Recommendations and Policy Considerations for Aligning for Health (A4H): Oregon's Regional Multi-Payer Global Budget Model

HOUSE BILL 2010 (2021)

OREGON HEALTH AUTHORITY
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Attachment 1: BerryDunn Report, Aligning for Health: Oregon's Regional Multi-Payer Model

Attachment 2: Health Equity Impact Assessment Summary & Engagement Recommendations

Acknowledgments

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Report Executive Summary

OHA is pleased to submit this report as required under House Bill 2010 (2021) to provide recommendations for a global budget health care delivery pilot in Oregon. The proposed model, Aligning for Health (A4H), is designed to fundamentally change incentives for payers and health care providers from the current system—which promotes delivering and paying for individual services—to a global budget model that would incentivize improving health for a full population in a region under a sustainable rate of cost growth (see text box).

The full report is linked here and can be accessed on the OHA Office of Health Policy's webpage. The report includes:

1. OHA Recommendations and Policy Considerations on Aligning for Health: Oregon's Regional Multi-Payer Global Budget Model (A4H), which draws from and highlights the technical findings and expertise of our three consultants; [1]
2. Attachment 1: OHA consultant BerryDunn's full technical report, describing financial and policy considerations in more detail;
3. Attachment 2: OHA's Health Equity Impact Assessment Summary and Engagement Recommendations.

This package provides an extensive set of considerations, technical analysis, and recommendations meant to prepare the Legislature for next steps in a possible global budget pilot. This Executive Summary highlights key information, including relevant page numbers.

What do we mean by Aligning for Health (A4H)?

The A4H model establishes an annual, predetermined total budget for a defined population ("global budget"), which offers new flexibility for how health services are reimbursed, so that providers can focus their services on keeping people healthy instead of "counting widgets."

The model also includes shared expectations around promoting high-quality care, paying for outcomes, and addressing health inequities.

In contrast, traditional health care reimbursement focuses on the specific services patients receive. When individuals receive more services, providers are paid more. This can result in providers delivering unnecessary, expensive care that doesn't meaningfully improve people's health.

A4H and health systems transformation (pgs. 4-5)

The A4H model was designed to align with and support other Oregon health system transformation efforts including:

- Leveraging aspects of the coordinated care model implemented by Oregon's Medicaid coordinated care organizations (CCOs);
- Requiring pilot participants to meet the state's cost-growth target; and
- Requiring participants in the A4H pilot to achieve the targets set by the Value Based Payment (VBP) Compact.

Key recommendations and next steps

The A4H model has the potential to advance health system transformation and improve health equity by promoting greater alignment across payers and providers in a region. This will be a complex undertaking, requiring balancing regulatory, policy, and other considerations across multiple health insurance purchaser markets. To support the state in considering a pilot, OHA has provided summary answers to four key questions

[1] To develop and assess the model, OHA contracted with three consultants: Tenfold Health; BerryDunn; and Michael Anderson-Nathe.

below, which are addressed in detail in the accompanying recommendations and attachments.

1. What would it take to implement an A4H pilot? (pgs. 5-10)

It may take roughly 36-48 months to launch an A4H pilot; further, OHA recommends continuing a pilot for three-five years to sufficiently test the model. OHA lays out three buckets of activities to further develop and implement an A4H pilot (see Table 5, pg. 10 of OHA's recommendations), which are activities necessary to: (1) refine the model and locate the pilot; (2) engage and procure A4H pilot participants; and (3) implement the pilot.

Additionally, the state should consider beginning a pilot with purchasers and payers that have the fewest regulatory considerations, including large group plans.

2. What should be considered in selecting a pilot region? (pgs. 11-12)

Based on recommendations from OHA consultants and unique considerations to Oregon's insurance markets, OHA recommends weighing the following criteria to select an ideal pilot location:

- Minimum population size
- Social determinants of health and health equity
- Payer, provider and community interest
- Purchaser, payer, and provider mix
- Provider competition, delivery system complexity and network breadth
- Payer/provider experience with VBPs

3. What requirements should A4H participants be held accountable to? (pg. 13)

Depending on readiness of a pilot region, OHA recommends conducting a formal procurement, including a Request for Proposals (RFP). An RFP is a key strategy to hold participants accountable to the global budget and cost growth requirements, as well as quality, health equity, and health system transformation goals. The RFP development process should involve a robust engagement effort drawing on recommendations in the attached Health Equity Impact Assessment Summary and Engagement Recommendations (Attachment 2). In particular, the state should consider including in an RFP:

- Results of engagement efforts
- Requirements for addressing the social determinants of health and health equity
- Requirements for payers to meet targets in the VBP Compact

4. How should potential costs and savings be considered in an A4H pilot? (pgs. 13-14)

The state will need to consider costs to carry out activities in each of the three buckets outlined above, including support for engagement efforts prior to and when developing the RFP; technical consultants and/or appropriate staff to develop the global budget; and resources to operate and evaluate the pilot, and hold participants accountable. Additionally, the state may need to consider appropriate incentives as needed to ensure enough participation in a voluntary model.

Background

Oregon is exploring several strategies to increase equitable health care experiences and outcomes for individuals across health insurance plans ("payers"), and to make health care more affordable for individuals and for health care purchasers, such as businesses and government ("purchasers"). The Oregon Legislature passed House Bill 2010 in 2021 to advance two of these strategies: a "public option" health insurance plan and a "regional global budget health care delivery model pilot," which is the topic of this report. HB 2010 tasks the Oregon Health Authority (OHA) with making recommendations to the Legislature for a global budget pilot that takes "into account state and private participation in the health insurance exchange" (i.e. Marketplace) and "may include employer-sponsored plans" (i.e., multi-player and across health insurance markets). The pilot must also align with the state's health care transformation goals, including the use of value-based payments and Oregon's health care cost growth target.

The model, Aligning for Health: Oregon's Regional Multi-Payer Global Budget Model (A4H), would be designed to fundamentally change incentives for payers and health care providers from the current system—which promotes delivering and paying for individual services—to a model that would incentivize improving health for a full population in a region under a sustainable rate of cost growth. See page 2 for an overview of how this model would work, and page 15 of Appendix 1 for additional detail.

The main goals of the A4H model are to:

- Help achieve optimal health for all people in Oregon by addressing systemic variations in health care access and quality faced by different groups, otherwise known as health inequities. A4H will achieve this by establishing health equity[2] as a core principle and aligning payers and their contracted providers through shared payment models and expectations for health outcomes.
- Improve access to preventive and health-related services, as payers and providers have more flexibility and incentives to pay for these types of services.
- Promote smarter spending, as payers and providers work within a sustainable and predictable budget with flexibility and incentives to invest in higher-quality and more efficient care. Smarter spending in the health system means more money back in the pockets of individuals and purchasers, including businesses and government.

[2] OHA has adopted the following definition of health equity: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
• The equitable distribution or redistributing of resources and power; and
• Recognizing, reconciling and rectifying historical and contemporary injustices

How would the A4H model work?

Start with a reasonable budget for participating payers in a defined geographic region to cover the total cost of care for their members.

Pair this budget with common expectations for improving equity and quality, community engagement, payer and provider partnerships, and advancing value-based payments (i.e., paying for outcomes rather than services) using a request for proposals (RFP) and a common contract to hold payers accountable.

Trend the budget forward annually at a fixed rate that is more affordable to individuals and purchasers.

The federal government has also prioritized greater alignment across different health purchasers and payers. In its strategic plan,[3] the Centers for Medicare and Medicaid Service's (CMS) Innovation Center identified multi-payer alignment as a critical strategy to achieve health system transformation. The Innovation Center has reached out to OHA to begin to explore a potential partnership related to multi-payer alignment.

OHA contracted with three consultants—Tenfold Health, BerryDunn, and Michael Anderson-Nathe—to develop recommendations and considerations for the A4H model and implementation of a pilot. Tenfold Health provided policy analysis and development throughout the process. BerryDunn's full technical report describing financial, analytical, and policy considerations in more detail is attached to this document. Michael Anderson-Nathe consulted on the Health Equity Impact Assessment and Community Engagement Recommendations that are also attached.

OHA's recommendations and key policy considerations below are intended to summarize and supplement these materials by highlighting considerations that are particularly critical for the success of an A4H pilot.

Assumptions

Considerations to advance the A4H model rely on the following assumptions, which are addressed throughout OHA's recommendations:

- A4H will be a regionally focused pilot model in at least one region in the state. There are no restrictions on how a region is defined (e.g., at a zip code or county level), as long as it meets essential criteria such as adequate enrollment.
- Participation in the A4H model will be voluntary for purchasers, payers, and providers. A voluntary approach may offer more challenges than if it were mandatory. Since an A4H model requires payers and providers to agree to make

[3] https://innovation.cms.gov/strategic-direction

potentially substantial changes in business practices, benefits should be made very clear to all participants in a voluntary model (see Appendix 1, page 4, which also lists A4H benefits for members). In addition, there may need to be added consideration for the types of incentives that could entice purchasers, providers, payers, and members to participate.

- The global budget will be allocated to payers and, in turn, payers will manage the funds and negotiate payment terms with providers.
    - To ensure global budgets at the payer level lead to transformation at the provider level, participating payers will be held to value-based payment (VBP) requirements in the state's VBP Compact (details below).
    - The A4H model is not designed to require the same payment rates for health care providers who participate in different purchaser markets (e.g., commercial, Medicaid, Medicare).
- Members enrolled in A4H should still have access to similar benefits as they would have outside of the model, as purchasers and payers will not have to change their benefit packages in order to join the model.
- Eventually, all purchasers would participate—Medicaid and Medicare (government); and Public Employees' Benefit Board (PEBB)/Oregon Educator's Benefit Board (OEBB), Marketplace, and Employer (commercial). However, certain purchasers have fewer regulatory considerations and may therefore participate earlier (see pg. 6).

A4H Principles and Model Design

In developing the A4H model, OHA established a set of principles which were informed by OHA's definition of health equity and its strategic goal of eliminating health inequities by 2030; community and health system partner input on other Oregon transformation efforts; and the CMS Innovation Center's strategic plan. These principles and related examples of A4H model features are outlined in Table 1 below.

Table 1. A4H Principles and Example Model Features

A4H Principles	Example A4H Model Features
Center Health Equity	• Proactively engage communities to establish priorities, identify key measures and actions needed, and inform spending • Dedicate funding for equity initiatives and ensure accountability for reducing inequalities • Increase payer and provider ability to meet population health goals and address health-related social needs, like housing and food
Shared Accountability to Quality and Health Equity	• Align and create common quality and equity measurement and incentive frameworks across all participating payers and providers • Hold payers accountable for addressing health inequities
Contain Costs	• Meet the state's cost growth target by establishing a budget, holding increases to a statewide target, and aligning payer and provider incentives
Build on and Advance Health System Transformation	• Spread the coordinated care organization (CCO) coordinated care model into other markets and incorporate existing CCO structures to prioritize community needs (e.g., community advisory councils) • Expand VBPs that reward lower costs and higher quality across payers
Seek Alignment and Promote Broad Participation and Partnership	• Increase engagement and partnership with community-based organizations and other health system partners • Increase VBP alignment across participants to standardize provider payment models, gain efficiency, and improve outcomes • Provide an opportunity for payers to expand into other service areas and markets and serve more people in Oregon
Flexible, Scalable and Resilient Model	• Ensure model design allows varying patient needs to be addressed • Identify core characteristics and criteria needed for both statewide implementation and regional specificity

Oregon's Health System Transformation Efforts and A4H

The A4H model is designed to align with other health system transformation efforts in Oregon, with a focus on the efforts below.

Oregon's coordinated care model: Leverage the coordinated care model implemented by Oregon's Medicaid CCOs by including the following features:

- Budgets and prospective payments that cover all health care (behavioral, physical, and dental) and grow at a fixed rate
- Hold plans to targets for health care quality, health equity, and VBP contracting
- Require community advisory councils and other structured feedback opportunities for health plan and community members
- Integrate health care providers, community members, and other partners in governance structures

Sustainable Health Care Cost-Growth Target Program: Tie to the statewide Sustainable Health Care Cost-Growth Target Program as a required budget target for all participating payers and providers who are financially "at risk" (see text box) in the A4H pilot. The annual increase in the A4H per-person risk-adjusted budget will be constrained by—rather than just measured against—the growth target rate.

VBP Compact: Require participants in the A4H pilot to achieve the targets set by the VBP Compact, a voluntary compact co-sponsored by OHA and the Oregon Health Leadership Council that currently has 47 signatories covering 73% of the people in Oregon.

Health Care Market Oversight (HCMO) program: To the degree the A4H pilot inspires mergers between health care entities that would warrant review under the Health Care Market Oversight (HCMO) program, a HCMO review would serve as an additional opportunity to evaluate whether proposers for the A4H pilot were in alignment with statewide health goals related to health equity, costs, access and quality.[4]

What does it mean to be "at risk" in a health care payment arrangement?

In a prospectively paid value-based payment like a global budget, payers and/or providers have to stay within a set budget while maintaining quality care. The goal is to deliver better care more efficiently, so that a payer or provider can keep any savings as profit. However, if the payer and/or provider doesn't meet the budget, they're still responsible, or "at-risk" for the remaining expenses.

Key policy considerations for an A4H pilot

To support Oregon's legislature as it considers whether to refine and/or implement an A4H pilot, OHA provides considerations in answer to the following four key questions:

1. What would it take to implement an A4H pilot?
2. What should be considered in selecting a pilot region?
3. What requirements should A4H participants be held accountable to?
4. How should potential costs and savings in an A4H pilot be considered?

What would it take to implement an A4H Pilot?

While other states have implemented versions of multi-payer, global budget and/or VBP programs or pilots, these efforts generally focus on a type of provider (e.g., hospitals), one purchaser market (e.g., Medicare), or a multi-payer VBP model that does not include a global budget. To date, no state has attempted to establish a global budget across multiple purchasers covering a regional population of individuals and all

[4] The HCMO program, launched in March 2022, is responsible for reviewing business deals of health care entities, such as hospitals, health insurance companies, and provider groups. The program's goals are to promote public transparency of health care business transactions; ensure that health care consolidation in Oregon supports statewide goals related to health equity, lower costs, increased access, and better quality; and assess how transactions impact people in Oregon.

components of the health care system that serves them (see Attachment 2, pg. 69). Given its innovative nature and the inherent complexity of working across purchaser markets (see Table 4), OHA recommends allotting sufficient time and resources to develop and launch the A4H pilot.

OHA estimates the overall process to launch A4H could take approximately 36-48 months beginning from the passage of authorizing legislation (see Table 5), and if the state begins the pilot with those purchasers that have the fewest regulatory considerations (i.e., large group). Additionally, OHA recommends that any pilot continue for at least 3 to 5 years to sufficiently build and test the model.

Ultimately, the activities and timelines in Tables 4 and 5 below will need to be considered together to identify the full amount of time necessary for an A4H pilot launch. Specifically, if the state chooses to move forward with a pilot that aims to include Medicaid, Medicare and/or individual or small group commercial plans, the timeline could be longer. For example, as the largest joint state and federal health care program, Medicaid (the Oregon Health Plan) will not only require a CMS § 1115 waiver, but timing to amend the waiver and build changes into a future contract cycle will need to be part of and align with other transformation initiatives for the program.

Table 4 State and Federal Regulatory Approvals and Timing Considerations for Specific Purchaser Markets

Purchaser Market	State and Federal Regulatory Approvals Needed
Medicaid	Requires a CMS § 1115 waiver and integration into CCO contracts. • CMS § 1115 waivers cover a five-year period. Oregon is in the process of negotiating its 2022-2027 waiver, and development of the next waiver will likely begin in 2025/2026. • The next round of CCO contracts are planned to begin in 2025 and are typically re-procured every five years.
Medicare	Requires CMS approval.
Commercial Payers – Individual and Small Group (within and outside the Marketplace)	Subject to state and federal law (Affordable Care Act [ACA]) requirements (including plan design, rate review/rate setting, and risk management) and approval on an annual basis. Could require state carve-outs and a CMS § 1332 waiver. Interactions with the state's existing reinsurance waiver and potential waiver proposals related to the Bridge Plan would also need to be considered.
Commercial Payers – Large Group (including OEBB)	Requires additional research on potential timeline and regulatory issues.
Self-insured Business (including PEBB)	Federal law (Employee Retirement Income Security Act [ERISA]) protects the autonomy of self-insured (usually larger) employers. Some self-insured businesses may have the opportunity to join the program on an annual basis and consequently may be early participants in A4H.

Implementation timeline

The recommended timeline for development and implementation of the A4H model is largely influenced by the many organizational, technical, regulatory, and logistical factors for each health care purchaser and payer group. These include:

- Regulatory considerations unique to each purchaser market, such as necessary changes to state law or approvals for waivers to federal laws (Table 4);
- Requirements and timelines for plan and rate development, contracting cycles, and enrollment periods[5]; and
- Levels of overall readiness of regions and interest of payers and providers to engage in this model on a voluntary and pilot basis.

Given this complexity, OHA recommends considering three buckets of activities to further develop and implement an A4H pilot: (1) those necessary to refine the model and locate the pilot; (2) those necessary to engage and procure A4H pilot participants; and (3) those necessary to implement the pilot. An approximate timeline for these activities is shown in Table 5.

OHA estimates the overall process to launch A4H could take approximately 36-48 months beginning from the passage of any authorizing legislation—depending on the purchasers included—and recommends that any pilot continue for at least 3-5 years to sufficiently build and test the model.

Model refinement and pilot location

Before commencing with a procurement process, additional research and engagement is needed to confirm viable regions and participating markets, select a region, and refine the model. For example, during this period OHA recommends:

- Developing and executing a robust and equitable engagement process among community, local business, and health system partners, with direction from Oregon's Legislature. Attachment 2, Health Equity Impact Assessment Findings Summary & Recommendations for Community and Other Partner Engagement outlines considerations for this work.
- Conducting additional legal and regulatory research and analysis, including contract review, for state-administered health care programs and regulated commercial health insurance products (see Table 4 for considerations). An example of an area requiring further assessment is how the A4H model might

[5] For example, the A4H pilot launch would need to coincide with the start of the benefit plan year, which varies by group (for example, it is January 1 for PEBB and October 1 for OEBB).

accommodate or account for ACA market regulatory elements, including rate regions, essential health benefits, risk adjustment, and cost-sharing provisions.

- Conducting additional analysis to determine potential pilot regions. OHA's recommendations on pgs. 11-12 below (with more detail in Attachment 1, pgs. 24-28 and Technical Supplement G) provide a framework and a set of criteria to determine geographic regions. Analysis should consider feedback that reflects community and other partner input, as well as these criteria. More granular data specific to the state, local areas, payers, providers, and members would aid selection of a pilot region.

- Assess readiness for the pilot region to move straight to formal procurement to implement the A4H pilot. BerryDunn outlined a potential two-phased process for the A4H pilot, recommending the state consider an initial phase to prepare providers for a population-based payment before moving to a full RFP that could expand or otherwise change the payers in a region (Attachment 1, pgs. 17-20). Because this initial phase would only include contract modifications for current payers in a region, it may not allow the state to implement important aspects of the model fully, such as contractual requirements for health equity and VBP. OHA recommends proceeding toward a full RFP unless it becomes clear during model refinement that a preparation phase is necessary.

Procurement

As noted above, OHA recommends the state use a formal procurement process (request for proposals [RFP]) to select participants in the pilot region. Assuming the A4H pilot is voluntary, an RFP would offer the most latitude to require all essential aspects of the A4H model. The procurement stage of the process would involve:

- Continuing the engagement process with a focus on the pilot region among community, local business, and health system partners (see Attachment 1, Health Equity Impact Assessment Summary & Engagement Recommendations).

- Refining strategies to manage and mitigate risk for participants, based on regions and potential participants.

- Developing and conducting an RFP incorporating requirements related to social determinants of health and health equity, quality measures,[6] VBP, and accountability to community as described in "what requirements should participants be held to" section on pg. 13 below.

- Negotiating and awarding contracts to successful proposers in a region.

[6] OHA recommends drawing on the work of the state metrics committees (e.g. the Health Plan Quality Metrics Committee or its future iteration) and working directly with regional representatives to develop measures that evaluate equity, access, and quality of care.

Pilot implementation

Once contracts have been awarded, the A4H pilot should continue for at least three years to sufficiently test the model and begin to realize transformation goals. During the implementation of the pilot, the following activities should occur:

- Develop the global budget for a specified region, once the pilot region per-member-per-month (PMPM) payments are designed to cover the projected claims and provider administrative expenses for the population included in the pilot. OHA recommends also incorporating strategies to increase investment in the social determinants of health and health equity, including a Health Equity Fund as recommended by BerryDunn (Attachment 1, pgs. 14 & 19).
- Payers and providers negotiate contracts, which must meet the targets of the state's VBP Compact.
- Pilot participants implement robust engagement strategies and ensure accountability to community, including operating community advisory councils.
- OHA conducts evaluation, monitoring, and compliance activities to hold participants accountable, including qualitative and quantitative strategies to ensure participant compliance related to reducing health inequities in their communities, maintaining robust access to health care services, and delivering high-quality care.

The overall process to develop and implement a pilot will likely be iterative, with many aspects at play. These include the state and federal regulatory approvals and other factors previously mentioned for purchaser contracting timelines and requirements, as well as participants' overall readiness. Table 5 presents a possible timeline for the activities described above.

Table 5. Estimated Timeline for A4H Pilot development and implementation*

Activities required for A4H pilot launch*	Year 1		Year 2				Year 3				Year 4				Years 5-9
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Model refinement and pilot location															
Hiring and program staff and issuing external contracts[7]															
Legal and regulatory analysis															
Engagement process															
Additional analysis to determine potential pilot regions															
Readiness assessment															
Procurement															
Continued engagement and RFP development															
Refine risk mitigation strategies															
RFP open															
Successful proposers identified															
Contract awards															
Pilot implementation															
Open enrollment															
Pilot launches (minimum of three-five years); includes global budget development, payer/provider negotiations, participant-led community engagement, state evaluation and accountability efforts															3-5 →

* Many of the activities required for an A4H pilot launch and the ultimate timeline will depend on and be driven by regulatory approval

[7] At a minimum, additional financial and actuarial services and expertise would be needed, through either additional OHA staff or a substantial RFP to contract for these services.

What should be considered in selecting a pilot region?

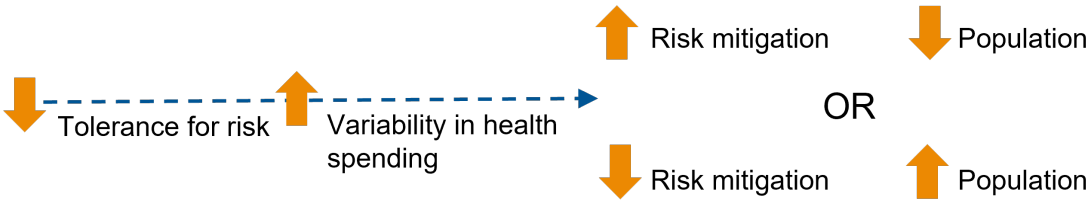
While ensuring a sufficient population size is a key consideration for selecting the A4H pilot region, there are a number of other factors that are critical for the pilot to be viable and achieve the goals of the A4H model. Based on recommendations from consultants and considerations of Oregon's health care landscape, OHA recommends the following key criteria for A4H pilot region consideration:

- Minimum population size
- Social determinants of health and health equity
- Payer, provider and community interest
- Purchaser, payer, and provider mix
- Provider competition, delivery system complexity and network breadth
- Payer/provider experience with VBPs

The selection of a pilot region will need to be an iterative process considering the complexities and interactions between these criteria.

Minimum population size: The minimum A4H pilot population size depends on a number of factors including population profile, risk tolerance of pilot participants, and the risk mitigation strategies employed to attract payer and provider participation. These factors are mutually interdependent, as illustrated in the example in Graphic 1.

Graphic 1. Factors in Determining Population Size



In order to attract participant interest and ensure tolerable levels of risk, as well as to minimize the cost of risk mitigation strategies, OHA recommends considering a 95% confidence level that spending will be withing 2.5% of budget and stop-loss/reinsurance at a $500,000 cap, which suggests enrolling 30,000 or more enrollees in the pilot. Additional detail can be found in the BerryDunn report (Appendix 1, Technical Supplement A, Table 10, pg. 38). When identifying a region, OHA further recommends initially areas with a higher percentage of commercially insured lives, including the number of PEBB and OEBB lives (Appendix 1, Technical Supplement A, Table 13, pg. 48). As noted in Table 4, these purchasers generally have fewer regulatory considerations than other types of purchasers.

Social determinants of health and health equity: In order to test A4H model assumptions and have the greatest impact on health inequities, Oregon should prioritize regions with a higher concentration of individuals with social needs, as well as those where substantial health inequities exist. To assess these areas, OHA recommends a comprehensive composite measure of the harm to communities and populations by health inequities and the effects of social inequities should be used, such as the social vulnerability index (SVI) developed by the Centers for Disease Control and referenced in the BerryDunn report (Appendix 1, Technical Supplement A, Table 14, pg. 51).

In addition, it is critical for a pilot region to have the capacity and infrastructure to serve the needs of the community. Regions where community-based organizations or other entities with experience addressing social determinants of health and health equity should be considered.

Payer, provider, and community interest: Given the voluntary nature of the A4H pilot, the state should consider where there may be interest to participate by purchasers, payers, providers, and community partners and organizations.

Purchaser, payer, and provider mix: Due to regulatory and timing considerations described above, the most likely early participants may be public and private large group commercial and self-insured plans. Due to the federal regulatory requirements of Medicaid and Medicare, their participation in the A4H pilot likely requires a longer implementation horizon compared to large group commercial markets. Similarly, waivers of federal and state regulation may be necessary in order for individual and small group insurers to participate. (See Table 4, pg. 6).

Provider competition, delivery system complexity and network breadth: A region with more provider competition could garner provider interest in A4H participation if providers in the region see the pilot as an opportunity for shared savings and ability to gain market share. On the other hand, a region with more competition – for example, multiple hospitals with overlapping service areas – could present challenges for A4H implementation, particularly when it comes to identifying which provider is responsible for the health outcomes of their patients. A measure of provider competition should be considered in selecting a region, and the design of the A4H RFP should also account for the degree of provider competition in a chosen region (see BerryDunn report, Appendix 1, pgs. 27 and 28). Additionally, delivery system complexity should be taken into consideration, which may be assessed by considering measures such as the number of Primary Care Service Areas, Hospital Service Areas, hospitals, and Hospital Referral Regions (see BerryDunn report, Appendix 1, pg. 41).

Payer/provider experience with VBPs: The A4H pilot region selection process requires assessment of potential participating payers and providers, their current environment, their interest in and commitment to population health, and existing constituent engagement strategies. This may be part of the readiness assessment described on page 8.

What requirements should payers be held accountable to?

The development of an A4H RFP should rely on a robust engagement process, including engaging all purchasers to ensure aligned strategies and buy-in. The BerryDunn report, Appendix 1, beginning on page 19 lays out the high-level steps for the process and key considerations for RFP rating criteria, which include:

- Provider network breadth
- Quality scores
- Demonstrated success in medical and population health management
- Submitted plan for advancing health equity, specifically identifying measures on which the payers will work to close equity gaps
- Submitted plan for community engagement and social determinants of health investments

An RFP provides the opportunity to not only hold participants accountable to the global budget and state cost growth target, but is also the key strategy for ensuring the A4H model reaches health equity and population health goals. Three components of the RFP will be critical to achieving these aims:

- **Incorporating results of engagement efforts with community and other partners into the rating criteria of the RFP:** As mentioned above, critical to developing the A4H RFP is a robust and equitable engagement process with community, local business, and health system partners. Final selection criteria should reflect the needs, interests, concerns, and priorities of the various participants from this engagement process.
- **Including requirements for addressing the social determinants of health and health equity** that are informed by community and other partner feedback. For example, plans could be required to develop and maintain strong community engagement processes; be held accountable to health equity measures; and spend a portion on revenue on social determinants of health and health equity (see Appendix 1, pgs. 10-13).
- **Requiring payers meet the targets outlined in the state's voluntary VBP Compact, including considering common payment models if developed** to ensure flexibility if the global budget is passed down to the bulk of health care providers, giving them latitude to meet their patient's holistic health-related needs.

How should potential costs and savings be considered in an A4H pilot?

The potential savings available from the global budget model will depend on the

populations, payers, purchasers, and regions participating. It may be possible prior to procurement to prepare preliminary estimates of potential savings based on modeling and use publicly available data in lieu of member- and payer-specific information. This would provide further policy insight for the potential benefits of pursuing the model.

Cost estimates for an A4H pilot will need to consider resources for a variety of program activities, including:

- Robust engagement of community, health system, and regional business partners to inform region selection, model refinement, and RFP development, as well as to build support for model implementation;
- Soliciting and selecting contractors to implement and evaluate the model;
- Soliciting, selecting, and establishing agreements with participants;
- Developing the global budget, risk mitigation strategies, and any financial strategies to promote health equity and investment in population health; and
- Operating and evaluating the A4H pilot over three-five years.

Additionally, the state will need to consider what kinds of incentives, including any financial incentives, may be necessary to attract participants to A4H.

Conclusion

Overall, the A4H model has the potential to advance health system transformation and improve health equity by promoting greater alignment across payers and providers in a region. The recommendations in these materials can support careful planning, engagement of communities and partners, and implementation of a model that achieves these goals.

For more technical and policy detail: Attachment 1: BerryDunn report, Aligning for Health: Oregon's Regional Multi-Payer model, and technical supplements

For recommendations related to health equity and engagement: Attachment 2: Health Equity Impact Assessment Summary and Engagement Recommendations

BerryDunn

Aligning for Health: Oregon's Regional Multi-Payer Model

Considerations, Analysis, and Next Steps

Final Report

Delivered to the Oregon Health Authority

June 24, 2022

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List of Acronyms

A4H	Alignment for Health
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
APAC	All Payer All Claims database
APM	Alternative Payment Model
AQC	Alternative Quality Contract
CBO	Community-Based Organization
CCO	Coordinated Care Organization
CMS	Centers for Medicaid and Medicare Services
FFS	Fee-for-Service
HCCI	Health Care Cost Institute
HPQMC	Health Plan Quality Metrics Committee
HRA	Health Referral Region
HSA	Hospital Service Area
ISL	Individual Stop-Loss
KFF	Kaiser Family Foundation
MEPS	Medical Expenditure Panel Survey
OEBB	Oregon Educators Benefit Board
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OHSA	Oregon Health Sciences University
PCSA	Primary Care Service Area
PEBB	Public Employee Benefit Board
PMPM	Per-Member-Per-Month capitation payments
PRP	Provider Risk Pool
RFP	Request for Proposals
RSF	Risk Stabilization Fund
SDOH	Social Determinants of Health
TCC	Total Cost of Care
TPA	Third-Party Administrator
VBP	Value-Based Payment

Terms, Definitions, and Usage

This report adopts the following terms, definitions, and usage for the contemplated model.

(Alternative)/ Value-Based Payment Models (VBPs)[1]	A type of payment model that adds performance-based adjustments to a base payment model, usually fee-for-service, whereby purchasers and payers hold health care providers financially accountable for improving quality and lowering health care costs. VBPs add to (or subtract from) base payments based on performance against quality and spending targets. This performance assessment results in bonuses for meeting targets ("upside risk") and can also include penalties for failure to do so ("downside risk"). These models fall under HCP-LAN categories 2 and 3 (see advanced VBP models for category 4).
Advanced Value-Based Payment Models[2]	HCP-LAN payment categories 3A and higher. Category 3A and 3B models encompass fee-for-service-based payment models with upside risk, downside risk, or both, including those with a population-based spending target. Category 4 models are fully-prospective (no fee-for-service payment) population-based payment models, which include capitation, global budgets, and prospective condition-specific sub-population models.
Community-Based Organizations	Community nonprofit agencies that deliver health and social services to members that often have not been payable under standard medical billing codes, but they may be included as part of a health benefits under a population health payment model.
Constituents	Persons and entities that are parts of the whole. This includes collaborators, partners, contributors, affected communities, policymakers, service providers, government officials, entities or persons with strategic or other interests in the project.
Capitation	Prospectively determined and prospectively paid per-member-per-month payment amounts, typically paid by purchasers to payers for insurance coverage. Capitated payments to insurers include allowances for total medical spending, as well as for insurer administration and profit. Insurance premiums are capitated payments (as are HCP-LAN category 4 payments to provider organizations).
Sub-Capitation	Prospectively determined and prospectively paid per-member-per-month payment amounts, typically paid by payers to providers for specific-condition sub-populations (e.g., cancer) or for specific clinical roles (e.g., primary care patient management), and primarily covering the associated sub-component of overall medical expense reflected in the capitation rate. Sub-capitation amounts are in practice sometimes referred to simply as "capitation."
Global Budget[3]	A global budget is a financial arrangement that establishes an annual, predetermined total cost of health care for a defined population. It is initially calculated based on the health of the population, defined reimbursement rates, covered benefits, geographic location, and key policy goals such as social needs or service priorities. Once established, the global budget is trended forward at an established sustainable rate of growth. In the pilot, the global budget will be the responsibility of payer organizations, who will share risk with providers via mutually negotiated VBPs that are consistent with the payer-purchaser agreement's terms.
Purchasers	Entities that fund and purchase health insurance coverage for a group or population. Sometimes referred to as plan sponsors. Purchasers include those in the private sector (commercial) health insurance markets and in the public insurance markets. ▪ Purchasers of commercially provided health insurance: o Private employer groups – large and small group o Public employer groups such as PEBB and OEBB o Individuals – through the Marketplace or off-exchange

	▪ Government insurance programs: o Medicaid (state/federal partnership primarily for lower income individuals) o Medicare (federal program primarily for the elderly and permanently disabled) o Both Medicaid and Medicare provide direct coverage (combining purchaser and payer roles) but also often subcontract the payer role to private insurers for provision of government-defined benefits (e.g., Medicaid CCOs, Medicare Advantage)
Payers	Entities that pay for services for members of a purchasers' group or an individual purchaser, and responsible for administering all aspects of that coverage. In commercially insured groups, this entity is usually a licensed insurance company paid a premium to insure health care claims risk for the purchaser. For self-insured large employment groups, the employer (sometimes through a benefit trust) both purchases for and bears financial risk for the employee group's total per-member health care spending; a third party administrator (TPA) almost always handles claims processing and payment -- but does not manage the claims risk, which remains with the purchaser. TPAs also handle other functions, including enrollment, member service, network contracting, and clinical management. Private (nonprofit or proprietary) payer organizations are also sometimes referred to as ▪ Insurance Carriers ▪ Managed Care Organizations (MCOs) ▪ Coordinated Care Organizations (CCOs) ▪ Third-Party Administrators (for self-insured purchasers, MCOs, CCOs, or other groups)
Multi-Payer	Including more than a single payer in the plan/design
Multi-Purchaser	Including more than a single plan sponsor or purchaser market segment.
Providers	Entities that employ licensed health care practitioners and/or own licensed health facilities, contracted with and paid by payers to provide healthcare services to members of the insured coverage plan. May also refer to individual clinicians that provide direct clinical services to patients and bill health care payers for those services. Providers include: ▪ Health care delivery systems ▪ Hospitals ▪ Physician and other provider (e.g. certified nurse midwife, nurse practitioner, physician assistant) offices ▪ Clinics, Community Health Centers, Tribal Health Clinics ▪ Dental, behavioral health, therapeutic service providers ▪ Other
Members	Individuals enrolled in a health insurance coverage plan. Sometimes referred to as enrollees or consumers.
Risk	The range of possible variation in future average per-person health care spending for an insured group during a contract period. Purchasers who are fully insured typically eliminate their risk for a given contract year by paying a fixed PMPM to a payer who contractually agrees to accept the risk for variation in spending. The payer taking on that risk is, accordingly, responsible for healthcare spending levels at, below, or above the expected level.
Risk adjustment	Statistical methods adjusting outcome performance measures — including quality and cost — to account for differences in patient health status and clinical factors (e.g., comorbidities, severity of illness), and other factors (social determinants of health) that are present at the start of care.

Risk-Sharing	At-risk entities (most payers, some purchasers) may pay providers in a way that shares some of the risk for per-member health spending. For purposes of this report, risk-sharing does not refer to out-of-pocket spending by insured members for their use of health care services.
Total-Cost-of-Care Contracts[4]	Agreements between payers and providers wherein a provider organization accepts clinical and financial responsibility for an entire population of patients, regardless of where a patient receives care. HCP-LAN identifies alternatives whereby TCOC can either be for total medical expense (i.e., all member allowed costs for a contract year), or all member costs related to a specific condition (e.g., cancer). Unless otherwise specified, in this report total-cost-of-care contracts encompasses total medical expense (HCP-LAN categories 3B, 4B, or 4C), and have both upside and downside provider risk-sharing.
Total Medical Expense[5]	Claims-based and non-claims-based payments to providers, net of drug rebates. These expenses are measured as per-member-per-month costs.

I. Executive Summary

This report supports the Oregon Health Authority (OHA) in assessing the potential for a regional global budget model pilot, as required of OHA by Oregon statute HB 2010. Aligning for Health (A4H) aims to test a model for more alignment across purchasers (including under the Public Employee Benefit Board/Oregon Educators Benefits Board - PEBB/OEBB - plans, Medicaid, employer-sponsored plans and, potentially, Medicare), payers, and the delivery system.

Gaining Payer and Provider Participation

A global budget model poses significant challenges, along with opportunities, and requires substantial change in payer and provider business practices. A model relying on voluntary participation must provide a clear path to success, addressing several essential factors for each constituent. Oregon's existing reforms — including Medicaid Coordinated Care Organizations (CCOs) and the multi-sector Value-Based Payment (VBP) Compact — provide a foundation for advancing this process.

- The launch of the global budget pilot program stands as an ambitious effort, requiring support for preparation and training, modeling and actuarial support, infrastructure, and implementation. A Risk Stabilization Fund and other risk mitigation features will increase confidence of providers as they gain experience with population-based payment models.

Launching the Initiative

Successful launch may best proceed through an initial phase focused on technical and modeling support for providers in the pilot region, building toward and informing a subsequent formal procurement process. The first phase will improve the specification of the Request for Proposals (RFP) procurement process, ease the burden of implementation, and gain buy-in from the providers and payers. Once a target region is identified, the first phase uses region-specific detailed data and model prototyping, along with provider preparation steps. The conditions for provider readiness bolstered, the next phase RFP may proceed. OHA will develop and issue an RFP to payers for an initial joint procurement for interested purchaser groups covering enrolled members in the target region.

The pilot will eventually expand to include additional payers and payer markets. Each payer and purchaser sector brings specific circumstances and challenges. Medicaid participation will likely require a federal CMS waiver, as will individual Marketplace and small group participation (regulated by the Affordable Care Act -ACA). Federal law (Employee Retirement Income Security Act - ERISA) protects the autonomy of self-insured (usually larger) employers, but this should not be barrier for their voluntary participation in the pilot. Smaller employers will be subject to payers' interest in participation. Plans and payers have differing contract and enrollment periods, all of which will need to harmonize in a multi-payer model.

Identifying Enrollment Numbers and Regions

There is not a single minimum number of enrollees required for program viability but, rather, a set of risk management and risk mitigation features available to accommodate different populations and different degrees of risk aversion and tolerance among participants. Risk mitigation techniques—including reinsurance and risk corridors—can facilitate willingness and ability of payers and providers to manage patients and populations under a fixed prospective budget.

Stop-loss (reinsurance) coverage can substantially reduce the number of individuals required to attain reasonable certainty for participants in the model. As enrollment size increases, so do probabilities that spending would land within the global budget. The model can reasonably operate with enrollment of approximately 5,000 members, if given a risk sharing arrangement that includes individual stop-loss reinsurance protection for providers along with risk corridors. Without risk corridor protection, 5,000 would yield unacceptable risk for most organizations, and particularly for providers sharing risk for member total cost of care.

- The quantitative analysis does not incorporate the necessary qualitative considerations for selecting a pilot region. A selection process requires assessment of the participating organizations, their current environment, and constituent engagement. Providers and payers with prior experience managing prospective payments will be more adept at transitioning to Oregon's global budget pilot.

Promoting Equity

OHA holds equity as leading principle in its initiatives.[6] The term "health disparities," OHA notes, describes measured differences between population groups, while the term "inequity" refers to differences that are unnecessary, avoidable, and unjust.[7] Health equity requires that "people are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, and social class, intersections among these communities or identities, or other socially determined circumstances."

Promotion of equity, and model outcomes more generally, depend on choices about how to set the initial budget, whether and how to risk adjust payments, and how to measure and reward performance. Historical utilization and spending experience generally provide the basis for calculating rates for a prospective payment system, as would be used under a global budget model. Past utilization experience, however, rarely captures resource needs of vulnerable or underserved populations, given barriers accessing health care services. Standard rate-setting methods need risk adjustment, to reward and incent providers that care for higher need patients and populations.

- The use of various analytic and actuarial techniques, including assessment of non-medical (social) risk factors, will be essential for promoting Oregon's equity goals. These goals also will benefit from a set-aside Health Equity Fund, which may be resourced as part of the pilot program funds flow.
- The pilot program should inform whether the model can generalize to other geographies and populations throughout the state of Oregon. This intent, along with commitment to equity, requires inclusion of populations with diverse needs. The Social Vulnerability Index, Area Deprivation Index, and other measures may be incorporated into the factors for selecting potential regions for participation.

Next Steps

Next analytic steps include, broadly: 1) more regionally-targeted and granular data analysis; 2) appropriate risk-adjustment parameters; 3) region assessment and selection; 4) per-member-per-month (PMPM) and global budgets for specified regions; and 5) estimates of potential savings. Next steps will also need to address various regulatory matters, including how the model may accommodate existing ACA and State of Oregon regulation of the individual and small group markets. The analysis should also consider existing payer and provider competition within regions, and implications for model adoption and success. These and other next steps require a robust constituent engagement process, with attention to the interests, concerns, readiness, and needs of potential participants.

Summary of Recommendations

Analyze Numbers and Engage Voices in Selecting Participating Regions

1. Pursue a structured approach for engagement of purchasers, payers, and providers, while involving community and other constituent voices in planning, decision-making, and governance processes.

2. Use more granular data specific to the state, ZIP codes, payers, providers, and members, in order to attain greater specificity in direction and region selection.
   - Build on the current analysis presented in this report, using it as first stage work to inform OHA's policy considerations and discussions with the legislature and constituents and guide its path forward toward implementation.
   - Assess sub-county geographies and care utilization patterns across counties, to simulate patient activity with providers and by payer under the pilot. Consider Primary Care Service Areas, Hospital Service Areas, market rating regions, and other geographic units in data analysis and selection of the pilot region.

3. Consider initiating the pilot in a region with relatively concentrated provider and payer market shares. Small numbers of participants (providers, payers, employers) will make the pilot more feasible administratively and logistically, and facilitate providers' adaptation to the payment model
   - Engage a substantial proportion of the provider patient care activity in the model.
   - Promote consistent incentives aligned across payer types, to support providers' ability to manage risk.

Design for Effective Purchaser, Payer, and Provider Participation

4. Pursue a phased approach to engage various purchaser and payer sectors, beginning with the large group commercial market. Successful launch may best proceed through a volunteer contract prototyping phase with providers and commercial payers, building toward and informing a subsequent formal procurement process.

5. Aim RFP procurement toward inclusion of PEBB/OEBB with one or more additional commercial payers.

6. Plan for eventual expansion to additional commercial and government payers, including detailed analysis of regulatory and other barriers to A4H inclusion.

7. Prioritize VBP compact signatories, and providers with VBP operational experience, as strong candidates for the global budget pilot.

8. Engage purchasers to participate in the pilot to provide enough enrollment, in combination with risk mitigation strategies, to provide stable (adequately predictable) revenue for participating payers and providers.

9. Set initial year pilot rates at actuarially sound levels, providing actuarial certification with rate publication.

10. Create specific conditions to support providers' confidence that entering into the model is consistent with their fiduciary duty to maintain their organizations' financial health.

- Provide significant technical support for the provider(s) to accomplish the changes required, with the specific types and levels of support dependent on the pilot region chosen.
- Well-articulate and communicate benefits of the program, such that potential participants can assess consistency with organizational mission, financial health, and other aspects of their fiduciary responsibility.

11. Consistent with the VBP Compact, promote providers' shift away from volume-based payment systems. Promote strong upside shared savings percentages, allowing providers the potential to offset reductions in FFS-related revenue, with commensurately strong downside risk-sharing to remove the FFS incentives and business model.

12. Adopt a multi-pronged risk mitigation strategy, to account for the risk tolerance of both providers and payers. This will facilitate provider and payer willingness to participate even where population numbers might be smaller.
    - Address provider risk tolerance and risk management concerns with a risk corridor structure, with capped provider risk, along with a multi-year provider Risk Stabilization Fund.
    - The design of the complementary risk mitigation features depends on a particular situation; the specific context will determine the specification of the reinsurance, risk corridors, and risk-stabilization fund.
    - Consider, as funds allow, a specified total level of available OHA funding to support risk mitigation solutions appropriate to the pilot region, and publicize availability of support prior to region selection.

13. Adopt structures and processes available through Oregon's Sustainable Health Care Cost-Growth Target Program, the VBP Compact, and Medicaid CCOs, for guidelines and monitoring of rates, performance, measurement, and outcomes.

14. Explore CMS Innovation Center payment models, falling under HCP-LAN Category 3 and 4, as potential templates for participants in the A4H global budget pilot.

Promote Equity

15. Measure variation in population needs within and among participation regions, payers, and providers. Incorporate the Social Vulnerability Index or Area Deprivation Index into the factors for selecting regions.

16. Apply equity-related performance measures, and tie earning incentives to these measures.

17. Consider risk adjustment, in quality measurement and in rate setting, to avoid penalizing providers that care for higher-need patient populations.

18. Phase in the implementation of downside risk for safety net providers and smaller organizations serving vulnerable populations, consistent with the VBP Compact principles.

19. Include, in the model, a set-aside Health Equity Fund, resourcing it as part of the funds flow, as a percentage of the capitation up front and of excess earnings on back end.

20. Request that payers submit regional strategies for addressing the social needs of enrolled members. Consider, as part of the RFP process a set requirements that payers partner with CCOs and/or CBOs operating in a given region. and report on the role of these partnerships in addressing social determinants of health.

II. Introduction

A. Legislative and OHA Directive

Oregon HB 2010 requires the Oregon Health Authority to submit recommendations to the legislature for a regional global budget health care delivery pilot ("Aligning for Health: Regional Multi-Payer Model"):[8]

> *HB 2010 Section 2: No later than July 1, 2022, the Oregon Health Authority shall report to the interim committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, recommendations for a regional global budget health care delivery model pilot. (2) The recommendations must: (a) Take into account state and private participation in the health insurance exchange and may include employer-sponsored plans; and (b) Be aligned with the state goals for health care transformation, including the use of value-based payments and the health care cost-growth target established in accordance with ORS 442.386.*

Oregon's Aligning for Health (A4H) initiative aims toward the following outcomes:

- More predictable, aligned payment models, metrics, and other expectations for providers, regardless of payer
- Increased numbers of Oregon providers receiving population-based payments that are tied to outcomes
- Rewards for the health system for keeping people healthy and containing costs
- Flexibility to allow systems and providers to be more innovative in how they deliver care and address the complex drivers of health
- More equitable, meaningful access to quality health services and increased continuity of care.

OHA contracted with BerryDunn to perform modeling and analysis necessary to make recommendations regarding the structure of a regional, multi-payer model for Oregon for inclusion in a legislative report by July 1, 2022, as required by HB 2010. This report proceeds through a discussion of the following, along with principal recommendations:

- Considerations for a Global Budget Model Design
- Process and Design for Funds Flow
- Governance and Community Engagement
- Modeling and Potential Pilot Regions
- Next Steps

The Technical Supplements address each of these points in detail beyond the body of the report.

B. What is a Global Budget?

The term "global budget' has various and often inconsistent applications.[9] Population-based global budgets set prospective payment for entities, and these entities are responsible for the total cost of care, and quality of care, for a patient population. Facility-based global budget models set a prospective budget for a facility's spending (inpatient, outpatient, or both), not linked to specific patient visits or services. Models may be voluntary, whereby purchasers, payers, and providers may choose whether to participate, or mandatory, such that regulators set the form and level of payment to providers in a designated region or statewide.[10] Table 1 displays the existing global budget models operating under demonstration authority from the U.S. Centers for Medicaid and Medicare Innovation (CMMI).

Table 1. Current CMMI-designated Global Budget Models

	Voluntary	Mandatory
Population-Based	Massachusetts BCBS ACQ, Accountable Care Organizations (ACOs)	
Facility-Based		Maryland TCOC Pennsylvania Rural Hospital Demonstration

Purchasers provide payers a per-member-per-month (PMPM) budget, called capitation. Each purchaser-specific PMPM amount rolls up to generate a single overall average per-person global budget for participating purchasers. The budget level grows at a defined rate each year and is not re-based on the prior year's actual spending; It thereby produces a predictable level of spending, presenting opportunity to re-deploy savings for other priorities – to improve prevention, deliver high-value, health improving services, and address equity.

A global budget approach, with growth targets, necessarily constrains the growth in capitation rates received by payers, heightening the payers' interest in using a risk-sharing partnership with providers to manage their exposure to claims risk. In global budget models, health care providers generally assume accountability for a defined group of patients, bear financial risk for spending targets, and are eligible to receive bonuses for quality.[11, 12] Arrangements may allow providers to share in the savings they produce by coming in under budget (called "one-sided" or "upside" risk) and providers may share in any losses from coming in over budget (called "two-sided" or "downside" risk).

The fixed per-person level of resources under global budgets creates an incentive for providers to select cost-effective care and avoid unnecessary services. Providers manage patient care and outcomes within the specified budget, sharing risk with payers for the budget; they may benefit from savings or experience the penalty of shortfalls relative to the budget. Providers must also report on quality measures related to both health care processes and outcomes. This increases provider incentives to invest in prevention and quality care. Risk adjustment, in quality measurement and in rate setting, help avoid penalizing providers that care for higher-need patient populations.

OHA intends specific features for its A4H global budget model: voluntary, regional, population-based, centered on a contract with one or more payer organizations, with a per-person payment rate trended forward at a contractually-defined, sustainable rate of growth. The global budget will be allocated to payers and, in turn, payers will manage the funds and negotiate payment terms with providers. Provider payment could involve a mix of fee-for-service or value-based payment mechanisms -- an arrangement similar to existing managed care capitation models between purchasers and payers -- while moving toward the goal of the Oregon VBP compact. That goal: by 2024, payers should have 70% of all their payments under advanced value-based payment models that involve shared savings with both upside and downside risk.[13]

C. Why Pursue This Kind of Reform?

OHA, in 2021, outlined its case for pursuing a global budget strategy and its anticipated benefits. As well, the 2018 Oregon State Health Assessment reports substantial inequities among Oregon residents, with communities of color experiencing adverse conditions across a broad range of social conditions. These and other OHA reports document the high and rising costs in Oregon health care, the challenges facing Oregon's health care system, consumers and families, and the disparate and inequitable outcomes that result.

OHA recently reported the burden of high health care costs on Oregon state residents, and its disproportionate impacts that exacerbate existing inequities:

- Personal spending on health care is higher in Oregon than the national average.
- Health insurance premiums and deductibles represent a substantial share of income for families in Oregon.
- High health care costs jeopardize the financial stability of people in Oregon.
- High health care costs can prevent people from accessing needed care.
- High health care costs burden some communities in Oregon more than others; this exacerbates health and wealth inequities across the state

D. Potential Benefits of a Global Budget Multi-Payer Model

Global budgets allow policymakers and purchasers to directly constrain total health care spending by paying a lump sum for all services in their covered populations. Payers reduce uncertainty about total claims cost through value-based payment mechanisms and, specifically, by sharing financial risk with providers. Such shared risk may promote efficient use of services, and facilitate payers' budget and provider revenue projections.[14]

The global payment model nonetheless challenges existing ways of providing and paying for health care, and requires new partnerships among various sectors. This change offers significant potential benefits, discussed in further detail throughout this report. Potential participants—payers, providers, community organizations, and members—will weigh potential benefits against the effort required to move to this model. The benefits will need to be well-articulated and communicated, such that leaders of potential participants can assess the consistency with organizational mission, financial health, and other aspects of their fiduciary responsibility. Table 2 displays the potential benefits that may motivate participation from the various constituents.

Table 2. Potential Benefits for Payers, Providers, Purchasers, and Members

Potential Benefits	Payers	Providers	Purchasers/ Employers	Members
Contain costs/reduce rate of cost growth/adhere to cost-growth target	X	X	X	X
Predictable risk and costs	X	X	X	X
Achieve goals of VBP compact ▪ Opportunity for creative contracting, ▪ Move away from FFS/gain experience with VBP	X	X		
Simplify administrative processes: ▪ Consistent contracts between payers and providers ▪ Streamline and harmonize reporting of metrics	X	X	X	
Gain market share – expand number of enrolled members	X	X		
Potential for upside gain with positive performance, sufficient ability to manage and mitigate negative outcomes	X	X		
Alignment among payers; consistency in payment and requirements for performance and reporting	X	X	X	
Substantial portion of patient base in predictable and consistent payment model		X		
Flexible funds to support health and social needs of patients		X		X
Improve quality of care and outcomes for enrolled population	X	X	X	X
Improved transparency and accountability	X	X	X	X
Reduced disparities in outcomes	X	X	X	X
Providers focused on and accountable for quality and outcomes	X	X	X	X
Funding for social needs to support health improvement		X	X	X
Lower cost-growth offers potential savings for households				X

E. OHA Design Principles

The OHA Aligning for Health initiative has defined a set of principles to which it is designing its global budget model. OHA's Regional Global Budget Concept Paper (Appendix 1) includes a table that compares OHA's principles to the current picture of health care and a vision change under a regional global budget. The design work currently underway measures potential policy and program elements against this defined set of principles.

OHA Design Principles
Center Equity
Support Innovation to Maximize Health for Oregonians
Build On and Advance Health System Transformation Efforts
Contain Costs
Promote Broad Participation
Seek Alignment across Participants
Shared Accountability to Quality & Health Equity
Flexible, Scalable & Resilient Model

F. Intersection with other Delivery System Reforms

OHA's global budget pilot initiative is a logical progression of the long and productive path of health system transformation undertaken in Oregon.[15] This includes Medicaid CCOs[16], Oregon's Sustainable Health Care Cost-Growth Target Program[17], and the voluntary Oregon VBP Compact[18] among key health care system constituents. These initiatives are ongoing and affect all regions of the state.[19] Some aspects of them have particular relevance, provide existing resources, structures, and processes for advancing the global budget pilot. This relevance is outlined briefly here, followed by a discussion of the implications for the global budget pilot model.

F1. Target on Allowed Annual Cost Growth

Oregon's Sustainable Health Care Cost-Growth Target Program[20] is intended to serve as a budget target for the annual per capita rate of growth of total health care spending in the state. Health insurance companies' and health care providers' health care spending will be compared to the cost-growth target each year, and the program will report on cost increases and drivers of health care costs annually. The cost-growth target committee outlined a collaborative process between the state and payer and provider organizations toward achieving its goals, and the accountability mechanism includes performance improvement plans and fines for repeat failures to meet the target.

The state adopted an implementation timeline that includes an annual per capita health care cost-growth target of 3.4% for 2021 – 2025 and then 3.0% for 2026 – 2030, though the 2026 – 2030 target may be adjusted. The global budget target will be tied to the cost-growth target, but, the global budget will serve as a binding target budget for the insurers and/or providers at risk under the pilot, and the year-to-year increase in that per-person risk-adjusted budget will be constrained by (rather than just measured against) the growth target rate. The method for doing so is discussed below in Section IIIA of this report.

F2. Oregon VBP Compact

The Sustainable Health Care Cost Growth Target Implementation Committee identified the spreading of VBP as the first strategy to support Oregon's cost growth goal. The Oregon VBP Compact emerged as a voluntary commitment by payers and providers to participate in and spread VBPs, and in meeting specified targets and timelines.[21] The Compact, jointly sponsored by the Oregon Health Authority and the Oregon Health Leadership Council, has 47 signatories, covering 73% of the people in Oregon. The Compact, while not a legally binding document, demonstrates a commitment to the VBP principles, including targets for VBP implementation.[22] Its signatories demonstrate clear commitment to moving into advanced payment models, and are likely to be ahead in this effort already. As such, they are strong candidates for the global budget pilot—a more advanced step in VBP.

The VBP Compact includes 16 principles, several of which particularly shaped the model design outlined in this report. Table 3 displays these principles.

Table 3. VBP Compact Principles and Considerations for Pilot Design

	VBP Principle
1.	Prospective budget-based and quality-linked payment, where a provider is paid up front for a population of patients and a predefined set of services, should be the primary payment model utilized wherever feasible for the following reasons: a. It provides essential financial stability to providers, particularly for small, independent, and rural providers, through a consistent source of revenue, which is an important part of alleviating the most damaging economic consequences of the pandemic. b. It is supportive of the Cost-Growth Target because it defines a budget for the care of a population of patients. c. It may give providers flexibility to address the most critical health needs of their patients, including non-medical social supports that might improve health and save costs, rather than having to rely on reimbursable treatments. This will depend on the ability to move beyond current restrictions in plan design and code-based billing. d. It allows for investment in a population of patients, and for flexibility in the type of provider delivering care and the type of care provided, which supports more holistic patient-centered care.
2.	The structure of advanced value-based payment models should be aligned across payers to allow providers to have a sufficient volume of similar value-based arrangements to make meaningful change in their clinical practice and reduce administrative burden. Structural alignment should include but not be limited to the use of common performance measures.
3.	Advanced value-based payment models should be designed and implemented with consideration for unintended consequences, including potential adverse impacts on health care quality.
4.	Health plan enrollees should be encouraged or required to select a primary care provider, whether or not required by benefit design, to support advanced payment model effectiveness.
5.	Small and safety net providers should be offered technical assistance by payers and/or by OHA's Transformation Center to set them up for success under advanced value-based payment models. Those with limited experience in value-based payment, such as behavioral health providers, should also be considered for technical assistance.
6.	Advanced value-based payment models should be designed to promote health equity, assure that new upside or downside risks will not exacerbate existing inequities, and mitigate adverse impacts on populations experiencing health inequities: ▪ Payment model design features and measures to protect against stinting ▪ Sufficient prospective payments to cover the cost of infrastructure changes to support health equity (e.g., traditional health workers, changes to IT systems to track equity) ▪ Additional supports (e.g., technical assistance, infrastructure payments) for providers serving populations experiencing health inequities ▪ Future potential for adjusting payments based on social risk factors

III. Global Budget Pilot Design Considerations

In Brief

- A global budget model relying on voluntary cooperation design must provide a clear path to success for each constituent. The model requires substantial change in business practices and poses significant challenges, along with opportunities. Participation by purchasers, payers, and providers will depend of a range of essential factors.
- Participation by commercially insured groups/individuals and their payers depends on confidence in (1) managing a shift in business models toward VBP as the primary means managing claims risk; and (2) the opportunity for a positive margin commensurate with the risk level assumed.

  Success of the payment model in shifting of overall organizational incentives requires a substantial proportion of the provider patient care activity in the model, including substantial commercial payer inclusion.
- Achieving equity, and model outcomes more generally, depend on choices about how to set the initial budget, whether and how to risk adjust payments, how to measure performance, and how to adjust budgets for changes over time in average health status and benefit plan.
- Payers may submit regional strategies for addressing the social needs of their enrolled members and/or regional community. These strategies may include mechanisms by which partnered CCOs or CBOs interact with payers and providers on behalf of enrolled members.

A4H participants will be engaging in a substantial change process, toward achieving OHA's financial, quality, and equity improvement goals. Participation involves these basic agreements:

a. Purchasers agree to include their employee (or otherwise enrolled) populations in pilot;

b. Payers submit proposals and agree with OHA's multi-year fixed growth rate capitation rate and other OHA requirements, and

c. Providers agree to participate in VBP contracts with payers, consistent with the VBP Compact 2024 goals.

This section addresses factors and design features essential to securing such agreement and participation. Technical Supplement B further details this discussion.

The A4H pilot offers purchasers the potential benefit of relatively low, predictable cost growth rates – an attractive selling point. However, these benefits will require significant adjustments. Purchasers may need to change their payer(s), depending on the outcome of the payer procurement (Request for Proposals –RFP) process. Benefit plans will remain in place but, under a multi-payer global budget model, purchasers will be shifting their payer procurement and contracting processes to OHA. Table 2 in Section II, above, reviews the potential advantages of this change, although current payers and brokers may not see such participation in their interest.

Purchaser participation over time will also depend on the satisfaction of current and prospective employees/members with the health coverage offered, as health benefits are an important factor in labor market competitiveness. Employer purchasers will need confidence that the program promotes robust quality and access to care for its members. Members, particularly in commercial sector plans, will be sensitive to potential changes in pricing, premiums, and cost-sharing

Note, as well, that large, self-funded groups may be able to induce their third-party administrators (TPAs) to participate, but fully insured groups will likely only be able to participate if their payers agree to do so. Participation in this model will rely on payers' assessment of the path forward.

A. Payers

Payer's interest in winning a large contract will be a powerful incentive to participate in A4H. At the same time, given the substantial changes to the current business processes and revenue model, payers will first seek information about all participating purchasers, their membership and benefit composition, and the definition of the region/location for the pilot.

OHA currently envisions provision of the global budget to payers for their management, and with the payment terms for providers negotiated between payers and providers. This could involve a mix of fee-for-service or value-based payment mechanisms -- an arrangement similar to existing managed care capitation models between purchasers and payers -- while moving toward the goal of the VBP compact. That goal: by 2024, payers should have 70% of all their payments under advanced value-based payment models that involve shared savings with both upside and downside risk.

VBP experiments nationwide over the past decade thus far demonstrate mixed spending and quality results, with little impact on health disparities. [23] In part, this reflects providers' unwillingness in, and market forces gravitating against, managing a population-based budget and its associated risks. And Oregon will be paving a new path with its contemplated global budget model, which goes beyond global budget models in others states that focus on hospital services (Maryland and Pennsylvania) or involve one commercial carrier (Massachusetts).

The Oregon A4H approach, tied to the growth rate target, will likely fix growth rates below historical trend. Such growth rate guardrails necessarily constrain the growth in capitation rates received by payers – a constraint that may amplify payers' exposure to claims risk over time. Under the pilot model, payers will lose some tools they have used to manage their financial risk, including annual renegotiation of both capitation rates (revenue) and provider rates (expense). These conditions elevate the payer—provider contract as the primary means of managing costs within the global budget constraint. Technical Supplement B further discusses the purchaser and payer contracting, payment, and financial risk management considerations.

Payers' participation, given the uncertainty of these changes, depends on the opportunity for financial upside commensurate with the risk level assumed, and revenue sufficient to protect the required underwriting capital base. Risk-sharing with providers shifts the way payers manage their providers' incurring of claims costs, currently handled through oversight of provider decisions—via care management, utilization review, prior approval, and other means. Payers will rely more on provider incentives (including bonuses and, in more advanced models, upside and downside risk) to promote cost-effective service provision, within available resources, for enrolled members.

B. Providers

Provider organization(s) are the linchpin of the global budget pilot for several reasons:

- Providers have historically been paid on a fee-for-service basis, such that more office visits, hospitalizations, or procedures generate more revenue and margin.[24] Early steps in VBP provide incentives for clinical quality on specific measures, or focus on specific episodes of care. The VBP Compact and global budget pilot aim to move providers to manage responsibility for the members' overall health over time. Oregon has made significant progress in enhancing the ability of primary care providers to support long-term member health. But most expenditures lie with specialists and hospitals, which largely remain on FFS payment.
- The providers in the pilot will have a substantial proportion of their patient care base in the pilot, whereas the pilot region will likely represent only a small fraction of any payer's membership base.
- Many parts of the state with the low population density rely on one significant provider. The stakes are high for participation (and associated risk-assessment) by these essential community providers.
- TCOC-based payment poses a substantial change for providers—perhaps more so than for payers, who effectively operate under population payment in receiving a per-person payment rate for each covered member. At high risk-sharing percentages, one of many fundamental changes that result for providers is that traditional profit centers (high-end imaging, for example) become cost centers. The global budget strategy depends on this shift for reducing spending, but it requires substantial change in provider business and clinical practices.
- The move of a delivery system to a global budget requires changing payment, incentives, information system, and management infrastructure and processes.

Providers can best adapt practice patterns, and manage risk, when they face consistent incentives that reach broadly across payer types, and when a substantial portion of their patient base is enrolled in a similar incentive model. Payers will also be reassured by providers adopting population-focused payment for their other payer populations, as aligned provider incentives promote practice changes consistent with shared goals. Strong upside shared savings percentages offer providers the potential to offset reductions in FFS-related revenue,, while commensurately strong downside risk-sharing is necessary to actually remove their FFS incentive.[25]

Capitation models, in the past, have raised concerns that restrained budgets may reduce access to and provision of needed services.[26] VBP models address this concern in holding providers accountable for quality targets, with a portion of payments contingent on meeting goals. To stay under budget and achieve savings, providers focus on reducing suboptimal and unnecessary services.[27] Note here the importance of structuring payments to incent, rather than penalize, providers in caring for high-risk populations and high-acuity patients. The application of risk adjustment, in both quality measurement and rate setting, helps assure that providers do not preferentially select patients with favorable risk profiles. Risk mitigation also alleviates providers' potential exposure to financial volatility—a particularly sensitive matter under the conditions of and recovery from the COVID-19 public health emergency. Sections VI and VII further discuss such risk-adjustment considerations.

Table 4 summarizes the model's Essential Success Factors for constituents.

Table 4. Essential Success Factors for Global Budget Pilot

Participant	Key Requirements
Providers	▪ High proportion of patient activity in the global budget model ▪ High sharing percentages on both upside and downside ▪ Technical and resource support for required infrastructure changes ▪ Clear, efficient administration of risk model process
Payers	▪ Provider incentive shifted to population focus, with two-sided risk ▪ Opportunity for financial gains commensurate with risk ▪ Strong provider performance measurement system ▪ Clear, efficient administration of risk model process
Community Members	▪ Retain plan choices, coverage value, and ready access to providers ▪ Plan choices/benefits evolve with clinical technology improvements ▪ Improved equity in access to quality care
Purchasers/Employers	▪ Clear communication materials for employees/covered members ▪ Transparency of process and outcomes
State Government	▪ Measurable outcomes, including cost, quality, and equity ▪ Support for start-up, training, data collection, reporting, and evaluation ▪ Clear, efficient administration of risk model process ▪ Effective, ongoing constituent engagement processes

C. Incorporating Social Determinants of Health (SDOH) and Equity

Oregon's VBP Compact[28] designates that advanced VBP models should be designed to promote health equity, ensure that new upside or downside risks will not exacerbate existing inequities, and mitigate adverse impacts on populations experiencing health inequities. Oregon's global budget model can promote these principles through a various design features, along with a robust implementation and evaluation process that accounts for the experience of disadvantaged populations. Oregon has significant experience to inform this process through its CCO efforts.[29] Specific payment design elements and incentives may encourage investments in health equity and SDOH, and may prevent underinvestment in health care services.

C1. Target Populations for Pilot

Payers enrolling, and providers caring for, substantial and disproportionate numbers of higher-risk or vulnerable patients may hesitate to participate and take on the risk associated with a global budget model. Financial incentives will need to be properly structured to engage them, with protections for vulnerable populations. The global budget model may enhance enrollment of vulnerable populations by identifying and selecting pilot regions with a higher concentration of individuals with social needs, and adjust per-member payments to account for these differing levels of need. This information should be quantified using existing public data sources and operationalized through several domains: living conditions, segregation and social vulnerability, employment, poverty, income; education; crime, environment; food, housing; and transportation. Section VII, below, provides more detail on this process.

C2. Community Partnerships

Health care payers and providers often lack the capacity and experience to address SDOH and, in turn, reduce disparities. The payer model will need to support engagement of and coordination among health and social care organizations.

CCOs play an integral role in Oregon's Medicaid program and have extensive experience managing members' social and clinical needs, along with processes to engage communities. CCOs partner with Community-Based Organizations (CBOs), nonprofit entities focused on addressing SDOH. As part of the RFP process for enrolling participating payers into the global budget model, OHA could set requirements that they partner with CCOs and/or CBOs operating in a given region.

Payer requirements to partner with CCOs or CBOs will likely need to vary on several dimensions. These include the number of CCOs or CBOs with operational capacity in a region and the relevant expertise and experience of those organizations. OHA could request that payers submit regional strategies for addressing the social needs of their enrolled members and/or regional community. These strategies may include mechanisms by which partnered CCOs or CBOs interact with payers and providers on behalf of enrolled members.

C3. Investment and Accountability Mechanisms

A sustainable impact on equity and SDOH requires focused and coordinated action across multiple sectors, including commercial and public payers, providers, social work, and public health, and in partnership with communities and CBOs. Evaluations of the federal Accountable Health Communities and Medicaid models emphasize the need for continued engagement of both medical and non-medical sectors, new data integration infrastructure, and alignment of multiple payers through innovative payment models.[30]

Oregon has experience with this challenge. In the first iteration of its CCO program, Oregon found that spending on health-related services made up a very small percentage of total spending—only about 0.14%. In response, the state's next waiver included additional incentives for covering health-related services, including a bonus fund to reward CCOs that meet certain SDOH-related goals, along with a reinvestment mandate and requirements that CCO spending align with community health assessments and improvement plans.[31]

To participate in Oregon's global budget model, OHA could require that payers invest a set percentage of total revenue (by way of per-member payments made through the program) toward SDOH and report on an annual basis how those targeted funds were invested.[32] These could be included in payers' regional equity strategies, along with requirements that payers update said strategies annually—as well as gain approval for how funds will be allocated.

Payers may under-invest in SDOH, given the long-run nature of avoided costs and may not be confident in the opportunity to realize gains on SDOH investments. Vulnerable populations, enrolled in Medicaid and otherwise, often demonstrate the high level of entry, exit, and plan switching. As well, through the competitive bidding process for contracts, payers may lose their contracts and enrollees in a given geographic area before realizing the full benefits of their SDOH investments.

A potential solution involves a financial instrument known as a social bond.[33] Such bonds, administered under a joint entity, can create a sustainable funds pool among multiple payers that can be equitably distributed to SDOH initiatives provided by CBOs, social services, and public health organizations. Specific bond features allow the financial risks and returns from these interventions to be distributed equitably across health plans and other potential

investors, while targeting funding to interventions that promote racial equity and health equity.

The joint issuance structure of multiple payers provides attractive incentives for organizations to participate, as it enables risk-sharing coupled with future cost-saving benefits. The combined mechanism allows for the continuity of access to SDOH projects for enrollees, even as they switch plans or payers. And a social bond approach, by offering financial instruments to investors, leverages additional funds for SDOH solutions.

C4. Payment Design, Rate-Setting, and Equity Implications

Section IIB defines a global budget and the differing versions of this model, all of which rely on rate setting. Promotion of equity, along with outcomes generally, depends on choices about how to set the initial budget, whether and how to risk adjust payments, how to measure performance, and how to adjust budgets for changes over time in average health status and benefit plan.

Standard approaches to rate setting include trending forward historical utilization and spending, from claims or encounters on a provider's patient population, as well as the use of parameters/assumptions from the literature. An administrative process typically adjusts the budget, following the first year, potentially by a measure of general or medical inflation.

The historical utilization and spending experience, however, rarely captures resource needs of vulnerable or underserved populations, given a wide range of barriers accessing health care services—from poor availability of health care providers to economic and social constraints. Relatively low Medicaid provider payment rates distort spending comparison, setting an artificially low spending baseline for this population. Standard rate-setting methods thus disproportionately allocate more resources to advantaged populations, exacerbating existing health care disparities.

- The use of historical spending preserves higher payments due to historically high prices or overuse of services in the base period.
- Providers cannot correct any underuse that occurred in the base period without being penalized by going over budget or becoming more efficient.

Two available analytic techniques may help OHA ensure greater alignment between actual and desired outcomes. These approaches may be applied when setting per-member global budget payments to individual payers participating in Oregon's global budget model, and with health care providers that serve their members under population-based payment arrangements. Both options require defining or operationalizing desired outcomes or needs, and quantifying existing disparities among insured members enrolled in Oregon's global budget model:

1. Apply risk adjustment methods that includes SDOH factors, resulting in adjusted payment levels that deviate from historical spending in the direction of reducing inequity; or
2. Include SDOH performance measures in the annual settlement process (discussed in Section IV).

An evolving, peer-reviewed literature current shapes risk adjustment methodology with SDOH measures, and has not yet resulted in an established comprehensive algorithm comparable to those for historical-cost-based risk adjustment.[34,35,36] Technical Supplement C further discusses social risk-adjustment and related performance measures, including their merits, challenges, data requirements, and other considerations. Technical Supplement G provides county-level data on SDOH and equity-related measures for the 36 Oregon counties.

Table 5 reviews how payment design may affect providers' care for higher-need populations, potential investments in SDOH, and partnerships with CBOs that can help promote equity.

Table 5. Payment Incentive Structure Design Questions and Equity Considerations[37,38]

VBP Incentive Structure - Design Questions	Equity Considerations
When, if at all, will participants be eligible for savings or face downside risk?	Consistent with the VBP Compact principles, Oregon's global budget model may achieve greater success by phasing in the implementation of downside risk for safety net providers and smaller organizations serving vulnerable populations. Downside risk ensures that organizations attend to quality and cost expectations and face consequences for poor outcomes. But, particularly in voluntary models, payments must be adequately risk-adjusted in order to avoid penalizing providers that care for higher-need patients.
What are the bonus or penalty amounts?	VBP models will more effectively change a payer or provider's behavior when bonuses or penalties account for a greater share of that organization's total revenue. Investment requirements for most social determinants that enhance equity will be high. The magnitude of available bonuses (and penalties) should reflect the relative investment needed to achieve performance targets.
What criteria are required to unlock savings or face penalties once eligible?	A tiered payment structure based on multiple benchmark targets may be administratively complex but may allow greater opportunities for payers or providers to achieve incentive bonuses. This is particularly important when addressing challenging performance measures such as social determinants.
Will savings or penalty amounts vary at different performance thresholds; if so, what levels?	
How will savings or penalties be distributed across participating payers and/or providers?	CBOs and others that address social determinants may lack sufficient resources or market/negotiating power to leverage a fair share of shared savings. The distribution and collection of funds among multiple organizations will affect their incentive to collaborate and achieve performance targets.
Over what period will performance be evaluated, and savings distributed/penalties collected?	Payers and providers should be evaluated on their performance, with recognition that savings produced or outcomes achieved through improved social determinants of health may follow longer time frames.

IV. Model Design and Implementation

In Brief

- Successful launch may proceed best through a volunteer prototyping phase in the commercial sector, building toward and informing a subsequent formal procurement process. The first phase will improve the specification of the RFP, ease the burden of implementation, and gain buy-in from payers and providers.
- Prototyping allows providers in a target region to simulate potential contract terms, providing field-test informed modeling, while working with a broad range of constituents toward the RFP.
- The prototyping phase allows commercial payers and their contracted providers, to work out design specifications without substantial disruption to their current business model, increasing the likelihood of their participation with new partners under an RFP process.
- With the conditions for provider readiness bolstered during the prototyping phase, the next phase RFP process may demonstrate a multi-payer model more broadly.
- Inclusion of Marketplace plans, Medicaid, and Medicare, will depend on state and federal regulatory processes.
- Funds flow includes a Health Equity Fund and a Risk Stabilization Fund as essential components of the model.

The contours the global budget model include a) budget and rate setting, b) performance measurement, and 3) funds flow to the participants based on that performance. This section outlines the model structure, then describes a process for engaging providers and payers in the pilot.

A. Rate Setting, Performance Model, and Funds Flow

Figure 1 depicts how a potential multi-payer global budget model would handle payment rates and benefit designs across participating payers. The model includes following basic features:

- Purchaser groups retain freedom to define and adjust their own benefit packages.
- OHA sets overall rates for participating pilot regions, with PMPM rates adjusted specifically for each payer's enrolled population benefit package(s) and health status.
- Provider payment risk/incentive design features focus on significant provider risk for population-level total cost of care.
- Existing measurement programs inform quality/outcomes measurement, led by OHA,[39], and emphasize health equity measures and incentives.[40]

Figure 2 displays the provider performance model and outlines the potential funds flow. This may be modified, with various possible alternatives, based on constituent and analytical processes, and on experience gained through the process outlined in Section B. Figure 3 illustrates the funds flow in more detail, from purchaser contributions through final performance year settlement. The diagram includes specific values, as examples, for the global budget, risk-sharing, and related parameters.

Attainment of the model depicted in the Figures 1 through 3 requires working through a series of deliberate steps and stages. That process will allow specification of the actual parameter values. Section B discusses the process.

Figure 1. Setting the Global Budget: Benefit Designs and Membership across Participating Payers

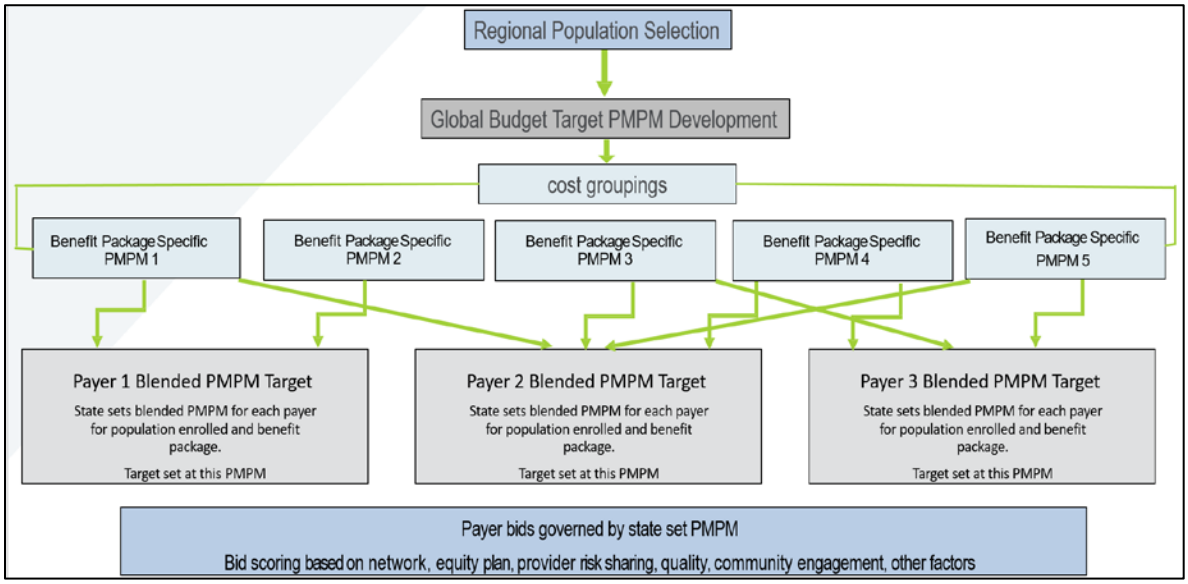


Figure 2. Provider-Payer Performance Model Example

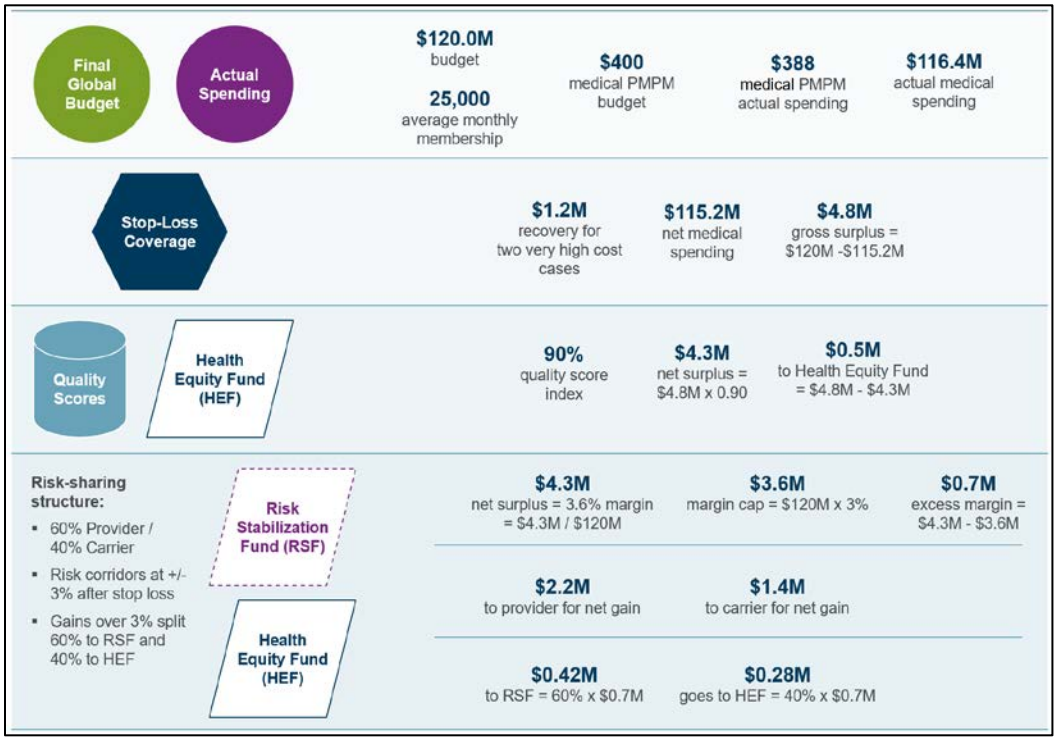
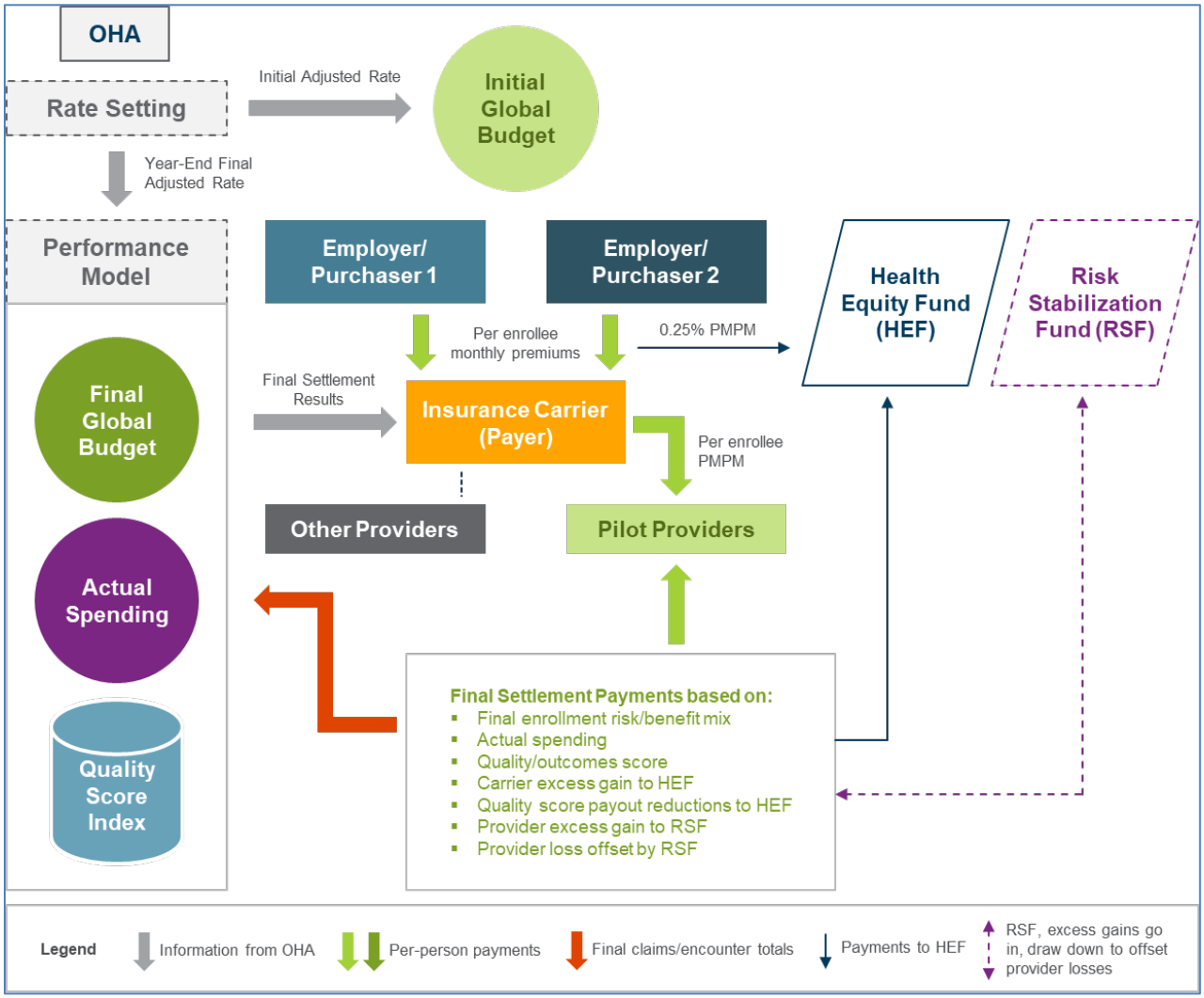


Figure 3. Potential Funds Flow, Detail



B. Phases: Detailed Design and Implementation of Global Budget Pilot

In Brief
A two-phase process will inform and advance implementation of the model.

Phase 1 will improve the specification for the RFP, gain buy-in from providers and payers, and ease the burden of implementation. This route advances payers' voluntary, direct contracting with providers under existing arrangements, and possible expansion to government payer population contracts (such as the Medicare Shared Savings Program) – apart from whether or when an RFP process may gain interested participants under Phase 2.

A process that does not expand beyond Phase 1 may limit the momentum toward the specific goals for the global budget outlined in the OHA principles and vision documents. The RFP process allows OHA to specify requirements associated with its policy and programmatic priorities:

- Alignment of payment models and performance requirements across many/most payers, with its associated consistent incentive structure, administrative efficiencies, and other benefits.
- Promotion of health equity and the statewide reduction/elimination of disparities.

Phase 1 may leverage progress toward these goals, via various add-on mechanisms. For example. OHA might offer support to partners in their population health enterprise, in exchange for commitment to specific OHA priorities.

This section presents two phases for moving toward implementation of the model in a target geography for an initial pilot, informed by a focused analytic and constituent engagement process. Although the phases may stand as separate options, the following narrative explains how the model benefits by following a sequence, staging the model through Phase 1 to inform and implement Phase 2.

- *Phase 1 – Provider preparation for population payment pilot:* This phase begins by identifying pilot region(s) and engaging provider(s) in the target area(s). The participants will benefit from technical support provided/funded by OHA for financial/actuarial simulation of potential provider risk global budget contracts. The risk contract model simulations will address the options for commercial contracts. They can also incorporate government payer groups, suggesting an eventual path to a wider global budget model.
- *Phase 2 – Multi-purchaser procurement for global budget pilot:* Anchored by PEBB and OEBB, solicit employer groups for participation in a multi-purchaser/multi-payer procurement; RFP requirements include standardized quality/outcome performance measures, along with features to address and reduce inequities in the pilot region(s).

Phase 1: Provider Preparation for Population Payment Model

Phase 1, in advance of the RFP, focuses on supporting providers in technical aspects of population health models. It is intended to inform the specifics of eventual Phase 2 contract terms and prepare the groundwork for adding payer and purchaser sectors into the global budget model. This phase aims to explore and refine, in advance, the features for the chosen pilot community, as national experience suggests that models work best when designed around the particular community context.[41]

Phase 1 is based on two specific challenges discussed in Section III and in Technical Supplement B. First, provider experience with and adaptation to population financial risk contracts varies,[42] and the degree of support required will vary depending on the choice of pilot site. Phase 1 focuses on preparing and supporting potential participants to accelerate change in the direction required. Phase 1 can build infrastructure and expertise through simulated prototyping of contract terms, potentially informed by discussions with interested commercial payers. Second, provider organizations have hesitated or struggled to adopt risk-based payment in situations where FFS payment provides the primary engine of their financial health. Providers may be more successful under a global budget once they have moved a substantial portion of their patient base to a population-based payment model.[43].

Phase 1 will improve the eventual RFP and facilitate provider readiness and buy-in, and participation for model implementation. Technical Supplement D further details modeling and prototyping elements under Phase 1.

> The Oregon CCO program for Medicaid, covering over 20% of hospital revenues, has a decade of experience moving Medicaid service delivery to a population health perspective. The federal Medicare program, which accounts for roughly one-third of Oregon hospital revenues, also offers providers the opportunity to voluntarily enroll in Accountable Care Organization (ACO) payment models that offer various levels of population financial risk, up to and including full capitation. Commercial payers for employee populations and individuals also account for 30 – 40% revenue for Oregon hospitals.

Phase 2: Design via RFP

Phase 2 engages in a "drawing board" design informed by constituent and modeling processes. The Phase 2 procurement could potentially involve a single procurement for PEBB/OEBB, and one or more additional commercial payers, with possible eventual expansion to additional commercial and government payers. The participation of various purchaser groups will involve myriad organizational, technical, and logistical factors specific to each group and sector. These include different contracting cycle timelines, along with state and federal regulatory, statutory, and waiver requirements. Technical Supplement B further discusses these considerations, and Supplement E reviews needed next steps..

The high-level elements of the RFP process include the following:

1. A robust engagement process to inform RFP development, including the state, purchasers, payers, and providers.
2. OHA partners with participating purchasers to develop a single RFP that will help assure access to health insurance for all participating members (subscribers and dependents) who live within the defined region.
3. The RFP offers insurers a single PMPM covering all members in the insurance programs in a chosen region.
    - PMPM amount is a weighted average based on historic costs for all included members.
    - Insurer-specific payments are adjusted based on which members enroll with the insurer such that actual payments reflect member mix, benefit package, and any other relevant adjustments.
    - The global PMPM amount and payment adjustment methodology is fully transparent in the RFP, and insurers are not expected to bid based on price.

4. RFP rating criteria could include:
    - Network breadth
    - Submitted plan for advancing health equity, specifically identifying measures on which the insurers will work to close equity gaps
    - Demonstrated success in medical and population health management
    - Quality scores
    - Submitted plan for community engagement and social determinants of health investments
5. Payers and purchasers maintain control over setting the benefit packages. Members may have access to the same benefit options they currently have, although packages may change as payers roll into the model and adjust to budget and model expectations.
6. Medical, pharmacy, and behavioral health benefits are included in the demonstration.
7. Dental and vision benefits are excluded from this process and will be administered as they are today on the commercial side. These benefits may be carved into the agreement in the future, as Medicaid is added to the program.
8. The number of insurers approved to participate is based, in part, on the number of members in the region.
9. Gains earned on each insurer's total global payment are subject to quality scores, with any penalties paid into the Health Equity Fund (described below). Insurers will be able to earn these funds by demonstrating improvements in quality and reductions in health inequality.
    - OHA and its partner organizations establish the quality measures for this quality pool program and establish goals for each measure.
    - Insurers are scored based on their ability to show improvement in each measure using a "gap to goal" method.
    - These measures and scoring methodology are fully disclosed in the RFP.
    - OHA could include quality measures related to the social determinants of health (likely on a pay for reporting basis), such as screening for social needs, to further align to the policy goals of OHA.
10. Initial contract duration would be three years in length.

C. Timeline Considerations

The global budget pilot program will rely on a phased approach, with various regulatory and logistic considerations regarding commercial, PEBB, OEBB, Medicaid and Medicare.

The planned RFP process may occur as the second phase of the pilot program following the Phase 1 prototyping process or, (although less optimal), as a stand-alone phase and the official launch of the program. Over time, OHA may proceed to phase in payers. As a statewide program, OHA and its partners may consider a single statewide procurement. This could reduce administrative costs and maximize the collective purchasing power of the participating organizations. High-level considerations for additional payer expansion include the following:

Commercial Insurers

- Joining by these organizations will mean that they agree to adopt the VBP Roadmap and align their purchasing strategies in the region with other participating public payers. This may occur at any time.
- The primary benefit to these payers will be the ability to leverage more efficient contract and payment arrangements with providers, which in turn will drive savings and improve patient outcomes.
- Federal and state rating regulations constrain individual and small group market participation in the pilot. Participation in the pilot for these market segments would require breaking up the single risk pool rating system regulated in the ACA. This may be possible under a federal Section 1332 State Innovation Waiver,[44] although it presents significant challenges to the timing for their participation in the pilot.

Self-Insured Business

- Self-insured businesses may have the opportunity to join the program at each three-year procurement cycle, when OHA will calculate a global budget payment for each interested business based on their benefits and member health status profile.
- Secure agreements well in advance of the three-year contract period to avoid selection issues.
- The calculated global budget payment will be sufficient to cover employee and dependent costs based on historic expenditures.
- Businesses will retain their current freedoms relative to benefit design and cost sharing. Participating insurers will manage these unique benefit packages.
    - Any additional costs for the insurer associated with administering a business' benefit package will be charged to the business.
    - OHA may provide recommendations to the business regarding how the business may modify its benefit package to minimize these administrative expenses.
- OHA will report savings for businesses, to reflect the benefits of the program, such as the annual target in spending growth and other efficiencies generated under the program.

Note, in terms of timing, that both fully insured and self-insured large group accounts may have their contract renewal date in any month of the year. Once candidate payers are identified, the model will likely require harmonizing the renewal dates for all accounts participating.

Medicaid

- Requires a CMS § 1115 waiver.
- When Medicaid joins the program, CCOs may participate under the same requirements identified in the insurer RFP and associated contracts.
- Only Medicaid members would be able to select CCOs as their insurer.

V. Governance and Community Engagement

A. Decision-Making: Community and Service Delivery System Engagement

The global budget model depends on changes in service delivery and on member engagement. Participation in the global budget model by payers and providers will need a structured approach for such engagement, with a plan for involving community voices (patients/members/residents) in decision-making processes. Similar to Oregon's other transformation processes, entities participating in the global budget model would engage a community advisory committee that includes CCO representatives, providers, members, patient advocates, and community leaders, including direct involvement of patients/members/residents. OHA may review and approve plans for these engagement and accountability structures, with annual updates.

The Center for Health Care Strategies recently conducted an environmental scan of national organizations to uncover promising practices for effective consumer engagement and reported key considerations to facilitate such engagement in program and policy design and implementation.[45] These address the following, each of which merit attention in engaging community input in the global budget pilot program development and operations:

- Reduce barriers to participation
- Develop relationships and build trust
- Focus on racial and health equity
- Provide compensation
- Ensure transparent and effective communication
- Create opportunities for power sharing
- Provide training programs for community participants

B. Other States' Models and Processes

The structure and governance models for health service and payment reform programs provide the vehicles and processes for engagement of constituents. Currently, 14 states have various versions of ACO payment models in their Medicaid programs.[46] A broad range of resources and best practices exist for working with providers, MCOs, and consumers.[47]

As well, other states have operated various versions of multi-payer, total cost of care, and global budget models. These other states' approaches differ from Oregon's intention in that other states generally focus on a specific sector (hospitals) for a global budget approach, or pursue multi-payer model for VBP separate from a global budget.

Oregon's plan is somewhat more ambitious, in that the state seeks to establish a global budget with an annual, predetermined total cost of health care for a defined population, beginning with a limited number of payers and expanding to an all-payer model. Oregon has existing experience with community engagement via its CCO model that may be applied to the global budget pilot. In addition, the varying models from other states, with varying governance and approaches to community engagement may inform Oregon's approach.

A 2016 study reviewed consumer engagement in Medicaid ACOs in six states, including Oregon. The review focused at two levels: the state level and the ACO level.[48] This study notes the need for appropriate support, such as funding and training for consumers and consumer advocates, and that "structures for consumer engagement, such as

member participation in advisory committees, constituent groups or governance bodies, were not sufficient on their own to drive meaningful consumer engagement." State-level engagement refers to participation in the design, implementation, or oversight of the state's Medicaid ACO program, including, for example, participation in policy workgroups or steering committees. ACO-level engagement refers to participation in the governance of the ACO itself, such as serving as a member of the governing board, on a board subcommittee or on an advisory committee. (Technical Supplement E provides further detail.)

All of the models reviewed, including Oregon, include some structure for consumer engagement at both the state and ACO levels. The format and level of engagement varied substantially across each of the six states. Technical Supplement E. Review of Other State Governance Models, reviews consumer engagement structures at the state and the ACO levels for selected states that currently have operational models of potential relevance to Oregon.

VI. Measuring Success

In Brief

- OHA has a defined set of principles against which to measure model features.
- OHA's Health Plan Quality Metrics Committee has existing criteria for evaluating and adopting measures, including those related to social determinants of health and health equity.

A. Alignment with OHA Framework and Principles

OHA sought to assess the extent to which the scenario modeled and the options for staged adoption align with the OHA's global budget goals and principles. Table 6 displays the alignment of the principles to the design elements described in this report. The quantitative modeling and results described in Section VII assess potential regions for performance relative to the project goals established under other parameters provided by OHA.

B. Benchmarking & Performance Measures

The current OHA Health Plan Quality Metrics Committee (HPQMC) currently identifies health outcome and quality measures that may be applied to services provided by CCOs or paid for by health benefit plans sold though the health insurance exchange or offered by the PEBB and OEBB.[49] The committee assures health outcome and quality measures used in Oregon are coordinated, evidence-based, and focused on a long-term statewide vision. This committee has existing criteria for evaluating and adopting measures, including those related to SDOH and health equity. Going forward, ongoing and evolving OHA quality measurement efforts may provide a structure and process for developing and monitoring quality measures under the A4H initiative.

Table 6. Global Budget Design Principles and Model Features

OHA Design Principle	Potential Model Features
Center health equity	Dedicated funding for equity initiatives; accountability for reducing inequality.
Support innovation to maximize health for Oregonians and promote smarter spending	Dedicated funding for SDOH interventions; significant expansion in value-based purchasing across multiple payers.
Contain health care costs to alleviate burden on Oregonians, free up funding for other government services, and reinvest savings in communities	Oregon's cost growth target offers aggressive value-based purchasing plan to standardize provider reimbursement and reward lower costs and higher quality.
Complement related health system transformation efforts	Incorporates existing CCO structures in addressing communities' needs; builds off existing innovations among public payers.
Promote broad participation across payers, providers, and other health system partners	High incentive for payer competitive participation due to consolidation of lives into a single RFP; the model suggests evaluating (via the RFP) insurers based on approaches to ensuring broad participation in the global budget pilot.
Seek alignment across health system participants to ease provider burden and maximize impact	Program will grow over time to include all public payers, and non-public payers will be free to join at any time. Value-based purchasing plan will be developed and implemented by all participating payers.
Ensure shared accountability to quality and health equity across pilot participants	Clear performance metrics associated with quality and equity. Insurer payments are at risk based on performance. Measures standard across all participating payers.
Create a flexible, scalable, and resilient model that maximizes the value of tax dollars being spent on health care	Program will expand over time and will be resilient. Model is structured to avoid adverse selection and ensure payments to insurers are adequate.

VII. Modeling – Potential Pilot Regions

In Brief

- There is not a single minimum number for program viability but, rather, a set of risk management and risk mitigation features available to accommodate different populations and different degrees of risk aversion among participants.
- Risk mitigation techniques—including reinsurance and risk corridors— are key elements in the payment design, facilitating participant willingness to accept the risk associated with lower enrollment levels.
- A region with fewer numbers of payers and providers will more readily lend itself to the administrative and logistic needs of the pilot, bringing a substantial portion of providers' patients within the model and aligning payments among payers.
- Consider selecting geographic regions with a higher concentration of individuals with social needs, as well as those where substantial disparities exist.

BerryDunn assembled data to capture health system, SDOH, and demographic variables relevant for assessing potential pilot regions. The data, are primarily from national and state sources, reported here at a county level for all 36 Oregon counties, including enrollment levels for various categories of insurance coverage. The enrollment data are useful input for assessing whether a potential region has sufficient membership in particular insurance categories to support a pilot with relatively stable year-to-year spending levels.

In order to quantify "sufficiently high" enrollment, BerryDunn also modeled the stability of different enrollment levels for different payer categories. This section includes estimates of the minimum enrollment size needed for the effort to be viable, and analyzes how risk mitigation methods can reduce the required enrollment level. This section also outlines criteria to guide choosing a pilot region. Technical Supplement A provides more detail and discussion about the approach to modeling, including data sources, methods, constraints, and other considerations.

A. Estimates: Enrollment Thresholds for Pilot Feasibility

In Brief

The number of enrollees required depends on the inherent risk of the particular enrolled population and its participants, the organizations' risk tolerance, and the structure of the risk-sharing provisions.

- *Inherent risk:* The historical spending specific to covered populations (for example, Medicaid, Medicare, and commercial).
- *Risk tolerance:* Willingness and ability, both within organizational cultures and among the people running the organizations, to manage risk.
- *Structure of risk-sharing:* How the risk is distributed among various participants in the arrangement, and the proportion of resulting risk relative to organizational size.

Payers (and providers that share risk with payers) rely on their ability to manage claims costs, which are inherently difficult to predict, owing to volatility over time. The inherent risk in a population of insured members varies significantly by payer type (commercial, Medicaid, Medicare) and can also vary significantly within payer types -- depending on location, health status, and other factors. As enrollment size increases, stability of costs over time increases, and thus the ability to predict and manage these costs.

People and organizations have different levels of ability and willingness to manage financial risk. Insurance companies are in the business of absorbing risks and managing them. Providers manage clinical and other risks, but have not historically faced significant financial risk for the health care use of their patients, and have not had the same level of expertise and specialized infrastructure to manage such risk. In general, payers will be more experienced at handling -- and therefore more tolerant of -- larger potential revenue variations than will providers.

Several methods can reduce, manage, or reallocate risk. One method is individual stop-loss (ISL, or reinsurance) coverage, which can substantially reduce the minimum enrollment required to reduce uncertainty on financial outcomes. We tested the impact of ISL on minimum group size at two coverage levels. Relatively modest risk reduction can be achieved by stop-loss that pays for all claims for an individual beyond $500,000 per year, and much more significant risk reduction for coverage that pays for all claims over $100,000 for an individual. We ran scenarios at both $500,000 and $100,000 "attachment points" for stop-loss coverage, and re-estimated minimum group sizes needed. Risk corridors are another mitigation technique to further reduce minimum sizes.

Table 7 summarizes the results for three coverage scenarios. For any scenario, the columns show how the inherent risk varies by payer type. For each coverage scenario, three sub-scenarios indicate how enrollment size is related to risk tolerance – ranging from low tolerance for variation (actual exceeds expected within 2.5%) to high tolerance (actual exceeds expected within 10%). Panels 1, 2, and 3 display three risk mitigation scenarios, first without stop-loss coverage (Panel 1), then repeated for $500,000 stop-loss (Panel 2), and $100,000 stop-loss (Panel 3).

- Inherent risk differences reflected in payer type populations cause minimum enrollment size to vary substantially. With no stop-loss and a 10% tolerance for exceeding expected cost, minimums range from 5,000 for Commercial to 13,000 for Medicaid.
- Risk tolerance affects the minimum necessary enrollment size significantly, other things being equal. Achieving actual spending that falls within 10% of the budget with no stop-loss would require 5,000 members; reducing the tolerance to 5% and 2.5% increases the required membership size to 18,000 and >30,000 respectively.
- Risk mitigation via stop-loss insurance also has a large impact. Commercial coverage at 5% risk tolerance, without stop-loss, requires 18,000 members. The addition of $500,000 stop-loss reduces the required membership level to 10,000, and $100,000 stop-loss yields and estimated minimum membership size of 7,000.

Stop-loss coverage of $100,000 provides a large reduction in needed enrollment size. But cost for $100K coverage varies widely, depending on a variety of factors, and may cost 10% to 20% of the total medical premium. Cost for much less protective $500K stop-loss also varies widely but, other things being equal, might range from 1%-2% of premium. Use of higher attachment point stop-loss is likely a preferred path for risk reduction. Other risk mitigation tools, including risk corridors and the risk sharing fund (RSF), reinforce these guardrails.

Table 7. Minimum Population Size Estimates, by Stop-loss Level[50]

Budget Overage %	All Three Purchasers	Commercial (N = 12,844)	Commercial* (N = 275,837)	Medicaid (N = 6,812)	Medicare (N = 6,349)	Commercial & Medicaid	Commercial & Medicare	Medicaid & Medicare
Panel 1: No Stop-loss Coverage - *enrollment necessary to have 95% confidence actual spending will exceed expected level by no more than:*								
2.5%	30,000+	30,000+	30,000+	30,000+	30,000+	30,000+	30,000+	30,000+
5%	23,000	18,000	24,000	30,000+	10,000	30,000	14,000	23,000
10%	6,000	5,000	6,000	13,000	3,000	9,000	5,000	6,000
Panel 2: $500K Stop-loss Coverage - *enrollment necessary to have 95% confidence spending will exceed expected level by no more than:*								
2.5%	30,000+	30,000+	30,000+	30,000+	23,000	30,000+	30,000+	30,000+
5%	11,000	10,000	15,000	14,000	7,000	13,000	10,000	9,000
10%	3,000	3,000	4,000	5,000	2,000	4,000	3,000	3,000
Panel 3: $100K Stop-loss Coverage - *enrollment necessary to have 95% confidence spending will exceed expected level by no more than:*								
2.5%	20,000	24,000	25,000	26,000	11,000	22,000	17,000	18,000
5%	6,000	7,000	6,000	7,000	3,000	6,000	5,000	4,000
10%	2,000	2,000	2,000	2,000	1,000	2,000	2,000	2,000

Data source: Agency for Healthcare Research and Quality, Medical Panel Expenditure Survey (MEPS)
*The 2nd commercial scenario was run with an extract of detailed PEBB and OEBB data to confirm the applicability of the MEPS data; the similarity of the results between MEPS and the PEBB and OEBB data provides reassurance on the use of the survey for this analysis.

The provider performance model (depicted in Figure 2, Section IV) includes risk corridors and the RSF in its structure. The addition of stop-loss protection to the parameters of the risk model proceeds with the following conditions:

- Stop-loss coverage applies before risk sharing.
- Risk sharing with 60% provider risk and 40% payer risk up to the risk corridors.
- Risk corridors at +/- 3%.
- Provider gains are capped at 3%, with excess gains going to the RSF; losses are capped at 3%; providers may offset any losses with the RSF as funds are available.
- Payer gains are capped at 3%; payer assumes 100% downside risk after the risk corridor threshold (stop-loss coverage would apply first.

This approach provides reasonable protection for both provider and payer. Since provider losses are capped at 3%, the probability of the provider exceeding the global budget by more than 3% is zero regardless of the membership enrollment size. Stop-loss coverage will help reduce the provider loss within that 3% range, other things being equal. The RSF may also provide additional protection. From the provider's perspective, this combination of risk mitigation features significantly reduces, but would not eliminate, concerns about smaller enrollment levels.

In traditional fee-for-service payment, payers normally assume 100% of downside risk. In the proposed model, they would first have stop-loss coverage to reduce risk, and then have only 40% risk up to the 3% corridor, at which point the 100% risk would commence. On balance, this significantly reduces risk compared to business as usual. In

addition, the payer in the pilot would have a relatively small portion of its statewide business in the model. Lower levels of model enrollment would increase volatility of results for the payer. However, lower levels would also reduce the absolute size of the exposure. And, unlike the provider, payers can balance the volatility against their much larger non-pilot business occurring outside the pilot region. Taken all together, this makes $500,000 stop-loss coverage much more feasible, serving as a form of partial catastrophic coverage for the payer.

The bottom line: The enrollment threshold will be based on risk tolerance of both provider and payer. But, risk corridors enable viability at enrollment levels of about 5,000. With stop-loss but no risk corridors, enrollment of 5,000 would yield unacceptable risk for most organizations, and particularly for providers.

Technical Supplement A provides more detail on the development of these estimates and on the results.

B. Data and Criteria for Selecting Pilot Region(s)

Section III, above, reviews factors—relevant to providers, payers, members, and other organizations—essential for the success of Oregon's global budget model. These factors should inform and guide regional selection. The quantitative analysis presented here does not incorporate the necessary qualitative considerations. A selection process requires assessment of the participating organizations, their current environment, their interest and commitment to population health, and constituent engagement. We reiterate two factors here:

- Providers and payers with prior VBP experience, particularly total cost of care models, will be more adept at transitioning to Oregon's global budget pilot. Those that have made sizable investments in related infrastructure will also require less technical and financial support and will be better prepared to implement the model.
- Equity objectives would favor regions that include multiple CBOs or other entities with substantial experience across relevant SDOH domains, with which payers and providers can partner.

County-level quantitative information, assembled for consideration in region selection, provides a preliminary resource to illuminate pertinent community-level health system features. The refining of the data further to ZIP code level, and including provider- and payer-specific information, will better support assessment of potential sites and pilot participants. Section VIII discusses these next steps for the analysis.

Potential criteria, reviewed in Technical Supplement A, include measures in the following categories:

- Estimated enrollment, spending, and related information for commercial, Medicare, and Medicaid insurance
- Delivery system information including Primary Care Service Areas, Hospital Service Areas, number of hospitals, Hospital Referral Regions, and Oregon Medicaid CCO regions
- Several categories of SDOH measures providing county-level context on demographic and social factors, average health status, economic status, and physical environment

In addition, for the pilot, areas with competitive provider systems may motivate participation, if providers see potential upside and ability to gain market share. However, specific challenges emerge in a region with multiple hospitals with overlapping service areas and patients crossing county boundaries, particularly related to identifying which provider is responsible for each member.[51] The potential advantages for providers will requires specific features in the insurance procurements. Table 8 reviews such features and likely challenges.

Table 8. Competitive Provider Markets: Insurance Product Features and Challenges

Feature	Challenge
Network narrowed to a specific pilot provider entity.	Narrow networks have proven unpopular in commercial populations and are disallowed in Medicare.
Tiered network steering members toward pilot organizations.	This may require a new insurance product and changed benefits.
Use of member assignment and/or attribution methods.	Some government programs may require, and commercial members often demand, freedom of choice.

The exercise conducted here applies quantitative guidelines to specific measures to guide region selection. The parameters served as filters, not rankings. The quantitative ranges were used to bucket the counties into areas for consideration. The following lists the criteria and parameters of relevance. An asterisk designates those relevant for inclusion in future iterations of the exercise as more complete data become available. Technical Supplement A more completely describes the data and methods, with county-specific data available in Table 12 through Table 15.

1. Total population in each payer group to stabilize average per-person spending over time. Population sizes, as guidelines, and may vary with sub-population, stop-loss coverage, and provider risk tolerance.
    - Commercial PEBB: Aiming toward 5,000+
    - Commercial OEBB: Aiming toward 5,000+
    - Other large group Commercial accounts, with similarly large population sizes.
    - Sufficient total population to support insured sub-population sizes within individual payer groups (Medicare, Medicaid, Commercial): generally tending toward >75,000 total population
2. Ability to leverage a significant portion of providers' patient base within the model.
    - One or two Hospital Service Areas (HSAs)
    - Low Primary Care Service Area (PCSA) overlap to other counties
3. Medicaid and Medicare populations, relevant to possible eventual model expansion
    - Medicaid and Medicare enrollment as percentage of overall population
    - Medicaid CCO: Aiming toward 10,000+, preferably with zero CCO overlaps
    - Number of Medicare FFS beneficiaries

Other considerations

4. Percentage of PEBB/OEBB to commercial: at or above the statewide average
5. SDOH geographic indices, both average levels and variation (disparities) within geography – accounting for factors described in Section III and in Technical Supplement C. Potential Risk-Adjustment Factors, Data Sources, and Relative Impact

Other important elements, not directly measured:

- Payer that has PEBB/OEBB contracts also covering other (commercial) employer groups
- Willingness/motivation of payers and providers
- Experience with population health
- Dominant health system and dominant payer

Technical Supplement G provides detailed data for Oregon's 36 counties, including payer mix and SDOH factors.

VIII. Next Steps

In Brief

- The next steps for quantitative analyses will require the following elements:
    1. Data collection and analysis
    2. Region definition and selection factors
    3. Risk adjustment considerations
    4. Develop PMPM and global budget
    5. Estimate of savings
- This work requires attainment and application of individual member-level data to measure actual historical medical spending by payer type.
- Next steps will need to address several regulatory matters pertaining to the Affordable Care Act and Medicaid.

The information provided in this report is intended to inform OHA, in its consultation with Oregon's legislature and other partners, in selecting a pilot region or regions. This report has demonstrated an approach to assessing geographic areas for pilot selection, demonstrating the need to use quantitative analysis in combination with qualitative factors. The model, with available risk mitigation strategies, will not yield a single number for inclusion of exclusion of a geographic area or population. However, the model can provide greater specificity in direction and selection. That will depend on the use of more granular data specific to the state, local areas, payers, providers, and members.

Next steps require 1) assembling, organizing, and analyzing large amounts of detailed data, 2) providing detailed information to support the region selection process, including simulations of potential model structures, 3) developing and testing a rate-setting process, and 4) estimating potential savings. Technical Supplement D. Future Analytic and Actuarial Work, further details these data-building and quantitative analysis steps.

Note here again: Beyond quantitative analyses, effective planning and implementation will require qualitative data collection and constituent engagement processes. As well, several policy points will need further review. These include assessment of how the global budget initiative might accommodate or account for ACA market regulatory elements, including rate regions, essential health benefits, risk adjustment, and cost-sharing provisions. Inclusion of Medicaid will depend on new or changes to existing waivers, along with other regulatory steps.

The launch of the global budget pilot program stands as an ambitious effort, requiring up-front funds to support preparation, infrastructure, and implementation. CMS has outlined the phases and investments needed to stand up similar model tests, beyond ideas and concept, planning, and design.[52] Two major phases, each of which require time and resources, include 1) Solicit and build, and 2) Run and evaluate. Technical Supplement F: Funding to Implement the Regional Global Budget Pilot, further discusses the resources needed for implementing the global budget pilot.

IX. Technical Supplements

A. Global Budget Region Selection

B. Contracting and Payment Considerations among Purchasers, Payers, and Providers

C. Potential Risk-Adjustment Factors, Data Sources, and Relative Impact

D. Future Analytic and Actuarial Work

E. Review of Other State Governance Models

F. Funding to Implement the Regional Global Budget Pilot

G. County Data Files

Technical Supplement A. Global Budget Region Selection

This supplement addresses the parameters for selecting a site for the pilot regional global budget model.

1. Enrollment thresholds and the impact of risk mitigation strategies
2. Geographic units and clustering
3. Delivery system features
4. Payer mix and spending
5. Social determinants of health

This supplement also addresses constraints and limitations on the analysis.

In applying the parameters outlined above, the following lists principles, assumptions, and important elements about the global budget model in the pilot program leading to eventual adoption in much or all of the state:

- Consistency with OHA's system transformation goals is a central organizing principle and lens for design.
- Constituent interest and success in participating in a global budget model, beyond the pilot, will hinge critically on the payment model and its ability to change cost-growth incentives while improving quality and equity.
- Providers, payers, and government—those involved in the pilot and beyond—must see the success in promoting these goals and in the best interests of their organizations.
- Success of the payment model in shifting of overall organizational incentives requires a large proportion of the provider patient care activity in the model, including substantial commercial payer inclusion.
- A consistent and efficient payment mechanism across payers will improve the implementation, operation, and testing of the model.
- Mitigating provider risk is a key aspect of the payment design. Assuming a significant portion of provider patient base is in the model, and owing to the geographic focus of the pilot, the provider will bear the most risk as measured by proportion of business affected, with each payer having only a limited fraction of their enrollment involved in the pilot. Providers are also least prepared for risk and are most cautious about it.
- Small numbers of participants (providers, payers, employers) will make the pilot more feasible administratively and logistically, and they will improve the ability to focus on testing/proving the ability of the provider system to respond successfully to the payment model. The presence of relatively highly concentrated provider and payer market shares is consistent with this consideration.

The information provided in this report is intended to inform OHA, in its consultation with Oregon's legislature and other partners, in selecting a pilot region or regions. Additional analytical work, discussed in Technical Supplement F, will be needed to support selection of a pilot site. Region selection will ultimately require consideration of both empirical and qualitative factors.

1. Minimum Enrollment Thresholds and Risk Mitigation

In Brief

- The design of the complementary risk mitigation features depends on a particular situation; the specific context will determine the specification of the stop-loss, risk corridors, and risk stabilization fund.
- In advance of full information, the pilot will best proceed if the State provides up-front funding to support individual stop loss, set at a fixed dollar level, which can then be tapped by the pilot as needed, up to the funding level.

Various means of sharing risk exist,[53] and their use will influence the enrollment size needed for the viable participation of payers and providers:

- Risk Adjustment: Adjusts payment rates for health risk, based on enrollee average expected utilization, accounting for the enrollment and provision of care for populations with higher needs or risk. Such adjustment protects against adverse selection and risk selection by aligning financial risk with payment rates across populations.
- Reinsurance: Includes individual stop-loss (ISL), which provides payments if particularly high-cost cost claims are incurred, outside of a specific limit. If an enrollee's annual costs exceed a certain threshold (called an attachment point), the plan or provider is eligible for payment (for amounts over the attachment point, sometimes also including a cap per enrollee).
- Risk Corridors: Limits losses and gains beyond an allowable range. Protects against inaccurate rate setting during initial years of the reform by limiting gains and losses of participants. The funds outside the risk corridor are reallocated within the program (displayed in Section IV, Figure 2, of the main report.)

This section presents the results of a simulation of individual stop-loss (ISL) insurance at two coverage levels. Both cover claims for any individual member with total claims incurred over a fixed level; one covers claims over $500K, and one covers claims over $100K. If ISL were used as the only risk mitigation strategy, the simulation findings have the following implications for minimum enrollment thresholds:

- Even with $100,000 stop-loss coverage, OHA should expect a 23 – 30% probability that actual spending would be 5% above the global budget if only 1,000 individuals enrolled in the pilot.
- Consistent with the Law of Large Numbers, these probabilities fall exponentially as enrollment sizes increase, particularly when a tight stop-loss is put in place.
- With a $100,000 stop-loss, for example, OHA can reduce the probability of having spending more than 5% over the budget to 2.8% if 7,000 individuals participate.

Cost for such coverage varies widely, depending on a variety of factors, but might cost 10% to 20% of the total premium. Cost for $500,000 stop-loss (providing far less protection) also varies widely but, other things being equal, might range from 1%-2% of premium.

The pilot can benefit from a multi-pronged risk mitigation strategy, facilitating provider and payer willingness to participate even where population numbers might be smaller. In addition to risk adjustment of payment rates and ISL, the payment model can include 1) risk corridors; and 2) a multi-year risk pool with carryover (the "Risk Stabilization Fund" or RSF discussed in Section IV).

- Risk mitigation features in combination can, with $500,000 stop-loss coverage, make minimum enrollment thresholds around 5,000 feasible.

Risk corridors would allow payers to take on more of the total risk, further assisting providers in their respective, and relatively small, pilot model population sizes. With a risk corridor, the provider losses are capped as a percentage of dollars in the risk model. This feature should make providers more comfortable taking on smaller panels of enrollees, other things being equal. Generally speaking, risk corridors are symmetrical; that is, the percentage of gains is also capped at the same percentage. As a means of further protecting providers, and also protecting payers and policy makers, upside gains should be symmetrically capped, with a specific approach to use of the gains above the cap.

A multi-year risk pool (the RSF) allows provider gains above a certain threshold to be placed in a reserve account to be retained for use in future periods. It can then be drawn upon by the provider in future periods of unfavorable financial results. This feature provides a positive way to re-direct funds in circumstances where excessive positive margins may otherwise occur, retaining them to provide reserves in the event of future provider losses.

The provider performance model (depicted in Figure 2, Section IV of the main report) includes risk corridors and the RSF in its risk sharing structure. The addition of stop-loss protection to the parameters of the risk model proceeds with the following conditions:

- Stop-loss coverage applies before risk sharing
- Risk sharing with 60% provider risk and 40% payer risk up to the risk corridors
- Risk corridors at +/- 3%
- Provider gains are capped at 3%, with excess gains going to the RSF; losses are capped at 3%; providers may offset any losses with the RSF if funds are available
- Payer gains are capped at 3%; payer assumes 100% downside risk after the risk corridor threshold (stop-loss coverage would apply first)

This approach provides reasonable protection for both provider and payer. For the provider, since provider losses are capped at 3%, the probability of exceeding the global budget by more than 3% is zero regardless of the panel enrollment size. Stop-loss coverage will help reduce the provider loss within that 3% range, other things being equal. The RSF may also provide additional protection. From the provider's perspective, this combination of risk mitigation features significantly reduces but would not eliminate concerns about smaller enrollment levels.

In traditional fee-for-service payment, payers normally assume 100% of downside risk. In the proposed model, they would first have stop-loss coverage to reduce risk, and then have only 40% risk up to the 3% corridor, at which point the 100% risk would commence. On balance, this is significantly reduced risk compared to business as usual. In addition, the payer in the pilot would have a relatively small portion of their statewide business in the model.

Lower levels of model enrollment would increase volatility of results for the payer. However, lower levels would also reduce the absolute size of the exposure. And, unlike the provider, payers can balance the volatility against their much larger non-pilot business occurring outside the pilot region. Taken all together, this makes $500,000 stop-loss coverage much more feasible, serving as a form of partial catastrophic coverage for the payer.

The bottom line: The enrollment threshold will be based on risk tolerance of both provider and payer but, with risk corridors in place, the enrollment levels can be in the range of 5,000, an enrollment level that strains feasibility with stop-loss but no risk corridors

2. Calculating Minimum Threshold Simulations

For purposes of this analysis, we rely primarily on data summarized at the county level. This restriction is based on data limitations for this initial analysis and limited time frame, but it does not overly restrict the usability of the results. This is discussed further in Section 2. Two Excel files are provided as attachments.

- Enrollment Thresholds
- County Data

These files are the source of tables and figures presented in the memo and contain information about data sources, field descriptions, and the underlying methods used to generate them. The County Data file provides a reference and a resource for examination of the various enrollment, financial, delivery system, and social determinants of health variables associated with all 36 Oregon counties. Table 9 displays the enrollment size for PEBB, OEBB, Medicaid, and Medicare for each of Oregon's 36 counties.

The simulation sought to determine the number of individuals in a pilot group that are needed to have a probability, P, of not exceeding a percentage, k, relative to the expected claim amount. This analysis uses a value of P = 95% and k = 10%, 5%, or 2.5%. In this description, the 5% level is assumed.

We modeled the distributions of claims for different payers with a fixed percentage of individuals with no claims and remaining claims for each individual following a lognormal distribution. 2019 Medical Expenditure Panel Survey (MEPS) data from the Agency for Healthcare Research and Quality's (AHRQ) was used to derive parameters of the claims distributions. Then we simulated different sizes of groups of individuals based on these claims distributions and repeated random sampling 1,000 times for each group size. We determined the minimum group size that has a total spending not exceeding the expected spending by 5% for at least 95% of all 1,000 simulations.

We also tested the impact of individual stop-loss on minimum group size. By applying a $100,000 and a $500,000 attachment point to simulated claims for each individual, we calculated the total spending and compared it to the total expected spending with these caps. Then we determined a minimum group size that meets the criteria described above.

Table 9. Oregon Counties, Total Population and Enrollment in PEBB, OEBB, Medicaid, and Medicare, 2022

County	Population	Commercial PEBB	Commercial OEBB	All Commercial (including PEBB/OEBB)	Medicaid Managed Care (CCO)	Medicare
Oregon Total	4,142,776	130,345	128,384	2,000,741	890,660	799,471
Baker	16,054	725	615	4,568	4,217	4,807
Benton	90,951	8,920	2,197	33,531	12,558	15,431
Clackamas	412,672	7,015	10,923	239,608	61,977	77,520
Clatsop	39,182	780	1,602	15,282	9,286	9,662
Columbia	51,782	686	1,630	28,949	9,842	10,997
Coos	63,888	1,379	3,063	23,501	18,182	19,247
Crook	23,123	494	803	9,528	6,057	6,670
Curry	22,669	316	578	5,860	5,766	8,755
Deschutes	186,875	3,399	8,435	87,502	36,087	42,400
Douglas	109,405	2,009	3,855	39,756	30,511	31,481
Gilliam	1,855	53	157	891	359	489
Grant	7,190	305	392	2,066	1,519	2,109
Harney	7,289	335	699	2,406	2,183	1,864
Hood River	23,377	361	1,376	9,725	5,279	4,027
Jackson	217,479	4,400	3,922	82,353	59,361	53,600
Jefferson	23,758	756	1,152	9,494	5,884	5,103
Josephine	86,352	1,362	2,625	25,839	28,882	25,240
Klamath	66,935	2,182	3,353	20,271	19,450	16,633
Lake	7,863	497	316	3,019	1,955	2,109
Lane	374,748	15,372	9,796	158,527	88,166	82,329
Lincoln	48,920	1,007	1,473	13,858	12,676	15,286
Linn	125,047	6,804	5,809	56,004	32,171	27,606
Malheur	30,480	1,220	1,517	6,607	10,840	5,848
Marion	341,286	30,794	16,132	165,489	86,015	60,091
Morrow	11,166	279	605	4,050	2,895	1,969
Multnomah	807,555	11,870	15,359	414,113	171,269	114,788
Polk	83,696	9,546	4,333	42,810	16,728	16,874
Sherman	1,758	55	124	882	350	487
Tillamook	26,690	670	1,189	10,285	6,444	7,615
Umatilla	76,985	4,105	4,372	25,079	18,900	13,497
Union	26,222	1,983	1,228	10,653	6,419	6,109
Wallowa	7,051	267	287	2,387	1,785	2,342
Wasco	26,437	605	1,217	9,726	6,710	6,008
Washington	588,957	7,530	12,847	383,322	88,346	80,072
Wheeler	1,357	70	90	444	310	456
Yamhill	105,722	2,196	4,314	52,356	21,281	19,952

In addition to the simulation method, we tested a random sampling method with the PEBB and OEBB personal level claims data, which has a sufficient population size. By randomly drawing a certain size of group out of the whole PEBB/OEBB population, we calculated total spending for the sample group and compared it to the expected spending based on the average per-member-per-month for the full PEBB/ OEBB population. Then we repeated the sampling 1,000 times and determined the minimum group size that meets the criterial above. We found it generated similar results to the simulation method above with the commercial MEPS data. This provided confidence that the simulation method with MEPS was performing as expected.

Risk varies significantly among Medicare, Medicaid, and commercial, and so the population and payer mix in a particular global budget will be relevant to the inherent risk of the overall budget pool. To illustrate this point, the estimates provided here reflect payer commercial, Medicaid, and Medicare individually and in combination with one another.

The multiple payer scenarios within the simulation use the proportions of members from each payer group reflected in the survey sample. We also performed the same simulations using the data provided for the PEBB/OEBB population. The results were very similar for PEBB/OEBB and the commercial data within MEPS, adding confidence that MEPS is a reliable basis for gauging these enrollment thresholds at this stage in the process. Ultimately, recommendations will include the importance of using Oregon APAC data for determining the historical variation in specific sub-populations.

In Brief

The number of enrollees required depend on three factors: the population in question with its particular participants, the organizations' risk tolerance, and the structure of the risk-sharing provisions.

a) *Inherent risk:* The amount of risk inherent in a per-person prospective budget is based on two key factors:
    - The Law of Large Numbers – The basic statistical principle that the amount of variation in the average of a future uncertain outcome depends on the number of times the uncertain event is repeated. In this case, increasing numbers reduces variation in spending per person.
    - The variability of the outcome in a specific sub-population. The variation in historical spending is much larger in some populations (e.g., Medicaid) than it is in others (e.g., Medicare) and can vary within each population.

b) *Risk tolerance:* Both the organizational cultures and the people running the organizations have risk tolerances that vary. This consideration affects both the enrollment size threshold and the distribution of risk to different parties.

c) *Size of Risk:* The amount of risk borne by a particular organization will depend on how the risk is distributed to various participants in the arrangement, and on a proportion of resulting risk to organizational size.

The simulation analyzes the impact of three ISL insurance scenarios. ISL insures individual members spending over a specified threshold, creating a per-person target on risk assumed. Three ISL scenarios are examined as to their impact on the risk level:

- No stop-loss
- $500,000 per-enrollee stop-loss
- $100,000 per-enrollee stop-loss

This simulation assumes that all risk will be borne by the payer and the provider and not by the purchaser (global budget is binding). Since the provider will be more risk averse and will have more at stake financially, the simulation assumes the payer will provide the ISL, as part of the risk structure and payer-provider contract, and will not require separately obtained insurance.

For each payer mix and stop-loss level combination, we ran simulations to estimate a minimum enrollment size at three different levels of confidence: probability that actual per-person spending falls within 10%, 5%, and 2.5% of the global budget. Which of these levels of certainty is relevant will depend on both the inherent risk and the risk-sharing structures, and may be perceived differently by providers and payers. Table 10 displays the results of these various simulation scenarios.

The empirically measured level of risk expressed in the enrollment minimum will depend on the inclusion of various populations and purchasing groups—commercial, Medicaid, and Medicare. Purchasers whose members experience greater volatility in health spending, such as Medicaid, or purchase that may have lower numbers of enrollees in a region (such as PEBB/OEBB), require more members to enroll in the pilot to achieve that level of reduced uncertainty. For instance, to achieve actual spending within 5% of the global budget, with a $500,000 stop-loss in place, OHA would need to enroll 14,000 Medicaid members compared with only 7,000 Medicare members.

Lower thresholds for ISL can substantially reduce the number of individuals required to get to a particular level of reduced uncertainty for providers. The use of a $100,000 stop-loss (compared with no stop-loss), when including commercial and public-sector purchasers, would enable a provider to get to 5% chance of exceeding the budget with only 6,000 members, as compared to 23,000 without stop-loss.

The level of confidence necessary has a very large impact on the minimum enrollment size, other things equal. Achieving actual spending that falls within 10% of the budget would require between 3,000 and 13,000 enrollees, depending on payer, without stop-loss. However, these minimum enrollment numbers rise very significantly to reduce uncertainty to 5%, and exceed 25,000 members even with $100,000 ISL to reduce uncertainty further to 2.5%.

Table 10 provides detail about how enrollment size affects confidence level of remaining within a specified percentage of the budget target. The tables demonstrate the following:

- Even with $100,000 stop-loss coverage, OHA should expect a 23 – 30% probability that actual spending would be 5% above the global budget if only 1,000 individuals enrolled in the pilot.
- Consistent with the Law of Large Numbers, these probabilities fall exponentially as enrollment sizes increase, particularly when a tight stop-loss is put in place.
- With a $100,000 stop-loss, for example, OHA can reduce the probability of having spending more than 5% over the budget to 2.8% if 7,000 individuals participate. However, $100,000 stop-loss is very expensive.

Figure 4 and Table 11 display more detail, for an example commercial population, of the probability of exceeding the spending target by 5% at different enrollment levels, at varying levels of stop-loss coverage.

Table 10. Minimum Population Size Estimates[54]

Stop-Loss Level	All Three Purchasers	Commercial (N = 12,844)	Commercial (N = 275,837)	Medicaid (N = 6,812)	Medicare (N = 6,349)	Commercial & Medicaid	Commercial & Medicare	Medicaid & Medicare
For 95% Confidence, Actual Spending Will Be Within 2.5% of Budget								
None	30,000+	30,000+	30,000+	30,000+	30,000+	30,000+	30,000+	30,000+
$500K Cap	30,000+	30,000+	30,000+	30,000+	23,000	30,000+	30,000+	30,000+
$100K Cap	20,000	24,000	25,000	26,000	11,000	22,000	17,000	18,000
For 95% Confidence, Actual Spending Will Be Within 5% of Budget								
None	23,000	18,000	24,000	30,000+	10,000	30,000	14,000	23,000
$500K Cap	11,000	10,000	15,000	14,000	7,000	13,000	10,000	9,000
$100K Cap	6,000	7,000	6,000	7,000	3,000	6,000	5,000	4,000
For 95% Confidence, Actual Spending Will Be Within 10% of Budget								
None	6,000	5,000	6,000	13,000	3,000	9,000	5,000	6,000
$500K Cap	3,000	3,000	4,000	5,000	2,000	4,000	3,000	3,000
$100K Cap	2,000	2,000	2,000	2,000	1,000	2,000	2,000	2,000
Note: While 10% variation from budget is not a viable level of risk to impose, these figures demonstrate the substantial impact that smaller population has on the risk exposure and confidence level.								

Figure 4. Probability of Exceeding Spending Target by 5%

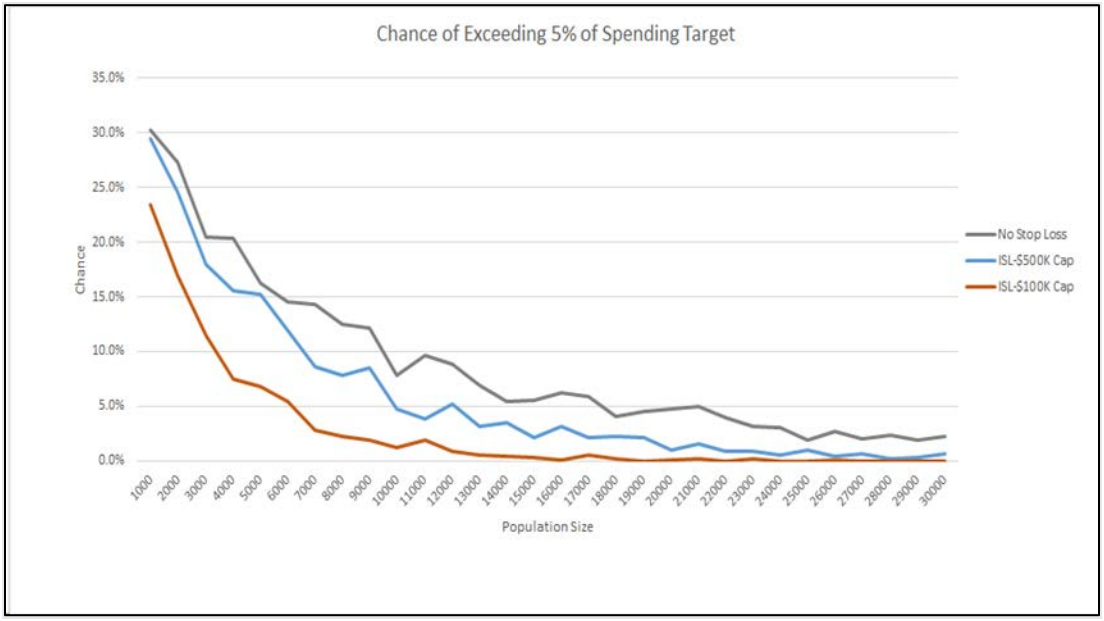


Table 11. Probability of Exceeding Spending Target by 5%: Commercial Population Example

Population Size	No Stop-Loss	Individual Stop-Loss: $500K Cap	Individual Stop-Loss: $100K Cap
1,000	30.3%	29.5%	23.4%
2,000	27.3%	24.5%	16.9%
3,000	20.5%	18.0%	11.5%
4,000	20.3%	15.6%	7.5%
5,000	16.3%	15.2%	6.8%
6,000	14.5%	11.9%	5.4%
7,000	14.3%	8.6%	2.8%
8,000	12.5%	7.8%	2.3%
9,000	12.2%	8.5%	1.9%
10,000	7.8%	4.8%	1.2%
11,000	9.6%	3.9%	1.9%
12,000	8.8%	5.2%	0.9%
13,000	6.9%	3.2%	0.5%
14,000	5.4%	3.5%	0.4%
15,000	5.6%	2.1%	0.3%
16,000	6.2%	3.2%	0.1%
17,000	5.9%	2.1%	0.5%
18,000	4.1%	2.3%	0.2%
19,000	4.5%	2.1%	0.0%
20,000	4.8%	1.0%	0.1%
21,000	5.0%	1.6%	0.2%
22,000	4.0%	0.9%	0.0%
23,000	3.2%	0.9%	0.2%
24,000	3.1%	0.6%	0.0%
25,000	1.9%	1.0%	0.0%
26,000	2.7%	0.4%	0.1%
27,000	2.0%	0.7%	0.0%
28,000	2.4%	0.2%	0.0%
29,000	1.9%	0.3%	0.0%
30,000	2.3%	0.7%	0.0%

This analysis, while providing minimum enrollment threshold estimates to OHA, also emphasizes the following:

There is not a single minimum number for program viability but, rather, a set of risk management and risk mitigation features available to accommodate different populations and different degrees of risk aversion among participants

2. Geographic Units and Clustering

The selection of a pilot region requires analysis of data at a specific level of geography. Various considerations, and complications, guide the decision about how to construct or designate a region for data analysis and for program implementation.

Counties provide a common geographic unit of analysis and potential way to identify a pilot region, either as a singular county or as a cluster of counties. County-level data are readily available, facilitating the inputs needed for planning. Oregon's 36 counties, however, vary greatly in size, geography, and population. Counties are political units, not self-contained economies and service markets. Counties often do not reflect residents' health service use patterns and the patient base/service area of providers. Particularly in non-urban counties, a resident's most proximate health care provider may be across a county border.

Sub-county geographies and clusters of areas across counties may more accurately represent use of health care services. Among the established small geographic boundaries, postal ZIP code areas follow transportation and market patterns. Needed data—including demographics, health care use, and other—are often available at the ZIP code level, but not through public use formats.

This current report, given the restricted time frame and available data, relies on county-level data and geographies to provide an initial perspective on the composition of potential regions. As a next step, planning and selection of regions would best rely on clustering and analysis at the ZIP code level. This would involve use of data from Oregon's APAC data for commercial payers,[55] in combination with person-level Medicaid, PEBB, and OEBB data.

While there are tradeoffs and implementation challenges inherent in all geographic regions, primary care service areas (PCSAs) offer analytic granularity at the ZIP code level while mapping cleanly to Oregon counties. They also reflect existing patterns of primary care that are central to population-based payment models. Since PCSAs line up nearly perfectly with ZIP codes, they can be well supported with data such as APAC. We recommend PCSAs as the fundamental building block of the regional pilot selection. However, other geographic categorization schemes will be useful, in addition to the PCSAs, in selection of the pilot region. Several differing, and overlapping geographic units require consideration and analysis, whether based on the more-limited data currently available, or on an eventual more detailed, APAC-based analysis:

- Primary Care Service Areas (PCSAs)
- Oregon Coordinated Care Organizations (CCOs)
- Individual and Small Group Market Rating Regions
- Hospital Service Areas (HSAs)
- Hospital Referral Regions (HRRs)
- Tribal Service Areas

2a. Primary Care Service Areas (PCSAs)

The Oregon Health Sciences University (OHSU) has defined, by ZIP code clusters, the state's primary care service areas (Figure 5).[56] OHSU, in consultation with state and local agencies, chose ZIP codes as building blocks of sub-county service areas, and grouped all of Oregon's ZIP codes using the following criteria:

- Health resources generally located within 30 – 40 minutes travel time
- Defined areas contain a population of at least 800 – 1,000 or more people, capable of supporting at least a single midlevel health care provider
- Defined areas not smaller than a single ZIP code, with ZIP codes geographically contiguous and/or follow main roads
- Defined areas constitute a "rational" medical trade or market area considering topography, social and political boundaries, and travel patterns
- ZIP codes congruent with existing special health or hospital taxing districts

2b. Coordinated Care Organizations (CCOs)

Oregon currently operates its CCO program with geographic areas defined by the respondents to an RFP process. This results in 16 CCO regions,[57] some of which overlap one another, and several of which operate in specified ZIP codes, but not full counties. OHA publishes a map of the current service areas of the CCOs.[58] Figure 6 displays detail at the ZIP code level, with numbers designating areas of overlap.

Note that Oregon also has designated rating regions for the individual and small group market, as regulated under the Affordable Care Act.[59] These rating regions, displayed Figure 7, correspond somewhat with the existing CCOs.

2c, Hospital Service Areas and Referral Regions (HSAs and HRRs)

Geographic patterns of hospital use are useful for understanding how the delivery system overlays geographical location for patients. HSAs and HRRs are built from Medicare claims data at the ZIP code level.[60] HSAs reflect local health care markets for hospital care: a collection of ZIP codes in which residents receive most of their hospitalizations from the hospitals in that area (Figure 8).[61] HRRs are larger geographically and are defined as regional health care markets where patients within those areas are most often referred for tertiary care (Figure 9). Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery.

2d. Tribal Service Delivery Areas

Nine federally recognized American Indian tribes, with tribal governments as sovereign nations, reside within the State of Oregon.[62] The specific rights, needs, and potential participation of tribal nations and their members require separate consideration, beyond the scope of this report's analysis. For now, it important to note that 1) many tribal members do not live on tribal lands, and each tribe's area of interest may extend far beyond its tribal governmental center or reservation location, and 2) persons who are American Indian, whether or not they are tribal members, may rely on commercial insurance, Medicaid, and Medicare as any other U.S. resident would. OHA has developed a crosswalk table between CCO Service Delivery Areas and Tribal Service Delivery Areas.[63]

Figure 10 displays the designated service areas of each of the tribal nations.[64]

Figure 5. Oregon Primary Care Service Areas[65]

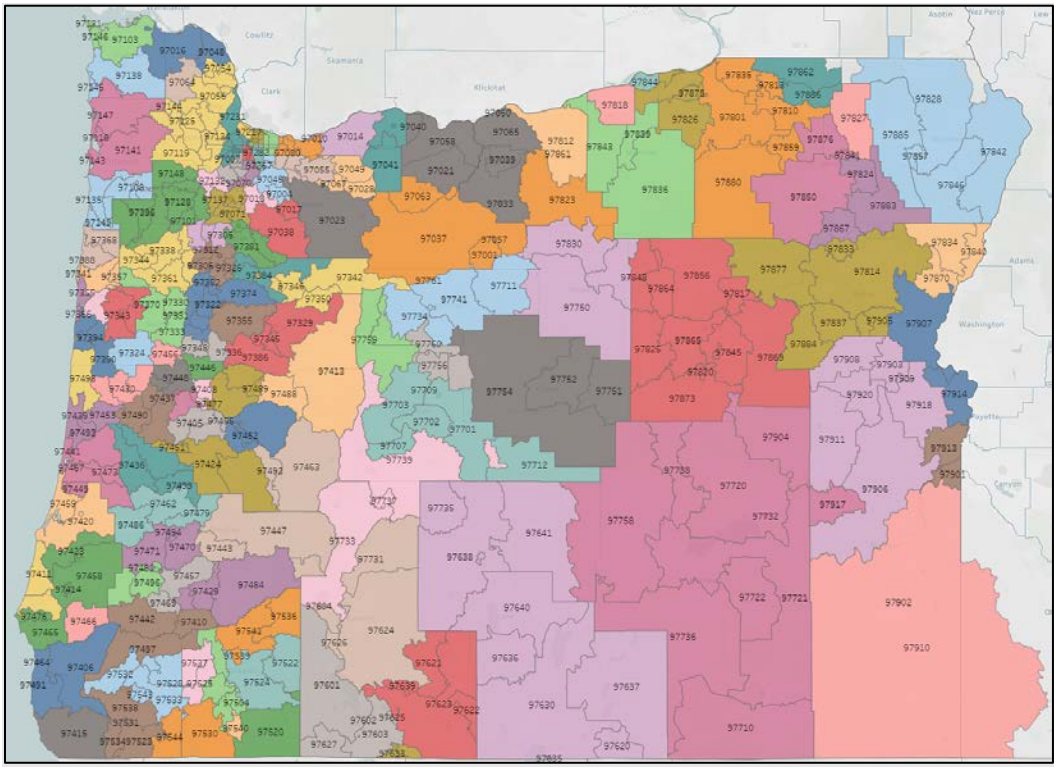


Figure 6. Oregon CCO Service Areas[66]

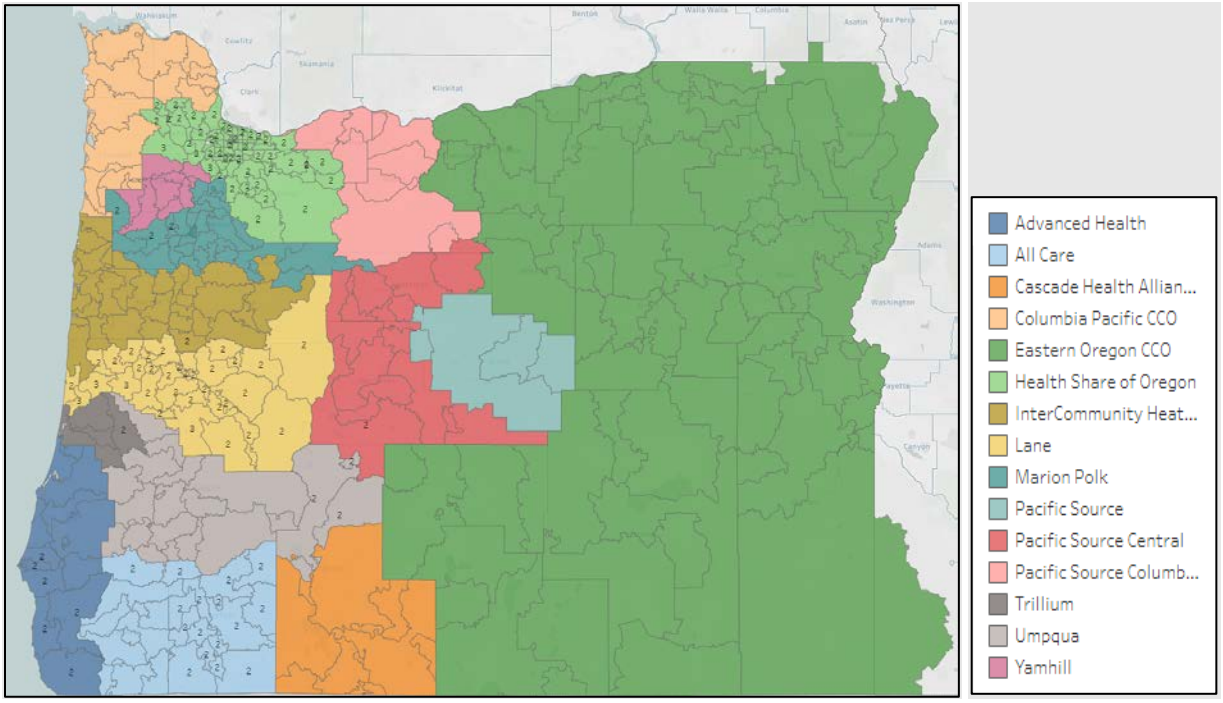


Figure 7. Rating Regions, Individual and Small Group Market

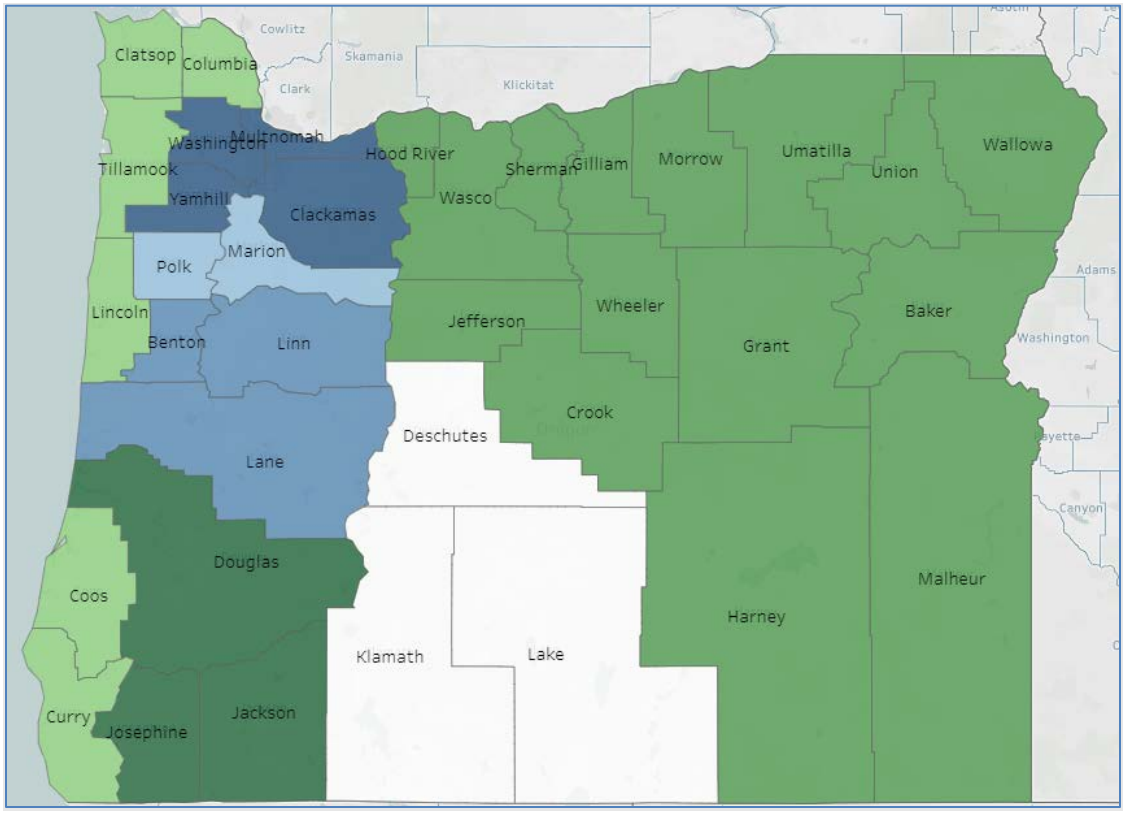


Figure 8. Hospital Service Areas (HSAs)[67]

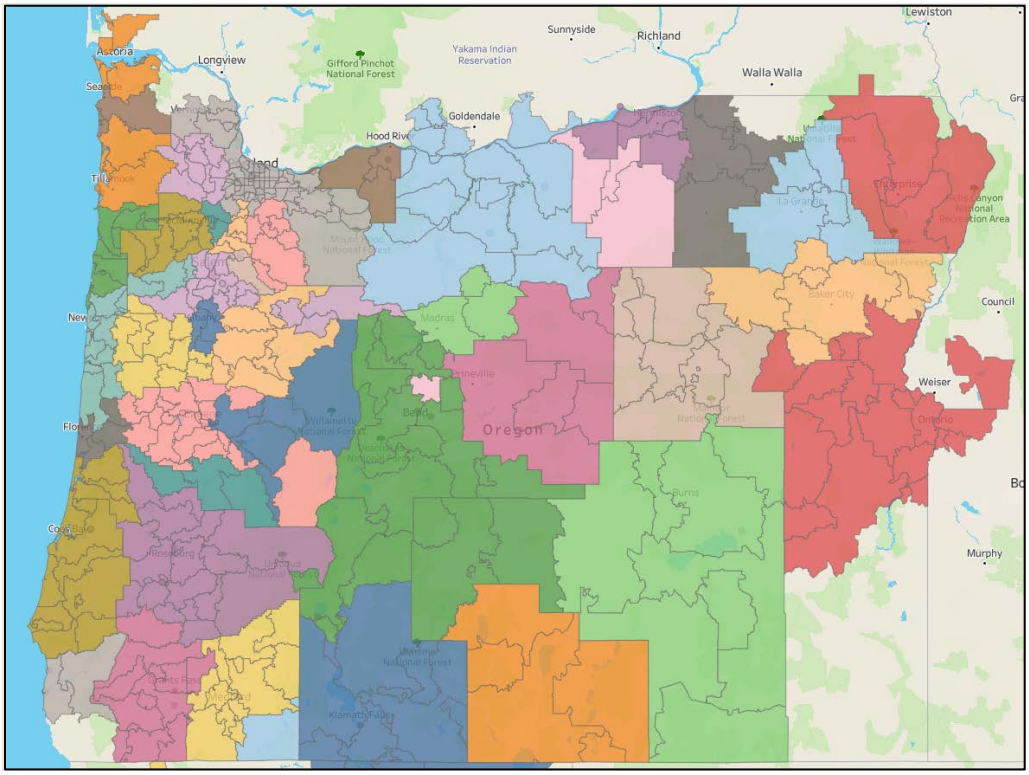


Figure 9. Hospital Referral Regions (HRRs)[68]

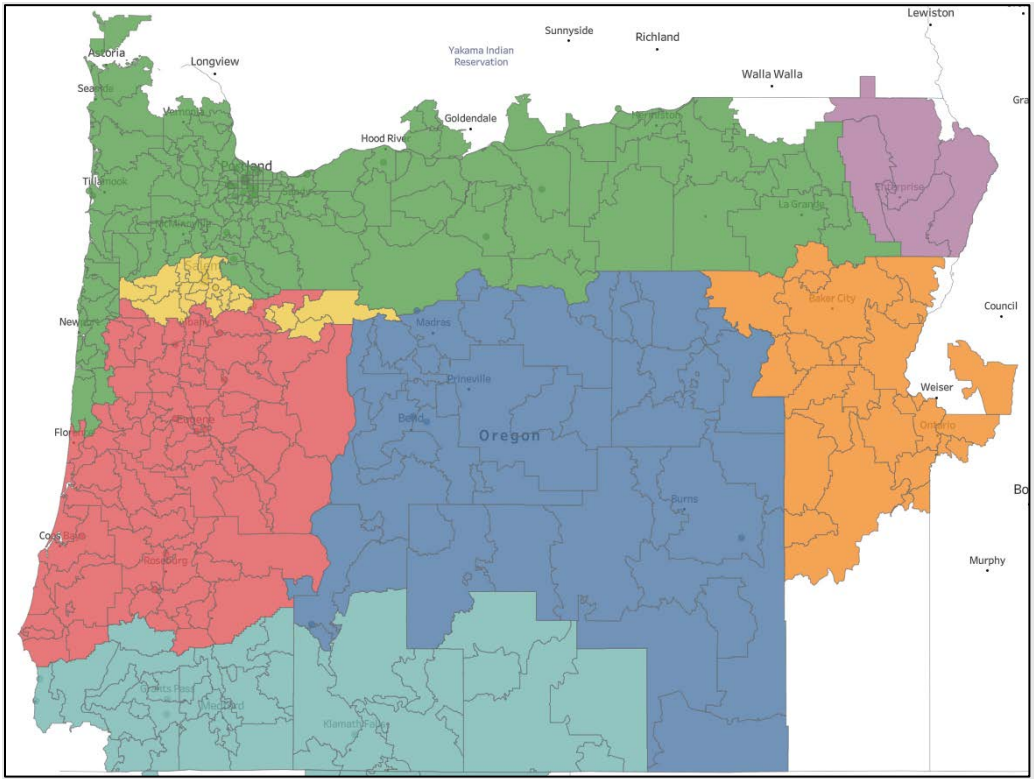
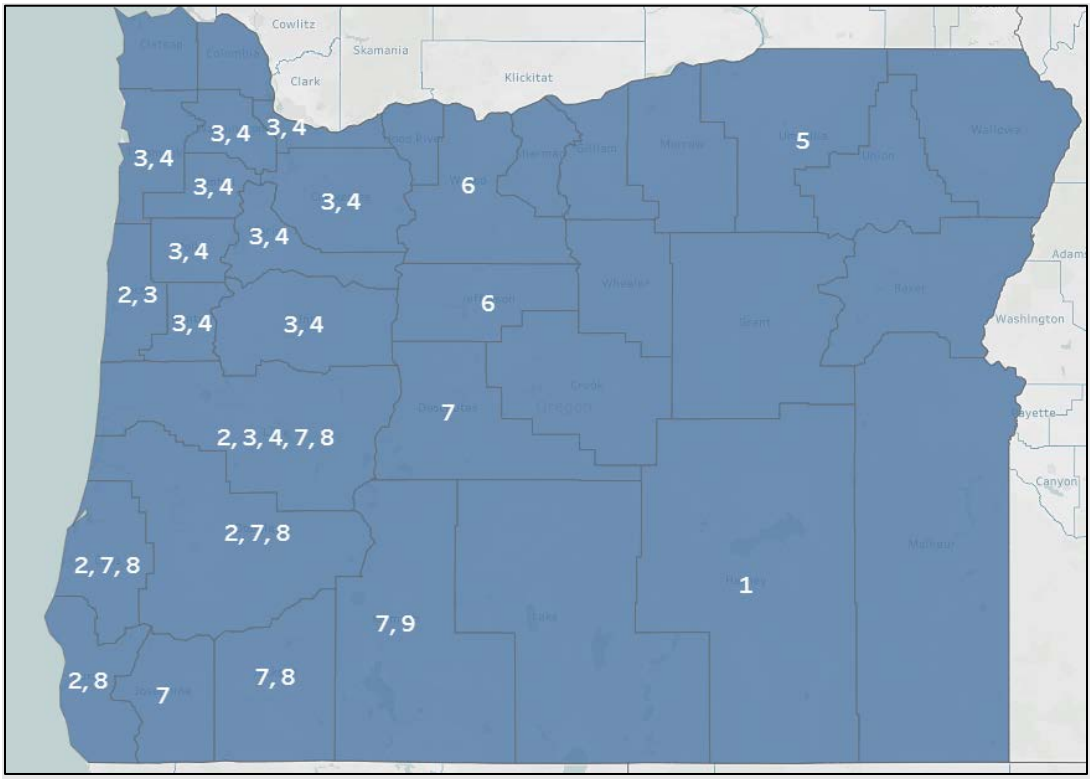


Figure 10. Tribal Service Areas



	Map Key: Tribal Nations
1	Burns Paiute of Harney County
2	Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
3	Confederated Tribes of Grand Ronde
4	Confederated Tribes of Siletz
5	Confederated Tribes of Umatilla Reservation
6	Confederated Tribes of Warm Springs
7	Cow Creek Band of Umpqua Indians
8	Coquille Indian Tribe
9	Klamath Tribes

2e. Use of Geographic Categories in Pilot Selection

As noted, PCSAs are most aligned with the delivery system and OHA policy priorities for construction of a pilot region. The other geographic units can be useful in assessing which area of the state, and which particular PCSAs in that area, should be chosen for the pilot.

A region with a single HSA, and a single in-state HRR will tend to reduce the quantity/complexity of contracts, negotiations, and settlements. Similarly, CCO involvement in the payment model will be significantly simpler if only a single CCO operates in the pilot region.

Table 12 applies these criteria for Oregon's 36 counties. With respect to the geographic delivery system criterion, Benton, Josephine, and Deschutes have characteristics that would tend to reduce the number of participants and complexity of arrangements: specifically, one to two HSAs, a single HRR in Oregon, and a single CCO operating in the region. Polk and Marion, which seem likely to be included together if chosen, are favorable in a number ways including PEBB/OEBB membership. However, they have three and six HSAs respectively, and Marion has multiple HRRs. Finally, Malheur for instance has a single HSA and HRR, but (in addition to having a low population), has an HRR out of state in Boise.

3. Payer Mix and Spending

Consideration of potential purchaser groups, for participation in Oregon's global budget pilot, involves both technical factors and qualitative considerations. Ongoing discussions with OHA suggest that some combination of PEBB, OEBB, and large group commercial entities might offer viable early pathway, with Medicaid and Medicare participation dependent upon the model's design specifications and regulatory requirements. Table 13 shows payer mix data for Oregon's 36 counties. (Excel files with this report provide data for all counties). PEBB and OEBB spending as a proportion of total commercial, Medicare, and Medicaid spending in 2019 ranged by county from 4% (Multnomah, Jackson, Curry, Washington) to 18% (Polk, Benton). These numbers suggest that OHA will likely need other purchasers to participate in the pilot to achieve an actuarially sound global budget and provide adequate financial incentive for providers to shift away from volume-based payment systems.

Table 12. Geographic Region Selection Factors: Oregon Counties

County	Population	# of ZIP Codes	# PCSAs	PCSA Overlaps	# of HSAs	Hospital Service Area	Hospital Referral Region	HRR State	CCO1	CCO Overlaps
Baker	16,054	11	3	546	2		Boise	ID	Eastern Oregon CCO	0
Benton	90,951	8	4	-	1	Corvallis	Eugene	OR	InterCommunity Health Network	0
Clackamas	412,672	27	8	-	2	Portland-Oregon City	Portland	OR	Health Share of Oregon	2
Clatsop	39,182	7	2	-	2	Astoria-Seaside	Portland	OR	Columbia Pacific CCO	0
Columbia	51,782	8	3	-	1	Portland	Portland	OR	Columbia Pacific CCO	0
Coos	63,888	9	5	1,955	1	Coos Bay	Eugene	OR	Advanced Health	0
Crook	23,123	4	2	2,594	2	Prineville-Bend	Bend	OR	Pacific Source	0
Curry	22,669	8	4	508	2	Coos Bay-Gold Beach	Medford-Eugene	OR	Advanced Health	2
Deschutes	186,875	10	4	-	2	Bend-Redmond	Bend	OR	Pacific Source Central	0
Douglas	109,405	26	9	-	4	Roseburg	Eugene-Medford	OR	Umpqua / Trillium	2
Gilliam	1,855	2	2	-	1	The Dalles	Portland	OR	Eastern Oregon CCO	0
Grant	7,190	10	1	-	1	John Day	Bend	OR	Eastern Oregon CCO	0
Harney	7,289	9	1	-	1	Burns	Bend	OR	Eastern Oregon CCO	0
Hood River	23,377	4	2	-	1	Hood River	Portland	OR	Pacific Source Columbia Gorge	0
Jackson	217,479	15	7	-	3	Medford	Medford	OR	All Care	2
Jefferson	23,758	6	4	7,691	2	Bend-Madras	Bend	OR	Pacific Source Central	0
Josephine	86,352	12	4	4,096	1	Grants Pass	Medford	OR	All Care	0
Klamath	66,935	18	5	929	2	Bend-Klamath	Medford-Bend	OR	Cascade / Pacific Source	0
Lake	7,863	9	2	-	2	Bend-Lakeview	Medford-Bend	OR	Eastern Oregon CCO	0
Lane	374,748	37	12	-	4	Eugene-Springfield	Eugene	OR	Pacific Source / Lane	2
Lincoln	48,920	16	7	293	3	Newport-Lincoln City	Portland-Eugene	OR	InterCommunity Health Network	0
Linn	125,047	16	8	2,610	5	Eugene-Albany	Eugene-Salem	OR	InterComm / PS Marion Polk	0
Malheur	30,480	13	4	-	1	Ontario	Boise	ID	Eastern Oregon CCO	0
Marion	341,286	32	7	8,176	6	Salem-Tualatin	Salem-Portland	OR	Pacific Source Marion Polk	0
Morrow	11,166	5	3	-	2	Hermiston-Heppner	Portland	OR	Eastern Oregon CCO	0
Multnomah	807,555	53	7	35,194	1	Portland	Portland	OR	Health Share of Oregon	2
Polk	83,696	7	3	34,019	3	Salem-Dallas	Salem	OR	Pacific Source Marion Polk	0
Sherman	1,758	5	2	837	1	The Dalles	Portland	OR	Eastern Oregon CCO	0
Tillamook	26,690	13	3	-	2	Tillamook-Lincoln City	Portland	OR	Columbia Pacific CCO	0
Umatilla	76,985	13	3	-	2	Hermiston-Pendleton	Portland	OR	Eastern Oregon CCO	0
Union	26,222	7	3	-	2	La Grande-Baker	Portland-Boise	OR	Eastern Oregon CCO	0
Wallowa	7,051	5	1	-	1	Enterprise	Spokane	WA	Eastern Oregon CCO	0
Wasco	26,437	7	2	-	2	The Dalles-Madras	Portland-Bend	OR	Pacific Source Columbia Gorge	0
Washington	588,957	29	4	-	2	Portland-Hillsboro	Portland	OR	Health Share of Oregon	2
Wheeler	1,357	3	1	-	2	Prineville-The Dalles	Portland-Bend	OR	Eastern Oregon CCO	0
Yamhill	105,722	10	3	-	2	McMinnville-Newberg	Portland	OR	Yamhill	0

Table 13. Payer Mix for Oregon Counties

County	Population	PEBB		OEBB		PEBB & OEBB		Commercial Large Group	Commercial Non-PEBB or OEBB	Medicaid Managed Care (CCO)
Baker	16,054	725	5%	615	5%	1,339	10%	15%	24%	31%
Benton	90,951	8,920	14%	2,197	4%	11,117	18%	26%	36%	20%
Clackamas	412,672	7,015	2%	10,923	3%	17,937	5%	41%	58%	16%
Clatsop	39,182	780	2%	1,602	5%	2,382	7%	25%	38%	27%
Columbia	51,782	686	1%	1,630	3%	2,316	5%	39%	53%	20%
Coos	63,888	1,379	2%	3,063	5%	4,442	7%	19%	31%	30%
Crook	23,123	494	2%	803	4%	1,297	6%	26%	37%	27%
Curry	22,669	316	2%	578	3%	894	4%	15%	24%	28%
Deschutes	186,875	3,399	2%	8,435	5%	11,834	7%	28%	46%	22%
Douglas	109,405	2,009	2%	3,855	4%	5,863	6%	20%	33%	30%
Gilliam	1,855	53	3%	157	9%	210	12%	30%	39%	21%
Grant	7,190	305	5%	392	7%	698	12%	12%	24%	27%
Harney	7,289	335	5%	699	11%	1,034	16%	10%	21%	34%
Hood River	23,377	361	2%	1,376	7%	1,736	9%	25%	42%	28%
Jackson	217,479	4,400	2%	3,922	2%	8,322	4%	27%	38%	30%
Jefferson	23,758	756	4%	1,152	6%	1,908	9%	25%	37%	29%
Josephine	86,352	1,362	2%	2,625	3%	3,986	5%	19%	27%	36%
Klamath	66,935	2,182	4%	3,353	6%	5,535	10%	18%	26%	35%
Lake	7,863	497	7%	316	4%	813	11%	10%	31%	28%
Lane	374,748	15,372	5%	9,796	3%	25,168	8%	29%	41%	27%
Lincoln	48,920	1,007	2%	1,473	4%	2,480	6%	17%	27%	30%
Linn	125,047	6,804	6%	5,809	5%	12,613	11%	26%	37%	28%
Malheur	30,480	1,220	5%	1,517	7%	2,737	12%	10%	17%	47%
Marion	341,286	30,794	10%	16,132	5%	46,925	15%	26%	38%	28%
Morrow	11,166	279	3%	605	7%	884	10%	21%	36%	32%
Multnomah	807,555	11,870	2%	15,359	2%	27,229	4%	39%	55%	24%
Polk	83,696	9,546	12%	4,333	6%	13,879	18%	27%	38%	22%
Sherman	1,758	55	3%	124	7%	179	10%	30%	41%	20%
Tillamook	26,690	670	3%	1,189	5%	1,860	8%	20%	35%	26%
Umatilla	76,985	4,105	7%	4,372	8%	8,477	15%	19%	29%	33%
Union	26,222	1,983	9%	1,228	5%	3,212	14%	18%	32%	28%
Wallowa	7,051	267	4%	287	4%	554	9%	16%	28%	27%
Wasco	26,437	605	3%	1,217	5%	1,821	8%	26%	35%	30%
Washington	588,957	7,530	1%	12,847	2%	20,377	4%	51%	66%	16%
Wheeler	1,357	70	6%	90	7%	160	13%	16%	23%	26%
Yamhill	105,722	2,196	2%	4,314	5%	6,510	7%	34%	49%	23%
Statewide	4,142,776	130,345	4%	128,384	3%	258,728	7%	33%	47%	24%

4. Social Determinants of Health

Oregon's global budget model aims to promote health equity by incentivizing payers and providers to strengthen access to affordable, high-quality health care services. Health outcomes, however, depend on a range of factors beyond clinical care. SDOH are the conditions in the environments where people are born, live, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[69] Inequities in SDOH factors create disparities and inequities in health outcomes.

It will be challenging for payment incentives embedded in Oregon's global budget, including value-based payment strategies, to address disparities that may be associated with social determinants if pilot regions are homogenous or lack social vulnerabilities. OHA may consider selecting geographic regions with a higher concentration of individuals with social needs, as well as those where substantial disparities exist. To inform such decisions, BerryDunn reviewed the counties in Oregon on measures related to each SDOH domain using 2019 data from the Neighborhood Atlas Area Deprivation Index,[70] County Health Rankings,[71] and the AHRQ SDOH database.[72]

The Area Deprivation Index data are based on ZIP code clusters. This offers a robust data opportunity if building service areas based on PCSAs or other sub-county units of analysis. The map in Figure 11 displays the relative rankings of areas throughout the Oregon.

Figure 11. Area Deprivation Index, Oregon, 2019

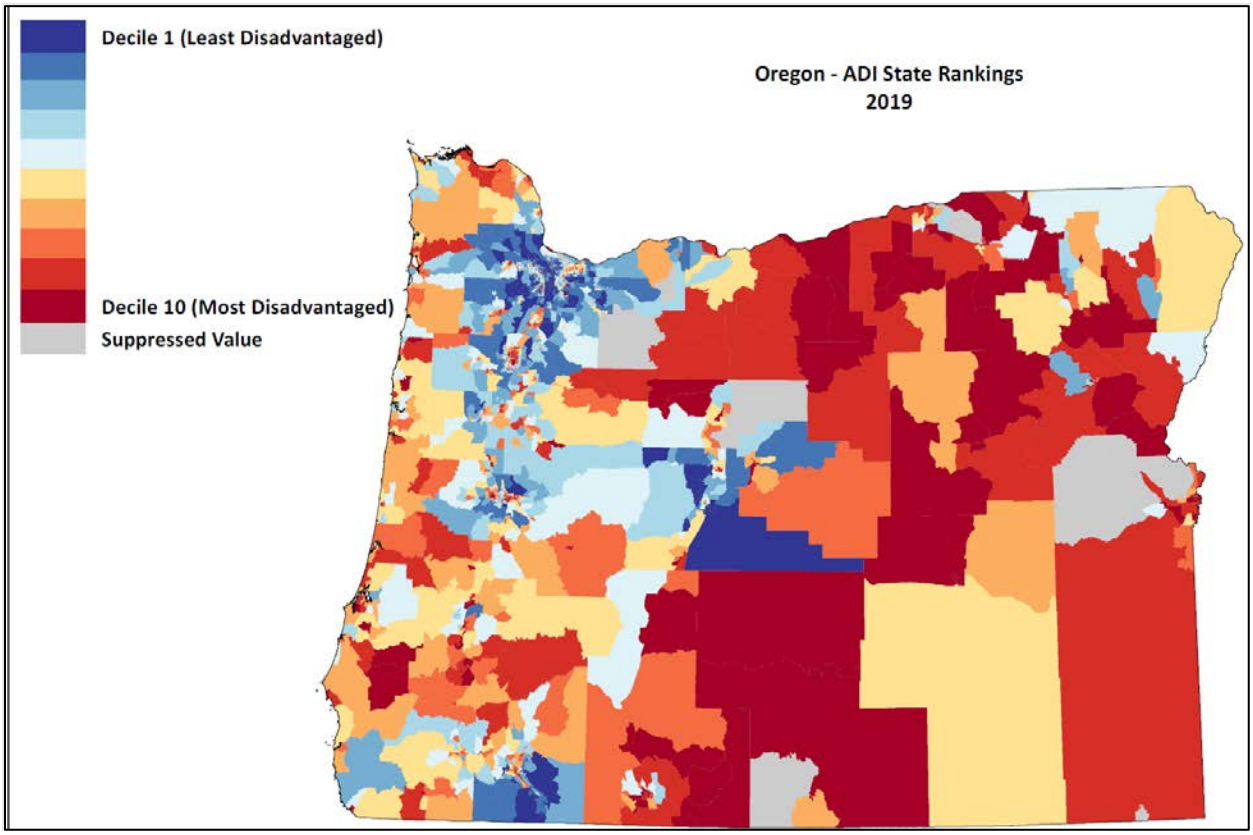


Table 14 presents performance on social and economic factors across all 36 Oregon counties, specifically an overall and economic-specific Social Vulnerability Index (SVI), unemployment rate, percent of children living in poverty, income inequality, and median household income. The SVI is a composite of 15 individual measures across four domains: socioeconomic status, household composition and disability, minority status and language, and housing type and transportation. The economic-specific SVI captures the socioeconomic component of that composite measure, and is thus more closely correlated with the remaining factors in Table 14. These six factors had, overall, a strong statistical relationship with average per capita health care spending in bivariate analyses presented in Table 17. Malheur, Umatilla, Jefferson, and Klamath Counties performed poorly on these indicators.

OHA places particular priority on measures related to food and housing insecurity. Table 15 displays the performance of all 36 Oregon counties on food insecurity and severe housing problems. While there was generally limited overlap between counties with high food insecurity and housing problems, Josephine County had the worst combination of food and housing issues among all Oregon counties. While Deschutes County normally scored well on other SDoH domains, it was below average on these two topic areas.

Table 14. Social Determinants: Social and Economic Vulnerability[73,74]

County	Population	Social Vulnerability Index (All)	Social Vulnerability Index (Economic)	Unemployed (%)	Children in Poverty (%)	Income Inequality Ratio	Median Household Income
Baker	16,054	0.69	0.6	5.5%	27%	4.3	$43,929.00
Benton	90,951	0.35	0.37	3.3%	12%	5.8	$60,572.00
Clackamas	412,672	0.19	0.09	3.7%	10%	4.2	$79,404.00
Clatsop	39,182	0.52	0.31	4.1%	17%	4.2	$52,706.00
Columbia	51,782	0.4	0.4	5.2%	17%	4.1	$61,453.00
Coos	63,888	0.74	0.63	5.5%	27%	4.7	$42,464.00
Crook	23,123	0.57	0.65	6.3%	21%	4	$47,940.00
Curry	22,669	0.49	0.54	6.1%	25%	4.6	$40,580.00
Deschutes	186,875	0.16	0.17	4.2%	12%	4.1	$65,506.00
Douglas	109,405	0.73	0.64	5.4%	23%	4.2	$47,157.00
Gilliam	1,855	0.51	0.52	4.2%	18%	3.5	$53,792.00
Grant	7,190	0.55	0.58	6.8%	25%	4.2	$46,329.00
Harney	7,289	0.71	0.66	6.3%	23%	4.1	$42,883.00
Hood River	23,377	0.55	0.33	3.6%	15%	3.8	$63,951.00
Jackson	217,479	0.74	0.5	4.8%	21%	4.7	$51,364.00
Jefferson	23,758	0.91	0.83	5.6%	26%	4	$49,616.00
Josephine	86,352	0.66	0.67	5.4%	27%	4.7	$43,492.00
Klamath	66,935	0.87	0.76	5.9%	26%	4.5	$41,875.00
Lake	7,863	0.76	0.68	5.7%	24%	4.5	$43,627.00
Lane	374,748	0.65	0.54	4.5%	18%	4.8	$50,711.00
Lincoln	48,920	0.55	0.49	4.7%	26%	4.3	$45,435.00
Linn	125,047	0.68	0.57	4.8%	18%	4.1	$51,888.00
Malheur	30,480	1.00	0.92	4.7%	30%	4.7	$41,786.00
Marion	341,286	0.85	0.6	4.3%	20%	4.1	$56,148.00
Morrow	11,166	0.76	0.69	4.4%	19%	3.4	$51,673.00
Multnomah	807,555	0.47	0.31	3.6%	17%	5	$63,587.00
Polk	83,696	0.58	0.5	4.3%	16%	4.3	$56,917.00
Sherman	1,758	0.14	0.2	4.8%	17%	4.5	$56,096.00
Tillamook	26,690	0.66	0.4	4.3%	22%	4.2	$48,470.00
Umatilla	76,985	0.97	0.8	4.8%	20%	4.3	$51,586.00
Union	26,222	0.67	0.45	5.3%	18%	4.6	$46,753.00
Wallowa	7,051	0.5	0.29	5.6%	20%	4.7	$47,822.00
Wasco	26,437	0.84	0.46	4.1%	21%	4	$49,735.00
Washington	588,957	0.32	0.16	3.5%	9%	4.2	$80,845.00
Wheeler	1,357	0.39	0.7	3.9%	40%	4.8	$40,047.00
Yamhill	105,722	0.66	0.41	3.8%	13%	4	$62,759.00
Statewide	4,142,776			4.1%	17%	4.6	$60,123.00

Table 15. Social Determinants: Food Insecurity and Housing Problems[75]

County	Population	Food Insecure (%)	Limited Access to Healthy Foods (%)	Severe Housing Problems (%)
Baker	16,054	15%	19%	17%
Benton	90,951	15%	7%	22%
Clackamas	412,672	11%	3%	18%
Clatsop	39,182	13%	6%	19%
Columbia	51,782	13%	4%	14%
Coos	63,888	16%	5%	18%
Crook	23,123	15%	8%	21%
Curry	22,669	15%	5%	17%
Deschutes	186,875	13%	5%	21%
Douglas	109,405	15%	11%	18%
Gilliam	1,855	13%	17%	11%
Grant	7,190	15%	18%	17%
Harney	7,289	15%	15%	13%
Hood River	23,377	9%	2%	17%
Jackson	217,479	14%	7%	23%
Jefferson	23,758	13%	9%	16%
Josephine	86,352	16%	9%	23%
Klamath	66,935	15%	14%	18%
Lake	7,863	15%	23%	19%
Lane	374,748	15%	6%	22%
Lincoln	48,920	15%	6%	19%
Linn	125,047	14%	9%	19%
Malheur	30,480	13%	7%	23%
Marion	341,286	12%	5%	21%
Morrow	11,166	8%	15%	15%
Multnomah	807,555	15%	3%	22%
Polk	83,696	13%	10%	19%
Sherman	1,758	15%	31%	20%
Tillamook	26,690	13%	4%	18%
Umatilla	76,985	12%	12%	16%
Union	26,222	16%	8%	19%
Wallowa	7,051	15%	10%	17%
Wasco	26,437	12%	17%	18%
Washington	588,957	11%	2%	18%
Wheeler	1,357	15%	38%	17%
Yamhill	105,722	12%	6%	19%
Statewide	4,142,776	13%	5%	20%

5. Constraints on and Limitations of the Analysis

Accurate measurement of health care use and potential enrollment size requires historical data from the relevant populations. This study, conducted within a restricted time frame, relies on publicly available state and national data sets, and did not have available person-level data from Oregon-based payers.

In addition, this study relies on county-based data as readily available and most complete for the current purpose. However, county boundaries are political jurisdictions and do not well-represent travel patterns for use of health care services. Sub-county data and health service areas are preferred units of analysis for next stage planning.

The compressed time frame for this study also constrained the range and depth of simulations and robustness checks applied. Future work will require more detailed modeling and actuarial work, described in Section VIII of the report and in further detail in the associated Technical Supplement D.

Given these constraints and limitations, the current analysis is not sufficiently robust to use for firm specification of pilot populations or regions. Rather, this analysis provides a first stage work to inform OHA's policy considerations and discussions with the legislature and constituents and guide its consideration of the path forward toward implementation.

Technical Supplement B. Contracting and Payment Considerations: Purchasers, Payers, and Providers

This supplement focuses on considerations for both payers and providers in the large group commercial sector as the starting point for the A4H initiative – and subsequent considerations for small group, individual market, Medicaid, and Medicare participation.

Commercial Large Group

In the large group commercial market, generally the purchaser (employer or otherwise) defines coverage features, plan benefits, network choice and rules, and employee premium contribution levels. Payers bid on and negotiate per member rates with the purchaser, using an underwriting formula with various rating factors. (For self-insured large groups, the bid would be only on the administrative component, as the employer maintains responsibility for the actual costs of health care service claimed by enrollees). For fully-insured groups, the purchaser's per-member premium is set annually and paid in advance periodically, and the payer assumes risk for the total expenses incurred for that group's members.

After the first contract year, in subsequent years, the payer recalculates the per-member rates based on actual spending in prior experience period(s). This process results in variable increases from year to year. The ongoing increase in underlying health care costs affects the per-member average claims cost experience, such that these annual rate increases may substantially exceed the overall rate of growth in the economy.[76] Smaller group sizes (below 500 employees or approximately 1,000 covered lives with dependents) can experience relatively large increases in premium levels, as these smaller groups are less able to smooth out the impact of high cost cases on their group's per-member average claims cost experience.

Oregon's A4H global budget pilot will shift purchasers' procurement roles to OHA, which will set rates and negotiate contracts with payers on behalf of the participating purchaser(s). The AH4 pilot's payer procurement process will change established business methods for both purchasers and payers. Purchasers will no longer directly choose the payer(s) to manage their benefits and, along with this change, they will no longer face costs and other administrative burdens of selecting payers.

- Participating commercial purchasers will submit benefit plan information, recent historical enrollment and claims data, and other information to OHA.
- OHA will then calculate the overall per-member global budget level for participating enrollees, and subsequent benefit- and risk-adjusted payment rates for each purchaser to contribute. (Self-insured employers will contribute "working rates" that do not have charges for payer risk assumption.)
- These first year PMPM rates to participating payers in the A4H pilot should be actuarially sound.
- OHA will develop a request-for-proposals (RFP) for payer response, with both fully-insured and administrative services only (ASO) components, depending on fully-insured/self-insured status of participants.
- Payers interested in participating in the A4H pilot would submit proposals, which would require acceptance of OHA's risk-adjusted per-member-per-month rate and other specified requirements, including those related to health equity and quality.
- Each participating fully insured purchaser would contribute a benefit and risk-adjusted PMPM to the global budget, based on the overall rate set by OHA.

- Each participating self- insured purchaser would contribute the appropriate ASO fees and be responsible for the health care costs of its members. The self-insured benefit and risk-adjusted global budget PMPMs, based on the overall rate set by OHA, provide the basis for the underlying risk arrangements with participating providers, including the defined annual growth rate.

Under the A4H model, payers will no longer negotiate with purchasers for rates, with opportunity to adjust rates annually tied directly to actual claims experience. Instead, payers will need to operate within OHA's rate-setting process, and within a defined growth rate (after adjustment to reflect changes in mix of benefit and health status of members). Payers' willingness to participate in, and potential success under, this model depend on their ability to control claims risk and exposure. Participation in the A4H pilot will require adjustments to the usual means of doing so.

Payers operating in the large group, commercial sector currently have a number of levers to manage the balance between competitive market premiums and the actual costs of delivering benefits within the fixed per member rate received from their purchaser customers. Table 16 presents current levers, how they would change under the A4H pilot, and recommendations for encouraging payer participation in the model.

Table 16. Levers for Payers to Manage Cost Exposure

Lever	Traditional Insurance	Global Budget Pilot	Recommendation
Premium level	Payers free to set PMPM premiums within regulatory guidelines (large group not regulated, small group and individual rates require review).	No ability to set rates; payers must accept OHA-developed PMPM rates as condition for submitting proposal.	OHA should make historical data for participating purchasers' employees available in summarized form to bidding payers and certify that PMPM rates in A4H pilot during initial year are actuarially sound.
Reset rates in annual cycle	Large group annual rates subject to fluctuations based on year-to-year claim volatility.	No ability to reset rates; risk- and benefit-adjusted rates to payers grow at a fixed annual rate according to cost-growth target.	OHA should put in place special conditions whereby payers can appeal rates; could follow rules and process for cost-growth target guidelines.
Benefit plan	Purchasers and Payers adjust benefits, particularly cost sharing, to control premium levels.	Benefit reductions (e.g., higher member cost sharing) are not a means of controlling cost and should be monitored as part of the Cost Growth Target process.	OHA or regulators will need to ensure that payers do not excessively shift cost burden to covered members, and may rely on the Cost Growth Target monitoring process.[77]
Provider Rates	Private contract negotiation between payer and providers, which are affected by market forces; the cost-growth target and corresponding penalties may influence both parties.	At high provider risk levels, provider FFS rates become less relevant to all parties; at low risk levels, provider rates will remain important to all parties.	Continue emphasis on reaching VBP Compact goals, will lessen the importance of FFS provider rates as providers accept higher risk sharing levels.

Lever	Traditional Insurance	Global Budget Pilot	Recommendation
Network	Payers maintain broad networks to suit consumer preferences, with tiered networks better tolerated by consumers than narrow networks.	Changes to network may result from provider contracting process during initial pilot implementation.	OHA should encourage a broad network for the pilot to encourage access to care, particularly for disadvantaged populations.
Care or Utilization Management	Payers often require prior authorization for procedures, expensive imaging, facility admissions, other services.	Payers will continue utilization prior authorization, though these responsibilities will likely shift to providers as payment reforms shift greater financial risk to them.	OHA should encourage or require participating payers to adopt population or risk-bearing payment arrangements driving transition away from payer management of service decisions.
Provider Payment Methods	Percent of charges or DRG (case-based) are common base payment models; PEBB/OEBB are using reference pricing tied to Medicare for many hospitals.[78] Value-based payment (VBP) as a secondary method is growing, with variable impacts on performance. Payers are frequently skeptical about VBPs' ability to lower costs, as downside risk is typically too low due to provider market share, particularly for large health systems.	Oregon's Cost Growth Target and VBP Compact, which will inform the global budget pilot, specify a transition to 70% VBP under HCP-LAN category 3B or greater for inpatient and primary care services) by 2024.	OHA should encourage or require VBP models that (a) are evidence-based at enhancing quality, equity, outcomes and lower costs, (b) account for a large share of total medical spending, and (c) apply higher upside and downside provider risk sharing, accounting for the need to phase in such approaches for safety-net providers.

Payers will increasingly rely on provider payment methods that replace traditional fee-for-service volume incentives with those focused on value, quality, and equity. The framework and expected timing of this shift in provider payment methods has already been set in motion by several OHA policy initiatives:

- The VBP Roadmap for regional CCOs administering Medicaid benefits[79]
- The Cost Growth Target law (cite section, etc.) and implementation process[80]
- The Value-Based Payment Compact[81]

All three of these initiatives use the Health Care Payment Learning Action Network (HCP-LAN) framework for categorizing VBPs[82], using the phrase "advanced value-based payments" to reference HCP-LAN category 3A and higher. The VBP Compact establishes goals that by 2024, 70% of overall payments will be in advanced value-based payment models (3A and above), and that 70% of hospital and primary care payments will be in level 3B or above.

Category 3B VBPs (upside and downside risk) will likely play a more significant role for payers, for two reasons:

- Hospital and primary care accounts for a sizable portion of total medical spending.[83]
- Procedure bundling is allowable under Category 3A and 3B, but its potential scope represents a small percentage of carrier payments. Bundling initiatives are also administratively and technically complex.[84]

Under Category 3B mechanisms, providers may continue to be paid fee-for-service with upside and downside risk sharing but constrained within a population-focused, total-cost-of-care budget.

Commercial Small Group, Individual Marketplace, Medicare, Medicaid

The inclusion in the A4H pilot of small group commercial, individual Marketplace, Medicaid, and Medicare all involve various regulatory processes including waivers at the federal level and modifications at the state level --steps not anticipated for the initial pilot implementation. While enrolled populations within these purchaser groups would be excluded from the pilot's initial joint procurement and rate setting process, there participating providers in the pilot region may choose to enter parallel advanced VBP arrangements with the payers in those markets. Consistent with VBP Compact Principle 11, providers would thereby operate under similar incentive structures for a much larger portion of their patient base:

> *"The structure of advanced value-based payment models should be aligned across payers to allow providers to have a sufficient volume of similar value-based arrangements to make meaningful change in their clinical practice and reduce administrative burden. Structural alignment should include but not be limited to the use of common performance measures."*

Commercial small group and individual marketplace payers contract with provider organizations to create networks. Contracted payment methods and rates typically apply across multiple lines of commercial business, even where benefit plans differ. It is conceivable that commercial large group payers participating in the model may adopt identical payment methods and/or rates for their commercial small group or marketplace segments within the A4H pilot region(s).

Both the VBP Compact document[85] and OHA's Cost Growth Target Implementation Committee report[86] note: "A CCO who signs the voluntary compact and works to meet the targets outlined in these principles will not be in conflict with their contractual requirements." The OHA report further notes that "these principles are conceptually and directionally aligned with the CCO 2.0 VBP Roadmap and with recommendations from the Primary Care Payment Reform Collaborative." The VBP Compact FAQs[87]: note that the current cost growth target is "more aggressive than under the CCO 2.0 contract" but that the majority of CCOs have signed the VBP Compact.

These observations indicate that CCOs, operating under the current Medicaid waiver, are able to implement HCP-LAN 3B payment mechanisms with their providers. CCOs may choose to re-contract with providers in the pilot region, during the initial pilot, using a model aligned on the risk sharing features. To the extent that payers not participating in the pilot take up comparable provider payment contracts, it may ease the pathway for inclusion of other commercial groups and Medicaid in the A4H pilot.

In addition, pilot region participants may choose (or already participate in) one of the existing Medicare ACO options, which have risk sharing options broadly similar to HCP-LAN levels 3B/4B/4C. In the longer term, Oregon providers may pursue various demonstration models through the CMS's Innovation Center. The agency's suite of payment initiatives include "all-payer" options aimed at alignment among Medicaid, Medicare, and commercial sectors.

Recommendations

- Payers participating in the A4H pilot sign and adhere to objectives in the VBP Compact, indicating capacity to implement HCP-LAN Category 3 or 4 payment models.
- Where feasible, encourage commercial small group and marketplace, CCOs, and Medicare payers to align payment models with those used by large group commercial payers participating in the A4H pilot
- Many of CMS Innovation Center payment models fall under HCP-LAN Category 3 and 4, providing potential templates for participants in the A4H global budget pilot.

Technical Supplement C. Potential Risk-Adjustment Factors, Data Sources, and Relative Impact

Risk adjustment is an analytic process that accounts for a payer or providers' unique member/patient mix when evaluating their performance or setting payments. When either entity manages a population with relatively higher clinical or social risk, poor performance against a benchmark may be due to the presence of resource-intensive individuals who are prone to worse outcomes or higher spending. The opposite is true for payers or providers managing populations with relatively lower risk. A comparison of true performance requires assessment of how risk varies among providers or payers. Risk-adjustment accounts for these differences, so that they are measured on factors specific to their performance.

Table 17 presents potential risk adjustment factors. Per-member-per-month spending (expenditures) represents the outcome measure of interest when developing risk-adjusted capitated rates, Member out-of-pocket costs include premiums and cost-sharing associated with a given plan, payer, and purchaser group. Utilization can be stratified by service area, such as hospital outpatient and inpatient, professional services, and drugs. Demographic fields include age, gender, race, and ethnicity, while clinical characteristics entail diagnostic-related risk scores and proxies such as length of hospital stay.

Several public and private organizations have developed rigorous risk-score methodologies for use among select insured populations (e.g., HCC score for Medicare beneficiaries). These should be used where applicable. Social determinant domains include social and economic conditions, education, and environmental factors. Market-based adjustments address differences across geographic regions, including competition among payers and providers. Finally, risk-adjustment models should include time-related trends in order to address events like COVID-19.

Unlike clinical or demographic characteristics, the application of social risk factors (determinants) to enhance equity is still gaining traction. Social risk adjustment, when appropriate, ensures that providers or payers are not unfairly penalized for managing individuals with high social needs. The counter argument has been that adjusting for social risk factors may mask true variation in care quality, thereby reducing incentives for improvement and resulting in different standards of care across patient groups.

Several resources inform this assessment and process. The U.S. Department of Health and Human Services recently reviewed 10 existing health equity measurement approaches that may be suitable for inclusion in Medicare's VBP programs and quality reporting efforts.[88] As well, the National Quality Forum's (NQF) has also endorsed 17 health care performance measures for social risk factors adjustment.[89] An NQF Technical Guidance document contains steps, good practices, and minimum standards for developing risk adjustment models for quality performance measures that account for social and/or functional risk factors.[90]

The decision to adjust for social risk will depend on the selected A4H region, payer participation, and other factors including policy objectives. Moreover, the following criteria can also be used when determining whether social risk adjustment is appropriate for evaluating performance or setting payment rates:

- The risk-factor is not under the control of the entity being measured
- Necessary data elements are available
- Adjustment meaningfully impacts a payer or provider's performance ranking
- Social risk-adjustment does not mask poor quality of care but reflects differences in care processes

Table 17. Potential Risk-Adjustment Factors and Data Sources

Risk-Adjustment Category	Risk-Adjustment Field	Data Source
Expenditures	PMPM Spending	All Payer All Claims (APAC) database Employer data extracts for self-insured population
Premiums & Cost Sharing	PMPM Out-of-Pocket Spending	APAC Employer data extracts for self-insured population
Utilization	PMPM Utilization, by Service Category	APAC Employer data extracts for self-insured population
Demographics	Age, Gender, Race/Ethnicity	APAC Employer data extracts for self-insured population
Clinical Characteristics	Clinical Risk Scores	APAC[91] Employer data extracts for self-insured population
	Total Inpatient Length of Stay	APAC Employer data extracts for self-insured population
Social Determinants of Health	Quality of Care	Agency for Healthcare Research and Quality American Community Survey Area Deprivation Index County Health Rankings Agency for Toxic Substances and Disease Registry (SVI) Area Health Resource File
	Segregation Index	
	Social Vulnerability	
	Employment, Poverty, and Income	
	Living Conditions, Education, Crime	
	Food, Housing, Transportation	
Market Characteristics	Population	American Community Survey
	Concentration (Insurer and Hospital)	CMS, Medicare Advantage Contract and Enrollment Data PEBB, OEBB, OHA, Health Care Cost Institute Marketplace Index
Health Insurance Coverage	Purchaser Mix	APAC Employer data extracts for self-insured population Centers for Medicare and Medicaid, Medicare Advantage Contract and Enrollment Data Centers for Medicare and Medicaid, Geographic Variation Files Medicaid Eligibility and Enrollment Reports PEBB, OEBB, and OHA Department of Consumer and Business Services
Insurance Benefit Design	Actuarial Value	Carriers, Marketplace
Provider Payment	Price Index, by Service Category	Health Care Cost Institute Kaiser Family Foundation Congressional Budget Office
Trends & Events	Year	Time series variable using existing data sources
	COVID-19	Indicator variable using time series data

Table 18 displays results of bivariate analysis showing the relationship between various risk-adjustment factors and average, capitated spending for all 36 Oregon counties, using a blend of the following purchaser groups:

- PEBB and OEBB
- Medicaid
- Medicare FFS
- Medicare Advantage
- Commercial Large Group, Fully Insured
- Commercial Large Group, Self-Insured
- Commercial Small Group
- Commercial Individual

With the exception of some social and demographic measures, most risk-adjustment factors were significantly correlated with capitated spending at the $p<0.10$ level. Findings may inform the next steps work developing risk-adjustment models for the pilot initiative.

Report Section 3A discusses how risk-adjustment model specifications will ultimately depend on data availability and policy strategies, including whether risk-adjustment modeling should occur separately for each purchaser group or collectively across them. Tradeoffs exist with either approach. Because purchaser groups in the United States have already developed tailored methods for their enrolled populations (for example, HCC scores for Medicare), purchaser-group specific approach would result in a more robust and validated risk-adjustment method.

The need to build separate risk-adjustment models by purchaser group would nonetheless be more time consuming, and failure to align risk-adjustment categories or fields across each purchaser group could result in per-member-per-month spending budgets that were not directly comparable. Finally, it would be impossible to adjust for purchaser-specific factors – like provider prices or covered benefits – during the modeling process, thus requiring post-hoc payment adjustments to address these drivers of capitated spending across purchaser groups.

Risk-adjustment that pooled members across purchaser groups would allow for development of a single model. This modeling Phase would be less fragmented and would not require as many post-hoc payment adjustments. However, risk-adjustment under this approach would be more exploratory given the absence of experience within the United States around pooling and re-distributing funding across public and private purchaser groups on a risk-adjusted basis. While such risk-adjustment methods are used in other countries, such as Netherlands and Germany,[92] these European counties generally have greater alignment in benefit structure and prices across purchaser groups, and may have demographically less diverse populations.

Table 18. Bivariate Analyses Examining Risk-Adjustment Factors and Capitated Spending

Category	Measure	Relationship with All-Payer, Average County Capitated Spending (CY 2019)*
Payer Mix (Membership and Enrollment)	PEBB Enrollment (%)	
	OEBB Enrollment (%)	
	Commercial Large Group Fully Insured Enrollment (%)	
	Commercial Large Group Self-Insured Enrollment (%)	
	Commercial Small Group Enrollment (%)	
	Commercial Individual Enrollment (%)	
	Medicaid Managed Care Enrollment (%)	
	Medicare FFS Enrollment (%)	
	Medicare Advantage Enrollment (%)	
	PEBB and OEBB Enrollment (%)	
	All Commercial Enrollment (%)	
	All Medicare Enrollment (%)	
Clinical Characteristics	Medicare Dual Enrollees (%)	
	Medicare HCC Score	
Social and Demographics	Female (%)	
	Under 18 (%)	
	65 and Older (%)	
	African American (%)	
	American Indian/Alaskan Native (%)	
	Asian (%)	
	Native Hawaiian or Pacific Islander (%)	
	Hispanic (%)	
	Non-Hispanic White (%)	
	Rural (%)	
	Not Proficient in English (%)	
	Social Vulnerability Index (All)	
	Residential Segregation Index (Black/White)	
	Residential Segregation Index (Non-White/White)	

Category	Measure	Relationship with All-Payer, Average County Capitated Spending (CY 2019)*
SDOH Health Care Context	Health Outcomes (z-score)	
	Length of Life (z-score)	
	Quality of Life (z-score)	
	Health Behaviors (z-score)	
	Clinical Care (z-score)	
	Uninsured (%)	
SDOH Economic Context	Social & Economic Factors (z-score)	
	Social Vulnerability Index (Economic)	
	Unemployed (%)	
	Children in Poverty (%)	
	Income Inequality Ratio	
	Median Household Income	
SDOH Physical Infrastructure	Average Daily PM2.5 (Air Pollution)	
	Drinking Water Violations	
	Physical Environment (z-score)	
	Food Insecure (%)	
	Limited Access to Healthy Foods (%)	
	Severe Housing Problems (%)	
Provider Supply and Competition	Number of Primary Service Areas per County	
	Number of HSAs per County	
	Number of PEBB Carriers per County	
	Number of OEBB Carriers per County	
	Number of MA Carriers per County	

* Light blue shading = $p<0.10$; Moderate blue shading = $p<0.05$; Dark blue shading = $p<0.01$

Technical Supplement D. Future Analytic and Actuarial Work

The next steps for quantitative analyses will require the following elements:

1. Data collection and analysis
2. Region definition and selection factors
3. Risk adjustment considerations
4. Develop PMPM and global budget
5. Estimate of savings

1. Data Collection and Analysis

Construction of an A4H pilot budget requires measuring actual historical medical spending PMPM by purchaser sector (e.g., Commercial, Medicaid, Medicare), market segment (e.g., Commercial large group fully insured, large group self-insured), and payer. The Oregon All Payer All Claims (APAC) database can serve well as a primary data source for next-step analyses. APAC data includes member ZIP code of residence data and associates it with member demographics, claim activity, and diagnostic information.

Risk adjustment and equity measurement will require diagnostic information at the individual member level. Member-level data is essential for estimating a global budget and determining risk-adjusted average per-person funding for each payer, which requires risk scores for each enrolled individual. Exact model specifications will depend on available data sources, fields, and years. Subsequent work to develop the actual global budget for the pilot will require payer claims and eligibility extracts. These are similar to the APAC, but more recent time periods are required for the rate development.

BerryDunn has collected data on social determinants and market characteristics at a ZIP code level and county level, which can be tied to unique members' residential area. The use of claims and enrollment data stores, such as APAC and employer extracts, requires several data preparation and validation steps. These include the following:

- Check for and remove any data duplication across extracts.
- Validate calculated aggregate PMPM costs, service utilization per 1,000 members, and member month results against public sources (such as rate filings for commercial insurance, OHA and CMS reporting for public-sector programs, and APAC documentation).
- Specify definitions for various sub-populations of interest (e.g., identifying the correct data fields and values to identify different payer groups, insurance payers, age groups, geographies), with careful attention to building consistent definitions across data sources.
- Compare member counts and demographics by geographic subdivisions to population data and publicly available reporting to confirm reasonableness.

Once validated, APAC and payer extract data can be used to develop PMPM cost and utilization measures and health insurance market profiles to support region selection and later regional global budget estimates.

Further data work is also needed in order to assess and monitor disparities and equity. Enrollment and claims data on race, ethnicity, language may be available, but often incomplete and of poor quality, from both Medicaid[93] and commercial payers.[94] Indeed, CMS designated Oregon as a state of "high concern" in assessing the quality of the Medicaid race and ethnicity data.[95] Nonetheless, it is worthwhile to assess and apply the available data, setting a baseline for improvement.

2. Region Definition and Selection Factors

Sub-county geographic areas (ZIP codes, for example) may be used to construct the pilot service areas. APAC data, which includes member ZIP code of residence data and associates it with member demographics, claim activity, and diagnostic information, is a rich source of the needed information, in contrast to publicly available de-identified data. Measuring equity-related factors requires geographic analysis at the ZIP code level (through use of the Area Deprivation Index) or at an even more granular level, such as census block, if feasible. Again, the necessary data elements are available from the APAC, but not publicly available data. It may also be worthwhile to include a provider competition factor in the selection of regions, with use of the data and ratings from the Health Care Cost Institute.[96]

This report presents several criteria and parameters for selecting potential regions. Next steps require refining and weighing those factors to specify these elements for inclusion in the RFP.

3. Risk Adjustment Considerations

The next phase of the analysis will need to focus on the potential payer groups and populations participating in the pilot, in order to recommend specific levels of confidence and risk for these participants. This will also inform the approach to reinsurance, and which other risk mitigation strategies to add to the program.

Table 15 in Technical Supplement C presents risk-adjustment categories, fields, and data sources for consideration in Oregon's global budget risk-adjustment model. To estimate risk-adjusted, per-member-per-month payments to participating payers, models should include factors that impact capitated spending or need. These broadly consist of member out-of-pocket costs, utilization, demographics, clinical composition, social determinants, market characteristics, health insurance coverage (payer mix), benefit design, and provider payment rates. Table 16 in Technical Supplement C presents statistical relationships between many of these factors and capitated spending in Oregon, using public data by county in 2019, as proof of concept for their inclusion in future risk-adjustment models.

The exact specifications for Oregon's global budget risk-adjustment model, such as which categories or fields would be included and how they would be operationalized, will ultimately depend on data availability and policy strategy. Insofar as the latter, OHA will need to decide whether risk-adjustment should incorporate social determinants and, if so, which domains are particularly important for enhancing equity. The agency will also need to decide whether risk-adjustment modeling should occur separately for each purchaser group or collectively across them. These considerations are described in detail in Technical Supplement C.

4. Model Parameter Considerations

Conduct a simulation exercise, prior to the RFP, testing the model under a few different pricing and environmental conditions to further refine the prototype mechanisms. Table 19 outlines steps to simulate the global budget model and its effects under a range of scenarios. Simulations should focus, first, on the large group commercial market (and, later, other payer types) using actual region-specific data. This will refine specifics of the risk model prior to the RFP release. This modeling activity can also support provider VBP readiness (see report Section IV).

Table 19. Phase 1 Modeling Support Elements

	PEBB/OEBB	Commercial Large Group	Medicaid/ CCOs	Medicare
Provider Payment Simulation Modeling	• Standard provider payment model structures tested with significant upside/downside for provider organization (at or above Medicare savings sharing %, applied upside and downside). • Symmetrical risk corridors applied to each contract tested. • Risk-sharing and risk-corridor parameters may be standard or negotiated within standard OHA-specified ranges. • Simulated population-based spending targets based on an overall GB per-enrollee spending level, with adjustments for plan-specific average health status and plan benefit structures. • Technical support provided for simulations and development of infrastructure. • An opportunity exists to readily leverage PEBB/OEBB involvement to other Large Group employers for the successful RFP bidder; this possibility can be included in the payer discussions and simulation modeling.	• Medicare Shared Savings Program features minimum 40% upside savings. • No downside risk in Tracks A and B of the Medicare Shared Savings Program. • Medicare patient volume dramatically increases breadth of population financial incentive for savings without adding to downside risk. • Medicaid provider contracts subject to federal requirements for Medicaid managed care contracting.		
Global Budget Determination	Global budget calculated by aggregating per-person spending targets across the participating payers, where the PMPM spending targets are actuarially standardized for each of the pilot region's participating payers. • Individual spending targets may not exceed 3.4% growth over the prior year. Payer-provider negotiations will include joint identification of savings opportunities as necessary. • All risk absorbed by the payers, provider(s), and possibly external sources such as stop-loss insurance, so the budget is binding from the sponsors' perspective. • Standardization based on adjustment for risk status and benefit structure. • Standardized values and enrollment counts (member months) used to compute a weighted average PMPM global budget.			
Provider Risk Management/ Mitigation	• Any contract realizing gains above the level indicated by risk corridor will have margin above the risk-corridor cutoff distributed to the provider risk pool. • Provider risk mitigated by offsetting any net losses with collective balance in provider risk pool. • Provider gains above threshold percentage are directed to provider risk pool. • Any remaining balance in PRP after transfers to/from provider would carry over into subsequent year(s). • Individual stop-loss reinsurance, as well as limited service/sub-population exclusions from the spending target (e.g., highly vulnerable populations) may also be considered to stabilize the spending targets.			

5. PMPM and Global Budget Development

The global budget for the regional pilot requires an actuarial pricing projection. Once the pilot region, participating payers, and covered population are selected, the development of the global budget can begin. The goal of the global budget PMPM calculation for the initial pilot year is to develop an actuarially sound PMPM amount that is adequate to cover the projected claims expense and provider administrative expense for the population included in the pilot. Historical claims data for the population, and standard actuarial methods, support calculation of the global budget. This includes the following components:

a. Base period data collection and preparation
b. Base period adjustments
c. Base period projection
d. Global budget retention
e. Global budget carrier payment adjustments

5a. Base period data collection and preparation

The most recent 12 months of historical claims (with a minimum of two months runout) are used to develop a per-member-per-month (PMPM) base period claims estimate. A four-year period of historical claims PMPMs is typically used in trend development. In order to use the most recent data possible, a data call should be made requesting information from payers, including billed charges, allowed claims (plan paid and member cost share amounts), member cost-share amounts, plan paid claims, utilization statistics (e.g., number of allowed units/services), risk scores, and the corresponding covered membership, in addition to site of service and member benefit plan and demographic information. Claims data should be summarized and validated against external sources of information for reasonability (such as rate filings and/or APAC). Claims should be adjusted to a fully incurred level using historic claim completion patterns.

5b. Base period adjustments/considerations

- Benefit plan differences (in member cost share and utilization) should be quantified using an actuarial benefit pricing model to calculate plan factors needed to normalize for plan differences.
- Risk scores should be used to normalize for differences in morbidity between subsets of the population. Consideration should be given to use of a single risk model across market segments, to degree feasible.
- COVID-19 adjustments should be considered (through the use of an established model such as the Society of Actuaries Health Care Cost Model[97]), including the cost of testing and treatment, and for the impact of deferred and eliminated care related to the pandemic.
- Large claim impacts should be adjusted through the use large claim pooling. Large claim pooling smooths out the adverse impact of large claims on individual members. When the total claims on a member in the base period exceed a set threshold, claim amounts above the threshold are removed from the allowed claims and replaced with a pooling charge that smooths the value of the excess claims across years. The amount of the threshold (and resulting pooling charge) is dependent on the size of the population.

5c. Trend to global budget period

The application of an actuarially sound trend is essential to setting the global budget in the initial year. This allows the payers, providers, and employers to have an achievable target in the initial pilot year. The constituents then need to work together to achieve the 3.4% growth target in future years. Considerations in developing the trend to adjust the base period to the budget period are outlined below.

- Analyze historical medical trends at a detailed service category level, including at a minimum hospital inpatient, hospital outpatient, professional services, ancillary services, and pharmacy.
- Normalize for population changes and other significant trend drivers.
- Consider impact of COVID-19 on historical trend.
- Consider future trend drivers during period between base period and budget period (such as network reimbursement changes, cost of care initiatives, average wholesale price for pharmacy claims, and any introduction of new specialty or generic drugs).

5d. Global budget retention

Consider adding a factor to the global budget claims to address the shift in care management costs from the payers to the providers as well as the additional risk assumed by the providers under the global budget model.

5e. Global budget payment adjustments

Global budget payments to each of the participating payers include adjustments for benefit factors, risk factors, and enrollment levels. Apply the benefit adjustment, risk adjustment, and network adjustment to the overall global budget to calculate the unique global budget payments for each participating payer.

5f. Global budget development in future periods

The global budget for future periods should be trended forward at the annual cost-growth target, adjusted for any changes in benefits and the risk profile of the participating payers (given that the initial global budget is not representative of the overall statewide population), and then allocated to the payers. Allowance for special circumstances should be considered (such as the declaration of a public health care emergency or significant new medical technology). In addition, there should be a provision to monitor future benefit changes during the years of the pilot to protect against cost-shifting to members.

6. Estimate of Potential Savings

The potential savings available from the global budget model will depend on the populations, payers, purchasers, and regions participating. It may be possible to prepare preliminary estimates of potential savings, based on modeling and use of proxy (publicly available) data in lieu of member- and payer-specific information. This would provide policy insight for the potential costs and benefits of pursuing the model. Such modeling and evaluations have occurred elsewhere, reported in the peer-reviewed and grey literature; an Oregon-specific exercise at this level may not yield more insight.

A specific estimate of potential savings may occur once the region and likely participants are identified, and the modeling and actuarial work conducted. A comparison may then occur between the global budget and the current and expected expenditures for the population under the current health care delivery and payment model.

Technical Supplement E. Review of Other State Governance Models

Oregon, in its contemplated all-payer global budget not restricted to hospital services, would go beyond any existing state reform experiments. Table 20 summarizes the existing more-advanced state models operating as demonstrations with support from the Centers for Medicare and Medicaid Innovation Center (CMMI).[98] The discussion that follows reviews the governance and engagement structures of selected state payment reform initiatives, including ACO models, with features similar to Oregon's.

A. Global Budget Models[99]

Table 20. CMMI State Advanced Payment Model Reforms

State	Description	Participating Payers	Global Budget
Massachusetts	Blue Cross Blue Shield Alternative Quality Contract. Total cost of care for a patient population with a set payment to a provider responsible for care of that patient. This model is operate by a single large commercial insurer.	Single commercial insurer	Yes One Payer only
Maryland	The Maryland Total Cost of Care Model holds the state fully at risk for the total cost of care for Medicare Beneficiaries. The Maryland All-Payer Model established global budgets for Maryland hospitals.	Total cost of care – Medicare only All payer for hospital program	Yes Hospitals only
Pennsylvania	CMS and other participating payers pay rural hospitals a global budget to cover all inpatient and hospital-based outpatient services.	All payer model	Yes Hospitals only
Vermont	OneCare Vermont operates the only multi-payer ACO in Vermont. It includes Medicare, Medicaid, and commercial insurers. This ACO multi-payer model seeks to include the majority of insurers and providers in order to achieve its desired outcomes and has yet to reach that scale. It allows for innovation in payment across payers and establishes total cost of care targets. It does not establish a global budget that the ACO is held to.	Medicaid, Medicare, some commercial insurers	No ACO model

B. Governance Structures: Selected State Reform Initiatives

Colorado

State-Level Engagement

Colorado's Accountable Care Collaborative is the primary payment reform vehicle.[100] The program began with Regional Care Collaborative Organizations (RCCOs) administering the program by connecting members to a medical home.[101] Regional Accountable Entities (RAEs) later replaced RCCOs and Behavioral Health Organizations, acting as a single administrative organization for behavioral and physical health in each of Colorado's seven regions.[102] The ACC Program Improvement Advisory Committee (PIAC) provides guidance and recommendations to help improve health, access, cost, and satisfaction of members and providers in the Accountable Care Collaboratives.[103] PIAC bylaws require diverse membership; each of the seven RCCOs has two representatives on the PIAC, with one of the

two positions reserved for a client or client advocate. Public meetings must be held at least quarterly with meeting materials posted to the state agency website.

ACO-Level Engagement

Each RAE is required to have a local advisory committee to ensure the provider and member voice is part of the program. The advisory committees provide input into the performance and administration. The committees are required to have representation from members, families, advocates, providers, the behavioral health community and community organizations. Public meetings must be held at least quarterly with minutes posted on the RAE website.

New York

State-Level Engagement

The New York State Department of Health (Department) governs the approval of Accountable Care Organizations, issuing certificates of authority.[104] State statute define criteria for such designation. State certification requires that the ACO governing body meet the following requirements:[105]

1. Include at least one representative or designee from each of the following groups:
    - Recipients of Medicaid or child health plus
    - Persons with other health coverage
    - Persons who do not have health coverage.
2. Such persons shall have no conflict of interest with the ACO, and no immediate family member shall have a conflict of interest with the ACO.
3. At least 75% control of the ACO's governing body shall be held by ACO participants, and in addition to otherwise required representatives set forth above, an ACO shall use its best efforts to include a representative from each Federally Qualified Health Center (FQHC) that serves the population to be served by the ACO.

ACO-Level Engagement

The Adirondacks ACO offers a particular example of interesting, operating in a highly rural area. The ACO originally formed to carry on the work of its predecessor effort, the Adirondack Region multi-payer Medical Home Pilot, known as the "ADK demonstration." ADK's ACO has since then expanded its contracts with Medicaid and Medicare and developed similar value-based-payment contracts with commercial payers.[106] Funding and measurement initially occurred within three non-competitive sub-regional groups, following the region's natural geographic alignments, and are known as "pods." [107] These governance pods provided local, physician-directed governance, involving disparate and unaffiliated practices. Currently, the Adirondack Health Institute (AHI) works with local providers and organizations through the coordination of planning, recruiting, clinical activities, outreach, and managing of grant-supported programs.[108] AHI is a joint venture of health provider entities, covering the same service area as the ADK demonstration. AHI oversees the demonstration's pay-for-performance (P4P) program and provides a variety of central services to support the ADK demonstration, including governance and oversight of the pods in the project.

New Jersey

State-Level Engagement

New Jersey currently certifies three ACOs as an alternative to managed care, testing various payment reform models that include pay-for-performance metrics and incentives.[109] The certified ACOs qualify as nonprofit organization serving a minimum of 5,000 Medicaid beneficiaries within a designated region. The certified ACO is required to contract with 100% of the hospitals, 75% of the primary care providers, and at least four mental health providers within the intended service region.

New Jersey uses its Medical Assistance Advisory Council (MAAC) for input and oversight of this program.[110] The MAAC holds a quarterly public meeting about Medicaid-related issues, to discuss implementation and oversight of its ACOs. The Council includes consumers and consumer advocates appointed by the state, along with other constituents and Medicaid agency staff.

ACO-Level Engagement

The authorizing legislation[111] for ACOs requires very specific representation for certified governing boards:

1. Individuals representing the interests of health care providers, such as: general hospitals, clinics, private practice offices, physicians, behavioral health care providers, and dentists; specifically, the governing board must include at least one primary care physician and also include representation from other physician specialties.
2. Individuals representing the interests of social service agencies or organizations, such as legal aid organizations, charitable and religious groups, and groups providing support for the needy and elderly.
3. Voting representation from two or more consumer organizations capable of advocating on behalf of patients residing in the designated area.
    A. At least one of the organizations must have extensive leadership involvement by individuals residing within the designated area, such as: community organizing entities, faith-based organizations, and grassroots leadership development entities.
    B. At least one of the organizations must have an office or other physical presence in the designated area.
    C. At least one of the voting representatives must reside within the designated area.
4. Organizations may fit the description of more than one of the categories above. To ensure a balanced governing board, an organization can qualify in only one category for purposes of this requirement.

The legislation also designates that each ACO have a process for engaging members of the community to develop health care goals and for receiving comments with respect to its gainsharing plan.

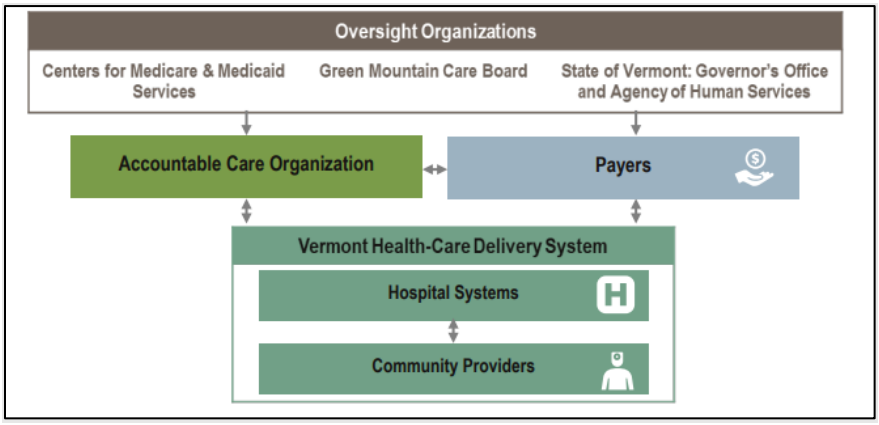
Vermont

State-Level Engagement

The State of Vermont set up the Vermont Health Care Innovation Project (VHCIP), which fosters collaboration among the Green Mountain Care Board, the Vermont Agency of Human Services, Medicaid, private health insurers, and health care providers in the state.[112] Constituent engagement includes a Steering Committee, a Core Team, and workgroups.[113] The Core Team meets monthly to provide overall direction, synthesizes and acts on guidance from the Steering Committee, makes funding decisions, sets project priorities, and helps resolve conflicts within the project initiatives.

Currently, Vermont operates a multi-payer ACO model that includes Medicare, Medicaid, and commercial insurers, but without a global budget.[114] OneCare Vermont operates an ACO that seeks to include the majority of insurers and providers and establishes total cost of care targets.[115] This model operates with a multi-layered accountability structure among CMS, state agencies, payers, and the health care delivery system. The Green Mountain Care Board (GMCB), an independent, nonpartisan, regulatory body, oversees health reforms, innovation, and evaluation, and is charged generally with moderating health care spending growth and improving population health. GMCB regulates health insurance rates, individual hospital budgets, insurance rates, and major health care capital spending.

Figure 12. Accountability Structure of Vermont APM



Source: NORC, 2021.

GMCB is an All-Payer Model signatory, in partnership with the governor and Agency of Human Services. Under the All-Payer ACO Model Agreement, the GMCB regulates and certifies ACOs, develops benchmarks for Vermont's Medicare's ACO initiatives, and produces data and reporting for CMS on progress toward targets. OneCare is currently Vermont's singular private sector statewide ACO that operates Vermont's all-payer model. The GMCB is required to coordinate with OneCare to achieve the Model's ACO scale beneficiary attribution targets, statewide financial targets, and statewide health outcomes and quality-of-care targets.

ACO-Level Engagement

OneCare was founded by and is co-owned by the University of Vermont Medical Center and Dartmouth Hitchcock Health. A Board of Managers leads OneCare. The Board is comprised of representatives from independent primary care, hospitals, federally qualified health centers, home health, skilled nursing facilities, designated agencies, and consumer representatives.[116] Vermont's OneCare Strategic Planning process included a broad range of industry and government constituent participants. Along with the OneCare Patient and Family Advisory Committee.[117]

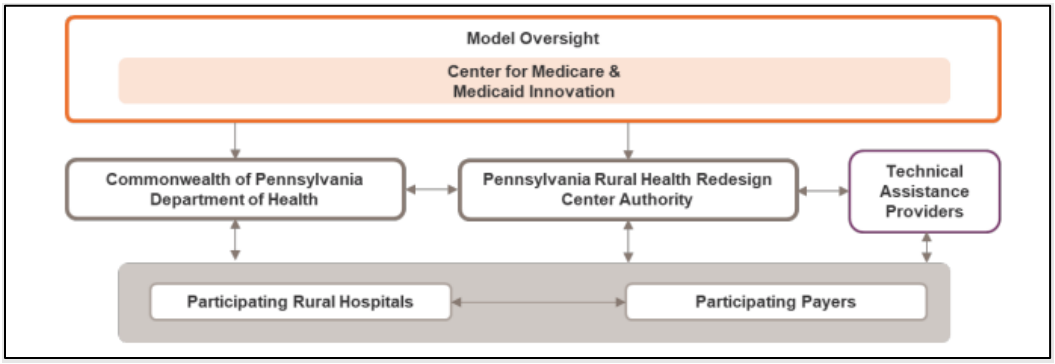
Other Non-ACO Global Payment Models

Other global payment models, in Maryland, Massachusetts, and Pennsylvania, focus on hospital services. Maryland and Massachusetts rely on existing hospital governance and community engagement processes, while Pennsylvania operates its model through a separate authority structure.

The Maryland Total Cost of Care Model holds the state fully at risk for the total cost of care for Medicare Beneficiaries. The Maryland All-Payer Model for hospital services stands as an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis – a hospital global budget model.[118] The Massachusetts global budget model involves a single large commercial insurer, Blue Cross Blue Shield.[119] The payer manages the total cost of care for a patient population, under the Alternative Quality Contract, using both a global budget and performance incentives. The global budget is based on historical levels of health care expenditures and covers all inpatient, outpatient, pharmacy, behavioral health, and other health services. Providers face both upside and downside risk with this budget. Bonus payments are linked to clinical performance measures related to process, outcomes, and patient care experience in both the inpatient and ambulatory care settings.

Pennsylvania's rural hospitals receive a global budget, paid by CMS and other participating payers, to cover all inpatient and hospital-based outpatient services.[120] Pennsylvania's Department of Health jointly administers this model with CMS. Participating rural hospitals sign agreements with both CMS and the Commonwealth and submit a hospital transformation plan for approval. The Commonwealth set up the independent Rural Health Redesign Center Authority (RHRCA), which is responsible for model implementation and monitoring, quality assurance, and technical assistance to participating rural hospitals.[121]

Figure 13. Accountability structure of Pennsylvania hospital global budget model



Source: NORC, 2021.

The RHRCA is governed by a board comprised of model constituents: leaders of Commonwealth agencies or designees along with equal representation from payers and hospitals participating in the Model. The Rural Health Redesign Center governance model identifies a five-person Board of Directors, and a list of partners and collaborators.[122] RHRCA authorizing legislation[123] defines the composition of the board.

Technical Supplement F: Funding to Implement the Regional Global Budget Pilot

In Brief

- Oregon might require an initial investment of $20 million for project initiation.
- Ongoing state-level operational expenses are estimated to require $5 million for project staffing, actuarial services and accounting services, and independent evaluation.
- The state may consider funding risk-mitigation features, such as reinsurance, to promote participation in the pilot. This would require substantial additional funding, which could be garnered in manner similar to the funding for the existing Marketplace reinsurance pool or other approaches.

The launch of the global budget pilot program stands as an ambitious effort, requiring up-front funds to support preparation, infrastructure, and implementation. CMS has outlined the phases and investments needed to stand up similar model tests, beyond ideas and concept, planning, and design.[124] Two major phases, each of which require time and resources, include the following:

1. Solicit and build
    - Solicit and select contractors for implementing and evaluating model
    - Solicit, select, and establish agreements with participants
    - Build operational and participant support
        - Information technology systems that collect, maintain, and provide access to data
        - A learning system that promotes known improvement strategies that support participants in achieving the goals of the model's learning activities
        - A communication plan that establishes communication channels among participants and for information released to the general public
        - A monitoring system that establishes requirements for participant reporting and, if applicable, corrective action plans
        - An operational plan that establishes steps—including training—to help ensure the Innovation Center and participants understand how the model will operate once it is implemented
2. Run and evaluate
    - Testing period is typically set for three to five years. Monitoring may indicate that the model should be modified, terminated, or expanded before this period ends.

- Collect data for cost and quality measures. Identify and construct a comparison group representing patients or providers that are not participating in the model to determine the model's impact. When comparison groups are not possible, data for model participants are compared to "baseline" data that represent a period prior to the test period.
- During the testing period, collect and share information on a regular basis with participants. "Rapid cycle" feedback provides timely information so that participants can make improvements during the testing period.

The amount of funds allocated toward specific project infrastructure and operations will depend on pilot program design, and specific policy decisions about participating entities, risk arrangements, and equity set-asides. Experience from other state initiatives inform estimates for likely costs in Oregon.

Vermont is currently testing an alternative payment model in which Medicare, Medicaid, and commercial health care payers align their payment structure for the majority of health care providers. [125] The initiative includes providers in two-sided risk Medicare ACOs. The overall initiatives operate under the authority of a federal 1115A waiver, supported by the CMS Innovation Center, under a six-year performance period from calendar years 2017 through 2022.

CMS made $9.5 million available to Vermont in 2017 in start-up funding to support care coordination and to bolster collaboration between practices and community-based providers. At the outset, CMS also provided $7.5 million in other Innovation Center funds to support design, implementation, and evaluation of the model.[126]

Pennsylvania Rural Health Model provides a more circumscribed example, designed to test a global budget for participating rural hospitals.[127] This initiative, in an eight-year performance period in calendar years 2017 – 2024, focuses on whether the predictable nature of a global budget would promote investments that strengthen delivery of care by these hospitals. CMS made available to Pennsylvania start-up funding of $10 million. CMS also provided $2 million in other Innovation Center funds to support design, implementation, and evaluation of the model.

The Maryland All-Payer Model tests a mandatory all-payer system for hospital payment, accountable for the total hospital cost of care on a per capita basis.[128] During the CMS Innovation performance period, from 2014 – 2018, CMS made available to Maryland $21.2 million to support design, implementation, and evaluation of the model. Similarly, CMS provided nearly $3 million for Maryland's next stage Total Cost of Care Model,[129] for a performance period of 2019 – 2026. This all-payer model holds the state fully at risk for the Medicare total cost of care.

These experiences suggest that Oregon might require an initial investment of an estimated $20 million project initiation. ongoing actuarial and related technical support services may require an estimated $2 – 3 million annually. A contract for independent evaluation can be expected to range from $500,000 – $1 million per year, depending on the scope of the project and the goals for monitoring and evaluation. OHA will need to analyze costs required for staffing and administering the A4H program overall.

Risk Mitigation for Participating Providers and Payers

Alongside model operations itself, Oregon may consider adding and funding risk mitigation features for participants. The modeling and simulation section (Section VII) above, discusses the relevance of stop-loss reinsurance coverage and its effect at various enrollment levels. State support for this type of risk-mitigation mechanism may attract commercial payers and providers to participate, where they might otherwise hesitate to take on the full financial risk themselves. The project will require a substantial increase in risk assumption by providers, and reduce the levers of control that payers have traditionally used by payers to manage medical spending.

Reinsurance is an insurance policy or program that protects insurers (and providers sharing in insurer risk) against the large swings in total medical expenditures that can result from individuals with very high claims for costly medical needs. It usually involves a third party acting as an insurer for the insurance company by paying for medical expenses above a specific level for any one member, or by covering part or all of the claims for individuals with predetermined, high-cost conditions.

Risk mitigation features can be tailored to the pilot model, to the particular region chosen for the pilot, and to the risk tolerances of the participants. The specific implementation design and associated costs will not be known until implementation planning is well underway. The pilot preparation will benefit from the State designating, in advance, a fixed funding level to support risk mitigation features for the pilot.

Technical Supplement C discusses methods of risk mitigation, including reinsurance, and considerations in cost of coverage. The estimated level needed will depend on the size of the pilot population (coverage is priced on a per-member basis), on the degree of risk protection (premiums may vary by a factor of 10X or more depending on the degree of cost covered), and on specific area of a state (within-state variation of 4X or more is common).

While the state will require a Federal waiver to include the individual market in the global budget pilot, Oregon's individual market already has a reinsurance mechanism in place. Oregon is among 15 states that, through a federal Section 1332 waiver,[130] gain federal approval and pass-through funding for state-based reinsurance programs.[131] The details of this program are illustrative.

Such reinsurance programs are funded by a mix of state and federal dollars. Through a Section 1332 waiver, states receive federal pass-through funding—or the amount the federal government saves in premium subsidies resulting from the reinsurance program.[132] States then provide additional funding for the reinsurance programs from several sources, including assessment fees on insurers and providers or state general funds.

Oregon operates a claims cost-based reinsurance model, reimbursing issuers for a portion of the costs of enrollees whose claims exceed an attachment point. The program is funded at about $100 million annually, supporting the state-based Marketplace that had about 130,000 average monthly members in 2021, and enrolled about 145,000 members for 2022.[133] The features of, and amount of funding that supports, this program provides some guidance for what might be required for a reinsurance under Oregon's multi-payer global budget model.

Technical Supplement G: County Data File

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Recommendations and considerations for Aligning for Health (A4H): Appendix 2

Health Equity Impact Assessment Summary & Engagement Recommendations

Health Equity Impact Assessment Summary & Engagement Recommendations

In the development and planning of Aligning for Health: Oregon's Regional Multi-Payer Global Budget Model (A4H) established under House Bill 2010, the Oregon Health Authority (OHA) prospectively applied a health equity impact analysis (HEIA) tool. When applied prospectively, the tool is designed to be used for planning purposes by OHA in partnership with impacted communities to develop policies, programs, or other types of concepts to advance health equity[1] in alignment with OHA's strategic goal of eliminating health inequities in Oregon by 2030.

The HEIA tool is designed to apply to and inform three stages of concept, policy, and/or program development: planning, decision-making, and accountability.

OHA's recommendations for community and partner engagement related to A4H focus on opportunities for future engagement in preparation for an RFP or other interim

[1] OHA has adopted the following definition of health equity: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
• The equitable distribution or redistributing of resources and power; and
• Recognizing, reconciling and rectifying historical and contemporary injustices

advancement of the A4H model. Engagement will need to refine the perceived problems related to the health system as well as the values, priorities and solutions to solve them that are identified by community members, local businesses, community-based organizations, and health system partners in a given region and whether the A4H model effectively addresses those issues. As such, additional analysis and planning using the prospective portion of the HEIA tool should occur to ensure that health equity is centered from the beginning as community and other partners are engaged to refine the model and ot prepare for implementation of the A4H pilot. As the A4H concept develops for a specific region, and before implementation of an RFP, the retrospective form of the tool should be applied to inform decision-making by assessing all proposed policy concepts and/or program design features.

Below is a summary of findings from the prospective analysis OHA conducted on the A4H model and recommended next steps for an engagement plan.

Summary of Prospective Health Equity Impact Analysis Findings

What is the problem that is being addressed and who is impacted by the problem? Three primary issues were identified: People receive different quality of care, sometimes in the same clinic. The current health system lacks common goals and payment structures for health insurance plans ("payers") and providers. This means that patients who receive care from the same provider but are covered by different payers may receive different care. Also, health care workers have to spend too much time managing different contract requirements and have less time for patient care. People often don't have easy access through the health system to everything they need to stay healthy. Social needs (like housing and transportation) have a greater impact on overall health than medical care. In the current system, payers and providers typically do not have financial incentives to invest in prevention, nor do they have the flexibility to get paid for providing "health-related services." Meanwhile, health care costs continue to rise for everyone. The inefficiencies in the health care system mean that providers have to spend time on administrative work rather than patient care. Further, the inflexible payment models encourage simply providing more services, rather than improving health. The resulting high, and rising, cost of health care is unaffordable for Oregon families and businesses. Most importantly, a fragmented and unaligned health system means that health inequities persist. A lack of access to health-related services and high medical costs disproportionately harm communities of color and Tribal communities who, because of historical and contemporary injustices, face the greatest barriers to receiving quality care.
Recommended Next Steps: Key messaging in the early stages of A4H engagement should verify that the above problems are top priorities for community, local businesses and health system partners, and that the A4H model will be effective in addressing these issues. The needs of different partners should be balanced as much as possible but ultimately solutions need to be responsive to community needs and promote health equity. Messaging should also convey that the A4H model be aligned with the State Health Improvement Plan (SHIP)—which was informed by community—as well as the local/regional community health needs assessments and community health improvement plans in the regions that are being considered for a pilot.

Ask community what it looks like to be accountable to this problem and what level of community ownership and governance should be considered? Messaging for community and local business should be clear, concise and in plain language.
How does OHA know this is a problem and who informed the problem? OHA drew from prior community engagement, reports, and Community Input for OHA's Strategic Plan[2] (in particular, learnings and experience from the Medicaid 1115 Waiver process[3],[4],[5]) that spoke to the lack of access to social needs is a problem and is impacted by payer and funding structure. Feedback on challenges to accessing care for both Medicaid and commercially insured members in Oregon were pulled from OHA Ombuds reports[6] and a 2019 OHSU Issue Brief.[7] A journal article reviews how access to care for Medicaid members is also challenged by the lower payments rates to Medicaid providers relative to those of other payers[8] and this also results in different provider networks across payers and health insurance markets. The impacts of rising health care costs of people and business in Oregon was informed by findings from Oregon's Health Care Cost Growth Target Program and their recently published report on the Impact of Health Care Costs on People in Oregon, 2019. A recent national blog post highlights that people of color and Tribal Nations are disproportionally impacted by poverty, have higher social needs, and are more impacted by high health care costs and other social inequities resulting from the current health system[9] and other social systems. Directive from Oregon's Legislature via HB 2010 (2021) was informed by a steering group of health system partners and convened by Representative Dexter.
Recommended Next Steps: As part of the next level of quantitative and qualitative analysis in determining potential pilot regions, additional analysis should be done to identify geographic areas with high social needs and disparities, as well as populations and communities that are disproportionally experiencing inequities--specifically people who are receiving poor quality care or experiencing challenges of rising health care costs. Consider partnering with community or populations harmed by health inequities and most affected by social inequities to prioritize findings from additional data and other analysis as well as get to the root of the drivers of those problems in order to target investments and other interventions. This should also be reflected in proposals and work should take place prior to and after the selection of a pilot region.

Continuum of Community/Public/Partner Engagement

Community and public engagement of state-level initiatives exist on a continuum, ranging from processes that inform the community/public about the issue, to processes that place the final decision in the community/public's hands. Developing more participatory and collaborative engagement processes is recommended when:
a decision will have a significant impact on communities
the impacted communities have faced historic or ongoing marginalization, discrimination

[2] https://www.oregon.gov/oha/OEI/THWMtgDocs/OHA%20Strategic%20Plan%20Report.pdf
[3] https://www.oregon.gov/oha/OEI/HECMeetingDocs/Waiver-Slides-060921.pdf
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[9] https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue

or oppression
there exists a significant imbalance in power and equity leading to communities being excluded from decision-making and leadership

While all forms of engagement are often valuable in different contexts, when done without thoughtful intention, planning, and coordination there is also the potential for harm to community and to relationships between the state and community. Some examples of potential harm include eroding trust by setting unrealistic expectations, displaying bias, having a predetermined outcome, creating confusion by being overly technical or unorganized, lacking sufficient resources for proper engagement, and causing engagement fatigue.

OHA recommends a robust and equitable engagement process that is participatory and collaborative and is intentionally structured to elevate community needs and priorities. The following sections provide considerations for addressing engagement levels for various partners throughout different phases of the project and are supported by best practices for engagement, which are critical to successfully advance the A4H model.

Which partners are impacted?

The variety of partners that would be impacted by this proposal generally fall into four groups: 1) health plan and community members, 2) purchasers/employers, 3) payers/insurers, and 4) providers. Subgroups of partners will be impacted at different times and in different ways depending on how the model develops and advances. Examples of subgroups are also listed:

1) Health plan and community members (including priority populations[10]). Health plan members specifically include those covered under by the following: • Marketplace • Medicare Advantage • Medicare FFS • OEBB • Oregon Health Plan (Medicaid/CHIP/Healthier Oregon) • PEBB Self-Insured • Other employer self-insured 2) Purchasers/Employers • PEBB	3) Payers/Insurers • PEBB • OEBB • Marketplace • Oregon Health Plan (Medicaid/CHIP/Cover All People) • Medicare FFS • Medicare Advantage 4) Providers[1] • Behavioral health providers • Culturally specific providers (communities of color, LGBTQIA+, etc.) • Hospital and health systems • Primary care (FQHCs)

[10] Communities and/or populations that OHA considers priority populations include groups that have historically and, in many cases, continue to be harmed by health inequities and most affected by social inequities due to their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, immigrations status, intersections among these communities or identities, or other socially determined circumstances.

• OEBB • Small and Large Group • Self-Insured Other partners and interested groups include: • The Federal Government (e.g., Centers for Medicaid and Medicaid Services) • Oregon Tribal Nations • Research/academia	• Producers/Agents • Rural health clinics • Self-Insured or Medicare Advantage • Tribal health clinics

Continuum of Community/Public/Partner Engagement[11]

Levels of public involvement, impact, trust and communication flow

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Public participation goal	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public
Communication and information flow	Communication flows in one direction to the other to inform Entities coexist	Communication flows to community and back; answer seeking We seek input from community then make plans/ recommendations Entities share information	Communication is participatory and flows in both directions More participation with community on issues Entities cooperate with each other	Communication is bidirectional Partner with community on all aspects of project Entities develop bidirectional communication channels	Final decision-making is at community level Entities have formed strong partnership structures
Promise to the public	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision. We will seek your feedback on drafts and proposals.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will work with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible	We implement what partners decide or provide them with the resources and power to implement

[11] Adapted from the International Association of Public Participation (IAP2) https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5x11_Print.pdf

How should partners be engaged throughout the different phases of the project?

The table below provides suggestions for the type of engagement that could be done among the different partner groups over the project phases. Actual engagement levels will depend on the interest of different groups throughout the state and should be continually assessed and adapted as appropriate as project and engagement plans develop and are implemented.

Project Phase and Proposed Partner Engagement Approach*			
Partner Groups	Model refinement and pilot location	Procurement	Implementation (Governance/ Member Satisfaction/ Quality Improvement) *Timeline TBD*
Health plan members	Consult/Involve	Involve	Empower
Purchasers/ Employers	Consult/Involve	Involve	Empower
Providers	Consult/Involve	Involve	Involve
Payers/Insurers	Consult/Involve	Involve	Involve

*Careful attention needs to be made throughout the cycles of project development and engagement to comply with procurement laws and regulations so as not to create an unfair advantage for any potential proposer and otherwise jeopardize any phase of the procurement process.

Best Practices for Engagement

The following best practices should be considered and observed in a final engagement plan for future stages of this project. The BerryDunn report highlights recent work from the Center for Health Care Strategies[12] and outlines key considerations to facilitate community and public engagement in policy and program design, implementation and operations. These considerations include:

1. Reducing barriers to participation
2. Developing relationships and building trust
3. Focusing on racial and health equity
4. Providing compensation
5. Ensuring transparent and effective communication
6. Creating opportunities for power sharing
7. Providing training programs for community participants

In addition, OHA's Division of Equity and Inclusion has developed a Community Engagement Strategies Checklist[13] that addresses considerations including relationship building, cultural competency, language access and alternate formats,

[12] https://www.chcs.org/engaging-families-in-program-and-policy-development-to-ensure-equitable-outcomes/
[13] https://www.ohsu.edu/sites/default/files/2020-12/Community%20Engagement%20Strategies%20Checklist%20Oregon%20Health%20Authority.pdf

accommodations, compensation and other incentives, how to ask for feedback from community including questions to ask during engagement events, and links to additional resources.

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