2023 CCO 2.0 Value-Based Payment (VBP) & Health Information Technology Pre-Interview Questionnaire

Introduction

As described in Exhibit H, Section 6, Paragraph b of the 2023 contract, each Coordinated Care Organization (CCO) is required to complete this VBP Pre-Interview Questionnaire prior to its interview with the Oregon Health Authority (OHA) about VBPs.

OHA's interviews with each CCO's leadership will be scheduled for June 2023. Please schedule here. Staff from the OHSU Center for Health Systems Effectiveness (CHSE) will be conducting the CCO VBP interviews again this year. Similarly, they will be using information collected as part of the larger evaluation effort of the CCO 2.0 VBP Roadmap.

Instructions

Please complete **Section I** of this document and return it as a Microsoft Word document to OHA.VBP@dhsoha.state.or.us by **May 5, 2023**.

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

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

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

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Part I. Written VBP Pre-Interview Questions

Your responses will help OHA better understand your CCO's value-based payment (VBP) activities for 2023, including detailed information about VBP arrangements and HCP-LAN categories. A prior version of this questionnaire was collected from your CCO in May 2021 and 2022. Some questions will request an update on previously submitted information, which will be provided.

The following questions are to better understand your CCO's VBP planning and implementation efforts for VBP Roadmap requirements.

1) **In 2023, CCOs are required to make 60% of payments to providers in contracts that include an HCP-LAN category 2C or higher VBP arrangement. Describe the steps your CCO has taken to meet this requirement.**

   YCCO estimates performance that is already above 60% with current VBP arrangements but has implemented new VBPs with two hospitals for 2023, as well as a new specialty provider VBP. Actual performance projections are based upon the current CCO benefit package and will be adversely impacted by significant changes/additions to what CCOs are contractually obligated to integrate in 2023 and beyond such as the inclusion of Behavioral Health Directed Payments.

2) **In 2023, CCOs are required to make 20% of payments to providers in arrangements classified as HCP-LAN category 3B or higher (i.e., downside risk arrangements). Describe the steps your CCO has taken to meet this requirement.**

   YCCO estimates performance that is already above 20% with current VBP arrangements but is implementing new increased risk and complexity of VBPs with one primary hospital, as well as expanding PCP Capitation to an additional provider. Actual performance projections are based upon the current CCO benefit package and will be adversely impacted by significant changes/additions to what CCOs are contractually obligated to integrate in 2023 and beyond such as the inclusion of Behavioral Health Directed Payments.

3) **a. What is the current status of the new or enhanced VBP model your CCO is reporting for the hospital care delivery area requirement?** (mark one)

   ☒ The model is under contract and services are being delivered and paid through it.
   ☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
   ☐ The model is still in negotiation with provider group(s).
   ☐ Other: Enter description

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

The hospital VBP of focus includes a LAN category 3B structure, with downside risk equivalent to [redacted] of total contract value being tied to quality performance metrics. The VBP also includes quality metrics focused on maternal care.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

This contract has been executed for 2023.

4) a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>maternity</u> care delivery area requirement? (mark one)

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

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

The maternity focused VBP model includes a LAN category 3A VBP with participating OB/GYN providers, that includes both Pay-For-Performance incentives and case rate payments based upon and incentivizing early prenatal engagement rates.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

This contract has been executed for 2023.

5) a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>behavioral health</u> care delivery area requirement? (mark one)

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

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

The behavioral health focused VBP includes a LAN category 3A VBP with key network providers of mental health outpatient care. VBP payments include monthly capacity payments for direct outpatient mental health services providing access and services to all YCCO members. In addition, a Quality Incentive VBP Payment in place for meeting set of metric benchmarks, inclusive of focusing on co-occurring disorders and meaningful language access.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

This contract has been executed for 2023.

6) a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>oral health</u> care delivery area requirement? (mark one)

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

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

YCCO has restructured the VBP arrangement with our primary oral health provider (LAN Category 4A), with greater shifts of funding from capitation to quality performance incentives.

YCCO is also evaluating future options for oral health integration into our PCP cap pilot program, inclusive of integration of care and managing Total Cost of Care.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

This contract has been executed for 2023.

7) a. What is the current status of the new or enhanced VBP model your CCO is reporting for the <u>children's health</u> care delivery area requirement? (mark one)

☒ The model is under contract and services are being delivered and paid through it.
☐ Design of the model is complete, but it is not yet under contract or being used to deliver services.
☐ The model is still in negotiation with provider group(s).
☐ Other: Enter description

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

The VBP of reference is a primary care capitation (LAN category 4A) VBP, with a Total Cost of Care quality component currently consisting of upside only payment potential. The VBP has been developed with a specific Children cohort of focus, inclusive of payment, risk stratification, Total Cost of Care tracking, and engagement reporting functions.

c. If this model is not yet under contract, please describe the status of your negotiations with providers and anticipated timeline to implementation.

This contract has been executed for 2023.

8) a. Does your CCO still have in place any VBP contract modifications to reporting or performance targets that were introduced during the COVID-19 public health emergency?

☐ Yes, our CCO's VBP contracts retain COVID-19 modifications.
☒ No, all of our CCO's VBP contacts are back to pre-pandemic reporting and targets.

b. If yes, describe which modifications are still in effect, including provider categories and types of reporting or performance target that remain modified.

Not applicable.

These questions address your CCO's work engaging with providers and other partners in developing, managing, and monitoring VBP arrangements.

9) In May 2021 and 2022, you reported the following information about how your CCO engages partners (including providers) in developing, monitoring or evaluating VBP models.

2021 response:

YCCO primarily utilizes several methods and forums of developing and engaging stakeholders in the development of VBPs:

Alternative Payment Model (APM) Sub-Committee of the Board of Directors -YCCO has had a long-standing APM Sub-Committee which meets on a recurring basis to discuss and provide input on the development of new VBPs, review quality metrics programs/performance, and update/adjust current VBPs when necessary.

Quality and Clinical Advisory Panel (QCAP) – YCCO also formally engages with contracted network providers during monthly QCAP meetings to review VBP model metrics and performance as well as to gain strategic clinical insight into model VBP model development.

Regular Contracted Clinical Network Site Visits - YCCO directly engages with providers on a clinic level in the development of new VBPs, discussing concerns, goals, and implications of both parties during the process. Dedicated YCCO provider relations staff with operational and clinical expertise lead these discussions. Doing so allows for YCCO to better understand provider perspectives on what VBPs have or have not worked for the provider previously, as well as ensuring that YCCO and the provider are working towards common goals as part of a strategic partnership.

Technical Assistance (TA) Forums – YCCO hosts TA forums for contracted providers to provide education and ensure understanding of VBP models in place. General model and specific clinic level questions are addressed during these events covering topics such as the member assignment process for VBP arrangements.

2022 additions:

Primary changes include pre-scheduled and recurring work sessions with key provider hospitals, to develop and implement higher level LAN VBPs. Additional changes include quarterly check-ins with clinical quality and data reporting representatives from a key provider system, inclusive of primary care, specialty care, and hospital services.

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

The following activities are occurring at regular intervals with external partners:

Joint Operations Committee (JOC) meetings with hospital system(s) designed to reduce disconnects between the two organizations; eliminate unnecessary delays in patient care and associated costs; and maintain patient outcomes and satisfaction.

Patient and Population Centered Primary Care (PC3) Learning Collaborative to facilitate clinic to clinic sharing of best practices with the goal of achieving improved clinic and member outcomes.

Incentive Metrics Subcommittee held monthly with contracted providers including OHA-designated Patient Centered Primary Care Homes (PCPCHs) to discuss quality incentive data and strategies.

Immunization Workgroup meets regularly with the goal of improving access to and administration of vaccines with the goal of meeting OHA child and adolescent immunization benchmarks.

10) In your work responding to requirements for the VBP Roadmap, how challenging have you found it to engage providers in negotiations on new VBP arrangements, based on the categories below?

Primary care:		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Behavioral health care:		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Oral health care:		
☐ Very challenging	☐ Somewhat challenging	☒ Minimally challenging
Hospital care:		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging
Specialty care		
☐ Very challenging	☒ Somewhat challenging	☐ Minimally challenging

Describe what has been challenging [optional]:

The largest challenge in specialty health is around quality metrics. This would include both identifying viable metrics (starting with the CCO 2.0 roadmap metrics set), as well as setting up the infrastructure within the clinics to track and act upon the metrics.

The largest challenges in hospital care is also around quality metrics. More specifically for hospitals is the ability to align with metrics that hospitals are already tracking and have the infrastructure to track/focus on, while also ensuring that the hospitals are able to focus on YCCO specific members (a fraction of their total population served). The second challenge has been around aligned primary care access/services working in partnership with the hospitals, to viably impact quality measures and cost containment efforts (e.g. emergency department utilization reductions).

11) Have you had any providers withdraw from VBP arrangements since May 2022?

☐ Yes
☒ No

If yes, please describe:

Not Applicable.

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

12) In May 2021 and 2022, your CCO reported the following information about processes for mitigating adverse effects VBPs may have on health inequities or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally based communities; LGBTQIA2S+ people; people with disabilities; people with limited English proficiency; immigrants or refugees; members with complex health care needs; and populations at the intersections of these groups).

2021 response:

YCCO continues to monitor VBPs for any unintended consequences that adversely impact any specific population's access to care. YCCO is exploring and leveraging risk adjustment models that also evaluates utilization by demographics to identify if specific populations have different access to care. Through the use of a population health platform, Metrics Manager, YCCO routinely looks at quality measure performance across the system, disaggregated by provider. Performance can be measured through a variety of filters including age, gender, diagnosis, geographic distribution, race, ethnicity, and language. On an annual basis, YCCO evaluates year-end performance as it applies to the CCO's unique improvement targets and through an equity lens determines where disparities exist. In partnership with providers, YCCO then develops actions to address gaps in care. By doing this detailed disaggregation, the CCO is able to identify vulnerable populations and identify and avoid any adverse or unintended outcomes related to VBP agreements. YCCO provides incentives for Member engagement and outcomes for assigned Members.

YCCO will continue to provide Continuing Education for providers to better manage and interact with diverse Members within YCCO. YCCO has a policy that providers must follow in order to reassign or "fire" a Member. In the event that this occurs, a YCCO Community Health Worker (CHW) will reach out to the Member.

2022 additions:

Integration and tracking of language access measure into multiple VPBs.

Please note any changes to this information since May 2022, including any new or modified activities.

YCCO staff meet with PCP APM clinics on a bi-annual basis to review clinic performance under VBC arrangements. As part of these visits, provider education and discussions took place in 2022 regarding clinics ability to provide appropriate language access and understand barriers clinics were facing providing language access. Discussions took place

with clinics regarding how APM payments can help support clinic staff in facilitating appropriate access to language services. Technical assistance was offered to clinics to understand language access tracking and interpreter services supported by YCCO.

YCCO continues to hold regular APM subcommittee meetings but have expanded its scope to explore options for evolving incentive metric-related payments to clinics, and is developing workplans to incentivize utilizing and reporting language service provision for YCCO members, ensuring that the VBPs are structured in a way that not only limits restricting access (e.g. turning a patient away when language services cannot be provided) but incentivizing clinics to offer appropriate services to patients of any language.

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

Ideal state would be to integrate social factor risk adjustment into certain capitated agreements, likely starting with primary care once viable and reliable models are available.

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

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

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

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

2021 response:

Throughout 2019 and 2020, YCCO has collaborated with its strategic partner, [redacted], to model some existing VBP arrangements and administer related payments in CIM while relying upon its use of NetSuite to administer some other VBP arrangements. During 2020, YCCO also collaborated with [redacted] and [redacted] implement [redacted], a web-based provider performance measurement and population health management tool. Updated weekly based on recently adjudicated claims, this tool supplanted CCO Metrics Manager in July 2020. 100% of the contracted providers with whom VBP arrangements have been established have had access to [redacted] since January 2019 and, all but two, have had access to [redacted] since September 2020. The remaining two contracted providers are expected to have access to [redacted] by March 2021.

YCCO shares information regarding providers' performance across measures pertinent to VBP arrangements in one of two ways:

1. When the measures of relevance are tracked within [redacted], providers for whom these measures pertain are invited and encouraged to monitor their performance through this application.
2. For measures that aren't tracked within [redacted], YCCO uses Jupyter Notebook, SQL queries, Tableau, and Excel to produce and distribute reports on a recurring schedule (e.g. quarterly for most; monthly for some) to pertinent providers.

Over time, the set of measures tracked within [redacted] is expected to align with all measures pertinent to VBP arrangements established with providers thereby eliminating the need for YCCO to produce and distribute separate reports.

Patient attribution is based on PCP assignments administered by YCCO. PCPs to whom YCCO members are assigned, including those with VBP arrangements, learn of assignments by virtue of viewing and, if desired, downloading an up-to-date PCP roster report available within the [redacted]. In addition, an up-to-date provider roster is available to PCPs engaged in [redacted]

2022 additions:

Since hiring an Information Systems Director in the fall of 2021, IS efforts have been largely focused on building our IS capabilities, including adding IS staff and implementing infrastructure enhancements to better support YCCO in performing on our mission. That said, in reference to the above section of the March 15, 2021 HIT Roadmap, we have:

- Integrated most but not all VPB metrics into [redacted], reducing the need for a separate methodology for communicating status of VBP metrics to providers.
- Successfully established Ayin Quality Insights access to the two remaining providers, resulting in 100% of contracted VBP providers having access to [redacted] and [redacted] Insights for ongoing monitoring of metrics. YCCO has performed multiple site visits with each VBP provider confirming their ability to access [redacted] and [redacted].

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

2023 additions:

We continue to focus on improvements and year-to-year updates of the [redacted] reporting and analytics tool available to providers via the [redacted].

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

2021 response:

Member-specific gaps in care are summarized within [redacted] which providers are encouraged to monitor and address proactively or in the context of scheduled encounters. Contracted providers can view members' demographic data including "flags" indicative of certain known characteristics within [redacted] For those privileged, additional member-specific information is also visible within [redacted] – e.g.

prior authorizations and referrals as well as historical claims and related documentation.

YCCO's Care Management team utilizes [redacted] solution seamlessly integrated with [redacted] system to assess member cost, risk and quality; identify, profile and stratify members; and determine which members are in need of specialized intervention programs and which intervention programs are likely to have an impact on the quality of individuals' health. This information informs who the team is to engage in specific care management programs as well as crafting member-specific care plans. As warranted, this information is shared with providers servicing members engaged in care management programs.

As described in the response to 5.i above, YCCO expects to further bolster population health and risk management activities by incorporating a member-specific REALD and SDH demographic data elements into [redacted], and reports that YCCO shares with contracted providers with whom VBP arrangements have been established. YCCO also intends to provide actionable data, including risk-based cohorts, to contracted providers with whom VBP arrangements have been established.

YCCO acknowledges the importance of understanding the diversity and health outcomes of the population we serve. It is of critical importance that YCCO partner with the providers in the community to best serve our patients and share timely and actionable information when warranted. YCCO also acknowledges the necessity to effectively manage financial risk associated with the administration of OHP benefits for its members.
YCCO intends to stratify its membership based on one or more risk scores (e.g. CDPS+, ACG) in order to target appropriate interventions and inform care management and care coordination efforts aimed at improving health outcomes and managing financial risk thereby enabling YCCO to achieve the triple aim objectives.

YCCO receives CDPS+ risk scores calculated for each of its members from OHA and its actuary, Wakely, on an annual basis and YCCO can calculate ACG risk scores for each of its members whenever it desires via the use of DST Health Solutions' ACG System. Although neither type of risk score is currently incorporated into YCCO's data warehouses, based on an assessment of value and relevance, YCCO expects one or both to be incorporated into its data warehouses during the 1st half of 2021 at which point YCCO will be able to identify, analyze and report upon a broader set of member characteristics of interest.

YCCO expects the risk score(s) deemed valuable and relevant to be incorporated and possibly presented within [redacted] and [redacted] in the 2nd half of 2021, thereby enabling an additional means by which YCCO can identify and report upon member characteristics of interest and share risk-based cohorts with pertinent contracted providers.

Lastly, beginning in 2020, YCCO began embracing the Prometheus (MEPP44)-derived data shared by OHA with YCCO to analyze potentially avoidable costs. This analysis has and is expected to continue spawning ideas for new/revised VBP models, particularly related to contracted specialty providers.

2022 additions:

Since hiring an Information Systems Director in the fall of 2021, IS efforts have been largely focused on building our IS capabilities, including adding IS staff and implementing infrastructure enhancements to better support YCCO in performing on our mission. That said, in reference to the above section of the March 15, 2021 HIT Roadmap, we have:

- Incorporated the CDPS+ risk score into our database providing for enhanced care management, reporting, and analytics.
- Initiated an effort to enhance our Tableau deployment in order to provide more readily available data and analytics.

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

2023 additions:

YCCO is making significant enhancements to our Tableau analytics capabilities, implementing a Tableau Server on the MS Azure cloud. This will allow for deeper, more visible, and meaningful analysis of our VBP program. This is in addition to the reporting available to providers via [redacted] on the [redacted] provider portal.

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

2021 response:

YCCO and our partners, [redacted], dedicate various resources to VBP initiatives and Population Management Analytics. By monitoring and reporting provider performance across process and quality outcome measures applicable to VBP arrangements established with contracted providers and informing providers of member-specific gaps in care, we aim to ensure that our members receive appropriate whole-person care regardless of the PCP to whom they're assigned while simultaneously reducing health disparities or inequities when observed. We administer assessments that strive to identify health risks and health-related social needs (i.e. social determinants of health). Through our population health and risk management analytics, we continually identify and assess member risks and needs and, when appropriate, engage high-need members in comprehensive care management programs aimed at addressing needs and minimizing risks. These care management programs often require effective care coordination across providers of medical and social services, delivery systems, or settings to effectively manage member safety and outcomes during transitions.

With regards to YCCO's staffing model for VBP and population management analytics, the following staff, board members, and strategic partners play integral roles:

APM Sub-committee (CEO, CFO, CMO, 4 BOD members) – YCCO's board of directors (BOD) has established and designated the APM Sub-Committee as the group to initially

review and help develop new APMs/VBPs for the CCO. The APM Sub-Committee recommends new proposals and contract changes to the BOD for ultimate approval when needed.

[redacted] – [redacted] acts as advisors to the APM Sub-committee and ensures that the design and development of APMs align with related intentions and expectations.

[redacted] – [redacted] define APMs, collaborate with partners to implement payments based on the APMs, and craft and share reports regarding the APMs with relevant stakeholders.

[redacted] – [redacted] bears responsibility for the successful implementation and use of [redacted] among providers with whom APM-based contracts are established.

[redacted] – [redacted] responsible for provider relations communication and collaborate with providers with whom APM-based contracts are established to ensure they understand the APM and related implications and expectations. They also ensure that leverage tools (e.g. [redacted]) and reports appropriately as they service members and manage population health risk.

[redacted] – [redacted] ensures that [redacted]-enabled Provider Payments (FFS, Capitated) are made in accordance with APM contracts, produces APM Reports, processes monthly 820 files and conveys related capitated payment information to applicable providers [redacted] and processes daily and monthly 834 files and conveys related membership assignments to capitated partners [redacted]

[redacted] – [redacted] implements and maintains [redacted], and administers Utilization Management and Care Management activities in accordance with APM contracts.

2022 additions:

[redacted] – [redacted] are responsible for providing stable, accurate, and readily available data and analytics tools, intended to enhance YCCO internal analysis supporting operational and strategic initiatives.

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

2023 additions:

No changes/additions to the previous response, other than acknowledging that staffing changes have occurred.

16) You previously provided the following information about your <u>strategies</u> for using HIT to administer VBP arrangements. This question included:

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

2021 response:

YCCO's five-year Value-Based Payment (VBP) roadmap includes all the necessary focus areas for CCO 2.0, inclusive of PCPCH foundational payments, hospital, maternity, child, behavioral, and oral health care. During the five-year term of our CCO 2.0 contract, we are committed to transitioning provider payments from 20% VBP-based to 70% in accordance with OHA's COVID-19 revised timeline. By 2024, VBP arrangements will be predicated on Health Care Payment Learning & Action Network (LAN) category 2C or higher as summarized below. The primary partners in focus for upscaling include primary care, hospital, specialty care, and oral health care providers. Within primary care, YCCO's foundational payments for PCPCH tier levels will continue to be leveraged and expanded, with the goal of increasing tier levels and certified providers. The projected roadmap is subject to change as well, pending further development and discussions with providers.

Year one VBP advances focus on primary care, behavioral health, and hospital care. For hospital and maternity care, LAN Category 2C pay-for-performance VBP are to be implemented with one hospital, as well as developed for future expansion to at least one additional hospital in year two. Behavioral health payment models were revamped from a LAN Category 4N to a LAN Category 4A VBP with one provider. Primary care efforts focused on development of a LAN Category 4A VBP pilot with two provider groups, with implementation in 2021.

Year two VBP advances include implementation of the primary care LAN Category 4A pilot VBP, as well as development and adjustments to the pilot model for expansion in year three to include as many as thirteen primary care and children's care providers. The hospital care LAN Category 2C VBP will expand to a second hospital, and development for LAN Category 3B or higher VBPs are targeted. Solely within maternity care, YCCO's Maternal Medical Home model will be adjusted from a LAN Category 3N to a LAN Category 3B VBP, as well as expanded from one to two providers.

Year three VBP advances include implementation of primary care LAN Category 4A VBP for up to thirteen more providers, inclusive of three children's care specific clinics. Additional advances target implementation of up to two more hospitals on LAN 2C VBPs, and implementation of one hospital advancing from LAN Category 2C to LAN Category 3B VBP. Within behavioral health, LAN Category 2C VBPs are targeted for development and possible implementation for possibly five more providers.

Year four and five VBP advances currently target focuses on primary care with behavioral and oral health integration, as well as possible total cost of care risk to up to twenty-two providers. Additional advances may include maternity care expansion to one or more providers, behavioral health expansion, oral care revamping and risk advancement, and hospital expansion to two or more hospitals.

2022 additions:

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

Increase staffing support/infrastructure for both HIT and VBP analysis.

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

Ensure systems are scalable to new benefits, metrics, and populations.

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

YCCO has recently implemented technology improvements to initiate a more reliable cloud-based infrastructure, moving our primary business server to Microsoft Azure. This gives us the ability to quickly and reliably add IS resources as they become necessary. That, along with our previous responses to 13.a and 13.b positions us to scale as needed.

Please note any changes or updates for each section since May 2022.

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

Response unchanged - increase staffing support/infrastructure for both HIT and VBP analysis. Although please note that staffing increases in the YCCO IS department have recently been realized and will have an impact in 2023and forward.

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

Response unchanged - Ensure systems are scalable to new benefits, metrics, and populations.

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

YCCO is currently deploying cloud-based MS Azure Tableau Server and SQL Server infrastructures. In addition to the previous move of our primary business server to Microsoft Azure, these deployments further our ability to quickly and reliably add IS resources as they become necessary.

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

For this question, please modify your previous response, using underlined text to add updates and strikethrough formatting to delete content from your previous responses from May of 2021 and 2022. If the field below is blank, please provide updates on specific milestones from your 2021 HIT Roadmap submission.

2021 response:

YCCO is in the process of updating their HIT Plan of which the previous response was an excerpt. The follow updates (in black font) will reflect the current status of those activities and milestones along with any cosmetic edits and corrections.

The following goals and related strategies, and tactics summarize our complementary HIT plans to enable and support YCCO's VBP Roadmap.

Goal 11: Ensure that existing and future VBP arrangements can be modeled and related payments can be administered in CIM

YCCO desires to model all VBP arrangements and administer related payment exclusively in [redacted] and intends to collaborate with [redacted] to achieve this goal.

Strategy 20: Confirm PH TECH's ability to model VBP arrangements

Tactic 20.a.: Before establishing a VBP arrangement with contracted providers, collaborate with [redacted] to ensure that the VBP arrangement can be accurately modeled and related payment can be appropriately administered in [redacted]
Tactic 20.b.: If an enhancement to [redacted] is required before a new VBP arrangement can be accurately modeled and/or a related payment can be appropriately administered in [redacted], ensure that the effective date of any provider contract(s) predicated on the new VBP arrangement follows the date at which [redacted] confirms intent to release the necessary enhancement.

Timeline for Strategy 20

	2020				2021				2022				2023				2024			
Strategy	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tactic 20.a	O			X																
Tactic 20.b	O			X																

O	Anticipated Start Date
X	Anticipated Completion Date
	Ongoing Effort

Evaluation of Strategy 20
YCCO will evaluate the success of this strategy by monitoring the instances in which [redacted] is unable to administer payment related to VBP arrangements established with

contracted providers within [redacted] thereby necessitating a less desirable alternative payment mechanism.

Goal 11, Strategy 20 and Tactics 20.a and 20.b are in place and in "Ongoing Effort" status as shown in the Timeline above.

Goal 12: Enable stakeholders to actively monitor provider performance pertaining to VBP Arrangements predicated on provider performance and/or health outcome measures

YCCO staff and contracted providers with whom VBP arrangement exists must be able to actively monitor provider performance and/or health outcome measures upon which VBP arrangements are predicated.

Strategy 21: Ensure that YCCO and contracted providers with whom VBP arrangements are established can measure, report, and actively monitor provider performance across related performance measures

Tactic 21.a.: For performance measures that YCCO is capable of measuring, ensure that requisite data is obtained and stored within appropriate YCCO's data warehouses and that performance is calculated, reported, and monitored in the context of [redacted] or dashboards and reports shared with pertinent YCCO staff and contracted providers with whom related VBP arrangements exist.

Tactic 21.b.: For performance measures that YCCO is incapable of measuring, ensure that contracted providers with whom VBP arrangements are established can calculate and report performance across these measures in a mutually acceptable manner and cadence prior to establishing VBP arrangements predicated on these performance measures.

Timeline for Strategy 21

	2020				2021				2022				2023				2024			
Strategy	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tactic 21.a			X																	
Tactic 21.b			X																	

O Anticipated Start Date

X Anticipated Completion Date

Ongoing Effort

Evaluation of Strategy 21

YCCO will evaluate the successful execution of this strategy by assessing the number of VBP arrangements for which related provider performance measures can't be accurately calculated, reported, and monitored.

Goal 12, Strategy 21 and Tactics 21.a and 21.b are in place and in "Ongoing Effort" status as shown in the Timeline above.

Strategy 22: Ensure that YCCO and contracted providers with whom VBP arrangements are established can measure, report, and monitor related health outcome measures

Tactic 22.a.: For health outcome measures that YCCO is capable of measuring, ensure that requisite data is obtained and stored within appropriate YCCO's data warehouses

and that achievement of these measures is calculated, reported, and monitored in the context of [redacted] or dashboards and reports shared with pertinent YCCO staff and contracted providers with whom related VBP arrangements exist.
Tactic 22.b.: For health outcome measures that YCCO is incapable of measuring, ensure that contracted providers with whom VBP arrangements are established can calculate and report achievement of these measures in a mutually acceptable manner and cadence prior to establishing VBP arrangements predicated on these health outcome measures.

Timeline for Strategy 22

	2020				2021				2022				2023				2024			
Strategy	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tactic 22.a	O					X														
Tactic 22.b	O				X															

O Anticipated Start Date
X Anticipated Completion Date
Ongoing Effort

Evaluation of Strategy 22

YCCO will evaluate the successful execution of this strategy by assessing the number of VBP arrangements for which related health outcome measures can't be accurately calculated, reported, and monitored in a timely and effective manner.

Goal 12, Strategy 22 and Tactics 22.a and 22.b are in place and in "Ongoing Effort" status as shown in the Timeline above.

2022 additions:

YCCO has initiated processes to work closely with [redacted] to ensure that VBP contract arrangements can be administered effectively from a payment/processing perspective as well as a provider VBP metric reporting and collaboration perspective.

Briefly summarize updates to the section above:

There have been no changes to the previous status/efforts as defined…all of these VBP efforts are in maintenance mode, with key YCCO staff working with providers and PHTECH to continuously incorporate necessary updates and improve our ability to communicate status to providers.

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

2021 response:

See Question 11

2022 additions:

Since hiring an Information Systems Director in the fall of 2021, IS efforts have been largely focused on building our IS capabilities, including adding IS staff and implementing infrastructure enhancements to better support YCCO in performing on our mission. That said, in reference to the above section of the March 15, 2021 HIT Roadmap, we have:

- Incorporated the CDPS+ risk score into our database providing for enhanced care management, reporting, and analytics.
- Initiated an effort to enhance our Tableau deployment in order to provide more readily available data and analytics.

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

As mentioned in an earlier response, YCCO is making significant enhancements to our Tableau analytics capabilities, implementing a Tableau Server on the MS Azure cloud. This will allow for deeper, more visible, and meaningful analysis of our VBP program. This is in addition to the reporting available to providers via [redacted] on the [redacted] provider portal.

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

We've not yet encountered any challenges as the HIT we utilize to administer VBP arrangements has satisfied our needs and expectations to date.

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

No changes/updates to our previous response.

20) 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.

2021 response:

As described in the response to 6.a.i. above, YCCO shares information regarding providers' performance across measures pertinent to VBP arrangements in one of two ways:

1. When the measures of relevance are tracked within [redacted], providers for whom these measures pertain are invited and encouraged to monitor their performance through this application.

2. For measures that aren't tracked within [redacted], YCCO uses Jupyter Notebook, SQL queries, Tableau, and Excel to produce and distribute reports on a recurring schedule (e.g. quarterly for most; monthly for some) to pertinent providers.

Over time, the set of measures tracked within [redacted] is expected to align with all measures pertinent to VBP arrangements established with providers thereby eliminating the need for YCCO to produce and distribute separate reports.

As described in the response to Question 11 above, Patient attribution is based on PCP assignments administered by YCCO. PCPs to whom YCCO members are assigned, including those with VBP arrangements, learn of assignments by virtue of viewing and, if desired, downloading an up-to-date PCP roster report available within the [redacted] Provider Portal. In addition, an up-to-date provider roster is available to PCPs engaged in [redacted]

2022 additions:

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

We are maintaining our strategy in the direction of providing all important metrics to providers via [redacted] and [redacted]. YCCO will continue to initiate site visits with providers and encourage/confirm their ability to access [redacted] and A[redacted]

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

No change in our previously stated strategy at this time.

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

No changes in tools intended for delivery of metrics analysis to providers. Although we are enhancing our own internal Tableau environment to better serve/inform internal YCCO staff.

Please note any changes or updates to your strategies since May of 2022.

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

No changes to the previous update.

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

No changes to the previous stated strategy.

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

No changes to the previous stated strategy.

How frequently does your CCO share population health data with providers?

☒ Real-time/continuously
☐ At least monthly
☒ At least quarterly
☐ Less than quarterly
☐ CCO does not share population health data with providers

21) You previously reported the following information about how your CCO <u>uses</u> data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

2021 response:

See response to Question 11

2022 addition:

The most impactful change has been our incorporation of the CDPS+ risk score providing for enhanced care management, reporting, and analytics.

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

No changes to the previous response.

22) You previously reported the following information about how your CCO <u>shares</u> data for population management to identify specific patients requiring intervention, including data on risk stratification and member characteristics that can inform the targeting of interventions to improve outcomes.

As noted in the response to Question 11 above, member specific data intended to inform and enable population health management activities is shared with providers within whom VBP contracts have been established in the context of [redacted]. In addition, YCCO's Care Management team pro-actively communicates with and shared information about members engaged in care / case management via phone, fax, and the [redacted] provider portal.

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

No changes to the previous response.

23) Estimate the percentage of VBP-related performance reporting to providers that is shared through each of the following methods:

Estimated percentage	Reporting method
15%	Excel or other static reports
85%	Online interactive dashboard that providers can configure to view performance reporting for different CCO populations, time periods, etc.
	Shared bidirectional platform (example: Arcadia) that integrates electronic health record data from providers with CCO administrative data.
	Other method(s): Click or tap here to enter text.
[Total percentages should sum to 100%]	

How might this look different for primary care vs. other types of providers (hospital care, behavioral health care, maternity care, oral health care, children's health care)?

No significant differences except for those providers/clinics not engaged in VBP

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

2021 response:

See Question [14]

2022 addition:

No major changes or updates. Although, we continue to work closely with [redacted] and internal YCCO experts to enhance reporting and analytics; and make them available to our providers.

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

No changes/updates to our previous response

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

2021 response:

We've not yet encountered any challenges as the HIT we utilize to administer VBP arrangements has satisfied our needs and expectations to date.

2022 additions:

It probably does not need to be said, but as is true for numerous of our strategies, the COVID-19 pandemic led us to slow some strategies and efforts across our contracted network. We have also been in the process of building our IS capabilities, including adding IS staff and implementing infrastructure enhancements to better support YCCO in performing on our mission. To some degree, the focus and timing on these initiatives have impacted progress as well.

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

Our challenges are likely similar to any other organization – resources to get the work done, and slow/resistance to adopt change.

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

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

Two key components and focus areas that TA would be of benefit are as follows:

1) Assistance in the development and identification of a reliable and viable risk adjustment for social factors platform, similar to CDPS +Rx used for current risk adjustment. Alignment with provider and CCO mechanisms such as risk adjustment is ideal.
2) Assistance in the development of VBPs for prescription drugs, or in the exclusion of pharmacy costs from the CCO VBP calculations. With the ever-growing denominator for evaluation of CCO VBPs, 70% or greater will be a more difficult threshold to meet with the addition of significant program changes such as Behavioral Health Directed Payments and Health Related Social Needs. The costs of prescription drugs remains the most significant care delivery area where VBPs are quite challenging and needing development.

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

In alignment with question 26 above, a review of the CCO 2.0 VBP requirements with consideration for today's landscape would be quite beneficial. The size of the program, the complexities of non-Medicaid contracting, and significant changes in benefit structures continues to generate highly volatile and ever-moving targets for CCOs to achieve.

Optional
These optional questions will help OHA prioritize our interview time.

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

Click or tap here to enter text.

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

Please ensure that the information within the questionnaire is not duplicative of the ever-expanding VBP and PCPCH reporting template that is also submitted by CCOs at the same time. Much of the information on focus areas above is relatively duplicative.

Part II. Oral Interview

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

Purpose

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

Format

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

Interview topics

Question topics will include your CCO's VBP activities and milestones in 2022, any early successes or challenges encountered in this work so far, and how your CCO's plans for future years are taking shape. Questions will cover three primary areas:

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

2) Implementation of VBP models required in 2022 and 2023. These questions will address how your CCO is making decisions about and designing required VBP models. We may ask about factors influencing the design and scale of your PCPCH infrastructure payment model and models to meet the Care Delivery Area requirements. These questions may address your experience designing quality strategies in hospital, maternity, behavioral health, oral health, and children's health VBP arrangements, as well as your progress developing HIT capabilities with providers to implement these VBP arrangements.

3) Promoting health equity through VBP models. These questions will explore how your CCO's work on health equity relates to your VBP efforts. We may ask about your CCO's progress with collecting social needs data; how health equity informs

your VBP planning in specific areas such as maternity care; and whether you have identified opportunities to use VBPs to address other CCO 2.0 priorities or requirements.