Cascade Health Alliance

2022 CCO 2.0 Value-Based Payment & Health Information Technology Pre-Interview Questionnaire

Introduction

Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, will be scheduled for June 2022. Please schedule here.

Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the CCO VBP interviews again this year. Similarly, they will be using information collected as part of the larger evaluation effort of the CCO 2.0 VBP Roadmap.

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **Saturday, May 7, 2022**.

All the information provided in Section I is subject to the redaction process prior to public posting. OHA will communicate the deadline for submitting redactions after the VPB interviews have been completed.

Section II of this document describes the oral interview topic areas and suggestions for CCO preparation. CCO responses to oral interview questions will be de-identified in publicly reported evaluation results.

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

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Transformation Analyst, OHA Transformation Center

Section I. Written VBP Interview Questions

Your responses will help the Oregon Health Authority (OHA) better understand your CCO Value-based payment (VBP) activities this year, including detailed information about VBP arrangements and HCP-LAN categories.

A prior version of this questionnaire was collected from your CCO in May 2021. Unless a question specifically instructs otherwise, please focus your responses on new information not previously reported.

1) **In May 2021, you reported the following information about how your CCO engages partners (including providers) in developing, monitoring or evaluating VBP models.**

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

   Annually, CHA meets with its providers that have a value-based payment component as part of their contract to discuss any changes needed for the following year. Changes would include updating the quality measures included in the contract and/or the targets or measurements of success to ensure the appropriate outcomes. These changes are finalized through a contract amendment.

   CHA monitors VBP's throughout the year, creating both dashboards and gap lists. These are shared with providers throughout the year.

   Please note any changes to this information, including any new or modified activities or formal organizational structures such as committees or advisory groups.

   No changes.

2) **Has your CCO taken any new or additional steps since May 2021 to modify existing VBP contracts in response to the COVID-19 public health emergency (PHE)?** ***[Select one]***

☐ CCO modified VBP contracts after May 2021 due to the COVID-19 PHE.
[Proceed to question 3]

☒ CCO did not modify VBP contracts after May 2021 due to the COVID-19 PHE.
[Skip to question 4].

3) If you indicated in Question 2 that you modified VBP contracts after May 2021 in response to the COVID-19 PHE, please respond to a–f:

a) If the CCO modified *primary care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing PMPM)

b) If the CCO modified *behavioral health care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

c) If the CCO modified *hospital* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

d) If the CCO modified *maternity care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

- ☐ Waived performance targets
- ☐ Modified performance targets
- ☐ Waived cost targets
- ☐ Modified cost targets
- ☐ Waived reporting requirements
- ☐ Modified reporting requirements
- ☐ Modified the payment mode (e.g. from FFS to capitation)
- ☐ Modified the payment level or amount (e.g. increasing a PMPM)

e) If the CCO modified *oral health* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

- ☐ Waived performance targets
- ☐ Modified performance targets
- ☐ Waived cost targets
- ☐ Modified cost targets
- ☐ Waived reporting requirements
- ☐ Modified reporting requirements
- ☐ Modified the payment mode (e.g. from FFS to capitation)
- ☐ Modified the payment level or amount (e.g. increasing a PMPM)

The following questions are to better understand your CCO's plan for mitigating adverse effects of VBPs and any modifications to your previously reported strategies. We are interested in plans developed or steps taken since CCOs last reported this information.

4) In May 2021 your CCO reported the following information about processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally based communities; LGBTQ 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).

CHA will use historical cost and quality performance information to set VBP targets. We plan to set the performance targets that trigger an incentive payment at either the CHA target or improvement from the contracted provider's prior year performance using the Minnesota method. This will decrease the likelihood that the VBP will adversely affect any of the specific populations listed above.

CHA has implemented risk adjustment VBP models that will calculate and report documented medical complexity for members assigned to PCPs and members treated by specialists. Providers that care for members with higher documented medical complexity have the potential to receive an increased share of VBPs. Medical complexity is a VBP balancing measure and will decrease the likelihood of VBP adversely affecting members with high medical complexity.

In the future, CHA plans to develop the capacity to measure and track social complexity for members and incorporate social complexity in our VBP methodology.

CHA also monitors the number of members that are "fired" from Providers taking capitation payments by tracking all PCP and Oral Health member assignment changes which includes changes initiated by both the provider and the member. Member-initiated requests are valuable to look for more subtle methods which providers may use to deselect members. CHA also tracks all patient grievances related to providers. Assignment changes and complaints are tracked and in the case of primary care and oral health providers, rates are calculated. Data feedback is reported to providers. If CHA identifies a provider in an outlier status for assignment changes or grievances, CHA will pursue the following interventions as appropriate:

- Provider notification of outlier status
- Ongoing monitoring
- Request for Provider assessment of the root cause
- Request for Provider development of a Corrective Action Plan
- Eventual consideration of financial penalties, exclusion from VBP participation or possibly network participation

Please note any changes to this information since May 2021, including any new or modified activities.

CHA has added a complexity/burden of illness component of its VBP model for behavioral health providers.

5) Is your CCO planning to incorporate risk adjustment for social factors in the design of new VBP models, or in the refinement of existing VBP models? [Note: OHA does not require CCOs to do so.]

CHA is planning to incorporate risk adjustment for social factors in the refinement of existing VBP models. This is not anticipated until more complete data is available.

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements that will take effect in 2023 or later. This includes oral health and children's health care areas. CCOs are required to implement a new or enhanced VBP in <u>one</u> of these areas by 2023. CCOs must implement a new or enhanced VBP model in the remaining area by 2024.

6) **Describe your CCO's plans for developing VBP arrangements specifically for <u>oral health care</u> payments.**
    a. **What steps have you taken to develop VBP models for this care delivery area?**

        CHA currently has 3 VBP programs impacting oral health care.

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

        CHA's currently VBP models for oral health care include
        1. One focused on primary care dentists that includes capitation, a quality incentive, and an access measure
        2. One incentivizing delivery of preventive dental services in primary care
        3. One incentivizing delivery of preventive dental services in community settings

    c. **When do you intend to implement this VBP model?**

        This is currently implemented.

7) **Describe your CCO's plans for developing VBP arrangements specifically for <u>children's health care</u> payments.**
    a. What steps have you taken to develop VBP models for this care delivery area?

        CHA currently has a mature VBP model for children's health care.

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

The VBP model for children's healthcare providers incorporates

1. Capitated payment methodology
2. Performance on OHA incentivized metrics
3. Percent of members seen each year
4. Upside and downside risk based on plan utilization
5. Medical complexity

c. When do you intend to implement this VBP model?

This is currently implemented.

8) CCOs will be required in 2023 to make 20% of payments to providers in arrangements classified as HCP-LAN category 3B or higher (i.e. downside risk arrangements). Describe the steps your CCO is taking in 2022 to prepare to meet this requirement.

This requirement is already met for in 2022.

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

9) What TA can OHA provide that would support your CCO's achievement of CCO 2.0 VBP requirements?

Sharing of VBP best practices for specialists and hospitals.

10) Aside from TA, what else could support your achievement of CCO 2.0 VBP requirements?

Aggregated CCO utilization data that can be analyzed by provider type, service type and diagnosis.

Health Information Technology (HIT) for VBP and Population Health Management

Questions in this section were previously included in the CCO HIT Roadmap questionnaire and relate to your CCO's HIT capabilities for the purposes of supporting VBP and population management. Please focus responses on new information since your last HIT Roadmap submission on March 15, 2021.

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

11) You previously provided the following information about the HIT tools your CCO uses for VBP and population management including:

a. HIT tool(s) to manage data and assess performance

- **SQL Server and Quantum Choice Plexis:** CHA utilizes SQL Server and run regular queries to produce the population health management and VBP details we need to disseminate internally and with contracted providers and major clinics. This reporting includes all attributed provider gap lists and current progress status towards VBP agreements.
- **Tableau:** Utilized for visualization of Provider Dashboards.
- **Reliance eHealth Collaborative:** CHA has built full capabilities internally to produce OHA quality measure reporting for progress and gap list reporting. CHA also utilizes Reliance as a validation tool for quality measure performance tracking. CHA has also been working with Reliance since 2020 to populate all claims & EHR measure data as well. This duplication between CHA and Reliance has enhanced the quality of this measure reporting.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

None.

b. Analytics tool(s) and types of reports you generate routinely

- **Milliman PRM Analytics:** Population Management tool to assist in risk stratification for leadership and CM assignment for intervention and care plans. This is a predictive model platform that ingests CHA claims monthly and applies patented algorithm logic models from PRM Analytics. Reports are generated through the user interface based on cohorts built within the tool.
- **Pareto Intelligence:** Currently, CHA utilizes provider scorecards to generate insights on providers' performance across multiple dimensions and inform the

actions providers should take to improve clinical performance. This tool also generates suspected and captured chronic condition reporting for each attributed provider. Elements of these current scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.
- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

- **Collective Medical:** CM utilizes alert notifications, cohorts, flags, and reporting tools to assist in care coordination efforts, complex needs, and population health management.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

In 2021 CHA receives the Clinic Network Engagement Metrics report from Collective Medical that shows utilization metrics for the clinics in our network. This report is utilized to track adoption and target education for clinics not currently engaged in Collective Medical. In 2022 CHA is continuing to financially support the Collective Medical EDie Insights tool for the provider network.

12) You previously provided the following information about your staffing model for VBP and population management analytics, including use of in-house staff, contractors or a combination of these positions who can write and run reports and help others understand the data.

CHA currently has a department (Business Intelligence) dedicated to support writing, running reports, maintain databases and network, and assisting staff with understanding data to include: (2) Data Analysts, (1) Database Administrator, (1) IT Systems Administrator, and (1) Director of Decision Support & Business Intelligence. These team members also support administration of platforms listed above related to reporting for VBP and Population Health Management. This department also utilizes Pareto Intelligence as a 3rd party consultant for producing additional data analysis reports regarding VBP arrangements and population health management.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

In 2021 CHA made some adjustments to the in-house staff regarding reporting and data analytics. The Director of Decision Support & Business Intelligence was promoted to Chief Operations Officer (COO), a Data Analyst was promoted to Business Intelligence Manager. Now reporting directly to Chief Financial Officer. There are still (2) Data Analyst and (1)

Database Administrator. The IT Systems Administrator was moved to Operations department and reports directly to the COO.

Questions in this section relate to your CCO's plans for using HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models).

13) You previously provided the following information about your <u>strategies</u> for using HIT to administer VBP arrangements. This question included:

a. how you will ensure you have the necessary HIT to scale your VBP arrangements rapidly over the course of the contract,

b. spread VBP to different care settings, and

c. include plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.

Pareto Intelligence: Along with risk adjustment performance data, CHA currently utilizes provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. CHA plans to expand the report to include additional insights and combine quality metric gaps by Q1 2022. This tool also generates suspected and captured chronic condition reporting for each attributed provider. By Q4 2024 CHA plans to integrate these Provider Scorecards and chronic condition reports within a Provider Portal for real-time access for attributed providers. Elements of these current scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.
- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

Tableau & SQL Server: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards (described above) with quality metric and VBP results to attributed providers.

CHA's current VBP agreements include some OHA quality measures and other alternative local community focused incentives. By 2023 CHA intends to expand these local community focused incentives VBP to include local needs within the Klamath Falls community related to SDOH/HE.

Please note any changes or updates for each section since your HIT Roadmap was previously submitted March 15, 2021.

a. how you will ensure you have the necessary HIT to scale your VBP arrangements rapidly over the course of the contract,

No changes anticipated.

b. spread VBP to different care settings, and

No changes anticipated.

c. include plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.

No changes anticipated.

14) You reported the following information about your <u>specific activities and milestones</u> related to using HIT to administer VBP arrangements.

For this question, please modify your previous response, using black font to easily identify updates from your previous HIT Roadmap submission on March 15, 2021. If the field below is blank, please provide specific milestones from your previous HIT Roadmap submission.

Pareto Intelligence: Along with risk adjustment performance data, CHA currently utilizes provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. CHA plans to expand the report to include additional insights and combine quality metric gaps by Q1 2022. This tool also generates suspected and captured chronic condition reporting for each attributed provider. By Q4 2024 CHA plans to integrate these Provider Scorecards and chronic condition reports within a Provider Portal for real-time access for attributed providers. Elements of these current scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
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- Condition prevalence.
- Members with captured conditions.
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Tableau & SQL Server: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards (described above) with quality metric and VBP results to attributed providers.

CHA's current VBP agreements include some OHA quality measures and other alternative local community focused incentives. By 2023 CHA intends to expand these local community focused incentives VBP to include local needs within the Klamath Falls community related to SDOH/HE.

Briefly summarize updates to the section above.

Tableau & SQL Server: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards with quality metric and VBP results to attributed providers. By Q4 2024 CHA plans to integrate Provider Risk Scorecards and chronic condition reports within a Provider Portal for real-time access for attributed providers. In 2022 CHA expanded the reporting to include additional insights and combined quality metric gap opportunities.

In 2021, CHA continued to use Pareto Intelligence, Tableau, and SQL Server to administer VBP arrangements and reporting.

In early 2021, Tableau dashboards with VBP metrics and quality metrics were finalized and shared with attributed providers.

Working in partnership with Pareto Intelligence, the combined report for risk adjustment related chronic conditions and quality metric gaps was developed as expected by Q1 2022.

15) You provided the following information about <u>successes or accomplishments</u> related to using HIT to administer VBP arrangements.

Pareto Intelligence: CHA utilized this tool in 2020 to produce Specialist Risk Adjustment reporting with attribution logic based on services provided to a member in that year. By Q4 2024 CHA plans to integrate these reports with a Provider Portal for real-time access.

Tableau & SQL Server: In 2020 CHA successfully implemented an in-house solution for creating Oral and Medical Health reporting dashboards in 2020 (described above) with quality metric and VBP results to attributed providers.

In 2020 CHA conducted a Quality Metrics monthly meeting with Primary Care Physicians (PCP) to discuss the overall performance along with barriers or concerns, shared successes, and best practices. CHA was able to utilize in-house capabilities for generating the Quality Metrics Dashboard visualization and gap lists. CHA was also successful in conducting a BH Metrics monthly meeting facilitated by the CHA CM & BH Director.

Please note any changes or updates to these successes and accomplishments since your HIT Roadmap was previously submitted March 15, 2021.

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16) You also provided the following information about <u>challenges</u> related to using HIT to administer VBP arrangements.

COVID-19 related activities and extra work/guidelines/safety procedures for providers and clinics.

Please note any changes or updates to these challenges since your HIT Roadmap was previously submitted March 15, 2021.

Click or tap here to enter text.

Questions in this section relate to your CCO's plans for using HIT to support providers.

17) You previously reported the following information about your <u>strategies, activities and milestones</u> for using HIT to effectively support provider participation in VBP arrangements. This included how your CCO ensures:

a. **Providers receive timely (e.g., at least quarterly) information on measures used in the VBP arrangements applicable to their contracts.**
b. **Providers receive accurate and consistent information on patient attribution.**
c. **If applicable, include specific HIT tools used to deliver information to providers.**

Tableau: CHA has created a specific visualization, Oral and Physical Health Metrics Dashboards monthly that includes VBP in the contracted provider agreements. By Q4 2023 CHA plans to utilize Tableau Server to provide web-based real-time access for Quality Measure and VBP agreements progress and results across all provider types. In 2020 CHA disseminated this information via secure emails with attributed providers.

Pareto Intelligence: Along with risk adjustment performance data, Pareto produces attributed Provider Scorecards described above and updated monthly and disseminated by Compliance and Provider Network Management department on a regular basis (min. Quarterly) via secure email. CHA also utilizes this tool in 2020 to produce Specialist Risk Adjustment reporting with attribution logic based on services provided to a member in that year. These results are disseminated on an annual basis since members are not assigned to a Specialist.

The above reporting includes monthly actionable services gap lists sent by secure email that includes updated member attribution and current eligibility for each provider. Specialist attribution is based on annual progress reports of attribution logic for members who received services by the Specialist provider in that year.

Please note any changes or updates to your strategies since your HIT Roadmap was previously submitted March 15, 2021.

a. Providers receive timely (e.g., at least quarterly) information on measures used in the VBP arrangements applicable to their contracts.

Change in responsibility for disseminating reports from Compliance to Risk Adjustment.
In 2022 CHA expanded the reporting from Pareto to include additional insights and combined quality metric gap opportunities.

b. Providers receive accurate and consistent information on patient attribution.

Not included in previous submission, oral health and physical health providers are sent updated full member rosters weekly with change reports sent daily.

c. If applicable, include specific HIT tools used to deliver information to providers.

No changes

18) You previously reported the following information about how your CCO <u>uses</u> 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.

SQL Server and Quantum Choice Plexis: CHA has an internal Data Analyst team that utilizes SQL Server and run regular queries to produce the Population Health Management details we need to disseminate internally and with contracted providers and major clinics. This reporting includes all attributed provider gap lists. Additional Population Health Management reporting is available to identify specific members in need of intervention based on historical data and services available within submitted claims in Plexis.

Milliman PRM Analytics: Population Health Management tool to assist in risk stratification for leadership and CM assignment for intervention and care plans. This is a predictive model platform that ingests CHA claims monthly and applies patented algorithm logic models from PRM Analytics. Reports are generated through the user interface based on cohorts and specific data points built within the tool.

Accessmobile: In 2020 CHA completed multiple campaigns for targeted cohort text messaging for Population Health Management efforts that included: Health-Related Goals, Improving Health Literacy, Flu-Shot Education, Breast Cancer Screening, Colorectal Cancer Screening, Medical Supply Delivery, Breathing Issues, Child/Adolescent Immunizations, Telehealth, Available Benefits, PPE Distribution, Stress, Community Information Exchange, SDOH/HE Surveys, and Behavioral Health Needs.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

Accessmobile is now InOn Health.
In 2022, we are working on a pilot project with Pareto Intelligence and an additional analytics vendor to deploy predictive data models to measure/identify social risk across member populations.
Not included in previous submission:
Collective Medical: Collective Medical is utilized daily by CHA CM department to monitor cohorts built in Collective Medical, and service utilization by members with open cases to coordinate care, ensure member needs are being met, and reduce unnecessary use of services.
Reliance: Reliance eHealth is used by CHA to integrate the disparate information from multiple EHRs used within our service area. CHA pulls data from Reliance to validate and supplement EHR metric reporting. CHA's Business Intelligence department uses Reliance to help supplement member demographic information in reports sent to providers and partners, as well as reports used internally.

19) You previously reported the following information about how your CCO <u>shares</u> 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.

Pareto Intelligence: Attributed Provider Scorecards described above are updated monthly and disseminated by Compliance and Provider Network Management department on a regular basis (min. Quarterly) via secure email. There are occasions prior to the current COVID pandemic when Provider Network Management department would meet in-person to discuss current progress with an attributed provider and discuss intervention needs and how CHA can assist when necessary. During these times of provider intervention CHA may produce additional reports for Population Health Management to enhance the identification necessary interventions for those members in need of services.

Provider Network Management department conducts dissemination and collaboration at least quarterly for Physical and Oral Health Dashboards (described above), with attribution identification within gap lists for targeted provider intervention to assist in improving outcomes. CHA is currently researching technology solutions for enhancing sharing data related to VBP arrangements and Population Health Management. CHA plans to have a new HIT solution in place by Q4 2023. This solution will give providers a single web-based location with the most current data available produced by CHA and/or other data resources.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

In 2022, we are working on a pilot project with Pareto Intelligence and an additional analytics vendor to deploy predictive data models to measure/identify social risk across member populations.

20) You previously reported the following information about your <u>accomplishments and successes</u> related to using HIT to support providers.

Tableau: In 2020 CHA successfully created new Physical and Oral Health Dashboards and disseminated to attributed providers at least quarterly.

Pareto Intelligence: in 2020 CHA successfully created new Provider Risk Adjustment Scorecards for the provider and clinic level with all attributed members to include details on suspected and captured chronic conditions and other risk related details. CHA also successfully created Behavioral Health scorecards and chronic conditions reporting for the (2) major clinics with VBP arrangements for members seen in the last year.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

No new changes

21) You previously reported the following information about your <u>challenges</u> related to using HIT to support providers.

N/A

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

Click or tap here to enter text.

<u>Optional</u>
These optional questions will help OHA prioritize our interview time.

22) Are there specific topics related to your CCO's VBP efforts that you would like to cover during the interview? If so, what topics?

None

23) Do you have any suggestions for improving the collection of this information in subsequent years? If so, what changes would you recommend?

None. It was very helpful to have last year's responses included and only require reporting of changes.

Part II. Oral Interview

This information will help your CCO prepare for your VBP interview.
Written responses are <u>not</u> required.

Purpose

The purpose of the CCO 2.0 VBP interviews is to expand on the information CCOs report and have provided in the written questionnaire; provide CCOs an opportunity to share challenges and successes; and discuss technical assistance needs. OHSU staff will ask these questions of all CCOs, tailoring the questions to each CCO based on written interview responses.

Format

Oral interviews will be conducted via a video conference platform (such as Zoom) and will be recorded, transcribed and de-identified for further analysis. Analysis may include overarching themes and similarities or differences in how CCOs are engaging in VBP-related work. OHA may publicly report de-identified and aggregated results next year. Before we begin, participants will have an opportunity to ask about the interview format. CCOs are encouraged to send questions to OHA *prior to* the interview, as discussion time will be limited.

Interview topics

Questions topics will include your CCO's VBP activities and milestones in 2021, any early successes or challenges encountered in this work so far, and how your CCO's plans for future years are taking shape. Questions will cover four primary areas:

1) Provider engagement and CCO progress toward VBP targets. These questions will explore what has been easy and difficult about your CCO's VBP efforts so far, recognizing that each CCO operates within a unique context that must be considered when designing new payment arrangements. We may ask questions about your perception of provider readiness for or receptivity to VBP arrangements, factors affecting your progress toward VBP targets for future years (including overall VBP participation as well as downside risk arrangements), and how to make OHA technical assistance most relevant to your needs.

2) Implementation of VBP models required in 2022. These questions will address how your CCO is making decisions about and designing required VBP models. We may ask about factors influencing the design and scale of your PCPCH infrastructure payment model and models to meet the Care Delivery Area requirements. These questions may address your experience designing quality strategies in hospital, maternity and behavioral health VBP arrangements; and your progress developing HIT capabilities with providers to implement these VBP arrangements. We are particularly interested in understanding CCOs' experiences promoting VBP arrangements with a) various hospital reporting groups (DRG, A/B, etc.), b) behavioral health providers operating independently

as well as in integrated primary care settings, and c) maternity care providers reimbursed in standalone as well as bundled payment arrangements.

3) Planning and design of VBP models required in 2023 or later. These questions will follow-up on information you provide about your progress developing VBP arrangements in children's health and oral health. We may ask about factors influencing your planning in these areas, perceived provider readiness, and assistance needed from OHA.

4) Promoting health equity through VBP models. These questions will explore how your CCO's work on health equity relates to your VBP efforts. We may ask about your CCO's progress with collecting social needs data; how health equity informs your VBP planning in specific areas such as maternity care; and whether you have identified opportunities to use VBPs to address other CCO 2.0 priorities or requirements.