024, no less than 70% of the CCO's payments to providers must be in the form of a VBP and fall within Category 2C (Pay for Performance) or higher and it is expected that beginning 2024, no less than 25% of the CCO's payments to providers fall within LAN Category 3B (Shared Savings and Downside Risk) or higher.

Description of why data are needed: Renewed in 2017, Oregon's 1115 Medicaid waiver required OHA to develop a plan describing how the state, coordinated care organizations

(CCOs) and network providers would achieve and measure an established VBP target by June 30, 2022.

In 2018, Governor Brown outlined four priorities for CCO 2.0, including a continued emphasis on paying for value and transforming how CCOs pay for care. As such, the CCO 2.0 Request for Applications outlined all VBP-related requirements including the annual VBP targets that CCOs will be contractually required to meet from 2020-2024. Paying for value and quality, instead of quantity, is a critical component of Oregon's health care transformation efforts for Medicaid.

Specific details and technical specifications:

- Inclusion and exclusion criteria:
    - For this specific calculation, only spending in LAN's Pay for Performance category 2C or higher (i.e. LAN category 2C) or higher counts.
    - If any component of the payment fits in category LAN category 2C or higher, then the entire payment counts towards the VBP percentage.
    - Payments count towards the VBP percentage if fee-for-service as well as a component in LAN category 2C or higher is used.
    - Patient attribution logic may be applied for risk-based contracts.
    - Include total expenditure in file for CCO to commercial comparison
    - Multi-payer, standardized definition of "risk" for all submitters

- Numerator: The payments that are LAN category 2C or higher VBPs or have components that are VBPs.

- Denominator: The denominator in this calculation is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. Administrative expenses, profit margin, and other non-service-related expenditures are excluded from the calculation.

Additional information (if necessary):
Additional CCO VBP requirements, detailed below, that currently cannot be captured in APAC payment arrangement file but would ideally be in the future.

Beginning 2021, CCOs must develop new, or expanded from an existing contract, VBPs in care delivery areas which include hospital care, maternity care, children's care, behavioral health care, and oral health. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher through the duration of the CCO 2.0 period.

Links and other resources:
Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017"

OHA's Value-based Payment Roadmap for Coordinated Care Organizations

Value-based Payment Roadmap: Categorization Guidance for Coordinated Care Organizations

APAC Payment Arrangement File

Data Need Use-Case for Value-based Payments (VBP) or Alternative Payment Methodologies (APM)

Title of the use-case: Shared risk potential gain and loss

Unit or Division needing data: Health Policy & Analytics, OEBB and PEBB

Timing and schedule of when data are needed: Data desired for payer VBP payments made to providers in 2020, to be reflected in Payment Arrangement File submitted in September 2021.

Description of why data are needed: Increasing the proportion of total health care dollars paid to providers under value-based payment arrangements is a stated goal of OHA health insurance programs (Medicaid, OEBB, and PEBB). Important context is provided when looking at the proportion of VBP dollars that are at risk under provider contracts. Understanding the dollar amount of providers' potential gain or loss relative to the total amount paid to the provider allows understanding of the magnitude of risk within shared risk value-based payment arrangements.

PEBB (Public Employees' Benefit Board) and OEBB (Oregon Educators Benefit Board) provide health benefit plans that cover approximately 100,000 employees of state agencies, universities, school districts, education service districts, and local governments in Oregon (roughly 300,000 covered lives when spouses and dependents are included). Both PEBB and OEBB are directed by Boards whose members are appointed by the Governor and represent stakeholder constituencies. OEBB and PEBB seek to increase the value of health benefits provided through alternative payment models that incentivize improved outcomes and sustainable cost and engage the delivery system in shared risk related to outcome and cost targets.

Consistently capturing data on potential gain and loss under shared-risk arrangements and examining these amounts in the context of total dollars paid to a provider will allow OHA health insurance programs to better understand risk bearing arrangements across carriers and compare to the wider commercial market. These data will inform internal OHA decision making, including but not limited to potential VBP requirements in future PEBB and OEBB contracts.

Desired Data Elements (new):

1. Total potential gain from upside risk – the maximum dollar amount of provider's potential gain from possible upside risk in shared savings or shared risk arrangements
2. Total potential loss – the maximum dollar amount of provider's potential loss or downside risk possible under shared risk arrangement(s)

Specific details and technical specifications:

- Inclusion and exclusion criteria:
    - For this specific calculation, only spending in LAN's Pay for Performance category 2C or higher (i.e. LAN category 2C) or higher counts as a "value-based payment".
    - If any component of the payment fits in category LAN category 2C or higher, then the entire payment counts towards the VBP percentage.
    - Payments count towards the VBP percentage if fee-for-service as well as a component in LAN category 2C or higher is used.
    - Patient attribution logic may be applied for risk-based contracts.
    - Include total expenditure in file for comparison to non-PEBB, non-OEBB commercial plans and CCOs
    - Multi-payer, standardized definition of "risk" for all submitters
    - The potential gain for shared savings corresponds with LAN category 3A or higher
    - The potential gain and loss for shared risk corresponds with LAN category 3B or higher

APAC Payment Arrangement File

Data Need Use-Case for Primary Care Spending Report

Title of the use-case: Primary Care Spending Report

Unit or Division needing data: Health Policy & Analytics as well as Department of Consumer and Business Services (DCBS)

Timing and schedule of when data are needed: Primary care spending data are currently pulled from two sources for the annual report: claims files from Oregon's All Payer All Claims database (APAC) and a stand-alone spreadsheet with non-claims expenditures that carriers submit to OHA.

Description of why data are needed: The Payment Arrangement file is currently not used to generate the primary care spending report, but if it were used, we could cease the collection of the stand-alone spreadsheet with non-claims expenditures data. These data are needed to comply with Senate Bill 231 (2015) and Senate Bill 934 (2017).

Specific details and technical specifications:

- Inclusion and exclusion criteria –
  - All payments made regardless of LAN category are included in the calculations of primary care spending
  - Statute specifies that primary care providers shall include "family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry."

- Numerator – primary care is defined as the set of service codes and a set of provider specialty codes.

- Denominator – total medical expenditures is used as the denominator in the calculation of primary care spending percent. Statute defines total medical expenditures as "payments to reimburse the cost of physical and mental health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism."

Additional information (if necessary):

Primary care spending reports can be found here –
https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Reports-Evaluations.aspx