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

## SECOND ANNUAL PROGRESS REPORT

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CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

**Prepared for:**
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OHSU

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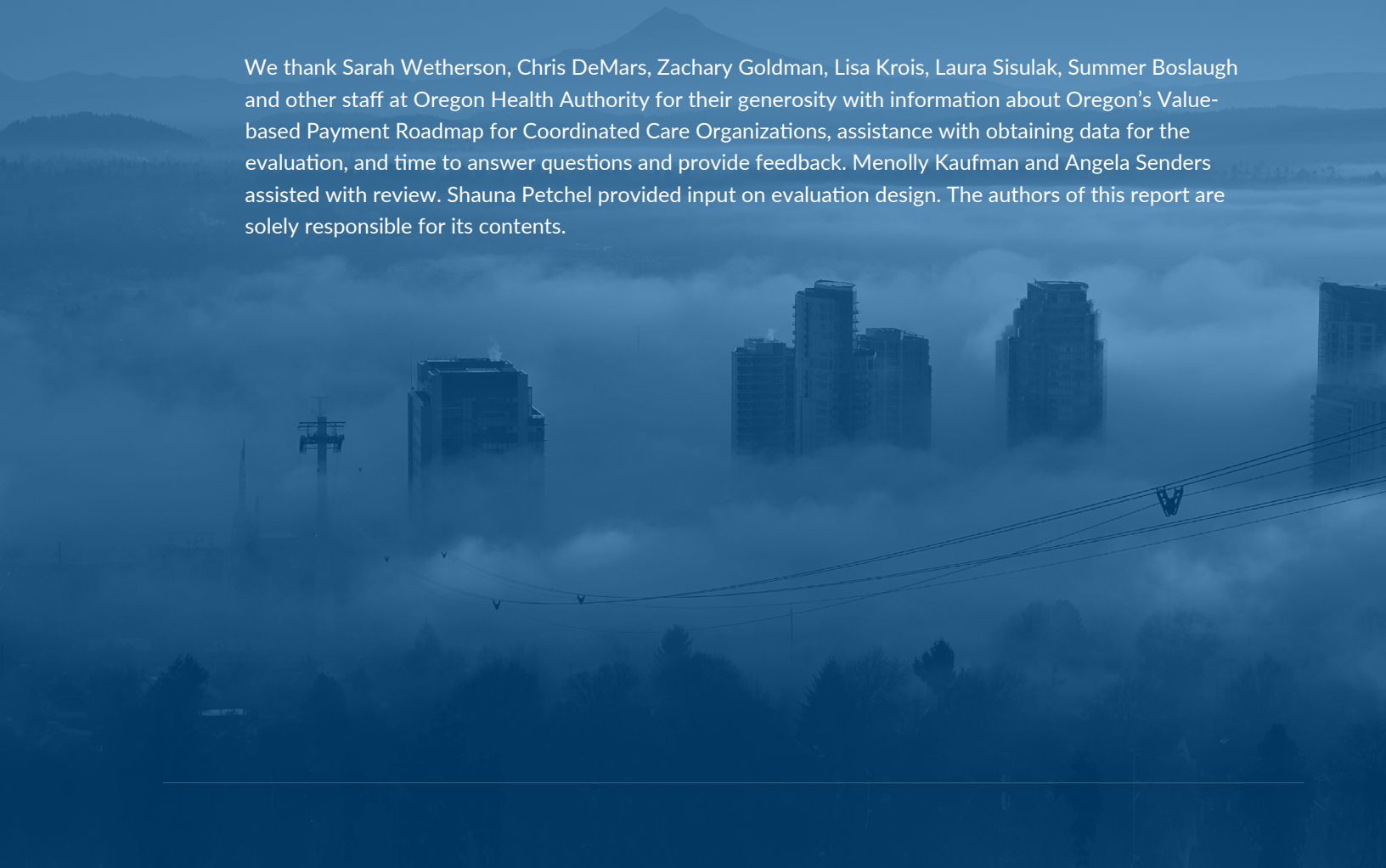


# Executive Summary

Moving away from volume-based health care payment toward models that support transformation to a more patient-centered, equitable, and efficient delivery system has been a theme of Oregon Medicaid reform since initiation of the coordinated care organization (CCO) model in 2012, and a key strategy for reaching the Triple Aim. In the CCO contracting cycle that began in 2020, the Oregon Health Authority (OHA) intensified the focus on payment transition by adopting the Value-based Payment Roadmap for Coordinated Care Organizations. The Roadmap, which runs from 2020 to 2024, includes multiple initiatives designed to reshape payment:

- **CCOs must meet annual goals for the overall percentage of payments made within VBP arrangements** that include a quality component (categories 2C or higher in the Health Care Payment Learning and Action Network[1] system, referred to here as the "LAN"). This target was set at 20% in 2020, advancing to 35% in 2021, 50% in 2022, 60% in 2023, and 70% in 2024. The 2020 target was expanded to include LAN categories 2B and higher in response to the COVID-19 Public Health Emergency (PHE).
- **CCOs must support patient-centered primary care homes** with infrastructure payments that increase each year.
- **CCOs must create new or enhanced payment models** in a total of five specific care delivery areas (CDAs). New models in behavioral health, hospital, and maternity care were due in 2022, with children's and oral health care following in 2023 and 2024 (order to be determined by each CCO).
- In later years of the Roadmap, **CCOs must meet annual targets for the percentage of payments in arrangements that include downside risk** (LAN categories 3B or higher). This target is set for 20% in 2023 and 30% in 2024.

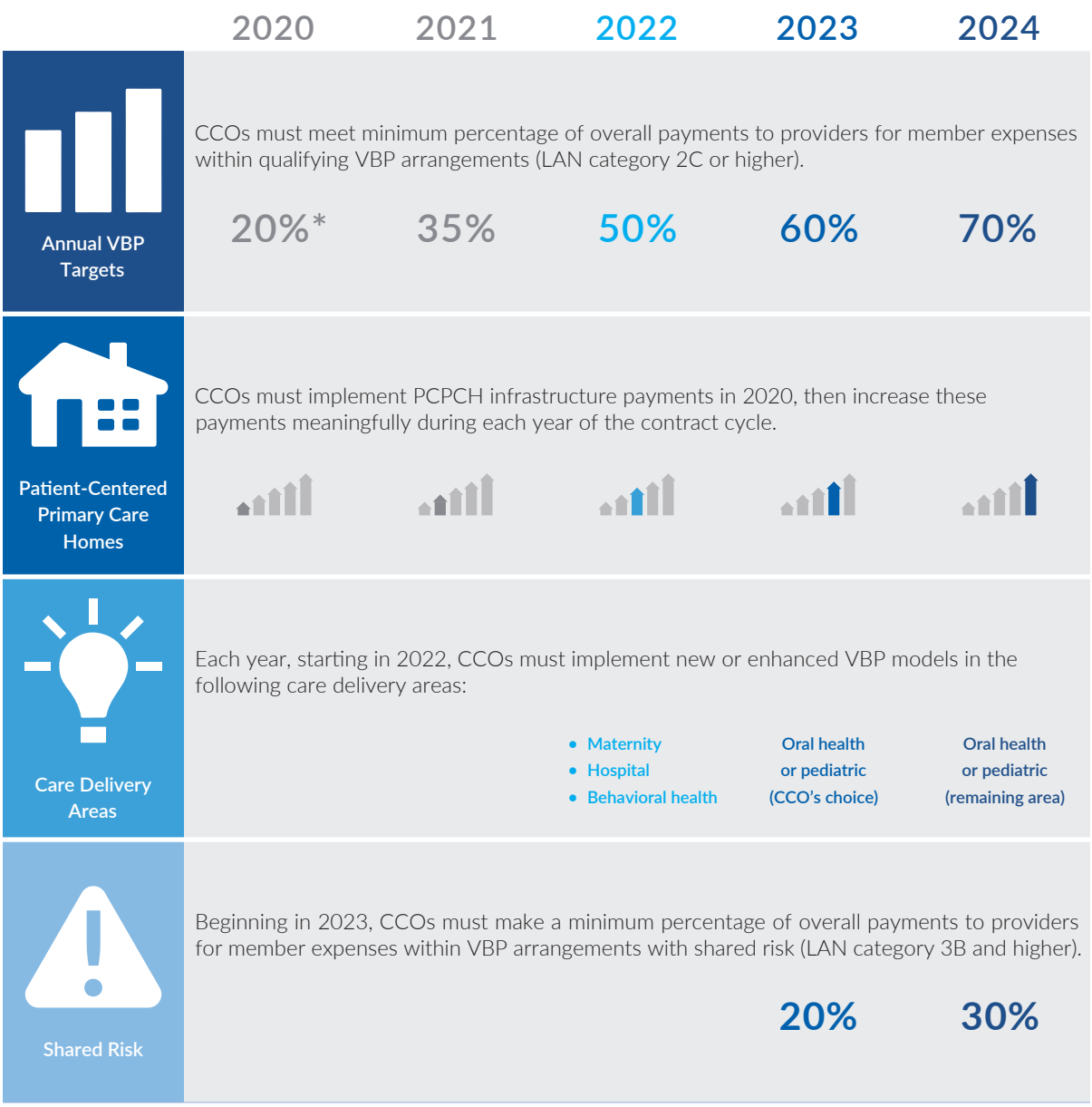
These requirements are summarized in Exhibit A on the next page.

## ABOUT THIS REPORT

The Center for Health Systems Effectiveness conducted its second annual interim evaluation of CCOs' progress toward these requirements in mid-2022. Exhibit B shows Roadmap requirements evaluated in the current report and the sources of data used to assess work in each area. Evaluation topics included:

- **Summarizing CCOs' performance on the 2020 target of 20% for overall payments in arrangements in LAN categories 2C or higher** using data reported in CCOs' annual Payment Arrangement Files (PAFs). These data are also displayed online on the Oregon All Payer All Claims Reporting Program's payment arrangements dashboard[3] as of June 2022.
- Evaluating performance on requirements for **increasing infrastructure payments to PCPCHs** and **developing new or enhanced VBP models in the three CDAs** required for 2022.
- **Assessing CCOs' self-reported progress** in developing and implementing new payment models to meet VBP Roadmap requirements for 2022-24.

**Exhibit A. VBP Roadmap milestones for 2020-2024.[2]**




**CCOs were allowed to temporarily convert arrangements to pay-for-reporting (category 2B) without penalty due to the COVID-19 PHE*

The evaluation drew on CCO-reported information from three sources: (1) payment arrangement data for contract year 2020 (the most recent available), to assess compliance with overall payment targets; (2) May 2022 reporting on VBP models and PCPCH payments; and (3) June 2022 interviews with CCO leaders. Interview, questionnaire and model reporting data from 2020 and 2021 were used for background context.

**Evaluation Areas and Data Sources for Second Annual Interim Report.**

| Evaluation Area | Report Section | Data Source |
|---|---|---|
| **CCO performance on 2020 requirement for overall payments by LAN category** | 2 | OHA payment arrangement files |
| **CCO progress toward requirements for overall payment targets for 2022-2024** | 3 | June 2022 interviews and pre-interview questionnaires |
| **CCO performance on requirement for annual increases in PCPCH infrastructure payments** | 3 | 2022 CCO VBP PCPCH Data and CDA templates |
| **CCO performance on required first three CDA models (due January 1, 2022)** | 4 | 2022 CCO VBP PCPCH Data and CDA templates, 2022 interviews |
| **CCO progress in using HIT to support VBP and leverage VBP for health equity** | 5 | June 2022 interviews and pre-interview questionnaires |

## INTERIM EVALUATION KEY FINDINGS

### As of mid-2022, CCOs were meeting Roadmap milestones and on track to continue meeting them through the end of this year, with the exception of the CDA model requirement.

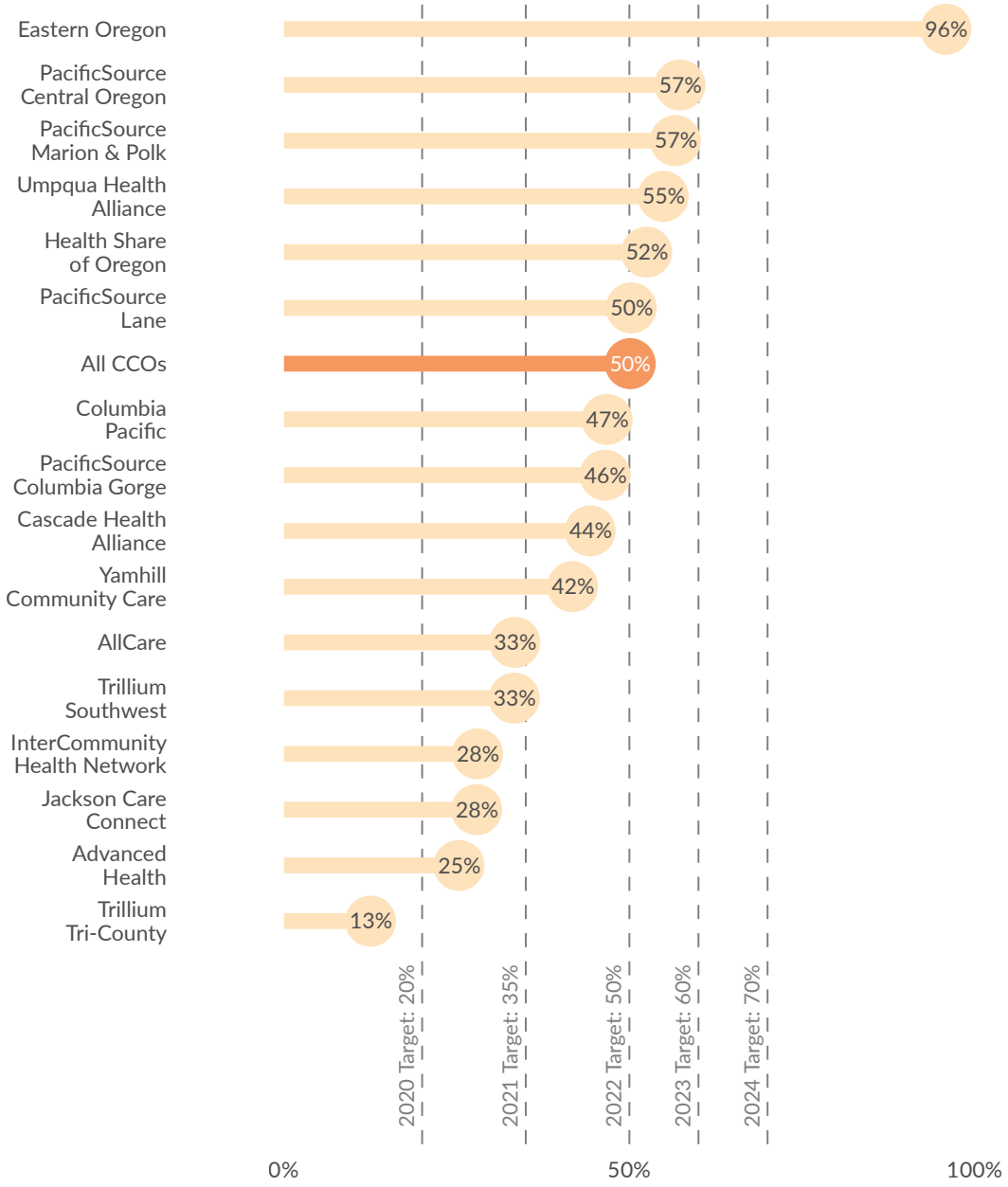
- **All but one CCO met the 2020 overall target of having at least 20% of payments occur through payment arrangements at LAN category 2B or higher.**

Based on quantitative data from the 2020 OHA Payment Arrangement Files Dashboard, 15 of 16 CCOs met the overall milestone, with a statewide average of 50% of total payments occurring in VBP arrangements that qualified for the target. While the target was originally set at LAN category 2C or higher, it was revised to category 2B[4] for 2020 as part of OHA's response to the COVID-19 PHE. Exhibit C on the next page shows CCOs' performance on the milestone.

CCOs made these advances through a variety of strategies. Some new payment models reorganized payment in ways that moved the state toward the Roadmap's goals of reducing fragmentation and increasing person-centered care. For example, four CCOs reported models that included traditional health workers (THWs), such as peer workers and doulas, and six CCOs had new or ongoing total cost of care models that incentivized stronger care coordination. In the majority of new models, however, CCOs made incremental changes to existing contracts that would promote value, such as adjusting or adding new quality measures to agreements or introducing financial risk.

In 2022 questionnaires and interviews, CCOs expressed confidence in meeting 2022 and 2023 targets for percentage of overall payments in arrangements at LAN category 3B or higher.

**Exhibit C. Percentage of 2020 provider payments for each CCO that qualified for the 2020 overall payment milestone by occurring through contracts in LAN Category 2B or higher.**




- **CCOs, on average, increased infrastructure payments to PCPCHs between 2020 and 2021 as required. Changes were modest, and wide variation remained between rates paid by different CCOs.**

Average PCPCH payments in 2021, the last year for which data are available, increased over those in 2020, although three individual CCOs did not make changes. The largest average increase was for Tier 5 clinics, where the statewide average went from $8.70 per member per month (PMPM) in 2020 to $9.70 in 2021. Payments still varied greatly between CCOs – for example, payments to Tier 5 practices varied from $1.77 PMPM to $23.19 PMPM.

- **CDA model development was a weak point in 2022 performance, with three CCOs failing to develop the three required CDA VBP arrangements by mid-2022. Others reported models that did not meet Roadmap specifications.**

Two CCOs had yet to complete models in any of the required CDAs (behavioral health, hospital, and maternity care), while a third CCO was missing a maternity model. In addition, pending a formal compliance review, it appeared that more than 10 other models did not fully meet Roadmap requirements, either through being in a LAN category below 2C or not including a quality component specific to the CDA.

Most models identified for the CDA requirement consisted of small adaptations to existing arrangements, such as adding a new quality measure. A few, such as those incorporating THWs, were more innovative. The Roadmap did not specify a minimum or maximum size for the requirement, and the number of members involved in submitted models varied from fewer than 50 to an entire CCO population. Although a minority of models ventured into new modes of care delivery, the milestone clearly had stimulated new conversations about quality and financial risk in these three service areas.

## Despite challenges, CCOs continued efforts to engage new providers in VBP arrangements and worked toward greater shared risk in 2022.

- **While CCOs gradually returned VBP performance targets to their pre-COVID-19 status, the COVID-19 PHE continued to impact provider and CCO capacity for new VBP contracts.**

In the aftermath of the COVID-19 PHE, CCOs reported ongoing systems disruptions, reduced provider capacity for engaging in VBP discussions, and a continuing crisis in the behavioral health workforce that affected service delivery and VBP contracting. CCOs also faced staffing constraints, especially among data analysts essential to VBP.

- **CCOs with lower levels of readiness for VBP at the start of the Roadmap in 2020 faced greater difficulty meeting targets in 2022.**

CCOs that started the Roadmap with less experience with VBP and fewer arrangements in place in 2020 were among those that struggled to meet the CDA requirement in 2022. They reported more difficulty restarting provider negotiations in 2022 than CCOs that had more VBP contracts in place pre-COVID-19 PHE and maintained them during 2020 and 2021. In addition, CCOs in communities with smaller, less integrated provider groups described a generally more difficult progression toward risk-bearing arrangements than those with larger, more vertically integrated providers.

- **CCOs slowly increased the proportion of their VBP agreements with financial risk, although some care delivery areas presented challenges.**

Arrangements with risk-sharing increased, although CCOs faced difficulties engaging independent specialists as well as hospitals in areas where Medicaid market share was low and other payers had no aligned VBP efforts. All CCOs expressed confidence in meeting the 2023 requirement for having 20% of payments occur in LAN category 3B or higher.

- **More CCOs reported "total cost of care" agreements, which had potential for increasing provider collaboration.**

Six CCOs reported having total cost of care risk-sharing arrangements in place this year, several of them new in 2022. In these arrangements, the provider partner (or a consortium of providers) accepts accountability for the cost of all medical services to attributed members. In several communities, these arrangements had enhanced collaboration between providers or stimulated investment in health-related social services, potentially offering a promising model for member-centered care.

### Over the past year, CCOs made incremental advances in health information technology capacity for supporting VBP contracts and assessing impacts on health equity.

- **CCOs continued to develop capacity to support VBP contracts in their health information technology systems, although status varied across CCOs.**

In line with previous progress CCOs had reported in building processes and tools for monitoring VBP arrangements and sharing data with providers, nine CCOs this year reported delivering information to providers through online portals, which typically included member rosters and other data related to VBP performance. Other CCOs shared VBP performance data with providers through regular reporting. Four CCOs reported implementing bidirectional health information exchange platforms that merged provider electronic health record (EHR) data with claims and other member data, potentially enabling powerful population health tools. At the same time, some CCOs were relying on more manual systems, and one was struggling with an incomplete EHR transition that complicated reporting. Monitoring payments by LAN category to track progress on Roadmap targets continued to be mostly manual and was time-intensive for CCOs, which noted the lack of commercial software for VBP administration.

- **CCOs worked to incorporate health equity goals into VBP processes, but lacked consistent data and strategies.**

CCOs lacked comprehensive information about members' race, ethnicity, language, and disability (REALD) status, as well as social needs. They pursued diverse and diverging strategies to obtain these data and incorporate them into VBP planning and reporting, with six CCOs identifying six different potential additional data sources. Eight CCOs described stratifying or being close to stratifying quality measure reporting by available partial REALD data, and one CCO had built provider incentives to collect these data into its payment models. Two CCOs reported creating or planning VBP models that supported providers of color and culturally specific THWs. CCOs were also contemplating (though not yet implementing) ways to adjust VBP models for social complexity.

### CCOs would benefit from clarification of several technical areas of the VBP Roadmap.

CCOs exhibited mixed understanding of several technical requirements in the Roadmap. One area concerned subcapitated agreements. These are arrangements in which a CCO delegates service delivery with a fixed budget to a subcontractor, such as a dental care organization, which then contracts with individual providers. CCOs had an inconsistent understanding of the requirements for these subcontracting organizations to engage in VBP arrangements with their individual providers. CCOs also expressed confusion over whether VBP models fulfilling the five CDA requirements needed to include quality measures specific to that CDA —for example, hospital measures for a hospital CDA model. Finally, CCOs that were using expansions of existing VBP contracts to meet CDA requirements asked for more details about how or how much they needed to expand their existing contracts to qualify them for the requirement.

## RECOMMENDATIONS

**Promote greater VBP alignment across payers and regions.** CCOs have limited leverage to engage hospitals and other independent specialty care providers in VBP contracts to meet their Roadmap goals. OHA contracts for and administers benefits for approximately 1.5 million Oregon residents (including Medicaid, the Public Employees' Benefit Board, and the Oregon Educators Benefit Board), providing an opportunity to encourage participation in VBP models and to support payer alignment around a consistent group of performance measures. In addition, OHA could revisit pre-COVID-19 plans for requiring discussions on alignment in quality measures and other key VBP features between CCOs with regional overlap (work that was a feature of the Roadmap but delayed by the COVID-19 PHE).

**Continue creating opportunities for CCO cross-pollination to share successful models and novel approaches.** CCOs frequently asked for information on approaches and strategies used by their peers to address challenges in VBP development. In addition to its ongoing VBP workgroup, OHA could promote additional opportunities (through presentations or publications) for CCOs to learn from one another.

**Develop additional guidance on quality measures for specialty services and integrated care.** CCOs described difficulty finding appropriate metrics for specialty services, including both physical specialties and mental/behavioral health. OHA could provide technical assistance to CCOs for identifying and sharing information about successful quality approaches for these providers. OHA could also help CCOs identify effective quality measurement strategies in the growing area of integrated behavioral health services, along with ways to incentivize adequate access for these services if included in total cost of care arrangements.

**Work with CCOs to develop best practices for applying health equity goals within VBP strategies.** CCOs lacked comprehensive data and tools to effectively assess the potential adverse impacts of VBP arrangements on members experiencing health inequities. In addition, efforts to improve health equity and meet members' social needs through VBP design were in their infancy. The state could support this critical work by (1) compiling and sharing successful strategies that CCOs are exploring to expand currently available data on members, (2) describing evidence-based practices for evaluating potential adverse effects of existing VBP arrangements, and (3) showcasing new contracting models that leverage VBP to support health equity.

**Monitor progress of CCOs not meeting 2022 Roadmap targets and consider opportunities for additional support.** CCOs that could not report qualifying VBP contracts in behavioral health, hospital, and maternity care for the CDA requirement in 2022 appear to be at risk for noncompliance with future-year Roadmap milestones, especially as overall payment targets increase to 60% and 70% in 2023-2024, respectively. OHA could closely monitor work by CCOs facing challenges with Roadmap performance in 2022 to assess whether additional technical assistance would support them in regaining compliance.

**Ensure that CCOs have a consistent understanding of Roadmap requirements for subcapitated arrangements, CDA-specific quality measures and enhancement of existing models for CDA requirements.** OHA can support CCOs and ensure regionally consistent implementation of the Roadmap by providing more detailed guidance on areas where CCOs showed inconsistent interpretations of requirements. These included the Roadmap requirements that subcapitated agreements include quality components affecting frontline providers and that required CDA models include CDA-specific measures (e.g. hospital-specific measures for hospital models). For CCOs that are expanding existing VBP models to meet upcoming CDA requirements, the state can provide additional detail about the type or degree of expansion required.

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**SUGGESTED CITATION**

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# Acronyms and Abbreviations

| | |
|---|---|
| **APAC** | All Payer All Claims |
| **BHO** | Behavioral health organization |
| **CCO** | Coordinated care organization |
| **CDA** | Care delivery area |
| **CHSE** | Center for Health Systems Effectiveness |
| **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 |
| **OPIP** | Oregon Pediatric Improvement Partnership |
| **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 |
| **SRA** | Social risk adjustment |
| **SUD** | Substance abuse disorder |
| **TCOC** | Total cost of care |
| **THW** | Traditional health worker |
| **VBP** | Value-based payment |

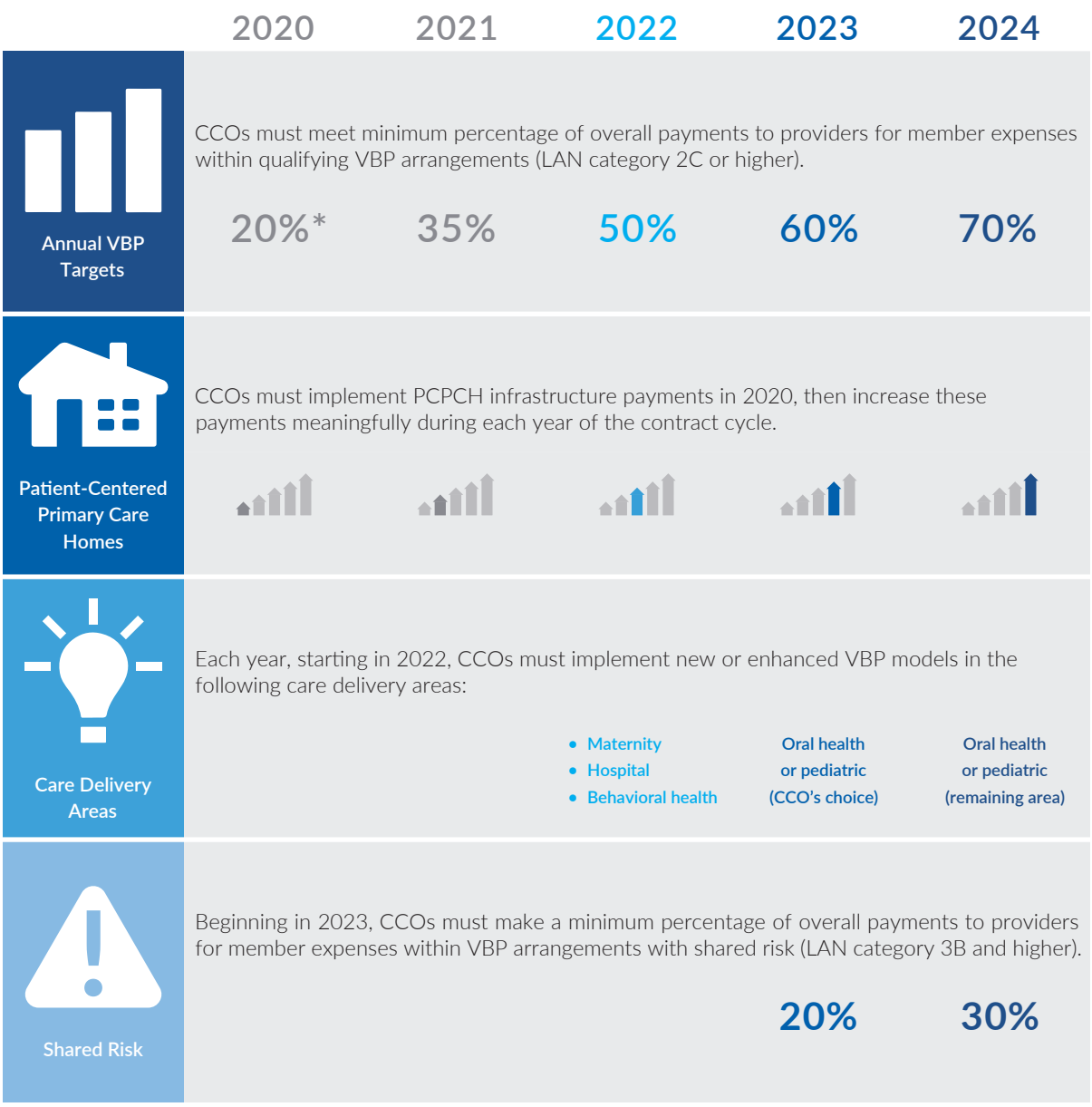
# Introduction

In 2022, Oregon's coordinated care organizations (CCOs) entered the third year of the Value-based Payment Roadmap[2] ("Roadmap"), a key element of the CCO 2.0 contract running from 2020-2024. The Roadmap is one component of the state's program to transform Medicaid health care delivery and outlines CCO requirements for advancing value-based payment (VBP) arrangements. After the COVID-19 PHE delayed full implementation of some VBP milestones, CCOs were accountable for significant VBP expansions in 2022. These included implementing new or enhanced payment models in three care delivery areas (CDAs) (behavioral health, hospital, and maternity care), global increases in the proportion of payments occurring under contracts in VBPs models, and increases in payments to patient-centered primary care homes (PCPCHs).

## ROADMAP REQUIREMENTS

The Roadmap aligned Oregon Medicaid's VBP definition with the Health Care Payment Learning and Action Network's Alternative Payment Model framework ("LAN framework").[5] The LAN framework supports the categorization of CCOs' qualifying VBP models and enables measurement of VBP adoption within these categories over time. See Appendix A for a description of the framework and its payment model categories. The Roadmap requires CCOs to meet annual targets[5] 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. Second, CCOs must annually increase PMPM payments within each PCPCH tier to support infrastructure investments that enhance care delivery. Third, CCOs must implement new or enhanced VBP models in specific CDAs in 2022-2024. Finally, in later years, a minimum percentage of provider payments must occur in arrangements with downside risk (LAN category 3B or higher).

**Exhibit A. VBP Roadmap milestones for 2020-2024.[2]**




**CCOs were allowed to temporarily convert arrangements to pay-for-reporting (category 2B) without penalty due to the COVID-19 PHE*

## PREVIOUS FINDINGS ON THE ROADMAP

The Center for Health Systems Effectiveness (CHSE) was engaged to evaluate CCOs' progress toward the VBP Roadmap goals and requirements. An initial interim report assessed progress through mid-year 2021, and the current report provides updates on CCOs' work through mid-year 2022.

For the first interim report (released in March 2022),[6] CHSE conducted interviews with CCOs in mid-2021 about their Roadmap progress (as required annually by OHA) and analyzed 2021 CCO VBP questionnaires and payment model reporting to the state. This assessment found CCOs working to engage provider organizations still disrupted by the COVID-19 PHE and hesitant to take on new financial risk. CCOs found traction with some providers interested in population-based payments and made progress creating systems to monitor and report on VBP arrangements, including potential impacts on health equity. CCOs had started

work on new models for the first three CDAs (behavioral health, hospital, and maternity care), although they had encountered challenges related to health information technology (HIT) infrastructure and selection of appropriate measures. Additional challenges and questions emerged as CCOs asked a broader swath of providers to take on downside risk.

## ABOUT THIS REPORT

In this year's annual interim report, we continue to chart CCOs' advances in developing and maintaining VBP arrangements and the infrastructure to support them. Here, we:

- **Summarize CCOs' performance on the 2020 requirement for 20% of overall payments to be through qualifying VBP arrangements,** using data reported in CCO's annual Payment Arrangement Files (PAFs). These data are also displayed online on the Oregon All Payer All Claims Reporting Program's payment arrangements dashboard[3] (*Section 2*). These data became available in June 2022.
- **Shift forward to 2022 to assess CCOs' self-reported progress** in developing and implementing new payment models and engaging providers over the past 12 months (June 2021 to May 2022) to meet this and future years' Roadmap requirements (*Section 3*).
- **Report on CCOs' 2021 infrastructure payments to PCPCHs** to assess compliance with the Roadmap requirement of increasing these annually. (*Section 4*).
- **Evaluate CCOs' 2022 implementation of new or expanded payment models in required CDAs,** including those in behavioral health, hospital, and maternity care due in 2022, as well as those in development for 2023 and 2024 (*Section 5*).
- **Examine 2022 developments in CCOs' use of health information technology (HIT)** to monitor and report on VBP arrangements, address health equity, and support providers using VBP data for population health improvement (*Section 6*).
- **Offer recommendations** for how the OHA can support CCOs' continued progress toward Roadmap objectives (*Section 7*).

## DATA SOURCES AND METHODS FOR THIS REPORT

This report draws from multiple data sources, as shown in Exhibit B. First, evaluators used payment arrangement data from the OHA dashboard[3] to evaluate CCOs' performance on the Roadmap target for overall payments in qualifying VBP arrangements. These data cover plan year 2020, the most current year for which they were available. Second, evaluators used data collected in mid-2022 to assess performance on 2022 requirements, as well as CCO progress toward future-year milestones. These data included responses CCOs submitted to questionnaires and reports (titled "VBP PCPCH Data and CDA Template") submitted by CCOs describing their current VBP models in May 2022. In addition, evaluators conducted OHA-required interviews with CCO leaders in June 2022.

A detailed description of data sources and methods used for this evaluation can be found in Appendix B.

**Evaluation Areas and Data Sources for Second Annual Interim Report.**

| Evaluation Area | Report Section | Data Source |
|---|---|---|
| **CCO performance on 2020 requirement for overall payments by LAN category** | 2 | OHA payment arrangement files |
| **CCO progress toward requirements for overall payment targets for 2022-2024** | 3 | June 2022 interviews and pre-interview questionnaires |
| **CCO performance on requirement for annual increases in PCPCH infrastructure payments** | 3 | 2022 CCO VBP PCPCH Data and CDA templates |
| **CCO performance on required first three CDA models (due January 1, 2022)** | 4 | 2022 CCO VBP PCPCH Data and CDA templates, 2022 interviews |
| **CCO progress in using HIT to support VBP and leverageVBP for health equity** | 5 | June 2022 interviews and pre-interview questionnaires |

## LIMITATIONS

This evaluation relies on CCO self-report via interviews and questionnaires. The evaluation team had access to aggregated data shared on the state's PAF dashboard but did not have access to CCOs' PAFs for a comprehensive review of VBP models. Interview time allowed only summary-level discussion. OHA will report quantitative LAN categorization data for 2021 provider payments in 2023.

# CCO and Provider Capabilities to Monitor and Report on VBP Performance

## KEY TAKEAWAYS

- **All but one CCO met the state's 2020 milestone** of at least 20% of payments to be issued under qualifying VBP arrangements. While the target had originally been set at LAN category 2C or higher, it was adjusted to category 2B or higher for 2020 in response to the COVID-19 PHE.
- **However, performance on the milestone varied across CCOs.** CCOs meeting the milestone had between 25% and 96% of payments in qualifying VBPs.
- **The state's method for categorizing contracts may distort payments in each LAN category in an upward direction.** When CCOs had contracts with components in different LAN categories, OHA attributed the sum of all payments to the highest category. The state follows LAN guidance for categorizing VBP models.

## METHODOLOGY FOR ASSESSING LAN CATEGORY OF CONTRACTS

CCOs' performance on VBP Roadmap payment milestones is documented in payment arrangement files submitted annually to OHA, listing each provider contract and its corresponding LAN category(s). The state All Payer All Claims (APAC) reporting program then produces a dashboard showing payment percentages in each LAN category. For a full description of methods, see the online dashboard.[3]

Although the 2019 baseline report did include 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 2020 payment data. Thus, 2020 payment data are the effective baseline for assessing progress in establishing VBP contracts.

The methodology[3] used by the APAC program bundles all payments in a given 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, or FFS) but has a $5,000 LAN level 2C component would count as $80,000 at LAN 2C for reporting purposes. A number of CCOs indicated their largest reported VBP contracts include payments in LAN categories of less than 2C, suggesting the APAC program dashboard may overestimate the proportion of qualifying payments by an undetermined extent.

## PERFORMANCE ON OVERALL VBP PAYMENT TARGETS FOR 2020

The following two pages show data from 2020 payment arrangement files. Exhibit C shows aggregate CCO payments in arrangements at LAN level 2B or higher. While the overall VBP payment target for 2020 had originally been set at LAN category 2C or higher, it was adjusted to category 2B or higher for 2020 as part of OHA's response to the COVID-19 PHE. All but one CCO, Trillium Tri-County, met the 2020 target of having at least 20% of payments at LAN category 2B or higher.

Exhibit D shows where CCOs stood in 2020 with arrangements at LAN categories 3B or higher. These arrangements include downside risk and will be required for Roadmap milestones in 2023 and 2024. In 2020, nine CCOs had already met the 2023 target of 20% of payments in these arrangements. The remaining CCOs will need to increase risk-bearing arrangements to succeed.

**Exhibit C. CCO performance on overall targets for payment through advanced VBP arrangements. Future-year targets shown at bottom.**

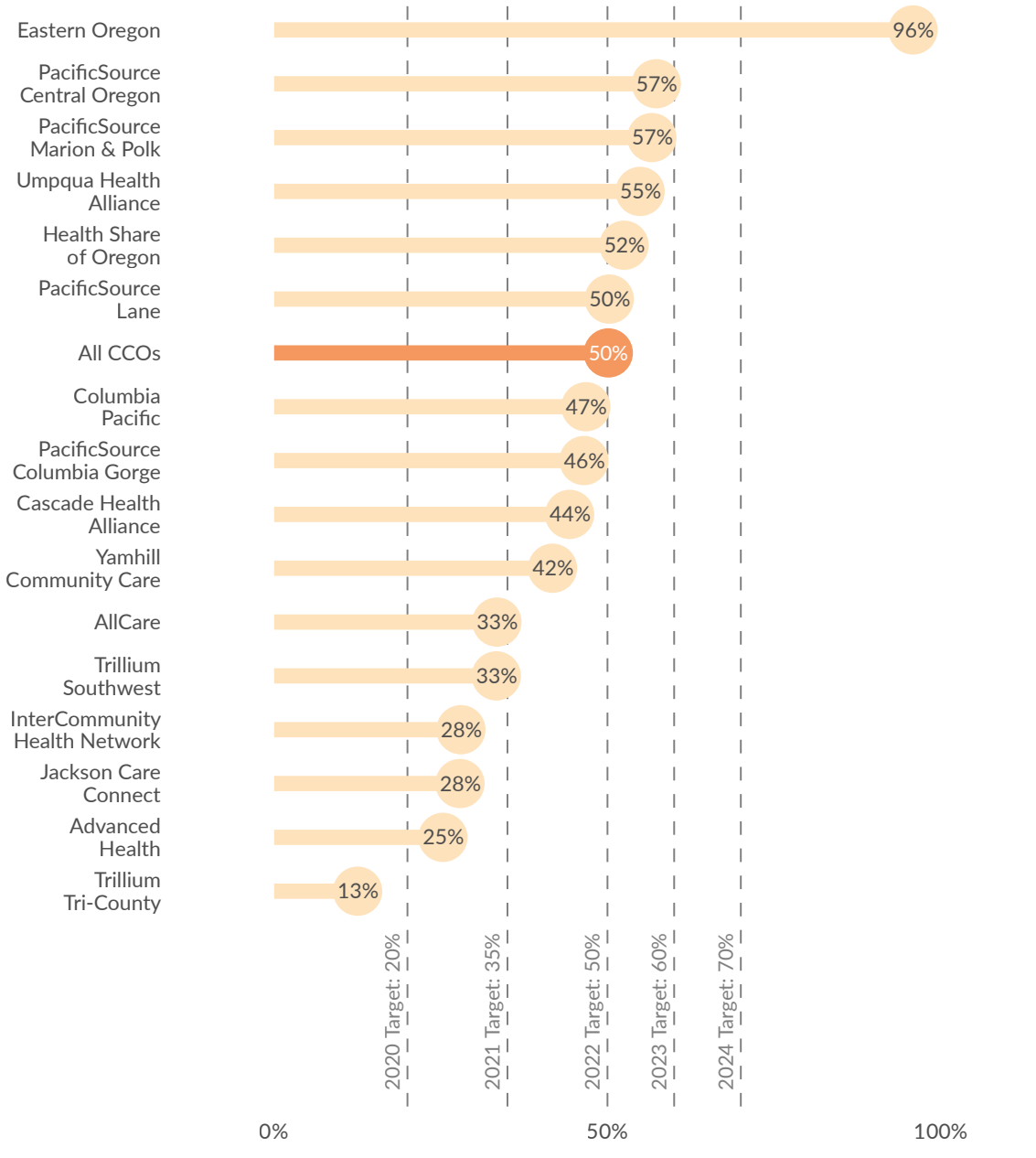
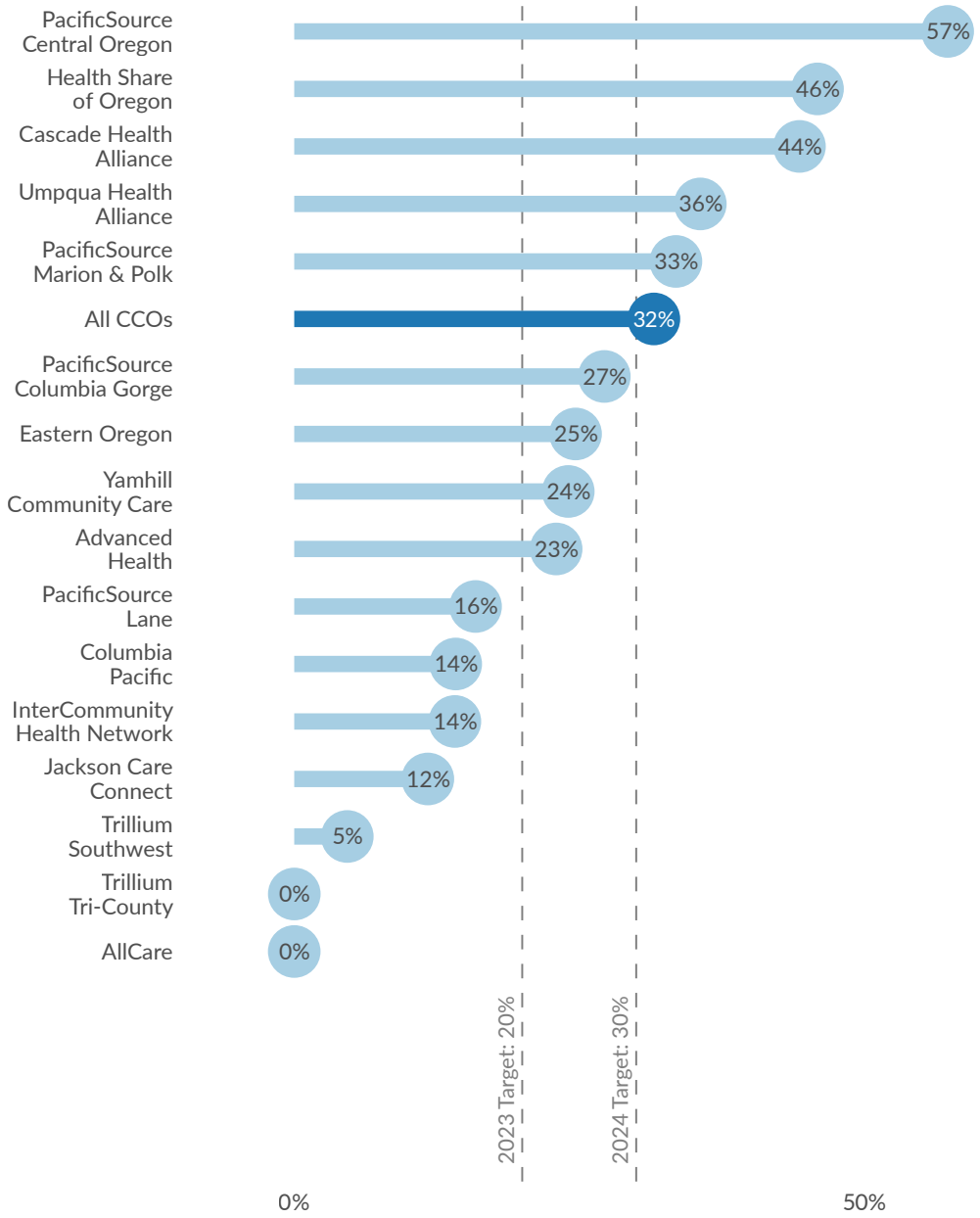


**Exhibit D. Proportion of CCOs' overall payments in arrangements with downside risk in 2020.**



SECTION 3

# CCO Work Advancing VBP Arrangements in 2022

## KEY TAKEAWAYS

- **CCOs were confident** they would meet Roadmap targets for 2022 and 2023, although a few struggled with some elements or had concerns about later-year targets. Pockets of VBP advancement occurred around the state, and providers were generally more receptive to VBP arrangements. However, providers and CCOs were exhausted by two years of COVID-19 PHE disruptions.
- **Many CCOs engaged providers** through regular meetings or learning collaboratives to review performance data and discuss quality improvement strategies. These meetings were key to developing relationships and provider capacity for more advanced VBP arrangements.
- **Experience with VBP arrangements prior to CCO 2.0** continued to facilitate development of VBP models in 2022, as did provider structures in CCOs' communities, such as integrated healthcare systems and federally qualified health centers (FQHC).
- **Specialists, hospitals and behavioral health providers** remained challenging provider categories for new VBP arrangements for some CCOs, particularly those with numerous independent providers to engage.

For CCOs, the first two years of the VBP Roadmap were primarily characterized by building capacity to engage and support providers in VBP arrangements. The capacity-building work occurred against the backdrop of the COVID-19 PHE, which compounded challenges in engaging providers, reporting, monitoring, and achieving quality and cost targets. Frequent leadership turnover within provider organizations often disrupted the momentum of VBP discussions. Some providers were reluctant to implement new VBP arrangements or advance to downside risk models during this time of instability. As one CCO put it:

> *"The COVID environment has made value-based payments more difficult. I heard one quote from a conference that said, 'COVID set value-based payments back two years.' I thought that was a simple statement and a dramatic statement, but maybe even an accurate statement in terms of a provider willingness perspective."*

Although health system operations remained disrupted in 2022, with prominent staffing shortages, CCOs reported a renewed focus on VBP development to meet the milestones of the Roadmap. They reinstated performance targets that had been waived or modified during the COVID-19 PHE and continued to meet with providers already in VBP arrangements and report on their performance. A few CCOs piloted new models and tested new structures involving downside risk in LAN categories 3B and above, focusing on achievable goals and building off or "fine-tuning" existing models.

In this section, we cover CCO assessments of their status meeting 2022 and future-year VBP milestones and discuss strategies they were using to maintain and advance payment models.

## CCO SELF-ASSESSMENT OF STATUS ON UPCOMING OVERALL VBP PAYMENT TARGETS

CCOs expressed confidence that they would meet 2022 and 2023 milestones for the overall proportion of payments at LAN category 2C or higher. Some reported already exceeding these targets based on internal monitoring. Others had brought large providers on board or planned to adjust contracts to achieve the required percentages. CCOs were similarly confident about meeting 2023's targets for 20% of payments in arrangements with downside risk.

> *"I think we feel like we're in a good position. Our provider community knows the mission we're trying to achieve, and I feel like we have the right knowledge internally to achieve those metrics as well."*

Despite expressions of confidence, some CCOs struggled to meet milestones. These CCOs did not have appreciable VBP contracting history prior to the Roadmap and had trouble gaining traction in provider negotiations during the COVID-19 PHE. One CCO had led its outreach with a specific VBP model that did not get much uptake from providers; another was experiencing challenges with HIT systems and having difficulty monitoring its payments by LAN category. Three CCOs had failed to complete at least one of the three required CDA models for 2022.

In addition, two CCOs voiced concerns about predicting their future performance. One CCO cited continued uncertainty about how the state would categorize some of its payments, especially for hospital arrangements that included only certain services. For another, shifting payment denominators due to changes in Medicaid benefits made percentages hard to predict.

> *"How do you maintain the current arrangements you have? I mean, one challenge … is our denominator continues to move. It continues to inflate. Every time you bring in a new benefit or an extended benefit, like [the] SUD waiver or behavioral health fee schedule changes, that changes that denominator. So just maintaining our VBPs that we even currently have is walking us backwards on that percentage."*

## ENGAGING WITH NEW AND EXISTING PROVIDERS TO ADVANCE VBP ARRANGEMENTS

In 2022, CCOs deepened partnerships within existing VBP arrangements, often to support performance and move providers toward a greater capacity for risk. They also reached out to engage providers not already involved in VBP contracts.

### Fostering collaborative relationships with providers already in VBP contracts

CCOs continued to engage providers in maintaining and improving VBP arrangements in place prior to 2022. Relationship-building, though time-consuming, was viewed as an essential part of the VBP development process. CCOs used meetings with providers as forums for bidirectional engagement and opportunities to review performance data, train providers, investigate cost drivers, and assess strategies. One CCO described how, after several years of discussing and vetting performance data with providers, a level of trust had developed.

> *"Usually we can come in and say, 'Yep, here's your reporting.' I haven't seen anything in the last few years where they say, 'You're wrong.' And, so, I think there's a matter of trust at this point that we're reporting [the] right information."*

Other relationship and reporting strategies used by CCOs included:

- Having a dedicated provider engagement team that worked to maintain relationships with provider groups and monitor VBP progress.
- Conducting biannual PCPCH clinic site visits for providers with VBP arrangements.
- Creating provider collaboratives or network task forces across disciplines to discuss topics such as electronic health record (EHR) data reporting, best practices, and improvement in cross-provider communication. Two CCOs noted that providers were especially receptive to learning about their colleagues' work.

### Updating and expanding existing arrangements

CCOs supported their provider networks to improve models in a variety of ways, including amending contracts, tailoring models to certain provider groups, and providing technical or strategic planning assistance. In provider communities with more VBP experience, CCOs described increasing acceptance for continued work. As one CCO reflected:

> *"Historically speaking, the more groups you get onboard, the more positive the outcomes, the greater the appetite [for VBP arrangements]."*

Other signs of increased momentum for VBP uptake with already engaged providers included provider initiation of partnerships in pursuit of VBP contracts, provider engagement with CCO staff to troubleshoot problems such as service reimbursement, and increased willingness among larger practices to discuss downside risk arrangements. One CCO noted, as a positive sign, that providers had stayed in their VBP contracts through the COVID-19 PHE and were not looking to exit these arrangements.

### Seeking to engage providers new to VBP contracts

The COVID-19 PHE created challenges in outreach to new providers that were sustained into 2022. Health systems were strained by COVID-19 workforce shortages within provider organizations and CCOs. Staff availability was a major challenge in moving model development forward. One CCO reported that discussions with a large hospital provider had "ground to a halt" due to the overwhelmed system. Another noted:

> *"Meeting with providers and offices, whether it is the independent practice or large institution right now, just because of staffing, it's very difficult to get on their schedule."*

## Model design strategies for new VBP arrangements

Whether aiming to move providers with existing VBP contracts to higher LAN categories or onboard new providers, CCOs had several methods for making VBP more palatable to providers. CCOs aimed to reduce provider burden, promote alignment with other payers and programs, ease providers into risk and build provider trust and engagement. Approaches included:

- **Converting existing population-based or shared-risk arrangements with no quality components into VBP arrangements** through the addition of quality measures. This was a frequent approach in areas with long-standing capitated agreements, such as those with behavioral health agencies.
- **Introducing financial risk slowly** for skeptical or risk-averse providers — for example, starting with upside risk only until providers were familiar enough with their performance to accept downside risk.
- **Introducing proven or standard measures** that were familiar to providers and easily understood and tracked.

## Selection of measures and performance targets

**Measure selection** was a central concern of model design for new and modified arrangements. CCOs collaborated with providers to select or modify clinically-relevant and actionable measures, although approaches varied. One CCO with numerous PCPs and hospitals worked to find measures with enough service volume to standardize across all providers in its territory. Other CCOs customized measures for individual providers or even created new measures to address specific needs. In general, CCOs preferred to use standard measures (including those from the Oregon Health Plan Quality Metrics Committee's Aligned Measures Menu[7]) and worked to build on existing measures or other quality improvement efforts that providers were already pursuing to reduce risk and reporting burden. One CCO shared the story of negotiating a VBP contract with a hospital initially reluctant to take on a new arrangement. In response, the CCO adopted a quality measure the hospital was already working on for its parent organization.

> *"We said, 'Well, let's not reinvent the wheel, let's choose a metric that you're interested in and align it.' And so I think that's the key when you're working with providers, is to find something that they already are working on or that engages them."*

Tactics to reduce provider measurement burden included choosing claims-based measures that did not require EHR or patient chart review or other reporting that would require work for the provider.

> *"Whenever possible, if we have access to the data, we'll have our own administrative staff do that legwork and calculate performance without any additional work for providers and their staff."*

One CCO raised a concern with LAN category 4 models, noting the requirement for CCOs to submit encounter data for services could be a higher burden than claims reporting. Per this CCO, the additional work in reporting these data was substantial enough to discourage providers from entering these models.

> *"We're being asked to say, 'Well, we need greater reporting from you.' We need basically a health-plan level report from a provider…You start pushing providers further and further, and they're going to back off and say, 'That's not worth it, put me back on fee for service or I'm out.'"*

**Target selection** also required a collaborative approach. Two CCO leaders commented that moving to more advanced LAN categories in VBP contracts could be perceived as a big leap, especially by smaller providers. To address concerns about increased risk, CCOs might use phased or improvement-based approaches to setting measure targets. One CCO set "stepped" incentives for providers unsure about meeting higher targets. Other CCOs passed on OHA's targets for the CCO incentives measures set. Two CCOs mentioned using 2021 as a baseline for target improvement rather than going back to pre-COVID-19 years. CCOs also had mixed approaches to setting cost targets for shared-risk models. Some CCOs negotiated cost targets based on provider experience, while others adopted the state's 3.4% cost-growth benchmark or based the target on medical loss ratio.

## Challenges to creating VBPs in specific provider categories

Certain categories of providers and services presented challenges to some CCOs, especially as they anticipated overall VBP payment targets of 60% and 70% coming in the next two years.

**Specialty care**, including specialty mental, dental and oral health care, was a common area of difficulty. CCOs in regions without integrated delivery systems (including several rural CCOs) spoke of challenges convincing independent specialty practices to sign on for VBP arrangements when they were accustomed to FFS payment and Medicaid members made up a small portion of their patients. Finding appropriate quality measures for specialty services or multispecialty practices was also challenging.

**Behavioral health care** was characterized as having severe workforce shortages. In some regions, providers had left agency or group settings to practice independently, requiring more work to establish VBP contracts.

**Hospital negotiations** were an area in which CCOs described divergent experiences this year. While one found hospitals to be "some of the most accepting" provider types of VBP arrangements, another described this provider category as "one of the bigger challenge areas" in hitting later-year Roadmap targets. Two rural CCOs with hospitals not affiliated with PCPs found it challenging to engage hospitals in risk arrangements, given the lack of system-wide levers.

> *"We do have an agreement in place that does get into downside risk by next year, but it's just not the lever approach or the negotiation opportunities that I think we would all want, us and them, because of that primary care base not really being as robust as it could be."*

One CCO reported working with a hospital that did not "believe in capitation," with capitation acting as a perceived barrier to the hospital's plans for growth. This CCO anticipated their agreements would not advance past LAN category 2C.

## Expansions in total cost of care VBP models

Relative to previous years, more CCOs had implemented or were working on total cost of care models. These models were typically LAN category 3 arrangements in which a provider was accountable for controlling the costs of all medical services for attributed members. One CCO was piloting such an arrangement with one of its large FQHCs, with the potential for rolling it out to additional practices. Another CCO had engaged primary care, hospital, and other providers in county-level risk pools with annual financial targets. Shared savings were returned to the community to address members' social needs. These arrangements appeared to incentivize effective coordination between different categories of providers. One CCO viewed them as preparing providers to take on greater risk:

*"It's like we start with total cost of care and, over years, we can kind of grow into capitated arrangements and then advance, of course, into [the] 4A category."*

A rural CCO noted that this kind of arrangement required providers to have sufficient Medicaid panel sizes, which could be a barrier for regions with smaller practices. One group of smaller providers had approached the CCO about joining forces.

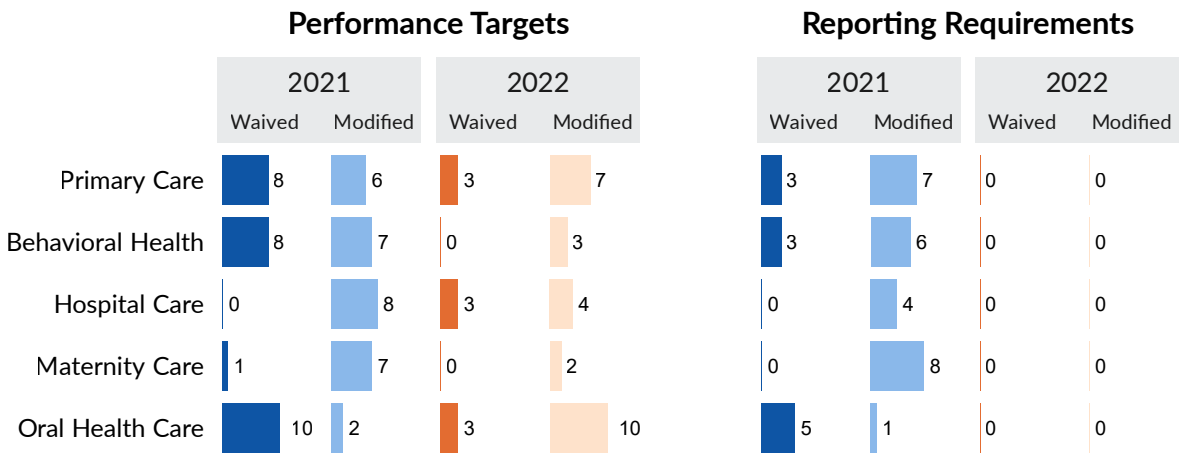
*"We did have some providers reach out to us that say, 'Hey, what if we formed our own little mini pool, just of us and our buddies that we really feel like we can work with and get on the same team?' There's ways to have smaller pools, and we would look at that."*

## EMERGING FROM COVID-19 MEASURES MODIFICATIONS

In 2020, OHA allowed CCOs to count payments in pay-for-reporting arrangements (LAN category 2B) toward the annual Roadmap target for overall percentage of payments in qualifying VBPs. CCOs, for their part, changed existing VBP contracts by waiving or modifying provider targets for performance, cost, and reporting for 2020 and 2021 (see Exhibit E). Modifications included switching from pay-for-performance to pay-for-reporting, relaxing performance targets, and waiving requirements altogether.

As CCOs slowly emerged from the public health emergency in 2022, most who made these modifications had already transitioned or were transitioning back to pre-COVID-19 targets. The number of CCOs waiving and modifying performance targets dropped substantially except for in oral health and primary care, where changes to targets were generally sustained. Of the few CCOs that had implemented cost target modifications, only one continued to waive targets in 2022, for behavioral health. By 2022, no CCO was waiving or modifying reporting requirements in any care delivery area.

**Exhibit E. Total number of CCOs waiving or modifying provider VBP requirements in 2021 and 2022.**



## CHALLENGES TO ADVANCING VBPS AND MEETING FUTURE-YEAR MILESTONES

CCOs were confident they would meet 2022 and 2023 VBP targets. They were engaging with providers to improve the performance of existing VBP models, move toward greater financial risk and extend VBP contracts to new providers. Nevertheless, CCOs reported a number of common challenges in advancing these arrangements.

- **Lingering effects of COVID-19** on staffing (among provider and CCO teams), provider capacity to engage in VBP negotiations and quality efforts, and provider confidence for engaging in financial risk arrangements.
- **Unique challenges with specific provider groups**, including medical specialists, dental providers and some behavioral health providers.
- **Incorporating downside risk into hospital arrangements** due to continued COVID-19 uncertainty, incompatible organizational goals or financial risk aversion.
- **Contracting with small provider groups**, at least in some regions, especially in VBP categories requiring financial risk.
- **Balancing provider burden with the need for complete reporting** of encounter data in capitated arrangements.

# Advancement in PCPCH Payment Structures

## KEY TAKEAWAYS

- **CCOs, on average, increased their infrastructure payments to PCPCHs** between 2020 and 2021 as required by the Roadmap, although increases were modest and three CCOs kept payments at 2020 levels.
- **PCPCH payments continued to vary widely between CCOs,** with the highest payments more than 10 times more than those of the lowest-paying CCOs.

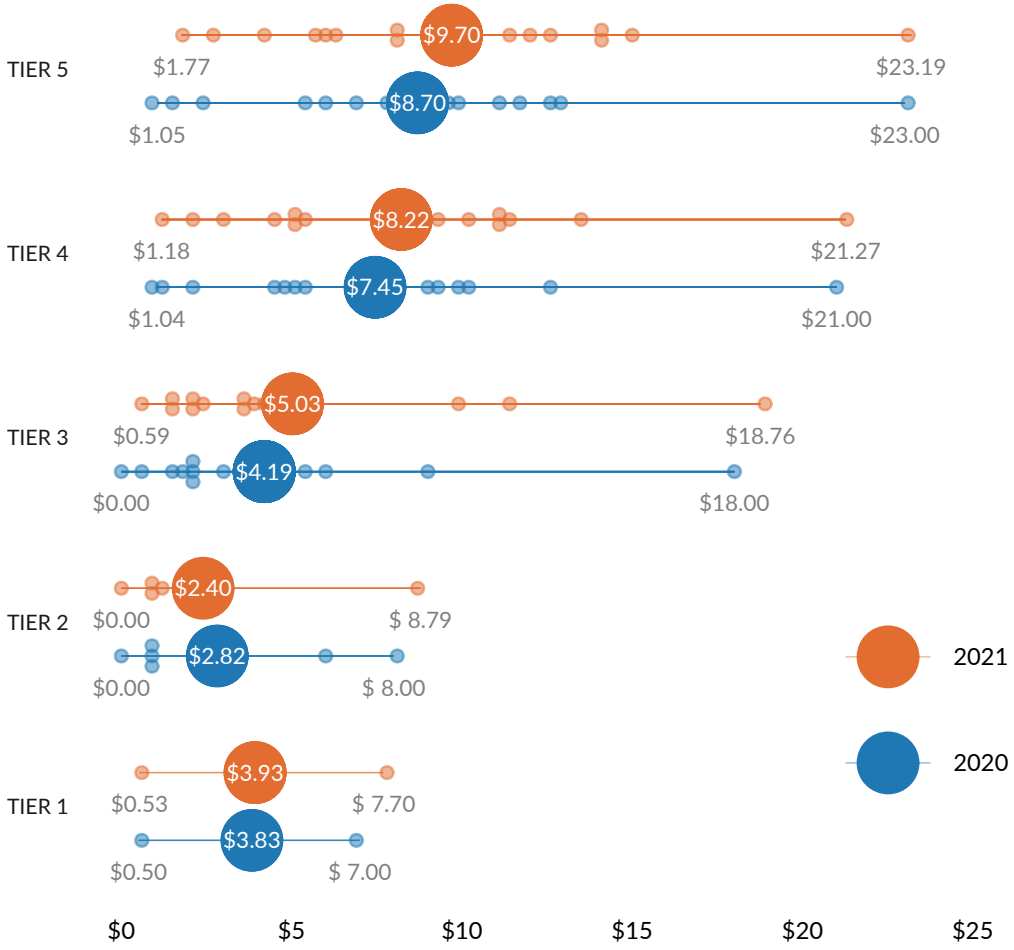
One component of the Roadmap requires CCOs to make infrastructure payments to PCPCHs recognized through Oregon's five-tier system, increasing these payments annually. These payments must feature:

- **Tiered PMPM amounts** that increase by clinics' PCPCH recognition level so that clinics with higher recognition status received higher PMPM amounts.
- **Increased PMPM amounts** in each tier during each year of the CCO contract cycle.

These infrastructure payments, unless combined with higher category payments, fall into LAN category 2A and do not count toward Roadmap targets for overall VBP payments.

Exhibit F shows average payments made by CCOs to PCPCHs at each tier in 2020 and 2021, as reported on CCOs' 2022 CCO VBP PCPCH Data and CDA templates (tabular payment data is displayed in *Appendix C*).

**Exhibit F. Increases between 2020 and 2021 in per member per month infrastructure payments to Patient-Centered Primary Care Homes, Tiers 1-5.**




2021 data for one CCO omitted due to data quality concerns.

*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 2021 calendar year.*

The average PMPM amounts that clinics could earn within each tier increased slightly from 2020 to 2021, although three CCOs made no changes. As indicated in Exhibit F, payments remained varied across CCOs. Many clinics advanced to higher tiers in 2021, with more clinics in Tiers 3-5 than in 2020. This resulted in a lower statewide average payment for Tier 2 clinics in 2021 than in 2020, as clinics in higher-paying CCOs left Tier 2 for higher tiers.

The state has not set a minimum value for PCPCH payments, instead requiring that they offer "meaningful" support for patient-centered care. Wide variations in payments between CCOs may warrant an assessment of the extent to which PCPCH payments facilitate other components of the Roadmap. For example, the state may want to assess whether CCOs providing higher infrastructure payments to PCPCHs were more successful at engaging providers in more advanced VBP models. If so, the state might consider setting minimum PCPCH payment thresholds.

SECTION 5

# Implementation of VBP Models in Priority Care Delivery Areas

## KEY TAKEAWAYS

- **Almost all CCOs submitted VBP models for the three CDAs (behavioral health, hospital and maternity care)** due in 2022. Two CCOs were still working on these milestones in mid-2022, and one additional CCO had yet to finalize a maternity model.
- **Models varied in size and innovation.** The CDA milestone had no specific requirements for size of CDA models. Several CCOs introduced new broad-based shared-risk arrangements, while others made small tweaks to existing programs. Dollar values varied greatly, and the number of members included in models ranged from fewer than 100 to entire CCO populations. Several smaller models supported innovative provider partnerships, and one targeted culturally and linguistically specific care.
- **A few models appeared to miss standards for the requirement** by falling into a LAN category below 2C or not including CDA-specific quality measures.
- **CCOs' progress toward 2023 and 2024 CDA milestones was mixed,** with some CCOs having models already in place and others still in the planning process.

The Roadmap identifies five areas of health care services in which CCOs must develop and implement new or enhanced payment models. Initially slated for 2021, the first CDA requirement – implementation of new or enhanced VBPs in behavioral health, hospital, and maternity care areas – was postponed until 2022, in response to the COVID-19 PHE. New models in the final two required care areas, oral health care and children's health care, are due for implementation in 2023 and 2024, with CCOs choosing which to submit first. CCOs may pair up to two CDAs in a single model (for example, hospital and maternity care). The requirements do not specify size of models (in terms of members included or dollar value) and leave CCOs latitude for experimentation.

CCOs reported on the CDA requirements to OHA in mid-2022. Reports included a description of each model, LAN category, associated quality measures, total contract value, and maximum potential gain and loss for providers. CCOs also reported their five largest overall VBP arrangements, some of which were also in these three CDAs.

**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*

In this section, we provide an overview of CCOs' work implementing the initial three models for 2022, updates on their progress toward the final two models, and discussion of challenges and successes in these care delivery areas.

## BEHAVIORAL HEALTH VBP MODELS

In 2020, most CCOs had some experience with non-FFS payments for behavioral health, although not all of these featured quality components. Most CCOs intended to meet the behavioral health CDA requirement by enhancing existing agreements. By 2021, the COVID-19 PHE required CCOs to place more emphasis on stabilizing networks, reinforcing their incremental approaches to VBP advancement.

All but two CCOs submitted new or enhanced behavioral health VBP arrangements for the CDA milestone in 2022. Exhibit G summarizes these models.

**Exhibit G. Behavioral health models for 2022 care delivery area requirement.**

| LAN Category | Count | Description |
|---|---|---|
| **Category 4** | 7 | Most models reported under LAN category 4 included long-term or ongoing capitation models with quality enhancement. Enhancements might consist of adding a single key metric (e.g. emergency department utilization among members with a mental-health diagnosis) or multiple metrics, sometimes "homegrown" measures capturing nuances of utilization or access. One CCO included a THW case rate model that provided peer services for members in substance use disorder (SUD) recovery. |
| **Category 3** | 4 | Three models featured upside and downside risk for providers, while the fourth had only upside risk. Two models were community-wide (covering all providers): one was a joint behavioral health and maternity model covering perinatal care (including postpartum depression screening), and the other rewarded primary care clinics for offering integrated services for mild to moderate mental illness and SUD. |
| **Category 2** | 3 | Level 2 agreements included quality metric incentives for services to several member subgroups: children in Department of Human Services (DHS) custody, new mothers, and MH/SUD clients. |
| **In development** | 2 | Two CCOs had not yet implemented models as of June 2022. |

## Characteristics of behavioral health CDA models

Several CCOs with pre-existing capitated arrangements with large behavioral health provider groups described simply adding or updating quality components in those agreements, sometimes to address follow-up or treatment initiation. For example, one CCO in a capitated agreement added an emergency department (ED) utilization metric for members with mental-health diagnoses to address concerns about access.

Two CCOs described undertaking in-depth efforts to understand complexities of behavioral health care delivery and design new shared-risk models with providers. In one instance, providers in the CCO's region earned county-based payments, with additional individual and county-level incentives for meeting performance targets. In the other, the CCO's data team spent two years working with providers to achieve a deep understanding of claims and billing details, leading to development of customized quality measures.

> *"We had to get pretty creative for some things on, like, combinations of different code sets and providers and different things like that, to be able to kind of whittle down and kind of get through the noise there to actually land on something that is meaningful for us and the providers, so it's something that they can use to actually influence some quality improvement efforts in their clinics."*

Another two CCOs used bundled payments for delivery of evidence-based treatment models (Assertive Community Treatment and Intensive In-Home Behavioral Health Treatment). One CCO noted that OHA used a bundled payment model to reimburse CCOs, making it easy to pass this model on to providers, with increased payment if desired.

In addition to the new or enhanced models submitted specifically to meet the 2022 CDA requirements, 14 CCOs reported additional behavioral health VBP arrangements among their largest overall VBP contracts. These included capitation agreements with community mental health programs, payments to PCPs for integrating behavioral health services, and capitated payments for specific programs, such as Assertive Community Treatment.

The number of members included in behavioral health CDA models ranged between 80 and almost 9,000, although one included 65,000 members. The potential gain or loss topped out at about $100,000, although one CCO had budgeted $3 million for a new incentive program across all its behavioral health providers.

## Behavioral health models and strategies

In addition to the models mentioned above, CCOs used VBP arrangements to address specific concerns about quality, access, and member support. These included:

- Paying primary-care clinics an incentive for offering integrated services for mild and moderate mental illness, to improve access to specialty mental health services for members with more severe illness.
- Creating new, direct contracts with clinicians who also had separate subcontracts with community health agencies, to alleviate contracting and measurement burdens on agency staff.
- Providing a PMPM payment to support peer services for members in SUD recovery.
- Working to support large, more sophisticated primary care clinics that were looking to "lean in" to behavioral health integration, even to the point of obtaining a Certificate of Approval from the state to provide services.

## Challenges encountered by CCOs in creating behavioral health models

Despite general success at meeting the CDA milestone, CCOs struggled with a number of challenges in developing behavioral health VBP contracts. Even CCOs with established, successful models raised ongoing concerns.

**Workforce shortages** disrupted services in multiple areas. For two urban CCOs, challenges in the behavioral health workforce presented a crisis for contracting and delivering services. While CCOs could set their own payment rates for behavioral health providers, one CCO referred to basing its payments on the state's fee schedule and finding it insufficient for retaining providers.

> *"We have had providers directly reaching out to us to say, "Hey, the rates are not allowing us to achieve market rates to even recruit staff. We're having staff leave out the back door, but we have nobody coming in."*

Two CCOs had made prospective payments to stabilize and sustain provider capacity, and another asked for state support in finding ways to use Medicaid funds to support the development and retention of new providers. One rural CCO had switched from capitation to FFS payments for outpatient visits, hoping this would incentivize access to those services.

Several rural CCOs also brought up a trend of behavioral health clinicians leaving employment at community agencies and "hanging a shingle" as solo practitioners. CCOs were finding it more difficult to create VBP arrangements with these independent providers, even though these providers were needed to maintain access for members.

> *"From the perspective of successful value-based payment schemes, what we have currently is implemented with larger clinics that have some infrastructure. And as this trend continues, I fear a smaller and smaller percent of our providers will be in those types of organizations."*

One CCO described a challenge with solo practitioners "cherry-picking" less complex behavioral patients, leaving community agencies with a higher-acuity mix of clients.

In addition to workforce challenges, CCOs reported several other difficulties in setting up VBP arrangements for behavioral health services:

- **Attribution.** To assess providers' performance on quality and cost, CCOs needed to attribute members to them. When all members of a CCO received care from a single behavioral health agency, this was not a challenge. But in CCOs where members might seek services from multiple providers, attributing members presented a "moving target," according to several CCOs.

> *"Primary care is pretty basic where you've got assignment of membership to a primary care provider. Specialty behavioral health, hospital care, you don't always have that direct correlation. So I think that's one of the challenges."*

- **Information exchange.** Some CCOs identified a lack of EHR interoperability as an added barrier to quality measurement and reporting with behavioral health providers. One CCO had succeeded this year in working with Arcadia, the HIT platform vendor, to onboard community mental health programs to the platform, which allowed records exchange. Another was providing an interface it called an "EHR lite."

- **Finding appropriate quality measures.** As with other specialty areas, CCOs had questions about measures appropriate for behavioral health care. One CCO requested a statewide effort to identify and obtain buy-in from providers for a standard set of measures.
- **Strategies for integrated care.** One CCO asked for ideas on how behavioral health services might be integrated into its total cost of care model without disincentivizing utilization.

## HOSPITAL CARE VBP MODELS

All but two CCOs reported new or enhanced VBP arrangements for hospital care in 2022. Exhibit H summarizes the models reported.

**Exhibit H. Hospital models reported for 2022 care delivery area requirement.**

| LAN Category | Count | Description |
|---|---|---|
| **Category 4** | 3 | New models reported in category 4 included facility capitation for a diagnosis related groups (DRG) based hospital, an episodic payment for perinatal hypertension, and a per diem rate for skilled-nursing level care for patients for whom appropriate discharge settings were unavailable. |
| **Category 3** | 9 | Most category-3 models featured shared savings and downside risk (category 3B), with one upside-only model. Most models included all hospital services, although one focused on maternity care and another was with a behavioral health hospital. |
| **Category 2** | 2 | Two CCOs reported arrangements in which hospital partners received incentives or paid penalties based on whether they met defined sets of quality metrics. |
| **Under development** | 2 | Two CCOs had not yet implemented models as of June 2022. |

### Characteristics of hospital CDA models

CCOs submitted an array of hospital-focused models for the CDA requirement. About half covered comprehensive hospital services with performance incentives, category-3 arrangements for all services, or facility-level capitation. Several of these arrangements included hospital-specific metrics such as readmissions. In contrast, four arrangements had no hospital-specific metrics, instead relying on metrics associated with other levels of an integrated system (e.g., primary care); these appeared not to comply with milestone requirements.

The remaining models targeted particular areas within hospital care. These included models for inpatient behavioral health and a daily rate for members medically ready for discharge but lacking suitable post-discharge accommodations. Two CCOs combined hospital and maternity care into joint models. One model focused on a maternal hypertension episodic payment, with the other acting as a category 3B model for hospital maternity care. Nine CCOs reported having other hospital VBP arrangements in addition to those they had identified for the CDA requirement.

Hospital CDA models varied in terms of magnitude, with one impacting slightly more than 100 members while others encompassed all eligible CCO members. Potential financial loss or gain to providers ranged from less than $100,000 to over $4 million, although some CCOs with new models did not report financial risk potential.

## Innovative hospital models and strategies

CCOs reported several successes in their hospital-care VBP development, including:

- Adding a readmissions measure for a hospital that had struggled in this area.

> *"We're really happy that they were willing to include readmissions as their metric, because this is something that, overall, for them, including all their payers, they've struggled with over the years. And so they came to the table and were perfectly willing to work with us on it."*

- Overcoming provider resistance by using a payment bundle the hospital was working on with its parent organization.
- Engaging hospitals as part of a "county risk" collaboration holding all providers jointly accountable for cost targets.
- Adopting a new hospital measure with sufficient service volumes for a rural CCO to include all hospitals throughout its region.

## Challenges encountered by CCOs in creating hospital care models

CCOs reported several challenges specific to hospital VBP development:

- One CCO was negotiating with a hospital that aimed to grow and was not interested in cost containment.
- Some CCOs experienced Medicaid's relatively low market share and reimbursement rates as barriers to attracting hospitals into negotiations, particularly for arrangements with financial risk following the COVID-19 PHE.

> *"Before [COVID-19], they were really hesitant. I think they're extremely hesitant now with all of the uncertainty that we have."*

- In areas with CCO overlap, one CCO perceived a reluctance among hospitals to contract with more than one CCO.

One CCO reported a successful fully capitated agreement with a DRG-based regional hospital. The CCO that helped create it, however, questioned whether this type of model could be widely replicated with other organizations.

> *"The hospital needs to have people, strategies, and capabilities beneath the contract that helps them be successful… So, they have to really invest in a lot of things in terms of how their hospital operates and performs, how they track information, and how they might intervene on a high-cost case to make sure that they're getting unnecessary costs out of the system."*

## MATERNITY CARE VBP MODELS

Last year, CCOs described their maternity CDA models primarily as works-in-progress, with two main approaches: models that bundled care for hospital and outpatient settings, and models targeting single provider types.

This year, 13 CCOs submitted maternity models to meet the milestone. Exhibit I displays these models.

**Exhibit I. Maternity models reported for 2022 care delivery area requirement**

| LAN Category | Count | Description |
|---|---|---|
| **Category 4** | 5* | Two CCOs arranged category 4 episodic payments for maternity services (one hospital-only, one hospital plus related outpatient care), while a third had an episodic arrangement with a clinic. Two other CCOs had models providing episodic rates for extra-clinical care, one for doula services and one for medication-assisted treatment for pregnant members. |
| **Category 3** | 6 | Four CCOs had 3B (upside/downside risk) arrangements for general maternity care. Three were with vertically integrated providers and covered most CCO members, while one was with a single hospital. One CCO was trying out a new shared-savings (3A) model with its practices using the OHA postpartum visit measure, and another had a 3A upside/downside risk model with a maternity medical home that did not include sufficient financial risk to qualify for LAN category 3B. |
| **Category 2** | 3 | One CCO reported a pay-for-performance model for a maternity medical home, while two others reported models at the 2A-B levels supporting a county health pre- and postnatal home visiting program and peer opioid use disorder services for pregnant members. |
| **Under development** | 3 | Three CCOs had not yet implemented models as of June 2022. |

**One CCO reported two maternity models on its template, both in category 4.*

### Characteristics of maternity care VBP models

Models submitted this year varied somewhat from the plans CCOs described in 2021, suggesting the complexity of negotiating with providers. About half the reported models appeared to involve minimal change, such as adding a maternity-related metric in a pre-existing VBP arrangement. As one CCO noted, minimizing provider burden was a goal this year. Two CCOs had created joint hospital and maternity care models, as permitted by the Roadmap.

Multiple CCOs had incorporated OHA's current Prenatal and Postpartum Care[8] incentive measure for quality targets, illustrating the influence of statewide incentive metrics on provider contracts downstream. One CCO noted that OHA essentially pays CCOs for maternity care as a bundle, so passing that arrangement to providers seemed intuitive.

The number of members and dollars involved in maternity care models was smaller than in either hospital or behavioral health models. Among CCOs reporting numbers, affected members ranged from 48 for a home-visiting program to about 4,700 for an episode-based model with a large clinic. Only about a quarter of CCOs estimated maximum prospective gain or loss for their models. Those that did had financial incentives or risk ranging from $13,142 to slightly over $1 million.

Two CCOs provided details on their process for choosing models and building provider buy-in. One CCO with numerous smaller providers had evaluated potential maternity-related metrics to find one with sufficient

denominators for all its practices. Once it selected the metric, it met with providers to discuss requirements and ensure participation.

> *"We wanted to be very inclusive to our provider community to be able to have everybody participate. We looked at postpartum care as the measure that would be meaningful and also have an appropriate denominator size."*

Another CCO targeting a joint hospital/maternity model talked through a series of potential services with its local hospital and finally agreed on a maternity bundle the hospital had already implemented for its parent organization. The model to date has proved successful for the CCO.

## Innovative maternity care models and strategies

Several models were innovative in bringing THWs or social-service partnerships into maternity care. These included a doula model intended to address REALD disparities, two models providing peer support for SUD treatment during the pre- and postnatal period, and one home visiting program with a county health department. Although these models were small, the CCOs that created them saw them as addressing priority concerns with health equity or complex member needs.

> *"We did an analysis. We might be meeting the [maternity care] metric, but, if you drill in by race and ethnicity, there are some disparities there. So we're working on that right now. And I think doulas and other traditional health worker peer supports are the perfect match for that disparity."*

> *"We are trying to figure out how to get all of the providers in this space, understanding the different services provided by public health, how to better integrate those services and how — with our own delivery system and the more traditional providers, the medical and specialty providers — to get everybody connected."*

> *"That [combined SUD and maternity model] was really in response to needs that our members were presenting and that our network was leaning in and wanting to solve for. So, it's a smaller population, but a real high-need one that we targeted."*

## Challenges encountered by CCOs in creating maternity care models

CCOs mentioned several challenges in setting up new maternity models:

- Administrative coordination could be complex for the more innovative models involving providers from disparate systems (e.g., clinical and SUD providers).
- Boundaries of responsibility were not always clear between the health system and other system partners, such as county agencies, for maternal and family services delivered outside the clinic.
- As in other areas, provider shortages continued to limit VBP contracting. During COVID-19, one rural CCO lost one of its two contracted maternity-care practices to retirement, halving its services under value-based arrangements.

## VBP MODEL DESIGN FOR REMAINING CARE DELIVERY AREAS

CCOs were still primarily focused on requirements for behavioral health, hospital, and maternity care models in 2022, as some were still implementing these models. However, some were also looking ahead to next year's requirement for an additional new or expanded model in oral health or children's health.

### Oral health models

In mid-2022, nine CCOs reported having at least one oral health VBP arrangement in place. The majority of CCOs (10) administered oral health benefits through subcontracts with dental care organizations (DCOs). Some CCOs had transitioned these arrangements into VBP models to satisfy the oral health VBP requirement, for example, by adding quality measures. In addition to capitated models, CCOs had plans to meet the milestone through shared savings and risk models and the addition of new quality measures. They mentioned access, health equity, and delivery integration with primary care and behavioral health settings as areas of focus for new or existing oral health VBP arrangements.

CCOs that subcontracted with DCOs did not always know how quality measurement or financial risk was negotiated between the DCO and its provider network. However, several CCOs mentioned encouraging DCOs to increase value-based contracting with individual dental providers. Some CCOs also focused on engaging dental providers accustomed to a fee-for-service environment and building health information exchanges with DCOs.

### Children's health models

As of mid-2022, seven CCOs had at least one children's health VBP arrangement in place, while five described being in varying stages of planning for the upcoming requirement. Most CCOs with models in place had incorporated quality metrics related to children or adolescents into existing primary care VBP agreements, on top of other quality metrics. One CCO called primary care clinics a logical place for pediatric VBP arrangements since most included pediatrics or family practice.

Two CCOs specifically mentioned working with the Oregon Pediatric Improvement Partnership (OPIP) to consider how to incorporate the new 2023 social-emotional health incentive metric[9] into the design of children's health VBP models. Other CCOs brought up different areas of focus for their children's health models, including a Department of Human Services measure focused on assessments and preventive care, pediatric inpatient cases, and piloting a total cost of care model.

One CCO reported piloting VBP arrangements with pediatric-specific entities, with mixed performance results across organizations. Another CCO reported having a pediatric clinic terminate a 3B arrangement in early 2022, at least temporarily, due to concerns about downside risk exposure.

## SUMMARY OF PROGRESS ON ADVANCING PRIORITY CDA MODELS

For the most part, CCOs appear to have met the Roadmap's milestone for model creation in the first three designated CDAs, initiating contract development in areas where VBP models were not prevalent. While most models were not groundbreaking or highly novel, they nonetheless spurred new conversations between CCOs and providers and, in some cases, stimulated new infrastructure for assessing and reporting on new arrangements.

Some CCOs appeared to be challenged in classifying their models by LAN category and reporting dollars anticipated to flow through a given model or maximum gain or loss to providers, suggesting that some models are still in formative stages and relevant data may be difficult to generate. In addition, a few models were in LAN categories less advanced than 2C or appeared to lack quality measures specific to the CDA area (for example, hospital services), meaning they did not fully qualify for the requirement.

The immediate impacts of the new CDA requirement were harder to assess. For many models across all CDAs, CCOs and providers added incremental new elements – a single quality metric, in some cases – to existing agreements. These additions may address quality concerns, enhance collaboration among providers, and stimulate further infrastructure development. However, they suggest that some changes in care delivery due to the Roadmap are likely incremental.

SECTION 6

# CCO Progress in Monitoring and Reporting on VBP Performance

## KEY TAKEAWAYS

- **CCOs made headway in the frequency, sophistication and automation of sharing VBP-relevant information with providers,** mainly through improvements in HIT systems and processes. Variations remained, with some CCOs advancing more quickly than others.
- **Some CCOs still faced challenges monitoring the status of their payments by LAN category,** and much of this work was manual due to a lack of suitable HIT tools.
- **CCOs were exploring a range of strategies to obtain information** about REALD and social needs of members in order to monitor the impacts of VBP arrangements on health equity and use payment models to address disparities. CCOs continue to need guidance from OHA on best practices in these areas.

To meet the Roadmap's goals, CCOs needed information systems and processes to support multiple important VBP functions. These included:

- Monitoring of CCO contract portfolios by LAN category to assess progress toward Roadmap payment-category milestones.
- Acquiring clinical data from providers for assessing performance on non-claims-based quality measures.
- Monitoring and reporting to providers on individual VBP arrangement performance.
- Assessing the impacts of VBP arrangements on health equity.

In 2020 and 2021, CCOs reported having systems to perform these functions, although some were largely manual. Some CCOs were adding to their analytics teams and looking for more efficient HIT approaches to meet these needs.

In this section, we assess in more detail CCOs' progress in carrying out these functions and identify continuing challenges in 2022.

## DEVELOPING HEALTH INFORMATION TECHNOLOGY CAPACITY TO SUPPORT VALUE-BASED PAYMENT

By mid-2022, CCOs reported acquiring additional capacity to support and advance VBP contracts within three areas. First, CCOs increased their capacity to monitor VBP contracts, assess potential new arrangements, and monitor provider performance on current arrangements. Second, CCOs adopted platforms, reports, and processes for bidirectional exchange of information with providers with VBP contracts. Finally, some CCOs supported HIT capacity development within their provider partners through meetings or collaboration on new platforms. CCOs also sought to continue developing the capacity to assess the impacts of VBP arrangements on health equity and to use VBP arrangements as levers to address disparities. Improvements in HIT supported those goals.

As shown in Exhibit J, all CCOs reported working to develop HIT capacity across three areas, with varying levels of progress: (1) CCO internal capacity to monitor and assess VBP arrangements, (2) tools and processes for exchanging VBP performance data with providers and (3) capacity of providers to use reports and share VBP-related data back with CCOs.

**Exhibit J. Examples of CCO monitoring and reporting capabilities at earlier and later-stage development**

## CCO MONITORING OF OVERALL PAYMENTS BY LAN CATEGORY

As in previous years, CCOs primarily used manual processes to monitor their progress toward VBP targets, including the state's annual overall payments milestones. Confusion among some CCOs about how to categorize their different payment arrangements compounded the time- and resource- intensive nature of manual monitoring. CCOs did submit data to OHA on the LAN categories of their provider contracts. However, our comparison of responses to the CDA 2022 CCO VBP PCPCH Data and CDA templates, the pre-interview questionnaires, and the interviews revealed continued uncertainty about the relevant components of VBP arrangements and the criteria for classifying an arrangement in a particular LAN category.

Several CCOs remarked on the difficulty of using administrative platforms to track payments by LAN category. One larger CCO noted in its questionnaire a lack of mature commercial platforms for managing VBP arrangements, which had led it to develop its own proprietary approach:

> *"We have been researching and exploring scalable solutions to meet the many requirements of administering mature VBP. To date, no clear comprehensive solution has been identified."*

## MONITORING AND REPORTING ON PROVIDERS' VBP PERFORMANCE

Overall, CCOs made progress in sharing more data with more providers, with greater regularity, in a more automated fashion, and with more risk stratification than in the first two years of the Roadmap. Differences in CCO capabilities persisted, however. Exhibit K compares how CCOs at earlier and later stages of reporting and monitoring development described accomplishing tasks.

**Exhibit K. Examples of CCO monitoring and reporting capabilities at earlier and later-stage development**

| Function | Earlier stage | Later stage |
|---|---|---|
| **VBP monitoring within CCO** | • Platform not able to integrate data sources.<br>• Static reports dominate; ad-hoc reporting time-consuming and prone to error. | • Flexible platform able to integrate data sources, scale as VBP business grows, and require minimal effort to produce ad-hoc reports in response to internal team questions/investigations. |
| **Provider-level information systems** | • Numerous, diverse EHRs.<br>• No or unsystematic capture of REALD data. | • Multiple providers within CCO region on a shared EHR platform.<br>• Integration of REALD and Z-code data into health record. |
| **Health information sharing from providers to CCOs** | • Periodic, manual-based EHR reporting from providers to CCO. | • Platforms to intake and combine claims and EHR data into a single shared system (e.g. Arcadia). |
| **CCO reporting to providers on VBP performance** | • Infrequent communication, focus on contract monitoring.<br>• Manually pushing out canned reports, with non-actionable frequency.<br>• Lack of support for peer learning or comparison. | • Regular meetings, multi-provider learning collaboratives for VBP, quality improvement.<br>• Reporting to practices on peer provider performance.<br>• Customizable provider portal with real-time data delivered via both canned and ad-hoc reports. |
| **Population health support** | • No risk stratification to guide care management priorities.<br>• Social risk data collected unsystematically and/or solely from provider observation.<br>• CCO/provider care management decisions and monitoring siloed. | • Ability to integrate claims and clinical data in risk assessments.<br>• Coordinated provider/CCO care management. |

### Development of within-CCO monitoring and reporting capacity

CCOs' support for VBP arrangements occurred within different organizational contexts. Six CCOs were part of larger enterprises that brought staff and resources to bear in supporting Medicaid VBP models. The remaining CCOs either relied solely on dedicated teams to design, produce, and analyze reports on VBP performance, or contracted with external organizations to supplement the efforts of internal teams. Both groups of CCOs reported staff shortages and turnover in 2022 on teams supporting VBP efforts.

### Support for provider-level HIT systems and health information exchange (HIE)

Providers' EHR systems could facilitate or inhibit VBP arrangements depending on features. In a few rural regions, CCOs encouraged, incentivized, or subsidized providers to adopt EHRs that enabled flexible and robust data integration and reporting that could be used to improve provider performance. The COVID-19 PHE had delayed one CCO's implementation, and it struggled with delayed and uneven uptake.

> *"We have some offices that have just gone with another EMR that may be cheaper or a little more geared towards their specialty, and we're finding that they are struggling significantly trying to pull those reports as well without the help of our eHealth department."*

These delays forced providers to rely on manual data collection and reporting for metrics that required a linkage between claims and chart records. CCOs with more advanced information exchange systems had more automated ways to integrate these data.

On the other end of the spectrum, four CCOs reported having implemented HIE platforms, such as Arcadia, that allowed for bidirectional data sharing and integration of claims, EHR, and sometimes additional member data. One CCO had worked with its Arcadia vendor to onboard oral and mental health providers, an apparently novel accomplishment. Connecting to this type of platform required up-front effort from the provider and CCO. However, it subsequently allowed the use of a wide range of reporting and risk-assessment tools helpful for VBP design. Two CCOs mentioned using or contemplating VBP models to incentivize the adoption of these HIE tools.

> *"There's going to be different tiers of providers that are engaging with VBPs… But as providers are more willing to engage with Arcadia and full integration with their EHR and higher levels of value-based payment care and payments, we should reward them."*

Provider validation of VBP-related reporting was a necessary step when new arrangements came online. While this process could be time-consuming for analytics teams, it also served as a means for CCOs to develop trust with providers about the reliability of data.

### CCO reporting to providers on VBP model performance

As noted above, CCOs had established regular channels to engage with providers and share quality and cost reporting on VBP arrangements. Electronic portals and reports were a component of this work.

At a minimum, nine CCOs reported sharing member rosters through a provider portal. Some used a portal or other web-based platform to share more robust population health information, such as risk categories, gap lists, and performance on clinical quality and cost metrics. Some portals contained real-time, customizable data, while others were limited to fixed reports available on a periodic (e.g., weekly) basis. For example, one CCO shared a weekly report showing members in urgent need of drug or alcohol treatment, which was intended to help providers improve performance on the Initiation and Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET) quality measure.

The types of data CCOs shared varied by provider type. Multiple CCOs provided population management data to primary care providers to assist with developing shared care planning. Reports for other types of providers (for example, behavioral health providers or specialists) could be limited by a lack of standard methods for attributing members for these services. At least one CCO, however, was working to integrate different types of care (e.g., physical and oral health) into gap lists sent to providers. In some instances, CCOs provided scorecards comparing providers' performance with that of other providers within the CCO or across the state. HIT also enabled CCOs to track relationships between member- and provider-level characteristics.

Providers varied in their capacity to use dashboards and act on data from CCOs. Small panel sizes, staffing shortages, and lack of familiarity with HIT platforms could inhibit provider engagement with data related to VBP performance. CCOs described a need to offer time-intensive face-to-face support to ensure providers actually could make use of reporting in an effective and actionable way.

> *"One of the things we've been talking about is even hiring a staff person that's, for lack of a better term, an HIT/HIE type of coordinator role. Because, it really does take manpower on our side to spend time with the clinics, to really sit down and show them the value of the tool and getting them engaged in how to use it."*

Several CCOs had teams that met regularly with practices to give feedback, provide technical assistance and identify potential problems.

### Work to support population health management

Different CCOs screened, monitored, and stratified members using a variety of methods and data sources to create cohorts with similar care needs. All CCOs used some combination of demographic and medical information to stratify members into risk categories, such as:

- Diagnostic and pharmaceutical data.
- Illness or chronic disease burden.
- OHA capitation payment categories.

Most CCOs reported progress in supplementing the standard demographic and clinical data available with other data sources or algorithms for risk stratification, including:

- Supplementing missing demographic information by integrating data from multiple EHRs.
- Using clinical data to identify conditions potentially not captured in claims.

Members determined to be high-risk were often referred to the CCO's care coordination team to prioritize intervention and develop care plans. Providers could also refer members to CCOs for care coordination.

## USING DATA TO BRING HEALTH EQUITY AND SOCIAL DETERMINANTS INTO VBP PLANNING AND MONITORING

In 2020 and 2021, CCOs' efforts to combine health equity and VBP strategies were in their early stages and diverged widely in their approaches. The baseline and initial progress reports cataloged several issues slowing this work:

- Difficulty obtaining demographic data on individual members, especially related to REALD, which would allow CCOs to stratify members in reporting and detect inequities.
- Ambiguity about options and responsibilities for collecting these data.
- Small numbers in some REALD subpopulations, making conclusions difficult to draw when data for stratification were available.
- Multiple unproven strategies for using payment models to address disparities.

These difficulties persisted in 2022. However, there were bright spots of advancing capacity for identifying disparities and efforts to target VBP arrangements toward equitable care. OHA had introduced its Meaningful Language Access incentive metric in 2021, and multiple CCOs were passing it down as a quality measure in provider-level VBP models, stimulating conversations on quality measurement outside of strictly clinical measures.

## Capacity to collect and use REALD and social needs data

Comprehensive REALD data remained unavailable in 2022. In response, CCOs used a range of strategies to understand their populations, both by racial/ethnic/linguistic communities and by social determinants of health. These approaches had little overlap and appeared to depend on organizational and community resources. They included:

- Use of Bayesian surname calculation to impute REALD data.
- Use of U.S. Census data, such as area deprivation indices.
- Collection of Z-code data by providers and partners.
- Jail booking and release information.
- Incorporation of data CCOs encountered while participating in the Integrated Care for Kids[10] and Accountable Health Communities[11] projects.
- Use of large commercial databases with detailed social-economic household profiles (e.g. Axiom).

CCOs identified challenges and limitations with these strategies. For example, one CCO had queried providers on their use of Z codes and found differing interpretations. Despite incremental advances, CCOs as a whole were still distant from a comprehensive understanding of member needs.

## Sharing and reporting equity-related data with providers

Where member-level data were available, CCOs made progress in reporting and acting on it with providers. Seven CCOs mentioned disaggregating performance measures using what REALD data they could access. Three reported sharing stratified reports with providers, while others were still assessing how to approach this or sharing about inequitable outcomes they had detected. For example, CCOs had uncovered disparities in childhood and adolescent immunization rates among Spanish-speaking members and racial disparities in ED use in particular neighborhoods. One CCO called its conversations with providers on these data still "not very deep," while another noted that not all providers understood how to use this information and needed support from the CCO.

> *"Even though it's been a couple of years, we still get asked 'What am I supposed to do with this? What is the expectation?' And we ask them to use it as another piece of information and informing how they're going to care for their patients."*

## Leveraging VBP models to address known disparities

No single CCO articulated a fully developed approach to using payment to address health equity. However, several CCOs used VBP designs to bolster culturally responsive care and incorporate metrics that promoted equity. One CCO used VBP arrangements to compensate doulas with a goal of increasing access to culturally appropriate care for members of color. Doulas were paid a per-delivery case rate, with the option to earn a quality pool incentive based on success in connecting members to community resources, reducing cesarean rates, timeliness of postpartum care, and postpartum depression screening. The program's population was primarily non-English speakers. Another model still under consideration would incentivize the inclusion of culturally-specific providers in regional networks.

Several CCOs used VBP models to reward providers for other equity-related efforts, such as reporting Z codes, training staff on health equity, or seeing members of racial or ethnic minority groups or those with higher levels of medical complexity, including those with behavioral health diagnoses.

One CCO allowed providers with medical-loss ratio (MLR) spending targets to count health-related services spending in the numerator of its ratio. Allowing health-related services to be counted as medical spending increased the provider's chances of achieving its MLR target, thereby encouraging the use and reporting of health-related services. Six CCOs had incorporated the new OHA Meaningful Language Access measure into arrangements with providers, although this proved challenging in areas without a ready supply of certified medical interpreters.

> *"Everybody in general is, 'How do we get into that one and actually do a pay for performance on language access?' That's a learning curve for all, across the board for everybody."*

CCOs also cautioned of potential harm to members from a reductionistic focus on "numerator hits" rather than broader strategies for meeting the needs of particular communities, noting that successful scores on a specific measure did not indicate overall culturally responsive care. Internally, three CCOs reported working to raise employee awareness of equity issues in data analysis through team trainings. Another used data and clinical work groups to identify equity needs across the continuum of care.

### Speculation on future social risk adjustment strategies

CCOs did not use social risk adjustment (SRA) in 2022. However, several were considering data sources and methods, anticipating a future OHA requirement. One analytics team had compared SRA modeling strategies to its current risk-adjustment strategy. Another CCO experimented with the SRA module in its Arcadia system to assess members' needs for air filters during wildfire season. One CCO followed one of OHA's recommended strategies, using improvement-based performance targets instead of standard benchmarks, avoiding penalizing providers treating more socially complex patients.

Several CCOs noted, however, that introducing payment differentials based on social risk would require more "rock-solid" REALD and social-needs data than are currently available. Overall, no consistent strategy for SRA had emerged, and CCOs looked to the state for further guidance.

## SUMMARY OF CHALLENGES IN MONITORING AND REPORTING ON VBP PERFORMANCE

Despite continuing advances in the capacity to monitor and report on VBP arrangements, CCOs faced a variety of challenges in this area. These included:

- **Determining the LAN classifications** of provider contracts, especially those with atypical features that did not fit neatly within the LAN framework.
- **Devising automated systems to track and sum provider payments** in each LAN category.
- (For some CCOs) **Obtaining clinical data from providers** to integrate efficiently with claims data in CCO-level systems.
- **Integrating a diversity of provider types** (e.g., behavioral health providers, oral health providers, and THWs) into information exchange systems for inclusion in VBP development and assessment.
- **Identifying strategies for attributing members** to non-primary care providers, such as specialists, for VBP design and reporting purposes.
- **Obtaining and making use of individual-level data on member REALD** and social needs for VBP monitoring and reporting.
- **Identifying evidence-based models** for using VBP design to address health equity.
- **Assembling qualified analytics teams** to support VBP reporting and provider engagement with data.

# Recommended Next Steps and Opportunities for Continued Support of the Roadmap

We recommend the following steps to support CCOs in meeting their VBP Roadmap requirements in 2022 and beyond.

## RECOMMENDATIONS

### Promote greater VBP alignment across payers and regions.

CCOs have limited leverage to engage hospitals and other independent specialty care providers in VBP contracts to meet their Roadmap goals. OHA contracts for and administers benefits for approximately 1.5 million Oregon residents (including Medicaid, the Public Employees' Benefit Board, and the Oregon Educators Benefit Board), providing an opportunity to encourage participation in VBP models and to support payer alignment around a consistent group of performance measures. In addition, OHA could revisit pre-COVID-19 plans for requiring discussions on alignment in quality measures and other key VBP features between CCOs with regional overlap (work that was a feature of the Roadmap but delayed by the COVID-19 PHE).

### Continue creating opportunities for CCO cross-pollination to share successful models and novel approaches.

CCOs frequently asked for information on approaches and strategies used by their peers to address challenges in VBP development. In addition to its ongoing VBP workgroup, OHA could promote additional opportunities (through presentations or publications) for CCOs to learn from one another.

### Develop additional guidance on quality measures for specialty services and integrated care.

CCOs described difficulty finding appropriate metrics for specialty services, including both physical specialties and mental/behavioral health. OHA could provide technical assistance to CCOs for identifying and sharing information about successful quality approaches for these providers. OHA could also help CCOs identify effective quality-measurements strategies in the growing area of integrated behavioral health services, along with ways to incentivize adequate access for these services if included in total cost of care arrangements.

### Work with CCOs to develop best practices for applying health equity goals within VBP strategies.

CCOs lacked comprehensive data and tools to effectively assess the potential adverse impacts of VBP arrangements on members experiencing health inequities. In addition, efforts to address health equity and member social needs through VBP design were in their infancy. The state could support this critical work by (1) compiling and sharing successful strategies that CCOs are exploring to expand currently available data on

members, (2) describing evidence-based practices for evaluating potential adverse effects of existing VBP arrangements, and (3) showcasing new contracting models that leverage VBP to support health equity.

### Ensure that CCOs have a consistent understanding of Roadmap requirements for subcapitated arrangements, CDA-specific quality measures, and enhancement of existing models for CDA requirements.

OHA can support CCOs and ensure regionally consistent implementation of the Roadmap by providing more detailed guidance on areas where CCOs showed inconsistent interpretations of requirements. These included the Roadmap requirement that subcapitation agreements include quality components affecting frontline providers and that CDA models include CDA-specific measures (e.g. hospital-specific measures for hospital models). For CCOs that are enhancing existing VBP models to meet upcoming CDA requirements, the state can provide additional detail about the type or degree of enhancement required.

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# 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.

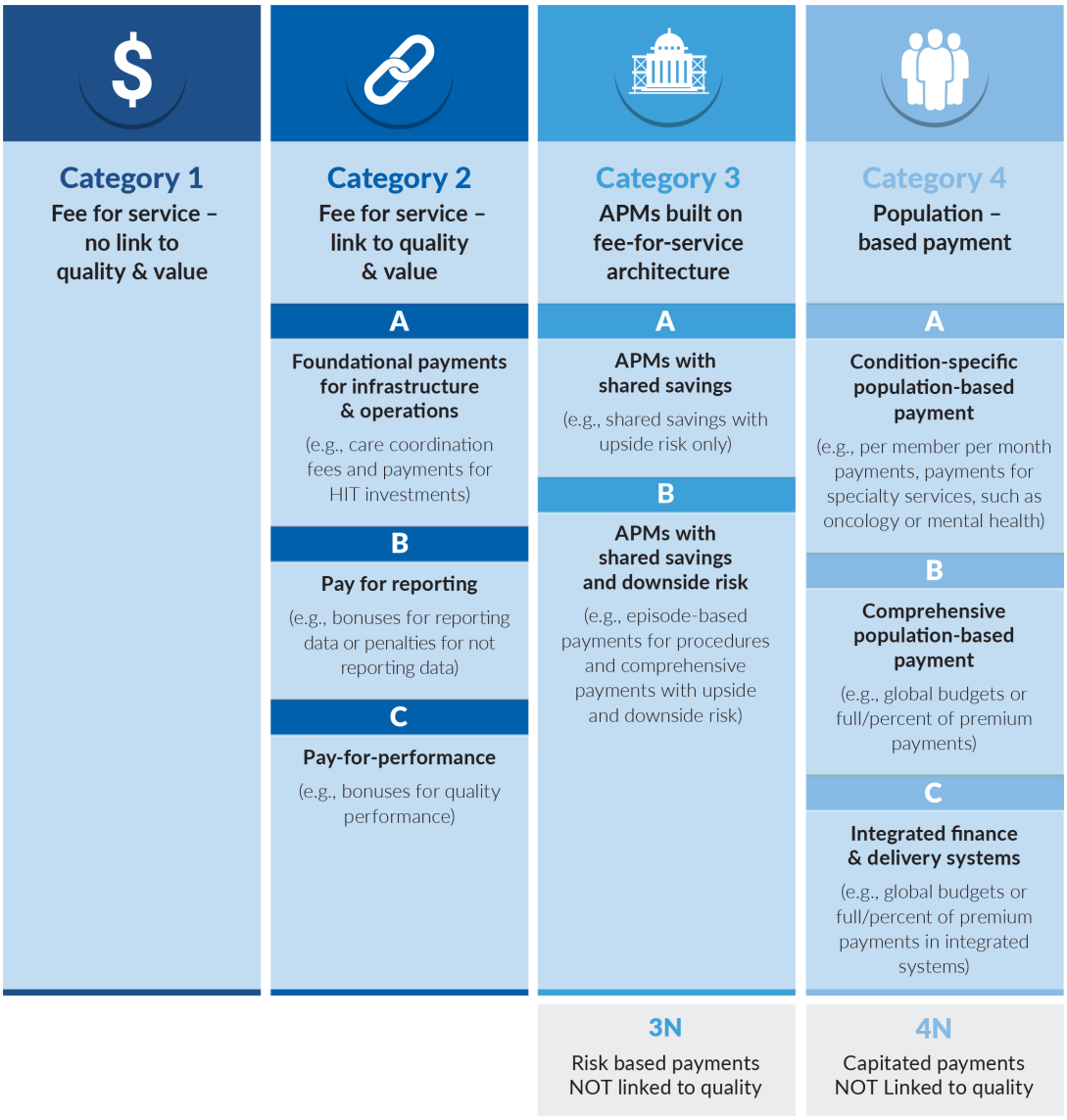


*Image adapted from the Health Care Payment Learning and Action Network's 2017 (refreshed) Alternative Payment Model APM Framework available at https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf*

# Data Sources and Methods

This report presented a) results of a qualitative analysis of key informant interviews and written information provided by Coordinated Care Organizations (CCOs) in 2022, b) results of a quantitative analysis of CCO-reported payment models for Patient-Centered Primary Care Homes (PCPCHs), and c) data on 2020 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 (a) and (b); analytic methods for CCO payment arrangement data is provided on the OHA payment dashboard website.[3]

## VBP Pre-Interview Questionnaires

CCOs are required to participate annually in 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.

In May 2022, 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 by question and CCO in an analytic matrix. This matrix was reviewed by members of the research team 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.

Two financial entities, PacificSource Community Solutions and Trillium Community Health Plan, operated multiple CCOs in 2022. These entities each submitted a single combined questionnaire for their CCO regions. CCOs' responses to questions regarding COVID-19-related contract modifications were counted multiple times if the response represented multiple CCO regions.

## VBP Key Informant Interviews

In June 2022, CHSE conducted 11 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. Jackson Care Connect and Columbia Pacific CCO are owned by CareOregon and representatives from these CCOs also completed a single interview. 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. Staff from OHA's Transformation Center and OHA's Health Policy Office also joined these calls. Interviews lasted approximately ninety 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.ti[12] for data management and analysis. A subset of the data was a priori coded by four research analysts 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. Each transcript was then coded independently by two members of the 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 for key themes independently by two analysts. Finally, the entire team met in a series of sessions to review key impressions, reconcile differences and develop key findings. Findings from key informant interviews and written questionnaires were integrated at the interpretation and reporting stage to summarize overarching findings from the two analyses.

## PCPCH Data Templates

For analysis of this year's three 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 fall 2021 and May 2022. These data templates contained information from CCOs about payments made in 2020 and 2021 to meet OHA's VBP Roadmap requirement for PCPCH infrastructure payment models. 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 for one CCO was suppressed for 2021 for one CCOs 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 amount among all CCOs within each PCPCH tier was 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.

# 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 |

*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 and 2021 calendar years.*