Oregon's Value-Based Payment Roadmap for Coordinated Care Organizations

THIRD ANNUAL PROGRESS REPORT

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The Center for Health Systems Effectiveness at Oregon Health & Science University is a research organization that uses economic approaches and big data to answer pressing questions about health care delivery. Our mission is to provide the analyses, evidence, and economic expertise to build a more sustainable health care system.

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Executive Summary

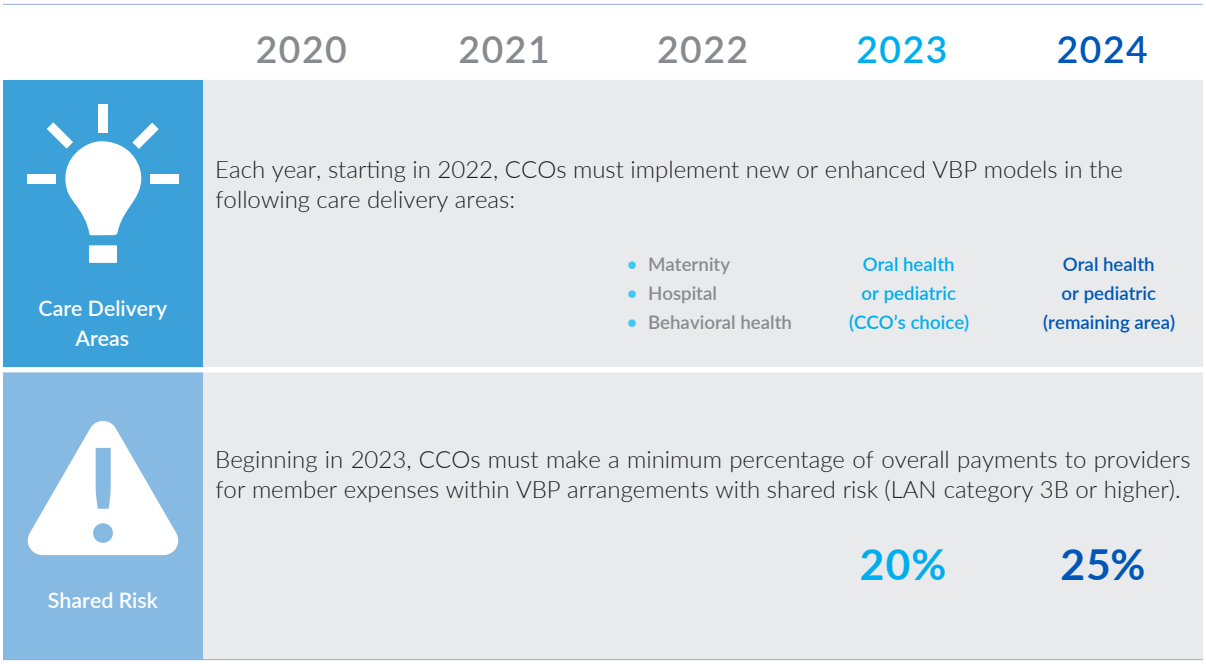
In 2023, Oregon's coordinated care organizations (CCOs) entered the fourth year of the Value-Based Payment Roadmap,[1] Oregon's effort to shift the majority of state Medicaid expenditures away from volume-based payment and into agreements with accountability for quality and cost. Launched in 2020, the Roadmap is a key component of Oregon's plan to create a more patient-centered, equitable, and efficient delivery system. The Roadmap includes progressive requirements for the percentage of overall Medicaid payments that must come through qualifying value-based arrangements and, starting in 2023, arrangements with provider downside risk. Individual CCOs determine the types of VBP arrangements to implement with their contracted providers.

To enable categorization of payment arrangements, the state adopted the Health Care Payment Learning & Action Network's APM Framework (the LAN framework).[2] The Roadmap also requires CCOs to create new or expanded value-based arrangements in five mandated care delivery areas, such as behavioral health and oral health, as a way to drive new payment design into a wide range of contracting areas. If implementation of the Roadmap is successful, more providers within the Medicaid delivery system will work within revised contract structures that incentivize high-value care by 2024. These structures will also support innovative delivery models that are more difficult to sustain through traditional fee-for-service arrangements.[3]

Components of the Roadmap are detailed in Exhibit A.

Exhibit A. VBP Roadmap milestones for 2020-2024.[1]

	2020	2021	2022	2023	2024
Annual VBP Targets	CCOs must meet minimum percentage of overall payments to providers for member expenses within qualifying VBP arrangements (LAN category 2C or higher).				
	20%	35%	50%	60%	70%
Patient-Centered Primary Care Homes	CCOs must implement PCPCH infrastructure payments in 2020, then increase these payments meaningfully during each year of the contract cycle.				



About the Roadmap evaluation

The Center for Health Systems Effectiveness conducted its third annual interim evaluation of CCOs' progress toward the Roadmap requirements in 2023. Exhibit B shows the requirements evaluated in the current report and the data sources used to assess progress.

The evaluation drew on CCO-reported information from three sources: (1) Payment arrangement data for contract year 2021 (the most recent available) to assess compliance with overall payment targets; (2) May 2023 reporting by CCOs on VBP models and PCPCH payments; and (3) June 2023 interviews with CCO leaders.

Exhibit B. Evaluation Areas and Data Sources for the 2023 Annual Interim Report.

Evaluation Area	Report Section	Time Frame Evaluated
Annual VBP Targets: CCO performance on 2021 payment targets	Oregon Health Care Payment Arrangement File (PAF) Dashboard	2021
Annual VBP Targets and Shared Risk: CCO Progress in 2023	2023 Questionnaires 2023 Interviews	2023
Patient-Centered Primary Care Homes: CCO Advancement in PCPCH Payment Structures	2023 CCO VBP PCPCH Data and CDA Templates 2023 Interviews	2022-2023
Care Delivery Areas: Implementation of VBP Models in Priority Care Delivery Areas	2023 CCO VBP PCPCH Data and CDA Templates 2023 Questionnaires 2023 Interviews	2023
CCO Progress in Monitoring and Reporting on VBP performance	2023 Questionnaires 2023 Interviews	2023

Interim evaluation key findings

The majority of CCOs were meeting Roadmap milestones in 2021 for overall value-based payments, though a subset of CCOs continued to lag behind

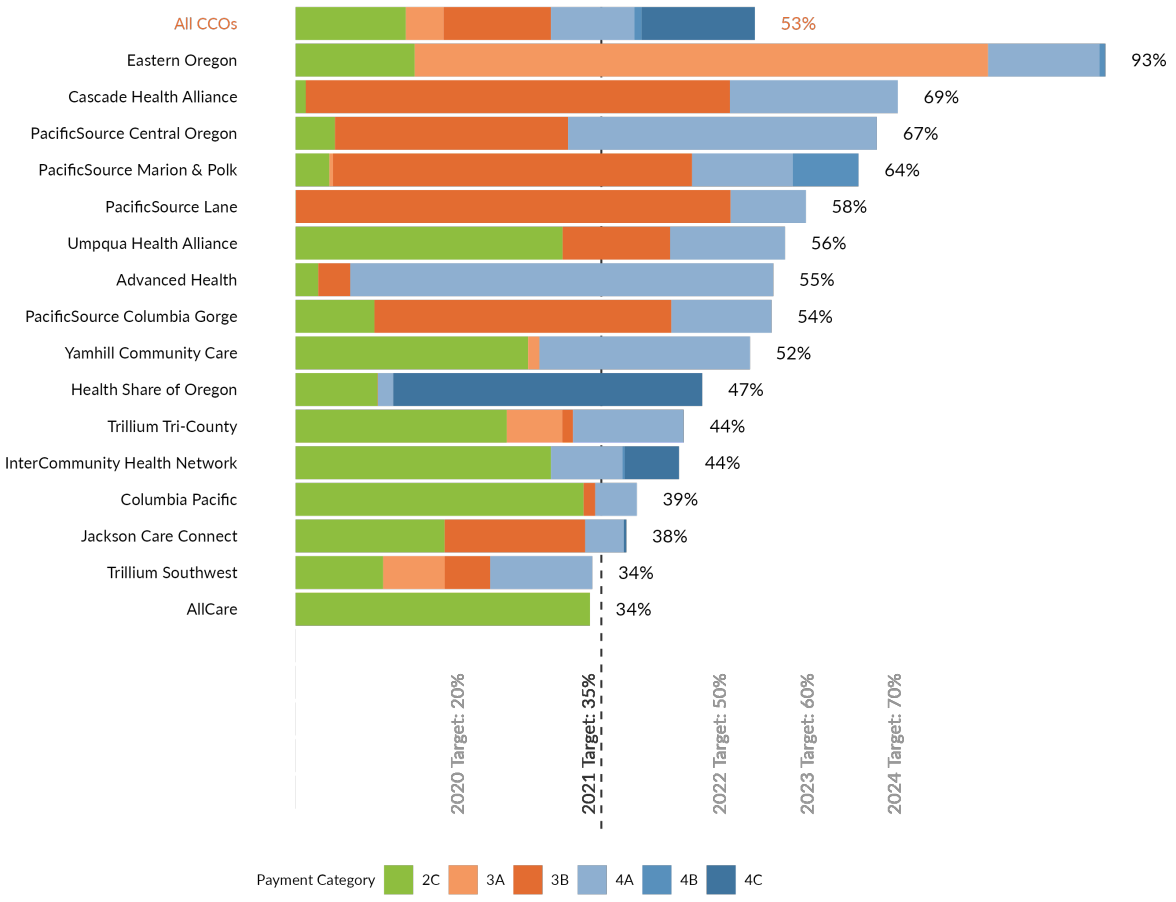
Data from CCOs' 2021 payment arrangement files (PAFs), released in mid-2023, indicated that 14 of 16 CCOs met Roadmap targets for overall payments at category 2C or higher that year. AllCare and the Trillium Southwest CCOs missed the targets by one percentage point each. Both these CCOs had reported 33% of payments at 2C or above in 2020 and inched up by only a percentage point in 2021, as shown in Exhibit C.

In mid-2023, most CCOs expressed confidence about 2023 requirements, including the new 20% target for arrangements with shared risk and the 60% target for overall value-based payment

Based on self-monitoring, most CCOs predicted meeting or exceeding 2023 targets for overall payments through qualifying VBP arrangements in LAN category 2C or higher and arrangements with downside risk (3B or higher). Two CCOs did not express firm confidence about meeting targets, one CCO anticipated barely clearing the 20% 3B target, and one CCO had difficulty assessing its VBP payment status this year.

Network fragility throughout the state slowed CCOs' momentum with VBP in 2023, particularly in rural areas. CCOs described provider organizations that were financially destabilized, understaffed, and reluctant to enter new downside-risk arrangements or increase risk in existing arrangements. Several rural CCOs reported particular difficulty retaining oral and behavioral health providers.

Exhibit C. Payment arrangement file data from 2021 show that all except two CCOs met the overall VBP target of 35% for that year



Infrastructure payments to PCPCHs continue to increase on average, though half of CCOs did not increase rates for all tiers in 2022

Only half of CCOs increased PCPCH infrastructure payments in all tiers as required by the Roadmap, although statewide averages continued to increase modestly. Payments remained widely varied across CCOs. Many CCOs reported bundling quality incentives or payment for additional practice features into PCPCH infrastructure payments. Nearly all practices under contract with CCOs were in the top three tiers of the PCPCH program.

With a couple of exceptions, CCOs keep pace with requirements for new models in prioritized care delivery areas

The majority of CCOs had successfully executed VBP models in the four required care delivery areas (CDAs) for 2023, including the three areas that continued from 2022. Two CCOs were less confident about overall targets and were also missing at least one CDA model. Several others reported models that either did not comply with LAN category criteria or did not include a quality measure specific to the CDA as required. A handful of reported arrangements included innovative collaborations or approaches to quality measurement, while the majority were alterations to existing contracts.

Structural and regional factors affect CCOs' ability to meet increased Roadmap targets in 2023 and 2024

CCOs that had financial relationships such as shared ownership with their provider organizations found it easier to meet growing requirements for overall VBP, especially those with shared risk. One CCO (Health Share of Oregon) had been reporting about half of its payments as an integrated delivery system (IDS, LAN category 4C) since the beginning of the Roadmap. A second CCO shared its intent to report as an IDS starting next year, and several others appeared to be similarly structured. CCOs that had no shared ownership with their providers experienced greater difficulty engaging them in shared risk. Local provider market structures, regional histories of payment methods, and trust all appeared to affect ease of engagement. For example, CCOs in regions with vertically integrated health systems could wrap specialty care into large system-level VBP arrangements, while CCOs with independent specialists needed to seek multiple smaller arrangements. CCOs' comments suggested that individual providers within larger system-level VBP models could be less informed about their roles in supporting VBP performance than providers with VBP arrangements directly with CCOs.

CCOs expand total-cost-of-care and other "layered" arrangements

As targets approached 70% in 2024, CCOs were motivated to bring as many payments as possible under the VBP umbrella even if they could not negotiate models directly with all categories of providers. By putting a provider at risk for members' total cost of care (TCoC), CCOs were able to count expenses such as hospital and specialty care as VBP expenditures without having direct VBP arrangements with those providers. In several cases, CCOs expanded these arrangements to include behavioral health, pharmacy, and non-emergency medical transportation. Several CCOs also "layered" CCO-wide shared risk or savings pools for all providers on top of other VBP arrangements with individual providers.

Efforts to advance health equity through VBP show minimal progress from 2022

Although some arrangements were in place to support traditional health workers (THWs) or case management, CCOs still lacked comprehensive data for assessing VBP needs or impacts based on REALD. Strategies for collecting, managing, and using this data in the future varied greatly across CCOs. They were still assessing how to manage and hierarchize data from the state, providers, and community partners on members' social needs and REALD. There was little evidence that CCOs were

systematically monitoring for possible disparities resulting from VBP models across REALD-based subgroups, especially in regions with small REALD subpopulations.

CCOs asked for state support in raising the profile of VBP efforts among providers, vetting additional quality measures, and coordinating strategies for incorporating social needs into payment

CCOs asked that OHA communicate more directly to the state's providers, particularly hospitals, about expectations for VBP, rather than expecting CCOs to make the case to providers in isolation, often without alignment with other payers. CCOs also asked the state to identify and endorse quality measurement strategies for provider categories not included in current CCO measures sets, such as hospital and specialty providers. CCOs were interested in adjusting payment for social risk factors to direct additional resources to providers treating members with the most complex social and health-related needs. They asked the state for help navigating the evidence base in this nascent policy area to avoid duplicative effort and inadvertent harm. Some asked for coordination between different Medicaid social-needs strategies, including social risk adjustment, the social-needs screening incentive metric, and the health-related social needs benefits in the new Section 1115 Medicaid waiver.

Impacts of the VBP Roadmap on care delivery remain difficult to assess

The Roadmap's implementation coincided with other Medicaid system changes and with the COVID-19 public health emergency (PHE), making separate evaluation of changes to cost and quality outcomes infeasible. Some CCOs reported positive performance results on newly implemented models, and all reported changes to contracting approaches due to Roadmap requirements. However, the structure of VBP arrangements and the services and quality metrics included varied greatly, as did provider and regional factors. All these factors made it difficult to draw comparative conclusions about the success of different VBP models or the impacts of the Roadmap on care delivery overall.

Recommendations for continued support of the VBP Roadmap

Increase the state's profile as a convener and proponent of multipayer VBP alignment

CCOs voiced several needs for greater coordination and leadership in support of VBP. First, they asked for a stronger message from the state directly to providers about expectations for engaging in VBP. They also sought a central convener for conversations about alignment of measures and models across regions and payers to reduce burdens for everyone involved in VBP implementation. Absent another prominent stakeholder volunteering, the state is in the best position to rally providers, payers, advocates, CCO members, and others for this work.

Promote standardization and exchange of successful VBP models to facilitate increased implementation, improve consistency across the state, and continue knowledge exchange between CCOs

CCOs shared common concerns about areas where access or care coordination needs might be effectively addressed by VBP. While CCOs appreciated the flexibility to design locally responsive VBP arrangements, they also noted the burdens of creating models from scratch and appreciated learning about solutions from other CCOs and states. Some CCOs put considerable work into developing innovative VBP models and measurement approaches that could benefit others. Support from OHA in identifying and promoting VBP models with demonstrated success could leverage CCOs' efforts and facilitate consistent evaluation of VBP outcomes. Models that support the work of THWs and other services related to social needs could be especially useful, as billing structures for these areas are challenging for CCOs. In addition, OHA can continue to support information exchange between CCOs.

Several respondents mentioned the CCO VBP Workgroup sessions with national expert Bailit Health as especially useful for learning about VBP work in other states. One CCO team member asked for similar sessions for staff in specialized VBP support roles, such as health information technology (HIT).

Develop additional guidance on quality measures for specialty services and strategies for low-volume services

CCOs described difficulty finding appropriate clinical quality metrics for specialty providers, both individual specialties and multispecialty groups. Some were interested in measures of member access to specialty care and others were wrestling with quality measurement strategies for lower-volume services. State assistance in developing uniform quality approaches for these service areas could support CCOs and promote alignment across regions and payers.

Work with CCOs to identify best practices for promoting health equity through VBP and strategies for social risk adjustment

To ensure that CCOs are using consistent, evidence-based practices for monitoring for inadvertent negative impacts of VBP on health equity, OHA could facilitate collaboration toward a statewide consensus on best approaches in this area. The state could also highlight models that deliberately use VBP to reduce existing health inequities. In response to CCOs' requests, the state can provide additional research and technical assistance with identifying feasible social-risk adjustment models.

Monitor progress of CCOs not meeting 2023 Roadmap targets and consider opportunities for additional support

Four CCOs appeared at risk of missing one or more Roadmap requirements in 2023. Compared with CCOs in compliance, they may have faced more adverse market circumstances, for example, the need to engage with smaller and more isolated provider groups or provider networks that were particularly hard-hit with staff losses and financial stress during the PHE. OHA could assess whether additional technical assistance would support these CCOs in regaining compliance.

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SUGGESTED CITATION

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Introduction

In 2023, Oregon's coordinated care organizations (CCOs) entered the fourth year of the Value-Based Payment Roadmap,[1] a key element of the 2020-2024 CCO 2.0 contract. The Roadmap is one component of the state's effort to transform Medicaid health care delivery and outlines CCO requirements for advancing VBP arrangements including progressive requirements for the percentage of overall Medicaid payments that must come through qualifying value-based arrangements. The requirement started at 20% in 2020 and increased annually to 60% in 2023 with individual CCOs determining the types of VBP arrangements to implement with their contracted providers.

The 60% target in 2023 was considerably more challenging even for CCOs with significant experience in alternative payment prior to 2020. An additional requirement went into effect in 2023 that 20% of arrangements with providers include downside risk. In 2023, CCO contracts also required the implementation of new or expanded models in one more care delivery area (CDA) and continued increasing payments to patient-centered primary care homes. All these tasks had to be accomplished against the backdrop of health care systems that remained understaffed and financially fragile from the COVID-19 public health emergency (PHE).

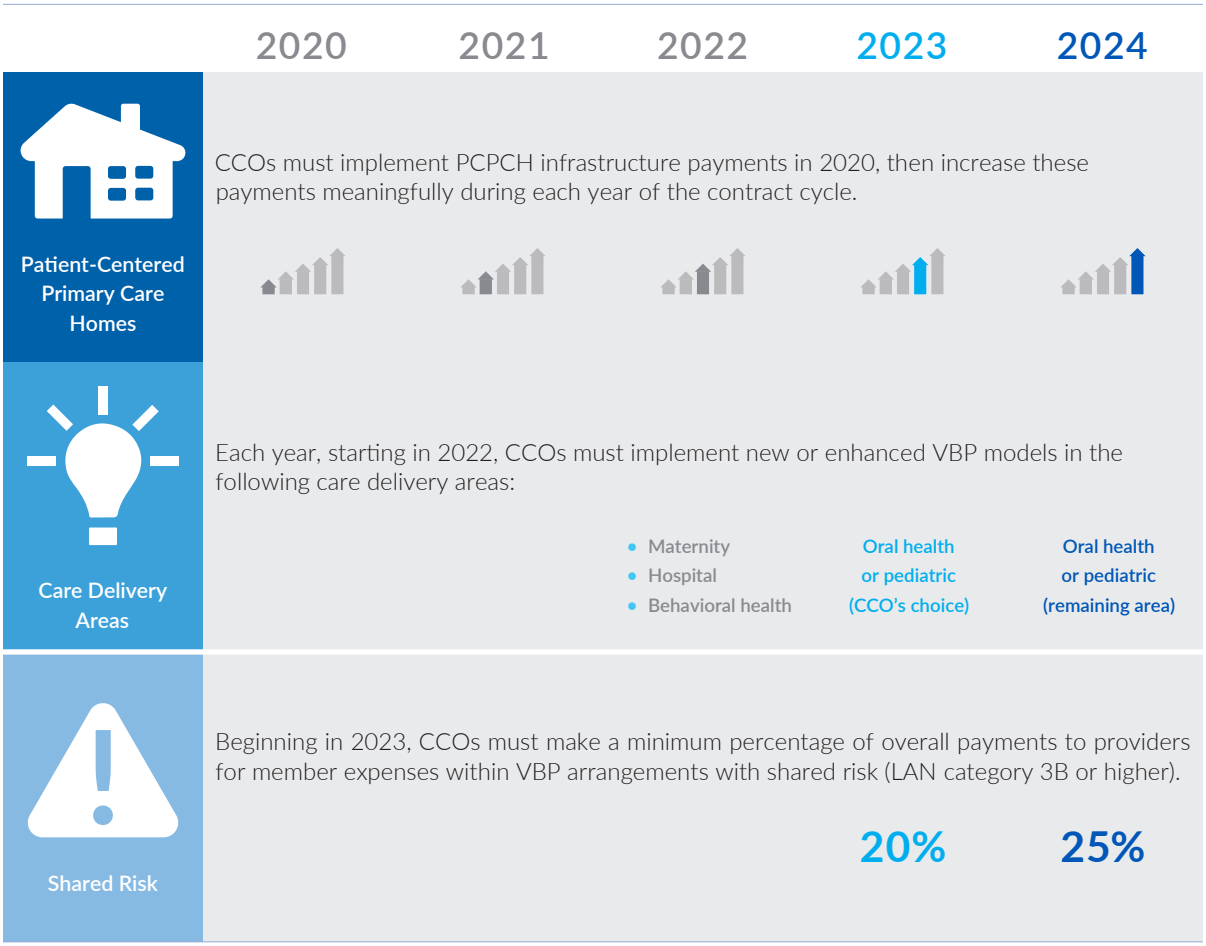
VBP Roadmap requirements

The Roadmap aligns Oregon Medicaid's VBP definition and categorization model with the Health Care Payment Learning and Action Network's Alternative Payment Model framework ("the LAN framework").[2] The alignment enables consistent measurement of CCO adoption of VBP over time. Appendix A describes the framework and its payment model categories.

The Roadmap requires CCOs to meet annual targets[1] in four key areas (Exhibit A). First, a minimum percentage of provider payments must occur in VBP arrangements that are LAN category 2C or higher. The target percentage increases annually. Second, each year CCOs must increase PMPM payments within each PCPCH tier. Third, CCOs must implement new or enhanced VBP models in specific CDAs in 2022-2024, the last three years of the contract. Finally, in 2023-2024, a minimum percentage of provider payments must occur in arrangements with shared risk (LAN category 3B or higher).

Exhibit A. VBP Roadmap milestones for 2020-2024.[1]

	2020	2021	2022	2023	2024
Annual VBP Targets	CCOs must meet minimum percentage of overall payments to providers for member expenses within qualifying VBP arrangements (LAN category 2C or higher).				
	20%	35%	50%	60%	70%



About the report

The Oregon Health Authority (OHA) engaged the Center for Health Systems Effectiveness (CHSE) to evaluate CCOs' progress toward meeting Roadmap requirements, starting with a baseline report[4] in 2020 and continuing with annual updates.[5,6] The current report is the third annual update.

Four data sources inform the annual reports. In February of each year, OHA fields a questionnaire to CCOs about their Roadmap progress. In May, CCOs report on their VBP arrangements, including required CDA arrangements, and their PCPCH payment amounts. In June, CHSE and OHA interview leaders from each CCO. Interview questions follow up on CCO questionnaire responses to gain a more detailed understanding of CCOs' experience implementing the Roadmap. The final data source is CCO Payment Arrangement Files, which categorize all member service payments by LAN category and are submitted annually to the Oregon All-Payers All Claims database program.

Because of varied lag time in data sources, the report assesses performance benchmarks spanning three years (2021-2023). Exhibit B lists evaluation areas covered in each section of the report with their data source(s) and time frame(s). Appendix B provides a complete description of data sources and methods.

Exhibit B. Evaluation Area, Data Source, and Time Frame Evaluated by Report Section

Report Section	Evaluation Area	Data Source	Time Frame Evaluated
2	CCO Performance on VBP Milestones in 2021	Oregon Health Care Payment Arrangement File (PAF) Dashboard	2021
3	CCO Progress on VBP Milestones and Shared Risk in 2023	2023 Questionnaires 2023 Interviews	2023
3	CCO Advancement in PCPCH Payment Structures in 2022	2023 CCO VBP PCPCH Data and CDA Templates 2023 Interviews	2022-2023
4	Care Delivery Areas: Implementation of VBP Models in Priority Care Delivery Areas	2023 CCO VBP PCPCH Data and CDA Templates 2023 Questionnaires 2023 Interviews	2023
5	CCO Progress in Monitoring and Reporting on VBP performance	2023 Questionnaires 2023 Interviews	2023

Please note: A complete list of acronyms used in the report and their definitions can be found in Appendix D.

Limitations

The evaluation relies in large part on CCO self-report via interviews and questionnaires. The sections using self-reported data reflect an evaluation of CCO experiences and perceptions, not of CCO compliance with the Roadmap or health system outcomes of VBP arrangements. Some written reports CCOs provided were incomplete. The evaluation team had access to aggregated data shared on the state's Payment Arrangement File (PAF) dashboard but not to CCOs' PAFs. Access to the PAF for each CCO would have allowed for a more comprehensive review of VBP models. Interview time allowed only summary-level discussion of VBP experience.

CCO Performance on VBP Milestones in 2021

KEY TAKEAWAYS

- **Fourteen of 16 CCOs met the state's 2021 milestone** of having at least 35% of payments issued under VBP arrangements at LAN category 2C or higher, with an average of 53% of payments in qualifying arrangements statewide. Two CCOs missed the 2021 target.
- **Statewide, shared-risk arrangements saw the greatest proportional increase,** followed by pay-for-performance. Population-based models such as case rates and capitation declined as a proportion of overall payments.
- **CCOs took different paths to grow their VBP portfolios.** For example, one CCO had distinctly more shared-savings agreements than any other, while another cluster relied heavily on shared-risk arrangements. This variation suggests the influence of different organizational and regional factors on VBP implementation.

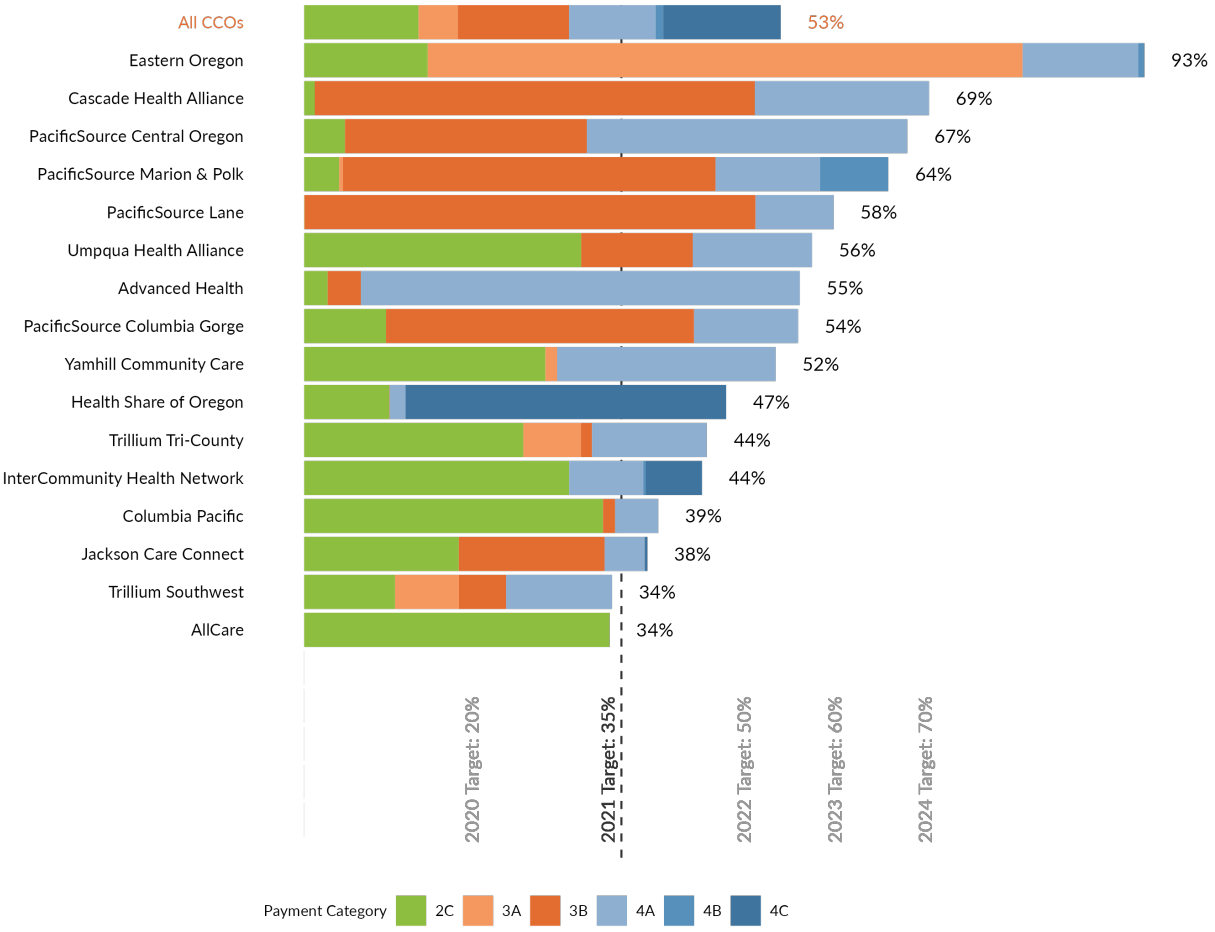
Data source for Section 2: 2021 payment arrangement files

Data from CCOs' payment arrangement files (PAFs), submitted annually to the Oregon All-Payers All-Claims database, show total CCO payments by LAN category. PAF reporting (displayed in Exhibit C) indicates that all CCOs aside from AllCare and Trillium Southwest met the 2021 overall VBP target of 35%. Both CCOs reported 33% of payments at LAN category 2C or above in 2020 and increased by one percentage point in 2021 to land just short of the requirement.

Please note: Quantitative payment data from the APAC dashboard is not available until approximately two years after the calendar year of services. Thus, data displayed in this section reflects payments made in 2021.

Payment arrangement file data from 2021 show that all CCOs except two exceeded the 2021 VBP Roadmap target of 35% or more of overall payments through agreements at LAN category 2C or higher

Exhibit C. Percent of CCOs' total payments in LAN category 2C or higher, 2021



VBP arrangements in 2021 show different patterns between CCOs

Exhibit C shows variations in VBP approaches used by CCOs in 2021. For example:

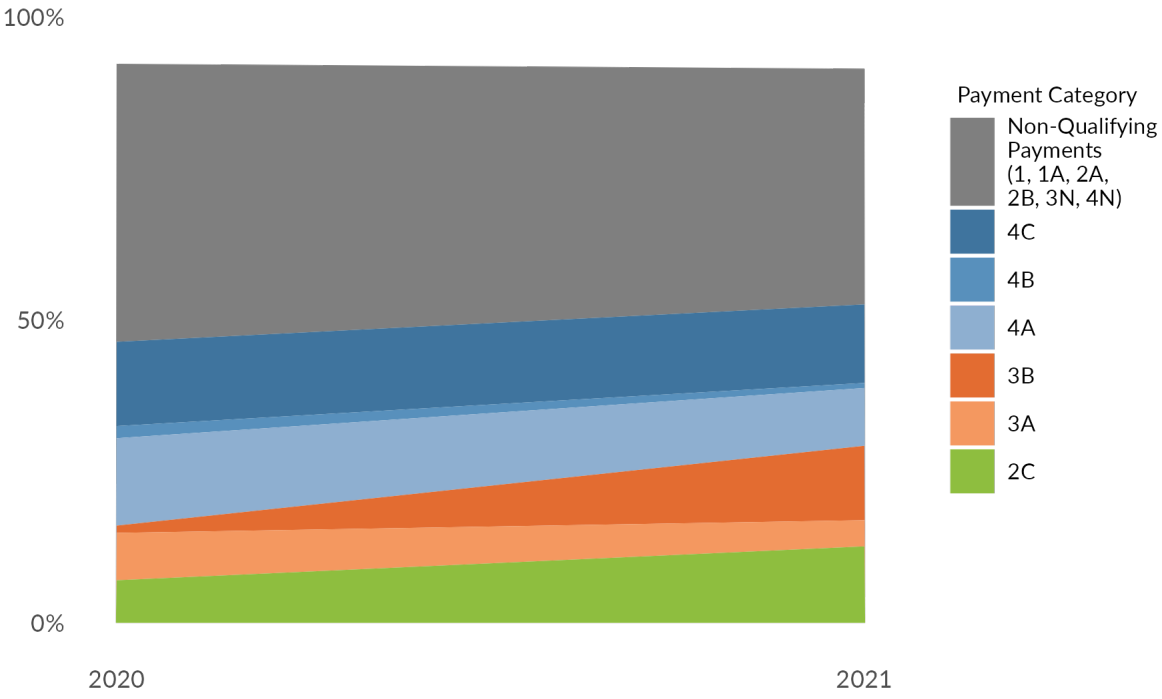
- **Only one CCO (Health Share of Oregon) reported significant payments made through an integrated finance and delivery system (LAN category 4C).** Multiple CCOs had significant portions of their payments made through LAN category 4A arrangements, which include quality-linked population-based payment in specific areas such as behavioral health, oral health, or hospital care.
- **Four CCOs (Cascade Health Alliance and three PacificSource CCOs) had large components of their payments in LAN category 3B arrangements,** which are fee-for-service-based with cost targets and shared downside risk.
- **One CCO (Eastern Oregon) used predominantly LAN category 3A arrangements** (shared savings with quality requirements) in its VBP portfolio.

In 2021, half of CCOs already made more than 20% of overall payments through shared-risk arrangements (a 2023 requirement)

Altogether, more than half of CCOs in 2021 already had enough payments in arrangements in LAN categories 3B or higher to meet the Roadmap's 20% requirement in Year 4. Notably, however, two smaller rural CCOs (AllCare and Columbia Pacific) had yet to establish strong footholds in shared-risk arrangements.

Statewide, overall payments through qualifying VBP arrangements increase from 46% to 53% between 2020 and 2021

Exhibit D. Statewide percentages of payments through VBP arrangements at LAN category 2C or higher



Summed across CCOs, the proportion of overall Medicaid payments occurring through agreements at LAN categories 2C or higher increased from 46% in 2020 to 53% in 2021. As shown in Exhibit D, the largest change was in LAN category 3B agreements, which feature cost targets with shared savings and shared downside risk. Payments in LAN category 2C, pay-for-performance, also increased.

CCO Progress on VBP Milestones and Shared Risk in 2023

KEY TAKEAWAYS

- **CCOs increased payments in value-based arrangements in 2023,** and all but three felt confident of meeting the 2023 overall payment targets. However, staffing and financial challenges among provider organizations and changed utilization patterns among members made providers reluctant to add downside risk.
- **Escalating Roadmap requirements compelled CCOs to consider VBP models in areas some found challenging,** such as hospitals, specialty care, and pharmacy. Some reached out to these providers directly, while others found ways to incorporate their costs into total cost of care arrangements.
- **As overall payment targets climbed, structural and regional factors played a more visible role in CCOs' success** and in the types of VBP arrangements they created. VBP was easier where CCOs and providers were co-owned, or where CCOs could contract with integrated provider organizations, and more difficult for CCOs contracting with numerous, smaller provider groups.

Roadmap targets for overall VBP payment increased to 60% in 2023, with a final target of 70% in 2024. In 2023, CCOs were also required to implement arrangements with downside risk (LAN category 3B or higher). For CCOs without a history of shared-risk arrangements, this requirement presented a significant challenge. Looking at its work in 2023, one CCO executive summarized, "We've got all the low-hanging fruit, and so now we're trying to ratchet up the complexity." A second explained:

Data Source for Section 3: 2023 CCO questionnaires and interviews

> *We're starting to get into the space where the number of providers who are not converted to value-based payment are… There aren't many of them, and they're pretty small providers, or they're large but challenging, like orthopedic surgeons or eye surgeons. What do you [do] for them?*

The majority of CCOs indicate confidence in meeting 2023 payment targets

In mid-2023, CCOs broadly voiced confidence in meeting the two requirements for overall payments in Year 4: the LAN category 2C or above target of 60% and the LAN category 3B or above target of 20%.

Three CCOs were less clear about compliance, including one that experienced recent key staff turnover and two that did not clearly state their status. A fourth CCO assessed itself as right on the line of meeting the 3B target.

CCOs make advances in value-based payment implementation in 2023

Most CCOs reported success in advancing VBP arrangements in 2023, either by developing new models or by advancing models previously in place. These included:

- Signing **pay-for-performance arrangements with two hospitals** after years of negotiation.
- Executing a **system-wide total cost of care (TCoC) agreement** between a CCO and the health system serving the majority of its members.
- Adding a **pharmacy measure to a regional TCoC agreement**, allowing pharmacy costs to count as VBP expenses.
- Advancing a **novel maternity and behavioral health care model** from pay-for-reporting to pay-for-performance.
- Advancing a **new, multi-CCO behavioral health quality incentive model** from baseline targets to improvement targets in its second year.

In several cases, CCOs reported that provider groups, predominantly in primary care, approached them to initiate VBP arrangements. A large Federally Qualified Health Center (FQHC) asked one CCO to take on more risk in exchange for potential savings in managing total costs for patients. Another model involved a community-driven effort to expand a home visiting program for new families, coordinated by a local county health department.

Post-PHE network fragility saps provider interest in new downside risk arrangements, especially in rural regions with minimal history of VBP

"Network fragility" was the term several CCOs used to describe a combination of provider challenges that included shortages in clinical staff, higher costs from relying on locums providers, exhausted financial reserves following the PHE, long wait times for services, and reduced member utilization of primary care. Southern Oregon was particularly hard-hit.

> *We've seen patients showing up with much more acute, especially behavioral health conditions, although we're hearing some about physical health conditions as well. So when they do seek care, it's a much more acute level.*

Cumulatively, network fragility resulted in providers "stressed beyond anything experienced before" and reluctant to add downside risk. CCOs that had not put significant downside-risk agreements in place prior to the PHE found it difficult to persuade provider organizations, particularly hospitals, to move in that direction in 2022. As one said,

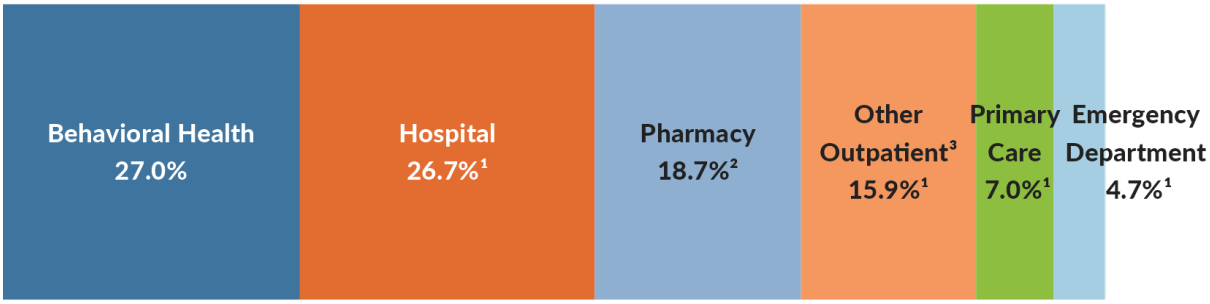
> *Any type of value-based that has risk, providers are just not willing to entertain that, especially hospital providers...The only discussions that they're willing to participate in is upside-only pay-for-performance for a quality metric, no downside risk, so no adjustment to any current revenue for them.*

Higher VBP payment targets for 2023 and 2024 push CCOs into more challenging provider terrain

CCOs turn attention to hospitals, specialty care, and pharmacy, areas with lower historic VBP penetration

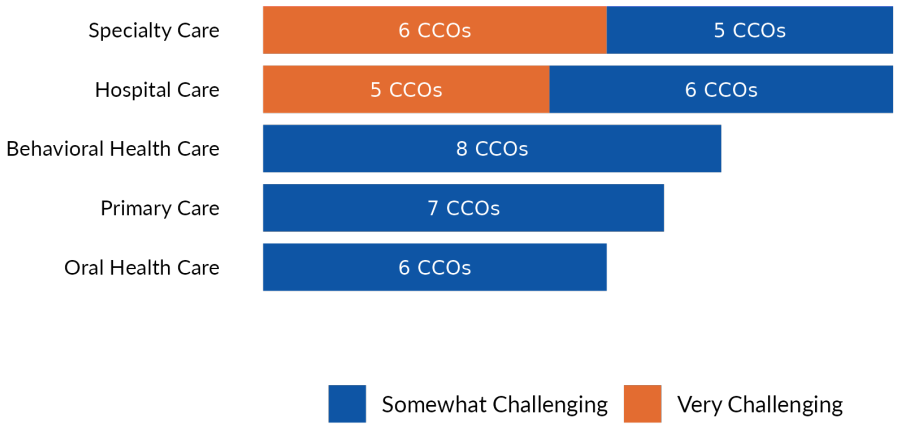
To reach 2023 and 2024 overall VBP requirements, most CCOs needed to approach providers they found more difficult to engage in VBP. Excluding the CCOs that had pay-for-performance or shared-savings pools with all their providers, the new VBP requirements pushed CCOs into three areas where most struggled to establish VBP arrangements: specialty care, hospitals, and pharmacy. Exhibit G shows spending by category of care in 2021. Most CCOs needed to include at least some payments in these three areas within VBP arrangements to reach the 2023 and 2024 targets.

Exhibit G. Break-out of CCO spending by categories of care in calendar year 2021. Hospital, pharmacy, and "other outpatient" (including specialty) made up a large proportion of expenditures.[7]



1. Excludes behavioral health services.
2. Excludes NDC codes on OHA's mental health prescription drug carveout list. Spending measures use imputed prices for claims where the "amount allowed" is zero due to capitation or other payment arrangements.
3. Includes specialty care and other non-primary-care outpatient services. Spending measures for the evaluation were calculated using Medicaid claims/encounters and enrollment records from OHA's Health Systems Division (HSD). The data source and definition of primary care differ from those used in the Primary Care Spending in Oregon report resulting in different percentages of primary care spend.

Exhibit H. More CCOs found specialty care and hospital providers to be either very or somewhat challenging to engage in VBP arrangements compared with other areas of care.



Experiences engaging hospitals varies by region, provider structures, and timing

As in 2022, CCOs had widely divergent experiences engaging hospitals in VBP. Approximately half of CCOs had successful contracts in place with hospitals (or health systems including hospitals) involving

either capitation or shared downside risk of up to 10%, well over OHA's meaningful risk threshold of 3%. The majority of such contracts were executed pre-PHE. However, CCOs lacking pre-PHE hospital VBP arrangements reported little success convincing their hospital partners to accept downside risk. Two CCOs spent over a year negotiating upside-only pay-for-performance models, and a third had yet to succeed at that. One CCO described how it succeeded in executing a LAN category 2C agreement this year:

> *Do we have the right folks in the right place at the right time to work through some of the hurdles? Others, I hate to say it, [it's] kind of a bit of throwing money at it. To be honest, you talk about getting paid for performance, a lot of it does come back to reimbursement. Upside only is the biggest focus. If they see upside and quantifiable upside, then there's investment in it.*

CCO efforts to extend VBP to specialty care are complicated by lack of quality measures and leverage for engaging with small practices

Motivated by overall VBP payment targets and community-specific needs, many CCOs explored VBP negotiations with specialty providers. Approximately half of CCOs held system-wide VBP contracts with vertically integrated health systems that included at least some specialty providers, bringing those services under the VBP umbrella. In contrast, small or rural CCOs frequently had to approach smaller specialty practices unaffiliated with larger groups. Such practices typically served few Medicaid members and thus did not feel strong motivation to enter VBP models.

Five CCOs said that a lack of vetted or OHA-sanctioned quality metrics encompassing both individual- and multi-specialty practices impeded their VBP advancement in this care area. Other barriers included difficulty attributing members to practices and general clinical access shortages. Two rural CCOs were interested in developing metrics for Medicaid member access that could apply across specialties.

> *I think the bigger thing we've been looking at more recently is looking at access and if we could begin to build in more access measures into our specialty contracts… If we could just start on the first level of just being able to get them in the door and enticing a desire to see [our] members, that would be our first step.*

Multiple CCOs negotiated arrangements with small specialty practices to preserve access for members. For example, one rural CCO established a VBP model with the area's sole pulmonologist to maintain local access for members needing sleep studies.

CCOs strategize ways to bring pharmacy costs under VBP umbrella to meet targets

Pharmacy remained one of the largest cost areas not included in VBP for many CCOs. To address Roadmap targets and community needs, CCOs used two main approaches: creating VBPs directly with pharmacy providers, and building pharmacy spending into TCoC agreements with medical providers willing to assume risk for their patients' medication costs.

Using the direct strategy, a group of co-owned CCOs piloted a pay-for-performance arrangement

MODEL FOCUS

Two CCOs had VBP agreements underway with independent small-town pharmacies that played a more critical role in their communities than simply filling prescriptions. One CCO used pay-for-performance incentives to support a small drugstore that delivered medications to members, helped fill immunization gap lists and had done mobile COVID-19 tests during the PHE. Another CCO was aiming to enlist rural pharmacies to screen for social needs and share this data through Unite Us.

"As the state's investing in social determinants of health and health equity and these mobile clinics and everything else they're doing, you already have that with these community pharmacies too, especially in these rural regions." – CCO staff

with its pharmacy benefits manager that it subsequently expanded. Two other CCOs were exploring VBP models to support critical access pharmacies in rural areas, as rural pharmacists typically interacted more regularly with members than medical providers and required additional support to stay solvent.

Four other CCOs included pharmacy costs in TCoC arrangements with large provider groups or CCO-wide risk pools so that costs qualified as VBP expenditures.

With escalating Roadmap payment targets, CCOs approach common challenges with a range of solutions

CCO arrangements reflect influence of organizational and regional context

As CCOs faced the challenge of bringing more hospital, specialty, and pharmacy costs under VBP arrangements, the role of regional and structural factors became more visible in their strategies and levels of success. Exhibit I (see next page) lists a range of factors that CCOs associated with their VBP success or difficulty.

Total cost of care arrangements and the "layer cake" of VBP

While much early VBP effort focused on VBP arrangements made directly with individual providers — primary care, behavioral health, hospitals, and others — higher targets in later years of the Roadmap encouraged CCOs to include expenses in VBP arrangements indirectly though TCoC arrangements. In these arrangements, one provider organization (for example, a large FQHC) assumes risk not only for its own spending on attributed members, but for all costs incurred in member care — including that by unaffiliated provider organizations.

CCOs began reporting these arrangements earlier in the Roadmap, but they expanded markedly in 2023. TCoC arrangements had several permutations, depending on which services were included:

- One group of FQHCs was in its second year of a shared-accountability model featuring shared savings and risk for **all member medical expenses.**
- Two CCOs with primary-care capitation models had layered on a TCoC component. In one CCO, the TCoC assessment included not only medical costs, but also **oral health and non-emergency transportation services,** although maternity care was carved out.
- Almost half of CCOs had large LAN category 3B (shared risk/savings) agreements with large integrated systems that captured **nearly all categories of medical services.**

In addition to TCoC arrangements with individual providers, about half of CCOs had general CCO-wide shared-risk/shared-savings pools. Some were opt-in and others mandatory. Levels of shared risk also varied. Typically, the pool compared all plan expenditures to a predetermined target, or the CCO kept a withhold for plan-wide performance. In Year 4 of the Roadmap, these arrangements resulted in what one CCO described as a "layer cake" of overlapping VBP arrangements, some provider-specific, some broader.

Provider communications and engagement with data within TCoC and large shared-risk models vary

Levels of provider engagement in TCoC models varied depending on where risk was held. When CCOs worked with a single provider (for example, a large FQHC) that assumed risk for TCoC of members, CCOs described high provider engagement in monitoring population health, attending to service gaps, and ensuring services were coordinated to manage costs. In contrast, engagement with performance data was more variable within large system-wide agreements. It was unclear how consistently providers within these systems understood their role within the VBP model or received data on individual performance. One CCO that had

Exhibit I.

CCOs describe structural and regional factors that facilitated advances in VBP arrangements and shared risk, as well as a few factors that created barriers

CCO OWNERSHIP STRUCTURE

+ CCOs have shared ownership with their provider networks, aligning financial interests.

  One-third of CCOs were owned in whole or part by contracted providers. One CCO reports a portion of its expenditures as an integrated delivery system (LAN category 4C), and a second CCO shared its intent to start reporting as a 4C in 2024. CCOs with shared ownership indicated an easier time executing shared-risk arrangements, since financial impacts were mutual.

  "The ownership structure of [CCO] includes virtually every large provider organization in the area, including [local physicians' association]. And so, when there's some new policy or some new requirement, typically, our providers come to the table and we'll do whatever is needed to ensure [CCO] is a high performer."

+ CCOs' parent companies own multiple CCOs, providing shared infrastructure and potential for cross-regional arrangements.

+ CCO parent companies have other lines of business, allowing them to leverage other relationships for Medicaid arrangements.

PROVIDER OWNERSHIP AND MARKET STRUCTURES

+ CCO's region has vertically integrated systems or a large IPA able to manage most member services.

  "You have this nice thing in [region], you have this entity called [IPA name] that has 600 docs that are all part of one contract. So that means you sweep up all the specialists and all the PCPs and whatnot. Some communities don't have an IPA like that... it's a little harder when you don't."

+ CCO's region has large FQHCs with integrated oral or behavioral health care and strong capacity to manage member needs.

Barriers

– The CCO must contract with small, unaffiliated practices without strong HIT infrastructure, financial relationships with other providers, or large Medicaid patient panels.

– Major provider organizations such as hospitals have out-of-state ownership.

  "The other challenge is that the decision makers for these contracts are sometimes in a different state. And so there can be difficulties helping those decision makers understand what we're doing, why we're doing it, and having them feel comfortable with the contracts that we're proposing."

– Geography leads members to seek services outside the region, where health systems were less invested in the CCO's priorities.

  "Those entities probably don't want to participate with a little regional plan, in a value-based payment, and it doesn't make sense either sometimes."

RELATIONSHIP FACTORS

+ CCOs and provider communities have a history of trust and collaboration.

  "We're not going to surprise anybody, and we are not going to make decisions unilaterally that might harm somebody. And if the program doesn't go the way we think it's going to go, then we'll change it."

+ CCOs have succeeded at drawing providers (and other community organizations) to a "shared table" based on mutual interests.

  "We have two of the hospitals that actually are represented on our board of directors. They're at the table and engaged with us and committed to the work in regards to what [CCO's] trying to do."

just executed a large health-system contract was considering how to support clinicians in embracing their role in the arrangement.

> *This is really understood very well at the senior leadership levels, on both our sides. But how do we communicate this down to the PCP level? And even how to get some of the funds down to the PCP level, so they can understand how they really influence the greater financial targets?*

Another CCO recently created a VBP model in which, for the first time, behavioral health providers received incentive payments specifically tied to their own programs, rather than based on CCO performance overall. The CCO noted higher levels of provider engagement under this new structure.

> *I think the value-based payment arrangement made sure that folks were looking at this on their individual performance and not just as a CCO-wide, since it is [multiple] counties.*

CCO challenges and requests for assistance in advancing VBP

During interviews, OHA invited CCOs to identify areas where technical assistance from the state could facilitate their VBP efforts. CCOs offered a number of suggestions, summarized in Exhibit J.

Exhibit J. CCO challenges and requests for OHA support

VBP Area	Challenge or need
Provider communication and convening	CCOs asked OHA to communicate its VBP expectations and Roadmap goals more directly to provider groups in the state. *"We love it when we can say, 'This is what the OHA has said we have to do. Let's work on this together.' And so there's some theme in some of these TA questions around, is there a possibility to … take us out of the messenger role and have some more kind of provider-directed guidance?"* CCOs also asked for help explaining to providers how the VBP Roadmap was related to the state's work on sustainable health care cost targets.
Quality measures	Five CCOs asked for OHA assistance in adding to the limited selection of state-endorsed quality measures for hospital and specialty care to facilitate VBP in those areas.
Financial reporting	For some CCOs, the state's APAC and Exhibit L reporting formats were barriers to reporting certain kinds of VBP arrangements – particularly those with THWs. *"I just want to make sure that it's understood that some of the Schedule L reporting requirements around value-based payment really [limited]me with what I want to do on maybe an arrangement, because as we're creating an arrangement, I'm always in the back of my head, 'Can I report this on schedule L the way they need to?'"*
Social risk adjustment	Half of CCOs voiced interest in adjusting payment based on member social determinants but wanted OHA support in identifying viable methods and ensuring that efforts would align with the state's social-needs screening measure and related programming.
MLR requirements	Two CCO leadership teams asked for clarification on medical-loss ratio requirements for subcontractors in the 2022-2027 CCO waiver. They anticipated less provider willingness to engage in capitated agreements if providers were not allowed to retain upside revenue in good years.
Workforce supply	Because provider shortages constrained member access and provider performance, CCOs were interested in models that used VBP to develop and sustain health care workforce.

CCO Advancement in PCPCH Payment Structures in 2022

KEY TAKEAWAYS

- **Only half of CCOs increased PCPCH infrastructure payments in all tiers between 2022 and 2023,** as required by the Roadmap, although statewide average payments increased modestly at each tier.
- **PCPCH payments continued to vary widely between CCOs,** with the highest payments approximately 10 times higher than those of the lowest-paying CCOs.
- **About half of CCOs offered enhanced payments within PCPCH tiers** for extra features such as integrated behavioral health or pharmacy support, access to traditional health workers, or services for rural populations.

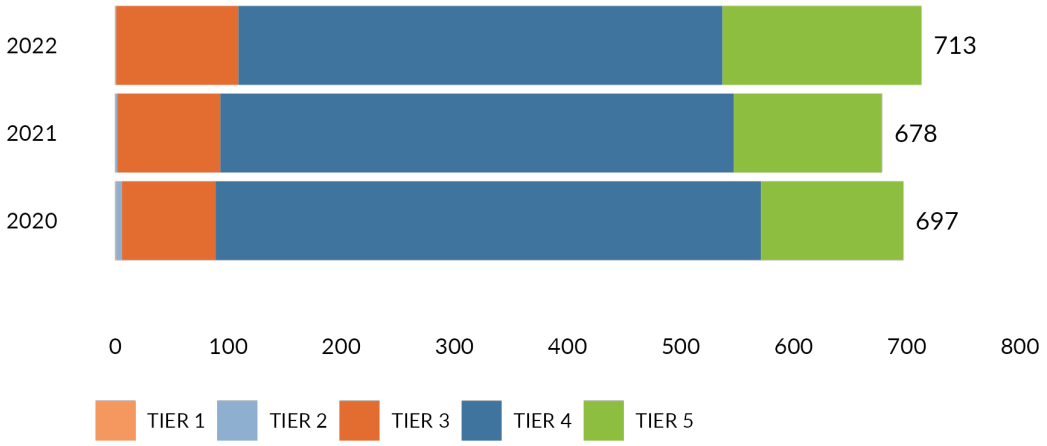
Data Sources for Section 4: 2023 CCO Interviews, 2023 PCPCH and CDA Data Templates

The Roadmap requires CCOs to make infrastructure payments to patient-centered primary care homes (PCPCHs) recognized through Oregon's five-tier system. CCO infrastructure payments must advance by PCPCH tier, with practices in higher PCPCH tiers receiving higher payments. Payments must also increase each year during the CCO contract cycle. Infrastructure payments by themselves fall into LAN category 2A and do not count toward Roadmap targets for overall VBP payments, unless combined with other payment models in higher LAN categories.

The number of qualified PCPCHs grows slightly in 2022, with more practices moving to the highest tier

Exhibit E shows the distribution of CCO-contracted practices by PCPCH tier. For 2022, only one CCO reported contracting with practices in tiers 1 and 2. The count of practices in tier 5 increased in 2022.

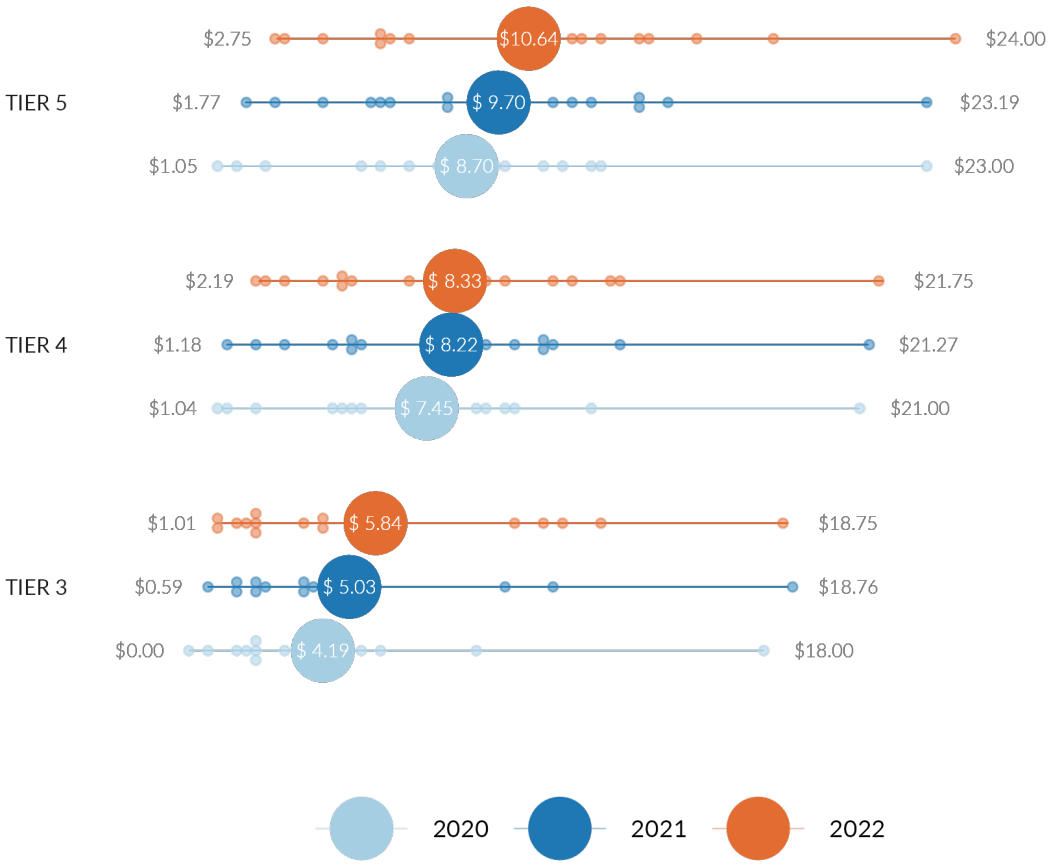
Exhibit E: Count of PCPCH contracts held by CCOs, 2020-2022, by tier.



Average per-member per-month payments increase from 2022 to 2023 in tiers 3 to 5

Exhibit F shows changes in average PCPCH payments between 2020 and 2022 for tiers 3-5. (Tabular payment data for all tiers is displayed in Appendix C.) For 2022, 50% of CCOs increased average PCPCH payments in all tiers. The other half did not increase average payments in at least one PCPCH tier. In interviews, CCOs described paying higher PMPMs for clinics with high performance or those offering enhanced features (for example, behavioral health integration). Changes in the number of practices in each tier receiving these higher rates may explain the lack of increased averages in some tiers. In addition, several CCOs active in multiple regions transitioned PCPCH payments to a single standard dollar figure. Payments continued to vary widely across CCOs.

Exhibit F: Range of payments made by CCOs to PCPCHs in tiers 3-5, 2020-2022. Average payment amounts are indicated in the center circle.



Note: Minimum and maximum values reflect the lowest and highest dollar PMPM payments by any CCO to a PCPCH in that tier. The average PMPM is the mean of all CCOs' reported average PMPM payments in that tier, weighted by their clinics' attributed Medicaid members. Source: 'PCPCH+CDA Data Templates' submitted by CCOs to OHA for the 2020-2022 calendar years.

Some CCOs provide enhanced infrastructure payment for extra practice features

For 2020 and 2021, some CCOs reported a range rather than a single figure for PMPM payments at each PCPCH tier. Roadmap interviews in 2023 confirmed that a subset of CCOs offered enhanced payment to practices meeting specific criteria. Examples included:

- One group of CCOs with a primary care VBP model used higher PCPCH rates to incentivize **clinical quality performance and integration of behavioral and oral health services.**
- A rural CCO used enhanced PMPM payments to reward practices **seeing more than 500 CCO members** and practices **more than 10 miles outside a city center**.
- Several other CCOs paid extra to clinics for **advanced features** such as having behavioral health or pharmacy providers on staff, offering case management and traditional health worker (THW) services, and treating members for mild and moderate mental-health conditions and substance use disorders.

In 2023, OHA updated guidelines for PCPCH payments in the VBP Technical Guide for CCOs.

VBP Implementation in Priority Care Delivery Areas

KEY TAKEAWAYS

- **Almost all CCOs met the requirement to have four CDA models in place for 2023.** These included models in behavioral health, hospital care and maternity care that were due in 2022, plus a new or expanded model in either oral or children's health.
- **CCOs' interpretation of requirements varied,** with some CCOs developing entirely new or innovative models and others reporting pre-existing VBP models with minimal tweaks.
- **CCOs chose a mix of oral health and children's care models** for the new 2023 requirement, although all CCOs reported having capitated oral health models in place, most pre-dating the Roadmap.

The Roadmap identifies five areas of health care services in which CCOs must develop and implement new or expanded payment models. In 2022, CCOs completed and reported on the first round of required CDA models, consisting of behavioral health, hospital, and maternity care. For 2023, CCOs supplied updates on 2022 models and reported on the additional required model in either oral health or children's health care.

Data Sources for Section 5: 2023 PCPCH and CDA Data Templates, 2023 CCO Interviews, 2023 Questionnaires

Models must meet criteria for LAN category 2C or higher and include a quality metric specific to the CDA. CCOs may pair two CDAs in a single model (for example, hospital and maternity care). While the Roadmap does not provide a definition for model expansion, verbal communications from OHA confirmed that adding new metrics, services, or populations would qualify. The Roadmap does not specify a minimum or maximize size (in dollars or included members) for CDA models.[3]

In this section, we review CCOs' work to date implementing the models in these five CDAs. Descriptions of some models during interviews differed from what CCOs previously submitted in their reporting templates. In these cases, the evaluation team relied on the more recent interview data.

OHA expectations for CDA models

"[Models are expected] to achieve significant advances in the way health care is paid for, with a strong focus on value and quality, to promote an integrated approach to providing physical, oral and behavioral health services at the level of care delivery (as opposed to solely financial integration). In addition, OHA encourages payment models that include traditional health workers (THWs), who are an integral component of Oregon's health care delivery system, meeting members' and community health needs, while delivering high-quality and culturally competent care."

The Roadmap does not specify a minimum or maximize size (in dollars or included members) for CDA models. To meet the CDA requirement, models must fit into LAN category 2C or higher.

– VBP Technical Guide for CCOs

Behavioral health CDA models

15 of 16 CCOs report behavioral health models, 13 ongoing from 2022

CCOs first reported new or expanded VBP models for behavioral health in 2022. Thirteen CCOs carried these models forward through 2023, while one CCO reported a new arrangement, and another CCO that hadn't previously reported a model added one for 2023. Exhibit K shows a summary of reported models.

Exhibit K. Behavioral health models for 2023 care delivery area requirement

LAN Category	Count	Description
Category 4	7	Most category 4 models were capitation arrangements, typically with community mental health organizations offering comprehensive mental health or substance use disorder (SUD) services to a population. One CCO reported a "capacity" arrangement that maintained space for CCO members within the practice. The one new model reported in 2023 funded additional staff for rural outreach in a county behavioral health program.
Category 3	7	Three models were part of larger agreements with health systems that included both behavioral health and medical services. Two were models specifically for behavioral health programs, and two were TCoC agreements including both behavioral health and primary care providers.
Category 2	1	One CCO reported a pay-for-performance model with behavioral health providers.
Under development	1	One CCO did not report a model in June 2023.

New VBP models, enhanced provider payments breathe new life into behavioral health services despite ongoing challenges

Access and workforce challenges continue to slow VBP efforts, but CCOs see payoffs

CCOs reported workforce shortages and other challenges that continued to hinder novel contracting efforts this year. One executive commented, "I think because the network is fragile, we can't be too creative and innovative on the behavioral health side, as much as we want to." One CCO provided workforce recruitment support to its community mental health centers, and others were looking for ways to wrap workforce-development projects into VBP arrangements. CCOs concurred that electronic health record (EHR) and data analytics capacity among behavioral health providers generally lagged behind that of medical providers,

making reporting and integration of behavioral health service data with other data more complicated. VBP participation could bring enhanced support for reporting; for example, one CCO provided access to its analytics platform so providers could track metrics performance.

Despite these challenges, CCOs reported several successful new arrangements over the past two years. New quality measurement strategies at four CCOs got positive receptions from providers, with one CCO reporting increased peer service engagement and use of medication-assisted treatment. A unique maternity care and SUD treatment model advanced from pay-for-reporting only to pay-for-performance. Another program saw reduced emergency department use in its integrated VBP arrangement for high-needs members. Two rural CCOs used "capacity" payments in their models to fund provider staffing for specific services, or to reserve service capacity for CCO members. Capacity payments may fit LAN category 4 if they include defined services and populations.

"Homegrown" quality metrics incentivize access, care coordination, and other local needs

CCOs continued to use customized or "homegrown" measures to steer provider attention to identified care-delivery goals. Among these were timeliness of care, care coordination and case management, access to supports such as peer workers, and use of medication-assisted treatment for SUD. Three CCOs used homegrown measures of emergency department utilization by members with mental health conditions as indirect indicators of behavioral health care access. CCOs also incorporated OHA incentive metrics such as the Initiation and Engagement of SUD Treatment and Assessments for Children in DHS Custody measures.

Additional funding for providers opens doors and precipitates other challenges

In 2023, OHA increased rates for behavioral health and required CCOs to distribute one-time directed payments to providers as authorized by the Oregon Legislature. Several CCOs commented that the additional funding had "sweetened the pot" for providers to participate in VBP arrangements or had opened new, more expansive conversations with providers who were previously reluctant to increase services. One CCO remarked:

> *I've been saying to [county provider], "Let's not use our current capitation rate as a ceiling." They have been underspending in there. But they say, "We don't want to increase our services because you're not going to give me more capitation." … But with the behavioral health-directed payments, it's really freed up the conversation of, "Yes, what do you need? We've got money here. So let's talk about big picture stuff and let's get big about mental health."*

At the same time, several CCOs commented that OHA's roll-out of the payments was oriented toward a fee-for-service payment structure, both contradicting the aims of the Roadmap and complicating payments for CCOs using VBP. In addition, one rural CCO noted that rate increases led providers to leave community agencies to set up their own practices.

> *We used to just have two very large entities to work with and very few independents. And it's starting to change, where we're having a lot of independents. I don't know how interested they are in shared risk models and value… I'm concerned this is a net access problem for our sicker and more needy individuals who tend to be serviced in one of these organizations.*

CCOs contemplate future behavioral health models to address specific populations and needs

Several CCOs shared aspirations for future VBP models that would support specific populations by incorporating funding for services difficult to bill directly, such as health-related services and support from THWs, on-staff pharmacists, social workers, and integrated pediatric behavioral health providers. One CCO got positive responses to a new feedback-informed treatment model and was building a VBP model around it.

Hospital care VBP models

14 CCOs report hospital care VBP models, though some miss requirements

As with behavioral health, 2023 was the second year in which CCOs reported hospital VBP models for a Roadmap milestone. The overall distribution of models across LAN categories remained the same, although CCOs updated some arrangements. Exhibit L summarizes reported models.

Exhibit L. Hospital models reported for the 2023 care delivery area requirement

LAN Category	Count	Description
Category 4	3	Continuing models included facility capitation for a DRG-based hospital, an inpatient maternity services case rate, and a per diem rate for skilled-nursing level care for patients without an appropriate discharge setting.
Category 3	9	Most category 3 models featured shared savings and downside risk (category 3B). Two revised models fell under category 3A because shared risk did not meet the minimum 3% standard. Most models included all hospital services, although one was with a behavioral health hospital.
Category 2	2	Two CCOs reported arrangements featuring incentives or penalties based on performance on hospital-related quality metrics.
Under development	2	Two CCOs had not yet implemented models as of June 2023.

Broad shared savings and risk arrangements continue to make up the majority of reported hospital CDA models

As in 2022, the majority of reported models included comprehensive hospital services with either shared financial risk or pay-for-performance. Other models included a similar comprehensive agreement with a specialty psychiatric hospital, an inpatient maternity case rate, and a per diem rate for inpatient intravenous drug therapy for members with no suitable discharge options. One rural CCO that did not complete a hospital model in 2022 was able to join an existing model with its larger sibling CCO. Readmissions were the most common quality measure, included in six models. Four CCOs incorporated C-section rate measures, and five used infection-related or care transition measures.

Three models appeared not to satisfy Roadmap requirements. Two featured hospital services within larger vertically integrated provider contracts that did not include hospital-specific metrics. The third used a per diem rate, which does not fall into the Roadmap's qualifying LAN categories. One respondent explained the absence of hospital metrics in the CCO's model:

> *Sometimes there's objections to that or you just get pushback, and not everybody views the same hospital metric with the same smile on their face. And so sometimes you get some hospitals that say, "Hey, I don't want to be beholden to that." Sometimes you hear, "We don't do very good on that, so I don't like that metric." And you just have to work with those providers. And sometimes that means, well, we're going to try for it again next year.*

"Cratered" workforce, increased costs, challenges with metrics dampen enthusiasm for new arrangements and risk

As discussed in Section 3, CCOs that had not negotiated downside risk arrangements with hospitals before the PHE found it an uphill battle to introduce these in 2023. Post-PHE, CCOs described a "cratering" of workforce and fragile provider financial status that made hospitals averse to taking on any new risk. One CCO

was trying to engage a hospital that perceived Medicaid as a money-losing line of business and did not want to adopt metrics the CCO found relevant to its population. These challenges were not seen in all cases. A rural CCO found a reluctant hospital more prepared to "come to the table" in search of VBP support for workforce recovery. A second CCO described how one of its small hospitals had benefitted financially from low utilization during the PHE and had managed to keep expenditures low even as systems recovered.

Maternity care VBP models

14 CCOs report maternity care VBP models, several with updates from 2022

Maternity care was the third required CDA to continue from 2023. In 2022, the two main approaches to maternity care VBP were models that bundled care for hospital and outpatient settings and models targeting single provider types. This year, 14 CCOs submitted models for the maternity CDA milestone. Exhibit M displays these models.

Exhibit M. Maternity care models reported for 2023 care delivery area requirement*

LAN Category	Count	Description
Category 4	2*	Two CCOs had episode-based maternity arrangements.
Category 3	8	Two CCOs had 3B maternity/hospital arrangements, one tracking elective deliveries and one C-section rates. Four CCOs had category 3B arrangements for prenatal and postpartum care, including one for a public health home visiting program. One CCO had a category 3A maternity medical home with pay-for-performance for prenatal engagement. Another had a 3A maternity episode with a bonus for timely postpartum visits.
Category 2	4	One CCO reported a pay-for-performance model for a maternity medical home, while two others reported models at the 2C level supporting peer opioid use disorder services for pregnant members. One CCO had a 2C maternity/hospital arrangement with a C-section metric.
Under development	2	Three CCOs had not yet implemented models as of June 2023.

**At least one CCO described models in interviews that were not reported on its formal CDA reporting template.*

Changes from last year's maternity care models show the complexity of implementing arrangements in this care delivery area

Of the 11 CCOs that maintained the same models from 2022-2023, all but two stayed in the same LAN categories, with one advancing to a higher LAN category and one moving down from category 4 to category 2. One CCO reported a qualifying model for the first time in 2023. Three models were revised downward from LAN category 4 to category 2 or 3 because the CCOs had not fully implemented payments in category 4. Two were reclassified to category 2C (pay-for-performance), and the third CCO reported a different model in category 3B. Several CCOs added metrics, expanded covered populations, or increased the dollars invested in maternity models to meet the Roadmap requirement. Interviews highlighted the difficulty of advancing maternity models in some rural communities due to small numbers, the temporary nature of the population, attribution issues, and the complexity of working with the multiple provider types involved in maternity care.

As in 2022, most CCOs used the OHA incentive quality metric Prenatal and Postpartum Care, although three used C-section rates and one continued its elective delivery rate measure. The frequent choice of the OHA prenatal and postpartum measures illustrated the influence of the state's incentive measure selections on VBP design at the CCO-to-provider level; one CCO commented that providers might resist taking on a metric

that was not part of the incentive metric set. CCOs using the C-section metric set different performance targets, suggesting this measure could be an area for greater statewide alignment.

> *The [hospital] team that's been working specifically on that C-section rate is really engaged… In fact, they wanted to set a more aggressive target than I even thought we would do.*

Innovative models integrate social services and THW support with maternity care

Three CCOs had maternity models integrating non-traditional providers such as THWs or public health nurses, while two more CCOs had similar models in the development stage. Additionally, two CCOs had maternity medical homes that included wrap-around services and equity-focused quality measures such as the OHA Meaningful Language Access metric.

Children's health CDA models

7 CCOs report children's health care arrangements to satisfy the additional 2023 CDA requirement

The Roadmap required CCOs to develop one additional new or expanded CDA model for 2023, in children's health or oral health care areas. Seven CCOs reported children's health care models, summarized in Exhibit N.

Exhibit N. Children's health models reported for 2023 care delivery area requirement

LAN Category	Count	Description
Category 4	3	Two models integrated pediatric quality metrics into capitated agreements, one within a primary care model with a pediatric-specific cohort, and the other within a capitated oral health model. At third CCO was using capacity payments to provide mental health and Child and Adolescent Needs and Strengths (CANS) assessments for children in Department of Human Services (DHS) custody.
Category 3	1	One CCO reported a model within its broader shared-savings arrangement that paid incentives to providers who were the first in the community to assess a child in DHS custody.
Category 2	3	Three CCOs had similar models that offered performance incentives to primary care homes with pediatric-specific care models.
Under development	9	Nine CCOs did not report pediatric models for 2023.

Children's health models make use of existing pediatric and primary care arrangements

Most models integrated pediatric-focused metrics from the OHA incentive metrics set into existing primary care agreements. Pediatric-specific practices were not prevalent in all regions, so some agreements were with general primary care organizations. Two CCOs had models focused on screening and services for children in Department of Human Services (DHS) custody – one incentivizing providers to perform these assessments, and the other funding assessments through a community-based organization. One model incorporated pediatric measures into a dental care arrangement, linking children's and oral health models.

CCOs encounter challenges due to changes in utilization patterns and limited pediatric measures

CCOs described little pushback to implementing children's care VBP models. However, concerns around access and utilization were pressing in some regions. Providers in one southern-Oregon CCO observed shifts in member behavior toward decreased primary care use and higher resistance to immunizations, causing the CCO to scale back quality improvement targets. One CCO had difficulty choosing measures for a pediatric model because it had already built all OHA pediatric-related metrics into its CCO-wide incentive model and was unsure how to expand further.

Two CCOs implement innovative children's health models and access strategies

In addition to the community-based model supporting children in DHS custody, one CCO had a care model for pediatric asthma under development and others were contemplating models to serve children with special care needs. To address access concerns, a rural CCO had negotiated a performance penalty that one of its largest providers would pay if it did not complete services for a predefined number of children.

Oral health VBP models

12 CCOs report oral health care VBP models, although all 16 had oral health care VBP arrangements in place

Twelve CCOs reported oral health models for the 2023 requirement. The four remaining CCOs did not submit complete information on metrics, risk and performance for oral health arrangements although, based on CCO interviews and surveys, all 16 CCOs had capitated oral health contracts, including 15 with dental care organizations (DCOs). Exhibit O outlines models reported this year for the CDA requirement.

Exhibit O. Types of oral health models reported in 2023

LAN Category	Count	Description
Category 4	12	All but one CCO had capitated contractual arrangements with one or more DCOs. Twelve CCOs reported these in 2023 to meet the Roadmap's oral health CDA requirement. Eleven CCOs incorporated all or mostly OHA incentive metrics into their arrangements, including the preventive dental or oral health services for children 1-5 and 6-14 metrics; almost half integrated screening for chronic conditions.
Under development or not reported	4	Four CCOs did not report on oral health in data template spreadsheets. Based on interviews and survey data, they had LAN category 4 capitated arrangements.

Nearly all oral health models use OHA incentive metrics

Eight of the 12 reporting CCOs used performance incentives and penalties in their capitated arrangements; three had incentives only and the other was not reported. Eleven CCOs used all or mostly OHA incentive metrics, most commonly the metrics for preventive dental or oral health services for children 1-5 and 6-14. Four CCOs incentivized provider performance on the OHA incentive metric on mental, physical, and oral health assessments for children in DHS custody within 60 days. Several CCOs incentivized care integration for chronic conditions with metrics for oral evaluation for diabetes, tobacco screening and cessation, and hypertension screening. One CCO used only custom metrics, and two CCOs added a custom dental services utilization measure to their metrics suites.

CCOs enhance long-existing capitated plans with DCOs to satisfy Roadmap requirements

Fifteen out of 16 CCOs contracted with DCOs for member care, 11 exclusively. One CCO highlighted the benefits of DCO administrative and analytic capacities for VBP. The majority of CCOs reported knowing that their DCOs used VBP models with individual dental provider groups, although only one group of CCOs required this in contract.

As most CCOs had implemented oral health capitation prior to 2020, several enhanced their existing models with new measures, increased risk levels, or new features such as integration within primary care. Four CCOs built connections between primary and oral health care. One CCO provided capacity payments to DCOs to expand the role of dental hygienists by screening patients for hypertension and diabetes. Three other CCOs incorporated an opt-in program within primary care homes for providing fluoride varnish, oral health education, and referrals to dentists. Three CCOs introduced OHA's Meaningful Language Access metric to address problems with low access to qualified or certified interpreters in oral health settings. One CCO noted many members are unaware of their oral health benefits and it hoped to see increased oral health access with referrals from primary care.

> *We're really trying to build that pathway to get people connected into that benefit and utilizing that as a resource, because we know a lot of people don't realize they have that.*

Provider supply issues add difficulty to oral health VBP in some regions

Similar to other care areas, oral health experienced acute provider shortages and high turnover, especially in rural areas with private practitioners. CCOs, particularly those with high percentages of independent practitioners, faced difficulty with provider willingness to accept Medicaid patients and enter VBP arrangements.

> *It [contracting] is still so predominantly with our delegates, it's predominantly their staff model clinics there because there are so few dentists who will contract with Oregon Health Plan.*

One CCO also mentioned that smaller standalone practices were less likely to have EHRs and administrative resources beneficial for VBP, but that a few more practices added EHRs in the past year.

Summary of progress in advancing CDA VBP models

CCOs largely continued to meet Roadmap requirements for developing new or expanded models in selected areas of care in 2023, with some irregularities. Two CCOs continued to miss reporting for at least one required model, and two models were missing required CDA-specific quality metrics. Several models featured payment categories (like per diem rates or capacity payments) that met important CCO needs but did not fit into qualifying LAN categories. In some cases, CCOs did not include quality metrics specific to the CDA model.

For the additional children's health or oral health CDA model due in 2023, about half of CCOs reported arrangements in children's health. All 16 CCOs reported models in oral health care as part of their CDA reporting or described them during interviews. Many of these oral health models were long-standing capitated or percent-of-premium arrangements with regional DCOs. In some cases, CCOs included additional quality metrics or confirmed that VBP arrangements were in place with front-line providers as well.

The Roadmap requires models submitted for the CDA requirement to be either new or expanded in some way, although OHA omitted strict criteria for "expansion" to allow room for CCO innovation. CCOs' interpretation of the expansion requirement varied, with some creating new arrangements or adding new quality metrics while others submitted existing VBP arrangements with minimal changes. During interviews,

CCO Progress in Monitoring and Reporting on VBP Performance

KEY TAKEAWAYS

- **CCOs made incremental advances in VBP capacity between 2022 and 2023.** They increased the use of platforms that integrate electronic health records with claims data and employed stronger internal systems to track VBP arrangements. At least one CCO struggled to report on VBP Roadmap compliance due to health information technology challenges.
- **CCOs still lacked adequate strategies for monitoring for adverse impacts of VBP on health equity and using VBP to promote health equity.** While CCOs were interested in leveraging VBP to support equitable care, they were hampered by incomplete member REALD data, small numbers for some metrics and programs, and challenges with integrating REALD information from multiple sources. There was little consistency in approaches across the state.
- **With health-related social need benefits coming up in the 2022-2027 Medicaid waiver, CCOs requested guidance from OHA** in integrating social-need factors into VBP and coordinating across the state's initiatives related to social needs.

CCOs reported on the three primary ways they were using health information technology (HIT) to support VBP arrangements:

Data Sources for Section 5: 2023 CCO Interviews, 2023 Questionnaires

- Monitoring their payment arrangements by LAN category to ensure Roadmap compliance.
- Exchanging data with providers to assess and report on VBP performance.
- Monitoring whether VBP arrangements were creating or exacerbating health inequities.

Monitoring payment arrangements by LAN category

CCOs did not find ready-made applications for tracking contract expenditures by LAN category (as required for Roadmap reporting); thus, tracking remained a manual process. One group of CCOs with multiple lines of business completed a major database development project, building their capacity to track and administer value-based arrangements across products. A small CCO supplied a cautionary tale for manual monitoring: After a key team member left the organization, remaining staff struggled to understand the CCO's portfolio of contract arrangements.

Exchanging data and VBP performance information with providers

More CCOs move toward real-time bidirectional platforms incorporating EHRs, claims, and population health data

In 2022, three CCOs used commercial platforms with the capacity to combine provider EHR data with claims and other information to assess VBP performance, identify population health opportunities, model risk, and draft new arrangements. In 2023, another group of co-owned CCOs was piloting the Payer Platform in Epic, enabling a similar combination of data and exchange of information.

CCOs found these tools to be powerful facilitators for VBP. The platforms enabled new kinds of arrangements and supported performance analytics for providers whose own HIT systems were suboptimal. The risk-assessment module in Arcadia, a commercial platform, allowed one CCO to set rates informed by member EHR data, a feat instrumental in setting up a large TCoC agreement. A CCO piloting Epic Payer Platform hoped the real-time exchange of data with providers would allow a shift to a quality measurement paradigm that focused less on "counting widgets" and more on assessing total costs and downstream outcomes.

> *If we can get widespread adoption of Epic Payer Platform, I think we're going to see a lot of clinics more willing to engage in more complex VBPs. Like right now... because we don't have that bidirectional data feed it's like, "We'll give you a patient list with this thing and then you run that against yours so that you can then reconcile the data and then you send us back the data and then we evaluate to see how you've performed." Which is a whole lot of admin burden on both sides. Whereas this, hopefully, would allow technology to take care of that, and then we just get to look at performance. I mean, that's the dream.*

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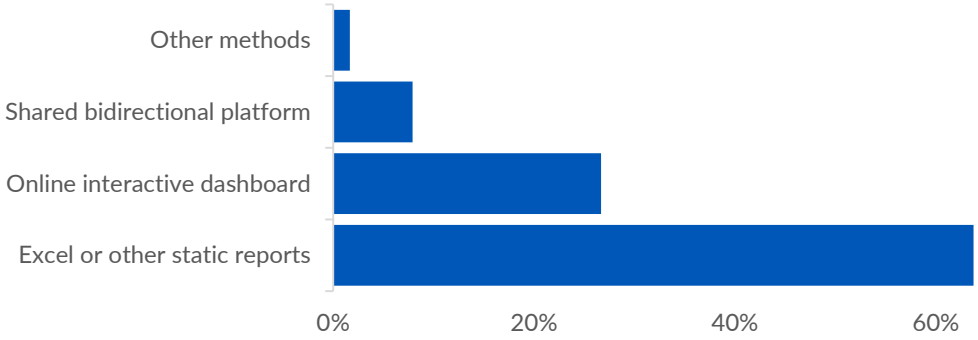
VBP and HIT converged in recent discussions within one CCO community shared-risk pool. The hospital in the group was on a different EHR system from other community providers. The systems had recently quit "talking" to one another, meaning lab results and other crucial clinical data couldn't be shared across providers.

Though no decisions have been made yet, the risk pool is contemplating how it might use shared VBP savings to fund a community-wide EHR solution.

"That venue of being able to have those conversations and everything and then also be able to make collective choices of what they want to fund has been very, very valuable."
– CCO CEO

While CCOs increasingly shared population health data with providers through real-time platforms, static formats such as Excel still accounted for the bulk of reporting on VBP performance (see Exhibit P). Almost half of CCOs (seven of 16) used real-time platforms to push population health data to providers. Six others shared data with providers at least monthly, and the other three at least quarterly.

Exhibit P. CCOs reported doing about two-thirds of performance reporting through static formats



CCOs continued to see value in engaging face-to-face with providers about VBP performance. They used in-person interactions to troubleshoot performance issues, discuss quality strategies, demonstrate capabilities of software, and encourage uptake of reporting tools. CCOs saw benefits to VBP performance from outreach efforts, which they attributed to more frequent provider engagement with performance data.

Prolonged HIT transitions and gaps in provider HIT capacity constrain VBP

Shortcomings in HIT systems could hold back VBP progress. Three smaller rural CCOs had undergone HIT transitions that impacted VBP performance monitoring. One was wrapping up a claims-system transition that had interrupted VBP reporting. Another was mired in an EHR platform transition among contracted clinics that required performance data to be pulled from separate systems for three-fourths of members.

A third rural CCO had, during the course of the PHE, engaged with more small, locally owned practices to serve members — a boon for access, but a challenge for reporting given lean office teams and the lack of dedicated HIT support among these small providers. The CCO's leader described the challenges:

> *The challenge for us in that space, I believe, is two-fold, and sometimes they're opposing forces. One is to really hold accountability to providers that they are meeting our expectations around quality, around equity, around access. And the other is building systems with enough creativity and latitude and space for them to do non-traditional work or work in very small settings. And not overly burden them with requirements or data, HIT, things they have to buy just to engage with us.*

CCOs perceived lags in the functionality of HIT systems among behavioral and oral health providers relative to those of medical providers, unless providers were part of larger systems such as DCOs or sophisticated FQHCs. Several rural CCOs offered assistance to boost provider capacity in the form of funding, establishing Arcadia connections, providing technical support, or taking on most reporting burdens. Provider organizations with internal analytics capacity were able to take over some reporting functions from CCOs.

Monitoring for adverse impacts of VBP on health equity and populations with complex social and clinical needs

Health equity monitoring efforts stall in 2023 as CCOs wrangle with REALD data challenges

Almost all CCOs encountered impediments evaluating impacts of VBP by member REALD characteristics. Many did not report changes in VBP-related health equity efforts from 2022. Four CCOs underscored the challenge of tracking disparities with a high rate of incomplete REALD data, citing 20-40% missingness in CCO enrollment files. An equal number of CCOs pointed to difficulties in stratifying VBP metrics with a small number of members in some REALD categories, particularly for rural areas and low-volume services. In

addition to REALD disparities, four CCOs focused on disparities based on rurality, which often corresponded with lower access to services and lower income.

Four CCOs shared data platforms with providers allowing for REALD stratification but did not themselves evaluate whether VBP arrangements exacerbated disparities. Two CCOs maintained that providers did not yet have the ability to interpret and address REALD disparities, even if they were provided with REALD-stratified VBP outcome data.

> *We are able to stratify data by different categories of members, but I would say we use that for our internal reporting and our internal knowledge more than we take it and we bake it into our reimbursement models. That's like a place that I don't [think]... A, number one, is a high capability space and it's a space we're aspiring to. B, I don't know that the providers would understand.*

Before attempting REALD stratification in VBP, two CCOs mentioned waiting for soon-to-be-released enhanced enrollment data from OHA's REALD and SOGI (Sexual Orientation and Gender Identity) Data Repository. Six CCOs described plans to focus on health equity monitoring in the future, including one that planned to phase in health equity discussions with providers. Two CCOs used measures of member engagement this year in their VBP models to detect potential disparities.

> *One of the things I know in the questions is always these unintended consequences or any discrimination against populations that you don't expect to have happen. So, having the percent of members seen threshold is really important to make sure that that's a metric, making sure we're not paying capitation and services that aren't being rendered.*

CCOs leverage data platforms and repositories for REALD data collection

Most CCOs were leaning into HIT platforms (e.g., Collective Medical and Reliance eHealth) or community information exchange (CIE) platforms (primarily Unite Us) that allow sharing or exchange of member care data among organizations. CCOs planned to combine Medicaid enrollment data with EHR data and data from community-based organizations with the support of in-house or software vendor analysts. To improve REALD data completeness and track social needs data, 10 CCOs planned or continued investments in data information exchanges, platforms, and repositories. Given that many OHA measures were EHR-based, improved pooling of data sources would strengthen CCOs' ability to track disparities for different types of quality measures. Several CCOs were contemplating ways to include VBP in work with community-based organizations under the next Medicaid waiver, with CIE as a potential tool for tracking any payment.

> *The encounter-based world and the electronic health records and all of those don't necessarily apply as easily to non-clinical, non-traditional services. And that will be ramped up as we move into the health-related HRSN benefit as well, in pretty significant ways.*

Although CCOs intended to merge REALD from the same types of data sources, significant variation existed in their choice of data systems and approaches. CCOs lacked knowledge of a single best-practice data integration strategy. Two CCOs were

Oregon's new REALD and SOGI unit brings improved health equity data to CCOs

In autumn 2023, the OHA Equity & Inclusion Division launched several activities with CCOs to improve REALD data availability, quality, and appropriate use in the Medicaid program. Among these:

- OHA began sharing more complete and high-quality REALD & SOGI data from OHA's repository twice monthly with CCOs, starting in September 2023. No sexual orientation was available to CCOs as yet.
- OHA's REALD & SOGI unit convened a data analytic institute from October 25-November 3 to develop the capacity of CCO data and research analysts to effectively utilize the shared REALD & SOGI data for improved patient care and other transformational work.

-From the OHA REALD & SOGI unit

creating in-house data repositories but wrestled with the quality of REALD data and the lack of consistent taxonomies.

> *So, there's multiple taxonomies, sort of nationally around REALD. And then, so I think sort of frame one is, aligning on a mapping framework of how you move from one taxonomy to another, because EHR might adopt a taxonomy from some other geographic part of the U.S. And we have to figure out how to align those and normalize and standardize those.*

> *How can we take all of this data? How can we format it to have it make sense? What's the hierarchy of data? If somebody says in one data piece that they're white and another piece, data piece they say they're non-white? And what about somebody that has multiple races? Can we put those all into our system? Because we do have multiracial individuals out there, everywhere.*

Providers show reluctance to take extra time for REALD and social needs data collection

CCOs contended with provider resistance collecting REALD and social needs data. Providers shared with one CCO that additional data collection took away time from providing care. Despite VBP incentives, another CCO struggled with getting providers to document REALD and social needs with Z codes in their EHR. The CCO hoped for more success in next year's VBP contracting by switching to PRAPARE, a common social risk assessment tool integrated into some EHRs. Not all clinics had capacity in their EHRs to enter these data.

Population health teams track some health disparities but lack integration within VBP models

Despite delays in evaluating REALD disparities within VBP measures, several CCOs performed internal health equity analyses that informed VBP strategies. This work was done by different internal CCO teams, including population health or health services. It was unclear how closely these teams worked with those designing VBPs. One CCO employed a Tableau REALD dashboard to track health inequities among its highest-cost conditions, and two CCOs planned dashboards to monitor members with their top 30 chronic conditions in 2023. Three CCOs tracked REALD disparities for specific populations or health conditions. One CCO brought its population health and quality teams together with providers to regularly discuss both health equity and VBP performance goals but acknowledged that each team's work was still siloed.

CCOs leverage VBP models to promote health equity

Taking a further step in equity planning, a few CCOs used or planned VBP arrangements to promote health equity by paying for noncovered Medicaid services for underserved communities. One CCO used a VBP model to fund outreach and case management at a clinic staffed with bilingual THWs. The CCO also used a case management tool available from Unite Us to reimburse CBOs based on "touchpoints," or contacts with members.

Multiple CCOs promoted health equity by including the OHA Meaningful Language Access measure in VBP models.[7] Introduced in 2020 and added to

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For one CCO, VBP is a route to supporting the critical work of a community-based provider alliance offering culturally specific behavioral health services. The organization offers not just clinical care but meals, social support, art classes and chronic disease management for members of color, largely from immigrant and refugee communities. The CCO and its partners are slowly "co-creating" a model to sustains the organization's member-centered activities.

"What we know about these community groups and providers is that this is the one place that they really find community and trust the people that they're interacting with because they're of their culture and of their community."

– CCO leader

the OHA incentive list the following year, the metric consists of identifying members in need of interpreter services, documenting acceptance of services, assessing wait times for appointments, and completing a quantitative reporting template. Six CCOs offered VBP financial incentives to support adoption of the metric.

CCOs use clinical risk adjustment and monitoring to protect members with complex care needs

Members with complex care needs are another group at risk for adverse impacts from VBP arrangements.[8] CCOs were aware of the risk and confident they had solid strategies in place to ensure appropriate care.

Most CCOs used clinical risk adjustment to set payment rates, allowing providers with more medically complex patients to receive higher compensation. As shown in Exhibit R, most CCOs adopted the CDPS +Rx model used by OHA.

Exhibit R. Clinical risk adjustment models in use by CCOs

Model	Number of CCOs
CDPS +Rx	9
Optum Health Symmetry	2
Third-party actuarial firm	1
Not using clinical risk adjustment model	4

How CCOs incorporated risk adjustment varied. For example, one used risk adjustment only in primary-care models, one also used it to adjust PCPCH payments, and one gave higher quality-pool payouts to providers with more complex patient panels. CCOs pointed out limitations with these models, such as their reliance on past documentation and difficulty in risk-adjusting for subcategories of services or special populations such as pediatrics. The four CCOs not using formal risk-adjustment models had previously reported using Medicaid eligibility groups to set rates.

Along with adjusting payment, CCOs described using care coordination or utilization management teams to identify members with complex medical needs and monitor their use of services to ensure appropriate access to care. One CCO viewed its behavioral health VBP model as a tool to address complex care needs, since many members with complex needs had mental health diagnoses.

CCOs ramp up data collection for social needs screening measure and social risk adjustment

Some CCOs used VBP to step up efforts to implement the new OHA Social Needs Screening and Referral[9] incentive measure. Three CCOs intended to use the social screening measure in 2023 as the "quality gate," or minimum performance threshold for shared savings, for their primary care models. One CCO aspired to analyze data from the measure as a precursor to applying social risk adjustment in VBPs. One of the first steps towards fulfilling the social screening requirements was an environmental scan of existing social needs data and collection systems of the CCO's provider network. CCOs were surveying this data and asked OHA to help align work on the screening measure with other Medicaid health-related social needs processes.

> *Let's figure out how to learn from the data we collect and the things that we learn about the population, as we start to implement some of those new benefits and start connecting some of the CBO networks and partnerships that we're going to have to build with what we do today. Because I feel like if we*

created more kind of structure around that before we're able to dig into that work, we might risk creating unnecessary complexity or working, parallel processes.

Preventing over-screening was already an OHA measure requirement, but two CCOs emphasized their intention to avoid traumatizing members with repeated questions about social needs in different settings.

Three CCOs were researching and developing plans for social risk adjustment, while others were interested but less actively investigating methods. Two took their lead from states like Massachusetts[10] and considered how to combine member data with publicly available social indicator data, such as neighborhood SES rankings and the Social Vulnerability Index. The third CCO chose to employ what it called a "score blocking" approach that involved a modular framework for building a social risk score. Most CCOs requested technical assistance on social risk adjustment from OHA and wanted to align efforts with OHA's expectations. CCOs looked forward to more guidance with the formation of OHA's social risk adjustment workgroup, a subgroup of the Primary Care Reform Collaborative.

Summary and Recommendations

CCOs seek higher-profile leadership from the state in aligning and promoting implementation of VBP

States that have introduced VBP to their Medicaid programs have taken various approaches. Some have been more prescriptive, implementing accountable care-like models or episodic payments for common procedures.[11] Others, including Oregon, have set payment targets but left the details of model development to individual health plans. After four years of the VBP Roadmap, Oregon's CCOs have shifted their contracting practices to meet ambitious payment targets within the HCP-LAN framework. They implemented a spectrum of VBP models varying from individualized arrangements with single practices to large system agreements. Some VBP arrangements created new and innovative care models, while others were modest adaptations of existing arrangements. VBP was welcomed by some provider organizations and resisted by others that were not able or willing to take on new risk or measurement burden.

Oregon's less prescriptive approach encourages local innovation but presents several trade-offs. Roadmap outcomes are difficult to measure since strategies vary across CCOs and occur against differing local contexts and other CCO transformation initiatives. Providers working with multiple payers may be overwhelmed with numerous, possibly unaligned models. From the state, CCOs sought more visible leadership in identifying, aligning, and messaging VBP objectives across regions and payers, as well as in development of shared strategies and tools.

As part of Oregon's legislatively mandated initiative to contain growth in health care costs, the state has engaged payers and providers to collaborate in advancing payment reform and moving to VBP. Much of this work is taking place through the Oregon VBP Compact, a joint commitment by payers and providers to work together to meet specified targets and timelines through 2025. While engaging participants in the Compact has been challenging, the state reports that participants are working to develop resources to help payers and providers prepare for new VBP arrangements, implement arrangements, and overcome challenges to operating successfully within increasingly advanced VBP models.

We recommend the following steps to support CCOs in meeting their VBP Roadmap requirements in 2024 and beyond.

Recommendations

Increase the state's profile as a convener and proponent of multipayer VBP alignment

CCOs voiced several needs for stronger coordination and leadership in support of VBP. First, they asked for a stronger message from the state directly to providers about expectations for engaging in VBP. They also sought a central convener for conversations about alignment of measures and models across regions and payers to reduce burdens for everyone involved in VBP implementation. Absent another prominent stakeholder volunteering, the state is in the best position to rally providers, payers, advocates, CCO members, and others for this work.

Promote standardization and exchange of successful VBP models to facilitate increased implementation, improve consistency across the state, and continue knowledge exchange between CCOs

CCOs shared common concerns about areas where access or care coordination needs might be effectively addressed by VBP. While CCOs appreciated the flexibility to design locally responsive VBP arrangements, they also noted the burdens of creating models from scratch and appreciated learning about solutions from other CCOs and states. Some CCOs put considerable work into developing innovative VBP models and measurement approaches that could benefit others. Support from OHA in identifying and promoting VBP models with demonstrated success could leverage CCOs' efforts and facilitate consistent evaluation of VBP outcomes. Models that support the work of THWs and other services related to social needs could be especially useful, as billing structures for these areas are challenging for CCOs. In addition, OHA can continue to support information exchange between CCOs. Several respondents mentioned the CCO VBP Workgroup sessions with national expert Bailit Health as especially useful for learning about VBP work in other states. One CCO team member asked for similar sessions for staff in specialized VBP support roles, such as HIT.

Develop additional guidance on quality measures for specialty services and strategies for low-volume services

CCOs described difficulty finding appropriate clinical quality metrics for specialty providers, both individual specialties and multispecialty groups. Some were interested in measures of member access to specialty care and others were wrestling with quality measurement strategies for lower-volume services. State assistance in developing uniform quality approaches for these service areas could support CCOs and promote alignment across regions and payers.

Work with CCOs to identify best practices for promoting health equity through VBP and strategies for social risk adjustment

To ensure that CCOs are using consistent, evidence-based practices for monitoring for inadvertent negative impacts of VBP on health equity, OHA could facilitate collaboration toward a statewide consensus on best approaches in this area. The state could also highlight models that deliberately use VBP to reduce existing health inequities. In response to CCOs' requests, the state can provide additional research and technical assistance with identifying feasible social-risk adjustment models.

Monitor progress of CCOs not meeting 2023 Roadmap targets and consider opportunities for additional support

Four CCOs appeared at risk of missing one or more Roadmap requirements in 2023. Compared with CCOs in compliance, they may have faced more adverse market circumstances, for example, the need to engage with smaller and more isolated provider groups or provider networks that were particularly hard-hit with staff losses and financial stress during the PHE. OHA could assess whether additional technical assistance would support these CCOs in regaining compliance.

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"Flashlight" icon used courtesy of the Noun Project

HCP-LAN Payment Framework

In 2017, the Health Care Payment Learning & Action Network (HCP-LAN) published the Alternative Payment Model Framework (Refreshed) to help align alternative payment approaches across the U.S. health care system. Oregon's VBP Roadmap for CCOs uses the HCP-LAN framework as a common language for categorizing CCOs' contracts with providers.

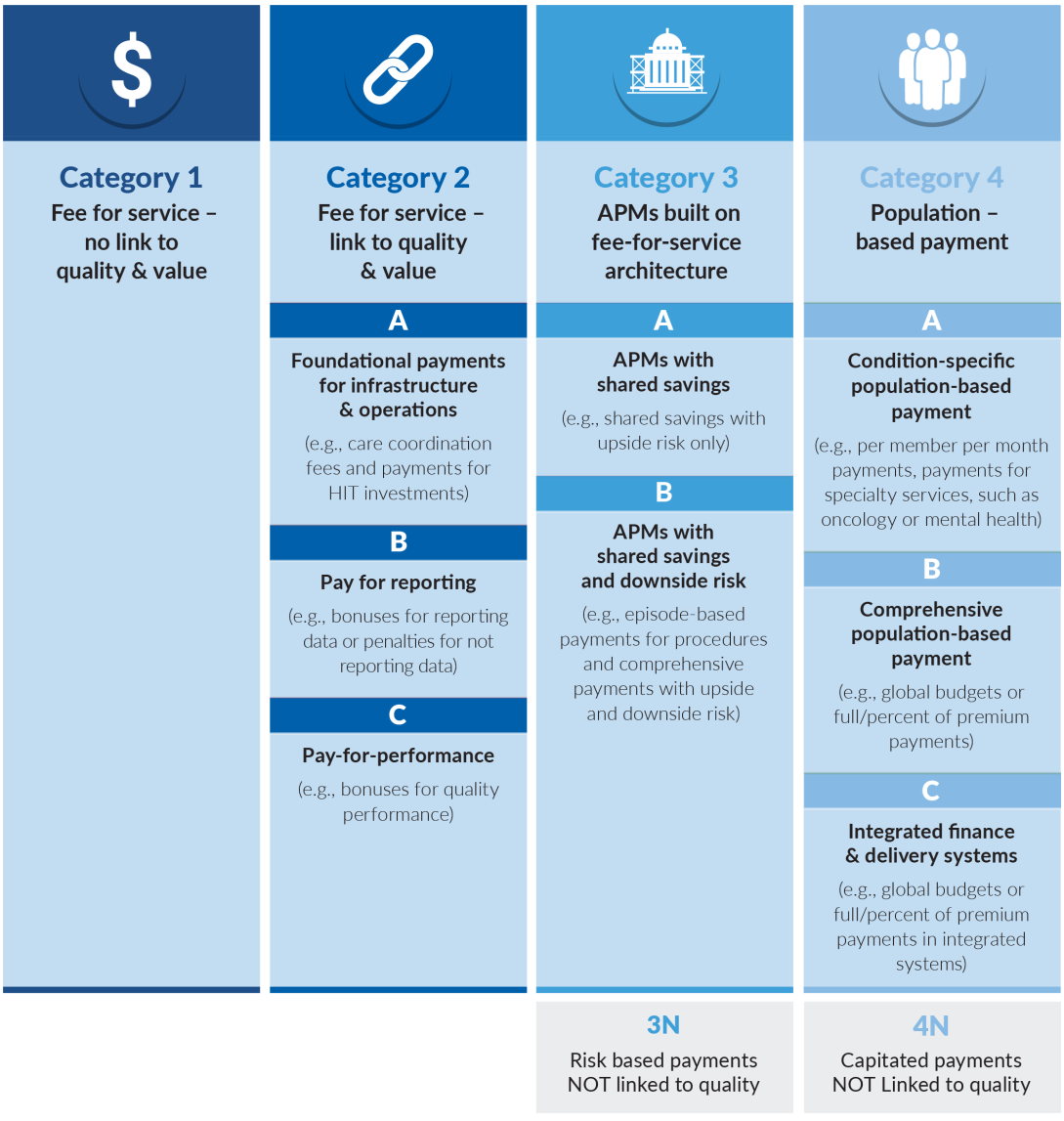

Image adapted from the Health Care Payment Learning and Action Network's 2017 (refreshed) Alternative Payment Model APM Framework available at https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

Data Sources and Methods

This report presents (1) results of a qualitative analysis of key informant interviews and written information provided by Coordinated Care Organizations (CCOs) in 2023, (2) results of a quantitative analysis of CCO-reported payment models for Patient-Centered Primary Care Homes (PCPCHs), and (3) data on 2021 CCO payment arrangements provided by CCOs to the Oregon Health Authority and compiled by the Oregon All-Payer All Claims database program. This appendix describes data sources and analytic methods for analyses of

Areas (a) and (b). Analytic methods for CCO payment arrangement data are provided on the OHA payment dashboard website.6

VBP Pre-Interview Questionnaires

CCOs are required to participate in annual interviews with the state to discuss progress toward VBP Roadmap requirements. The OHSU Institutional Review Board determined that this project did not meet the definition of human subjects research and waived oversight of data collection and consent procedures.

Between February and May 2023, the state administered a pre-interview questionnaire to all CCOs to gather information about their VBP activities at that time. The questionnaire was developed in partnership with CHSE following identification of priority topics and questions for the evaluation. All CCOs responded to this request for information.

CHSE conducted a content analysis of CCOs' responses to the questionnaire. Responses to specific questions in these documents were summarized in an analytic matrix by question and CCO. The research team used this matrix to summarize findings across CCOs and identify similarities and differences in approaches to VBP model design, progress toward VBP milestones and requirements, and challenges and successes encountered in developing and implementing new VBP models. Responses varied in length and detail.

Three financial entities, PacificSource Community Solutions, CareOregon, and Trillium Community Health Plan, operated multiple CCOs in 2023. PacificSource and Trillium each submitted a single combined questionnaire for their CCO regions. CareOregon submitted individual questionnaires for its two CCOs, Columbia Pacific and Jackson Community Connect.

PCPCH and CDA Data Template

In 2023, for analysis of the five care delivery area models and review of CCOs' overall largest VBP models, the evaluation team used administrative data obtained from Oregon Health Authority's PCPCH-CDA

Data Templates ("data templates") collected from CCOs in May 2023. These data templates contained information from CCOs about payments made in 2022 to meet OHA's VBP Roadmap requirement for PCPCH infrastructure payment models and about arrangements that CCOs reported for the 2023 CDA model requirements.

PCPCH infrastructure payments

Information included the number of contracted clinics recognized at each of five PCPCH tiers, the PMPM dollar amount (or range) clinics could earn at each tier, and the average PMPM payment to clinics in each tier, weighted by clinics' Medicaid member attribution.

Data templates were received as individual files from each CCO and contained a combination of quantitative and qualitative information. Quantitative information about CCOs' PCPCH payment models was extracted into a single analytic file. Data elements were assessed for missing and outlier values. Rows were excluded when CCOs reported a payment model with zero contracted clinics and a $0 PMPM amount. In addition, data were suppressed in 2021 for one CCO that entered conflicting data. Rows with zero clinics and a non-zero PMPM amount, and rows with non-zero clinics and a $0 PMPM amount, were retained.

The minimum and maximum amounts paid by each CCO in each PCPCH tier were identified to calculate the minimum and maximum PMPM amount paid by any CCO in each PCPCH tier. Where CCOs reported a single PMPM payment amount for a PCPCH tier, this value was considered both the minimum and maximum PMPM amount for that CCO and tier. Where CCOs reported a PMPM payment range rather than a fixed amount, the highest and lowest values reported by that CCO for that PCPCH tier were used. The lowest and highest reported PMPM amounts among all CCOs within each PCPCH tier were then identified.

To find the average PMPM amount paid by CCOs in each PCPCH tier, we calculated the mean of all CCOs' weighted average PMPM amounts reported in each PCPCH tier. These CCO-reported average PMPMs were already weighted by clinics' Medicaid member attribution and no further adjustments were made.

CDA Data Templates

Data templates were submitted by CCOs along with the questionnaire in May 2023. Pacific

Source and Trillium submitted separate data templates for each of their regions. Data templates were submitted in the form of spreadsheets with tabs for each of the five CDA models and one for the CCO's five largest VBPs defined by dollars spent and VBPs implemented, which could overlap with any of the CDA areas. Each page had columns for CCOs to describe details of each model. The column categories included:

Care Delivery Area (for CCOs to identify models that are used to meet two CDA requirements such as a hospital and maternity model)

- LAN category
- Description of the model
- How the model considers complex care needs or disparities
- Total dollars spent
- Number of unique members served
- Maximum provider gain
- Maximum provider loss
- Quality metrics
- Steward of quality metrics (e.g. OHA or National Quality Forum)
- How metric performance is assessed
- Provider performance on quality metrics

- Percentage of max gain
- Percentage of max loss

The CHSE evaluation team combined this year's data templates with the data templates submitted last year to compare models and performance changes. The CHSE evaluation team either verified or revised CCOs' self-reported LAN categories of models with payment data provided. The findings from reviewing the data templates were used to inform each CCO's interview guide such as requesting clarification on inconsistent reporting or asking for more detail on novel models.

VBP Key Informant Interviews

In June 2023, CHSE conducted 12 key informant interviews with leadership representatives from Oregon's CCOs. PacificSource Community Solutions and Trillium Community Health Plan each participated in a single interview for all regions they served. CHSE partnered with the state to develop an interview guide with standard questions for all CCOs. Interview questions for each CCO were then customized following review of each CCOs' responses to the written questionnaire and data template. Staff from OHA's Transformation Center joined these interviews. Interviews lasted approximately 90 minutes and were conducted and recorded using a video call platform. All interviews were professionally transcribed.

CCO interview transcripts were de-identified and entered into Atlas.ti13 for data management and analysis. A subset of the data was reviewed by a group of five research analysts who created a codebook with consideration for the evaluation aims and specific areas of focus. The team compared initial application of codes and made updates to code definitions to promote reliability. The remaining transcripts were then coded independently by two members of the final three-person evaluation team, who subsequently came together to reconcile coding decisions into a single coding record. The team then generated reports for each code, each of which was analyzed independently by two analysts for key themes. Finally, the entire team met in a series of sessions to review overall impressions, reconcile differences and develop key findings. Findings from key informant interviews and written questionnaires were summarized and integrated at the reporting stage.

Methodology for assessing LAN category of contracts

CCOs' performance on VBP Roadmap payment milestones is documented in payment arrangement files, submitted annually to OHA, that list each provider contract and its corresponding LAN category(s). The state All Payer All Claims (APAC) reporting program produces an annual dashboard showing payment percentages in each LAN category. (For a full description of methods, please see the online dashboard6.)

Although the 2019 baseline report included an assessment of CCO payments by LAN category before the launch of the VBP Roadmap, these data were created using a slightly different methodology and cannot be compared directly with payment data in subsequent years. Thus, 2020 payment data are the effective baseline for assessing progress in establishing VBP contracts.

The methodology used by the APAC program bundles all payments in each contract together under the highest LAN category that is part of the contract. Thus (per the published methodology), an $80,000 contract that is mostly LAN category 1 (fee for service) but has a $5,000 LAN level 2C component would count as $80,000 at LAN 2C for reporting purposes. The APAC program dashboard may overestimate the proportion of qualifying payments by an undetermined amount.

CCO Infrastructure Payments to Primary Care Homes

CCO Infrastructure Payments to PCPCHs, 2020-2021

	Tier 1 clinics	Tier 2 clinics	Tier 3 clinics	Tier 4 clinics	Tier 5 clinics
Number of contracted clinics, all CCOs (N), 2020	1	5	83	482	126
Average PMPM payment (weighted) 2020	$3.83	$2.82	$4.19	$7.45	$8.70
Number of contracted clinics, all CCOs (N), 2021	0	2	91	454	131
Average PMPM payment (weighted) 2021	$3.93	$2.40	$5.03	$8.22	$9.70
Number of contracted clinics, all CCOs (N), 2022	0	1	108	428	176
Average PMPM payment (weighted) 2022	$2.65	$2.97	$5.84	$8.33	$10.64

Notes: 2021 data for one CCO was omitted due to quality concerns about payment data; this resulted in lower counts for higher-tier PCPCHs than would have otherwise been the case. Some CCOs reported a payment range rather than fixed amount per tier. The average PMPM payment (weighted) is the mean of all CCOs' reported payments in that tier after payments are weighted by clinics' attributed Medicaid members. Source: 'PCPCH+CDA Data Templates' submitted by CCOs to OHA for the 2020, 2021 and 2022 calendar years.

Acronyms and Abbreviations

APAC	All Payer All Claims
BHO	Behavioral health organization
CCO	Coordinated care organization
CDA	Care delivery area
CLAS	Culturally and linguistically appropriate services
DCO	Dental care organization
DRG	Diagnosis related groups
EHR	Electronic health record
FFS	Fee-for-service
FQHC	Federally qualified health center
HCP-LAN	Health Care Payment Learning and Action Network (also simply "LAN")
HIT	Health information technology
IDS	Integrated delivery system
IET	Initiation and engagement in alcohol and other drug abuse or dependence treatment
MH	Mental Health
OHA	Oregon Health Authority
PAF	Payment Arrangement File
PCPCH	Patient-Centered Primary Care Home
PHE	Public Health Emergency
PMPM	Per-member per-month
REALD	Race, ethnicity, language and disability
SOGI	Sexual orientation and gender identity
SRA	Social risk adjustment
SUD	Substance abuse disorder
TCoC	Total cost of care
THW	Traditional health worker