Data Sharing Between CCOs and Providers in VBP Arrangements: Environmental Scan

April 2025

Background

The Oregon Primary Care Association (OPCA) and primary care providers from across the state have expressed a need for additional data from coordinated care organizations (CCOs). Providers need this data to make informed decisions: (1) when entering risk-based value-based payment (VBP) arrangements, and (2) to be successful in risk-based VBP arrangements. To support this goal, the OHA Transformation Center conducted an environmental scan to better understand current data sharing practices in Oregon. The environmental scan was conducted between July and October of 2024 and included interviews with all CCOs, 18 provider organizations, and one independent practice association.

Key themes from interviews

CCOs and providers agree that effective data sharing plays a key role in supporting successful VBP arrangements. However, providers report a wide range of experiences in sharing and receiving data from CCOs. Some are satisfied with the data they receive, while others feel that what they receive is inadequate. CCOs report a wide range of investments and capacities for data sharing.

Key themes from interviews include the following:

1. **Data sharing practices vary widely.** There is significant variation in data sharing practices across CCOs, with no standardized approach to sharing data with providers. CCOs share different types of data with providers using different platforms, file formats and schedules. Several providers interviewed found the variation in data sent by CCOs to be a barrier to using the data effectively.

2. **Access to transaction-level cost and utilization data ("raw claims data") is inconsistent.** While many CCO representatives believe their program staff are sharing transaction-level cost and utilization data with providers who are in risk-based VBP arrangements, providers who contract with these CCOs report mixed

experiences in receiving the data — some say they are receiving it and some say they are not. Most CCOs say they are willing to provide raw claims data upon request.

3. **Providers want reliable prepared reports and dashboards from CCOs with patient-level detail.** While not all interviewed providers want access to raw claims data, they all said they want and use the prepared reports and dashboards provided by CCOs. Smaller clinics often do not have the data analytic capacity to process raw claims data on their own and rely on CCOs to provide accessible, accurate and timely information.

4. **Collaboration between CCOs and providers is crucial.** Both CCOs and providers recognize the need for ongoing support and collaboration to succeed in VBP arrangements. CCOs offer varying levels of technical assistance to help providers understand and use data, including joint meetings that providers cite as a valued source of collaboration.

Interview methodology

OHA held interviews between July 25 and October 1, 2024. Interviewees included all CCOs, 18 providers and one independent practice association. Interviews were typically 30 minutes unless more time was requested by the participant. Multi-region CCOs combined their time into a single interview, and Advanced Health responded to interview questions via email in lieu of an oral interview. The interview with Health Share only covered data sharing for the portion of members assigned to CareOregon.

Providers selected for interviews included a mix of Federally Qualified Health Centers (FQHCs) and non-FQHCs, small and large clinics, and rural and urban locations. The FQHCs interviewed were recommended by OPCA, while non-FQHCs were included based on achievement of the VBP standards in OHA's Patient-Centered Primary Care Home program. The participating independent practice association was selected based on their relevant knowledge and expertise. The Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program have expressed a preference for opting out of VBP arrangements and thus were not selected for interviews.

OHA used pre-interview surveys to customize interview questions and inform areas of interview focus. Participating providers completed a pre-interview survey that provided baseline information about the data elements they receive from CCOs, including data types, data formats, data sharing platforms, and data sharing schedules. Participating CCOs completed a parallel pre-interview survey describing the data elements they share with providers.

Theme 1: Data sharing practices vary widely.

Summary: There is significant variation in data sharing practices across CCOs, with no standardized approach to sharing data with providers. CCOs share different types of data with providers using different platforms, file formats and schedules. Several providers interviewed found the variation in data sent by CCOs to be a barrier to using the data effectively.

CCOs decide what data they will make available to the providers they contract with, and CCOs vary widely in the types of data they choose to share. Examples of data commonly shared by CCOs with providers include raw claims data and prepared reports and dashboards.

Raw claims data are transaction-level cost and utilization data provided for attributed patients' total cost of care. Other terms that are commonly used to describe this data include:

- Cost and utilization data
- Claims extracts
- Claims feed
- Claims data

Prepared reports and dashboards are documents prepared by CCOs and sent to providers to (1) define the patient population covered by the VBP arrangement, and (2) show how a clinic is performing against cost and/or quality targets. Examples include:

- Metrics performance data
- Gaps in care lists
- "Hotspotter" reports
- Pharmacy reports
- Cost of care trends
- Assignment/attribution files

In addition to variation in the types of data shared with providers, there are differences in CCOs' file formats, data sharing schedules/frequency, and platforms used for data transmission:

- **Format:** While CCOs often send prepared reports as Excel files or PDFs, some CCOs make data available through interactive dashboards. Raw claims data may be sent in a variety of file formats (Claim and Claim Line Feed, OHA encounter data files, etc.).

- **Frequency:** Depending on the CCO, data is shared weekly, monthly or quarterly, with real-time data access available in some instances.

- **Platforms:** Data is shared through secure email (Excel, PDF), secure file transfer protocol (SFTP), provider portals, and population health analytics platforms (for example, Arcadia or Acclivity).

Data sharing depends on VBP arrangement. As providers are increasingly being asked to take on more financial risk in their VBP arrangements, they are recognizing the importance of having access to cost and utilization data to help them manage that risk. The majority of CCOs only share raw claims data with providers in more advanced or risk-based VBP arrangements (those in HCP-LAN category 3B or higher). This is because they recognize that providers who take on financial risk cannot manage that risk effectively without access to data to help them identify patient care patterns, manage population health, and control costs.

Data sharing is limited before providers enter VBP arrangements. Before entering VBP arrangements, some CCOs share limited data with providers to illustrate what payments will look like under the new contract. Multiple CCOs run reports that model future prospective payments based on past data, and one CCO shares "illustrative risk reports" to demonstrate financial expectations. However, many participating providers could not recall whether data had been shared prior to entering a VPB arrangement. Others reported they did not receive data before entering VBPs.

Providers have data quality concerns. In interviews, providers expressed concerns about the accuracy, completeness and timeliness of data received from CCOs. When data is not reliable and timely, it can create challenges for providers in managing financial risk and making informed decisions about patient care. One clinic expressed frustration with the timeliness of data received from their CCO, stating that "we would rather have imperfect data sooner." Data quality problems can also create a significant administrative burden for clinics that must spend time validating and cleaning up data, requesting missing data points, following up with CCO staff and working to fill in gaps with other data sources. Providers reported this was particularly true for attribution data.

Providers want better tools from CCOs. Some providers expressed a desire for more interactive and real-time data systems to help them close gaps in care and manage patient populations more effectively. These providers find that static reports limit their ability to take timely action and improve patient outcomes. One clinic expressed a desire for "functional tools to help manage gaps" and "tools that are easier to use to manage population health."

Providers want data standardization. A lack of standardized data formats and definitions creates challenges for providers working with multiple CCOs. This

inconsistency forces providers to spend time and resources to standardize data before they can use it for analysis and decision-making. One clinic explained that "the differences in information received from [CCO 1] and [CCO 2] creates administrative burden. [Our clinic] needs to do a lot of work to standardize data definitions to ensure consistency in our analyses." They also noted uncertainty about whether individual data elements are comparable, explaining that the ways CCOs calculate risk scores can vary.

Theme 2: Access to transaction-level cost and utilization data ("raw claims data") is inconsistent.

Summary: While many CCO representatives believe their program staff are sharing transaction-level cost and utilization data with providers who are in risk-based VBP arrangements, providers who contract with these CCOs report mixed experiences in receiving the data — some say they are receiving it and some say they are not. Most CCOs say they are willing to provide raw claims data upon request.

Providers report mixed experiences in receiving raw claims data from CCOs. There are variations in the availability, format and usability of data, with most CCOs only sharing raw claims data upon request. In interviews, providers shared ideas about how CCO data sharing practices could be improved.

- **Data availability:** Some providers reported differences between what CCOs say they are willing to share and what they receive. A more limited number of providers described experiences where CCOs were not responsive to requests for data.

- **Data format and usability:** Providers sometimes receive data in formats they find difficult to analyze or integrate into their systems. This can be due to a lack of standardization across CCOs, with each CCO using different file formats and content structures.

Most CCOs make raw claims data available upon request. While some CCOs automatically offer transaction-level cost and utilization data to providers in advanced VBP arrangements, most provide this data only upon request. The majority of CCOs say they have a process in place for responding to provider requests for data. One CCO expressed willingness to provide raw claims data upon request but does not yet have a system for handling requests.

CCOs who provide raw claims data only upon request cited concerns about administrative capacity and data security. CCOs who shared concerns about administrative capacity said that sharing the data more broadly could create an administrative burden for themselves and for providers without providing much benefit. CCOs who shared concerns about data security and confidentiality said that sharing the data only upon request allows them to maintain greater control over its use and dissemination.

Providers share ideas about how CCO data could be improved. Several providers cited the data they receive from the Centers for Medicare and Medicaid Services for their Medicare population as an example of what they would like to receive from CCOs. Providers that participate in the Medicare Shared Savings Program (MSSP) routinely receive transaction-level cost and utilization data through accountable care organizations and population health management platforms (for example, Arcadia, Aledade or Acclivity) that make it easier to interact with the data. Several providers said that MSSP data improves their ability to care for and manage Medicare patients, describing features that help them proactively identify high-cost patients, enhance care coordination, and inform population health management strategies.

Theme 3: Providers want reliable prepared reports and dashboards from CCOs with patient-level detail.

Summary: While not all interviewed providers said they want access to raw claims data, they all said they want and use the prepared reports and dashboards provided by CCOs. Smaller clinics often do not have the data analytic capacity to process raw claims data on their own and rely on CCOs to provide accessible, accurate and timely information.

Many providers, especially smaller clinics, lack the data analytic capacity to process raw claims data and instead rely upon the prepared reports and/or dashboards provided by CCOs. Providers cited three main reasons why they do not have the interest or capacity to process raw claims data:

1. **Limited resources:** Smaller clinics often have limited staff and financial resources, making it challenging to invest in the infrastructure, software and personnel required for sophisticated data analysis.

2. **Lack of analytic expertise:** Processing and analyzing raw claims data requires specialized knowledge and skills that many clinics lack.

3. **Preference for user-friendly information:** Many providers find prepared reports and dashboards more convenient and user-friendly than raw data.

Prepared reports and dashboards are essential for small clinics. Providers who do not have the capacity to process raw claims data rely on the prepared reports and dashboards provided by CCOs to evaluate their performance in VBP arrangements (see table on page 3). For example, a VBP metrics performance report may highlight specific areas for improvement, show how many additional patients need care within a specified period, and/or compare to other clinics' performance as a reference point. Providers use this information to determine what steps need to be taken to meet performance benchmarks.

Prepared reports and dashboards are also used to validate internal data. For providers who do receive and process raw claims data, prepared reports and dashboards are still useful. Many providers cross-reference the information provided in prepared reports and dashboards with their own internal data to validate their findings and ensure accuracy. Providers may also limit their own internal analyses to specific areas and rely otherwise on prepared reports and dashboards to inform decisions.

Prepared reports and dashboards are not always timely, reliable or detailed. Because prepared reports and dashboards play an important role in clinic decision-making, it is important that they are actionable. Of the providers interviewed for this project, several expressed concerns about data lags, problems with reliability, and insufficient detail hindering their ability to make informed decisions about patient care.

- **Concerns about data lag:** Several providers reported experiencing significant delays in receiving data, particularly claims-based data used to evaluate performance against quality metrics. Providers say that delayed data impacts their ability to effectively manage gaps in care.

- **Concerns about data reliability:** Providers reported sometimes finding discrepancies between the data provided by CCOs and the data they generate themselves. These challenges were most often reported around assignment/attribution data and metrics performance data. A more limited number of providers reported technical issues with data platforms impacting data reliability and accessibility.

- **Concerns about level of detail:** Prepared reports sometimes lack the granularity and detail required for effective population health management. Providers expressed a strong desire for more patient-level detail in the data they receive from CCOs, citing a need for detailed and specific data to close gaps in care and achieve metric benchmarks.

The quality of prepared reports and dashboards varies, with some providers expressing satisfaction with the data they receive. While several providers

expressed concerns about the data they receive, many providers offered comments about what is working well. Many providers feel they are receiving sufficiently detailed and robust data from specific CCOs while struggling with others. Additionally, providers commend CCOs that actively engage with them to review data, provide support, and collaboratively improve care and manage costs.

Theme 4: Collaboration between CCOs and providers is crucial.

Summary: Both CCOs and providers recognize the need for ongoing support and collaboration to succeed in VBP arrangements. CCOs offer varying levels of technical assistance to help providers understand and use data, including joint meetings that providers cite as a valued source of collaboration.

Both CCOs and providers acknowledge that consistent support and collaboration are important for achieving success in VBP arrangements. In interviews, providers expressed a need for consistent and reliable support from CCOs in understanding data, navigating VBP arrangements, and implementing changes to improve care. One provider explained that when they are supported and equipped to use data effectively, they are better able to actively participate in improving care quality and cost effectiveness.

CCOs offer varying levels of support to providers to help them understand and use data effectively. Examples include:

- **Technical assistance:** CCOs offer varying levels of technical assistance to help providers understand and use data. For example, one CCO described a process for providing one-on-one onboarding for providers to help them understand the Tableau dashboards the CCO uses to share data.

- **Joint meetings:** CCOs and providers value having regular meetings together to review data and discuss performance. Providers who are offered regular meetings with CCOs said these meetings contribute to their success in VBP arrangements.

- **Interactive dashboards:** Providers cited interactive dashboards as valuable tools for accessing real-time data, tracking performance, identifying care gaps, and engaging in ongoing population health management.

The level of support and collaboration offered by CCOs often depends on the VPB arrangement in place. Providers in risk-based arrangements typically receive

more data and support than providers in pay-for-performance arrangements. One CCO noted that small providers are rarely in risk-based arrangements and therefore do not typically require the same level of support as large health systems.

Recommendations

This environmental scan highlights the complex landscape of data sharing practices within Oregon's CCO system. Addressing the identified challenges and implementing the recommendations will be important for fostering data-driven health care transformation and achieving the goals of VBP arrangements.

While interview participants had a variety of suggestions for improvements that could be led by OHA, three recommendations were widely supported by participants. These recommendations to OHA include:

- Establish clear and standardized data sharing recommendations for CCOs, including guidance (1) describing what data is needed by providers for different types of VBP arrangements and (2) recommending best practices for data file formats, schedules and platforms.
- Offer technical assistance and training to CCOs to support effective data sharing practices in VBP arrangements.
- Foster collaborative partnerships between CCOs and providers to address data-related challenges and ensure meaningful use of data for improving patient care.

CCOs and providers agree that effective data sharing plays a key role in VBP success, but they may need guidance to achieve shared goals. Establishing clear expectations, offering technical assistance, and building collaborative partnerships can help CCOs and providers achieve shared goals around VBP and address the concerns expressed by interview participants.

Health Policy and Analytics
Transformation Center
421 SW Oak, Suite 775
Portland, OR 97204
503-753-9688

Appendix A: Interview participants

Coordinated Care Organizations
Advanced Health
AllCare CCO
CareOregon CCOs (Columbia Pacific CCO, Jackson Care Connect, Health Share)
Cascade Health Alliance
Eastern Oregon CCO
InterCommunity Health Network
PacificSource Community Solutions – Central Oregon, Columbia Gorge, Lane, Marion Polk
Trillium CCOs (Tri-County and Southwest)
Umpqua Health Alliance
Yamhill Community Care Organization

Patient-centered Primary Care Home Clinics	Contracted CCOs	FQHC
Housecall Providers	Health Share (CareOregon), Trillium	No
Neighborhood Health Center	Health Share (CareOregon), PacificSource, Trillium	Yes
Community Health Centers of Benton and Linn Counties	InterCommunity Health Network, PacificSource, Trillium	Yes
La Pine Community Health Center	Eastern Oregon CCO, PacificSource	Yes
Adapt Integrated Health Care	Advanced Health, AllCare, Umpqua Health Alliance	Yes
Asante Physician Partners	AllCare, Jackson Care Connect (CareOregon)	No

Yakima Valley Farm Workers Clinic	Health Share (CareOregon), PacificSource, Trillium, Eastern Oregon CCO	Yes
Siskiyou Community Health Center	AllCare CCO	Yes
Klamath Health Partnership	Cascade Health Alliance	Yes
Winding Waters Clinic	Eastern Oregon CCO	Yes
Mosaic Community Health	PacificSource	Yes
OHSU Primary Care at Marquam Hill	Health Share (CareOregon)	No
Rogue Community Health	Jackson Care Connect (CareOregon)	Yes
Northwest Human Services	PacificSource, Yamhill Community Care Organization	Yes
Samaritan Health Services	InterCommunity Health Network	No
Children's Health Alliance (Independent Practice Association)	Health Share (CareOregon, Providence)	N/A
Multnomah County Community Health Centers	Health Share (CareOregon), Trillium	Yes
Neighborhood Health Center	Health Share (CareOregon), Trillium, PacificSource	Yes
Valley Med	PacificSource, Trillium	No

Appendix B: Interview questions

Interviews with CCOs

1. VBP arrangements require some element of data sharing with provider organizations (for example, assignment/attribution data, performance data, cost data, utilization data, etc.).

    a. What types of data do you currently share with clinics participating in existing VBP arrangements?
    b. What types of data do you currently share with provider organizations when you are negotiating a potential VBP arrangement?
    c. What types of data do you currently share with provider organizations not participating in VBP arrangements?
    d. For all the above, do your data sharing practices differ based on type of organization, arrangement or other factors? If so, how?

2. Does your CCO routinely provide lists of attributed/assigned patients to provider organizations participating in VBP arrangements? If so, what information is provided? How often do you provide this? If not, why not and what barriers stand in your way?

3. Does your CCO routinely provide cost and utilization data to clinics participating in VBP arrangements (especially risk-based arrangements)? If so, how often do you provide this data? If no, what barriers stand in your way?

4. What systems or platforms do you use to share data with providers? How well are these systems working for your CCO and for your contracted providers? Are there any obstacles to sharing cost and utilization data through these systems/platforms?

5. We have heard from provider organizations that cost data are essential for making informed decisions to enter VBP arrangements. Could you tell us how sharing data affects provider readiness/willingness to enter VBP arrangements?

6. Do provider concerns around data sharing impact your ability to meet annual VBP targets?

7. The Oregon Primary Care Association presented a data sharing proposal at the January 25th meeting of the Health Information Technology Advisory Group (HITAG). The proposal suggested that CCOs share the following information with clinics:

    a. Attribution files and claims files (cost and utilization data on attributed members for all settings of care, including billed and paid costs)
    b. As a minimum standard using a CCLF file format or OHA encounter data file format

c. As a minimum standard, through a monthly transmission by SFTP to provider's choice destination, or
d. An alternate format that provides at least the minimum cost and utilization data by attributed member reflective of what is shared in claim and claim line feed (CCLF) or encounter data files.

How feasible is this proposal for your CCO? If this does seem feasible, and your CCO is not already providing this information to clinics in the requested format and timeframe, when could your CCO do so? If this does not seem feasible, what barriers do you foresee?

Interviews with Providers

1. VBP arrangements require some element of data sharing with clinics (for example, assignment/attribution data, performance data, cost data, utilization data, etc.).

    a. What data are you receiving from CCOs for current VBP arrangements?
    b. What data are you receiving from CCOs to determine if a potential VBP arrangement is appropriate for your clinic? How do your data sharing experiences impact your readiness and ability to enter risk-based VBP arrangements?
    c. Is there any data that you are not currently receiving that you need to determine if a potential VBP arrangement is appropriate for your clinic?
    d. What data are you receiving from CCOs for non-VBP arrangements?
    e. How frequently do you receive data?
    f. If you contract with multiple CCOs, what variations have you experienced in the data you receive from CCO to CCO? If you don't receive the data you need, please explain.

2. What systems or platforms are you using to access, share and receive data from CCOs?

    a. How well are these systems working for your practice?
    b. Are you receiving data in file formats that are actionable for your practice?
    c. Are there other systems, platforms or formats that you would prefer to use, and why?

3. What data do you receive from payers for other (non-Medicaid) lines of business? How does this compare with what you're receiving from your CCO partners?

    a. Is there a best practice you have experienced related to receiving cost and utilization data?
    b. We have heard that FQHCs routinely receive cost and utilization data through the Medicare Shared Savings (MSSP) VBP program. How does your

experience receiving this data compare and contrast with your experience receiving similar data from CCOs?