PAYING FOR VALUE IN HEALTH CARE:

A Roadmap for Implementing the Oregon Value-Based Payment Compact

July 2022

Dear Colleagues:

As co-chairs of the Value Based Payment (VBP) Compact Workgroup (Workgroup), we are pleased to share the 2022 VBP Roadmap. This Roadmap represents a year of research, expert consultation and deliberation by the Workgroup, resulting in strategies, actions and milestones to advance ambitious VBP goals in Oregon, which are laid out in the VBP Compact.

In January 2021, Oregon's Sustainable Healthcare Cost Growth Target Implementation Committee, established under Senate Bill 889, recommended that the health care cost growth target be 3.4% for 2021-2025 and 3.0% for 2026-2030. The first strategy the Implementation Committee recommended to help payers and provider organizations meet the cost growth target was advancing VBP models across the state through a voluntary Compact. To ensure the Compact is successfully implemented, the VBP Compact Workgroup was co-convened in 2021 by the Oregon Health Leadership Council and the Oregon Health Authority with support from the Oregon Association of Hospitals and Health Systems and the Oregon Medical Association. Signatories to the Compact, including 47 health systems, hospitals, physician groups and health centers, cover 73 percent of the people in Oregon.

While the origins of the VBP Compact stem from the Sustainable Healthcare Cost Growth Target Implementation Committee, achieving the cost growth target is not the charge of the VBP Compact Workgroup. Rather, the Workgroup was established to facilitate the adoption of VBPs to assist payers and providers in meeting the VBP targets set out in the Compact. The Workgroup is focused on increasing the use of VBP with the goal of lowering the rate of cost growth, improving health care quality and outcomes and fostering health equity.

This VBP Roadmap includes:

- VBP targets set by the Cost Growth Target Implementation Committee
- Analysis of barriers to VBP implementation
- Strategies to address these barriers, including actions and accountable parties
- Milestones and indicators of success

The VBP targets are ambitious, and we acknowledge that meeting them requires ongoing individual and collective commitment to transformation. Building on the work of many partners already on this journey, we endeavor to learn from and accelerate VBP adoption by creating tools and strategies that harness the innovation and lessons of

these early adopters and improve upon and align work behind the most promising VBP models and approaches.

The Roadmap has been developed against a backdrop of significant demands on our partners, most notably the continuing effects of the COVID-19 pandemic and substantial workforce challenges. While we recognize that we must be realistic about how this environment affects the pace of our work, our Workgroup has an urgency to move forward and gather momentum for improving value-based care and payment in Oregon. The pandemic has shown that this work is more critical than ever.

We appreciate the opportunity to share the VBP Roadmap and contribute to this important work in Oregon. We look forward to our continued collaboration to move these strategies forward with colleagues throughout the state in the months and years to come.

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Contents

Executive summary **5**
VBP Compact targets 5
Strategies to accelerate adoption of advanced VBP models 6
Measuring progress 7
Introduction and background **8**
Oregon's Roadmap to value-based payment **9**
Where are we headed? 10
Where are we now? 10
Challenges to accelerated adoption of advanced VBP models 11
Strategies to accelerate adoption of advanced VBP models 13
Measuring progress **18**
Looking ahead **19**
Appendix A: VBP Compact **21**
Appendix B: Paying for health care value: What does it mean? **28**
How providers are paid matters 28
Value-based payment models 28
Success factors 31
Stay informed 31
Appendix C: State and federal VBP initiatives **32**
Oregon initiatives 32
Federal initiatives 32
Appendix D: Collaborative value-based payment (VBP) model development process **34**
Appendix E: Health equity and value-based payment (VBP) **35**
Health Equity Action Team (HEAT) 35
Oregon at the forefront 36
Appendix F: VBP survey: Actions to accelerate value-based payment (VBP) adoption **37**

Executive summary

Oregon has long been a national leader in health system transformation, focused on creating a system that delivers equitable, affordable, high-value coordinated quality care. Currently, the majority of health care is paid based on quantity, or fee-for-service (FFS). In contrast, value-based payment (VBP) supports providers in delivering whole-person care and holds them accountable for improving quality, costs, patient experience, and — increasingly — equity.

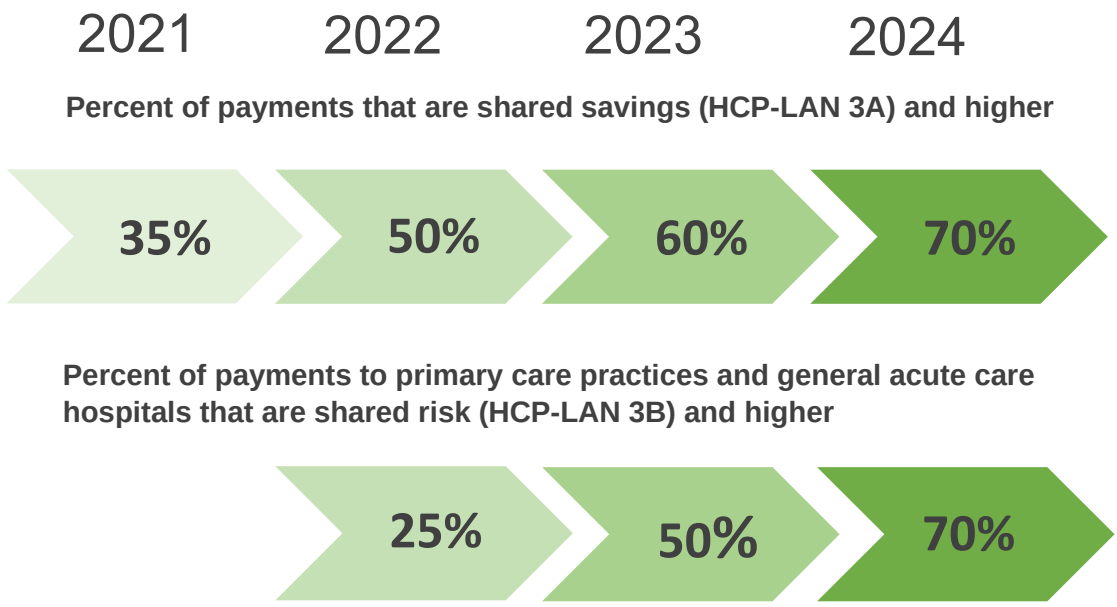
In 2019, the Legislature created the Sustainable Health Care Cost Growth Target Implementation Committee under Senate Bill 889. The Implementation Committee was charged with identifying mechanisms to lower the growth of health care spending to ensure health care costs do not outpace wages and the state's economy. The first strategy the Implementation Committee identified to support this goal was spreading VBP across Oregon.

The Oregon VBP Compact — which is jointly sponsored by the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC) to help achieve this goal — is a voluntary commitment by payers and providers across the state to increase the use of VBP to lower the rate of cost growth, improve quality and outcomes, and foster health equity. The Compact currently has 47 signatories including commercial payers, coordinated care organizations (CCOs), Medicare Advantage payers, health systems, hospitals, physician groups and health centers, covering 73 percent of the people in Oregon. While the Compact is not a legally binding document, the signatories have committed to a set of principles and targets for VBP implementation that were designed by the Implementation Committee to balance the importance of quality, health equity and cost containment.

VBP Compact targets

Given the urgent need to contain costs, the Implementation Committee recommended the following VBP targets as a percent of total spending, by payer, for adoption across the state. The VBP model categories and framework were 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



Strategies to accelerate adoption of advanced VBP models

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. The VBP Compact Workgroup, convened in 2021, is charged with ensuring the VBP Compact is successfully implemented across the state. As the first step in its work, the Workgroup identified significant barriers to VBP adoption and validated those concerns through a provider and payer survey. Among others, key barriers included managing multiple VBP models, concerns about provider financial loss, lack of data infrastructure and the ongoing impact of the COVID-19 pandemic.

In the summer of 2021, the Workgroup began identifying strategies to address these barriers and facilitate the adoption of VBP in Oregon, supported by staff research, consultant recommendations and survey results. This full Roadmap, which was approved by the Workgroup in June 2022, includes six strategies (see below) with action steps, accountable parties, milestones and indicators of success. Changing the culture of payment and the model of care is a long-term endeavor. Even when the specific milestones outlined in the Roadmap are achieved, the strategies will continue to inform and facilitate VBP adoption across the state.

Strategies to accelerate adoption of advanced VBP models

 Short VBP Menu	Develop a short menu of VBP models for use in Oregon that is developed by and reflects the priorities of key stakeholders 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 and payment arrangement models reported by payers and providers. Progress toward the Roadmap goals will be measured by achieving the strategy indicators of success and will be reported as specified in the Workgroup's charter.

Introduction and background

Oregon has long been a national leader in health system transformation, focused on creating a system that delivers affordable, high-value coordinated quality care. Value-based payment (VBP) models reward health care providers based on the quality of care delivered and patient outcomes, rather than the quantity of care they give patients. Currently, the majority of health care is paid based on quantity, or fee-for-service (FFS). In contrast, VBP supports providers in delivering whole-person care and holding them accountable for improving quality, costs, patient experience, and — increasingly — equity.

In 2019, the Legislature created the Sustainable Health Care Cost Growth Target Implementation Committee under Senate Bill 889. The Implementation Committee was charged with identifying mechanisms to lower the growth of health care spending so health care costs do not continue to outpace wages and the state's economy. The first strategy the Implementation Committee identified to support this goal is spreading VBP across Oregon.

Oregon is one of the first states to develop a compact between payers and providers to promote VBP. The Oregon VBP Compact is a voluntary commitment by payers and providers across the state to increase the use of VBP to lower the rate of cost growth, improve quality and outcomes, and foster health equity. The Compact, jointly sponsored by the Oregon Health Authority (OHA) and the Oregon Health Leadership Council (OHLC), currently has 47 signatories including commercial payers, coordinated care organizations (CCOs), Medicare Advantage payers, health systems, hospitals, physician groups and health centers, covering 73 percent of the people in Oregon. A list of signatories can be found in the VBP Compact (Appendix A) and on the VBP Compact webpage.

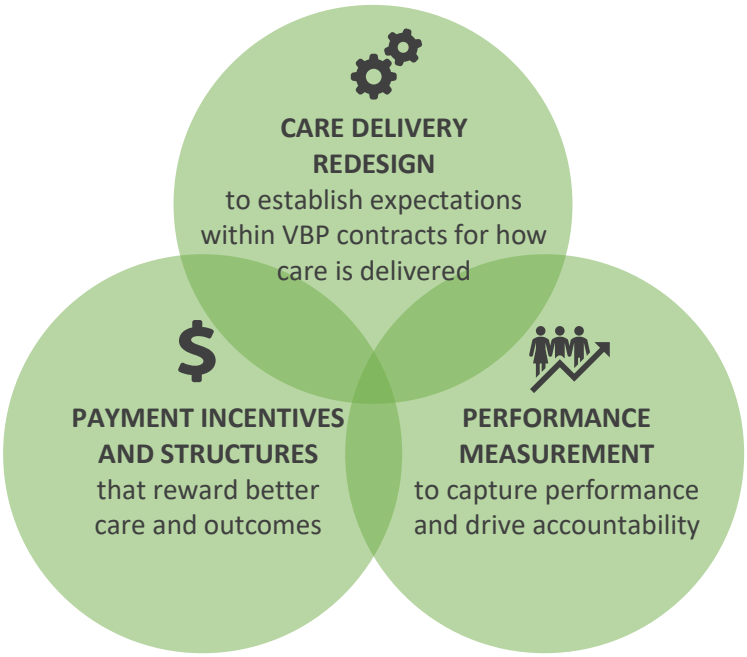
Oregon is one of the first states to develop a compact between payers and providers to promote VBP.

While the Compact is not a legally binding document, the signatories have committed to a set of principles and targets for VBP implementation (see Appendix A). The principles, which were designed by the Implementation Committee, balance the importance of quality, health equity and cost containment.

VBP models leverage three interrelated features that are especially important for advancing quality and health equity: care delivery redesign, payment incentives and structures, and performance measurement. These features:

- Hold provider organizations accountable for delivering better care and achieving better health outcomes for all people

- Give providers greater flexibility to deliver whole-person care, consistent with each individual's community, culture, and identity
- Increase accessibility and use of effective, appropriate, and affordable care and services



Oregon's Roadmap to value-based payment

OHA and OHLC convened Oregon's VBP Compact Workgroup (the Workgroup) to foster innovation that accelerates the adoption of VBP, and strategies to address implementation challenges and barriers.

Successful VBP initiatives are developed and sustained through multi-stakeholder collaboration and collective responsibility. Ideally payers, purchasers, providers (for example, physicians, nurses, physician assistants, community health workers, health systems), and community-based organizations (CBOs) partner with individuals, families, and their communities to change the way health care is paid for to improve quality, costs, and patient experience, while addressing health inequities.

To realize the promise of the Compact, the Workgroup identified the following key steps:

1. Identify challenges to VBP implementation
2. Develop a roadmap that includes strategies and action steps to address potential obstacles to VBP adoption
3. Implement strategies
4. Expand VBP across markets

5. Track progress against VBP targets
6. Monitor outcomes: access, quality, cost and equity

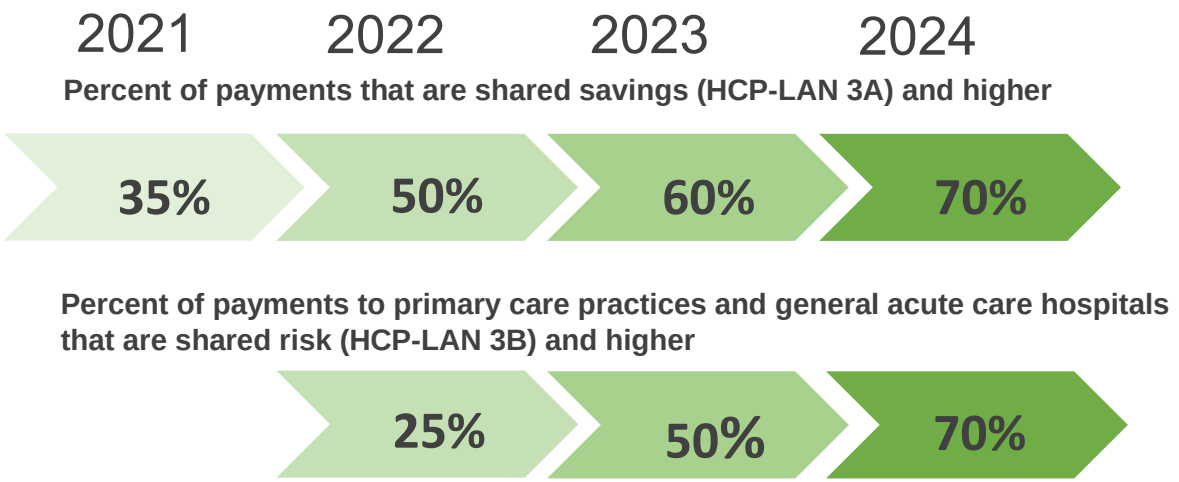
This VBP Compact Roadmap, the Workgroup's first deliverable, outlines the challenges to VBP adoption and proposes strategies, milestones and indicators of success.

Where are we headed?

Given the urgent need to contain costs, the Sustainable Health Care Cost Growth Target Implementation Committee recommended VBP targets as a percent of total spending, by payer, for adoption across the state. The VBP model categories and framework were 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. More details on the HCP-LAN framework and categories are in Appendix B.

The figure below shows the VBP targets, out of total spending, for which each payer is accountable, by year. These targets are linked to advanced VBP models, or HCP-LAN category 3A (shared savings) and higher. Note that separate targets were identified for payments to primary care practices and general acute care hospitals.

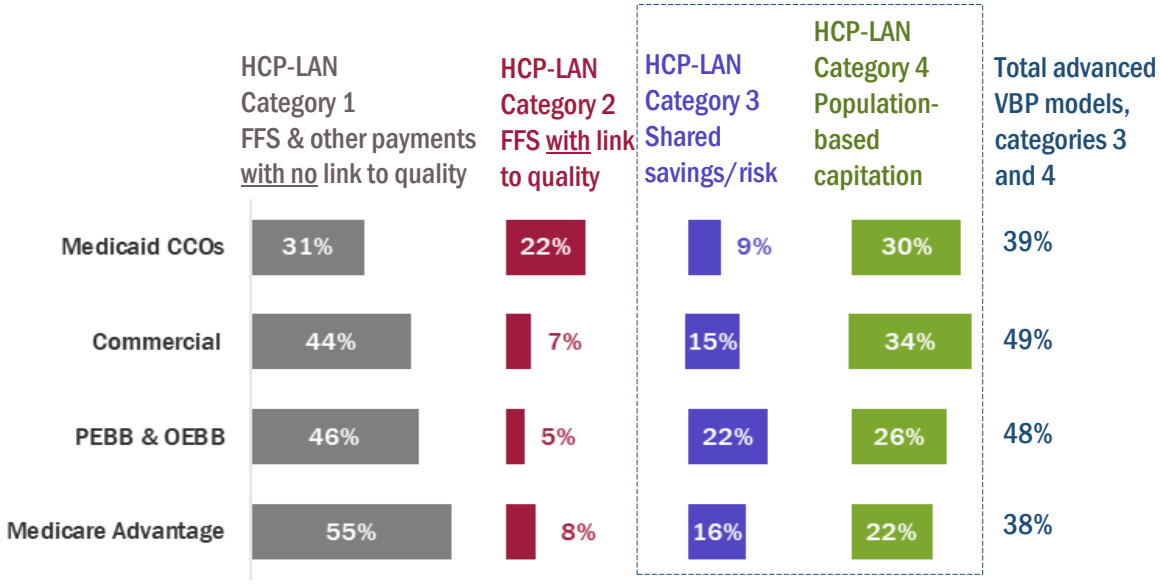
VBP Compact targets



Where are we now?

Oregon is one of only a few states that collects data from health insurers about how they pay health care providers, including through VBP arrangements. These data provide a baseline for current VBP implementation across insurance markets. The most recent data available are from 2020.

All payers in Oregon are implementing VBP models*



*2020 Payment Data from Oregon's All Payer All Claims (APAC) Database

(Note: The percent of payments for Medicaid CCOs in the payment categories do not sum to one hundred percent due to the differences between data submitted to APAC and audited financial data.)

Oregon payers and providers have participated in multiple state and federal initiatives and programs to support and increase VBP model implementation across settings of care. Some of these are ongoing. Each has contributed to a strong foundation for VBP adoption across Oregon. These include:

- Patient-Centered Primary Care Home Program
- Coordinated care organizations
- Public Employees' Benefit Board and Oregon Educators Benefit Board
- Primary Care Payment Reform Collaborative
- Comprehensive Primary Care Plus (CPC+)
- Primary Care First

Detailed descriptions of each initiative are in Appendix C.

Challenges to accelerated adoption of advanced VBP models

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 significant challenges to VBP adoption, which are summarized below.

Challenges to VBP adoption

Challenge	Description
Transition from FFS system to VBP	Shifting from FFS payment to advanced VBP (LAN 3A shared savings, LAN 3B shared risk and 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.

Challenge	Description
COVID-19	The COVID 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 state that VBP has 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

In the spring of 2022, the Workgroup began identifying strategies to address these challenges and facilitate the adoption of VBP in Oregon. The following strategies build on staff research, consultant recommendations, and payer and provider survey results.

The strategies are not in sequential order, as many should be implemented concurrently. Implementing them will require collaboration and leadership. Key partners in this work are OHA, OHLC, the Oregon Medical Association (OMA) and the Oregon Association of Hospitals and Health Systems (OAHHS). In addition, much of the work will likely be supported by consulting resources, as needed.

Strategies to accelerate adoption of advanced VBP models

Short VBP menu 	Develop a short menu of VBP models for use in Oregon that is developed by and reflects the priorities of key stakeholders and allows for greater model alignment between payers	**Challenges addressed**	• Transition from FFS to VBPs • Multiple VBP models
Action steps	Identify priority areas for developing VBP models for 2024 implementation (for example, primary care, hospital and specialty care)	**Accountable partner(s)**	Workgroup
	Select priority areas and develop a standard framework for each VBP model (for example, structure, measurement, quality and equity considerations; guidance for implementation; considerations for rural participation). The framework will be used to guide the development of		Workgroup

	each VBP model toolkit component to ensure some consistency between model implementations.		
	Identify stakeholder and consulting support to lead the development and documentation of each priority VBP model for the toolkit. Determine scope, cost, timeline and financial support needed to do so.		Workgroup and partners leading model development
	Support a collaborative process (Appendix D) among key stakeholders to develop the preferred VBP model(s) for each priority area (for example, primary care, hospital and specialty). For example, the Primary Care Payment Reform Collaborative (PCPRC) would be accountable for identifying the preferred primary care model.		OHLC, OAHHS, OMA and PCPRC
	Document preferred model(s) for each of the priority areas to be included in the VBP toolkit		Model leads
	Develop and implement a communication strategy to raise awareness of VBP Compact targets, to share and promote strategies and models laid out in the toolkit (note this is replicated in "VBP toolkit" below)		OHLC, OAHHS, OHA, OMA
Milestones	Agree to two priority VBP areas, identify leads and process to engage stakeholders for each	**Timeline**	Q4 2022
	Develop priority VBP model(s)		Q4 2023
	Develop communications/TA plan		Q4 2023
	Identify leads and develop models for subsequent priority area(s) (for example, specialty care episodes)		Q2 2024
Indicators of success	Strong leadership and participation in model development process by key stakeholders		
	Increased adoption of models on the list as measured by plan reporting		

VBP toolkit 	Develop a set of VBP tools and models to inform, support and encourage provider and payer entry into value-based payment models	**Challenges addressed**	• Provider concern about significant financial loss

			• Transition from FFS system to VBP • Small patient populations
Action steps	Administer and analyze a survey of payers and providers to understand status of VBP adoption. Use analysis to consider how these strategies and priorities should be adjusted based on results.	**Accountable partner(s)**	Convening partners (OHA, OHLC) and provider associations (OMA, OAFP (Oregon Academy of Family Physicians), OAHHS, OPCA (Oregon Primary Care Association))
	Develop a standard framework for each core component of the toolkit, which will ensure consistency between stakeholders and tools. Core components include two categories: "building blocks," which are foundational aspects of any VBP (such as quality metrics, building data capacity, workforce considerations for VBP, equity, geography, risk) as well as explicit VBP models for primary care, hospital and specialty care.		Workgroup
	Identify and develop priority VBP building blocks and VBP models for providers, informed by the payer and provider survey. Note: the toolkit will also include VBP models as referenced in the short VBP menu.		OHA, OHLC, OAHHS, OMA
	Develop and implement a communication strategy to raise awareness of VBP Compact targets and promote strategies and models laid out in the toolkit (note this is replicated in "Short VBP menu" above)		Convening partners and provider associations
	Complete remaining priority toolkit components (priority VBP models and building blocks)		Convening partners and provider associations
Milestones	Implement communications strategies to roll out toolkit components	**Timeline**	Q1 2024

	Complete additional priority elements for toolkit (second tier of priority building blocks or VBP models)		2024
Indicators of success	Increase in VBP adoption as measured by plan reporting (All Payer All Claims Database Payment Arrangement File)		
	Participation rates in webinars promoting the toolkit components		

Equity 	Consider targeted, explicit strategies to integrate equity considerations into VBP efforts (additional health equity and VBP information in Appendix E)	**Challenges addressed**	• Lack of meaningful risk adjustment • Data infrastructure
Action steps	Review and apply the equity principles[1] as outlined by the Sustainable Health Care Cost Growth Target Implementation Committee agree to components of the VBP toolkit (VBP models, building blocks)	**Accountable partner(s)**	Workgroup
Milestones	VBP toolkit integrates equity strategies in key VBP models, building blocks	**Timeline**	2023
Indicators of success	Increased adoption of equity elements in health plan agreements across markets		

Mitigating financial risk 	Address provider concerns about financial risk/loss	**Challenges addressed**	• Provider concern about significant financial loss • Transition from FFS system to VBP

[1] Principles developed by the Sustainable Health Care Cost Growth Target Implementation Committee in October 2020: 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:

- Employing payment model design features and measures to protect against stinting;
- Ensuring prospective payments are sufficient to cover the cost of infrastructure changes to support health equity (for example, traditional health workers, changes to IT systems to track equity);
- Providing additional supports (for example, technical assistance, infrastructure payments) for providers serving populations experiencing health inequities;
- Ensuring new upside or downside risks will not exacerbate existing inequities; and
- Ensuring providers serving populations experiencing health inequities who are at greater risk of closure due to COVID-19 remain open.

			• Lack of meaningful risk adjustment
Action steps	Develop education tools for inclusion within toolkit regarding provider mitigation of risk under VBP; this may include risk corridors, population size, risk adjustment. Will be informed by provider survey.	**Accountable partner(s)**	Convening partners and provider associations
	Draft common principles for risk adjustment. Consider using the principles for attribution developed by PCPRC and CPC+ as a model.		Workgroup
	Monitor evidence around medical and social risk adjustment models		OHA
	Explore and potentially support collaborative ways for payers to combine populations		Workgroup, payers and providers
Milestones	Develop educational materials "building block" for the toolkit on mitigating risk	**Timeline**	Q2 2023
	Finalize principles for risk adjustment		Q4 2022
Indicators of success	Financial risk/loss is less cited as barrier to VBP participation in provider survey		
	Increase in providers with shared risk (LAN category 3B) or higher VBP participation		

Data and policy alignment	Maximize data, program and policy alignment to advance Workgroup goals and remove barriers to VBP adoption	**Challenges addressed**	• Lack of data infrastructure • Multiple VBP models
Action steps	Routinely engage with Health Information Technology Oversight Council (HITOC) to monitor, support, and leverage the development of data and health information exchange (HIE) infrastructure in Oregon, including collection of REALD[2] and SOGI[3] data (see Equity strategies), collaborative information technology solutions to support social	**Accountable partner(s)**	Workgroup

[2] Race, ethnicity, language and disability
[3] Sexual orientation and gender identity

	determinants of health, and strategies to address provider data capacity		
	As needed, engage in the development of common data standards and definitions		Workgroup and HITOC
	Make VBP Compact targets required for OHA lines of business: Coordinated Care Organizations, PEBB/OEBB, Marketplace		OHA
Milestones	Primary care model shared with Workgroup and added to short VBP model priorities	**Timeline**	Q4 2022
	VBP targets are aligned across markets		TBD
Indicators of success	VBP targets are met across systems and markets, including and beyond OHA lines of business		
	Strong model alignment across markets, beginning with primary care		

Attribution	Address the barrier of attribution in VBP implementation	**Challenges addressed**	• Diverse attribution models
Action steps	Share and adapt PCPRC principles with the Workgroup	**Accountable partner(s)**	Workgroup, OHA, OHLC
Milestones	Principles shared and adjusted as needed	**Timeline**	TBD
Indicators of success	Principles adopted by Workgroup and shared with relevant stakeholders		

Measuring progress

Quantitative progress toward the VBP targets will be measured using Oregon's All Payer All Claims Database and payment arrangement models reported by payers and providers. Progress toward the Roadmap goals will be measured by achieving the strategy indicators of success and will be reported as specified in its charter as follows:

- The Workgroup will submit deliverables and provide updates at least twice per year to the organizations that convened the signers of the Compact. Those are the Oregon Association of Hospitals and Health Systems, Oregon Health Authority, Oregon Health Leadership Council, Oregon Medical Association, Public Employees' Benefit Board/Oregon Educators Benefit Board.

- The Workgroup will provide deliverables and updates to the Sustainable Health Care Cost Growth Target Advisory Committee[4] at least twice per year.
- The Workgroup will send its annual report to the Oregon Legislature. The Workgroup will provide additional information and updates to the Legislature, as requested.

The Workgroup relied on and will continue to seek feedback from payers, health systems, hospitals, primary care clinics and specialty care clinics to inform its work. In the spring of 2022, the Workgroup surveyed these stakeholders to get a rough estimate of the status of VBP adoption across the state.[5] While the nonscientific survey had a small response rate that was not statistically representative of the state, responses confirm what we know from Oregon's All Payer All Claims Database — that while VBP models are in place across payers, VBP models are more widely used by the CCOs in the Medicaid market.

The survey also asked respondents about actions that would most accelerate VBP adoption across Oregon. The themes across respondents align with the strategies included in this Roadmap:

- Timely and transparent data, and support for using the data, are necessary.
- Education and awareness about VBP is critical for success, including the sharing of best practices.
- Providers and payers need to be ready to implement and engage in model design.
- Support should be provided for smaller practices that cannot take on risk alone.
- Implementation should be about better outcomes, not just lower costs.
- A single set of aligned metrics is needed.

Appendix F lists the themes by organization type.

Looking ahead

This VBP Roadmap is part of Oregon's ongoing efforts to accelerate VBP adoption in the state. The Workgroup recognizes that the VBP targets and implementation

[4] The Sustainable Health Care Cost Growth Target Implementation Committee recommended that an ongoing governance committee should be established to oversee the Health Care Cost Growth Target Program. The Oregon Health Policy Board appointed the Sustainable Health Care Cost Growth Target Advisory Committee members on May 3, 2022.

[5] Survey results caveats: 1) accuracy is unknown — respondents may not have all the information needed to answer the VBP questions accurately; 2) some organizations submitted multiple responses from different people, with different answers; 3) some respondents did not list their organization name; 4) many organizations did not respond, and the reasons for this are unknown — they may not be engaged, it didn't reach the right person, or it wasn't their focus; 5) some categories had a low response rate (%).

strategies are ambitious and that meeting them will require continued individual and collective commitment to transformation. Many payers and providers in Oregon are already well on their way to changing the way care is paid for and delivered. We hope this Roadmap supports and accelerates their efforts. For those just embarking on this journey, we are optimistic that the strategies in the Roadmap will make adoption and implementation of VBP easier and more successful, leading to better patient outcomes and decreased disparities. Collaboration across the health care industry is imperative, and the Workgroup looks forward to providing a constructive forum for this joint work to continue.

Stay informed

To learn more about the implementation of the Roadmap, go to the VBP Compact web page: https://orhealthleadershipcouncil.org/oregon-value-based-payment-compact/

Appendix A: VBP 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.

We, the undersigned, commit to making a good-faith effort to advancing value-based payment models in Oregon, in accordance with the following principles developed by the Sustainable Health Care Cost Growth Target Implementation Committee.

As signatories to this compact, we agree to commit and, where applicable, work to achieve the targets set forth in the principles for increasing the use of advanced VBP models. We agree OHA and OHLC should reconvene the signatories of this voluntary compact no later than fall 2022 to revisit this compact to ensure effectiveness in advancing payment reform and supporting cost containment efforts in Oregon.

This compact shall remain in effect until 12/31/24.

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James Schroeder, Chief Executive Officer
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Kathryn Correia, President and Chief Executive Officer
Legacy Health System

William Johnson, President
Moda Health

Betsy Boyd-Flynn, Executive Director
Oregon Academy of Family Physicians

Becky Hultberg, President and Chief Executive Officer
Oregon Association of Hospitals and Health Systems

Andrew R. Stolfi, Director and Insurance Commissioner
Oregon Department of Consumer and Business Services

Geoff Brown, Chair
Oregon Educators Benefit Board

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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 organizations in the state, should develop a voluntary compact to increase the use of

[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 https://hcp-lan.org/apm-refresh-white-paper/.

[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.

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

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 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

[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.

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:

https://hcp-lan.org/apm-refresh-white-paper/

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

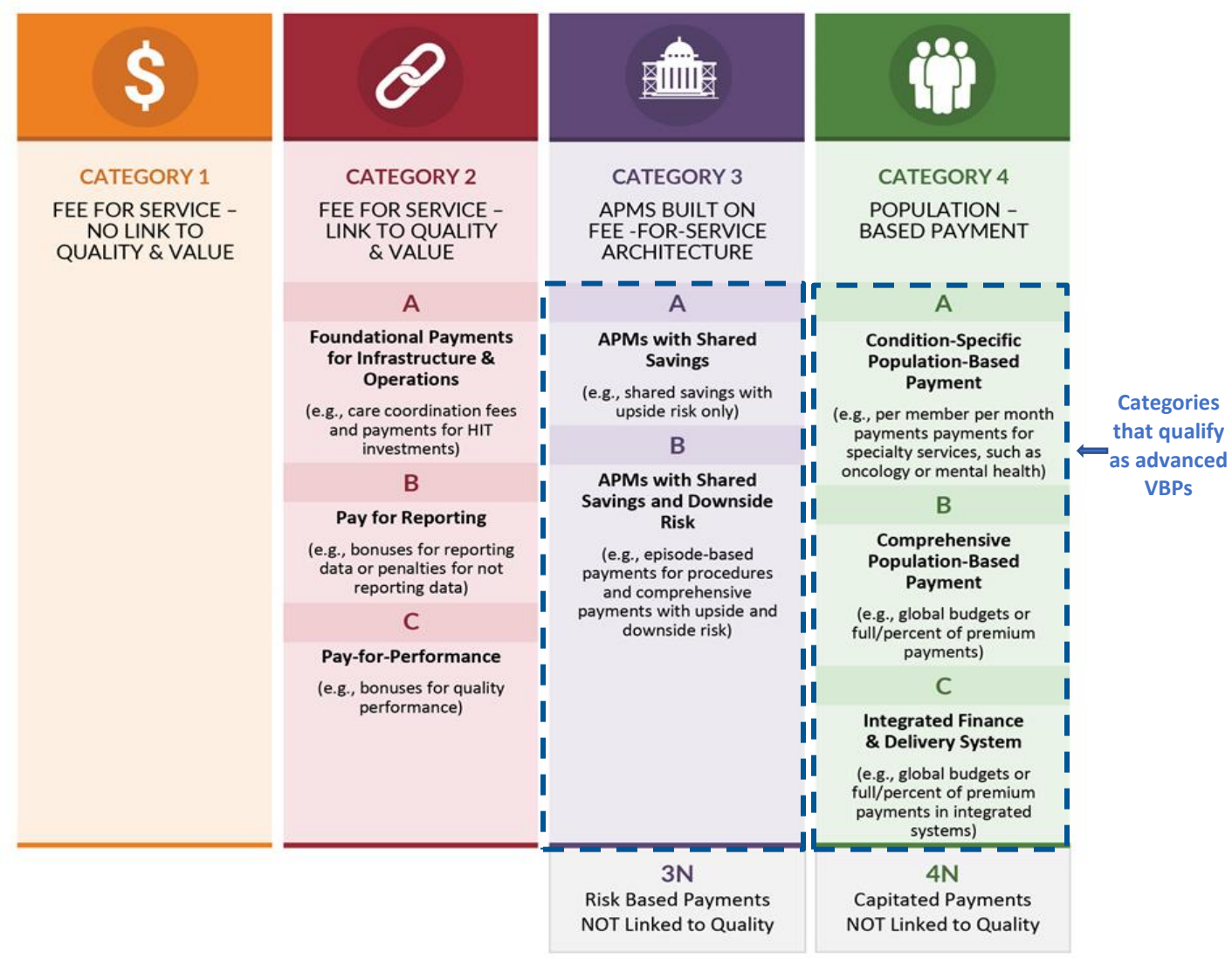
Most health care services today are paid via **fee-for-service (FFS)**, where providers are paid to deliver services — incentivizing increased volume of services — with little financial incentive to improve quality, reduce cost or address health disparities. FFS is also a barrier to provider organizations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

Appendix C: State and federal VBP initiatives

Oregon initiatives

Patient-Centered Primary Care Home Program

The Patient-Centered Primary Care Home (PCPCH) program, Oregon's version of the "medical home," is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety.

Coordinated care organizations (CCOs)

The five-year CCO contracts that began in 2020 significantly advance VBP adoption in Oregon. CCOs are required to annually increase the proportion of payments that are in the form of a value-based payment (VBP) and within Health Care Payment Learning & Action Network (HCP-LAN) HCP-LAN Category 2C (Pay-for-Performance) or higher, throughout the duration of the CCO contract.

Public Employees' Benefit Board and Oregon Educators Benefit Board

PEBB, OEBB and all three of the PEBB/OEBB contracted medical carriers are signatories to the VBP Compact and have expressed commitment to work toward reaching the annual VBP targets outlined in the Compact. OEBB and PEBB 2022 contracts include requirements that payers annually report their VBP levels, including both the potential and actual upside and downside risk-sharing payments made to or withheld from providers.

Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative, established in 2015 with Senate Bill 231, is charged with developing and sharing best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care.

Federal initiatives

Comprehensive Primary Care Plus

From 2017 to 2021, the Centers for Medicare and Medicaid Services (CMS) ran the Comprehensive Primary Care Plus (CPC+) program, a national advanced primary care medical home model that aimed to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation.

Primary Care First

Primary Care First is a voluntary alternative five-year payment model developed by CMS based on the principles underlying the CPC+ model design. Like CPC+, Primary

Care First prioritizes the clinician-patient relationship and focuses on enhancing care for patients with complex chronic needs with financial incentives for improved health outcomes.

Appendix D: Collaborative value-based payment (VBP) model development process

1. Identify participants who will be part of a Workgroup to develop a VBP model, considering the need for representativeness and content expertise, and OHA's objective of equity.
2. Establish principles that should guide the VBP model design.
3. Review general payment model options that qualify as Health Care Payment Learning & Action Network (HCP-LAN) HCP-LAN 3B and higher.
4. Provide "deep dive" education into the payment model(s) of greatest interest to the Workgroup, including available evaluation findings.
5. Develop the VBP model specifics for implementation by walking through a sequence of individual design decisions, such as covered services, covered populations, quality measures, ensuring equity and evaluation. Actual design decisions will be dictated by the specific payment model selected for development.
    - This activity will constitute the primary activity of the Workgroup and will consume most of its time.
    - While the process follows a sequence, there is flexibility to revisit prior discussions given the interactions of the design features.
6. Draft recommendations.
7. Distribute recommendations to the larger community of interested partners; consider and incorporate feedback.
8. Obtain commitments from key payers and providers to implement the payment model as recommended.
9. Transition to implementation phase (to be defined based on model design).

Appendix E: Health equity and value-based payment (VBP)

Health inequities related to race, ethnicity, language, disability, sexual orientation and gender identity have endured for reasons such as socioeconomic factors at the individual and community level, implicit and explicit biases, and structural racism. Compared to White patients, patients of color continue to experience worse health care and outcomes in areas such as infant mortality, heart disease, diabetes and cancer. Individuals with disabilities experience health disparities in cancer screening and care, among other conditions. Individuals living in rural areas are more likely to die from heart disease, cancer and stroke than urban residents. The disparate outcomes seen in the COVID-19 pandemic have led many to examine the health care system's role in the perpetuation of health disparities and determine what can be done to eliminate inequities.

The Sustainable Health Care Cost Growth Target Implementation Committee principles for VBP, which were incorporated into the VBP Compact, include the following expectations around health equity.

> Advanced VBP models should be designed to promote health equity, as well as to mitigate adverse impacts on populations experiencing health inequities by:
>
> - Employing payment model design features and measures to protect against withholding appropriate care;
> - Ensuring prospective payments are sufficient to cover the cost of infrastructure changes to support health equity (for example, traditional health workers, changes to IT systems to track equity);
> - Providing additional supports (for example, technical assistance, infrastructure payments) for providers serving populations experiencing health inequities;
> - Ensuring new upside or downside risks will not exacerbate existing inequities; and
> - Ensuring providers serving populations experiencing health inequities who are at greater risk of closure due to COVID-19 remain open.

Health Equity Action Team (HEAT)

This work is critical, emergent and cutting edge. The national Health Care Payment Learning and Action Network (HCP-LAN) has convened a team of experts, called the Health Equity Action Team, that is devoted to identifying and prioritizing opportunities to advance health equity through payment. Their goal is to leverage VBPs to help make needed care more accessible, drive better patient outcomes, and reduce disparities.

This team will be a resource for identifying best practices, technical assistance, training and other consultation to inform Oregon's roadmap strategies and VBP models.

Oregon at the forefront

As they implement Roadmap strategies, the VBP Compact Workgroup will strive to integrate equity in prioritized VBP models and toolkit design. Oregon has a strong foundation of equity-focused work in measurement, care and payment, which includes:

- **Data collection**: Oregon's REALD (race, ethnicity, language and disability data) effort aims to increase and standardize race, ethnicity, language and disability data collection across the Oregon Department of Human Services (ODHS) and OHA. In 2020, Oregon passed a law requiring the collection and reporting of REALD data for all health care encounters related to COVID-19. Further, Oregon has approved a measure for the collection of social determinants of health/social needs data within the Medicaid program and is in the process of reviewing draft specifications for the measure. Collecting these data is critical to identifying health inequities.
- **Coordinated care organization (CCO) contract standards**: OHA contracts with CCOs include significant requirements that impact the delivery of equitable care (for example, Standards for Culturally and Linguistically Appropriate Services (CLAS); a required Health Equity Plan; and support for traditional health workers including a plan for sustainable payment). These contract elements can be incorporated into VBP arrangements in Medicaid, commercial and Medicare Advantage contracts.
- **Equity-driven performance metrics**: In January 2021, Oregon launched a state-developed incentive metric: meaningful language access to culturally responsive health care services. This metric, which measures the provision of quality interpreter services, is based on the proportion of member visits with spoken and sign language interpreter needs provided with OHA qualified or certified health care interpreters. Further, as a part of the state's 1115 Medicaid waiver, Oregon is seeking authority to revise its metrics and incentive program to focus on a new set of equity-driven performance metrics for upstream health factors in addition to the state's traditional quality and access measures. This offers an opportunity to align equity-focused performance metrics with VBP models.

Appendix F: VBP survey: Actions to accelerate value-based payment (VBP) adoption

In the spring of 2022, the VBP Compact Workgroup surveyed payers, health systems, hospitals, primary care clinics and specialty care clinics to get a rough estimate of the status of VBP adoption across the state. While the nonscientific survey had a small response rate that was not statistically representative of the state, responses confirm what we know from Oregon's All Payer All Claims Database — that while VBP models are in place across payers, VBP models are more widely used by the CCOs in the Medicaid market.

The survey also asked respondents about actions that would most accelerate VBP adoption across Oregon. The following are responses to this question grouped by the type of organization responding.

Health systems

- Require through legislation
- Help address small numbers in rural areas
- Uncouple from CGT
- Align with Washington state
- Reasonable rates, factor in pandemic
- More post-acute capacity for discharge
- Staffing support
- Data – current, sharing/transparency, analytical support
- Support primary care
- Aligned achievable metrics (health system, primary care)
- Provider participation in VBP design and monitoring

Hospitals

- Reasonable models
- Solve for small population actuarial soundness
- Government mandates for increased reimbursement
- Process to prioritize services
- Publish data by hospital or county with correction for high-cost drugs/implants/equipment
- Education on VBP

Payers

- Providers ready and willing to take risk, especially hospitals
- Better attribution / require PCP assignment

- Provider organizations joining to have large enough patient numbers to take on risk
- Better data
- SDOH and equity data to incorporate into risk models
- OHA data requirements on demographics data
- Claims system that can adjudicate complex VBP models (such as case rates, capitation, monthly lump sum payments, and PMPM)
- Streamline metrics
- Standards for NPIs
- Significant efforts around care redesign
- Alignment with PEBB/OEBB efforts
- Solutions to provider labor issues
- Educate providers
- Help small practices with data on utilization
- Build meaningful incentives for providers
- Change CGT to include professional fees
- Eliminate any mandates tied to FFS rates

Primary care practices

- Education on VBP
- Willing payers
- Account for SDOH in risk models
- Increase wraparound services for patients experiencing homelessness
- Way to share successful models
- Higher rates, index to inflation/staffing cost
- Compensate for whole-person care, not siloed
- Implement strategies to promote collaborative competition between provider organizations, rather than incentivizing entities to out-compete each other for assigned lives
- Mandate VBP
- Provider voice in developing and implementing VBPs
- Single set of aligned metrics
- Achievable targets with PCP input
- Equitable access to robust EHRs with capability to pull all needed data; integration with payer systems for automated reporting
- Transparency of what is included in capitation and FFS
- Increased investment, especially in pediatrics
- Reward high quality clinics better
- Make patients financially responsible if they are making choices that impact the ability to reach a target, like not vaccinating, smoking, not exercising, etc.
- Educate patients about appropriate testing, medication, etc.

- Reliable, timely and transparent data
- Recognize provider organizations are also employers
- Better patient attribution
- Make specialists and hospitals, including ERs, much more accountable, not just primary care

Specialty care practices

- VBP education
- Don’t do it
- Willing payers
- Early palliative care consults
- Patient copays for multiple versions of the same imaging studies
- Higher copays for urgent care clinics
- Sharing labs, imaging among providers
- Timely payments
- Mitigation for significant inflation
- Consistent models to reduce administrative burdens and provider complexity
- Fairness, shared success/value, collaboration/support
- Publicize goals and methods
- Require providers participate
- Don’t focus on increasing the pace of adoption but instead on creating a collaborative and supported system