VALUE-BASED PAYMENT TECHNICAL GUIDE

FOR COORDINATED CARE ORGANIZATIONS

UPDATED NOVEMBER 2020

Oregon Health Authority

Acknowledgments

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Value-Based Payment Roadmap for Coordinated Care Organizations
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Introduction and Overview of the CCO VBP Roadmap

Oregon has a long history of health system transformation, including substantial efforts to move away from traditional volume-based health care payments to payments based on value that support positive member health outcomes and cost savings. In the second iteration of coordinated care organization (CCO) contracts, or "CCO 2.0," beginning January 2020 and continuing through 2024, the Oregon Health Authority's (OHA's) value-based payment (VBP) policies require the increased use of payment methodologies that emphasize quality rather than quantity of services provided. To provide the vision for, and parameters of, the VBP expectations under CCO 2.0, OHA developed a *VBP Roadmap for CCOs*.

The Health Care Payment Learning and Action Network (LAN), a national effort supported by the Centers for Medicare and Medicaid Services (CMS) to accelerate VBP across markets, developed a framework for categorizing VBPs that has become the nationally accepted method to measure progress on VBP adoption. As noted in the *VBP Roadmap for CCOs*, OHA will use the LAN Alternative Payment Model Framework (2017) to categorize and track CCOs' use of VBPs across Oregon (see Figure 1).

All VBP models should support transformation of care delivery and the sustainability of care innovations across the care continuum. VBP requirements for CCOs beginning in 2020, include the following.

Patient-Centered Primary Care Home VBP

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 PMPM amounts such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPM amounts 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.

Please note: Unless combined with a LAN Category 2C or higher, the PCPCH-related requirements do not count toward the annual CCO VBP minimum threshold or CCO annual target, described below, which requires a LAN Category 2C (Pay-for-Performance) or higher.

Annual CCO VBP targets

CCOs are required to annually increase the proportion of payments that are in the form of a VBP and fall within LAN Category 2C (Pay-for-Performance) or higher, throughout the duration of the CCO 2.0 period, according to the following schedule:

- 2020: no less than **20%** of the CCO's payments to providers;
- 2021: no less than **35%** of the CCO's payments to providers;
- 2022: no less than **50%** of the CCO's payments to providers;
- 2023: no less than **60%** of the CCO's payments to providers; and
- 2024: no less than **70%** of the CCO's payments to providers.

Please note: If quality requirements within an existing VBP contract were relaxed or removed due to COVID-19 and this change resulted in paying providers for reporting under LAN Category 2B instead of LAN Category 2C or higher, the amounts paid under LAN Category 2B will count toward the VBP target for 2020, per notification in the April 3 Coordinated Care Organizations COVID-19 Weekly Update, and detailed below.

Each CCO's VBP percentage will be calculated by summing the following:

1. Payments to providers that include Category 2C (pay-for-performance) or higher, and
2. Payments to providers for pay-for-reporting (LAN Category 2B) due to COVID-19 impacts on the delivery system. Pay-for-reporting flexibility will only apply to 2020 VBP requirements and, at this time, 2021 VBP requirements will not be altered.

The total of the payments noted above will be divided by total medical expenses for the year, as reported in the Exhibit L Financial Reporting Template. The resulting product will be the CCO's percentage of 2020 VBP spending. When submitting the APAC Payment Arrangement File (PAF), CCOs should report LAN Categories 3A, 3B, 4A, 4B, and 4C even if the link to quality is LAN Category 2B or pay-for-reporting.

If, for example, a CCO had planned to implement a LAN 4A VBP with a link to quality, but because of the public health emergency converted the arrangement to a prospectively paid capitated arrangement without any quality metrics but with a payment for reporting (LAN 2B), the CCO should report category 4A in the APAC PAF even though the link to quality is now pay-for-reporting. The APAC PAF is designed such that the CCO stratifies the arrangement in its components. In the example above the CCO should report the capitated dollar amount that was paid prospectively as "4A" and any additional payment for reporting as "2B." OHA will add the "4A" and the "2B" and count the total towards the CCO's VBP percentage.

Annual CCO risk based VBP targets

Beginning in 2023, CCOs will be required to increase the amount of VBPs, as a percent of total payments to providers, that fall within LAN Category 3B (Shared Savings and Downside Risk) or higher to no less than 20% (in 2023) and 25% (in 2024).

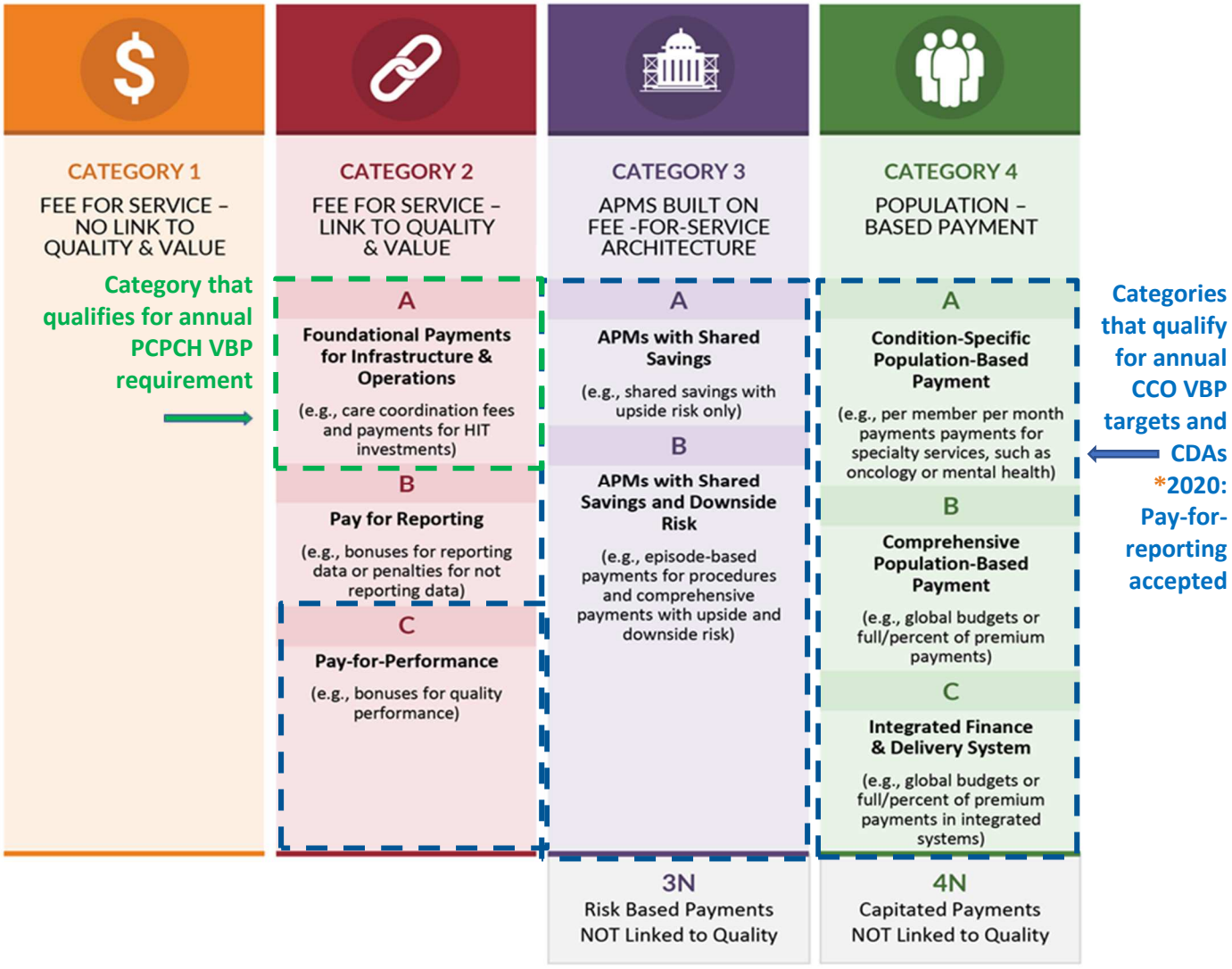
Care delivery area VBPs

CCOs are required to develop VBPs in the following care delivery areas (CDAs): hospital care, maternity care, behavioral health care, children's health care and oral health care. Required VBPs in CDAs must fall within LAN Category 2C (Pay-for-Performance) or higher throughout the duration of the CCO 2.0 period. Due to COVID-19, the requirements regarding the implementation of CDA VBP models have changed. The updated requirements as of June 2020 are as follows:

- **2022:** CCO shall implement three new, or expanded from an existing contract, CDA VBPs by 1/1/22. The three new or expanded VBPs must be in hospital care, maternity care, and behavioral health care. A VBP may encompass two CDAs concurrently (for example, a hospital maternity care VBP that meets specifications for both hospital care and maternity care CDAs could count for both).
- **2023 and 2024:** CCOs shall implement a new or expanded VBP at the beginning of each year in each of the remaining CDAs (children's health care and oral health care). VBP contracts in all five CDAs must be in place by the end of 2024.

Social determinants of health (SDOH) and the social needs of members, such as housing or food insecurity, have a significant impact on health outcomes and health inequities. OHA supports more purposeful approaches in applying VBP, as they incent providers to invest in delivery system improvements that reduce health disparities; examples include models that explicitly embed mechanisms for improving health equity, and/or encourage providers to address SDOH. Strategies could include SDOH screening tools for adults and children or using trauma-informed survey instruments that identify members' unmet social needs.

Figure 1: LAN Payment Categories



DESCRIPTION OF ELIGIBLE PAYMENT MODELS BY LAN CATEGORY

Table 1 provides definitions of each payment model by LAN category.[1] Payment arrangements with providers often combine models. For measuring performance against annual OHA-required VBP targets, a contract with a provider shall count as compliant so long as the payment arrangement includes a strategy defined in LAN Categories 2C and higher. In all cases, to count toward the VBP threshold, payment arrangements must include a specific link to quality.

Within the current health system, many provider payment arrangements remain in **Category 1** (see Figure 1), which is a traditional fee-for-service payment with no financial link to quality or value. These arrangements pay providers to deliver a service without providing any incentive to improve quality or reduce costs. Payments in this category include Diagnosis-Related Group (DRG) hospital payments, payments based on a percentage of charges, and the traditional fee-schedule method.

Payment models within **Category 2** utilize traditional fee-for-service payment but provide enhancements or reductions to the payment as a way to create incentives and disincentives for superior performance on quality, patient satisfaction, efficiency, or for having certain provider qualities or completing certain activities that could lead to improved care. The LAN Framework describes these models as an "on-ramp" to more advanced VBPs, but these models may also be coupled with more advanced VBP concepts (for example, shared savings or shared risk). While three subcategories comprise Category 2, only Category 2C will count toward OHA's VBP target requirements.

Payment models within **Category 3** are still built on the fee-for-service "chassis" as the means to administer payment but are considered more advanced than Category 2 payment models because they use potentially more powerful incentives for well-coordinated care for (a) a comprehensive set of services in a single episode of care, or (b) a patient's total cost of care. Providers participating in Category 3 payment models are eligible to share in savings they generate with the payer, but they may also be at financial risk if costs exceed a budget. Performance on quality measures influences the distribution of any earned savings and may also mitigate provider losses relative to the budget target.

Payment models in **Category 4** break free from the fee-for-service chassis and are prospectively paid models — meaning the payment to providers is made up-front, in a lump sum, either once (as with an episode) or on a periodic basis. Category 4 includes comprehensive capitation payments to a provider group as well as models that focus on all care provided for a certain

[1] The descriptions that follow regarding the LAN categories are excerpted from a Bailit Health brief for State Health Values and Strategies. See Burns M, Bailit M. Categorizing value-based payment models according to the Learning and Action Network alternative payment model framework: examples of payment models by category. State Health Values and Strategies, February 2018. Available from: www.shvs.org/wp-content/uploads/2018/02/SHVS_APM-Categorization_Brief-Final.pdf.

condition (for example, cancer) or all care provided by a certain provider type (for example, primary care or mental health). Quality metrics play a role in these payment models by leading to adjustments in future prospective payments (up or down), or in the form of incentive payments and penalties.

Payments within Categories 3 and 4 must be specifically linked to quality performance; there must be a consequence to the provider if the quality performance does not meet or exceed set expectations. Without such link to quality, payments will be considered a 3N or 4N under the LAN and will not count toward the OHA VBP annual targets.

Table 1. LAN Category Definitions

LAN Category	Definition	Eligible toward OHA VBP Target (2C and higher)
Category 2A: Foundational Payments for Infrastructure & Operations	Payment models within Category 2A provide incentives for physicians and/or other clinicians to invest in resources that are thought to improve the value of patient care, such as care managers and electronic medical records, or for other infrastructure that aids practices in becoming PCPCHs. In Category 2A, payers recognize the significant provider investment required to improve the quality of care through additional payments that continuously support the value-added work or resources. The concept of providing additional financial support to providers for infrastructure and operations has been a common concept among patient-centered medical home programs such as PCPCHs, and it is often coupled with other models within Category 2 and 3.	**No** (These payments count as the PCPCH VBP requirement only)
Category 2B: Pay for Reporting	Most VBP models require providers to report quality data to payers. In the nascent days of VBP models, and still in some cases today, payers commonly incentivized providers to report data for the first time or improve upon existing data reporting. Some payers still pay for reporting, particularly for newly developed or introduced measures, and with providers new to VBPs. In addition, some payers will *reduce* annual rate increases to providers who do not report quality measures. By focusing on reporting, some payers gain more complete data on the quality performance of contracted providers. Like Category 2A, this category is often coupled with other payment models.	**No, unless quality targets were relaxed or removed due to COVID** [2]

[2] Exclusively for 2020, if quality requirements within an existing VBP contract were relaxed or removed due to COVID-19 and resulted in paying providers for reporting under LAN Category 2B instead of LAN Category 2C or higher, the amounts paid under LAN Category 2B will count toward the VBP target for 2020

Table 1. LAN Category Definitions		
LAN Category	**Definition**	**Eligible toward OHA VBP Target (2C and higher)**
Category 2C: Pay-for-Performance/ Penalties for Performance	Historically one of the most popular VBP models, pay-for-performance incentives have been used in health care for decades. This category covers both incentives and disincentives for providers that achieve (or fail to achieve) payer-defined quality improvement or performance excellence targets. Incentives could be in the form of a bonus payment to the provider, a percentage increase in rates for the following year, or reductions in payments. Incentive payments could be made prospectively or retrospectively.	**Yes**
Category 3A: Shared Savings	In this category, providers share with the payer any savings the provider generates. The amount of potential savings varies by a number of factors across different payment models. For example, some shared-savings payment models require a certain percentage of savings to be achieved before additional savings are shared. In addition, a stronger performance on quality measures is often tied to a greater proportion of savings shared with the provider. This category also includes "incentive-at-risk" payment models, in which incentive payments are based on utilization measures that are a close proxy for total cost of care (for example, inpatient hospital and emergency department utilization). Examples of payment arrangements in Category 3A include a primary care payment model with shared savings based on the estimated total cost of care.	**Yes**
Category 3B: Shared Savings and Downside Risk	This category is different from 3A in that providers are eligible to share in savings, but they are also at risk for financial penalties based on their performance against cost budgets of the estimated total cost of care, and potentially also for performance on quality measures. The amount of exposure to financial loss a provider has varies by payment model. In some models, provider risk can modulate based on quality performance, in that high quality can reduce the amount of losses a provider must share if they exceed the budget. This concept recognizes the importance of high-quality performance. Similarly, quality not only modulates risk positively, but it can also increase risk if performance is poor. In certain models, providers must exceed the budget by a set percentage before being required to repay the payer. This allows payers and providers to be more confident that the losses generated by the providers are "real" and not a result of random variation.	**Yes**

Table 1. LAN Category Definitions		
LAN Category	**Definition**	**Eligible toward OHA VBP Target (2C and higher)**
Category 4A: Condition-Specific, Population-Based Payment	This category refers to prospectively paid VBP arrangements that cover a specific condition, or all the care delivered by a particular type of clinician. This category can include intensive medical home models that care for a specific condition like oncology (if it covers care for the entire condition, not just chemotherapy), or models that cover all the primary care or specialty care delivered. The payment must include accountability for quality measures of appropriate care to provide additional safeguards against incentives to limit necessary care. Partial capitation or episode-based payment models are examples of these.	**Yes**
Category 4B: Comprehensive Population-Based Payment	This category addresses prospective payments made to providers to cover most or all of a population's health care needs, often including pharmaceutical and behavioral health expenses. These payment arrangements, which are currently used in limited fashion with accountable care organizations, provide incentives to providers to not only manage the cost and quality of care they deliver, but also to examine their referral patterns, ensuring they are referring patients to high-quality and efficient providers. The payment must include accountability for quality measures of appropriate care to provide additional safeguards against incentives to limit necessary care.	**Yes**
Category 4C: Integrated Finance and Delivery System	Category 4C seeks to recognize the unique and complicated payment arrangements between highly integrated finance and delivery systems in which insurance plans and health care providers are part of one organization. These models align the incentives of providers and payers, instead of the traditional push-and-pull of contrasting incentives to manage costs and quality. While relatively few organizations fit this arrangement, they may become increasingly common as provider and insurer consolidation takes place. The payment must include accountability for quality measures of appropriate care to provide additional safeguards against incentives to limit necessary care.	**Yes**
Category 3N: Risk-based Payments without a Quality Component	This category includes traditional risk-based models in which quality has no role in the arrangement. These arrangements are not considered to be VBPs.	**No**

Table 1. LAN Category Definitions		
LAN Category	**Definition**	**Eligible toward OHA VBP Target (2C and higher)**
Category 4N: Capitation Payments NOT Linked to Quality	This category includes traditional capitation models in which quality has no role in adjusting the capitation level or being included as an incentive. Those models are not considered to be VBPs.	**No**

Meaningful Level of Downside Risk

To count as LAN Category 3B and higher for OHA reporting, the payment arrangement must include a meaningful level of downside risk to ensure that arrangements put real dollars at risk for a provider. Consistent with the Centers for Medicare and Medicaid Services (CMS) definition of meaningful risk for advanced VBPs under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), OHA requires each of the following three risk-sharing model attributes to be included in payment arrangements for providers:

1. **Risk exposure cap**[3]: at least 3% of expected expenditures (for example, total cost of care for an attributed population) or 8% of payer revenues
2. **Risk sharing rate**[4]: at least 30% of all losses (not just those above the minimum loss rate)
3. **Minimum loss rate**[5]: no more than 4%

Providers may, of course, assume more risk than prescribed by these parameters, and many total cost of care risk-sharing agreements do involve more risk than prescribed by these minimum requirements.

For example, a CCO enters into an arrangement with a hospital system for a $10 million capitated budget with a 2% minimum loss rate, a risk exposure cap of 5%, and a 40% risk share

[3] The applicable parameter depends on how risk is applied in the provider/payer contract. The revenue-based nominal amount standard, defined by CMS in the paragraph above, is only applicable if financial risk under the payment arrangement is defined in terms of revenue. The risk exposure cap refers to the threshold that defines the maximum potential amount of risk to which a provider could be subjected.

[4] The risk sharing rate refers to how the CCO and providers would share the risk.

[5] This refers to the size of the loss that must be incurred against the budget target before the CCO and provider begin to share the loss.

rate. This meets requirements because the min loss rate is no more than 4%, the exposure cap is at least 3%, and risk sharing rate is at least 30%.

- Scenario 1: The hospital exceeds the budget by incurring $10,150,000. This is 1.5% above the budget, but because this does not exceed the minimum loss rate of 2%, no penalty is paid.
- Scenario 2: The hospital exceeds the budget by incurring $10,250,000. This exceeds the minimum loss rate of $10.2 million and therefore triggers a repayment. The hospital exceeded the budget by $250,000 and therefore must pay 40% of $250,000, or $100,000. This payment amount does not exceed the exposure cap of 5%, or $500,000.
- Scenario 3: The hospital far exceeds the budget by incurring $15 million. Obviously, the hospital has triggered a repayment but because of the 5% risk exposure cap, the most the hospital will pay the CCO is $500,000. Had it not been for the risk exposure cap they would have paid 40% of $5 million, which is $2 million. The hospital will pay $500,000 in penalties and the CCO will cover the rest.

VBP and Quality

In addition to meeting the annual targets, VBP contracts between CCOs and providers must have a clear link to quality. Specifically, for the provider to qualify for the incentive under a payment arrangement, a process must be in place for the CCO to review the provider's performance against a pre-selected set of quality or performance measures and targets. For the provider to receive payment under the arrangement, they must demonstrate they have met the quality thresholds or, at the CCO's option, demonstrate significant improvement over prior performance. CCOs are required to use measures selected from the Health Plan Quality Metrics Committee (HPQMC) Aligned Measure Menu Set, the National Quality Forum (NQF), a national measure steward, or seek approval from OHA for alternate measures, as part of their performance measure review requirements.

Table 2 provides examples of payment models and whether they would count as an eligible VBP model toward the OHA VBP target. In alignment with LAN measurement guidance, when a payment model includes components of multiple LAN categories, the total payment will be reported as part of the most advanced LAN category. If a CCO is interested in implementing a model that is not described below and wants to know whether OHA will consider it as counting toward the minimum threshold, the CCO may request OHA review and approval of the payment model prior to implementation. See page 21 for contact information.

Table 2. Examples of Payment Models

Payment Arrangement Example	LAN Categories Included	Eligible toward VBP Target (2C and higher)
A PCPCH provider receives a monthly PMPM infrastructure payment from a CCO.	2A	No, but meets **PCPCH VBP Requirement**[6]
A PCPCH provider receives a monthly PMPM infrastructure payment from a CCO and also participates in the CCO's pay-for-performance model, which provides incentive payments to the provider for meeting certain performance benchmarks.	2A 2C	Yes *and* meets **PCPCH VBP Requirement**
A provider receives payment from a CCO for reporting performance data, regardless of the quality of performance.	2B	**No, unless quality targets were impacted by COVID**[7]
A provider receives payment from a CCO for both reporting performance data for certain measures and is eligible to receive payment for actual performance if it meets benchmarks on specific quality measures.	2B 2C	**Yes**
A provider participates in a shared savings arrangement whereby the CCO will make payment to the provider if the actual spending on the provider's attributed population is less than expected spending. There is no quality requirement to receive this payment.	3N	**No**
A provider participates in a shared savings arrangement whereby the CCO will make a retrospective payment to the provider if the actual spending on the provider's attributed population is less than expected spending and the provider performs well on specific performance measures during the performance period.	3A	**Yes**

[6] While Category 2A VBP contracts do not count toward meeting OHA's VBP target, OHA continues to believe in the importance of the PCPCH model as foundational to implementation of VBP models. CCOs are required to provide per-member-per-month (PMPM) payments to their PCPCH clinics as a supplement to any other payments made to PCPCHs, including fee-for-service and VBPs. CCOs are required to also vary the PMPMs such that higher-tier PCPCHs receive higher PMPM payments than lower-tier PCPCHs. The PMPM payments must be meaningful amounts and increase each year over the five-year contract in order to financially support clinics to provide essential PCPCH functions not explicitly funded by base service payments.

[7] Exclusively for 2020, if quality requirements within an existing VBP contract were relaxed or removed due to COVID-19 and resulted in paying providers for reporting under LAN Category 2B instead of LAN Category 2C or higher, the amounts paid under LAN Category 2B will count toward the VBP target for 2020

Table 2. Examples of Payment Models

Payment Arrangement Example	LAN Categories Included	Eligible toward VBP Target (2C and higher)
A provider participates in a shared savings arrangement whereby the CCO will make a retrospective payment to the provider if the actual spending on the provider's attributed population is less than expected spending based on the provider's performance in the previous year and the provider meets or exceeds targets on specific performance measures.	3A	**Yes**
A provider participates in a shared risk arrangement whereby the CCO will make a retrospective payment to the provider if the actual spending on the provider's attributed population is less than expected spending and the provider performs well on specific performance measures; or the provider will make a payment to the CCO if actual spending is more than expected spending. The level of risk in the arrangement meets OHA's definition of meaningful risk.	3B	**Yes**
A provider participates in a shared risk arrangement whereby the CCO will make a retrospective payment to the provider if the actual spending on the provider's attributed population is less than expected spending and the provider performs well on specific performance measures; or the provider will make a payment to the CCO if actual spending is more than expected spending. The level of risk in the arrangement does not meet OHA's definition of meaningful risk.	3A[8]	**Yes**
A CCO subcontracts with a health plan or a managed specialty plan (for example, for behavioral health or oral health), and the subcontracted plan pays its entire network providers on a fee-for-service basis.	n/a	**No**
A CCO's subcontracted plan pays a network provider through a contract that includes pay-for-performance on particular quality measures.	2C	**Yes**
A primary care provider receives a capitation payment for all primary care services for its attributed members. There is no link to quality in the payment model.	4N	**No**
A primary care provider receives a capitation payment for all primary care services for its attributed members. In order to continue to participate in the model, the primary care provider must meet quality metrics.	4A	**Yes**

[8] Note that this payment model does not qualify within 3B because the risk arrangement was determined to not be at a meaningful level of risk.

Table 2. Examples of Payment Models

Payment Arrangement Example	LAN Categories Included	Eligible toward VBP Target (2C and higher)
A group of providers contracts with the CCO using an episode-based payment for knee and hip surgeries based on a retrospective review of total cost of care as compared to the estimated total cost of care. If there are savings, the providers can share in them based on their performance on quality metrics.	3A	**Yes**
A group of providers contract with the CCO using a reconciled total cost of care model through which the providers may share in savings, contingent on quality performance. The providers also are eligible to receive a payment for performance based on how they performed against specific quality metrics.	2C 3A	**Yes**
A group of providers who are members of a large health care system contract together with a CCO for a capitated payment that covers comprehensive services for its attributed population, and the contract allows for the providers to retain savings. In order to participate in the program, the providers must have met CCO quality performance standards in the previous contract period.	4C	**Yes**
A group of providers who are members of a large health care system contract separately with the CCO. Both contracts include a capitated payment for comprehensive services for attributed populations and require that quality performance standards be met. The contracts are managed separately.	4B (each contract separately)	Yes
A CCO contracts with a drug manufacturer and/or a pharmacy benefit manager to provide payment for certain types of drugs only based on member outcomes. Other drugs continue to be paid for based on prescription.	4B	Yes

Provider Definition and Considerations for OHA VBP Targets

Given the differences in arrangements among CCOs in Oregon, it is important to clarify the definition of a provider organization for the purposes of determining when a payment counts toward OHA's VBP target. VBP payments are payments made to *providers* of services. CCO payments to a subcontracting entity that contracts with a provider network to provide services to CCO members do not constitute VBP payments. The following text includes some case examples to clarify the definition of qualifying provider organizations and payment arrangements.

1. Integrated finance and delivery systems

As noted in the 2017 LAN Framework refresh, "The past several years has witnessed a considerable expansion of integrated finance and delivery systems – i.e., joint ventures between insurance companies and health systems, insurance companies that own provider groups, and provider organizations that offer insurance products." For instance, an integrated finance and delivery system may include a health plan that owns one or more provider groups (for example, a hospital and medical groups) and vice versa. Payments to an integrated finance and delivery system will constitute a Category 4C payment, as long as the payments take quality into account as previously described in this guidance document.

2. Tiered health plan arrangements

A CCO may serve as a contracting intermediary between OHA and multiple other Medicaid health plans through contracts with health plan partners (including acute care, dental and behavioral health plans). Payments to health plan partners do not constitute payments to health care providers unless the provider is an integrated finance and delivery system. However, a payment arrangement by a health plan partner to its provider partners that meets VBP requirements may be included as part of the CCO's VBP report to OHA.

3. Prescription drug payment arrangements

Because spending on prescription drugs continues to rise, OHA expects an increased focus on development of VBP strategies for pharmacy. A payment from a CCO to a pharmacy benefit manager (PBM) in and of itself will not constitute a VBP payment. However, CCOs may develop VBP contracting arrangements that include both the PBM and drug manufacturer that ties payment for a drug to its efficacy. In addition, CCOs and their PBMs may develop a payment arrangement with pharmacists that includes a VBP component, such as a PMPM for enrollee counseling with potential to share in savings when there are reductions in total cost of care and improved quality outcomes.

CARE DELIVERY AREA SPECIFICATIONS

The goal of the CCO VBP Roadmap CDA requirement is to develop new or expanded VBPs in settings that — or with providers who — historically have not had extensive take-up of VBPs. The purpose of this requirement is to encourage CCOs to develop innovative payment arrangements as pilots, with the longer-term goal of OHA identifying successful models that can be shared and spread across the state. Given the flexible approach of the VBP CDA requirement, OHA expects CCOs' pilots to achieve significant advances in the way health care is paid for, with a strong focus on value and quality, to promote an integrated approach to providing physical, oral and behavioral health services at the level of care delivery (as opposed

to solely financial integration). In addition, OHA encourages payment models that include traditional health workers[9] (THWs), who are an integral component of Oregon's health care delivery system, meeting members' and community health needs, while delivering high-quality and culturally competent care.

CDA VBPs must fall within LAN Category 2C (Pay-for-Performance) or higher and should include relevant measures from the HPQMC, NQF, a national measure steward or seek approval from OHA for alternate measures, as part of their performance measure review requirements.

Additional Resources

OHA VBP home page, including reporting forms: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

Information about the All Payer All Claims (APAC) Payment Arrangement File, including file specifications and frequently asked questions: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx

Conclusion and Next Steps

This document is intended to further clarify and streamline OHA's interpretation of the LAN Framework, including how quality must be considered, and to provide technical guidance for OHA's CCO VBP Roadmap requirements for VBP development, implementation and reporting. This document will be updated annually as experience is gained to best respond to frequent questions and gaps in collective understanding of key definitions and/or processes. Please submit comments or relevant questions to OHA.VBP@dhsoha.state.or.us.

[9] As defined in OAR 410-180-0305