

# Primary Care Value-Based Payment Model

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## Introduction

This document describes the process and decisions made by the Primary Care Payment Reform Collaborative (PCPRC) Value-Based Payment (VBP) Model Development Workgroup from fall 2022 to spring 2023 in developing a multi-payer primary care VBP model. The PCPRC endorsed the model at its June 14, 2023, meeting. The recommendations are intended to facilitate discussion between payers and providers to maximize the benefits of multi-payer alignment, while recognizing that payers and providers may mutually agree on different terms than those identified – especially in the areas where case-by-case decision making is noted in this document as particularly appropriate.

The PCPRC charter is in Appendix A and roster is in Appendix B. The roster of the VBP Model Development Workgroup is in Appendix C.

## Background

High-quality primary care is the foundation of the health care system, providing continuous, person-centered care for individuals, families, and communities. A commitment to primary care has been a central and consistent component of Oregon’s health care transformation efforts in Medicaid, commercial and Medicare Advantage health plans for well over 15 years.

Greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. A study of Oregon Patient Centered Primary Care Home (PCPCH) practices between 2011 and 2019 found that total healthcare expenditures per person were reduced by 6.3% or approximately \$76 per person per quarter. Nearly \$12 in savings in other services were created, including emergency department and inpatient care, for every \$1 increase in primary care expenditures related to the PCPCH program.

There is recognition in Oregon and nationally that fee-for-service (FFS) payment, which rewards volume of services delivered, does not help advance primary care transformation. Alternatively, value-based payment (VBP) ties the amount health care providers earn for their services to the results they deliver for their patients, such as the quality, equity, and cost of care.

VBP models can reduce overall health care spending by incentivizing preventive care and reducing unnecessary use of high-cost forms of care like emergency department visits and inpatient admissions. To increase savings, utilization of primary care must increase. Therefore, the goal of this VBP model is not to reduce primary care spending, but rather to increase spending in primary care to achieve savings elsewhere in the health care system. Increased spending also supports the delivery of more services to patients with complex medical and social needs.

Intentionally designed VBP models, such as this primary care model, incentivize and support care delivery changes that improve patient outcomes and make care more equitable. Patient-centered team-based care can help mitigate the negative impact that explicit and implicit biases and structural racism have on historically marginalized communities and the providers that serve them, driving better patient outcomes, reducing disparities, and advancing health equity.

The Oregon primary care VBP model was developed through a participatory process facilitated by Bailit Health and the Oregon Health Authority from fall 2022 to spring 2023. While not all participants agreed on every discussion topic, this document summarizes the model components agreed on by the majority of the PCPRC participants.

# Alignment and collaboration with the VBP 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 63 signatories, covering 73% of the people in Oregon.

The VBP Compact Workgroup, charged with ensuring the Oregon VBP Compact is successfully implemented, identified the development of a short menu of VBP models as a strategy to increase VBP implementation. The VBP Compact Workgroup requested the PCPRC develop a primary care VBP model as the first model on the short menu of models. Further, to facilitate implementation of VBP across settings of care, including primary care, the VBP Compact Workgroup and the PCPRC developed an online [VBP toolkit](#) for clinicians, provider entities, and their payer partners. The toolkit educates users about VBP arrangements and helps them implement these arrangements and overcome specific challenges to operating successfully within increasingly advanced VBP models.

## Implementation

PCPRC members, with the assistance of OHA staff, have begun education and outreach to promote implementation of the model and use of the toolkit. Activities include coordinating with partner organizations to educate providers and payers and collaborating with other health care transformation initiatives. The PCPRC will monitor implementation across payers over time.

## Principles and process

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 (PCPCH); have reasonable benchmarks and improvement targets; incorporate total cost of care and financial sustainability.

The development process consisted of addressing the following ten primary design decision topics, which, together, form the foundational elements of any VBP model:

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

## **Primary care VBP model**

The Workgroup's all-payer primary care VBP model includes the following four components:

1. **Prospective capitated payments** for a defined set of primary care services that are widely performed by primary care practices, represent a preponderance of primary care spending, and could potentially be overutilized in the traditional model of fee-for-service
2. **Fee-for-service payments for all other covered services** such as prenatal visits, end of life and advanced care planning, home visits and after-hours care
3. **Infrastructure per-member-per-month payments** that include: 1) a base payment tied to PCPCH tier, and 2) additional payments for specific high-value services
4. **Performance-based incentive payments** based on an aligned set of quality measures

The payment model includes 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.

## **Defining primary care practices and prerequisites for the VBP model**

The first step to implementing the payment model is to define primary care practices eligible to participate. The model outlines the following framework:

The payment model strongly recommends and incentivizes Oregon PCPCH recognition, but recognition is not a prerequisite for practice participation. Recognition can be incentivized and rewarded through supplemental payments (such as infrastructure payments).

There are no other practice participation prerequisites, such as minimum practice size or performance pre-qualifications.

The model will phase-in organically with the goal of all practices participating 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 model focuses on services provided, not on specific provider types, allowing for the inclusion of services provided by a diverse array of care team members. The following guiding principles inform whether services are 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 payers that signed the VBP Compact to determine 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. Based on this survey and input from the VBP Model Development Workgroup members, the workgroup developed a common code list of all services that should be included in the primary care capitation payments (Appendix D). In addition to the principles outlined above, the code list was informed by an analysis of codes 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 codes included in the primary care capitation payments account for the following percentage of total primary care spending:

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”—or incentives to limit care—when including these and other codes in capitated payments, such as incentives to refer out more medically complex patients. The model includes a list of strategies to protect against such unintended adverse consequences including incorporating strategies to identify and respond when practices are withholding or limiting care or making too many specialty, urgent care and emergency department referrals.

### Attribution and PCP selection

The Workgroup revisited the attribution principles from the 2018 PCPRC report (Appendix 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 adopted the 2018 Attribution Principles and added the following hierarchal order to guide attribution:

1. Prioritize patient choice – always ask the patient for primary care provider (PCP) in enrollment information (even if not “required” by the health plan).
2. If the patient does not choose a PCP, attribute the patient to a provider based upon utilization/attribution process (as defined in Attachment B).
3. If the patient chooses a PCP, but then has predominant utilization with another primary care provider, assign the patient to that provider and communicate to the patient opportunity to re-select their preferred PCP.
4. If there is no patient choice and no prior utilization, assign all patients to primary care providers to enable the best opportunity to serve the entire insured population.



The model also includes the requirement that insurers establish a primary care provider assignment correction process that works in partnership with providers to correct inaccurately assigned enrollees.

The attribution in the model aligns with Oregon Administrative Rule 836-053-0028 developed in response to SB 1529 (2022) requiring insurers to assign enrollees who are residents of the state of Oregon to an individual or group of individuals who are "primary care providers" in a specified hierarchical order.

## **Prospective payment rate development methodology**

The prospective payment rate is set based on an analysis of historic per-member per-month (PMPM) with spending according to the following guidelines:

- For larger providers, payers and 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 model acknowledges the challenge that certain services performed inconsistently across practices may fall under a broader billing code and that 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 model description also acknowledges the limitations of 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 will account for primary care services delivered by providers outside of the capitation according to the following guidelines:

- Payers apply monthly re-attribution to shift the prospective payment to a new primary care site as quickly as possible.
- Payers 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 will be updated annually.
- Payers will provide a general description of the rate methodology to providers using a common template to be developed by OHA.

## Accounting for patient cost-sharing in rate development

Capitated payments will be adjusted to remove any patient cost-sharing obligation, rather than paid using full “allowed” amount, with a subsequent retrospective deduction of the patient cost-sharing obligation. This approach anticipates the practice will receive additional revenue directly from the patient regarding services provided.

## Risk adjustment

The Workgroup decided that, at a minimum, payers should risk adjust based on age and sex. The Collaborative discussed clinical risk adjustment and decided on the following considerations:

- For any application of clinical risk adjustment, separate methodologies should be used for adults and pediatric populations using a validated methodology specific to that population, as available.
- Clinical risk adjustment should be used when measuring a practice on total cost of care as an addition to the primary care VBP model and mutually agreeable to payers and providers.
- Clinical risk adjustment is optional for prospective primary care capitation payments.
  - Considerations in favor of applying clinical risk adjustment:
    - Adjusting payments based on a clinical risk score can help ensure a more accurate estimate of how much it will cost to care for a patient population based on the patients’ conditions.

- Risk-adjusted capitation payments that reflect the relative clinical risk of the patient panel could result in higher capitated payments to providers who treat patients with greater health care needs.
- Limitations of clinical risk adjustment:
  - A commonly accepted methodology to estimate how much primary care someone needs based on their medical condition(s) does not yet exist.
- Prospective payment rates can instead be calculated based on historical utilization with an additional payment increase to compensate for capitated procedure codes not historically reimbursed by a given payer, as described in the section above on “prospective payment rate development methodology.”
- Clinical risk adjustment should be used for infrastructure payments that entail care management and other services involving support for patients with higher medical complexity. Payers may use clinical risk adjustment for other infrastructure payments.

OHA convened a subgroup to discuss methods to risk adjust for social factors, such as income, employment and housing status, and develop one or more pilots. The social risk adjustment subgroup met three times in 2023 and established the following principles to guide social risk adjustment:

- Support primary care to meet the needs of patients with socially complex needs.
- Be good stewards of the data used for social risk adjustment, including selecting appropriate data and being transparent about data sources.
- Consider both community and individual data sources to inform social risk adjustment.
- Involve people who experience health inequities and historical and contemporary injustices in model development for a better outcome.
- Identify and mitigate against possible unintended consequences of social risk adjustment.
- Design a social risk adjustment approach that supports people already seeking care and those that are attributed to a primary care provider but have not been seen.

- Take a first step and do not let perfect be the enemy of good.

The subgroup is continuing to meet in 2024 to explore possible data sources, including claims data and geographic indices available using census data and learn about approaches implemented in Massachusetts and Minnesota. The subgroup is also working together to develop and implement one or more pilots to test social risk adjustment approaches.

## **Value incentives and rewards**

The model includes incentives to reward practices 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 total eligible incentive payments should be equal to 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 will 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 aligned primary care measure set (Appendix F) balances minimizing the reporting burden for primary care providers while sufficiently demonstrating quality, and:

- Includes separate sets for adults and children
- Does not exceed eight measures for adults or children to help with alignment and simplify tracking at the practice level
- Contains at least one behavioral health measure for each population
- Contains at least one equity-focused measure
- Aligns with measure sets currently used by commercial and public payers

The VBP Model Development Workgroup considered various options to integrate equity into the metrics and decided on three parallel approaches:

1. Include National Quality Forum (NQF) identified disparity sensitive measures, applying the following identification process: 1) prevalence of the condition in minority population; 2) disparity in the quality gap between the disadvantaged population and the group with the highest quality; and 3) impact financially,

publicly, and on the community at large. The following measures are included in the measure set and on the NQF list of identified measures:

- Cervical cancer screening
  - HbA1c poor control
  - Depression screening – youth
  - Controlling high blood pressure
2. Consider adopting the CCO incentive metric “Social determinants of health: Social needs screening and referral” in 2025.
  3. Evaluate each quality measure through an equity lens. Whenever feasible, payers will identify disparities by aggregating data on each quality measure across contracted providers and stratifying measures by race, ethnicity, geography and possibly other demographic factors. Payers will communicate the findings with providers to inform strategies to reduce disparities.

### **Infrastructure payments**

The Workgroup decided that infrastructure payments to all practices participating in the VBP model should include the following components:

- A base payment tied to PCPCH tier, which includes payments to non-PCPCH practices that are actively seeking to obtain PCPCH recognition; and
- Additional payments, as agreed upon by the payer and practice, for specific high-value services. These additional infrastructure payments should be for: a) services that are not already paid for via the PCPCH program, or b) services that are included in the PCPCH program where the practice has identified a need for additional financial support for implementation or sustainability.

Examples of such services include, but are not limited to:

- Additional case management and care coordination for patients with higher levels of medical and social risk.
- Integrated behavioral health services not typically paid for by fee-for-service.
- Traditional health worker services.
- Integrated pharmacist services, such as medication consultations.

- Addressing health-related social needs.
- Infrastructure (technology and staff) to collect and use data on race, ethnicity, language or disability (REALD) and sexual orientation or gender identity (SOGI).
- PCPCH Health Equity Designation

To receive an infrastructure payment to support behavioral health integration, a primary care practice must meet at least one of the following sets of behavioral health integration standards, which should include a minimum threshold for behavioral health clinician staffing ratio or population reach percentage:

- PCPCH Measure 3.C.3: PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.
- Integrated Behavioral Health Alliance (IBHA) Recommended Minimum Standards for PCPCHs Providing Integrated Health Care (<https://cobhc.org/wp-content/uploads/2023/02/IBHA-Minimum-Standards-2.0-02062023.pdf>).

## Equity in the primary care VBP model

The primary care VBP model includes components to promote health equity and strategies to protect against negative consequences.

### Promoting health equity

Health equity components of the primary care VBP model include:

- Inclusion of equity-focused quality measures in the aligned measure set as described above.
- Financial incentives for practices to stratify quality measure performance by REALD and SOGI to identify any potential disparities and develop targeted interventions.
- Support for services such as health-related social needs screening and/or traditional health worker (THW) services in the prospective payment or via fee-for-service or supplemental payments.

- Infrastructure payments to support collaboration and data sharing between primary care practices and social service organizations to address identified social needs.
- Exploration of risk adjustment methodologies that account for social risk factors.

## **Protecting against negative consequences**

Implementation of VBP can sometimes result in unintended adverse consequences when practices make decisions based on the desire to keep capitated payments, such as withholding or limiting care or making too many specialty, urgent care and emergency department (ED) referrals. To minimize this risk, payers can incorporate strategies to identify and respond, including:

- Monitoring practice behavior to identify cases where access is decreasing or there are other signs of limiting care, such as through using patient experience survey questions regarding access or tracking trends in visit volume.
- Monitoring practices' data-stratified quality measure performance by REALD and SOGI to identify any potential disparities and develop targeted interventions.
- Creating incentives and/or disincentives for practices to minimize inappropriate use of specialists, urgent care and EDs, 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.
- Making additional payments to practices that treat patients with higher medical complexity.
- Excluding from prospective payment and enhancing payment for care delivered outside of normal care delivery hours to incentivize expanded access.

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# Appendix A: Primary Care Payment Reform Collaborative Charter

2021

## 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:

- Strategies to support implementation of payment models in the Initiative including attribution, data aggregation and reporting; and
- 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)
  - Medicaid Division
  - External Relations Division

## Appendix B: Primary Care Payment Reform Collaborative members

May 2024

- Carolyn Anderson, Clinical Quality Director, Mountain View Medical Center
- 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
- 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
- Tim Hachfeld, Program Manager, Primary Care APMs, Regence BlueCross BlueShield & Cambia Health Solutions\*
- Ruben Halperin, Medical Director, Providence Health Plans\*\*
- Amy Hill, Vice President, 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 Service Line, Oregon Network, PeaceHealth
- Barbara Martin, Director of Primary Care, Central City Concern
- Miranda Miller, Director of Value-Based Performance, Samaritan Medical Group\*\*

- Angela Mitchell, Vice President, VBP and Contracting, CareOregon
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Health Services Officer and Chief Medical Officer, Winding Waters Community Health Center\*\*
- 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\*\*
- Danielle Sobel, Policy Director, Oregon Primary Care Association\*\*
- Larry Soderberg, Chief Financial Officer, Yamhill Community Care
- Rebecca Tiel, Senior Vice President of Operations and Membership, Oregon Association of Hospitals and Health Systems
- Rebel Williams, Assistant Vice President, Network Strategy & Contracting, Samaritan Health Plans, InterCommunity Health Network CCO \*, \*\*
- 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 2023

\*\*Member of Steering Committee

## Appendix C: VBP Model Development Workgroup members

Convened from May 2022 to June 2023

- 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, Health Services Officer and Chief Medical Officer, Winding Waters Community Health Center
- 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\*

\* Not a Collaborative member



## Appendix D: Common code list for primary care capitation payments

1. Office or outpatient visit for an established patient (99211-99215)
2. Office or outpatient visit for a new patient (99202-99205)
3. Telephone calls for patient management (99441-99443)
4. Prolonged physician services (99354, 99355, 99358- 99360)
5. Preventive medicine counseling or risk reduction intervention (99401-99404)
6. Preventive medicine initial evaluation (99381-99387)
7. Preventive medicine periodic re-evaluation (99391-99397, 99429)
8. Administration of immunizations (90460, 90461, 90471-90474)
9. Transitional care management services (99495, 99496)
10. Medical team conference (99366-99368)
11. Therapeutic, prophylactic or diagnostic injection (96372)
12. Group preventive medicine counseling or risk reduction intervention (99411, 99412)
13. 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)
14. Non-face-to-face online medical evaluation (99444)
15. Non-physician telephone services (98966, 98967)
16. Online assessment, management services by non-physician (98969)
17. Annual wellness visit, personalized prevention plan of service (G0438, G0439)
18. Comprehensive geriatric assessment and treatment planning performed by assessment team (S0250)
19. Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month (S0320)

All other codes are excluded from the primary care capitated payments.

# Appendix E: Matching patients and providers: Definitions and framework

## Prepared by the CPC+ Payer Group and the Primary Care Payment Reform Collaborative, 2018

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.<sup>1</sup>

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

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<sup>1</sup> Health Care Payment Learning & Action Network. Accelerating and Aligning Population-Based Payment: Patient Attribution. June 30, 2016.

- 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.

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.<sup>2</sup>
9. The Collaborative will consider alignment across payers at level of attribution (clinic vs. individual provider).

## Shared Definitions

### Member selection

According to the Health Care Payment Learning & Action Network, patient choice is the ideal way to connect a patient and a provider.<sup>3</sup> 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

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<sup>2</sup> Billing 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.

<sup>3</sup> Id. p. 8. “The ideal method for patient attribution is active, intentional identification or self-reporting by patients.”

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 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.

# Appendix F: Primary care VBP model quality measures

April 2024

Adult Primary Care Measure Set			
Measure	Steward	Reporting entity	Data Source
Controlling High Blood Pressure	NQF#0018/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Diabetes Care: HbA1c Poor Control+	NQF#0059/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Breast Cancer Screening	NQF#2372/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Cervical Cancer Screening	NQF#0032/NCQA	Clinic	Administrative, hybrid, or EHR
Colorectal Cancer Screening	NQF#0034/NCQA	Clinic	Claims/Clinical Data (eCQM measure)
Medicare Annual Wellness Visit	N/A	Clinic	Claims
Depression Screening and Follow-up Plan+	NQF#0418/CMS	Clinic	Claims/Clinical Data (eCQM measure)
Initiation and Engagement of Substance Use Disorder Treatment+	NQF#0004/NCQA	Clinic	Administrative or EHR

+CCO Incentive Measure

Pediatric Primary Care Measure Set			
Measure	Steward	Reporting entity	Data Source
Childhood immunization status by 2 (Combo 3*)+	NQF#0038	Plan	Claims
Immunizations for adolescents by 13 (Combo 2)	NQF#0038	Plan	Claims
Well visits: Six within 15 months**	NQF#1392	Plan	Claims
Well visits: Two within 15-30 months**	NQF#1392	Plan	Claims
Well visits: 3-6 years***+	NQF#1516	Plan	Claims
Well visits: 7-11 years***	NQF#1516	Plan	Claims
Well visits: 12-21 years***	NQF#1516	Plan	Claims
Depression Screening and Follow-up Plan+	NQF#0418	Clinic	Clinical Data (eCQM measure)

\*Commercial only payers may use Combo 10

\*\*If the denominators are too small, replace with Well Child Visits in First 30 months (W30) – eight visits in 0-30 months

\*\*\*If the denominators are too small, replace with Child & Adolescent Well Visits (WCV) – well visits 3-21 years

+CCO Incentive Measure