

Paying for Value  
Maturity Assessment of CCO 1.0  
January 9, 2018

## Background

The development of a payment system that rewards improvement in health outcomes and not volume of services delivered, or value-based payment (VBP), has been a key strategy of Oregon's health system transformation to achieve the triple aim of better health, better care and lower costs. The Oregon Health Authority (OHA) has many initiatives to grow VBP utilization, such as the federally qualified health center alternative payment methodology<sup>1</sup> and the Comprehensive Primary Care + initiative.<sup>2</sup> While these VBP initiatives are important to note as they help drive the system towards paying for value, the two largest opportunities for enhanced VBP in Oregon's Medicaid program, the Oregon Health Plan (OHP) are:

- (1) OHA's payments to Coordinated Care Organizations (CCOs); and
- (2) Encouraging CCOs' use of VBP approaches with their contracted providers.<sup>3</sup>

In September 2017, Governor Brown asked the Oregon Health Policy Board (OHPB) to provide recommendations to increase the use of VBP approaches and performance-based payment when considering the future of CCOs.

### **OHA payments to CCOs**

OHA pays CCOs using a VBP comprised of a global budget and an incentive metrics quality pool. Specifically, OHA pays CCOs using a global budget that grows at a fixed rate and incorporates payments connected to performance on incentive metrics. The CCO incentive metric quality pool rewards CCOs for the quality of care and outcomes provided to Medicaid members, based on their performance on 17 metrics. The quality pool is funded based on a percentage of aggregate payments made to all CCOs for a given contract year (which is currently set at 4.25%). The Health Plan Quality Metrics Committee (HPQMC) is currently working to identify a menu set of metrics for use across Oregon. Measures from this menu will be used to guide the CCO incentive metrics design committee, the Metrics and Scoring Committee<sup>4</sup>, starting in late 2018.

### **Definitions**

**Value-Based Payment (VBP):** CMS defines VBP for Medicare as "programs that reward health care providers with incentive payments for the quality of care they give to people." CMS further defines VBP through its Medicaid Innovation program as, "payment models that range from rewarding for performance in fee-for-service (FFS) to capitation...." and "ties provider payment directly to specific indicators of quality or efficiency and can be built through rewards and penalties."

**Pay-for-Performance:** Generally considered to be a synonym for value-based payment.

<sup>1</sup> <https://www.orpca.org/initiatives/alternative-care-model>

<sup>2</sup> <http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Comprehensive-Primary-Care-Plus.aspx>

<sup>3</sup> For the purposes of this brief, the word providers means a group of providers, practice(s) or a clinician

<sup>4</sup> <http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx>

A key component of the CCO model includes health-related services, which are non-covered services that promote health.<sup>5</sup> The CCOs’ global budget gives CCOs increased flexibility to use health-related services to meet their members’ needs.

### CCO payments to providers

Oregon’s recent 1115 Medicaid Demonstration Waiver renewal<sup>6</sup> requires OHA to advance CCOs’ use of VBPs by ensuring “through its CCO contracts that VBP arrangements, structured to improve quality and manage cost growth, are used by CCOs with their network providers. The state will develop a VBP plan that describes how the state, CCOs and network providers will achieve a set target of VBP payments by the end of the demonstration period.”

Beginning in February 2018, OHA will begin working with CCOs to develop a CCO VBP Roadmap to be completed by summer of 2018. The CCO VBP Roadmap will define value and VBP; establish statewide and CCO-specific VBP benchmarks; and identify reporting and monitoring requirements. OHA will update the Board on the VBP Roadmap development process at its April, 2018 meeting, and share a final draft of the Roadmap at the Board’s June, 2018 meeting.

### Indicators of Oregon’s Performance

The Board requested information and data regarding VBPs as part of its maturity assessment development process and to inform potential recommendations for the future of CCOs. Information requested by the Board is noted below, but due to data constraints, some information is not available. The Board may consider making a recommendation pertaining to the collection of this data in the future.

### OHA payments to CCOs

The following tables shows, for 2013-2016, the total incentive metric quality pool dollars; percent of total CCO payments that are represented through the CCO quality pool; the number of metrics required to receive 100 percent of quality pool payments; and the number of CCOs that met the targets and received 100% of their quality pool payments.

	2013	2014	2015	2016
<b>Total quality pool</b>	\$47M	\$128M	\$168M	\$186M
<b>% of CCO global budget</b>	2%	3%	4%	4.25%
<b># of metrics for 100% of payment</b>	12+	12+	12+	13+
<b># of CCOs met targets and received 100% of payment</b>	11	13	15	7

<sup>5</sup> <http://www.oregon.gov/oha/HPA/CSI-TC/Pages/Health-Related-Services.aspx>

- The CCO incentive pool, as currently designed, is capped by federal regulation at 5% of total payments and is currently a bonus but may move to a withhold in 2018 or 2019.
- While the quality pool percentage has increased each year, the 2014 ACA expansion in membership resulted in a significant one-year increase.
- The incentive metrics change yearly to raise the bar for payout of the quality pool.

### **CCO payments to providers**

Percent of CCO payments that are value-based

- Approximately 30% of global budget payments to CCOs are paid out to their contracted providers via non fee-for-service payments, including capitation.
- OHA does not have data collection processes in place to determine which CCO capitation payments may be tied to quality or outcomes.

In 2016, OHA staff requested information from CCOs about their VBPs adoption, and found that all had implemented some form of VBP with 73 total VBPs in process across the 16 CCOs. Most VBP initiatives were in primary care, but other major areas of focus included behavioral health care, medical specialty care and dental care.

### **Lessons Learned**

Oregon’s summative Waiver evaluation featured lessons learned regarding payment reform in the form of recommendations:

#### **OHA payments to CCOs**

Increase the portion of total CCO payments awarded for quality and access, and raise the bar for awards. A larger quality pool and higher performance standards can be used to drive improvement in areas with relatively little progress.

#### **CCO payments to providers**

Require CCOs to report detailed data on use of VBP arrangements. More detailed data will be essential for identifying effective VBP arrangements and monitoring progress toward VBP targets required by the waiver.

Following are lessons learned from qualitative analysis and experience about CCO incentive payments and VBP utilization by CCOs from 1) stakeholders and providers through Bailit Health’s *CCO Perspectives Report*, 2) the OHPB 2016 CCO listening sessions; and 3) OHA staff evaluations.

#### **OHA payments to CCOs**

- The CCO incentive metric quality pool works as a VBP model.
- Constant communication and transparency is vitally important for the development of pay for performance metrics. OHA has maintained an open dialogue with CCOs regarding specifications and current status of metrics. This has kept most CCOs focused on doing what they can on the ground to improve the metrics. Many CCOs have replicated the performance program in place at the state level within their CCOs and provider panels.

- Changes in how incentives are awarded could be further explored and developed; the same basic methodology could still be used, but it may need to change or be tweaked in the future to improve the overall program. Developing metric composite scores and related processes has historically been a challenge.
- Some CCOs have rigorous systems for monitoring metrics within their infrastructure and have used those systems for VBP utilization, but they likely need to be incentivized to spread VBP adoption.

Is there a correlation in improvements to access/quality/outcomes that can be tied to VBPs?

- CCO incentive metrics show performance improvement over time, and CCOs and stakeholders report that these pay-for-performance metrics have refocused the delivery system. CCO metrics reports show improved outcomes and quality when metrics are tied to pay-for-performance payment arrangements and it's likely that incentive metrics have driven improved access for the specific intervention being measured.
  - The CCO incentive metrics program has exposed problems with the data in meeting expectations associated with equity issues.
- Major transformational modifications in the way clinicians practice and make decisions take time at the practice level and some of the incentive metrics help to drive that transformation (e.g. integration and coordination of care changes).
- Process quality measures can have a transformative impact, but the desire from the quality community is to move to outcome measures as electronic health record software becomes more sophisticated.
- To some degree, improvements like those seen in developmental screening have probably been influenced by improved data submission for many of the services. Finding metrics that "fit" for specialty care is a barrier.

#### **CCO payments to providers**

- Payment reform is in progress but needs more clarity, coordination and technical assistance to achieve critical mass.
- Use of VBPs beyond primary care capitation is much more limited, with the exception of full capitation and global budget arrangements with regional behavioral health entities and with dental care organizations. CCOs have been especially slow to adopt VBPs for medical specialists and hospitals. There is some use of risk pools for referral and hospital services, and quite limited use of episode-based payment and case rates.
- There is significant variation in practice across CCOs. Some CCOs are utilizing VBPs to a much greater degree than others. These differences reflect both organizational and market history, and differences in CCO network composition, geographic reach and size.
- CCOs did not describe ambitious plans for expanding their use of VBPs in the future. They often described plans for incremental change. CCOs operating in rural geographies often noted that their networks were comprised of only a couple of providers that were large enough to contract using VBPs.

Are there differences in VBP utilization between rural and urban communities? Why?

- Rural areas are often underserved where providers have more leverage in negotiations and tend to shy away from VBP models due to the risk and lack of partners. Additionally, due to the small populations and homogeneity in rural areas, many VBP models simply don't "fit" because they can't be measured or targeted accurately.

Do VBPs "reach down" to individual providers?

- OHA does not have comprehensive data to answer this question, though a few CCOs do report they have implemented VBPs which "reach down" to providers.

What are the barriers/facilitators that help explain CCO adoption of VBPs?

- No target number or specific goal for utilization of VBPs is currently contractually required, though Oregon's 1115 Waiver mandates VBP targets by the end of the Waiver period, (June 30, 2022)
- VBP categories have not been defined
- Lack of total cost of care management experience
- Lack of sophisticated data analytics tools
- Limited network capacity and lack of "leverage" with some providers, e.g. rural providers
- Medicaid "book of business" isn't big enough to encourage specialty practices to invest in different payment systems
- Performance compliance

## CCO 2.0 Questions for 2018 Investigation

Based upon lessons learned, existing data, and subject matter expertise, the gray boxes below identify questions that could be further explored in 2018 in order to build upon the first phase of CCOs. At the 2018 OHPB retreat, board members will consider and confirm whether answering these specific questions will address the lessons learned and give them the information needed to develop final recommendations for CCO 2.0.

Workgroups, OHA staff, stakeholders, members of the public and OHPB members will all be consulted and included in the process to investigate these questions and consider next steps and potential policy options in the spring/summer of 2018.

<p>Should the percentage of CCO global budgets tied to performance and quality increase? <b>(OHA payments to CCOs)</b></p>	<p><i>Potential policy options to investigate:</i></p> <ul style="list-style-type: none"> <li>(1) CCO incentive metrics               <ul style="list-style-type: none"> <li>(a) Metrics &amp; Scoring Committee incentive measure design</li> </ul> </li> <li>(2) Global budgets               <ul style="list-style-type: none"> <li>(a) CCO global budget incentive methodology design (e.g. bonus and withhold)</li> </ul> </li> </ul>
	<p>(1) CCO VBP Roadmap</p>

<p>How can OHA encourage VBPs between the CCOs and their providers and hold CCOs accountable? <b><i>(CCO payments to providers)</i></b></p>	<ul style="list-style-type: none"> <li>(a) CCO flexibility</li> <li>(b) TA and support</li> <li>(c) Targets &amp; goals for CCOs <ul style="list-style-type: none"> <li>- Tracking</li> </ul> </li> <li>(d) Incentives and Bonuses</li> </ul>
<p>Should VBPs be developed to reduce health disparities and address the social determinants of health? <b><i>(OHA payments to CCOs; CCO payments to providers)</i></b></p>	<p><i>Potential policy options to investigate:</i></p> <ul style="list-style-type: none"> <li>(1) Health-related services <ul style="list-style-type: none"> <li>(a) Addressing the social determinates of health</li> </ul> </li> <li>(2) VBP roadmap <ul style="list-style-type: none"> <li>(a) Coordination and alignment with partners</li> <li>(b) Targets</li> </ul> </li> <li>(3) CCO incentive metrics <ul style="list-style-type: none"> <li>(a) Metrics &amp; Scoring Committee Measure Design</li> </ul> </li> </ul>
<p>Should VBPs be developed to foster improvements in behavioral health outcomes? <b><i>(OHA payments to CCOs; CCO payments to providers)</i></b></p>	<p><i>Potential policy options to investigate:</i></p> <ul style="list-style-type: none"> <li>(1) VBP roadmap <ul style="list-style-type: none"> <li>(a) Coordination and alignment with partners</li> <li>(b) Targets</li> </ul> </li> <li>(2) CCO incentive metrics <ul style="list-style-type: none"> <li>(a) Metrics &amp; Scoring Committee Measure Design</li> </ul> </li> </ul>
<p>What changes to data collection are necessary to track progress on, and improve our understanding of, VBP utilization? <b><i>(OHA to CCO payments; CCO to provider payments)</i></b></p>	<p><i>Potential policy options to investigate:</i></p> <ul style="list-style-type: none"> <li>(1) VBP roadmap <ul style="list-style-type: none"> <li>(a) CCO reporting requirements</li> <li>(b) OHA monitoring requirements</li> </ul> </li> <li>(2) All-Payer-All-Claims database <ul style="list-style-type: none"> <li>(a) Appendix G</li> </ul> </li> </ul>

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# Value-Based Payment CCO 1.0 Maturity Assessment

OHPB Retreat – January 16, 2018

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# Governor's Letter

Governor Brown sent a letter to the OHPB in Sept 2017 about the need for recommendations regarding increased value-based payment when considering the future of CCOs

- Raise the bar on quality and outcomes through value-based payment (VBP)
- Reduce disparities and tie payment to performance over time
- Accelerate VBP utilization across the delivery system



# VBP Topic Area: CCO incentives

*Lessons learned: Increasing the portion of total CCO payments awarded for quality and access raises the bar. A larger quality pool and higher performance standards can be used to drive improvement in areas with relatively little progress.*

## *Key information:*

- The CCO incentive pool, as currently designed, is capped by federal regulation at 5% of total payments and is currently a bonus, but may move to a withhold in 2018 or 2019.
- Changes in how incentives are awarded could be further explored and developed; the same basic methodology could still be used, but it may need to change or be tweaked in the future to improve the overall program.
- CCO incentive metrics show performance improvement over time and CCOs as well as stakeholders report these pay-for-performance metrics have refocused the delivery system. It's likely incentive metrics have driven improved access for the specific intervention being measured.

## CCO 2.0 Question for 2018

### Investigation:

Should the percentage of CCO global budgets tied to performance and quality increase?  
(OHA payments to CCOs)

## Potential next steps and policy options to consider:

- (1) CCO incentive metrics
  - (a) Metrics & Scoring Committee incentive measure design
- (2) Global budgets
  - (a) CCO global budget incentive methodology design (e.g. bonus and withhold)

# VBP Topic Area: VBP provider payments

*Lessons learned: There is significant variation in VBP adoption by CCOs. Some CCOs utilize VBPs to a much greater degree than others; this reflects differences in organization, market history, network composition, and geographic reach and size.*

**Key information:**

- Approximately 30% of global budget payments to CCOs are paid out to their contracted providers via non fee-for-service payments, including capitation; it is unknown what percentage of these are tied to quality.
- Limited network capacity and lack of “leverage” with some providers is a barrier to VBP adoption at the provider level, e.g. rural providers.
- Use of VBPs beyond primary care capitation is limited, with the exception of full capitation and global budget arrangements.
- Requiring CCOs to report detailed data on use of VBP arrangements will facilitate more detailed data essential for identifying effective VBP arrangements and monitoring.

CCO 2.0 Question for 2018

Investigation:

How can OHA encourage VBPs between the CCOs and their providers and hold CCOs accountable? (CCO payments to providers)

Potential next steps and policy options to consider:

- (1)CCO VBP Roadmap
  - (a) CCO flexibility
  - (b) TA and support
  - (c) Targets & goals for CCOs
    - Tracking
  - (d) Incentives and Bonuses

# VBP Topic Area: Behavioral Health

*Lesson learned: CCO metric reports show improved outcomes and quality when metrics are tied to pay-for-performance arrangements and it's likely incentive metrics have driven improved access for the specific intervention being measured.*

*Key information:*

- Major transformation modifications in the way clinicians practice and make decisions take time at the practice level and some of the incentive metrics help to drive that transformation (e.g. integration and coordination of care changes).
- Use of VBPs beyond primary care capitation is limited, with the exception of full capitation and global budget arrangements with regional behavioral health entities and with dental care organizations, but OHA lacks data to determine if these payments are tied to quality.

CCO 2.0 Question for 2018 Investigation:

Should VBPs be developed to foster improvements in behavioral health outcomes? (OHA payments to CCOs; CCO payments to providers)

Potential next steps and policy options to consider:

- (1) VBP roadmap
  - (a) Coordination and alignment with partners
  - (b) Targets
- (2) CCO incentive metrics
  - (a) Metrics & Scoring Committee Measure Design

# VBP Topic Area: Social determinants of health (SDoH) & health disparities

*Lesson learned: Disparities in access to and quality of care are evident related to race/ethnicity, disability, and behavioral health status; CCOs have reported minimal investments in flex services/health-related services (HRS) related to SDoH.*

*Key information:*

- The CCO incentive metrics program has exposed problems with the data in meeting expectations associated with equity issues.
- No targets or specific goal for utilization of VBPs generally or by policy focus area is currently defined.
- Flex services/HRS makes up roughly 0.14% of CCO total member service expenses and the range of flex services/HRS as a % of total member expenses is between .7% (1 CCO) and 0 (1 CCO).

CCO 2.0 Question for 2018 Investigation:

Should VBPs be developed to address the social determinants of health and reduce health disparities? (OHA payments to CCOs; CCO payments to providers)

Potential next steps and policy options to consider:

- (1) Health-related services
  - (a) Addressing the social determinants of health
- (2) VBP roadmap
  - (a) Coordination and alignment with partners
  - (b) Screening/Referral for SDOH
  - (c) Targets
- (3) CCO incentive metrics
  - (a) Metrics & Scoring Committee Measure Design

# VBP Topic Area: reporting & data collection

*Lessons learned: Requiring CCOs to report detailed data on use of VBP arrangements is recommended. More detailed data will be essential for identifying effective VBP arrangements and monitoring progress toward VBP targets required by the waiver.*

## *Key information:*

- To some degree, improvements tied to the CCO incentive metrics program have probably been influenced by improved data submission for many of the services.
- OHA does not have data collection processes in place to determine which CCO capitation payments may be tied to quality or outcomes.
- Lack of sophisticated data analytics and total cost of care management is a barrier.
- VBP categories have not been defined.

## CCO 2.0 Question for 2018 Investigation:

What changes to data collection are necessary to track progress on, and improve our understanding of, VBP utilization?  
(OHA to CCO payments; CCO to provider payments)

## Potential next steps and policy options to consider:

- (1) VBP roadmap
  - (a) CCO reporting requirements
  - (b) OHA monitoring requirements
- (2) All-Payer-All-Claims database
  - (a) Appendix G

# CCO 2.0 Questions for 2018 Investigation

- Should the percentage of CCO global budgets tied to performance and quality increase? (*OHA payments to CCOs*)
- How can OHA encourage VBPs between the CCOs and their providers and hold CCOs accountable? (*CCO payments to providers*)
- Should VBPs be developed to reduce health disparities and address the social determinants of health? (*OHA payments to CCOs; CCO payments to providers*)
- Should VBPs be developed to foster improvements in behavioral health outcomes? (*OHA payments to CCOs; CCO payments to providers*)
- What changes to data collection are necessary to track progress on, and improve our understanding of, VBP utilization? (*OHA to CCO payments; CCO to provider payments*)