2023 CCO 2.0 Value-Based Payment (VBP) & Health Information Technology Pre-Interview Questionnaire

Introduction

As described in Exhibit H, Section 6, Paragraph b of the 2023 contract, each Coordinated Care Organization (CCO) is required to complete this VBP Pre-Interview Questionnaire prior to its interview with the Oregon Health Authority (OHA) about VBPs.

OHA's interviews with each CCO's leadership will be scheduled for June 2023. 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.

Instructions

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **May 5, 2023**.

All the information provided in Section I is subject to redaction 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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Part I. Written VBP Pre-Interview Questions

Your responses will help OHA better understand your CCO's value-based payment (VBP) activities for 2023, including detailed information about VBP arrangements and HCP-LAN categories. A prior version of this questionnaire was collected from your CCO in May 2021 and 2022. Some questions will request an update on previously submitted information, which will be provided.

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

1) **In 2023, CCOs are required to make 60% of payments to providers in contracts that include an HCP-LAN category 2C or higher VBP arrangement. Describe the steps your CCO has taken to meet this requirement.**

   Cascade Health Alliance has had greater than 60% of payments to providers that include an HCP-LAN category 2C or higher VBP arrangement for several years. This includes capitation contracts for both primary care and dental as well as shared risk contracts for primary care, dental, mental health, hospital, and specialists.

2) **In 2023, CCOs are required 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 has taken to meet this requirement.**

   As noted above, Cascade Health Alliance has in place capitation contracts and shared risk contracts for a large part of its network and met this requirement in 2022 and will do so in 2023 as well.

3) **a. 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

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

   This model is under contract with the local hospital and includes four components—
   1. Upside and downside risk sharing

2. Achieving an early elective delivery rate of less than or equal to target.
3. Reduction of the congestive heart failure all cause readmission rate
4. Improved performance on the initiation component of the OHA Initiation and Engagement in Treatment measure

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

NA

4) a. 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

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

This model targets the local hospital and obstetric patients. It is focused on elective delivery rates and has a target rate of less than 5%.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

NA

5) a. 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

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

This model is contracted with our largest behavioral health clinics and includes—
1. Upside and downside risk sharing

2. Achievement of a benchmark or improvement from the prior year's performance based on members receiving a qualifying follow up behavioral health service within 30 days of an initial evaluation.
3. Achieving a targeted Assertive Community Treatment Score or Wraparound Fidelity Index.
4. Provision of services qualifying for the OHA Initiation and Engagement Measure

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

The portion based on the OHA Initiation and Engagement Measure is currently being added to provider contracts.

6) a. 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

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

This model is with all our contracted primary care dental (PCD) providers and includes—
1. Capitated payment for PCD services
2. Upside and downside risk sharing
3. Performance Payment based on performance on OHA dental quality measures
4. Performance Payment based on percentage of members seen of the average assigned panel size during the year
5. Payment for the reporting of Health Information Technology information

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

The portion based on OHA Quality Metrics is currently being added to provider contracts.

7) a. 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

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

This model is contracted with pediatric primary care providers (PCP) and includes—
1. Capitated payment for PCP services retrospectively adjusted based on acuity
2. Upside and downside risk sharing
3. Performance Payment based on performance on OHA PCP quality measures
4. Performance Payment based on percentage of members seen of the average assigned panel size during the year and aligned to the acuity of the member

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

The portion based on OHA Quality Metrics currently being added to contracts.

8) a. Does your CCO still have in place any VBP contract modifications to reporting or performance targets that were introduced during the COVID-19 public health emergency?

☐ Yes, our CCO's VBP contracts retain COVID-19 modifications.
☒ No, all our CCO's VBP contacts are back to pre-pandemic reporting and targets.

b. If yes, describe which modifications are still in effect, including provider categories and types of reporting or performance target that remain modified.

NA

These questions address your CCO's work engaging with providers and other partners in developing, managing, and monitoring VBP arrangements.

9) In May 2021 and 2022, you reported the following information about how your CCO engages partners (including providers) in developing, monitoring or evaluating VBP models.

2021: 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.

2022: No changes

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

CHA is adding more specific information describing the distribution of OHA quality pool funds to provider contracts in 2023.

10) 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 [optional]:

Click or tap here to enter text.

11) Have you had any providers withdraw from VBP arrangements since May 2022?

☐ Yes
☒ No

If yes, please describe:

NA

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 your CCO last reported this information.

12) In May 2021 and 2022, 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; 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).

2021: 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

2022: CHA has added a complexity/burden of illness component of its VBP model for behavioral health providers.

Please note any changes to this information since May 2022, including any new or modified activities.

CHA has begun to collect member level data for HER metrics, including REALD data. Analysis of performance on each metric related to REALD is performed quarterly and shared with providers. Phase one of the Health Equity Dashboards will be implemented and include REALD data as it relates to top chronic diseases for our population.

13) **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.]

Not at this time.

Questions in this section were previously included in the CCO Health Information Technology (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 submission.

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

14) **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**

2021:

- **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

2022: None

Please note any changes or updates to this information since May 2022:

None

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

2021:

- **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.

2022: 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.

Please note any changes or updates to this information since May 2022:

In 2023 CHA is in current development of a new population management tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. CHA anticipates full transition completed by Q4 2023. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks and machine learning capabilities. With this implementation, CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

15) 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.

2021: 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.

2022: 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.

Please note any changes or updates to this information since May 2022:

The current Business Intelligence department is made up of the Business Intelligence Manager, two Senior Data Analysts and one Data Analyst. This department continues to report directly to the CFO.

16) 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. **Plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.**

2021: 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

2022:

a. No changes expected
b. No changes expected
c. No changes expected

Please note any changes or updates for each section since May 2022.

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

No changes expected

b. How you will spread VBP to different care settings.

No changes expected

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

In 2023 CHA is in current development of a new population management analytics tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. CHA

anticipates full transition completed by Q4 2023. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks, and machine learning capabilities. With this implementation, CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

17) 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 underlined text to add updates and strikethrough formatting to delete content from your previous responses from May of 2021 and 2022. If the field below is blank, please provide updates on specific milestones from your 2021 HIT Roadmap submission.

2021: 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

2022: **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.

Briefly summarize updates to the section above:

In 2023 CHA is in current development of a new population management analytics tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. CHA anticipates full transition completed by Q4 2023. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks and machine learning capabilities. With this implementation, CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

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

2021: 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.

2022: N/A

Please note any changes or updates to these successes and accomplishments since May of 2022.

No changes

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

2021: COVID-19 related activities and extra work/guidelines/safety procedures for providers and clinics.
2022: N/A

Please note any changes or updates to these challenges since May of 2022.

NA

20) 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.**

2021: **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.

2022:

a. 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. Not included in previous submission, oral health and physical health providers are sent updated full member rosters weekly with change reports sent daily.
c. No changes

Please note any changes or updates to your strategies since May of 2022.

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

Not included in the previous submissions, however, behavioral health providers are also sent VBP metrics performance information monthly.

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

No changes

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

No changes

How frequently does your CCO share population health data with providers?

☐ Real-time/continuously
☐ At least monthly
☒ At least quarterly
☐ Less than quarterly
☐ CCO does not share population health data with providers

21) 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.

2021: 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

2022: 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.

Please note any changes or updates to this information since May 2022.

In 2023 CHA is in current development of a new population management analytics tool upgrade and transition from Milliman's PRM Analytics to MedInsight platform. CHA anticipates full transition completed by Q4 2023. The new platform will include enhanced reporting capabilities with advanced query tools and assist in future VBP arrangement adjustments. The new platform provides additional industry leading groupers, methodologies, benchmarks and machine learning capabilities. With this implementation, CHA anticipates a deeper understanding of the member population and the providers services that impact their overall health.

22) 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.

2021: 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

2022: 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.

Please note any changes or updates to this information since May 2022.

No changes

23) Estimate the percentage of VBP-related performance reporting to providers that is shared through each of the following methods:

Estimated percentage	Reporting method
100%	Excel or other static reports
	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
	Shared bidirectional platform (example: Arcadia) that integrates electronic health record data from providers with CCO administrative data.
	Other method(s): Click or tap here to enter text.
[Total percentages should sum to 100%]	

How might this look different for primary care vs. other types of providers (hospital care, behavioral health care, maternity care, oral health care, children's health care)?

No difference between provider groups.

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

2021:

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

2022: No new changes

Please note any changes or updates to this information since May 2022.

No changes

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

2021: N/A
2022: N/A

Please note any changes or updates to this information since May 2022.

NA

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

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

The current VBP learning collaboratives have been helpful.

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

Click or tap here to enter text.

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

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

Click or tap here to enter text.

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

Click or tap here to enter text.

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

Question topics will include your CCO's VBP activities and milestones in 2022, 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 three 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, and how to make OHA technical assistance most relevant to your needs.

2) Implementation of VBP models required in 2022 and 2023. 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, behavioral health, oral health, and children's health VBP arrangements, as well as your progress developing HIT capabilities with providers to implement these VBP arrangements.

3) 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.