

# Concept Paper on Increasing Use of Health-Related Services and Value-Based Payments

In 2012, under an amendment to its 1115 waiver, Oregon began the process of transforming its Medicaid delivery system by establishing Coordinated Care Organizations (CCOs), charging them with integrating and coordinating care and requiring them to meet key quality metrics, with financial incentives for achieving performance benchmarks. As contemplated by the waiver, CCOs receive an integrated global payment for each member, which provides CCOs with the flexibility to offer health-related services, in addition to health services, to improve care delivery and member health. The waiver also established an annual sustainable growth rate target of 3.4 percent for aggregate health care costs. To date, Oregon has succeeded in meeting this growth rate target and efforts to “bend the cost curve” remain a top priority for the State.

To continue meeting this growth rate target, Oregon has determined that additional actions are necessary to ensure that CCOs and the providers and community organizations with which they partner are positioned to drive the delivery of cost-effective, quality care and advance population health. Today, 16 CCOs provide services to more than one million Medicaid beneficiaries throughout the State. Some CCOs are using **flexible services** and **community benefit initiatives (CBIs)** to address member and community needs. Flexible services, specifically authorized through the current waiver, are cost-effective services offered instead of or as an adjunct to covered benefits (e.g., home modifications and healthy cooking classes). CBIs are community-level – as opposed to member-specific – interventions focused on improving population health and health care quality, such as investments in care management capabilities or provider capacity in line with the waiver’s goals. Both flexible services and CBIs aim to promote the efficient use of resources and, in many cases, target social determinants of health. Flexible services have generally been funded through Medicaid capitation dollars while CBIs have generally been grant-funded. For the purposes of this paper, flexible services and CBIs are collectively referred to as “**health-related services.**” Oregon seeks to increase the use of health-related services, which are essential to achieving the triple aim of better health, better care and lower costs – the core of the State’s transformation goals.

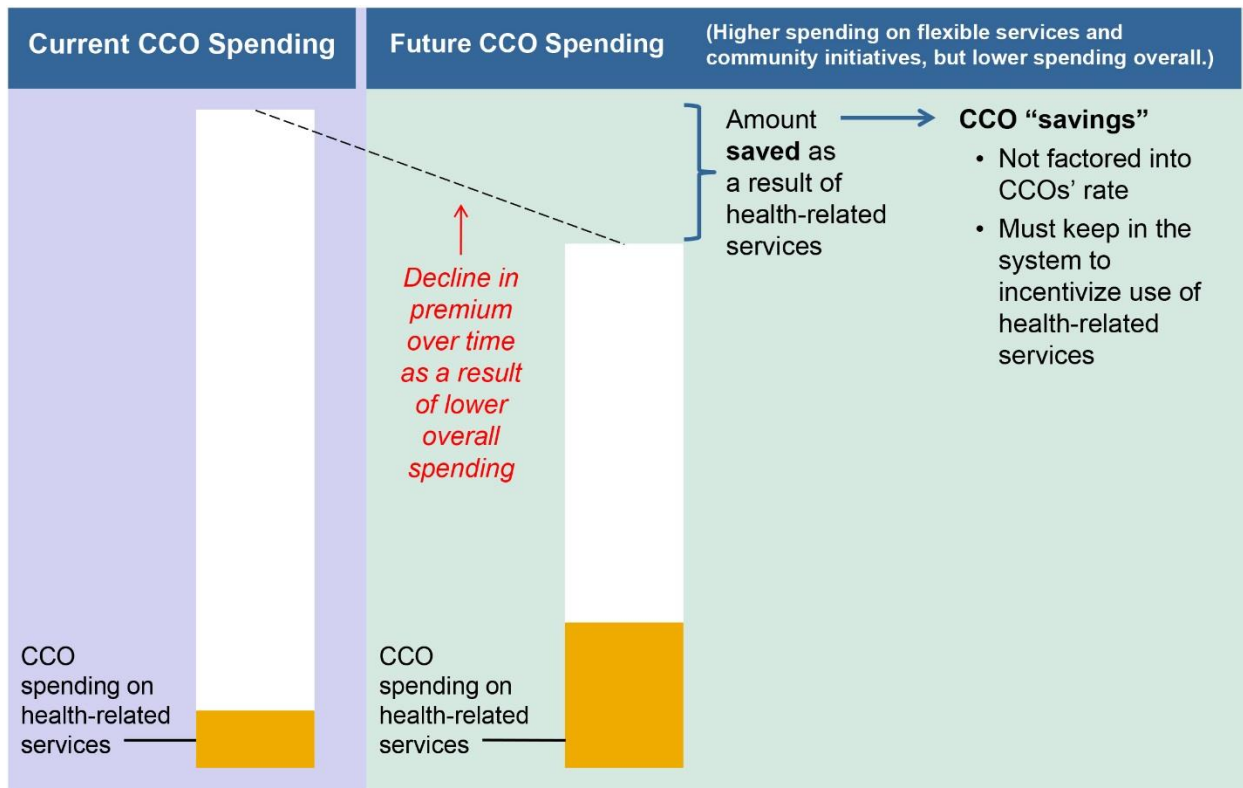
Oregon has identified several barriers to achieving greater use of health-related services. Under the existing waiver, the costs of these services<sup>1</sup> cannot be counted as “medical” expenses in building the premium rate paid to CCOs, thereby inflating the CCOs’ non-medical (administrative) expenses. In addition, when CCOs reimburse providers on a fee-for-service basis, there is no incentive – and no resources – to invest in health-related services. Moreover, as investment in cost-effective health-related services reduces utilization of state plan services (on

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<sup>1</sup> CBIs are not referenced in the current Waiver or the State’s contracts with CCOs.

which the capitated rate is based), CCO rates may decline over time. (This decline is referred to as “premium slide.” See Figure 1 below.) As premium slide occurs, there is neither funding nor incentive for CCOs and providers to continue investing in these health-related services. While the waiver contemplates the flow of incentives outside the premium rates, CMS restricts the amount of payments that can be made outside of the capitated rate to no more than five percent.<sup>2</sup> Oregon’s quality incentive program will reach this limit by the end of its current waiver period.

**Figure 1. Depicting Premium Slide Concept**



As discussed below, Oregon seeks approval from CMS to amend its waiver and adjust its rate setting methodology to better support and incentivize the use of health-related services consistent with the intent of the waiver, the interest of CMS to promote value-based purchasing within managed care, and the need to assess the program’s risk through the lens of actuarial soundness. The State also seeks CMS approval to amend its contracts with CCOs to require investment in health-related services through, among other things, use of value-based payment arrangements that support *provider* use of these services. The following proposals, when implemented together, should enable the State to continue meeting its growth rate targets. Accordingly, the State requests CMS approval to do the following:

<sup>2</sup> CMS requires that incentive payments not exceed 5% of the certified rates to managed care plans; see 2016 Medicaid Managed Care Rate Development Guide, September 2015, and 42 C.F.R. § 438.6.

**1. Include the costs of certain health-related services in the medical portion of CCOs' capitated rate.**

STC 34(c) of the waiver currently requires the State to include the costs of flexible services in the administrative expense portion of the capitated rate. Oregon seeks to amend its waiver by removing STC 34(c), which would then allow the costs of health-related services meeting the requirements of 45 C.F.R. § 158.150, “activities that improve health care quality,” to be included in the medical portion of the CCO capitation rate. Doing so would allow the State to treat the costs of these services as benefit expenses for rate setting purposes and would help prevent premium slide.<sup>3</sup> Oregon will also modify its rate setting methodology and amend its contracts with CCOs to reflect this change.

**2. Implement a three-year rolling medical loss ratio standard to keep a portion of CCO savings in the system.**

Oregon will further amend its contracts to implement a medical loss ratio (MLR) standard of 85%, where:

- a. CCOs calculate and report their MLR annually and in line with the State's and CMS' MLR reporting requirements;
- b. A three-year average MLR is calculated based on the CCOs' MLRs from the previous three years;
- c. This three-year average is compared against the State's 85% MLR standard; and
- d. CCOs with a three-year MLR below 85% must rebate to the State the difference between their three-year MLR and 85%.

A standard that utilizes a three-year rolling average MLR with a rebate—paired with an annual MLR reporting requirement—should allow CCOs to monitor their MLRs and offset lower expenditure on benefits and quality improvement activities in one year against higher expenditures in the previous or subsequent year(s). Such a policy enables some or all of the CCO's savings achieved to remain in the rates going forward, instead of being returned to the State, and be reinvested in members' care (e.g., a CCO that is seeing reductions in spending on benefits due to prior investments in health-related services may increase their investment in these services in subsequent years and avoid returning funds to the State, so long as its three-year average MLR is 85% or higher).

For the purposes of calculating CCOs' MLRs to determine compliance with the State's MLR standard, spending on *all* health-related services would be included in the numerator (consistent with 42 C.F.R. § 438.8). CCOs with a three-year average MLR at 85 percent or above would not be subject to any rebate. Oregon will work with CMS,

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<sup>3</sup> Per the Medicaid and CHIP Managed Care Final Rule, “activities that improve health care quality” pursuant to 45 C.F.R. § 158.150 are included in the numerator of MLR calculations, which must be considered in developing the capitation rates (see 42 C.F.R. §§ 438.4, 8). As a result, once STC 34(c) is removed, there is no need for a waiver.

CCOs and other stakeholders to further develop this MLR requirement as well as a phased-in implementation timeline.

- 3. Require CCOs to enter into value-based payment (VBP) arrangements with network providers.** Oregon's current demonstration calls for CCOs to adopt alternative payment methodologies to "align CCOs and their providers with health system transformation objectives." However, the State's CCO contracts do not require CCOs to enter into a minimum percentage of VBP arrangements, and at present, many CCO payments to providers are made through fee-for-services arrangements, which do not support provider investment in health-related services. Accordingly, Oregon will submit to CMS a VBP plan that describes how the State and CCOs will achieve a specific percentage of VBP payments by the end of the demonstration period. The plan will provide a clear definition of VBP that involves the sharing of risk (not just savings) and quality measures, describe how CCO contracts will be amended, and propose a schedule that ensures phased-in implementation over the course of the demonstration. The State will work with CCOs and providers to develop this VBP plan.

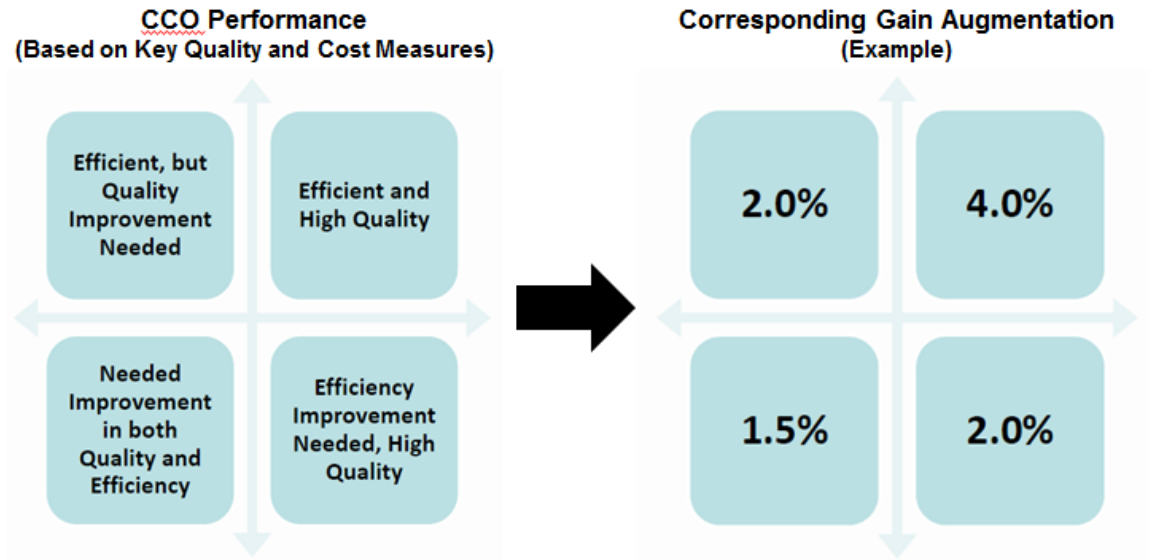
In addition, Oregon may also require CCOs to have policies in place that instruct VBP-contracted providers to report their medical spending and revenue and invest a portion of any surplus on health-related services. Currently, a number of CCOs have subcapitation arrangements with network providers (e.g., primary care provider groups or hospitals) in which the CCOs pass a percent of their premium payments from the State directly onto the providers and the providers become the risk-accepting entities for the CCOs' members. While these arrangements may constitute value-based purchasing, many of these risk-accepting entities perform a mix of medical and administrative services and the breakdown of their spending has historically not been reported to the State. Requiring this breakdown to be reported would help ensure that CCOs and their provider partners are both investing in health-related services to ensure efficient use of resources and address the social determinants of health.

- 4. Implement a CCO performance incentive program.** To further incentivize CCOs to utilize health-related services, Oregon will enhance the rate setting methodology to prevent premium slide and compensate CCOs identified as high performing (i.e., CCOs showing quality improvement *and* cost reduction). To do so, Oregon would implement a gain augmentation program, through which the State would develop rates with a profit margin range, such as 2 percent to 4 percent, as opposed to a fixed percentage of premium as is used today. (The range of gain could change year to year, based on MLR results, to help ensure that CCOs who are being rewarded through this program are not being adversely affected through the MLR program.)

The percentage of gain built into the rates would vary based on CCO-specific scoring within each rating region, where higher performing CCOs would receive higher

percentages than lower performing CCOs. CCO scoring would be based on *multidimensional* measurement that incorporates both quality and efficiency. (See Figure 2 for an example.)

**Figure 2. Depicting Gain Augmentation Concept**



This approach will require the State to develop a mechanism for measuring CCO performance. Oregon will leverage, to the maximum extent possible, the existing quality and cost metrics included in the waiver. While the details of measuring CCO performance still need to be developed, the overall goal is to incorporate an approach in the State’s rate setting methodology in a manner consistent with all Actuarial Standards of Practice and CMS and OACT guidance.

## Actions Needed to Implement These Concepts

To implement the proposals described above, Oregon plans to take the following actions:

1. **Amend the 1115 Waiver.** The State proposes to amend its waiver so that costs of health-related services that meet the requirements of “activities that improve health care quality” pursuant to 45 C.F.R. § 158.150, are included in the medical portion of the CCO capitation rate. The State may also make technical and other adjustments to ensure that the policy programs contemplated in this paper are accurately reflected in the waiver.
2. **Amend its CCO contracts.** Oregon intends to amend its contracts with the CCOs to include the following:

- a. Requirements related to the collection of information on health-related services to determine whether the services meet the requirements of 45 C.F.R. § 158.150;
  - b. Information on the three-year rolling MLR standard;
  - c. The requirement that a certain percentage of CCO payments to providers be made through VBPs (this will include a definition of VBP and a timeline for phasing in the requirement);
  - d. The potential requirement that CCOs have policies in place that instruct VBP-contracted providers to report their medical spending and revenue and invest a portion of any surplus on health-related services; and
  - e. Information on a CCO performance incentive program involving gain augmentation.
3. **Amend State rules to include the costs of health-related services categorized as “activities to improve health care quality” in the medical portion of CCOs’ rate and to define new terms as needed.** Oregon intends to amend recently adopted State rules that define flexible services and prohibit them from being counted in the benefit costs portion of the capitated rate. The State will also include definitions for health-related services and community benefit initiatives.
  4. **Enhance the rate setting methodology.** Working with CMS and OACT, the Oregon Health Authority (OHA) and its actuaries will enhance the CY 2016 rate setting methodology to incorporate the features of the approach described above in the CY 2018 methodology. OHA will continue to evaluate the risk of the program through the lens of actuarial soundness, ensuring that the rate setting methodology is consistent with all applicable CMS and OACT guidelines and Actuarial Standards of Practice.

## Public Notice and Engagement

Since January, the State has met with the CCOs and State legislators to discuss and obtain feedback on the concepts described in this paper. In addition, interviews were conducted over a two and a half-month period with representatives from nine CCOs across the State. Since March, the State has met several times with CMS and OACT to discuss drafts of the concept paper. This version of the concept paper reflects feedback received from the CCOs, CMS, OACT and other stakeholders during these various discussions.