Oregon Value-Based Payment Compact

Annual Progress Report

August 2023

Oregon Health Authority

OREGON HEALTH LEADERSHIP COUNCIL

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Acknowledgements

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

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, meeting specified VBP targets and timelines over the next four years. The Compact, jointly sponsored by the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC), has 47 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.

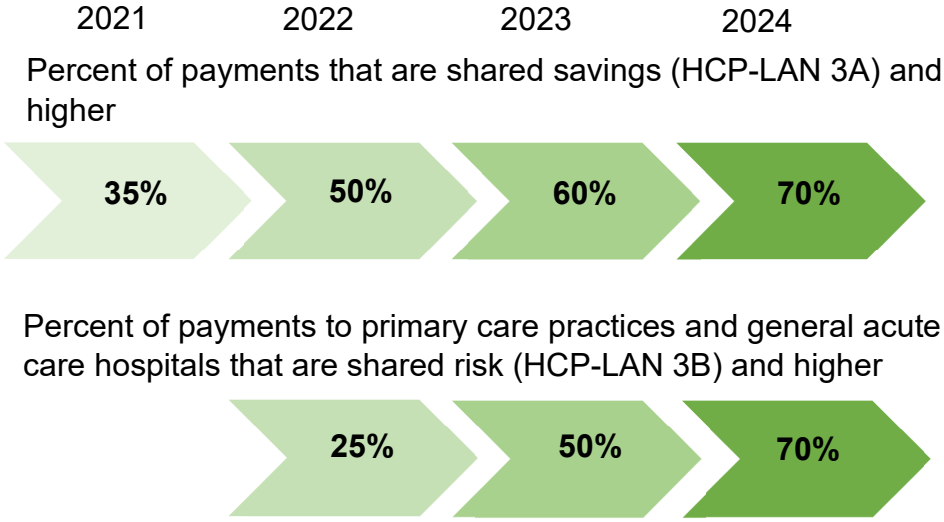
In January 2021, the Implementation Committee approved recommendations to implement a health care cost growth target, including a set of principles (Appendix A) to increase the spread of VBP models across the state as a strategy to improve quality and lower costs. These VBP principles, including targets,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

This report, the second issued about the Compact, is meant to inform VBP Compact signatories, the organizations that convene signers, the Legislature and the public of the actions taken between July 2022 and June 2023 to implement the VBP Compact.

Compact targets

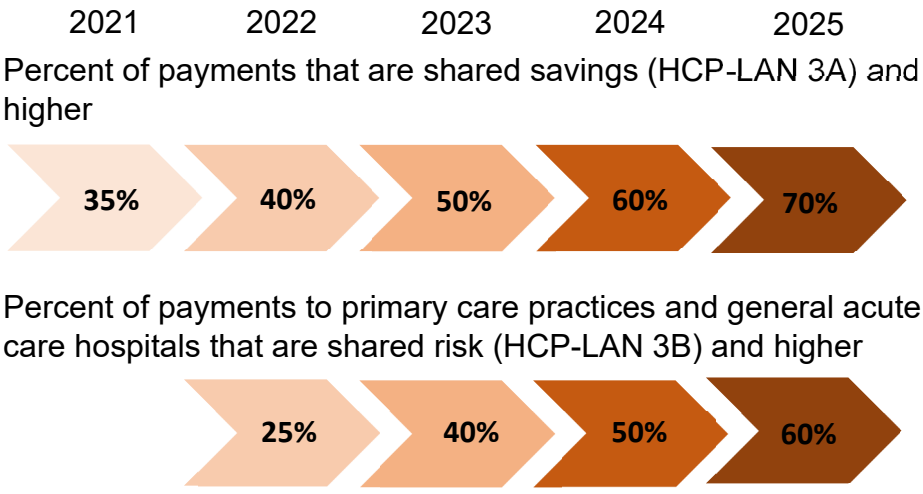
The Compact envisions a transition over the next several years to new payment models, with the principles setting out an original target of moving 70% of payers' payments to an advanced VBP model by 2024. The Compact also makes clear that changes "should be designed to promote health equity, as well as to mitigate adverse impacts on populations experiencing health inequities," and lays out a variety of strategies to achieve that goal. The VBP framework — 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 (original)



Since the Compact targets were set in October 2020, the health care clinical and economic landscape has changed considerably. The pandemic, workforce shortages, and lack of access to all levels of care have made implementation of VBP arrangements more challenging. In response to this situation, the VBP Compact Workgroup exercised its authority to modify the targets to make achieving them more feasible given the current environment.

Revised Oregon VBP Compact targets



Compact Workgroup

To ensure the Compact is successfully implemented, the VBP Compact Workgroup (Workgroup) was co-convened in 2021 by OHA and OHLC with support from the Oregon Association of Hospitals and Health Systems (OAHHS) and the Oregon Medical Association (OMA).

The Workgroup is charged 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 state VBP efforts; and monitoring progress on achieving the Compact principles, including the VBP targets.

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

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 and Execution	Cambia Health Solutions
Kevin Ewanchyna	Vice President and Chief Medical Officer and President	Samaritan Health Services and Oregon Medical Association
Ali Hassoun	Interim Director, Health Policy and Analytics Division	Oregon Health Authority
Kirsten Isaacson	Research Coordinator and Board Member	SEIU Local 49 and Oregon Health Policy Board
Richard Jamison	President	The Oregon Clinic
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 and Chief Medical Officer	Winding Waters Community Health Center

Name	Title	Organizational affiliation
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

VBP Roadmap

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

- Analysis of barriers to VBP implementation
- Strategies to address these barriers, including actions and accountable parties
- Milestones and indicators of success

Challenges to VBP adoption

Accelerating VBP model adoption 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.

Challenge	*Description*
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 public health emergency continues to have substantial impact on the capacity and availability of providers. Both small and large providers have been under tremendous stress resulting in workforce burnout, and staff shortages are widespread. While some providers found that VBP improved financial stability during the fluctuations of the pandemic, for others the uncertain environment has 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. The strategies, listed below, are not in sequential order, as many should be implemented concurrently.

 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

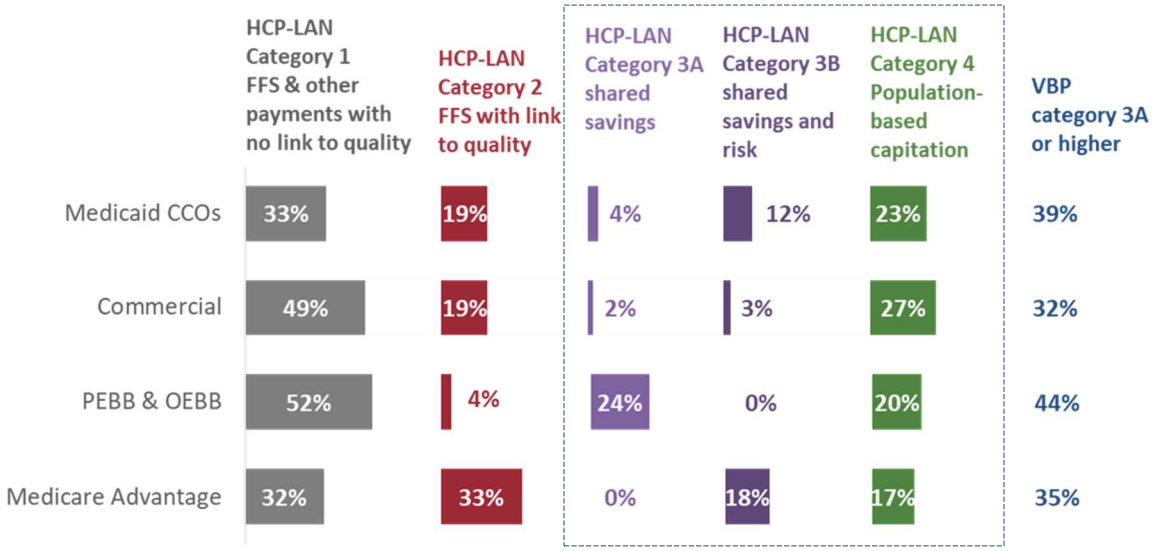
Measuring progress

The Workgroup is committed to measuring Oregon's progress toward the VBP targets and monitoring the implementation of these strategies. Quantitative progress toward the VBP targets will be measured using Oregon's All Payer All Claims Database (APAC) and payment arrangement models reported annually by payers and providers. As shown in the chart below, Medicaid coordinated care organizations (CCOs), Public Employees' Benefit Board and Oregon Educators Benefits Board plans, and Medicare

Advantage plans have met the 2021 target of 35% of payments in shared savings (HCP-LAN 3A) and higher. Commercial plans lag at 32%.

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, and progress will be reported with data available in early 2024.

Oregon's Health Care Payment Arrangements in 2021



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.

Progress toward the VBP Roadmap goals will be measured by achieving the strategy indicators of success and will be reported as specified in the Workgroup's charter.

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 volume to a value focus. While the primary audience for the toolkit is expected to be 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 VBP Compact Workgroup asked the Oregon Primary Care Payment Reform Collaborative (Collaborative), 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 is the first on the short menu of VBP models. To accomplish this, the Collaborative convened a VBP Model Development Workgroup that met monthly starting in May 2022. The Model

Development Workgroup developed an all-payer model which includes the following payment model components:

- **Prospective capitated 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 capitated 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, and advanced care and end-of-life planning.

The model includes an infrastructure payment tied to PCPCH tier. 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 incentive payments will be paid on an aligned quality measure set that will be created by a workgroup of the Primary Care Payment Reform Collaborative convening this fall. The model specifies that the measure set will include no more than eight measures and will reflect both pediatric and adult measures and at least one equity measure. The model also specifies that total eligible incentive payments should equal at least 10% of the value of annual projected practice service payments (capitated + fee-for-service).

In addition to infrastructure payments to support HRSN and the inclusion of at least one equity measure, 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.

During the development of the model, Model Development Workgroup members expressed interest in risk adjustment for social complexity. Because there is not an established methodology for this nascent area, the Collaborative will convene a workgroup this fall to explore possible methodologies and develop a pilot for implementing social risk adjustment.

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 making too many specialty, urgent care and ED referrals. Strategies in the 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

Next steps

OHA will work with VBP Compact Workgroup members and organizations supporting Compact implementation — OHLC, OMA and OAHHS — to disseminate the VBP toolkit, including the primary care VBP model, to their constituencies. In addition, the Workgroup is partnering with other organizations, including the Oregon Academy of Family Physicians, the Oregon Primary Care Association, coordinated care organizations and the PCPCH Program to share the toolkit. OHA also will host a webinar introducing the toolkit featuring clinical case studies.

Future model development will focus on specialty and hospital care over the next few years. As they are drafted, these models will be added to the toolkit. Collaboration across payers, providers and the state were key to the development of the primary care VBP model. Success in the development and implementation of future models will continue to rely on partnerships and engagement across the health system.

Appendix A: Oregon Value-Based Payment Compact

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.[1] 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.[2] 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.

1. All members of the Sustainable Health Care Cost Growth Target Implementation Committee, plus representatives of other larger insurer, purchaser and provider

[1] 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 http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

[2] 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.

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[3]
    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

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

[3] While contracts for 2021 may have been signed, nothing precludes a payer from offering to renegotiate contracts to offer advanced value-based payment models.
[4] Non-federal, non-specialty hospitals open to the general public providing broad acute care.

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 healthcare 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:
http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

CCO 2.0 VBP roadmap:
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

Primary Care Payment Reform Collaborative:
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx

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

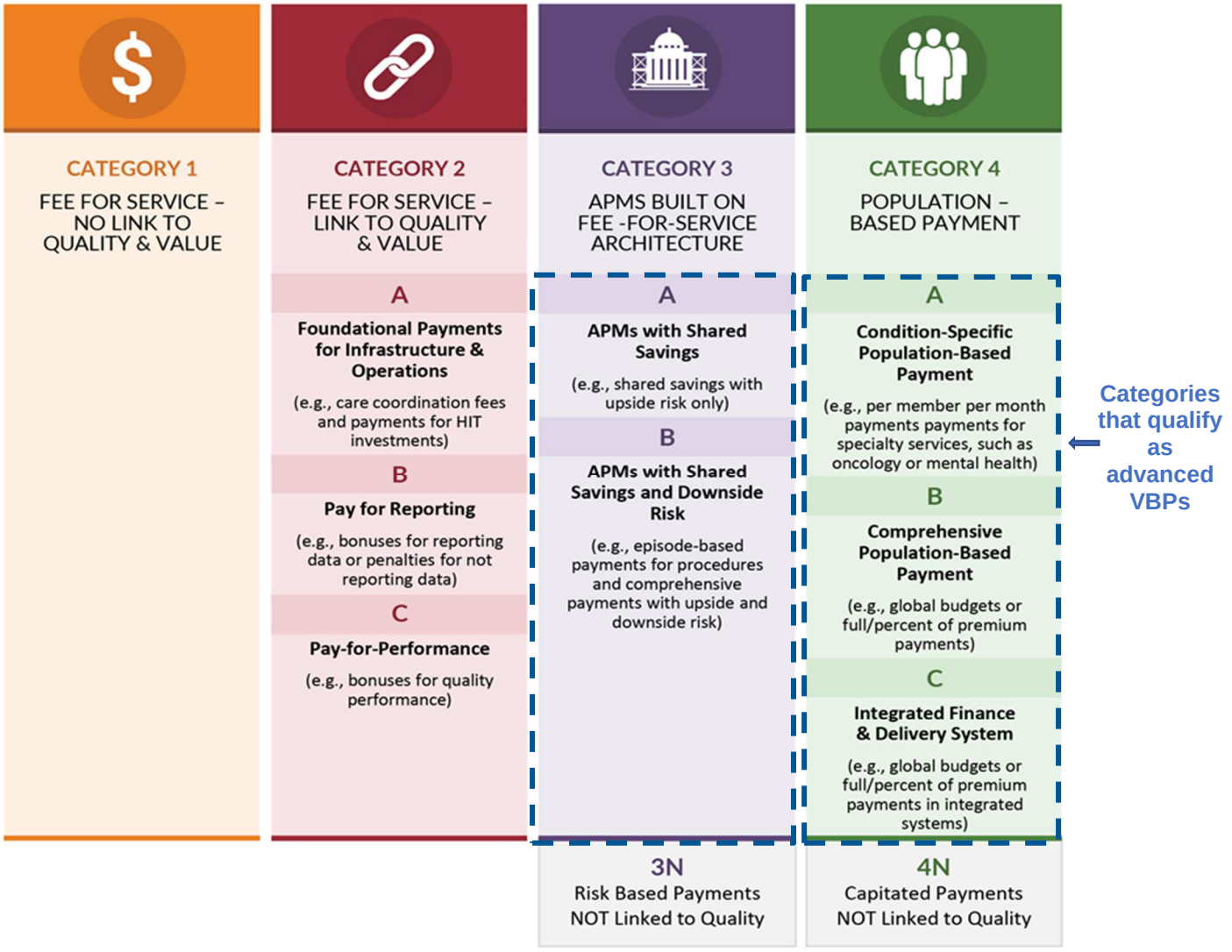
Most health care services today are paid via **fee-for-service (FFS)**, where providers are paid to deliver services — incentivizing increased volume of services — with little financial incentive to improve quality, reduce cost or address health disparities. FFS is also a barrier to provider organizations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



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 & 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 of 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

Care management and coordination

Leadership committed to practice transformation and ready for organizational change

Data analytics and connectivity

Patient engagement and wellness programs

Stay informed

To learn more about VBP in Oregon, see the VBP webpage:
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

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