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:

   Over the years, we've built a system that enables UHA to consistently surpass the 70% benchmark. We regularly review our performance against quality and cost metrics, proactively monitor our data, adjust risks strategically, and engage our providers continuously, etc. This approach gives us the confidence to say that we've already met the minimum threshold for contracts with 2C or higher LAN category VBPs.

   Describe any challenges you have encountered:

   During a meeting with OHA earlier this year, it was noted that there is a discrepancy in the interpretation of the submission requirements for the annually submitted PAF for APAC, particularly in relation to the methodology UHA uses to group costs under our incentive program. UHA highlighted that the current PAF requirements do not accurately reflect the impact of payments on our community partners, as determined by our primary care assignment logic. As a result, pharmacy costs are excluded from consideration in meeting LAN requirements, which significantly reduces UHA's LAN percentages—bringing them to a level that only narrowly meets the current threshold.

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:

With our system, as stated in response to question 1, UHA is confident that it has met the 25% minimum threshold for contracts with a 3B or higher LAN category.

Describe any challenges you have encountered:

There have been no significant challenges.

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?**

   UHA has implemented a community-wide incentive program in which both the overall plan costs and performance and the individual clinic costs impact the incentive payouts for all contracted vendors whose agreements include some level of risk.

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?**

   The implementation of our VBP program and the continuous refinement of quality and cost metrics have allowed us to address potential challenges proactively, which is why we have been able to meet VBP LAN targets. As mentioned in section 1.1, we are unsure of what OHA's solution will be in regards to UHA's cost reporting and contracting methodology for our incentive plan. We are looking at potential alternatives in the meantime to help elevate our 2C and above percentage requirements.

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)?

UHA has chosen to implement a blended VBP model for hospital and maternity care. Our sole community hospital's delivery DRG payments are paid under a case rate agreement for maternity services which includes a quality incentive measure associated with it.

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.

This model 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)?

As previously stated in question 6, UHA elected to implement a blended VBP model for hospital and maternity care. Our sole community hospital's delivery DRG payments are paid under a case rate agreement for maternity services which includes a quality incentive measure associated with it.

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.

This model 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)?

UHA provides a PMPM payment with a withhold and quality component to incentivize PCPCH clinics to provide integrated behavioral health care to its members that require access to care for mild to moderate mental illness or substance use diagnoses. Additionally, UHA further expanded our Behavioral Health VBP program in 2022 by increasing access to care through new behavioral health vendors with associated quality measures that meet LAN category 3B or higher.

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.

This model 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)?

UHA has enhanced its existing Dental Care Organization (DCO) model by adding a third quality metric which started in 2024.

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.

This model 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)?

On January 1, 2023, UHA implemented a new incentive payment centered around the children in DHS custody on the health plan. Providers are incentivized to render services that assist in meeting the Assessment for Children in DHS Custody measure. Incentives are paid on a per-service methodology, with an additional bonus payment provided to each provider who assists in successfully delivering all required services for a child in DHS custody.

In addition, UHA has implemented a Complex Chronic PMPM payment model designed to support providers who care for members identified with a Complex Chronic PMCA designation. This payment includes a withhold tied to a quality component, which focuses on care coordination to ensure members receive services that qualify under the social-emotional health metric. UHA recognizes the critical importance of delivering social-emotional care to our younger members, as it contributes to improved health outcomes later in life.

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.

This model 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?**

Behavioral health and specialist measures continue to be difficult to create without being specific to each contracted vendor based on their specialty.

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:

    UHA's PCPCH payments are distinct from other payments made to PCPCH Clinics.

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:

    Baseline PMPM payments are not contingent on meeting any additional requirements.

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.**

UHA continues to engage providers through workgroup meetings and Provider Relations events, maintaining open channels for ongoing feedback and routinely sharing data via our provider portal.

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]:

There are limited behavioral health measures available, and developing new ones has proven challenging. Specialty care measures are also difficult to implement, as they are often highly specific to each provider's specialty. Our goal is to establish plan-wide measures whenever possible, rather than vendor-specific ones.

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)?**

UHA is deeply committed to advancing health equity and actively works to mitigate any adverse effects value-based payment (VBP) models might have on health outcomes for vulnerable populations. In 2024, UHA achieved NCQA Health Equity Accreditation, underscoring our commitment to equity in all aspects of care delivery.

As part of this accreditation process, UHA implemented a formalized approach to conducting disparity analyses on quality metrics within our VBP program. These analyses inform targeted quality improvement initiatives, particularly for disparity-sensitive measures such as Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and Diabetes: HbA1c Poor Control, both of which have been focus areas over the past two years.

UHA disaggregates many VBP metrics by REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) data. In addition to data provided by OHA, we collect updated demographic information directly from members through our Health Risk Assessment and via clinical data feeds. Our Health Information Technology (HIT) incentive, part of the VBP structure, incentivizes providers to collect and submit updated REALD, SOGI, and Social Determinants of Health (SDoH) data for their assigned members.

At a minimum, UHA conducts an annual Cultural Needs and Preferences Analysis, which evaluates both provider and member demographic data. This analysis identifies opportunities to improve alignment between our provider network and the communities we serve. Resulting initiatives may include efforts to recruit and retain a more diverse provider workforce and to expand training in culturally responsive care.

To further support culturally and linguistically appropriate services, UHA offers an additional VBP incentive for clinics that employ Oregon Certified or Qualified interpreters or language-proficient bilingual providers, ensuring meaningful access for members with limited English proficiency.

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.

UHA worked with a third-party actuary to formulate an approach that would risk adjust and weigh providers equitably, considering all aspects of a provider's assigned membership pool (total population size, risk, and extreme outliers).

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

The calculation is beneficial to all parties involved as it weighs all providers fairly.

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.)

We are currently testing a potential total cost of care capitation arrangement with our largest PCP clinics which involves incorporating risk adjustment based on the clinic assigned population.

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?**

UHA uses the following health IT tools to support VBP operations and population health management:

- **UHBI** – Our centralized business intelligence platform and provider portal. It provides access to quality, cost, attribution, and performance data for both internal users and external providers.
- **Tableau Dashboards** –utilized to display real-time VBP performance, gaps in care, and utilization trends.
- **SQL Server** – Used for data transformation, automation of recurring reports, and ad hoc analyses supporting VBP operations.
- **Arcadia** – Used as our care management platform, integrating clinical and claims data to support care coordination, and identification of high-need members.
- **PointClickCare** – Helps care teams collaborate to support their most vulnerable patients and those whose needs cannot be met in any single care setting. Using unique technology, PCC unifies a patient's entire care team including hospitals, primary and specialty care, post-acute care, behavioral health providers, community service organizations, and health plans to collaborate for better patient outcomes. PCC delivers

real-time notifications with insights at the point of care not just to ED physicians, but to the patient's entire care team. Provider offices get notifications for patients with patterns of high utilization or complex needs as soon as they register. Notifications are also sent to other members of the patient's care team, so they can intervene and redirect patients to more appropriate settings for care to avoid misuse of emergency room services.

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

UHA administers VBP arrangements using a centralized, data-driven strategy anchored by our HIT tools. Internally, UHBI offers population- and provider-level views into cost, utilization, and performance metrics, making it easier to track key indicators. Automated SQL Server processes feed these data streams into our Tableau dashboards for real-time visualization.

Since May 2024, we've enhanced our reporting by expanding our Tableau dashboards and increasing the automation of core performance reports. For example, we built the Comprehensive Behavioral Health Plan (CBHP) Metrics dashboard. This dashboard displays behavioral health metrics and underscores our continuous monitoring and improvement efforts in behavioral health services and provider performance. These updates have improved the accuracy and timeliness of our information, streamlined internal workflows for metrics and payments, and expanded our capacity for data-driven decision-making in provider engagement and contract management.

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?

Attribution data is updated in real time on UHBI, our secure provider portal. We use automated reconciliation processes to sync the data against claims and enrollment records, ensuring maximum accuracy. Providers can log in anytime to access the latest, real-time information. Additionally, some providers receive monthly email summaries, and we host collaborative work groups to review and validate the data. This approach ensures that providers have continuous, reliable access to precise patient attribution information.

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

VBP performance measures are provided real time through UHBI. This includes gaps in care, trends, and target benchmarks. Additionally, the platform provides an automated member roster for each clinic's assigned population with member level details, including REALD data elements to assist providers in ensuring they are meeting health equity

requirements. UHA also has the capability to run reports on our raw data through our SQL server, which allows us to construct ad-hoc reporting at providers' request.

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

- UHBI (Provider Portal) – Secure platform for accessing attribution files, quality metrics, assigned member data, and VBP performance data.
- Tableau –Tableau dashboards present quality utilization trends specific to providers
- SQL Server – Supports custom report generation and automates feeds into dashboards and file outputs.

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.

UHA leverages UHBI and claims data to proactively identify members who may benefit from early intervention. We stratify members by analyzing clinical conditions, historical utilization, behavioral health diagnoses, and social risk factors. In 2024, our focus expanded to target gaps in lower-performing measures such as the IET measure for behavioral health. Additionally, we're working to identify performance gaps with providers who self-report their performance, enabling us to pinpoint root causes and continuously improve care delivery. These enhancements help us optimize care coordination and intervention strategies.

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?

Our PCPCHs have access to the provider portal which harbors our incentive program for reviewing raw claims data and overall performance. Providers can see what service type the claims are attributed to, and how a member may directly affect their performance. Additional review is provided upon clinic request.

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: UHBI Provider Portal
Quality performance & gap reports	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☒ Monthly ☐ Quarterly ☒ Other	☒ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool UHBI Provider Portal
Performance reports with numerator/ denominator details	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☐ Monthly ☐ Quarterly ☒ Other	☐ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: UHBI Provider Portal
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: UHBI Provider Portal
Member-level risk score details	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Weekly ☐ Monthly ☐ Quarterly ☒ Other	☐ Excel, static reports ☐ Interactive dashboard ☐ Bidirectional platform Tool: UHBI Provider Portal
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: UHBI Provider Portal

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?

Yes. Providers have secure, real-time access to UHBI, which functions as both our business intelligence platform and provider portal. Through UHBI, they can view a wide range of dynamic scorecards and reports that support VBP success, including metrics at the clinic, plan, and community levels. These tools allow providers to monitor quality performance, track member attribution, review clinical and utilization data, and identify patients needing follow-up. We also offer customized reporting on request and one-on-one support to help providers interpret the data and apply it to their performance goals if needed.

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

UHA has made significant progress in leveraging health IT to strengthen the administration of VBP arrangements and enhance provider support. Key accomplishments include expanding the functionality of UHBI to serve as both an internal analytics engine and a real-time provider portal, improving transparency and ease of access to performance data. We've automated core reporting workflows using SQL and Tableau, significantly reducing manual effort and increasing reporting accuracy and frequency. The integration of care management insights through Arcadia has enhanced our ability to identify at-risk populations and align care coordination efforts with VBP goals.

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

Some measures require a shorter turnaround time to actively engage a member (i.e. the IET measure). While PointClickCare provides some data that providers can use to guide care coordination for members, UHA is often limited in data lag for the entire cohort (e.g. claims data).

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?**

Further clarification and guidance are needed regarding the PAF submission and the VBP requirements, given our contract and incentive structure.

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

Currently, UHA does not require any additional assistance.

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

    Click or tap here to enter text.

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