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:

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Part I. Written VBP Pre-Interview Questions

Your responses will help OHA better understand your CCO's value-based payment (VBP) activities for 2023, including detailed information about VBP arrangements and HCP-LAN categories. A prior version of this questionnaire was collected from your CCO in May 2021 and 2022. Some questions will request an update on previously submitted information, which will be provided.

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

1) **In 2023, CCOs are required to make 60% of payments to providers in contracts that include an HCP-LAN category 2C or higher VBP arrangement. Describe the steps your CCO has taken to meet this requirement.**

   To help achieve the VBP requirement of 60%, IHN-CCO has implemented contracts with our largest provider group, [redacted] our county mental health providers, multiple PCP Clinics, the regional NEMT provider, and all area dental care organizations (DCOs).

2) **In 2023, CCOs are required 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 has taken to meet this requirement.**

   IHN-CCO has met the 20% 3B or higher requirement because all the contracts mentioned in number 1 qualify towards the requirement. Starting in 2021 [redacted] entered an upside/downside VBP which covered approximately 70% of the IHN population.

3) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>hospital</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: IHN-CCO is developing an episode payment VBP model for [redacted] Maternity episodes. This VBP will meet both the hospital and maternity care delivery area requirements. The report is still being developed and vetted. We are using the OHA Maternity Kick Payment logic to identify deliveries in any of the 5 [redacted] hospitals.

   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)?

IHN-CCO will tie in quality measures focused on maternity care. Quality measures applicable include reduction in cesarean sections, increase in prenatal and post-partum care. The model will also drive behaviors in the facility and save costs by incentivizing reduction in c-sections.

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

The claim data report needed for this model is still being built and vetted. We plan on implementing this VBP soon and it will have an effective date on 1.1.2023.

4) a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>maternity</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: See response to the hospital CDA status.

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)?

See response for 3.b.

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

See response for 3.c.

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)?

IHN-CCO has implemented a VBP contract with [redacted] Alcohol and Drug Program to expand substance abuse services in Linn County. The [redacted] A&D program is reaching rural areas with the addition of 3 addiction specialists. Community outreach will

include middle and high schools. The VBP ties in quality measures focusing on Early Intervention, referral tracking and closure, and IET.

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

Click or tap here to enter text.

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)?

IHN-CCO has enhanced the [redacted] CCO VBP contract to expand the delivery care model. This model utilizes an EPDH practicing at the top of their licensure as a Primary Care Dental Provider in a dental office to incorporate traditional dental care with tele-dentistry and the increased management of chronic conditions such as diabetes and hypertension.

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

Click or tap here to enter text.

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)?

IHN-CCO is currently in negotiations with [redacted]. The VBP model will focus prioritizing DHS behavioral clients for CANS and mental health assessments. The model will tie in quality measures such as the Assessments for Children in DHS Custody.

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

Click or tap here to enter text.

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.

Enter description

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:
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.

2022:
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. In 2022 IHN funded a consultant to perform interviews with key PCPs under a VBP. This feedback will help IHN improve new and existing VBP arrangements.

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

2023: IHN-CCO still utilizes the VBP Roundtable meetings as a platform for internal discussion. IHN-CCO has enhanced its quarterly VBP reporting for Provider Groups using the Arcadia Bindery platform. IHN-CCO currently sends [redacted] and [redacted] an Executive Summary and Performance Summary reports. Both are geared to show the group's effectiveness and utilization. Areas for improvement can be spotted and providers can make a targeted approach. We will add more Provider Groups to the list as soon as their EHR is connected to Arcadia.

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:

Click or tap here to enter text.

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:
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.

2022:
IHN-CCO Quality Improvement Committee convened a value metrics workgroup to evaluate VBP 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 [redacted] to better match services to members' cultural needs.

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

2023
Since May 2022 the value metrics workgroup was combined with the provider network taskforce to incorporate provider voice in the review of value-based metrics. The quality and population health team is also working with the provider network to understand data needs as it relates to their gap lists. Our goal for 2023 is to begin an assessment of provider data capabilities and organize their gap lists based on their needs. For example, if they do not have the capability to establish data dashboards that show members race and ethnicity, we will support their needs by ensuring their gap lists have the member's racial and ethnic profile as well as aggregated data that shows potential disparities in care for that specific VB metric.

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.]

IHN-CCO has implemented capitation models for PCP clinics using CDPS risk scores. Scoring incorporates demographics, condition categories specific to the Medicaid population as well as models for disabled, TANF adults and TANF children.

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

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

14) You previously provided the following information about the HIT tools your CCO uses for VBP and population management including:

a. HIT tool(s) to manage data and assess performance

2021:

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.

2022:

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.

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

2023:
IHN continues to implement Arcadia for CCO quality measures by combining claims and EHR clinical data.

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

2021:
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.

2022:

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).

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

Click or tap here to enter text.

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:
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.

2022:
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.

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

The quality and population health management team are making strategic changes in staffing, roles and responsibilities, and how the team partners with the network strategy, finance, and data analytics teams. The quality improvement program manager has been a standing position within health plans and focuses on state and federal projects. The responsibilities of this position are expanding to be an additional support for the provider network with VBP contracts when it comes to data analytics and metric specification. The provider network taskforce (which inherited the value metrics workgroup -see question 12) will be used to help the quality and population health team, network strategy, finance, and data analytics teams reduce silos and ensure full collaboration for support equitable and high quality VBP outcomes.

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:
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.

2022:

a. 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. 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. 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.

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.

Click or tap here to enter text.

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

Click or tap here to enter text.

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:

Click or tap here to enter text.

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:
See response to question [16] above.

2022:
IHN-CCO continued to implement VBP and expand use of technology, incorporating risk, SDOH and rate of growth into VBPs.

Briefly summarize updates to the section above:

2023:
IHN-CCO will continue to implement Arcadia with all contracted sites throughout 2023 where sites can access their CCO measure scorecards, dashboards, and gap lists in real time. In the next phase for 2023, we are expanding EHR integration to our FQHCs

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

2021:
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 ([redacted] and [redacted]) 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.

2022:
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.

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

While there have been challenges, we have been able to integrate a majority of CCO metrics that are part of VBP contracts with EHR data with [redacted] being the pilot clinics

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

2021:
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.

2022:
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.

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

There have been numerous roadblocks to providing accurate scorecards, dashboards, and gap lists in Arcadia. These include missing and/or incomplete data from sources (EHR); variations in mapping to individual measure builds causing some data inaccuracies in Arcadia; long timelines in data delivery, and validation/reprocessing efforts.

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:

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)

2022:

a. IHN-CCO is working collaboratively with provider practices to streamline PCP assignment and using technology through Arcadia for more accurate PCP attribution.
b. 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. Arcadia, Clinical CareAdvance (CCA), Collective Medical, Provider Connect, Unite Us.

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.

Click or tap here to enter text.

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

Click or tap here to enter text.

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

Click or tap here to enter text.

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:

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.

2022:

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.

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

Current efforts to implement MAO004 and MOR reports into Arcadia for HCC recapture. IHN-CCO is working closely with Samaritan Health System to ensure provider workflows and their Epic build is built to ensure HCC's are captured more consistently and accurately. These tools include adding HCC information to the Storyboard; soft stopping providers before closing encounters to address HCCs yearly; and dashboards to track HCC capture rates.

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:
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.

2022:
Expanded data sharing through Arcadia as stated above.

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

The quality and population health management team are establishing a population assessment that follows NCQA's Population Health Management Model. The data are shared through the Quality Management Council and other provider related committees.

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

Estimated percentage	Reporting method
	Excel or other static reports
	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
	Shared bidirectional platform (example: Arcadia) that integrates electronic health record data from providers with CCO administrative data.
	Other method(s): Click or tap here to enter text.

[Total percentages should sum to 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)?

Click or tap here to enter text.

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

2021:

- 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.

2022:

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.

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

Click or tap here to enter text.

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

2021:

- 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.

2022:

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

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

Click or tap here to enter text.

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?

Click or tap here to enter text.

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

Click or tap here to enter text.

Optional
These optional questions will help OHA prioritize our interview time.

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

Click or tap here to enter text.

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

Click or tap here to enter text.

Part II. Oral Interview

This information will help your CCO prepare for your VBP interview.
Written responses are <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.