

Oregon's Primary Care Transformation Initiative

2022 Progress Report

Primary Care Payment Reform Collaborative

January 2023

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Acknowledgments

This publication was prepared by the Oregon Health Authority’s Transformation Center.

For questions about this report, please contact:

Oregon Health Authority
Delivery System Innovation Office, Transformation Center
Chris DeMars, Director, Delivery System Innovation Office
chris.demars@dhsosha.state.or.us



Executive Summary

The Primary Care Payment Reform Collaborative (Collaborative) is charged with developing and sharing best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Specifically, Collaborative activities should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improve reimbursement methods, including by investing in the social determinants of health; and
- Align primary care reimbursement by purchasers of care.

This annual report reviews the Collaborative's work in 2022 and outlines next steps for making progress in 2023.

The disproportionate impact of the COVID-19 pandemic on people of color motivated the Collaborative to continue to focus on how primary care payment reform could positively impact health equity. The Collaborative brought this focus to the development of a primary care value-based payment (VBP) model.

The Collaborative launched the VBP Model Development Workgroup to build upon its recommendations to the VBP Compact Workgroup and develop a primary care payment model with sufficient specificity to achieve alignment across payers. The Workgroup started with the following principles to guide the payment model design.

- Support the unique needs of adult and pediatric populations to ensure equitable access to, and delivery of, care.
- Support practices to provide the full scope of care patients need to address medical and social complexity, while not disincentivizing them from serving complex patients.
- Align models and metrics across payers to ease administrative burden on practices and maximize healthcare teams' impact on health outcomes, while allowing for flexibility in implementation by diverse types of practices.
- Support interdisciplinary teams to provide team-based care.
- Support ability of practices to build and invest in partnerships with community-based organizations to increase patient access to services that address health-related social needs and social determinants of health.
- Include metrics that are evidenced-informed and parsimonious; address all populations served by Patient-Centered Primary Care Homes; have reasonable

benchmarks and improvement targets; and incorporate total cost of care and financial sustainability.

The primary care VBP model development process consists of the following ten primary design decision topics:

1. Base payment model options
2. Defining primary care practices and services for the VBP model
3. Primary care provider selection and attribution
4. Rate development methodology
5. Risk adjustment
6. Accounting for cost-sharing in capitated payments
7. Value incentives and rewards
8. Aligned quality metrics
9. Ensuring equity
10. Protecting against negative consequences

The Workgroup will continue to meet through the beginning of 2023 to complete development of the recommended primary care VBP payment model. Once finished, the Workgroup will bring the model to the Collaborative for discussion, modifications, and approval. After approving the model, the Collaborative will present it to the VBP Compact Workgroup.

Introduction

The Primary Care Payment Reform Collaborative (“Collaborative”) is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA). According to Senate Bill 934 (2017), the Collaborative advises and assists OHA in implementing a Primary Care Transformation Initiative (“Initiative”) to:

- Use value-based payment (VBP) 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

- Facilitate the integration of primary care behavioral and physical health care

The legislation directs the Collaborative to develop strategies that support the implementation of the Initiative, including the provision of technical assistance; the aggregation of data and alignment of metrics; and evaluation of the Initiative. The charge, deliverables and composition of the Collaborative is outlined in its charter (Appendix A). The Collaborative currently includes 36 members (Appendix B) representing a range of providers, payers and other primary care stakeholders. The full Collaborative – which has met regularly since 2016 – convened three times in 2022 and established a VBP Model Development Workgroup (Appendix C) which met nine times.

In 2022, for the first time, the Collaborative chartered a Steering Committee to provide leadership to the Collaborative and OHA, help guide and plan the work of the group, and assist in meeting the Collaborative’s legislatively proscribed goals. Steering Committee members are noted in the Collaborative roster in Appendix B.

This annual report reviews the Collaborative’s work in 2022 and outlines its next steps for making progress in 2023.

COVID Impact and Role of Primary Care Payment Reform on Practice Sustainability

As the end of the third year of the pandemic approaches, it is clear that Collaborative members, particularly providers, continue to feel the impacts. The pandemic exposed the vulnerability of a Fee-For-Service (FFS) payment system – which has long been the status quo payment approach – to providers. Providers and practices that were prepaid and received consistent payments via VBP models were better positioned to transform their practices to meet patient needs and benefited from payment sustainability which allowed them to manage the financial uncertainties of the pandemic.

The expansion of VBPs and evidence of cost savings associated with some VBP models prior to COVID-19, coupled with increased interest in models such as capitation during the pandemic, creates a window for accelerated transition to VBPs across the system. Based on a request from the VBP Compact Workgroup, the Collaborative has leveraged this momentum in 2022 and is nearing completion of a detailed primary care VBP model with prospective, capitated payments at the core. The model will be finished in the first half of 2023 when the Collaborative will shift focus to supporting implementation by providers and payers.

Role of Payment Reform Strategies to Increase Health Equity

The COVID-19 pandemic also brought social and racial injustice and inequity to the forefront. A key learning both in Oregon and across the country is how deeply the virus

exacerbates existing racial and economic inequities with wide-ranging health, social, and economic implications. For example, long-standing health inequities have caused higher rates of chronic health problems within communities of color compared to white communities. Because people with chronic health conditions are at increased risk for severe COVID-19 illness, people of color face a greater chance of experiencing severe COVID-19 illness¹.

In light of the pandemic's disproportionate impact – and in alignment with OHA's goal to eliminate health inequities in Oregon by 2030 – the Collaborative focused on integrating health equity within the primary care VBP model.

Alignment and Collaboration with the Value-based Payment Compact Workgroup

As part of Oregon's legislatively mandated initiative to contain growth in health care costs, the [Health Care Cost Growth Target Implementation Committee](#) identified advancing VBPs across Oregon as its first strategy to achieve its cost-growth target. The [Oregon VBP Compact](#), jointly sponsored by OHA and the Oregon Health Leadership Council, is a voluntary commitment by payers and providers to participate in and spread VBPs. The Compact has 47 signatories, covering 73 percent of the people in Oregon.

The Collaborative has a keen interest in Oregon's VBP Compact and wants to work in partnership with the VBP Compact Workgroup to promote the spread of primary care VBPs across the state. Two Collaborative members also sit on the VBP Compact Workgroup. To initiate a partnership with the VBP Compact Workgroup, the Collaborative drafted and presented a memo (see Appendix D) to the Workgroup outlining overarching recommendations for primary care VBP and recommendations specific to the continuum of VBP models, attribution, complex care, behavioral health integration and care for children and youth.

The memo includes recommendations related to the following:

- Alignment to minimize administrative burden
- VBPs to address health equity
- Inclusion of enhanced FFS and per-member-per-month (PMPM) payments
- Exclusion of high-cost health care such as certain specialist procedures and inpatient stays that are largely outside the control of primary care

¹ Ndugga, N., & Artiga, S. (2021, May 11). Disparities in Health and Health Care: 5 Key Questions and Answers. KFF. Retrieved December 28, 2022, from (2021). <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>

- Analysis of quality, access and utilization data by race, ethnicity, language and disability (REALD)
- Limited metrics that address care across the lifespan
- Improvement targets
- Risk and mitigation strategies

The VBP Compact Workgroup expressed gratitude to the Collaborative for its input and expertise, and requested the Collaborative develop a primary care payment model incorporating these recommendations. The payment model will be included in a menu of VBP models, the first strategy identified by the VBP Compact Workgroup in its [VBP Roadmap](#) to increase the use of VBP. During 2022, the Collaborative has built upon the contents of the memo and its 2018 recommended payment model to draft a primary care VBP model for adoption across payers.

Development of the Primary Care VBP model

Development of a payment model with enough specificity to achieve aligned implementation requires consideration and decisions on many design elements. The Peterson-Milbank Program for Sustainable Health Care Costs has supported technical assistance for OHA from Bailit Health, a consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and employer purchasers. Consultants from Bailit Health are facilitating the VBP Model Development Workgroup, which is comprised of both payers and providers, through the model design process.

Process and Principles

The Workgroup started the primary care VBP model development process by agreeing on the following principles to guide the payment model design.

- Support the unique needs of adult and pediatric populations to ensure equitable access to, and delivery of, care.
- Support practices to provide the full scope of care patients need to address medical and social complexity, while not disincentivizing them from serving complex patients.
- Align models and metrics across payers to ease administrative burden on practices and maximize healthcare teams' impact on health outcomes, while allowing for flexibility in implementation by diverse types of practices.
- Support interdisciplinary teams to provide team-based care.

- Support ability of practices to build and invest in partnerships with community-based organizations to increase patient access to services that address health-related social needs and social determinants of health.
- Include metrics that are evidenced-informed and parsimonious; address all populations served by Patient-Centered Primary Care Homes; have reasonable benchmarks and improvement targets; and incorporate total cost of care and financial sustainability.

With the principles established, Bailit Health has guided the Workgroup through a series of questions on specific design decisions to enable development of the VBP model. The Workgroup has made preliminary recommendations using a consensus-based approach. The Workgroup has updated the Collaborative throughout the process and will present the final draft model to the Collaborative in spring 2023.

The development process consists of the following ten primary design decision topics:

1. Base payment model options
2. Defining primary care practices and services for the VBP model
3. Primary care provider selection and attribution
4. Rate development methodology
5. Risk adjustment
6. Accounting for cost-sharing in capitated payments
7. Value incentives and rewards
8. Aligned quality metrics
9. Ensuring equity
10. Protecting against negative consequences

Preliminary Design Recommendations

The Workgroup is building on the Collaborative payment model recommendations developed in 2018 which aligned with CMS' then Comprehensive Primary Care Plus (CPC+) model. The 2018 model included the following payment model components:

- Risk-adjusted advanced infrastructure payments
- Performance-based incentive payments
- FFS payments

- Prospective capitated payments for a defined set of primary care services

The payment model will include support for integrated behavioral health services provided by any provider type. While total cost of care (TCOC) is not part of the primary care VBP model, it could be added as a complement if payers and providers choose to do so.

Below are preliminary recommendations for the payment model which are subject to change. The Workgroup will continue to meet through the beginning of 2023 to complete development of the recommended model and finalize the recommended model components. Once complete, the Workgroup will bring the model to the Collaborative for discussion, modifications, and approval. After approving the model, the Collaborative will present it to the VBP Compact Workgroup.

Defining primary care practices and prerequisites for the VBP model

The first step to implement the payment model is to define primary care practices eligible to participate. The Workgroup is recommending the following:

- The payment model should strongly recommend and incentivize Oregon PCPCH recognition, but recognition should not be a prerequisite for practice participation. Recognition can be incentivized and rewarded through supplemental payments (such as infrastructure payments).
- No other practice participation prerequisites, such as minimum practice size or performance pre-qualifications, should be required for participation in the model.
- The model should phase-in organically with the goal of all practices phasing in within three years, in a manner to be decided between individual payers and their contracted practices.

Defining primary care services to include in capitated payments for the VBP model

The Workgroup recommends that the VBP model design should focus on services provided, not on specific provider types, allowing for inclusion of services provided by a diverse array of care team members. The following are guiding principles for whether services should be included in or excluded from the capitated service payments:

- Include services that are:
 - Widely performed by primary care practices
 - Represent a preponderance of primary care spending
 - Prone to overuse when paid fee-for-service
- Exclude services that are:
 - Performed at widely varying rates among providers and/or offered inconsistently

- Subject to potential underutilization and where there is interest in incentivizing increased volume

To help inform which services to include, OHA surveyed all of the payers that signed onto the VBP Compact to better understand whether payers include specific types of primary care team members (such as traditional health workers) and service categories (pharmacist services and integrated behavioral health services) in current primary care prospective payment VBP contracts and which services/codes are included in or carved out from current primary care prospective payment contracts.

The Workgroup developed a common code list of all services that should be included in the primary care capitation payments. In addition to the principles outlined above, this discussion is informed by an analysis of which codes the health plans identified as being included in current primary care capitation contracts, and which codes/services comprise the largest amount of total primary care spending.

The Workgroup reached recommended including codes² in the primary care capitation payments that account for the following percentage of total primary care spending:

² Primary care codes recommended for inclusion in the primary care capitation payment:

- Office or outpatient visit for an established patient (99211-99215)
- Office or outpatient visit for a new patient (99202-99205)
- Telephone calls for patient management (99441-99443)
- Prolonged physician services (99354, 99355, 99358- 99360)
- Preventive medicine counseling or risk reduction intervention (99401-99404)
- Preventive medicine counseling initial evaluation (99381-99387)
- Preventive medicine periodic re-evaluation (99391-99429)
- Administration of immunizations (90460, 90461, 90471-90474)
- Transitional care management services (99495, 99496)
- Medical Team Conference (99366-99368)
- Therapeutic, prophylactic or diagnostic injection (96372)
- Group preventive medicine counseling or risk reduction intervention (99411, 99412)
- Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes, 11-20 minutes, 21 or more minutes (99421, 99422, 99423)
- Non-face-to-face online medical evaluation (99444)
- Non-physician telephone services (98966, 98967)
- Online assessment, management services by non-physician (98969)
- Annual wellness visit, personalized prevention plan of service (G0438, G0439)
- Comprehensive geriatric assessment and treatment planning performed by assessment team (S0250)
- Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month (S0320)

Commercial		Medicaid	
% of total PC spending (age 0-18)	% of total PC spending (age 19+)	% of total PC spending (age 0-18)	% of total PC spending (age 19+)
92.62%	86.46%	92.94%	83.06%

Workgroup members acknowledged the need to avoid “moral hazards” when including these and other codes in capitated payments, such as incentives to refer out more medically complex patients. The Workgroup will discuss strategies to mitigate against such unintended consequences during its February meeting.

Attribution and PCP selection

The Workgroup revisited the attribution principles from the 2018 PCPRC report (see Attachment E), which were developed to foster alignment and transparency on methodology, and to ensure outcome metrics associated with VBPs accurately reflect a clinic’s patient population. The Workgroup had no recommended changes to the 2018 Attribution Principles for the purposes of specifying the primary care VBP model.

Prospective payment rate development methodology

To set the prospective payment rate analysis of historic per-member per-month (PMPM), the Workgroup recommends that spending should occur according to the following guidelines:

- For larger providers, payers and these providers may agree to develop practice-specific rates on a case-by-case basis or utilize a standard PMPM capitation rate based on a market-wide calculation.
- For smaller providers, payers may offer a standard PMPM capitation rate based on a market-wide or small practice-only calculation.
- Payers may also offer PMPM capitation rates specific to practices with special patient profiles, such as children with high medical complexity.
- Additional considerations:
 - The Workgroup acknowledged the challenge that certain services performed inconsistently across practices may fall under a broader billing code and including the broader billing code in the capitated payment may not guarantee adequate revenue for all services that fall under that broader code. Therefore, looking at historic PMPM spending on a *practice-specific* basis may be the preferred approach to ensure adequate revenue for all services that fall under that broader code.

- The Workgroup also acknowledged the limitations with developing payment rates based on historical spending, as such rates will reflect only the specific services that payers have traditionally covered and previous patterns of utilization.
- Rate development should account for primary care services delivered by providers outside of the capitation according to the following guidelines:
 - Payers should apply monthly re-attribution to shift the prospective payment to a new primary care site as quickly as possible.
 - Payers should monitor the percentage of primary care services delivered to attributed members outside the primary care practice and develop an improvement plan with practices with a high percentage.
- Rates should be updated annually.
- Payers should provide a general description of the rate methodology to providers using a common template to be developed by OHA.

Accounting for cost-sharing in rate development

The Workgroup has not yet reached consensus on accounting for cost-sharing in rate development. Workgroup staff are in the process of following up with commercial payers to understand their methodology for adjusting capitated payments to account for patient cost-sharing, including whether current capitation payments are based on the full allowed amount without deducting cost-sharing, which would be deducted retrospectively after claims are received, or whether the capitation is based on the paid amount.

Risk adjustment

The Workgroup decided that, at a minimum, payers should risk adjust based on age and sex. Members will explore how medical complexity and social risk complexity could be used to adjust risk. On October 19, the Workgroup convened a meeting on social risk adjustment (SRA) to achieve a shared understanding of SRA and consider next steps for moving forward with SRA in the model. OHA staff are reviewing data sources and available research to date and developing a proposal for discussion at a future Workgroup meeting.

Value incentives and rewards

The Workgroup came to consensus on several model components related to incentives and rewards. The group recommends that practices be rewarded for both high performance relative to external benchmarks and for improvement over time.

- External benchmarks can be national benchmarks, statewide CCO benchmarks (for Medicaid), or statewide insurer-specific network benchmarks.
- Improvement rewards should be equivalent to high performance rewards to provide a strong incentive for practices with lower performance scores to improve.

- Improvement targets should represent meaningful improvement and be reasonably attainable.
- Practices identified by payers as serving patient populations with unusually high medical and/or social risk may be held accountable only for improvement if the payer and practice agree that external benchmarks are not applicable.
- Measures for which there have been substantial specification changes should be temporarily removed from the incentive methodology until new practice-specific and external benchmark data are available.

The Workgroup also recommends that total eligible incentive payments should equal at least 10% of the value of annual projected practice service payments (capitated + fee-for-service) for the practice's attributed patients.

- This does not mean the practice will earn the full 10%, but that it would do so if it meets all incentive metrics.
- Payers for which eligible incentive payments equal less than 10% may transition to 10% over three years.
- Incentive payments should be made as proximate to the practice's actions to achieve rewards as possible.
 - One recommended technique is to make reward payments tied to delivery of specific services, such as a bonus payment for each claim related to a prescribed screening.
 - Payers should make certain reward payments during the performance period if feasible, rather than at the end of the performance period, to ensure sufficient and sustainable resources for performance improvement investments.
 - Different methods can be used for different metrics. For example, some metrics might still be assessed for the calendar year after the year is complete if that is the most appropriate method.

Incentives should be tied to a common set of performance measures used by commercial and Medicaid payers, with flexibility for limited use of common Medicaid-specific measures by CCOs.

Aligned quality metrics

- The Workgroup recommends a separate workgroup of the PCPRC establish an aligned primary care measure set for the VBP model, derived from the Health Plan Quality Metrics Committee's (HPQMC's)³ primary care measures (including equity). There should be a balance of child, adolescent and adult-focused measures.
- The total size of the primary care aligned measure set should be limited. Consensus has *not* yet been reached on the following:

³ Workgroup will coordinate with OHA and the upcoming changes to the HPQMC.

- Whether the set of measures should be inclusive of all core and menu measures.
- Whether the set of measures should be inclusive of child, adolescent, and adult-focused measures, or whether there should be separate measure sets for pediatric-focused measures and adult-focused measures, each with a maximum of measures.
- The VBP model should specify that payer contracts should not include any quality incentive measures beyond those in the aligned primary care measure set.
- The measure set workgroup of the PCPRC should meet annually to make updates due to changes in measure steward specifications, national measure endorsement, and/or changes to the composition of the HPQMC's primary care measures.
- Every third year, the workgroup of the PCPRC should consider changes that reflect changing opportunities for improvement and priorities.

The following design decision topics will be discussed at future Workgroup meetings

- Infrastructure payments to support important aspects of primary care, including, but not limited to, behavioral health integration, social risk, medical complexity and incorporation of traditional health workers.
- Opportunities for OHA and payers to support clinics in implementing the VBP model with data, technical assistance and by removing administrative barriers.

Equity in the Primary Care VBP Model

At the August meeting, Collaborative members discussed potential strategies to promote health equity and protect against negative consequences of VBP. Possible negative consequences include referring out medically complex patients to specialists when the practice could manage their care, withholding care, discouraging a panel of high morbidity patients, and/or accepting patient panels of excess size. The Workgroup will build on this discussion at the February 2023 meeting.

Ideas to promote health equity via the primary care VBP model include:

- Equity-focused quality measures in any aligned measures set(s).
- Financial incentives for practices to stratify quality measure performance by race, ethnicity, preferred language, and disability (REALD) to identify any potential disparities and develop targeted interventions.
- Support for services such as health-related social needs (HRSN) screening and/or traditional health worker (THW) services in the prospective payment or via FFS or supplemental payments.
- Infrastructure payments to support collaboration and data sharing between primary care practices and social services organizations to address identified HRSNs.

- Exploration of risk adjustment methodologies that account for social risk factors.

Ideas to protect against negative consequences include:

- Payers monitoring practice behavior to identify cases where access is decreasing or there are other signs of stinting on care, such as through using patient experience survey questions regarding access or tracking trends in visit volume.
- Payers monitoring practices data stratified quality measure performance by race, ethnicity, preferred language, and disability (REALD) to identify any potential disparities and develop targeted interventions.
- Payers creating incentives and/or disincentives for practices to minimize inappropriate use of specialists and emergency departments, such as including quality measures that measure access and other patient-reported measures of satisfaction, and/or that evaluate patterns of specialist referrals and identify excessive use.
- Additional payments made to practices that treat patients with higher medical complexity.
- Exclusion from prospective payment and enhanced payment for care delivered outside of normal care delivery hours to incentivize expanded access.

Collaborative Role in 2023

In 2023 the Collaborative will focus on completing development of the primary care VBP model and working with the VBP Compact Workgroup to engage payers and providers to promote its implementation. The VBP Toolkit, under development by the VBP Compact Workgroup, is a valuable resource for dissemination of the model. The Toolkit will help clinicians, provider entities, and their payer partners prepare for new VBP arrangements, implement these arrangements, and overcome challenges to operating successfully within increasingly advanced VBP models. The Toolkit also will include information that supports implementation of the primary care VBP model.

The Collaborative looks forward to its ongoing partnership with the VBP Compact Workgroup to continue to align payment and increase investment in primary care in 2023.

Appendix A: Primary Care Payment Reform Collaborative 2021 Charter

I. Authority

Oregon is required by statute (Chapter 575 Oregon Laws) to convene a Primary Care Payment Reform Collaborative to advise and assist in the implementation of a Primary Care Transformation Initiative. The purpose of the Initiative is to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Senate Bill 934 (2017) states that the Initiative should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improve reimbursement methods, including by investing in the social determinants of health; and
- Align primary care reimbursement by purchasers of care.

To achieve the implementation of this Initiative, the Collaborative will support:

- Use of value-based payment methods;
- Incorporation of health equity into primary care payment reform;
- Provision of technical assistance to clinics and payers in implementing the initiative;
- Aggregation of data across payers and providers;
- Alignment of metrics, in concert with work of the Health Plan Quality Metrics Committee established in ORS 413.017; and
- Facilitation of the integration of primary care behavioral and physical health care.

II. Deliverables

Senate Bill 934 (2017) requires the Collaborative to report annually to the Oregon Health Policy Board (OHBP) and the Oregon Legislature on the implementation of the Primary Care Transformation Initiative and progress toward meeting primary care spending targets. The third progress report was delivered by April 1, 2020. The goals of the Initiative will be met by 2027.

The Collaborative has combined the Implementation and Technical Assistance work groups, convened in 2019, into one work group to move the Initiative forward in 2021. This group will meet regularly in between Collaborative meetings to identify:

1. Strategies to support implementation of payment models in the Initiative including attribution, data aggregation and reporting; and

2. Technical assistance (TA) resources to support implementation of the Initiative payment models, including leveraging existing TA resources.

The Collaborative is focused on primary care transformation and reimbursement. Specialty care and inpatient hospital services are not within the scope, except to the extent to which that these topics impact the goals of the Initiative.

The Collaborative is committed to coordinating and aligning with related initiatives including, but not limited to, Comprehensive Primary Care Plus (CPC+), Health Plan Quality Metrics Committee, the Patient-Centered Primary Care Home Program and the Sustainable Health Care Cost Growth Target Program.

III. Dependencies

To the extent directed and supported by OHA, the Committee will coordinate its recommendations to align with national and state health policy initiatives in formal reports submitted to:

- OHA Leadership
- Oregon Health Policy Board
- Oregon Legislature

The ability of the Committee to fulfill its statutory duties as outlined in sections I and III is contingent upon support of and direction by OHA, as well as coordination with other health policy advisory bodies.

IV. Membership

In accordance with Chapter 575 Oregon Law, Collaborative membership includes representatives from the following entities:

- Primary care providers
- Health care consumers
- Experts in primary care contracting and reimbursement
- Independent practice associations
- Behavioral health treatment providers
- Third party administrators
- Employers that offer self-insured health benefit plans
- The Department of Consumer and Business Services
- Carriers
- A statewide organization for mental health professionals who provide primary care
- A statewide organization representing federally qualified health centers
- A statewide organization representing hospitals and health systems

- A statewide professional association for family physicians
- A statewide professional association for physicians
- A statewide professional association for nurses
- The Centers for Medicare and Medicaid Services

Additional members may be invited to participate based on their experience and knowledge of primary care. Collaborative member terms are for a minimum of two years, with up to six meetings per year.

V. Resources

Internal staff resources include the following:

- Executive Sponsors: OHA Health Policy & Analytics Division Director; OHA Chief Medical Officer
- Staff support:
 - Health Policy and Analytics Division, Transformation Center (lead)
 - Health Systems Division
- External Relations Division

Appendix B: Primary Care Payment Reform

Collaborative Members

- Carolyn Anderson, Clinical Quality Director, Mountain View Medical Center
- Gary Ashby, Health Insurance Specialist, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
- Tanveer Bokhari, VP, Quality & Health Equity, Umpqua Health Alliance
- Bill Bouska, Director of Community Solutions and Government Affairs, Samaritan Health Plans, InterCommunity Health Network CCO
- Vanessa Casillas, Regional Director of Behavioral Health Integration and Specialty Clinics, Providence* Medical Group – Oregon
- Joy Conklin, Vice President of Practice Advocacy, Oregon Medical Association
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Lisa Emerson, Senior Health Insurance Programs Analyst, Oregon Department of Consumer and Business Services*
- Eleanor Escafi, Assistant Director of Strategy and Execution, Network Management/Provider Partnership Innovation, Regence BlueCross BlueShield of Oregon & Cambia Health Solutions**
- Scott Fields, Chief Medical Officer/Chief Informatics Officer, OCHIN
- Brian Frank, Physician, Oregon Academy of Family Physicians*
- Carlos Gomez, Manager, Provider Network Operations, Umpqua Health Alliance*
- Maribeth Guarino, High Value Care Associate, OSPIRG
- Ruben Halperin, Medical Director, Providence Health Plans
- Amy Hill, VP, Provider and Network Management, Health Net Health Plan of Oregon Inc. and Trillium Community Health Plan
- Kristan Jeannis, Quality Improvement Coordinator, Tuality Health Alliance
- Lisa Ladd, Director of Contracting & Provider Network, WVP Health Authority
- Cat Livingston, Medical Director, Health Share of Oregon
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics
- Lynnea Lindsey, Director of Behavioral Health Services, Legacy Health
- Barbara Martin, Director of Primary Care, Central City Concern
- Angela Mitchell, Vice President, VBP and Contracting, CareOregon
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Innovations Officer & Chief Medical Officer, Winding Waters Community Health Center & Wallowa Memorial Hospital**
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Deborah Rumsey, Executive Director, Children’s Health Alliance
- Ben Sachdeva, Senior Financial Analyst, Advanced Health*

- Divya Sharma, Medical Director, Central Oregon Independent Practice Association
- Christi Siedlecki, Chief Executive Officer, Grants Pass Clinic
- Martha Snow, Project Manager, Oregon Rural Practice-based Research Network
- Danielle Sobel, Policy Director, Oregon Primary Care Association
- Larry Soderberg, Chief Financial Officer, Yamhill Community Care
- Maria Tafolla, Manager, equity, Diversity and Inclusion, Health Share of Oregon
- Rebecca Tiel, Director of Public Policy, Oregon Association of Hospitals and Health Systems
- Megan Viehmann, Pharmacist, OHSU Family Medicine at Richmond
- C.J. Wilson, General Counsel, ATRIO Health Plans

Oregon Health Authority staff and consultants

- Diana Bianco, Collaborative Facilitator, Artemis Consulting
- Summer Boslaugh, Transformation Analyst, Oregon Health Authority Transformation Center
- Chris DeMars, Director, Oregon Health Authority Transformation Center and Interim Director, Delivery Systems Innovation Office
- Amy Harris, Manager, Oregon Health Authority Patient-Centered Primary Care Home Program

* New member in 2022

**Member of Collaborative and VBP Compact Workgroup

Appendix C: VBP Model Development Workgroup Members

- Hayes Bakken, Physician Improvement Specialist, Oregon Pediatric Improvement Partnership*
- Trent Began, Director, Financial Operations, Samaritan Health Plans*
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Stephanie Dreyfuss, Vice President, Provider Services, Providence Health Plans*
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Eleanor Escafi, Assistant Director of Strategy and Execution, Network Management/Provider Partnership Innovation, Regence BlueCross BlueShield of Oregon & Cambia Health Solutions
- Brian Frank, Physician, Oregon Academy of Family Physicians*
- Ruben Halperin, Medical Director, Providence Health Plans
- Lisa Ladd, Director of Contracting & Provider Network, WVP Health Authority
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics
- Lynnea Lindsey, Director of Behavioral Health Services, Legacy Health
- Peter McGarry, Chief Financial Officer, PacificSource Health Plans*
- Laura McMahon, Providence Health Services*
- Angela Mitchell, Vice President, Value-based Payment and Contracting, CareOregon
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Innovations Officer & Chief Medical Officer, Winding Waters Community Health Center & Wallowa Memorial Hospital
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Deborah Rumsey, Executive Director, Children's Health Alliance
- Divya Sharma, Medical Director, Central Oregon Independent Practice Association
- Brandie Thielman, Director, Provider Network, Health Net*
- Megan Viehmann, Pharmacist, OHSU Family Medicine at Richmond

* Not a Collaborative member

Appendix D: Memorandum to Value-based Payment Compact Workgroup

To: Oregon Value-based Payment Compact Workgroup

From: Primary Care Payment Reform Collaborative

Date: December 6, 2021

Subject: Value-based Payment and Primary Care

The Primary Care Payment Reform Collaborative (“Collaborative”) is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA). The Collaborative advises and assists OHA on increasing investment in primary care and using value-based payment (VBP) to align primary care reimbursement and improve reimbursement methods, including by investing in the social determinants of health. The Collaborative also seeks to facilitate the integration of behavioral and physical health in primary care through VBPs.

The legislation that created the Collaborative also directs it to develop strategies that support the use of VBPs in primary care, including the provision of technical assistance, the aggregation of data and alignment of metrics, and evaluation. The Collaborative includes thirty-nine members with expertise in primary care payment representing a range of providers, payers and other primary care stakeholders. Two Collaborative members -- Eleanor Escafi from Cambia Health Solutions and Dr. Elizabeth Powers from Winding Waters Community Health Center -- also sit on the VBP Compact Workgroup.

The Collaborative has a keen interest in Oregon’s VBP Compact and wants to work in partnership with the VBP Compact Workgroup to promote the spread of VBPs across the state. The purpose of this memo is to share recommendations for your consideration regarding primary care and VBPs.

Before presenting the recommendations, it is important to acknowledge the continued impact of the coronavirus on the healthcare system—including primary care. Early in the pandemic, primary care practices experienced an abrupt decrease in patient visits, which led many to struggle financially to keep the doors open. VBP arrangements, particularly population-based payments, allowed some practices the flexibility to meet the changing demands of the pandemic while minimizing the stress of a decreasing cashflow. Even as patient volume has stabilized, the workforce is still impacted by trauma, stress and burnout.

Overarching recommendations

The 2018 Collaborative recommendations called for an aligned VBP structure to support primary care practices to improve quality and reduce health care costs. The Collaborative is pleased with the creation of the VBP Compact Workgroup and strongly urges the following be adopted by the Workgroup:

1. Create alignment of VBP models and metrics across lines of business to eliminate fragmentation, duplication and administrative burden and costs.
2. Design VBPs to address health equity by setting care delivery expectations for provision of person-centered, culturally appropriate care (e.g., community health workers [CHWs] and translation services); and pay incentives to reduce health disparities in quality of care, outcomes, and patient experience.
3. Implement, at a minimum, a blended model of enhanced fee-for-service and per-member-per-month (PMPM) payments to support Patient-Centered Primary Care Homes (PCPCHs) and providers delivering high-quality care.
4. Exclude expensive health care costs for children and adults such as certain specialist procedures and inpatient stays that are largely outside the control of primary care.
5. Collect and analyze quality, access and utilization data by race, ethnicity, language and disability (REALD) to understand health disparities and develop outreach and other mitigation strategies to improve health equity.
6. Incorporate a limited number of metrics from the Health Plan Quality Metrics Committee Aligned Measure Menu Set⁴ that measure both short- and long-term outcomes, such as primary care engagement of patients who have not previously established with a PCP, and address care across the lifespan.
7. Set improvement targets for metrics when there is a significant gap in performance from established benchmarks. For example, a clinic with a tobacco use rate of 65% could reasonably reduce the rate to 62% while achieving a benchmark of 25% would be very difficult.
8. If using a total cost of care VBP model, outline risks and mitigation strategies in contract such as stop-loss insurance, exclusion of high-cost patients, available networks, and associated rates and pharmacy costs.
9. Recommend primary care practices participating in VBP models be an OHA recognized PCPCH.

Below are additional recommendations specific to the following topics: the continuum of VBP models, attribution, complex care, behavioral health integration and care for children and youth.

⁴Health Plan Quality Metrics Committee Aligned Measure Menu Set Reflecting HPQMC decisions through May 25, 2021 <https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/Aligned-Measures-Menu.pdf>

Considerations	Recommendations
<p>Continuum of VBP models</p> <p>There is a continuum of VBP models and many primary care practices are not equipped to take on full financial risk for patients.</p>	<ul style="list-style-type: none"> • Implement aligned shared savings models that are more attractive for clinics to participate in and could provide a steppingstone toward more advanced VBP arrangements. • When developing shared risk agreements, ensure they will not negatively impact clinics that are working with the highest risk clients by including representatives from some of these clinics in the development of the agreements. • Implement appropriate risk adjustment for addressing high-cost patients. Leverage the experience of Massachusetts. Risk-adjust for youth separately from adults to adequately address the complexities of children’s health conditions and risk factors.
<p>Attribution</p> <p>Better attribution alignment and transparency will improve practice understanding of and success in VBP models.</p>	<ul style="list-style-type: none"> • Payers, providers and patients need to work collaboratively to ensure accuracy and agreement about patient attribution. • Clearly communicate at the beginning of the VBP performance period—in advance of care delivery—which providers can take on accountability for patients, prioritizing primary care providers. Regularly communicate member assignment to primary care providers with opportunities for providers to make corrections. • Allow and facilitate member selection of a primary care provider within the applicable network at time of enrollment across lines of business. If patient input cannot be obtained, attribute patients to providers based on claims evaluation and management visits for a minimum of 24 months, prioritizing primary care and preventive care visits.
<p>Complex care</p> <p>Providers who deliver care to patients with complex health and social needs require support to maintain services.</p>	<ul style="list-style-type: none"> • Implement appropriate risk adjustment for addressing high-cost patients. Risk-adjust for youth separately from adults to adequately address the complexities of children’s health conditions and risk factors. Work towards development and adoption of a risk adjustment model that incorporates the impact of social determinants of health and health related social needs on outcomes for any VBP model. Leverage the experience of Massachusetts.

Considerations	Recommendations
	<ul style="list-style-type: none"> Implement an enhanced PMPM based on comprehensive risk stratification for health and social needs that fully captures the cost of providing complex care.
<p>Behavioral health integration VBP's can sustainably support integrated team-based behavioral health care in primary care.</p>	<ul style="list-style-type: none"> Pay primary care providers and behavioral health clinicians working in a clinic with integrated health care for an agreed-upon set of FFS codes with no pre-authorization requirements. Include population-based payments, based on meeting standards of integration or quality benchmarks, that sustainably support key elements of behavioral health integration in primary care that are not typically paid for under FFS mechanisms, such as same-day brief consultations; preventive behavioral health; warm hand-offs between the primary care provider and the behavioral health clinician; behavioral health clinician participation in pre-visit planning and team huddles; consultations between primary care and behavioral health clinicians; and care coordination and communication, especially outside the primary care clinic, including with specialists, schools, teachers, community services, etc. Payment models include risk adjusted PMPM based on meeting standards of integration or benchmarks. For VBPs use both child and adult measures such as behavioral health screening and intervention, population reach, access to care, patient experience or other outcomes and physical health measures that are impacted by behavioral health integration such as HbA1c, blood pressure, and nicotine use, asthma medication adherence and ADHD medication adherence. Contract with integrated clinics for all services delivered at the clinic in a single contract that does not require prior authorization for behavioral health services and double co-payments for patients who see a primary care provider and behavioral health clinician on the same day. Remove policies that reject two payments for services provided on the same day by a primary care provider and behavioral health clinician.

Considerations	Recommendations
<p>Children and youth VBPs are appropriate for health care for children and youth if they take into account the unique aspects of pediatric care.</p>	<ul style="list-style-type: none"> • Risk-adjust for youth separately from adults to adequately address the complexities of children’s health conditions and risk factors. • Structure VBP models to incentivize increased screening, preventive care and effective management of chronic health conditions, recognizing that investment in children’s health and well-being may support lifelong wellness and result in a long-term return on investment for society. • Recognize that there are limited opportunities for short-term, direct health care cost savings among pediatric populations compared to adult populations. VBP models that incentivize short-term cost savings may not optimally serve most pediatric patients.

Next steps

Thank you for the opportunity to share these recommendations for consideration. The Collaborative requests a response describing how the recommendations will be integrated into the Workgroup activities. The Collaborative looks forward to further engagement with the Workgroup and is available to speak to the Workgroup on specific topics and answer questions.

The following members of the Collaborative endorsed these recommendations

- | | |
|---|--|
| Advanced Health | Oregon Rural Practice-based Research Network |
| Atrio Health Plans | OSPIRG |
| CareOregon | PacificSource Health Plans |
| Central City Concern | Providence Health Plans |
| Central Oregon Independent Practice Association | Providence Medical Group – Oregon |
| Children's Health Alliance | Public Employees' Benefit Board |
| Columbia Pacific CCO | Regence & Cambia Health Solutions |
| Creach Consulting, LLC | Samaritan Health Plans |
| Grants Pass Clinic, LLP | Trillium Community Health Plan |
| Hagan Hamilton Insurance Solutions | Tuality Health Alliance |
| Health Net Health Plan of Oregon, Inc. | Umpqua Health Alliance |
| Health Share of Oregon | Willamette Family, Inc. |
| InterCommunity Health Network CCO | Winding Waters Clinic |
| Legacy Health | WVP Health Authority |
| Metropolitan Pediatrics | Yamhill Community Care Organization |

Mountain View Medical Center
OCHIN
OHSU Family Medicine at Richmond
Oregon Academy of Family Physicians
Oregon Association of Hospitals & Health Systems
Oregon Department of Consumer and Business
Services
Oregon Educator's Benefit Board
Oregon Medical Association
Oregon Pediatric Improvement Partnership
Oregon Primary Care Association

Appendix E: Matching Patients and Providers: Definitions and Framework

Prepared by the CPC+ Payer Group and the Primary Care Payment Reform Collaborative

The processes used to identify a patient-provider health care relationship are fundamental to population health and value-based payment (VBP) models. Patient attribution both designates the population for whom a provider will accept accountability under the model and forms the basis for performance measurement, reporting and payment.⁵

Lack of clarity and variation of attribution methodologies is a challenge for practices and payers. Benefits of more transparency and alignment include improved cost and quality benchmarking, increased understanding across the health system, building trust between practices and payers, enhancing the ability of practices to focus their efforts and better engage patients, and maximizing the benefits of data aggregation.

The CPC+ Payer Group and the Primary Care Payment Reform Collaborative have prepared this document to clarify definitions and provide a framework outlining the components and principles that drive processes that “match” patients and providers. The definitions and framework will be used by members of the CPC+ Payer Group and the Collaborative to communicate the methods used in primary care VBP models. Described below are four distinct methods commonly used to identify a patient-provider relationship: member selection, health plan assignment, enrollment, and use of claims or encounter data.

Purposes of shared definitions and framework:

- To agree to shared definitions of terms, enabling consistent use and intention
- To provide a framework for describing attribution methodologies to stakeholders, particularly providers
- To provide educational materials about attribution for practices
- To reduce complexity and confusion for payers and practices
- To build trust and transparency around attribution methodologies
- To facilitate the reliable identification of a provider-patient relationship

Attribution principles

Payers, purchasers, providers and patients will adopt the following principles for patient attribution to ensure more effective VBP-based investment in primary care. The intent of these principles is to foster alignment and transparency on methodology, and to ensure outcome metrics associated with VBPs accurately reflect a clinic’s patient population.

⁵ Health Care Payment Learning & Action Network. Accelerating and Aligning Population-Based Payment: Patient Attribution. June 30, 2016.

1. Payers will adopt policies such as lower patient cost sharing, transformation in benefit design, and educational efforts to encourage patient choice of a primary care provider.
2. Payers, providers and patients will work together to develop and implement strategies to ensure that patients who want to identify their primary care providers can, and this patient choice will be prioritized for attribution, regardless of business line of coverage for those patients.
3. Payers, providers and patients should work collaboratively to ensure accuracy and agreement about patient attribution. Payers will ensure providers have clear and actionable information about patients assigned to them and providers will ensure the accuracy of the claims data they submit that support the attribution process. This information should be shared by payers at least quarterly.
4. Payers will use the same approach for attribution for performance measurement and financial accountability.
5. Payers will prioritize primary care providers and preventive care visits when analyzing claims or encounter data for attribution, and may consider other factors such as geographic location, family selection of primary care provider, and past claims.
6. Payers will use other claims-based evaluation and management visits if patient input cannot be obtained, and preventive care visits cannot be used and link those visits with primary care provider types. At least 24 months of claims-based data should be used, if available.
7. Payers will define which providers would be eligible to take on accountability for patients at the beginning of the performance period and share this information with providers in advance. Identify clearly who can serve as primary care providers (for example, could recommend all providers in recognized PCPCHs).
8. To support payer alignment and ensure accurate attribution — which allows for proper VBPs being made to a provider or clinic — providers agree to work in good faith with payers to ensure billing practices allow for submission of complete claims data to payers.⁶
9. The Collaborative will consider alignment across payers at level of attribution (clinic vs. individual provider).

Shared Definitions

Member selection

⁶Billing practices should consistently utilize the CMS claim form fields and definitions to ensure accurate attribution of members at the participating clinic level. For example, CMS 1500 box 32 should properly reflect the Service Facility Location information to include name, address and National Provider Identifier of the site the services were delivered.

According to the Health Care Payment Learning & Action Network, patient choice is the ideal way to connect a patient and a provider.⁷ Member selection is a prospective process in which a payer solicits from a health plan member the selection of a primary care provider or clinic. Often this is part of the health plan enrollment process. In CMS payment models like CPC+ and Primary Care First, this process of using the patient identification of the PCP/clinic is called “voluntary alignment.” In some health plan products, the selected PCP is tied to the plan benefit structure.

Assignment

Assignment is a prospective process in which a payer matches a health plan member with a primary care provider based on specific criteria such as zip code, availability, age or other considerations. Some payers encourage member selection of a PCP prior to using the assignment process and members have the option to change their assigned PCP. Outreach to patients may be conducted as part of the health plan enrollment process, particularly if an assigned PCP is tied to the health plan benefit structure. Some payers share rosters with providers that combine member selections and health plan assignments since both are prospective and do not rely on claims history of prior visits. Primary care clinics are often encouraged by payers to contact patients on the roster to establish a relationship so patients may choose a provider or team (empanelment).

Enrollment

The enrollment method is similar to member selection and is sometimes used to prospectively recruit members to a specific program that has selection criteria, for example, the Primary Care First Seriously Ill Population (SIP) released by CMS in 2019. According to CMS, patients lacking a primary care practitioner will have an opportunity to enroll in care with a Primary Care First practice that opts in to participate in the SIP payment model. To identify the SIP-eligible population, CMS will run claims attribution and identify “un-attributable” Medicare beneficiaries to use as a roster for potential enrollment. In enrollment models, members sometimes enroll in the program in the primary care office (for example, Chronic Care Management) or with the payer/health plan (for example, SIP). Enrollment is important in cases where the services will result in member cost share because it enables the member to make an active choice.

Attribution by analyzing claims- or encounter-based data

This attribution method is a retrospective process in which a health plan uses a member’s prior claims experience or encounter data to infer a patient-provider health care relationship. Each payer’s attribution algorithms have a defined look-back period, a claims code set, criteria for eligible providers, and rules regarding most recent visits and plurality of visits in cases where a patient saw multiple PCPs during the lookback period. The strategy and frequency of running

⁷ Id. p. 8. “The ideal method for patient attribution is active, intentional identification or self-reporting by patients.”

attribution may vary by payer. Although all attribution methods are inherently retrospective (relying on prior visits to infer a patient-provider relationship) the application of attributed populations can be used either retrospectively or prospectively:

- An example of a retrospective application could be a pay-for-performance program: attribution reports completed at the end of the performance period determine the patient population of the pay-for-performance program.
- An example of a prospective application could be care management fees paid prospectively: attribution reports completed at the beginning of a payment period would prospectively determine the population of patients for a care management fee. Another example is a total cost of care, risk-based payment made prospectively to a large clinic system, using claims-based attribution reports completed at the beginning of a payment period to determine the population of patients and estimated costs.