

VALUE-BASED PAYMENT ROADMAP: CATEGORIZATION GUIDANCE 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. The Oregon Health Authority's (OHA's) value-based payment (VBP) policies in the second iteration of the coordinated care organizations' (CCO) contracts, "CCO 2.0," beginning January 2020 and continuing through 2024, support the increased use of payment methodologies that emphasize the quality rather than quantity of services provided.

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. OHA will use the [LAN's "Alternative Payment Model Framework White Paper Refreshed 2017"](#) framework to categorize and track CCOs' use of VBPs across Oregon. The 2017 "refresh" of the LAN Framework addresses the role of quality in VBP models with its eighth principle: "Payment models that do not take quality into account are not considered APMs¹ in the APM Framework, and do not count as progress toward payment reform."

CCOs' VBP requirements beginning 2020 include:

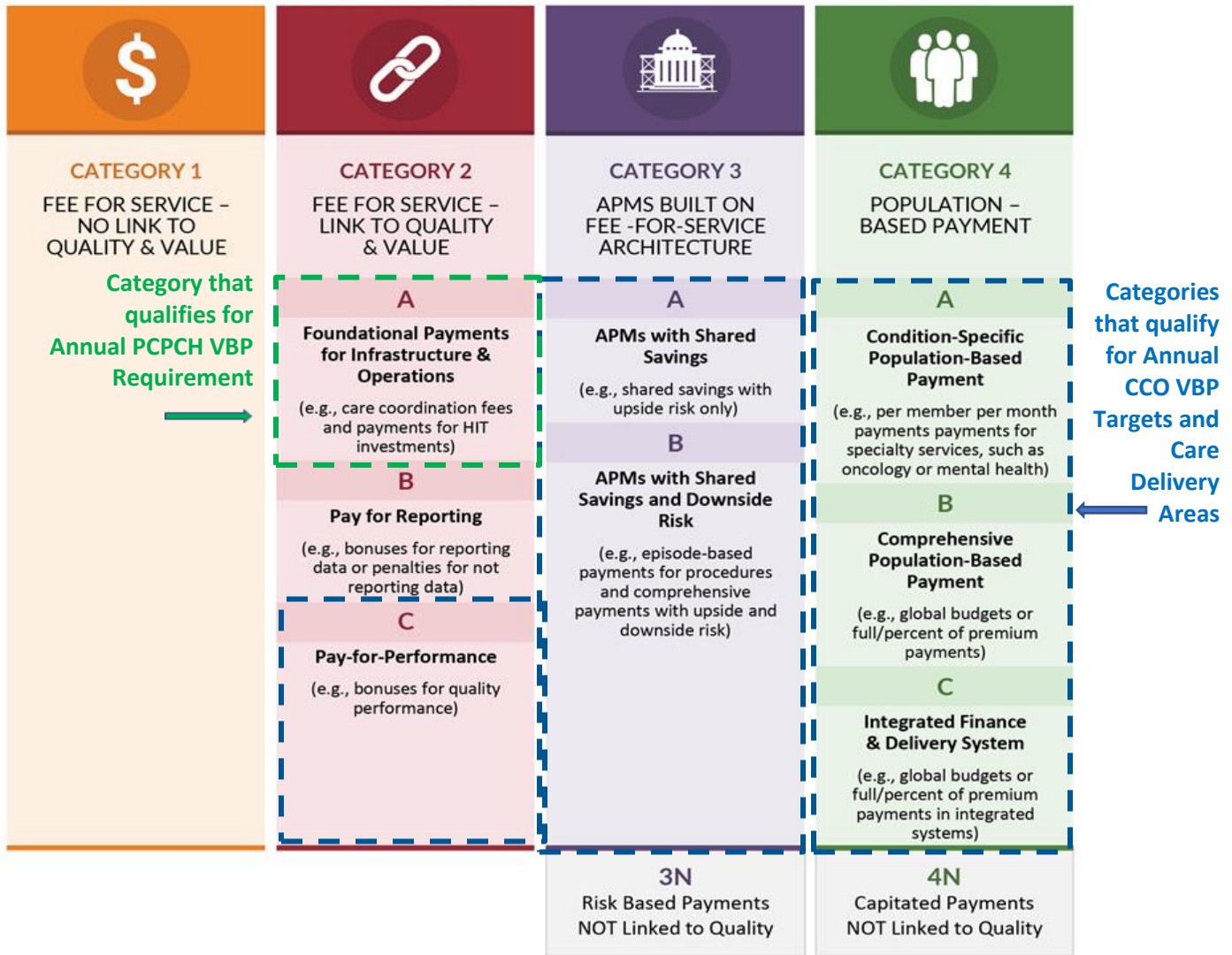
- **Patient-Centered Primary Care Home VBP:** CCOs are required to provide per-member-per-month (PMPM) payments to their Patient-Centered Primary Care Home (PCPCH) clinics. A Category 2A VBP (Foundational Payments for Infrastructure & Operations) is required as defined by the LAN Framework. CCOs are required to also vary their PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPMs must increase each year over the five-year contract and be meaningful amounts. Although OHA is not defining a specific minimum dollar amount, the payments should meaningfully support clinics' work to deliver patient-centered care.
 - Note, unless combined with a LAN category 2C or higher, this requirement does not count toward the annual CCO VBP minimum threshold or CCO annual target, described below, which require a LAN Category 2C (Pay for Performance) or higher.
- **Annual CCO VBP targets:** CCOs will be required to annually increase the level of payments that are in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher, through 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.

¹ OHA has transitioned from the term "alternative payment models" (APMs) toward value-based payment (VBP) to signify the need for payments to reflect quality of care and outcomes.

- **Care delivery area VBPs:** CCOs are required to develop VBPs in the following care delivery areas: hospital care, maternity care, children’s health care, behavioral health care, and oral health care. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher through the duration of the CCO 2.0 period, according to the following schedule:
 - **2020:** CCO shall develop two new, or expanded from an existing contract, VBPs. The term “expanded from an existing contract” includes, but is not limited to, an expansion of a CCO’s existing contract such that more providers and/or members are included in the arrangement, and/or higher-level VBP components are included. The two new or expanded VBPs must be in two of the care delivery areas listed above, and one of the areas must be either hospital care or maternity care. A CCO may design new or expanded VBPs in both hospital care and maternity care. A VBP may encompass two care delivery areas concurrently (for example, children’s mental health VBP would count for both care delivery area requirements).
 - **2021:** CCO shall implement the two new or expanded VBPs developed in 2020.
 - **2022:** CCO shall implement a new or expanded VBP in one more care delivery area.
 - By the end of 2022: new or expanded VBPs in both hospital care and maternity care must be in place.
 - **2023 and 2024:** CCO shall implement one new or expanded VBP each year in each of the remaining care delivery areas.
 - By the end of **2024:** new or expanded VBPs in all five care delivery areas must be in place.
- **Annual CCO risk-based VBP targets:** Beginning 2023, CCOs will be required to increase the amount of VBP, as a percent of total payments to providers, that fall within LAN Category 3B (Shared Savings and Downside Risk) or higher.
 - Beginning **2023**, it is expected that no less than **20%** of the CCO’s payments to providers must fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. Payments that fall within LAN Category 3B or higher will qualify for the overall VBP target of 60% because LAN Category 3B is higher than LAN Category 2C.
 - Beginning **2024**, it is expected that no less than **25%** of the CCO’s payments to providers must fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. Payments that fall within LAN Category 3B or higher will qualify for the overall VBP target of 70%, as noted above.

This document is intended to further clarify and streamline OHA’s interpretation of the LAN Framework, including how quality must be taken into account, and provide guidance for CCO VBP categorization for required reporting. This document will continue to be updated 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@dhsosha.state.or.us.

Figure 1: LAN Payment Categories



DESCRIPTION OF ELIGIBLE PAYMENT MODELS BY LAN CATEGORY

Table 1 provides definitions of each payment model by LAN category². 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 threshold, the payment arrangements must include a specific link to quality.

² The descriptions that follow regarding the LAN Categories are excerpted from a Bailit Health brief for State Health Values and Strategies on LAN Categorization. See Burns, M; and 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; accessible at: www.shvs.org/wp-content/uploads/2018/02/SHVS_APM-Categorization_Brief-Final.pdf.

Today, many provider arrangements remain in **Category 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 it should be noted that these models are sometimes 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 to be more advanced than Category 2 payment models because they utilize 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 should 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 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 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 target.

Table 1: LAN Category Definitions

LAN Category	Definition	Eligible toward OHA VBP Target (2C and higher)
<p>Category 2A (Foundational Payments for Infrastructure & Operations)</p>	<p>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 patient-centered primary care homes (PCPCHs). In Category 2A, payers recognize the significant provider investment required to improve the quality of care through additional payments that support the continuous use of 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.</p>	<p>No (These payments count as the PCPCH VBP requirement only)</p>
<p>Category 2B (Pay for Reporting)</p>	<p>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 do, particularly for newly developed or introduced measures, and with providers new to VBPs. In addition, some payers will <i>reduce</i> 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.</p>	<p>No</p>
<p>Category 2C (Rewards for Performance/Penalties for Performance)</p>	<p>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.</p>	<p>Yes</p>

<p>Category 3A (Shared Savings)</p>	<p>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, often the stronger the performance on quality measures, the greater the proportion of savings shared with the provider. This category also includes “incentive-at-risk” payment models where 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 on the total cost of care.</p>	<p>Yes</p>
<p>Category 3B (Shared Risk)</p>	<p>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 based on 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, 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. The mechanics of implementing these models is as follows. Providers agree to an estimated total cost of care target. They are initially paid on a fee-for-service basis and the shared savings or shared risk is reconciled based on actual total cost of care compared to the estimated target, as well as quality requirements.</p>	<p>Yes</p>

<p>Category 4A (Partial Capitation or Episode-Based Payment)</p>	<p>This category covers 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.</p>	<p>Yes</p>
<p>Category 4B (Comprehensive Population-Based Payment)</p>	<p>This category addresses the prospective payment arrangements currently used in limited fashion with Accountable Care Organizations. They are payments made to providers to cover most or all of a population’s health care needs, often including pharmaceutical and behavioral health expenses. These types of arrangements provide incentives to providers to not only manage the cost and quality of care they deliver, but also 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.</p>	<p>Yes</p>
<p>Category 4C (Integrated Finance and Delivery System)</p>	<p>Category 4C seeks to recognize the unique and complicated payment arrangements that exist 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.</p>	<p>Yes</p>
<p>Category 3N (Risk-based Payments without a Quality Component)</p>	<p>There are traditional risk-based models in which quality has no role in the arrangement. These arrangements are not considered to be VBPs.</p>	<p>No</p>
<p>Category 4N (Capitation Model without a Quality Component)</p>	<p>There are traditional capitation models in which quality has no role in adjusting the capitation level or being included as an incentive. Those models are included in Category 4N and are not considered to be VBPs.</p>	<p>No</p>

MEANINGFUL LEVEL OF DOWNSIDE RISK

To count as LAN Category 3B and higher for purposes of 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 CMS definition of meaningful risk for purposes of 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.

VBP AND QUALITY

In addition to meeting the annual VBP targets, CCOs' provider contracts 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 the Health Plan Quality Metrics Committee (HPQMC) menu measures set, or seek approval for use of alternates measures, as part of their performance measure review requirements.

Should OHA contract with one or more other CCOs serving members in the same geographical area, OHA may require the CCO to participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP provider contracts for common provider types and specialties. OHA will inform the CCO of the provider types and specialties for which the performance measures shall be discussed. Each CCO will incorporate all selected measures into applicable provider contracts.

Table 2 provides examples of payment models and whether they would count as an eligible VBP model toward the OHA VBP target. When a payment model includes components of multiple LAN categories, the total payment will be reported as part of the most advanced LAN category. To the extent a CCO is interested in implementing a model that is not described below and wants to understand whether OHA will consider it as counting toward the minimum threshold, the CCO may request OHA review and approve a payment model prior to implementation.

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

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.

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 PCPCH VBP Requirement⁶
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 <i>and</i> PCPCH VBP Requirement
A provider receives payment from a CCO for reporting performance data, regardless of the quality of performance.	2B	No
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
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

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.

Payment Arrangement Example	LAN Categories Included	Eligible toward VBP Target (2C and higher)
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 ⁷	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
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 for 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	4B (each contract separately)	Yes

⁷ 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.

Payment Arrangement Example	LAN Categories Included	Eligible toward VBP Target (2C and higher)
require that quality performance standards be met. The contracts are managed separately.		
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
A CCO contracts with a transportation provider to reduce unnecessary emergency department (ED) visits. The transportation vendor uses Emergency Medical Technicians (EMTs) to provide care management to a set of defined patients at high risk for use of the ED. The transportation vendor receives a PMPM payment and has ability to share in a portion of savings to the CCO based on a quality component, which is reduced ED usage by those patients.	4A	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 have 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

At least one previous CCO served 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 continue to rise, OHA expects an increased focus on development of VBP strategies focused on 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.

CALCULATING THE 20% VBP THRESHOLD FOR 2020

To calculate whether a CCO meets the 20% VBP requirement in 2020, OHA will ask the CCO to report on provider contracts that include a component of VBP in LAN category 2C or higher. The CCO will be required to provide a narrative description of the contracts it is counting toward the 20% VBP requirement, as well as complete the RFA VBP data template, which is a quantitative report of the total value of those contracts relative to all of the CCO's medical expenditures.

For this calculation, the numerator is the total value of current contracts that have a VBP component (as defined above), including both the underlying payment for services as well as the potential incentive to be earned. Payment arrangements that do not meet the VBP requirements as described above may not be included within the numerator.

The denominator is the total dollars paid for medical, behavioral, prescription drug, oral, and other health services (including provider care management-related expenses). Administrative and overhead expenses and other non-service related expenditures should not be included in the denominator.

OHA has an interest in ensuring that the linkage of quality to payment is accomplished with integrity both in terms of size of reward for performance and demonstration of excellence and meaningful improvement to receive the awards. As outlined above, OHA may ask CCOs to provide detailed information on the size of the incentive payment within the overall contract to ensure there is a meaningful level of incentive to the provider to improve overall quality performance.