2020 CCO 2.0 VBP Interview Questionnaire and Guide

August 24, 2020

Introduction

As noted in the July 7 CCO Weekly Update, the contractually required Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, were rescheduled for the week of September 14. Please see Appendix A for the interview schedule. Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the interviews and using information collected as part of a larger evaluation effort of the CCO 2.0 VBP Roadmap.

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **Friday, September 4, 2020**. Submissions should be approximately 10–15 pages and should not exceed 15 pages.

All the information provided in Section I will be shared publicly.

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.

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

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Health Share of Oregon VBP Written Interview Questions

1) **Describe how your CCO engages stakeholders, including providers, in developing, monitoring or evaluating VBP models. If your approach has involved formal organizational structures such as committees or advisory groups, please describe them here.**

Health Share holds subcontracts with four Integrated Delivery Systems (IDS) and an Integrated Community Network (ICN) to deliver the full range of OHP services to Medicaid recipients. These contracts entail full-risk arrangements with sub-contractors and include quality incentives to support continuous quality improvement and on-going focus on the needs of special populations.

Integrated Delivery Systems are integrated delivery and finance systems comprising integrated inpatient, specialist and outpatient networks, while the Integrated Community Network holds contracts for a broad primary care and specialty provider network. The ICN also oversees network processes for dental, behavioral health and NEMT services on behalf of the IDS partners. This arrangement necessitates a significant amount of collaboration, coordination and shared decision making to ensure alignment around common goals.

Health Share has redesigned its organizational governance and engagement structure to better meet the requirements of CCO 2.0, including improvements on performance in quality metrics, investment in SDoH and Health Related Services, achieving HIT Roadmap objectives and meeting VBP thresholds. The intent of this structure is to align stakeholders within Health Share's delegated accountability model around significant transformation efforts in those and other areas in accordance with OHA's CCO contract.

The primary governance bodies responsible for VBP activities include Health Share's full Board of Directors, and Board Subcommittees including the Board Governance and Operational Excellence Committee, Finance Committee and Quality Health Outcomes Committee. Hitting OHA's VBP thresholds across the CCO's network will depend on operational and policy-level accountability, financial reporting and resource allocation, and intentional monitoring of quality performance. Each of these Board Committees also sponsors a Member Advisory Committee, uniquely charged with engaging Health Share IDS, ICN, County, and Provider partners in joint decision making and collaboration toward Board and OHA priorities, including VBP. Health Share's Clinical Advisory Panel is also responsible for recommending and supporting implementation of payment models and new VBP arrangements that reflect integration priorities and to into account the complexity of models of optimized care delivery including care coordination and coordination with community-based services.

Health Share's VBP arrangements are embedded in the core subcontracts mentioned above and in downstream subcontractor arrangements, driven by contract requirements that they engage in VBP development and implementation. Direct subcontracts with the

IDSs in Health Shares network qualify as LAN 4C as they include full population risk at the delivery system level and are inclusive of quality metrics with incentives based on performance. This represents 44% of Health Share's assigned membership.

In the Integrated Community Network, provider stakeholders are directly engaged in the design, implementation, and evaluation of VBP models through the ICN Advisory Committee, the Clinical Workgroup, and the Behavioral Health Workgroup. A focus is placed in development payment models that support shared goals of improving member access, experience, and outcomes with reducing unnecessary administrative burden by providers. Particular attention has been paid to aligning payment models and reporting structures with other external reporting requirements (e.g. PCPCH, FQHC reporting).

2) **Has your CCO taken steps in 2020 to <u>modify existing VBP contracts in response to the COVID-19 outbreak</u>?** ***[Select one]***

☐ ***CCO did not modify any existing VBP contracts in response to the COVID-19 outbreak. [Skip to question 5].***

☐ ***CCO modified all existing VBP contracts due to the COVID-19 outbreak, and we used the same rationale and process for all modifications. [Proceed to question 3]***

☐ ***CCO modified all existing VBP contracts due to the COVID-19 outbreak, but we used different rationales and processes for some modifications. [Skip to question 4]***

☒ ***CCO modified some, but not all, existing VBP contracts due to the COVID-19 outbreak. [Skip to question 4]***

3) **<u>If you indicated in Question 2</u> that you modified all existing VBP contracts under a single rationale and process, please respond to a–c:**

A) Describe the rationale for modifying existing VBP contracts in 2020.

B) Describe the process you used for modifying VBP contracts, including your key activities, stakeholder engagement and timeline.

C) Describe the payment model/s you have revised (or are revising) this year, including LAN category, payment model characteristics, and implementation date/s.

4) **<u>If you indicated in Question 2</u> that you made modifications to some (but not all) existing VBP contracts, or that your rationale and process varied by VBP model, please respond to d–g:**

D) Among the existing VBP contracts that have been modified due to COVID-19, which payment models included the largest number of members? Describe your rationale for modifying this existing VBP model in 2020.

IDS Subcontracts

The CCO's year 1 VBP arrangements are based on full-risk contracts with the five IDS and ICN subcontractors, inclusive of risk-based rewards for performance on OHA's incentive measures. The cancellation of OHA's metrics program included providing CCOs with withhold payments beginning in April of 2020. This required revision of/expediting creation of the CCO's incentive measure policy to more quickly distribute funds.

In a normal year, the CCO works through its Board structure to design an equitable and fairly administered process to distribute funds based on performance improvement. As the 2020 funds were released early, prior to performance totals being available, payments for Q2-Q4 (or the length of the withhold suspension) were decoupled from quality and distributed based on proportion of revenue to each IDS/ICN. This was done to ensure that these important funds would flow to the delivery systems, supporting providers during uncertain clinical and economic circumstances.

The core ICS and ICN contracts have not been modified, only the proposed payment approach—dictated through policy—used to embed quality incentive payments in these larger risk sharing arrangements. Payments still flow from the CCO to each of these IDS/ICN contracts on a PMPM basis and include full-risk across all benefit types. Payments for the monthly quality withhold have been distributed routinely following receipt of these funds from OHA.

ICN Subcontracts

For downstream provider VBP arrangements in the ICN, a similar strategy was followed, including continuing to require providers to do reporting but to hold them harmless for meeting outcomes while the pandemic emergency is ongoing. This approach acknowledges the reality of the situation and ensures providers don't dramatically lose cash-flow during a time when it is most needed.

Within the ICN contract, several key subcontracts were modified including:

- **Primary Care Payment Model (PCPM) program**: as detailed in the RFA, an alternate payment program that aims to support PCPCHs in building capacity for population health management and reward clinics that achieve high quality performance across multiple care areas.
    - Continued pursuit by PCP's to work on some of the quality measures and Targets contained in the model were counterintuitive to behaviors and practices desired by the population to counter the spread of COVID-19. This was especially prevalent with those in the preventive care and patient outreach areas.
    - PCP resources were strained and it was felt that requiring reporting of data was an unnecessary administrative burden particularly since the expected data results would be unfavorable as a result of the stay at home practices put in place during the middle of the reporting period.
    - The visit modality needs changed through a shift from in office to telehealth, so resources needed to quickly refocus on meeting that

challenge, both for payors and PCP clinics as providers. This wasn't a key element of the program at the time.

- **Integrated Behavioral Health (IBH) program**: as detailed in the RFA, an alternate payment program that and supports practices ability to integrate behavioral health services to provide same-day access to integrated population-based preventive behavioral health services.
    - Same as PCPM, above
- **Shared Risk Model** – as detailed in the RFA, a model that facilitates upside payments/downside risk based either on the total cost of care, or a Medical Loss Ratio (MLR) model with upside payments influenced by established quality metric gates. The Impact to cost targets and metrics are being evaluated and needed adjustment will be made in collaboration with provider partners.
    - As service volume dropped and elective services postponed, we saw changes in the total cost of care for our members. We are monitoring how service levels recover and will make any necessary target or metric adjustments in collaboration with our partners.
- **Behavioral Health Case Rates** – Case rates with performance bonuses for performance for mental health services, PRTS, and feedback informed treatment.
- **Mental Health Composite Score**- Comprised of 7 outcome metrics; performance bonus based on composite score (A-F).

E) Describe the process you used for modifying this VBP model, including your key activities, timeline/s and stakeholder engagement.

IDS Subcontracts

Because OHA withhold funds were released suddenly and with the expectation that the CCO distribute funds to vulnerable providers quickly, Health Share convened weekly meetings with each subcontractor—including both 2020 and 2019 subcontracts (because 2019 funds were also released early, requiring a separate set of discussions).

In past years, when Health Share had to distribute funds from the quality pool for measures where performance was difficult to determine (who contributed how much to the overall success) the CCO used a revenue based allocation approach, to align the payment with the amount of overall risk taken by each subcontractor and ensure that resource needs are accounted for. That same approach was proposed, reviewed and supported by Health Share's partners during these meetings, and the approach was approved by the CCO Board. The CCO was notified of the suspended withhold in April of 2020, and the Board approved this methodology for recurring monthly distribution in May.

ICN Subcontracts

For downstream provider VBP arrangements in the ICN, key providers in the network were consulted to provide feedback on the approach in bi-monthly meetings and 1:1 clinic outreach in April – June 2020. Details of feedback and activities include

- **PCPM and IBH** – ICN staff developed a set of recommendations for modifying the program requirements through the end of 2020. Communications were sent to providers advising that the current program would continue unchanged through the end of 2020, with forthcoming communications describing any changes to the program in 2021.
- **Shared Risk Model** – Collaboration with community risk model partners occurs through monthly Joint Operating Committee (JOC) meetings. Monthly cost and metric progress is reviewed and discussions on the COVID –19 implications continue.
- **Behavioral Health Case Rates and Mental Health Composite Score** – Outreach and provider meetings were conducted to understand risk to the system and perspective from providers.

F) Describe how you modified this VBP model, including changes in LAN category, payment model characteristics, or implementation dates.

IDS Subcontracts

The IDS subcontracts were not altered, but the policy approach has changed the implementation of the methodology. At this time, the subcontractors are held harmless for meeting metric targets but the infrastructure to re-implement still exists. For our IDS and ICN subcontracts, in order to effectively align incentives, Health Share intends to follow the process and timing outlined by the OHA in the CCO Incentive metrics program with our VBP contracts.

ICN Subcontracts

The ICN subcontracts details include:

- **PCPM & IBH** – The LAN category will remain a 2C. Agreements were amended to continue through the end of the year instead of terming in July, the planned renewal APM program containing additional measures, and more aggressive measure targets and different reporting processes was postponed until January 2021. Additionally, the data reporting event for submitting performance on the first 6 months of 2020 was cancelled. Current PMPM rates remained in place through December 2020. PCP's that were able to submit reports and did meet or exceed their targets were granted any earned increases. PCP's unable to report or significantly declined in performance level were not penalized and will have an opportunity to increase their performance and payment levels in the next APM program.
- **Shared Risk Model** – The LAN category will remain a 3B. We will review, discuss and agree on any needed adjustment as more data is available over the next few months.
- **Behavioral Health Case Rates and Mental Health Composite Score** – Risk corridors for case rate payments were forgiven and payments were made for providers participating in the composite score program based on membership.

The following questions are to better understand your CCO's plan for mitigating adverse effects of VBPs and any modifications to your original plans.

5) **Describe in detail any planned 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; lesbian, gay, bisexual, transgender and queer [LGBTQ] people; persons with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).**

As the CCO incentive metric program returns, we plan to enhance our standardized reporting on metric performance for our subcontracts to include stratification by race/ethnicity and language. Decreases in performance for subpopulations will be called out during the oversight process with the Quality and Health Outcomes Committee. We are also leveraging the Health Equity Plan requirement in the CCO contract to better assess our measurement processes and are in the process of formally evaluating our policies for opportunities to increase our explicit focus on racial and health inequities. Additionally, our measurement systems analyze provider performance against historical performance and we monitoring grievances and patient re-assignments on a routine basis.

As described previously, Health Share's CAP is also focused on how best to ensure that our VBP arrangements address the complexity of member needs across multiple service types and community based services, including through additional risk adjustments.

Health Share's Board structure is currently engaged in development of an equity tool that can be used to guide more of our decisions. We will apply this tool to future strategy decisions around VBP implementation and include consultation with the CAC. In addition, downstream ICN subcontracts were scheduled to include an incentive around an equity focus for a metric which was postponed due to COVID but will be implemented at the next available opportunity.

6) **Have your CCO's processes changed from what you previously planned? If so, how?**

As noted above, in a traditional year the CCO monitors each subcontractor's metrics performance against OHA targets and establishes a corporate quality funds policy to incentivize improved performance. In the current situation that CCO-to-subcontractor relationship has been impacted as noted.

Efforts to thoughtfully respond to COVID and to ensure, to the extent possible, no adverse impact to members or providers has also caused us to slow the development of new VBPs based on our previously described roadmap. In addition to assuring that

existing models were not harming providers in a way that would compromise their ability to serve members, we also focused quickly on operationalizing telehealth parity and assuring that those services are accessible to members. We are finding now that, due to bandwith and to non-ordinary utilization patterns, providers are more reluctant to engage in VBP arrangements.

We are committed to continually evaluating utilization patterns and the current environment to ensure that the VBP work continues and incorporates our learning in COVID including telehealth parity and utilization of community supports.

7) **What approaches are you taking to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?**

IDS Subcontracts

Health Share's LAN 4C models include risk adjustment based on OHA risk adjustment methodology and take Health Share's global budget decisions into account (i.e. a CCO wide priority on BH).

ICN Subcontracts

ICN subcontracts incorporate a variety of risk adjustment models including traditional risk adjustment models in shared risk models and risk adjustment that is modified to account for the work that providers with lower acuity members still need to do in order to achieve quality metrics for primary care based contracts.

8) **Have you considered social factors in addition to medical complexity in your risk adjustment methodology?**

Yes, consideration of social factors in addition to medical complexity in VBP strategies is a component of the scope of our CAP.

If yes, please describe in detail your use of social risk adjustment strategies in your VBP models, including the following:

a) **Whether social risk adjustment is applied to quality metrics, overall payment (for example, capitation), or both;**
b) **Specific social factors used in risk adjustment methodology (for example, homelessness); and**
c) **Data sources for social factors, including whether data is at the individual/patient or community/neighborhood level.**

Health Share has done initial exploration into the process of adjusting for medical and social complexity but has not landed on a methodology for implementation. As previously outlined, it is within the scope of the CAP to consider and make recommendations.

We have evaluated the utilization of the pediatric health complexity data provided by the OHA in conjunction with OPIP. We do not have a similar data source right now for adult members. We did explore how we might use the pediatric health complexity data in our risk adjustment methodology for pediatric clinics. However, implementing this would have disadvantaged our family practice clinics who also see a large portion of pediatric patients but who would not receive the same social complexity adjustment. Trying to implement the social complexity adjustment for all pediatric patients regardless of whether they seek care at pediatric or family medicine practice also comes with methodological challenges as we would have a different methodology for adults and children assigned to the same practice.

We are also partnering with community groups, to better understand how they assess these types of needs. Examples of pilots include:

- Alliance of Culturally Specific BH Providers where, through the ICN, we are engaged in a collaborative process to design a comprehensive model(s) of service delivery that encompasses the continuum of supports needed to sustainably provide whole-person care, improve health, and enhance quality of life for the individuals the Alliance members serve. As part of this process, we will collaboratively develop and design payment models to support this work which could then be potentially tailored to other providers.
- We have developed a Foster Care Medical Home model and are currently exploring ways to develop an APM that supports this complex population specifically.
- We have developed a case rate model for the Recuperative Care Program, which provides immediate housing, intensive case management and access to primary care to members who are able to discharge from the hospital but need additional support. This program services a very complex population, often with multiple co-morbidities.

The following questions are to better understand your CCO's plan to achieve the CCO 2.0 VBP Patient-Centered Primary Care Home (PCPCH) requirements.

9) Describe the process your CCO has used in 2020 to address the requirement to implement per member per month (PMPM) payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement.

Health Share fully supports the PCPCH program and for over 6 years have incorporated the PCPCH tier status into various value based payment models, program eligibility criteria, and PMPM payment calculations. PCPCH participation is an expectation of our primary care network and is foundational for practices that participate in LAN 3 and 4 payment models. Because of our strong history of working on primary care payment reform, nearly all of our PCPCH payments are in payment models in LAN Category 2C or higher. Health Share is in the process of evaluating the revised PCPCH standards and measures to assess the need to modify the existing approach to Primary Care payment. The recent decision by the PCPCH Program to make available to payers upon request

the PCPCH application summaries will also be evaluated for inclusion into existing payment methodologies.

10) Has your CCO implemented new, or revised existing, payments to PCPCHs during 2020?

☒ Yes
☐ No

If yes, describe the characteristics of new or revised PMPM payments to PCPCHs.

If no, describe how your CCO intends to address this requirement in the remainder of 2020.

All Health Share subcontractors are evaluating how to most effectively utilize the new standards and reporting from the PCPCH program. In addition, new components were developed in the PCPM program were developed to incorporate health equity, oral health, and Access and Engagement measures into the program.

The following questions are to better understand your CCO's VBP planning and implementation efforts. Initial questions focus on the three care delivery areas in which VBPs will be required beginning in 2022 which are behavioral health, maternity and hospital care.

11) Describe your CCO's plans for developing VBP arrangements specifically for <u>behavioral health care</u> payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Health Share, in partnership with the ICN and provider network, has begun work on several additional VBP arrangements in the area of behavioral health. Programs currently in development include:

- A case rate and bundled payment model for psychiatric emergency services and inpatient psychiatric services.
- A SUD Composite Score program that will start with a performance bonus in 2021 and will progress to include a withhold in subsequent years.
- Additional episode of care payments are in development for PRTS, subacute, day treatment and in home services but have been paused due to COVID. We expect to resume development in 2021.
- A payment model, described above, in collaboration with the Alliance of Culturally Specific Behavioral Health providers.

Health Share will also continue to utilize our governance structure, including the Behavioral Health Advisory Council to solicit strategic direction and feedback on behavioral health VBP development.

12) Describe your CCO's plans for developing VBP arrangements specifically for maternity care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Health Share utilizes maternity bundle payments in our provider network. Through 2020 -2021, we will evaluate the inclusion of quality metrics to the existing bundle structure. In addition, Health Share has chosen pregnancy as one of its areas of focus in the Prometheus Potentially Avoidable Complications work and learnings from that effort will inform VBP development.

Health Share currently has a case rate payment methodology for Project Nurture, a program for pregnant women engaging in substance use treatment. This payment methodology will be evaluated and considered for expansion in 2022.

Additionally, payment enhancements have been implemented to provide improved access and network sustainability for doula services. Enhanced payment applies to bundled doula services (prenatal, birth, postpartum) as well as the itemized service for labor/birth. A Doula VBP has been created with an estimated implementation in Q4 of 2020 or Q1 2021 with a community-based doula organization offering linguistically responsive/specific services.

Health Share will also continue to utilize our governance structure, including the Childrens Health Advisory Council to solicit strategic direction and feedback on maternity VBP development.

13) Describe your CCO's plans for developing VBP arrangements specifically for hospital care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Health Share will utilize our governance structure, including the Clinical Advisory Panel, the Finance Committee, and the Global Budget workgroup to develop the strategy for VBP for hospital care payments. Currently, though the IDS subcontracts, hospital payments are in a LAN 4C framework and through the ICN subcontracts, a quality reporting program has been established.

14) Have you taken steps in 2020 to develop any other new VBP models?

☒ Yes (please respond to a–c)

☐ No (please respond to d–e)

a) Describe the care delivery area(s) or provider type(s) that your new value-based payment models are designed to address.

- **Integrated Behavioral Health in Primary Care** – Health Share is developing an enhancement to the model we utilize to pay for integrated behavioral health services in primary care.
- **Alliance of Culturally Specific BH Providers** – Health Share is engaged through the ICN in a collaborative process to design a comprehensive model(s) of service delivery that encompasses the continuum of supports needed to sustainably provide whole-person care, improve health, and enhance quality of life for the individuals the Alliance members serve. As part of this process, we will collaboratively develop and design payment models to support this work which could then be potentially tailored to other providers.
- **Recuperative Care Program** – We have developed a case rate model for the Recuperative Care Program, which provides immediate housing, intensive case management and access to primary care to members who are able to discharge from the hospital but need additional support. This program services a very complex population, often with multiple co-morbidities.

b) Describe the LAN category, payment model characteristics and anticipated implementation dates (2021, 2022, etc.) of new payment models you have developed (or are developing) this year. <u>If you have developed multiple new value-based payment models this year</u>, please provide details for each one.

- **Integrated Behavioral Health in Primary Care –** Health Share anticipates the IBH payment model to be implemented in 2021 and refined further in 2022. We expect the model to be LAN 4A and incorporate components of complex care management and traditional FFS to simplify the support needed for this type of clinical practice.
- **Alliance of Culturally Specific BH Providers** – Health Share anticipates the Alliance population payment model to be implemented in 2021 and refined further in 2022 and beyond. We expect the model to be LAN 2A to start and to advance to LAN 2C or 4A, depending on the outcome of the collaboration.
- **Recuperative Care Program** – This case rate model exists in category 2B and we are working to increase the model components to make it LAN 4A.

c) Describe whether your approach to developing these payment models is similar to, or different from, what you had originally intended in 2020; if different, please describe how and why your approach has shifted (for example, please note if elements of your approach changed due to COVID-19 and how you have adapted your approach).

- **Integrated Behavioral Health in Primary Care –** The pace of the development of this program has slowed as a result of COVID but implementation is on track to begin in Q4 2020 or Q1 2021. Additional components of quality metric refinement will be developed in 2021.

- **Alliance of Culturally Specific BH Providers** – This program was designed to begin work in Q2 and Q3 of 2020 but to effectively respond to the needs of the community, the pace of development was slowed. All partners continue to meet but the pace of measure development will be much slower than initially anticipated. Additionally, the needs of members served under this model have changed as a result of COVID and we are committed to designing a model that supports the health and wellness of the members served by the Alliance and are taking time to understand those additional needs.
- **Recuperative Care Program** – The refinement of this program was intended for Q2 -Q3 of 2020 and has had to be paused as a result of COVID to better focus on the clinical model and community response.

If no, please respond to d–e:

d) **Describe any decisions made to date regarding the eventual design of your payment models, including the care delivery area(s) or provider type(s) that VBPs will cover, LAN category, payment model characteristics, and implementation dates.**
e) **Describe whether your approach to developing these models will be similar to, or different from, what you had originally intended in 2020, and why.**

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

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

- Health Share has relied on the transition of the CCO incentive metric program to a withhold methodology for a component of our VBP strategy. We would appreciate support in understanding how the transition back to a bonus impacts our existing methodology.
- As we move to risk adjustment models that account for social complexity, additional TA from OHA or other resources would be appreciate.

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

- A collaborative conversation on how to think about VBP requirements in light of the ongoing nature of COVID-19 and the balance between the administrative burden of renegotiating contracts vs keeping on course would be most welcome.
- Additional considerations about OHAs expectations on connection between other areas of the CCO 2.0 contract and VBP would be welcome (e.g., Prometheus, THW utilization, Health Related Services).

Optional

These optional questions will help OHA prioritize our interview time.

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

- We would like to understand how the OHA is considering these requirements in light of the ongoing nature of COVID-19. Health Share and our provider stakeholders are committed to continuing to provide high quality care in this setting and have explored options for revising our metric structure but the unknowable timeline of the pandemic has created challenges in balancing the administrative burden of changing the models on providers and the CCO with a desire to continue to expand these efforts.

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