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:

   To help ensure IHN achieves the requirement of 70%, IHN is maintaining VBP contracts with our largest provider group, [redacted], our county mental health providers, multiple PCP Clinics, the regional NEMT provider, and all area dental care organizations (DCOs).

   Describe any challenges you have encountered:

   A challenge we faced this year was a provider's reporting capabilities were limited. The provider did not have the needed staffing or established workflows to support metric reporting.

   One challenge we encountered was mid-year a VBP provider cut support staff to maintain cashflow and reduce losses. This directly impacted the VBP program and our CCO metric performance.

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:

IHN-CCO has continued the shared risk agreement with [redacted] into 2025. Since this provider accounts for nearly 70% of the IHN-CCO population, and all costs for that population are at risk, it helps ensure the 25% requirement is met.

Describe any challenges you have encountered:

For the [redacted] risk sharing agreement, all the members' costs are included. When it comes to submitting the data in the APAC PAF, a manual process is required to ensure all the costs tied to this risk are indeed being counted and getting the LAN category credit.

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?**

   N/A

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?**

   N/A

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)?

   IHN-CCO implemented a risk sharing agreement with [redacted] on all costs for members assigned to [redacted] PCPs, including inpatient care, outpatient hospital

surgeries, maternity, and emergency room departments. [redacted] consists of 5 regional hospitals, 21 PCPCHs, and several specialty clinics. [redacted] Pay-for-Performance Quality Metric scorecard consists of measures listed as approved in the 'hospital sector' of the Aligned Measures, from the OHA VBP Roadmap website.

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)?

IHN-CCO is partnering with [redacted] and [redacted] to support their program expansion. The program provides low barrier, integrated clinical (prenatal/ postpartum) care co-located with SUD recovery services. [redacted] will use an [redacted] medical mobile van to provide clinical care to coincide with perinatal recovery groups.

- Conduct community outreach to engage hard-to-reach populations in prenatal/postpartum care.
- Support coordination of services and access to resources using the peer support or CHW model.
- Collaborate with [redacted] Behavioral Health to integrate mental health care as needed.
- [redacted] supports several CCO incentive metrics including Childhood Immunization, Health Equity, SDOH, and Timeliness of Postpartum Care.

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.

The contract is between IHN-CCO, [redacted], and [redacted]. [redacted] is supplying the Medical Van, their contracting team is reviewing the terms.

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)?

IHN-CCO has implemented a VBP agreement with [redacted]s. [redacted] provides treatment for substance use disorders in adult members (18 and older). The [redacted] platform and program consists of a digital therapeutic app, telehealth, and medication management. In addition, the care program includes health and risk assessments, group therapy, individual counseling, cognitive behavioral therapies, recovery/peer support, and contingency incentives to provide a comprehensive approach for treatment. The program care team includes Psychiatrists, Licensed Substance Abuse Counselors, Clinical Social Workers, and Peer Recovery Coaches. [redacted] payment is per episode with a potential quality pool. [redacted] will support IHN-CCO with the following quality metrics on their pay for performance scorecard:

- IET (Initiation & Engagement)
- ED Diversion (No SUD ED Visits within Measurement Month)
- Retention (Remained in Treatment Beyond Month One)

Although the contract took some time to model, negotiate and implement, it was towards the mid-year mark IHN-CCO saw some traction on work being done. [redacted] joined IHN-CCO at VBP quarterly meetings with PCP groups to help promote the program in Q3. As we progressed into end of year, utilization remained low. Since [redacted] can directly assist with the IET measures, IHN-CCO will continue to work with [redacted] to boost awareness. Q1 reports for 2025 already show increased utilization.

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.

Last year, IHN-CCO highlighted the [redacted] expansion program for the behavioral health CDA. For 2024, this VBP agreement became part of the [redacted] VBP contract. The mental health contract is a 4A LAN, and has a quality metrics scorecard, but none of the metrics are specific to SUD. IHN-CCO opted to include [redacted] as an additional agreement for the behavioral health CDA.

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)?

Over the last few years IHN-CCO has incorporated dental measures into one of the FQHC PCP scorecards. This provider group's dental program offers dental screenings and dental referrals. These providers have done well in helping IHN-CCO work towards meeting the Preventive Dental measure.

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)?

IHN-CCO has implemented a VBP contract with the [redacted]. The [redacted] provides care coordination for children in DHS custody. This program focuses of kids in foster care, which are the most vulnerable population, and often time higher risk. [redacted] team works closely with the County Mental Health, DCO's and Primary Care clinics to help ensure these children receive the necessary assessments and screenings. The program has helped IHN work toward meeting the DHS Custody metric.

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?**

N/A

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 VBP Technical Guide.**

    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.

A VBP Committee was established. The Committee meets quarterly and consists of the AVP-Finance, AVP-Network Strategy & Contracting, AVP-Clinical Services. All proposed VBP's are to be vetted by the VBP Committee. The goal of the VBP is to have more interactive, and meaningful VBPs, collaboration and post-VBP reviews to determine best practices.
Our Clinical Services Division meets with VBP providers on a monthly basis to review and discuss quality metric gap lists, trends, and areas for improvement. These meeting are a 'deep dive' compared to the quarterly VBP meetings held.

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]:

N/A

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)?**

As a Medicaid health plan committed to value-based care, we recognize that achieving equitable outcomes for all of our members is important. We also understand that implementing value based payments can inadvertently create or exacerbate existing disparities if not carefully managed. We are taking steps to embed health equity more fully into the core of our VBP strategy.

Below is how we are mitigating potential adverse effects:

1. Data-driven equity assessment:
    a. We stratify our performance by race, ethnicity, language, and other relevant social determinants of health- allowing us to identify any disparities in quality, utilization, and outcomes that may be associated with our VBP models
2. Equity-adjusted Performance Metrics
    a. We are working through an equity-adjusted performance metric to where appropriate, account for social risk factors and ensure fair compensation
    b. We are also actively exploring risk adjustment methodologies that address social determinants of health, recognizing that these factors significantly influence health outcomes.
3. Community Engagement and Collaboration
    a. We actively engage with community members, partners, and providers to understand the unique needs and challenges faced by diverse populations. This is to help incorporate community input into the design and implementation of our VBP programs
4. Provider Accountability and Training
    a. We also hold our provider partners accountable for achieving equitable outcomes and provide them with the necessary training to deliver culturally competent care
    b. We are also working on providing data to our providers so they can see where disparities exist within their own patient populations.

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.

N/A

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

N/A

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.)

IHN-CCO is undertaking the development of a value-based payment model that incorporates social risk adjustment. The organization has successfully completed the first iteration of a member specific Social Determinants of Health profile, which integrates member social needs with clinical data to provide a comprehensive assessment of health status. A pilot site has been identified to implement a VBP model that links payment to the coordination, completion, and where feasible, resolution of member social needs that present barriers to optimal medical care. IHN-CCO is currently in the process of finalizing specific, risk-adjusted performance metrics to initiate discussions with the designated pilot site.

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?**

IHN-CCO utilizes the Arcadia platform for VBP and population health management to both manage data and assess performance. For VBP providers who do not have the EHR connector established with Arcadia, IHN-CCO uses PowerBI analytics to produce the quality metrics reporting and gap lists.

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

IHN-CCO uses the Arcadia platform for reporting member risk scores and Provider Group Quality performance progress. Each month, PCP Provider Groups with a capitation agreement, receive their member's Risk Score data to help manage the population. Additionally, VBP PCP Provider Groups can log into the Arcadia platform to monitor their panel's open care gaps tied to the Pay-for-Performance scorecard.

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?

Within the Arcadia Platform, providers have access to members attributed to them in near real time. If attribution changes occur, that information is fed into Arcadia as soon as it is completed in our internal Facets system on the next file run, which is a daily process. For providers not on Arcadia, but have a capitated agreement, they receive their patient attribution through detailed capitation payment files (in excel format), sent via an SFTP site. Non-capitated providers have access to attribution information via the OneHealthPort Provider Portal. (All contracted providers have this access.)

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

As of first quarter of 2025, our [redacted] provider clinic, our County Clinics [redacted] and [redacted] are all live in Arcadia. Utilizing Arcadia, these clinics are able to access their performance and gap list. We also have ongoing monthly calls to provide support and work through any barriers that our provider partners may have. For clinics not yet on Arcadia, we continue to leverage manual scorecards and claims-based utilization. The intent is to provide all provider clinics with access to Arcadia even if there is no EHR connection, so they can at minimum see their claims-based utilization. It is also on the roadmap to turn all supplemental data currently being received from clinics without EHR connectors into external measures structured data sets to be ingested into Arcadia, so provider can see their EHR metrics as well. For our providers leveraging Arcadia, they can log in at any time to look at their gap lists and scorecards. For providers not yet on Arcadia, they receive monthly gap lists and quarterly scorecards.

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

IHN-CCO leverages Arcadia. Providers have log-in information. They are able to log in at any time to see their gap lists and scorecards. In addition, there are various population health KPIs down to the provider level they can access. Our Vista dashboards within Arcadia provides a nice summary for various categories of utilization for a provider to view and export.

For VBP providers who do not have access to Arcadia, IHN-CCO uses PowerBI analytics to produce the quality metrics reporting and gap lists. PowerBI is our internal

business intelligence platform used for intuitive data visualization, detailed analytics, and interactive dashboards such as scorecards.

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 ("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?**

IHN-CCO utilizes a risk stratification model that incorporates data (both clinical and non-clinical, including social determinants of care) both within and outside of Arcadia to categorize members into risk levels: no, low, moderate, and high. While the model has been active for just over a month, the intent is to share this data with our VBP providers. This initiative supports expanding our VBP arrangements with primary care physicians beyond current metrics to include total cost of care, aligning with the patient-centered primary care home model's goal of providing more comprehensive member care.

Although the above-mentioned model has only been active for just over a month, IHN-CCO began using risk stratified PCP agreements a few years ago. IHN-CCO will move these agreements to the updated model in 2026.

23. **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: Arcadia
Performance reports with numerator/ denominator details	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☒ Monthly ☒ Quarterly ☐ Other	☒ Excel, static reports ☐ Interactive dashboard ☒ Bidirectional platform Tool: Arcadia
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: Arcadia
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.

24. 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?

N/A

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

Our biggest accomplishment to date is having successfully onboarded 4 of our largest provider network partners encompassing about 90% of our membership on to the Arcadia platform. In addition to the metric data and performance, they have access to member level and aggregate data on member utilization patterns, pmpm information, member risk care

gaps, and claim information. This information is updated daily within the Arcadia platform and offers near real-time access to information.

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

Arcadia is the platform IHN-CCO uses to track quality measures for VBP contracted partners that possess the necessary technical capabilities: a robust electronic health record (EHR), information systems (IS) infrastructure, and standardized clinical workflows. Arcadia integrates clinical/EHR data with IHN-CCO's claims data to calculate measure components (numerator, denominator) and identify gaps in care. However, many smaller VBP partners lack a robust EHR system or the IS support/infrastructure required for full data integration with Arcadia. Additionally, Arcadia has limitations in its ability to accurately process measures for members with Dental-only or Behavioral Health-only coverage (CCO-E, CCO-F, and CCO-G). Currently, Arcadia cannot differentiate between these distinct Medicaid coverage types. Consequently, IHN-CCO cannot build these specific measures within the system and continues to generate them through manual reports using a separate supplemental data process. This manual scorecard process is also used for VBP partners unable to establish a connection with Arcadia. We are actively collaborating with Arcadia to explore potential solutions for accurately differentiating between the various Medicaid coverage types to enable all measure capturing and reporting to happen through Arcadia.

For providers and data not available in Arcadia, IHN-CCO uses the PowerBI reporting system to produce the quality metrics reporting and gap lists. PowerBI is our internal business intelligence platform used for intuitive data visualization, detailed analytics, and interactive dashboards such as scorecards. For example, dental data and dental measures are not available in Arcadia, so IHN-CCO is utilizing PowerBI to produce the scorecards and gap lists for all our DCO provider groups. The need to have two different reporting systems is challenging.

Section 7: Technical Assistance

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

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

No TA is required at this time.

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

To meet the VBP requirements for the various CDAs, CDA specific quality metrics could be easier to locate and better defined. The resource available on the OHA website is outdated.

Measures are not easily identified as meeting the CDA. More hospital related CDA measures would be beneficial.
IHN-CCO was approached by an oncology group for a VBP. Assistance with developing metrics and improvement targets for specialty contracts would also be helpful.

29. <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?

N/A

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