2021 CCO 2.0 VBP Interview Questionnaire and Guide

Introduction

Coordinated Care Organization (CCO) leadership interviews on value-based payment (VBP), per Exhibit H, will be scheduled in June 2021. Please schedule here if your team 'hasn't already done so.

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 **Friday, May 28, 2021**. Submissions should be approximately 10–15 pages and should not exceed 15 pages.

All the information provided in Section I will be shared publicly.

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

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

Lisa Krois, MPH (she/her/hers)
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Section I. Written Interview Questions

Your responses will help OHA better understand your VBP activities this year, including detailed information about VBP arrangements and HCP-LAN categories.

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.

Development:
Annually, through the Umpqua Health Alliance's (UHA) Budget Committee, comprised of representatives from the provider community, including the sole community hospital, the Community Mental Health Program (CMHP), local physician groups, and other community stakeholders, we review VBP programs and continue to expand VBP programs. Additionally, UHA regularly engages physician-led workgroups such as our UHA Board, Delivery System Advisory Council, Health Equity Committee, Quality Metrics Workgroup, and scheduled Provider Network events. Collaboration from these events and physician feedback has been instrumental in developing, modifying, and expanding VBPs. UHA also engages external actuaries to provide recommendations for certain VBPs to ensure fair and equitable settlements amongst the provider community.

Monitoring:
UHA provides monthly and quarterly updates to participating providers to assist in quality measure achievements, with integration of additional quality metrics through our secure provider portal. For VBP arrangements linked to OHA's CCO Quality Metrics, UHA utilizes its secure provider portal for participating providers, which updates nightly to ensure our providers have the most up-to-date Quality Metrics information. This capability allows our providers to improve any clinical quality gaps to achieve optimal clinical outcomes for UHA's members.

Evaluating:
Beginning in 2021, UHA, through its collaboration and feedback with the provider network and external actuaries, implemented the Member Attribution Cost Summary (MACS) and Network Performance Report (NPR) under its VBP program. This program was created and refined throughout 2020 with participating provider feedback. The program has a four-year implementation timeline that begins with participating provider's risk withholds, dependent upon the success of the MACS/NPR year-end performance to achieve an MLR of 87%. The four-year implementation timeline uses an incremental approach of 25%, 50%, 75%, and ending at 100% risk to their withholding. All participating providers who have a withhold component are included under

this new VBP. Providers are not penalized or rewarded for the relative acuity of disease burden of their members, such as SPMI, and to help mitigate health disparities, external actuaries have implemented adjustments to "normalize and recognize the relative differences in the patient populations" such as:

- **Risk score adjustments are made at the member level and recognize the severity of member diagnoses and predictive cost implications.**
- **Exclusion of individual annual claims costs above $120,000.**
- **Cost neutrality and credibility adjustments are applied to each provider to minimize the impact of a low member assignment.**

The objective is to increase the quality of care due to increased communication and care coordination between PCP, specialists, and facilities regarding the managing of member care.

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

☒ CCO modified VBP contracts due to the COVID-19 PHE. *[Proceed to question 3]*
☐ CCO did not modify any existing VBP contracts in response to the COVID-19 PHE. *[Skip to question 4].*

3) <u>If you indicated in Question 2</u> that you modified VBP contracts 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 fee-for-service [FFS] to capitation)

☒ Modified the payment level or amount (e.g. increasing per member per month [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 the payment mode (e.g. from FFS to capitation)

☐ Modified the payment level or amount (e.g. increasing a PMPM)

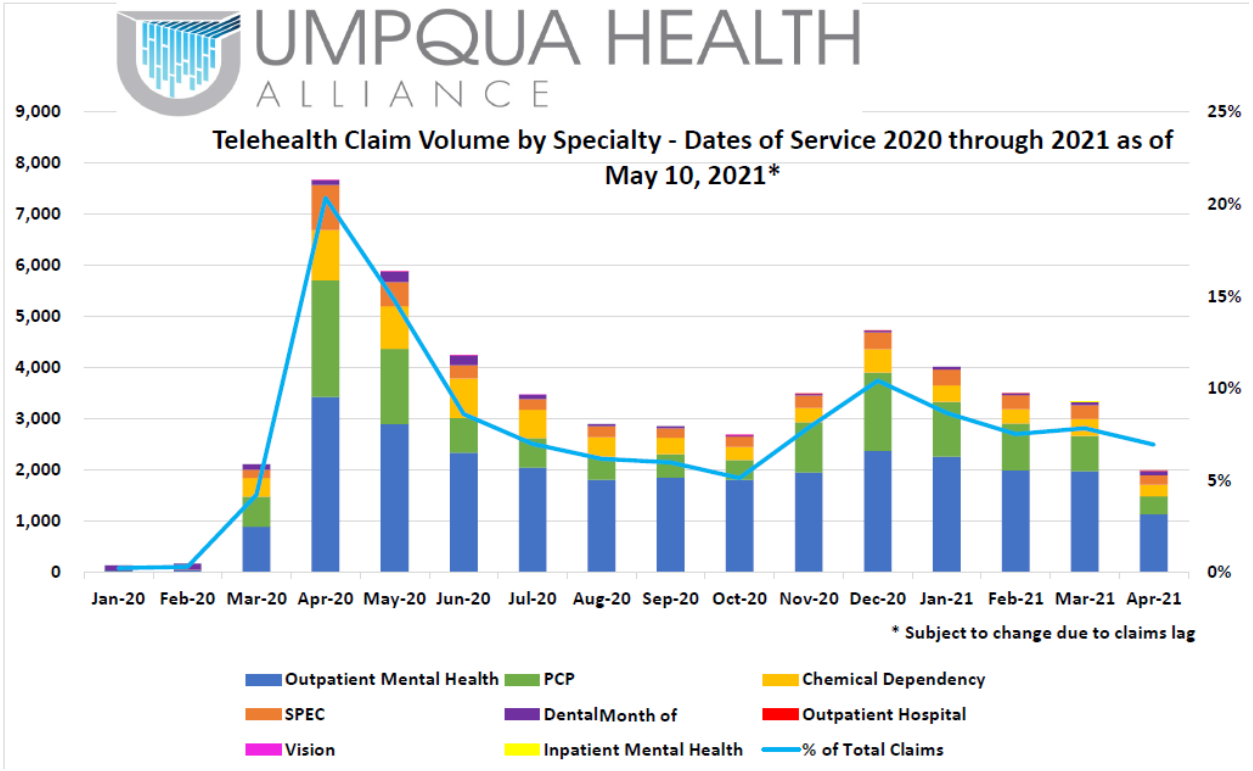
4) Did your CCO expand the availability or the provision of telehealth to members as a result of COVID-19? If so, describe how telehealth has or has not been incorporated into VBPs in 2021.

Recognizing the potential benefit of telehealth to the delivery system in a pandemic environment, UHA implemented telehealth changes to our provider network per OHA's guidelines as they were released, including adjusting reimbursement rates accordingly. In order to ensure our network was capable and comfortable implementing telehealth, UHA also provided technical assistance to practices utilizing telehealth services. This also included, assistance to providers who elected to link their telehealth capacity within their EHR functionality, if available.

UHA has not limited telehealth services from counting toward any targeted VBP quality metric if said service impacts their metric.

UHA collaborated with OHA to gather the telehealth reporting specifications and develop a telehealth utilization trend report early into the pandemic. These reports are shared monthly during UHA's Utilization Management Workgroup and Quality Metrics Workgroup, as depicted below. As UHA followed this report, we recognized an initial spike in services early in the CoVid-19 related closures in March of 2020, and we have since realized a stabilization with most consistent utilization of telehealth services in the outpatient mental health

service line.



5) Has your 'CCO's strategy to measure quality changed at all as a result of COVID-19? Please explain.

Rather than changing strategy to measure quality, UHA made several modifications connected to our VBP quality program in response to COVID-19. With 'OHA's release of withhold funds, UHA elected to fund up to 75% of 2021 VBP payments to our participating providers as the withheld funds were received. UHA adjusted the metrics to a report-only basis for our contracted providers and waived CCO quality metric targets to maintain funding to ensure their business continuity, and reduce the loss in momentum in achieving quality metric performance and reporting. Our goal was to maintain the quality of care our members receive, by assuring our provider network could sustain their viability and continue to provide healthcare for our rural population. To ensure we were engaging our network in the efficacy of our strategy, UHA continued to hold virtual meetings of our monthly Quality Metrics Workgroup and continued direct reporting to our network providers of their attainment of CCO Quality Metrics to assist them in providing care to our members. Our Quality and Health Equity Department continued its regular activities, providing quality assistance, best practices, and guidelines, as usual, only adjusting to a virtual delivery of those services in response to COVID-19 guidance.

The following questions are to understand better 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 September 2020, when CCOs last reported this information.

6) Describe in detail any 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). Please focus on activities that have developed or occurred since September 2020.

UHA continues to review and assess our VBP arrangements to mitigate any adverse effects on health disparities or any adverse health-related outcomes. In addition, UHA has implemented a Behavioral Health Access and Health Equity Awareness Program as an enhancement to our PCPCH program effective January 1, 2021. The program is designed to provide financial support to Primary Care Providers who are actively working on developing and improving behavioral health access in primary care settings and increasing health equity Awareness. Recognizing that the funding mechanisms in Medicaid programs to support stand-alone behavioral health services are often not sustainable, this Behavioral Health Access and Health Equity Awareness Program, which was implemented as an enhanced payment methodology, and is designed to reduce financial barriers to ensure effective integration. Additionally, the program is developed to expand traditional health workers' usage and development while promoting a behavioral health workforce in the Douglas County area.

The Behavioral Health Access portion of the new program incentivizes 'PCP's to manage members with mild to moderate mental illness and/or substance use disorders within the primary care setting to free up access within the CMHP for members with persistent and severe mental illness.

The Health Equity Awareness portion incentivizes 'PCP's to raise awareness and knowledge of concepts related to health equity including CLAS standards. Additionally, this program incentivizes the reporting of REAL+D and SDOH . Specifics of the program include:

- **Training for staff and providers on the use of CLAS Standards in the provision of services.**
- **Implementation of at least five CLAS Standards.**
- **Provision of cultural responsiveness and implicit bias training to staff and providers.**
- **Collected and supplied Race, Ethnicity, Language, and Disability (REAL+D) data consistent with OHA's OARs 943-070-0000 through 943-070-007 (Appendix B).**

- **Screen members for three (3) SDOH domains and use Z-codes for reporting [via claims]: Housing (Z59.0-1; Z59.8-9), Food Insecurity (Z59.4), and Income (Z56.0; Z59.6-9).**

Both of these programs have a quality withhold component and qualify as a VBP LAN.

To date, 90% of our members are assigned to primary care providers who elected to participate under this new VBP program.

UHA began collecting data under the new programs and reporting its results during the monthly Quality Metrics Workgroup.

UHA plans to utilize this additional reporting and screening to review further our VBP arrangements and direct future investments and VBP programs.

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

As mentioned previously, UHA has a five-year implementation plan for our VBP program that began in 2020. Effective January 1, 2021, the Member Attribution Cost Summary (MACS) and the Network Performance Report (NPR) have minimum clinic financial performances to achieve. Suppose a PCP does not achieve their financial performance target. In that case, fulfill their financial performance target. They will be eligible for partial payment of withhold according to the schedule below.

Provider Withhold Payout Criteria	2020	2021	2022	2023	2024
Tier 1 - UHA must meet its global budget	Yes	Yes	Yes	Yes	Yes
Tier 2 - Minimum % of Quality Metric Targets Provider must meet	40%	50%	60%	70%	70%
Tier 3 - Requirement of Provider Achievement of clinic level financial target	No	Yes	Yes	Yes	Yes
% of Withhold at risk for clinic financial performance	0%	25%	50%	75%	100%
% Withhold Payout if Clinic Financial Target Not Met	100%	75%	50%	25%	0%

For non-primary care providers (facilities, specialists, ancillary providers, NEMT, Dental, etc.), the payment of withhold will be determined by the financial performance of the PCPs in managing the continuum of care. The non-primary care providers will receive compensation of the withhold associated with their services to the members of the PCPs to the extent the PCP meets its financial target. 'UHA's objective is to have increased communication between PCP, specialists, and facilities regarding the coordination of care for its members.

UHA follows a continuous process improvement model with regards to providing services for our members and providers. Throughout 2020 UHA solicited feedback from its provider community and will be implementing additional modifications to the MACS/NPR reports that include moving from the Milliman MARA risk adjustment to CDPS+Rx to better align with OHA and risk modeling of the Medicaid population.

8) Is your CCO planning to incorporate risk adjustment in the design of new VBP models, or in the refinement of existing VBP models?

As detailed above, UHA currently incorporates risk adjustment within our MACS and NPR report. We continue to explore new methodologies further to refine our current and future VBP arrangement models. UHA has recently implemented Arcadia within our Care Management Department, and we are working to incorporating risk adjustments within our contracting processes. One area of consideration for future implementation is including a risk adjustment within our current PCPCH program.

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

9) Describe the process your CCO has used to address the requirement to implement PMPM payments to practices recognized as PCPCHs (for example, region or risk scores), including any key activities, timelines and stakeholder engagement. Please focus on new developments, changes or activities that have occurred since September 2020.

In January 2021, UHA implemented a Behavioral Health Access and Health Equity Awareness Program connected to our PCPCH funding for our primary care providers who elected to participate. This program provides additional PMPM payments for primary care providers focused on behavioral health integration within the primary care setting, focusing on services for members with Mild to Moderate Mental Illness and/or Substance Use Disorders. The second half of this new program, Health Equity Awareness, is an added incentive for primary care providers to train and implement CLAS standards, provide cultural responsiveness and implicit bias training to their staff, collect and report on REAL+D data, and screen and report on SDOH domains for their assigned members.

10) Please describe your 'CCO's model for providing tiered infrastructure payments to PCPCHs that reward clinics for higher levels of PCPCH recognition and that increase over time. If your CCO has made changes in your model to address this requirement since September 2020, please describe any changes or new activities.

UHA has had a PCPCH PMPM payment for our primary care providers since 2015. Our PCPCH payment program has a graduated-payment methodology

with increased PMPMs based upon the current PCPCH tier status for our primary care providers. UHA has incorporated a Behavioral Health Access and Health Equity Awareness enhancement to our PCPCH payment effective January 1, 2021. 'UHA's Quality and Health Equity Department work with our contracted providers in providing information, best practices, and assistance in moving towards higher PCPCH tier recognition.

Due to 'UHA's long-standing investment in our primary care network, we have seen an increase for our members assigned to a PCPCH recognized provider from 94.52% to 97.84% (PCPCH Tier 3 or higher). Additionally, our member assignment has increased for Tier 4, or higher PCPCH recognized providers from 89.74% to 93.61% (PCPCH Tier 4 or higher).

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? 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).

UHA has VBP arrangements in place with our local Community Mental Health Program (CMHP) provider, as well as two Substance Use Disorder (SUD) providers in our area since 2019. We also implemented LAN category 4A payment arrangements with our CMHP and one of the SUD providers in 2020 and have continued those arrangements into 2021. For 2022, we are evaluating changes or modifications to our quality measures with these organizations to target high needs population additionally. UHA is also looking to encourage and support additional traditional health worker integration within our behavioral health network providers.

As discussed previously, the new Behavioral Health Access and Health Equity Awareness program that went into effect on January 1, 2021, as an added incentive to our PCPCH program does have a quality metric tied to the withhold for this new program which is a LAN category 4A.

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? 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).

CCO 2.0 contract requires development of 3 VBP contracts in 2021, to include a hospital, maternity, and behavioral health condition.

UHA has determined that it is pursuing combining the first two into a Maternity Case Rate with defined quality metrics for the local hospital (Mercy Medical Center), where >90% of all births occur and the Obstetricians and Pediatricians who perform labor, delivery, and newborn services. We have identified clinical champions representing these areas and are convening these partners to develop this program's financial and clinical parameters.

There are various payment alternatives that can align incentives for providers and hospitals to adhere to evidence-based practices that improve outcomes for both infant and mother and decrease the growth in health care spending for maternity care services. Implementing maternity care payment reform can help reduce the growing burden of health care costs and improve health outcomes for infants and mothers. A blended payment for the delivery fee creates a single rate for maternity care, whether it be a vaginal or cesarean delivery. Three rate methodologies were scrutinized to account for various levels of care:

- **Option 1: Bundle the hospital delivery payment for both mother and infant into a single payment. Creating a bundled payment that includes infant costs takes current facility case rates for delivery that cover the 'mother's expenses and adds on the 'infant's care immediately after delivery into the case. In essence this model adds into the bundle any neonatal/NICU expenses for term infants without pre-existing conditions. Additional payment for outliers, such as premature infants or those with known congenital anomalies, would be paid outside of the bundle.**
- **Option 2: A comprehensive, single bundled payment for a maternity care "episode". A single, complete payment for pregnancy entails one risk-adjusted price paid for pregnancy, from prenatal office visits to ultrasounds, to lab work, to the actual delivery, including anesthesia. The provider(s) are paid this rate per pregnancy, regardless of the resources expended. Lower cesarean delivery rates and fewer complications will lead to higher margins for providers.**
- **Option 3: A combination of option 1 and 2, where all maternity costs (costs incurred related to the delivery, including prenatal [270 days before delivery] and postpartum [60 days post-delivery] care) and neonatal costs (costs incurred related to the neonate, including 60 days of post-delivery encounters).**

The goal of proposing a Maternity Case Rate is to reduce costs and improve outcomes and the experience of care for mother and child. To this end, UHA is

proposing Option 3 as a means to facilitate achieving 'OHA's Triple Aim: Better Health, Better Care, and Lowered Costs.

UHA is dedicated to improving health equity. According to the CDC, black women are significantly more likely to experience conditions such as weakened heart muscle, thrombotic pulmonary embolism, and high blood pressure, contributing to a significantly higher proportion of pregnancy-related deaths compared to white women. Addressing these issues with the mother during prenatal care could potentially improve the 'mother's safety and well-being, but also help eliminate unnecessary costs. In addition, preterm birth rates for minorities are disproportionally higher when compared to their white counterparts. According to the March of Dimes, in 2015, the overall preterm rate was 9.6%, but 13.4% of black infants were preterm, as compared to the 8.9% rate for white infants. Furthermore, non-white infant mortality caused by preterm birth and related complications was significantly higher (44.2% for black infants compared to 31.5%). Because of these disparities, we will be incorporating a metric related to women and children of color in future VBP arrangements. But for now, we are focused on the collection of data to define the scope of that measure.

UHA believes that encompassing all aspects of care related to maternity under one payment model should lead to better care coordination for all members.

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? 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).

UHA already has a VBP arrangement with our sole Community hospital, specialist, and hospitalist group centered around five core quality measures related to hospital care which was implemented in 2019. We have continued these arrangements with increased improvement targets through 2021, with the intent to continue forward into 2022.

In addition, as mentioned above, UHA has convened a workgroup with our Sole Community Hospital and community providers to develop a VBP model for implementation by 2022. Early discussions are centered around a maternity case rate. Still, UHA will be continued discussion and development during 2021 to have a VBP model in place by the start of 2022.

14) Have you taken steps since September 2020 to develop any new VBP models in areas other than behavioral health, maternity care or hospital care? If so, please describe.

UHA has convened a workgroup with our Sole Community Hospital and community providers to develop a VBP model for implementation by 2022. Early discussions are centered around a maternity case rate but UHA will be continued discussion and development during 2021 in order to have a VBP model in place by the start of 2022.

15) Beyond those that touch on models described in questions 11-13, describe the care delivery area(s) or provider type(s) that your new value-based payment models are designed to address.

a) Describe the LAN category, payment model characteristics and anticipated implementation year 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.

UHA has been successful in developing value-based payments models with our contracted network providers in the past several years, with just below half of our contracts incorporating a value-based payment model of a LAN category 3B or higher. UHA continues to work with our provider partners in developing meaningful and quality driven VBP models to facilitate achieving OHA's Triple Aim: Better Health, Better Care, and Lowered Costs.

UHA has implemented our Behavioral Health Access and Health Equity Awareness Program, a LAN category 4A arrangement, as a PMPM to develop behavioral health capacity within our contracted primary care providers' practices as of January 2021. This PMPM payment includes a withhold component with associated quality metrics for withhold payment. This program provides additional PMPM incentives for primary care providers focused on behavioral health integration within the primary care setting with a focus on services for members with Mild to Moderate Mental Illness and/or Substance Use Disorders. The second half of this new program, Health Equity Awareness, is an added incentive for primary care providers to train and implement CLAS standards, provide cultural responsiveness and implicit bias training to their staff, collect and report on REAL+D data, and screen and report on SDOH domains for their assigned members.

UHA is developing a Maternity Case Rate with defined quality metrics for the local hospital (Mercy Medical Center), where >90% of all births occur and the Obstetricians and Pediatricians who perform labor, delivery and newborn services. We have identified clinical champions representing these areas and are meeting to develop the financial and clinical parameters of this program. The specific LAN category for this new

payment model is still being developed, with an implementation of this model by January 1, 2022.

b) If you previously described these plans in September 2020, describe whether your approach to developing these payment models is similar to, or different from, what you reported in September 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).

No, UHA had not previously described these plans in September 2020. The new VBP models were developed or being developed to further our long standing PCPCH payment model with a focus on behavioral health integration and health equity, and our maternity program is under development and on track to meet the implementation timeframe as approved by OHA. UHA continues to utilize our development framework of working with our local providers, members, and community in addressing areas of opportunity to integrate value-based payment models within our providers' practices.

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

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

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

Optional

These optional questions will help OHA prioritize our interview time.

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

UHA would like to demonstrate the MACS/NPR on our secure provider portal, during the interview, if that's of interest.

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

Part II. Oral Interview

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

Purpose

The purposes of the CCO 2.0 VBP interviews are to expand on the quantitative information CCOs report and have provided in the written section; provide CCOs an opportunity to share challenges and successes; and to identify 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:

Accountability and 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 follow-up questions about your written interview responses, including your approach to developing new payment models and any technical assistance you may need. We may ask about how COVID-19 has impacted your 'CCO's plans.

Design of VBP models and CCO capacity for VBP. These questions will relate to how your CCO is designing new VBP models and payment arrangements. We are interested in better understanding your approach and process as you work toward your 'CCO's VBP goals. We may ask about the types of information you are drawing on to inform the design of your VBP models. We may ask follow-up questions regarding the characteristics of your new VBP models described in your written interview responses, particularly in the areas of behavioral health, maternity and hospital care.

Promoting health equity and VBP models. These questions will explore how your 'CCO's work on health equity is informing your VBP efforts. We may ask about how your VBP models are being designed to promote health equity and to mitigate health inequities. We may also ask about your future plans to promote health equity through VBPs.

Provider engagement and readiness for VBP. These questions will explore how your CCO is supporting providers in VBP arrangements, and how COVID-19 may be affecting these arrangements. We may ask about any data or support tools your CCO is using with providers in VBP arrangements, and any successes or challenges you have had.