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:

   PacificSource believes it achieved the 70% level in years prior to 2024.

   Describe any challenges you have encountered:

   PacificSource Columbia Gorge CCO: Columbia Gorge CCO Hospitals are not participating in VBP Arrangements.
   All Other CCOs; NA

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:

   PacificSource believes it achieved the 25% level in years prior to 2024.

   Describe any challenges you have encountered:

None.

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:

   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)?

   PacificSource has incorporated upside/downside risk tied to quality performance – thus qualifying as LAN 3B.

   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.

   NA

6. **What is the current status of the new or enhanced VBP model your CCO is reporting for the maternity 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)?

PacificSource has incorporated upside/downside risk tied to quality performance – thus qualifying as LAN 3B.

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.

NA

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)?

PacificSource has incorporated upside/downside risk tied to quality performance – thus qualifying as LAN 3B.

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.

NA

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)?

As shared in previous reporting, qualifying VBPs with each of PacificSource contracted Dental Care Organizations (DCOs) have been in effect for several years, across all CCO regions. When applicable, PacificSource updates DCO VBP arrangements to reflect changes with CCO quality incentive metrics.

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.

NA

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)?

PacificSource has incorporated upside/downside risk tied to quality performance – thus qualifying as LAN 3B.

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.

NA

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 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:

    Click or tap here to enter text.

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:

    Click or tap here to enter text.

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.

- PacificSource continues to engage with provider partners to educate on VBP contracting requirements and collaboratively determine quality metrics from the OHA's Aligned Measures Menu set (these metrics span the sectors of primary care, hospital, behavioral health, and oral health). In the second and third quarters of each year, the PCS contracting team for each CCO region meets to determine if there are any contract terms that need to be modified or added for the following year. The team proposes new terms, models, or metrics as appropriate and that adequately meet current OHA requirements. We consult our regional VBP Roadmaps during this internal process. In the third and fourth quarters, we meet with provider partners to discuss the internal contract team's proposals. Negotiations follow, often bi-weekly, until the respective agreement is finalized. Meanwhile, there is an additional quality team (as well as representation from our Analytics Department) that meets with provider partners to determine which quality metrics to include in the agreement, as well as to determine the target and weight of each metric.
- PacificSource continues to contract directly with providers, clinics, facilities, and health systems, and through Independent Practice Associations (IPAs). We set arrangements with both upside and downside risk and aligned quality measures, consistent with the OHA requirements on the HCP-LAN classification for value-based payment (VBP) arrangements.
- PacificSource continues to offer optional Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration (BHI) program participation to support non-billable services that have immense value for OHP members with physical and behavioral health needs. The programs are tied to state criteria and evidence-based standards. Regional meetings, which include both internal stakeholders and provider partners, occur throughout the contract cycle to evaluate and discuss progress on the quality metrics and other contract terms. PCS increased its PCPCH base payments to providers and clarified and simplified some of the program requirements as requested by providers.
- PacificSourcemonitors and evaluates VBP models through monthly contract-based reports (known as "risk reports") that it sends to the contracted entities. These reports include performance on the financial model and other measures, including Quality Incentive Measures.
- PacificSource has added accountable care organizations and IPA primary care populations to Insight, our member analytics platform. The platform, which filters by provider groups, allows for further monitoring of contract performance in various areas, including inpatient and emergency room service utilization, disease prevalence,

performance on gap-in-care measures, potentially wasteful care, and a host of other measures that supplement contract monitoring. Our Population Health team works with our provider partners to review reported performance.

- PacificSource also engages with stakeholders in regional and partner-specific committees, and reviews data such as quarterly cost of care and other trend reports.
- As part of the strategy to develop and evaluate VBP models, PacificSource maintains a VBP capabilities roadmap. As part of this roadmap work, PacificSource is assessing vendor VBP capabilities to further scale and expand its own VBP capabilities to meet VBP objectives. This project includes internal stakeholder teams such as Provider Network, IT, Analytics, Finance, and Actuarial.
- PacificSource attempts to initiate discussions with the few primary care entities, or their integrated hospital systems, which are either non-contracted, or contracted at VBP LAN category 1, with the goal of establishing or enhancing relationships which meet OHA requirements. Discussions are ongoing, but dependent on clinic readiness, shifting clinic leadership perspectives, and other factors not of our control.

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:

Click or tap here to enter text.

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)?

PacificSource does not believe any of the previously instituted VBPs have created any adverse effects on health equity or for any specific population of members (racial, ethnic, LGBTQ, disabled, limited language proficiency, immigrants, medical complexity, etc.). We are mindful of creating contract language that does not impede or exacerbate issues of health equity.

The following examples illustrate our processes designed to mitigate adverse effects:

- Our Quality and Health Services teams negotiate performance measures that support health equity. Language currently exists in base provider agreements around health equity and Culturally and Linguistically Appropriate Services (CLAS) practices. PacificSource has updated this language for prior agreements. Some examples of measures that support health equity include Follow-Up after Emergency Department Visit for Mental Illness, Assessments for Children in DHS Custody, and the Language Access Measure.

- We monitor VBP arrangements to evaluate health outcomes, utilization, cost, and grievances and appeals, with reporting on a regular basis. We have expanded this oversight to include monitoring of language access needs of primary care groups by creating a set of health equity dashboards. We added filtering to our Insight platform to include accountable care organizations and IPA-specific groups.

- When setting targets for contracted provider performance, we consider historical measure performance or benchmarks and adjusts to provide the contracting entity with a target that is both achievable and meaningful. An example of this is the Central Oregon CCO, where we apply a higher benchmark to the Postpartum Care QIM to some providers, since the historical performance has been higher than the state benchmark. We continue to review our measure methodology in the VBP Roadmap workgroup to evaluate and improve our contracting measurement strategy to support health equity.

- We've been considering various VBP methods that could better match payment to risk. While we have done preliminary research, the lack of available models and the relative immaturity and incompleteness of the social complexity data continues to present significant challenges. We encourage a workgroup or some level of partnership with OHA to find an optimal solution.

- PacificSource uses the rate category as a proxy to align payment with risk for direct VBPs (i.e., capitation) and risk-sharing settlements with providers. We base our risk-sharing settlements on a budget-based expense target relative to revenue, with the revenue varying by the member's rate category, and adjust to the mix of adults versus children, duals versus non-duals, etc. Rate category captures several areas of social complexity, including dual eligibility, disability, and foster care. PacificSource would find it informative to understand how much additional gain would be leveraged by layering on additional risk adjustment relative to the current status, to evaluate additional strategies.

- Over the past few years PacificSource has chartered a multi-year work plan and launched an internal workgroup dedicated to better understanding social determinants of health (SDOH) data and its relationship to healthcare outcomes. To date, we have:

    - Conducted a preliminary literature review and research on models and factors.

    - Loaded extensive publicly available data sets to further analyze and have started running some statistical tests. We have developed enhanced logic to identify individual-level SDOH indicators.

    - Worked closely with Connect Oregon (Unite Us) to ensure that we will be able to leverage patient-level SDOH screening and referral data from that platform. We receive data files from Connect Oregon in support of that work.

    - Participated in a pilot with both the Alliance of Community Health Plans and Socially Determined to learn more about the landscape among other carriers and commercially available products.

    - Attended the Evidence-Based Strategies for Advancing Health Equity webinar and had a technical assistance session with Dr. Marshall Chin specifically around VBP and Health Equity to help inform our strategy. Ongoing work and education continue.

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.

NA

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

NA

18. **Is your CCO planning 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.)

PCS has participated in OHA's VBP workgroup around social risk factor adjustments and recommends that CCOs adopt a statewide risk adjustment model that is based on statewide data. This will ensure that any payment adjustments for social risk factors is based on a large enough population sample.

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 health IT tools does your CCO use for VBP and population health management, including to manage data and assess performance?**

Cognizant TriZetto Facets – Core Administration platform with VBP capabilities around capitation and PMPM based VBP.

Dynamo – Core Care and Case Management Solution. Used to track and manage complex care and record member communications related to it.

Data Storage Tools – Azure Databricks, Microsoft SQL Server and Microsoft SQL Server Analysis Services, SAS OLAP Cube

Data Modeling Tools – Azure Databricks, Microsoft SQL Server Integration Services, Alteryx Designer and Scheduler, Tableau Prep

Analytics Models – Cotiviti-certified HEDIS software, SQL-built Quality Incentive Measures (mirroring OHA specifications), PacificSource -developed identification algorithm with risk stratification, Cotiviti DxCG Risk Models, Milliman Health Waste Calculator, Milliman HCG Grouper and Benchmarking, Optum Symmetry Episode Treatment Grouper and Procedure Episode Grouper

Advanced Analytics Processes – SAS, R integration into Tableau, R integration into Microsoft SQL, Databricks integrated languages including R & Python.

Analytic Languages – SAS, SQL, R, C#.NET, Python

PointClickCare – The PointClickCare platform provides a critical and near real-time collaboration between the CCO and provider partners supporting population health and VBP performance.

Proprietary PacificSource **Tools developed by** PacificSource **Analytics:**

Member Insight Provider Insight (MiPi) – A comprehensive suite of analytic tools, reports and data visualizations used to support population health and VBPs.

Care Program Identification Algorithm (CPIA) – A categorization algorithm that identifies best fit population health programs for PacificSource members.

PCS Provider Portal – Supports the delivery of data, analytics, and member assignment data to providers.

PCS standard population health data feeds – PacificSource has developed a standard set of data feeds with specifications that are provided to providers upon request. These files are typically ingested into a provider's EHR or Population Health Management System. These standard files are accepted by several popular vendors like; Lightbeam, Arcadia, Epic, Deerwalk, Springbuk, and numerous others.

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

As mentioned in prior years' responses PacificSource executed a strategy to implement an automated internally built reporting solution to administer VBP budget based and pay for performance arrangements. This solution successfully went live in the summer of 2023 and is now in its second year. This solution helps scale and support providers with enhanced information about their financial performance within the community VBP model and has reduced ad hoc questions from providers around payments and methods as the reporting provides more robust information.

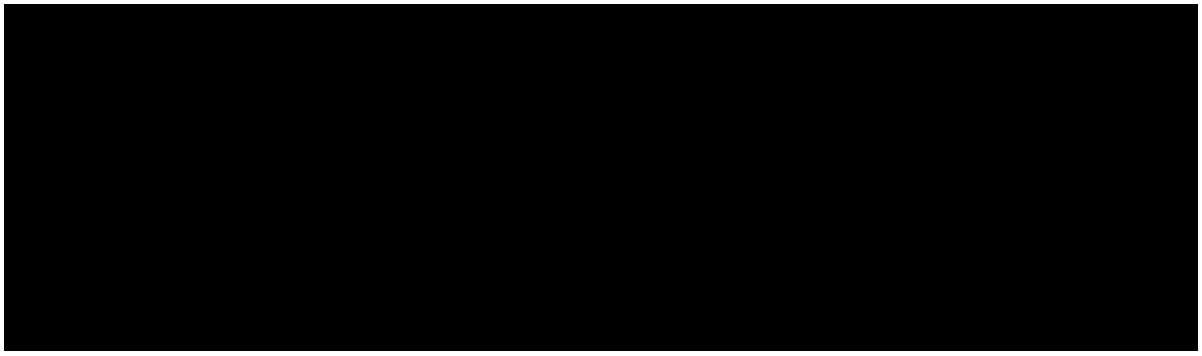
21. Describe your strategies and activities for using health IT to effectively support provider participation in VBP arrangements, noting any changes since May 2024.

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

PacificSource provides member assignment/attribution reports to primary care providers on the PacificSource provider portal. The reports update daily and can be accessed by providers on demand as outlined in prior years' roadmap responses.

Primary Care Attribution is undergoing a maintenance and enhancement process. PacificSource also has strategies to identify specialist attribution using our Optum Episode Treatment Grouper. PacificSource is currently performing a software upgrade of this tool; as part of this upgrade, we are working with the vendor to identify and improve the specialist attribution to specific member condition and procedure-based episodes of care. The goal of this strategy is to allow for PacificSource to share information with specialist providers on the performance of condition-based episodes for their members so they can see how they perform compared to peers as well as identify specific opportunities to improve delivery of care for their attributed members.

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



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

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 2024 PacificSource, developed an enhanced risk stratification model in support of the new Care Management OAR requirements building upon the work of an existing model. This model stratifies members in the high, moderate, and low risk cohorts for interventions. The following data sources are integrated into the model: claims, PointClickCare HIE events, Connect Oregon CIE events, clinical supplemental data source feeds that include lab results

and other data, DHS custody files, events from the care management platform including assessments, HRA responses, enrollment and demographic information, APD data where received, etc.

The model and supporting member risk profile identify members risk in the following areas: readmissions, emergency room visits, IP utilization and preventable IP admits, outpatient utilization, specialist utilization, and cost. The model is used to identify members for care management interventions such as complex care management, rising and emerging risk care management, transitions of care management, and other targeted interventions. Our strategy is to share elements of this new model with providers via our Member Insight Reporting solution to help improve their ability to identify members for care management and other inventions. The current reporting system facilitates risk stratification and provides other pertinent information, which this model aims to enhance.

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?

PacificSource provides claims and enrollment data extracts to providers who are contracted to manage a VBP risk population based on the request of the provider. PacificSource does not provide these extracts by default, as they require data use agreements with the providers and contracted entities (such as IPAs) to ensure that the provider has the necessary infrastructure in place to accept and store large amounts of PHI data securely and has the HIPAA supported purpose to access the data. However, once we determine appropriate agreements and IT are in place, PacificSource can and does share these extracts to be run and delivered automatically.

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: .
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?

PacificSource provider partners have not requested member level premium data for Medicaid members as part of the data sharing agreements for claims and enrollment and other reporting to manage the performance of the risk populations. If that was desired PacificSource would support the request. In addition to the things listed in question 24, PacificSource does provide the Member Insight report, which includes information about members chronic conditions, demographic information about the member such as race, dual

status, primary language, and area deprivation index which can help providers identify members who may have higher needs around social determinants of health.

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

In 2024 and early 2025 PacificSource, implemented new vendor functionality to expand the types of prospective payment VBP models that can be administered and has successfully piloted new functionality to support these models. The models would allow for conditions and other types of risk stratification level-based payment levels.

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

Consistent with our response from 2024, as PacificSource continues to work through the multi-year work plan around the Social Determinants of Health (SDOH) Quality Incentive Measure (QIM), we continue to see opportunities for SDOH QIM to better align with the HEDIS Social Needs Screening Measure (SNS-E) measure specifications. We perceive that providers face some challenges in building and maintaining workflows and HIT Data exchange that meet the needs of both measures particularly for patients like dual eligible members that have both coverages and need to have their screening and referral results meet the needs of both measures.

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?

We do not need any technical assistance at this time.

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

The CCO VBP workgroup has been helpful to discuss this work across CCOs, OHA and Bailett Consulting and would recommend that work continues. Additionally, as OHA updates and revises the quality incentive measures, continuing to incorporate national measure specification standards and alignment with CMS and NCQA around a measure standard will help support and provide focus for providers efforts around measure improvements across their patient populations.

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?**

No, this format works well for us. Thank you!

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