2025 Value-Based Payment (VBP) Questionnaire

Introduction

As described in Exhibit H, Section 6, Paragraph a of the 2025 contract, each Coordinated Care Organization (CCO) is required to complete this Value-based Payment (VBP) Questionnaire (previously VBP Pre-Interview Questionnaire).

Beginning in 2025, OHA will no longer be pre-filling a version of this document with previous years' responses. The intent of this change is to (1) streamline submissions, given that there are now several years of information included in previous responses, and (2) provide a new "baseline" to pre-fill over the next couple of years.

Your responses will help OHA better understand your CCO's VBP activities for 2024-2025, including detailed information about VBP arrangements and Healthcare Payment Learning and Action Network (HCP-LAN) categories.

Instructions

Please complete and return this deliverable as a Microsoft Word document, via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/, by **May 2, 2025**. The submitter must have an OHA account to access the portal.

- Please be thorough in completing each section of this document. Incomplete submissions will be returned for revision.
- Please provide responses for all required questions. Questions #3, #4, #10, and #31 are optional.
- All the information provided in this document is subject to redaction prior to public posting. OHA will communicate the deadline for submitting redactions after reviewing your submission.

If you have questions or need additional information, please contact:

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Section 1: Annual VBP Targets

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

1. **In 2025, CCOs are required to make 70% of payments to providers in contracts that include an HCP-LAN category 2C or higher VBP arrangement.**

   How confident are you in meeting the 2025 requirement?

   ☐ Very confident
   ☒ Somewhat confident
   ☐ Not at all confident
   ☐ Other: Enter description

   Describe the steps your CCO has taken to meet the 2025 requirement since May 2024:

   CHA added a value-based payment arrangement to its NEMT capitated provider to move this from 4N to 4A in 2024.

   Describe any challenges you have encountered:

   Our service area is very rural, and CHA relies on non-contracted or out-of-area providers for significant portion of specialty services and all secondary and tertiary institutional services. CHA constitutes a small portion of the book of business for these providers making VBP arrangements impractical.

2. **In 2025, CCOs are required to make 25% of payments to providers in arrangements classified as HCP-LAN category 3B or higher (i.e., downside risk arrangements).**

   How confident are you in meeting the 2025 requirement?

   ☒ Very confident
   ☐ Somewhat confident
   ☐ Not at all confident
   ☐ Other: Enter description

   Describe the steps your CCO has taken to meet the 2025 requirement since May 2024:

Cascade Health Alliance has in place capitation contracts and shared risk contracts for a large part of its network. CHA met this requirement for multiple years and will do so in 2025 as well. No additional steps are required.

Describe any challenges you have encountered:

None.

3. **<u>Optional</u>: Can you provide an example of a VBP arrangement your CCO has implemented that you consider successful? What about that arrangement is working well for your CCO and for providers?**

   Click or tap here to enter text.

4. **<u>Optional</u>: In questions 1-2, you described challenges that you have encountered in meeting annual VBP targets. How has your CCO responded to and addressed those challenges?**

   Click or tap here to enter text.

Section 2: Care Delivery Area VBP Requirements

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

5. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>hospital</u> care delivery area requirement? (mark one)**

   ☒ The model is under contract and services are being delivered and paid through it.
   ☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
   ☐ The model is still in negotiation with provider group(s).
   ☐ Other: Enter description

   What attributes have you incorporated, or do you intend to incorporate, into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier)?

   This hospital CDA is under contract with the local hospital and includes SDOH data collection, two quality measures with performance targets (early elective delivery rate and all cause readmissions), and upside and downside risk sharing.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

6. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>maternity</u> care delivery area requirement? (mark one)**

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or do you intend to incorporate, into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier)?

The maternity CDA incorporates hospital payments related to achieving an early elective delivery rate of less than 3% and payments to obstetrical providers who successfully complete timely post-partum visits.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

7. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>behavioral health</u> care delivery area requirement? (mark one)**

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or do you intend to incorporate, into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier)?

The behavioral health CDA encompasses contracts with our three largest BH providers and each incorporates upside and downside risk sharing plus one or more of the following--

1. Quality measures including follow-up after receiving mobile crisis services, follow-up after initial evaluation, and increasing the percentage of out of hospital mobile crisis services.
2. Payment for services qualifying for the OHA incentivized metrics including Initiation and Engagement in Treatment, DHS Assessments, and Meaning Language Access Measures.
3. Increased access as determined by unique members seen each year.

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

8. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>oral health</u> care delivery area requirement? (mark one)

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or do you intend to incorporate, into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier)?

The oral health CDA includes all CHA's contracted primary care dental (PCD) providers and incorporates the following attributes—

1. Upside and downside risk sharing
2. Capitated payment for PCD services
3. Payment based on performance on OHA dental quality measures
4. Payment based on percentage of members seen of the average assigned panel size during the year
5. Payment based on net patient increase of panel size
6. Payment based on data reporting of time to third next available appointment

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

9. **What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>children's health</u> care delivery area requirement? (mark one)**

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

What attributes have you incorporated, or do you intend to incorporate, into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier)?

CHA's children's health CDA is contracted with pediatric primary care providers (PCP) and includes—

1. Capitated payment for PCP services
2. Upside and downside risk sharing
3. Payment based on performance on OHA PCP quality measures
4. Payment based on percentage of members seen during the year

If this model is not yet under contract, or if a previous contract is no longer in place, describe the status of your negotiations with providers and anticipated timeline to implementation.

N/A

10. **<u>Optional</u>: In designing new or enhanced VBP models in additional care delivery areas, what have you found to be most challenging? What is working well?**

Click or tap here to enter text.

Section 3: PCPCH Program Investments

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

11. **OHA requires that PCPCH infrastructure, or per-member per month (PMPM), payments made by CCOs to clinics are independent of any other payments that a clinic might receive, including VBP payments tied to quality. In September 2023, OHA provided updated guidance on this in the <u>VBP Technical Guide</u>.**

Are the infrastructure payments made to your PCPCH clinics independent from other payments made to those clinics?

☒ Yes
☐ No

If no, explain your plan to meet this requirement going forward:

N/A

12. **If a clinic meets the requirements to be recognized as a PCPCH clinic at a given tier level, the baseline PMPM payment made to that clinic should not be contingent upon meeting any additional requirements (e.g., VBP quality metrics, added clinic integration or functionality, etc.). CCOs may use VBP arrangements and other quality incentives to supplement baseline PMPM payments made to clinics (p. 12, VBP Technical Guide).**

    Are the infrastructure payments made to your PCPCH clinics contingent upon meeting any additional requirements?

    ☐ Yes
    ☒ No

    If yes, explain:

    N/A

Section 4: Engaging with Providers on VBP

These questions address your CCO's work engaging with providers and other partners in developing, managing, and monitoring VBP arrangements.

13. **How does your CCO engage partners (including providers) in developing, monitoring, and evaluating VBP models? Note any formal organizational structures such as committees or advisory groups involved in this process.**

Cascade Health Alliance (CHA) created an Alternative Payment Model (APM) Committee in November of 2015. Its members are made up of primary care providers, specialty providers, behavioral health providers, and community at-large members. The Committee met monthly until various alternative payment methods were decided upon. In September 2015, CHA applied for technical assistance from Oregon Health Authority via the Center for Evidence Based Policy at Oregon Health & Science University Center. As part of this initiative, the technical assistance enabled CHA to explore various health care payment learning & action network (LAN) payment

models and enhance strategy around value-based payments. The Committee is no longer active.

CHA engages our primary care and behavioral health providers through a monthly collaborative quality metrics work group meeting where performance for the community and each clinic is shared openly with the group. Barriers, solutions, and best practices are shared openly. Primary care providers receive metrics dashboards and gap lists monthly usually beginning in the second quarter of each year. Other VBP measures are provided to PCPs monthly in a separate dashboard.

Dental providers receive VBP performance dashboards as well as outreach offering technical assistance monthly.

New or changing VPBs and discussed and developed collaboratively with the providers involved

14. In your work responding to requirements for the VBP Roadmap, how challenging have you found it to engage providers in negotiations on new VBP arrangements, based on the categories below?

Primary care		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Behavioral health care		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Oral health care		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Hospital care		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging
Specialty care		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging

Describe what has been challenging, if relevant [optional]:

Click or tap here to enter text.

15. Have you had any providers withdraw from VBP arrangements since May 2024?

☐ Yes
☒ No

If yes, describe:

N/A

Section 5: Health Equity & VBP

The following questions are to better understand your CCO's plan for ensuring that VBP arrangements do not have adverse effects on populations experiencing or at risk for health inequities.

16. **How does your CCO mitigate possible adverse effects VBPs may have on health outcomes for specific populations (including racial, ethnic and culturally diverse communities, LGBTQIA2S+ people, people with disabilities, people with limited English proficiency, immigrants or refugees, members with complex health care needs, and populations at the intersections of these groups)?**

    Cascade Health Alliance (CHA) is committed to embedding health equity considerations across our value-based payment (VBP) strategy. While we do not currently engage CBOs in VBP arrangements, we work closely with our provider partners to identify and address disparities in care delivery.

    CHA mitigates potential adverse effects by promoting culturally responsive care, encouraging providers to screen for social drivers of health (SDOH), and incorporating member-centered design into our broader quality initiatives. We also stratify quality metrics by race, ethnicity, preferred language, and disability status where data is available, helping to identify disparities and inform targeted interventions outside of direct VBP models.

17. **Is your CCO <u>currently</u> employing medical/clinical and/or social risk adjustment in your VBP payment models?** (Note: OHA does not require CCOs to do so.)

    ☒ Yes
    ☐ No

    If yes, describe your approach.

    CHA does currently include medical/clinical risk adjustment in some of its VBP models. CHA does not currently include social risk adjustment in our VBP models. On a recent OHA VBP technical assistance call, it was noted that risk adjustment alone does not sufficiently mitigate the risk of unintended consequences from a health equity perspective. This aligns with national guidance from the Health Care Payment Learning & Action Network (HCP-LAN) and the National Quality Forum (NQF), which caution that traditional risk adjustment can sometimes mask disparities rather than expose them.

    Instead of relying solely on risk adjustment, CHA is exploring strategies that more directly support health equity. This includes integrating stratified performance measures by REALD data, aligning with equity-focused clinical standards such as the updated PCPCH model, and considering VBP design elements that promote transparency and accountability for closing equity gaps.

Describe what is working well and/or what is challenging about this approach.

CHA utilizes the same methodology as OHA to calculate risk adjustment by member and applies it to some of its VBP models. As stated above, CHA does not want to rely solely on medical/clinical risk adjustment as it may have unintended consequences.

18. **Is your CCO <u>planning</u> to incorporate new medical/clinical and/or social risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?** (Note: OHA does not require CCOs to do so.)

CHA is not currently planning to implement formal social risk adjustment in our VBP models, but we are taking steps to integrate equity-informed design elements that serve a similar purpose. Specifically, we plan to leverage the 2025 updates to Oregon's PCPCH standards, which emphasize equity, community responsiveness, and stratified performance tracking.

Four of our five contracted PCPCH clinics have already achieved Tier 4 or 5 recognition, putting them in a strong position to stratify their clinical performance using REALD and SDOH data. Our goal is to begin reporting these stratified measures as part of our VBP evaluation process, and to incorporate provider-collected equity data into population health strategies. We are also exploring the inclusion of process-oriented equity metrics (e.g., completion of SDOH screenings or referrals for LEP members) as a more actionable and transparent way to drive equitable care.

Section 6: Health Information Technology and VBP

Questions in this section were previously included in the CCO Health Information Technology (IT) Roadmap questionnaire and relate to your CCO's health IT capabilities for the purposes of supporting VBP and population management.

Note: Your CCO will not be asked to report this information elsewhere. This section has been removed from the CCO HIT Roadmap questionnaire/requirement.

19. **What <u>health IT tools</u> does your CCO use for VBP and population health management, including to manage data and assess performance?**

Milliman's MedInsights: For population health management and utilization reporting, Pareto Intelligence, and claims data
Tableau/SQL Server: Pulled from Quantum Choice Plexis claims data for reporting quality metric and VBP results to attributed providers.
Ayin Health: CHA is currently finalizing implementation of a new quality metric reporting platform that will allow providers self-access to performance data and comparison to overall CHA population.

Reliance eHealth Collaborative: Supplemental data from Health Information Exchange for quality metric gap chart reviews for performance validation for participating providers sharing data.
Pareto Intelligence: For risk adjustment related performance data to attributed providers.

20. Describe your strategies and activities for using health IT to <u>administer VBP arrangements</u>, noting any changes since May 2024.

CHA has used the same tools to administer our VBP arrangements for multiple years. CHA is currently finalizing the implementation of a new quality metric reporting platform that will allow providers self-access to performance data and comparison to overall CHA population. The expected go-live is scheduled by end of Q2.

21. Describe your strategies and activities for using health IT to effectively <u>support provider participation</u> in VBP arrangements, noting any changes since May 2024.

a. How do you ensure that providers receive accurate and timely information on patient attribution?

By Q2 2025 providers will have direct access to the Ayin Health platform for quality metric performance data vs. regular email communications to report progress.

Other VBP measures are delivered monthly or quarterly via provider dashboards utilizing Tableau.

b. How do you ensure that providers receive timely (e.g., at least quarterly) information on measures used in their VBP arrangements?

Most reports are scheduled for monthly distribution to attributed providers, with a few sent at least on a quarterly basis.

c. What specific health IT tools do you use to deliver information to providers (list and provide a brief description of each)?

Tableau/SQL Server: Pulled from Quantum Choice Plexis claims data for reporting quality metric and VBP results to attributed providers. This data populates the monthly Quality Metric performance reporting for providers.
Ayin Health: CHA is currently finalizing implementation of a new quality metric reporting platform that will allow providers self-access to performance data and comparison to overall CHA population. This will replace the Tableau/SQL Server reporting above.
Reliance eHealth Collaborative: Supplemental data from Health Information Exchange for quality metric gap chart reviews for performance validation for participating providers sharing data.
Pareto Intelligence: For risk adjustment related performance data to attributed providers on a monthly basis.

22. **One way to support providers in meeting the quality metrics used in VBP arrangements is by helping to identify patients who require intervention. Describe how your CCO uses data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes. Note any changes since May 2024.**

In Q4 2024 CHA filled a new position of Population Health Manager to assist in research and investigation of available data to analyze high-risk needs members and potential intervention initiatives. This includes data for risk stratification and monitoring.

23. **Does your CCO routinely provide transaction-level cost and utilization data ("raw claims data") for attributed patients' total cost of care to providers participating in risk-based VPB arrangements? If so, do you provide this data automatically to all providers participating in risk-based VBP arrangements or only upon request?**

No, CHA does not currently provide raw claims data to providers.

24. **Using the table below, indicate (a) which types of data files, prepared reports, or dashboards you make available to providers in each type of HCP-LAN VBP arrangement, (b) how often you make the data available, and (c) how the information is provided (please include the name of the tool).**

For reference: Online interactive dashboards are websites where providers can configure settings to view performance reporting for different CCO populations, time periods, etc. Shared bidirectional platforms integrate electronic health record data from providers with CCO administrative data (such as: Arcadia, Azara, Epic Payer Platform).

	HCP-LAN 2C	HCP-LAN 3A/B	HCP-LAN 4	Frequency	How is this information being provided?
Attribution files, including dates of coverage	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Weekly ☒ Monthly ☐ Quarterly ☐ Other	☒ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.
Quality performance & gap reports	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Weekly ☒ Monthly ☐ Quarterly ☐ Other	☒ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.

Performance reports with numerator/ denominator details	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☒ Monthly ☐ Quarterly ☐ Other	☒ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.
Total cost/utilization data with transactional details	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other	☐ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.
Member-level risk score details	☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☒ Monthly ☐ Quarterly ☐ Other	☒ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.
Total premium data with member-level details	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other	☐ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: Click or tap here to enter text.

25. Are there any significant operational details about the way you share data with providers that are not captured in the chart above? Are there any additional types of data or reports that you make available to providers in VBP arrangements to support their success?

No

26. Describe your <u>accomplishments</u> related to using health IT to administer VBP arrangements and support providers.

CHA is currently finalizing the implementation of a new quality metric reporting platform, Ayin Health that will allow providers self-access to performance data and comparison to overall CHA population. This will replace the Tableau/SQL Server reporting above. CHA has demonstrated the tool at the Quality Metrics meetings and Community Advisory Council and has received positive feedback.

27. What <u>challenges</u> are you experiencing related to using health IT to administer VBP arrangements and support providers?

Updating quality metric performance reports for overall CHA performance is difficult when a major provider serving 25% of the population has struggles with accurate and timely reporting with a recent new EHR implementation. CHA did leverage Reliance eHealth Collaborative to supplement reporting for Diabetic A1C measure.

Section 7: Technical Assistance

The following questions are to better understand your CCO's technical assistance (TA) needs and requests related to VBPs.

28. **What TA can OHA provide that would support your CCO's achievement of VBP requirements outlined in Exhibit H of the CCO Contract?**

    CHA would like more assistance with incorporating health equity into VBPs.

29. **Aside from TA, what else could support your achievement of VBP requirements outlined in Exhibit H of the CCO Contract?**

    More complete, validated, and updated HE data.

30. **<u>Optional</u>: Do you have any suggestions for improving the collection of the information requested in this questionnaire in future years? If so, what changes would you recommend?**

    Click or tap here to enter text.

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