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.**

   The CCO has continued to develop 2C or higher contracts in the region. In 2023 alone, we are continuing 3A/B contracts with 2 FQHCs and two 4A contracts with the FQHC partners. We have also developed and maintained 2C contracts with provider groups through both physical health and behavioral health metrics. The CCO expects to have over 60% of its payments tied to 2C or higher in 2023.

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 CCO has worked tirelessly with providers that are currently in 3B (but do not meet the definition of meaningful risk) to transition them to meaningful risk 3B. It has not always been successful due to the challenges some providers are having today with staffing shortages and COVID ramifications. The CCO has worked to tweak the model to lessen the probability of shared losses, but it has not been successful. We have moved one more group into 4A in 2023 and that same group is close to signing a 2023 3B contract that would have meaningful risk. We expect to have more than 20% of payments as 3B or higher, but it will not be much more than 20%.

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)?

We have focused on incorporating quality measures that aim to reduce readmissions, improve patient safety, and transitions of care. In the future we would like to apply an equity focus to our quality measurement strategy with the goal of reducing health disparities in health outcomes.

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 <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: 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)?

This contract is with SUD and maternity care providers who are delivering the Project Nurture model of care focused on providing maternity and SUD services to high-risk pregnant members with SUD diagnoses. The quality measures are focused on key maternity care services being delivered and SUD management services. The design is a case rate withhold (4A).

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)?

We launched a P4P (2C LAN) program focused on incentivizing the behavioral health specialty network providers for providing high quality care and services focused on the following key domains: outpatient mental health, outpatient SUD, withdrawal management, and SUD residential.

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

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 delegated to our dental plan partner organizations. Contracts currently include performance-based metrics that must be met to reach full payment from the CCO. Some of our 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 65% of provider payments are LAN 4 or higher. We continue to work with our partners to grow and enhance VBP opportunities for dental providers. Additionally, we have added an oral health component to our primary care payment model that incentivizes referral pathways to a dental home and the use of fluoride varnish in primary care.

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)?

One of our key APM programs is our Primary Care Payment Model (PCPM) Program. The PCPM program contains three tracks that are focused on clinical subspecialities within primary care, one of which is pediatric care. We incentivize the clinics serving our pediatric members in our region through this program track. This is P4P (2C LAN) program, and the quality measure set for this track is focused on key pediatric preventive activities, like immunizations, well visits, and social emotional health.

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:
Jackson Care Connect (JCC) actively collaborates with stakeholders and providers in the development, monitoring and evaluation of VBP models across our physical health, behavioral health, and oral health networks. Providers are engaged at the beginning of the process to help identify quality measures through a shared, iterative process. Multiple data points are reviewed jointly, and key performance indicators are chosen. Once those areas are identified, targets for improvement are jointly agreed upon. A monthly review process is then set up for the providers and JCC staff to review how the provider is performing. During

these meetings, performance is reviewed, areas of improvement are discussed, and technical assistance offered if needed to support the provider.

The JCC Board of Directors has knowledge of the VBP models and provides input through the following committees: Finance, Network and Quality, and the Clinical Advisory Panel. Quarterly reports are provided on the VBP performance; however, 2021 reporting has been placed on hold due to the impact of COVID-19. The JCC Board was kept abreast of adaptations to the VBP made in response to COVID.

The JCC Board's Finance Committee is comprised of Board members with financial expertise and includes representatives from the hospitals, FQHCs, and CareOregon. The Network and Quality Committee is comprised of a cross section of providers within the JCC network, and reviews performance indicators at both a clinic and CCO level. Committee recommendations based upon their expertise guide JCC improvement activities. The Clinical Advisory Panel reviews the VBP models from the clinical perspective with a focus on the impact on health outcomes.

JCC 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.

In addition to the forums to engage with our network partners described above, JCC is participating with CareOregon and FQHCs across CareOregon's network in the development of a Safety Net - Shared Accountability, Total Cost of Care (TCOC) Model. We are collaborating with the Community Health Center of Oregon (CHCNO)[1]and non-CHCNO clinics to define a VBP model that shares savings/risk across the FQHCs and with CareOregon for the total cost of care. We are currently in the process of formalizing a structure to co-design the model, define data / reporting needs, and share learnings to achieve the desired outcomes. The oversight team and work groups will include organizational and clinical leadership from participating FQHCs, (CHNCO and non-CHCNO clinics) JCC and CareOregon.

This TCOC model is intended to further the goals of the quadruple aim. Specifically, we hope to:

- Build shared ownership and accountability among partners and CareOregon for patient health at the provider and community level
- Encourage service redesign and practice transformation to meet the needs of the whole population
- Increase the partners clinical, technical, and administrative ability to participate in total cost of care contracting models and meet their needs for more revenue opportunity
- Align partners' financial incentives around cost, access, quality, and member experience

[1] Community Health Center of Oregon (CHCNO). 15 FQHCs across the state of Oregon founded by Oregon Primary Care Association. 8 of the 15 clinics are in CareOregon's service areas.

- Incent and support providers and community partners in working together sharing data-driven, experience-based approaches, to improve quality care and reduce avoidable costs and utilization
- Supports CCOs' commitments to implement value-based payment arrangements and further the goals of CCO 2.0

The JCC/CareOregon team also remains an active member of the statewide Primary Care Payment Reform Collaborative, CPC+ state payer group and has signed on to the Oregon Value-based Payment Compact sponsored by OHA and OHLC

2022:

The information above is still accurate. However, the timeline for the PCPM evaluation was pushed back slightly due to the COVID-19 PHE and inability to meaningfully engage participating providers in the qualitative portion of the study. We have also begun to reinstate reporting requirements that had previously been placed on hold due to the COVID-19 pandemic.

JCC also remains active in the above collaboratives except for the CPC+ state payer group due to sunset of the program.

While there have been challenges, we have also seen successes in developing new arrangements that provide additional financial support to our provider partners while serving the needs of our members.
We developed a model with Oasis to provide a PMPM case rate, along with an additional potential earning for quality metrics, for enhanced coordinated care delivery for pregnant mother who use substances. Another example of our success is the execution of an agreement with Roue Retreat to help fund supportive housing with care coordination.

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

The information is still accurate.

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]:

The CCO has worked tirelessly with providers that are currently in 3B (but do not meet the definition of meaningful risk) to transition them to meaningful risk 3B. It has not always been successful due to the challenges some providers are having today with staffing shortages and COVID ramifications. The CCO has worked to tweak the model to lessen the probability of shared losses, but it has not been successful.
Additionally, our smaller provider partners have the same staffing and financial struggles as our larger hospital partners but also have less infrastructure, and less sophisticated data sharing tools and platforms which adds additional challenges (particularly in the sphere of Traditional Health Worker arrangements).

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:
The activities described in the last report are still in place. Jackson Care Connect continues to review each clinic engaged in our Primary Care Payment Model (PCPM) on performance

including equity initiatives. This process of review includes a narrative report provided by the clinics as well as qualitative data that is reviewed with clinic systems to determine areas of opportunity or challenges. This process is completed via the use of a dashboard that identifies potential disparities with specific populations in metric achievement and widespread population and engagement.

Jackson Care Connect has also focused efforts on specific metrics that have been identified organizationally that need additional focus and technical assistance for our network that impact our most vulnerable populations. Through conversations with network partners in choosing metrics for VBPs, JCC also considers the overall disparities for the population with the clinic data and evaluates if changes need to occur in focus for the VBP measures. For example, both JCC and many of our clinic partners identified through review of both overall and specific clinic data the need to focus on the Initiation and Engagement metric. In providing both data and technical assistance to our network, we are helping engage clinics in meeting the needs of some of our most complex members.

How data is stratified and analyzed has also been a focus of work done over the last six months. JCC has also partnered with CareOregon on development of a Data equity guide which will inform analytic activities, including VBP performance measures, moving forward. The guide includes practical recommendations for integrating equity into data analysis and data visualization.

Recognizing that how we think about data, interpret, and utilize data from an equity lens has been the focus on this work. Every report created and shared by JCC is now viewed from an equity lens. JCC also has analytic tools that allow providers to also analyze their own data to use for quality improvement and help further conversations around health inequities and underserved populations.

The impact of COVID and the wildfires have had an impact on our members, providers, and community. We continue to be very engaged with our network partners to ensure that our most vulnerable members are not adversely impacted by payment models and external factors.

2022:
Since May of 2021 Jackson Care Connect 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 consume 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, we are beginning to explore ways to bring non-claims data into VBP work, such as EHR or patient-reported outcomes data. This work is in the early stages in 2023 and will include discussion on data ethics and how we should or not should 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.]

The CCO is exploring various approaches to including social risk factors into new VBP models. In 2023, we plan to conduct an analysis of the literature on existing approaches to understand the pros and cons of different approaches. Recent literature suggests that incorporating risk adjustment in specific types of risk contracts or models may perpetuate disparities and inequities. It is our intention to use the findings from the literature review to inform our own exploratory analysis employing different approaches to compare outcomes and asses for possible unintended consequences. We aim to have a social risk adjustment policy defined by the end of 2023.

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:
We use industry standard tools, processes, and practices for managing data and for assessing performance. Our tool set includes comprehensive EDW and Data Marts as data repositories. Our data repositories are primarily SQL Server Enterprise running on robust infrastructure. We use SSIS as our tool of choice for moving data between

systems and databases. We use third party software platforms, such as Cotiviti, as well as internally programmed applications to assist with clinical quality measure calculation

2022:

The information above remains accurate in 2022.

CareOregon has built an Enterprise Data Warehouse (EDW) for analytics. The warehouse is built using the Kimball Dimensional Model, converting raw data into star schemas for efficient and accurate ingestion and storage, and subsequently modeled into flatter analytical tables for analyst consumption.

In addition, CareOregon will also begin implementing Epic Payer Platform with the goal of establishing bidirectional data exchange with key health systems and FQHCs to streamline data sharing processes and quality improvement measure development, monitoring, and reporting.

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

The information is still accurate.

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 clinic 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.

Excel is used as reporting tool where it is appropriate. JCC uses SAS auto jobs and other tools to generate these files on regular basis. Frequency of refresh for these files varies from weekly to quarterly depending on business needs.

Tools such as R, SAS, SPSS, and Python are used 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: The information listed above remains accurate in 2022.

CareOregon utilizes an Enterprise Data Warehouse (EDW), along with the Cotiviti measurement and reporting software to integrate and aggregate Value Based Payment data. Data is calculated using these systems through SQL queries and direct analysis.

This data forms the basis for many reports that are delivered automatically and manually through SQL Server Reporting Services (SSRS) and other tools.

While we recognize that specific questions regarding HIT in OHA reporting deliverables are not duplicated verbatim, there is up-to-date information around our capabilities and strategies related to HIT for purposes of VBP administration, spread, and population health management in our 2022 HIT roadmap and ISCAT Tool. Both were recently submitted to the OHA.

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

The information previously reported remains accurate in 2023. In addition, CareOregon is collaborating with our actuarial consultant, Wakely, to build and implement improved data tools and reports to our network partners who are in risk arrangements with the CCO.

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:

We have robust data and reporting teams. In collaboration with CareOregon, we have 30 permanent data and analytics staff members who manage our HIT and databases, assure data quality, develop reports, conduct statistical analyses, develop predictive models, and perform other data/analytics functions across the enterprise. We can also subcontract to outside vendors if additional specialized skills are needed. Our team includes software developers, data architects, database administrators, business analysts and healthcare analysts; these skill sets cover the entire spectrum of activities and skills needed to deliver high quality analytics.

In addition, we have dedicated quality improvement and technical assistance staff to offer support for data/report translation and implementation activities both internally and externally. Our quality improvement staff are skilled in explaining data to internal staff and external provider partners on the level that meets the need. Our staff have dedicated time over the past year to honing data visualization skills in order to better communicate complex analyses to wider audiences. Our quality improvement team has also directly helped clinics run reports, especially as related to disaggregated data reports.

Our Innovation Specialist team offers technical assistance directly to providers and can help with report reading and translation, as necessary. This team also assists providers with using data in meaningful ways for quality improvement purposes. Lastly, our Panel

Coordinators, working full-time directly in the provider's offices, are also available to assist clinic staff in understanding data and reports.

2022:
While we have experienced some staffing turnover, our approach and roadmap for analytics has remained largely unchanged.

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

While we have experienced some staffing turnover, our approach and roadmap for analytics remains the same as described in 2022 and 2021.

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:
JCC is 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.**
We continue 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. In 2021, 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, which is powered by CareOregon's analytics platform and resources, 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. See section Question 11 for additional detail.

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. It also manages attributions for dental relationships. 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.

CareOregon continues to partner with Wakely, our consulting actuaries, to provide monthly reporting packets to our 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 our flexibility and nimbleness in meeting the needs of our provider partners.

3. **Explore additional enhancements and technologies.**

While the PIPS tool remains a key to our VBP programs and oversight, we are continuing to evaluate the market for tools to enhance our capabilities. We are evaluating a potential RFP process in Q2 2021 to identify additional tools and opportunities.

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-premise MSSQL infrastructure to Snowflake (hosted on Microsoft's cloud platform – Azure) in support of the increasingly large datasets which we have cultivated.

2022:

a. The information above remains accurate in 2022.

CareOregon has built an Enterprise Data Warehouse (EDW) for analytics. The warehouse is built using the Kimball Dimensional Model, converting raw data into star schemas for efficient and accurate ingestion and storage, and subsequently modeled into flatter analytical tables for analyst consumption. This infrastructure is scalable into the future as VBP arrangements grow and evolve.

b. The information above remains accurate in 2022. We are also specifically engaging more with our behavioral health care provider community to develop meaningful arrangements, including acquisition of data for performance measurement.

c. The current HIT used by Jackson Care Connect and CareOregon administers value-based payment arrangements as set forth in the contract. CareOregon systems continue to enhance the collection and automation of data processing as much as possible to ensure efficiency, timeliness, and accuracy. Data developed through electronic health record/electronic clinical quality measures must meet Oregon Health Authority specifications.

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.

The information above remains accurate and there no significant changes to report.

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

We have successfully launched a P4P (2C LAN) VBP with our specialty BH network in 2023

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:

There are no significant changes to what was previously reported.

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:

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	2022
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:

While each of these milestones remain accurate for development of each model addressed, robust implementation of each has been slightly delayed. We are currently reviewing the status of each care area and reassessing specific milestones associated with each to develop a workplan for the next two years.

Briefly summarize updates to the section above:

The milestones have been delayed. Providers are expressing concern in moving towards value-based in this region due to the challenges they face with capacity and staffing. We are actively collaborating with providers to find a model that will work for them.

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

2021:

JCC currently has implemented VBP arrangements with several providers and is committed to increasing VBP over the next five years. Our 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, or other measures related to quickly emerging VBP arrangements.

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

We 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 FFS 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, we 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 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 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 also be used to proactively outreach to members with chronic conditions to ensure they are receiving preventive care.

2022: Jackson Care Connect aligned with CareOregon continue progress in partnership with our provider network in the development of arrangements which incentivize and hold providers accountable for performance on measures of clinical quality.

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

La Clinica has successfully integrated their attributed patients' claims data provided by Wakely and CareOregon into their Epic Payer platform. This work has led to the hiring of additional clinic staff who focus on clinical informatics to support their clinical quality improvement initiatives and ongoing monitoring of outcomes.

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

2021:

All of the systems that house data needed to administer VBP arrangements, including those supported by the OHA, contain different file formats, fields, and provider identification information. Therefore, generating the information to respond to OHA's payment arrangement reporting is difficult. We have to combine both claims payment data, along with other types of payments made in relation to a VBP (e.g., PCP risk agreement includes both the FFS claims data, and settlement payments made when the agreement year ends with a surplus). It can be challenging when combining data from the general ledger, with claims data to match up those payments with the right provider contracts, and so associating with the correct LAN category.

2022:

Our provider network continues to be challenged by the impact of COVID 19 and its effect on operations and workforce availability.

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

There are no changes since May of 2022

20) You previously reported the following information about your strategies, activities, and milestones 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:

Strategy 1: Provide timely and accurate performance data

The CCO regularly shares data, at least quarterly, with its providers. We are currently expanding this capability to ensure that data provided to clinics is specific to VBP arrangements in which they participate. Our 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 our ability to deliver additional measures, 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. See Question 11 for additional detail.

The CCO is also in collaborative risk arrangements in Jackson County. The partners include hospitals, primary care, and community mental health partners. The CCO shares performance data related to their total cost of care with each set of county partners every other month and quality metric performance data quarterly. For our more advanced partners, the CCO provides a claims data feed that enables their internal population segmentation tool to include cost analysis.

Moving forward, providers will have access to a more comprehensive array of reports through our FIDO web portal (the front end for our EDW). We are currently piloting access to a limited group of users including one of our FQHCs, with full implementation planned by the end of 2021.

Strategy 2: Ensure providers have access to accurate and consistent patient attribution data

Our reporting platform includes data on patient assignment and utilization. For purposes of VBP arrangements, we calculate performance based on the providers assigned member population. In instances where members are inappropriately assigned, we have staff that work to quickly reconcile and reassign as appropriate and coordinate these activities with providers. We also employ auto-assignment for new members, and auto-reassignment for existing membership. New members are assigned to a PCP based on their address, history of OHP eligibility and PCP assignment, assignment of eligible family members, etc. Current members are automatically reassigned to a new PCP if their actual utilization patterns indicate they see a different PCP. Information on patient assignment is available both through our data reporting platform as well as our provider portal. Transparency of this information allows for productive conversations around population health management expectations under our VBP arrangements

2022:

a. The information listed above remains accurate in 2022.

   CareOregon uses Tableau and a Tableau server to maintain an externally available quality dashboard for network clinics. The dashboard includes information on member attribution, member characteristics, aggregate performance on measures included in VBPs and member level gaps in care. This dashboard is available to any provider involved in a primary care VBP with CareOregon.

   Providers participating in risk-share agreements also received detailed cost, utilization, and risk files compiled by a third-party.

b. Patient Rosters are available online through our Provider Portal, CareOregon Connect. Roster information is refreshed daily. Providers may pull their clinic rosters at their convenience 24/7. There is no limitation as to how many times rosters may be pulled. Providers can export their patient rosters to for further review. In many cases this information is updated daily.

c. CareOregon uses Tableau and a Tableau server to maintain an externally available quality dashboard for network clinics.

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.

See above

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

See above

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

See 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:
Strategy 3: Implement a multi-prong approach to facilitate population management in service to population health and quality improvement. These approaches include:

Member level data as a tool for population management:
1. We can generate member-level data and lists to identify gaps in care are provided to our clinic partners, so our network can outreach and provide clinical services to close the gaps. We are working to integrate physical health data and oral health data in order to provide a member-centered population management list. Contracted providers within our network have regular/real-time access to data and patient-lists through our data portal (FIDO). JCC also has executed a LOA with Jackson County Public Health to

share member lists related to vaccines, including COVID-19, as an opportunity to close gaps in care more broadly than within contracted clinics.

2. Risk stratification (member level and population level) reports are currently being enhanced to include several markers of risk, including health care condition recapture data. These reports are the foundation for discussion of clinical quality improvement best practices held at our network-wide learning collaboratives and one-on-one technical assistance meetings.
3. Population Health explorer: We have developed a dashboard called population health explorer that allows us to look at member level data from a variety of lenses in order to develop care plans, gaps in care.
4. We have developed a COVID-19 dashboard, both in general and one focusing on vaccines. We used an equity-data approach to categorize populations and can pull member lists to share with our network or public health department for direct outreach.
5. Collective for population management: We have many providers using Collective to outreach to unengaged members seeking care through the Emergency Department and using our Medecision care coordination platform to coordinate services for members with complex chronic health problems or psychosocial issues. The team is also working to identify a member caseload for each JCC panel coordinator based on risk criteria and will be responsible for ensuring that each member has meaningful contact, gaps in care addressed, and are engaged with their primary care provider.

Support to use data for action:
In addition to external provider reporting, the CCO has internal staff that directly support identification and coordination of members in need of services. We have a team of panel coordination staff who are out-stationed in our network and act directly as a part of the clinic care team. This team uses the reports previously described, as well as data obtained directly through chart review, to prepare providers for member office visits. They currently focus primarily on needed services identified by a gap in a CCO incentive, CMS Star measure, or lack of engagement with their primary care provider. With onset of COVID and COVID-19 vaccine efforts, these staff also are helping with outreach to members to ensure they have necessary services and will be outreaching related to access to COVID-19 vaccine.

Population Level Data- though not used for direct patient outreach, this level of data does greatly contribute to overall improved health outcomes.
CareOregon and JCC use sophisticated methods to pull and analyze claims data based on different populations, incorporating pharmacy data, NEMT data, geomapping, as well an ensuring data is disaggregated based on REAL-D. This data is utilized to develop broader population health strategies and initiatives to help improve health outcomes for our membership. These strategies are developed in a data-informed way, in partnership with our CAC and CAP, and informed by our regional health improvement plan.

- **Population level data available to the network:** We make data inclusive of clinical quality measure performance and health system utilization available to providers

continuously through an online platform. We also present this data to help inform strategy development on a larger systems level, informed by our network. We have developed multiple other population level data dashboards focusing of different populations and elements of care (SUD, specialty access, opioid prescribing). These are not available for external use, but we do share the data individually with clinics, and with our region clinical advisory panel. We also use this data for strategy development.

- **Population level data for strategy development:** The same dashboards described in #3 above are used for population level strategy development. We also have developed a tool entitled "population health explorer," that allows both a member view (as described above) and a population view to identify population-level gaps and opportunities. As noted above, we have a COVID-19 dashboard that can also be used for planning, tracking, and continual improvement at a population level.

- **Predictive modeling**: On a quarterly basis, we also use the Johns Hopkins ACG model to generate risk scores for our population. We stratify our population using advanced clustering and machine learning to identify populations which may benefit from interventions. Our regional care teams use information from these tools to guide their work in the Medecision care coordination platform. This data also helps to inform targeted population-level strategies, as noted above.

Equity data approach: Our Quality Improvement Team is in the process of developing a training curriculum on how to use data to support equity work. This training covers best practices on centering equity in analyses and when making data-driven decisions. We are currently seeking feedback from key stakeholders, with a focus on partners of color and organizations that serve communities that have been marginalized. By improving both the quality of our data and shifting our culture around how we use data, we hope to build better strategies to support our members.

2022:
The information listed above remains accurate in 2022.

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

This information listed above remains accurate since May 2022.

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:

Contracted providers within our network have regular/real-time access to data and patient-lists through our data portal (FIDO)(see above).

As indicated, we also can share data from dashboards that are not yet externally facing with individual organizations, in a more manual manner, or through an interactive meeting

2022:
The information listed above remains accurate in 2022.

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

This information listed above remains accurate since May 2022.

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)?

N/A

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

2021:
Progress, including accomplishments and successes, are all described in the specific sections above.

2022:

Progress, including accomplishments and successes, are all described in the specific sections above.

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

No Changes since May 2022

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

2021:
Technology available to CCOs has not quite caught up with the increasing VBP reporting demands, particularly as categorized by the LAN. While the aim of the reporting requirements is directionally correct, fulfilling them remains equally or more challenging than implementation of the VBP arrangements themselves.

2022:
Our area continues to experience the challenges caused by the COVID 19 pandemic in operations and workforce availability.

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

No changes/updates since May 2022

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 considering 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 don't 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.

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?

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.