InterCommunity Health Network

2022 CCO 2.0 Value-Based Payment & Health Information Technology Pre-Interview Questionnaire

Introduction

Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, will be scheduled for June 2022. 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.

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **Saturday, May 7, 2022**.

All the information provided in Section I is subject to the redaction process 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:

Lisa Krois, MPH (she/her/hers)
Transformation Analyst, OHA Transformation Center

Section I. Written VBP Interview Questions

Your responses will help the Oregon Health Authority (OHA) better understand your CCO Value-based payment (VBP) activities this year, including detailed information about VBP arrangements and HCP-LAN categories.

A prior version of this questionnaire was collected from your CCO in May 2021. Unless a question specifically instructs otherwise, please focus your responses on new information not previously reported.

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

   Currently IHN utilizes a cross functional team including Finance, Quality, and Contracting to strategize and develop VBPs. IHN is in quarterly meeting with key VBP Providers, where VBP performance and feedback is discussed to improve future VBP contracts.

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

   IHN implemented a VBP roundtable which incorporates viewpoints from Finance, Quality, Product leads, Clinical Services, and VBP. This has led to better role definition in the creation and evaluation of VBPs. IHN continues to meet quarterly with VBP Providers to review performance and seek feedback on the effectiveness of the VBP model.

2) **Has your CCO taken any new or additional steps since May 2021 to modify existing VBP contracts in response to the COVID-19 public health emergency (PHE)? *[Select one]***

   ☒ CCO modified VBP contracts after May 2021 due to the COVID-19 PHE.
   [Proceed to question 3]

   ☐ CCO did not modify VBP contracts after May 2021 due to the COVID-19 PHE.
   [Skip to question 4].

3) **If you indicated in Question 2 that you modified VBP contracts after May 2021 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 FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing 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 reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

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 CCOs last reported this information.

4) In May 2021 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; LGBTQ 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).

In our Health Equity plan we have focused efforts on education and awareness of bias and specifically institutional bias, creating a new lens to identify and reduce health disparities. We are working implement those evidence-based interventions that reduce health disparities by improving access to care and services. We are collecting social risk factor data to gain deeper insights into our member population. We are also engaging providers in project work to develop new approaches to address members with cooccurring mental health and substance use disorders, who may also be unhoused and or have complex health needs. Additionally, we are providing Trauma Informed Care training broadly across the provider network. We understand much more work is needed in this arena and believe our continued efforts to better understand our member population and share those insights with our provider network will continue to guide our efforts toward health equity.

Please note any changes to this information since May 2021, including any new or modified activities.

IHN-CCO Quality Improvement Committee convened a value metrics workgroup to evaluate VPB arrangements through the lens of health equity. Additionally, IHN-CCO added the CCO

Metric Meaningful Language Access to VBP contracts and provider scorecards as a focus measure. We are also exploring VBP with the Community Doula Program to better match services to members' cultural needs.

5) **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.]**

IHN is not planning to incorporate risk adjustment for social factors at this time. Existing payment models and quality measures do not fully account for SDOH factors. Incorporating social factors in risk adjustment must be considered carefully to account for all variables to avoid unintended consequences of gaps in data or misapplied models. IHN continues to evaluate the collection of SDOH data through screening and clinical coding to see if this is a viable option.

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements that will take effect in 2023 or later. This includes oral health and children's health care areas. CCOs are required to implement a new or enhanced VBP in <u>one</u> of these areas by 2023. CCOs must implement a new or enhanced VBP model in the remaining area by 2024.

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

      At this point IHN is discussing opportunities to integrate oral care in the PCPCH clinics. Coordination of oral care involves the entire network, not just DCOs. Additionally, IHN-CCO has implemented transformation projects to align these efforts, i.e., the Encompass Program and TQS Project: Integrating Oral Health through the Expanded Practice Dental Hygienist.

   b. **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).**

      To better integrate oral health care within primary care and behavioral health for special populations and members with diabetes. CCO Metrics used are the HbA1c

Poor Control >9%, Oral Evaluation of Adults with Diabetes, and the Assessments for Children in DHS Custody.

c. **When do you intend to implement this VBP model?**

2023 or 2024

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

In 2021 IHN entered into a VBP with SHS's Encompass program. The goal is to help Eligible Members who have been placed in DHS custody, improve their health and wellness by working together with families and community partners; ensuring that the medical, dental, and mental health needs are met and to identify gaps in care. The Provider's team follows Eligible Members during their time in resource transition care.

   b. **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).**

The program focuses on care coordination and meeting all preventive, oral, physical, and behavioral health quality measures and achieving the CCO Metric: Assessments for Children in DHS Custody.

   c. **When do you intend to implement this VBP model?**

2021, ongoing

8) **CCOs will be required in 2023 to make 20% of payments to providers in arrangements classified as HCP-LAN category <u>3B or higher</u> (i.e. downside risk arrangements). Describe the steps your CCO is taking in 2022 to prepare to meet this requirement.**

IHN is working with SHS on an upside/downside risk model to be implemented in 2022. This would capture around 70% of IHN's costs in this type of model.

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

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

SDOH data and incorporation into VBPs has been difficult to implement. The data and reporting requirements are still being developing by the industry. Incorporating this into VBPs can be difficult if data is not complete or trusted. Utilizing SDOH data in VBPs can pose challenges if not fully understood by both parties.

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

Adopting statewide standards and common methodology for screening and measuring health disparities. A systemized and statewide focus on reducing administrative burden for providers and centralized data collection would assist CCOs in furthering progress.

Health Information Technology (HIT) for VBP and Population Health Management

Questions in this section were previously included in the CCO HIT Roadmap questionnaire and relate to your CCO's HIT capabilities for the purposes of supporting VBP and population management. Please focus responses on new information since your last HIT Roadmap submission on March 15, 2021.

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

11) 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

IHN-CCO utilizes multiple data sources to support our VBP programs. IHN-CCO has robust claims reporting through SQL queries, crystal reporting, and the HPXR/Empower data warehouse. We also use supplemental data, stored in our data warehouse, from the Provider to evaluate performance and compare to reimbursement expectations. IHN-CCO is going live with Arcadia as the primary VBP platform in 2021. This tool will enable near real time reporting on quality and cost performance, utilization trends, and other performance measures.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

IHN-CCO established provider learning collaboratives in late 2021 to support the collection and integration of data for provider performance reports to improve CCO Metric performance. IHN-CCO's population health system, Arcadia has been configured to integrate provider and other data to support metrics performance.

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

Currently VBP Scorecards and gap lists are generated monthly and financial reports are generated quarterly. Monthly scorecards are focused on Quality measure tracking to achieve performance goals and achievement of the Quality Pool. Capitated providers receive financial reporting that tracks assumed costs and encounters. This allows IHN-CCO to compare expected service levels to what has been reimbursed. IHN meets regularly with the providers to review the mentioned reports. These meetings are productive in driving towards expected performance level.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

IHN-CCO consistently engages community partners and providers to address data challenges related to health equity and VBP arrangements. While this data is difficult to obtain and is based on voluntary reporting, IHN-CCO has made efforts to align system data collection and reporting across multiple operational components (e.g., utilization management, care coordination, language access, and REALD).

12) 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.

To support the VBP program IHN-CCO cross coordinates across several functions:

- Finance – The VBP Analyst, Finance Dept, and Finance Director are responsible for VBP scorecard and report publishing. The department develops the reports based on contracts, financial goals, and aligned incentives. Finance also develops VBP payment models, strategy, and provides analysis of VBP objectives.
- Network Strategy – The VBP Coordinator, Provider Relations Team, and Director of Network Strategy distribute and coordinate VBP scorecards and contracts. The team matches the best VBP model for the Providers services, cost profile, and operational capabilities. This team is key in education and evaluation of VBPs.
- Quality – The Quality Analysts and Director of Population Health are key in identifying and developing the quality metrics used in VBP contracts. The department looks at the health priorities of IHN and establishes metrics and targets that will improve Health Outcomes of our IHN members.
- Information Technology – The IT supports the above departments with the data warehouses, data feeds, and reporting solutions required to maintain VBP processes.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

IHN-CCO has established a population health taskforce and value metrics workgroup to improve surveillance and reporting for state and federal metrics and to measure the impact VBPs have on health equity.

Questions in this section relate to your CCO's plans for using HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models).

13) 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. include plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the contract.

IHN-CCO's goal is to centralize and simplify VBP arrangements to maximize our HIT capabilities. This means reducing the number of custom metrics to reduce development workloads. With Arcadia we will utilize their set of OHA, NCQA, and HEDIS measures wherever possible. We will also limit the number of metrics in scorecards so that Providers can focus on the key drivers of performance. In 2020 we reduced the number of measures per scorecard and the number of custom measures to ease HIT workloads.

Payment models will also be standardized based on service type and size. Only Providers over a certain attribution size would be allowed to deviate from a standard VBP contract. This will simplify configuration and HIT requirements for each VBP contract administered. It will also ease education of the VBP payment structures. In 2020 we shifted from SHS's capitation model, which was costly to administer, to a rate of growth target model. This continued into 2021 with simplified County, PCPCH, and THW models.

Long term IHN-CCO will develop standardized PCP VBP models that incorporate Risk Scores, SDOH, and Rate of Growth targets. This work will require Arcadia risk modeling to achieve. Episode payments are also on the horizon, pending contracting HIT solutions. Beyond that VBPs models will require HIT that allows us to disconnect the underlying VBP payment structure from FFS to either a Value/Outcome payment structure and/or market-based pricing.

IHN-CCO is also moving away from "custom" metrics to more standardized metrics via Arcadia.

Please note any changes or updates for each section since your HIT Roadmap was previously submitted March 15, 2021.

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

IHN-CCO has ensured that utilized technology platforms can support CCO metrics and the efficient delivery of care across the continuum. The Arcadia population health management system is currently being upgraded, with a phased approach to data integration and reporting capabilities that will allow IHN-CCO to scale to numerous data sources and provider types. Additionally, IHN-CCO is upgrading its Facets NetworX module to enhance and scale VBP modeling and payment arrangements using pricing and bundling capabilities.

b. spread VBP to different care settings, and

IHN-CCO is providing education and technical assistance to community-based providers, i.e., doulas. IHN-CCO is evaluating barriers and exploring ways to reduce implementation costs and subsidizing providers to adopt and use technologies for care coordination, referral management and outcome tracking.

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

IHN-CCO is leveraging the HIT Strategy Committee and existing committee structures with providers to address Health Information Exchange (HIE) strategy. IHN-CCO is evaluating HIE platforms based on functionality and configurability that will allow integration and exchange of data. IHN-CCO is augmenting provider contracts to incorporate any changes necessary to encourage providers to integrate with the implemented HIE.

14) 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 black font to easily identify updates from your previous HIT Roadmap submission on March 15, 2021. If the field below is blank, please provide specific milestones from your previous HIT Roadmap submission.

See response to question 13 above.

Briefly summarize updates to the section above.

IHN-CCO continued to implement VBP and expand use of technology, incorporating risk, SDOH and rate of growth into VBPs.

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

IHN-CCO made great strides in 2020 by implementing Arcadia data feeds and development. We also developed or expanded VBP scorecard tracking and performance monitoring. Utilizing data, we were able to shift major contracts (SHS and Benton County) to new VBP models in 2021 that will simplify payments while aligning long term financial and quality goals. IHN-CCO rolled out PCPCH tier-based payment capability in 2020 and expanded it in 2021.

Please note any changes or updates to these successes and accomplishments since your HIT Roadmap was previously submitted March 15, 2021.

The PDM team has created a PCPCH-tier report to validate incentive payments. Additionally, we published first ever executive level cost and utilization standard reporting.

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

Getting to a higher level of HIT coordination with our Providers has been a challenge. In some cases that means getting quality data from providers at lower HIT sophistication levels, or complex data from higher level HIT partners. Then IHN-CCO is challenged with reporting back the data in a meaningful way that Providers can ingest and develop actions around.

Past VBPs have been very customized around the Provider's HIT capabilities. Going forward we will have standard data requirements under Arcadia so that we can quickly onboard Providers to a VBP model and report back to them in a consistent well-established method.

Please note any changes or updates to these challenges since your HIT Roadmap was previously submitted March 15, 2021.

IHN-CCO continues to work through barriers and challenges associated with certain provider types i.e., THW with limited access to technologies required for data collection. Additionally, collecting SDOH screening data. Additionally, smaller provider practices with limited technology and staffing to support metrics reporting proved to be a challenge. IHN-CCO continues to provide technical assistance and training.

Questions in this section relate to your CCO's plans for using HIT to support providers.

17) 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.**

IHN-CCO provided 100% of Providers on a VBP contract either monthly or quarterly scorecards on metric performance. In addition, capitated providers receive financial reports detailing payment history and encounter data.

In 2020 these performance measures were created manually and delivered via SFTP. The strategy 2021 going forward is to automatically deliver robust reporting via Arcadia and provide on-demand performance via Arcadia's web user interface.

VBP Providers receive a monthly attribution and gap list of the members being counted towards their Quality measures. This information is accurate at the Clinic level but may vary at the PCP level due to reassignments within the Provider's office.

Future strategies are in development with Arcadia to ingest PCP attribution from the Provider's EHR and/or reassign based on claims-based algorithms (i.e., most frequent PCP utilized).

Please note any changes or updates to your strategies since your HIT Roadmap was previously submitted March 15, 2021.

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

IHN-CCO is working collaboratively with provider practices to streamline PCP assignment and using technology through Arcadia for more accurate PCP attribution.

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

IHN-CCO continues to improve patient attribution and has created streamlined process for managing ongoing changes (PCP changes i.e., providers leaving or joining practice, new members, redeterminations etc.).

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

Arcadia, Clinical CareAdvance (CCA), Collective Medical, Provider Connect, Unite Us.

18) 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.

IHN-CCO regularly assesses its population integrating multiple types and sources of data. Medical, pharmacy, behavioral, and oral health claims data are integrated and combined with available member characteristics such as ethnicity, language, race, and disabilities, and social and economic factors such as food insecurity, housing instability and lack of transportation that can impact a member's overall health. Criteria are used to monitor, screen, and risk stratify the population and to identify and segment individual members into cohorts with similar care needs. IHN-CCO identifies members with special health care needs and screens for care coordination needs and Intensive Care Coordination services. The first level of stratification uses claims and demographic data and the second level of risk stratification is based on the health risk and clinical assessment, and other screenings completed with the member.

The risk level segments members with similar complexity and care needs into four levels:

- Low risk (I) – stable medical conditions, able to obtain medical services and access providers without barriers;
- Rising risk (II) – stable medical conditions that require monitoring to ensure medical services are obtained and any barriers addressed;
- High risk (III) – unstabilized condition(s) or recently diagnosed new condition i.e., chronic kidney disease, coronary artery disease, chronic obstructive pulmonary disease, depression, diabetes and issues obtaining medications or adhering to treatments, or barriers accessing providers; and
- Complex (IV) – new health catastrophic event or condition or diagnosis with significant resource needs i.e., motor vehicle accident, traumatic brain injury, spinal

cord injury, amputations, difficulty adjusting to new serious diagnosis and not well connected with PCP or specialist, i.e., Lupus, HIV, Multiple Sclerosis, active cancer with chemotherapy and complications, unplanned hospital admission, difficulty performing activities of daily living.

The process of risk stratification is ongoing throughout the member's eligibility. Risk levels may be adjusted based on a change in the member's status identified through clinical review, event notification, screening, and/or referrals.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

We have expanded risk identification and stratification through Arcadia. The Arcadia Analytics Risk module allow for more efficient risk modeling for VBP and the ability to share real-time risk indicators and data with providers.

19) 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.

Results of screenings, assessments and risk level are shared with the member's PCP and used to develop the shared plan of care. Member care gap lists are provided monthly.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

Expanded data sharing through Arcadia as stated above.

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

- IHN-CCO has implemented Arcadia Analytics platform and is testing the output of new risk stratification models that provide deeper insights into the member population.
- Despite initial project delays due to the Covid-19 pandemic, IHN-CCO was able to engage providers in focused project work on three initiatives. The initiatives are focused on identifying and reducing potentially avoidable costs while at the same time, improving member experience and health outcomes. Subsequent data analysis identified three conditions with opportunity – diabetes with co-occurring substance use disorder and/or mental illness, high risk pregnancy, and hypertension.

- Due to Covid-19, 2020 was only a Reporting year. In April, a final reconciliation will be conducted, and we will be able to see how the provider groups preformed for 2020.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

IHN-CCO has supported providers in achieving metrics through project work, such as the CCO Metric HbA1c Poor Control >9% and Initiation, High-risk pregnancy and Postpartum Care, and Initiation and Engagement in Substance Use Treatment.

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

- Covid-19 response presented challenges for the provider network and IHN-CCO staff;
- Our current processes are manual and some of the VBP Provider Groups do not have EHR systems.
- Consistent data for analysis; and
- Competing priorities.

Please note any changes or updates to this information since your HIT Roadmap was previously submitted March 15, 2021.

IHN-CCO and its provider network continued to face challenges with staffing and resource constraints associated with the COVID-19 pandemic.

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

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

Standard Behavioral Health metrics and VBP best practices, standard methodology for determining health disparities and incorporating social factors in risk adjustment, and additional resources and best practices for VBP modeling.

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

Streamline and standardize VBP reporting.

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

Questions topics will include your CCO's VBP activities and milestones in 2021, 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 four 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 (including overall VBP participation as well as downside risk arrangements), and how to make OHA technical assistance most relevant to your needs.

2) Implementation of VBP models required in 2022. 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 and behavioral health VBP arrangements; and your progress developing HIT capabilities with providers to implement these VBP arrangements. We are particularly interested in understanding CCOs' experiences promoting VBP arrangements with a) various hospital reporting groups (DRG, A/B, etc.), b) behavioral health providers operating independently

as well as in integrated primary care settings, and c) maternity care providers reimbursed in standalone as well as bundled payment arrangements.

3) Planning and design of VBP models required in 2023 or later. These questions will follow-up on information you provide about your progress developing VBP arrangements in children's health and oral health. We may ask about factors influencing your planning in these areas, perceived provider readiness, and assistance needed from OHA.

4) 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.