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:

Karolyn Campbell, Ph.D. (she/her)
Transformation Technical Analyst, OHA Transformation Center
karolyn.campbell@oha.oregon.gov

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.**

   The existing models that are in place today achieve the current VBP targets for 2023. EOCCO will continue its shared savings model, capitation, hospital, maternity, behavioral health CDAs and implement a fourth CDA for oral health. EOCCO will continue to offer VBP models to additional clinics as needed.

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.**

   EOCCO's shared risk model which includes total cost of care risk sharing agreement, four CDAs, episode based capitation and quality performance payment for primary care practices meets this requirement for 2023. EOCCO will continue to measure these percentages and modify models as needed to achieve the VBP targets.

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)?

EOCCO implemented this model in 2022 and made a slight modification to the readmit measure to base the bonus on how well the hospital performs against a target calculated from their own case mix. There were no changes to the LAN tier, affected provider types or overall measure description.

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

N/A, Hospital CDA is under contract.

4) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the maternity care delivery area requirement?** (mark one)

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

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)?

EOCCO implemented this measure in 2022 to focus on improving maternity care with OBGYNs. Once this CDA is evaluated in 2023, EOCCO may make additional modifications.

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

N/A Maternity Care CDA is under contract

5) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the behavioral health 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)?

Ensure that CMHP's for outpatient mental health and outpatient SUD place an emphasis on access to care. Other quality measures are aligned to help meet EOCCO incentive measures.

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

N/A, CDA is under contract

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 CDA was implemented on 1/1/2023 to focus on providing quality interpreter services for members who have limited English proficiency and Deaf and hard of hearing. This creates an emphasis on members receiving quality communication, language access services and culturally responsive care.

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

N/A this CDA is recently under contract as of 1/1/2023.

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: EOCCO's workgroup will begin evaluating options for a 2024 children's health CDA in the coming months.

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)?

TBD

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

EOCCO's workgroup will begin discussing this CDA in the coming months and will have this CDA implemented for 1/1/2024.

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 of 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.

N/A

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:
EOCCO has an internal VBP workgroup that creates VBPs and engages the quality measure subcommittee of its board to develop, monitor and evaluate VBP models. The subcommittee is made up of hospital, primary care, behavioral health, and public health representatives across EOCCO's geography. EOCCO also discusses VBP models with its Clinical Advisory Panel (CAP) and its contracted providers taking their input and suggestions into consideration when developing new or modifying existing VBP models.

Any changes or modifications to VBP models or implementation of new VBP models are taken to the EOCCO Board of Directors for approval.

2022:
Due to the strain of the pandemic on the delivery system, EOCCO did not engage the subcommittee made up of hospital, primary care, behavioral health, and public health representatives across EOCCO's geography. EOCCO will continue to evaluate and may engage the quality measure subcommittee in the future.

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

There are no significant changes to EOCCO's formal committee or advisory groups. For 2023 VBP models, EOCCO will continue to engage its workgroup to create and provide recommendations on existing VBP models, engage the Clinical Advisory Panel, clinical consultant, and its Board of Directors to review, provide feedback and approval VBP changes.

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]:

Sometimes the measures to choose from are limited and we want to be thoughtful of the additional work that is required to meet the measures when providers are already feeling the impact of other required reporting or initiatives.

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

☒ Yes
☐ No

If yes, please describe:

There were two providers and this was due to a small volume of claims. There is not a significant impact on EOCCO meeting its targets for 2023 or 2024.

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:
EOCCO has strategies in place for addressing health equity, which help ensure that VBPs do not have adverse effects on any underserved population.

These include strategies targeting both processes and outcomes.

Examples of process strategies include the following:

1. EOCCO reviews cost and utilization data on a bi-annual basis that includes race, ethnicity, and language data.
2. EOCCO's Diversity Equity and Inclusion Committee analyzes languages spoken to ensure that there is alignment with languages provided and quality of interpreters on a bi-annual basis.

To measure outcomes, EOCCO uses a 'health equity index' to quantify disparities in utilization. This index is based on comparing the age-adjusted utilization levels of certain indicator services (such as PCP office visits) by population. Due to the low number of members in certain groups and the low utilization counts for certain services (e.g. back surgeries for non-English-speaking Asian members), the index is based on a basket of higher-volume services for which a sufficient volume of data exists to achieve credibility. Initial findings of the health equity index suggest that primary care VBPs might be correlated with a reduction in health inequity, perhaps due to the significant focus on member outreach across the entire EOCCO population to achieve quality measures.

EOCCO provides clinics with monthly quality reports and member rosters that include demographic and language data. EOCCO is currently working on collecting more comprehensive REALD data through Arcadia Analytics, our population health management tool, as well as the Accountable Health Communities (AHC) grant project.

The EOCCO Quality Improvement Team stratifies incentive measures by race, ethnicity, language, disability, and other demographic data to identify disparities in care or health

outcomes. The team will then implement targeted interventions to address the identified disparities.

2022:

EOCCO collected updated REALD data through the Accountable Health Communities (AHC) Grant project. A team of students at OHSU conducted SDoH screening calls with EOCCO members and collected updated REALD data. Updated REALD data is vital for EOCCO to mitigate adverse effects VBPs may have on health inequities. EOCCO was able to integrate this data into its Data Warehouse to include in its provider reporting package that is described in the response above and in more detail in question 11.b.

Additionally, EOCCO is in the process of implementing the Unite Us platform across our 12-county service-area which will help all health care and community-based organization send and receive referrals for social needs. In addition to this, EOCCO will receive SDoH data on its population which will further assist us in addressing the complex needs of our member populations. EOCCO is considering how best to integrate this data into its reporting package as well.

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

EOCCO has fully implemented the Unite Us platform across our 12-county service area. Traditional Health Workers and our partnership with the Accountable Health Communities Grant Project are championing the efforts to screen members and collect SDoH data on the EOCCO population.

While data is being collected and entered into our data warehouse, data validation process discovery has started, to ensure accurate data across multiple data sources. EOCCO's enterprise project management team is building workflows and a hierarchy to ensure a process to resolved data inconsistencies. We anticipate the discovery phase running through Q3 2023.

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.]

EOCCO values the impact that social factors play in a member's health outcomes. While EOCCO does not have immediate plans to incorporate risk adjustment for social factors in the design of new VBP models, we will continue to evaluate this option in the future.

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:
EOCCO utilizes the Arcadia Analytics Population Health Management tool to manage data and assess performance on VBP measures. Arcadia Analytics is a health information exchange (HIE) platform that integrates EHR data with pharmacy, medical, behavioral, and oral health claims as well as EOCCO eligibility files to create a single patient record to be shared across the exchange. The platform provides a quality performance dashboard, care gap lists, condition history, utilization history, upcoming appointments, medications, problem lists, demographics, provider attribution, and risk scores.

2022:
EOCCO has three new healthcare systems live on the Arcadia platform since March 15, 2021, and one that is in the initial phases of onboarding. EOCCO also plans to utilize the Arcadia Analytics platform to measure performance on the Plan All-Cause Readmission measure that's part of one of our new care delivery areas.

Since the previous year's submission, EOCCO has implemented VBP arrangements with its contracted community mental health programs (CMHPs) utilizing a different measure set than what is used under EOCCO's primary care agreements. In addition to Arcadia Analytics, EOCCO is currently utilizing the Collective Medical platform to track performance on multiple behavioral health metrics used in the VBP arrangements with CMHPs. Care coordinators within the CMHPs, and at the CCO, are using Collective Medical to track ED and acute care utilization for our members with behavioral health diagnoses, coordinate follow-up visits, and review progress on readmission targets under the behavioral health VBP arrangements.

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

Since March 2021, EOCCO has onboarded one new clinic to the Arcadia platform. No other additions have been made to our VBP capabilities.

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

2021:

EOCCO's Analytics team provides an electronic monthly reporting package through a provider reports portal for all primary care clinics who have assigned members and participate in EOCCO's VBP arrangements. In addition, we provide quarterly reporting to hospitals and specialty care groups who participate in shared savings/shared risk VBP arrangements. The available reports and frequency are outlined below.

Report	Description	Use Cases	Frequency
Member Roster	A complete list of all assigned members for which a VBP applies, plus risk stratification, diagnosis history, recent utilization, assigned PCP, and contact information.	Identification of members most likely to benefit from PCP outreach Outreach to high-risk members who utilize the ED and/or are admitted Connect members to primary care	Monthly
Quality and Care Gap Report	Performance statistics on all quality measures that are part of VBPs administered by EOCCO. Also includes list of potential care gaps.	Outreach to members with a care gap Track clinic performance toward quality bonuses	Monthly
Pharmacy Opportunity Report	Specific evidence-based pharmacy management opportunities for all VBP members, such as low medication adherence, low-cost (generic) drug alternatives, polypharmacy, and high-risk opioid prescribing.	Discuss potential opportunities with patients, to: • Lower patient expense • Increase adherence • Reduce opioid risk Manage pharmacy spend to increase shared risk or total cost of care bonus	Monthly
ER-IP Notification Report	Frequent updates on any member admitted for an inpatient stay or to a hospital emergency department.	Follow up with members to ensure continuity of care Manage ED/IP to increase shared risk or total cost of care bonus	Weekly

EOCCO Shared Risk Report	For participating EOCCO providers, shows the amount of shared risk / shared savings bonus accrued under the EOCCO shared risk/shared savings model.	Track performance on cost of care and estimated bonus	Quarterly
Primary Care Scorecard	For participating EOCCO primary care providers, shows a variety of cost and utilization statistics for their assigned population.	Compare clinic performance to peer group and benchmarks; analyze utilization and referral patterns	No less than Quarterly
Behavioral Health VBP Progress Report	Performance statistics on all behavioral health quality measures that are part of VBPs with contracted CMHPs.	Aid in coordination of care for members eligible for / seeking Medication Assisted Treatment Outreach to members to coordinate outpatient treatment and reduce readmissions to ED and acute care Track clinic performance toward quality bonuses	Quarterly

2022:
The only changes since March 15, 2021, are: 1) the frequency of the ER-IP notification report has changed to weekly; 2) the Primary Care Scorecard has recently been developed and is in the final stages of review and testing; and 3) The addition of the Behavioral Health VBP Progress Report.

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

EOCCO has deployed the Primary Care Scorecard. The update had been made in the table above.

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:
EOCCO has two distinct teams who provide support for VBP and population management analytics. First, EOCCO has an in-house analytics team who produces, maintains, and

distributes reports. This team has a deep knowledge and experience in health care data and VBP reporting through the use of analytics tools such as SAS, Tableau, and Power BI. The analytics team uses a robust data warehouse that is built on SQL Server technology, updated daily, which includes all medical, pharmacy, vision, dental, behavioral health, enrollment, and demographic data needed to support VBP administration.

The analytics team produces and maintains the recurring reports described above, often adjusting the content or design based on provider feedback, to make sure the data is as clear and actionable as possible. In addition, the team responds to various provider and internal EOCCO requests for data and analysis. For example, some providers have detailed questions about ow they can succeed under their VBPs, and some additional ad hoc analysis on their specific member panel is often helpful.

Additionally, EOCCO has a quality improvement team who communicates regularly with the provider network regarding VBP arrangements and population health management. This team serves as data translators between the analytics team and the clinic staff in EOCCO's provider network. The quality improvement team reviews the monthly reports with clinic staff, identifies opportunities for improvement, works to integrate workflows that may impact their quality performance, and discusses additional resources available to them. Lastly, EOCCO's quality improvement team works with Arcadia Analytics and providers who are onboarded to ensure that data is being captured accurately and transmitted correctly. This includes validating information, working as a liaison when there are issues, and providing technical assistance when providers need to make workflow updates in their EHR.

2022:
One minor clarification to EOCCO's staffing model for VBP and population management analytics, EOCCO always collects feedback on proposed VBP changes and enhancements from our Clinical Advisory Panel and our clinical consultant who is an MD.

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

No changes to staffing models to report in 2023.

16) You previously provided the following information about your strategies 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:
EOCCO has had advanced VBP arrangements for several years, with most primary care practices already converted to HCP-LAN category 4A reimbursement methodologies. In

addition, a shared savings/shared risk (3B) model captures most other spending, including prescription drugs. EOCCO maintains robust HIT infrastructure for administering these arrangements which will prepare us to scale our VBP arrangements over the course of the contract with OHA. This includes, for example:

1. Arcadia HIE platform enabling providers to identify and close care gaps, to improve performance on quality measure VBPs
2. Robust analytics and reporting infrastructure capable of producing customized VBP reports for each participating provider in an automated way
3. Monthly automated VBP and care gap reports accessible to all providers, even those not connected to Arcadia
4. Provider reports platform through which participating providers can browse and access information on their own VBP performance, in a secure manner
5. Member assignment processes to accurately connect members to PCPs, which is the foundation of most VBPs
6. Dedicated VBP analytics team, which can track and report on all aspects of EOCCO's VBPs – for example calculating the percent of payments that are in the form of a VBP as required throughout the contract.

EOCCO is committed to investing in additional HIT solutions across care delivery areas as needed.

2022:

a. EOCCO has an HIT Committee with representatives from physical health, behavioral health, and oral health partners. The Committee discusses necessary HIT expansion to meet the needs of our provider networks as well as our contract requirements such as VBP expansion. Additionally, EOCCO established a VBP workgroup in Q3 2021 with a primary focus on VBP expansion where HIT needs are regularly evaluated.

b. EOCCO is continually working on expanding HIT for VBP to support different care settings and integrate additional data sources. Since March 2021, EOCCO has expanded the Arcadia Analytics platform to its Behavioral Health providers and is currently in the process of onboarding two of EOCCO's largest Community Mental Health Programs (CMHP). Additionally, EOCCO incorporated dental claims data into the Arcadia Analytics platform and is exploring the idea of connecting dental EHR data from one of its integrated primary care practices. This is innovative work that has never been done before at Arcadia.

c. EOCCO is still committed to investing in additional HIT solutions across care delivery areas as needed or expanding its current HIT tools. Examples of this are listed in section b.

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 update to the 2021 and 2022 responses.

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

In 2023, EOCCO implemented a new Dental Care CDA, meaningful access to culturally responsive healthcare. EOCCO is working with provider on the data collection and sharing of this measure, since the reporting of this measure is extremely manual.

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:

No update to the 2021 and 2022 responses.

17) You reported the following information about your specific activities and milestones 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:

HIT to Administer VBP Strategy 1 - Use HIT to inform how EOCCO develops new VBP models: Throughout 2021 EOCCO will be working with our provider partners to implement the three new care delivery areas including hospital care, maternity care, children's health care, behavioral health care, and oral health care over the next four years. This includes the reporting necessary to inform and ultimately administer these new VBP arrangements. EOCCO will select measures from the HPQMC aligned measure set for each category. These measures will be integrated into the current reporting systems including Arcadia Analytics and EOCCO's internal data warehouse to be included in current/future reporting packages. Currently, EOCCO is working on implementing a behavioral health integration VBP arrangement with integrated primary care practices. EOCCO will incorporate quality performance metrics and reporting requirements into this arrangement.

Milestones:

By 12/31/2022, implement behavioral health integration VBP arrangement with 4 integrated primary care practices and collect VBP quality data using Arcadia Analytics and standardized reporting mechanisms.

This milestone is complete, EOCCO executed a behavioral health integration arrangement with 10 integrated primary care practices and developed an attestation process for reporting. EOCCO will also utilize Arcadia Analytics to measure performance on screening based VBP measures such as SBIRT and Depression Screening.

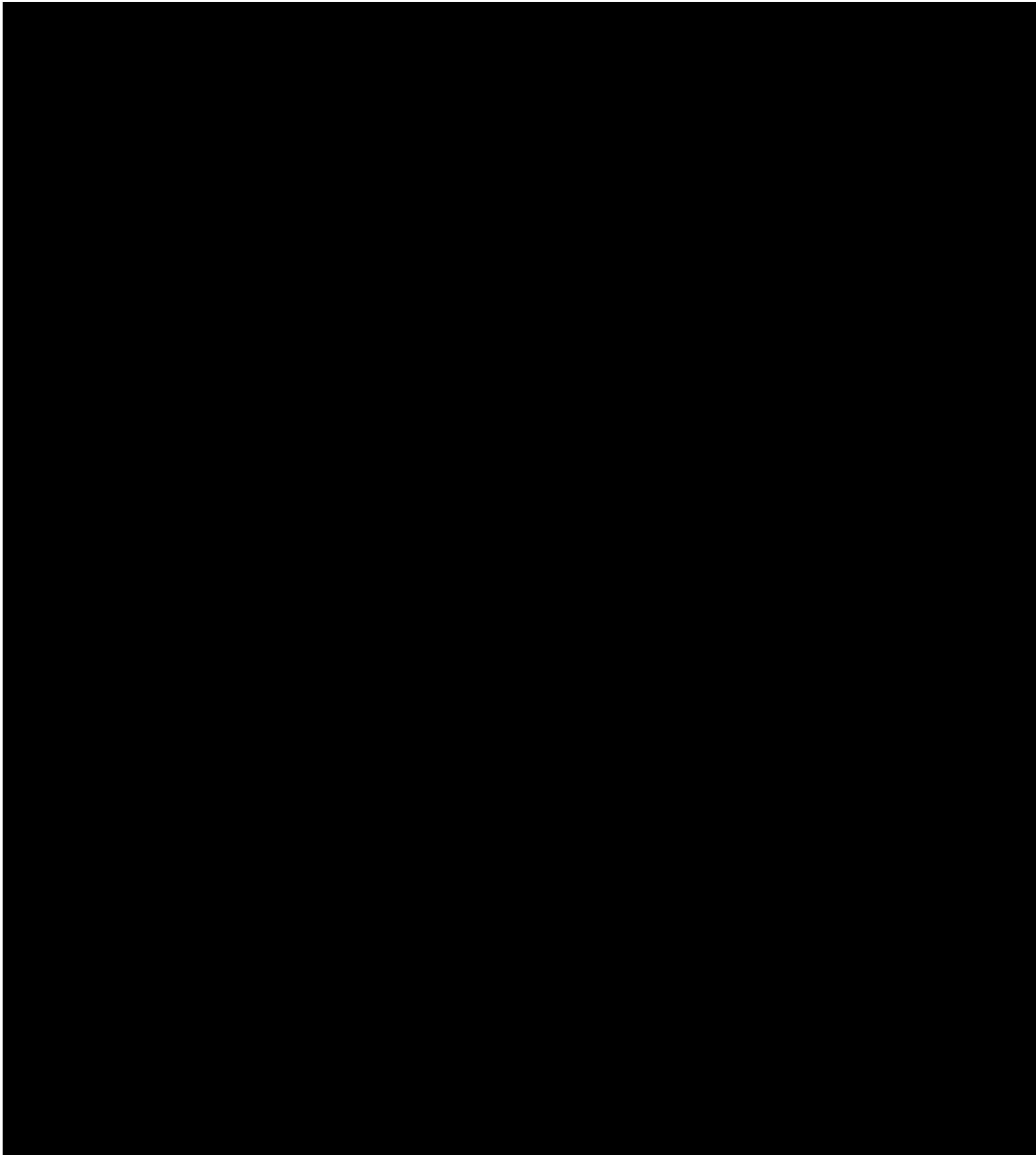
By 12/31/2022, design and implement an Oral health care CDA, effective 01/01/2023 and incorporate into EOCCO's reporting packages.
New milestone added. EOCCO will utilize the established VBP workgroup to design and implement this CDA.
Milestone complete as of 1/1/2023,

By 12/31/2023, design and implement a Children's health care CDA, effective 01/01/2024 and incorporate into EOCCO's reporting packages.
New milestone added. EOCCO will utilize the established VBP workgroup to design and implement this CDA.
Milestone is in progress for implementation in 2024.

By 12/31/2024, EOCCO will integrate the metrics outlined in the new VBP arrangements for hospital, maternity, and behavioral health into Arcadia Analytics and EOCCO's internal reporting packages.
EOCCO is working with Arcadia to integrate the new Plan All-Cause Readmission measure into the platform for the new hospital care delivery area. EOCCO established a separate tracking process for the maternity care delivery area using Smartsheet.

HIT to Administer VBP Strategy 2 - Onboard additional EOCCO primary care practices to the Arcadia Analytics platform:
EOCCO currently has 12 large clinics systems onboarded with Arcadia Analytics, this makes up approximately 57% of EOCCO's membership. EOCCO plans to onboard additional clinic systems over the course of the next four years as outlined in the table below to get to 80% membership representation by 2024. This will provide opportunities for reporting on quality measures outlined in the primary care VBP arrangements as well as future arrangements including a behavioral health integration model that is under development.

Milestones:
By 12/31/2024, onboard four additional primary care practices to Arcadia Analytics to achieve goal of 80% membership representation in the platform.
This milestone is in progress.

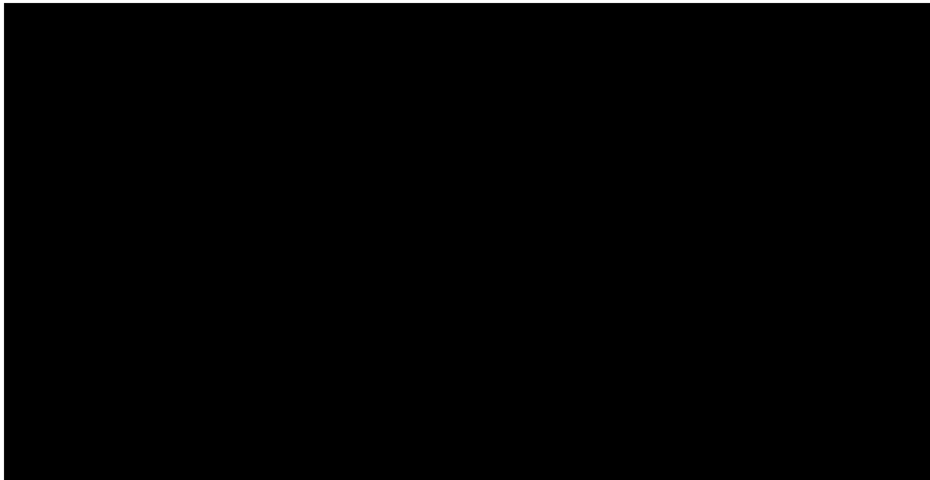


HIT to Administer VBP Strategy 3 - Onboard Community Mental Health practices and utilize the platform to administer VBP arrangements:

This will provide further opportunities for care coordination and improve the HIT tool. Additionally, EOCCO will be able to utilize Arcadia Analytics to calculate performance on behavioral health metrics and initiatives using integrated EHR and claims data to establish VBP arrangements.

Milestones:

By 3/30/2022, onboard all contracted CMHPs to Arcadia Analytics. This milestone is in progress, EOCCO has held meetings with HIT leads at each of the CMHPs to coordinate onboarding to Arcadia. The updated goal date for this milestone is 3/31/2023.
By 12/31/2022, implement VBP arrangements with CMHPs tied to behavioral health metrics tracked through Arcadia Analytics. This milestone is in the initial phase. The updated goal for this milestone is 3/31/2023.
By 6/31/2023, the below goals are updated. VBP arrangements with CMHPs were implemented into contracts for 2022 and CMHPs are able to track 3 out of the 5 measures through both Arcadia Analytics and Collective Medical if they are connected to those platforms.



Over the past few years, EOCCO has worked to enhance the Arcadia Analytics tool in order to meet VBP requirements. This includes the addition of dental claims data, behavioral health claims data, new quality metrics, and a data extract to integrate into EOCCO's data warehouse. EOCCO also works with clinics who change EHRs and have to reconnect to the Arcadia Analytics platform. EOCCO is prepared to change its HIT solution if needed to administer VBP arrangements for the remainder of its contract with OHA.

2022:

EOCCO successfully onboarded three new Primary Care Practices (PCP) to the Arcadia Analytics platform and one CMHP. EOCCO is currently in the process of onboarding one more PCP and two additional CMHPs.

New milestones have been added to account for EOCCO's work related to the Oral health care and Children's health care CDA's.

EOCCO has worked diligently throughout 2021 to provide technical support to our contracted CMHPs in connecting to the Arcadia Analytics platform, though many have

experienced a number of unforeseen business challenges in adopting this HIE technology. EHR transitions, CMHP county contract transitions, and technical workforce shortages / transitions have all been challenges to CMHP adoption of the Arcadia Analytics platform. As such, EOCCO have adjusted targets for implementation with some of these CMHPs to provide additional technical support and give CMHPs the time needed to work through these complexities. Despite these challenges,

Additional updates to question #14 are noted throughout the response in black font

2023:
EOCCO has made notable strides in expanding the Arcadia Analytics platform by onboarding two additional CMHPs in 2022, with plans underway to onboard all remaining CMHPs this calendar year. So, despite the number of agencies captured in this effort being small, the impact on expanding the connections for our members is significant. Similar to the challenges described in previous updates, EOCCO's contracted CMHPs experienced a number of difficulties in platform adoption including ongoing technical workforce shortages/transitions, administrative burden felt from additional statewide BH initiatives, as well as incidences of internal software / EHR transitions.

EOCCO was able to implement VBP arrangements into contracts with all of the region's CMHPs in 2022. We hope that the implementation of the behavioral health VBP program will add additional incentive for adoption of Arcadia Analytics as a means of tracking performance on incentive measures in the program by the remaining CMHPs.

Briefly summarize updates to the section above:
EOCCO has onboarded a new physical health clinic in April 2022 and has increased the percent of members connected to Arcadia from 47% to 57%.

One additional CMHP on boarded in 2022 and one additional CMHP is currently in process and almost finished. Once completed, three CMHPs covering 7 of the 12 counties of EOCCO and 71% of members will be connected to Arcadia.

Click or tap here to enter text.

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

2021:
Due to the pandemic, EOCCO had to adjust its VBP arrangement specifically related to quality. In alignment with OHA, EOCCO released quality pool funds to the delivery system early which meant that we couldn't include quality components for 2020. EOCCO distributed partial payments based on 2019 performance in which EOCCO utilized Arcadia Analytics to calculate EHR based quality measures for the connected clinics.

EOCCO implemented a reporting bonus using quality funds to incentivize clinics to report on the EHR based quality measures for 2020. Many clinics who are connected to Arcadia Analytics plan to report that way. EOCCO will extract numerator, denominator, exclusion, and exception data from the platform on behalf of the clinics for calendar year 2020.

2022:
EOCCO is holding clinics accountable for quality measure performance through the clinical quality bonus formula in our shared savings model for 2021. Many clinics who are connected to Arcadia Analytics report clinical data using the HIT tool. EOCCO extracted numerator, denominator, exclusion, and exception data from the platform on behalf of the clinics for calendar year 2021.

While progress in this area has been slow, behavioral health clinical data remains a top priority for the CCO's ongoing HIE development efforts supporting VBPs and developing infrastructure to ensure the safe, secure, sharing of this data is paramount.

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

EOCCO continues to use Arcadia Analytics to report performance for the clinical quality bonus formula that is housed within our shared savings model for 2022.

EOCCO has onboarded additional clinics to the Arcadia Analytics platform, one being a public health department and the rest in the behavioral health space. These typically are more challenging providers to the onboard.

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

2021:
EOCCO has a large provider network with clinics of varying sizes that each utilize different EHR vendors. EOCCO currently has 13 different EHR vendors in our service area. This makes it challenging to onboard every clinic with a Health Information Exchange platform such as Arcadia Analytics

2022:

The above challenges remain the same.

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

In 2023, the challenges remain the same, as it relates to administration of VBP arrangements.

20) You previously reported the following information about your strategies, activities and milestones 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:
EOCCO provides monthly reports to all primary care providers and quarterly reports to all other providers who participate in VBP arrangements. These reports include, for example:

1. Year to date performance data on VBPs, such as current numerators/denominators of quality measures and cost vs. budget for shared savings/shared risk models
2. Care gap data on specific members that providers can use to improve VBP performance
3. Specific action items that providers can use to improve chronic condition management, such as highlighting members with low medication adherence
4. Identification of members most likely to benefit from PCP outreach to improve performance on quality and total cost of care targets – such as high-risk members with a history of ED/Inpatient utilization but no primary care connection
5. Member attribution lists to help providers understand the specific patient population they will be measured on, including warning flags for chronic conditions, care gaps, high utilization, demographic data, etc.

For the IET quality measure, we are in beta testing of a weekly report showing members in urgent need of drug/alcohol treatment, which is intended to help providers improve performance on that measure. The EOCCO quality team will conduct outreach to providers on a weekly basis to encourage utilization of the report.

Support for Providers with VBP Strategy 1: Providers utilize the monthly reports regularly to outreach to members and track clinic performance toward quality bonus

payments. EOCCO plans to implement enhancements and improvements to the existing reports as well as integrate additional clinical data into existing HIT tools.

Milestones:
By 8/31/21, roll out a package of enhancements to existing reporting, such as identification of some care gaps on clinical measures that can be determined from claims, even for providers who have not yet been submitting clinical data.
By 12/31/21, integrate EHR data from data sharing agreements and Arcadia extract.
By 12/31/23, integrate ALERT data into the Arcadia Analytics tool to view more comprehensive gap lists for immunization measures included in VBP arrangements.

Additionally, the providers outlined in the table in Question 14 have access to Arcadia Analytics which provides real time data on quality measure performance for all claims, EHR, and hybrid quality measures. Clinic staff can view gap lists, prepare for upcoming visits, and compare performance by provider. The tool also includes a full patient registry with condition history, risk scores, and cost saving data. The pre-visit planning report allows providers to prepare for upcoming appointments by viewing risk and condition gaps, quality gaps, recent utilization, and recent medication fills. The milestones for increased onboarding and support for providers is also outlined in Question 14.

EOCCO provides monthly member rosters to providers that includes a complete list of all assigned members for which a VBP applies, plus risk stratification, diagnosis history, recent utilization, assigned PCP, and contact information. In addition, the reports show a summary of all credentialled PCPs at each clinic, so that clinics can have complete visibility into the results of member attribution processes and notify EOCCO of any problems. EOCCO also sends patient attribution and provider hierarchy data files to Arcadia on a monthly basis.

Support for Providers with VBP Strategy 2:

Milestone:
By 8/31/21, EOCCO will implement a patient attribution audit process that evaluates utilization to ensure that the patient is assigned to the provider that they are seeking care from. This will then get updated in the member roster report that is available on a monthly basis.

2022:

In March 2021, the Analytics department began generating weekly reports documenting all EOCCO members that entered the denominator for the Initiation & Engagement in Substance Use Disorder Treatment (IET) incentive measure. The Quality Improvement Specialist uses these reports to update a shared Smartsheet tracking document with the newly diagnosed members each week. The Quality team also created a small IET workgroup with members of the GOBHI Substance Use Disorder (SUD) team. This

workgroup uses the Analytics report and the Smartsheet tracking system to perform outreach to primary care clinics and behavioral health providers whose assigned patients have entered this measure.

Minor formatting and logic updates have been made to the weekly Analytics report over the past year to streamline the data. The Analytics team is currently working to update the weekly reports to align with the 2022 statewide IET measure specifications. These updates include revising the continuous enrollment criteria, expanding the negative diagnosis history period, and adding a negative medication history component.

a. EOCCO still provides monthly information and performance on measures in our VBP arrangements via its reporting package. Some of the milestones outlined above in the Support for Providers with VBP Strategy 1 section have been accomplished. In the past year, a significant amount of clinical data has been incorporated into the reports, along with claims data. For example, blood pressure and HbA1c test results are now used to calculate providers' performance on quality measures, for providers who submit clinical data directly to EOCCO. For providers who provide their clinical data via the Arcadia platform, the process for integrating that data into the reports is nearing completion and we hope it will be complete by 9/30/22. Additionally, EOCCO clinics who are onboarded to Arcadia have access to performance measure data that is updated daily. EOCCO has engaged in initial conversations with Arcadia about integrating ALERT data into the platform for the immunization measures as well. The timeline for that milestone remains the same.

   Additionally, EOCCO has begun providing quarterly Behavioral Health VBP Progress Reports to its contracted CMHPs to support behavioral health VBP arrangements. These reports include:
   1. Year to date performance data on behavioral health VBPs, such as current numerators/denominators of quality measures.
   2. Results of timely access reporting requirements.
   3. Member attribution and care coordination gaps related to the 5 measures included in the behavioral health VBP arrangements.

b. PCPs still receive accurate and consistent information on patient attribution through their monthly member rosters. EOCCO also implemented a PCP assignment reconciliation process that evaluates utilization data on a monthly basis to ensure that the patient is assigned to the provider that they are seeking care from. This then gets updated in the clinic's member roster. Therefore, the milestone outlined above for Support for Providers with VBP Strategy 2 has been completed.

   Under EOCCO's behavioral health VBP arrangements with contracted CMHPs, patient attribution is assigned by county of benefit and sourced from CCO enrollment data. As part of quarterly Behavioral Health VBP Progress Reports,

providers receive lists detailing member attribution for each of the 5 reporting measures

c. Our HIT tools haven't changed since our previous submission.

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.

2023: Reports are now being delivered quarterly to Behavioral Health providers. No other updates to the 2022 response.

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

No updates to the 2022 response.

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

N/A

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:
Support for Providers with VBP Strategy 3: EOCCO utilizes a CCO level quality performance report to monitor performance towards VBP measures. EOCCO's analytics team produces a quarterly cost and utilization report that informs targeted inventions, for example the implementation of a primary care utilization roster. EOCCO also utilizes Arcadia Analytics for population management to view complete gap lists for all EOCCO members represented in the platform (57%) for each quality measure. This data includes demographic

information, risk score, risk percentage, and open risk categories as well as provider and appointment information. Additionally, we have access to COVID-19 risk outreach lists to inform targeted interventions in response to the pandemic. EOCCO plans to develop a full member roster and complete gap list within the CCO level quality performance reports that includes all EOCCO members, not just those represented in Arcadia Analytics.

Milestone:
By 12/31/21, integrate a full member roster and full gap list of all EOCCO members for the EOCCO quality team to utilize to identify patients/populations who need interventions.

Support for Providers with VBP Strategy 4: EOCCO's data infrastructure has enabled staff to carry out analytics functions focused on health equity, such as: compiling and analyzing our membership's linguistic preferences and ethnic/racial backgrounds estimating service needs relative to current membership demographic profiles, anticipating preventive, specialty, and critical care needs and developing dashboards with the disaggregation of metrics by key demographic identifiers, such as race and ethnicity. EOCCO's quality team is working on analyzing incentive measure data using REAL D (race/ethnicity, language, and disability) stratifications as well as gender, age, county/zip code, primary care provider, and service utilization patterns to find overarching trends in data. Once trends are identified, EOCCO's quality team will develop novel targeted interventions that address the health disparities.

Milestones:
By 12/31/21, identify a health disparity among one of the incentive measures using internal data infrastructure and Arcadia Analytics.

By 12/31/22, implement a targeted intervention that addresses the disparity and improves health outcomes.

2022:
EOCCO's Analytics team successfully integrated a full member roster and full gap list of all EOCCO members for the EOCCO quality team to utilize to identify patients/populations who need interventions. Therefore, the milestone outlined in Support for Providers with VBP Strategy 3 has been completed.

The milestones outlined in Support for Providers with VBP Strategy 4 have been delayed. In 2021, EOCCO has realigned our focus to collect updated demographic information to fill the gaps in missing or incomplete demographic information prior to stratifying measures. During a yearend review of non-compliant members, EOCCO identified a moderate rate of Hispanic/Spanish speaking members who have not completed their childhood or adolescent immunization series. This has prompted the need to address vaccine hesitancy in a culturally relevant format. EOCCO is also in the process of creating a Spanish Resource Guide, which will provide members with direct access to services such as interpretation,

transportation, and assistance with medical, dental, and behavioral health services. While the initial version of this guide will provide support to operational services, future versions will include member education on topics such as addressing vaccine hesitancy or managing chronic conditions.

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

EOCCO has implemented components of the Spanish Resource Guide and will continue to deploy the full strategy in 2023.

The milestones outlined in Support for Providers with VBP Strategy 4 have been delayed. EOCCO is working on a discovery project to ensure data from multiple sources are able to be validated, to ensure the most accurate and up-to-date data.

22) You previously reported the following information about how your CCO shares 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:
The monthly member rosters that EOCCO's analytics team provides to all clinics who participate in VBP arrangements includes risk stratification data. Providers are able to use this data to outreach to high-risk members. Additionally, the quality and care gap reports provide care gap lists for the majority of the quality measures to assist with population management.

Arcadia Analytics provides data on risk stratification to the onboarded EOCCO clinic systems. The risk scores are calculated using the HCC algorithm. Providers are also able to view a full risk and condition gap list that are weighted based on severity so providers can prioritize and target interventions to improve health outcomes.

Support for Providers with VBP Strategy 5: Some EOCCO clinics have expressed interest in implementing a more interactive risk module where they are able to dismiss certain conditions that may be included in a given risk score. This would help them prioritize which conditions to focus on and which are weighted higher in the risk calculation.

Milestone:
By 12/31/23 EOCCO will explore additional risk module solutions to share interactive risk data on EOCCO members with providers.

2022:
EOCCO has been working with Arcadia to enable a risk module for clinics to be able to view interactive risk data on EOCCO members. We plan to implement this over the next few months.

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

EOCCO has implemented the risk module solution that shares interactive risk data on EOCCO members with providers. Internally, we are working with our actuarial team to see how to utilize and integrate the data into provider reports.

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

Estimated percentage	Reporting method
80%	Excel or other static reports
0%	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
20%	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.
[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)?

EOCCO is continuing to explore how to integrate data from the oral health care space. In collaboration with our DCO partners, we are looking to solutions for data integration outside of sharing of excel documents.

In the EOCCO service area, many of the spaces are incorporated within the health systems that report data. For example, children's health care, for the large part, is incorporated into primary care.

Behavioral health is continuing to onboard providers to Arcadia, which assists in the integration of data on members.

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

2021:

EOCCO has provided monthly quality and care gap reports for years however, they were recently redesigned to include more pertinent information and data points centered around

VBP models. This milestone was completed in Q3 2020, and the access was streamlined to a centralized portal.

EOCCO has worked with four clinics systems to improve workflow mapping for two specific VBP quality measures in the Arcadia Analytics portal over the course of 2020. This included many meetings with the clinics, Arcadia Analytics, EOCCO staff, and the EHR vendors. EOCCO has also worked to optimize data resources within the Arcadia Analytics tool to assist with VBP arrangements such as dental claims data, behavioral health claims data, and improved backend EHR data collection.

Most clinic systems who participate in the VBP arrangements are engaged and actively use the HIT and population health resources that EOCCO provides however, there are a handful of clinics who are less engaged due to leadership decisions. One clinic system in particular has declined to participate in our VBP arrangement in the past but in 2020 we were able to get them involved, this was a huge success as they hold a large portion of our membership.

2022:
EOCCO was able to onboard three additional primary care practices to Arcadia and is beginning implementation with one additional practice. This is a huge accomplishment for EOCCO after not onboarding any new practices over the past two years. Overall, clinics seem to be more engaged with Arcadia and EOCCO was able to host a joint training with all onboarded practices to increase engagement overall.

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

EOCCO integrated one new clinic in December 2022. This accomplishment was a first for EOCCO, and it was a County Health Department. We are looking forward to seeing how we can continue to support and use health department data collected through the platform. Additionally, health departments throughout the EOCCO region and statewide have been slower to adopt HIT solutions. We are optimistic about this partnership.

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

2021:
Integrating all of the data sources into one platform has always been a challenge. We are very fortunate to have a robust analytics team and data warehouse to create our own in-house reporting packages. However, we don't have access to every clinic's EHR data therefore there are gaps in reporting capabilities. When it comes to implementing HIT tools such as Arcadia Analytics, the platform isn't particularly useful to clinics who don't have a large portion of our membership or who have less advanced EHRs that are unable to integrate with the tool. We also run into barriers with clinic or hospital systems that have parent companies out of state. There is often pushback to utilize the HIT tools

that EOCCO provides. We have worked really hard to address these barriers and will continue to do so throughout the next four years.

2022:
The sharing of mental health and substance use disorder clinical data across our provider network has proved to be a particularly challenging effort to work through, especially in the rural and frontier communities of Eastern Oregon. EOCCO has concentrated efforts in 2021 and 2022 on expanding the use of Arcadia Analytics to contracted CMHPs across the region, which all face a different set of challenges to supporting HIE technologies comparative to larger hospital and primary care settings. Ensuring compliance to 42 CFR Part 2 and HIPAA data sharing requirements, working with smaller behavioral health EHR vendors, and providing HIE technical assistance to CMHPs have all required more care and FTE than originally assumed in the 2020 HIT Roadmap. EOCCO continues to make significant progress in this area but acknowledges that the unique resources challenges facing the state's behavioral health network can decelerate adoption and use of HIE platforms.

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

EOCCO, in partnership with the delivery system, has experienced challenges with the language access measure. Providers are expressing the difficulty in being able to record and report data on the use of Oregon certified and qualified interpreters. These challenges include the lack of knowledge from their EHR vendors related to the measure as well as having a field to record this within their system. The ability to report on this measure has been reported by providers as a manual process. EOCCO will continue to provide support to providers to help identify solutions and ease reporting requirements.

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?

Not at this time.

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

Not at this time.

Optional
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 not 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.