CBO 2.0 Value-based Payment Policy Proposals

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. A movement toward value-based payment (VBP) is supported nationally as it is broadly accepted that the status quo fee-for-service payment model promotes a fragmented health system unable to provide patient-centered, whole person care.

Recent support toward VBP in Oregon includes: Governor Brown’s letter to the Oregon Health Policy Board requesting the amount of payments tied to performance increase over time; Oregon’s 1115 Medicaid waiver requiring OHA to develop a plan describing how the state, coordinated care organizations (CCOs) and network providers will achieve an established VBP target by June 30, 2022; and CCOs’ 2018 contracts requiring them to engage in collaborative efforts with OHA to develop a VBP Roadmap.

The CCO VBP Roadmap aims to:
- Reward providers’ delivery of patient-centered, high-quality care
- Reward health plan and system performance
- Align payment reforms with other state and federal efforts
- Ensure consideration of health disparities and members with complex needs
- Support the triple aim: better care, better health and lower health care costs

Proposed CCO 2.0 VBP policies have been informed by:
- The Evaluation of Oregon’s 2012-2017 Medicaid Waiver
- CCO VBP Workgroup, convened three times beginning in February 2018
- VBP Provider Survey that targeted diverse providers in terms of geography and care delivery
- OHA staff participation in technical assistance (TA) provided by CMS’s Innovation Accelerator Program; national experts provided tools such as an environmental scan of Medicaid VBP efforts across the country^1
- CCO 2.0 surveys and public engagement meetings

Supporting VBP success
Widespread VBP adoption in Medicaid is a new and emerging approach by states to control cost and improve quality of care for beneficiaries. VBP evidence is currently limited and mixed largely due to:
- The variability among payment models (difficult to report generalizable outcomes)
- Limited peer-reviewed research focuses on Medicare with very little rigorous analysis for VBP in Medicaid

Experience seems to suggest that several factors influence the success of a VBP model, including:
- Specific technical details of the VBP model design and its implementation
- The duration of time a provider has used the VBP arrangement
- The potential financial impact on the provider (i.e., potential for loss is a stronger motivator than opportunity for gain)

^1 Most states that have implemented VBP through their Medicaid managed care contracts have developed statewide standards or goals with a focus on incrementally increasing the percentage of payments tied to VBP each contract year. This approach mirrors the federal government’s own nationwide goal of having 30% of all Medicare fee-for-service payments attributed to APMs (categories 3 and 4) by 2016 and 50% by 2018. [https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/](https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/)
To foster successful adoption of VBP, OHA’s Transformation Center plans to develop and provide ongoing VBP TA for CCOs and providers. In VBP models such as CMS’s Comprehensive Primary Care Plus, the provision of TA appears to be a key element of success for VBP implementation.

**Key stakeholder feedback**

Proposed CCO 2.0 VBP polices and the planned implementation approach broadly align with what OHA has heard from many stakeholders. For instance, stakeholder comments support:

- Providing flexibility to develop VBP models based on local needs and resources
- Using the nationally recognized Health Care Payment Learning and Action Network (LAN) framework to further define and develop VBP categories
- Implementing a Patient-centered Primary Care Home (PCPCH) VBP model
- Continuing the current Federally Qualified Health Center VBP in Oregon
- Transparency around how VBP models will be measured

**Plans to mitigate common stakeholder concerns**

*Stakeholder concern:* Align metrics reporting, when possible, both within Medicaid and across payers.

- OHA plans to support payer alignment of provider metrics to ease administrative burden. OHA will work with national consultants and provide ongoing TA and stakeholder engagement for CCO alignment, and will work through other avenues, such as the multi-payer Primary Care Payment Reform Collaborative, to seek alignment across Medicaid and commercial payers.

*Stakeholder concern:* Value-based incentives should be meaningful enough to motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage.

- Financial incentives, by themselves, aren’t sufficient to change provider behavior and achieve person-centered care. OHA plans to use additional, complementary levers (such as promoting specific VBP model components that ensure provider flexibility) to transform the health care system.

*Stakeholder concern:* Changing the health care delivery system needs to include more than Medicaid to be successful.

- OHA plans to extend the VBP Roadmap to other payers, including the Public Employees’ Benefit Board, the Oregon Educators Benefit Board, and the multi-payer Primary Care Payment Reform Collaborative.

*Stakeholder concern:* VBPs can cause unintended, negative consequences for priority populations.²

- As part of the required VBP reporting to identify issues and best practices, OHA will conduct annual CCO interviews that will include details on how VBP models address priority populations.

² Priority populations defined here as: racial, ethnic and culturally based communities, LGBTQ people, persons with disabilities, people with limited English proficiency, and immigrants or refugees.
CBO VBP statewide targets
The statewide goal of CBO VBPs to providers will be 70% of the weighted average of all CCOs’ payments to their providers in the form of a VBP by the end of the CBO 2.0 contract, 2024. This goal—which was informed by preliminary CCO baseline VBP data, VBP targets in other states, and national VBP experts—is sufficiently high to serve as a statewide goal, but not so high as to be unachievable.

All CCOs will need to demonstrate a minimum of 20% VBP in primary care in their RFA response. Preliminary CCO VBP data indicates all CCOs currently have some form of VBP in primary care and approximately 50% of CCOs’ payments to providers are in the form of a VBP. Each CCO will be responsible for meeting an annual VBP growth target calculated with their baseline VBP data. This will ensure that all CCOs increase their use of VBPs.

VBP evidence: examples
- Maternity care: VBPs that incentivize appropriate and high-value maternity care have shown results. Arkansas pays for maternity episodes and saw a reduction in C-sections and an increase in the length of stay for the procedure, which could indicate a shift to more clinically appropriate use of C-sections. Tennessee also uses an episode-based VBP for maternity care and, in the first year, saved over $4 million while improving quality metrics.

- Primary care: Primary care is one of the more common areas for VBPs. Oregon’s CBO 2.0 policy options include a requirement for VBPs that support Oregon’s PCPCHs. Nationally, some primary care medical home models (PCMH) result in reduced emergency department utilization and increased quality and outcomes, while other PCMH models show no effect. A 2016 evaluation of Oregon’s PCPCH program shows overall savings and improved quality as a result of the PCPCH model.

In addition, an external 2015 evaluation found that OHA had successfully supported CCO-level reforms that may increase efficiency, including global budgets, a quality reporting system, and an incentive payment system for quality measures—which, combined, act as a VBP between OHA and CCOs.

Realizing the vision of a transformed health system will require significant multi-sector, system-wide collaboration and individual commitments to take action to improve how we collectively pay for services. The CBO VBP Roadmap is a key element toward ensuring partners are able to develop payment systems with the flexibility to ensure care focuses on the whole person and supports the development of healthier and better integrated communities.

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3 Note that OHA’s statewide VBP goal will be based on CCO VBPs in at least LAN category 2C, or “performance-based incentive payments,” which is similar to the CCO incentive metric program.