

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

BASELINE EVALUATION REPORT

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CENTER FOR HEALTH SYSTEMS EFFECTIVENESS



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Executive Summary

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

Policymakers in Oregon face a complex challenge of transforming the state's health care delivery system to achieve health equity and promote high quality of care in Oregon's Medicaid program.

In 2019, the State of Oregon developed a Value-based Payment (VBP) Roadmap for Coordinated Care Organizations (CCOs) as a foundational element of the CCO 2.0 contract cycle (2020-2024).

In 2020, the Roadmap introduced requirements to be implemented over the course of the new contract cycle. These requirements include the development of new VBP models in specific care areas and targets for the adoption of VBP arrangements with provider organizations over time.³ CCOs' readiness to achieve these requirements was a consideration in the CCO 2.0 award cycle.

OVERVIEW OF THE EVALUATION

Oregon Health Authority engaged the OHSU Center for Health Systems Effectiveness (CHSE) to evaluate the implementation and early outcomes of the Roadmap.

This baseline report explores whether and how the Roadmap supported the state's health care payment reform goals in 2020.

The evaluation analyzed CCO payment arrangement data from January to December 2019 and key informant interviews with CCO leaders in September 2020 to achieve three specific aims:

- Establish a baseline understanding of CCO payment models and contracting strategies during 2019, the year immediately before the launch of the Roadmap requirements.
- Provide an early look at how CCOs responded to new VBP requirements in 2020, the first year of the CCO 2.0 contract cycle.
- Highlight early successes or achievements, and identify challenges CCOs are encountering in implementing VBP strategies.

Key Findings from the Evaluation

Oregon's CCOs began 2020 with varying levels of experience with VBPs. CCOs faced steep challenges as they sought to accelerate providers' adoption of VBP models while also responding to the COVID-19 public health emergency.

Our analysis of CCOs' payment arrangements in 2019, the year before CCO 2.0 contracts, revealed the following:

- In 2019, CCOs paid roughly one-third (32.3%) of all Medicaid expenses to providers in VBP arrangements that will qualify toward the state's new requirements.
- However, the percentage of 2019 dollars paid through VBPs varied substantially across CCOs, ranging from zero to more than fifty percent of expenses. Thus, some CCOs faced substantial work to meet the state's 20% target in 2020 while others already exceeded this goal in 2019. CCOs also varied in the proportion of payments made within specific HCP-LAN tiers in 2019, with FFS payments ranging from a low of 6.2% to a high of 67.9% of all CCOs' expenses.
- In 2023, CCOs will be required to make 20% of payments in downside risk arrangements. In 2019, 22.2% of CCOs' payments were made in this category. Rates varied by CCO, with six CCOs already exceeding the state's target that will take effect in 2023.
- While the percentage of total payments made through qualifying VBP arrangements was moderate (32.3%), these payments were part of a relatively small number of contracts. Overall, contracts structured as VBP arrangements were rare and represented only 3.2% of all contracts that CCOs held with Medicaid providers.

CCO leaders reported a range of capacity building efforts to support new VBP requirements in 2020, focusing on developing new processes and infrastructure to support VBP contracting:

- CCO leaders described 2020 as a capacity-building year. They sought to develop the processes and infrastructure necessary to support new VBP requirements. Capacity-building priorities were dependent on a CCO's contracting mix in 2019, with CCOs reporting different needs depending on prior experience with VBP elements, such as capitation or risk-sharing.
- CCOs employed a range of strategies to assess members' needs and promote equity as they designed new VBP models. CCOs were limited in their ability to collect and analyze demographic and social needs data in 2020, but were building this capacity. CCO leaders requested guidance on selecting quality measures and establishing provider performance targets for their VBP arrangements. CCOs wanted additional options for state-sponsored quality measures.
- At this early stage, CCO leaders identified general challenges promoting provider adoption of VBP arrangements. The COVID-19 public health emergency shaped CCO and provider VBP negotiations in 2020. CCOs sought ways to reduce reporting burdens for VBP-contracted providers. The state may need to take additional steps to support the alignment of VBP approaches across CCO regions, as CCOs were often looking to providers to lead these efforts.
- CCOs reported a wide range of strategies and tools for supporting and monitoring providers in VBP arrangements depending on provider organizations' size and capacity to analyze data. Some early challenges were identified in developing reports that met providers' needs. Many CCOs were still working to understand and define their role in promoting providers' use of health information technology.

CCOs appeared on track to achieve **the earliest requirements of the Roadmap**, but during 2020 interviews, CCO leaders requested additional state efforts to support their progress toward later years' requirements:

- Despite major disruptions occurring in 2020 related to COVID-19 and Oregon wildfires, CCO leaders expressed confidence in their ability to meet annual targets for payments made in qualifying VBP arrangements in the early years (e.g., 2020 and 2021) of the CCO 2.0 contract period. They were less confident about meeting targets that would incrementally increase in later years.
- The COVID-19 pandemic led some CCOs to make widespread temporary changes to existing and planned VBP arrangements, often waiving performance targets or reducing reporting requirements for 2020. CCO leaders reported that some providers were more reluctant to enter into new VBP arrangements because of uncertainty about financial risk or members' care needs in future years.
- The state delayed CCOs' requirements to develop VBP models for behavioral health, maternity care, and hospital care until 2021 for implementation in 2022. However, CCOs still made some progress developing new models in these areas in 2020. In particular, there is evidence of progress in developing behavioral health and hospital care payment models. There is less evidence of the development of maternity care VBP models, with most CCOs reporting they paused these efforts while responding to the COVID-19 pandemic.
- While CCOs made progress developing new payment models, a statewide strategy may be useful to promote provider adoption of some VBP models. There is a perception among some CCO leaders that negotiating provider uptake of hospital or specialty care models may be difficult because CCOs lack purchasing power and leverage in these negotiations. One CCO also requested a statewide strategy for promoting adoption of maternity care VBPs.
- CCOs have encountered relatively few challenges in implementing tiered infrastructure payments to Patient-Centered Primary Care Homes (PCPCHs). CCOs often developed these payments to align with existing or planned primary care VBPs rather than as independent models. Thus, these approaches sometimes bolstered CCOs' other efforts to promote primary care integration. These VBP models may indirectly promote the state's physical, behavioral and oral health care integration priorities from its 1115 Medicaid waiver in addition to promoting PCPCH recognition and advancement.

Recommendations

Recommendations to the State of Oregon arising from these findings include:

1. **Ensure the state's quality measurement priorities are aligned with its VBP goals.** CCOs looked to Oregon's Aligned Measures Menu to guide their VBP model design and negotiations with providers. Still, gaps were noted for some care areas that lack state-endorsed measures. This was a barrier to promoting VBP adoption and aligning efforts across CCOs and other payers. CCOs may need quality measure recommendations for consideration in hospital, maternity, and specialty care VBPs to promote integrated care, align models with other payers and reduce reporting burdens on providers. The state should explore options to guide CCOs' quality measure selection for VBPs, such as through a VBP measures menu. The state may also wish to provide guidance directly for providers to navigate conversations with CCOs and other payers about aligning VBP monitoring and reporting requirements.

- 2. Provide guidance to identify disparities and address health equity.** CCOs' capacity to use demographic and social needs data to monitor disparities was still developing. CCOs were also highly reliant on claims-based quality and performance measures to identify health inequities. A measure-by-measure approach to monitoring providers may overlook larger patterns or population health needs or be limited by missing member-level demographic data. The state may wish to guide CCOs' collection and use of demographic or social needs data and elevate emerging models such as CCOs' development of health equity indices or the use of quality measures to inform member listening sessions. These approaches could lead CCOs toward more comprehensive, timely, and community-informed health equity priorities.
- 3. Consider statewide strategies to promote VBP adoption among hospitals and specialty care providers.** Lack of CCO market share means a statewide strategy may be useful to engage certain providers in new VBP arrangements. All CCOs are now signatories to the state's Value-Based Payment Compact that aims to align payer and provider efforts across markets and between public and private VBP initiatives. The state should explore options to further promote multi-payer alignment in care delivery areas (CDAs) such as hospital care, where some CCOs reported low leverage in negotiations. Specific convenings, guidance or technical assistance may be helpful in these focused areas.
- 4. Monitor CCOs' efforts to promote VBP adoption in areas where sub-capitation arrangements are common.** The VBP Roadmap requirements provide an opportunity for Oregon to further incentivize progress toward physical, behavioral and oral health integration – key priorities in its federal 1115 Medicaid demonstration waiver. However, CCOs face additional challenges negotiating and monitoring VBP arrangements with providers in these areas due to current or historical reliance on sub-capitated arrangements. Sub-capitation may create additional barriers to CCOs monitoring inequities or establishing provider quality targets because of the additional layer of administration that exists between CCOs, sub-capitated entities and providers.
- 5. Consider options for standardizing the reporting of CCOs' VBP model characteristics in the state's five priority CDAs and for PCPCH infrastructure payments.** CCO leaders expressed a desire for access to a library of sample VBP models. They noted that visibility into other CCOs' approaches helped to reduce the burden on providers. As CCOs develop a range of new VBP models in specific CDAs, opportunities may arise to compare the effectiveness of these approaches across regions and populations. The state now collects the HCP-LAN tiers of provider VBP arrangements and quality measures in use with specific providers. However, this reporting does not yet support the systematic identification or comparison of VBP model characteristics (e.g., emphasis on specific subpopulations or quality improvement measures) that CCOs are adopting. The state may wish to guide CCOs to support standardized descriptions of their VBP models and explore options to develop a repository of sample models.

Background and Introduction

CCO 2.0: Transforming Oregon's Medicaid Program

Since 2012, the State of Oregon has provided coverage to its Medicaid-enrolled population through Coordinated Care Organizations (CCOs).¹ CCOs are locally-governed entities that contract with a network of medical, behavioral, and oral health providers to deliver care to Medicaid members in their geographic regions. CCOs are responsible for meeting targets for the quality and accessibility of care. They are held to a 3.4% annual cost growth rate and accept full financial risk for their members.

In 2017, Governor Kate Brown directed the Oregon Health Policy Board to provide specific recommendations in four key areas to inform Oregon Health Authority's (OHA's) design and implementation of Oregon's Medicaid program:

1. focus on social determinants and health equity.
2. increase value and pay for performance.
3. improve the behavioral health system.
4. maintain sustainable cost growth.

In establishing the second goal, the Governor noted that Oregon's CCO model – a global budget linked with incentives to meet quality performance targets – had demonstrated success in tying Oregon's Medicaid payments to quality. To make additional progress in paying for value rather than volume of services would require 1) increasing CCOs' quality goals, 2) achieving reduced health inequities, and 3) increasing the proportion of CCOs' payments to providers that were tied to performance.²

A Value-based Payment Roadmap for CCOs

In response to the Governor's directive, the state worked with CCOs to develop OHA's Value-Based Payment Roadmap for Coordinated Care Organizations ("the Roadmap") in September 2019.

The Roadmap would serve as a foundational element of CCO requirements during the CCO 2020-2024 contract cycle (CCO 2.0).³ It established a common definition of value-based payments (VBPs) for Oregon's CCOs: "payments to a provider that explicitly reward the value that can be produced through the provision of health care services to CCO members" (pg. 5). The Roadmap also aligned Oregon's payment reform efforts with the Health Care Payment Learning and Action Network's Alternative Payment Model Framework ("the HCP-LAN framework", see Exhibit A).⁷ The HCP-LAN framework established standard definitions of four health care payment types, including:

1. Traditional fee for service (FFS).
2. FFS with a quality or performance-based component.
3. FFS with quality and cost targets and shared financial risk between a provider and payer.
4. Prospective population-based (rather than volume-based) payments with a quality component.

Exhibit A: The Health Care Payment Learning & Action Network's Alternative Payment Model Framework

In 2017, the Health Care Payment Learning & Action Network (HCP-LAN) published the Alternative Payment Model Framework (Refreshed) to help align alternative payment approaches across the U.S. health care system in an effort to support health care payment reform, promote quality and contain costs. The framework describes categories of health care payment models that advance from FFS (HCP-LAN category 1), to models that reward quality and performance (category 2), to models that incorporate shared financial savings and risk (category 3), to fully population-based arrangements (category 4) that depart from volume-based FFS payments.

Oregon's VBP Roadmap for CCOs uses the HCP-LAN framework to create a common pathway for adoption of VBPs in CCOs' provider contracts, instituting a shared language and supporting comparison of approaches across CCOs while allowing for locally tailored VBP models and implementation strategies.

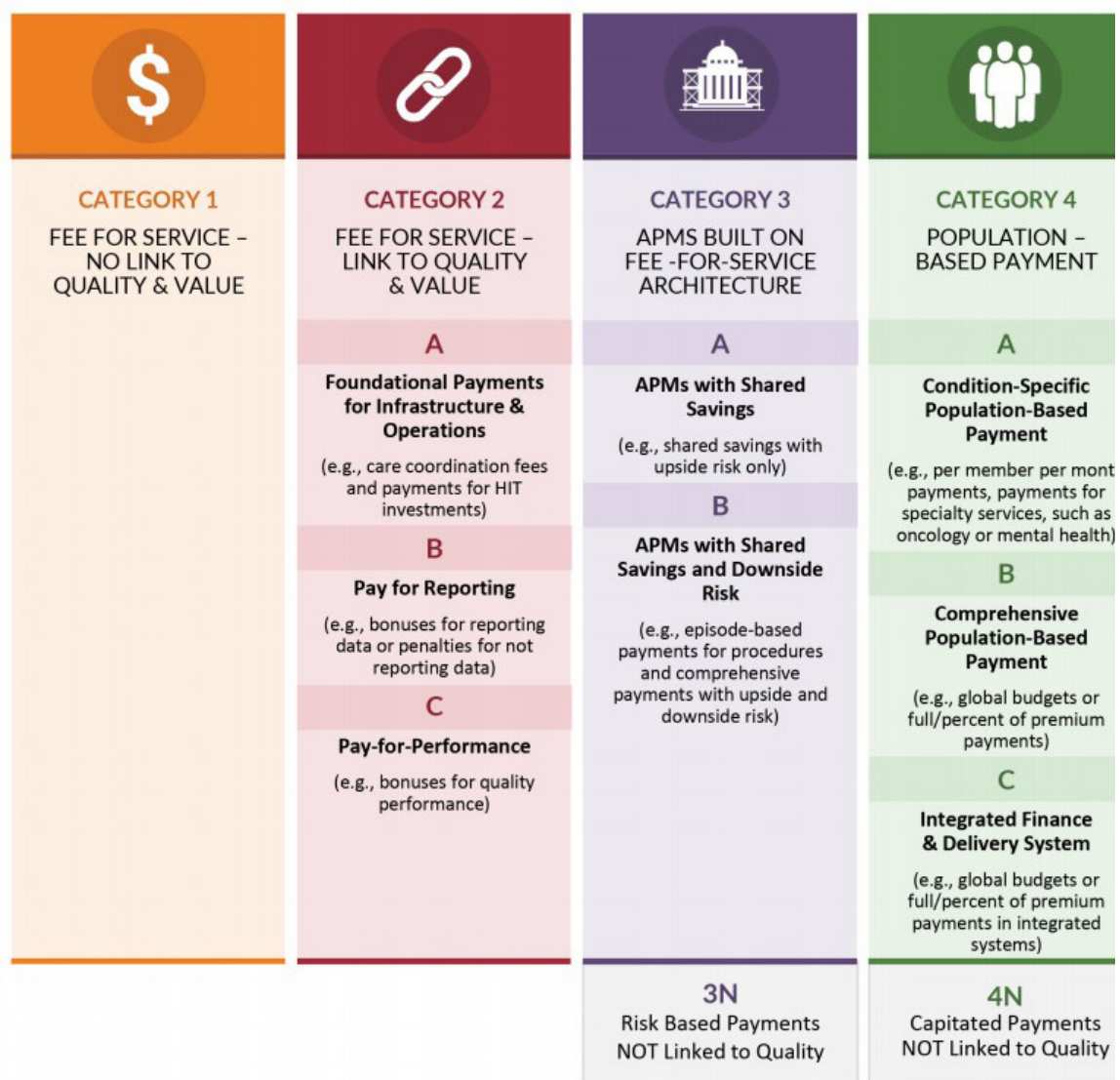


Image reproduced from the Health Care Payment Learning and Action Network's 2017 (refreshed) Alternative Payment Model APM Framework available at <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

Requirements for CCOs in 2020-2024

Oregon's VBP Roadmap for CCOs outlined specific requirements during the CCO 2.0 contract cycle (2020-2024), including:



Establishing a new per-member per-month (PMPM) “Foundational Payment for Infrastructure and Operations” for Patient-Centered Primary Care Homes (PCPCHs). This payment model was required to include tiers that rewarded organizations for achieving higher levels of PCPCH recognition, with payment amounts increasing during each year of the CCO 2.0 contract.



Meeting increasing annual targets for the overall percentage of a CCO's payments that are tied to quality (i.e., category 2C or higher in the HCP-LAN framework). By 2024, all CCOs are required to make at least 70% of payments as category 2C or higher payments.



Meeting annual targets for the overall percentage of a CCO's payments that qualify as shared savings with downside risk (i.e., HCP-LAN category 3B) beginning in 2023. By 2024, all CCOs are required to make at least 25% of payments as category 3B payments.



Developing targeted category 2C or higher payment models in five care delivery areas (CDAs), including hospital care, maternity care, behavioral health care, children's health care, and oral health care.

To evaluate progress toward these goals, OHA is monitoring CCOs' efforts to design, implement and expand VBP models.

Changes to VBP Requirements in 2020

Sixteen CCOs executed new agreements with the state in 2020 that included these VBP requirements. In early 2020, the COVID-19 pandemic in Oregon began to cause widespread disruption to the health care delivery system across the state. In response to this disruption, OHA aimed to remove barriers to providing quality care to members by making changes to some of the CCO 2020 contractual requirements. These changes are outlined in Exhibit B.³ OHA planned to reevaluate these requirements at a future date.

Exhibit B: Changes in CCO requirements for 2020 in response to COVID-19

Contractual Requirement	Original due date	Revised requirement and/or due date
Submit VBP Reporting Measures template	October 12, 2020	Reporting requirement waived for 2020. Retrospective reporting for 2021 and prospective reporting for 2022 were changed to October 2021.
At least 20% of projected annual payments paid to providers in VBP contracts	Already in place	OHA allowed CCOs to relax provider reporting of quality metrics in 2020
Develop new or expanded VBPs in CDAs	Develop in 2020 for implementation in 2021	Postponed by one year
Participate in OHA-facilitated discussions to align performance measures for CCOs with overlapping service areas	During 2020	Canceled discussions for 2020. Remains in contracts for 2021.
Executive leadership shall engage in interviews with OHA	June 2020	Postponed to September 2020

About this report

The State of Oregon engaged the Center for Health Systems Effectiveness (CHSE) at OHSU to evaluate the implementation and early outcomes of the VBP Roadmap for CCOs to explore whether it supports the achievement of the state's CCO 2.0 and health transformation goals. The baseline evaluation had three goals which are addressed in this report:

- 1. Establish a baseline understanding of CCO payment models and contracting strategies in 2019, the year immediately before the launch of the VBP Roadmap requirements.** Chapter 2 presents an analysis of payment arrangement data from 2019, including the proportion of CCO dollars paid in qualifying VBP arrangements, CCO dollars tied to risk-sharing agreements, and variation in CCO approaches to provider contracting.
- 2. Provide an early look at how CCOs responded to new VBP requirements.** Chapter 3 describes the variation in CCOs' baseline capacity to implement CCO 2.0 and outlines the process CCOs have initiated for developing VBP models and negotiating with and supporting providers.
- 3. Highlight early successes or achievements, and identify challenges CCOs are encountering in implementing VBP strategies.** Chapter 4 outlines CCO progress toward VBP requirements in 2020 as well as CCO successes and challenges in VBP implementation across different CDAs.

Data sources and methods

We drew from a variety of data sources, using quantitative and qualitative methods to achieve the evaluation goals. Our approach included three elements:

- **A quantitative analysis of CCO payments to providers in 2019**, measured through Payment Arrangement Files (PAFs) submitted annually to OHA by each CCO as a contractual reporting requirement. PAFs include data on a CCO's provider contracts, including the total dollar amount and

HCP-LAN category of specific arrangements. Our approach mimics the state's methodology (see Appendix A) for calculating CCOs' proportion of member expenses paid to providers in qualifying VBP arrangements, which will be used to ascertain CCOs' achievement of VBP targets and milestones during the CCO 2.0 contract cycle. See Chapter 2.

- **Interviews with CCO leaders in 2020.** We conducted semi-structured interviews with CCO leaders in August and September 2020. These interviews explored CCOs' experiences implementing new VBP activities in 2020. They sought to identify early challenges, emerging best practices, and needs for assistance from the state. Participation in these interviews was also a requirement of CCOs in their state contracts. See Chapters 3 and 4.
- **A qualitative analysis of data collected from CCOs in 2020.** We collected responses to a written questionnaire from each CCO in August 2020 to gather information about their progress toward developing and enhancing new VBP models. This questionnaire also addressed changes the CCO made to provider payment arrangements due to COVID-19. These written responses and other publicly available CCO documents were analyzed to identify emerging themes.

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

Limitations

We note several important limitations. First, CCOs' contracts can include provider payments made within multiple HCP-LAN categories under a single contract ID. Our quantitative analysis replicates the state's approach for calculating CCOs' progress toward annual VBP targets. This methodology classifies CCOs' provider contracts within the most advanced HCP-LAN category that is applicable to that contract, even if some portion of the contract payments are made as less advanced VBPs. For example, a provider contract containing category 4A and 4N payments would be classified as a 4A contract. Thus, the percent of payments reported within each HCP-LAN category in chapter two may understate the true proportion of payments in less advanced categories (e.g., FFS, 3N, or 4N).

Second, our qualitative findings rely on self-reported information collected from CCOs that varies in its specificity and detail. Independently verifying the accuracy of these reports was beyond the scope of this evaluation; these reports may not capture the full scope of some CCOs' efforts. We cataloged CCOs' reported efforts as described, recognizing this is likely to be an incomplete picture of all VBP-related efforts CCOs engaged in during 2020. The terminology used to describe VBPs is also rapidly evolving. While the VBP Roadmap for CCOs established a shared language, there was variation in how CCO staff members understood and described their efforts through the lens of the HCP-LAN framework. Thus, CCOs with similar approaches may have described them differently.

Finally, the period covered by this report (2019-2020) spans two CCO contracting periods (2015-2019 and 2020-2024). The number of CCOs (and their service area boundaries and assigned members) changed between 2019 and 2020. In Chapter 3, we report a quantitative analysis of payment arrangement data for the thirteen CCOs that were operating in 2019 and contracted with the state in 2020. Qualitative data in Chapters 4 and 5 were collected from representatives of sixteen CCOs contracted with the state in 2020, regardless of whether the CCO had operated in 2019. Exhibit C displays CCOs included in each analysis of this report. Readers should note that results may not be directly comparable across chapters due to differences in the CCOs providing data for the quantitative and qualitative portions of this report.

Exhibit C: Oregon's Coordinated Care Organizations included in the Baseline Evaluation Report

	2015-2019 Contract Period	2020-2024 Contract Period	Included in Chapter 3 Payment Arrangement Analysis	Included in Chapters 4-5 Qualitative Analysis
AllCare	•	•	•	•
Advanced Health	•	•	•	•
Cascade Health Alliance	•	•	•	•
Columbia Pacific	•	•	•	•
Eastern Oregon	•	•	•	•
Family Care	•			
Health Share of Oregon	•	•	•	•
Intercommunity Health Network	•	•	•	•
Jackson Care Connect	•	•	•	•
PacificSource Central Oregon	•	•	•	•
PacificSource Columbia Gorge	•	•	•	•
PacificSource Lane County		•		•
PacificSource Marion Polk Counties		•		•
Primary Health	•			
Trillium Community Health Plan – Lane County	•	•	•	•
Trillium Community Health Plan – Portland Metro		•		•
Umpqua Health Alliance	•	•	•	•
Willamette Valley Community Health	•			
Yamhill Community Care	•	•	•	•

Summary

Since the inception of CCOs in 2012, Oregon has engaged in ambitious work to improve health care quality and control costs within its Medicaid program. The VBP Roadmap for CCOs created a new framework for CCOs to promote VBPs with Medicaid providers. This evaluation sought to understand CCOs' VBP efforts before the CCO 2.0 contract cycle and their early experiences with the requirements and milestones of the roadmap. As Chapter 2 demonstrates, CCOs varied meaningfully in their engagement with value-based purchasing before the 2020-2024 contract cycle.

CCOs' Baseline Experience with VBPs in 2019

KEY FINDINGS

- In 2019, CCOs on average paid one-third (32.3%) of all expenses to providers in VBP arrangements that will qualify toward the state's new requirements.
- However, the percentage of 2019 expenses paid through VBP arrangements varied substantially across CCOs, ranging from zero to more than fifty percent of expenses. Thus, some CCOs faced substantial work to meet the state's 20% target in 2020 while others already exceeded this goal in 2019. CCOs also varied in the proportion of payments made within specific HCP-LAN tiers in 2019, with FFS payments ranging from a low of 6.2% to a high of 67.9% of all CCOs' expenses.
- In 2023, CCOs will be required to make 20% of payments in downside risk arrangements. In 2019, 22.2% of CCOs' payments were made in this category. Six CCOs already exceeded the state's target, while seven did not.
- While the percentage of total payments made through qualifying VBP arrangements was moderate (32.3%), these payments were part of a relatively small number of contracts. Overall, contracts structured as VBP arrangements were rare and represented only 3.2% of all contracts that CCOs held with Medicaid providers.

In 2020, Oregon's CCOs embarked on a new five-year contract period (2020-2024) during which they will be required to achieve milestones and targets related to VBP. One goal of this baseline evaluation was to understand where CCOs started from before these new requirements.

This chapter presents findings from an analysis of CCO payment arrangements to ascertain the scale and penetration of provider contracts at various levels of the HCP-LAN framework in 2019. These analyses include the following:

1. The proportion of CCO member expenses paid in qualifying VBP arrangements in 2019.
2. Variation in CCOs approaches to provider contracting in 2019.
3. The proportion of CCO member expenses tied to risk-sharing arrangements in 2019.

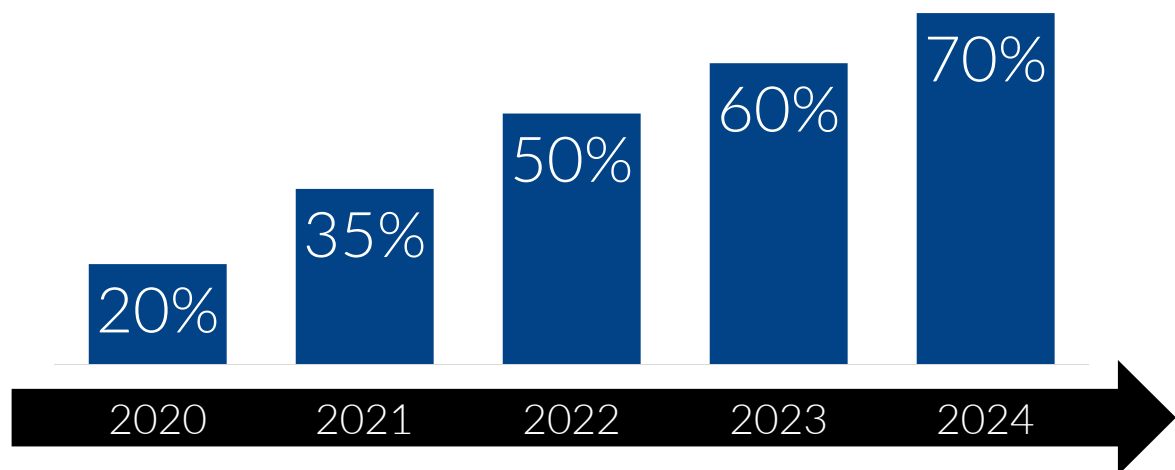
See Appendix A for a description of data sources and methods related to this chapter.

Payments to Providers in Qualifying VBP Arrangements Before CCO 2.0

CCOs' provider contracts are classified into the various VBP categories of the Health Care Payment Learning and Action Network's (HCP-LAN) framework (see p. 9) when the arrangements exhibit certain characteristics, such as tying payments to quality measures or overall cost targets.

Beginning in 2020, CCOs were required to make at least 20% of their member service expenses (hereafter "expenses") in contracts classified as LAN category 2C or higher (see Exhibit D). These payment categories tie a portion of provider payments to performance measures and require providers to achieve quality targets to earn full payments. CCOs' readiness or capability to meet these VBP requirements during the CCO 2.0 contract cycle were a consideration during the award cycle in 2019.

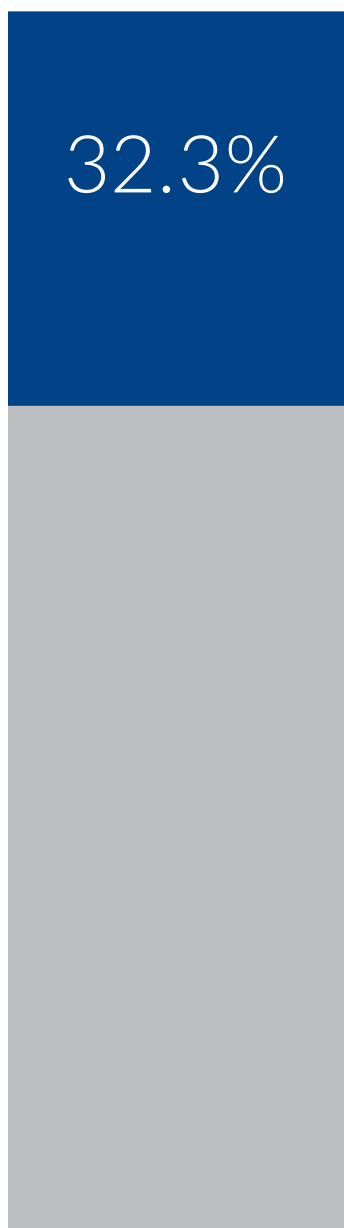
Exhibit D: CCOs are required to increase the percentage of provider payments tied to quality over the five-year CCO 2.0 contract period.



Beginning in 2020, Oregon required CCOs to report the HCP-LAN tier classification of all provider contracts held in the prior year to support the monitoring of CCO's progress toward required VBP targets.

This report analyzed data from 2019, the first year in which payment arrangement data were reported by CCOs. These results provide a snapshot of CCOs' provider arrangements in the year immediately before the start of the CCO 2.0 contract period and new VBP Roadmap requirements. These results reveal the overall prevalence of Medicaid VBP contracting among Oregon's CCOs in the year before CCO 2.0 and how CCOs' experience with VBPs at various HCP-LAN tiers varied before the launch of the Roadmap.

We note one important limitation: CCOs' contracts can include provider payments made within multiple HCP-LAN categories under a single contract ID. Our analysis classifies contracts within the highest HCP-LAN category that is applicable to that contract, even if some portion of contract payments are made as less advanced VBPs. For example, a provider contract containing category 4A and 4N payments would be classified as a 4A contract. Thus, the percent of payments reported within each HCP-LAN category may understate the true proportion of payments in less advanced categories (e.g., FFS, 3N, or 4N) and overstate the proportion of qualifying payments (2C or higher).



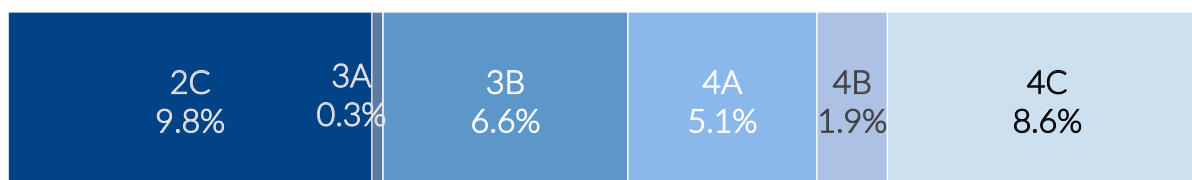
In 2019, roughly one-third of all CCOs' Medicaid member expenses were paid through arrangements that will qualify toward CCOs' annual VBP target in 2020.

32.3% of all CCO member expenses in 2019 were made through HCP-LAN category 2C or higher arrangements that qualified as VBP arrangements under the state's new VBP Roadmap requirements. However, this varied widely across individual CCOs.

CCOs' provider payments made in **qualifying VBP arrangements** were reported in the following HCP-LAN categories in 2019 (see Exhibit E):

- **9.8%** of all expenses were paid under category 2C arrangements (e.g., FFS payments that tied a portion of the provider's payment to quality or performance).
- **8.6%** of expenses were paid under category 4C (e.g., prospective, population-based payments to an integrated delivery system).
- **6.6%** of expenses were paid under category 3B (FFS payments with downside risk sharing and a quality component).
- **5.1%** of expenses were paid under category 4A (prospective PMPM payments made for a specific condition or episode).
- **1.9%** of expenses were paid under category 4B (PMPM payments for the total cost of care).
- **0.3%** of expenses were paid under category 3A (FFS payments with shared savings and a quality component).

Exhibit E: Category 2C payments were the most common type of qualifying VBP arrangement reported in 2019, reflecting 9.8% of all CCOs' expenses.




The remaining payment arrangements CCOs reported in 2020 for 2019 were arrangements that do not qualify as VBPs under the state's new requirements.

These **non-qualifying arrangements** included:

- 30.8% of expenses paid under category 1 (FFS) arrangements with no quality component.
- 2.3% of expenses paid under category 4N capitated payments with no quality component.
- 1.2% of expenses paid under category 2B pay-for-reporting arrangements.
- 0.2% of expenses paid under category 2A infrastructure payments.
- 0.2% of expenses paid under category 3N (e.g., downside risk-sharing arrangements with no connection to quality).

The percentage of payments in HCP-LAN tiers does not sum to 100%. We follow the state's methodology outlined in the VBP Roadmap, which calculates a CCO's payments to providers in VBP arrangements as a percentage of the CCOs' total Member Service Expenses subtotal reported in CCOs' 2019 Exhibit L, Report L6. See Appendix A for a description of this methodology.

In 2019, CCOs varied substantially in the total percentage of expenses paid to providers in qualifying VBP arrangements.



CCO 1	55.1%
CCO 2	53.9%
CCO 3	52.9%
CCO 4	39.5%
CCO 5	36.1%
CCO 6	35.8%
CCO 7	31.8%
CCO 8	30.4%
CCO 9	29.3%
CCO 10	19.1%
CCO 11	17.3%
CCO 12	2.2%
CCO 13	0.0%

CCOs varied in the proportion of total dollars paid under qualifying VBPs (e.g., category 2C or higher) in 2019, ranging from a low of 0% to a high of 55.1% of all expenses.

Nine CCOs had more than 20% of 2019 payments in qualifying VBP tiers, exceeding the state's target for 2020 before CCO 2.0. CCOs that began the CCO 2.0 contract cycle with few or no VBP arrangements in 2019 faced more significant challenges in meeting the 20% target in 2020.

CCOs varied in payments made within specific HCP-LAN categories.

The majority of CCOs had experience with 2C, 3B, and 4A arrangements. Experience with shared savings (e.g., HCP-LAN category 3A) and population-based payments (e.g., HCP-LAN categories 4B and 4C) were less common.

The percentage of payments made in each HCP-LAN tier varied:

- 2C payments ranged from 0-36% of CCOs' expenses.
- 3A payments were relatively rare, ranging from 0-4.4%.
- 3B payments ranged from 0-42.8%.
- 4A payments ranged from 0-27%.
- 4B payments ranged from 0-17.4%.
- 4C payments ranged from 0-19.7%.

All CCOs reported some payments made under FFS arrangements. Still, there was striking variation across CCOs in the proportion of total dollars paid under these arrangements in 2019, ranging from a low of 6.2% to a high of 67.9%.

CCOs also varied in the proportion of Medicaid dollars they paid in other non-FFS arrangements that do not qualify toward the state's annual VBP targets.

These arrangements included HCP-LAN categories 2A, 2B, 3N, and 4N:

- Seven CCOs reported 2A payments* that ranged from 0-2.2% of all provider payments.
- Two CCOs reported 2B payments that ranged from 0.2-10.2% of payments.
- Two CCOs reported 3N payments that ranged from 0-7.3% of payments.
- Six CCOs reported 4N payments that ranged from 0-57.6% of payments.

*Beginning in 2020, all CCOs will be required to make 2A payments to Patient-Centered Primary Care Homes, though these payment arrangements do not count toward annual VBP targets.

CCO Approaches to Provider Contracting in 2019

A CCO may hold relatively few VBP contracts that nonetheless capture a large proportion of the CCOs' total expenditures. We observed variation across CCOs in both the prevalence of VBP arrangements and the level at which CCOs typically reported contracts (e.g., at the delivery system level or smaller scales).

A third of CCO expenses were paid in VBP arrangements in 2019. However, these arrangements were rare and represented less than 4% of CCOs' Medicaid contracts.

CCOs reported 20,375 unique Medicaid provider contracts in 2019. Of these, 654 provider contracts fell within categories that will qualify in 2020 toward the state's VBP targets.

32.3% of CCO member expenses
were paid in VBP arrangements.



Contracts structured as qualifying VBP arrangements ranged from 0% to 19.5% of CCOs' contracts in 2019.

The prevalence of contracts that contained qualifying VBP elements (e.g., HCP-LAN category 2C or higher) varied by CCO. Two CCOs reported zero contracts contained these elements, while at the upper end, one CCO reported that 19.5% of its contracts did (see Exhibit F).

Exhibit F: The percent of CCO provider contracts structured as qualifying VBP arrangements (HCP-LAN category 2C or higher) varied in 2019.

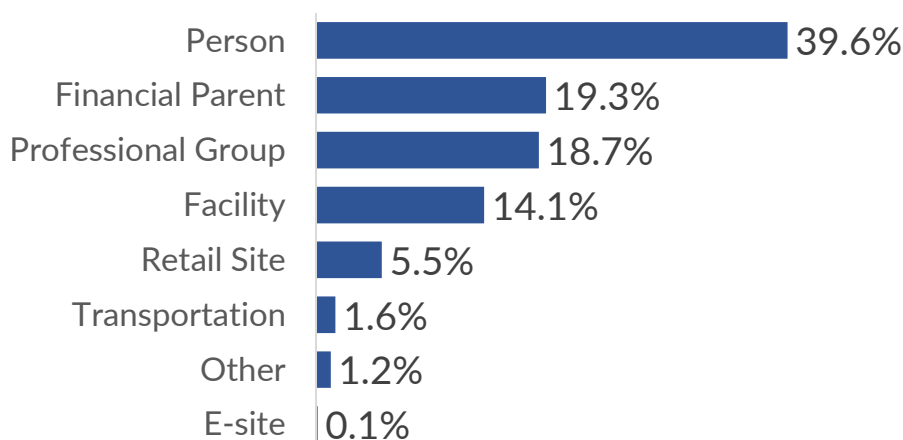
19.5%	12.9%	9.6%	9.1%	6.6%	6.4%	5.0%	4.6%	4.4%	2.6%	1.0%	0.0%	0.0%
CCO 7	CCO 1	CCO 9	CCO 4	CCO 2	CCO 6	CCO 3	CCO 10	CCO 6	CCO 11	CCO 8	CCO 12	CCO 13

In contrast, CCOs structured most of their 2019 contracts as FFS arrangements, with 96.1% of all contracts falling in this category (without consideration for how these contracts varied in size). This percentage ranged from 78% to 98.9% across all CCOs.

CCOs varied meaningfully in their contracting approaches but most often reported holding contracts at the provider level.

Some CCOs reported contracts (both VBP and non-VBP) primarily at the individual provider level. In contrast, other CCOs reported that much of their contracting occurred with large delivery systems or organizations. The number of total reported contracts varied substantially by CCO, ranging from a low of 154 unique contracts to a high of 7,541 contracts.

Exhibit G: CCOs' Payment Arrangements with Providers in 2019, by Financial Entity Type



This variation in CCOs' approaches to reporting provider contracts may point to differences in how CCOs will need to approach provider negotiations to meet VBP targets in future years. Among CCOs whose contracts are primarily held with large organizations or delivery systems, the impact of renegotiating a single FFS contract to include VBP elements can have a meaningful impact on the CCO's progress toward its VBP target. In contrast, CCOs reporting many provider-level contracts may need to renegotiate a large number of contracts to achieve the state's annual VBP targets.

CCOs holding many smaller VBP arrangements may also face additional challenges in building monitoring and reporting platforms that can assess VBP performance. The burden of these negotiations and performance monitoring may also be higher for smaller providers than for large organizations.

This will be an important factor to monitor in future years. While some CCOs may have opportunities early in the CCO 2.0 contract cycle to meet annual targets through renegotiation of large contracts, it is likely that all CCOs will face pressure in later years to focus their efforts on the renegotiation of smaller scale contracts.

CCO Provider Payments Made in Risk-Sharing Arrangements

In future years, CCOs will be required to meet annual targets for the proportion of expenses paid in arrangements that include downside risk and a quality component. Capitated payment arrangements in HCP-LAN categories 4A, 4B, and 4C count toward this requirement in addition to risk-sharing arrangements in category 3B.

Experience with downside risk arrangements was rare among CCOs.

CCOs as a group reported only 238 provider contracts (1.2% of all contracts) that were structured as downside risk arrangements with a quality component in 2019, making these arrangements extremely rare. More than half of these arrangements (n=140) were category 3B arrangements. The remainder (n=98) were category 4 capitated arrangements, including categories 4A (n=48), 4B (n=42), and 4C (n=8). The overall prevalence of downside risk arrangements varied by CCO, ranging from none (n=0) to 8.2% (n=62) of each CCO’s contracts. Only one CCO reported no experience with either category 3B or category 4 VBPs.

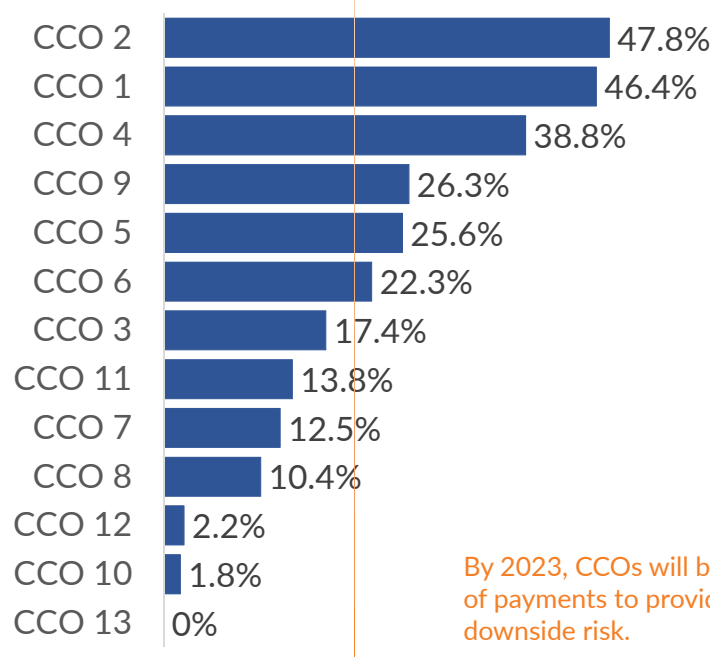
Statewide, approximately one quarter of CCO Medicaid expenses were paid under these downside risk arrangements in 2019.



In 2019, 22.2% of all CCO expenses were paid under downside risk arrangements. However, this percentage varied meaningfully by CCO (see below).

Oregon’s VBP Roadmap for CCOs requires that 20% of CCOs’ Medicaid expenses be paid to providers in arrangements with downside risk by 2023, increasing to 25% in 2024.

Some CCOs reported a large percentage of their Medicaid expenses paid under downside risk arrangements in 2019, despite the relative infrequency of these arrangements.



By 2023, CCOs will be required to make 20% of payments to providers in arrangements with downside risk.

The small number of downside risk arrangements masks the fact that some CCOs pay a relatively large proportion of their Medicaid dollars to providers under these arrangements. For example, one CCO reported 47.8 % of its provider payments were made under downside risk arrangements in 2019, even though these arrangements represented only 4% of the CCO's total contracts.

Six CCOs reported making more than 20% of payments in downside risk arrangements in 2019, already exceeding the state's target for these arrangements that will take effect in 2023.

In contrast, six CCOs reported a smaller proportion of expenses in downside risk arrangements, and one CCO reported no existing downside risk arrangements.

Summary

On average, Oregon was well-positioned to achieve 20% of CCO member expenses paid to providers in VBP arrangements in 2020. However, CCOs began the five-year CCO 2.0 contract period with varying levels of experience and ability to meet this target. Some CCOs already exceeded the target in 2019, and thus were well positioned to meet the state's new requirement in 2020. Others faced substantial work to meet this goal in 2020 even prior to disruptions posed by the COVID-19 pandemic.

CCO provider contracts containing downside risk elements were extremely rare, though most CCOs had at least some experience with these arrangements. However, the infrequency of downside risk arrangements masks the fact that some CCOs already pay a relatively large proportion of their Medicaid expenses in these arrangements. Nearly half of CCOs already exceeded the state's target for downside risk that will take effect in 2023.

In Chapter 3, we describe efforts made by CCOs to develop capacity for VBP arrangements in 2020.

CCOs Capacity-building Efforts in 2020

KEY FINDINGS

- CCO leaders described 2020 as a capacity-building year. They sought to develop the processes and infrastructure necessary to support achievement of new VBP requirements. These efforts reflected their contracting mix in 2019 and prior experience with VBP elements such as capitation or risk sharing.
- CCOs used a range of strategies to assess members' needs and promote equity in their design of new VBP models. CCOs were limited in their ability to collect and analyze demographic and social needs data in 2020, but were building this capacity. CCO leaders requested guidance on selecting quality measures and establishing provider performance targets for their VBP arrangements. Some CCOs wanted additional options for state-sponsored quality measures.
- CCO leaders identified challenges in promoting provider adoption of VBP arrangements. The COVID-19 public health emergency shaped CCO and provider VBP negotiations in 2020, with CCOs seeking to reduce reporting burdens. The state may need to take additional steps to support alignment of VBP approaches across CCO regions, as CCOs were often looking to providers to lead these efforts.
- CCOs reported a wide range of strategies and tools for supporting and monitoring providers in VBP arrangements. Many CCOs were still working to understand and define their role in promoting providers' use of HIT.

Most CCOs began the current 2020-2024 contract cycle well positioned to achieve the state's 2020 target for payments to providers made in qualifying VBP arrangements. However, CCOs varied widely in their individual experience with VBP arrangements in 2019 and their capacity to develop and implement new VBP models in 2020.

This chapter describes CCO efforts and activities to build capacity and infrastructure to meet the state's CCO VBP Roadmap requirements. These findings were developed from key informant interviews and written questionnaires collected from CCOs in late 2020. A complete description of data sources and methods is provided in Appendix B.

Readiness for CCO 2.0 VBP Requirements

CCOs were focused on capacity building for VBP arrangements in 2020.

CCO leaders described 2020 as a capacity-building year for their VBP efforts. Increasing the use of VBP contracting required enhanced infrastructure, data collection, and management strategies, and staff capacity to support additional performance monitoring and reporting work.

Previous participation in payment reform workgroups and the introduction of national VBP models in primary care helped prepare CCOs to meet the CCO 2.0 VBP requirements. Efforts to establish VBP arrangements in primary care raised awareness of the necessary infrastructure, encouraging CCOs to develop in-house subject matter expertise. Financially integrating member benefits for primary, behavioral, and oral health care was also described as a factor that contributed to some CCOs' and providers' readiness for VBP contracting.

However, CCOs appeared to vary in their readiness to implement new VBPs in 2020. Some CCO leaders reported they were still building internal awareness and familiarity with the HCP-LAN framework. In some cases, CCOs struggled to identify how their existing payment models fit within the HCP-LAN framework categories and were uncertain if existing payment models met state requirements to qualify as a VBP. CCO leaders also reported reluctance to change long-standing payment arrangements with providers to bring them in alignment with the VBP Roadmap's definition of a VBP:

"We want to make sure that we can identify where the LAN framework fits our arrangements, versus the other way around." – CCO leader, 2020

Building familiarity with the HCP-LAN framework and the ability to manage the increased complexity of value-based contracting was cited as an ongoing area of learning for several CCOs.

CCO leaders identified several elements of the state's VBP strategy that supported their readiness to meet VBP requirements during CCO 2.0.

CCO leaders noted that the state had begun promoting VBP arrangements within Medicaid before 2020. State strategies identified as supporting CCOs' readiness for VBP included:

- **Multi-payer focus.** CCO leaders described the importance of aligning VBP efforts among Oregon's commercial, Medicaid, and Medicare payers, citing the importance of efforts like the state's Health Care Cost Growth Benchmark workgroup formed through Senate Bill 889 (see Exhibit H). CCO opportunities to participate in statewide and multi-payer learning collaboratives were instrumental in building CCOs' VBP readiness.
- **Clear expectations and feedback from the state.** CCO leaders appreciated when the state had signaled future priorities well in advance of new requirements and established models for change that built incrementally over time. Opportunities to meet with representatives from OHA to confirm strategies and approaches were also helpful and desired. CCO leaders appreciated opportunities to see how their CCO performance compared to other CCOs.
- **Shared performance measures.** The state's Aligned Measures Menu was frequently cited as an important element of CCO readiness for VBP, helping the CCO coordinate its selection of provider performance measures with other payers to promote provider buy-in.
- **Alignment of CCO 2.0 requirements.** One CCO leader described CCO 2.0 as "a lot of irons in the fire" with potential for disconnected activities. CCO leaders noted the importance of the state promoting alignment across CCO requirements for VBP, health information technology (HIT), health equity, and quality improvement.

Exhibit H: Oregon's Senate Bill 889: A Strategy to Contain Rising Health Care Costs

Health insurance deductibles for Oregonians are the third highest in the country and health care costs are growing at an unsustainable rate for the state economy. In response to this crisis, effective July 15, 2019 the Oregon legislature passed Senate Bill 889, aimed at controlling the growth of public and private health care expenditures, increasing access to high quality care, and establishing an annual benchmark for cost growth. Building on previous efforts within Medicaid and other state programs, the bill established the Health Care Cost Growth Benchmark program, with the following objectives:

1. Create a state health care cost growth benchmark which is reviewed annually.
2. Develop a process for calculating total health expenditures.
3. Establish reporting requirements for all health care entities in the state.
4. Publish an annual report which includes findings and recommendations for improving efficiency.
5. Hold health care entities accountable for achieving annual cost growth benchmark.

The Health Care Cost Growth Benchmark Implementation Committee was tasked with developing an implementation plan to operationalize the objectives of the benchmark program. This committee was under the direction of the Oregon Health Policy Board and included members from Oregon Health Authority, the Oregon Department of Consumer and Business Services, experts in health care administration and economics, and various other stakeholders appointed by the Governor.

The Implementation Committee issued their recommendations to the state in January 2021. The following recommendations are salient for the Medicaid program and for CCOs' efforts to implement new VBP models:

- Setting an annual cost growth target for all providers in the state of 3.4% for 2021-2025 (the current target for Medicaid) and 3.0% for 2026-2030.
- Promoting the adoption of VBP models across all payers and providers.
- Identifying quality measures that align with CCO measures.
- Holding all payers and providers accountable for achieving the cost growth target.

These recommendations are intended to create alignment between Oregon's VBP goals for CCOs and commercial health care payers, potentially spurring increased provider VBP adoption. CCOs have identified lack of market share as a barrier to achieving VBP adoption among providers with a small proportion of Medicaid members. Thus, aligning all payers with the same requirements may enhance CCOs' leverage when negotiating with providers to adopt VBP models.⁴⁻⁶

Capacity-building efforts and priorities depended on a CCO's existing provider contract mix in early 2020.

CCO leaders noted that their strategy for developing capacity for further VBP contracting depended on “where they were starting from” with their existing provider contract mix. CCOs that were already frequently contracting with providers on a capitated basis reported focusing their early efforts on building capacity to integrate quality and performance requirements into these contracts. Conversely, some CCOs were beginning the contract cycle with a higher proportion of contracts structured as pay-for-performance arrangements. These CCOs described efforts to move toward capitation payments, including developing the ability to attribute members to providers.

CCO leaders were eager for ongoing feedback from the state to identify where they were excelling or struggling relative to other CCOs. There was also strong interest in opportunities to learn about VBP models or approaches from other CCOs, including “confidential learning spaces” where CCOs could discuss shared challenges and lessons learned without outside observers.

The CCO-Provider Contracting Process

CCO leaders often described a cyclical process in the development and implementation of new VBP models. The process proceeded through the following stages:

1. Reviewing data and developing or refining VBP models.
2. Discussing and negotiating new arrangements with providers.
3. Engaging providers in contracts and providing ongoing support, while continuing to review performance data to further refine models.

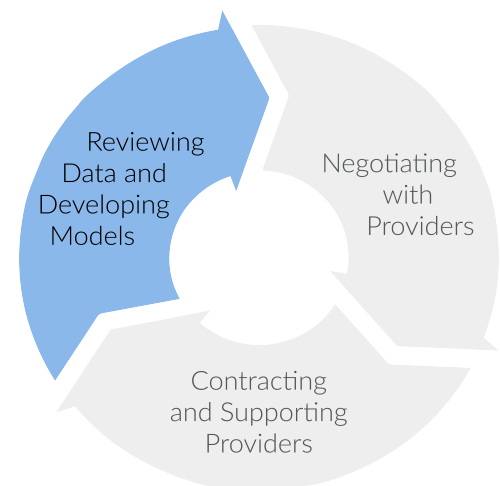
Interviews with CCO leaders in late 2020 suggested CCOs were building capacity to review data and develop new payment models while encountering challenges negotiating and contracting with providers. These phases are further described below.

Reviewing Data and Developing VBP Models

CCOs varied in the formality of the processes they described to develop new VBP models, with two distinct approaches emerging.

In some cases, CCO leaders described a process in which the CCO internally identified VBP priorities and developed and received approval for a model before conducting outreach to potential providers. In this approach, the CCO relied broadly on its member and population data to identify priorities for VBP models.

In other cases, CCOs described VBP arrangements as emerging primarily from conversations with individual provider organizations on an ongoing basis, with priorities developed based on a review of providers' performance and consideration for the specific members served.



CCOs reported a range of strategies to assess population and member needs to inform VBP planning.

Most CCOs reported involving multiple internal committees, such as Board of Directors subcommittees, Finance and Quality Committees, and Clinical Advisory Panels (CAPs), to analyze quality and cost data related to VBP arrangements. Some CCOs reported that they involved Community Advisory Councils (CACs) to establish priorities for VBP quality measures, monitor adverse impacts of VBPs, and anticipate VBP implementation challenges.

Several CCOs noted the importance of reviewing performance measures disaggregated by race, ethnicity, and other member demographic factors to inform priorities for their VBP model development. One CCO reported using disaggregated quality measures to frame questions for community listening sessions:

“A part of the robust discussion that we’re having with our quality improvement teams and our analytics team is about the limitations of quantitative data for any of this... we’re trying to put together some principles around data use and data interpretation that take it one step beyond just spitting out what appears to be disparities around the measures, and have a more meaningful conversation with the community. [...] I think that everyone gets tired of just mining through claims data to find differences, and instead wants to understand what the implications of those differences are, and how that could tailor different interventions in a true partnership with the community.” – CCO leader, 2020

In contrast, one CCO leader spoke of “drinking from the fire hose” with too many options and data sources potentially relevant for the CCO’s VBP planning, creating difficulties in prioritizing. In some cases, CCO leaders reported tension between relying on community data to identify member needs versus aligning with the state’s requirements. These two lenses sometimes pointed to different priorities that were not easy for the CCO to reconcile.

Exhibit I lists sources of information CCOs described as informing their planning efforts.

Exhibit I: Information Sources CCOs reported Relying on for VBP Planning

- Community Health Assessments and Community Health Improvement Plans (CHIPs)
- Community listening sessions
- Provider reports of community needs
- Performance measures disaggregated by member demographics
- Conferences
- Academic journals
- Learning collaboratives
- Actuarial and analytic team expertise
- Member grievances and appeals
- Recommendations from CACs
- Member and care coordinator interviews

CCOs attempted to identify health inequities among their members. However, the lack of reliable demographic data was frequently cited as a challenge in developing VBP models that promoted health equity.

CCOs were actively working to develop their capacity to collect and use member demographic data for VBP planning. Some noted that using these data to inform their VBP model design and health equity strategies was better described as a goal rather than an existing competency:

“That’s our goal, to develop VBPs informed by health equity in 2021. One other thing that we will be able to do in 2020 would be to also look at if there are any disparities, not only from utilization aspect, from a quality aspect also within our population.” – CCO leader, 2020

CCOs’ ability to identify and calculate member risk or assess the effects of COVID-19 on access and utilization within certain populations was hindered by lack of member-level demographic data for new enrollees. Changes in service areas that occurred during the transition to CCO 2.0 created an additional challenge. To address gaps in demographic data, some CCOs conducted chart reviews.

“We’ve been piloting some different chart review pieces to supplement [our data], particularly around preferred language, to supplement what we have. We know that we have a lot of gaps in our data right now.” –CCO leader, 2020

Despite challenges related to the lack of member demographic data, CCOs found ways to promote health equity in new provider VBP arrangements.

Some CCOs explicitly referenced using a health equity lens in their efforts. For example, CCOs provided equity training for their data analysts or hired analytic and quality improvement staff with specialized expertise in population health and health inequities. CCOs also developed health equity decision tools to guide future VBP planning.

Other CCOs included requirements for cultural responsiveness training as a component of their provider contracts, required providers to develop health equity initiatives, and developed performance incentives for culturally-specific behavioral health providers. One CCO provided support for bilingual staff or Traditional Health Workers to become certified interpreters to expand access to in-person language and translation services.

“There are some other contractual requirements and other ways in which we engage the provider network that supports [equity]. So even though it’s [not] tied directly to a value-based payment per se, there are other ways in which we’ve been supporting the network through either educational components or required training in which we’re further supporting health equity.” – CCO leader, 2020

Some CCOs expressed concerns about their ability to promote health equity through VBP arrangements.

In some cases, these concerns reflected difficulties in finding a common definition or conceptualization of health equity. In some cases, these concerns reflected technical challenges, such as the difficulty of moving beyond monitoring disparities to begin tying payments to the provision of equitable care. Furthermore, there were concerns that CCOs may not have a clear path

forward if and when disparities were identified because of their intersection with complex social determinants of health:

“The interplay between the health system and other systems is just front and center all the time. So, thinking about kindergarten readiness and early life health pushes us to think about what type of braided funding structures across different silos need to be in place to best support the social well-being of our population. And so that’s a different form of payment model. It’s hard enough to just get a traditional health-related value-based payment model in place.” – CCO leader, 2020

CCOs expressed a desire for additional support in establishing measure targets and benchmarks.

Several CCOs reported that they primarily aligned their measure selection and target setting for providers with the state’s CCO performance targets, modeling their provider VBP contracts on the state’s pay-for-performance framework for CCOs. Although less frequent, some CCOs reported selecting measures and targets for providers on a case-by-case basis.

CCO leaders identified areas of desired support for setting both quality and cost targets and benchmarks in provider contracts. Specific issues included:

- **Balancing the emphasis on quality targets and cost growth management.** One CCO leader expressed concern that pushing providers to focus too intensely on improving access to care was likely to lead to the CCO exceeding its target for sustainable cost growth.
- **Perceived fairness.** Multiple CCO leaders reported a perception among providers that their reimbursements should grow at the same rate as the CCO’s global payment or that a provider’s financial risk-sharing should mirror the CCO’s financial risk regardless of the value produced by a particular type of services. CCOs struggled with messaging to address these concerns when the CCO intended to shift investment toward higher-value services over time in ways that could benefit Medicaid members as a whole while negatively impacting reimbursement for a given provider.
- **Whether and how to adjust quality targets during COVID-19.** The COVID-19 public health emergency was described by many CCOs as requiring changes to providers’ performance targets. One CCO leader suggested it may be beneficial for the state to promote a statewide approach for when and how providers’ quality targets would be reset in light of the pandemic.
- **Risk adjustment to promote health equity.** Most CCOs reported setting providers’ performance targets based on their historical performance to avoid penalizing providers serving members in poorer health. One CCO was using members’ clinical risk scores to adjust providers’ performance targets. Several CCO leaders desired additional guidance on stratifying members based on clinical or social risk scores to offer tiered rates that would not penalize providers serving members with more intense care needs.

Few CCOs had fully scaled approaches to collect data on social risk factors. This may hinder CCOs’ ability to monitor disparities or develop risk-adjusted payment models.

Some CCOs reported plans to implement platforms for collecting data on social determinants of health (SDOH) and risk factors, including homelessness or food insecurity. CCOs implemented social needs screening and referral platforms such as UniteUs and planned to incentivize or require providers to collect and report these data in future VBP contracts:

“Future VBPs will crosswalk claims experience for special populations with social determinants of health and race, ethnicity, language, and disability data. A good example would be an informed maternity case management VBP that integrates a risk screening tool.” – CCO leader, 2020

The Centers for Medicare and Medicaid Services has recommended the use of Z codes (special ICD-10 encounter codes used to document SDOH data) as one strategy for collecting and monitoring members' social needs and risks.¹⁰ Some CCOs began to experiment with collecting Z codes from providers. However, one CCO noted challenges:

“We’ve had a little bit of reluctance from providers to submit [z codes] to us. We recently just got an email last week asking, “Do we still need to report these codes to you?” I’m like, “Yes.” That’s the only way we know that information.” – CCO leader, 2020

One CCO reported that they had introduced a pay-for-reporting program to build provider capacity in collecting and reporting Z-codes, intending to leverage these data in VBP design and monitoring. Another CCO noted that the data infrastructure and processes they were developing to support monitoring of equity in their VBP arrangements would also support other CCO 2.0 requirements, such as the SHARE initiative (see Exhibit J):

“I’m leading the effort of diving into our SHARE strategy and our HRS/SDOH CBI investment policy that aligns not only with the SDOH focus areas outlined by the state but also is informed by our regional data that reflects our community health and regional disparities in that regard.” – CCO leader, 2020

Exhibit J: Oregon’s SHARE Initiative for CCOs

In 2018, the Oregon legislature created Supporting Health for All through Reinvestment (SHARE) through House Bill 4018. The SHARE Initiative requires CCOs to invest a portion of net income or reserves in projects that address social determinants of health and health equity (SDOH-E).

Beginning in 2021, CCOs were required to develop and submit to the state a SHARE Initiative spending plan. These spending plans were required to outline how the CCO would partner with its Community Advisory Council and other SDOH-E partners such as community nonprofits, Tribal governments and public health authorities to invest in projects to address SDOH-E. The CCO’s SHARE Initiative activities must align with community priorities identified in the CCO’s CHIP and fall within four domains including:

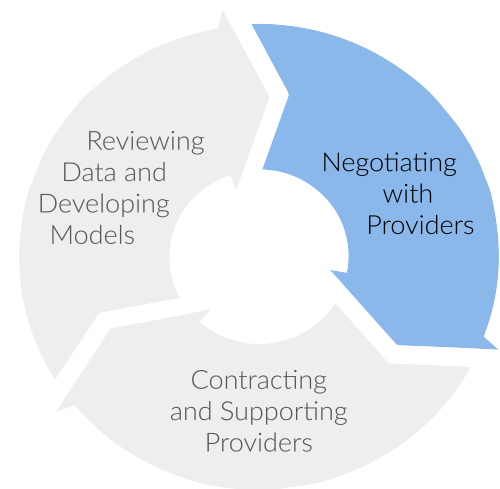
- **Economic stability**, such as housing, employment and food security initiatives.
- **Neighborhood and built environment**, such as access to parks or non-medical transportation.
- **Education**, such as early childhood programs or high school retention programs.
- **Social and community health**, such as Traditional Health Worker (THW) programs and initiatives focused on reducing experiences of trauma and discrimination.

Additional details about the SHARE Initiative are available at <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx>

Discussing and Negotiating VBPs with Providers

At the start of CCO 2.0, CCOs primarily reported strategies for provider engagement that focused on moving existing VBP-contracted providers into more advanced VBP arrangements.

Some CCOs reported that most providers within their network were already engaged in some form of VBP arrangement. In these cases, CCOs focused on expanding existing VBP models or transitioning to more advanced models. There were fewer examples where CCOs described formal processes or plans to conduct widespread VBP outreach to non-VBP-contracted providers in 2020, other than in the context of offering capitation arrangements to providers during COVID-19.



When CCO leaders described outreach strategies to engage new providers, they identified the following ways of stratifying or grouping providers for further outreach:

- By CDA (e.g., behavioral health, hospital, or maternity care)
- By contract status (e.g., initial outreach to a new provider versus ongoing discussions with an existing provider)
- By purpose or focus (e.g., providers to be engaged in quality discussions versus those to be engaged in risk-sharing discussions)
- By venue or setting (e.g., regional or facility-based outreach, or connecting with providers through specific community groups or existing CCO committees)
- Through the use of claims data to identify potential candidates for VBP adoption

In general, providers were described as supportive of the transition to VBP models and exhibiting “buy-in” for the CCOs’ work in this area.

Most CCOs identified challenges with provider adoption of VBP arrangements.

Overall, CCO leaders tended to describe negotiation challenges broadly, including factors such as:

- **Availability of providers or organizations in some regions.** CCOs sometimes had limited options to build their provider networks, particularly in rural areas where specialists or hospitals were sometimes located across state lines.
- **Differences in VBP frameworks across payers and states.** CCOs, commercial and Medicare payers sometimes interpreted the HCP-LAN framework differently. This challenge also arose between states, with CCOs sometimes encountering challenges when providers were contracted with Medicaid Managed Care Organizations in Washington State or Idaho.
- **Lack of experience with value-based contracting among providers.** While CCO leaders reported few instances where providers were openly opposed to transitioning to VBP, many providers had little experience with these arrangements. They required support to understand VBP concepts such as downside risk.

- **Negotiating performance and risk-based arrangements during a public health emergency.** Some CCO leaders noted the inherent tension in establishing performance goals or targets during the COVID-19 pandemic. Many organizations were operating under conditions of extreme uncertainty about future health care or public health needs. This was further exacerbated by Oregon's devastating 2020 wildfire season that caused closures and evacuations across several areas of the state. VBP negotiations typically involved ongoing discussions and the inability to meet in person or on a frequent enough basis hindered CCOs' efforts.
- **Inadequacy of incentives.** Several CCO leaders described difficulty engaging providers in VBP arrangements due to the perceived inadequacy of Medicaid reimbursement. Smaller provider organizations and those with few Medicaid members faced challenges in improving their performance on quality measures.

Some CCO leaders expressed a belief that while developing new VBP models that could meet the state's requirements for care delivery area may be straightforward in some areas, promoting provider adoption of these models to meet the state's annual VBP targets would be more challenging. Where CCOs could adapt existing capitated models by incorporating a new quality component, they perceived fewer challenges in transitioning providers to VBP arrangements. When model design required the development of new member attribution strategies or bundled payments, these shifts were perceived as more difficult to implement.

As CCOs approach deadlines for developing new VBPs in specific CDAs, it may be important for the state to further explore the challenges arising with VBP promotion and adoption in these areas to provide more targeted support to CCOs and providers.

In Chapter Four, we describe challenges CCOs have reported in areas of hospital, maternity, behavioral health, children's health, and oral health care.

CCO leaders identified certain factors that facilitated negotiation with providers to promote VBP adoption.

The following approaches were described as helpful when engaging providers in VBP negotiations:

- **Aligning provider contract language with CCO 2.0.** Making the connection to CCO 2.0 or VBP Roadmap requirements explicit, including the alignment of quality and performance goals, was described as helpful for promoting buy-in. The CCO's incentive measures and Oregon's Aligned Measures Menu were useful as starting points for negotiations.
- **Being flexible** and willing to pursue a tailored approach for individual providers or organizations, rather than aiming for a one-size-fits-all model. This sometimes meant being willing to introduce providers to basic information about the HCP-LAN framework. One CCO reported using a readiness assessment for VBP to identify specific provider needs.
- **Introducing multi-year agreements that phase in VBP elements over time.** This approach may begin with a pay-for-reporting year to build the provider's familiarity with reporting quality measures and incrementally phase-in bonuses, shared savings, and shared risk. One CCO leader noted that in taking this approach, it was important to "begin with the end in mind" and be clear about the ultimate goal of moving a provider toward a risk-sharing arrangement.
- **Emphasizing implementation milestones and quality over cost targets in new VBP contracts.** CCOs more often described VBP negotiations focused on quality rather than cost targets in 2020 because of the financial challenges posed by the pandemic. Some CCOs reported beginning with provider

quality targets related to infrastructure development and VBP reporting capabilities in 2020 to minimize providers' risk exposure in VBP arrangements during the pandemic.

- **Transparency in CCO strategies.** For CCOs negotiating with providers with multiple CCO contracts, it was especially important to have clarity regarding the strategies and approaches being taken by other CCOs. Having sample VBP models and risk adjustment approaches or methodologies was also useful in avoiding incompatible approaches across payers.
- **Reducing uncertainty.** CCO leaders noted the importance of a stable operating environment for providers to feel comfortable engaging in VBP arrangements. While the COVID-19 pandemic had introduced substantial uncertainty, offering stability or predictability in member attribution strategies, HIT requirements or products, or funding levels, could reduce provider hesitation.

CCOs sought to minimize reporting burdens on providers but lacked a clear process to align quality measures with other payers and CCOs.

The reporting burden on providers is a concern. The state required CCOs in overlapping service areas to take steps to align the selection of quality measures for providers who may contract with more than one CCO. Interviews with CCO leaders suggest that CCOs understand and support this effort but lack clear processes or models to do so. One CCO leader noted:

"I hear a lot of fatigue from our clinics because of the many different metrics they're chasing from many different payers. So, I think having those spread out so broadly is a challenge that we face, and we've tried our best to align them. We have multiple CCOs here, and historically that presented a challenge both for our providers and for ourselves."
– CCO Leader, 2020

One CCO leader noted that it was useful to have providers lead these discussions. Providers possessed unique mixes of contracts (and, in some cases, other funding streams with reporting requirements such as federal grants). CCOs could not adopt a single strategy for all providers. CCOs also relied on providers to identify when action plans or improvement goals from other payers conflicted with their ability to prioritize the CCO's own quality goals.

"I can point to a number of examples of us participating [with CCOs] in work groups and honoring providers' requests to handle quality dollars in a somewhat similar way." – CCO leader, 2020

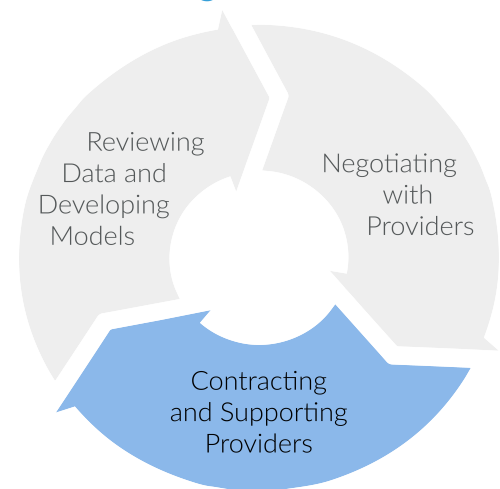
"All three of us agreed that we would be responsive to requests if someone said, 'Look, this isn't aligned, we should get together and talk.'" – CCO leader, 2020

Another CCO leader noted that this issue would be best addressed as a statewide HIT issue rather than a payment issue. A CCO's internal reporting platforms often dictated whether and how the CCO could modify its approach to align with other payers. This was a particular concern in the emerging area of social needs and social determinants of health, where CCOs were potentially developing highly individualized approaches to data collection.

Contracting with and Supporting Providers in VBP Arrangements

Performance monitoring grounded in a quality improvement mindset is an important mechanism for building providers' confidence in VBPs and trust in CCOs.

The process of CCO staff meeting with providers to discuss performance was an important aspect of developing confidence and trust in VBP arrangements. These conversations were described as being best approached through an adaptive quality improvement rather than a compliance mindset.



Some CCOs established formal standing committees with larger provider organizations to facilitate these discussions over time. This typically included meeting with VBP-contracted providers at various points throughout the year, engaging in bidirectional sharing of performance data, reviewing performance, discussing targets, and soliciting recommendations to improve VBP models over time.

Several CCOs reported that they were already providing, or were developing the capacity to provide, analytic reports or interactive dashboards for VBP-contracted providers.

Once providers engaged in a VBP arrangement, they often needed a year or more to develop the infrastructure for VBP monitoring and reporting. Some CCOs described intentional efforts to move away from past reports, which included all of the CCO's incentive measures, transitioning toward reports tailored to each provider and focused on specific quality or cost measures in a given provider's contract. This approach supported the CCOs' efforts to engage in more targeted technical assistance with providers. However, one CCO leader reported that providers had been less engaged in these meetings during COVID-19, with performance targets waived during the pandemic.

CCOs varied in their approaches to developing staff capacity for VBP monitoring. Some CCOs reported the involvement of their actuarial or data analytic teams. In contrast, others described developing new population health analytic teams to serve both as subject matter experts within the CCO and to providers. One CCO leader described the importance of training the CCO's care coordinators to understand quality measures being incorporated into VBP arrangements with providers. Another CCO reported its intention to engage a third-party evaluator to assess new primary care VBP models. In another case, a CCO reported that data literacy among their contracting team was essential, but they also needed staff with different types of expertise to monitor performance related to providers' quality targets versus cost targets.

Exhibit M: Examples of Quality or Financial Reports CCOs were Making Available to Providers

- Monthly or quarterly financial reports displaying progress relative to a provider's cost target.
- Reports displaying providers' receipt of early-released funds that would typically be tied to performance were it not for COVID-19, as well as receipt of COVID-19 relief funds.
- Reports of quality measures including member engagement, member-level care gaps (e.g., "gap lists"), or utilization (e.g., "hot-spotting").
- Quality reports disaggregated by member demographics such as race and ethnicity.
- Scorecards providing a comparison of a provider's performance to other providers in the network or the region's network performance to out-of-area performance.
- Reports of risk scores for provider panels or clinics and comparison to others in the CCO's provider network.

CCO leaders reported several challenges with collecting or analyzing data for monitoring providers in VBP arrangements. These challenges included:

- **COVID-19 related impacts on 2020 data.** The pandemic impacted both CCOs' collection of data from providers in the first half of 2020 as well as the usefulness of data, which reflected some periods of the public health emergency when health care providers were restricted from offering elective procedures.
- **Identifying the appropriate level of analysis.** CCOs reported that providers varied in the granularity of reports they needed for monitoring or quality improvement. Some organizations benefitted from provider-level reports. Others required measures aggregated at a higher level due to small numbers of Medicaid members. CCOs also reported uncertainty identifying the best level of analysis to identify member health inequities.
- **Service area incongruencies.** CCOs had difficulty developing reports for providers when the CCO's service area boundaries did not align well with a provider's service area. CCOs needed different reporting strategies for providers located wholly in their service region versus those serving multiple regions.
- **Lack of CCO access to clinical data.** Health care claims were of limited value to CCOs for real-time VBP monitoring due to the months-long claims lag. Some CCOs were interested in developing strategies to directly link with providers' electronic health record systems but reported also being challenged when providers were unable or unwilling to directly share clinical data for performance or accountability.
- **Integrating data sources from across the CCO's programs or services.** When data for VBP monitoring were collected across multiple initiatives or platforms, additional steps were often needed to link these data for analysis. For example, one CCO described needing to modify its claims system to link behavioral health and substance use disorder (SUD) treatment claims that were previously reported via separate systems. Existing claims-based systems also needed modification to track VBP-relevant information such as contract HCP-LAN tier.

The role of CCOs in promoting providers' use of HIT was evolving and not always clear.

Using data for provider performance monitoring and quality improvement will be central to CCOs' VBP strategies. However, CCOs varied in their approaches or understanding of their roles in this area. Some described their role as directly building providers' capacity to receive and use data. This approach sometimes involved making claims data available directly to provider organizations to link with their clinical data. In other cases, the CCO described linking clinical and claims data internally because the CCO held member-level data from multiple providers and could provide a more complete picture of a member's health history or needs.

The decision to rely on static reports or interactive platforms when sharing data with providers was a central decision often driven by cost, the desire to shorten the time lag in making reports available to providers, and the existing capacity of providers to engage in population health management. CCOs also varied in the degree to which they required providers to actively engage in using HIT tools as a contractual requirement. Some CCOs described making reports or tools available to providers through "self-service" portals or secure file transfer links. Other CCOs either incentivized or required providers to exchange clinical information through tools such as the Collective Medical platform.

Provider buy-in was perceived as critically important. One CCO reported conducting "user acceptance testing" before launching a HIT platform to ensure provider acceptance before purchasing. Another CCO leader deliberately phased in new technologies over time to avoid overwhelming providers with too many new requirements.

CCOs' ability to monitor disparities arising from VBP arrangements was limited in 2020, though all CCOs reported efforts to continue building this capacity.

Several CCOs reported that they were reviewing quality measures related to VBPs on an ongoing basis for adverse impacts related to health equity, including monitoring data disaggregated by demographic categories (to the extent such data was available).

CCOs reported a wide range of measures in use to monitor equity and disparities in VBP arrangements (see Exhibit N). Most CCOs reported that they monitored member reassignments and patient dismissals by providers, though fewer described a specific intervention process in place to address identified issues. Several CCOs reported they monitored patient satisfaction surveys, with some introducing new data collection related to member experiences of bias, discrimination, and cultural insensitivity in 2020.

In some cases, CCOs reported challenges in analyzing data on specific member groups. Small numbers of members included in certain performance measures made it difficult or impossible to share those performance metrics with stakeholders due to privacy concerns. To address this challenge, one CCO was developing a health equity index that aggregated multiple measures to allow comparison of outcomes for small subpopulation groups. One CCO described needing more specific technical assistance to know, for example, what sample sizes were necessary to ensure validity in the analysis of quality measures.

Exhibit N: Data Elements Frequently Referenced as Relevant for Equitable VBP Model Design and Monitoring for Health Inequities

Demographic data

- Language, and preferred language access
- Race and ethnicity
- Gender
- Age
- ZIP code

Health status and risk

- Disease state
- Medical complexity (e.g., the Seattle Children's medical complexity algorithm, the Charlson Comorbidity Index, and the Johns Hopkins ACG predictive risk model)
- Z codes
- Social needs screening measures

Measures of health care access or quality

- Patient grievances
- Primary care provider assignment and engagement
- Patient dismissals by a provider
- Access to services in a preferred language
- Access to in-person and/or telephonic translation services
- Hospital readmissions
- The ratio of telephonic to in-person translation services

Plans to reduce disparities included monitoring access to culturally and linguistically appropriate services, introducing performance measures based on translation services, offering provider support for bilingual staff certification, and assessing digital equity and barriers to telehealth for some member populations.

Summary

CCOs made substantial efforts to develop capacity for VBP arrangements in 2020. They reported contracting cycles that proceeded through similar phases of assessing needs, negotiating with providers, and monitoring providers in VBP arrangements. However, some CCOs took a data-driven approach to develop new VBP models based on member needs, while other CCOs reported a stakeholder-driven approach to developing models tailored for specific providers. Emerging challenges included increased reporting burdens, lack of reliable data on members, and provider reluctance to adopt VBP models. These challenges existed against the backdrop of the COVID-19 public health emergency and other external events in 2020 that challenged CCOs' efforts.

Despite these challenges, CCOs demonstrated progress in developing the capacity to meet VBP targets and milestones in future years. CCOs also described specific and concrete examples of planning to leverage VBP arrangements to promote health equity among their members.

In Chapter 4, we present findings related to CCO progress toward new VBP requirements in 2020, including provider adoption of VBP arrangements and CCO development of new VBP models in specific areas required under the VBP Roadmap.

Progress toward VBP Roadmap Requirements in 2020

KEY FINDINGS

- *Despite major disruptions occurring in 2020 related to the COVID-19 public health emergency and other events, CCO leaders expressed confidence in their ability to meet annual VBP targets in the early years of the CCO 2.0 contract period (e.g. 2020 and 2021).*
- *They were less confident about meeting incrementally increasing targets in later years in part because of concerns about promoting VBP adoption among specialists, hospitals and maternity care providers.*
- *COVID-19 led some CCOs to make widespread and temporary changes to existing and planned VBP arrangements, often waiving performance targets or reducing reporting requirements for 2020. CCO leaders reported that some providers were more reluctant to enter into new VBP arrangements due to increased uncertainty about financial risk or members' care needs in future years.*
- *While the state delayed CCOs' requirements to develop behavioral health, maternity care and hospital care VBP models, CCOs still made some progress developing new VBP models in these areas. In particular, there is evidence of progress in behavioral health and hospital care arrangements. There is less evidence of development of maternity care VBP models, with most CCOs reporting they paused these efforts while responding to the COVID-19 pandemic.*
- *While CCOs made progress developing new payment models, a statewide strategy may be needed to promote provider adoption of VBP models in some care delivery areas. There is a perception among some CCO leaders that negotiating provider uptake of hospital (and to a lesser extent, maternity care) models will be difficult because CCOs lack purchasing power and leverage in negotiations.*
- *CCOs have encountered relatively few challenges implementing tiered infrastructure payments to PCPCHs.*

The earliest CCO requirements and milestones in the VBP Roadmap took effect in 2020. This chapter presents findings related to CCOs' progress toward these goals in 2020, the first year of the contract cycle. These results rely on key informant interviews and written questionnaires gathered in late 2020. A complete description of data sources and methods informing these findings is provided in Appendix B.

CCOs' VBP Requirements in 2020

CCOs were required to achieve certain VBP milestones in 2020. These requirements included:



VBP Targets. CCOs were to make 20% or more of their payments to providers in qualifying arrangements (HCP-LAN category 2C or higher). On April 6, 2020, OHA announced that this requirement would not be affected by COVID-19 as it was already in place before the pandemic. However, the state gave CCOs flexibility to relax provider reporting of quality or performance measures during the pandemic. Category 2C (pay-for-performance) arrangements that were temporarily transitioned to category 2B (pay-for-reporting) would not result in CCOs losing credit for these arrangements toward the annual target due to the challenges of collecting data during the COVID -19 public health emergency.



CDAs. CCOs were charged with developing or enhancing VBP models in three CDAs for implementation in 2021: maternity care, hospital care, and behavioral health care. On April 6, 2020, in response to the COVID-19 pandemic, the state announced that this requirement would be deferred by one year. CCOs would be required to develop these three VBP models in 2021 for implementation in 2022.



PCPCH Payments. CCOs were to implement tiered infrastructure payments to PCPCH that rewarded clinics for higher levels of PCPCH recognition. As this requirement was already in effect at the beginning of the pandemic, the state made no changes for 2020.

In the following sections, we discuss CCO-reported progress and emerging successes and challenges in each of these areas.

Progress Toward Annual VBP Targets



CCOs were required to achieve at least 20% of payments to providers within qualifying VBP arrangements (HCP-LAN category 2C or higher) in 2020. As reported in Chapter 2, many CCOs already exceeded this threshold in 2019.

The COVID-19 pandemic caused widespread changes in CCOs' plans for VBP arrangements in 2020.

Payment arrangement data for the calendar year 2020 were not yet available at the time this report was published. However, interviews conducted with CCO leaders in late 2020 suggest the COVID-19 PHE had substantial impacts on CCOs' VBP arrangements with providers.

While CCOs reported general efforts to promote provider adoption of VBP arrangements in 2020, much of their focus was described as helping providers navigate specific financial and operational disruptions related to the COVID-19 pandemic. One CCO leader noted concerns about being “too innovative” in the current environment:

“It does lead to a holding pattern, and I think that it probably means less pushing for innovation now in the face of not messing anything up. Let’s not mess anything up by getting too creative now, but also recognizing that we have a limited time window to do this, and the outcomes [...] can be really meaningful when you get it right for the population. We feel obligated to also continue pushing forward and continuing to be disruptive in the sense of health system transformation. So that’s a fine line for CCOs, and I think that it’s an especially tough call for our leadership and our governance structure to know exactly when we can push a little bit harder on these things in the current context.”
-- CCO leader, 2020

COVID-19 was expected to continue to be a major factor in providers’ willingness and ability to engage in VBPs in 2021.

Late in 2020, CCOs suspended most performance and risk-sharing elements of their VBP contracts to provide relief to providers during the pandemic.

Following OHA’s early release of quality pool funds from 2019, most CCOs reported that they fully released incentive payments withheld for 2019 and suspended further withholds from payments made in 2020. Two CCOs reported reserving a portion of incentive payments to be directed toward COVID-19 relief to highly adversely impacted providers. CCOs with a larger proportion of providers in capitated payment arrangements (with or without quality components) described these arrangements as a vital source of stability for provider networks during the pandemic and reported few changes in these models. Many CCOs also offered financial assistance to providers through advance payments based on historical payment levels. One CCO increased reimbursement rates for FFS providers to offset pandemic-related decreases in service volume.

Beyond changes in payments, we observed variation in CCOs’ responses to COVID-19 with respect to provider performance requirements.

Some CCOs opted to fully waive performance targets for providers in VBP arrangements, keeping the overall structure of these performance-based contracts intact for future periods. Other CCOs initially made no changes in performance requirements but were revisiting these targets late in 2020 for potential contract renegotiations.

In addition to these changes to existing arrangements, several CCOs deferred planned enhancements to providers’ performance targets or the addition of new quality measures to 2021. Variation in the renegotiation of performance requirements will be an important area to monitor, as it may lead to differences across regions in CCO progress toward CCO 2.0 requirements or provider reimbursements under VBP arrangements in the future.

CCOs incorporated community outreach to providers and members as part of their COVID-19 response.

COVID-19 required providers and members to shift to telehealth for the delivery of many types of care. Some CCO leaders reported that supporting this shift was a major focus during 2020. These efforts included providing mobile phones and subsidized internet access to members to facilitate continuity of care. CCOs also offered support directly to providers to establish the infrastructure needed to provide telehealth services. Despite these efforts, CCO leaders were concerned that quality measures established in providers' contracts did not translate well to telehealth, necessitating a shift in measurement strategy or the contracts themselves.

In response to the pandemic, CCOs also evaluated and engaged high-risk members to ensure continuity of care during service limitations, facilitated connections with and provided enhanced flexibility for community-based organizations to provide services, and created new programs, such as providing non-medical transportation support for members.

The pandemic was perceived to influence providers' willingness to engage in new VBP arrangements with CCOs.

CCO leaders reported that the pandemic had impacted providers' willingness to move into VBP arrangements. Providers were described as being more risk-averse and acutely aware of financial vulnerability. They also struggled with staff turnover.

Capitation arrangements may have offered relative stability in 2020, but CCOs also used other mechanisms to support providers. CCOs reported developing COVID-19 response strategies that directed support toward providers acutely impacted by COVID-19, including those in FFS payment arrangements. Some CCOs opted to set aside a portion of incentive funds to establish COVID-19 relief payments for providers affected by facility closures and lost revenues. Additionally, some CCOs reported that many of their providers contracting with the CCO on an FFS basis also accessed federal COVID-19 relief such as CARES Act funds.

CCO leaders were generally optimistic about meeting VBP targets in 2020, but less so about later years.

CCO leaders expressed optimism that they were on track to achieve the 2020 target of 20% of payments in qualifying VBP arrangements. They were less confident about achieving the target of 70% of payments in qualifying arrangements by 2024. Some CCO leaders emphasized the importance of securing participation and buy-in from specific sectors such as hospitals and specialists. CCOs also noted that pharmacy claims may be an important area of focus in future years. They requested that the state provide support such as sample models and contract language to introduce quality components into Pharmacy Benefit Manager (PBM) contracts.

Progress in VBP Roadmap Care Delivery Areas



The VBP Roadmap for CCOs originally required the development of new payment models in behavioral health, maternity care, and hospital care in 2020.

The state directed CCOs to develop new or enhance existing category 2C or higher VBP models in these three CDAs to be implemented no later than January 2021. Additional requirements to develop models in oral health care and children's health care were scheduled to take effect in later years of the CCO 2.0 contract cycle.

In April 2020, the state delayed the 2020 CDA requirements by one year. CCOs were granted an additional year to develop qualifying payment models, with behavioral health, maternity care, and hospital care models to be developed no later than 2021 for implementation in 2022.

Despite the challenges posed by the pandemic, CCOs made meaningful progress toward developing VBP models for these priority areas.

Some CCO leaders reported a perception that achieving the requirement to develop new VBP models in care delivery areas would be easier than meeting new annual VBP targets. In the sections below, we describe CCOs' progress toward CDA requirements that were reported in 2020.

Behavioral Health Care

Most CCOs reported prior experience with non-FFS arrangements with behavioral health care providers before CCO 2.0 contracts.

CCOs provided the following examples of non-FFS behavioral health payment arrangements in place before CCO 2.0:

- Capitation agreements with providers and provider groups (other than county sub capitation arrangements).
- Shared savings arrangements.
- Shared savings and shared risk arrangements.
- PMPM payments for specific services.
- Case rates and bundled payments for episodes of care.

Few other details were available regarding the structure of these arrangements before 2020. Arrangements that lacked a quality component would not qualify as a VBP arrangement. In written responses and interviews conducted with the state in 2020, twelve CCOs reported that they planned changes to their existing behavioral health arrangements to meet new CCO 2.0 requirements. Six CCOs reported plans to introduce or expand quality measures tied to existing FFS-based arrangements, while four CCOs reported additional plans to implement or modify capitated payments. Two CCOs were exploring the development of new shared risk arrangements.

SPOTLIGHT: THE OREGON VALUE-BASED PAYMENT ROADMAP AND COVID-19 PANDEMIC STUDY

In February 2020 the State of Oregon took steps to slow the spread of the SARS-CoV2 virus including the delay of non-urgent health care services and procedures, a statewide closure of non-essential businesses and services, and “stay at home” mandate. These steps sharply reduced utilization of health care services and revenues, and health care providers had to adapt to providing services in a rapidly changing and unpredictable environment.

OHA funded a team of researchers at Oregon Health & Science University, led by Dr. Deborah Cohen⁹, to assess organizations’ operational modifications made in response to the pandemic, and to understand how provider payment arrangements affected their organizational stability and adaptability. Sixteen (16) provider organizations across CCO regions and service types, were interviewed, to assess the impacts of the COVID-19 pandemic. Their research found:

- In order to accommodate new COVID-19 safety measures, providers needed to make changes to care delivery such as limiting in-person visits, implementing infection control measures, and beginning curbside consultations and telehealth visits.
- Financial and administrative support from the federal government, the state, and CCOs helped facilitate continued operations for providers.
- Mental health and SUD providers experienced particular barriers to receiving external support due to ineligibility for some federal assistance, low prioritization for receiving personal protective equipment, and reluctance to seek help from CCOs based on negative past experiences.
- Payment arrangements providing the most stability for providers during the pandemic included prospectively paid population-based payments, capitated payments not linked to quality, and Alternative Payment and Advanced Care model payments. For providers with a high proportion of these arrangements, the frequency and predictable nature contributed to stability and allowed providers to make operational adaptations to COVID-19.
- Conversely, retrospective payment arrangements (pay-for-performance or shared savings) and FFS arrangements did not provide the same financial stability and flexibility to implement changes in care delivery.
- Primary care providers were more likely than mental health and SUD care providers to have VBP arrangements in place, as well as existing infection protocols and prior experience with telehealth services. Thus, they were better able to adapt to care delivery changes. In contrast, some mental health and SUD providers experienced financial losses due to lack of infrastructure for telehealth, restructuring of resource allocation, and being tasked by county governments with additional COVID-19 related responsibilities.

The COVID-19 pandemic created many challenges for health care providers and brought to light how different payment arrangements can potentially affect provider resiliency under adverse circumstances. This study helped to identify the characteristics of payment arrangements that were important in facilitating this resiliency. They *“were also described as valuable during normal operations, suggesting that the ability to adapt during a crisis may also have implications in non-emergency situations.”*

CCOs were in an early stage of planning these efforts; specifics on finalized arrangements were not yet available.

CCOs described a variety of new or modified behavioral health arrangements they were designing that spanned different populations and care settings, including models focused on behavioral health and SUD. Examples included:

- Inpatient or residential services including a “recuperative care” model incorporating housing navigation for people with complex needs following hospital discharge.
- Outpatient care, including models for pediatric and maternal behavioral health care and people with co-occurring physical and behavioral health conditions.
- Incentives for primary care and behavioral health integration, for health information exchange, and culturally-specific behavioral health providers and services.
- In-home behavioral health services.
- Crisis response, navigation, and case management support for people with serious mental illness.
- Supported employment for people with behavioral health-related employment barriers.
- SUD treatment, including models focusing on opioid-use disorder or medications for addiction treatment.

CCOs considered a range of factors in their behavioral health VBP planning efforts. These included the CCOs’ infrastructure to incentivize or support integrated behavioral health services, whether the CCO had historically sub-capitated its behavioral health contracts to other entities such as a county behavioral health provider, and whether the CCO had decided to attribute members to individual behavioral health providers or adopt models such as a behavioral health home.

Successes and Areas for Focus

The COVID-19 pandemic impacted CCOs’ ability to maintain momentum on behavioral health VBP planning efforts.

Many CCOs temporarily modified their existing arrangements in mid-2020, removing performance requirements or risk-sharing to help stabilize and maintain existing behavioral health arrangements.

Some CCO leaders reported strong buy-in from behavioral health providers for a transition toward VBPs. However, the pandemic increased behavioral health providers’ financial risk aversion. Providers anticipated substantial increased behavioral health treatment needs in future years in response to traumatic events occurring in 2020, including the COVID-19 pandemic, wildfires, and protests related to racial injustice. CCOs expressed the desire for support from the state to develop culturally-specific behavioral health care models that addressed language and translation services or access to traditional health workers. Others requested support to develop shared risk arrangements with behavioral health providers, particularly in working through whether and how to assign risk to individual providers.

Despite these challenges, there were indications of progress in executing new behavioral health VBP arrangements.

CCOs reported some early success negotiating new VBP arrangements with providers in 2020. One CCO executed a new category 3A arrangement (i.e., shared savings) for crisis intervention and supported employment. Another CCO had implemented a new category 3B arrangement (i.e., shared risk) for inpatient psychiatric care late in 2020. A third CCO had successfully transitioned an existing capitated contract to a category 4A arrangement by adding new patient engagement quality measures.

VBP Success Case: A Phased Approach to Achieving Shared Savings and Quality in Behavioral Health Care

Some CCOs have outlined a path to achieving shared savings models with behavioral health providers, phasing in more advanced VBP elements over time.

One CCO reported that they initiated PMPM arrangements with their two largest behavioral health providers in 2019, with six percent of payments withheld and tied to three performance measures related to access to care. While the CCO waived reporting for the first part of the year to relieve administrative burden in acknowledgment of COVID-19, the CCO intended to develop a new outcomes-based behavioral health care payment model tied to a composite of outcome measures weighted by provider and program types. They intended to expand this model to their larger network of behavioral health and SUD treatment providers over time, beginning with a pay-for-reporting model that would transition to pay-for-performance and then shared savings in future years.

Another CCO reported they had engaged a group of behavioral health and SUD providers in contracts that included a shared savings component for services including supported employment and crisis intervention. They were working to develop a composite performance measure for behavioral health providers based on a set of outcome measures including Feedback Informed Treatment that would be adjusted for different provider types.

Some CCOs struggled to identify appropriate behavioral health quality measures and requested support from the state in this area.

Some CCOs were in the process of developing composite quality measures that combined several performance indicators for behavioral health services. Others conducted listening sessions with members to identify specific needs and priorities. These approaches may eventually serve as models for other CCOs.

The need for HIT systems that supported cross-sector information exchange was also cited as particularly important for “bringing in” behavioral health providers to a CCO’s larger provider network. CCOs emphasized the importance of collaborating with behavioral health providers to design the HIT that would support VBP model implementation.

Maternity Care

CCO experience with non-FFS payment models for maternity care was generally limited in the years before CCO 2.0, according to descriptions CCOs provided of their activities in 2019 and early 2020.

CCOs reported few examples of maternal health quality measures incorporated in provider payment arrangements before 2020. Despite this, some CCOs reported the existence of programs focusing on maternal health before CCO 2.0. These programs had typically not been developed with a VBP component at the outset. They did not include quality or performance components that would qualify as VBPs. Examples included:

- A maternal medical home model.
- Maternity care case management programs or screening and referral hubs for navigation support.
- Integrated delivery of maternity care and SUD treatment.
- Integrated payments for doula and maternity care.

These existing maternal health programs were often cited as a starting point for CCOs in planning to meet the CDA requirements for maternity care.

Few CCOs had yet formalized a strategy or focus for new or enhanced maternity care VBP models.

A range of approaches and potential priority areas were under consideration to meet the CDA requirement in 2022, including:

- **Integrated maternity care models.** Multiple CCOs reported plans to implement payment models integrating maternity care and SUD treatment. These plans included bundled payments or the creation of capacity-building payments to support the integration of SUD care into maternity care settings. Two CCOs were planning to leverage their VBP models to promote the integration of primary and maternity care, including supporting the integration of maternity care providers into PCPCHs. Two CCOs reported plans to transition a universal screening and referral hub for pregnant women to a VBP arrangement.
- **Doula care models.** Some CCOs reported plans to create or enhance VBP arrangements for doula care focused on labor and delivery or pre-, peri- and post-natal care. One CCO reported working to develop a payment model supporting culturally and linguistically specific doula services.
- **Transition to bundled or capitated payments.** Three CCOs reported plans to transition maternity care reimbursements to case rates tied to quality measures, such as cesarean rate, doula access, and postpartum care access. One CCO was negotiating with its local hospital to transition perinatal care to a capitation basis. Another CCO reported working to transition an existing maternity care case management program to a per-member, per-month basis tied to quality measures.
- **Introducing or expanding maternity-care quality measures.** One CCO planned to open its primary care quality bonus program to include OB/GYN specialists. Others planned to enhance existing models with new maternity-specific performance measures for cesarean rates or postpartum care access.

Some CCOs intended to implement new VBP arrangements for maternity care in 2020, but these plans were deferred because of disruptions related to the COVID-19 pandemic.

Despite these challenges, some CCOs made progress developing maternity care VBP models for later implementation. By late 2020, four CCOs had drafted or approved a maternity care VBP model for future implementation. Two were actively in negotiations with provider organizations to finalize new agreements ahead of schedule. Two CCOs also reported they had already implemented or enhanced doula care VBPs in 2020.

VBP Success Case: Bundled Payments for Maternity Care

Several CCOs reported interest in developing bundled payments or case rates for a range of services provided to members during and after pregnancy. There was a desire for examples or models CCOs could replicate.

One CCO reported working to develop a new bundled payment arrangement for maternity care. This payment model was described as a case rate for all pregnancy-related care including hospital, prenatal and postpartum services and behavioral health. Under this payment arrangement, a portion of the provider's case rate payment would be withheld and tied to meeting performance targets for the number of prenatal visits during the pregnancy. The CCO was working collaboratively with its regional hospital and local OB-GN specialists to develop this model.

CCOs identified several challenges related to the development and implementation of VBP arrangements for maternity care.

In some cases, CCOs requested support from the state to identify the appropriate way forward. Specific challenges included:

- **Lack of CCO market power with maternity care providers.** Some CCOs noted they had little leverage with hospitals or individual maternity care providers. Some expressed a desire for a statewide solution in this CDA, such as establishing a statewide VBP model for maternity care that all CCOs could adopt. The Primary Care Payment Reform collaborative was identified as a model that could be replicated for multi-payer coordination in maternity care.
- **Overlap with other CDAs.** Multiple CCOs described uncertainty arising from the overlap of maternity care and other care such as primary care, behavioral health, hospital care, or children's health. The emphasis on integrated care models can lead to confusion about how to classify a model within a given CDA. The VBP Roadmap allowed CCOs to meet the maternity and hospital CDA requirements through a single new VBP model, but some CCOs still reported uncertainty regarding integrated models spanning other areas.
- **Maternity care as primary care.** Some CCOs struggled to identify appropriate payment models for maternity care providers who also function as primary care providers. Some CCOs noted that these providers were interested in integrated care or medical home models. However, PMPM payment arrangements were often not suitable when members were attributed to other PCPs for their primary care. Multiple CCOs were exploring case rate models as a potential solution to this challenge.
- **Unique challenges monitoring performance.** CCOs reported that developing appropriate systems to monitor the performance of maternity care VBP arrangements was particularly challenging given

the crossover with other CDAs, the number of providers potentially involved in integrated maternal health care, and uncertainty regarding how members should be attributed to these providers.

Hospital Care

CCO experience with hospital VBP arrangements before CCO 2.0 was mixed.

Several CCOs reported existing payment arrangements in 2019 or earlier that contained some but not all of the required elements to qualify as a VBP. Relative to other CDAs, CCOs' approaches to hospital contracting before CCO 2.0 were influenced by rural or urban geography. Examples of non-FFS arrangements in place in 2019 or earlier included:

- **Pay-for-reporting models with Diagnostic Related Group (DRG) hospitals** (see Exhibit K). Three CCOs reported that they paid DRG hospitals for reporting quality measures before the CCO 2.0 contracts. These payments did not include performance-based risk.
- **Shared risk arrangements with no quality component.** Three CCOs reported prior downside risk arrangements with rural hospitals. These arrangements held hospitals accountable for meeting cost targets but did not contain quality targets or reporting requirements. One CCO reported integrating quality measures into this arrangement in late 2019, immediately before CCO 2.0.
- **Tying payments to quality.** Two CCOs reported arrangements with rural hospitals that tied payments to quality measures. In one instance, the CCO had developed a risk-sharing model with a quality component at the county-wide level with participation from multiple rural hospitals and providers.
- **Integrated delivery system.** One CCO reported an arrangement with an integrated delivery system in an urban area that reimbursed hospitals under a global (population-based) payment arrangement.

Exhibit K: Oregon Hospital Types

The Oregon Health Authority's Hospital Reporting Program classifies hospitals in the following way:

- **DRG hospitals.** These hospitals are reimbursed through standard Medicare diagnosis related groups (DRG) and are typically located in large urban areas.
- **Type C hospitals.** A subset of DRG hospitals with more than 50 beds that are typically located in a rural area and do not serve as a referral center in their region.
- **Type A hospitals.** These smaller and often rural facilities are located more than 30 miles from another hospital, with fewer than 51 beds.
- **Type B hospitals.** These smaller facilities are less than 30 miles from another hospital, with fewer than 51 beds.

Source: <https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/Hospital%20Type%20Document.pdf>

Many CCOs were working toward implementing hospital VBP arrangements ahead of the required CCO 2.0 deadline.

While the state's requirement that CCOs implement a new hospital VBPs will not take effect until 2022, several CCO leaders reported they would be unable to meet the state's target for the overall percentage of the CCO's payments that must be made in qualifying VBP arrangements in later years of CCO 2.0 unless the CCO achieved meaningful hospital participation. Thus, CCO leaders felt they "need to start now" in negotiating and executing new hospital VBP arrangements.

CCOs reported a wide range of approaches they were pursuing in 2020, including:

- **Introducing new quality measures and bonus structures.** Six CCOs reported plans for new or enhanced models that would integrate quality targets and bonuses into existing risk-sharing or FFS arrangements.
- **Converting a pay-for-reporting arrangement to pay-for-performance.** Three CCOs with existing hospital quality reporting arrangements reported plans to convert these models to qualifying VBPs by withholding a percentage of payments tied to new quality targets.
- **Developing new shared risk models with a focus on behavioral health and preventable emergency department utilization.** Four CCOs were negotiating with hospitals to implement new arrangements that included both quality targets and shared downside risk. One of these arrangements was being negotiated with a psychiatric hospital, while the others were designed to include a range of quality targets, including behavioral health.
- **Capitation and Cost Growth Targets.** CCOs' discussions with hospitals at the outset of CCO 2.0 were frequently focused on moving hospitals into shared savings or shared risk arrangements. However, the COVID-19 pandemic opened the door to more wide-ranging discussions. One CCO was negotiating a "capitation lookalike" model, described as a hospital PMPM prepayment that would later be reconciled to what the hospital would have earned under its prior FFS arrangement. Another CCO established a hospital cost growth target of 3.4% per year (aligned with the recommended target from the state's Sustainable Health Care Cost Growth Target Implementation Committee in 2021).⁶
- **Bundled payments.** One CCO was exploring a bundled hospital VBP for orthopedic joint care that would incorporate provider, facility, physical, and occupational therapy payments.

VBP Success Case: Hospital Care Transitions

Several CCOs noted the importance of strategic alignment between the CCOs' hospital VBP efforts and its VBP plans in other areas. One CCO was noteworthy for its holistic approach. The CCO held an existing payment arrangement with a regional hospital that held the hospital accountable for cost targets but lacked quality or performance requirements. The CCO intended to meet its requirement to develop a hospital VBP by incorporating new quality measures into this agreement.

To promote coordination of care and hospital buy-in for this model, the CCO reported that it was working to also renegotiate its specialty care contracts to include the same quality measures and performance targets that the hospital would be accountable for, including rates of follow-up care after hospitalization, all-cause emergency department visits, emergency department visits for behavioral health needs, 30-day readmissions, and mortality. In addition to this intentional alignment of performance requirements, the CCO was planning to sponsor new Traditional Health Workers or patient navigators at the hospital to provide support for care transitions.

Successes and Areas for Focus

CCOs reported progress implementing hospital VBP arrangements in 2020.

By September 2020, six CCOs had executed new qualifying VBP arrangements with hospitals, while two CCOs reported that formerly VBP-contracted hospitals had exited these arrangements in 2020. The remaining CCOs stated that their plans to implement new hospital arrangements in 2021 had not changed or that their plans had been deferred to 2021.

Hospitals were generally seen as supportive of VBP efforts. Still, CCOs described the importance of including hospital representatives in the advisory groups that developed new VBP models or quality improvement programs. This engagement was an important first step in soliciting input and concerns before negotiating hospital VBP arrangements. One CCO leader noted:

“[Our hospitals] understand that this is the direction things are going, and they’re willing to test the water.” – CCO Leader, September 2021

Several early challenges have emerged for CCOs in advancing hospital adoption of VBP arrangements.

The state should consider whether additional action or technical assistance is needed with regards to the following points raised by CCOs:

- **CCOs desire additional options for state-endorsed quality measures relevant to hospital and specialty care.** Several CCOs were drawing from Oregon’s Aligned Measures Menu but CCO leaders reported the menu lacked sufficient options for quality measures that were relevant for the development of hospital VBPs and performance targets. A lack of appropriate measures for specialists (such as radiologists) was believed to slow momentum and interest in VBP arrangements.
- **Lack of CCO market power and need for a statewide approach.** A lack of purchasing power or leverage with individual hospitals or specialists was a challenge to promoting the adoption of hospital VBP arrangements. One CCO leader noted, “the conversation with hospitals is less about how to earn more and more about how to lose less” when serving Medicaid patients. Additionally, CCOs were challenged in setting hospital benchmarks. Quality measures that were based on historical performance often had relatively small numbers of Medicaid members. Hospital VBPs—like maternity care VBPs—were identified as an area that would benefit from an aligned statewide approach across all CCOs.
- **Challenges with hospital VBP rate setting.** Some CCOs reported a lack of knowledge in developing attribution models for hospital risk-sharing in regions served by many hospitals. They were also uncertain about how to determine which types of specialty care to include or exclude from a hospital capitation model.
- **Concerns about the inadequacy of rural primary care networks.** Rural hospitals expressed concerns that payment models that redirect patients to primary care providers may be challenged by inadequate primary care capacity. One CCO noted the importance of coordinating a region’s primary care and hospital VBP efforts, aligning goals and metrics, and monitoring the combined impact of these arrangements over time. The CCO had established a community-level risk-sharing model that required coordination among its hospital, primary care, and behavioral health providers. The CCO was working to refine how this model attributed risk to participating providers, noting the difficulty of

balancing collective responsibility for health outcomes with individual providers' ability to influence particular aspects of care.

Oral Health Care

The majority of CCOs subcontracted with Dental Care Organizations (DCOs) rather than directly managing an oral health care provider network.

CCOs must implement new VBP models for behavioral health, maternity, and hospital care by 2022, but VBP models for children's health and oral health can be implemented later. Specifically, CCOs are required to develop or enhance a VBP model related to either oral health care or children's care in 2022 for implementation by 2023. The remaining CDA model must be developed in 2023 for implementation in 2024, the final year of CCO 2.0.

The structure of DCO contractual arrangements varied. Three CCOs had DCO contracts that included quality or performance requirements, and four CCOs had DCO-contracted dental care that used a pay-for-reporting arrangement. In contrast, one CCO reported operating its own dental provider network through direct provider contracts.

Because oral health requirements take effect later in the CCO 2.0 contract period, relatively few CCOs reported specific plans for developing or enhancing oral health VBP models.

Where details were available, CCO leaders described the following priorities and early efforts related to oral health VBPs:

- **Working with DCOs to incorporate VBP elements into existing sub capitation arrangements.** Four CCOs planned to begin withholding a percentage of existing PMPM payments to DCOs that would be tied to performance measures. Quality targets included oral health access (including a measure for pregnant women), emergency department visits, receipt of dental sealants, oral health assessments for people with type 2 diabetes, and measures of patient satisfaction.
- **New capitation or population-based payment models.** Three CCOs described plans to develop new PMPM or population-based oral health VBP models in future years. One CCO reported working toward a risk-sharing model.
- **Incorporating oral health quality measures into primary care provider agreements.** Three CCOs described strategies that would incentivize oral health care through existing primary care arrangements, either by adding new oral health access measures and targets to primary care VBP models or developing a payment model that would specifically support the delivery of integrated oral health services in primary care settings. One CCO was exploring options to incorporate dental care into a total cost of care model it was developing for primary care providers.

In addition to these emerging plans to address Roadmap requirements, CCOs took steps to stabilize oral health providers in 2020 during the COVID-19 pandemic. Two CCOs temporarily transitioned DCOs to capitated (non-VBP) arrangements for financial stability. Four CCOs that had incorporated new pay-for-performance elements into DCO contracts temporarily converted these contracts back to a pay-for-reporting model to avoid penalizing providers for deteriorating quality measures during the pandemic.

VBP Success Case: Planning Upstream for Oral Health Integration

Integration of oral health and primary care is a strategic priority for Oregon and included as an area of focus in the state's 1115 Medicaid Demonstration Waiver from the Centers for Medicare and Medicaid Services. The interim evaluation of Oregon's progress under its Medicaid waiver identified oral health integration as an emerging area of success.

CCOs' efforts to develop VBP models related to oral health may serve as an important opportunity to further drive the state's oral health integration priorities. In interviews conducted in late 2020, one CCO leader reported that fully integrating members' physical and oral health benefits had been an important component of the CCO's oral health VBP planning.

Another CCO reported exploring options to incentivize oral health integration through its existing DCO subcontracts. The CCO held multiple DCO contracts and reported that it had discontinued randomly assigning members to DCOs. Instead, the CCO was adopting an approach where members were grouped based on their affiliation with a particular health system for physical health care. These members were intentionally assigned to a specific DCO to facilitate coordination of oral health integration efforts between the DCO and health system, increasing the health system's ability to influence oral health access measures and streamlining reporting efforts of DCO providers.

Successes and Areas for Focus

CCO leaders shared emerging insights and challenges that warrant future attention.

- **CCOs have had mixed success tracking quality measures related to oral health care.** One CCO reported “a lot of false starts” selecting oral health performance measures, discovering mid-year that the measures could not be tracked as intended. The inclusion of oral health measures on the state's Aligned Measures Menu helped engage providers and DCOs in performance monitoring. Another CCO noted the importance of directly tracking member-level data on dental care needs so that information could be retained and shared when members switched providers.
- **CCOs may need guidance on whether to target primary care or dental providers in new oral health-focused VBP arrangements.** Two distinct approaches are emerging, with some CCOs addressing this CDA through primary care arrangements and others focused on provider subcontracts with DCOs. Given that oral health integration is a strategic priority of Oregon's 1115 Medicaid demonstration waiver, it may be beneficial for CCOs to leverage the oral health requirement of the Roadmap to support further primary care and oral health integration efforts. OHA may also wish to provide guidance to differentiate between VBP efforts that target dental providers versus incentives for oral health services in primary care settings.
- **CCOs may need assistance to transition DCOs to VBP arrangements.** Increased adoption of VBP arrangements among oral health providers may be complicated by working indirectly through subcontracted DCOs. DCOs may lack the experience or capacity to monitor or report on quality measures. The state may need to guide how CCOs should work with DCOs to develop HIT capacity in this area.

- **CCOs would benefit from guidance on how to report the VBP elements of their dental care arrangements.** It was not always clear from program documents and interviews whether CCOs were describing contractual elements of the CCO's contracts with a DCO or a DCO's subcontracts with oral health care providers. One CCO noted they lacked information to directly report on the nature of DCOs' provider contracts. Some CCOs also reported the existence of multiple payment arrangements with a single DCO, which might include capitated payments as well as separate quality incentive programs with bonus payments. As CCOs design and implement new VBP models, it may be useful for the state to collect information about whether and how CCOs combine different types of payment models within oral health contracting.

Children's Health Care

CCO experience with VBP arrangements specific to children's health was rare before CCO 2.0.

Four CCOs reported that they offered payment models other than FFS arrangements to providers before the CCO 2.0 contract cycle. These existing arrangements were sometimes described as extensions of a CCO's primary care VBP model with adaptations specific to pediatric providers. One CCO specifically reported the existence of a pay for performance model in 2019 that tied a portion of providers' payments to child- or adolescent-specific quality measures, including developmental screening, weight assessment, and counseling for nutrition and physical activity.

Few CCOs had yet begun focused efforts to develop VBP models related to children's care in 2020.

Oregon's VBP Roadmap for Coordinated Care Organizations will require that by 2024, CCOs develop and implement VBP payment models for children's health. Where CCOs reported early VBP model planning related to this CDA, they provided examples such as:

- Aligning the CCO's existing primary care and pediatric payment models.
- Modifying the CCO's existing primary care payment model to allow participation by pediatric providers.
- Incorporating new quality measures specific to children's care into an existing primary care shared savings model.
- Participating in the state's collaborative to develop and pilot test a pediatric health complexity algorithm to support risk stratification of members.

Monitoring CCO progress toward this requirement will be an important focus in future years.

Because few CCOs were yet focused on meeting this future roadmap requirement, we do not provide details regarding specific implementation successes or challenges. One CCO leader noted that it will be especially important for CCOs to have reliable data regarding social risk factors to develop appropriate payment models for children.

Progress in Payments to PCPCHs

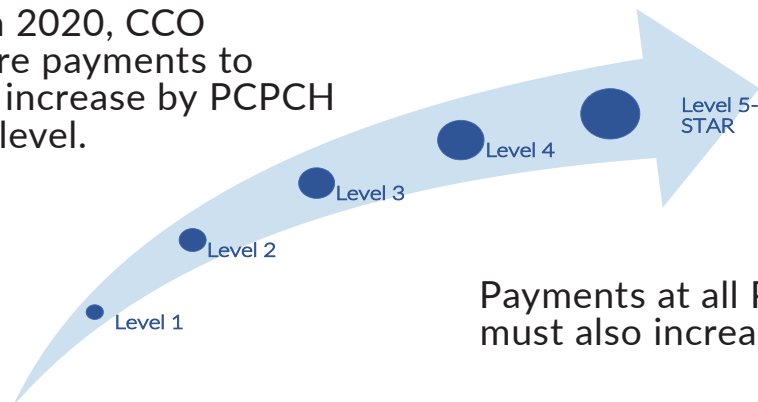


Under the VBP Roadmap, CCOs were required to implement a new payment model for Patient-Centered Primary Care Homes (PCPCHs) in 2020 (see Exhibit O). These payments were intended to support infrastructure investments such as care coordination within primary care clinics, and reward clinics that attained PCPCH recognition.

Prior to CCO 2.0, all CCOs have participated directly or indirectly in the CMS Comprehensive Primary Care Plus (CPC+) payment model program that requires participating clinics to achieve PCPCH recognition⁸ CCOs reported varying prior experience with other payment models rewarding primary care home status, including:

- **PMPM payments that did not vary by a clinic's PCPCH program recognition level.** Some CCOs reported payment models that reimbursed PCPCH-recognized clinics but lacked a tiered structure to reward higher PCPCH recognition levels. One CCO reported an existing care management PMPM for PCPCHs.
- **Tiered PMPM models that covered some but not all levels of PCPCH recognition.** Several CCOs made tiered payments that rewarded clinics at higher levels of PCPCH program recognition but did not offer this payment to clinics at lower levels (e.g., PCPCH level 1 or 2).

Beginning in 2020, CCO infrastructure payments to clinics must increase by PCPCH recognition level.



Payments at all PCPCH levels must also increase over time.

Under the Roadmap requirements, CCOs were required to make HCP-LAN category 2A or higher PMPM payments to all of their PCPCHs. The model must reward clinics for higher levels of PCPCH recognition by offering tiered payments for PCPCH levels. The value of payments at each PCPCH level must increase over time.

CCOs took varied approaches to meet this requirement in 2020, including:

- **Developing new tiered PCPCH payment models.** CCOs not previously making tiered payments to PCPCHs reported developing and implementing entirely new payment models in 2020 to meet this requirement.
- **Adding tiers to existing capitated payment models.** CCOs with existing capitated payment models for PCPCHs enhanced these arrangements by adding tier structures. One CCO evolved an existing care management PMPM to meet the requirement.
- **Enhancing existing tiered models with additional performance incentives.** Some CCOs took steps to incorporate additional enhancements or incentives into the PMPM beyond what was required. One CCO introduced an additional level of stratification within each PCPCH payment tier that rewarded clinics over time for increasing their Medicaid panel size. Four CCOs reported plans to integrate additional incentives for behavioral health integration beyond the core elements of the PCPCH model.
- **Incorporating risk adjustments in existing tiered payment models.** One CCO reported plans to introduce risk stratification to its existing tiered PMPM payments to PCPCHs to adjust payments based on panel complexity, while another CCO planned to risk adjust its PMPM payments based on member utilization.

Exhibit O: Oregon's Patient-Centered Primary Care Home Program

Since 2009, Oregon has promoted access to primary care through its Patient-Centered Primary Care Home (PCPCH) program¹³. Created by the Oregon Legislature through House Bill 2009, the PCPCH program recognizes clinics that achieve standards of excellence related to six core attributes:

- **Access to care.** Patients get the care they need, when they need it.
- **Accountability.** Recognized clinics are responsible for making sure patients receive the best possible care.
- **Comprehensive.** Clinics provide patients all the care, information and services they need.
- **Continuity.** Clinics work with patients and their community to improve patient and population health over time.
- **Coordination and integration.** Clinics help patients navigate the system to meet their needs in a safe and timely way.
- **Patient and family-centered.** Clinics recognize that patients are the most important members of the health care team and that they are ultimately responsible for their overall health and wellness."¹²

While Oregon's PCPCH program shares some common elements with initiatives such as the National Committee for Quality Assurance's Patient Centered Medical Home program, the program is unique to Oregon. The program recognizes clinics (including but not limited to physical, behavioral and school-based health clinics) at **five tiers** including 5-STAR, the highest level.

As of April 27, 2021, 643 clinics across Oregon held PCPCH recognition.¹³

Relative to other CCO 2.0 requirements, CCOs reported few challenges meeting the PCPCH infrastructure payment requirement.

The state has strongly emphasized primary care in its performance measurement framework, including state quality measures reported to CMS, CCO incentive measures (e.g., pay for performance), and Oregon's Aligned Measures Menu. One CCO leader indicated that this emphasis on primary care quality has "created a natural framework" in which CCOs can develop and implement primary care VBPs. CCO leaders also perceived strong buy-in for pay-for-performance models among primary care providers and Oregon's PCPCHs.

CCOs reported several factors they were considering as they planned for PCPCH infrastructure payment increases in future years.

Key factors being considered included:

- Tailoring PCPCH tier structures to accommodate clinics and provider organizations of different sizes and serving varied populations.
- Ensuring that tiered PCPCH payments continued to promote primary care integration with behavioral and oral health care, and support the development of HIT infrastructure for information exchange across care settings.
- Ensuring adequate support for Federally Qualified Health Centers that serve populations especially impacted by the COVID-19 pandemic.

CCOs may benefit from opportunities to learn from one another and share insights regarding these factors.

Summary

In conclusion, CCOs appear to have made progress toward the early requirements of the VBP Roadmap for CCOs despite the challenges posed by the COVID-19 public health emergency and Oregon's wildfires in 2020. CCOs made substantive changes to their provider VBP arrangements in 2020 and deferred or shifted plans for VBP models in future years.

CCOs were confident they could meet VBP targets in 2020 and 2021. They demonstrated progress with VBP models in behavioral health and hospital care, sometimes spurred by changes made in contracts in response to the public health crisis. However, the design of new maternity care VBP models was often delayed or postponed because of the pandemic.

CCOs' descriptions of their efforts in 2020 revealed certain challenges that may hinder progress in the coming years. In Chapter Five, we summarize key takeaways of the baseline evaluation and present recommendations to the state regarding next steps.

Recommendations and Next Steps

KEY TAKEAWAYS

- A third of all CCOs' Medicaid expenses (32.3%) were paid through arrangements that qualified as VBPs in 2019. However, rates of VBP participation varied by CCO.
- CCOs made substantial efforts to build capacity for VBP contracting in 2020. This work was challenged by CCOs' efforts to respond to the COVID-19 pandemic. CCOs' abilities to promote equity and monitor health inequities in VBP arrangements in 2020 was limited but growing.
- CCOs varied in their prior experience with VBP arrangements in 2019 and their readiness to implement new payment models during CCO 2.0. Still, CCO leaders reported meaningful progress developing new VBP models in some CDAs despite delays in implementation related to the pandemic.
- CCO leaders requested specific technical assistance, resources and training from the state to support their ability to meet VBP targets and milestones in future years of CCO 2.0.

Summary of Findings from the Baseline Evaluation

The baseline evaluation of Oregon's VBP Roadmap for CCOs sought to:

1. Establish a baseline understanding of CCO payment models and contracting strategies in 2019, the year immediately before the launch of the CCO VBP Roadmap requirements.
2. Provide an early look at how CCOs responded to new VBP requirements.
3. Highlight early successes or achievements, and identify challenges CCOs were encountering in implementing new VBP strategies.

This chapter presents a summary of the key findings discussed in detail in earlier chapters.

Our analysis of CCOs' payment arrangements in 2019, the year before CCO 2.0 contracts, revealed the following:

- In 2019, CCOs paid roughly one-third (32.3%) of all Medicaid expenses to providers in VBP arrangements that will qualify toward the state's new requirements.
- However, the percentage of 2019 dollars paid through VBPs varied substantially across CCOs, ranging from zero to more than fifty percent of expenses. Thus, some CCOs faced substantial work to meet the state's 20% target in 2020 while others already exceeded this goal in 2019. CCOs also varied in the proportion of payments made within specific HCP-LAN tiers in 2019, with FFS payments ranging from a low of 6.2% to a high of 67.9% of all CCOs' expenses.

- In 2023, CCOs will be required to make 20% of payments in downside risk arrangements. In 2019, 22.2% of CCOs' payments were made in this category. Rates varied by CCO, with six CCOs already exceeding the state's target that will take effect in 2023.
- While the percentage of total payments made through qualifying VBP arrangements was moderate (32.3%), these payments were part of a relatively small number of contracts. Overall, contracts structured as VBP arrangements were rare and represented only 3.2% of all contracts that CCOs held with Medicaid providers.

CCO leaders reported a range of capacity building efforts in 2020, focusing on developing new processes and infrastructure to support VBP contracting:

- CCO leaders described 2020 as a capacity-building year. They sought to develop the processes and infrastructure necessary to support new VBP requirements. Capacity-building priorities were dependent on a CCO's contracting mix in 2019, with CCOs reporting different needs depending on prior experience with VBP elements, such as capitation or risk-sharing.
- CCOs employed a range of strategies to assess members' needs and promote equity as they designed new VBP models. CCOs were limited in their ability to collect and analyze demographic and social needs data in 2020 but were building this capacity. CCO leaders requested guidance on selecting quality measures and establishing provider performance targets for their VBP arrangements. Some CCOs wanted additional options for state-sponsored quality measures.
- At this early stage, CCO leaders identified general challenges promoting provider adoption of VBP arrangements. The COVID-19 public health emergency shaped CCO and provider VBP negotiations in 2020. CCOs sought ways to reduce reporting burdens for VBP-contracted providers. The state may need to take additional steps to support the alignment of VBP approaches across CCO regions, as CCOs were often looking to providers to lead these efforts.
- CCOs reported a wide range of strategies and tools for supporting and monitoring providers in VBP arrangements depending on provider organizations' size and capacity to analyze data. Some early challenges were identified in developing reports that met providers' needs. Many CCOs were still working to understand and define their role in promoting providers' use of HIT.

CCOs appeared on track to achieve the earliest requirements of the Roadmap, but additional state efforts would support their progress toward later years' requirements:

- Despite major disruptions occurring in 2020 related to the COVID-19 pandemic and Oregon wildfires, CCO leaders expressed confidence in their ability to meet annual targets for payments made in qualifying VBP arrangements in the early years (e.g., 2020 and 2021) of the CCO 2.0 contract period. They were less confident about meeting targets that would incrementally increase in future years.
- The COVID-19 pandemic led some CCOs to make widespread and temporary changes to existing and planned VBP arrangements, often waiving performance targets or reducing reporting requirements for 2020. CCO leaders reported that some providers were more reluctant to enter into new VBP arrangements because of uncertainty about financial risk or members' care needs in future years.
- The state delayed CCOs' requirements to develop VBP models for behavioral health, maternity care, and hospital care until 2021 for implementation in 2022. However, CCOs still made some progress developing new models in these areas in 2020. In particular, there is evidence of progress in developing behavioral health and hospital care payment models. There is less evidence of the development of maternity care VBP models, with most CCOs reporting they paused these efforts while responding to the COVID-19 pandemic.

- While CCOs made progress developing new payment models, a statewide strategy may be needed to promote provider adoption of maternity and hospital care VBP models. There is a perception among some CCO leaders that negotiating provider uptake of these models will be difficult because CCOs lack purchasing power and leverage in negotiations.
- CCOs have encountered relatively few challenges in implementing tiered infrastructure payments to Patient-Centered Primary Care Homes (PCPCHs). CCOs often developed these payments to align with existing or planned primary care VBPs rather than as independent models. Thus, these approaches sometimes bolstered CCOs' other efforts to promote primary care integration. These VBP models may indirectly promote the state's physical, behavioral and oral health care integration priorities from its 1115 Medicaid waiver in addition to promoting PCPCH recognition and advancement.

Recommendations

We recommend OHA explore the following opportunities that may support CCOs' achievement of the state's VBP goals during the CCO 2.0 period.

1. **Ensure the state's quality measurement priorities are aligned with its VBP goals.** CCOs looked to Oregon's Aligned Measures Menu to guide their VBP model design and negotiations with providers. Still, gaps were noted for some care areas that lack state-endorsed measures. This was a barrier to promoting VBP adoption and aligning efforts across CCOs and other payers. CCOs may need quality measure recommendations for consideration in hospital, maternity, and specialty care VBPs to promote integrated care, align models with other payers and reduce reporting burdens on providers. The state should explore options to guide CCOs' quality measure selection for VBPs, such as through a VBP measures menu. The state may also wish to provide guidance directly for providers to navigate conversations with CCOs and other payers about aligning VBP monitoring and reporting requirements.
2. **Provide guidance to identify disparities and address health equity.** CCOs' capacity to use demographic and social needs data to monitor disparities was still developing. CCOs were also highly reliant on claims-based quality and performance measures to identify health inequities. A measure-by-measure approach to monitoring providers may overlook larger patterns or population health needs, or be limited by missing member-level demographic data. The state may wish to guide CCOs' collection and use of demographic or social needs data and elevate emerging models such as CCOs' development of health equity indices or the use of quality measures to inform member listening sessions. These approaches could lead CCOs toward more comprehensive, timely, and community-informed health equity priorities.
3. **Consider statewide strategies to promote VBP adoption among hospitals and specialty care providers.** Lack of CCO market share means a statewide strategy may be useful to engage certain providers in new VBP arrangements. All CCOs are now signatories to the state's Value-Based Payment Compact that aims to align payer and provider efforts across markets and between public and private VBP initiatives. The state should explore options to further promote multi-payer alignment in care delivery areas (CDAs) such as hospital care, where some CCOs reported low leverage in negotiations. Specific convenings, guidance or technical assistance may be helpful in these focused areas.
4. **Monitor CCOs' efforts to promote VBP adoption in areas where sub-capitation arrangements are common.** The VBP Roadmap requirements provide an opportunity for Oregon to further incentivize progress toward physical, behavioral and oral health integration – key priorities in its federal 1115 Medicaid demonstration waiver. However, CCOs face additional challenges negotiating and monitoring VBP arrangements with providers in these areas due to current or historical reliance on sub-capitated arrangements. Sub-capitation may create additional barriers to CCOs monitoring

inequities or establishing provider quality targets because of the additional layer of administration that exists between CCOs, sub-capitated entities and providers.

5. **Consider options for standardizing the reporting of CCOs' VBP model characteristics in the state's five priority CDAs and for PCPCH infrastructure payments.** CCO leaders expressed a desire for access to a library of sample VBP models. They noted that visibility into other CCOs' approaches helped to reduce the burden on providers. As CCOs develop a range of new VBP models in specific CDAs, opportunities may arise to compare the effectiveness of these approaches across regions and populations. The state now collects the HCP-LAN tiers of provider VBP arrangements and quality measures in use with specific providers. However, this reporting does not yet support the systematic identification or comparison of VBP model characteristics (e.g., emphasis on specific subpopulations or quality improvement measures) that CCOs are adopting. The state may wish to guide CCOs to support standardized descriptions of their VBP models and explore options to develop a repository of sample models.

Next steps

The Medicaid payment landscape in Oregon is poised to evolve considerably in the coming years. CCOs will face new VBP Roadmap requirements in 2021 and beyond. These include:

- Increasing the overall **annual targets** for the percentage of member expenses paid to providers in qualifying VBP arrangements (e.g., HCP-LAN category 2C or higher) to 35% in 2021 and 50% in 2022.
- Increasing the value of **tiered infrastructure payments made to PCPCHs** in 2021 above the value of these payments in 2020.
- Finalizing **new or enhanced VBP models** in behavioral health, maternity care, and hospital care in 2021 for implementation in 2022.

In addition to these escalating VBP Roadmap requirements, CCOs were required in spring 2021 to finalize and report their HIT plans for the CCO 2.0 contract cycle. CCOs' spending plans and priorities for social determinants of health and health equity under the SHARE Initiative will also be reported to the state in September 2021. These requirements will drive additional changes in CCOs' payment methodologies and processes for monitoring provider performance.

These changes in Oregon's Medicaid payment landscape will occur within a rapidly evolving national health care payment context and amid the ongoing COVID-19 public health crisis. In recognition of this evolving context, in mid-2020, the HCP-LAN convened a Healthcare Resiliency Collaborative, stating:

"The unprecedented COVID-19 public health emergency (PHE) has underscored the need for transition to payment models that enable the healthcare system to respond adequately in a pandemic and support population health. The COVID-19 PHE is a burning platform for recommitment to achieve, or even exceed, the [HCP-LAN framework's] 2025 goals, with the greatest emphasis on models that promote resiliency." – Health Care Payment Learning and Action Network, 2020

The Healthcare Resiliency Collaborative advanced **three priorities for health care payment reform** in the coming years (HCP-LAN, 2020), including:

- **Addressing root causes of inequity in healthcare** through intentional design and implementation of VBP models that address accountability, payment adequacy, and social determinants of health.
- **Accounting for differences in providers' resources and capacities** for VBP arrangements while promoting transparency of information regarding provider variation in cost and quality.
- **Promoting integrated models of care** emphasizing behavioral health and alternative care modalities such as telehealth.

These priorities and the related recommendations for payers, providers, and multi-stakeholder groups to promote health equity (see Exhibit P) may be important areas of focus for the Oregon Health Authority and Coordinated Care Organizations as they seek to maintain progress toward the state's VBP goals while adapting to the ongoing challenges of COVID-19.

Exhibit P: HCP-LAN Healthcare Resiliency Collaborative's Recommendations for Payer Actions to Promote Equity in Health Care

Short Term Payer Actions

1. *Use data to identify high-risk members and proactively share data and tools with health and social service providers.*
2. *Support stability of providers' cash flows during COVID-19 as well as providing other forms of non-financial relief.*

Medium to Long-Term Actions

1. *Address racial and ethnic health equity through specific and measurable organizational plan.*
2. *Collect and analyze member demographic data for disparities.*
3. *Link cost and quality incentives to addressing health inequities.*
4. *Ensure VBP payments are adequate to address inequities.*
5. *Engage Black, Indigenous and People of Color (BIPOC) providers and organizations in VBP model design and implementation.*
6. *Center the perspectives of members when designing and implementing VBP models (including use of measures that track patient experiences and satisfaction).*

The complete list of recommended payer actions, including recommendations related to promoting clinical integration, may be found at: <https://hcp-lan.org/resiliency-collaborative/framework/>

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Appendix A: Quantitative Methods

Chapter two of this report presented results of an analysis of Coordinated Care Organizations' payment arrangements held with providers in 2019. This appendix describes the data sources and methods used to calculate these results.

Data Source

This analysis utilized administrative data obtained from Oregon's All-Payer All Claims database (APAC). A limited set of APAC data files containing information regarding CCOs' provider contracts (i.e. "payment arrangement files") were obtained from the Oregon Health Authority's Office of Health Analytics. These payment arrangement files were submitted by CCOs to the State of Oregon in 2020 and contained records of unique provider (or billing entity) contracts held by CCOs during the calendar year 2019 as well as the Health Care Payment Learning and Action Network (HCP-LAN) classification of each contract as reported by the CCO. Individual providers or billing entities could have multiple contracts with each CCO classified under different HCP-LAN categories. Each contract could also have multiple entries for different providers, clinics, or billing entities associated with that contract.

Data Analysis

Payment arrangement files (PAF) were received as individual files for each CCO and were concatenated into a single analytic file. We assessed each data element for missing and outlier values. We excluded records where the payment model reported was "A" or "V" (indicating an informational row containing no payments). Rows missing a contract ID or HCP-LAN category were considered unique contracts and assigned to HCP-LAN category 1 (fee for service).

To calculate each CCO's proportion of contracts and payments made in specific HCP-LAN tiers during 2019, we calculated the sum of each CCO's total dollars paid to providers in each HCP-LAN category divided by the CCO's total expenses. This calculation required aggregating information about contracts that were reported multiple times in the PAF.

First, we re-coded each contract to retain the highest reported HCP-LAN tier for any component of that contract (following the state's methodology for calculating CCOs' achievement of annual VBP targets). The ranking of HCP-LAN categories was as follows: 1, 3N, 4N, 1A, 2Aii, 2Ai, 2B, 2C, 3A, 3B, 4A, 4B, 4C, with category 4C being the highest possible HCP-LAN designation. For example, if a single contract ID was reported for two billing entities, one of which was designated as a HCP-LAN category 1A arrangement and the other designated as a 3A arrangement, the contract as a whole was classified as a category 3A arrangement. We excluded contracts where the total dollar amount was \$0.

We then calculated the total dollar value of a contract as the sum of all rows containing a specific contract ID. The payment arrangement file contains records of provider contracts reported with negative dollar values, indicating amounts credited back to the CCO by providers for unearned payments. We followed the state's methodology of including the absolute value of these negative payments in the sum value of a contract. This approach awards credit to CCOs for the full value of qualifying VBP arrangements whether or not a provider meets performance or cost targets

necessary to earn all possible dollars under these arrangements. We calculated the sum value of all provider contracts for each CCO by HCP-LAN category.

To calculate the CCO's percentage of expenses paid to providers in qualifying VBP arrangements, we calculated the sum of each CCO's provider contracts in categories 2A, 3A, 3B, 4A, 4B, and 4C. This dollar amount was divided by a CCO's total Medicaid member expenses, as reported on row 17 of table L6 of each CCO's Exhibit L, submitted in 2020 for the calendar year 2019. The statewide total reflects the sum of all CCOs' qualifying VBP arrangements divided by the sum of all CCOs' Medicaid member expenses.

To calculate the CCO's percentage of expenses paid to providers in downside risk arrangements, we calculated the sum of each CCO's provider contracts in categories 3B, 4A, 4B, and 4C. This dollar amount was also divided by the CCO's total Medicaid member expenses from Exhibit L. The statewide total reflects the sum of all CCOs' downside risk arrangements divided by the sum of all CCOs' Medicaid member expenses.

All quantitative analyses were conducted in R and R studio.

Appendix B: Qualitative Methods

Chapters three and four of this report presented results of a qualitative analysis of key informant interviews and written information provided by CCOs about their VBP activities. This appendix describes the data sources and analytic methods used in these analyses.

Key Informant Interviews

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

In August 2020, the state administered a written questionnaire to all CCOs to gather information about their VBP activities in 2020. This questionnaire was developed in partnership with CHSE following identification of priority topics and questions for the evaluation. All CCOs responded to this request for information. Responses varied in length and detail.

In September 2020, CHSE conducted 12 key informant interviews with leadership representatives from Oregon's Coordinated Care Organizations. CHSE partnered with the state to develop an oral interview guide with standard questions for all CCOs. Interview questions for each CCO were then customized following review of each CCOs' responses to the written questionnaire. Staff from the Oregon Health Authority's Transformation Center, OHA's Office of Health Information Technology, and CCO Innovator Agents also joined these calls. Interviews lasted approximately ninety minutes and were conducted and recorded using a video call platform. All interviews were professionally transcribed.

CCO interview transcripts were de-identified and entered into Atlas.ti (cite Version 8, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management and analysis. A subset of the data was a priori coded by a single researcher using a codebook developed with consideration for the evaluation aims and specific areas of focus. The application of codes was then reviewed by two members of the research team to ensure consistency and alignment with code definitions. The remaining data were then coded. A series of code reports was produced and reviewed by three members of the research team, who met to review key impressions, reconcile differences and develop key findings.

Content Analysis

CHSE conducted a content analysis of documents including CCOs' responses to OHA's Request for Applications in 2019, supporting appendices, and CCOs' responses to the written questionnaire administered in August 2020 (described in the previous section). CCO responses to specific questions in these documents were indexed and organized into a matrix. This matrix was reviewed by members of the research team to develop a case summary organizing relevant information from each CCO into a standardized narrative format. The matrix and case summaries were reviewed by members of the research team to summarize findings across CCOs and identify similarities and differences in approaches to VBP model design, progress toward VBP milestones and requirements, and challenges and successes encountered in developing and implementing new VBP models.

Findings from key informant interviews and content analysis were integrated at the interpretation and reporting stage to summarize overarching findings from the two analyses.