Oregon Value-based Payment Compact

Final Progress Report

May 2024

OREGON HEALTH AUTHORITY

Oregon Health Leadership Council

Contents

Acknowledgements

This publication was prepared by the Oregon Health Authority's Transformation Center. For questions about this document, contact VBP.compact@oha.oregon.gov.

Dear Colleagues:

As co-chairs of the Oregon Value-Based Payment (VBP) Compact Workgroup, we present this final progress report on the VBP Compact. The VBP Compact, jointly sponsored by the Oregon Health Authority and the Oregon Health Leadership Council, is a voluntary commitment by payers and providers to participate in and spread VBP models by meeting specified VBP targets and timelines through 2025.

The Compact was founded in 2021 on the belief that value-based payments — aligning incentives with health care quality and outcomes rather than volume — are essential to controlling health care costs while improving patient care. Over the past several years, Oregon has led the way in advancing this approach; 63 signatory organizations covering 73% of Oregonians signed the Compact, committing to increase their VBP adoption. The most recent data available indicate Compact signatories are on track toward meeting Compact goals. Our shared efforts set ambitious targets, provided guidance to payers and providers, and offered an actionable VBP roadmap to accelerate VBP adoption across the state.

Despite challenges such as the complexity of transitioning from traditional fee-for-service models and the unprecedented disruptions of the COVID-19 pandemic, we made progress. We identified and addressed barriers, created a VBP toolkit to support providers and payers, and explored innovative payment models.

The work does not stop here. While this report marks the conclusion of the Compact Workgroup's efforts, the commitment to value-based payment will continue through ongoing collaborations, policy exploration, and the implementation of lessons learned.

Oregon remains a national leader in payment reform, and the insights gained from this work will shape future health care strategies at both the state and national levels.

We extend our gratitude to all those who contributed to this effort. VBP Compact Workgroup members and the staff at the Oregon Health Authority were instrumental in the development of the targets, the toolkit and payment models. We hope these efforts continue to evolve, ensuring that all Oregonians receive the highest quality care at a sustainable cost.

With appreciation and commitment,

Doug Boysen, Elizabeth Powers and Dan Stevens

Oregon Value-Based Payment Compact

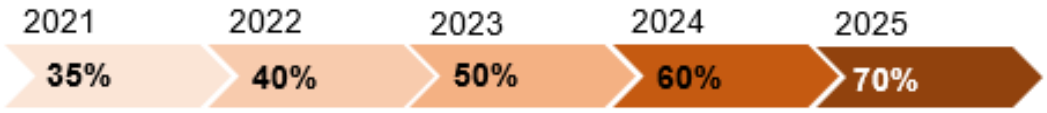
The Oregon Value-Based Payment (VBP) Compact is a voluntary commitment among payers and providers to transition payments towards value-based models, with a goal of improving health care quality, equity, and cost efficiency. The initiative, co-sponsored by the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC), has 63 signatories covering 73% of Oregonians.

Key goals and targets

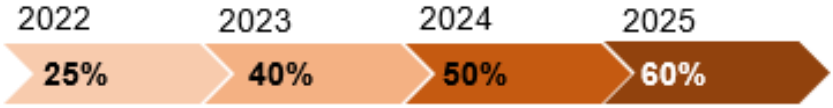
- **70% of payments** to be under advanced VBP models by 2025.
- **60% of primary care and hospital payments** to be under shared-risk models (HCP-LAN 3B and higher) by 2025.
- Emphasis on **health equity** and minimizing negative impacts on vulnerable populations.

Oregon VBP Compact targets

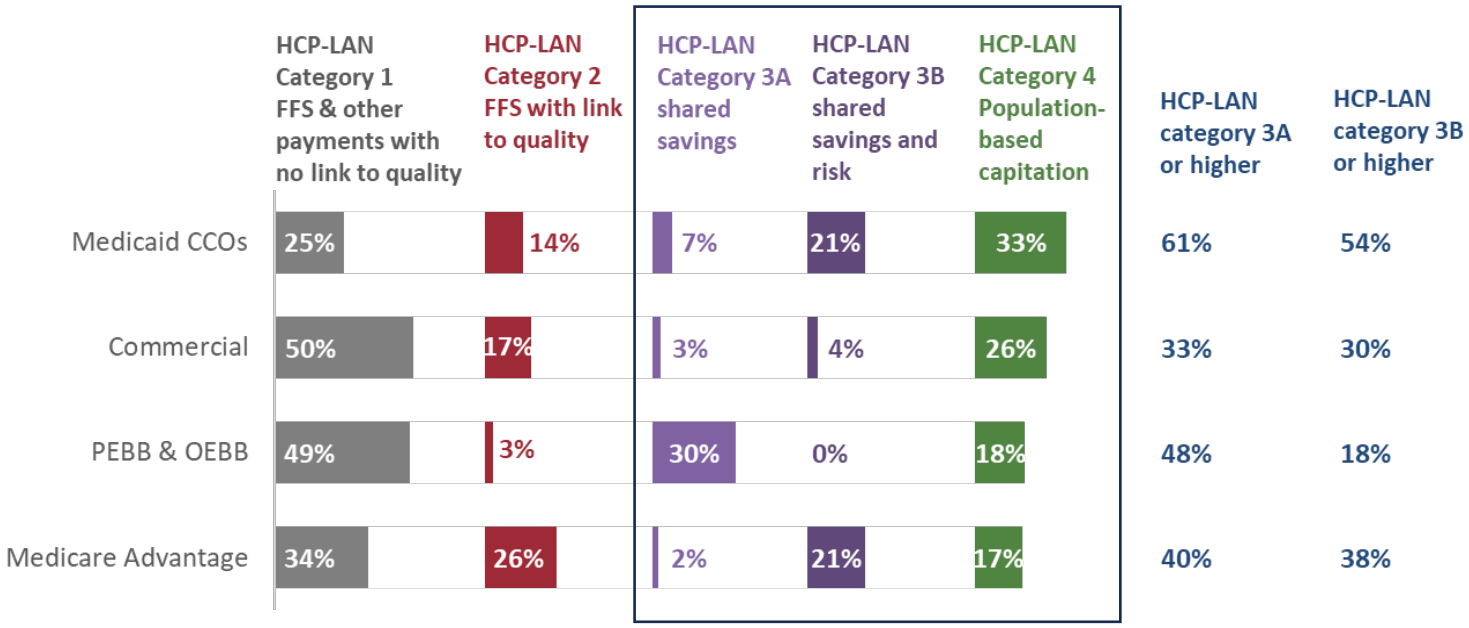
Percent of payments that are shared savings (HCP-LAN 3A) and higher



Percent of payments to primary care practices and general acute care hospitals that are shared risk (HCP-LAN 3B) and higher



Progress toward targets



- **Most recent data: 2022**: Medicaid CCOs, PEBB/OEBB plans, and Medicare Advantage met the **40% shared savings** target.
- **2023–2024**: Development of a primary care VBP model and exploration of hospital-based models.

Challenges in the transformation of payment

- **Transition from Fee-for-Service**: Requires significant cultural and operational changes.
- **Multiple VBP Models**: Administrative burdens for providers.
- **Financial Risks for Providers**: Concerns about managing downside risk.
- **Data Infrastructure**: Need for better analytics and reporting capabilities.
- **Attribution Complexity**: Lack of alignment.
- **Small Patient Populations**: Limits the financial viability of some models.
- **COVID-19 Impact**: Workforce burnout and operational strain.

Strategies to accelerate adoption

- **Standardized VBP Menu**: Aligning models across payers to reduce complexity.

- **VBP Toolkit**: Resources to support payers and providers in VBP transition.
- **Equity**: Targeted strategies to ensure equitable and effective care models.
- **Risk Mitigation**: Addressing financial concerns to encourage provider participation.
- **Data & Policy Alignment**: Strengthening infrastructure to support seamless implementation.
- **Attribution Transparency**: Enhancing clarity across payers and providers.

VBP models

1. Primary Care VBP Model: Completed
    - Prospective population-based payments for core services.
    - Performance-based incentives tied to equity-focused quality measures.
    - Infrastructure payments to support social determinants of health.
2. Hospital Global Budget Model: Explored
    - Fixed payment model providing financial stability.
    - Flexibility for hospitals to adjust services based on community needs.
    - Pilot projects focused on simulation launching in 2025.

Next steps and future work

- **Annual progress reporting** on VBP adoption and performance.
- **Pilots** of primary care and hospital VBP models.
- **Refining social risk adjustment** for consideration in payment models.
- **Ongoing education & engagement** with payers, providers, and policymakers.

Background and Compact overview

As part of Oregon's legislatively mandated initiative to contain growth in health care costs, payers and providers are working together to advance payment reform and move to value-based payments (VBP). The Oregon VBP Compact is a voluntary commitment by payers and providers to participate in and spread VBPs by meeting specified VBP targets and timelines. The Compact, jointly sponsored by the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC), has 63 signatories, covering 73 percent of Oregonians.

Oregon has long been a national leader in health system transformation, focused on creating a system that delivers affordable, high-value, coordinated quality care. In 2019, the Legislature created the Sustainable Health Care Cost Growth Target Implementation Committee (Implementation Committee) and charged it with identifying mechanisms to lower the growth of health care spending in Oregon to a financially sustainable rate.

In January 2021, the Implementation Committee approved recommendations to implement a health care cost growth target, including a set of principles (Appendix A) to increase the spread of VBP models across the state as a strategy to improve quality and lower costs. These VBP principles, including targets, form the basis of the VBP Compact.

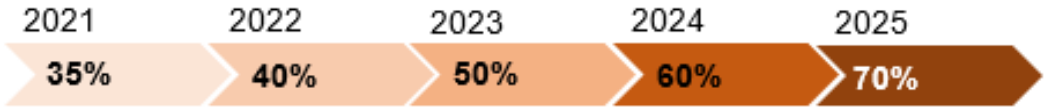
This report, the final issued about the Compact which originally ended in 2024, is meant to inform VBP Compact signatories, the organizations that convene signers, the Legislature, and the public of the actions taken between June 2023 and December 2024 to implement the VBP Compact.

Compact targets

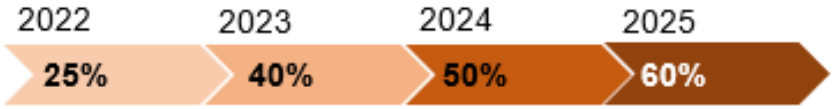
The Compact principles set the target of moving 70% of payers' payments to an advanced VBP model by this year (2025). The Compact also makes clear that VBPs "should be designed to promote health equity, as well as to mitigate adverse impacts on populations experiencing health inequities," and lays out a variety of strategies to achieve that goal. The VBP framework that was used to track progress toward meeting the Compact goal— which includes VBP model categories — was developed by the Health Care Payment Learning & Action Network (HCP-LAN), a national effort supported by the Centers for Medicare and Medicaid Services (CMS) to accelerate VBP adoption across the country. (For more details, see Appendix B.)

Oregon VBP Compact targets

Percent of payments that are shared savings (HCP-LAN 3A) and higher



Percent of payments to primary care practices and general acute care hospitals that are shared risk (HCP-LAN 3B) and higher



Compact Workgroup

To ensure the Compact was successfully implemented, OHA and OHLC co-convened the VBP Compact Workgroup (Workgroup) in 2021 with support from the Hospital Association of Oregon and the Oregon Medical Association.

The Workgroup was charged, by OHA and OHLC, with identifying paths to accelerate the adoption of VBP across the state; highlighting challenges and barriers to implementation and recommending policy change and solutions; coordinating and aligning with other Oregon VBP efforts; and monitoring progress on achieving the Compact principles, including the VBP targets.

Workgroup members, listed below, represent payer, purchaser and provider perspectives.

VBP Compact Workgroup members

Name	Title	Organizational affiliation
Doug Boysen, Co-Chair	President and Chief Executive Officer	Samaritan Health Services
Amy Dowd	Chief Operating Officer	CareOregon
Eleanor Escafi	Assistant Director, Strategy & Execution	Cambia Health Solutions
Kevin Ewanchyna	Vice President and Chief Medical Officer & President	Samaritan Health services & Oregon Medical Association

Ali Hassoun	Interim Director, Health Policy and Analytics Division	Oregon Health Authority
Tim Hachfeld	Program Manager, Primary Care APMs, Network Innovations	Regence Health Plans
Kirsten Isaacson	Research Coordinator and Board Member	SEIU Local 49 and Oregon Health Policy Board
Richard Jamison	President	The Oregon Clinic
Angela Mitchell	Vice President, VBP Provider Contracting	CareOregon
Leah Mitchell	Chief Integration Officer and Vice President, Kaizen Quality/Safety	Salem Health
Gil Munoz	Chief Executive Officer	Virginia Garcia Memorial Health Center
William Olson	Chief Operating Officer of Oregon	Providence Health and Services
Jeff Perry	Chief Financial Officer	Multnomah County Health Center
Elizabeth Powers, Co-Chair	Health Services Officer	Winding Waters Community Health Center
Ken Provencher, Co-Chair	Chief Executive Officer	PacificSource
Dan Stevens, Co-Chair	Executive Vice President of Provider and Regional Partnerships	PacificSource
Tom Syltebo	Board Member	Oregon Educators Benefit Board
James Tan	Medical Director, Government Programs and Products and Medical Director, KP National Medicaid	Kaiser Permanente
Jeremy Vandehey	Director, Health Policy and Analytics Division & Member	Oregon Health Authority & Public Employees' Benn

VBP Roadmap

The Workgroup developed a VBP Roadmap detailing strategies, actions and milestones to advance the VBP goals laid out in the VBP Compact. The VBP Roadmap includes:

- Analysis of challenges to VBP implementation
- Strategies to accelerate adoption of advanced VBP models
- Milestones and indicators of success

Challenges to VBP adoption

Accelerating VBP model adoption across Oregon is challenging. The work is complex and requires strong commitment by payers, providers, state agencies, employers, community members and persons affected by the payment models. As the first step in its Compact work, the Workgroup — supported by staff and consultants — identified major challenges to VBP adoption, which are summarized below.

Challenge	Description
Transition from FFS system to VBP	Shifting from FFS payment to advanced VBP (HCP-LAN 3A shared savings, HCP-LAN 3B shared risk and HCP-LAN 4 prospective, population-based) requires deep operational and culture change for payers and providers.
Multiple VBP models	Managing multiple VBP models is challenging for providers. Significant practice staff time is spent tracking and reporting on metrics that are not aligned, and accounting for payment amounts for the various models.
Provider concern about significant financial loss	Many providers, especially small providers, have limited knowledge of and experience with managing VBP contracts, and lack the capacity to do so. This results in provider concern about potential financial loss from downside risk and prospective payment VBP models. In addition, small population size (see below) may mean a practice is not large enough to weather one or two bad outcomes.
Lack of data infrastructure	A robust data infrastructure is necessary for providers to produce metrics for payers and act on population health. Many small- and medium-size providers do not have a data infrastructure with the necessary capabilities to maximize VBP contracts, and building the infrastructure is expensive.

Lack of meaningful risk adjustment for both downside risk and prospective payment	Risk adjustment is key for successful implementation of advanced VBP, which supports the provision of population health-based care. Providers are more focused on risk adjustment models when entering into payment structures where they take on risk, particularly for complex patients. While there is interest in social risk adjustment, there is not an agreed-upon method.
Diverse attribution models make advanced VBP challenging	Clarity in attribution approaches is critical for success in VBP. Lack of transparency and variation of attribution methodologies are challenges for practices. They often do not know which patients they are accountable for, making it difficult to manage a VBP model.
Small patient populations	Successful implementation of VBP models relies on sufficient patient populations by payer to provide enough funding for providers while improving quality and value. The large number of payers and medium/small clinics in Oregon presents challenges for implementation. Additionally, many small providers do not have the infrastructure to support VBP.
COVID-19	The COVID-19 pandemic had a substantial impact on the capacity and availability of providers. Both small and large providers experienced tremendous stress resulting in workforce burnout, and staff shortages. While some providers found that VBP improved financial stability during the fluctuations of the pandemic, for others the uncertain environment impacted their readiness and ability to implement new initiatives or payment models.

Strategies to accelerate adoption of advanced VBP models

The Workgroup identified six strategies to facilitate the adoption of VBP in Oregon.

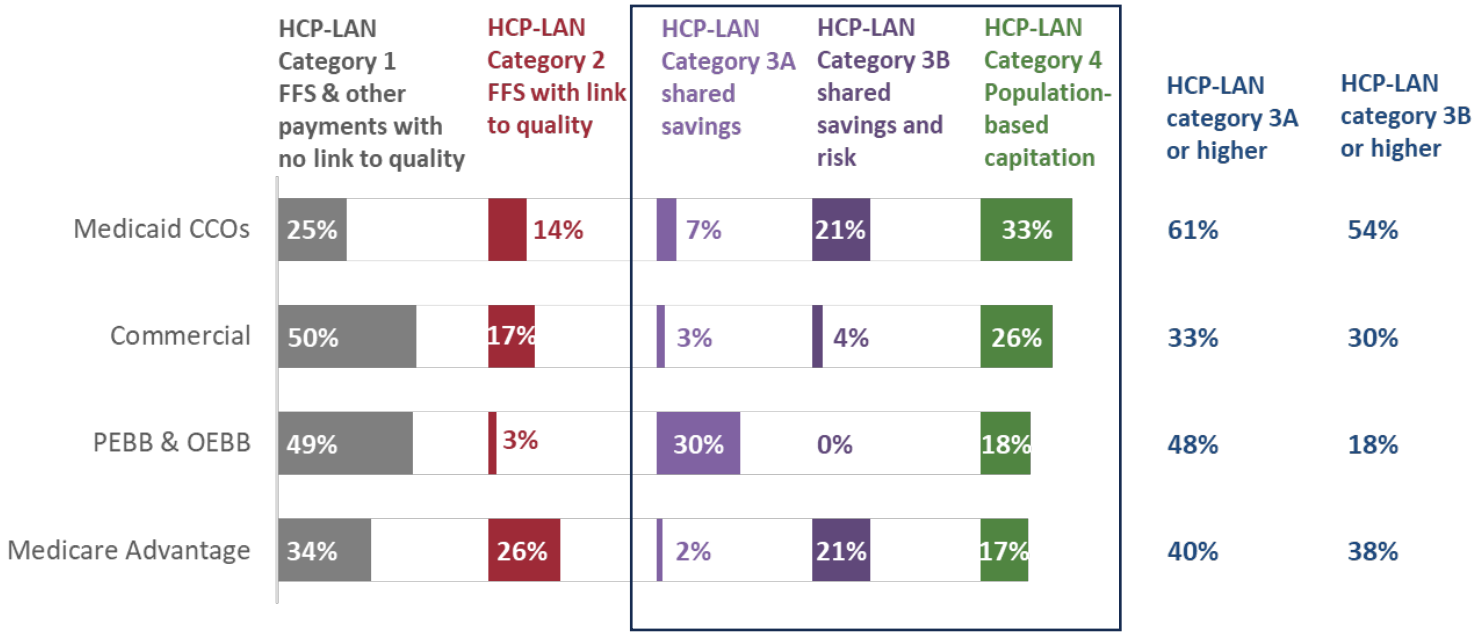
Strategy	Details
 Short VBP Menu	Develop a short menu of VBP models for use in Oregon that is developed by and reflects the priorities of key interested groups and allows for greater model alignment between payers.
 VBP Toolkit	Develop a compendium of VBP tools and models to inform, support and encourage provider and payer entry into value-based payment models.
 Equity	Consider targeted, explicit strategies to integrate equity considerations into VBP efforts.
 Mitigating Financial Risk	Address provider concerns about financial risk/loss.
 Data and Policy Alignment	Maximize data, program and policy alignment to advance Workgroup goals and remove barriers to VBP adoption.
 Attribution	Address the barrier of attribution in VBP implementation.

During the Workgroup's tenure, the VBP toolkit was completed and includes strategies for incorporating equity into VBP, mitigating financial risk, aligning data and policy and attribution. As part of developing a short VBP menu, the Workgroup also oversaw the development of a primary care VBP model and considered models for other care delivery areas that could be developed in the future. More details about these efforts are highlighted below.

Measuring progress

The Workgroup has been committed to measuring Oregon's progress toward the VBP targets and monitoring the implementation of these strategies. Quantitative progress toward the VBP targets were measured using payment arrangement models reported annually by payers and providers in Oregon's All Payer All Claims Database (APAC). Data from 2022 is the most recent available. As shown in the chart below, Medicaid CCOs, Public Employees' Benefit Board and Oregon Educators Benefits Board plans, and Medicare Advantage plans met the 2022 VBP Compact target of 40% of payments in shared savings (HCP-LAN 3A) and higher. Commercial plans lag at 33%.

Oregon's Health Care Payment Arrangements in 2022



Note:

- The percent of payments for Medicaid CCOs in the payment categories may not sum to one hundred percent due to differences between the APAC Payment Arrangement File data and audited financial data.
- Umpqua Health Alliance CCO's data have been excluded due to an issue with the data at the time of publication.

The targets for percent of payments to primary care practices and general acute care hospitals in shared risk (HCP-LAN 3B) and higher began in 2022. OHA is pursuing strategies to report on those targets in the annual Oregon Value-Based Payment Report.

VBP Toolkit

To inform, support and encourage provider and payer entry into value-based payment models, the Workgroup developed a web-based VBP toolkit. The toolkit includes instructive content and case studies from providers and payers to illustrate VBP implementation in action.

Successful VBP arrangements require an active partnership as payers and provider entities shift from a focus on volume to value. While the primary audience for the toolkit is provider entities and clinicians, the toolkit provides a shared language and approach for payers and providers, as well as key considerations for payers.

The toolkit is comprised of four sections with detailed action steps. While the toolkit presents information in a sequential order, the process of implementing a new or more advanced VBP approach is iterative. Therefore, users can jump from one section to another to focus on items that are of most interest depending on where the user is in their VBP journey.

Section I: Understand VBP models and terms

- Educate your team on VBP terms and models
- Assess internal interest and understanding of VBP
- Assess your readiness for a new or modified VBP model(s)
- Identify current data analytical capabilities and gaps
- Understand member attribution and assignment
- Understand your population and health disparities
- Understand types of financial risk in VBP models

Section II: Get ready for VBP

- Define your VBP objectives
- Identify and engage senior-level VBP champion(s)
- Identify and engage your VBP team
- Assess, interpret and leverage data

- Assess and prepare for financial risk
- Develop and document your VBP approach and workplan
- Engage and negotiate with payers

Section III: Go live with VBP model(s)

- Promote provider clinical transformation to foster VBP success
- Access technical assistance and peer learning
- Understand how quality is measured and used in different VBP models
- Maximize quality improvement and performance on measures
- Review results and make modifications
- Scale up current VBP contracts and engage additional payers

Section IV: Understand VBP compact models

- Primary care model
- Specialty care models (future content)
- Hospital care model (future content)

Primary care VBP model

The Workgroup asked the Oregon Primary Care Payment Reform Collaborative (PCPRC), a legislatively mandated multi-partner advisory body charged with increasing investment in primary care and changing the way primary care is paid for, to develop a primary care VBP model. This VBP model — which is the first on the short menu of VBP models — includes the following payment components:

- **Prospective population-based payments** for a defined set of primary care services that are widely performed by primary care practices, represent a preponderance of primary care spending, and are prone to overuse when paid fee-for-service
- Fee-for-service payments for all other covered services

- **Infrastructure payments** that include: 1) a base payment tied to Patient-Centered Primary Care Home (PCPCH) tier, and 2) additional payments for specific high-value services
- **Performance-based incentive payments** based on an aligned quality measures set

The prospective population-based payment covers 85–95% of primary care services. The exact percentage varies by payer and age group. Services not included in the capitation payment that will continue to be paid fee-for-service are those that are performed at widely varying rates among providers and/or offered inconsistently, are subject to potential underutilization, and where there is interest in incentivizing increased volume. Examples of these services include home visits, prenatal care, advanced care and end-of-life planning.

Implementation of the model is voluntary and has been adopted by at least one commercial payer and one CCO. OHA staff are working with several other CCOs that have implemented similar models to determine the level of fidelity. The goal is that adoption of the model will increase over time; OHA is exploring ways to support this goal.

Infrastructure payments

The model includes an infrastructure payment tied to PCPCH tier level. Payers and providers can decide to include optional infrastructure payments such as those that address health-related social needs (HRSN) and/or promote health equity, including:

- Additional care management and care coordination supports for patients with higher levels of medical and social risk
- Traditional health worker services
- HRSN screenings and supporting collaboration and data-sharing between primary care practices and social services organizations
- Technology and staff to collect and use REALD (race, ethnicity, language and disability) data

Performance-based payments

Performance-based incentive payments are tied to the aligned quality measure set endorsed by the PCPRC in Appendix F of the PCPRC VBP model. The total eligible

incentive payments should equal at least 10% of the value of annual projected practice service payments (population-based payment + fee-for-service).

The quality measures include National Quality Forum (NQF) disparity-sensitive measures. The following measures are included in the measure set and on the NQF list of identified measures:

- Cervical cancer screening
- HbA1c poor control
- Depression screening – youth
- Controlling high blood pressure

Each quality measure should be evaluated through an equity lens. Whenever feasible, payers will identify disparities by aggregating data on each quality measure across contracted providers and stratifying measures by race, ethnicity, geography and possibly other demographic factors. Payers will communicate the findings with providers to inform strategies to reduce disparities.

The PCPRC recommends a metrics workgroup comprised of PCPRC members meet annually to update the list with technical fixes and to meet every third year to update the measure set to reflect changing priorities and opportunities for improvement, including considering adopting this CCO incentive metric: *Social determinants of health: Social needs screening and referral in 2025*.

In addition to infrastructure payments to support HRSN and the inclusion of disparity-sensitive measures, the model includes other components to promote health equity. Practices identified by payers as serving patient populations with unusually high medical and/or social risk may be held accountable only for improvement for performance-based incentive payments if the payer and practice agree that external benchmarks are not applicable.

Social risk adjustment

PCPRC members expressed interest in risk adjustment for social complexity and convened a subcommittee in 2023 and 2024 to explore methodologies. Social risk adjustment (SRA) is an emerging area with limited literature examining data sources and only a few instances of implementation. The subcommittee reviewed and discussed

existing literature and learned from Massachusetts and Minnesota where SRA has been implemented by state Medicaid agencies.[1]

The subcommittee learned that there are two types of data that can be used for SRA – geographic-level and individual-level.

- Geographic-level data generally comes from publicly available data from the U.S. Census Bureau's American Community Survey (ACS), using the social risk factors associated with zip codes where individual patients live as a proxy for their own social risk factors and for community-level risk factors.
- Individual-level data can come from claims, electronic health records (EHRs), and administrative data on the characteristics of populations served by a health care system or social service program (such as demographics, type of service, diagnosis, and eligibility).

The subcommittee also looked at the following three geographic indices calculated from the ACS.

	Social Deprivation Index (SDI)	**Area Deprivation Index (ADI)**	**Social Vulnerability Index (SVI)**
Geography	Census tract	Census tract	Census tract
Source	American Community Survey	American Community Survey	American Community Survey
# of variables	7 variables	17 variables	16 variables
Health outcome correlation	Moderate correlation with life expectancy (-0.59)	Lower correlation with life expectancy (-0.53)	Moderate correlation with life expectancy (-0.55)
Frequency of update	Yearly (most recent 2019 data)	Every five years	Every other year

After reviewing literature and consulting with Medicaid staff from Massachusetts and Minnesota, the subcommittee selected the Social Vulnerability Index (SVI) as its recommended geographic-level data source because it:

[1] https://www.commonwealthfund.org/publications/2024/oct/paying-providers-address-health-related-social-needs.

- Includes 16 diverse variables in areas such as income, employment, housing, and minority status;
- Is updated every other year; and
- Is normalized for housing prices to allows for a more accurate comparison of economic data across different regions.

On January 1, 2025, Eastern Oregon CCO and Moda implemented SRA using the SVI. Both agreed to share their experience with implementation and the impact over time.

Protecting against possible unintended consequences of VBP

While VBP models support practices to improve quality, they can also have unintended adverse consequences such as incentivizing withholding of care, discouraging a panel of high morbidity patients, and excessive specialty, urgent care and ED referrals. Strategies in the primary care VBP model to protect against these unintended consequences include:

- Using data to identify early indicators of decreased access
- Adjusting payments so that practices that treat patients with higher medical and social complexity are paid more relative to those that do not
- Tracking patterns of specialty care, urgent care and ED use and discuss observed anomalous patterns with practices

Hospital VBP Model

The hospital global budget model was identified by the VBP Compact Workgroup as the second model to be developed for the VBP short menu that could help the state meet its VBP targets. A hospital global budget is a fixed payment, determined prospectively, based on historical utilization and adjusted annually to account for changing demographics, market share and case/service mix. Hospital global budgets can advance health care access, particularly in rural areas, by:

- Ensuring steady, predictable financing that support hospitals even when visit volume is unstable
- Providing greater flexibility to modify hospital service offerings to best meet community needs
- Producing positive outcomes without having adverse effects on hospital finances

- Controlling growth in hospital spending at an affordable level

In late 2023, OHA was selected to participate in the Commonwealth Fund State Affordability Technical Assistance (TA) Program to explore hospital receptivity to a hospital global budget VBP model. OHA partnered with the Hospital Association of Oregon and the Commonwealth program's TA provider, national VBP expert Bailit Health, to present two hospital leader educational sessions—one for small rural hospitals and one for health system hospitals—to increase understanding of hospital global budgets among hospital leaders and solicit initial feedback. Rural hospital and health system hospital participants expressed hesitation about moving toward global budgets, citing competing concerns about workforce costs, inflation, and reimbursement rates and the inability to take on something new. Rural hospitals were slightly more open to the concept, particularly the possible impact on financial stability.

Communicating about the work

VBP Compact Workgroup tri-chairs and staff shared Compact progress with the Cost Growth Target Advisory Committee in an educational webinar on June 27 and a presentation during the November 19 committee meeting. Progress was also shared with the Oregon Health Leadership Council on October 31.

The work is continuing

The VBP Compact Workgroup sunset in December 2024 per the VBP Compact principles in Appendix A; however, the work will continue through activities by payers and providers.

Measuring VBP implementation

OHA will continue to report annually on VBP performance against the Compact targets.

Testing VBP models

OHA is engaging partners in the design of two initiatives to test VBP models: one pilot of the primary care VBP model and one using a hospital global budget model.

- **Primary care VBP**
  OHA will build on the experience of one CCO that has implemented the primary care VBP model by piloting implementation with a minimum of one additional CCO and one of its contracted primary care provider organizations. OHA will provide custom technical assistance to support CCOs and primary care practices

to be successful in implementation, including, but not limited to, one-on-one meetings, peer learning, and access to national experts. Pilot activities could include:

- Education on model components
- Support with provider engagement
- Meetings with CCOs and providers already implementing the VBP model

In addition, OHA is considering opportunities to promote and/or require the model in future CCO and Public Employees' Benefit Board and Oregon Educators Benefit Board (PEBB/OEBB) contracts. The PCPRC will continue to educate payers and providers on the model and promote implementation.

- **Hospital global budget (HGB)**
  OHA is working with a consultant and national experts to simulate hospital global budget models to measure the impact on a hospital financial revenue stream in an environment of unpredictable utilization volume. OHA is collaborating with CCOs and hospitals to model one or more hospital global budget models (such as a model in development with support from Arnold Ventures and those used by Pennsylvania and Maryland). Data for the simulation will come from hospitals, CCOs, and OHA data sources, including hospital reporting and the OHA APAC Reporting Program. The simulation launched in March 2025 and results are anticipated in early summer.

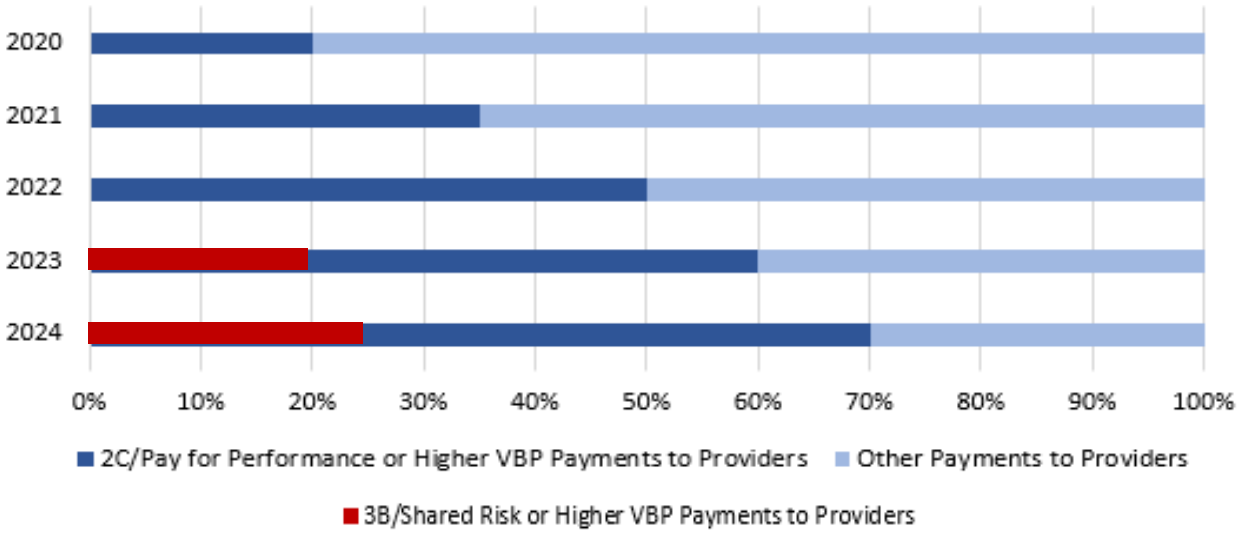
  Oregon will be a pioneer in modeling HGB and will inform national efforts. The National Academy for State Health Policy (NASHP) has convened ten states, including Oregon, to participate in conversations about hospital payment and delivery reform and this global budget simulation will inform those discussions.

Building on the successes of VBP contract requirements

- CCO VBP contract requirements (detailed in the chart below) were established in 2019 and included in the 2020 CCO contracts, prior to the development of the VBP Compact targets.
- CCOs have the highest rate of adoption of VBP compared to other payers in Oregon with 60% adoption in 2022, the most recent data available.

- The VBP Compact targets are more ambitious than the CCO contract requirements and meeting them requires ongoing individual and collective commitment to transformation.

CCO Contract VBP Requirements



The current contractual CCO VBP targets will stay the same through the end of the CCO contracts in 2026.

Requirements for the CCO 2027 contracts are in development and will promote and/or require meeting the Compact targets.

- PEBB/OEBB contracts have included the Compact targets since 2022, likely contributing to the rate of VBP adoption, which was 40% in 2022, meeting the Compact target. New contracts will continue to include the Compact targets, and the boards are considering holding payers at risk for meeting the targets.

VBP toolkit

OHA, the Oregon Health Leadership Council, the Oregon Medical Association, the Oregon Primary Care Association, the Oregon Academy of Family Physicians, the Primary Care Payment Reform Collaborative and other partners will continue to educate payers and providers about the toolkit. New content will be added to the toolkit as work evolves, including information about hospital global budget models.

Conclusion

VBP arrangements tie payment amounts for services provided to patients to the results that are delivered, such as quality, equity and cost of care. By aligning incentives and payment, this approach can result in more evidence-based, preventive and equitable whole-person care. Building on the work of many entities already on this journey, OHA and partners endeavor to learn from and accelerate VBP adoption by creating tools and strategies that harness the innovation and lessons of early adopters and improve upon and align work behind the most promising VBP models and approaches.

Appendix A: Oregon Value-Based Payment Compact: A statewide collaborative partnership for bending the cost curve

Oregon has long been a national leader in health system transformation, focused on creating a system for delivering affordable, high value coordinated quality care. In 2019, the Legislature created the Sustainable Health Care Cost Growth Target Implementation Committee and charged it with identifying mechanisms to lower the growth of health care spending to a financially sustainable rate.

In October 2020, the Implementation Committee created a set of principles to increase the spread of value-based payment (VBP) models across the state as a strategy to improve quality and lower costs, and recommended that payers, providers and other stakeholders across the state make a voluntary commitment, by signing a VBP Compact, to participate in and spread VBPs.

Principles

For the purposes of this document, "innovative payment models" are referred to as "advanced value-based payment models" and are defined to include HCP-LAN Categories 3A and higher.[2] This encompasses payment models with upside risk only, combined upside and downside risk, as well as prospective payment models. Prospective payment models include capitation, global budgets, prospective episode-based payment, and budget-based models with prospective payment and retrospective reconciliation.

These principles build on value-based payment (VBP) efforts for Coordinated Care Organizations and the Primary Care Payment Reform Collaborative.[3] Their intent is to align efforts across public and private initiatives and markets to the extent possible, including the self-insured market, bringing an aggressive focus on advanced value-based payment arrangements across the state.

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[2] For an explanation of the Health Care Payment Learning and Action Network's Alternative Payment Models (HCP-LAN) framework, including a description of its defined payment models, see the APM Refresh Whitepaper.

[3] While these principles are conceptually and directionally aligned with the CCO 2.0 VBP Roadmap and with recommendations from the Primary Care Payment Reform Collaborative, they do push Oregon payers and providers to adopt advanced VBP models more quickly. A CCO who signs the voluntary compact and works to meet the targets outlined in these principles will not be in conflict with their contractual requirements.

1. All members of the Sustainable Health Care Cost Growth Target Implementation Committee, plus representatives of other larger insurer, purchaser and provider organizations in the state, should develop a voluntary compact to increase the use of advanced value-based payment models to Oregon's providers that commit the signatories to these principles and to concrete action steps to achieve these principles.
2. The fee-for-service payment system has fundamental flaws and has not led to sustainable costs or promotion of improved quality, outcomes or health equity in the health system.
3. Providers, particularly those paid on a fee-for-service basis, face unique challenges due to the ongoing COVID-19 pandemic. Increasing the use of advanced value-based payment models will help stabilize Oregon's health system.
4. Advanced value-based payment models are a critical strategy to contain costs to meet the established health care cost growth target. The appropriate advanced value-based payment models may look different across the state, but implementation should be guided by these principles.
5. Prospective budget-based and quality-linked payment, where a provider is paid up front for a population of patients and a predefined set of services, should be the primary payment model utilized wherever feasible for the following reasons:
    a. It provides critical financial stability to providers, particularly for small, independent, and rural providers, through a consistent source of revenue, which is an important part of alleviating the most damaging economic consequences of the pandemic.
    b. It gives providers the flexibility to address the most critical health needs of their patients, including non-medical social supports that might improve health and save costs, rather than having to rely on reimbursable treatments.
    c. It allows for investment in a population of patients, and for flexibility in the type of provider delivering care and the type of care provided, which supports more holistic patient-centered care.

d. It is supportive of the Cost Growth Target because it defines a budget for the care of a population of patients.

6. Prospective budget-based and quality-linked payments are not feasible today for all Oregon providers due to lack of experience with advanced value-based payment and/or small provider size. Therefore, where they are not feasible to implement for a given line of business or provider, advanced payments models that include both shared savings and downside risk should be utilized, consistent with the intent of moving towards prospective payment models. Where value-based payment models categorized as 3B and higher are not feasible, payers and providers should implement value-based payment models categorized as 3A.

7. Payers should have the following percentage of all their payments under **advanced value-based payment models** (3A and higher) in the following time periods:

    a. 35% by 2021

    b. 50% by 2022

    c. 60% by 2023

    d. 70% by 2024

8. Payers should have the following percentage of their payments to primary care practices and general acute care hospitals[4] made under advanced value-based payment models (3B and higher) in the following time periods:

    a. 25% by 2022

    b. 50% by 2023

    c. 70% by 2024

[4] Non-federal, non-specialty hospitals open to the general public providing broad acute care.

9. Health plan enrollees should be encouraged or required to select a primary care provider, whether or not required by benefit design, to support advanced payment model effectiveness.
10. Small and safety net providers should be offered technical assistance by payers and/or by OHA's Transformation Center to set them up for success under advanced value-based payment models. Those with limited experience in value-based payment, such as behavioral health providers, should also be considered for technical assistance.
11. The structure of advanced value-based payment models should be aligned across payers to allow providers to have a sufficient volume of similar value-based arrangements to make meaningful change in their clinical practice and reduce administrative burden. Structural alignment should include but not be limited to the use of common performance measures.
12. Advanced value-based payment models should be designed with consideration of how to reduce excess capacity in the system, while recognizing reasonable health system overhead required to maintain flexible stand-by capacity. Implementation of value-based payment models should not be used to reduce wages of low-income health care workers.
13. Advanced value-based payment models should be designed and implemented with consideration for unintended consequences, including potential adverse impacts on health care quality.
14. Advanced value-based payments models should be designed to promote health equity, as well as to mitigate adverse impacts on populations experiencing health inequities by:
    a. Employing payment model design features and measures to protect against stinting,
    b. Ensuring prospective payments are sufficient to cover the cost of infrastructure changes to support health equity (e.g. traditional health workers, changes to IT systems to track equity),
    c. Providing additional supports (e.g. technical assistance, infrastructure payments) for providers serving populations experiencing health inequities,

d. Ensuring new upside or downside risks will not exacerbate existing inequities, and

e. Ensuring providers serving populations experiencing health inequities who are at greater risk of closure due to COVID-19 remain open.

Future efforts may also include adjusting payments based on social risk factors.

15. Implementation of advanced payment models should be accompanied by public transparency of price information, implemented through the Sustainable Health Care Cost Growth Target Data Use Strategy.

16. These principles represent the shared vision of the Implementation Committee as of October 2020. The passage of time and additional experience with advanced value-based payment implementation could inform future modifications to the targets herein. OHA should convene signers of the voluntary compact no later than fall 2022 to revisit these principles and the compact to ensure effectiveness in advancing payment reform and supporting reduced cost growth in Oregon.

References

HCP LAN framework

CCO 2.0 VBP roadmap

Primary Care Payment Reform Collaborative

Appendix B: Paying for health care value: What does it mean?

Oregon has a long history of health system transformation, including efforts to move away from traditional health care payments based on services provided to models based on value that support positive health outcomes and generate cost savings. There's widespread national consensus that the status quo fee-for-service payments institutionalize a fragmented health system. Transitioning to value-based payment increases flexibility and incentives for providers to deliver patient-centered, whole person care.

How providers are paid matters

Most health care services today are paid via **fee-for-service (FFS)**, where providers are paid to deliver services — incentivizing increased volume of services — with little financial incentive to improve quality, reduce cost or address health disparities. FFS is also a barrier to provider organizations redeploying their resources to deliver care more efficiently and effectively.

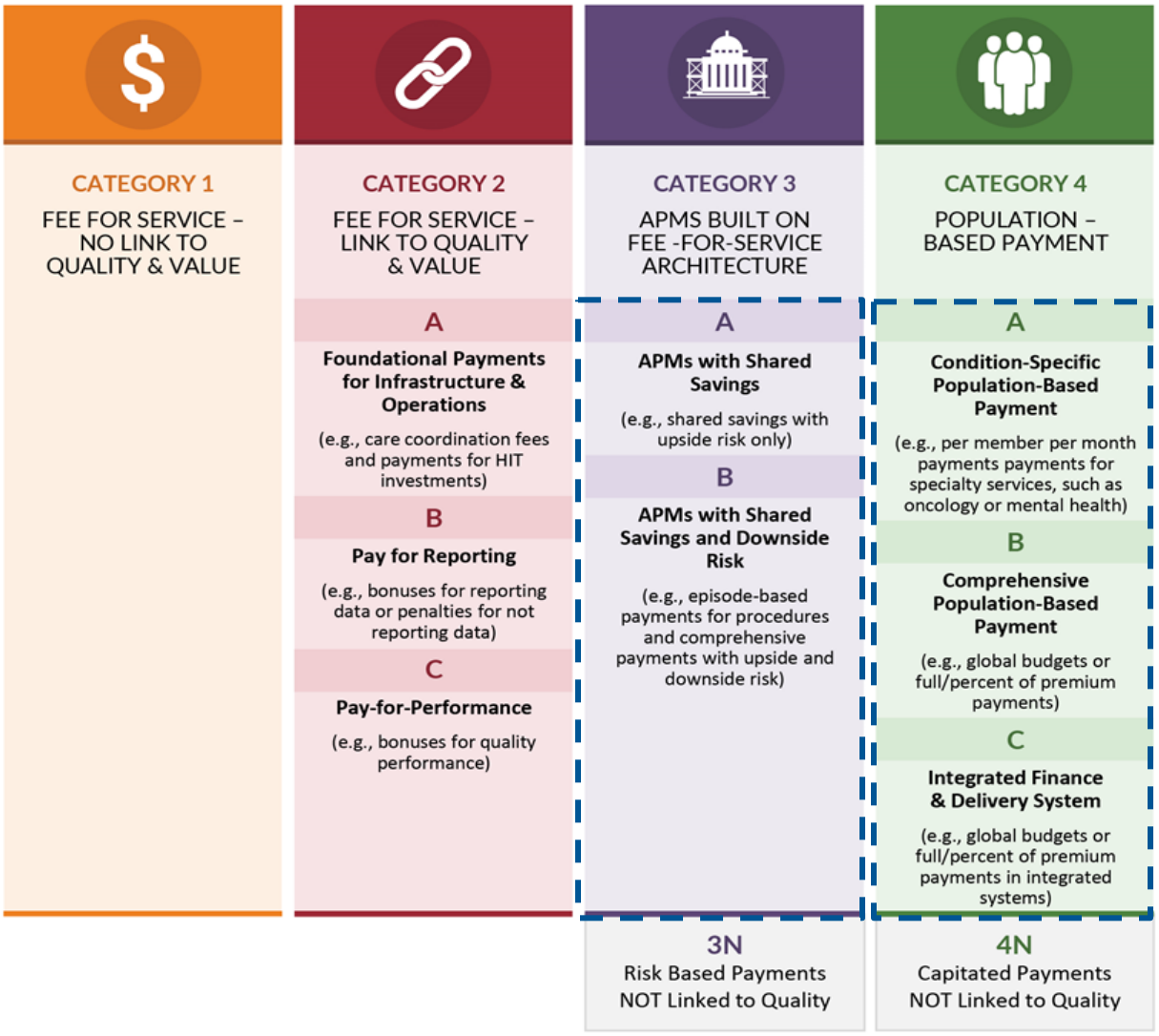
Alternatively, **value-based payment (VBP)** compensates providers for delivering evidence-based, person-centered, efficient care that contributes to improved quality, positive health outcomes and reduced health disparities at an appropriate cost. VBP — especially advanced VBP models — enables providers to focus on how best to organize health care resources and care delivery to meet population needs, and improve access, equity, patient experience and quality.

Value-based payment models

The Health Care Payment Learning and Action Network (LAN), a national effort supported by the Centers for Medicare and Medicaid Services (CMS) to accelerate VBP across markets, developed a framework for categorizing VBPs that has become the nationally accepted method to measure progress on VBP adoption. Multiple payment reform activities in Oregon, including Oregon Health Authority (OHA) contracts with coordinated care organizations (CCOs), are using the LAN Alternative Payment Model Framework (2017) to categorize and track use of VBPs.

Figure 1: LAN Payment Categories

See an accessible, text-only version of the LAN APM framework.



Category 1 payments are FFS with no link to quality and are not considered value-based payment methods.

Category 2 payments are FFS with a link to quality and value.

2A: Foundational Payments for Infrastructure and Operations: Often paid on a per member per month (PMPM) basis, these are also known as infrastructure investments. Examples include payments to support a community health worker or care coordinator, or to upgrade a clinic's electronic health record system.

2B: Pay for Reporting: Provide positive or negative incentives to report quality data to the health plan. They support providers in building internal resources to collect and report data.

2C: Pay for Performance: Rewards providers that perform well on quality metrics and/or penalize providers that do not perform well. These payments directly link payment to quality. 2A and 2B payment models set the foundation for being able to measure quality.

Category 3 payments are based on FFS with possible shared savings and shared risk.

3A: Upside Shared Savings: Providers can share in a portion of the savings they generate against cost or utilization targets if quality targets are met.

3B: Shared Savings and Downside Risk: Providers can share in a portion of the savings they generate against cost or utilization targets if quality targets are met. Payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.

Category 4 payments are prospective and population based.

Category 4 models involve:

- Prospective, population-based payments that encourage the delivery of coordinated, high-quality and person-centered care.
- Accountability for measures of appropriate care to safeguard against incentives to limit necessary care.

4A: Condition-Specific Population Based: Includes bundled payments for comprehensive treatment of specific conditions, such as cancer care, or all care delivered by specific types of clinicians such as primary care or orthopedics.

4B: Comprehensive Population Based: Prospective population-based payment that covers all an individual's health care needs. This category assumes that payers and providers are organizationally distinct.

4C: Integrated Finance & Delivery System: Integrated finance and delivery systems bring together insurance plans and delivery systems within the same organization. This may include joint ventures between insurance companies and

provider groups, insurance companies that own provider groups, or provider groups that offer insurance products.

Success factors

To be successful with VBPs, providers need critical core capabilities and systems.

 Clinical integration/teamwork

 Data analytics and connectivity

 Care management and coordination

 Patient engagement and wellness programs

 Leadership committed to practice transformation and ready for organizational change

Stay informed

To learn more about VBP in Oregon, see the VBP webpage.