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.

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'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.

As such the majority of effort to ensure that Health Share's arrangements meet the VBP thresholds in questions below are driven by activities within the ICN. Unless otherwise stated, answers to these questions and in the accompanying spreadsheet, represent ICN activities under the CCO contract.

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.**

2022 was a milestone year as the ICN developed a 3A VBP shared accountability contract with metro area FQHCs. The success of this contract in 2022 will continue into 2023, as they grow in their value-based contracting with the FQHCs. Since the FQHC's encompass many attributed members for the ICN, the amount of 2C contracts has grown significantly and will be well above 60%.

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.**

The ICN's 3B contract with Yakima Valley has continued to grow and encompasses a sizable portion of payments. They have primary capitation (4A) with this organization and Virginia Garcia as well as behavior health capitation (4A) with other behavior health specific providers. The ICN believes it will meet the 20% requirements for 2023.

The ICN has attempted to expand the shared accountability contract into shared risk beyond these organizations, but these clinics are still in the infancy of value-based efforts and the glidepath is expected to be longer for them and do not anticipate reaching a 3B or higher contract with them in 2023.

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)?

The ICN focused largely on transitions of care measures in this payment model.

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

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)?

The ICN focused on 2B and tied maternity to quality metrics based on ensuring standard care for pregnant people and transitioning to Primary care post-delivery for continuity of 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

5) a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>behavioral health</u> care delivery area requirement? (mark one)

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

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

The focus of work in this VBP area is with the Alliance of Culturally Specific Providers. This group consists of culturally specific organizations and programs serving a diverse range of members e.g., BIPOC, Refugee. The goal is that by January 1, 2025, all culturally specific Behavioral Health providers in the Alliance receive sufficient and sustainable compensation from CareOregon for providing ongoing quality services and interventions to meet the needs of their communities.

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

Currently in a co-design status with the provider group. Tentative launch date is June 2025

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)?

The dental benefit is partially delegated to our dental plan partner organizations who subcontract with the ICN. Contracts currently include performance-based metrics that must be met to reach full payment. Some of these partners are fully integrated, staffed care delivery models. Some dental plan partners also utilize various VBP models with their contracted provider networks. Others offer a blended model with various payment strategies and LAN categories for different providers or provider types. Approximately 45% of provider payments are LAN 4 or higher. The ICN continues to collaborate with partners to grow and enhance VBP opportunities for dental providers. Additionally, the ICN has added an oral health component to its primary care payment model that incentivizes referral pathways to a dental home and the use of fluoride varnish in primary 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

7) a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>children's health</u> care delivery area requirement? (mark one)

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

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

For children in Health Share's Integrated Community Network, the core payment models for children's health are pay for performance or LAN category 2C. The ICN is primarily focused on providers who exclusively serve the pediatrics population. In the ICN contract with its core pediatrics provider, they have defined quality measures focused on social needs screening and referral, chronic condition management, prevention, and equity. The goal is to move this P4P contract into a full value-based arrangement in 2024-2025.

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

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:
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 Children's 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.

2022:
The information above is still accurate. We have done significant work to address the workforce crisis within the Behavioral Health Network, including standing up a Task Force approved by the Health Share Board and chartered by the Quality and Health Outcomes Committee to address payment, process, and community investments needed to mitigate negative impacts on access and looking to maximize the skillsets of the BH workforce. The BH Advisory Council mentioned above is also updated on the task force work.

Additionally, the timeline for the PCPM evaluation was pushed back to the end of 2022 due to the COVID-19 PHE and inability to meaningfully engage participating providers in the qualitative portion of the study.

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

No significant changes to above.

10) In your work responding to requirements for the VBP Roadmap, how challenging have you found it to engage providers in negotiations on new VBP arrangements, based on the categories below?

Primary care:		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging
Behavioral health care:		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging
Oral health care:		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Hospital care:		
☒ Very challenging	☐ Somewhat challenging	☐ Minimally challenging
Specialty care		
☒ Very challenging	☐ Somewhat challenging	☐ Minimally challenging

Describe what has been challenging [optional]:

Click or tap here to enter text.

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

☐ Yes
☒ No

If yes, please describe:

N/A

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:
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 are 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.

2022:
Health Share focused significant effort on the Emergency Outcome Tracking Metric of COVID-19 vaccination and made very deliberate efforts to collaborate across county public health and community-based organization efforts to collaborate across county public health and community-based organization efforts to reduce disparities in vaccine administration. As a result, disparities in vaccination administration by race/ethnicity and language closed significantly and Health Share had the highest immunization rate among all CCOS. We are now in discussion about how best to apply the learnings from that process to our policy for quality pool distribution and utilization within our VBP models.

Additionally, since May of 2021, Health Share has partnered with CareOregon to develop and implement staff training on Equity in Data Analysis. This training is intended for all staff members who research and prepare or consumes data and is reviewed by staff who develop information around our Value Based Payment programs.

This course offers concrete suggestions to think differently about how our CCO prepare and view data, specifically as it relates to demographic characteristics like race/ethnicity, sex assigned at birth, language and more. This course is a starting point in learning about the intersection of equity, diversity, & inclusion (EDI) and data.

Training Outcomes:
- Learn the definition of Data Equity and why it is important

- Discover options for changing the way we view or interact with data
- Locate resources for continued learning
- Understand why there is a need for continued learning

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

The activities outlined in 2021 and 2022 remain an area of focus. In addition, our partners are continuing to explore ways to bring non-claims data into VBP work, such as EHR or patient-reported outcomes data (i.e., Feedback Informed Treatment [FIT] patient survey response data), specifically in less integrated settings. This work is in the early stages in 2023 and will include discussion on data ethics at numerous levels of the CCO's network, and how we should or should not be using different types of data for risk adjustment models or quality measurement associated with VBPs.

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.]

Health Share's ICN is exploring social risk adjustment and will be completing an analysis of the literature on existing approaches to understand the pros and cons of different approaches to incorporating social health indicator data into risk models and quality measurement. Recent literature and studies have shown that incorporating risk adjustment in specific types of risk contracts or models may perpetuate disparities and inequities. It is the ICN's intention to use the findings from the literature review to inform their own exploratory analysis employing different approaches to compare outcomes and assess for possible unintended consequences. This analysis includes acknowledgement that the network does not have a consistent way to document risk, nor do we have CBO networks optimal for holding clinics to the social risk of members.

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 <u>focus responses on new information</u> 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:
Health Share's HIT Roadmap related to VBP and Population Management is extensive. Health Share's VBP approach includes sub-capitated arrangements with IDS and ICN

partners who are at risk for their population with enhanced payments based on quality metric performance. In 2020 many of these requirements were waived both by OHA and by the CCO due to the substantial changes due to COVID. However, this primary arrangement whereby Health Share's VBP goals are largely addressed through a LAN-4C arrangement based on Quality performance measures, means that the CCO's provision of data, specifically as it relates to quality metrics, is crucial. Additionally, as a central aggregator of population level data, Health Share's data sharing supports many population management functions among and across partners, including perspectives on integration across care categories, risk stratification, and tracking patient movement from one CCO or IDS/ICN to another.

The six workstreams mentioned in our attached roadmap are as follows:

1. Risk Stratification Tools: Health Share has started to convene our IDS/ICNs in 2020 to discuss population health and risk stratification needs. This year we are focused on assessing local and national risk stratification methods, create a workgroup to discuss and create use cases, and then get approval from IDS/ICNs as well a provider on risk markers and stratification. Additionally, the CCO has focused substantial risk stratification efforts on emerging COVID vaccine provision efforts and ensuring equitable distribution. This including clinical risk and population risk based on known disparities due to language and race (see additional section of roadmap, 'O.COVID')

2. Improve Bridge (Tableau dashboards): As mentioned in the above HIE Care Coordination section, Health Share Bridge is widely used amongst up IDS/ICNs and partners. The dashboards are slated to be improved over the next year to increase speed, efficiency, look for any opportunities to enhance data sharing for better care of our members. In addition, we are looking at improving the overall usability of the interactive dashboards and filters to make them more seamless.

3. Composite Score in Behavioral Health: Refining the accuracy and availability of our provider data sets to lead to developing a score for SUD detox, residential, outpatient, and MAT programs.

4. Improve operational data collection and quality / Data Source: There are many manual reports that our IDS/ICNs send on a frequent basis, we are currently taking inventory of manual reports to see how we can operationalize them and create process improvements. We started this project in Q4 of 2020 and continue our efforts through our HIT Governance committee. To name a few we are currently operationalizing the DSN quarterly data submissions as well as the monthly PCPCR reports. There are more opportunities we are inventorying and prioritizing for process improvements.

5. Dissemination of Data: Tableau Public: Provide aggregate population data in order to provide transparency and insights into the metro region Medicaid population as it pertains to condition prevalence rates, BIPOC, race, ethnicity, and engagement in health activities.

6. Incorporate Geo-mapping: Incorporate geo-mapping into all relevant dashboards to enable more location relevant action and outreach programs.

2022:
Our approach remained largely the same, continuing to focus on data dissemination and improving data collection and automation across most domains. Our efforts to create more public facing data were largely thwarted by our shift to focusing on COVID vaccination response. Vaccination response required a deeper focus on risk stratification methods to support a more targeted outreach and engagement strategy.

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

Our approach remained largely the same as we are focused on the six workstreams outlined in 2021. Additionally, we have been able to shift our focus back to building more public facing data. The CCO has continued to refine its core dashboard set related to incentivized quality metrics, allowing for more accurate and actionable data. Additionally we are looking at the hardware and cloud-based resources needed to safely and effectively share more information across sectors and with partners who may not have a direct relationship with individual members, but who nonetheless participate in population health activities and related quality metrics efforts.

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

2021:
We use a variety of industry-leading tools to drive analytics. VBP data is ingested into our EDW, whereas Tableau is used for generating and distributing robust, meaningful, and easy-to-understand analysis dashboards and scorecards. Our Tableau infrastructure delivers these dashboards within our CCO and to our system partners. These dashboards are refreshed between weekly and quarterly depending on business needs.

We use SQL Server Reporting Services to deliver transactional and detailed reports to users on regular basis. Frequency of these reports varies from real-time to quarterly depending on business needs.

Tools such as R, SAS, SPSS, and Python are used across our partnership for statistical and predictive modeling to answer advanced analytics questions such as identifying populations at risk of adverse health related events.

Tools such as the Johns Hopkins ACG are used for risk assessments and stratification of population, and other third-party tools are used to distribute reports. We use our care Coordination platform to provide up-to-date information on care coordination activities.

2022:
In 2021, the CCO completed its planned migration to a new Enterprise Data Warehouse, and prioritized building the necessary VBP data supports in early stages of new development to maintain high quality and reliable data.
Related specifically to VBP infrastructure, Health Share continues to provide regular quality metrics data to all IDS/ICN partners on a monthly basis. This includes dissemination of OHA's calculated performance of annual metric rates broken out for each partner, as well as dashboards updated monthly for each of the claims-based metrics that reflect projected "Year to Date" performance, which look at month over month trends against a projected annual target.

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

The core set of tools described above continue to be refined and provided to partners to support quality and VBP efforts.

In 2022, the ICN has provided various tools to support shared accountability contract providers ranging from detailed claims extracts for their patient panels, Microsoft Excel based population health tools for patient chase, and financial models to help them understand their shared savings calculation. The work will continue as feedback is gathered and refinements are made.

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:
Going into 2020 Health Share had one IT team that consisted of 2 analysts, 2 business analysts, 1 project manager, and 1 systems administrator. The vision for the department was to substantially increase the analytics half of the department, as well as the technology half to increase responsiveness to requests for information, depth of analytics skills, and a create robust data platform.

Mid-year 2020 Health Share moved away from an IT department and rebranded themselves the IS (Information Services) department. The new department now employs an analytics manager and an IT manager to set strategic roadmaps and direction for analytics and technology, respectively. The analytics team now has 4 dedicated analysts reporting to the analytics manager. The IT team now has 1 DBA, 2 system administrators, 1 help desk person, and 1 project manager reporting to the IT manager. The additional staff and proper team infrastructure have allowed us to initiate building a proprietary enterprise data warehouse (EDW) which will allow for the ingestion of SDOH data along with many other non-health related information. We are currently halfway through this intense project.

2022:

Health Share underwent another organization restructure to its staffing model for this work. Technology and Quality Improvement remain under the same leadership structure, with a team now focused specifically on IS functions including database development, ETL, data provision and data validation, while analysts and BI Development have moved with an Analytics Manager to a new Quality and Analytics Insights (QAI) team which provides analytic support to a number of strategic areas, including the quality metrics program that supports our VBP model. Currently, the analytic staffing model supports 2 System Administrators, 1 DBA, 2 Database Developers, 2 Sr. Data Analysts, and 4 analysts spanning QI, Business, Operations and Population Health areas. These teams work under an IS Director and a Medical Director, spanning IS and QI functions, respectively. Unfortunately, workforce challenges are quite prevalent in this space, as analytic talent is in high demand. Health Share is currently exploring how to fill all the above roles and whether external resources will be needed to maintain or expand program offerings.

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

In 2022 Health Share's IS and analytic teams continued to grow and define their scope and processes. The team has added a Development Manager to oversee key data and product development, and has added additional database development capacity as demands have increased. It has been challenging to recruit for new employees in this area as there is considerable demand across the health care system.

In response to these challenges, in 2022 Health Share entered into a contract with Providence's Center for Outcomes Research and Education (CORE) for both program evaluation and business intelligence development. This is intended to expand capacity for the CCO while focusing on areas of population health need. This contract will continue in 2023 with particular focus on expanding Quality Metrics offerings, tools to track utilization, and likely exploration of SDOH and community-facing information.

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

a. How you will ensure you have the necessary HIT to scale your VBP arrangements rapidly over the course of the contract,
b. spread VBP to different care settings, and
c. Plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.

2021:

Between our IDS' and ICN, since the start of 2020, we estimate that at least 68% of Health Share's provider payments qualify as HCP-LAN 2C or above. While these numbers are continuing to be finalized, we anticipate that the CCO is on track to hit VBP targets initially established in the RFA.

Although we are starting from a position of strength in this area, we still have a lot of work to do to continue to advance VBP in our region. Health Share will build upon this strong baseline from year one and focus on:

1. Increasing the number and breadth of VBPs
2. Progressing existing VBPs beyond a LAN 2C status
3. Supporting our IDS partners' expansion of VBP within the LAN 4C payment category by expanding service categories covered by the IDSs (e.g., specialty behavioral health and dental)
4. Addressing social determinants of health and health equity through VBP

In years three and four, we will focus on developing HIT support for OHA's VBP payment priorities:
hospital, maternity, children's health, pharmacy, behavioral health, and oral health.

2022:

a. Health Share is continually monitoring resource needs against demand for information. As noted above, we are exploring options to ensure that all positions are filled and, when possible, external resources or analytic contracts to ensure adequate capacity. These capacity decisions are reviewed by Health Share's Executive team, as well as the CCO's HIT Governance Committee, which meets monthly to support organizational decision-making around IS capacity and focus. This will include exploring the use of HRS/HIT funds to support expanded population health analytics capacity as appropriate.

b. No significant changes to previous reporting in this area

c. Health Share remains committed to further enhancing analytics capabilities to better model, negotiate, administer, and monitor value-based payments by stronger integration of data between financial systems, contracting systems, clinical systems, and claims systems. Integration will allow us to better track the percentage of VBP payments in relation to claims payments and ensure provider expectations are being met. While data integration is the overarching strategy, Individual steps include:

    1. Ensure payment systems can administer non-FFS based arrangements as needed across the ICN Network. The ICN continues to leverage the Provider Incentive Payment System (PIPS), a tool which streamlines the administration of PMPM payments. The tool facilitates a programmatic structure to manage attributed member-based payments made according to different quality performance levels, and population risk tiers. The system is integrated with our claims system taking advantage of existing provider EFT payment pathways. This infrastructure has added significant efficiency to the process of evaluating and ultimately making PMPM payments to providers. Going forward, we plan to continue to migrate other PMPM based payment programs into PIPS to leverage the workflow and reporting capabilities. This will include all of our current and future Primary Care capitation contracts.

2. Ensure metrics calculation and analytics tools can generate robust reports

The CCO's HIT infrastructure will play a key role in monitoring both CCO performance and accountability of its partners. Our analytics platform is the result of considerable investments to ensure that validated and reliable metrics are available. Data and measures will be regularly shared with partners to identify opportunities and drive performance.

Our platform is capable of attributing members to particular clinics (PCPCH assignment) and can also track members as they move from one delivery network to another. Maintenance of provider attribution information has required considerable effort and will be an area of continuous improvement to ensure that performance is tracked accurately in an increasingly risk-bearing environment for physical, dental, and behavioral health.

Health Share's ICN continues to partner with consulting actuaries, Wakely, to provide monthly reporting packets to Total Cost of Care VBP partners. These reports are reviewed in depth at our monthly provider meetings. We plan to continue this partnership with plans to enhance reporting and bring pieces of the work in house. All of this will enhance flexibility and nimbleness in meeting the needs of provider partners.

3. Explore additional enhancements and technologies

While the PIPS tool remains a key to numerous VBP programs and oversight, we are continuing to evaluate the market for tools to enhance our capabilities.

During 2020 we explored integration options, feasibility of integration of these systems, and developed concrete roadmaps based on findings. In the coming years, we expect to implement identified roadmap items and make them fully operational in Years 4 and 5. Additionally, our capability to more nimbly calculate and report on metrics in new care delivery areas will be enhanced as we continue to expand our EDW. Given that we have not yet developed the payment models for future years, we cannot articulate specific data-related milestones as we do not yet know the performance metrics or other parameters associated with those models.

In latter half of 2020 we implemented a business glossary (data dictionary) in order to support continued data fluency across the organization. We are also migrating our EDW from on-premises MSSQL infrastructure to Snowflake (hosted on Microsoft's cloud platform – Azure) in support of the increasingly large datasets which we have cultivated.

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

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

No changes to what was previously reported

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

We will be working in collaboration with key network partners who provide care in the care delivery areas outlined in the OHA VBP roadmap and develop VBP arrangements in CDAs where we do not have any existing contracts.

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:**

Any HIT enhancements or changes to the CCO's HIT offerings will be reviewed by Health Share's Executive team, as well as the CCO's HIT Governance Committee, which meets monthly to support organizational decision-making around IS capacity and focus. This will include exploring the use of HRS/HIT funds to support expanded population health analytics capacity as appropriate.

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

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

2021:

In late 2020 and early 2021 we have completed a VBP assessment with each our IDS in their progress towards VBP arrangements and provider contracts. According to the original HIT Roadmap, the majority of areas for VBP growth for these IDS's occur in future years and as such these goals are largely on track. Health Share feels they have made sufficient progress in year one and will continue to set important dates/milestones for the subsequent years as the strategy in key population areas matures. Unfortunately, the shared focus on COVID response and now, vaccinations has made alignment more difficult.

As indicated in the original HIT Roadmap, a majority of the VBP work will exist within the ICN where direct payment arrangements between non-integrated PCPCHs, BH and Oral Health providers comprise the VBP arrangements.

Our ICN is uniquely positioned with not only physical health coverage but also manages all dental and behavior health as well as our non-emergency transport (NEMT). The ICN will support integration of behavioral health and oral health benefit administration on behalf of the broader network in partnership with Health Share, through the provision of data to behavioral health providers to ensure accurate panel management and improvement on key quality measures. We will also continue HIT strategies to hit the 70% VBP target by 2024.

In year five and beyond, we will pursue further integration of NEMT and SDOH event capture and benefit administration for non-health care provider entities. Developing and improving the HIT capacity to ensure accountability and measurement of these systems will be critical to monitoring the health and functioning of these efforts as they relate to VBP models.

We wanted to highlight the VBP work that CareOregon (ICN and largest partner) has put forth:
CareOregon's 2020 Payment Arrangement File submission, based on 2019 payment data, showed that over 72% of payments had a link to a qualifying VBP contract utilizing LAN categories and the OHA methodology defining that link. CareOregon anticipates this proportion will increase over time.

CareOregon's VBP arrangements incentivize and hold partners accountable for performance on Oregon's CCO incentive metrics as well as other measures of clinical quality. While the measures for these arrangements are currently aligned with OHA priorities, future governance decisions and VBP needs could expand these measures of accountability to include engagement with high-priority populations, elimination of health disparities, and other measures.

To that end, CareOregon is well poised to operationalize these evolving arrangements through their software platform that supports PMPM VBP administration. This VBP tool, a leading third-party application, currently allows us to administer payments, adjust performance-based payments, and integrate VBP and claims data. This functionality is critical for their ability to report on payment arrangements by LAN category, as required.

CareOregon will use this software to manage payments for our PCPM, CPC+ and IBH programs. The evolution of work in this area may seem intuitive, however, administration of non-claims-based payments in a health system that was built on a fee-for-service system has required a significant amount of operational overhaul. Moving from manually processing checks to integrating this work into our claims processing system, including records of performance has greatly improved efficiency and allows us to administer and record performance and associated payment in one location. In 2020, they expanded use of this tool to include capitation payments and other PMPM contract models.

Another critical tool supporting VBP expansion is the financial model developed by Wakely, an actuarial consulting service, which provides the architecture that supports our primary care Total Cost of Care (TCOC), and Medical Loss Ratio (MLR) risk agreements. This financial model calculates the total cost of care for a primary care partner's assigned membership, along with detailed cost data analytics allowing the provider to identify trends, and areas of opportunity to better manage resources. In 2019 and 2020, Wakely further developed modules within this model that aid in the process of risk recapture and managing the health of a population. The risk recapture/population health module allows the provider to search for members previously diagnosed with high-risk conditions, without a recent claim showing that diagnosis. This tool can be used to proactively outreach to members with chronic conditions to ensure they are receiving preventive care.

Activities	Milestones and/or Contract Year
Hospital VBPs – establish standard report sets for VBPs implemented with hospital partners	2021
Develop and implement a Behavioral Health VBP model, including development of performance management infrastructure	2021
Develop and implement a Maternity VBP model, including development of performance management infrastructure	2021
Develop and implement a Children's Health VBP model, including development of performance management infrastructure	2022
Develop and implement an Oral Health VBP model, including development of performance management infrastructure	2023
Conduct semi-annual reviews of existing reporting and performance management infrastructure. Identify opportunities to further develop and update HIT to streamline program administration	2021 - 2024

2022:
The above narrative remains largely accurate and was not edited. In summary, the CCO's efforts and focus areas have remained largely the same from the original HIT Roadmap submission, including working through delegated arrangements to IDS/ICN partners, and ICN efforts to support VBP arrangements in the BH and Oral Health spaces (detailed in previous sections).
The above table has one edit, which is moving the 2022 goal for development of an Oral Health VBP model to a 2023 goal. Please see Oral health answer in question 6 above.

Briefly summarize updates to the section above:

No significant changes to above.

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

2021:

Because Health Share's VBP arrangements include significant risk sharing among Integrated Delivery Systems who are held to Quality Incentive Measures, the arrangements largely classify as LAN-4C. Health Share provided key data related to both population health and quality measures to each of these systems as it has in the past, including both aggregate, year-to-date, and annualized performance reports on all key measures, data sets identifying gaps in care (ALERT and DHS Metrics) and other key clinical quality measures data. Unfortunately, due to COVID, OHA's Metrics Program—the backbone of Health Share's VBP arrangements with these IDSs—was suspended and so development of the nuances of this data sharing was suspended so the system could collectively focus on COVID response.

Similarly, within Health Share's ICN, 100% of the providers participating in VBP arrangements had access to the data referenced in the above section. Providers that participate in the ICNs risk agreements (TCOC, MLR) also have access to the Wakely financial model providing additional data regarding utilization patterns, and costs of services provided by other providers in the network.

The BH composite score quality payment methodology Health Share has adopted remains in place supported by CareOregon's data warehouse and associated analytics tools. This methodology offers quality incentive payments to providers for performance relative to a set of Behavioral Health quality metrics. In the future, the CCO plans to continue to update this program structure to incorporate downside risk, and augment quality metrics with outcomes-related metrics. The current iteration of the program should meet the BH CDA requirement.

2022:

Health Share's most substantial accomplishment in using HIT to administer VBP arrangements was completion of the significant shift to a new EDW in Q4 2021. This environment should prove more flexible to meet CCO and partner needs in quality metrics and related reporting.

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

As noted above, Health Share has started contracting with Providence's Center for Outcomes Research and Education (CORE) which has significant experience maintaining systems that track quality metric performance—a key to Health Share's VBP model. We believe this partnership will prove fruitful in supporting both analytic/business intelligence output as well as enhancing the types of available data and tracking for partners who are aiming to optimize quality performance under their VBP arrangements.

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

2021:
As noted above, many of the typical developments related to quality metrics data sharing to support VBP arrangements were necessarily delayed due to critical COVID response. However, over the course of 2020, the ICN nevertheless implemented a quality metric based VBP with a hospital partner that includes both up and downside risk for quality metric performance. This was particularly challenging as it required engaging with the system to determine metrics both parties felt they could influence with membership where their assigned PCP resides outside of that system and where the system does not have a direct connection with that member as it relates to their preventive care needs. This arrangement will satisfy the Hospital CDA requirement and is being implemented with other systems for 2021 and beyond.

2022:
Critical COVID response (vaccination) was a priority that required significant analytic resources in 2021, and the COVID EOT measure became part of the CCO's VBP arrangements. This, combined with the aforementioned workforce challenges were the largest barriers.

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

As the pandemic has slowed, we have begun revisit improving our HIT strategies to support VBPs. We are experiencing new challenges related to impact the pandemic has had on the workforce and the ability to pilot new tools with network partners. Additionally, the CCO has become involved in early preparation for the 1115 Medicaid waiver, notably through new partnerships and programming related to housing benefits and providing key resources through a CBO network. This has stretched capacity for core VBP and quality improvement work to focus on additional social and public health areas. While this is the right direction for the CCO to move it has challenged capacity and increased the areas of strategic focus.

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

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

2021:
Health Share has three primary mechanisms for sharing critical data and information (1) through Health Share Bridge, we have a number of Tableau dashboards and member lists in which plans, and providers can access, (2) we have secure Health Share Bridge SharePoint pages in which reports, and member information can be shared with providers, plans and the community at large, and (3) sending data to Collective Medical

Technologies' which allows providers, plans and care coordinators to access critical patient information real time.

Access to aggregated data down to specific member attribution and PHI via Health Share's Bridge site is controlled through a rigorous security layer that complies with HIPAA and assurances of appropriate data sharing agreements. At a high level, we ensure that our partners have access they need to regularly refresh reports, including aggregate and member level on all calculatable measures. We also deliver data like ALERT, DHS measures, etc. The types of data we have available on our Health Share Bridge sites are as follows:

- Detail claims data.
- Patient medical summary which includes such things as demographics, current medications, conditions, PCP, ED visits, inpatient visits and more.
- CCO metric leading indicators and member lists which is sent out each month and details members in the denominator, members in the numerator and members not meeting expectations.
- Member risk stratification tools that allow the user to define what attributes are of interest in calculating 'population at risk.' Attributes available for selection include number of chronic conditions, age, rate code, utilization and 15 others. Once risk attribution has been selected member lists can be generated in order to enable better care coordination and outreach.

Information that we send to Collective Medical Technologies includes TOC eligibility and risk level, care plans for TOC members, diabetic flag etc.

CareOregon subcontracts with a network of PCPCHs, BH providers and oral health providers and as such regularly shares data, at least quarterly, with its providers. They are currently expanding this capability to ensure that data provided to clinics is specific to VBP arrangements in which they participate. Our ICN's existing analytics infrastructure and software tools allow us to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis. Enhancements will continue to expand their ability to deliver additional measures and metrics, as appropriate based on VBP arrangement participation, to providers on a regular and automated basis. Providers will be able to view a broad menu of measures, as well as those applicable only to their payment arrangements. Scorecards include both aggregate (clinic-level) and member-level information, making data more actionable for intervention.

CareOregon has launched enhanced capabilities which include access to expanded data and scorecards as well as the ability to receive provider scorecards via secure email. These will be tailored to a clinic's VBP program participation and population needs. Their enterprise data warehouse will continue to evolve to support deeper integration of data between financial, clinical, contracting, and claims systems. As

richness of information in the underlying data warehouse grows with elements such as SDoH, it will open further opportunities for partnering with CareOregon's providers to drive improved performance and care. In the event that their current reporting applications do not include measures that are applicable to the VBP programs implemented future years, they will upgrade our reporting platforms to ensure that reports are comprehensive.

In addition to supporting performance analytic capabilities, CareOregon provides access to the GSI care coordination platform available to our provider partners which will further support care activities needed to succeed in a VBP environment.

Health Share collects and stores current and historic information regarding the PCP/PCPCH, PDP, and Behavior Health provider in which a member is paneled (in the case of PCP/PCPCH and PDP) or has an extended prior authorization (in the case of BH provider), and the dates associated with each panel assignment. The historic panel information allows us to ensure that the plans and current providers in which a member is associated has access to all critical clinical information and full member attribution current and historic.

Health Share's Bridge SharePoint site contains Tableau dashboards that provide full member attribution both current and historic. The member attribution information consists of current and historic PCP, PDP, and behavior health provider, the dates in which the member was associated to each of the providers, and the associated medical, dental and behavior health plans. Using the attribution information our dashboards show utilization by visits and cost categorized into primary care, specialty care, emergency care, pharmacy, hospital, metal health, SUD, and dental.

In addition to providing access on member attribution through Health Share Bridge, we also send out current member attribution information once per week to each plan for all of their currently active members.

Complementary to the work at Health Share, our ICN also has a reporting platform includes data on patient assignment and utilization. For purposes of VBP arrangements, they calculate performance on an "assigned" basis. In instances where members are inappropriately assigned, CareOregon has staff that work to quickly reconcile and reassign as appropriate. Information on patient assignment is available both through their data reporting platform as well as their provider portal. Transparency of this information allows for productive conversations around population health management expectations under our VBP arrangements.

CareOregon continues to use an authorization-based methodology for behavioral health member attribution for VBP performance measurement. This provides a fair and consistent way to align patient responsibility with behavioral health providers and

enables comprehensive measurement of provider performance to produce a "composite score" crucial to our VBP incentives for our Behavioral Health providers.

2022:

a. These functions remain largely unchanged. The CCO continues to use SharePoint and Tableau as primary vehicles to distribute dashboards and member level data relevant to VBP arrangements with IDS/ICN partners.

b. No significant change to above.

c. The only significant changed to HIT tools available is that with the migration from one EDW to another, Health Share has had to revisit which dashboards are supported for broader partner use. We have maintained almost all dashboards related to quality metrics and VBP arrangements those support, but other dashboards related to patient care and population health are being revisited to ensure they meet current need and contain valid information.

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.

These functions remain largely unchanged. The CCO continues to use SharePoint and Tableau as primary vehicles to distribute dashboards and member level data relevant to VBP arrangements with IDS/ICN partners

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

No significant changes to above.

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

No significant changes to above.

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:
Our IDS/ICN's leverage the Collective Platform for transparency of ADT data and sponsor their providers and provide Community of Practice sessions through their network to support teams to leverage the tool more in their day-to-day operations as well as identify unique contracting to include the tool in their practice. The Health Share partners, exchanges member care plans with each other through Collective when a member transfers from one partner to another.

Health Share maintains a comprehensive enterprise data warehouse combining data from administrative, care coordination, claims, SDOH, and analytic sources. We provide access to our Health Share Bridge platform to all of our plan's Population Health teams which can utilize the Population Health Explorer dashboard, utilization dashboards, and population segmentation built on this platform, to create interventions and programs

2022: As noted above, the methodology for sharing this information has not changed significantly. With a shift to a new EDW we are undertaking a review of which dashboards to rebuild, though almost all dashboard related to VBP quality metrics and individuals requiring intervention have been maintained.

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

The tools for this work remain largely unchanged. As identified in Health Share's HIT Roadmap, increased interoperability and information sharing through the expansive set of EMRs in the CCO's region has been the main focus of health information exchange efforts. Some Health Share partners have had success using shared information across networks to populate Clinical Quality measure performance in support of VBP performance.

22) You previously reported the following information about how your CCO <u>shares</u> data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

2021:
In addition to the data sharing described above, where Health Share Bridge is used to convey a significant amount of patient health, risk and metric-related information, Health Share currently shares claims detail and member attribution data in an Epic consumable layout for providers interested in receiving a more complete picture of member engagement across systems. Two large FQHC systems are currently the recipients of this data which is then ingested into Epic's Health Planet application specifically designed to support VBP analytics.

Our ICN CareOregon makes reports and interactive dashboards available to providers on VBP arrangements on a continual basis with data refreshes at least quarterly for risk

stratification and more frequently for other data elements. Member-level data is available using these tools to identify risks and interventions needed. Our ICN is actively deploying a new web-based analytics and report delivery system we call FIDO Web (Fully Integrated Data Organizer). FIDO Web uses newer technology and a more robust platform which enables them to provide single sign-on, enhanced dashboard functionality and expand the types of dashboards available to external users in the future. Rollout will be complete by the end of the second quarter of 2021.

Our IDS/ICN partners also broadly leverage the Collective Platform for transparency of admission/discharge/transfer data and sponsors providers to obtain access. They facilitate Community of Practice sessions through our network to support teams in leveraging the tool in their day-to-day operations as well as identify unique contracting to include the tool in their practice.

2022:
The practices described above are largely still in place.

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

No significant changes to above.

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

Estimated percentage	Reporting method
60%	Excel or other static reports
30%	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
10%	Shared bidirectional data exchange that integrates electronic health record data from providers with CCO administrative data.
0%	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)?

Because all CCO members are required to be assigned to a primary care provider, information flows more naturally to PCPs than to other care providers. This is due to the naturally established relationship (and often acceptance of financial risk) at the primary care

level. Establishing accountability for risk sharing and data access for specialists, hospitals and other types of care has been more difficult. These systems often rely on their own EMR information and real-time care coordination tools to delivery immediate care and are focusing less on an on-going population of interest.

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

2021:

In 2020, as part of its CCO 2.0 redesign, Health Share moved away from the 5 medical health plan, 5 dental plans and 3 behavior health plans to a completely different model. The CCO shifted to a model with 4 Integrated Delivery Systems (IDS) and an Integrated Community Network (ICN), with oral health, behavioral health and NEMT services managed under that network. This shift was considerable and was driven to create a more tightly integrated system, with stronger risk sharing arrangements among all of the local hospital systems and the majority of outpatient clinics in the region. The late stage of 2019 and the initial phase of 2020 was spent refining both data sharing and information flow to ensure the successful shift to this model and we are proud of what we have accomplished in standing up this model. Health Share is confident it will be better for our members and community.

In the new CCO structure we regularly share data, at least monthly, with our new ICD/ICN partners and some providers. Our existing analytics infrastructure and software tools allow them to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis.

The CCO's contract with CMT/Collective allows all provider networks to access the platform. The collaborative of partners continue to engage with providers to leverage data from the platform, including reports and dashboards that combine data gathered from Collective with internal information, to assist providers in improving quality and VBP performance.

With respect to behavioral health specifically, CareOregon contracted with OHLC to onboard and train 8 new BH providers in the use of the Collective platform, as well as training CareOregon staff to be able to provide ongoing technical support to current and new providers on the platform.

2022:

Health Share continues to leverage its data sharing and analytics infrastructure to regularly share information with IDS/ICN partners and certain providers. SharePoint provides secure data delivery and user access controls and Health Share continues to monitor user permissions to ensure ready access as needed.

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

We continue to leverage our data sharing and analytics infrastructure to regularly share information with our IDS/ICN and provider partners. Within the ICN, FIDO and ShareFile provide secure data delivery and facilitates user access controls. CareOregon continues to monitor permissions to ensure access is available for those necessary.

In addition, the ICN is continuing to support providers with EHR optimization through financial support. Central City Concern (CCC), Cascadia Health, and Native American Rehabilitation Association (NARA) received financial support through system investments for upgrading to EPIC through OCHIN. In addition to the listed providers, the ICN has provided other financial support to providers and the investments exceed over 10 million dollars of funding to support EHR platforms and integration.

CCC, Cascadia Health, and NARA are large integrated BH providers and are also FQHC's and CCBHC's in the region. These EHR upgrades will improve their ability to coordinate care through Care Everywhere, allow for safer prescribing, MyChart access for members and increase employee satisfaction through efficient processes. The ICN continues to provide support to interested providers on EHR optimization and push for more use of HIE in 2023 and beyond.

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

2021:

Provider capacity due to COVID impacted their ability to engage in this work.

2022:

Provider capacity has been consistently stretched due to COVID and workforce shortages. This impacts engagement in VBP programs generally, as well ability to embrace new HIT options related to population health management, health information exchange, or analytics.

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

Workforce and provider capacity challenges have continued into 2023 and are a high area of focus across all levels of care within the CCO. Additionally, as noted above, increased needs and collaboration across sectors in preparation for the 1115 waiver have required careful consideration of HIT opportunities and resources to ensure strategic alignment and partnership to address community needs.

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?

Generally, providers right now are hesitant to take on additional downside risk, particularly in light of volatility in recent years due to COVID, and volatility moving forward with redeterminations. This has been especially true for hospital-based providers/systems and Federally Qualified Health Centers (FQHCs) that have struggled financially recently. Something that would help would be making the meaningful risk definition more palatable to providers. We have providers who are currently in downside risk arrangements, they just do not quite meet OHA's definition of meaningful risk, and providers have been unwilling to increase the level of downside risk required to meet that definition.

We have also developed a series of learning collaboratives that is explicitly focused on supporting clinics participating in our Shared Accountability Model (SAM) program. The series of collaboratives is intended to support SAM clinics in improving their performance in a shared total cost of care VBP program and focused on optimizing use of data and data tools, improving risk accuracy, patient attribution, and identifying and operationalizing clinical quality initiatives to improve cost, utilization, and population health outcomes.

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

No Additional information to add 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?

The majority of focus will likely be on the learnings and progress of Health Share's ICN in their administration of VBP contracts across the care continuum

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

This is generally a good format. Appreciate including the previous year's answers and allowing for those efforts to be moving forward. The questions about using HIT to support VBP arrangements are well structured and seem appropriate to the scope of this document. It is unclear if this document is seeking a comprehensive review of other population health/HIT efforts but some questions seem to indicate that may be the case. Many of these

efforts exist outside of VBP arrangements and instead are intended to help address community needs and partnership. As such, answers to those questions are similar to those provided in the SDOH section of the HIT Roadmap.

Part II. Oral Interview

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

Purpose

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

Format

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

Interview topics

Question topics will include your CCO's VBP activities and milestones in 2022, any early successes or challenges encountered in this work so far, and how your CCO's plans for future years are taking shape. Questions will cover three primary areas:

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

2) Implementation of VBP models required in 2022 and 2023. These questions will address how your CCO is making decisions about and designing required VBP models. We may ask about factors influencing the design and scale of your PCPCH infrastructure payment model and models to meet the Care Delivery Area requirements. These questions may address your experience designing quality strategies in hospital, maternity, behavioral health, oral health, and children's health VBP arrangements, as well as your progress developing HIT capabilities with providers to implement these VBP arrangements.

3) Promoting health equity through VBP models. These questions will explore how your CCO's work on health equity relates to your VBP efforts. We may ask about your CCO's progress with collecting social needs data; how health equity informs

your VBP planning in specific areas such as maternity care; and whether you have identified opportunities to use VBPs to address other CCO 2.0 priorities or requirements.