AllCare CCO

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.**

AllCare CCO has constituted Provider Planning Committees for each of our VBPs. We currently cover the following care delivery areas with existing VBP's: Primary Care/Pediatrics (children's care); Specialty - OB/GYN (maternal), medical, and surgical subgroupings; Oral Health; and Behavioral Health. The committees consist of a cross-section of network providers/stakeholders as well as AllCare senior leadership, Medical Directors and our VBP team.

As in prior years, the 2021 VBP cycle officially began in the last quarter of 2020. We initiated the cycle by conducting a virtual meeting respectively with each VBP Provider Planning Committee to present AllCare's suggestions and recommendations for changes to the programs for the 2021 program. The presentations by AllCare staff to the committees include a recap of program history, overview of AllCare's strategic priorities, graphic displays of measure level performance results, and the recommendations of changes to the program for the coming year.

Once the committees have formalized their recommendations for the next year, those recommendations are presented to the AllCare Board of Governors for final approval. In addition, progress on VBP measure performance is presented to the AllCare Board of Governors on a quarterly basis. Last, our VBP team works directly with providers on an on-going basis to educate, coach and keep them informed of their progress. AllCare Board of Governors also reviews progress on a quarterly basis to provide feedback and support.

AllCare has developed an evaluation process within the VBP team that consists of reviewing performance of each measure within the program to determine inclusion/exclusion recommendation status for the upcoming year. The criteria used to determine a recommendation for future inclusion are measure relevancy, overall achievement trajectory of existing measures, AllCare CCO strategic priorities, and alignment with OHA, HPQMC, and the Governor's priorities. The VBP team uses the results of these indicators to formulate the recommendations we then present to our VBP Provider Planning Committees.

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

No changes to note.

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

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

☐ CCO did not modify VBP contracts after May 2021 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)
N/A

- ☐ 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).**

Our current VBP programs are upside sharing based on quality performance so withholding of services hasn't been a major concern to date. Having said that, our Health Equity Committee receives a quarterly report of VBP performance by measure that is stratified by race and ethnicity. The committee reviews the report with an eye toward any observed disparities. For example, our ED data indicated that we were experiencing much higher utilization amongst a couple disadvantaged populations. Having observed that, it was decided to hold listening sessions with members from those populations to get a better understanding of the barriers to care that might be driving people to seek care in the ED as opposed to their PCP. Our network providers were then given insight and training on the barriers that had surfaced in the sessions as a response to help better meet the needs of those populations going forward.

In our current environment (upside VBP programs) we have outlined the below as criteria for identifying unintended consequences. As we enter into downside risk programs we will expand our criteria for examining unintended consequences to make sure that services aren't being withheld from certain populations.

Criteria to Determine Unintended Consequences for a Measure

- Cause undue burden for provider offices:
  - Costly technology required
  - Additional staffing required
  - Significant adjustment to current processes and workflows
  - Staff needs additional training or resources to meet measure
- Alienate specific patient population:
  - Offices "firing" or shaming patients that refuse measure qualifying care. (Vaccine hesitancy, non-compliant diabetics, patients who 'no show').
  - Pull focus from other health issues not included in a measure (i.e.: providers making sure diabetics get their A1c but not diabetic eye exam).
- Reducing access for patients outside the measure parameters (well care visits for those older than age 6, dental visits for children vs. adults).

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

Review of the quarterly stratified VBP reports indicated that fewer of our African American members have Primary Care visits compared to the rest of our CCO population. One of our Health Equity sub-committees has taken this on as a project. Some of the interventions they have implemented include: a cultural competency questionnaire for PCPs upon credentialing and re-credentialing, contracting with a

new Family Nurse Practitioner who identifies as African American, panel discussion with members of the community who identify as African American and Hispanic to discuss their experiences in the community and community antiracism trainings.

Language Access has been added as a bonus measure in our Specialty, Dental and Behavioral Health VBPs. AllCare will stratify VBP performance by language spoken to further assist in identifying health disparities for our members with limited English proficiency.

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.]

AllCare provides risk stratified reports to clinics on a quarterly basis. Provider offices are asked to review the information and leverage the reports to help manage their patient population. The reports currently indicate if a member has housing or food insecurity based off results of the latest health risk survey. We will be adding REAL-D information to the risk stratification reports in 2022.

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 <u>one</u> 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 <u>oral health care</u> payments.

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

The VBP program is an incentive program based on quality metrics. Funding of the program is through OHA Quality Pool funds earned by the CCO as well as shared savings generated by the VBP programs. We plan to continue forward with this approach for oral health care moving into 2022. We will review the program annually and make changes to the program (i.e. measures, structure, etc.) as conditions warrant.

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).**

Currently oral health care payments are classified as 2C. Payment is capitated to the Dental Care Organizations. We are contracted with two Dental Care Organizations that provide oral health care for our members. The AllCare VBP measures are focused on preventive dental care, increased access and care for higher caries risk populations (smoking cessation, oral evaluation for diabetic patients and dental exams for children in DHS custody).

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

The oral health care VBP model has been implemented at AllCare since 2015. As stated above, we review the program annually and make changes as necessary.

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

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

The VBP program is an incentive program based on quality metrics. Funding of the program is through OHA Quality Pool funds earned by the CCO as well as shared savings generated by the VBP programs. We plan to continue forward with this approach for children's health care moving into 2022. We will review the program annually and make changes to the program (i.e. measures, structure, etc.) as conditions warrant.

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).

Currently children's health care payments are classified as 4A and 2C. Payment is capitated for most providers but some contracts remain fee-for-service. We are contracted with several pediatric clinics in our service area and many primary care clinics that provide pediatric care for our members as well.

The AllCare VBP measures are focused on ensuring our pediatric members receive necessary vaccinations, well care visits and screening/intervention for depression and substance use.

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

The children's health care VBP has been in place at AllCare since 2014. As stated above, we review the program annually and make changes as necessary

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.

We have initiated discussions with four key hospitals in our service area to move portions of care to a case rate reimbursement model. The areas of focus are emergency room care and maternal/newborn care. Negotiations are in process and contract agreements are expected to be in place by mid-2022. In addition, modifications are being made to the inpatient/outpatient pricing model that is more closely correlated to rate of growth expectations and commitments.

We also have an agreement in place for our members who are clinically ready for discharge but having difficulty finding appropriate placement to remain in hospital care until adequate arrangements are made for post-discharge.

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?

Technical assistance regarding LAN categorization would be helpful.

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

N/A

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

AllCare CCO administers VBP programs in several care delivery areas. Data extracts for each incentive measure that is based on administrative data (claims, eligibility) are generated by querying the core processing system using SQL. The extracts that are created via SQL are exported to Excel and then the files are imported into a reporting template. The reporting template is Excel based and has programmed macros that convert the imported data into a provider level quality report. The quality reports are exported to PDF files and distributed to program participants.

AllCare CCO hosts an EHR platform for a number of the primary care clinics in our service area. The service agreement with the clinics includes support of their required metric reporting. Reporting for incentive measures from the EHR is exported to Excel files and then imported into the reporting template using the same process as described for the administrative data extracts.

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

No changes to note.

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

Population Management: AllCare CCO utilizes a care management platform, HMS' Essette. Essette can import data from outside sources to support population health reporting. In addition, AllCare CCO utilizes Milliman MedInsight for risk stratification, predictive modeling and support for VBP.

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

The Collective Medical platform is being utilized to track ER and Inpatient stays related to substance use disorder. This assists in timely follow up and tracking of outcomes relating to engagement in treatment.

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.

AllCare CCO has a VBP/Population health department headed by the Value Based Payment Manager and supported by Quality Analysts, Health System Analysts and Provider Network Management. This position is supported by the Chief Operations Officer and Director of Provider Contracting and Director of Health Equity. The VBP department interfaces with virtually every department within AllCare CCO including Claims, eHealth Services, Health Information Technology and Clinical Areas. This department regularly interfaces with Providers in supporting their success with VBP and Population Health.

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

The VBP team has been divided into two separate departments; Practice Operations and Data Science. These two departments continue to work closely together and interface with Population Health, Claims, eHealth, Finance, Health Equity and Clinical Areas on a regular basis. This arrangement is supported by the Sr. Director, IPA & Practice Operations, Sr. Director Provider Network and Health Equity and the Chief Financial Officer.

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.

AllCare CCO currently has the capability to generate quality reporting for our VBP arrangements with a frequency of quarterly updates. The current process in place is as described above in the response to HIT Tools for VBP and Population Management.

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,

No changes to note.

b. spread VBP to different care settings, and

No changes to note.

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

AllCare's goal is to streamline reporting so that providers are able to access their performance data more frequently and/or in real-time once the measure programming has been completed.

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.

We began a transition of the data capture for the VBP programs in 2020 to consolidate it under a single platform. In developing the VBP programs over the prior several years we ended up with a situation where the administrative data used in support of the programs was derived from multiple sources. The goal of the consolidation initiative is to house the data

extraction exclusively within our HIT team. With that change we feel we will be better positioned with the resources needed to keep the measure coding up-to-date, and to maintain more reliable support with a higher level of confidence in the accuracy and consistency of the data.

AllCare CCO planned on getting the data extraction consolidation completed in time for 2021 reporting. Progress on that front didn't proceed according to plan and we are now looking at a 2022 timeframe to get that work completed. Once we have all of the programming for the measures transitioned to HIT we will focus on building a reporting module that is directly linked to the measure level data. This enhancement will reduce the amount of manual intervention currently involved in the generation of quality incentive reports. Another desired outcome of the more automated approach in reporting will be a change in frequency of reporting from quarterly to at least monthly, with the ultimate desire to achieve real-time reporting.

Briefly summarize updates to the section above.

The project of transitioning measure programming has been assumed by the newly formed Data Science team. We are on track to transition measure programming by the end of 2022. Some measures have already been transitioned and work continues to be done to complete the project by end of year reporting for 2022.

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

VBP Analytics Staff worked with HIT staff throughout 2020 on the project of coding development for the administrative data-based measures. There are 27 distinct deliverables with this phase of the project, 5 of them have been completed, with partial completion on several others. The combined progress represents about a 25% overall completion rate currently.

With the VBP and HIT teams working closely in tandem on the measure development project we have tightened up the coding on some measures. The expertise HIT has regarding our data capabilities has brought solid recommendations to the table on how the data can be queried to maximize accuracy.

A significant program enhancement in 2020 was setting up gap list distribution to VBP participants through our provider portal. Previously we sent the gap lists out via secure email in PDF files. By using the portal, the risk of sending member level data to the wrong clinic is eliminated. Also, the data is stored in a known location so the information is more easily found by clinic staff at time of need.

AllCare began an EHR transition from PrimeSuite to AllScripts in 2020. Data migration from the old to new platform didn't occur successfully. Our EHR reporting specialist has developed a process to merge the member level reporting from the two systems to produce an aggregate report for the full measurement year. This requires manual intervention but with several clinics yet to begin the transition to AllScripts this process will allow us to continue reporting for those clinics during the transition.

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

As stated above, the Data Science team has taken over the responsibility of transitioning programming for the measures. The EHR reporting specialist was able to successfully merge year-end reporting but has sought assistance from the VBP team to make data extraction and reporting a less manual intervention.

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

Our biggest challenge has been the fragmentation of our administrative data sets across multiple platforms. As described above we have undertaken a project with HIT to consolidate the data extraction under a single point of contact.

A couple challenges surfaced during our work with HIT in 2020 that have slowed down the project:

- HIT developers have good coding skillsets but aren't familiar with the business end of the measures. This knowledge gap can lead to delays due to multiple iterations of development and quality assurance required to get to an accurate result.
- HIT resources are a finite quantity and the business demands are ever increasing for their services. Thus, higher priority projects took resources away from our project at times limiting the ability to stay on track with the project.
- Response to the pandemic temporarily derailed important feedback between developers, providers and VBP staff. Resources were re-deployed to support COVID guidelines.
- Aggressive timelines related tin Interoperability Final Rules proved to be significant HIT resource consumer.

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

Due to the challenges listed above, the decision was made to transition the project to the Data Science department. It is challenging to make strategic decisions based on OHA measure performance data that is delayed more than four months. We have worked to create internal programming that will give

us more real-time data but it has been difficult to recreate measure results for the OHA incentive measures without access to all measure value sets or measure programming.

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.**

AllCare CCO provides quarterly reporting to the contracted providers that are participating in our VBP programs. Quality reports are produced that reflect measurement year-to-date progress relative to established targets. Quality reports are distributed via secure email. Gap lists are also distributed on a quarterly basis that provide member level detail on numerator compliance for each of the measures. Gap lists are loaded to the provider portal for access.

AllCare CCO has transitioned to an attribution methodology that is based on member assignment as of the end of the reporting period. This applies for the programs where member assignment occurs – Primary Care, Pediatrics, Oral Health. For VBP programs where provider assignment doesn't occur (i.e. Behavioral Health, Specialty – maternity, medical, surgical) attribution is based on the provider who renders services to a member.

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.

The gap lists that are now available on the provider portal provide real-time performance results for the offices to access and act upon.

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

No changes to note.

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

No changes to note.

18) 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.

In 2020, AllCare CCO began to produce and distribute to our primary care network a risk stratification report. With the disruption of normal operations in the industry due to Covid-19 the impact and value of that data was minimized. We are gathering feedback from the provider community on their perceived utility of the risk stratification report and will develop an outreach campaign designed to address the themes that emerge from that feedback.

The risk stratification data reported to the primary care network has also been shared with AllCare CCO's Care Coordination department. Targeted reporting of specific patient populations (e.g. non-compliant A1c patients) is referred to Care Coordination with their associated risk stratification data to help them identify those patients that need priority intervention.

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

No changes to note.

19) 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.

AllCare CCO provides rosters of patients where VBP measures are identified as a gap to participating providers. This information helps them target patient outreach to achieve better

VBP results and to increase the number of patients getting those targeted preventive services. Gap lists are housed on the provider portal and reflect current member level compliance status by measure.

Risk Stratification reports have been sent via secure email during 2020 on a quarterly basis to our primary care providers. Beginning with 2021 reporting we are planning on uploading these reports to our provider portal. This enhancement will improve the timing of delivery and provide for a consistent home for the data.

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

The Risk Stratification reports continued to be distributed to providers via secure email in 2021. We will revisit the goal of making them available via the provider portal in 2022.

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

AllCare CCO now is able to upload gap list files to the provider portal enabling the clinics to access more current information than the prior process in place that involved emailing secure files on a quarterly basis.

AllCare CCO has taken the lead in supporting EHR reporting for those clinics that are transitioning from our hosted platforms. This eases the burden on those clinics in producing credible reporting across two different EHR platforms. We also have representation on the CQM technical assistance program and will cascade information from that forum out to our contracted entities.

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

No changes to note.

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

The most significant challenge we're facing is in developing an efficient methodology to bridge CQM reporting across two platforms as we transition EHR systems for the clinics we host and support EHR services. Clinics are migrating platforms throughout the year and the

patient history is not transferring properly. Thus, reporting is being pulled from both systems and then we merge that data that requires more manual effort that is optimal.

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

The VBP team is assessing ways to alleviate the burden of reporting across two platforms and to make data extraction and reporting a less manual process.

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

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

N/A

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

N/A

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.