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

Introduction

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

Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the CCO VBP interviews again this year. Similarly, they will be using information collected as part of the larger evaluation effort of the CCO 2.0 VBP Roadmap.

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

All the information provided in Section I is subject to the redaction process prior to public posting. OHA will communicate the deadline for submitting redactions after the VPB interviews have been completed.

Section II of this document describes the oral interview topic areas and suggestions for CCO preparation. CCO responses to oral interview questions will be de-identified in publicly reported evaluation results.

If you have questions or need additional information, please contact:

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Section I. Written VBP Interview Questions

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

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

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

- PacificSource Community Solutions (PCS) continues to annually convene 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 PCS contracting team for each CCO region meets to determine if there are any contract terms that need to be modified or added for the following year. The 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 quality 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.
- PCS continues to contract directly with providers, clinics, facilities, and health systems, as well as through Independent Practice Associations (IPAs). 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.
- PCS continues to offer optional PCPCH (Patient-Centered Primary Care Home) and Behavioral Health Integration (BHI) program participation to support non-billable services that have great value for OHP members with physical and behavioral health needs. 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.
- PCS collaborates with partners to develop and align VBPs with our 5-year VBP Roadmap in key care delivery areas.
- PCS monitors and evaluates VBP models through monthly contract-based reports (known as "risk reports") that it sends to the contracted entities. These reports include performance on the financial model and performance measures, including Quality Incentive Measures.

- In early 2021, PCS added additional accountable care organizations and IPA primary care populations to Insight, our member analytics platform. The platform, which filters by provider groups, allows for further monitoring of contract performance in various areas, including inpatient and emergency room service utilization, disease prevalence, performance on gap-in-care measures, potentially wasteful care, and a host of other measures that supplement contract monitoring. Our Population Health team works with our provider partners to review reported performance.
- PCS also engages with stakeholders in regional and partner-specific committees, and reviews data such as quarterly cost of care and other trend reports.
- As part of the strategy to develop and evaluate VBP models, PCS maintains a VBP capabilities roadmap. As part of this roadmap work, PCS is currently assessing vendor VBP capabilities in order to further scale and expand its own VBP capabilities to meet VBP objectives. This project includes internal stakeholders such as Provider Network, IT, Analytics, Finance, and Actuarial.

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

PCS continues to offer Patient-Centered Primary Care Home, and Behavioral Health Integration program participation to support non-billable services that have great value for CCO members with physical and behavioral health needs. In 2022 PCS updated this program to include an additional [redacted] for participating providers/clinics that provide certified Traditional Health Worker services.

In the last year, PCS has begun two new engagements with key provider entities, with a focus on care provided to Medicaid members. PCS and WVP Health Authority have engaged in a series of Joint Operating Committees to review data and discuss improvements in cost management and quality for the 42,000 CCO members assigned to WVP primary care providers in the Marion-Polk CCO. Within the Lane CCO, PCS has begun a leadership forum with PeaceHealth to review success metrics that include the 20,000 CCO members assigned to PeaceHealth primary care providers.

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

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

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

3) <u>If you indicated in Question 2</u> that you modified VBP contracts after May 2021 in response to the COVID-19 PHE, please respond to a–f:

a) **If the CCO modified *primary care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)**

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing PMPM)

b) **If the CCO modified *behavioral health care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)**

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

c) **If the CCO modified *hospital* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)**

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

d) **If the CCO modified *maternity care* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)**

☐ Waived performance targets
☐ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements

☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

e) If the CCO modified *oral health* VBP arrangements due to the COVID-19 PHE, which if any changes were made? (select all that apply)

☐ Waived performance targets
☒ Modified performance targets
☐ Waived cost targets
☐ Modified cost targets
☐ Waived reporting requirements
☐ Modified reporting requirements
☐ Modified the payment mode (e.g. from FFS to capitation)
☐ Modified the payment level or amount (e.g. increasing a PMPM)

The following questions are to better understand your CCO's plan for mitigating adverse effects of VBPs and any modifications to your previously reported strategies. We are interested in plans developed or steps taken since CCOs last reported this information.

4) In May 2021 your CCO reported the following information about processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally based communities; LGBTQ people; people with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).

PCS does not believe any of the VBP instituted for 2021 have created any adverse effects on health equity nor for any specific population of members (racial, ethnic, LGBTQ, disabled, limited language proficiency, immigrants, medical complexity, etc.).

PCS 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:

- PCS's Quality and 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. PCS has updated this language for 2021 agreements. Some examples of measures that support health equity include Follow-Up after Emergency Department Visit for Mental Illness (2021), Assessments for Children in DHS Custody (2021), and the Language Access Measure (2021).

- PCS monitors VBP arrangements to evaluate health outcomes, utilization, cost, and grievances and appeals, with reporting on a regular basis. We have expanded this monitoring to include monitoring of language access needs of primary care groups by the creating a set of health equity dashboards. Additionally, we have added filtering to our Insight platform to include accountable care organizations and IPA-specific groups.

- When setting targets for contracted provider performance, PCS considers historical measure performance or benchmarks, and makes adjustments to provide the contracting entity with a target that is both achievable and meaningful. An example of 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. We continue to review our measure methodology in the VBP Roadmap workgroup to evaluate and improve our contracting measurement strategy to support health equity.

- In consideration of risk adjustment models for VBPs, PCS has been evaluating and considering 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 continues to present significant challenges. We would encourage a workgroup or some level of partnership with OHA to find an optimal solution.

  PCS currently uses rate category as a proxy to align payment with risk for both direct VBPs (i.e. capitation) as well as for risk-sharing settlements with providers. We base our risk sharing settlements on a budget-based expense target relative to revenue, with the revenue varying by the member's rate category, and adjust to the mix of adults versus children, duals versus non-duals, etc. Rate category captures several areas of social complexity, including dual eligibility, disability, and foster care. It would be informative to understand how much additional gain will be leveraged by layering on additional risk adjustment relative to the current status, in order to evaluate additional strategies.

  Since September 2020, PCS has chartered a multi-year work plan and launched an internal workgroup dedicated to better understanding social determinants of health (SDOH) data and its relationship to healthcare outcomes. To date, we have:

  - Conducted a preliminary literature review and research on models and factors.
  - Loaded extensive publicly available data sets for relevant external data to further analyze and have started running some statistical tests. We have developed enhanced logic to identify individual level SDOH indicators.
  - Worked closely with projects like Connect Oregon (Unite Us) to ensure that we will be able to leverage patient-level SDOH screening and referral data from that platform. We expect to start receiving data files from Connect Oregon in July 2021.
  - Participated in a pilot with Alliance of Community Health Plans and Socially Determined to learn more about the landscape among other carriers and commercially available products.

- In spring 2021, PCS representatives attended the Evidence-Based Strategies for Advancing Health Equity webinar and had a technical assistance session with Dr. Marshall Chin specifically around VBP and Health Equity to help inform our strategy.

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

PCS is continuing to evaluate if any additional gain will be leveraged by layering the deployment of social risk adjustments atop the current methodology of benefit categories.

PCS conducted several quantitative analyses to investigate relationships between individual and geographic-level social risk and outcomes of interest such as: cost, utilization, quality of care, and potential underservice. Different statistical modeling techniques were used including exploratory and confirmatory factor analysis, regression analysis, and descriptive statistics stratified by risk, and various correlation analyses. Similar to findings in other papers and briefs on this topic, we found the relationship between social risk, quality, and payments to be unclear.

Analyses also investigated potential bias underlying completeness of social indicator data. A recent article in the Journal of Health Care for the Poor and Underserved titled “Medicaid Social Risk Adjustment in Oregon: Perspectives from Stakeholders” pointed out that social risk data for individuals is fragmented and lacks standardization. In our analyses we found that in addition to these challenges, completeness of individual social risk data varied by race, language, and need for interpreter services. We plan to continue to explore potential biases to help mitigate any unintended consequences if social risk adjusted payments are implemented in the future.

5) Is your CCO planning to incorporate risk adjustment for social factors in the design of new VBP models, or in the refinement of existing VBP models? [Note: OHA does not require CCOs to do so.]

PCS has built a data set with available social factors at both individual and geographic levels and has been evaluating it for meaningful relationships with cost, quality, utilization, potential underservice, and other outcomes of interest. PCS is still in the exploration phase and has not found a strong relationship to date that leads it to implement social risk adjustment or other adjustments based on social factors. However, PCS continues to explore the data to examine social risk and outcomes of interest to better understand statistical relationships between social risk, spending, and quality in order to understand potential correlations, causality, and interactive effects.

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

6) Describe your CCO's plans for developing VBP arrangements specifically for oral health care payments.

a. **What steps have you taken to develop VBP models for this care delivery area?**

Qualifying VBPs with each of PCS's contracted Dental Care Organizations (DCOs) have been in effect in the Central Oregon and Columbia Gorge CCOs since 2017. Beginning in 2020, PCS expanded the same qualifying value-based payments with each DCO for the Lane and Marion-Polk CCOs. Additionally, PCS amended the 2020 DCO contracts in all CCOs to include the new CCO preventative dental Quality Incentive Measure.

Further, to achieve the overall VBP goals, PCS is working with DCOs to increase each DCO's implementation of qualifying VBP arrangements with contracted dental providers. PCS expects these efforts to result in a greater percentage of dollars flowing through qualifying VBP arrangements.

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

While contractual agreements with DCOs emphasize increasing qualifying VBP payments across the dental provider network, PCS has recently amended the VBP section of DCO contracts to include specific, measurable actions DCOs will take between 2022 through 2024 to meaningfully achieve qualifying VBP goals. These actions include conducting a baseline assessment to determine both the percentage of dental providers participating with VBP arrangements in LAN Framework Category 2C or higher and the percentage of total provider payments flowing through qualifying VBP provider contracts. Using 2022 data as the baseline, PCS and DCOs will collaborate to establish DCO VBP targets for 2023 and 2024. It is our intent that these collective actions will result in both a meaningful expansion of qualifying VBP arrangements and a measurable increase in dollars paid to providers in qualifying VBP contracts.

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

PCS has implemented this model.

7) **Describe your CCO's plans for developing VBP arrangements specifically for <u>children's health care</u> payments.**

   a. **What steps have you taken to develop VBP models for this care delivery area?**

      Central Oregon CCO – PCS has established VBP arrangements with physical health providers which include performance metrics for Well Child Checks, from the Aligned Measure Set. PCS also provides a Pediatric Hospitalist payment as part of the overall CCO budget to ensure children have appropriate pediatric care available.

      Columbia Gorge CCO -- PCS has established VBP arrangements with physical health providers which include performance metrics for Adolescent Immunization Rates, from the Aligned Measure Set.

      Marion/Polk CCO - PCS has established VBP arrangements with physical health providers, which include a suite of pediatric performance metrics from the Aligned Measure Set.

      Lane CCO - PCS has established VBP arrangements with physical health providers, which include a suite of pediatric performance metrics from the Aligned Measure Set.

      For all regions, PCS is exploring how to maximize the children's health complexity data within VBP arrangements with pediatric provider partners. These arrangements will likely be tied to the Social Emotional Health QIM.

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

      Central Oregon CCO – PCS will focus on pediatric performance metrics (e.g., Well Child Checks) from the Aligned Measure Set. These will fall primarily in LAN Category 2C.

      Columbia Gorge CCO -- PCS will focus on primary care performance metrics for youth (e.g., Adolescent Immunizations) from the Aligned Measure Set. These will fall primarily in LAN Category 2C.

      Marion/Polk CCO - PCS will focus on pediatric performance metrics (e.g., Well Child Checks) from the Aligned Measure Set. These will fall primarily in LAN Category 2C.

      Lane CCO - PCS will focus on pediatric performance metrics (e.g., Well Child Checks) from the Aligned Measure Set. These will fall primarily in LAN Category 2C.

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

2023

8) **CCOs will be required in 2023 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 is taking in 2022 to prepare to meet this requirement.**

PCS met this objective dating back to 2020 for three of its four CCOs, with the following percentage of payments at 3B or higher:

Central Oregon CCO: 50%

Columbia Gorge CCO: 20%

Marion-Polk CCO: 26%

Lane CCO: 10%

PCS would like to note that reported percentages are most likely lower than actuals given that risk withholds were removed from many contracts (thereby placing them in HCN LAN Category 3A) in 2020 because of the pandemic. The reason we removed withholds was because we intentionally reduced potential risk to improve providers' solvency to help ensure stability and access during the public health emergency. PCS anticipates that these percentages will be maintained, if not increased, for the Central Oregon, Columbia Gorge, and Marion-Polk CCOs in 2023. In the Lane CCO, PCS consistently evaluates opportunities to increase or enhance VBP arrangements across all provider and facility types. One area of focus is the development of behavioral health VBPs, supported by OHA-developed quality incentive metrics and access standards. Our care-delivery area initiatives are aligned with key provider partners to further PCS's VBP goals.

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

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

PCS would appreciate technical assistance in these areas:

- Establishing risk adjustment for social factors
- Developing strategies for gathering and maximizing REALD information
- Explaining VBP initiatives to provider partners

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

PCS would welcome an established data sharing mechanisms to provide CCOs with more complete social risk information than what is currently available, particularly for data elements collected upon enrollment but not shared with CCOs. For example, information such as refugee status or history, incarceration history, poverty level, or tribal affiliation would help ensure more complete and less fragmented data would be available to develop social risk factors to be used to investigate relationships with spending, quality, or potential underservice.

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

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

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

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

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

Cognizant TriZetto Facets – Core Administration platform with developing VBP capabilities.

VirtualHealth Helios – Population Health and Care Coordination platform with advanced integration capabilities to support real-time data exchange.

Data Storage Tools – Microsoft SQL Server and Microsoft SQL Server Analysis Services,
Microsoft Azure Data Lake, SAS OLAP Cube

Data Modeling Tools – Informatica, Edifecs, Microsoft SQL Server Integration Services, Alteryx Designer and Scheduler, Tableau Prep

Analytics Models – Cotiviti-certified HEDIS software, SQL-built Quality Incentive Measures (mirroring OHA specifications), PCS-developed identification algorithm with risk stratification (v1), Cotiviti DxCG Risk Models, Milliman Health Waste Calculator, Milliman HCG Grouper and Benchmarking, Optum Symmetry Episode Treatment Grouper and Procedure Episode Grouper

Advanced Analytics Processes – SAS, R integration into Tableau, R integration into Microsoft SQL
Server Management Studio, Alteryx Designer

Analytic Languages – SAS, SQL, R, C#.NET, Python

Reliance eHealth Collaborative (Analytics) – The Reliance platform provides for a source of data to support the performance management and quality reporting of CCO metrics. The Reliance platform also supports clinical workflows to minimize duplication and care quality.

Proprietary PCS Tools developed by PCS Analytics:

Member Insight Provider Insight (MiPi) – A comprehensive suite of analytic tools, reports and data visualizations used to support population health and VBPs.

Care Program Identification Algorithm (CPIA) – A categorization algorithm that identifies best fit population health programs for PCS members.

PCS Provider Portal – Supports the delivery of data, analytics and member assignment data to providers.

PCS standard population health data feeds – PCS has developed a standard set of data feeds with specifications that are provided to providers upon request. These files are typically ingested into a providers EHR or Population Health Management System. These standard files are accepted by a number of popular vendors like; Lightbeam, Arcadia, Epic, Deerwalk, Springbuk, and numerous others.

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

PCS tool set is consistent with the previous response from 2021 with the exception of Collective Medical Technology.

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

We have included this information in the responses for Section a., above.

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

PCS tool set is consistent with the previous response from 2021.

12) You previously provided the following information about your staffing model for VBP and population management analytics, including use of in-house staff, contractors or a combination of these positions who can write and run reports and help others understand the data.

PCS has staff who can write and run reports and who can help other staff understand the data. Our staff include Data Scientists, Healthcare Data Analysts, Value Based Payment Data Analysts, Business Intelligence report developers, Facets business support developers, Data Integration developers, Data Architects, Risk Adjustment Analysts, Actuaries, and Actuarial Analysts. For 2021, PCS has 17 FTE from these groups allocated to Medicaid. The majority of staff are in-house employees, although we do engage contracted staff as well. Staff also make reporting capabilities available to providers and staff in the company via self-service methods using tools like SSRS, Tableau, Microsoft Analysis Services, Power BI, and SSRS report builder. As we grow our capabilities and systems, we will be adding additional specialty system administration resources to support core VBP Systems.

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

The staffing model for 2021 is consistent with the previous year.

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

13) You previously provided the following information about your strategies for using HIT to administer VBP arrangements. This question included:

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

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Summary: One of the high-value use cases of HIE to CCOs and Health Plans is in the ability to improve the ability to gather and aggregate clinical data required to support performance metrics centrally. Performance on OHA QIMs is one of the foundational constructs of our CCO VBP contracts.

Today, much of this data collection is done via custom data feeds from each provider's EHR or through manual/human access to electronic charts stored in the EHR. Ideally, these data would be aggregated and received by the CCO/Health Plan via a consolidated data feed for their members. During the prior contract period, PCS established the viability of utilizing direct data feeds and is in discussion with Reliance and Diameter Health about file formats required to support these quality programs with supplemental data feeds replacing more manual information capture methods. As discussed in HIE Strategies we believe the NCQA DAV program sends a strong signal about the viability of this specific use-case to support VBP across Medicaid, Medicare, and Commercially insured lives.
Reference: https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/data-aggregator-validation/

Activities	Milestones and/or Contract Year
Implement Diameter Health tool or identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.	2022

Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Metrics (QIM), HEDIS, and other measures from Aligned Measure Menu.	2022
Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth the in the OHA VBP Roadmap.	2023 - 2024

VBP Strategy 7 – Acquire and implement modules, tools and platforms to improve the scalability and performance of value based payment arrangements.

Summary:

One of the greatest challenges in administering meaningful VBP is the immaturity of the VBP platforms market. We have been researching and exploring scalable solutions to meet the many requirements of administering mature VBP, to date, no clear comprehensive solution has been identified leading us to develop proprietary systems and processes to support arrangements. Starting in 2019, a PCS strategic initiative was created to construct a Roadmap of systems and processes to improve our ability to successfully support advanced VBP in alignment with the LAN framework.

The initial focus of this initiative was to identify and implement a more advanced and capable population health management system to support care and utilization management. One of the primary requirements for this new system was its ability to integrate with internal and external systems with a focus on real-time clinical data.

The focus of the 2021 strategic initiative is on developing a scalable VBP Administration Roadmap that is likely to be comprised of multiple components from existing and new vendors. We also anticipate that PCS will continue to build some proprietary solutions to address current needs. It is anticipated that the VBP Administration Roadmap will continue iteratively over the contract period as the market matures to meet the requirements of CCOs.

Activities	Milestones and/or Contract Year
Identify and select next gen Population Health Management/Care Management system.	2020 (completed)
Implement new Care Management platform (Helios).	2021 (Q4)
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3)
Implement or build selected solutions.	2022
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative.	2022-2024 (ongoing)

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

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

PCS HIT strategies continue to remain consistent with the prior response above. There are some changes to the specific activities, which are outlined below in question 14.

b. **spread VBP to different care settings, and**

We have included this information in the responses for Section a., above.

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

We have included this information in the responses for Section a., above.

14) You reported the following information about your specific activities and milestones related to using HIT to administer VBP arrangements.

For this question, please modify your previous response, using black font to easily identify updates from your previous HIT Roadmap submission on March 15, 2021. If the field below is blank, please provide specific milestones from your previous HIT Roadmap submission.

Activities that have been canceled or modified have strikethrough.

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Activities	Milestones and/or Contract Year
Pilot Diameter Health in partnership with Reliance to cleanse, codify, and “enrich” clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)
Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021

Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021
~~Implement Diameter Health tool or~~ identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.	2022
Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Metrics (QIM), HEDIS, and other measures from Aligned Measure Menu.	2022
Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth the in the OHA VBP Roadmap.	2023 - 2024

VBP Strategy 7 – Acquire and implement modules, tools and platforms to improve the scalability and performance of value based payment arrangements.

Activities	Milestones and/or Contract Year
Identify and select next gen Population Health Management/Care Management system.	2020 (completed)
Implement new Care Management platform (Helios).	2021 (Q4)
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3)
Implement or build selected solutions.	2022
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative	2022-2024 (ongoing)

Briefly summarize updates to the section above.

Listed below are the VBP initiative milestones back to Year One. Activities that PCS has added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethrough. Any dates that have changed will have strikethrough in the previous date and will have the revised date next to it.

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Activities	Milestones and/or Contract Year

Pilot Diameter Health in partnership with Reliance to cleanse, codify, and "enrich" clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)
Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021 (complete)
Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021 (complete)
~~Determine if the Diameter tool will transform and standardize clinical data to use alongside claims information for quality measure calculation.~~ -	~~2022~~
~~Implement Diameter Health tool or identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback.~~	~~2022~~
Integrate Reliance HIE clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Metrics (QIMs), HEDIS, and other measures from Aligned Measure Menu.	2022 -2023
Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, QIM, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth the in the OHA VBP Roadmap.	2023 - 2024

VBP Strategy 7 – Acquire and implement modules, tools and platforms to improve the scalability and performance of value based payment arrangements.

Activities	**Milestones and/or Contract Year**
Identify and select next gen Population Health Management/Care Management system.	2020 (complete)
Implement new Care Management platform (Helios).	~~2021 (Q4)~~ 2023
Identify prioritized requirements for VBP Administration Initiative.	2021 (Q2) (complete)
Identify and select VBP components for implementation in 2022 plan year.	2021 (Q3) (complete)
Implement or build selected solutions.	2022
Continue to re-assess and acquire or build components in alignment with VBP Administration Roadmap initiative.	2022-2024 (ongoing)

Integrate Reliance data into new Care Management platform (Helios).	2024-2025

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

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

Summary: In 2020, PCS determined that receiving and processing raw HL7 clinical data into its Edifecs Clinical Data Warehouse was not viable. This is primarily because of the data inconsistencies and the mapping management required to support these feeds. In Q4 of 2020, PCS discontinued the implementation of the Edifecs Clinical Data Warehouse and began pursuing a more direct file feed approach to establish a clean data feed for support of specific uses or quality programs. This platform was also discontinued by our vendor in favor of more modern FHIR-based approaches. PCS believes a partner like Diameter Health will be key in helping to ensure high quality and consistent data feeds from HIE partners such as Reliance.

Activities	Milestones and/or Contract Year
Pilot Diameter Health in partnership with Reliance to cleanse, codify, and "enrich" clinical data from Reliance to integrate into the quality measure platform.	2020 (complete)
Validate results of Diameter-calculated metrics against both provider and Reliance-calculated metrics.	2020-2021 (complete)
Identify standard specification(s) from Reliance for data feeds in supporting CCO quality programs.	2021 (in progress)

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

VBP Strategy 1 - Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

In 2021, PCS, in partnership with Reliance and their vendor IMAT Solutions, continued exploring how to leverage contributed HIE data directly into quality programs as supplemental data. After researching the National Committee for Quality Assurance Data Aggregator Validation program (often referred to as the NCQA DAV program), Reliance has applied to be part of the summer 2022 certification cohort.

The focus of this work is in support of HEDIS for Medicare and Commercial business lines, and establishes a certified process for payers to receive supplemental data from their provider partners. This creates a high-value use case, enabling administrative simplification for both providers and payers.

Our goal with this strategy is to create a strong incentive for payers and providers to join a centralized HIE like Reliance and dramatically grow the coverage of HIEs working to receive this certification. In our experience, most providers who service CCO members also have a strong panel of Medicare and/or Commercial members. We are hopeful this program will also establish an accepted standard for supplemental data in support of the various CCO quality metrics that rely on clinical data as a component for measurement.

As we wait for Reliance to go through the NCQA DAV certification process, we expanded our current EMR data model to include additional diagnosis codes and SNOMED codes fed from Reliance data and added this information to our clinical data warehouse, and then loaded this data from the data warehouse into HEDIS. Phase two of this effort will continue to enrich available data in 2022 for use in our HEDIS and QIM quality programs.

Additionally, PCS has made the decision to not move forward with Diameter Health after the evaluation work was completed which impacts the related 2022-2024 roadmap deliverables. The focus has instead moved to work with Reliance outlined above to put in place the data infrastructure to support Strategy 7. In 2022, PCS will make further adjustments to the roadmap through 2024 based on this.

VBP Strategy 7 – Acquire and implement modules, tools and platforms to improve the scalability and performance of value based payment arrangements.
In 2021, PCS begin the implementation of a new population health management platform. That work is still in progress in phases in 2022/2023. Additionally in 2021, PCS completed the VBP system solution activities outlined in the roadmap and has commenced the implementation of the phase 1 solution for 2022.

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

Vendor technology immaturity is a major driver. PCS has done several reviews of technology vendors supporting VBP administration over the years, including in 2020. Each time, we have determined that the solutions are too narrow in scope to truly address the broad set of capabilities required including the following:

1) Integration with other PCS systems (Claims Processing, Financial, Billing, etc.) – Integration with other systems for tracking total cost of care is critical for hybrid payment models. This feature is necessary to ensure VBP processes are working with, rather than against, our systems supporting the classic fee-for-service claims-processing model.
2) Support of multiple payment models (PMPM, Bundled Services, Pay for Performance, shared savings, etc.) – Our experience is that most solutions only

address one or two of these varied models, at most. This capability is necessary to address VBP approaches as we understand them today.

3) Flexible addition of novel payment models – Without the ability to add new types of models to a system, we are forced to manually track payment models outside of any system we purchase. This capability is critically necessary to support the future of VBPs.

Without these basic feature sets, too much manual administration becomes necessary outside of the VBP platform, thereby making the platform unusable.

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

In 2021, PCS completed an evaluation of VBP-administration vendors as well as a process improvement project that examined the existing infrastructure. This resulted in a 2022 Analytics/IT project charter to improve the existing internal reporting process for pay-for-performance and budget-based financial arrangements. The focus of the 2022 project is integration of non-standard data sources and moving all calculations into a data-access layer.

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

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

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

VBP Strategy 2 - Implement and develop measures for VBP arrangements that focus on provider efficiency and potentially wasteful care

Summary: In 2020, PCS developed visualizations as part of its Provider Insight platform that demonstrated provider performance with Milliman Health Waste Calculator measures. We piloted a set of provider-facing reports with a group of provider partners and got their feedback around improvements. In 2021 and beyond, we intend to develop patient-level reports and broadly distribute the aggregate and patient-level reports to our provider partners to give them the appropriate level of information to take action on these identified areas of potential waste. Milliman has its own roadmap to expand the list of measures, and will continue to adopt its software updates and new measures annually.

Activities	Milestones and/or Contract Year
Develop and deliver phase 1 reports for use in 2021 VBP contracts.	2021
Develop later phase reports for use in 2022-2025 VBP contracts, including member level detail.	2022-2024

VBP Strategy 3 - Implement and/or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements

Summary: In 2020, PCS developed and implemented a limited set of four of the Aligned Measures Menu set. PCS sent these to its provider partners via the existing gap care reports and Excel Member Insight. In 2021, we intend to implement a broader set of the Aligned Measures Menu in preparation for 2022 contracting. Our efforts initially focused on HEDIS measures, since currently we include our Medicaid population in our existing HEDIS measure calculation software and have results for the entire set of administrative measures. The work we intend to do in 2021 and beyond is to integrate that data into our enterprise data warehouse and provider reporting suite to expand the set of measures and create common measure options for our provider partners who also serve our Medicare and Commercial lines of business.

Activities	Milestones and/or Contract Year
Continue development to align measures in our value based arrangements with the OHA Aligned Measures Menu as measures are added or changed.	2021-2024
Evaluate software to support measure calculation measures and changes to specifications.	2022-2024
Continue to annually evaluate changes to measure sets and incorporate changes.	2021-2024

VBP Strategy 4 - Provider attribution supports accurate payment incentives for primary care and specialist physical health providers

Summary: In addition to longstanding reports that are regularly provided to providers regarding member assignment, we have expanded our focus to support specialist attribution. As listed in the 2020 progress section below work has taken place to implement Optum Episode Treatment Groups (ETG) and Procedure Episode Group (PEG) which contains a method for attributing responsible providers to a condition or procedure based episode of care. We started piloting reports of this attribution with our provider partners in early 2021, moving forward we will be sharing member-level reports in addition to the summary-based reports we have created to inform providers on the cost and utilization of those attributed episodes. This will give specialists a better understanding of how the uses of services vary for their attributed members. In addition, our future plan is to complete the improvements to 2021 Primary Care Physician (PCP) attribution and utilize that to inform member PCP assignment changes where the attributed PCP does not match what has been assigned.

Activities	Milestones and/or Contract Year
Specialist Attribution - Develop attribution capability to inform specialists about their performance related to peers.	2021-2022
PCP Attribution - Compare claims based PCP attribution to PCP assignment to identify possible changes in PCP assignment.	2021-2024 (Ongoing)
Specialist Attribution - Develop and distribution standard reports based on specialist attribution.	2021-2024

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

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

Listed below are the VBP initiative milestones back to Year One. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethrough. Any dates that have changed will have strikethrough in the previous date and will have the revised date next to it.

VBP Strategy 3 - Implement and/or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements

This strategy does not have any significant changes from the last roadmap. The expansion of new measures has transitioned to an annual standard work process and will be ongoing. PCS

did evaluate some platforms in 2021 to support measure calculation a year ahead of the roadmap activities and chose not to make a transition at the time.

Activities	Milestones and/or Contract Year
Compare the Aligned Measures Menu with existing Quality Incentive Measure, HEDIS, and other standard quality measures to identify any gaps for development.	2019 - 2020 (complete)
Add measures to existing gaps in care reports as well as the Member Insight and Provider Insight.	2019 – 2020 (complete)
Build workflows to share updated reports with provider partners.	2019 - 2020 (complete)
Continue development to align measures in our value based arrangements with the OHA Aligned Measures Menu as measures are added or changed.	2021-2024 (on-going)
Evaluate software to support measure calculation measures and changes to specifications.	2022-2024
Continue to annually evaluate changes to measure sets and incorporate changes.	2021-2024

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

Listed below are the VBP initiative milestones back to year one. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethrough. Any dates that have changed will have strikethrough in the previous date and will have the revised date next to it.

VBP Strategy 4 - Provider attribution supports accurate payment incentives for primary care and specialist physical health providers

Summary: Over 2020 and 2021, PCS tested a sample of specialist attribution of episodes of care with a small group of provider partners. As part of the process, PCS identified that changes with provider mapping needed to occur to better attribute specialist providers to these episodes. In 2022, PCS is improving the mapping to better address the specialist attribution. Once this process is complete, broader distribution of specialist episodes of care reporting will occur to help inform specialists of their performance relative to their (de-identified) peers.

Activities	Milestones and/or Contract Year
PCP Attribution - Implement modifications to claims based PCP attribution methodology in alignment with HCPLAN Patient Attribution white paper where applicable https://hcp-lan.org/pa-whitepaper/.	2020 – 2021 (in process)
Specialist Attribution - Implement software to attribute specialist providers to members for procedures and condition-based episodes of care.	2020 (complete)
Specialist Attribution - Develop standard Tableau reports based on specialist attribution.	2020 (complete)
Specialist Attribution - Pilot reports that use the software's specialist provider attribution logic.	2020 (complete)
Specialist Attribution - Test with provider that mapping of providers into software and attribution to episodes are accurate.	2020 – 2021 (complete)
Specialist Attribution - Develop attribution capability to inform specialists about their performance related to peers.	~~2021-2022~~ 2022-2024
PCP Attribution - Compare claims based PCP attribution to PCP assignment to identify possible changes in PCP assignment.	2021-2024 (ongoing)
NEW PCP Attribution- Collective pilot of "Assigned/Not Established Patients" functionality, which creates the ability to assign or attribute a population of patients to a specific provider or clinic in Collective, easing the provider's ability to meet value-based payment performance metrics by establishing care with patients from the health plans with whom they work.	2022
Specialist Attribution - Develop and distribute standard reports based on specialist attribution.	~~2021-2024~~ 2023-2024

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

Listed below are the VBP initiative milestones back to Year One. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethrough. Any dates that have changed will have strikethrough in the previous date and will have the revised date next to it.

VBP Strategy 2 - Implement and develop measures for VBP arrangements that focus on provider efficiency and potentially wasteful care

Activities	Milestones and/or Contract Year
Integrate Milliman MedInsight software in PCS IT environment.	2019 (complete)
Model output files in enterprise data warehouse in preparation for reporting.	2020 (complete)
Gather reporting requirements.	2020 (complete)
Develop and pilot initial set of provider-facing reports.	2020 (complete)
Develop and deliver phase 1 reports for use in 2021 VBP contracts.	~~2021~~ 2022
Develop later phase reports for use in 2022-2025 VBP contracts, including member level detail.	~~2022-2024~~ 2023-2024

18) You previously reported the following information about how your CCO uses 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.

VBP Strategy 5 - Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support

Summary: As mentioned in the 2020 progress response below, PCS made additional progress integrating additional sources of data into infrastructure to help identify which members will most benefit from these types of support. In support of this work, PCS has developed a proprietary prescriptive Care Program Identification Algorithm (CPIA) that allows it to identify and place members into best-fit programs. Today, population health information (including risk scores, provider/patient assignment, care program eligibility, gaps in care, ED visit rates and other key data) is shared via our Member Insight Provider Insight (MiPi) dataset. This dataset continues to be expanded to support providers in population health management. It is our vision that it will be further expanded to include SDOH information. As mentioned in other parts of this narrative, PCS will be receiving information about SDOH screening and will be looking to integrate it into algorithms and population-level reporting to help understand the needs of our members via our MiPi Platform and other means. Providers have access to MiPi in a number of different ways including our provider portal, Secure File Transfer Protocol (SFTP), and secure email, depending on their preferences.

Activities	Milestones and/or Contract Year
Annually implement new tools and algorithms.	2021-2024
Design and develop reports that will leverage data from the tools implemented in earlier years.	2021-2024

Integrate CPIA program identification into new PCS Helios Population Health solution.	2021 (Q4)
Define pertinent visualizations and weave them into our standard reporting structure.	2021-2024
Integrate provider efficiency tools into self-service platforms. Enhance reporting available through provider portals.	2021-2024

VBP Strategy 6 - Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

Summary: In 2020, PCS was able to add additional care management program information into its MiPi tool via CPIA. We share these care program enrollments externally with providers via our InTouch Portal, SFTP transfer, and in some cases via encrypted e-mail to help providers identify PCS programs in which members are enrolled. MiPi also includes a current and prior risk score to support risk stratification. We will continue to add new external data sources to the care program algorithm to expand the information set used to identify and prioritize members for care management programs.

Activities	Milestones and/or Contract Year
On an annual basis, update reporting with data from provider insight and care program identification.	2021-2024
Explore the applicability of SDOH information to augment clinical risk scores.	2021-2024

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

Listed below are the VBP initiative milestones back to year one. Activities that have been added since last year's roadmap are identified with "NEW" at the beginning of the initiative. Activities that have been canceled or modified have strikethrough. Any dates that have changed will have strikethrough in the previous date and will have the revised date next to it.

VBP Strategy 5 - Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support

Summary: PCS continues to further develop and refine metrics and algorithms to support provider partners in identifying members who will most benefit from outreach, intervention or care management support. PCS is currently engaged with the implementation of a new population health management platform that will receive and contain logic and information necessary for care management support. PCS also has been working with Collective Medical to create cohorts for intervention, which can be shared with participating provider partners via the platform. This is further explained in the HIT Roadmap under the Hospital Event Notification (HEN) section.

Activities	Milestones and/or Contract Year
Implement reporting of additional information to provider partners that supports population health management and quality of care.	2020 (ongoing)
Assess new types of information for addition to integrated database such as clinical, SDOH-E, and consumer data.	2020 (ongoing)
Assess validity of integrated data.	2020 (complete)
Alter Provider Insight to capitalize on available information.	2020 (complete)
Evaluate and implement new Tableau tools and algorithms that compare provider efficiency and quality of services provided.	2020 (complete)
Give providers actionable data about improvements.	2020 – 2021 (ongoing)
NEW Add high-value customized cohorts and reports built around the specific needs of internal users (HEN Strategy 1).	2020 - 2024 (ongoing)
Annually implement new tools and algorithms.	2021-2024 (ongoing)
Design and develop reports that will leverage data from the tools implemented in earlier years.	2021-2024 (in process)
Integrate CPIA program identification into new PCS Helios Population Health solution.	~~2021 (Q4)~~ 2023
Define pertinent visualizations and weave them into our standard reporting structure.	2021-2024
Integrate provider efficiency tools into self-service platforms. Enhance reporting available through provider portals.	2021-2024

VBP Strategy 6 - Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

Summary: In 2021, PCS participated in the Integrated Care for Kids initiative with OHA. As part of the work to support the initiative, PCS implemented Seattle Children's Pediatric Medical Complexity algorithm. PCS also developed logic to identify several social complexity factor flags for children and adults in the household and integrated information about member housing insecurity and SDOH factors collected by HIE and CIE partners. This helped PCS augment the medical and social information coming from OHA via the Childhood Health Complexity algorithm and allows it to apply the logic to children in all lines of business. The outcome of this work has been to integrate it into the PCS internal Care Program Identification Algorithm.

Activities	Milestones and/or Contract Year
Complete the third version of the care program identification algorithm to integrate non claims-based data sources.	2020 (complete)
Integrate care program information into reporting for provider partners.	2020 (complete)
NEW Development of pediatric social and medical complexity identification algorithm to help risk stratify pediatric members for care management.	2021 (complete)
NEW Develop enhanced SDOH identification methods that incorporate data from multiple sources (such as Connect Oregon/Unite Us, claims, Collective, etc.) to improve member stratification.	2021 (complete)
On an annual basis, update reporting with data from provider insight and care program identification.	2021-2024 (in process)
NEW Staging screening and other data from Unite Us CIE into Enterprise Data Warehouse	2021-2024 (on-going)
Explore the applicability of SDOH information to augment clinical risk scores.	2021-2024 (in process)

19) You previously reported the following information about how your CCO shares 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.

PCS educates its providers on HIT Tools and VBP-related data via a team of staff that includes Population Health Strategists, Quality Performance Coaches, HIE Clinical Strategists, Provider Representatives and others. When we meet with providers, we review dashboards and gap lists to ensure that provider partners and their staff understand how to use and "work" the reporting. During this review, we discuss what these numbers mean, how to drill down into the detail, and what the organization can take away as action items. The data can also help drive workflow changes that improve performance and efficiency. The reporting we developed is updated regularly and is immediately actionable. Additional information can be found in the response to Question 18, above.

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

Our process remains consistent with what we previously submitted in 2021.

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

VBP Strategy 2 - Implement and develop measures for VBP arrangements that focus on provider efficiency and potentially wasteful care

Summary: In 2020, we developed visualizations as part of our Provider Insight platform that demonstrated provider performance with Milliman Health Waste Calculator measures. The Waste Calculator is a stand-alone software tool designed to help health care organizations leverage value-based principles by identifying wasteful services, as defined by national initiatives, such as Choosing Wisely and the U.S. Preventive Services Task Force. This tool can add significant value to existing cost and quality reporting capabilities, specifically those efforts designed for efficiency and effectiveness measurement. Measure categories range from diagnostic testing, screening tests to preoperative evaluation, and routine follow up and monitoring. We piloted a set of provider-facing reports with a group of provider partners and got their feedback on improvements. This work aligned well with release of the *Better Health for Oregonians: Opportunities to Reduce Low-Value Care* released by Oregon Health Leadership Council (OHLC) and Oregon Health Authority (OHA).

Activities	Milestones and/or Contract Year
Integrate Milliman MedInsight software in PCS IT environment.	2019 (complete)
Model output files in enterprise data warehouse in preparation for reporting.	2020 (complete)
Gather reporting requirements.	2020 (complete)
Develop and pilot initial set of provider-facing reports.	2020 (complete)

VBP Strategy 3 - Implement and or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements

Summary: In 2020, we developed and implemented a limited set of four of the Aligned Measures Menu set out to our provider partners via the existing gap care reports and Excel Member Insight. We also evaluated the entire set and developed the longer term implementation plan which continues in 2021. We also identified that we may need to augment the Aligned Measures Menu with additional measures specific to Behavioral Health to more closely meet the goals of our emerging Behavioral Health VBP arrangements.

Activities	Milestones and/or Contract Year
Compare the Aligned Measures Menu with existing Quality Incentive Measure, HEDIS, and other standard quality measures to identify any gaps for development.	2019 - 2020 (Ongoing)
Add measures to existing gaps in care reports as well as the Member Insight and Provider Insight.	2019 – 2020 (Ongoing)
Build workflows to share updated reports with provider partners.	2019 - 2020 (Ongoing)

VBP Strategy 4 - Provider attribution supports accurate payment incentives for primary care and specialist physical health providers

Summary: In 2020, we began the process to better align our PCP based claims attribution logic with the HCPLAN patient attribution white paper to improve and align our methods with these national standards. These improvements will be used to inform PCP assignment changes. Additionally, we implemented the Optum Episode Treatment Groups and Procedures Episode groups which contain a responsible provider attribution method that allows us to identify a specialist provider to an episode of care. We built a set of Tableau visualizations as part of Provider Insight Platform and have been piloting views with provider groups to inform how their cost and utilization of services compare with others'.

Activities	Milestones and/or Contract Year
PCP Attribution - Implement modifications to claims based PCP attribution methodology in alignment with HCPLAN Patient Attribution white paper where applicable https://hcp-lan.org/pa-whitepaper/.	2020 – 2021 (in process)
Specialist Attribution - Implement software to attribute specialist providers to members for procedures and condition-based episodes of care.	2020 (Complete)
Specialist Attribution - Develop standard Tableau reports based on specialist attribution.	2020 (Complete)
Specialist Attribution - Pilot reports that use the software's specialist provider attribution logic.	2020 (Complete)
Specialist Attribution - Test with provider that mapping of providers into software and attribution to episodes are accurate.	2020 – 2021 (in process)

VBP Strategy 5 - Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support

Summary: In 2020, we made additions to our provider reporting suite to add additional elements to the Member Insight about participation in care management programs as well as new gap in care measures in our gap in care reporting to help providers identify additional measures and information for outreach and intervention. Additionally there was significant effort to integrate new data sources such as SDOH screening information, REAL+D information from the enrollment files, claims, etc., to help prepare for future data sharing of that information with providers.

Activities	Milestones and/or Contract Year
Implement reporting of additional information to provider partners that supports population health management and quality of care.	2020 (Ongoing)
Assess new types of information for addition to integrated database such as CIE data, SDOH-E, and consumer data.	2020 (Ongoing)

Assess validity of integrated data.	2020 (Complete)
Alter Provider Insight to capitalize on available information.	2020 (Complete)
Evaluate and implement new Tableau tools and algorithms that compare provider efficiency and quality of services provided.	2020 (Complete)
Give providers actionable data about improvements.	2020 – 2021 (Ongoing)

VBP Strategy 6 - Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

Summary: In 2020, we were able to add additional care management program information into our Member Insight tool which we share externally with providers via our InTouch Portal, SFTP transfers and, in some cases, via encrypted e-mail to help providers identify which PCS programs members are enrolled in and members' risk stratification.

Activities	Milestones and/or Contract Year
Complete the third version of the care program identification algorithm to integrate non claims-based data sources.	2020 (Complete)
Integrate care program information into reporting for provider partners.	2020 (Complete)

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

In 2021, in support of the new COVID vaccine measure, PCS created COVID vaccine reporting for providers that included data from Alert vaccine registry, Reliance, Collective Medical, claims, and the COVAX registry to help providers identify which members were meeting the COVID vaccine measure and which members had gaps in care. To help support providers with the risk stratification of members, PCS added Normalized Census Tract Area Deprivation Index (ADI) and Normalized Census Block Group ADI to the Excel MI Insight reporting that is shared with provider partners. The Area Deprivation Index (ADI) is a measure of socioeconomic neighborhood deprivation using census data. The index is a composite of different neighborhood characteristics such as poverty, housing, employment, and education. This information helps providers stratify and identify members who may have needs for additional social supports.

In 2021, PCS added eight additional measures, as previously mentioned throughout this narrative, for use in VBP contracts as part of the Aligned Measure Menu strategy.

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

In 2020, there was significant need for providers to pivot their focus to adapt to COVID-19 impacts, such as implementing and expanding telehealth, among other activities. This caused the focus on contract performance measures to diminish, and contracts moved to reporting-only for 2020. It also meant that the care delivery areas roadmap requirements changed, and our work has since adapted to those changing requirements. While we did continue to share performance measures including new performance measures from Aligned Measures Menu set, some activities and deadlines to support this work were adjusted accordingly. The biggest area impacted was provider education and training.

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

The COVID-related challenges outlined above continued through 2021 and continued to impact provider-facing strategies in 2021.

Optional

These optional questions will help OHA prioritize our interview time.

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

There are two additional topics that PCS would like to discuss during the interview:

1. PCS would like to discuss OHA's methodology for calculating the VBP threshold for reporting. Specifically, PCS is concerned that the calculation pulls a CCO's payments from Exhibit L, not APAC data, which results in a significant percentage of dollars being undercounted. The dollars presented in Exhibit L are based on a different timing and basis and thus will never reconcile to the dollars APAC PAF. PCS recommends that APAC PAF be used as the basis for the both numerator and dominator.
2. PCS would like to share its efforts around SB 889, the Voluntary VBP Compact, and what it is doing to align VBP efforts among its lines of business.

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

Not at this time.

Part II. Oral Interview

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

Purpose

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

Format

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

Interview topics

Questions topics will include your CCO's VBP activities and milestones in 2021, any early successes or challenges encountered in this work so far, and how your CCO's plans for future years are taking shape. Questions will cover four primary areas:

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

2) Implementation of VBP models required in 2022. These questions will address how your CCO is making decisions about and designing required VBP models. We may ask about factors influencing the design and scale of your PCPCH infrastructure payment model and models to meet the Care Delivery Area requirements. These questions may address your experience designing quality strategies in hospital, maternity and behavioral health VBP arrangements; and your progress developing HIT capabilities with providers to implement these VBP arrangements. We are particularly interested in understanding CCOs' experiences promoting VBP arrangements with a) various hospital reporting groups (DRG, A/B, etc.), b) behavioral health providers operating independently as well as in integrated primary care settings, and c) maternity care providers reimbursed in standalone as well as bundled payment arrangements.

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

4) Promoting health equity through VBP models. These questions will explore how your CCO's work on health equity relates to your VBP efforts. We may ask about your CCO's progress with collecting social needs data; how health equity informs your VBP planning in specific areas such as maternity care; and whether you have identified opportunities to use VBPs to address other CCO 2.0 priorities or requirements.