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:

   EOCCO has continued existing models that resulted in 90% or more at LAN 2c or higher since 2020. These results have exceeded the 70% payment targets for 2024 and are projected to remain at this level in 2025.

   Describe any challenges you have encountered:

   No challenges have been encountered since EOCCO has been strategic in implementing sustainable value-based payment models with our provider partners.

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:

   EOCCO has continued existing models and we've continued with downside risk to our primary care total cost of care model as well as the shared risk model's 10% withhold.

Describe any challenges you have encountered:

No challenges have been encountered since EOCCO has been strategic in implementing long term value-based payment models.

3. **Optional: 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. **Optional: 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 hospital 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 CDA model has been implemented and slightly evolved over the last three years now (back in 2022). In 2025, hospitals earn an incentive for controlling readmits better than expected given the level of patient risk. If the hospital has fewer than the expected number of readmits, a bonus of $4,000 per readmit saved will apply. If there are more than the expected number of readmits, a penalty of $4,000 per excess readmit will apply. In calculating the incentive, the number of saved or excess readmits will be rounded down to the nearest whole number.

There were no changes to the LAN tier, affected provider types or overall measure description.

We do not anticipate other changes in 2025.

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, CDA is under contract.

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)?

EOCCO implemented this measure back in 2022 to focus on improving maternity care with OBGYNs. There have been no foundation changes other than the addition of new codes based on allowed codes for provider use in 2024, EOCCO has not made additional revisions to this CDA in 2025.

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, CDA is under contract.

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)?

Ensuring that CMHP's for outpatient mental health and outpatient SUD place an emphasis on access to care. Other quality measures are aligned to help meet EOCCO incentive measures.

No changes to the foundation of the CDA.

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, CDA is under contract

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)?

This CDA has been implemented since 2023 to focus on providing quality interpreter services for members who have limited English proficiency and Deaf and hard of hearing. This creates an emphasis on members receiving quality communication, language access services and culturally responsive care. EOCCO has not significantly changed this CDA model either.

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, CDA is under contract.

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)?

This CDA has been implemented since 2024 to focused on well-child visits for children ages 7-21, measuring the number of children ages 7-21 that received one or more well-child visits between January 1 – December 31 of the measurement 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, CDA is under contract.

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, EOCCO is in compliance with the PCPCH payments.

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.**

    EOCCO has an internal workgroup that creates VBPs and engages the quality measure subcommittee of its board to develop, monitor and evaluate VBP models. The subcommittee is made up of hospital, primary care, behavioral health, and public health representatives across EOCCO's geography. EOCCO also discusses VBP models with its Clinical Advisory Panel (CAP) and its contracted providers taking their input and suggestions into consideration when developing new or modifying existing VBP models. Over the years, EOCCO has perfected this model but there have not been significant

changes. If EOCCO has an idea for a new VBP, we reach out to the impacted providers to go over the changes and seek any feedback before presenting the VBP concepts to other formal committees.

A recent example includes transitioning EOCCO's risk model from a target based model to a Medical Loss Ratio model (outcomes are based on EOCCO's financial performance). EOCCO staff presented the structural changes to a couple of hospital partners, then to the CAP and then onto the Board of Directors for final approval. The new risk model for 2025 was approved with no hesitation because of all the preliminary conversations and work done to ensure providers were being treated equitably.

Any changes or modifications to VBP models or implementation of new VBP models are reviewed by our internal workgroup, CAP and then to the board for approval.
ap here to enter text.

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]:

The hospitals and the availability of specialty care in our service area vary in size and many of the measures do not produce sufficient denominators for these provider types.

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)?**

    EOCCO has strategies in place for addressing health equity, which help ensure that VBPs do not have adverse effects on any underserved population.

    These include strategies targeting both processes and outcomes.

    Examples of process strategies include the following:

    1. EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data.
    2. EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis.
    3. The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health outcomes. The team will then implement targeted interventions to address the identified disparities.
    4. The EOCCO Quality Improvement Team analyzes Unite Us CIE [Connect Oregon] data to identify social determinant of health (SDOH) prevalence and social need trends across our service area. This informs the implementation of community-driven, system-level, strategies to address any identified SDOH disparities.

EOCCO provides clinics with monthly quality reports and member rosters that include demographic and language data. EOCCO is continuously working on collecting and ingesting more REALD and SOGI data through Arcadia Analytics, Unite Us CIE, and OHA reporting data.

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.

EOCCO risk stratifies PMPM payments for PCPCH. For example, tier 5 clinics with a higher risk member will receive higher PMPM payment than for a member with lower risk at the same level of PCPCH tier clinic.

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

There are no current challenges with this approach and this type of model helps support clinics who need to ensure high levels of care coordination for members with more risk.

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.)

EOCCO values the impact that social factors play in a member's health outcomes. Some challenges include data accuracy and completeness. We continue to work towards the incorporation of SDoH data and upon completion, will evaluate incorporation into VBP models.

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?**

EOCCO utilizes the Arcadia Analytics Population Health Management tool to manage data and assess performance on VBP measures. Arcadia Analytics is a health information exchange (HIE) platform that integrates EHR data with pharmacy, medical, behavioral, and oral health claims as well as EOCCO eligibility files to create a single patient record to be shared across the exchange. The platform provides a quality performance dashboard, care gap lists, condition history, utilization history, upcoming appointments, medications, problem lists, demographics, provider attribution, and risk scores.

EOCCO also uses the Collective Medical (Point Click Care) platform to track performance on multiple behavioral health metrics used in the VBP arrangements with CMHPs. Care coordinators within the CMHPs and EOCCO are using Collective Medical to track ED and acute care utilization for our members with behavioral health diagnoses, coordinate follow-up visits, and review progress on readmission targets under the behavioral health VBP arrangements.

For population health management and care coordination, EOCCO utilizes two HIT platforms: HMS Essette and Clinical Care Advance (CCA). HMS Essette is used by EOCCO's Behavioral Health Care Coordination Team and CCA is used by EOCCO's Physical Health Case Management Team. Both platforms allow for the tracking and documentation of diagnosis-driven member care plans in alignment with NCQA standards, and for the monitoring of health outcomes at both individual and population levels. The Behavioral Health Care Coordination and Physical Health Case Management teams have chart view access to each team's specific care management platform, allowing both teams to more effectively coordinate care and ensure member goals area aligned across all aspects of health and care needs.

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

No new changes since May 2024.

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?

EOCCO provides a monthly attribution report which is called a member roster. This report is a complete list of all assigned members for which a VBP applies, plus risk stratification, diagnosis history, recent utilization, assigned PCP, and contact information. Providers use this report to better understand which members are assigned to their clinic, identification of members most likely to benefit from PCP outreach, outreach to high-risk members who utilize the ED and/or are admitted and overall to ensure member connections to primary care are made. EOCCO also completes monthly re-attribution when there's claim evidence that a member is seeing another PCP (not their same assigned provider)

Providers can also contact EOCCO to assign a member to their clinic as needed.

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

EOCCO also has a monthly quality and care gap report. This entails performance statistics on all quality measures that are part of VBPs administered by EOCCO, which includes list of potential care gaps for assigned members.

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

EOCCO utilized the health IT tools outlined in answer #19, response copied below:

EOCCO utilizes the Arcadia Analytics Population Health Management tool to manage data and assess performance on VBP measures. Arcadia Analytics is a health information exchange (HIE) platform that integrates EHR data with pharmacy, medical, behavioral, and oral health claims as well as EOCCO eligibility files to create a single patient record to be shared across the exchange. The platform provides a quality performance dashboard, care gap lists, condition history, utilization history, upcoming appointments, medications, problem lists, demographics, provider attribution, and risk scores.

EOCCO also uses the Collective Medical platform to track performance on multiple behavioral health metrics used in the VBP arrangements with CMHPs. Care coordinators within the CMHPs and EOCCO are using Collective Medical to track ED and acute care utilization for our members with behavioral health diagnoses, coordinate follow-up visits, and review progress on readmission targets under the behavioral health VBP arrangements.

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.

EOCCO has a provider centric structure in place to communicate, educate and ensure providers have information available to meet quality measures. This includes offering concierge like services to providers, remaining agile, focus on engagement, ensuring data is readily available to stay informed of current performance gaps (data driven insights) and always receiving provider buy in by proactive communicating with our committees to receive feedback.

EOCCO has a dedicated team that specializes in population management and interprets data for providers. We have specialized staff for the following areas: Childhood Health, Behavioral Health, Oral Health, Clinical Measures, Health Equity and Social Determinants of Health. This includes monthly meetings with clinics to review the provider reports package, which includes member risk scores, pharmacy utilization and gaps in care.

Claims based reporting: The team works collaboratively with providers to ensure the proper reporting of encounters, including reviewing the measure technical specifications, numerator compliance, and gap lists. Additionally, the team will create and implement interventions to help support member engagement and activation with areas clinics have identified as barriers or opportunities. Lastly, the team works through workflow processes to ensure members are identified and visits occur, based on the gap lists and identified areas of quality improvement.

Clinical charts: The team provides technical assistance to clinics to ensure data accuracy in reporting clinical data. Additionally, reviews measure technical specifications, numerator compliance and gap lists. Similar to claims-based reporting, the team will create and implement interventions to help support member engagement and activation in areas clinics have identified as barriers or opportunities.

There have not been other changes since May 2024.

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?

Reports at this level are not routine for those outside of our organization but we do provide this information upon request from providers. EOCCO's member roster and its various reporting components has very detailed information of each attributed member and this is provided to clinics on a monthly basis.

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?

Here are additional reports that EOCCO offers to providers via our reporting portal:

Pharmacy Opportunity Report	Specific evidence-based pharmacy management opportunities for all VBP members, such as low	Discuss potential opportunities with patients, to:	Monthly

	medication adherence, low-cost (generic) drug alternatives, polypharmacy, and high-risk opioid prescribing.	• Lower patient expense • Increase adherence • Reduce opioid risk Manage pharmacy spend to increase shared risk or total cost of care bonus	
ER-IP Notification Report	Frequent updates on any member admitted for an inpatient stay or to a hospital emergency department.	Follow up with members to ensure continuity of care Manage ED/IP to increase shared risk or total cost of care bonus	Weekly
Primary Care Scorecard	For participating EOCCO primary care providers, shows a variety of cost and utilization statistics for their assigned population.	Compare clinic performance to peer group and benchmarks; analyze utilization and referral patterns	Quarterly

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

Based on the timely reporting of the data, most importantly gap lists, EOCCO has been able to support our providers in meeting the metrics outlined by OHA. This in return, has allowed EOCCO to reinvest back into providers, through our VBPs, resulting in better care and better outcomes for our members.

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

None.

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?

None at this time.

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

    None at this time.

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?**

    None at this time.

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