Umpqua Health Alliance

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 for 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.**

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.

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

In 2022, we continued to evolve and enhance our process in how we develop and monitor our VBPs. Our Quality Advisory Committee serves a significant role now in identifying/developing new VBPs as well as tracking the performance of our existing VBPs. Additionally, our Executive Committee of the UHA Board provides governance and oversight to the process through monthly meetings and through the budget process. The Contracting work group specifically develops VBPs in provider agreements, and the Contract Adherence work group monitors deployment of the provider contract for consistency purposes.

Evaluating: To continuously evaluate outcomes, UHA, in collaboration with its provider network and external actuaries, have agreed to move to the same risk stratification methodology as the OHA. Beginning January 2022, UHA will transition from Milliman MARA Concurrent risk methodology to CDPS+Rx risk methodology for purposes of reporting and risk adjusting members within the MACS report.

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) **If you indicated in Question 2 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).

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 supply 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 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.

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

In the second half of 2021 UHA transitioned to reporting REAL+D dashboards through Tableau. This included a dashboard of PCPs participating in the Behavioral Health Access and Health Equity Awareness (BH/HE) program. The dashboard is shared monthly with the PCPs during the Quality Metrics Workgroup.

For example, as we investigated 2022, we recognized gaps in the quality and quantity of the REAL+D and SDOH data. Similarly, behavioral health access continued to be a problem within our provider network, as many providers do not have the time and resources to

dedicate the level of care for some of our members with SPMI. As a result, UHA elected to modify one of its existing VBPs, by making the Behavioral Health Access and Health Equity Awareness Program available to all its primary care network. In prior years, this program was an "opt-in" contract in which UHA carefully selected a handful of PCPs to pilot the program. Once UHA recognized the potential of this program, it decided to use it as its 2022 Behavioral Health CDA by expanding it to all its primary care providers. PCPs are now automatically enrolled in this program in 2022, which will increase the number of providers participating in the program This expansion will help bring needed financial resources to the PCP community to support members with SPMI, while also producing important data to understand the SDOH needs of its community.

This program is intended to:

- Increase access of behavioral health services within the medical model
- Provide support to the PCP in addressing patients' behavioral health needs
- Mitigate negative impacts on physical health
- Improve patient clinical outcomes and increase overall satisfaction with care through the integrated care model.
- Improve access to specialty behavioral health when patient care can be addressed with the PCP

UHA, like many other areas throughout Oregon, recognize that we have limited provider resources for the management of psychotropic medication, limited patient access to behavioral health providers due to being in a rural area and COVID, limited behavioral health referral network for providers for specialty care, ongoing challenges for patients and providers when attempting to navigate the behavioral health system, unfamiliarity with the limited overall community resources specifically for behavioral health issues for both providers and members, and continued breakdown of social systems as a result of behavioral health issues. By implementing this program, it opens further access to specialty behavioral health care where mild to moderate behavioral health needs can be referred to the PCP clinics for ongoing care.

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.]

Yes, UHA has been using the Milliman MARA Concurrent risk scores in their MACS report as mentioned above. However, to align with the state risk models UHA has incorporated the CDPS+Rx risk scores into our VBP programs that includes all providers with a risk withhold component of their contracts. UHA believes that CDPS+Rx captures more efficiently the social factors of the Medicaid populations.

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?**

      UHA's internal workgroups will identify target oral health quality metrics that align with existing quality infrastructures. During the second half of 2022 UHA will finalize and implement an oral health quality metric with its integrated clinics that will go into effect on January 1, 2023.

   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).**

      UHA will focus on dental providers to increase access and availability in rural areas of Douglas County which would be a LAN tier 3B or higher.

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

      January 1, 2023.

7) **Describe your CCO's plans for developing VBP arrangements specifically for children's health care payments.**
   a. **What steps have you taken to develop VBP models for this care delivery area?**

      UHA's internal workgroup will identify target children's health care quality metrics that align with existing quality infrastructures. UHA is still contemplating on what form of CDA it would to deploy a children health care VBPs. Currently, UHA is evaluating whether to deploy one either in the primary care or behavioral health arena. During

the second half of 2023 UHA will finalize and implement children's health care quality metric that will go into effect on January 1, 2024.

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).

UHA will focus on pediatric, family practice, dental, or behavioral health providers to increase access and availability in rural areas of Douglas County which would be a LAN tier 3B or higher

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

January 1, 2024

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.

Through its monitoring and oversight committees UHA is exceeding the 20% minimum requirement of VBP payments to providers in HCP-LAN category 3B or higher. UHA continues to expand its VBP program to achieve the minimum requirement of 25% in the HCP-LAN category 3B or higher by 2024.
UHA continues to identify opportunities to improve its VBP program to address gaps, reduce costs and improve quality.

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?

UHA would like to talk more about models that include shared savings case rate approaches.

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

None at this time.

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

UHA utilizes the Umpqua Health Business Intelligence (UHBI) software platform for purposes of measuring and reporting VBPs along with measuring CCO Quality Metrics in real time for claims-based measures. UHA's provider portal on the UHBI platform allows participating providers secure, direct access to their CCO Quality Metrics performance as well as UHAs more recent VBP program; the Member Attribution Cost Summary that summarizes PCP performance for members assigned to them.

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

UHBI platform has added more information to the Gap-reports, available for providers to download, in the Provider-Portal section; this information relates to REALD for UHA members identified in the Incentive measure gap-reports. The providers are now able to stratify the population by REALD. Also, a new report "Clinic Data Report" has been added which provides information to clinics pushing EMR data pertaining to eCQM incentive measures; this report helps the clinic and the CCO to ascertain if complete datasets related to eCQM are being shared.

In 2020, UHA engaged with Arcadia Analytics to implement a case management and population health platform for the CCO. We have been using the platform for the past eleven months to be ready for phase two of the platform to begin the work of quality and population health use. 2022 adds an HIT bonus program where UHA encourages providers to connect their EHR to the system and use the platform for their population health analytics. This work, while slow, is coming along and expect to be able to see community results and will be able to capture SDOH, REAL + D and SOGI when that is defined. This data will assist in creating further developed VBPs.

UHA has been very active in rolling out Collective Medical for use in all the practices including dental and behavioral health. This tool is instrumental in capturing and being able to manage high utilizers of the ED and unplanned inpatient stays where discharge planning is critical for the success of the members. The capture of this data assists in VBP metrics where we are working to reduce the overuse of ED.

While still in the implementation period, UHA is spearheading the deployment of Connect Oregon (CIE) in Douglas County. First participants will join the platform by the end of May 2022, and UHA hopes to use some of the data to inform decision making on expanded VBPs towards population health. Our most significant achievements from our 2021 HIT Roadmap submission has been our ongoing collaboration and engagement with our community partners by identifying the CIE in Douglas County. We spent most of 2021 engaging our partners and have implemented Connect Oregon in 2022. We will use future data from Connect Oregon to inform our VBP arrangements with our providers and CBO partners.

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

In December 2020 UHA implemented their new population health platform, Arcadia. This population health management platform provides additional HIT tools to better manage population health such as development of provider specific reports delivered through Arcadia's Bindery functionality.

Arcadia is currently used primarily as a Case Management tool that works to identify members that are high risk, prioritized population such as SPMI, programs that we manage such as Hepatitis C, and Health Risk Assessments. However, phase two will be visible to provider groups to assist in closing of gaps, risk assessment, and will enable us to assist providers to optimize financial outcomes in both value-based care and fee-for-service payment models while empowering opportunities to deliver quality care. This tool will assist in:

- Aggregating disparate data from across the care continuum- from EHR, to unstructured note and health claims – into one common data asset that facilitates value-based care
- Enabling comprehensive views of target populations by generating longitudinal views of individual patients and customizable patient cohorts, across multiple contracts
- Engaging patients with optimized resources by automating workflows around care management
- Meeting health equity goals by identifying patients most likely to benefit from interventions
- Seamlessly surface actionable insights to providers at the point of care to act on quality and risk gaps
- Reconciling contract performance against plan-generated reporting

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

In mid-2021 UHA added Tableau a data visualization software to its HIT analytics toolbox. Tableau has been widely accepted throughout the organization, as well as providing real-time reporting from its wide range of data sources. The Tableau reports range from appeals and grievances dashboards that include REAL+D member stratification, to total cost avoidance. Recently UHA was recognized by the Criminal Justice Commission and the OHSU Technical Assistance Outreach teams for its robust Tableau reporting for its work under a statewide grant.

Tableau data sources currently include Medical/Dental/BH data from our third-party claims administrator, Rx data from the UHBI database, care coordination data from Arcadia. It also includes reference data from government agencies (OHA/CMS) that includes a wide range of information from member demographics such as REAL+D to physician federal register relative value units. Doing so allows UHA to coalesce multiple data sources into a single location for the purposes of developing Tableau dashboards for internal and external parties.

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.

UHA has doubled its programming and analytics workforce by bringing the programming department in-house, as well as new staffing hires to deepen its technical expertise that allows for SQL database reporting for all claims data, including pharmacy and dental as well as all membership files. UHAs investment in workforce and training of its analytics team allows UHA to maintain and excel at reporting and increasing their VBPs and population management into the future.

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

UHA has committed to investing in its analytics team through education and training to strengthen the report writing capabilities through SQL. UHA expanded its staffing model with two new analytics team members, a business analyst and software developer, were hired to support the developers and decision support teams. These skill sets enhance the ability query and analyze the data for high level decision maker or identify areas to improve, including the development of VBPs.

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 <u>strategies</u> for using HIT to administer VBP arrangements. This question included:

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

UHAs HIT analytics software, Umpqua Health Business Intelligence (UHBI), through its secure provider portal, allows providers to review their status on all claims based CCO quality metrics at any time throughout the year. UHA continues to expand transparency to providers for better care coordination and improve health outcomes through its HIT analytics software UHBI.

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,

As part of our HIT Roadmap and CCO 2.0 application Umpqua Health dedicated and identified significant HIT tools and resources that it will be deploying over the five-year period. Such resources include expanding and enhancing our internal analytics team, adding to our internal software development team, procuring a new population of health platform; Arcadia, deploying a CIE with Connect Oregon, greater utilization of Collective Medical throughout the community, and enhancing our HIT bonus program so all our provider community is participating in data exchange.

b. spread VBP to different care settings, and

We successfully deployed a Hospital and Maternity Care combined VBP using our HIT analytics software UHBI that went into effect January 1, 2022. We plan to further develop and utilize our software and solution to expand to Dental and Children's Healthcare VBPs in 2022 for deployment in 2023.

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

UHA feels confident that we have the right tools to perform VBP reporting, however most of our focus will be on making our reports more meaningful by leveraging our technology using Tableau and phase two of our population health platform, Arcadia where it will:

- Aggregating disparate data from across the care continuum- from EHR, to unstructured note and health claims – into one common data asset that facilitates value-based care
- Enabling comprehensive views of target populations by generating longitudinal views of individual patients and customizable patient cohorts, across multiple contracts
- Engaging patients with optimized resources by automating workflows around care management
- Meeting health equity goals by identifying patients most likely to benefit from interventions
- Seamlessly surfacing actionable insights to providers at the point of care to act on quality and risk gaps
- Reconciling contract performance against plan-generated reporting

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

For this question, please modify your previous response, using 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.

UHAs HIT analytics software, Umpqua Health Business Intelligence (UHBI), through its secure provider portal, allows providers to review their status on all claims based CCO quality metrics at any time throughout the year. UHA continues to expand transparency to providers for better care coordination and improve health outcomes through its HIT analytics software UHBI.

Briefly summarize updates to the section above.

High provider utilization of our UHBI platform is still something UHA hopes to achieve. Through interactions with its provider community, UHA hopes to reach the milestone of 75% of its PCPs accessing the UHBI platform in a given quarter. Additionally, with the deployment of Arcadia, UHA has established another milestone in having three separate provider groups submitting clinical data to Arcadia by the end of 2022. UHA will achieve this by actively engaging select PCPs and working with its vendor, Arcadia, to establish

appropriate connection and data submission specifications. This data will help inform any future VBPs with providers and UHA sees it as a crucial element in enhancing VBP reporting.

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

In 2020, UHA spent a considerable amount of time developing reports to support providers' VBP. Through a multidimensional workgroup, UHA was able to develop a report that provides clarity on the 'whole' member cost of care. Partnering with external actuaries and incorporating their recommendations to avoid unfairly penalizing or rewarding providers who have an overall relative prevalence of higher costs or lower cost members. After the reports were developed, UHA brought them to a large provider stakeholder group to review and provide feedback. The feedback was immensely important as it further allowed UHA to craft a report that providers could speak to, and say they had a role in its development.

Through the work of UHAs programming department, UHA is prepared to roll-out, on its UHBI <u>secure provider portal,</u> the Member Attribution Cost Summary (MACS) report as mentioned in 6.a above during the first quarter 2021. The provider portal of the MACS report allows providers to compare their performance to other clinics at a summary level.
Clinics also have availability to drill down to <u>their</u> specific attributed members:

- Risk score
- Months of eligibility
- Claims level detail (excluding those protected by 42CFR) by health care category
- Pharmacy claims

This HIT Platform allows providers to not only monitor to achieve their VBPs but also allows providers to develop care coordination for members through better understanding of the members' overall healthcare.

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

The MACS/NPR reports are reviewed at monthly provider facing meetings. UHA continues to encourage providers to access their MACS/NPR reports through the secure provider portal. UHA's Quality Department works with all PCP clinics to provide training on how to access OHA Incentive Metrics related data reports and, as part of this training UHA shares the User-Manuals which provide step-by-step guidance for navigating the UHBI Platform. All updates to the UHBI Platform are highlighted by banners within the system each time the user logs in.

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

None at this time

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

Having more complete race and ethnicity data from the eligibility files. Another challenge is rolling out VBPs to new CDAs in which they typically do not have a strong HIT infrastructure such as behavioral health and dental providers.

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.

UHAs provider portal, through their Umpqua Health Business Intelligence (UHBI) software platform, allows providers to securely access their CCO Quality Metrics, based on claims data, at their convenience. UHA has also expanded this program to allow Primary Care Providers secure access their performance of the Member Attribution Cost Summary (MACS) with the goal of collaborating amongst the provider network to achieve the triple aim. The MACS report includes costs associated to members from all network providers such as Dental, Facilities, SUD, MH, NEMT, PCP, Pharmacy, and Specialists. Each PCP clinic is measured based on the premiums received for attributed members and their associated costs for all healthcare service categories.

UHA socializes VBP reports and other health plan related reports with its provider network through its monthly Quality Metrics Workgroup and Delivery System

Advisory Committee meetings. UHA will be socializing VBP reports through quarterly Provider Network meetings in 2021, this includes the MACS and NPR reports as discussed above. Based on provider feedback we have expanded our report library shared at these meetings.

Each week, UHAs Customer Care team securely distributes member attribution reports to each of its PCP network providers. This allows providers to identify new members and provides opportunities for direct outreach and care coordination. Beginning in March 2021, from information on the member attribution reports providers will be able to log onto UHAs HIT secure provider portal UHBI - MACS report and review healthcare claims (except those protected under 42 CFR) for their attributed members as well as pharmacy claims history.

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.

We have successfully embedded our MACS/NPR report into our UHBI secure provider portal which allows providers to receive a static report monthly. This report allows them to see their performance measures and will provide significant insight on their VBP performance. In addition, UHA has deployed Arcadia as their Case Management and population of health solution which allows the organization to ingest significant amounts of clinical documentation from our provider community. We have successfully onboarded and digested clinical data from three provider practices thus far and will be using that information to help determine future VBP's as well as communicate those VBP's and the performance of those VBP's in the Arcadia desktop solution.

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

UHA continues to securely distribute on a weekly basis member attribution reports to each of its PCP network providers.

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

UHBI, Arcadia, Collective Medical and Tableau

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.

UHA incorporates Milliman MARA concurrent risk scores at the member level, on a monthly basis into its business intelligence platform UHBI to provide member level risk stratification reports for various cohorts or categories of need to identify for case management with the purpose of improving outcomes. UHA also uses the state MEPP fka Prometheus database for purposes of targeted area of potentially avoidable costs (PACs).

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

Beginning January 2022, UHA will transition from Milliman Mara Concurrent risk stratification to the same methodology used by OHA, CDPS+Rx for purposes of risk adjusting membership for reporting in the MACS report as mentioned previously.

CDPS + Rx is also built into the Arcadia platform and can be drilled down to the patient level along with other risk stratification methods such as HCC for members who may be duals.

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.

Collaborating through external actuaries, UHAs VBP for all network providers under the Member Attribution Cost Summary (MACS) report incorporates Milliman MARA concurrent risk scores. Through the calculations illustrated below, incurred actual costs are calculated to account for cost neutrality, effect of large claims, capitated payments and applies a credibility adjustment. Through this process, UHA avoids unfairly penalizing or rewarding providers who have an overall relative prevalence of higher costs or lower cost members. The result is the MACS report that is shared with the Providers through the secure provider portal and quarterly town hall meetings, monthly quality metrics meetings, etc.

Calculation	Population Information	Provider A	Provider B	Total
A	*Attributed Member Months*	20,000	40,000	60,000

B	*Total Incurred Costs Subject to Risk Adjustment*	$345.65	$487.65	$440.32
C	*Claims in Excess of Indemnification Level*	$0.00	$3.22	
D = B - C	*Costs Subject to Risk Adjustment*	$345.65	$484.43	**$438.17**
E	*Population Risk Score*	0.60	1.20	
F = D / E	*Initial Risk Normalized Costs*	$576.08	$403.69	
G	*Population Total Normalized Costs(1)*			$461.16
H = SQRT(A / 24,000)	*Credibility(2)*	91%	100%	
I = F * H + G * (1 - H)	*Credibility Adjusted Costs*	$566.07	$403.69	$457.82
J = D / I	*Cost Neutrality Balancing Factor(3)*			0.96
K = I * J	*Final Risk Normalized Costs*	$541.78	$386.37	**$438.17**
L	*Capitated Costs*	$50.00	$50.00	$50.00
M = K + L	*Total Attributed Costs*	**$591.78**	**$436.37**	**$488.17**
N = D + L	*Total Unadjusted Costs*	**$395.65**	**$534.43**	**$488.17**

1. Eligibility-weighted blend of provider-specific amounts
2. Maximum value of 100% (This is determined based on number of members)
3. The cost neutrality balancing factor is calculated based on total costs across all providers before and after risk normalization and credibility adjustment are applied. The single factor is applied uniformly to all providers.

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

UHA will be aligning with the state risk models and incorporating the CDPS+Rx risk scores into our VBP programs that includes all providers with a risk withhold component of their contracts.

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

Each month we have opportunities to engage our providers through various committees and workgroups. In 2020, we shadowed the MACS report for each participating PCP to allow them to become familiar with the program before it became part of their 2021 contracts. Through this process we held one-on-one meetings with providers to allow them to ask specific questions to their clinics performance or how the report impacts other providers in UHA's network. Their feedback was taken and vetted through our external actuaries and collectively we implemented additional modifications to the MACS report based on their feedback. An example of that was the exclusion of costs over $120,000 per member per year. As mentioned above, UHA's programming department automated the MACS report calculations and will be allowing providers to access attributed members claim specific data with exception to those claims protected under 42CFR.

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

UHA will be aligning with the state risk models and incorporating the CDPS+Rx risk scores into our VBP programs that includes all providers with a risk withhold component of their contracts.

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

UHA does not foresee any challenges to achieve our goals as related to VBPs.

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

None at this time

<u>Optional</u>
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?

When reviewing the LAN Alternative Payment Model Framework (2017), specifically pages 26-27, we are interested in OHA's position on holding providers accountable for "appropriate care." Specifically must the financial payment be directly linked to meeting an "appropriate care," metric, or if there is infrastructure in place to ensure providers are held accountable for "appropriate care" how is that sufficiently demonstrated? As an example:

Scenario 1: Provider is paid on a FFS basis with a 15% withhold. Withhold payout is contingent on meeting certain financial and quality measures.

Scenario 2: Provider is paid on a FFS basis with a 15% withhold. Withhold payout is contingent on meeting certain financial measures. Quality is assessed through deployment of certain initiatives (e.g. Choosing Wisely) and practice guidelines. The CCO monitors the performance to ensure "appropriate care," but the withhold is not directly tied to a specific quality measure but by ensuring quality practices are in place.

Do both of the scenario's described above meet the criteria of the LAN 3 category? If not, what is the opinion of both scenarios?

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

Possibly aligning the reporting to calendar year, for example the VBP Template covers PY information as well as CY information.

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.