2020 CCO 2.0 VBP Interview Questionnaire
PacificSource Community Solutions, September 4, 2020

Section I. Written Interview Questions

Your responses will help OHA better understand your VBP activities this year, including detailed information about VBP arrangements, HCP-LAN categories and how these compare to what had been planned.

Note: Our responses address all four PacificSource Community Solutions CCO regions unless noted otherwise with region-specific information.

1) **Describe how your CCO engages stakeholders, including providers, in developing, monitoring or evaluating VBP models. If your approach has involved formal organizational structures such as committees or advisory groups, please describe them here.**

   DEVELOPING

   - PacificSource convenes annually with provider partners to educate on any new contracting requirements for the coming year (including those in the VBP roadmap), negotiate the coming year's contract terms, and collaboratively determine quality metrics from the OHA's Aligned Measures Menu set (these metrics span the sectors of primary care, hospital, behavioral health, and oral health). In the second and third quarters of each year, the internal contract team for each CCO region meets internally to determine if there are any contract terms that need to be modified or added for the following year. The internal team proposes new terms, models, or metrics as appropriate and that adequately meet any OHA requirements for the upcoming year. We consult our regional VBP roadmaps during this internal process. In the third and fourth quarters, we meet with provider partners to discuss what the internal contract team has proposed. Negotiations follow, often bi-weekly, until the agreement is finalized. Meanwhile, there is an additional group of the internal contract team (as well as representation from our Analytics Department) and provider partners that meet to determine what quality metrics to propose for inclusion in the agreement, as well as to determine the targets and weights of each metric.
   - We contract directly with our provider network as well as through Independent Practice Associations, and we set arrangements with both upside and downside risk and aligned quality measures, consistent with the OHA guidance on the HCP-LAN classification for value-based payment (VBP) arrangements.
   - We offer optional PCPCH (Patient-Centered Primary Care Home) and Behavioral Health Integration (BHI) program participation to support non-

billable services and supports in these areas. The programs are tied to state criteria and evidence-based standards. Regional meetings, which include both internal stakeholders and provider partners, occur throughout the contract cycle to evaluate and discuss progress on quality metrics and other contract terms.

- We have begun collaborating with partners to develop and align VBPs with our 5-year VBP roadmap in key care delivery areas.

MONITORING

PacificSource monitors all VBP arrangements regularly on a rolling basis and at least quarterly after sufficient runout exists to support detailed evaluation. PacificSource provides feedback to providers in the form of claims-based metrics reports and financial risk reports. Providers also supply us with their own performance data and rates for which we do not have claims, e.g., clinical data for Quality Incentive Metrics (QIMs), BHI population reach, universal home visiting rates for maternity care, and hospital-based outcome metrics. PacificSource and providers collaboratively review these data in regular forums such as Clinical Advisory Panels, Joint Operating Committees, and meetings with leadership from regional provider organizations. Because of the adverse impacts on health care from COVID-19, and to align with OHA's decision to make the 2020 QIMs reporting only, we have suspended performance requirements for outcome measures through 2020. We continue to engage in monitoring and in robust discussions with provider partners, although the level of participation by provider group varies based on the respective impacts of COVID-19.

EVALUATING

PacificSource developed all VBPs to include performance targets, with payment contingent upon performance. Additionally, a continual evaluation of utilization and cost takes place via monthly reporting on VBP model performance, and we share this information with providers participating in those models. Again, because of adverse impacts on health care from COVID-19, and to align with OHA's decision to make QIMs reporting only, we have suspended monthly/quarterly reporting requirements through August 2020. We explain this further in response to Question 4 below.

2) Has your CCO taken steps in 2020 to <u>modify existing VBP contracts in response to the COVID-19 outbreak</u>? *[Select one]*

☐ CCO did not modify any existing VBP contracts in response to the COVID-19 outbreak. *[Skip to question 5].*

☐ CCO modified all existing VBP contracts due to the COVID-19 outbreak, and we used the same rationale and process for all modifications. *[Proceed to question 3]*

☐ CCO modified all existing VBP contracts due to the COVID-19 outbreak, but we used different rationales and processes for some modifications. *[Skip to question 4]*

☒ CCO modified some, but not all, existing VBP contracts due to the COVID-19 outbreak. *[Skip to question 4]*

3) <u>If you indicated in Question 2</u> that you modified all existing VBP contracts under a single rationale and process, please respond to a–c:

a) Describe the rationale for modifying existing VBP contracts in 2020.

b) Describe the process you used for modifying VBP contracts, including your key activities, stakeholder engagement and timeline.

c) Describe the payment model/s you have revised (or are revising) this year, including LAN category, payment model characteristics, and implementation date/s.

4) <u>If you indicated in Question 2</u> that you made modifications to some (but not all) existing VBP contracts, or that your rationale and process varied by VBP model, please respond to d–g:

d) Among the existing VBP contracts that have been modified due to COVID-19, which payment models included the largest number of members?

Please note: we approached our reporting in this question and the rest of this questionnaire consistent with our belief that the OHA will accept pay-for-reporting as a qualifying LAN category in 2020 (2B), based on most recent correspondence from the OHA, in light of the recent decision by the Metrics and Scoring Committee and due to the impacts of COVID-19. The modified payment models that included the largest amount of members were those payment models that included claims or capitation withholds as a component of provider payment, as well as those that included performance incentives based on QIMs or other outcome measures derived from the OHA's Aligned Measures Menu. These payment models include nearly all physical health and behavioral health services rendered in each CCO, excluding some very small provider groups or hospitals entitled to cost-based reimbursement.

PacificSource made two significant modifications to these arrangements.

PacificSource suspended claims-based and capitation-based withholds from providers throughout 2020 once the COVID-19 pandemic arose. These withholds were a significant downside risk feature of PacificSource contracts across all CCOs,

but represented vital dollars to sustaining provider practices beginning in April 2020. We took these steps consistent with requests by OHA leadership and as reported to the OHA beginning in March 2020.

Additionally, for physical health, behavioral health, and dental providers, PacificSource originally included significant financial incentives around QIM performance. Due to COVID-19 and based on guidance from the OHA, PacificSource has begun amending contracts to modify QIM incentives to "reporting only" for 2020.

PacificSource maintained all of its VBP contracting models in which shared community financial risk was established throughout agreements with providers in the community, with a continued commitment to distribute surplus dollars to providers should such surpluses exist.

e) Describe your rationale for modifying this existing VBP model in 2020.

PacificSource assessed the unintended consequences of the VBP arrangements that were in place in 2020, discussed the impact of the pandemic with providers, and made decisions in April 2020 about how best to help providers. Provider financial stability became a chief concern. While PacificSource used a variety of tools to assist providers financially, one of those tools was determined to be a significant financial concern and harm to providers. This was the absence of full provider payment (claims or capitation) due to quality performance withholds being retained by PacificSource. Even though withholds were part of 2020 VBP arrangements, PacificSource began paying these withholds to providers as a component of its financial assistance plan.

Additionally, there seemed to be consensus among many providers that QIM metrics would be impossible to achieve in a pandemic environment. As such and in alignment with OHA's July 2020 decision to modify QIMs as "reporting only" for 2020, PacificSource modified its performance metrics to match those changes instituted by OHA. PacificSource finds that it is inappropriate to require a connection to a particular provider performance level and payment during a pandemic, and that adjusting contracts to set artificially low benchmarks for value demeans the purpose of VBP and is inconsistent with the message we want to send providers. We await official notice from the OHA about 2B qualifying arrangements as part of the VBP requirements for 2020.

f) Describe the process you used for modifying this VBP model, including your key activities, timeline/s and stakeholder engagement.

The process used by PacificSource in modifying its VBP models was to explain the changes to providers via emails or telephonic/video communications, answer any questions, document shared understandings via email, and make changes to our claims and payment administration systems, accordingly. PacificSource is in the process of following up with requisite contract amendments, pending official notice from the OHA. This is true of the withhold suspension mentioned above, as well as the QIM modifications made once OHA modified the quality program to reflect a "reporting only" year.

g) Describe how you modified this VBP model, including changes in LAN category, payment model characteristics, or implementation dates.

See above for VBP model modification details. PacificSource is of the belief that many of the changes described herein will fall into LAN category 2B, and awaits OHA's formal inclusion of this category as a qualifying VBP arrangement.

While PacificSource has modified withholds and QIM metrics, it has maintained many components of the VBP model. PacificSource continues to pay capitation payments, and maintains the withhold components in its VBP arrangements once any suspension of these withholds is no longer enacted. In this manner, once the COVID-19 pandemic is no longer impacting providers, PacificSource will re-institute such features in its arrangements (after engaging in dialogue with provider partners). This is true for physical health, behavioral health, dental care, and other providers, as noted above.

The following questions are to better understand your CCO's plan for mitigating adverse effects of VBPs and any modifications to your original plans.

5) Describe in detail any planned processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally based communities; lesbian, gay, bisexual, transgender and queer [LGBTQ] people; persons with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).

PacificSource does not believe any of the VBP instituted or modified for 2020 have created any adverse effects on health equity nor for any specific population of members (racial, ethnic, LGBQT, disabled, limited language proficiency, immigrants, medical complexity, etc.)

PacificSource is mindful of creating contract language that does not impede or exacerbate issues of health equity. We list the following examples to illustrate our processes designed to mitigate adverse effects:

- Quality/Health Services teams negotiate performance measures that support health equity. Language currently exists in base provider agreements around health equity and Culturally and Linguistically Appropriate Services (CLAS) practices. PacificSource will updated this language for 2021 agreements. Some examples of measures that support health equity include Follow-Up after Emergency Department Visit for Mental Illness (2020), Assessments for Children in DHS Custody (2020), and the Language Access Measure (2021).

- We monitor our VBP arrangements to evaluate health outcomes, utilization, cost, and grievances and appeals, with reporting on a regular basis. Examples include monitoring performance on QIM measures by race, as well as Emergency Department (ED) and inpatient utilization rates by age, race, ethnicity, language, zip code, behavioral health diagnoses, etc. We also have geocoded maps for utilization that we use to assess geographic/regional differences, as zip codes are well understood to be correlated with health status. Such information is useful for assessing trends, and could be shared with providers if any opportunities for improvement for specific subpopulations were identified.

- For measures that are using the contracted provider performance only, we consider historical measure performance with external targets or benchmarking in target setting and adjustments are made to provide the contracting entity with an achievable target. We currently do this in the Central Oregon CCO, where we apply a higher benchmark to the Postpartum Care QIM to some providers, since the historical performance has been higher than the state benchmark.

- In consideration of risk adjustment models for VBPs, we are evaluating and considering risk adjustment models and other various methods that could better match payment to risk. While we have done some preliminary research, the lack of commercially available models and the relative immaturity and incompleteness of the social complexity data present significant challenges. We would encourage a workgroup or some level of partnership with OHA to work together to find an optimal solution. We adjust risk adjustment in greater detail, below, in response to Question 7.

  We currently use rate category as a proxy to align payment with risk for both direct value based payments (i.e. capitation) as well as for risk sharing settlements with providers. We base our risk sharing settlements on a target as compared to revenue, with the revenue varying by the member's rate category, so adjusting to the mix of adults versus children, duals versus non duals, etc.

Rate category captures several areas of social complexity, including duals, disability, and foster care. We want to understand how much additional gain will be leveraged by layering on additional risk adjustment, relative to the current status and evaluate additional strategies.

- PacificSource Analytics plans to support the required reporting for the VBP roadmap, by region, which includes reporting capabilities like providers who "fire" patients, and an internal template for equity assessments. We are in the process of finalizing the building of reports, pending a few reporting issues. This is anticipated for completion by September 30, 2020.

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

Yes, as previously described, modifications to withholds QIMs were detailed in response to Question 4.

7) What approaches are you taking to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?

We currently use rate category as an effective proxy to align payment with risk for both direct value based payments (i.e. capitation) as well as for risk sharing settlements with providers. The risk sharing settlements are based on a medical loss ratio target, with the revenue varying by the member's rate category, adjusting to the mix of adults versus children, duals versus non duals, etc. Rate category captures several areas of social complexity, including duals, disability, and foster care. Beyond rate categories, PacificSource is building capabilities to track social component information for our members. We are in an early phase in this work, which moves from research/information gathering, to testing, to collaborating with our provider partners on such information, to creating pilots in which incorporation into VBP is possible.

PacificSource currently has multiple clinical risk methods implemented and used to assess and stratify population risk which are foundational steps to incorporating such models in to a VBP methodology. The models are as follows: multiple DxCG risk models, Seattle Children's Medical Complexity Algorithm, and Charlson Comorbidity index. We have also been evaluating data collection and data completeness of social risk factors such as incorporating those factors into our risk stratification algorithms and into various reporting such as demographic, utilization, and performance reporting. These steps help inform future plans around integration of different methods of risk adjusting VBP models.

Recently, PacificSource has begun working on an Integrated Care for Kids (InCK) grant in our Central Oregon and Marion-Polk CCOs that will have risk stratification that includes medical and social complexity to identify children for interventions.

8) **Have you considered social factors in addition to medical complexity in your risk adjustment methodology?**

Yes. PacificSource has considered social factors as a component of reimbursement to those providers whose VBP reimbursement methodology would be impacted by such factors. We desire to pay providers in an equitable way that recognizes and supports social risk and complexity and medical risk and complexity. We recognize that social determinants of health are significant drivers of health outcomes and cost and desire to align our VBPs to support the Triple Aim.

We have not yet implemented any factors beyond rate category to current VBP models. The relative immaturity and incompleteness of the social complexity data currently presents some challenges. In our initial evaluation of patient level social risk factors, there are significant gaps in data sources and completeness that we will need to address to assess the effectiveness of using a social risk score to adjust VBP payment or performance measures. We perceive that our work with OHA under the InCK grant will help inform a path forward. Some of this data may be accessible to OHA, but not to the CCO directly, which indicates that a collaborative approach between OHA and CCOs will be most effective. Our initial work to integrate these social risk factors has been focused on risk stratification for programs as well as various reporting, including our annual population assessment. This work is foundational in understanding the application to a risk adjustment methodology. In 2021, we plan to complete a literature review on what clinical and social risk adjustment methodologies and related best practices exist.

Additionally, in mid-2020, PacificSource made provider stability payments to providers as a result of FFS payment decreases resulting from the COVID-19 pandemic, and prioritized extra payment amounts to behavioral health, substance use disorder, and other providers inherently believed to provide care for the most complex patients. We have not yet implemented additional payments while we explore social factor impacts and correlated risk adjustment impacts on those payments.

If yes, please describe in detail your use of social risk adjustment strategies in your VBP models, including the following:

a) **Whether social risk adjustment is applied to quality metrics, overall payment (for example, capitation), or both;**

We are using available social factors that are captured within a member's rate category (e.g., dual eligibility, disability and foster care) for overall payments and risk sharing. We are evaluating other factors and models to determine if they provide further enhancement above and beyond rate category.

b) **Specific social factors used in risk adjustment methodology (for example, homelessness); and**

See 8(a) above.

c) Data sources for social factors, including whether data is at the individual/patient or community/neighborhood level.

We are using the individual member's rate category to capture some social factors, such as the InCK work described in response to Question 7. Other data sources that are sufficiently available include REAL+D, Adult Acxiom, claims, zip codes, and geocodes.

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

9) Describe the process your CCO has used in 2020 to address the requirement to implement per member per month (PMPM) payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement.

PacificSource offers differentiated base payments according to PCPCH tiers to all PCPCH organizations, based on designations as provided by OHA's monthly PCPCH status report. PacificSource also offers a higher level of PMPMs for those organizations attesting to our own PCPCH Program requirements; these include staffing ratios for adequate care coordination, monitoring closed-loop referrals, and availability of acute care hours. Additionally, PacificSource offers a higher level of PMPMs (as published in our contract application) for those organizations that meet BHI standards as part of our PCPCH Program requirement; these include population reach of members seen by a behavioral health consultant, access to same-day behavioral health services, and identification and intervention with target sub-populations (e.g. substance use, chronic pain, diabetes). Payments are bundled along with regular monthly capitation payments. Payments will be increased annually as stated in our 5-year VBP Roadmap. Provider partners are regularly engaged through the contracting process (as described in response to Question 1) and monthly capitation reports. This two-tiered approach to payment (base and program) has been in effect in the Columbia Gorge CCO since 2019, and Central

Oregon, Lane, and Marion-Polk CCOs have had these in effect beginning January 2020.

10) Has your CCO implemented new, or revised existing, payments to PCPCHs during 2020?

☒ Yes

☐ No

If yes, describe the characteristics of new or revised PMPM payments to PCPCHs.

PacificSource implemented its PCPCH PMPMs in late 2019 for calendar year 2020. PacificSource will begin an evaluation of these payments, and payments per tier level, in fall 2020. PacificSource intends to collaborate with provider partners on the impact and sufficiency of PCPCH PMPM payments and will use such feedback to inform payment increases for 2021. Any such increases are required to be part of PacificSource provider contracts, which likely will not be implemented until January 1, 2021 and will become part of providers' overall VBP arrangements with PacificSource.

The following questions are to better understand your CCO's VBP planning and implementation efforts. Initial questions focus on the three care delivery areas in which VBPs will be required beginning in 2022 which are behavioral health, maternity and hospital care.

11) Describe your CCO's plans for developing VBP arrangements specifically for behavioral health care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Central Oregon: In this region PacificSource has incorporated a new VBP arrangement with the region's inpatient psychiatric hospital. Newly implemented risk withhold and shared savings amounts will be earned depending on performance on metrics aligned with the hospital metrics from the OHA's Aligned Measures Menu. At the time we reconcile contract performance for the prior measurement year, PacificSource will calculate quality performance and distribute withhold and quality-based performance payments.

Columbia Gorge: PacificSource is currently working on developing BH arrangements with our provider partners. PacificSource intends to implement an array of quality metrics aligned with the OHA's Aligned Measure Menu, with upside and downside risk. We have begun discussions about the VBP requirements and anticipate these will be included in 2022 agreements.

Lane: PacificSource is currently working on developing BH arrangements with our provider partners. PacificSource intends to implement an array of quality metrics aligned with the OHA's Aligned Measure Menu, with upside and downside risk. We have begun discussions about the VBP requirements and anticipate these will be included in 2022 agreements.

Marion-Polk: PacificSource is currently working on developing BH arrangements with our provider partners. PacificSource intends to implement an array of quality metrics aligned with the OHA's Aligned Measure Menu, with upside and downside risk. We have begun discussions about the VBP requirements, and anticipate these will be included in 2022 agreements.

12) Describe your CCO's plans for developing VBP arrangements specifically for maternity care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Central Oregon: PacificSource and community providers have discussed three potential concepts for developing a maternity care VBP to implement in 2022. Given the diversity of needs and strengths across communities, the plan allows for the model selected to best meet local needs for care transformation. The three concepts are:

1. A capacity payment to support program expenses of providing substance use disorder treatment integrated in outpatient prenatal care settings
2. Capacity funding to public health or other community providers to operate a universal screening and referral hub for home-visiting programs for pregnant women and families with young children
3. A pay-for-performance model to incentivize adoption of high-value postpartum care services.

Columbia Gorge: A maternity VBP was implemented in 2020 for universal screening and referral hub for home-visiting for pregnant women and families with young children. This will be evaluated and included in the 2021 agreement.

Lane: PacificSource and community providers have discussed three potential concepts for developing a maternity care VBP to implement in 2022. Given the diversity of needs and strengths across communities, the plan allows for the model selected to best meet local needs for care transformation. The three concepts are:

1. A capacity payment to support program expenses of providing substance use disorder treatment integrated in outpatient prenatal care settings
2. Capacity funding to public health or other community providers to operate a universal screening and referral hub for home-visiting programs for pregnant women and families with young children

3. A pay-for-performance model to incentivize adoption of high-value postpartum care services.

Marion-Polk: PacificSource and community providers have discussed three potential concepts for developing a maternity care VBP to implement in 2022. Given the diversity of needs and strengths across communities, the plan allows for the model selected to best meet local needs for care transformation. The three concepts are:

1. A capacity payment to support program expenses of providing substance use disorder treatment integrated in outpatient prenatal care settings
2. Capacity funding to public health or other community providers to operate a universal screening and referral hub for home-visiting programs for pregnant women and families with young children
3. A pay-for-performance model to incentivize adoption of high-value postpartum care services.

13) Describe your CCO's plans for developing VBP arrangements specifically for hospital care payments. What steps have you taken to develop VBP models for this care delivery area by 2022?

Central Oregon: PacificSource has incorporated a new VBP arrangement with the region's inpatient psychiatric hospital. Newly implemented risk withhold and shared savings may be earned based on performance on metrics aligned with the hospital metrics from the OHA's Aligned Measures Menu. At the time we reconcile contract performance for the prior measurement year, PacificSource will calculate quality performance and distribute withhold and quality-based performance payments.

Columbia Gorge: PacificSource has begun discussions with a hospital provider in this region who has historically been reluctant to enter into VBP arrangements. Negotiations continue, but we hope to enact a new VBP agreement for 2021 consistent with OHA requirements and aligned with the hospital metrics from the OHA's Aligned Measures Menu.

Lane: PacificSource will negotiate with community hospitals to implement a new risk model with upside and downside risk relative to performance. Downside risk will take the form of potential forfeiture of hospital risk withhold should there exist a budget deficit. In the event of shared savings, aligned hospital providers in the community will earn risk withhold and a percentage-based portion of shared savings via this VBP. Risk withhold and shared savings amounts will be earned depending on hospital performance metrics aligned with the hospital metrics from the OHA's Aligned Measures Menu. We will weight each of the four metrics equally to create uniform focus on the areas of ED utilization amongst members with mental illness, ambulatory care, standardized healthcare-associated infection ration, and plan all-cause readmission. At the time we reconcile contract performance for the prior measurement year, PacificSource will calculate hospital quality performance and

distribute earned risk withhold and payments based on each hospital's quality performance.

Marion-Polk: PacificSource will negotiate with community hospitals to implement a new risk model with upside and downside risk relative to performance against a contractually determined health care budget. Downside risk will take the form of potential forfeiture of hospital risk withhold should there exist a budget deficit. In the event of shared savings, aligned hospital providers in the community will earn risk withhold and a percentage-based portion of shared savings via this VBP. Risk withhold and shared savings amounts will be earned depending on hospital performance metrics aligned with the hospital metrics from the OHA's Aligned Measures Menu. We will weight each of the four metrics equally to create uniform focus on the areas of ED utilization among members with mental illness, ambulatory care, standardized healthcare-associated infection ration, and plan all-cause readmission. At the time we reconcile contract performance for the prior measurement year, PacificSource will calculate hospital quality performance and distribute earned risk withhold and payments based on each hospital's quality performance.

14) Have you taken steps in 2020 to develop any other new VBP models?

☒ Yes (please respond to a–c)

☐ No (please respond to d–e)

a) Describe the care delivery area(s) or provider type(s) that your new value-based payment models are designed to address.
PacificSource is modeling the application of VBPs to Traditional Healthcare workers (THW). We have also begun considering how VBPs may be incorporated into our Pharmacy Benefit Manager (with plans for implementation in 2023).

b) Describe the LAN category, payment model characteristics and anticipated implementation dates (2021, 2022, etc.) of new payment models you have developed (or are developing) this year. If you have developed multiple new value-based payment models this year, please provide details for each one. Still in development / planning / pre-development stage.
We will be implementing a THW VBP by 2022 and a Pharmacy VBP by 2023.

c) **Describe whether your approach to developing these payment models is similar to, or different from, what you had originally intended in 2020; if different, please describe how and why your approach has shifted (for example, please note if elements of your approach changed due to COVID-19 and how you have adapted your approach).**

Our approach has some differences. We had yet to develop any preliminary ideas about a THW VBP at the time our roadmap was initially drafted, so that was not included. We will need to assess COVID-19 impacts due to differing capabilities/staffing on many providers if the pandemic continues to harm practices in 2021.

Additionally, PacificSource originally encountered a lack of provider contracting/VBP progress in late 2019 with two key provider entities in the Marion-Polk community. This was largely due to the competitive proposal process to be the CCO for the Marion-Polk region at that time. PacificSource did not originally include VBP contracts with these key provider partners in its projections, but has since achieved those VBP arrangements with them.

If no, please respond to d–e:

d) Describe any decisions made to date regarding the eventual design of your payment models, including the care delivery area(s) or provider type(s) that VBPs will cover, LAN category, payment model characteristics, and implementation dates.

e) Describe whether your approach to developing these models will be similar to, or different from, what you had originally intended in 2020, and why.

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

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

We would appreciate being able to participate in a workgroup or in some way partner with OHA to achieve our shared goals around effective risk adjustment. Our questions include: what does that represent, how do we obtain complete data, which data is most correlated, are there processes for shared regions that make sense, is there some efficiency via a statewide process or just best practices that can be individually implemented with some flexibility at the CCO level?

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

We will improve our ability to enter into VBP arrangements if OHA no longer publishes a cost-based reimbursement schedule for non-contracted hospitals. This fee schedule is one example of something that currently limits our ability to increase VBPs. See our response to Question 13.

Optional

These optional questions will help OHA prioritize our interview time.

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

We would like to discuss and exhibit a comparison of our original plans and current state, which has been impacted by COVID-19.

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

We will find it helpful for the OHA to outline questions that align directly with contract requirements so that our work plans and existing strategies can be easily translated for interview format. We would also like to be clear that we are meeting the OHA's expectations for VBPs in terms of conforming our actions to contractual expectations.