2021 CCO 2.0 VBP Interview Questionnaire and Guide

Introduction

Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, will be scheduled in June 2021. Please schedule here if your team hasn't already done so.

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

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **Friday, May 28, 2021**. 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.

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

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Section I. Written Interview Questions

Your responses will help OHA better understand your VBP activities this year, including detailed information about VBP arrangements and HCP-LAN categories.

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.

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 (CAP) 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. The CAP also has 2 subgroups – a Behavioral Health Advisory Council and a Childrens Health Advisory Council, both of which are chartered to advise on VBP models in their relative areas of expertise.

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.

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 Outcomes Based Care Advisory Committee. 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).

The ICN is also working with a third-party evaluator on formal evaluation of the Primary Care VBP programs (Primary Care Payment Model [PCPM]). Preliminary results will be available at the end of 2021 and will be shared with network partners and used as a basis for program refinement.

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

   ☒ CCO modified VBP contracts due to the COVID-19 PHE. *[Proceed to question 3]*
   ☐ CCO did not modify any existing VBP contracts in response to the COVID-19 PHE. *[Skip to question 4].*

3) <u>If you indicated in Question 2</u> that you modified VBP contracts in response to the COVID-19 PHE, please respond to a–f:

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

      ☒ Waived performance targets

      ☐ Modified performance targets

      ☐ Waived cost targets

      ☐ Modified cost targets

      ☒ Waived reporting requirements

      ☐ Modified reporting requirements

      ☒ Modified the payment mode (e.g. from fee-for-service [FFS] to capitation)

      ☐ Modified the payment level or amount (e.g. increasing per member per month [PMPM])

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

      ☒ Waived performance targets

      ☒ Modified performance targets

      ☐ Waived cost targets

☒ Modified cost targets

☐ Waived reporting requirements

☐ Modified reporting requirements

☐ Modified the payment mode (e.g. from FFS to capitation)

☒ Modified the payment level or amount (e.g. increasing a PMPM)

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

☐ Waived performance targets

☒ Modified performance targets

☐ Waived cost targets

☐ Modified cost targets

☐ Waived reporting requirements

☐ Modified reporting requirements

☐ Modified the payment mode (e.g. from FFS to capitation)

☐ Modified the payment level or amount (e.g. increasing a PMPM)

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

☐ Waived performance targets

☐ Modified performance targets

☐ Waived cost targets

☐ Modified cost targets

☐ Waived reporting requirements

☒ Modified reporting requirements

☐ Modified the payment mode (e.g. from FFS to capitation)

☐ Modified the payment level or amount (e.g. increasing a PMPM)

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

☐ Waived performance targets

☐ Modified performance targets

☐ Waived cost targets

☐ Modified cost targets

☐ Waived reporting requirements

☐ Modified the payment mode (e.g. from FFS to capitation)

☐ Modified the payment level or amount (e.g. increasing a PMPM)

4) Did your CCO expand the availability or the provision of telehealth to members as a result of COVID-19? If so, describe how telehealth has or has not been incorporated into VBPs in 2021.

Health Share previously had telehealth as part of the LAN 4C payment models to the IDS and available as part of primary care capitation and quality incentives in the ICN prior to COVID. During the COVID crisis, Health Share supported the network through additional resources and materials to ensure provider knew how to access payment for telehealth.

Additionally, Health Share implemented the telehealth parity rules quickly in order to assure equitable access to telehealth in all other areas of the network.

5) Has your CCO's strategy to measure quality changed at all as a result of COVID-19? Please explain.

Health Share continues to track our performance in quality metrics and has modified our approach to focus on quality metrics where there is capacity within the system. We have engaged in ongoing dialogue with our CAP and Quality and Health Outcomes Committee about where to focus our efforts, given that many parts of our delivery system were not operating at full capacity during 2020 and, as provider sites reopened, necessary clinical bandwidth has gone to responding to the COVID-19 PHE in our communities and mobilizing to ensure equitable vaccination rates.

Of critical importance, all parts of Health Share's network have turned attention to COVID-19 vaccination rates and on eliminating disparities based on race, language, and age in vaccination rate. There are COVID-19 vaccine dashboard tracked every week with the ability to stratify and track improvement in all parts of our network.

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 September 2020, when CCOs last reported this information.

6) Describe in detail any 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). Please focus on activities that have developed or occurred since September 2020.

Health Shares Board recently approved our 2021-2024 Strategic Plan, which orients all our work toward an outcome of Health Equity. As part of that work, the collaborative has identified specific impacts in Racial Equity, Early Life Health, and Behavioral Health that we are aiming for in our areas of focus: Social Determinants of Health, Integration, and CCO 2.0 model requirements. Additionally, we have adopted a Racial Equity Tool to support our decision making in key processes and program decisions to help mitigate any adverse equity impacts.

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.

7) Have your CCO's processes changed from what you previously reported? If so, how?

2020 has been spent responding to the COVID-19 PHE, focusing efforts on the vaccination campaign, and supporting critical parts of our network in staying open and serving members. VBP changes were made to support those outcomes. Health Share has adopted a Racial Equity tool in 2020 and has begun utilizing it in decision making processes.

8) Is your CCO planning to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?

For its sub-capitated IDS and ICN, HSO applies a risk adjustment factor on a concurrent, retrospective basis. An interim risk adjustment factor based on historical experience is utilized for payment during the experience period, with a final determination and payment by July 31 of the following year.

Within the Integrated Community Network, 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.

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

9) Describe the process your CCO has used to address the requirement to implement PMPM payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement. Please focus on new developments, changes or activities that have occurred since September 2020.

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 and all program rates are developed with the intent of engaging and rewarding clinics that have attained higher levels of PCPCH Tier Status. The Health Share network currently includes approximately 180 Tier 4 and 5 clinics in the tri-county region. Nearly all Health Share members are assigned to a PCPCH and the majority are assigned to a Tier 4 or 5 clinic

The COVID-19 pandemic forced clinics to abruptly transition to remote/virtual care which has impacted clinic processes that support PCPCH standards. Since March of 2020, primary care providers and clinic leadership have struggled and have not had the ability to expend time and energy in tier advancement work.

The impact of COVID-19 was recognized by statewide PCPCH program leaders and they took steps to ensure challenges due to COVID-19 are considered as practices apply or re-apply for PCPCH recognition. PCPCH Program leaders and staff reviewed the PCPCH standards to identify those that may be more difficult for a practice to meet due to COVID-19 (e.g., if they made operational changes or because of decreased visit volume) and released alternative technical specifications that went into effect for clinics applying or re-applying beginning in January 2021. These alternative specifications will help clinics advance their tiers despite COVID-19 challenges.

10) Please describe your CCO's model for providing tiered infrastructure payments to PCPCHs that reward clinics for higher levels of PCPCH recognition and that increase over time. If your CCO has made changes in your model to address this requirement since September 2020, please describe any changes or new activities.

Value-based payment (VBP) implementation continued throughout 2020 with no major changes to the model of PCPCH payment. Health Share's partners utilize a number of VBP arrangements with their primary care networks. Across the network this included continued implementation of tiered PMPM payments based on PCPCH certification level, as well as an optional Integrated Behavioral Health APM that requires additional staffing and population reach

targets to participate. A new VBP contract was implemented with three Tier 4 and 5 primary care clinic systems in mid-2020, designed to increase access points for medication for OUD and SUD treatment within the primary care setting.

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 behavioral health care payments. What steps have you taken to develop VBP models for this care delivery area by 2022? What attributes do you intend to incorporate into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier).

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 Mental Health Composite Score program that will start with a performance bonus in 2021 and will progress to include a withhold in subsequent years.
- 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 below, in collaboration with the Alliance of Culturally Specific Behavioral Health providers.

Health Share is engaged through the ICN in a collaborative process with the Alliance of Culturally Specific Behavioral Health Providers 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.

Additionally, Health Share is developing additional payment models to support integrated Behavioral Health across the collaborative. Each of Health Share's IDS and ICN partners began providing an expanded set of behavioral health services, including services that were previously primarily only available in behavioral health settings, in primary care settings at several locations in 2020. Current work revolves around reconciling payment, defining the array of clinical models, and ensuring coordination with the existing specialty BH network. The pilot data is still being reconciled with claims data, but initial analyses show that approximately 3000 Health Share members received these expanded services through the pilot project in 2020. We use advanced alternative payment methodologies (population-based payments, LAN category 4C) with our IDS partners to incentivize further integration of behavioral and physical health services, and are

piloting a reconciliation process for payment in 2021, transitioning to incorporating integrated behavioral health into the IDS capitation in 2022.

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

Health Share utilizes maternity bundle payments in our provider network. Through 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. Additional 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 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? What attributes do you intend to incorporate into this payment model (e.g., a focus on specific provider types, certain quality measures, or a specific LAN tier).

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, arrangements with upside and downside risk have been established (LAN category 3B).

14) Have you taken steps since September 2020 to develop any new VBP models in areas other than behavioral health, maternity care or hospital care? If so, please describe.

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.

Safety Net - Shared Accountability Model (SAM): Through the ICN, CareOregon is in the process of co-creating a shared accountability, total cost of care (TCOC) model in partnership with the FQHCs in our network. It is anticipated that the model will focus on the total cost of care for our members assigned to a participating FQHC and initially include only costs associated with the physical health benefit. Over time, we anticipate the model will evolve to include additional types of physical health providers (e.g., specialists) and services including specialty behavioral health and dental.

Although our partners in the shared accountability model are primary care providers, we hope the incentives of the model will impact coordination among and utilization of specialty and hospitals services.

Traditional Health Workers: The ICN is currently developing a Traditional Health Worker (THW) VBP model proposal which would be gradually implemented over the next three years.

To-date, work has been focused on ensuring a common understanding of the THW requirements, developing program goals and reporting strategy, and how best to engage the network. The team building the model is centering the work around consideration of member needs and application of an equity lens. Several opportunities for optimizing existing VBP arrangements to incorporate support of clinically based THWs have been identified. Additional work is needed to develop sustainable payment models that support the community based THW network.

15) Beyond those that touch on models described in questions 11-13, describe the care delivery area(s) or provider type(s) that your new value-based payment models are designed to address.

a) Describe the LAN category, payment model characteristics and anticipated implementation year 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.

b) If you previously described these plans in September 2020, describe whether your approach to developing these payment models is similar to, or different from, what you reported in September 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).

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. 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. We are targeting Q4 of 2021 to resume this work.

Safety Net - Shared Accountability Model (SAM): The model will be based on a global budget for total physical health benefit cost. We anticipate the model will phase in the amount of downside risk over time based on the clinic's readiness. The entry phase in the model will be upside savings only with no downside risk (3A). The other phases will provide progressively higher levels of shared savings and downside risk (4B).

Medical Loss Ratio Risk Agreement: The ICN has implemented a Medical Loss Ratio (MLR) Risk Agreement with a primary care practice that manages the health of a large proportion of its membership. This agreement compares actual cost of care to the revenue the ICN receives for that assigned population. Any surplus earned is gated by performance relative to establish quality metrics and targets. Based on the current structure of this agreement, it falls into the 3B LAN category.

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

16) What TA can OHA provide that would support your CCO's achievement of CCO 2.0 VBP requirements?
    - As the Care Delivery Area requirements are areas of focus, additional guidance on how to address those areas within fully capitated LAN 4C systems of care would be helpful.

17) 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.

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

- Would appreciate any insight into interesting approaches to VBP 'flexibility' during times of crisis/challenge.

19) Do you have any suggestions for improving the collection of this information in subsequent years? If so, what changes would you recommend?
    - We already do quite a bit of reporting, especially on PCPCH in the TQS report and pulling from that work would be helpful.