Value-Based Global Budget

Oregon is requesting authority to create coordinated care organization (CCO) value-based global budgets that will better drive investments in health equity, incentivize spending on health-related services, and be developed to cover all reasonable, appropriate costs of running the CCO program while increasing at a predictable growth rate in line with the state's cost growth target.[1] The new value-based global budgets would provide longer-term predictability and flexibility to CCOs and providers, in turn driving additional upstream investments in prevention and health-related services to improve health outcomes and reduce avoidable health care costs.

This value-based global budget would further flip financial incentives in the delivery system: instead of being financially rewarded when Medicaid members are sick and access more care, CCOs would be accountable for Members' health and have more resources to invest when members' health improves, inequities are eliminated, and avoidable health events are prevented through better, more coordinated care for members.

In this 1115(a) demonstration waiver renewal, Oregon is requesting waiver flexibility in how Medicaid managed care (CCO) capitation rates are typically established, while maintaining reasonable and appropriate rates, in order to meet the goals described above. Specifically, Oregon requests the authority to:

1. Calculate a base budget (capitation rate) that is reasonable and adequate for covered services and the risk of the population, and is based on multiple years of historical utilization and spending, recent trends, and spending on health-related services.
2. Trend the base rate forward in a predictable way over five years, without resetting base budgets each year.
3. Increase predictability of costs through closer management of pharmacy costs, by allowing a commercial-style closed formulary approach that may exclude drugs with limited or inadequate evidence of clinical efficacy.

Problem and Background

Most of peoples' health is determined not by the medical care they receive but by social determinants, such as neighborhood and built environment, access to healthy food, and job opportunities and income.[2] Oregon increasingly recognizes that we need to address these social determinants of health to reduce medical costs and improve health equity.[3]

Further, Oregon's Nine Federally-Recognized Tribes and Tribal communities, Latino/Latina/Latinx, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, communities of color, people

---

[1] Annual per capita spending target that will apply across all health care markets beginning in 2021

[2] Magnan, S. (2017). Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine. Available at: https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

[3] https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/; https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-1-19.pdf

with disabilities, people with limited English proficiency, and immigrant and refugee communities have worse social and environmental conditions and worse health outcomes, resulting in part from chronic underinvestment by the state and federal government. The COVID-19 pandemic has underscored this point, with communities of color experiencing harm at a disproportionate rate when compared to their white counterparts.[4]

The current system for managed care organizations does not do enough to incentivize investments in health, prevention, improved outcomes, or health equity. Traditionally, managed care organizations and health care providers are paid based on how sick a member is and how many health care services they receive. Generally, managed care organizations see increases in their capitation rates year-over-year when members are sick and access more services and/or incur more costs and decreases in their rates if patients are healthier and need fewer services. This payment model is an inherent disincentive to focus on prevention, care management, and other lower-cost interventions that could avoid a health event and resulting services for a member.

When Oregon created CCOs and the Medicaid coordinated care model in 2012, a primary goal was to move from a model primarily focused on delivering health care services to a new model: community-governed organizations that operate under a different economic model and focus on improving health outcomes and managing population health. Oregon aspired to implement a rate-setting methodology with two goals:

1. blend physical, behavioral and oral health funding streams together so one organization is responsible for all of its members' health care needs; and
2. change the financial incentives in the health care system so that financial rewards come from populations served being healthier, rather than sick.

Under Oregon's original CCO rate setting methodology, the goal was to see the health system shift spending to focus on prevention that reduces avoidable acute care; for example, stronger investments in community behavioral health that could avoid hospital visits. Another goal was to see increasing amounts of funds spent on health-related services – such as those to address social needs, like housing and food – with the goal of improving health and avoiding medical costs.

Oregon has had success in blending funding streams for billable health care services; however, under the current federal requirements for capitation rates, we have yet to see a true change in financial incentives for the outcomes we seek. The vision of a value-based, global budget has not yet been fully realized in Oregon. Specifically, CCOs' rates remain largely based on recent medical expenses, perpetuating the built-in disincentives to shift resources to prevention and health-related services, and to contain costs.

Oregon has innovated as much as possible within the current CMS requirements for managed care capitation rates to change the financial incentive to promote population health. Despite Oregon's efforts to refine the rate setting process over time (see box on next page), these strategies have been insufficient to fundamentally change the economic model driving CCO spending. While increasing, Oregon has not seen a marked shift in how much CCOs spend on health-related services. Health-related services spending averages 0.7% of CCOs' annual budgets. Oregon's original global budget concept was intended to drive local, community conversations about how to shift spending within the system to better meet community needs and to spend wisely within limited resources to maximize health outcomes. However, the distribution of spending within Oregon's health care system (e.g. the

[4] https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

amounts split between physical, behavioral, and oral health) remains largely the same, indicating spending is following historical habits and market power, rather than a true shift in focus to population health. Oregon cannot fully address health inequities or correct historical racism and power imbalances in the health system, unless the financial incentives in the system more fully focus on population health and drive community conversations about prioritizing resources to achieve better outcomes.

> **Rate methodology changes to date**
>
> CCO rates are built using a methodology that has evolved over time in an effort to incentivize the use of high-value, low-cost services and reduce the opportunities for gamesmanship and excessive profit at the expense of member access and quality, while staying within the bounds of established actuarial principles. For example:
>
> - **Statewide base data.** During the most recent 5-year CCO contract procurement in 2019, OHA introduced the use of statewide base data when developing initial capitation rates. This was done to smooth the impact of high utilization by any single CCO and prevent it from driving rates up indefinitely, while applying regional factors to ensure rates were reflective of appropriate variations in utilization and pricing.
> - **Performance-Based Reward Program.** In 2022, OHA will implement Performance-Based Reward (PBR), a program approved through our last waiver renewal which is designed to reward achievements in health-related services and cost containment, subject to quality safeguards. The PBR functions by varying the profit margin of a CCO relative to how much it spent on HRS, to encourage wider adoption of high-value non-medical services. This partially guards against so-called "premium slide" where savings come at a disincentive to the CCO, i.e. when rates are built using historical cost and utilization data, CCOs that reduce costs see reductions in rates each year.

Oregon seeks authority to rely on a capitated rate development methodology for a new, value-based global budget that is as simple as possible and easy for the community and CCO to understand, as well as more predictable for the state and community. It needs to be clear that in focusing spending on health equity, prevention, care coordination and quality, CCOs will improve health and realize savings. This streamlined methodology will be paired with robust accountability to member and community needs, as well as strategies to ensure health equity spending is driven by the community.

With Oregon's proposed changes to create a value-based global budget, we would expect the following outcomes:

- A substantial increase in health-related services coupled with reduced administrative burden of detailed counting of health-related services in order to get "credit" in rate setting (as is currently required under the Performance-Based Reward). More spending on health-related services will lead to:
  - More investment in community health that promotes health equity
  - More investment in high-value, preventive services
- Increased care coordination and better management of members who incur high costs, including members transitioning between systems and life stages: corrections, Oregon State Hospital, Mental

Health residential services, foster care youth – due to clearer financial incentives for improving outcomes.

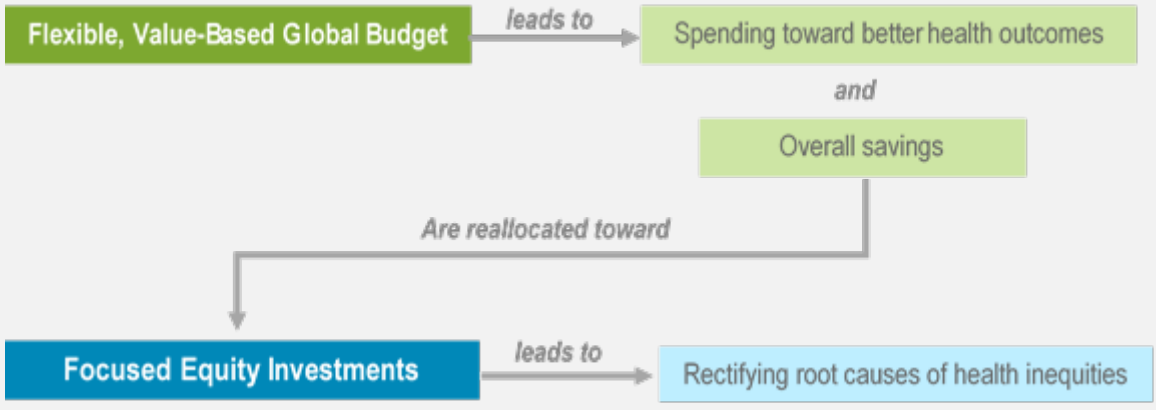
- A decrease in spending on lower value care and avoidable episodes as CCOs shift funds to prevention and care coordination.
- More accountability of the CCOs to the community they serve for how their value-based global budget is spent.
- The rate of cost growth is limited to publicly determined targets (see box below) and matches overall spending targets in Oregon's health care system.

Central to Oregon's value-based global budget strategy is a commitment to sustainable growth. The strategy has always been to save money through more efficient and effective spending that leads to better health outcomes rather than by reducing services or tightening eligibility.

Oregon's CCO model is innovative and cost-effective. But, keeping cost growth within the target continues to be a challenge. People in Oregon face a statewide housing crisis, regular climate emergencies brought on by climate change, and widespread inequities caused by structural racism – which, in sum, lead to higher health care costs.

The value-based global budget methodology proposed in this concept paper will reward spending on equitable, high-quality health outcomes **while helping Oregon continue to curb per capita cost growth.**

In the *Focused Equity Investments* concept paper, we propose that the federal and state savings achieved through our commitment to sustainable growth at 3.0-3.4% (across all markets, not just Medicaid) will be shared at the statewide and local levels to invest in long-range initiatives that will show measurable improvements toward health equity. By comparison, national Medicaid trend is projected at 4.9% for 2022 through 2028.[5]



[5] NHE Projections (national), Table 17 - NHE Projections 2019-2028

Proposed strategies

While the factors that most impact length and quality of life are the social and community conditions in which people live, work and play, the US health care system wastes billions of dollars every year on unnecessary services, inefficient delivery, and inflated costs. By changing and simplifying the underlying incentives, Oregon seeks to shift funding toward the expanded use of services designed to address social determinants of health and to health equity investments that are often outside the health care provider walls, thereby reducing health inequities and improving overall health.

Oregon is requesting waiver flexibility in how CCO capitation rates are typically established, while maintaining reasonable and appropriate rates, in order to meet the goals described above. Specifically, we request the ability to:

- Calculate a base budget (capitation rate) using up to five years of historical utilization and spending, while also looking at recent trends to ensure the base is reasonable and adequate for covered services and the risk of the population, and that it accounts for spending on health-related services. The base budget would be built considering both historical medical expenses as well as spending on health-related services, thereby incentivizing spending on activities that are proven to prevent morbidity and mortality.
- Trend the base rate forward in a predictable way over five years by adjusting the budget based on Oregon's new statewide health care cost growth target, as well other targeted adjustments needed to address unanticipated events, without resetting base budgets each year.
- Increase predictability of costs through closer management of pharmacy costs, by allowing adoption of a commercial-style closed formulary approach that may exclude drugs with limited or inadequate evidence of clinical efficacy. This strategy may also help contain pharmacy costs for emergent drugs in ways that could mitigate future rate adjustments.

To protect OHP members' right to the full array of medically necessary Medicaid benefits and mitigate any unintended impacts of the above waiver requests, Oregon will incorporate the following:

Mitigation strategy #1: Develop strong programmatic safeguards to protect members through ongoing measurement and reporting by CCOs of access, quality, and outcomes to assure against inappropriate underutilization or denials of necessary care.

Mitigation strategy #2: Develop robust annual financial monitoring, including monitoring utilization and spending, to monitor CCO solvency and ensure the annual targets are reasonable for covering expected costs, as well as develop a mechanism for budget adjustments if unforeseen events, such as new high-cost treatments, result in the annual trend being inadequate to cover members' health needs.

1. Calculate a base budget (capitation rate) that is reasonable and adequate for covered services and the risk of the population, and is based on multiple years of historical utilization and spending, recent trends, and spending on health-related services.

   To truly shift focus toward providing the highest value care, Oregon needs a value-based global budget for CCOs that is simpler and more predictable over the long term, and that removes any real or perceived incentives for unnecessary health care spending in the short term. Moving to a value-based budget will focus CCOs on providing high-value care rather than increasing annual spending to improve the next year's rates.

Under Oregon's waiver proposal, the state would set an initial statewide, reasonable and appropriate CCO value-based budget largely in line with how base budgets are set today, with two exceptions:

- Considering a longer period of time (up to five years) for historical trends to increase confidence that the base budget is sound, and
- Including health-related services spending, in addition to spending on state plan services, over a period of up to five years.

In addition, to maintain a focus on eliminating health inequities, Oregon plans to direct CCOs to invest at least 3% of their value-based global budgets toward health equity investments (as required by Oregon House Bill 3353), of which at least 30% would be directed to community entities, called regional community investment collaboratives (CICs), for community health equity investments. (See *Focused Equity Investments* concept paper). Oregon proposes to establish a community-led accountability structure for all required health equity spending that includes a statewide oversight committee in addition to the regional CICs. As noted above, Oregon requests the ability to count health-related spending under HB 3353 as part of the medical load when calculating rates, so that the requirement to make these health equity investments does not negatively impact CCOs' future rates.

Going forward, Oregon would adjust CCO budgets annually by a predictable growth trend rate, in line with statewide goals for sustainable growth, and would also carefully monitor CCO spending to identify any additional, targeted adjustments that may be necessary to address unanticipated events.

2. **Trend the base rate forward in a predictable way over five years, without resetting base budgets each year.**

Oregon proposes that, in line with reducing health care spending in all sectors, CCO budgets be trended forward for five years at the statewide health care cost growth target, which will be 3.0 to 3.4 percent during the demonstration period. This trending forward would allow more predictability for CCOs to make longer-term investments in health equity, prevention, and community improvement—leading to an overall healthier population and lower health care costs over time. Targeted rate adjustments would be made for significant changes in risk profile by CCO, covered benefits, and statewide population, for example, in times of significant change such as coverage expansion during the COVID-19 pandemic.

When combined with an enhanced quality strategy and the ability to count health-related services in the medical load for the purposes of rate setting, this design would allow CCOs to keep savings stemming from appropriate declines in utilization. It would also create more flexibility for CCOs to invest in care improvements, including through investments in preventive care, addressing social needs, and eliminating health inequities.

Oregon also recognizes that enhanced flexibility must be paired with robust member protections, specifically directed at addressing health inequities that exist. To that end, Oregon also proposes a robust accountability system with new mitigation strategies covering four priority areas: equity, member and provider satisfaction, access, and quality of care, described in more detail on pg. 8.

3. **Increase predictability of costs through closer management of pharmacy costs by adopting commercial-style closed formularies and by excluding drugs with limited or inadequate evidence of clinical efficacy.**

Oregon seeks the ability to more closely manage pharmacy costs in its Medicaid program, through a two-part strategy:

A. Adopt a commercial-style closed formulary approach

Taking a closed formulary approach for adult members, including at least a single drug per therapeutic class, would enable OHA and CCOs to negotiate more favorable rebate agreements with manufacturers. Oregon would keep an open formulary for children. For each therapeutic class, manufacturers could be offered an essentially guaranteed volume in exchange for a larger rebate. Currently, OHA and CCOs have limited ability to offer such volume deals to manufacturers, given the requirement to cover all drugs in the Medicaid rebate program. OHA would create a collaborative process that includes CCOs to select drugs for the closed formulary.

In recent years the majority of commercial pharmacy benefit managers (PBMs) have adopted such closed formularies, which allow them to customize their drug offerings based on clinical efficacy and cost considerations. As an example, for 2021 CVS Health excluded from its formulary 57 additional products– some because a less expensive, medically equivalent drug had become available and some because the drugs were hyperinflationary, having dramatically increased in price without clear justification. Medicare Part D commercial plan are also permitted to employ such closed formularies (as authorized under 42 CFR 423.120) with at least two drugs per therapeutic class. Medicare Part D plans may also include just a single drug per class if only one drug is available, or if only two drugs are available but one drug is clinically superior. Given that Medicare and other commercial plans are permitted to adopt closed formularies, we believe Oregon should have the same flexibility for Medicaid.

B. Allow exclusion of drugs with limited or inadequate evidence of clinical efficacy

Many drugs coming to market through the FDA's accelerated approval pathway have not yet demonstrated clinical benefit and have been studied in clinical trials using only surrogate endpoints. Oregon seeks the ability to use its own rigorous review process to determine coverage of new drugs and to prioritize patient access to clinically proven, effective drugs. Through this process, the state could avoid exorbitant spending on high-cost drugs that are not medically necessary. The 21st Century Cures Act was intended to expedite the drug approval process by reducing the level of evidence required for drugs to reach the market and allowing doctors, patients, and payers to decide whether to purchase them. Unfortunately, current rules do not allow Medicaid programs to exercise discretion about whether these drugs should be covered without being fully clinically proven.

Oregon proposes to utilize new flexibility granted under this waiver to exclude drugs with limited or inadequate clinical efficacy under its closed formulary approach. Limited or inadequate clinical efficacy may be defined as when one or more of the following conditions exist:

- Primary endpoints in clinical trials have not been achieved.
- Only surrogate endpoints have been reported.
- Clinical benefits have not been assessed.
- The drug provides no incremental clinical benefit within its therapeutic class, compared to existing alternatives.

New drugs approved under the FDA's accelerated approval pathway can be particularly costly and would be ideal for more rigorous evaluation of coverage and potential labeling as non-formulary where appropriate. In addition, re-formulations of older, existing drugs that provide no incremental clinical benefit might be labeled non-formulary as well. While commercial payers can exercise discretion to exclude drugs from their formularies in such situations, OHA and CCOs currently do not have this latitude.

As part of our efforts, we will ensure pharmacy protections for members, so that Oregon's closer management of pharmacy costs does not negatively impact member access to the spectrum of safe and effective drugs to treat various conditions.

Protect member access, quality, and health equity

All of these strategies and tools will promote predictability and flexibility for the CCOs, so that Oregon can achieve a fundamentally different economic model in its Medicaid program – one that rewards health equity, preventive services, and improved population health. However, it is critical that these rate setting changes be paired with appropriate safeguards to ensure that access and quality are maintained and to guard against any incentive to provide inadequate or low-quality care. In addition, careful monitoring of financial reporting will assure CCOs are not inappropriately awarding shareholders or business owners at the expense of OHP members and communities.

Mitigation strategy #1: Develop strong programmatic safeguards to protect members.

Oregon's value-based budget strategy is designed to create additional flexibility and allow CCOs to keep savings stemming from smart spending decisions. However, without a strong accountability system, there is the risk of negative impacts to health equity and members' access to high-quality care due to profit-seeking within the system. To mitigate such risk, Oregon proposes a comprehensive accountability structure to address health inequities, ensure member and provider satisfaction, and protect member access and quality of care. On an annual basis, Oregon will conduct an overall assessment of each plan paired with specific rate and contract-based mechanisms to hold CCOs to minimum standards in each of these four areas: equity, member and provider satisfaction, access, and quality of care.

First, Oregon will assess health inequities by monitoring disparities in member satisfaction, member access, and quality of care for priority populations most harmed by health inequities. These include but are not limited to Tribal Nations and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities. Oregon will use tools such as:

- Collecting data that allows the State to monitor quality of care by race and ethnicity, such as through REALD;
- Considering/reporting on as many of the core quality metrics by race, ethnicity and language as possible;
- Monitoring performance on equity-focused metrics (such as access to interpreters);
- Considering CCO network adequacy with regard to equity factors such as cultural and linguistic responsive provider capacity; and

- Using tools such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and qualitative data from the OHA Ombuds program and Community Partner Outreach Program (Oregon's enroller and navigator network) to identify concerns for priority populations.

Next, Oregon will assess overall member and provider satisfaction, access, and quality of care in the following ways:

- **Member and provider satisfaction:** OHA will assess by plan using tools such as the CAHPs survey, review of Notices of Adverse Benefit Determination, appeals, and grievances, and enhanced feedback mechanisms to assess provider satisfaction.
- **Access:** OHA will consider indicators in the areas of network adequacy, overutilization and underutilization, and timely and appropriateness of care. For network adequacy, OHA will use the Delivery System Network Reporting (DSN), which includes minimum standards for time and distance, to assess and monitor an individual CCOs provider capacity to serve projected and current member enrollment; have a network that meets the demographics of enrolled members including but not limited to preferred language or cultural representation; and a network sufficient across the continuum of care. For utilization of services, OHA will rely on an analysis and monitoring system that will focus on priority services prone to underspend, such as behavioral health; and member and provider-identified concerns. Timely and appropriateness of care assessment will use tools such as DSN and quality reporting to monitor member's access.
- **Quality of care:** In alignment with the Quality Incentive Program (see Incentivizing Equitable Care concept paper), OHA monitor quality of care through CMS Medicaid core set measures and potentially other measures as added in the metrics programs such as forthcoming CMS quality rating system measures. Measures will be benchmarked for a basic level of care (as opposed to more aspirational benchmarks used in the Quality Incentive Program).

OHA will push CCOs to further address health inequities by strengthening community voice and decision-making in the CCO model (see Focused Equity Investments concept paper) and restructuring the Quality Incentive Program so that equity is the primary organizing principle (see Incentivizing Equitable Care concept paper). OHA also intends to incentivize some of the metrics by race, ethnicity and language as guided by the Metrics and Scoring and the planned Health Equity Quality Metrics Committees.

Mitigation strategy #2: Develop robust annual financial monitoring

Oregon will develop robust annual financial monitoring, including monitoring utilization and spending, to monitor CCO solvency and ensure the annual targets are reasonable for covering expected costs, as well as develop a mechanism for budget adjustments if unforeseen events, such as new high-cost treatments, result in the annual trend being inadequate to cover members' health needs. OHA will use focused rate and contract mechanisms to hold CCOs accountable. Instead of spending significant resources on building annual rates based on the CCOs prior year's spending, Oregon will devote resources to analyzing health equity and health-related services spending trends, analyzing access to care and medical loss ratio (MLR). Oregon plans to tighten financial metrics (for example, minimum MLR requirements). Additionally, Oregon may employ other financial mechanisms to hold CCOs accountable for meeting targets for certain services, such as behavioral health or chronic disease management. By creating a new, flexible payment methodology, Oregon anticipates that the amount of money subject to both quality metrics and

accountability will grow over time as the CCO model improves care and reduces cost growth. OHA will continue to use tools developed for the most recent CCO procurement to monitor for high cost or low value health spending and push for redeployment of those resources to lower costs, higher value interventions.

What these policies would mean for OHP members

Establishing a value-based global budget will align financial incentives for CCOs so that OHP members with higher health care needs experience better care coordination, access to health-related services, including access to additional benefits when transitioning to and from institutions, such as jails and prisons.

OHP members will maintain access to the range of clinically effective drugs. At least one drug per drug class will be covered and OHP members will be able to ask to get a different one through their health care provider.

OHP members, families, and communities will see increased community investment by CCOs due to more sustainable cost growth and required community investments.

Conclusion

Over the past decade, Oregon has made strong progress in changing financial incentives from a near exclusive focus in traditional health care financing on health care spending and downstream treatment, to increasing attention to prevention, health-related services, and coordinated care to treat the whole person. However, despite these efforts, a fundamental shift in the economic model for Oregon's Medicaid plans has proven elusive, in large part due to limitations in the rate setting process. Oregon seeks waiver flexibility to create this fundamental shift, so that payment, incentives (see Incentivizing Equitable Care concept paper), and accountability all drive collectively to a healthier population. We request approval to better manage the rising cost of drugs that curtails the shift in resources necessary to achieve population health and health equity in our state. We further seek the ability to ensure a minimum amount of investment in health equity and social needs, under community leadership, as required by recently passed HB 3353 (see Focused Equity Investments concept paper).

You can get this document in other languages, large print, braille or a format you prefer. Contact the Community Partner Outreach Program at community.outreach@dhsoha.state.or.us or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.